Voluntary Leper Colonies and Clinics.

IN PLACE OF COMPULSORY SEGREGATION.

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(Hon. Medical Secretary.)

I have repeatedly pointed out that in tropical and sub-tropical areas compulsory segregation has yielded very disappointing results, although in Norway seventy years of isolation under mild conditions has at length reduced the disease to only 5 per cent. of the numbers found in 1856, and in Iceland a great reduction has taken place since the re-establishment of isolation in 1897. The splendid attempt of the Americans to stamp out leprosy by segregation in the Culion island settlement of the Philippines has reduced greatly the number of advanced lepers seen in the towns, but, as the admissions average 8 years' duration, during which they have had ample opportunities for infecting others, numerous new cases are still found every year, and recently the policy of compulsory segregation has been modified by adopting the plan, long advocated by Muir, myself and others, of allowing early cases to be treated at hospitals and clinics established near to where the patients live. In one of our British colonies our suggestion, to allow early cases, found by a medical board to be uninfective, to be treated at clinics is likely to be sanctioned before long. On the other hand, in South Africa the Union Government still has a policy of rigid compulsory isolation, with the result that a recent report stated that the duration of the cases on admission was of four, six or more years, and treatment was then of comparatively little avail, as compared with its effect in their earlier cases now being attracted to clinics in many of our colonies, and the disease will inevitably be maintained by infections from cases before they are detected and isolated.

For these reasons our Association has set its face against the introduction of compulsory isolation in our badly affected tropical African colonies, where anti-leprosy campaigns are being taken up energetically, in some cases under whole time medical officers trained in the modern treatment at the Calcutta School of Tropical

Medicine under Dr. Muir. In Tanganyika compulsory segregation was introduced by the Germans, but the British administration are now supporting our policy of attracting cases to come voluntarily to clinics and colonies for treatment, and in Uganda Dr. Wiggins has opened a splendid campaign by means of six clinics, visited once a week by motor, in which 1,500 cases were under treatment voluntarily within a few weeks of the work being started. It remains to be seen whether the patients will attend for long enough for good results to be obtained, but about two years' experience of Dr. Macdonald, at Itu in Southern Nigeria, with about 1,000 lepers now in his voluntary colony, has proved this measure to be of great value, although in the neighbouring French Cameroons attempts at isolating lepers by compulsion only led to the cases being hidden, but, after some good results had been obtained by treatment, patients doing well were sent in couples through the villages to persuade the lepers to come voluntarily for treatment, with far greater success in attracting the patients, without any compulsion whatever.

In addition to clinics for comparatively early and little infective cases, leper colonies are required where the more advanced and dangerous infective cases can be persuaded to reside for long periods under treatment. Fortunately the abundance of highly fertile land in tropical Africa makes such colonies feasible at a very minute fraction of the cost of compulsory isolation, as well as being far more effective in obtaining the desired residence of the patients. Our Association has given numerous grants to allow missionary and other doctors to build dispensaries and strong native huts for accommodation of the lepers, who are able to grow their own food within a few months, and thus become self-supporting, and the cost of treatment with sodium hydnocarpate, in the form of Alepol or Martindale's C fraction is only about half-a-crown a year per case, as far as the drug is concerned. When we recall that in New South Wales the cost of compulsory isolation is over £200 per case per annum, the immense advantage of attracting the infectious lepers to come voluntarily to our new leper colonies is very evident, and it is, in fact, the only feasible way of dealing with the problem in our none-too-wealthy African colonies. These leper colonies, then, provide both for the voluntary isolation of the infective cases at a nominal cost, as compared with compulsory isolation, and also attract the patients in earlier stages (when they are more amenable to treatment) than under compulsion. When a considerable proportion of the infective cases can thus be dealt with,

and many of the early uninfective ones can be cleared up and prevented from going on to the more advanced infective stage at colonies, a blow will then be struck at the disease which must inevitably result in the material reduction of its prevalence in a decade or two. As the Union of South Africa at present adheres to a policy of rigid compulsion, that area will serve as a useful control, and it will be most interesting to see if neighbouring areas, far less advantageously situated as regards both financial resources and climate, will not out distance the southern area of Africa in the race greatly to reduce leprosy in their respective territories.