NYASALAND

I left Dar-es-Salaam on 26th November and arrived at Blantyre about noon. I was met by Dr. Park, Principal Medical Officer, and proceded almost at once to Cholo, where we stayed with the District Medical Officer, who accompanied us the next day to Malamulu, a leprosy hospital of the Seventh Day Adventist Mission. The institution is well organised, but detailed medical supervision is difficult to maintain, as the general hospital work is very exacting.

The leprosy institution is extremely popular, patients coming from all over Nyasaland, and also from Northern Rhodesia. The routine treatment is oral dapsone, which has recently been changed to bi-weekly from daily dosages. Owing to the daily regimen there was considerable difficulty, and six cases of psychosis were encountered. In this connection, as I have mentioned in my Tanganyika report, it would be wise to have an alternative treatment, which I believe should be parenteral sulphetrone, which is non-toxic, and nearly as economical as dapsone, although it has the disadvantage of having to be given by subcutaneous or intramuscular injections. There appeared to be a relatively high percentage of lepromatous cases, but it is probably erroneous to conclude that leprosy may be a serious disease in the area, as patients are drawn from both Nyasaland and Northern Rhodesia. Again, there were a considerable number of healed and quiescent cases. The laboratory was well organised, but I had the impression that the technician needed further experience, for it was difficult to accept the results of the examination. The training of technicians has become of the greatest importance, for with sulphone therapy clinical results are very deceptive. It is well known that the marked clinical improvement so often seen is by no means commensurate with bacteriological improvement.

On November 28th I left Zomba with Dr. Watson en route for Kocira. We called first at Likwenu, a station of the U.M.C.A., and then at Utale, a Roman Catholic Mission station. Dr. Maclean is in charge of the U.M.C.A. medical work and lives at Fort Johnston. He visits Likwenu about four times a year. One sister is in charge of 160 patients. There was considerable difficulty with DDS as daily treatment had been given. It was suggested that twice weekly treatment should be given. There was a good microscope, but with the difficulty of supervision and lack of staff, it was difficult to keep this work up to standard. There was a large number of outpatients, but these were given hydnocarpus oil injections. With sulphone therapy now reasonably cheap, there seems no reason for withholding it. If there is difficulty in controlling oral DDS treatment, it would appear that hydnocarpus treatment should be replaced by parenteral sulphetrone (50% aqueous solution) subcutaneously. As the institution is organised for the giving of injections, it should be easy to change over to sulphetrone injections. On the other hand, provided the tablets are given under strict control, oral therapy can be given; if, however, there is likely to be a misuse of tablets, then injections are preferable. The difference in price per annum is so small that I consider the safer sulphetrone granules given by injection are more suitable for out-

patient treatment. Further, I am of opinion that patients are much more likely to maintain regular attendance when given injections than when oral therapy is the method of choice. I examined all the cases and found quite a large number were arrested or inactive cases. I was interested in the fact that over 30% of the cases were lepromatous, among which there were a fair proportion of advanced reacting cases. As these cases came from the locality, it would appear the disease may be serious and possibly on the increase. It would be interesting to do an intensive survey in this area, in order to ascertain the state of the epidemic of leprosy in this district.

From Likwenu we went on to Utale. This institution is rather inaccessible, being 14 miles from the main road and approached only by a bush track. During the rains the mission station is almost completely cut off from the main road. The leprosy institution is well conducted, clean and neat, and houses are excellent. Oral DDS was given, but the stock was temporarily exhausted. This, perhaps, was a blessing in disguise, as daily dosages were being given, and the Sisters were somewhat alarmed because of the number of serious reactions and occasional toxic signs. I was struck by a number of very severe lepromatous cases. There were several cases of acute laryngeal leprosy, which is, apparently, relatively rare in East and Central Africa, and one case of acute reacting tuberculoid leprosy. The tuberculoid leprosy here is mostly of rather a chronic, torpid, type, and the reacting type of case frequently seen in India is much less common. Medical supervision in this institution is badly needed, and I felt that parenteral sulphetrone would be safer where there are so many advanced lepromatous cases, and where there is no medical officer in charge, and medical supervision is limited. There was no microscope in the institution, and sulphone therapy was given according to rule of thumb.

A visit to this institution and to Likwenu emphasises the need for closer medical supervision. It is just here where a visiting leprologist would be of considerable help, and I shall be making recommendations in this connection at the close of this report.

From Utale we proceeded to Dedza, where we stayed with Dr. Whitfield, the District Medical Officer Despite heavy rain during the night Dr. Whitfield, accompanied by Mrs. Whitfield, took me down the escarpment to visit the Roman Catholic Leprosy Institution of Mua. This institution is near the Lake shore, and in an area of relatively high leprosy incidence, and is visited regularly by the Medical Officer at Dedza. In view of the heavy rain and threatening further heavy showers, our stay at Mua Mission had to be curtailed. In addition to the leprosy settlement there is general

work, with a large outpatient department. The leprosy settlemen was neat and tidy and DDS therapy was being used in smaller, and, therefore, safer dosages. The patients are housed both in well built brick houses and in mud and wattle huts. The latter seem to be reserved for married couples. Full advantage of the ground does not seem to be taken, for while patients grow food on individual shambas there is no communal farming, and there is a tendency to increase money crops, e.g. cotton, to the detriment of food crops. When finances are limited the decision as to the best division of ground between these crops is always difficult. It would be well, I believe, to introduce communal farming and insist on a number of compulsory hours of work in the week, so that those who are disabled and cannot farm are provided with food from settlement shambas.

