

Leprosy in Madras State, 1952–1957: A Historical and Public Health Study

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Abstract: Leprosy, or Hansen's disease, has a long history in South Asia and has been shaped not only by its medical consequences but also by stigma, poverty, institutional segregation and changing public-health policy. This article examines the historical development of leprosy in India with particular attention to Madras State. It places special emphasis on the period 1952–1957, a significant transition in which older institutional approaches increasingly gave way to treatment, field surveys, contact observation, health education and community-oriented control. The evidence indicates that South Arcot, including the Tirukoilur area, was an important focus of leprosy-control activity. The establishment of the Tirukoilur pilot project in 1955 brought treatment closer to rural patients and combined medical care with public-health surveillance. Contemporary accounts also show that the disease produced social exclusion and delayed treatment because of fear and stigma. The article argues that the impact of leprosy in Madras during 1952–1957 should therefore be understood not simply through the number of patients, but through its effects on family life, livelihood, access to treatment, social relationships and the organisation of public health.

Keywords: Leprosy, Hansen's disease, Madras State, South Arcot, Tirukoilur, Public Health, Sulphone therapy, Stigma.

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INTRODUCTION

Leprosy is a chronic infectious disease caused by *Mycobacterium leprae* and primarily affects the skin and peripheral nerves. Its long incubation period can delay recognition, while untreated disease may lead to nerve damage, disability and visible deformities. The medical history of leprosy is therefore inseparable from its social history. The disease has repeatedly been associated with exclusion, fear and misconceptions concerning heredity, contagion and moral or religious punishment. Standard histories of the disease note that the discovery of the bacillus by Gerhard Armauer Hansen in 1873 transformed medical understanding, although social prejudice continued long after the bacterial cause had been established.¹

India occupied an important place in the global history of leprosy. Archaeological and textual evidence points to a very long history of the disease in South Asia, while colonial records document

the growth of institutions, legislation and specialised medical services. This article emphasises that leprosy was shaped by changing medical practices and by social responses to the disease. It also identifies Madras as an important centre of colonial and later public-health activity and highlights Tirukoilur as a significant rural site for leprosy control.

LEPROSY IN INDIA: HISTORICAL BACKGROUND

Leprosy is a neurological disease. This is curable disease but it threatened public health . It was an ancient disease found at East Africa. Leprosy was mentioned in Vedic age as Kushth Rog. They were followed traditional treatment as like Chalmooogra Oil. ²

Leprosy has been described in early Indian medical traditions, including the *Charaka Samhita* and *Sushruta Samhita*³. These traditions demonstrate that chronic skin and neurological disorders resembling leprosy were recognised in early South Asian medicine. Later historical developments were shaped by systems of social exclusion, in the medieval period Leprosy was comprehended through the lens of ritual and religious beliefs and, during the colonial period, by institutional responses to perceived contagion. The Lepers Act of 1898 represented a particularly important stage in this history because it provided a legal framework for segregation and institutionalisation of persons considered to be affected by leprosy .⁴

Colonial leprosy policy was not uniform. Missionary organisations, charitable institutions and government hospitals all participated in treatment and relief. At the same time, institutional care separated patients from families and communities. The Madras State Archives record the long administrative history of leprosy settlements and hospitals in places including Madras, Chingleput, Cuddalore, Tirukoilur and other centres. The archival record also shows a gradual movement from isolation and asylum-based approaches toward outpatient treatment, dispensaries and integration with general health services.

LEPROSY IN MADRAS: FROM INSTITUTIONAL CARE TO PUBLIC HEALTH

Madras had an established institutional history of leprosy treatment well before Independence. Specialised facilities were created because medical authorities and administrators considered leprosy a distinctive public-health problem. The earlier approach relied heavily on hospitals, settlements and segregation. Over time, however, the limitations of institutional treatment became increasingly apparent, particularly because the majority of patients lived in rural areas and could not remain permanently in institutions.

