REPORTS

Bulletin Médical de L'Afrique Occidentale Francaise Janvier, 1954.
Tasks and Problems of Public Health in French West Africa.

This special number includes a section of four pages dealing with leprosy work, of which the following is an abbreviated translation:—

The creation of a Central Leprosy Service dates back to November, 1931, when the new Service was formed and placed under the direction of a special physician, with headquarters at Bamako in an institution built for the purpose. The development of anti-leprosy work in French West Africa as a whole, however, was for many years handicapped by administrative difficulties, and the Service remained a research centre, with limited activities outside. In 1945 the arrangement was revised and the activities of the Leprosy Service were incorporated into the Service d'Hygiène Mobile and its activities greatly extended.

The anti-leprosy campaign in French West Africa relies principally upon the detection of leprosy cases and their treatment. Segregation has been abandoned as ineffective and legally indefensible. Cases of leprosy are admitted to leprosaria but they are being transformed slowly to true health institutes, and the patients, although still maintained under certain discipline, can leave the leprosaria whenever they wish. This liberty permitted to those with leprosy with obvious lesions, has aroused in the larger towns a reaction of European opinion, which still believes in the isolation for life of those suffering from leprosy. In fact, the isolation of those with leprosy can only be applied to those with active infectious leprosy, as laid down by law; it can also be justified for those who have become so disabled that they cannot support themselves.

All the leprosaria carry on two main functions:—(1) the function of a hospital for the treatment and isolation of active infectious cases, and (2) the function of an asylum for patients who have become disabled. Whilst most of the leprosaria of the Federation are forced to refuse patients admission because of lack of room, in certain large towns, such as Dakar, there is difficulty in getting the patients into the institutions, partly because they can maintain themselves by begging. Here again, ill-informed public opinion has expressed itself.

The detection of cases. This is carried out by survey units. In certain areas the whole population is examined every year, in other areas less frequently. In December, 1952, the number of cases of leprosy recorded as living in French West Africa was 135,000, but the Mobile Health Service does not cover the whole territory, and the total is estimated at 250,000 in a population of 8 million. By contrast, in L.A.M., with 9 million population, the number of leprosy cases recorded was only 23,000. This difference is attributed partly to the Mobile Service method of work in French West Africa, whereas in L.A.M. the patients detected are only those who report themselves spontaneously.

Treatment. In 1952 there were 36 leprosaria, with 1,700 patients. The vast bulk of the patients are dealt with in sub-centres, which in 1952 numbered 400, where the patients attend once a week. Between 1946 and 1949 chaulmoogra oil was the main medicament used. Since 1949, sulphone treatment has been used on a small but increasing scale, and recently the introduction of treatment by injections of D.D.S. in oil, allowing treatment at long intervals, has made it possible to extend the use of sulphone treatment. In 1952, of the 60,000 patients under treatment, 10,000 received sulphone and 50,000 received chaulmoogra oil. In 1953 the use of sulphone was greatly extended, and 1954 should see sulphone treatment extended to 40,000 patients.

Leprosy in Netherlands New Guinea. South Pacific Commission. Technical Paper. No. 56.

Leprosy in the Trust Territory of the Pacific Islands. South Pacific Commission. Technical Paper. No. 57.

These two reports were prepared for the South Pacific Commission by Dr. Norman Sloan, who was appointed Leprologist to the Commission to study and advise with regard to leprosy problems in their area. Dr. Sloan spent 6 months (May-Oct. 1952) in the

Netherlands New Guinea and 3 months (Dec., 1952-March, 1953) touring the Trust Territory of the Pacific Islands. Conditions in these two areas were quite different, but it is interesting comparing the leprosy problems found in each.

