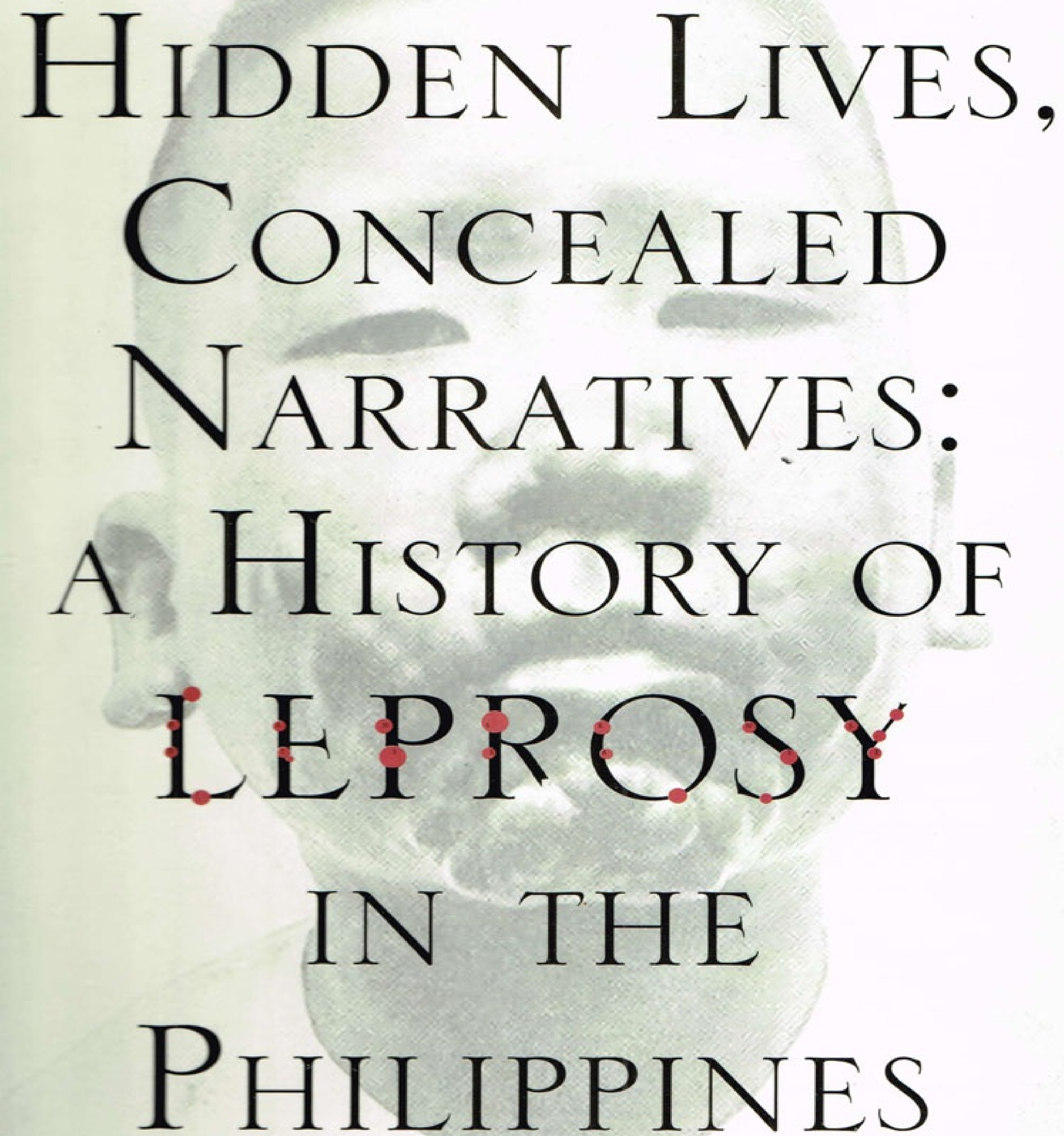

Hidden Lives, Concealed Narratives: a History of Leprosy in the Philippines

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CONTENTS

PREFACE

INTRODUCTION, FEAR OF CONTAGION, PUNISHMENT, AND HOPE

Maria Serena I. Diokno

I.

CHARITY AND CARE IN THE TREATMENT OF THE AFFLICTED

Early Encounters between the Spanish Religious Missionaries and Leprosy in the Philippines

Lorelei D. C. de Viana

Rediscovering a Paradigm: The Franciscan Order's Response to Leprosy and the Afflicted in the Philippines, 1578–1898

María Eloísa G. Parco de Castro

At the Crossroads: New Developments in Leprosy Care in Nineteenth Century Philippines

Celestina P. Boncan

II.

CONTROLLING THE SPREAD OF LEPROSY: CULION AS A PRIME EXAMPLE

American Public Health Policy on Leprosy, 1898–1941

Rene R. Escalante

Spaces and Boundaries in Culion: Mobility amidst Segregation

Veronica A. Dado

Landscapes of Isolation: Selected Leprosaria in Luzon and the Visayas

Ma. Florina y. Orillos-Juan

From Collection to Release: Segregated Lives in the Culion Colony, 1906–1935

Francis A. Gealogo and Antonio C. Galang Jr.

III.

TOWARD DESEGREGATION: THE WORLD OF HANSENITES

Hansen's disease and International Public Health in the Philippines, 1900–1930s

Ma. Mercedes G. Planta

Control of Hansen's Disease since 1946

Meynardo P. Mendoza

Women of Culion: Their Voices

Ma. Luisa T. Camagay

Identity and Stigma: Life Stories of Afflicted Men in Culion

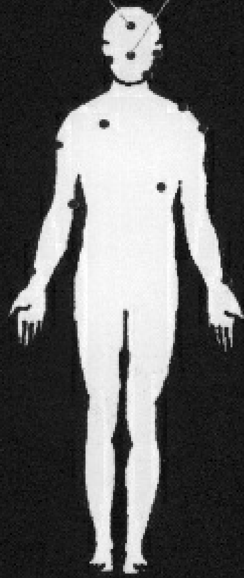
Ma. Carmen C. Jimenez

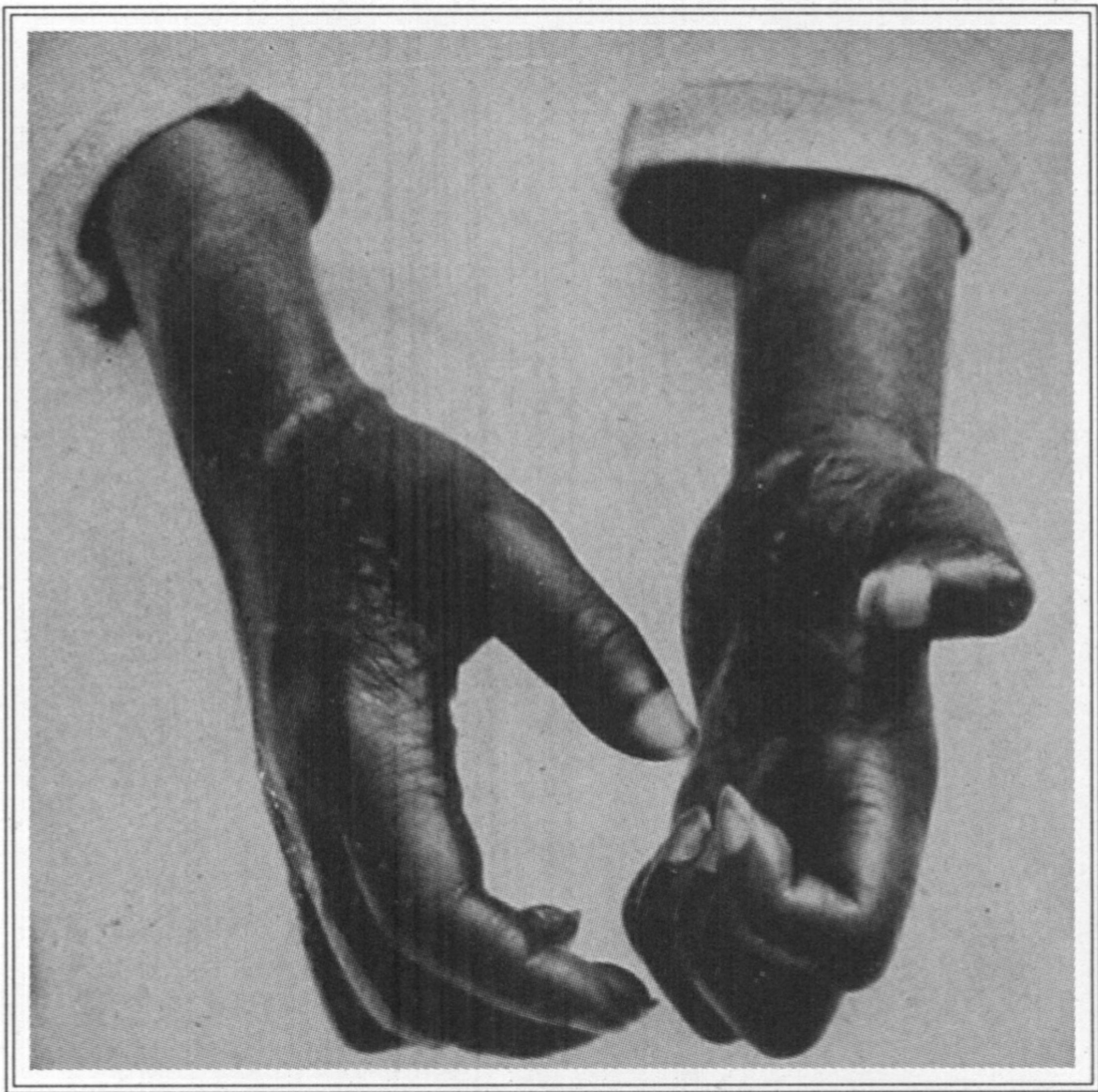
Index

Photo Credits

Preface

Introduction: Fear of Contagion, Punishment, and Hope





Typical "main en griff" in leprosy (Handbook of Medical Treatment, 1919)

PREFACE

This volume is the first of its kind by the National Historical Commission of the Philippines; most of our publications concern political and economic events, the traditional fare of historical work. Our interest in the history of Hansen's disease was spurred by a discussion with Ms. Nao Hoshino of the Sasakawa Memorial Health Foundation in 2013, following an international workshop the Foundation organized in Tokyo the year before. The idea of a global history of Hansen's disease was broached during the discussion and my immediate reaction was: why not begin with national histories and perhaps from there, proceed to the larger picture?

And so the project was born. With a grant from the Sasakawa Foundation, I assembled a team from various universities and the Commission, whose members agreed to focus on different periods and aspects of Hansen's disease in the Philippines in order to produce a comprehensive history from the earliest times to the present. Most of us are historians, so we relied on primary, oftentimes colonial, sources. Some gathered data from the field, while others obtained oral histories from the diseased themselves.