By the middle of the twentieth century, the availability of sulphone drugs changed the practical possibilities of treatment. Sulphone therapy made it possible to treat many patients without prolonged institutionalisation. However, cost, distance, limited rural medical facilities and social stigma continued to restrict access. Public-health programmes therefore increasingly attempted to take treatment to villages rather than expecting patients to travel to distant institutions. The later development of the National Leprosy Control Programme in 1955 reflected this wider change in strategy. ⁵

THE EFFECT OF LEPROSY IN MADRAS, 1952–1957

The years 1952–1957 are especially important because they cover a transitional period between the earlier treatment-oriented system and the more systematic control programme inaugurated in 1955. It is important to distinguish Madras city from the larger Madras State. Available historical evidence shows

that several districts were highly endemic, including South Arcot, North Arcot, Chingleput and Salem, while Madras city also had a significant institutional and public-health role. A later historical review of Madras public health identifies South Arcot as particularly affected and records the importance of mass sulphone treatment in affected villages.⁶

In the Census operations of 1951, the Madras Government caused a question on, leprosy to be included. The Census disclosed that in the State as a whole there were 53,688 definite leprosy cases and 18,434 doubtful cases or 72,122 infected cases in all, i.e., roughly 0-13 per cent of the population. The infection is heaviest in South Madras Division with 0-16 per cent, the North Madras Division comes next with 0.1 per cent, then the West Madras Division with 0.08 per cent and lastly the Deccan Division with 0:03 per cent⁷.

In the districts, the infection per 10,000 of the population varied from 2 to 47. The most heavily infected districts were South Arcot (47 per 10,000) North Arcot (25), Chingleput (23), East Godavari (20), Chittoor (18), Srikakulam Plains (15), West Godavari, Tiruchirappalli and Madurai (14) and Salem (13). Thus the Census figures reveal the relative position of the districts with regard to incidence, but the actual incidence is certainly very much higher. The State Leprosy Survey Unit has done extensive surveys in many parts of the State. The District Leprosy Survey Unit, South Arcot, has done survey in that district and particularly in the Tirukoilur area⁸. Some specimen data given from these surveys:

<i>Most affected Area</i>	<i>Number of cases per 10,000 of population</i>
Tirukoilur area (South Arcot)	535
Tiruvallur firka (Chingleput)	118
Kalasapakkam firka (North Arcot)	151
Nagari firka (Chittoor)	102
Veerapandi firka (Salem)	53
Shirva area (South Kanara)	34
Tirumangalam firka (Madurai)	128

However, the surviving sources do not provide a sufficiently consistent annual series of Madras-wide patient counts for each year from 1952 through 1957. Accordingly, the effect of leprosy during these years is better reconstructed through administrative reports, institutional developments and contemporary studies of control work.

First, leprosy had a substantial social effect. Fear of the disease could resulted in rejection of patients and even suspicion toward health workers. Dr. V. Ekambaram, an eminent Indian leprologist, who later described his experience of working at Tirukoilur, recalled that in the early 1950s people could refuse ordinary social contact with leprosy workers because of fear of infection. Such testimony demonstrates that stigma affected not only patients but also the wider social environment surrounding leprosy work.⁹

Second, the disease affected rural livelihoods and family life. A patient with visible lesions, nerve damage or disability could experience difficulty in agricultural work and other forms of manual employment. Where treatment required repeated travel, the cost of transport and loss of working days could further discourage attendance. These problems were particularly important in rural South Arcot, where health services were geographically dispersed. The later Tirukoilur study shows why bringing treatment nearer to villages was necessary: the pilot project established five outstation clinics and arranged weekly treatment so that patients could receive care as close as possible to their homes.¹⁰

Third, the disease influenced the organisation of medical services. The major shift was from relying primarily on institutions toward combining treatment with survey, contact examination, follow-up and health education. The Tirukoilur pilot project established in 1955 is especially significant because it combined a medical wing responsible for treatment with a public-health wing responsible for intensive surveys, examination of healthy contacts, follow-up of patients who missed treatment and health education. This model illustrates the changing philosophy of leprosy control in Madras State during the mid-1950s.

Fourth, treatment itself became more accessible through the use of sulphone therapy. Contemporary work from Tirukoilur describes oral dapsone (DDS) as the principal treatment used in the centre, while some patients who had already begun parenteral sulphetrone continued that therapy. The study is important historically because it records treatment in a predominantly rural population rather than only in institutional patients.

