NOT FOR PUBLICATION

INSTITUTE OF CURRENT WORLD AFFAIRS

JBG-52
East Africa High Commission
(7) The Interterritorial Leprologist

Washington, D.C.
August 27, 1954

Mr. Walter S. Rogers
Institute of Current World Affairs
522 Fifth Avenue
New York 36, New York

Dear Mr. Rogers:

Prior to World War II the leprosy problem of East Africa had been considered by the Colonial Office and the territorial Directors of Medical Services. Dr. E. Muir, C.I.E., C.M.G., a notable leprologist, advised the institution of a post of resident leprologist. A leprologist who had recently completed a survey in the British Solomon Islands was asked by the Secretary of State to accept the post, but the war held up the project. In 1947 the request was repeated and the same leprologist was appointed, arriving in Nairobi towards the end of June 1947 after a stopover in Nigeria to observe developments there. The Directors of Medical Services appeared to be the prime movers of the project. The British Empire Leprosy Relief Association (BELRA) took an interest and contributed £350 per year towards its finance.

The High Commission assumed administrative responsibility for the Interterritorial Leprologist on 1 January 1950.

Administered by the High Commission through the executive prerogative of the Administrator, the Interterritorial Leprologist is a one man unit. The Leprologist has only a driver to accompany him on tours. A laboratory and an office are made available by the Director of the Bureau of Research in Medicine and Hygiene.

The expenditures of the Leprosy Specialist in 1950 were £2,904. There was no C.D.&W. Scheme providing for this unit, and apparently all funds were provided by the equal contributions of Kenya, Uganda and Tanganyika (£932 each in 1950) and by a smaller contribution from the British Empire Leprosy Relief Association.

The fact finding and remedial work of the Interterritorial Leprologist is carried on for the three East African territories, Zanzibar, Northern Rhodesia and Nyasaland. Efforts through 1951 were mainly directed at securing better information regarding prevalence of the disease through travel and survey. First, all leprosaria in East Africa were visited, and during 1947-1950 surveys were rounded for these territories. In 1950 and 1951 further surveys were made in Zanzibar, Pemba, Northern Rhodesia, and Nyasaland, the Leprologist being "on loan" to these territories by the High Commission during these visits.

By the end of 1951 454,284 persons were reported to have been examined, 394,632 from East Africa. The total number of leprosy cases diagnosed were 7,072, of which 6,276 were in East Africa. Leprosy incidences were

were reported as 17.8 per 1,000 in Uganda, 10.2 in Kenya, 18.1 in Tanganyika, 3.9 in Zanzibar, and 5.5 in Pemba. East Africa as a whole was assessed as having 15.9 cases per thousand native population, Nyasaland 14.0 and Northern Rhodesia 12.6. Total estimated cases for East Africa was 216,000 of whom only about 7,000 were under care in leprosaria, while of 50,000 cases in Northern Rhodesia some 2,500 were under care. There were 18 leprosaria in East Africa. No territory, with the possible exception of Uganda, was found to have a first class, properly staffed leprosarium adequate to care for 1,000 patients. The large number of untreated cases and the inadequate capacities of leprosaria were reported to the Medical Departments.

Though only five percent of the cases encountered during the surveys were physically unfit for work, the social ostracism resulting tended to deny infected persons any opportunity to produce, with inordinate economic effects. The social roots of leprosy were evident in a higher incidence in areas of crowded housing, with poor ventilation, with high atmospheric humidity seeming to facilitate transmission of the disease.

Beyond the execution of the surveys the Leprologist was active in obtaining supplies of new drugs and in assisting in their trials in various localities. All governments were said to have responded to his advice to supply drugs free of charge to all agencies capable of administering them. The sulphone drugs used in East Africa have given good results, working a somewhat higher cure rate on the natives, who seem to tolerate them better than patients in other parts of the world. Tuberculoid cases, proportionally higher in East Africa than elsewhere, tend to be cured more often. By the end of 1951, with 6,000 patients under sulphone treatment, arrest of the disease was reported at 50 to 80 percent. These drugs, with fewer toxic reactions in East Africa, were assessed capable of shortening and limiting the disease and were concluded to be important in any scheme of control. In the course of the surveys and visits to leprosaria and other sites of treatment the Interterritorial Leprologist gave advice on treatment and control.