We are grateful to the Sasakawa Memorial Health Foundation for supporting this endeavor, and to Dr. Jo Robertson of Queensland University and Dr. John Manton of the University of Cambridge for commenting on our drafts. Through this book we hope to raise awareness of Filipino Hansenites and Hansen's disease, whose history is intrinsically tied into the larger history of the country but has remained silent for much too long.

Henri IV of France touching for scrofula (Engraving by Pierre Firrens, 1609)

FEAR OF CONTAGION, PUNISHMENT, AND HOPE

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In his seminal work, *The Royal Touch* (1924), Marc Bloch examined the belief in England and France from the Middle Ages to the eighteenth century that kings could cure scrofula (called 'the king's evil'), a tubercular inflammation of the neck glands, merely by touching the person afflicted with the disease. Bloch found that embedded in this miraculous belief was a notion of the power of kings that enabled royalty to exercise control over society.[1] The papers in this anthology on the history of leprosy in the Philippines present a variant of this finding though in a reverse (and quite perverse) way. Rather than touch serving as the (perceived) medium of healing, it became the (also perceived) means of contagion of a socially dreaded disease, and while in the instance of scrofula the king was the repository of power, in the case of leprosy the aim was to reduce the Hansenite to power's hapless object. Beliefs in the power of touch, whether to heal or to infect, were associated with notions founded not on science, but on fear and of understandings of authority and social relations.

THE DISCOURSE OF LEPROSY

The term, leprosy, itself is wrought with social meaning. Beyond the medical condition it specifies, "leprosy" carries with it a set of images and notions that conjure fear, shame, stigma, and control, all of them pejorative or, at the least, negative. When the contributors to this volume first gathered to discuss the project, we agonized over the use of the word in favor of the more accepted and less loaded term, "Hansen's disease." The latter, in contrast to "leprosy," speaks of cure and optimism rather than helplessness and certain decline.

But as this is a work of history that traces the disease, perceptions of it, and its treatment over time, the authors decided to stick to the word "leprosy," aware of its dark and unfortunate side, in the interest of fidelity to the sources we used. Hence, in the papers about the Spanish and American colonial periods and the time antedating the discovery of the cure, the term "leprosy" is used; in the later papers, the less painful term named after Gerhard Armauer Hansen, the discoverer of the bacterial causing agent *(Mycobacterium leprae)*, is applied. By using the term "leprosy" in a historical sense, our hope is that its historicity would confer realism and expose all the ugly truths that surrounded the disease and most especially, accompanied those pained by it.

With regard to the word "leper," however, we have applied greater caution, avoiding its use as much as possible or limiting it to translations of, or excerpts from, archival materials. Why the

hesitation in using "leper" and not "leprosy" when, as some argue,[2] the two terms are alike in that one defined the identity of the other? While we accept the social construction of the disease, we prefer to draw a distinction between leprosy—a condition—and the one stricken with leprosy—a human being, precisely to uphold the latter's humanity. The condition was no doubt ugly and frightening and, until the 1940s, incurable; its adjectives were thus apt to be so. But those sick with leprosy were persons whose humanity was denied by the social usage of the noun, "leper," which also became their assumed identity, and through institutional control best symbolized by that ugliest of terms, the "leper colony." Such denial of humanity was, therefore, not merely a matter of language but of reality that language represented: the workings of power on the powerless, grounded on the fear of contagion and justified in the name of public health. We contributors therefore agreed to write a history of Hansen's disease in the Philippines that would affirm the humanity of those stricken with it and assert their agency in the making of their own history.

This act of self-consciousness on our part accepts the centrality of power in the discursive aspect of language without, however, denying the historical agency of the powerless. No greater evidence of powerfulness and powerlessness is there than in the terms "leprosy" and "leper." The word "leper" was so extended in meaning that it found its way even in legal decisions unrelated to those afflicted with leprosy. In 1919, for example, the Philippine Supreme Court decision granting the application for *habeas corpus* of prostitutes rounded up in Manila by the city government and then shipped off to Mindanao as laborers, asserted that "these women *despite their being in a sense lepers of society* are nevertheless not chattels but Philippine citizens...[3] (*underscoring* supplied). Unfortunately, the same could not be said of inmates in Culion whose segregation had been sanctioned by law.

Indeed the connection between leprosy and prostitution—both viewed by officials as a menace to public health—found its way, too, in the spatial distribution of hospitals that treated patients with lingering ailments. A special team from Johns Hopkins University reported in 1900 that the "San Lazaro or leper hospital, in the outskirts of Manila, contained from 80 to 100 lepers during our stay," with men and women patients housed separately. "One wing of the building," added the team, "having a private entrance, is devoted to native prostitutes who apply regularly for examination and are incarcerated here and treated medically when found to be suffering from venereal disease."[4]

A HISTORY OF MENTALITIES

Given the highly discursive nature of Hansen's disease, its history inevitably becomes a history of mentalities, of people's assumptions and perceptions from the ground and up, in and outside isolation centers, not just about the disease but also implicitly about the workings of power and relations within society. These understandings are expressed in local languages, as well as in the language of religion and of law.

Religious friars, among the first Spaniards to arrive in the Philippines, noted the presence of persons ailing with leprosy and compiled indigenous words that described the disease or at least its outward symptoms. Lorelei de Viana (Chapter 2) explains that prior to Spanish rule, some form of isolation of the diseased was already in practice, albeit in limited and arbitrary ways, in part owing to the value and necessity of physical health in early societies. What emerges in her paper and runs through Maria Eloisa de Castro's (Chapter 3) is the continuing thread of mysticism that spanned the early and the colonial periods, starting with the non-Christian belief in leprosy as divine punishment for departing from tradition, leading to the Christian variant of sin (or the devil) as the cause of leprosy, and other Spanish beliefs that leprosy was contagious, hereditary, or caused by "backward", unsanitary habits. Celestina Boncan (Chapter 4) points out that toward the late nineteenth century,

certain types of food that comprised the regular Filipino diet came to be identified as the cause of leprosy. The primacy of spiritual causes prevailed for centuries until the professional *medicos titulares* of the 1880s began to consider natural causes of the disease, though again to a limited extent. The same spiritual dimension applied to the cure of the disease, which ranged from the application of local herbs for immediate relief to the ever important sacrament of baptism for long lasting cure, whose holy water was believed to wash away sins along with physical ailments. De Viana and de Castro refer to friar accounts describing how the promise of a miraculous cure induced early Filipinos to convert to Christianity.

PRIOR TO SPANISH RULE, SOME FORM OF ISOLATION OF THE DISEASED WAS ALREADY IN PRACTICE

It comes as no surprise, therefore, that for the most part of Spanish rule, the treatment of those afflicted with leprosy was considered an act of charity carried out mostly by missionaries. De Castro focuses on the central role played by the Franciscan Order that managed the San Lazaro Hospital in Manila, the main treatment center for leprosy patients, while Boncan discusses the shift from the religious order as the principal agent of charity to the diocese, in particular, that of Cebu, a hotspot of the disease. The Franciscans, moreover, initiated a more systematic collection of indigenous flora whose leaves were processed into soothing lotions that were applied to open wounds typical of the disease. The *medicos*, Boncan adds, came too late in the period to leave an indelible mark, their efforts in experimenting with local cures cut short by the revolution.

By the time the United States conquered the islands, the segregation of persons sick with leprosy was a longstanding practice in a formal (institutional) sense, but within the largely religious framework of charity toward the sick. The secular framework of public health, rigorously backed by legal and police power, was an innovation of the United States. This new intellectual scaffolding of public health made the segregation of persons afflicted with leprosy compulsory and punished those who refused to comply or abetted the latter.

MILITARY AND LEGAL PARLANCE

The initial impetus to guard against leprosy was the protection of American soldiers fighting Southeast Asia's earliest war for independence. The earliest reports of leprosy among soldiers were those who had served in foreign wars: the Spanish-American War (1898), the Philippine war for independence (1899–early 1900s), and the Boxer Rebellion (1900–1901). As the U.S. Army Medical Department's Office of Medical History explains, reports of the disease did not take place during the wars but at intervals over the years that followed. From 1921–1940, 32 veterans entered hospital because of leprosy, of whom 30 had served in action abroad. Out of these 30 men, 25 had served in the Philippines.[5]

THE LANGUAGE OF U.S. HEALTH POLICY ON LEPROSY WAS DECIDEDLY MILITARY IN CHARACTER.

The U.S. military thus played an important role in the field of health during the initial years of the occupation. Just as they had served as teachers in the first schools that opened in Manila, U.S. servicemen also supervised public health efforts until the Philippine Board of Health (created by Act No. 157 in 1901) was replaced by the Bureau of Health in 1904. American civilian officials then replaced Army medical officers although in some (more distant) parts of the Philippines, U.S. military doctors continued to act as community health officers in the early 1900s.[6]

Rene Escalante (Chapter 5) discusses public health policy on leprosy under American rule, which began with a disinterest in the disease owing to more pressing tropical ailments like cholera and rinderpest, then shifted to a focus on leprosy that culminated in the establishment of the Culion Leper Colony in 1904 and the passage of the so-called "Leper Law" in 1907, to the search for a cure to the disease and the establishment of regional leprosaria starting in 1927.

The language of U.S. health policy on leprosy was decidedly military in character. Dr. Victor G. Heiser, assigned to carry out the policy of segregation, described the implementation strategy as follows:

> ... the plan adopted and still followed, and which the geography of the country so eminently favored, consisted in removing all leprous patients from the well-isolated islands which contained only a few victims, and subsequently recanvassing the Territory two or more times for cases which might have escaped, been overlooked, or which subsequently developed. By the method pursued, the greatest amount of territory was freed in the shortest possible time. In military phraseology, the outposts were captured first and the lines gradually moved forward to the strongholds.[7]

The very title of the 1907 law, "An Act Providing for the Apprehension, Detention, Segregation, and Treatment of Lepers in the Philippine Islands," spoke of police powers in approaching the disease. With regard to persons believed to have leprosy, the action words of the law were: "subject to medical inspection," "arrest," "apprehend," "deliver to the Director of Health or his agents," "detain," "convey to such place as the Director of Health or his agents may require," "permanently remove," "control," "isolate," "segregate," "confine," and "punish." Similar police powers were applied to

THE VERY TITLE OF THE 1907 LAW, SPOKE OF POLICE POWERS IN APPROACHING THE DISEASE

> those who knowingly detain or harbor on premises subject to his control, or ... in any manner conceal or secrete, or assist in concealing or secreting, any person afflicted with leprosy, with the intent that such person be not discovered or delivered to the Director of Health or his agents, or who shall support or assist in supporting any leper living in concealment.[8]

The punishment for violating the law was a fine of up to 200 pesos (a hefty sum then), or imprisonment not to exceed six months, or both.[9]

Persons stricken with leprosy were forcibly "collected" and taken to Culion. In 1922, the Cebu Leper Detention Camp (note, again, the police terms) was established solely for this purpose: as a way station prior to the shipment of patients to Culion.

