EDITORIAL

In the course of the last three months of 1957, the Editor had the great privilege of a visit on behalf of the British Leprosy Relief Association to two countries where active and successful leprosy relief programmes are in progress. These were West Africa and India. Some account of these tours will be given here, with the liberty of returning to the subject more fully in later issues of "Leprosy Review," particularly in the case of the West African tour, which was by far the larger one.

Visit to West Africa

The visit to West Africa comprised 44 days of a schedule as comprehensive as possible kindly worked out by the Governments concerned. It began with 12 days in Northern Nigeria and went on to Eastern Nigeria, the Cameroons, Western Nigeria, and Sierra Leone. It was not possible to include Ghana on this occasion, but it is hoped to make a separate visit to Ghana in 1958.

In Northern Nigeria Dr. C. M. Ross, the Senior Leprologist, very generously gave his personal guidance and fellowship throughout the tour. We began at Kano and visited the Kano Leprosarium of 500 patients, a fine institution of the S.I.M. under Dr. Dreisbach. Each day we travelled many miles by road and visited leprosy work in institutions or district clinics. These included Bindawa; Azare Clinic where there was also residential accommodation for inpatients; clinics at Damagum, Damatura, and Benisheikh; the Bornu Provincial Leprosarium near Maiduguri with 361 inpatients and 1,000 outpatients under Dr. R. Marshall; Potiskum Clinic; Darazo Leprosy Dispensary; the new Zalamga Leprosarium of the S.I.M. with 120 inpatients and 60 outpatients; the Plateau Provincial Leprosarium at Mongo under Dr. F. C. Priestman. Dr. D. Hilton, the leprologist stationed at Jos, took us to visit Gyel Dispensary, a general dispensary which has 210 leprosy cases. From Kaduna, Dr. Ross was able to show Zaria Provincial Leprosarium under the C.M.S., with Dr. Mess and two BELRA workers, Miss Hardaker and Mr. J. Boyd, with 151 inpatients and 6,000 outpatients; also the leprosarium of the Albarka Fellowship, with Miss J. A. Whittle at present in charge and 135 inpatients and 1,500 outpatients; also the very interesting experience of visiting a class of 60 African trainees in leprosy who were receiving instruction from Dr. Ross. They were a thoughtful and intelligent body of men who left a very favourable impression on the visitor. Dr. G. K. M. Khomo, Superintendent of the Training School for Medical Assistants, also showed its buildings and hostel and facilities: this was an additional cheering experience.

Dr. C. M. Ross will be speaking for himself in this issue of

" Leprosy Review " in his article on Leprosy Control in Northern Nigeria. The Editor is glad to be able to add his personal testimony as a result of his visit. A large cross-section of the institution and district work was seen, giving the very clear impression of a sensible scheme of leprosy control suited to the country and amazingly successful in the short period of its operation to date. Dr. Ross and his helpers have succeeded in providing leprosy therapy to many thousands of patients, using a system of leprosy clinics and segregation camps staffed by African workers and integrating existing leprosaria into the general scheme. The Editor examined a considerable number of leprosy outpatients under treatment, and was able to be sure that they are getting their treatment regularly and obtaining the expected improvement in their disease. The faithful and competent work of African leprosy inspectors and dispensers was everywhere to be seen: they must have been wisely chosen and carefully trained. The whole scheme rests upon this, and all credit is due to the Government and people and the trainees themselves, in that they responded to the call of Dr. Ross. The peope of Northern Nigeria, if they go on like this, have a sporting chance of eradicating leprosy in a generation.

In Eastern Nigeria 19 days were spent altogether, beginning with kind hospitality from H.E. Sir Robert and Lady Stapledon, and it was possible to see a large part of the outstanding leprosy campaign there, which has attained a degree of success probably unique. The first centre visited was Oji River Area Headquarters with Dr. A. S. Garrett. There is a leprosarium there with all departments, a Training School, and a Social Welfare and Rehabilitation section. The decline in the number of inpatients at Oji River from a former 1,600 to a present 600, and outpatients from a former 14,000 to a present 7,800, is one of extreme interest and can only mean essentially that the leprosy prevalence has been reduced. Dr. A. Zahra, acting Leprosy Adviser, gave information on the proposed scheme in collaboration with WHO and UNICEF to spread a network of health centres throughout the region. These health centres would make a place for leprosy control. Many of the ordinary leprosy clinics were visited, and all in the stage of a reduced volume of work due to successful impact on the leprosy prevalence. As in North Nigeria, the work has been faithful and effective, and the role of the African staff a great one. Some of the new health centres were visited with Mr. Frank Hathaway who is building them. The prospects for the usefulness of these are very great.

