REPORTS OF MEETINGS

Reports of meetings that deal with leprosy are printed, so far as possible, when made available in suitable form.

REGIONAL HEALTH CONFERENCE OF AFRICA

HELD IN CAPE TOWN, UNION OF SOUTH AFRICA,
NOVEMBER, 1932

REPORT OF THE COMMITTEE ON THE CONTROL OF LEPROSY IN AFRICA WITH SPECIAL REFERENCE TO THE REPORTS OF THE BANGKOK AND MANILA CONFERENCES *

General.—From the ensuing discussion, it was clear that the leprosy policy problem and practice in the various regions of Africa varies within very wide limits.

BANGKOK REPORT

After discussion, the summary and conclusions contained in this report were found to be acceptable to all members.

Isolation of cases.—Members, while accepting the view that isolation of infectious cases is one of the necessary measures in prophylaxis of the disease, are of the opinion that a comprehensive system of effective isolation of all infectious cases is, in certain of the large regions of Africa, not at present a practicable proposition.

Members desire to emphasize that any system of compulsory isolation of cases of leprosy must be imposed with discretion, bearing in mind not only the public health and social interests of the community at large, but also the effect of such measures on the Native mind and the danger of undue rigidity causing Natives to hide cases which may be highly infectious.

Any form of propaganda, especially amongst Natives, and any measures which will encourage Natives to report early cases of leprosy, should be encouraged to the utmost.

Apart altogether from the question of discharge from leper institutions of arrested cases of the disease, members are in agreement

* The official report here published was kindly provided the JOURNAL by the chairman of the Committee. Inasmuch as the Report, in abbreviated form, has appeared in the *Quarterly Bulletin of the Health Organization of the League of Nations* (vol. 2, 1933, p. 108) permission for publication has now been received.—EDITOR.

that the cases or types of leprosy which may be regarded as "closed" and which, while still showing clinical evidence of active leprosy are nevertheless free from bacilli, should not be compulsorily detained in any leper institution.

MANILA REPORT

Members are in agreement generally with the views expressed in the conclusions of the Report. All are agreed as to the desirability for uniformity of methods and terms in such matters as the designation of cases, lesions and nomenclature.

With regard to the classification suggested in the report, members were informed that there are certain sub-types of leprosy in South Africa which do not fit in with the proposed classification. The matter is, therefore, still under consideration by the Union Government. The other members are prepared to accept the classification referred to.

Medical treatment of leprosy.—In practically all areas some form of chaulmoogra oil treatment is in use. Iodized ethyl esters are being tried out in several of the areas, and in two of them, namely, in the Union and Nigeria, this preparation is being successfully manufactured in the manner prescribed in the Manila report.

Evaluation of terms.—While the majority of members are in agreement with the definitions of "active cases", "quiescent cases", and "arrested cases", the South African delegate holds the view that the definition of an "arrested case" should receive further consideration in the light of South African experience, which goes to show that in many cases the period can be reduced to one year, provided the bacteriological examination over the yearly period is carried out monthly.

All members are agreed as to the necessity of abstaining from making use of the word "cure" as applied to leprosy.

CONCLUSION

At the outset it was stated that anti-leprotic activities and measures in operation in different African States varied considerably. The reasons for this are to be found in the fact that, apart from the incidence of disease and other factors, the public health problems and the magnitude of such problems, particularly in Africa, vary very widely, and health administrations dealing with such matters as yellow fever, plague, malaria, yaws, syphilis, sleeping sickness and

tuberculosis can only assign such energies and expenditure to leprosy as the disease warrants in view of its relative importance to other problems with which they are faced.

The recommendations contained in these reports can, therefore, only be applied to any of the African States to an extent which the public health, local needs, conditions, machinery and financial resources pertaining to the country concerned justify.

ALL-INDIA LEPROSY CONFERENCE

CONVENED BY THE BRITISH EMPIRE LEPROSY RELIEF ASSOCIATION (INDIAN COUNCIL), IN CALCUTTA, MARCH 27 TO 30, 1933.

