Leprosy Policy in Basutoland.

P. D. STRACHAN.

ALTHOUGH the problem presented by leprosy in Basutoland has certain aspects which are very similar to, or identical with, corresponding aspects in most parts of South Africa, there are certain other aspects which modify very considerably the policy which it is possible to carry out in Basutoland, the other Protectorates and the Native reserves, as compared with that which is possible in the greater land area of the Union of South Africa, owned and mainly occupied by Europeans. It is true that the last mentioned area contains also a large Native population of farm and industrial employees, but these, being in the employment of Europeans, can be kept more easily under observation, and can less easily escape to places of concealment on that account.

It is probable that the types presented by the disease are very similar in all parts of South Africa. Any marked differences in type that may be found would be due to several causes, among which may be mentioned in their order of importance the time during which the disease has been endemic in any area, distance from the coast, height above sea level and latitude. It is well known that a disease in a community becomes modified by a long period of endemicity, the severity of type and endemicity diminishing as the time increases. Leprosy appears to have been noticed among the Hottentots and bushmen of the southern Cape at a comparatively early period in the short history of the country. Dr. Macfarlane, late Principal Medical Officer of Basutoland, who spent the most of his life in the service of the territory, has expressed the opinion that leprosy was unknown among the Basuto fifty years ago, and that it was introduced into Basutoland by the Griquas from the south of the Orange Free State, who trekked through Basutoland to Griqualand East. The Griquas are a mixed race of Europeans and Hottentots.

Leprosy is said to be more severe in type and more liable to be complicated with intercurrent affections, such as pulmonary tuberculosis, in most low-lying areas. The climate of Basutoland is determined by conditions the opposite of the last mentioned. The height of the inhabited areas above sea level varies from 5,000 to 8,000 feet, and the latitude of the territory is in the neighbourhood of 29 and 30 South. The winter is dry and cold or cool, and the rainfall in summer

generally takes the form of short heavy falls accompanied by lightning. The coldness of the winter, in the opinion of the writer, militates to some extent against cleanliness in the personal habits of the people; they are not given so much to the washing of their bodies as the people of Bechuanaland, who live at a lower latitude and a lower altitude.

In the Native reserves under the Government of the Union of South Africa there is a certain amount of self-government through representative councils, and one would expect the enforcement of leprosy regulations conflicting with tribal customs to be more difficult in the reserves than it is in the areas occupied by Europeans and detribalised Natives. In Basutoland the difficulty of upsetting Native customs is much accentuated by the fact that the Basuto do not regard themselves as a conquered people. Their attitude towards the British Administration is that of a people who have entered into a voluntary alliance, and asked for paternal guidance. Like the Scots and the Russians, they may have been repulsed, and they may have lost territory, but never since they became a nation have they been conquered by an enemy.

In Basutoland a National Council of Chiefs and nominated educated Natives, presided over by His Honour, the Resident Commissioner, sits for some weeks every year to discuss new legislation and other matters. If the pious resolutions passed at these assemblies in the past had been carried out in practice by the chiefs the leprosy situation to-day would have been much easier than it is. Unfortunately, for the most part, the chiefs and headmen are ignorant, conservative and inert.

By proclamation towards the end of 1913, segregation was made compulsory, and the concealment or the failure to report the presence of a case in a village, was made a punishable offence. Early in 1914 the present settlement was opened for the reception of patients, and several hundred were admitted, most of them in a very advanced stage of the disease. The chiefs appeared to have made a good effort to collect sufferers, and it was hoped that the effort would be continued.

When the writer became Superintendent of the asylum in February, 1923, the population was 487. By the middle of June it had risen to 502, and by the end of December it had fallen, through discharges and deaths, to 467. The number of new admissions in that year was 66. In his first annual report the writer expressed the opinion that the population had probably passed through

a maximum. Unfortunately this was an erroneous opinion, based upon a misconception of the conditions existing outside the asylum. The maximum was a maximum only in the mathematical sense of this superlative, and the Superintendent was destined to experience several maxima and minima of that kind before he realised the true state of matters.

For the next three years the population fluctuated between 437 and 500, and the admission rate was from 70 to 80 per annum. In 1927 and 1928 the numbers of admissions were 105 and 115 respectively. These increases might have been due in part to an increase in the incidence of the disease, in part to some pressure put upon the chiefs by the Administration.

In June of 1928 a committee appointed for the purpose of devising means to limit the increasing expenditure on leprosy, reported that short of abandoning the existing policy altogether, no limiting of expenditure could be foreseen so long as the Government continued to rely upon the co-operation of chiefs and headmen only. The committee recommended that special machinery should be devised by the Government for the purpose of finding and bringing in the lepers, and that persons responsible for the harbouring of easily recognisable cases of leprosy should be prosecuted and punished as offenders against the Leprosy Proclamation. Before the end of 1928 a number of prosecutions had taken place, and the effect of this was seen in an increased rate of admissions early in 1929.