The next Centre visited for a stay of some days was Uzuakoli Research Centre and Leprosarium and Headquarters, where Dr.

Frank Davey and his staff showed a most stimulating piece of work. Among other things, the leprosy cases on the drug trial with DPT or SU 1906, and other drugs, were shown by Dr. Davey, who in this issue of " Leprosy Review " publishes his report on 3 years' experience with DPT. It is unusual for an Editor to have seen the cases on which a report is made, so it is worth while recording this fact, and that no point of disagreement occurs with Dr. Davey's assessment of the action of DPT. This new drug probably represents a genuine step forward in leprosy therapy, though much remains to be done. All departments of the work of the beautiful leprosarium were seen, and new buildings provided by BELRA for the children were formally opened (the " BELRA Wallich Feeding Centre "). It was noted that preventive and curative physiotherapy is going strong here, and the services of an orthopaedic surgeon are shortly to become available. The Research Centre was originally a BELRA foundation, and Dr. John Lowe worked here: now the work is in the able hands of Dr. Davey and Mr. S. Drewett. In discussion with Dr. Davey and the staff it was revealed that in that Province (Owerri) since 1937 there have been 16,000 discharges, and surveys have shown that there were 32,000 leprosy cases in 1948, and these were reduced to 15,000 in 1957. This is a remarkable result. Apart from the wisdom and energy and faithfulness of the whole body of leprosy workers, and the support of the U.K. Government and Nigerian Governments, and the help of all Missions and the Mission to Lepers and BELRA and WHO and UNICEF (what a magnificent co-operative effort by many bodies!), we discovered one other very important factor in success. This was the degree of understanding and co-operation which was brought to the leprosy campaign **by the people themselves.** One does not get great success in a leprosy campaign unless the people co-operate, and in this area undoubtedly they have co-operated.

The younger but active and growing leprosy campaign in Southern Ogoja was the next to be visited, where Dr. A. Macdonald is in charge. The leprosarium at Uburu under the Church of Scotland Mission deals with 300 inpatients and the 16 district clinics cover 2,500 outpatients. Uburu has simple and attractive buildings and the work progresses steadily. With Dr. Macdonald and Mr. Lowes of BELRA we visited Ukawu Clinic, and Yakurr and Mbembe leprosaria. Ukawu has 300 outpatients and 100 resident patients; the leprosaria are about the 500 inpatient size. In all cases it was possible to detect good and faithful work, and growing co-operation by the people.

The famous Church of Scotland leprosarium at Itu was next to be visited under the guidance of Rev. R. M. Macdonald and his

fine staff, which at the time of this visit included five BELRA workers. The Editor visited this leprosarium in 1947, when the inpatients were 4,000. The present number is 1,300, and the reduction must be ascribed to the waning of leprosy prevalence. The well-organized industrial stability of Itu still persists and has been the basis for the great volume of effective work in the past which continues to this day. Itu was founded in 1928 and many thousands of patients have passed through and returned to normal life. The present discharge rate per annum is about 300 patients; it is a glorious history.

Isoba Leprosarium in Rivers Province was next visited. Dr. M. Corcos is the Superintendent in this area, and Mr. O. S. Wilson the Leprosy Control Officer, and there are two nursing Sisters, Miss Alderman and Miss Boynes. This extremely beautiful and well-planned leprosarium on the banks of the New Calabar River contains 230 patients, and there are 40 district clinics. The whole is a fine piece of work intelligently pursued.

Returning later to Enugu the Editor had valuable interviews with the Hon. E. P. Okoya, Minister of Health, and Dr. S. E. Onwu, Director of Medical Services, and others, was able to express his high opinion of leprosy control in Eastern Nigeria, and to suggest that in the final stage of eradication now ahead the use of BCG might be helpful.