Completion of the surveys in 1951 provided a basis for advice regarding plans for more specific activities. The next step suggested by the Leprologist involved more detailed research into the use of new drugs (therapeutics and biochemistry of the new drug compounds) and also intensive investigation into the pathology, bacteriology and biochemistry of the disease. For such research a small research institute should be attached to a leprosarium. In 1951 on the initiative of BELRA the proposal was made that East Africa should have a Research Centre for Leprosy financed by BELRA and the East African governments. The East African Standing Committee for Medical Research approved the scheme in 1952 and the High Commission then sought the approval of the territorial governments. At the beginning of 1953 funds had been assured for the Centre but a site had not been chosen.

Another proposal put forward was for a statistical survey in collaboration with the East African Meteorological Service to investigate suspected correlation between leprosy prevalence and morbidity and the climatic quality of high atmospheric humidity.

Conclusions of the survey were that no territory is attacking the problem on a scale commensurate with its importance. By use of drugs and of concentration of the more communicable cases into leprosaria the disease should be successfully reduced within a decade, and complete control would be entirely feasible.

Recommendations by the Interterritorial Leprologist included several measures. Existing leprosaria should be expanded to the more economical 1,000 patient size. A new model leprosarium should be put up in each territory, at an estimated cost of £100,000 each, with the financing problem suggested handled by contributions by Government, missions, Red Cross, commercial firms, and the public. The Leprologist made a particular appeal to the Tanganyika Red Cross. Related needs were stated as a territorial leprologist for each territory, continued free supply of new drugs to all competent dispensaries, the investigation of regional or tribal schemes of control, assistance to medical missions from public funds.

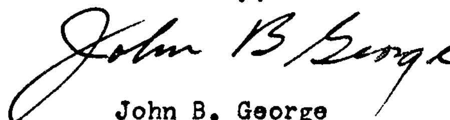
By the end of 1951 Uganda had recruited a leprologist who carried out a further survey in Uganda. The Kenya Government in 1952 had begun construction of a £50,000 modern leprosarium at Itesio in Nyanza Province. Patients were admitted in 1952 and a full-time medical officer assumed his duties early in 1953. In Tanganyika the Red Cross was adding substantial financial aid to that of Government for the provision of a central leprosarium. Difficulties in regard to site selection and other matters had prevented the construction from beginning, but in 1952 a Red Cross hospital was going up at Makete and several other leprosaria were being built or improved during the year.

Besides the cooperative efforts with medical authorities in the three territories and the role of coordination among various leprosy workers, the Leprologist has very close relations with the British Empire Leprosy Relief Association, whose Executive Committee is kept informed of efforts in East Africa. The General Secretary of BELRA visited East Africa in 1951, its Medical Secretary visited the area in 1952, and the Leprologist attended a BELRA sponsored conference on leprosy in London in 1951. A few trained lay workers are supplied, and their salaries - reimbursed in some instances by the governments - are paid by the Association. Financial help also extends to the construction of buildings.

The Director of Medical Services of Uganda, spaeking in Legislative Council in December 1952, opposed the expenditure of £2,000,000 for the eradication of leprosy in East Africa in 10 years (the estimate of an unnamed expert). He stated that of some 80,000 leprosy cases in Uganda, about 95 percent did not even know they were infected, with the remainder incapacitated in varying degrees. Far fewer were incapacitated by leprosy than by other diseases and there was no reason why the money should be spent on leprosy rather than against malaria or venereal diseases. He expressed the view that mention of the disease in the Bible and other religious writings had led to an emotional outlook on leprosy which tends to distort the economic importance of the affliction.[1]

An unofficial Uganda representative in Central Legislative Assembly, Mr. Fraser, said: "It would cost about £2,000,000 and take about 10 years to eradicate leprosy completely from the East African territories. Could we not make this our first priority?"[2]

Sincerely,



John B. George

P.S.

Footnotes

1. Uganda Herald, December 23, 1952
2. East Africa and Rhodesia, March 5, 1953, p. 872.

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