Dutch New Guinea is a large land mass with a few outlying islands with an area of 150,000 square miles (3 times the size of England), whereas the Pacific Islands have a land area of 687 sq. miles spread over 3 million sq. miles. The population of Dutch New Guinea is about one million (6 per sq. mile) whereas that of the islands is 55,000 (80 per sq. mile). In the administered areas of Dutch New Guinea the people who live on the coast or the islands dwell closely crowded together in insanitary conditions, which tend to the spread of infectious diseases. The vast interior was not visited owing to the difficulty in transport. Malaria, tuberculosis, yaws, filariasis and worms are very prevalent, and infant mortality is appallingly high in the first two years of life, being 40-50%. The staple diet is sago. In the Pacific Islands, on the other hand, the islands are small, scattered and relatively healthy. Malaria, yaws and filariasis are uncommon, though tuberculosis is on the increase. Infant mortality is not mentioned and is probably not a problem. Diet is varied and adequate.

Owing to the difficulty in transport, only a few places where leprosy was known to be prevalent were visited in Dutch New Guinea, so that only 16,882 persons were examined in 6 months, and amongst these 525 cases of leprosy were found. Probably a large number of cases were not seen.

In the Pacific Islands the small population of each island makes it probable that most of the leprosy cases are known. This makes any comparison between the two regions difficult.

In Dutch New Guinea, of the 525 cases, 300 were benign (i.e. tuberculoid or indeterminate) and 225 lepromatous. Males 285. Females 240. Children under 15 years, 138 (one-quarter of the total).

In the Pacific Islands. of the 223 cases, 175 were benign and 48 lepromatous. Males 137. Females 86. Children under 15 years 20 (one-tenth of total).

In Dutch New Guinea the leprosy problem is serious, and in some areas reaches alarming proportions, e.g. in the Wandammen area on the north coast 221 cases were found amongst 3,296 people examined. A prompt and adequate control programme is therefore recommended with the appointment of a full-time leprosy officer, central leprosarium and four leprosy villages.

In the Pacific Islands the small number of lepromatous cases, and of infected children is very encouraging. Leprosy in the Trust

Area is relatively mild, and the people value treatment and are anxious to receive it, so that there are probably only very few unknown cases. G. O. TEICHMAN.

East African Interterritorial Leprologist. Annual Report, 1953.

In this report the promising developments of antileprosy work in the territories of Uganda, Kenya and Tanganyika are outlined, including the work of Dr. J. A. K. Brown in carrying out surveys and setting up rural control work in Uganda, and the growth of local government leprosaria in various regions of East Africa.

The project of the East African Leprosy Research Centre is outlined, and the early phases of its development are described. In this project the British Empire Leprosy Relief Associaion, the East African High Commission and the Colonial Medical Research Committee are co-operating. The centre is to be developed at the new and growing leprosarium at Itesio, in Kenya, and the building programme is now in progress. The development of work in Uganda is described as follows:—

> "What has been achieved in Uganda is a system of surveys and control based on the people themselves. Leprosaria are not considered outmoded, but are preserved and supported, but a strong supplementary emphasis has been put on rural control of the disease. In propaganda amongst the people, emphasis is placed on county and parish housing of detected cases of leprosy. The tribal authorities are asked to build the re-housing units of detected cases away from other houses, and county or parish treatment centres are built. 'We have the medicine; you get the people organised to receive it.' This is one of the slogans of the campaign, of which the aim is to group the patients reasonably near their homes and near dispensaries, so there is segregation for most of the time and treatment can be given regularly. Dr. Kinnear Brown finds the response of the people good, and considerable progress in the scheme has been made in 1953."

The report contains an account of the International Leprosy Congress in Madrid.

The transfer of Dr. Wheate from the work at Kumi, in Uganda, to undertake work in Tanganyika is recorded. He is now in charge at Makete leprosarium.

A donation of £2,000 from the Mission to Lepers to Makete leprosarium is gratefully acknowledged.

The value of the visit of Dr. R. G. Cochrane, Medical Secretary of the British Empire Leprosy Relief Association, to East Africa is emphasised, and the East African number of the *Leprosy Review* which he published.

The building up of the leprosarium at Itesio is described, and the valuable work of various missions and individuals in leprosy work in Tanganyika is mentioned.