In the Cameroons leprosy work consists of two Mission leprosaria, one at Manyemen and the other at Mbingo, and a growing district work in outpatient clinics. Only partial surveys have been done as yet and the leprosy incidence varies between 7 and 35 per thousand. The work is still young, but the principles of leprosy relief and control as practised in Nigeria are thoroughly understood here and it awaits only an increase of staff and funds and perhaps also better road communications for a broader and deeper leprosy campaign to flourish. We were grateful for the informative and helpful contacts in Victoria with the Principal Medical Officer, Dr. B. L. Green, and also Dr. A. L. McKnight, and were able to travel up-country to stay at the Basel Mission Leprosarium at Manyemen. This is in charge of Dr. Voute, assisted by Dr. Petitpierre, and two nursing sisters, and a manager. The Basel Mission has requested BELRA to provide a replacement for the manager, who had retired, and recently Mr. R. Dunford has been chosen and has accepted the task. Manyemen was founded in 1954; it already has 514 inpatients and 200 outpatients in 6 district clinics. It lies in mountainous terrain, and there are real difficulties over district communications. The buildings are unpretentious but adequate and attractive. The work

has been founded and is being run on sound lines and has progressed a long way in the short period of its existence.

In Western Nigeria we visited the headquarters of the leprosy campaign at Ossiomo Leprosarium, where Dr. Basil Nicholson lives, who is the Senior Leprosy Officer of the Western Region. Dr. S. J. Healy is in charge of the leprosarium itself, and there are Dr. B. Lasisz, Miss Gilon, Miss Paradijs, Miss Vandermensbrugghe, Father O'Regan (the Leprosy Control Officer) and many African staff. The leprosarium contains about 600 inpatients and there is a chain of outpatient clinics and segregation villages. There are 28 leprosy inspectors and at the moment there is a training course in progress which will add 12 more. The leprosarium buildings and facilities are of high standard. Dr. Nicholson was a mine of information on the leprosy problem and the progress of the campaign. Surveys have been completed, but others are needed before a general incidence figure becomes available; it might be 30 per thousand or more. There are two features of the problem peculiar to this region. One is the existence of large native towns. Thus Ibadan has 750,000 people, and there are 6 towns with over 100,000 and 135 towns with over 5,000. A leprosy survey in towns is well-nigh impossible, and there is no real guarantee that the urban leprosy rate will be less than the rural rate. The other difficult feature is the existence of an exaggerated fear of leprosy among certain tribes, which reacts adversely on their co-operation.

We concluded the Nigerian tour by an evening and night in Lagos, not too short a time to receive great kindness from H.E. the Governor-General and Lady Robertson, from Sir Samuel Manuwa, and Dr. Norman Williams. It was also a great pleasure to hear of the resurgence and the flourishing activities of the Lagos BELRA.

In Sierra Leone we spent 4 days on a preliminary visit. Sierra Leone is about to open a modern leprosy campaign. BELRA has lately transferred to their service an experienced worker, Mr. Alan Waudby, and Dr. C. M. Ross of N. Nigeria was expected to arrive on loan in December to begin the necessary surveys and advise on how things should proceed. Dr. T. P. Eddy, the Director of Medical Services, kindly welcomed our visit and arranged many valuable meetings and a stay up-country at Magburaka, where we had the pleasure of meeting Dr. N. G. D. Campbell and Mr. Alan Waudby *in situ*, and seeing something of the country and of existing leprosy work. The Chief Secretary of Sierra Leone, Mr. A. N. A. Waddell, is our old comrade from Solomon Islands days, when he was a tower of strength during our leprosy survey there in 1937. It was very useful to see Sierra

Leone before the main campaign begins; a subsequent visit will be all the more valuable for assessing progress.

Reflections on the West African Leprosy Work

1. The coming of the sulphones offered a great opportunity which has been firmly grasped in West Africa, first in Eastern and Western Nigeria and latterly in Northern Nigeria and contiguous countries to Nigeria. Once it was established that a moderate twice-weekly oral dose of DDS was effective, the way was open to a great extension of the leprosy campaign.

2. Leprosy in West Africa is clinically moderate; the lepromatous rate is between 10 and 20%, and as a whole the disease responds to DDS in not too long a time, and with very few relapses.

3. The stage of opening-up of the campaign was wisely planned, and had the advantage of Lowe and Davey and collaborators working in a Research Centre in Uzuakoli right in the heart of the area, and the fine work at Oji River is also central. The essence of the campaign was henceforth to use oral DDS to treat patients in segregation villages and dispensaries, as well as the leprosaria, and to train a sufficient number of African staff to administer the therapy, keep the records, promote the rules of hygiene and prophylaxis, all under periodic supervision by medical officers. Surveys have been frequent, and close check has been kept on the progress of the campaign.