The fusion of medical and police terms is also apparent in the medical literature of the period. In 1936 George C. Dunham, technical adviser on public health to the Governor-General and chairman of the Philippine Islands Leprosy Commission in Manila, reported:

> Bacteriologically positive lepers who become bacteriologically negative are released, or "*paroled*," from segregation after a period of observation. A total of about 3,500 lepers have been paroled in the past 12 years. About 50 percent of the paroled lepers eventually

relapse, that is, again become clinically active and bacteriologically positive.[10] (emphasis supplied)

GEOGRAPHY OF CONTAINMENT

The reasons for segregation were medical—to contain the disease, and socioeconomic—to care for the sick since they could not find employment. Given the belief that leprosy, then incurable, could be transmitted by contact, with children as the most vulnerable population, the isolation of those with leprosy was seen as the only effective measure to prevent the spread of the disease. Home isolation, however, was ruled out as "impracticable," because it would not in practice protect the family or the community from infection with leprosy. The environment created by home segregation would not be for the best interests of the individual segregated, and it would tend to have an adverse effect on the progress of the disease under treatment. Home segregation would permit the individual to remain with the adult members of his family, but this single advantage would be far outweighed and nullified by the many disadvantages.[11]

AMERICAN OFFICIALS EYED CULION FOR ITS CLIMATE, OPEN SPACES, WATER SUPPLY, HARBOR AND, BEST OF ALL, ITS ISOLATED LOCATION

Following this logic, the most effective strategy was group segregation in regional colonies. Now where were these colonies located? Culion island in Palawan figured prominently as the main leprosarium and was touted as the finest example. In his study of regional leprosaria, Rod Edmond explains why: "Islands, because of their bounded geography, have frequently been used for detention and quarantine. They are natural sites of concentration, places where contaminants from the mainland can be dumped."[12] Veronica A. Dado (Chapter 6) confirms this; American officials, she points out, eyed Culion for its climate, open spaces, water supply, harbor and, best of all, its isolated location.

Subsequent regional leprosaria, as Ma. Florina Y. Orillos describes in her paper (Chapter 7), such as the Western Visayas Leprosarium in Sta. Barbara, Iloilo (1927), the Eversley Childs Leprosarium in Jagobiao, Mandaue, Cebu (1930), and the Central Luzon Leprosarium in Tala, Novaliches, Rizal (1940), shared a similar landscape of isolation, situated this time on rolling hills or sloped terrain. All of them were built up with infrastructure and facilities ranging from quarantine and treatment centers to dormitories and agricultural workspaces.

IN THE PHILIPPINE CASE A DUALITY OF WORLDS IS INSTANTLY PERCEPTIBLE

But were the islands truly "graveyards for the still-living," as Edmond puts it, or for an existence he called "death-in-life?" In her study of leprosia in India during the late colonial period, for example, Jo Robertson makes a more nuanced analysis by looking into the agricultural colonies created for patients to enable them to work gainfully.[13] Here a dimension of hope rather than pure resignation surfaces.

In the Philippine case a duality of worlds is instantly perceptible. On the one hand, there existed the leprosarium (or colony) as a "total institution," to borrow the words of Erving Goffman.[14] The power of the leprosarium was so encompassing that all ingress and egress were physically, manifestly blocked (by water, locked gates, etc.). In this tightly regulated regime, persons, hours, human interactions, clothing, other details, including coinage, were identified, prescribed, and monitored, and violations of the prescribed regime were punished.

On the other hand, there is the image of the leprosarium, or parts of it, to be accurate, as tolerant. Upon arrival in Culion, patients were welcomed by a band. Dado explains that Culion was divided into two worlds: the colony proper or the inner colony of the *leprosos*, and a settlement (Balala) outside the colony for the *sanos* (those without the disease). Within the colony proper, patients could move about freely. They elected their own representatives coming from the regional groups that comprised the patient population, who in turn enacted local laws, but inmates were not permitted to pass the gates that barricaded their world from that of the *sanos.* The names of structures in Culion were consistent with this duality: the "Get Well Club" residence, Sanitary Barrio, Colony Hall (the administrative center), the Upper Gate, and the Lower Gate. These demarcations were both physical and medical: at the Lower Gate leading to the colony of patients, for instance, as Dado notes, medical staff disinfected themselves before entering the colony proper, and once again when they departed.

The duality of worlds extended to the segregation of male and female inmates. Housed separately, men and women were not allowed to marry until 1910, and mainly because of religious strictures against pre-marital sex. The growing birth rate nonetheless alarmed health officials, prompting them to rescind the freedom to marry briefly in 1928 and to impose other regulatory (albeit short-lived) measures such as a marriage tax. Francis Gealogo and Antonio Galang (Chapter 8) discuss these restrictive measures, which were obvious proof of the failure of sexual segregation among patients.

MONEY AND TRADE

Culion's economy provided another arena of the dual worlds of the afflicted and non-afflicted. This self-contained colony had its own money (called "leper coins" or "leper money"), which was the only legal tender in the area. Noninmates who did business in the colony had to exchange their "government money" for "leper money" before entering Culion and did the reverse when leaving the place. The confinement of coinage within the colony was enforced by the local police.

SO COMPELLING WAS THE BELIEF IN THE POWER OF TOUCH BY THE DISEASED THAT THE COINS OF CULION WERE FEARED AS A MEDIUM OF CONTAGION AND THEREFORE DISMISSED AS A SOURCE OF COMPETITION FOR THE COLONIAL CURRENCY

The "leper coins" were made of aluminium and minted in Manila: the initial batch in 1913 by Frank and Company, and succeeding issues by the Manila mint (starting in 1920). Inscribed on the coins were the following phrases: "Culion Leper Colony" at the top of the obverse and "Philippine Islands" below it; and on the reverse, "Bureau Of Health" surrounding a caduceus (a winged staff with two snakes wrapped around it, symbolizing trade in ancient times).[15] Here yet again was another powerful symbol of the place of Culion in the island colony of the United States—a colony within a colony but demarcated from the latter in every conceivable way—and the almost limitless power of the Bureau of Health over the life of the colony and its residents, *leprosos* and *sanos* alike.

The coins of Culion also represented the mentality of the time. No government willingly or easily concedes its currency in favor of another, or creates another alongside its own, but so compelling was the belief in the power of touch by the diseased that the coins of Culion were feared as a medium of contagion and therefore dismissed as a source of competition for the colonial currency.

One would suppose that such fear also acted to isolate the Culion colony from trade. A contrasting image appears, however, of Culion as a land of commercial opportunity for outsiders. Fishing in the area, recounted Kensuke Mitsuda, a pioneer of Japan's segregation policy and the director of its first national leprosarium, was controlled by the Japanese, thereby limiting Culion's supply. This was the story told him by Perry Burgess, the president of the Leonard Wood Memorial, when Mitsuda visited

Culion in 1923. To address the shortage, Burgess

> asked the Japanese Consulate to contract a firm called Osaka Bazaar Co. Then the company sent some 40 fishermen from Okinawa to this area, who managed to catch enough fish to feed all the inmates. The fish catch before was barely enough to feed the inmates twice a week, but now they have abundant catch. Some suspected the fishermen might be using poison and refused to eat the fish. So the sanatorium authority allowed some of their staff to get on the fishing boats to inspect how they fished. Now the islanders were very happy with plenty of fish to eat, while Osaka Bazaar Co. was delighted with more than double income from fishing.[16]

This juxtaposition of contrasting realities—"government money" and "leper money," a colony within though apart from a colony, isolation and commerce—was a distinctive feature of the colony's foremost leprosarium, indicating the nature of this all-encompassing (total) institution as well as its slight crevices of breathing space.

THIS JUXTAPOSITION OF CONTRASTING REALITIES—"GOVERNMENT MONEY" AND "LEPER MONEY," A COLONY WITHIN THOUGH APART FROM A COLONY, ISOLATION AND COMMERCE—WAS A DISTINCTIVE FEATURE OF THE COLONY'S FOREMOST LEPROSARIUM

RESISTANCE TO SEGREGATION

Cracks within the policy of segregation were not a matter of wear and tear, which sometimes happens to rules that lose their rigor over time as officials tire or turn their attention elsewhere. Rather, spaces within the policy were cracked open by human actors out of pragmatism, as in the case of the fishing trade, or out of resistance, as evidenced by inmates or would-be inmates. The collection (apprehension) and segregation (detention) of persons with leprosy were harsh processes, deliberately executed by the colonial government, and involuntary on the part of the afflicted. Yet, persons with leprosy and their families and neighbors managed to poke holes into these processes that enabled them to slip away in some instances, or confront the government in others.

To be fair, notwithstanding the nearly absolute power of the Director of Health, the law entertained "protests and petitions" that challenged the finding of leprosy and required the confirmation of the disease by bacteriological methods as the basis of sending the person to a leprosarium. An additional safeguard provided for the guardianship of property and money of segregated persons by the provincial treasurer or his designated representative until the Court of First Instance in the patient's province of residence appointed a custodian.[17]

However, Gealogo and Galang cite complaints from some communities that local officials would pinpoint relatives of their political foes to collection agents. On the ground, the permanent removal of persons with leprosy from their loved ones and communities was painful and, in some cases, attended by violence. The removal of their children created additional agony. Gealogo and Galang provide numerous instances of resistance by inmates to segregation. Some of the methods of resistance could be likened to James Scott's "weapons of the weak," a term he used to describe ordinary (without flair), usually passive (nonetheless effective) means of peasant resistance. The forms of resistance detailed by Gealogo and Galang range from avoidance to confrontation in all phases of the segregation process. In the collection phase, for instance, some communities devised an early warning system so that members with leprosy could hide in the fields until the collection team

departed. Some of those who were caught tried to jump off ship, preferring to drown rather than experience indefinite incarceration in the great unknown of Culion, but the most confrontational incidents took place in the colony itself, with regard to the rule on sexual segregation. Here women and men inmates applied force to end such separation.

LEGAL ARENA OF OPPOSITION

There were, too, fugitives who were not within the normal radar of collection teams. One example was Arthur G. Moody, a wealthy American businessman who lived in Manila for decades until he left in 1928, "surreptitiously..., under cover of night, on a freighter, without ticket, passport or tax clearance certificate,"[18] to avoid detention in Culion. This is an interesting case because Moody had been advised by Dr. Herbert Windsor Wade, Culion's chief pathologist, to turn himself in or be apprehended, but the man of means managed to escape out of the country.