The official report of this meeting, which unquestionably was of primary importance to workers in India, and is of hardly less interest to leprologists elsewhere, was reported in full in the July issue of *Leprosy in India*. An effort was made to obtain a resumé of it for the JOURNAL but this was not forthcoming. Unfortunately, it would be impracticable to reproduce the entire report; aside from exigencies of space—it would fill more than 20 pages—there is much detail of more local than general interest. The following brief summary has been prepared in this office. For details of the papers read and the resolutions passed the readers must be referred to the original report. It is expected, however, that in due course the JOURNAL will be provided with abstracts of such papers as are published.—EDITOR.

PAPERS READ

The meeting convened under the presidency of Lt.-Col. A. D. Stewart, I.M.S., with twenty-one persons present. Papers on leprosy as a public health problem were read by Dr. I. Santra and Lt.-Col. Stewart, and Dr. L. Sen presented one on the organization of leprosy work. The training of doctors and health workers was discussed by Dr. B. N. Ghosh and by Dr. John Lowe. Leprosy institutions were dealt with by Dr. Santra, who discussed the leprosy clinic; by Dr. H. N. Gupta and Dr. H. H. Gass, who discussed hospitals, homes and colonies; and by Mr. A. D. Miller, who discussed general principles of the operation of such institutions. Organization and co-ordination of research were treated by Dr. G. Rao and Dr. Lowe, control by legislation by Sir N. Choksy, leprosy in school children by Dr. V. C. Rambo, treatment by Dr. D. F. Baxter and Dr. R. G. Cochrane, after-care of discharged patients by Mr. Miller, and dismissal of employees by Dr. T. Roy.

RESOLUTIONS ADOPTED

As a result of the discussions of the conference, including those of the papers read, seven resolutions and a number of "recommendations" were adopted. The nature of these is indicated in the following summaries.

No. 1. Co-ordination and organization.—The wide prevalence, severity and infectiousness of leprosy in India calls for: (a) consolidating, co-ordinating and extending the antileprosy work, (b) integrating it in the public health system, (c) providing in every province or state a trained leprosy officer, and (d) setting up in every province or state a leprosy board; finally (e) and (f), providing similar officers and boards in every administrative district where leprosy is highly endemic.

No. 2. Training.—The exigencies of antileprosy work require that (a) special instruction in leprosy should be given in all medical schools; (b) courses should be given to all government doctors, and private practitioners should be encouraged to attend these courses; (c) persons specially engaged in leprosy work should be given more thorough training, at least two weeks; (d) all dispensers should have training, including the technic of injections; (e) sanitary inspectors should be trained to recognize leprosy and to aid in propaganda and survey work; (f) other sanitary and health workers should be trained to recognize leprosy; and (g) the examination of industrial labor should be given special attention.

No. 3. Special leprosy clinics.—In each highly endemic district at least one model clinic should be established under a whole-time leprosy officer. This would serve as a center for demonstration, instruction, prevention, etc.

No. 4. Leprosy clinics in general hospitals.—Though special leprosy clinics are preferable, the need is such that all government medical officers and local practitioners should be encouraged to treat leprosy.

No. 5. In-patient institutions.—Though emphasis is laid on clinics for treatment and prevention, the need for residential institutions to provide for the voluntary isolation of infectious patients and the treatment of patients that require hospital care has not diminished. (a) The formation of voluntary isolation colonies should be encouraged; (b) existing institutions should to greater extent be

used for the isolation of infectious cases; and (c) there should be closer co-ordination between leprosy clinics and other leprosy institutions.

No. 6. Research.—Highly specialized research is best done in well-equipped laboratories, but (a) more research should be done in and by existing institutions; also, (b) there should be a special investigation center for study of the epidemiology and control of leprosy.

No. 7. Leprosy in children.—Statistics show an incidence among school children in endemic areas in India of from 0.5 to 3.0 per cent. All school children in such areas should be examined, definite cases treated, and infectious cases isolated.

RECOMMENDATIONS

These have to do in general with the general and special care of patients during and after treatment, and are for the most part set forth in the article on the treatment of leprosy by E. Muir, which appears in this issue of the JOURNAL.