4. The enlightened co-operation and financial support of many bodies was secured, from Government and WHO and UNICEF to the individual Missions, Mission to Lepers, and BELRA. The success achieved is a credit to all concerned. It does look as if in leprosy work in a given country the policy of " go it alone " is futile, and the co-operation of all interested bodies is indispensable.

5. There is one body whose co-operation is likewise indispensable. That is the people themselves. If it is not forthcoming, time and money and patience must be expended in explanation and persuasion, and the demonstration in sample clinics of the benefit of leprosy relief, i.e., the Propaganda-Treatment-Survey units long advised by Ernest Muir. In Nigeria they were fortunate in obtaining that co-operation and understanding.

6. Another great lesson to be learned from Nigeria is in the matter of personnel. They have shown that a leprosy campaign faced with a lack of national doctors to participate, but possessing a cadre of experienced leprologists, can fill the gap by training educated nationals in leprosy recognition and treatment and leprosy lore generally, and getting them to care for groups of patients under rural conditions. In Nigeria they call these trained laymen " leprosy inspectors." Their work has stood the test. Many

thousands of leprosy sufferers have been relieved of their disease beyond a shadow of relapse. The leprologists, in effect, in addition to being physicians and researchers, and planners and inspirers, become **teachers.** They have been fortunate in finding so many African nationals willing to be taught, and competent in carrying out what they have been taught.

7. Such a big bite has been made into the leprosy prevalence that one dares to think of the last mouthful. Nigeria in particular can begin to think of eradication. The stage preceding eradication is the hardest. Nigeria can be trusted to take another breath and continue to the end, using all hopeful means to augment the the campaign in this difficult last stage. A good sign of this is the development of the idea of Rural Health Centres which will include leprosy in their activities.

Visit to India

The Indian Association of Leprologists invited the Editor, in his capacity as Medical Secretary of the British Leprosy Relief Association, to attend their Third Biennial Meeting, which was to be held in Gorakhpur and followed by the All India Leprosy Workers' Conference. With the goodwill of BELRA, he was able to go to India, and in a short visit of 10 days had a most absorbing and valuable contact with the leprologists and leprosy workers of India, was able to see in Gorakhpur a most attractive and successful piece of leprosy work in progress, and to get an impression of the enormous advances that have been made in leprosy work in India. The Editor had not seen India for 11 years, and can testify to the widening and deepening of the dynamic attack on leprosy that has taken place. There are about 1½ million leprosy cases in India, and nowadays this formidable problem is being attacked by a growing regiment of leprologists and leprosy workers, a great deal of thought is being given to the complexities of the problem peculiar to India, and there has been an " opening-up " of the campaign to bring treatment to outpatients as well as to improve the leprosaria and create new ones. Under the stimulus of the wish of their former great leader, Mahatma Gandhi, who had a special care for leprosy sufferers and begged his people to share it, there has been a great growth of an enlightened and humane attitude amongst the peope, fostered and shared by the Government of India and the State Governments.

The Editor arrived in Delhi on 9th December to receive a great welcome from Col. Lakshman and Sardar Balwant Singh Puri of the Hind Kusht Nivaran Sangh (one of the great organizations in India which foster leprosy work), and this welcome was repeated of arrival in Gorakhpur from Dr. K. R. Chatterjee,

the Honorary Secretary of the Association of Leprologists, Dr. Dharmendra, Director of the Research Institute at Chingleput, and a host of others. Prof. Kanehiko Kitamura of the University of Tokyo also caused great pleasure by his arrival from Japan to attend the Conference. We two were cared for throughout our stay in Gorakhpur by the hospitable Mr. and Mrs. Bhisham Arora, and received endless kindnesses from all.

The Third Biennial Meeting of Leprologists was inaugurated on 13th December by **Sri Hukum Singh Visen,** Minister of Health for Uttar Pradesh. He mentioned the incidence of leprosy in Uttar Pradesh as 80,000 cases, or 1.4 per thousand population, and described the institutional facilities as 17 leprosaria, and the expansion of the work to outpatient clinics. The new control units are of two types, one for study and research, one for survey and treatment. Mobile units are also being tried, and the training of social workers goes on steadily. The training of medical students and graduates is also of highest importance.