In the 1920s and 1930s, public opposition to segregation began to grow. One reason, says Escalante, was the financial burden of leprosy, whose budget was far greater than, say, tuberculosis, but with significantly fewer patients. Orillos cites several Filipino doctors and various articles in Philippine newspapers that spoke of the failure or limitations of segregation. These public expressions worried American officials, who understood the causes of "political agitation" to be as follows: the growing public view that leprosy was not infectious (because it is was rarely transmitted to adults); advances in science that gave hope for a cure; and the difficulty families experienced in visiting their loved ones in Culion and other sites.[19]

OTHER ASPECT OF U.S. PUBLIC HEALTH POLICY: ITS CONCERN WITH MODERNITY AND THE INTERNATIONAL ROLE OF AMERICAN LEPROSY TREATMENT IN THE PHILIPPINES

The challenge to segregation also surfaced in the legal arena. In the late 1920s the Supreme Court was asked to set aside the judgment of the Court of First Instance of Manila that had upheld the law on segregation and denied the petition for *habeas corpus* of a patient confined in the San Lazaro Hospital. The Supreme Court ruled that facts about the nature of the disease were not for the Court to determine, and sustained the lower court."[20]

In 1935 yet another attempt was made, this time in the proper forum. The Philippine legislature passed the Nolasco bill that ended group segregation and provided instead for individual home isolation, treatment by private doctors, and release from isolation after a shorter negative period. Governor-General Frank Murphy, however, vetoed the bill and created a Leprosy Commission that upheld the group segregation of persons with leprosy as "the method of choice for the control of leprosy in the Philippine Islands," which was best carried out "by means of regional colonies, regional treatment stations, and leper hospitals for advanced cases."[21] In a measure aimed at easing the public outcry, the Commission reduced the pre-parole observation period for negative patients (no longer bacteriologically active) by half (from 12 to 6 months).[22] Given the heightened social awareness of the disease, it is doubtful that measures like this assuaged the general public.

PROJECT OF MODERNITY

Part of the reason for American reluctance in discarding segregation was its concern that desegregation "would not only destroy the excellent work which has been done during 17 years, but would put the Philippines back where they were before the Americans took charge of them." Here in an instant was the other aspect of U.S. public health policy: its concern with modernity and the

international role of American leprosy treatment in the Philippines. Conscious of developments in other parts of the world, American health officials often referred to examples abroad (such as Scandinavian countries) to justify segregation in the Philippines. There was, too, the conscious effort to create a treatment center that would hold up as a model to the rest of the world. As the editorial of the *American Journal of Public Health* asserted in 1925, the Culion colony, "said to be the largest in the world as well as the best, ... stands out as a great example of what can be done in eradicating leprosy *from the world"* (emphasis added). The international element was as much a part of the American project of modernity in the island colony of the Philippines as it was a part of the worldwide quest for a cure for leprosy.

The fact is that leprosy was a matter of international concern because of the fear of contagion from foreign lands and peoples. The First International Leprosy Congress in 1897 proposed a strategy of isolation that later took the form of segregation laws in the Philippines. The international leprosy program thus provided an anchor for Philippine policy. As the global network of leprosy agencies grew, the Philippines became part of it. Ma. Mercedes G. Planta (Chapter 9) discusses the significance of two international health organizations in the Philippine campaign in the early decades of the twentieth century: the Far Eastern Association for Tropical Medicine founded in Manila in 1908, and the International Health Commission of the Rockefeller Foundation founded in 1913. A key figure in the colonial and international scene was Victor Heiser, Director of Health in the Philippines (1905–1915), who headed the International Health Board, successor to the International Health Commission, from 1918 to 1927.

One of the arguments Planta makes relates to the role of government, international health organizations, and the array of formal and informal health agents as interlocking intermediaries of modern medicine. The working relationship between Heiser and Leonard Rogers of the Indian Medical Service, for example, boosted leprosy research, something that was never seriously or systematically undertaken during the Spanish period. Heiser's leadership of the Far East section of the Rockefeller Foundation's International Health Board further fostered the development of the science of medicine on an international platform. Heiser's visits to parts of Asia (Calcutta in 1915, for instance, and Java in 1916) reinforced his view that the American leprosy experiment in the Philippines was a resounding success not only in the colony but also in the world.

Personal ties also helped steer the development of the leprosy program. Heiser, for example, was able to persuade his close friend, Governor-General Leonard Wood, to pay attention to the disease. And Wood did; in 1922, Planta observes, Culion's 6,000 residents received more than a third of the colony's total health budget.

DESEGREGATION

The importance of Culion began to wane shortly after Leonard Wood left in the late 1920s and continued through the financial crisis of 1933, reaching its lowest point during the Commonwealth in 1935, particularly under President Manuel L. Quezon who opposed it. The decline of Culion was also the effect of advanced treatment methods and regional clinics in strategic parts of the Philippines, which steadily gained ground in the second half of the twentieth century.[23] The first effective treatment (promin) became available in the 1940s, followed by the introduction of dapsone in the 1950s, clofazimine and rifampicin in succeeding decades, and Multidrug Therapy (MDT) in 1982, which combined all three anti-leprosy drugs (dapsone, clofazimine, and rifampicin). MDT remains the standard treatment.[24]

These developments combined to enable the liberalization of segregation in the Philippines after it

secured its independence in 1946. Meynardo P. Mendoza (Chapter 10) traces the post-independence period in two stages: 1946–1986, which was marked by the entry of international organizations and other support institutions that assisted the Philippine government's leprosy control measures, which apparently lost focus toward the end of this phase; and 1987–2010, a period of resurgent interest in leprosy owing to international partnerships and the Philippine government's emphasis on community involvement in the treatment of the disease.

The first law to loosen the policy of segregation was Republic Act 753 (passed in 1952), which allowed home isolation subject to regular physician visits and other conditions. Mendoza points out that many patients nonetheless opted to remain in the leprosaria because of the financial and social burden of home care. Segregation came to an end with Republic Act 4073 (in 1964) except for those who required institutional care. The liberalization of segregation was bolstered by the formal entry of international health partners, local communities, and various civil society organizations, the latter two being innovations of the post-independence period. One reason for the participation of non-government actors was the need for home- and community-based health infrastructure to accommodate the change in leprosy policy. The shift in policy, as Mendoza points out, led to the devolution of leprosy treatment and its integration into the general public health services.

More significant, leprosy patients in different parts of the country organized themselves as crucial actors in their own development and that of their communities, attending to a range of medical and psychosocial needs. Mendoza cites as examples the Bicol Sanitarium Association of Persons with Disability, Inc., the *Grupo ng mga Registradong Pasyente ng may Mahusay na Oryentasyon*, Inc. (Group of Registered Patients with Upright Orientation), the Hansen's Club, and the Interactive Society Leprosy Association of Muslims. At present, these organizations are grouped under the Coalition of Leper Advocates of the Philippines.

MORE SIGNIFICANT, LEPROSY PATIENTS IN DIFFERENT PARTS OF THE COUNTRY ORGANIZED THEMSELVES AS CRUCIAL ACTORS IN THEIR OWN DEVELOPMENT AND THAT OF THEIR COMMUNITIES, ATTENDING TO A RANGE OF MEDICAL AND PSYCHOSOCIAL NEEDS.

SOCIAL CONSTRUCTION OF THE DISEASED

The self-mobilization of patients and former patients signalled a bold step in their development as autonomous members of society. The history of leprosy in the Philippines is certainly empty without their voices. Ma. Luisa T. Camagay (Chapter 11) and Ma. Carmen C. Jimenez (Chapter 12) share stories of Culion's past and present residents. Their narratives suggest the manner in which their identities were constructed, not out of the bacteria that had infected them—surprisingly to this day, some are still unaware of the scientific cause of their disease—but out of the social environment in which they were thrust. The voices of the women and men of Culion also serve the historiographic purposes of filling the void in historical writing about the disease, which relies heavily on colonial and official accounts, and of foregrounding the historical agency of persons with leprosy. Such historical redress is necessary for, as Charles Webster noted, historians of medicine tend to depict patients as docile channels of disease,[25] doing them (and history) a great disservice.

The women and men interviewed by Camagay and Jimenez demonstrate that the passivity of patients has indeed been artificially contrived in medical and official records, that, in fact, they are feeling and thinking human beings no different from the *sanos*. Stigma, imposed from outside and sometimes within, and social and emotional dislocation were recurrent themes expressed by the interviewees. In a sense, the official insistence on group segregation in regional colonies rather than

individualized home isolation helped create a shared identity among the residents of Culion. By its open discrimination of persons with leprosy, the colonial government made possible the creation of an identity founded on difference with regard to the larger society, and on commonality among the diseased. As British anthropologist Mary Douglas explains, "Each culture discriminates, but the hierarchical one does it overtly, handing out group badges of difference..."[26]

From the initial commonality of leprosy, the patients learned to form new relationships among regional groupings within the colony (allowed) and across, the sexes (forbidden but resisted). That they could speak of their pain—physical, emotional, and social—and recount their experiences as patients are a testament to the power of human agency amidst the lingering memories of segregation. Self-stigmatization was also evident, though perhaps not unusual for, as Douglas remarks, "Stigma is interesting as a self-fulfilling prophecy. Prejudiced and exclusionary behaviour validates itself."[27]

The struggle between utter resignation and hope was a constant battle; on some days, one won over the other. It appears from the interviews that the men were less optimistic than the women (for whom religious faith was a source of succor). Jimenez adds that although most of the men she interviewed were negative for leprosy, they continued to identify themselves as *leprosos.* The physical deformity of the disease was its permanent reminder, but so were other people who never let them forget that they once were afflicted with the disease.

PERSISTENT SOCIAL MARKERS

Evidence of these social reminders is found in Philippine languages. Once again we turn to the matter of mentality, of consciousness, that we started with in this paper. Consuelo J. Paz's study of five languages, Tagalog, Ilokano, Ilonggo, Cebuano, and Tausug, amply demonstrate the range of expressions relating to leprosy, nearly all of them with stigmatizing effect: in invocations, descriptions of symptoms, inarticulateness or refusal to name the disease, ignorance of it, fear of infection, superstition, metaphors for contamination, expressions of pain and loneliness that a diagnosis causes, outright ostracism, and self-stigmatization.[28]

THAT THEY COULD SPEAK OF THEIR PAIN—PHYSICAL, EMOTIONAL, AND SOCIAL—AND RECOUNT THEIR EXPERIENCES AS PATIENTS ARE A TESTAMENT TO THE POWER OF HUMAN AGENCY AMIDST THE LINGERING MEMORIES OF SEGREGATION

Paz's findings suggest the tenacity of stigma despite the reduction of leprosy, and ignorance of the disease as the foundation of stigma. In practice both feed each other, but the more important question perhaps is why ignorance—the lack of scientific understanding of the disease (even among former patients)—persists. The answer does not lie in language and neither in public health campaigns alone, but within the larger social fabric. Douglas explains:

> It may be a general trait of human society that fear of danger tends to strengthen the lines of division in a community. If that is so, the response to a major crisis digs more deeply the cleavages that have been there all the time. This will mean that if there is a big inequality of wealth, the poor will suffer more than if the distribution were more equitable.[29]

As stigma opens the door to fissures that surface when a society is under fear of contamination, the feared (those with leprosy) are pushed to the periphery. From this standpoint stigma need not be a permanent condition; it can and will change as the social conditions it represents improve.