The special machinery recommended was the appointment of a number of Native Inspectors, trained in the diagnosis of leprosy, whose duty it would be to scour the country on horseback looking for cases, paying particular attention to their relatives who were, or had been in the asylum, and reporting on the welfare of persons discharged to their homes on account of the apparent arrest of the disease.

At first two "Health and Welfare Inspectors" were appointed from among the guards at the Leper Asylum, and, after a period of training, they began work in April, 1929. In that month the writer spent twelve days with one of these inspectors traversing a mountainous area in the east of Basutoland. On this expedition four cases were found, two of them very early, and two very advanced. As a result of this experience the writer expressed the opinion that a larger number of inspectors would be required if the whole territory were to be traversed once a year. It was decided, before appointing more inspectors, to observe for some months the rate at which the two would be able to

work a portion of the west of Basutoland, which, besides a large mountainous area, contains on its border a strip of comparatively flat, agricultural and thickly populated country, 15 to 20 miles wide.

By November of 1929 the activities of these inspectors, combined with greater pressure put upon the chiefs, had resulted in an unprecedented influx of patients to the asylum. The total number admitted in 1929 was 184. Nevertheless, the two inspectors in a year succeeded in working through only about one-third of the total area of the territory, containing considerably more than one-third of the population.

In the beginning of 1930 four more inspectors, temporary servants bearing the title "Leprosy Inspectors," were appointed, and, after a period of six weeks' training at the asylum, they were sent to the various districts apportioned to them in March and April, 1930. With one of these the writer made a nine days' expedition in an agricultural area in the north-west of Basutoland, during which three cases were found.

It is now hoped that these six inspectors will be able to work through the whole territory at least once every year, and that the admission rate to the asylum, which is already beginning to show signs of falling off, will fall very considerably after the country has been once completely combed through. The proportion of patients being found in an advanced and highly infective state of the disease is still far too high, but it is hoped that this will diminish *pari passu* with the numbers being admitted.

The number of patients admitted during the first half of 1930 was 72, and the present population of the asylum (August 23rd, 1930) is 688, *viz.*, 314 men and boys, and 374 women and girls. Sixteen patients have just been certified fit for discharge, and a much larger number of discharges before the end of this year is contemplated.

It is proposed to build two villages for males and females at sites on the Asylum Farm nearly a mile distant from the compounds. The patients sent to live there will be the less disabled so-called burnt out cases, who have no home to go to in Basutoland, and the early slightly infective cases, in which the prospects of cure by the injection treatment are good.

The population of Basutoland is over half a million, and the number of lepers, including those in the asylum, is probably about one thousand, so that the incidence of the disease is in the neighbourhood of two per thousand of the population.

The greater part of the country is covered with mountains, of which the peaks are from 7,000 to 10,000 feet above sea level, and from 2,000 to 5,000 feet above the level of the western border and the neighbouring parts of the Orange Free State. The difficulties in the way of instituting a system of voluntary submission to treatment at treatment centres, in no case further than ten miles from a patient's home, are at present insurmountable. Even if the country were flat and medical officers could be stationed at the geometrically most advantageous points, say, each at the centre of a hexagon of 20 miles longest diameter, forty-seven medical officers would be required. The expense in salaries and the building of quarters would be altogether prohibitive. About half that number of medical officers might be able to supply treatment to every leper by means of peripatetic tent dispensaries. In addition to salaries in this case there would be the expense of several riding and pack horses for each man with his attendant, and probably permanent quarters would also be required; for it would be impossible to obtain a sufficient number of medical men willing for any length of time to spend their lives as "plain men dwelling in tents." Besides, treatment to be fully effective, should be administered by men of experience, who have learnt how to treat the patient, rather than the disease. It is also certain that most lepers would not walk or even ride ten miles as often as once a week with sufficient regularity to derive benefit from treatment. Even in the compounds, where they are all within one hundred yards of the dispensary, the regularity of attendance for injections is only about 50 per cent. of what it should be. To be effective, voluntary submission to treatment without segregation would have to be supplemented by grants of money from the Government for the purpose of feeding and clothing many of the patients in times of scarcity; for it seems obvious that in the absence of the necessaries of life drug treatment of any kind could be of little avail.

The highest ideal at which we can aim in Basutoland is to have leprosy voluntary treatment centres at each of the Government dispensaries in seven districts or sub-districts. Maseru dispensary could be excluded because it is within five miles of the Leper Asylum, where voluntary treatment to the most promising cases could be given at the villages about to be built. All advanced and comparatively hopeless cases would still require to be compulsorily segregated at the Asylum.

A patient in an early and slightly infective stage of the

disease should be given the option of going to live in the neighbourhood of a treatment centre, and in the event of acquiescence, the chiefs should be compelled by means of an exchange, to provide land for the patient's family or guardians near a treatment centre. In the event of a patient's attending for injections irregularly without a reasonable excuse, that patient should be compulsorily segregated in the Leprosy Asylum. The threat of such compulsory segregation would conduce to a greater regularity in submitting to treatment than that which is possible at the Asylum itself, where no means of compelling submission to treatment exists.