Dr. Dharmendra gave the first paper, on The Role of Chemotherapy in the Control of Leprosy, and this subject was also taken up by **Dr. N. Mukerjee.** Both speakers, while recognizing the potential role of therapy, wisely emphasized that some degree of segregation is still needed. Dr. Dharmendra pointed out that the protective value of the sulphones for contacts is still not proved. Dr. Mukerjee insisted on the regular follow-up of healthy contacts as a very important part of control programmes, and on the paramount importance of early diagnosis, as well as the willing and intelligent co-operation of the patients and public, for which a suitable educational campaign is essential.

Dr. K. R. Chatterjee described his studies in the Electron Microscopy and Cytochemistry of *M. Leprae* and Leprous Tissue. By the comparative use of phase contrast and electron microscopy he found either solid uniformly dense bacilli, or bacilli with alternate light or dark zones; there is a thin enveloping membrane, and a gloea. The electron microscope shows that the bacilli occur in nerve endings in the skin, in tactile corpuscles, in the myelin sheath, in Schwann cells, and in the axons; also attached to nerve fibrils and inside macrophages and foamy cells of leprous tissue. Cytochemical study showed that the nucleus, generally central in location, contained desoxyribonucleic acid, and the cytoplasm contains ribonucleic acid, muco-polysaccharides, and lipids. The polar condensations contain cytochrome oxidase and appear to be the mitochondria. The cell membrane is rich in mucopolysaccharides; the gloea seems to contain complex lipids.

Dr. A. T. Roy gave a paper on General Treatment. Though the usual dose of DDS is 600 mgm. a week, even 300 mgm. a week

has been found to be effective, and he found that 1.0 gm. of sulphetrone daily, and as little as 3 to 4 cc. of 50% aqueous solution of sulphetrone intramuscularly once a week produced clinical results. Thiosemicarbazone is especially good in cases who cannot tolerate DDS. **Dr. D. N. Bose** gave a paper on the same subject. He still finds it an advantage to combine with sulphones the injection of hydnocarpus oil and its derivatives. In lepra reaction he warned against the use of antimony in patients with a history of pleurisy or tuberculosis. Irgapyrin and unalgen are useful and intramuscular streptomycin for tuberculoid reaction, and corticosteroid therapy is valuable in refractory reacting conditions.

Dr. P. Fritschi described in detail Recent Advances in Reconstructive Surgery in Leprosy. He emphasized the prevention of deformities by splinting and bed rest and physiotherapy and described many reconstructive and plastic operations. There has been a great advance in this field.

Major E. J. Somerset gave a paper on Eye Lesions in Leprosy, describing the commoner ocular manifestations and their management, and showed how much can be done to prevent and alleviate eye damage in leprosy.

Dr. F. Hemerijkx described the work of the Belgian Leprosy Centre, Polambakkam. Here the emphasis has been on mass treatment in clinics and hospital, with some segregation where practicable. During the 2½ years of the existence of the Centre, almost 20,000 patients have been treated, and surveys of contacts and local regional leprosy surveys are being undertaken. The staff of the Centre includes 38 leprosy workers, of whom 24 are posted in the villages, and there are 2 doctors and 2 nurses.

Dr. H. Sharma Rao described the Leprosy Relief and Control Scheme in Thirumangalam under the Madras State Government. This scheme covers a rural area with 40 treatment centres which already treat over 4,000 patients, and treatment is often taken to the homes of the patients. Medical officers of general dispensaries provide medical supervision and lay workers are trained. The scheme is capable of expansion as time goes on.

The Sixth All-India Leprosy Workers' Conference began on 15th December, with Sardar Balwant Singh Puri as President. The inaugural address was given by **Dr. Sampurnanand,** the Chief Minister of Uttar Pradesh, who spoke with deep understanding of the problems of leprosy. **Sardar Balwant Singh Puri** spoke of his long association with leprosy work, as he has been the Honorary Secretary of the Indian Council of BELRA since its inception in 1925. In 1950 the Indian BELRA became Hind Kusht Nivaran Sangh, and of this he continues as Honorary Secretary. He pointed

out that India established the first full-time leprosy research centre. This was at Calcutta over 30 years ago, and this has been associated with the names of Sir Leonard Rogers, Dr. Ernest Muir, Dr. John Lowe, Dr. Dharmendra, Dr. S. N. Chatterjee, Dr. N. Mukerjee, and Dr. K. R. Chatterjee. Dr. Dharmendra has now become Director of the new Central Leprosy Teaching and Research Institute at Chingleput. The work of Dr. R. G. Cochrane was formerly associated with Chingleput and India acknowledges her debt to him. The Sardar went on to describe the expansion of leprosy work in India in his time, citing many other illustrious names. The need for personnel and funds still remains great.