The success story here is that leprosy has been controlled in the Philippines, and is fairly easy to cure if diagnosed early enough. Segregation has ended. Patients and former patients, however, continue to live with the burden of history, some of them more easily than others. Of the narratives recounted by Camagay and Jimenez, two stand out as instructive ways by which former leprosy patients have dealt with this burden. One, narrated to Jimenez by a man whose family had asked him to return home after being pronounced negative, asserted that he had found his own world in Culion: "*Iba na ang mundo ko*" (I have a different world/life now); "*Iba na ako*" (I am different now). The other, recounted to Camagay, is of a woman who, because of her numerous engagements—as federation president of Persons with Disability, secretary of the Association of the Culion Hansenites, Inc., member of the church choir—says she was able to pull herself out of the well of hopelessness and find fulfillment.

In both instances new worlds were created, the first involuntarily, and the second, wilfully. Yet there is hope in both. It is this that infuses the history of leprosy with its most human feature.

NOTES

1. Marc Bloch, *The Royal Touch,* trans. J.E. Anderson (London: Routledge, 1973).
2. See, for example, Julie H. Levison, "Beyond Quarantine: A History of Leprosy in Puerto Rico, 1898–1930s," *História, Ciências, Saúde-Manguinhos* 10, 1(2003): 227.
3. Justice George A. Malcolm, G.R. No. L-14639, Zacarias Villavicencio, et. al., petitioners, vs. Justo Lukban, et. al., respondents, 25 March 1919.
4. S. Flexner and L.F. Barker, "Report of a Special Commission Sent to the Philippines by the Johns Hopkins University to Investigate the Prevalent Diseases of the Islands," *Johns Hopkins University Circulars* 19, 143 (March 1900): 14.
5. James A. Doull, "Leprosy," U.S. Army Medical Department, Office of Medical History, in Volume V, Preventive Medicine in World War II Series, Communication Diseases: Transmitted through Contact or by Unknown Means <http://history.amedd.army.mil/booksdocs/wwii/-communicablediseasesV5/chapter4.htm> (accessed 8 June 2015).
6. Ibid.
7. Victor G. Heiser, "Leprosy in the Philippine Islands," *Public Health Reports (1896–1970)* 24, 33(13 August 1909): 1156.
8. Philippine Commission, Sec. 2 of Act No. 1711, An Act Providing for the Apprehension, Detention, Segregation, and Treatment of Lepers in the Philippine Islands, 12 September 1907.
9. Ibid., Sec. 6.
10. George C. Dunham, "Leprosy in the Philippines," *American Journal of Public Health* 26, 1(Jan 1936): 27.
11. Report of the Leprosy Commission in George C. Dunham, "Leprosy in the Philippines," *American Journal of Public Health* 26, 1(Jan 1936): 28.
12. Rod Edmond, *Leprosy and Empire: A Medical and Cultural History* (Cambridge: Cambridge University Press, 2006), 143.
13. Jo Robertson, "The Leprosy Asylum in India: 1886–1947," *Journal of the History of Medicine and Allied Sciences* 64, 4(October 2009): 47–517.
14. Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Harmondsworth: Penguin, 1975), 15–16.
15. JAA USA/Philippines Collection, "Culion Island Leper Colony Coinage" <http://-boards.collectors-society.com/ubbthreads.php?ubb=showflat&Number=6132613> (accessed 3

July 2013).

16. Kensuke Mitsuda, *Aiseien Nikki* (Tokyo: Mainichi Newspaper Co., Ltd., 1957), 95–97. Translated by Kazuko Yamaguchi.
17. Sec. 1, 1907 'Leper' Law.
18. Justice George C. Butte, G.R. No. 43314, A. L. Velilla, administrator of the estate of Arthur Graydon Moody, plaintiff, v. Juan Posadas, Jr., Collector of Internal Revenue, defendant, 19 December 1935.
19. George C. Dunham, "Leprosy in the Philippines," *American Journal of Public Health* 26, 1(Jan 1936): 27–28.
20. Justice George A. Malcolm, G.R. No. 27484, Angel Lorenzo, petitioner vs. The Director of Health, respondent, 1 September 1927.
21. George C. Dunham, "Leprosy in the Philippines," *American Journal of Public Health* 26, 1(Jan 1936): 28.
22. Ibid., 28–29.
23. Ronald Fettes Chapman, *Leonard Wood and Leprosy in the Philippines* (Washington, D.C: University Press of America, 1982), 83.
24. Editorial, "Treatment of Leprosy," *British Medical Journal* 328 (19 June 2004): 1447.
25. Charles Webster, "The Historiography of Medicine," in P. Corsi and P. J. Weindling (eds.), *Information Sources in the History of Science and Medicine* (London: Butterworth Scientific, 1983), 40.
26. Mary Douglas, "Risk and Justice," in M. Douglas, *Risk and Blame: Essays on Cultural Theory* (London and New York: Routledge, 1994), 35.
27. Ibid.
28. Consuelo J. Paz, "Language as a Vehicle of Stigma," research commissioned by the National Historical Commission of the Philippines, 2014.
29. Douglas, 34.

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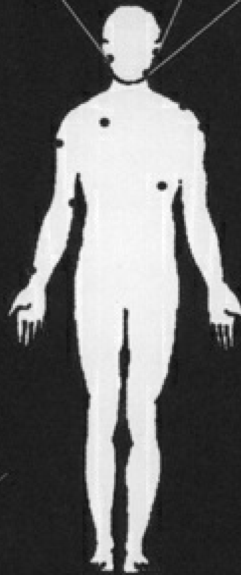
Rediscovering a Paradigm: The Franciscan Order's Response to Leprosy and the Afflicted in the Philippines, 1578–1898

Early Encounters between the Spanish Religious Missionaries and Leprosy in the Philippines

At the Crossroads: New Developments in Leprosy Care in Nineteenth Century Philippines



I. Charity and Care in the Treatment of the Afflicted

St Augustine (left), founder of the Augustinian order, offers his heart to illuminate the Philippine archipelago through divine light while King Philip II of Spain (right) points to the newly disacovered islands (1608).

Early Encounters between the Spanish Religious Missionaries and Leprosy in the Philippines

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This paper examines descriptions of leprosy in the Philippines from two kinds of sources:

- sixteenth and early seventeenth century accounts written by Spanish missionaries and foreign travelers to the Philippines, and
- early missionary dictionaries.

These sources describe their impressions of how the native peoples living in various mission areas of Luzon, the Visayas, and Mindanao understood leprosy in terms of its symptoms, causes, management, modes of transmission, and the social consequences for sufferers. The native peoples emerge from these sources as prizing good physical health, fearing the physical deformities of the disease, regarding leprosy as a mode of divine punishment for misdeeds, treating leprosy with traditional medicines and physical regimens, and in some cases isolating diseased individuals from their communities to protect healthy members. The writers of these accounts, particularly the Spanish friars, emerge as critical of the native peoples' responses to leprosy as ineffectual yet unable to respond with more effective remedies. However, they used report of miracles wrought by baptism into the Christian faith among the sick and the diseased, including those with leprosy, to further the evangelization and colonization of the newly discovered Philippine territory.

LEPROSY AMONG THE NATIVES ACCORDING TO THE FRIAR CHRONICLES

When the Spanish missionaries began their mission to convert the native Philippine people in the late sixteenth and seventeenth centuries, they noted the presence of leprosy among their potential converts. Friar dictionaries of various Philippine languages provide evidence of an indigenous vocabulary referring to symptoms of leprosy and other skin diseases. For example, Fray Francisco de San Antonio's 1624 Tagalog dictionary lists words like *bocol* (tumor or cyst), *butlig* (skin eruptions), *buni* (skin disease, i.e. ringworm), *cati* (skin itch), *an-an* (white blotches on the skin), *aliponga*

(fungal skin infection), and *nacnac* (to fester with pus).[1] Such evidence suggests the existence of leprosy in pre-colonial Philippines.

MEMBERS OF VARIOUS MISSIONARIES NOTED IN THEIR ORDERS' OFFICIAL RECORDS THAT LEPROSY WAS A POWERFUL CATALYST FOR CONVERSION TO CHRISTIANITY

Members of various missionaries noted in their orders' official records that leprosy was a powerful catalyst for conversion to Christianity. The Augustinian missionary, Pedro Chirino, wrote that during an evangelical mission to Dulac (now Dulag) in Leyte province from June 1598 to January 1599, the converts included some people long afflicted with leprosy but who, after baptism, regained their health and were able to go back to their homes and till their land.[2] The Jesuit chronicles of 1608–1609 reiterate the miraculous cure in Dulac as well as narrate religious conversions by the Society of Jesus in the area.

> There were also found in a little island forty lepers loathsome with filth and stench, unclothed, and without food, lacking everything. To all of them first the teaching of Christ, then baptism, and finally food and clothes were given.[3]

Dominican friar accounts likewise narrate incidents of encounters with leprosy-infected people during the late sixteenth century. The Dominicans arrived in Manila in 1588. Not long afterwards, they set out for the provinces of Pangasinan and Bataan to spread the Christian faith. In Pangasinan, the Dominicans not only preached to the healthy but also tended to, and healed, the sick with successful and miraculous cures. In most cases, such cures and healings became the catalysts for Christian conversion among the natives.[4]

> [These] works of charity, and in especial the cure of a woman with a disgusting leprosy, who had been abandoned by her relatives, won for the fathers the love of these Indians. At last even the chief of those who had planned to kill the religious gave his child to be baptized, and finally offered himself for baptism.[5]

In 1668, during an Augustinian mission to convert the Payao [Apayao] natives residing in the mountains near Cape Engaño in Cagayan in the northern Philippines, the missionary Fray Benito de Mena encountered a leprosy-infected native who consented to Christian baptism and was healed.[6] Unexpected healings from ailments together with a dead child's coming to life again after baptism served as an impetus for the natives to convert to Christianity[7] Both the missionaries and the natives saw being cured of the "incurable" and "dreaded" leprosy as a miracle performed by the Christians' God who deigned to lift the ultimate divine punishment, aside from death.

THE MISSIONARY CHRONICLES OFFER EXPLANATIONS FOR WHY THE NATIVE PEOPLE BELIEVED THESE CURES AND HEALINGS WERE MIRACLES PERFORMED BY THE CHRISTIAN GOD.