Fifth, the period saw a major policy transition. Before 1955, anti-leprosy work in India was substantially dependent on government institutions, charitable organisations and missionary agencies. The National Leprosy Control Programme, launched in 1955, sought to make control more systematic and community based. In Madras State, subsidiary centres and pilot projects supported mass treatment, surveys and health education. Thus, 1952–1957 can be interpreted as a period in which the public-health meaning of leprosy changed from a problem of institutional segregation toward a problem of community treatment and disease control.

MADRAS STATE

Tirukoilur provides an especially valuable case study because it represents the rural dimension of leprosy control in Madras State. The Government Leprosy Treatment and Study Centre at Tirukoilur (then Madras State) was developed into a pilot project in 1955. The centre covered a predominantly rural area in South Arcot District and combined curative and preventive work. Five outstation clinics were established so that patients could receive treatment nearer their homes. Contemporary documentation describes weekly clinics, examination of patients, bacteriological follow-up, contact observation and health education.¹¹

The significance of Tirukoilur lies not only in treatment but also in the attempt to understand the disease epidemiologically. The public-health component surveyed the population, examined healthy contacts and followed patients who failed to attend treatment. This represented an important departure from a purely institutional approach. Instead of waiting for patients to present themselves at a sanatorium, the programme attempted to identify disease within the community and maintain continuity of treatment.

The area also illustrates the role of stigma. Dr. Ekambaram's recollections show that leprosy produced suspicion even around medical workers. Such attitudes helped to explain why health education was an essential part of the control programme. Treatment alone could not succeed if patients concealed their condition or avoided clinics because of fear of rejection. The Central Leprosy Teaching and Research Institute (CLTRI), located at Chengalpattu in the former Madras State, was established in 1955 by the Government of India to strengthen leprosy treatment, research, and medical training.

MAJOR FACTORS CONTRIBUTING TO THE PERSISTENCE OF LEPROSY

Several factors contributed to the persistence and social impact of leprosy in Madras during this period. The first was delayed diagnosis. Because the disease can develop slowly and may initially produce

limited symptoms, patients could remain undiagnosed for long periods. The second was geographical access. Rural populations had fewer specialised services, making the development of outstation clinics particularly important. The third was poverty. Even when effective drugs were available, the cost of treatment, travel and lost working time could impose a significant burden on families. The fourth was stigma. Fear of exclusion encouraged concealment and delayed treatment. The fifth was the inherited institutional legacy of segregation, which had shaped public perceptions of leprosy for decades.¹²

PUBLIC HEALTH RESPONSE, 1955–1957

Treatment of leprosy was offered in leprosy clinics attached to all the government hospitals¹³. The establishment of the National Leprosy Control Programme in 1955 marked a turning point¹⁴. Its basic philosophy was to control the disease through early detection, regular treatment, contact examination, health education and integration with wider health services. Madras State was significant in this development because it already possessed specialised institutions and experienced medical personnel. The state could therefore combine institutional expertise with field-based control measures.

The Central Leprosy Teaching and Research Institute at Chingleput also became part of this institutional transition. Official institutional history records that the Lady Willingdon Leprosy Sanatorium at Tirumani and the Silver Jubilee Clinic and Children's Hospital at Saidapet were transferred to the governing body of the Central Leprosy Teaching and Research Institute in January 1955, and that Dr. Dharmendra became its Director in 1957. These developments demonstrate the increasing importance attached to specialised training, treatment and research in the control of leprosy.

SOCIAL CONSEQUENCES OF LEPROSY

The consequences of leprosy were wider than the physical symptoms of the disease. Patients experienced social isolation, loss of employment, difficulty in marriage and family relationships, and exclusion from ordinary community activities. Visible deformity intensified these problems. The historical literature on leprosy repeatedly demonstrates that stigma can become a secondary burden that is as significant as the disease itself.¹⁵

In Madras, the problem was particularly complex because older beliefs about contagion and hereditary transmission continued to influence social behaviour even as medical knowledge improved. The shift toward community treatment in the 1950s therefore had an important social dimension: it sought to normalise treatment and reduce the need for permanent separation. Health education was consequently not merely an educational activity but an intervention against stigma.