Dr. N. Mukerjee described the Leprosy Control Scheme which is a joint responsibility of the Union and State Governments, and the object is to give a trial to mass treatment with sulphone in the control of leprosy. Already 4 Study and Treatment Centres and 52 Subsidiary Centres have been established, and a further 73 are planned for the second five years, during which also 500 doctors and 2,000 ancillary personnel are to be trained and the sum of Rupees 27,150,000 (£2,036,250) is to be expended. In the 2 years' work so far, in a total population in the project areas of 3 millions, 57% have been examined and 25,000 cases of leprosy detected (an incidence of 15 per thousand). Of known cases the lepromatous rate is 34%. There are 81,000 contacts under observation.

Dr. R. V. Wardekar spoke on the Leprosy Control Work of the Gandhi Smarak Nidhi (Gandhi Memorial Foundation). The work covers 9 control units, by which a population of 192,835 is under observation for the detection of leprosy, treatment, and prevention. Training of doctors and health workers goes on. Because of the difficulty in getting enough doctors, Dr. Wardekar suggested that doctors from the general medical service should be detailed to leprosy work in rotation.

Dr. P. Chandy described the Development of Leprosy Work in Gorakhpur. The Kushta Sevasram at Gorakhpur is a leprosy institution started and maintained by Indian men and funds, and besides being a most attractive and efficient hospital, it has village clinics and a mobile unit and looks outward, and the co-operation of many doctors and social workers is abundant and faithful. It was established in 1951 and has treated 708 inpatients to date. There are 4 outpatient clinics, and a rehabilitation centre. (Members of the Conference later visited the Kushta Sevasram and can testify to the fine spirit and high standard of this work.)

Sri T. N. Jagadishan spoke on the Social Aspects including Rehabilitation. There is some softening of the old prejudice against leprosy, but there is still much prejudice to be overcome,

and social assistance for the relatives of the leprosy patient has hardly begun. Rehabilitation measures are growing but need organizing, for those who have recovered without deformities as well as those who are marked. Education of patients to prevent deformities is also needed everywhere. No patient should be discharged without regard to his physical and psychical condition.

Sri M. B. Diwan also spoke on the Social Aspects of Leprosy. He mentioned the small numbers of workers in this field, and asked for enlistment of the interest of every responsible citizen. Vigorous propaganda to remove social stigma, provide family assistance, assist in rehabilitation into society, should be carried on.

Dr. H. K. Lall dealt with Certain Important Questions, about the admission and discharge of patients and medical leave granted to employees who have leprosy. He advised special measures to help in the rehabilitation of discharged cases, including reservation of posts for them, and the provision of land. Two consecutive negative smears at an interval of 3 months should qualify a patient for discharge. Leave for an employee with lepromatous leprosy should be 2 years.

Miss Chandra Manuel discussed Rehabilitation, and called for many Rehabilitation Units with a specialist, physiotherapist, and social workers. Patients with gross deformity should be trained for and provided with "sheltered industry." Those with little or no deformity should also be helped to find employment. Those with medium deformity should be given the aid of reconstructive and plastic surgery.

Dr. Jawhar Lall Rohatgi described Leprosy Legislation for India. It has the defect of applying segregation to all cases, whereas many cases of leprosy do not need this, and also the defect of compulsion of segregation for pauper leprosy patients, whereas segregation, if needed, should be for all social classes. He thought there should be a ban on marriage for infectious cases, because of the great danger to children.

Dr. S. N. Chatterjee dealt with Customs, Laws, and Rules which affect leprosy. Disinheritance in Hindu Law can be imposed for leprosy on the grounds of its being a virulent and incurable disease: this has been amended in 1956 by the Hindu Succession Act: but the Hindu Marriage Act 1955 allows judicial separation for disease virulence, and divorce on the grounds of virulence and incurability of leprosy, and the foundation of this law is wrong, because healthy partners have a natural protection. The Railway Act (1890) also discriminates against leprosy, and under the Motor Vehicle Act (1939) leprosy is the only disease which debars a person from a licence to drive a public vehicle. Nor can a leprosy patient be accepted for life insurance. Also in Military

and other services a leprosy subject is liable to dismissal. A new law should be enacted to guide the public and correct all these unjust anomalies, and this will lead to the reversal of public opinion and make leprosy control easier and rehabilitation of patients the normal thing.