The missionary chronicles offer explanations for why the native people believed these cures and healings were miracles performed by the Christian God. Among some natives of the pre-colonial Philippines, there was a prevalent belief that the disease was a divine punishment of their gods for violating honored traditions and customs. Recollect missionaries noted this belief among the natives

of Zambales and Tugui during their evangelical mission to the area in 1604.[8]

> Their laws were only traditions and very old customs, but they observed these carefully—not so much for fear of punishment, as because they believed he who violated them would be instantly killed, or at least become afflicted with the disease of leprosy, and that another part also of his body would become corrupt.[9]

The chronicle of the Augustinian missionary, Casimiro Diaz, recounts another telling incident.[10] In 1648, another Augustinian, Fray Pedro de Valenzuela, was on his way unescorted to Ilocos. As he passed through Puntalón, between Pampanga and Pangasinan, a group of Aetas killed and cut off his head. They then celebrated the event with eating, dancing, and revelry. It was reported that the Aetas involved in the death of Father Valenzuela, including their descendants, became afflicted with leprosy. The Aetas later told other missionaries that the resulting affliction was "divine chastisement" for killing the priest. After this incident, the Aetas only robbed missionaries and other aliens crossing their territory, to avoid again the further divine punishment.[11] It would seem from Diaz's story that the Aetas may have thought that the Spanish priests were under the protection of their God who would punish those who hurt or killed priests.

However, the missionary chronicles and traveler journals also posit socio-physical causes of leprosy aside from divine punishment. For example, the Jesuit, Francisco Ignacio Alcina, in 1668 mentioned the existence of leprosy in pre-colonial Visayan society and attributed its causes to the native peoples' personal contact with each other and with nature. The disease was called *pamatas* and was characterized by large foul-smelling wounds. Alcina wrote that *pamatas* appeared to be a hereditary disease passed on by parents to their children that, in some cases, manifested itself only after many years. He also noted that those who did not inherit the disease acquired it because of their licentiousness, exposure to the rains when they were perspiring, and the harmful winds of the tropics.[12]

THE PHYSICAL MANIFESTATIONS OF LEPROSY AND ITS DEBILITATING EFFECTS MADE IT ONE OF THE MOST DREADED DISEASES TO BE CONTRACTED BY A NON-NATIVE IN EARLY PHILIPPINES.

The physical manifestations of leprosy and its debilitating effects made it one of the most dreaded diseases to be contracted by a non-native in early Philippines. Alcina described a second type of leprosy that was prevalent among the Visayans who called it *cascado.* The disease was thought to have originated from the Catanduanes islands where all men and women were believed to be infected.[13] This was not the form of leprosy where the skin becomes white and scaly and later breaks out in sores. Instead it began slowly and spread all over the body, causing fissures in the skin from which a foul smelling yellow fluid would issue. People died from the disease when the body swelled and the fissures covered the entire body. Alcina further recorded his anxiety at how the disease spread easily among the Visayans.[14]

> This contagion has spread so much..., that in the towns where I first stayed at the beginning, although there was not one with this plague, after some years when I returned to them, either for a stay or in passing, I discovered a third of the men and women were infected. In some places more than a half.

William Dampier who travelled to early Spanish Philippines wrote about the "distemper" of leprosy in Mindanao and the significant number of cases there.[15] He gave a graphic description of the ailment:

> The Mindanao People are troubled with a sort of Leprosie, the same as we observed at *Guam.* This Distemper runs with dry Scurf all over their Bodies, and causeth great itching in those that have it, making them frequently scratch and scrub themselves, which raiseth the outer skin in small whitish flakes, like the scales of little Fish, when they are raised on end with a knife. This makes their skin extraordinary rough, and in some you shall see broad white spots in several parts of their Body. I judge such have had it, but are cured; for their skins were smooth, and I did not perceive them to scrub themselves: yet I have learnt from their own mouths that this spots were from this Distemper. Whether they use any means to cure themselves, or whether it goes away of it self, I know not: but I did not perceive that they made any great matter of it, for they did never refrain any Company for it; none of our people caught it of them, for we were afraid of it, and kept off.[16]

Other foreign visitors and residents were less fortunate. Alcina mentions in his seventeenth century account of the Visayan peoples how foreigners with little care or concern for their health fell victim to, and died from, leprosy.

> As a result, these islands become the inescapable grave of many of them. I say 'inescapable' because of their excesses and little concern about their physical well-being, they pave the way to typhoid fever, malignant fevers, dysentery, beriberi, syphilitic tumors, leprosy and numerous other maladies, which force them to bed and carry them off to their graves. In fact, many die unless they become accustomed to the land and its climate.[17]

AMONG THE VISAYANS, TAKING MEDICATION OR BULUNG WAS CONSIDERED NECESSARY TO ADDRESS AND MANAGE DISEASES

MANAGING THE DISEASE, ITS SYMPTOMS, AND SIMILAR AILMENTS

Among the Visayans, taking medication or *bulung* was considered necessary to address and manage diseases. A remedy for *pamatas* (leprosy) was to drink *palo de China*, a concoction made from a plant called *palo*, also known as *banat* by the natives. According to Alcina, Chinese traders sold *palo* in the colony, thus the name, *palo de China*, although the plant was also seen to grow locally. It was a root crop similar to taro or yam and boiled in water or wine. The concoction made a patient sweat profusely. *Banat* was administered in a little room called the *burulungan*, so that the patient would not be exposed to the wind since he would be perspiring. If it was a sick woman who took *banat*, she would be left alone, and her husband was strictly forbidden to come near her. The *banat* drink was considered efficacious and even the Spaniards took it every time they developed sores or lesions on their bodies.[18]

There were a number of other Visayan herbal cures for sores and wounds like those associated with leprosy. For example, Alcina identifies *agonoy* (*Chromolaena odorata*), a plant whose leaves were ground up, mixed with coconut oil, and then boiled. The mixture was applied for treating sores, boils, inflammation, and snakebites. It was also used to flush kidney stones and stop the swelling of legs and joints.[19]

The bark of the *patcot*, which the Spaniards called *suelda* or *suelda con suelda* (*Phoradendron spp.*), was ground up and applied on wounds. All patients recovered from their wounds and illness when treated with this concoction. The tree was reportedly found in abundance on Bantayan Island in the province of Cebu.[20]

Another plant used by the Visayans was the castor plant (*Ricinus communis*) that they called *tangantangan*, and that the Spaniards called *biguerillas del infierno* (literally, fig tree from hell). Its seeds produced medicinal oil, and its leaves were used to relieve swellings, colds, and wounds.[21] Women used the oil to treat their hair and scalp. Tagalogs called the castor plant *lingansina*.[22]

However, Alcina did not see anyone cured of leprosy with these *bulung* or herbal medications. When such herbal remedies proved ineffective, "harsh and terrible" remedies were resorted to but always in vain.[23] For example,

> A hole was made in the ground just enough for one person seated in a chair. The patient was placed in that position in the hole, after which the opening was closed by spreading over it dry leaves and branches of trees which were subsequently covered with earth except at the center where a small opening was made to establish a means of communication between the patient and the "medicine man" and to provide a place through which food could be introduced for the patient. In the hole, the patient had to spend several years according to the prescription of the "medicine man." It was believed that the warmth and moisture that the patient received from the ground were the therapeutic agents to cure the disease[24]

ASIDE FROM HERBAL OR PLANT CURES BY THE NATIVES, AN OUTRIGHT FORM OF MANAGING THE DISEASE WAS ABANDONMENT OF THE AFFLICTED

Aside from herbal or plant cures by the natives, an outright form of managing the disease was abandonment of the afflicted and their segregation from the healthy populace. For example, Jesuit missionaries found a group of leprosy sufferers isolated, naked, hungry, and unkempt in an island in the Visayas. Likewise, Dominican missionaries found a woman suffering from leprosy abandoned by her relatives and living alone in Pangasinan province in Luzon.[25]

It was very rare to find among the natives anyone with physical disabilities or deformities.[26] In a pre-colonial society that valued physical perfection, the crippling disabilities and fearful manifestations brought about by leprosy, plus the stigma of the disease as divine punishment for the violation of honored traditions and social norms, led most, if not all, of the early Philippine societies to regard abandoning or segregating those suffering from leprosy as a reasonable course of action.

THE FRIAR AND TRAVEL ACCOUNTS . . . INDICATE THAT THERE WAS CONSIDERABLE CONTACT . . . BETWEEN THE NATIVES AND PEOPLE FROM CHINA, JAPAN, INDIA, AND INDONESIA WHERE LEPROSY WAS A RECOGNIZED AND ANCIENT DISEASE.

POSSIBLE MODES OF LEPROSY TRANSMISSION IN PRE-COLONIAL PHILIPPINES

Aside from indicating the existence of leprosy among the natives before the arrival of the Spaniards, the friar and travel accounts from the sixteenth and seventeenth centuries also indicate that there was considerable contact, mainly due to trade, between the natives and people from China, Japan, India, and Indonesia where leprosy was a recognized and ancient disease.[27] Martin de Goiti

noted in 1570 that many Chinese and Japanese were living with the native population in Manila.[28] The fact that other nations were already in contact with the pre-colonial natives of the Philippines suggests that this contact could have been a possible source of exposure and transmission.

The pread of leprosy among the natives was also seen as due to their grooming habits and their direct contact with infected people. Alcina mentions how the natives were so scantily clothed, that even if they bathed many times during the day, they would still use the same clothes which they would wear sparingly, exposing themselves to all kinds of diseases. Alcina opined that being infected with leprosy could result from a natural predisposition to the disease.

> In some I noticed with surprise how it was acquired. From this I infer that in order to contract the disease, one must have some disposition. I also observed that the husband was totally *cascado* and the wife not at all; in others, just the opposite, I noticed. Thus, having three or four or more children, some of these were totally unaffected while others completely *cascados.* This is worth bearing in mind that these people living as they live, and sleeping as they sleep, all grouped together; if this does not take place, then a sister lends her blanket to her brother and the mother to her children, it can be seen that some are not infected. Others, are easily infected. Hence, we may conclude that it lies in the nature of one's disposition.[29]

WHILE THE SICK WERE TREATED FOR THE DISEASE THROUGH THE USE OF HERBAL MEDICINES, THEY WERE ALSO PHYSICALLY ISOLATED. . . THEY WERE ALSO PHYSICALLY ISOLATED. . . FROM HEALTHY SOCIETY

LEPROSY IN EARLY PHILIPPINE SOCIETY

Leprosy was already prevalent in Philippine society upon Spain's arrival. It was found in the northern Philippines among the Apayaos in Cagayan, and the people living in Pangasinan, Bicol, Manila, Visayas, and Mindanao. Friar and travel accounts wrote of leprosy not only as a physical ailment but also as a perceived punishment brought about by divine wrath for those who deviated from social norms and traditions. While the sick were treated for the disease through the use of herbal medicines, they were also physically isolated, segregated from healthy society, and even abandoned by relatives. Social exclusion through isolation and segregation of the infected became the recourse in addressing leprosy for most pre-colonial societies where physical perfection was highly regarded and physical abnormalities were taboos.

The miracles brought about by Catholic Christian conversion among the sick natives, included healings from leprosy. As reported by the religious missionaries, reports of these miracles encouraged more baptisms to the Christian faith among the natives.