In many institutions in East and Central Africa the number of healthy children is high. I was surprised to find so many children, in whom there is no sign of leprosy, in this settlement. I was told separation was impossible. This is a serious problem, and if marriage is allowed facilities for accommodating the babies in a creche should be provided. I have already laid down directives with reference to marriage and healthy children in settlements and segregation units.

I left Dedza on December 1st at about 7.45 a.m. and stopped for a short time at Lilongwe, where I met Dr. Mitchell and Dr. Eberlie, and then proceeded to Kocira, the site of the new leprosy institution now being organised and built by a B.E.L.R.A. worker, Mr. Coffin. The site chosen for the Government Leprosy Institution is an excellent one, and was selected largely because it was the only one available in the Central Province that provided sufficient land for the accommodation of 1,000 patients, as recommended by Dr. Ross Innes. The drawback that this institution is some distance away from the area of high endemicity of leprosy, is somewhat counterbalanced by the fact that there is plenty of evidence to show that if an instiution is well run leprosy patients will travel great distances to secure accommodation and treatment. Another disadvantage is that, when Federation is completed, then all the leprosy institutions will be concentrated in the North. There will be three institutions within 50 miles of Kocira— Mwami and Nsadzu in N. Rhodesia, near Fort Jameson, and Kocira in Nyasaland—and only one institution in the South, Malamulo, and one institution, Mua, near the Lake shore. Considerable interest is being taken in this new institution at Kocira. There is ample land available, and once staff has been recruited, and the patients admitted, there are good prospects for its future development.

While at Kocira I took the opportunity to visit Mwami, the Seventh Day Adventist institution near Fort Jameson, in Northern Rhodesia. I returned from Kocira on December 2nd, and stopped the night at Lilongwe with Dr. Eberlie, whom I found interested in leprosy. The next morning I visited the African hospital and saw two cases of leprosy and demonstrated staining technique to the laboratory assistant. I arrived back at Zomba on the evening of December 3rd.

On December 4th I spent a considerable amount of time discussing the leprosy problem as it applies to the Protectorate of Nyasaland, and Dr. Mackenzie was good enough to give me the whole morning for these discussions. We went over a number of matters such as organisation of institutions, treatment, outpatient work, criteria of discharge, etc.

Nyasaland has recently had the good fortune of a legacy of £250,000. The funds available to the Brown Memorial Trust total approximately £250,000, of which a proportion only may be disbursed initially in capital grants, the remainder of the sum is being invested and the income used by the Trust. While it has not been decided what sum will be given to Kocira, the amount will be substantial. It is accepted that, leprosy being one of the endemic diseases of the country, it is the duty of the State to organise measures for the treatment and prevention of leprosy, giving that amount of attention to the subject in proportion to its seriousness as one of the endemic diseases of the country. Special funds, however, should be used with two objectives in mind. The use of these funds should (1) add to our sum total knowledge of the disease, and (2) hasten the day when leprosy is brought under control.

An urgent necessity in Nyasaland is an adequate appraisal of the situation and a plan of campaign, with the new Kocira Institution as the centre from which the whole campaign can be directed. In a short visit of fourteen days it is not possible to lay down directives for the development of a comprehensive leprosy campaign. There is no question that it is essential to appoint one officer to act as Leprosy Control Officer, through whom all plans for the development and control of leprosy should pass. It is difficult to secure an officer of sufficient experience, and, therefore, there seem to be three possible methods of approach.

1. Secure a local medical officer, who is interested in leprosy,
2. Give him the necessary training.
3. Ask him to take over Kocira Leprosy Institution, and gradually develop the Leprosy Campaign.

In this connection, the matter of training is always difficult. As an initial step W.H.O. or some other organisation might be asked to send out an expert for 2—3 months, whose main work would be to give a preliminary training to such a medical officer as suggested, and to lay down the broad principles of leprosy control. After such a preliminary training the officer who has been appointed as Specialist Officer for Nyasaland might be stationed at Kocira and develop, gradually, the Leprosy Campaign for the whole of the Protectorate. At a later date, when this officer has gained special experience, he might be sent to India, and elsewhere, so that he could gain an insight into the problems of the disease in other countries. If an officer were appointed, it seems to me better to follow the example of Northern Rhodesia, and nominate a senior officer in the Service. There are, unfortunately, as far as I know at present, no leprologists available, and in this case it would appear to me better to ask for volunteers from senior officers in the Medical Department, and appoint a Specialist (Leprologist) from among these, unless a Specialist with previous leprosy experience can be recruited. If this were done the Officer would have two favourable qualifications. Firstly, he would have the seniority necessary for such an appointment, and, secondly, he would have considerable experience of the people and country. The Northern Rhodesia Government have appointed as Leprologist-designate, an individual, who is of the Principal Medical Officer grade.

In view of the possibility of the Central African Federation finally eventuating, it might be well to bear in mind that it should not be impossible for a leprologist to be able to advise both Territories—viz. Nyasaland and Northern Rhodesia. The fact remains, however, that until a Leprosy Service is organised in this Protectorate the development of an adequate campaign will be delayed, and the day when leprosy comes under control indefinitely postponed. Today, when so much can be done for the leprosy patient, not only from the point of view of specific treatment, but to assist in his rehabilitation as a useful citizen, it behoves the medical profession, and particularly the Administration, to place leprosy in its proper perspective in relation to its importance as an endemic disease. The time for an advance in controlling this disease seems to be particularly ripe when one realises the publicity and interest the recent bequest of £250,000 has aroused.

I would like to express my deep sense of appreciation of the interest and support of the Director of Medical Services and the whole Medical Service in my recent visit, for I was enabled to see a great deal of the work despite the shortness of my visit.