Along with Prof. Kitamura the Editor had the great honour of being made an Honorary Member of the Indian Association of Leprologists. We consider it a very real distinction to be able to count ourselves as integral parts of this Association.

VII International Congress of Leprology, New Dehli, India

Dr. Dharmendra, Secretary of the Organizing Committee, asks that all note his change of address from Calcutta to **Central Leprosy Institute, Chingleput, South India,** of which the cable address is CENTLEPINS. Dr. Dharmendra also provides the following advance information:—

Because of requests from a large number of intending delegates, the **dates of the Congress have been changed to November 10th to 16th, 1958;** registration of delegates will take place on 8th and 9th November. A preliminary information brochure will be sent to all persons and organizations likely to be interested in participation in the Congress. The enrolment form included in the brochure may please be completed and returned at an early date, upon which further literature will be sent to those who enrol.

In New Dehli the conference hall set aside for all functions of the Congress is Vigyan Bhavan, Edward Road. It has facilities for simultaneous interpretation of languages used.

Membership fees. There will be two grades of membership—full and associate. A full member will be entitled to take part in all the functions of the Congress, both scientific and social; an associate member in social functions only. The full membership fee will be Rs. 50/- for those who are members of the International Leprosy Association and Rs. 100/- for those who are not. The associate membership fee will be Rs. 25/-. There will be an increase of 20% over these rates for those who enrol after 31st July, 1958. (The rupee is worth 0.21 of the U.S. dollar, and 1/6 sterling.)

Official Languages will be English, French, and Spanish, and there will be arrangements for simultaneous translation.

Themes for discussion include Classification, Therapy, Epidemiology, Immunology, Bacteriology and Pathology, and Social Aspects. The theme of Evaluation of BCG in Prophylaxis will be dealt with by a separate panel (see below), but the findings will be included under Epidemiology and Immunology.

In preparation for the scientific sessions the Council of the

International Leprosy Association has set up panels for the above themes. Each panel will discuss its theme beforehand by correspondence and will arrange for the presentation of the theme to the Congress. This new procedure arises from experience of the previous Congresses and is expected to be beneficial.

Categories of papers on the above themes will be two—"invited" and "proffered," (i.e. spontaneously submitted). The "invited" papers will be those presented in symposia by members of the respective panels; "proffered" papers may be submitted by any member of the Congress. The "proffered" papers will be assessed and arrangements will be made for presentation of those that are accepted.

Submission of Abstracts and Papers. Abstracts of not more than 200 words should be sent (2 copies) to the Secretary of the International Leprosy Association, 8 Portman Street, London, W.1, England, so as to be received not later than 1st August, 1958. Abstracts and papers should be in one of the official languages. It would be helpful if abstracts in languages other than English are accompanied by an English translation. **The papers themselves** should be addressed to the International Leprosy Association, c/o Dr. Dharmendra, Central Leprosy Institute, Chingleput, South India, so as to be received before the end of September, 1958.

Travel. New Dehli is served by many airlines linking it with all countries, and many international shipping lines touch Bombay and Calcutta. Delegates travelling to New Delhi must hold valid passports and entrance visas for India. Nationals of Australia, Canada, New Zealand, the Republic of Ireland and United Kingdom of Great Britain and Northern Ireland do not require entrance visas.

Hotel Charges. The charges for board and lodging in hotels in New Dehli are as below:—

	Single Room	Double Room
Grade A ...	Rs. 40 to 70	Rs. 60 to 85
Grade B ...	Rs. 30 to 40	Rs. 50 to 80
Grade C ...	Rs. 12 to 20	Rs. 20 to 25

Rates in Indian hotels include full board and lodging, and normally no reduction is made for meals not taken. The Organizing Committee will arrange for hotel reservations if duly notified.

Climate and Clothing. The weather in Dehli during November is generally fine; the average maximum daily temperature is 30.6 deg. C. (89 deg. F.) and the minimum 13.9 deg. C. (57 deg. F.). Visitors should bring woollen clothes.

Social Functions. Social and cultural programmes will be arranged in a way that they do not interfere with the scientific and business sessions of the Congress. It is proposed to arrange for sightseeing and study tours after the Congress.