Leprosy would infect more people during the Spanish colonial period and would continue to be regarded as a feared disease. Later, leprosy would be cited as a dreaded common illness in the colony together with elephantiasis, *el fuego de San Antonio* (Ignis Sacer), berbu, and syphilis.[30]

NOTES

1. Francisco de San Antonio, O.F.M., *Vocabulario Tagalo*, ed. Antoon Postma (1624; repr., Quezon City: Pulong: Sources for Philippine Studies, Ateneo de Manila University, 2000).
2. Pedro Chirino, S.J., *Relación de las Islas Filipinas* (Roma: 1604) in *The Philippine Islands (1493–1898)*, eds., Emma Helen Blair and James Alexander Robertson, 13:60 (Cleveland:

Arthur Clark Co., 1903). The Augustinian religious missionaries arrived in the Philippines in 1565, coming with the Legaspi expedition and Fray Andres de Urdaneta. From Cebu, they proceeded to Manila in 1571.

3. *Annuae Litterae Societatis Iesu Anni CDDCX*, 1610 in BR, 17:72.
4. Diego Aduarte, O.P., *Historia de la Provincia del Sancto Rosario* (Manila: Colegio de Santo Tomas por Luis Beltran, 1640), in *The Philippine Islands (1493–1898),* eds., Emma Helen Blair and James Alexander Robertson, 30:209, 213. The Dominican mission to Pangasinan departed in 1588 for the area and initiated conversion and baptism among the native children first because they could not gather enough adults.
5. Ibid.
6. Casimiro Diaz, *Conquistas de las Islas Pilipinas, 1641–1670, Tomo II.* (Valladolid: Imprenta de Luis N. de Gaviria, 1890), 240–241. Cape Engaño is in the Cagayan province in northern Luzon.
7. Ibid.
8. Andres de San Nicolas, "Historia General de los Religiosos Descalzos del Orden de San Agustin (1664)," in BR, 21:137.
9. Ibid., 141.
10. Diaz, *Conquistas de las Islas Pilipinas*, 171–172.
11. Ibid.
12. Francisco Ignacio Alcina, S.J., vol. 3, bk. 3, pt. 1 of *History of the Bisayan People in the Philippine Islands*, trans., eds., and anno. Cantius J. Kobak, O.F.M. and Lucio Gutierrez, O.P. (Manila: UST Publishing House, 2002), 465-471. Alcina arrived in Cebu in the Visayas in 1632 where he completed his theological studies. In 1634, he was assigned in Borongan, Samar.
13. Ibid., 483. The disease was noticed by Alcina in 1636 when he was in Samar. The Catanduanes islands are part of the Bicol region.
14. Ibid., 485.
15. William Dampier, *A New Voyage around the World*, vol. 1, (London: Printed for James Knapton, at the Crown in St. Paul's church-yard, 1703), in *The Philippine Islands (1493–1898)*, eds., Emma Helen Blair and James Alexander Robertson, 38:256. That leprosy was considered as distemper in olden days in the West suggests that the disease was considered to be caused by the imbalance of bodily fluids, also known as "humors," which were blood, yellow bile, black bile and phlegm. These influence human emotions and behaviors (temperament), and in this case the physical condition of the person.
16. Ibid., in *Philippine Islands*, eds., Blair and Robertson, 39:32.
17. Francisco Ignacio Alcina, S.J., vol. 1, bk. 1, pt. 1 of *History of the Bisayan People in the Philippine Islands*, trans., eds., and anno. Cantius J. Kobak, O.F.M. and Lucio Gutierrez, O.P. (Manila: UST Publishing House, 2002), 173.
18. Alcina, vol. 3, bk. 3, pt. 1 of *History of the Bisayan People*, 465-467. Cantius J. Kobak and Lucio Gutierrez, in their annotation of Alcina's book, write that the nearest they can associate *banat* is with *banati.* Mateo Sanchez, *Vocabulario de la Lengua Bisaya*, 1711, and George Dewey Tramp, *English-Waray Dictionary of the Eastern Visayan Language in Leyte and Samar*, 1998 point out that the local *banati* tree is also known as the *kamuning* tree (*Murraya paniculata*). See Alcina, vol. 3, bk. 3, pt. 1 of *History of the Bisayan People*, 565. However, the local *akapulko* plant (Senna alata (L.) Roxb.), which is a Filipino traditional cure for skin and venereal diseases, is also known in the Visayas as*palo de china* or*palo china.* See

Philippine Traditional Knowledge Digital Library of Health, accessed 12 July 2015, http://www.tkdlph.com/.

19. Alcina, vol. 1, bk. 1, pt. 1 of *History of the Bisayan People*, 557. *Agonoy* (Ilonggo) is also called *hagonoy* (Tagalog and Cebuano). It is also called popularly as *damong Imelda.* In the Philippines, a concoction of hagonoy leaves, *kalamansi* (native lemon), turmeric, pepper plant leaves, lime, and honey were made into a paste and applied on boils and wounds. See Godofredo Stuart, "Philippine Medicinal Plants, accessed 1 January 2015, www.-stuartxchange.org/index.html; Wellington Z. Rosacia, Arnel N. Achivar, and Marilou B. Avanzado, "Lantana and Hagonoy: Poisonous Weeds Prominent in Rangeland and Grassland Areas," Research Information Series on Ecosystems 16:2 (May–August 2004), accessed 1 January 2015, http://erdb.denr.gov.ph/publications/rise/r_v16n2.pdf.
20. Alcina, vol. 1, bk. 1, pt. 1 of *History of the Bisayan People*, 561.
21. Ibid., 559, 571.
22. *Tangantangan* is also called *katana* (Bontoc), *gatlawa* (Ifugao), *tacataca, tawa tawa* (Ilocano), *higuera del diablo* (Mexican), *jarak* (Malaysian), and *kasutaa biin* (Korean). See T. K. Lim, *Edible and Non-Edible Plants, vol. 2, Fruits* (Heidelberg: Springer Science + Business Media B.V., 2012), 488.
23. Alcina, vol. 3, bk. 3, pt. 1 of *History of the Bisayan People*, 485.
24. Eliodoro Mercado y Donato, *Leprosy in the Philippines and its Treatment*, trans. M. Tolentino, (Manila: Tip. Linotype del Col. de Sto. Tomas, 1915), 5.
25. Aduarte, *Historia de la Provincia del Sancto Rosario*, 213; *Annuae Litterae*, 72.
26. Alcina, vol. 3, bk. 3, pt. 1 of *History of the Bisayan People*, 457.
27. Linda A. Newson, *Conquest and Pestilence in the early Spanish Philippines* (University of Hawai'i Press, 2009), 14. Other diseases that could have been present in pre-colonial Philippines were tuberculosis and treponemal infections. Leprosy was recognized in the ancient civilizations of India, China, and Egypt. Human contact with the infected through migration, trade, wars, and religious expeditions is a mode by which leprosy spread to different nations of the world. Hurao, who was a Chamorro chief in Guam, led a Chamorro revolt against the Spaniards in the seventeenth century asserting in his famous speech of 1671 that the Spaniards introduced diseases with no known cures and pests in their island. See *Hurao's Speech in 1671*, http://ns.gov.gu/hurao.html, accessed on 1 July 2014.
28. "Relation of the Voyage to Luzon, 8 May 1570," in *Philippine Islands*, eds,, Blair and Robertson, 3:101.
29. Alcina, vol. 3, bk. 3, pt. 1 of *History of the Bisayan People*, 485.
30. *Crónica General Filipinas de España* (Madrid: Editores Rubio, Grilo y Vitturi, 1870), 13.

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St. Francis of Assissi and others treating victims of leprosy (La Franceschina, 1474)

Rediscovering a Paradigm: The Franciscan Order's Response to Leprosy and the Afflicted in the Philippines, 1578–1898

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I

The Order of Friars Minor (O.F.M.) founded by St. Francis of Assisi, popularly called Franciscans, made the greatest difference in the treatment of leprosy and the afflicted throughout the Spanish colonial period in the Philippines. This paper substantiates this assertion by tracing the Franciscan contributions in the treatment of leprosy patients and the disease. The history of leprosy in the Philippines cannot be written without considering their invaluable achievements in more than three centuries. In particular, this paper focuses on the development of the Franciscan response to leprosy and the afflicted, beginning with their initial steps to care for patients upon their arrival in the Philippines in 1578 to the holistic program they followed until the end of the Spanish colonial government in 1898. Simultaneously, this paper argues that this holistic program by its nature, objectives, and implementation, became a veritable paradigm of a public health plan in relation to leprosy before the twentieth century.

SIGNIFICANT PLACE OCCUPIED BY THE FRANCISCANS PIONEERING PRACTICES IN PATIENT CARE, WHICH MADE THE GREATEST DIFFERENCE IN LEPROSY TREATMENT AND THE AFFLICTED FOR OVER 300 YEARS IN THE PHILIPPINES

A clear understanding of the conditions existing within the period discussed is necessary to locate the significant place occupied by the Franciscans' pioneering practices in patient care, which made the greatest difference in leprosy treatment and the afflicted for over 300 years in the Philippines.

CONTEXTUALIZING LEPROSY

A fairly large number of natives suffered from leprosy at the time of Spanish contact, indicating the presence of the disease in the Philippines long before Spanish colonization. Many societies in the world rejected and isolated the afflicted owing to the horrible disfigurement in advanced cases and the belief that the disease was highly contagious. Philippine society at the point of Spanish contact was no different. In places where a considerable number of the afflicted were found, natives would take them as far away as possible from towns and settlements. This explains why Spanish Jesuit

missionaries in the Philippines found around 40 persons afflicted with leprosy isolated in a Visayan island in the early seventeenth century.[2] Even as late as 1897, it was reported that an estimated 500 such persons were once concentrated in Ibugus, an island in the Batanes group of islands in the northernmost part of the country.[3]

Extant records do not show whether or not these persons were offered medical relief. What is known is that there existed an impressive number of hospitals and infirmaries, as well as asylums, hospices, and College-*Beaterios* (schools for girls attached to a house where pious women [*beatas*] lived) founded by the Church and State during the 333 years of Spanish colonization.[4] A hospital or an infirmary was always one of the first structures built by Spaniards wherever they went. They were compelled to do so by the arduous crossing of the Pacific Ocean due to the poor condition of travel in the ships, typhoons in the open sea, harassment from hostile natives in the Pacific islands, exposure to familiar as well as unknown diseases, the great distance from Spain/Mexico, and the small number of Spaniards who would finally make it to the islands. Any of these factors, singly or in combination, resulted in the 1565 founding of the first hospital in the Philippines, the Hospital del Santo Nombre de Jesus in Cebu, by Miguel Lopez de Legazpi, the first Governor General of the Philippines.[5]

Six major religious orders played a major role in the operation of hospitals and infirmaries in the Philippines, excluding those primarily for military purposes. These were the Augustinians, Franciscans, Jesuits, Dominicans, Recollects, and the Brothers of St. John of God. The paths pursued by each order were always subject to conditions specified by the constitution of their respective religious orders and the royal patronage (*Patronato Real*) exercised by the King of Spain, whereby "the Spanish crown was given a special mandate by the Holy See to convert the natives, and defend and maintain them in the Roman Catholic faith."[6] Each missionary group arrived bearing its heritage of knowledge and extensive experience in the fields of medicine, nursing, and pharmacy in Europe and Latin America, ready to engage in their special areas of interest. However, not all the religious orders in Spain went to the Americas and among those who did, not all came to the Philippines. Consequently, the orders who arrived in the Philippines assumed responsibility for certain social services, though these services may not have been their exclusive domain previously. Moreover, the areas where such services were offered depended on the "spiritual districts" as determined by the Spanish Crown, which assigned each order specific areas in order to minimize work duplication. For example, during the more than three centuries of Spanish control in the Philippines, all the six religious orders founded hospitals in areas where there was a need for them and when resources were available for that purpose. Eventually, asylums became the particular interest of the Augustinians; the Brothers of St. John dedicated themselves to hospices aside from hospital administration; and leprosaria became synonymous with the Franciscans in the Philippines. Previously, Franciscans started out by taking charge of the newly-founded Royal Hospital for Spaniards by the government, also known as the Military Hospital in Manila. This came as a request of the Crown in 1578, the year they arrived in the Philippines.

