ZANZIBAR

On November 1st I flew to Zanzibar and was met by Dr. A. C. Howard, the D.M.S. In the afternoon I visited the Leprosy Settlement at Walezo. There were 59 cases, 30 of which were lepromatous. Sulphone therapy was in general use, but there were several cases which would benefit by intradermal injections of hydnocarpus oil. This would hasten the resolution of residual lesions.

The institution near Zanzibar is divided into three sections, (1) leprosy, (2) tuberculosis, and (3) a pauper home for destitute and/or crippled persons. The tuberculosis ward is large and airy and could well be divided and used, in addition, as a hospital ward for patients in the leprosy sector, if they became acutely ill or needed temporary medical or surgical treatment. There are also quite a number of arrested and deformed cases of leprosy. These should be transferred to the sector for cripples, if their relatives will not take them back.

I had several conversations with the Director of Medical Services and Mr. Bromley, the BELRA worker on Pemba Island, and our talk and suggestions can be summarised as follows.

Dr. Ross Innes' overall estimate of the incidence of leprosy is 5 per thousand, giving a total number of cases of 600 in Pemba and 600 in Zanzibar, and is based on a series of sample surveys in which approximately 22,000 persons in Pemba and 10,700 in Zanzibar were examined. It might, however, be found that, as in India,

so here, leprosy is extremely sporadic in its distribution, and that a number of areas have a very much lower incidence than 5.5 per thousand, and therefore the total figure may be somewhat lower.

Mr. Harry Bromley's first task, in co-operation with the Medical Department, should be gradually to find out from where all known cases of leprosy come. The chief aim in sending him to Zanzibar is to assist in controlling leprosy, first in Pemba and then in Zanzibar Island, in the shortest possible period. Therapy, of course, will form a powerful weapon in such a task. As detailed and intensive surveys are completed in Pemba, the pattern of leprosy will gradually be revealed. All open and definitely active cases should not only be treated, but should be in some way segregated. The preference would be isolation at the Leprosy Institution. If this is impracticable, then partial isolation (night segregation) should be considered. Some discrimination should be used with regard to treatment. In view of the fact that control is the primary objective, time should not be spent on the organisation of treatment for all and sundry—this is the task of the Medical Services in relation to disease in general—but every open case and every active case should receive regular treatment, and active cases should be sent to leprosy institutions. If, however, they are within reach of a dispensary and able, if infective, to be isolated from night contact with children, arrangements could be made for local treatment. In areas where the problem is insignificant, and where there are no infective cases, then there is no need to organise a special campaign. The system would ultimately be somewhat similar to that established in Ceylon—viz—

1. Isolation—institutional or village—of all open cases.
2. Follow-up and observation of all contacts, paroled cases, and known non-infective cases. The Health Inspectors could include this in their routine sanitary inspections.
3. Treatment of all active cases either (a) at a leprosy institution, or (b) as outpatients, at the Government hospital or dispensary.
4. The Government hospital should be prepared, where necessary, and when an acute medical or surgical condition supervenes in the course of treatment, to admit patients temporarily to the headquarters hospital.

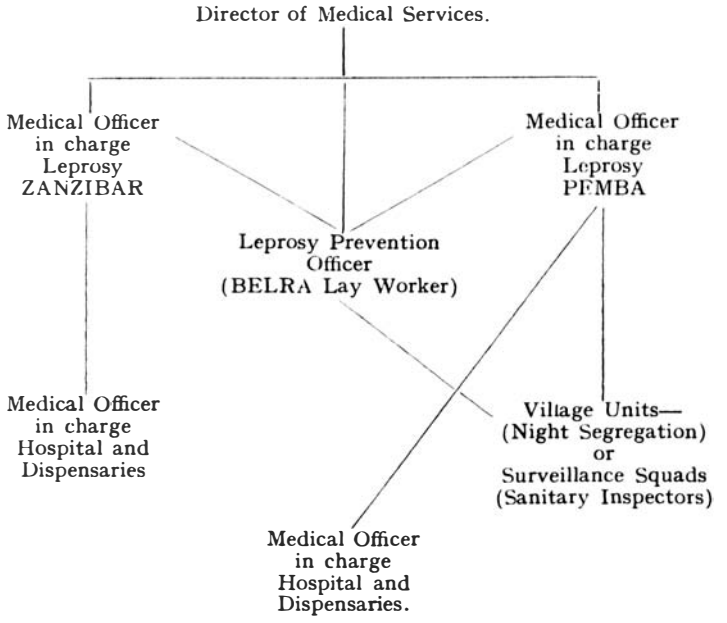
Where a patient either will not, or cannot, isolate himself satisfactorily, and is living with children, then the regulations for infectious diseases should be applied.

I believe, if a well thought out and carefully planned control

scheme, with adequate surveillance and careful supervision of treatment, along with observation of contacts, were organised, it should so affect the leprosy incidence in Zanzibar and Pemba that, without undue strain on the resources of the islands, leprosy would come under control within a relatively short time. Intelligent prevention, however, must be combined with therapy. In this connection all Health Inspectors should receive, on their course, lectures on the control and prevention of leprosy. While there is a BELRA worker on the spot to cover the period of organisation of the control scheme, opportunity should be taken to recruit intelligent Zanzibar nationals, so that they can assist the authorities; and the Government should ulimately assume the responsibility for their payment and allowances.

The following is a diagramatic outline of the system of control envisaged for Zanzibar and Pemba.

Outline of System of Control envisaged for Zanzibar and Pemba.



(Arrows indicate to whom the individual Officer is responsible.)

Medical Officers in charge of Government Hospitals and Dispensaries are definitely responsible to Medical Headquarters, but would work in co-operation with the Medical Officer in charge of the Leprosy Hospital, and, particularly in Pemba, have the assistance of the Leprosy Preventive Officer.