HISTORICAL SIGNIFICANCE OF THE PERIOD 1952–1957

The period 1952–1957 can be viewed as a formative stage in the modern history of leprosy control in Madras State. In 1952, the public-health system still carried the legacy of institutional and segregative approaches. By 1955, the launch of the National Leprosy Control Programme and the establishment of the Tirukoilur pilot project represented a decisive movement toward community-based treatment. By 1957, specialised institutions and field programmes were increasingly connected through treatment, research and training.

This transition was significant because it changed the role of the patient. Under a strongly institutional model, the patient was primarily someone to be isolated and treated within a specialised institution. Under the emerging control model, the patient was a member of the community who could

be diagnosed, treated and followed while remaining connected to family and livelihood. The historical importance of Madras therefore lies not only in the prevalence of leprosy but also in its contribution to the development of public-health methods for controlling a chronic disease in rural communities.

The National Leprosy Control Programme, the precursor of National Leprosy Eradication Programme (NLEP) was started in India in 1955. An important qualitative change in the programme occurred after it was rechristened as Leprosy Eradication Programme in 1982 and inclusion of this under the Prime Minister's 20 Point Programme. As a consequence, the management of leprosy patients are based on multi drug treatment in place of dapsone monotherapy that was the sheet anchor of the programme until then for over 25 years. This programme is being implemented in Tamil nadu with the ultimate aim of eradicating the disease by 2000 CE ¹⁶.

Tamil Nadu has historically been a pioneer in leprosy management, being the first state to integrate leprosy services into the primary healthcare system. The state officially achieved the public health milestone of leprosy elimination (defined as a prevalence rate below 1 case per 10,000 population) in March 2005 ¹⁷.

MILE STONES OF NATIONAL LEPROSY ERADICATION PROGRAMME

- Start of NLCP with Mono Therapy : 1955
- Start of NLEP with MDT : 1983
- MDT coverage completed : 1991
- Prevalence Rate at the start of MDT : 118 / 10000 pop.
- Date of Integration : 01.08.97
- Prevalence Rate at the time of Integration : 7 / 10000 Pop.
- Elimination Achieved on : March, 2005
- Prevalence Rate at the time of Elimination : 0.85 ¹⁸

CONCLUSION

Leprosy in India has a long and complex history in which medical knowledge, public-health administration and social attitudes have continually interacted. Madras was an important centre of this history because it possessed specialised hospitals, sanatoria, research institutions and field-based control programmes. The period 1952–1957 was particularly important because it witnessed the transition from a predominantly institutional approach toward community-oriented control.

The evidence relating to Madras State shows that the impact of leprosy during these years was multidimensional. It affected health, livelihood, family relationships and social participation, while stigma and inadequate access to rural treatment delayed diagnosis and care. South Arcot and Tirukoilur demonstrate how these difficulties were addressed through pilot projects, weekly outstation clinics, sulphone treatment, contact examination, follow-up and health education. The Tirukoilur project of 1955 is therefore an important example of the transformation of leprosy control in post-Independence India.

At the same time, historical interpretation requires caution. The available sources do not provide a complete, consistent annual series of Madras-wide leprosy cases for every year between 1952 and 1957. It is therefore preferable to use administrative records, census evidence and contemporary medical studies to reconstruct the nature of the burden and the public-health response rather than

supply unsupported numerical estimates. This approach makes it possible to understand leprosy as both a disease and a social-historical phenomenon.

Today, leprosy is a treatable disease, and patients can receive free diagnosis and multidrug therapy through government healthcare facilities. The National Leprosy Eradication Programme supports early detection, treatment, prevention of disability, rehabilitation, and awareness campaigns. However, new cases continue to be identified, showing that the disease has not been completely eliminated. Social stigma, delayed diagnosis, and limited awareness remain important challenges, particularly among vulnerable communities. The government therefore continues to strengthen surveillance, encourage early medical consultation, and promote the social inclusion of affected individuals. Although India achieved the national leprosy elimination threshold in 2005, this achievement does not mean that transmission has stopped or that every state and district is free from the disease.

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