The Franciscans' longstanding connection with leprosy, with their order becoming the largest in Europe during the sixteenth to the seventeenth centuries

Most likely, the Franciscans and all missionaries at this time had immediate exposure to local people afflicted with leprosy. The Chief of the Military Health Corps in his 1857 report which surveyed diseases in the archipelago had the impression that natives suffered from leprosy in general

because it was one of the fairly more common diseases in the archipelago beginning from much earlier, up to the year of the said report.[7] The journal *Cronica de Ciencias Medicas de Filipinas* (Chronicle of Philippine Medical Science) maintained that leprosy was more widespread than what was believed in the Philippines even by 1896.[8] The presence and spread of leprosy was constant throughout the 333 years of Spanish control of the islands. What changed considerably was the missionary's attitude to people with leprosy from the Middle Ages some 300 years earlier to the Spanish contact period in sixteenth century Philippines. Since the Middle Ages, people afflicted with leprosy in Europe had been regarded as pariahs. They were some of the most despised and deprived of the population. In fact, the Roman Catholic Church, for all intents and purposes, considered them as already dead.[9] This practice, as well as his well-documented rejection of the afflicted, may have led the young Francis of Assisi to overcome his initial repugnance, with special grace from God. Imbued with greater charity and compassion, he then began to live with people with leprosy and served them with humility.[10] It became Francis' primary vocation then.[11] When the Franciscan Order began attracting many postulants seeking admission in the early days, they were told that "nobles or commoners, among other things they would do is to serve the lepers and live in their hospitals."[12] The Franciscans' longstanding connection with leprosy, with their order becoming the largest in Europe during the sixteenth to the seventeenth centuries and bringing the biggest number of missionaries to the Americas,[13] are factors to consider in assessing how the slow but steady shift in missionary attitude to leprosy led to acceptance of the afflicted as another pathway to evangelization.

LEPROSY AND EVANGELIZATION

Leprosy is often mentioned as a divine punishment in the Bible. This was how at least one friar interpreted the killing of their Definitor (Church official belonging to a religious order who gives counsel and assistance) by a group of natives who had contracted leprosy. In this instance, the natives considered the disease as the consequence of their breaking time-honored laws and customs on taking a life.[14] Henceforth, they no longer killed any religious who they encountered in their region.[15] This event indicates how dreaded the disease was and, indirectly, how it contributed to the expansion of the areas covered by missionary activity.

In his work, *Relación de las Islas Pilipinas*, Fr. Pedro Chirino of the Society of Jesus attributed the restoration to health of some children and adults suffering from leprosy somewhere in Leyte to the sacrament of baptism. He also noted that the elderly who had been healed were even able to resume their agricultural work.[16] There is another account of a woman in Pangasinan who suffered from leprosy. She was abandoned by her family but was lovingly attended to by the Dominicans until she was considered cured of the malady. Her recovery won conversions for the Order of Preachers, which included the Chief of the natives and his child.[17] Without a doubt, these examples strengthened missionary influence since their loving attention to those who suffered from a crippling, incurable disease, made more terrible by the belief that it was contagious, was by itself amazing to witness. To achieve success against the disease, as these examples show, would have been no less than impressive from the natives' view.

However, there are also reports of contrasting treatment. For example, there is an account of Jesuit assistance being withheld from 40 people with leprosy until they were converted and baptized. Everyone was given food and clothes thereafter.[18]

Despite the seeming contrast in their methods, religious orders won converts and the confidence of natives. Nevertheless, these encounters with people with leprosy appear to have been more incidental

than planned. Laudable as they were, such incidents did not always lead to the eradication of leprosy nor the requisite care for those afflicted by it. Infirmaries and hospitals were constructed by the Jesuits in Leyte and the Visayas; the Augustinians in Luzon and Mindanao; the Dominicans in Cagayan, Pangasinan, and the Tagalog provinces; and the Brothers of St. John of God in Manila and Cavite. However, these were built primarily for the benefit of members of the order, and by extension, for the natives if there were no hospitals in the area. Given the prevalence of leprosy in the archipelago, such hospitals accommodated patients afflicted with the disease, although they were not built primarily for this purpose.

One case in point is the Hospital de San Gabriel, which was founded in 1587 by the Dominicans for the Christianized Chinese in Manila. Initially located near the bastion of San Gabriel in Intramuros, it moved twice—first to the Parian and then to Binondo in 1598.[19] There is little in the official history of the Dominicans that indicates any connection to leprosy. However, a 1774 floorplan of San Gabriel Hospital[20] made just before its official suppression by the government shows that there were nine Chinese and one Vietnamese in the infirmary and a separate and relatively isolated smaller infirmary for the *lazarientos* or people suffering from leprosy among the Chinese. This set-up shows how the Dominicans dealt with leprosy, not because it was their mandate, but because it was a reality that confronted them in their day-to-day dealings with the Chinese in Manila. It may also have been the case for all the religious orders in the Philippines whose official histories do not always express the special consideration granted to people with leprosy. The only exception is the Franciscans.

THE HONOR AND DISTINCTION OF PLANNING, PROVIDING, AND CARING FOR ALL THOSE SUFFERING FROM LEPROSY BY OPENING LEPROSARIA IN MANILA AND NAGA BELONGS SOLELY TO THE FRANCISCAN ORDER.

LEPROSY AND THE FRANCISCANS

The honor and distinction of planning, providing, and caring for all those suffering from leprosy by opening leprosaria in Manila and Naga belongs solely to the Franciscan Order.[21] The Franciscans engaged in the ministry of healing in the Philippines when the government turned over the Royal Hospital to them for their administration in 1578. Within the same year, the Franciscan lay brother, Fr. Juan Clemente, allowed many sick natives to stay at the entrance of the Franciscan Convent in Intramuros, the majority of whom were afflicted with incurable diseases like leprosy.[22] From an overcrowded little shack of bamboo and nipa, the structure grew until Fr. Clemente was able to eventually construct a full-blown hospital in 1580, solely through donations. It came to be known as the Hospital de Naturales.[23] Although the name signifies that it was for the natives, the hospital also accepted Japanese, Chinese, Thai, Cambodian, Bornean, and African patients. It burned down in 1583 leaving the patients without any provisions.[24]

In 1586, eight years after they arrived, the Franciscans opened a second hospital in Nueva Caceres (now Naga City) in Camarines Norte for people suffering from leprosy. Although the hospital was originally called Hospital de San Diego de Alcala, it soon came to be called Hospital de San Lazaro (after the patron Saint of people with leprosy). Declared a Royal Hospital in 1623 and reconstructed with bricks, its administration passed to the Diocese, even though it was the Franciscans who continued to provide spiritual care to patients. In 1733, the Franciscans reclaimed the hospital together with its *haciendas*—the landed estates attached to the hospital whose income was specifically for its upkeep.[25]

In 1603, the Franciscans constructed a new hospital for the natives in Manila after a fire destroyed the first one. It was located outside Intramuros in a place called Sta. Ana de Dilao, hence the name Hospital de Sta. Ana. It became a hospital exclusively for natives suffering from leprosy. In 1632, the name was changed to Hospital de San Lazaro, after the hospital was expanded to accommodate 150 patients suffering from leprosy who were sent to the Philippines by the Emperor of Japan.[26] The hospital was among those structures ordered destroyed in 1662 by Gov. Gen. Sabiniano Manrique de Lara, so the materials could be used for bolstering the defences of Manila against the Dutch. In 1673, it was rebuilt in Balete, a site closer to Intramuros towards the east. It was demolished in 1783 as a check of defenses revealed that the building impeded the Intramuros canons' line of fire. The third and final site of the Hospital de San Lazaro was Mayhaligue in the Santa Cruz district to the north of Intramuros.[27]

On 25 June 1784, a Royal Order turned over the expelled Jesuits' house and *hacienda* in Mayhaligue to the Franciscans.[28] The house was torn down and in the following year the construction of a new hospital on the same site began. The construction lasted until 1788. The total cost of the building was 27,540 pesos, 2 reales, and 2 granos.[29] From 1788 onwards, The shortfall for annual maintenance due to insufficient *hacienda* earnings and donations was covered by the government. The new hospital was considered huge and well-ventilated. It consisted of two wings, one each for men and women. Each wing accommodated 100 beds, or a total of 200 beds. Two separate areas were devoted to a chapel and a recreation area.

By 1823 or 39 years later, the hospital was accepting an average of 150 to 200 patients per year. There were more men than women even in the number of casualties, which averaged between 20 to 50 persons annually.[30] There were also more patients gaining admission compared to those who passed away, and this situation seriously affected the services rendered by the Franciscans. This may be extrapolated from new regulations of the hospital approved by the Governor General in 1830, seven years later. These included the following: improvement of food for patients, provisions for bed sheets and clothes, and increased vigilance by the Guardia Civil to prevent the patients from escaping. There was also the new requirement for a licensed doctor-surgeon (*medico-cirujano*) to serve the patients, in addition to the medical assistance provided by the Franciscans. This requirement was initially fulfilled by Esteban Lepeores, a French doctor.

The situation in the hospital rapidly worsened due to an outbreak of *Elefantiasis* and the loss of more than 12,000 pesos due to mismanagement by the hospital's syndic who added to the problems by his sudden death. It also did not help that the *haciendas* were flooded and abandoned, resulting in even more losses of income for the hospital.[31] Consequently, an unknown number of San Lazaro's 108 patients managed to get out of the hospital and freely wander about the city and nearby areas posing serious threats to public health. It was determined later that these unfortunate developments resulted from the non-enforcement of fund-raising measures which had been ordered by the government in anticipation of inadequate income.

The government swiftly dealt with the raging problem by issuing an order in 17 articles which required among others: appointing a new and competent syndic who would directly report to the Governor General and strictly follow directives for the funds to be checked monthly by the Royal Treasurer; building walls or covers around the hospital to prevent those afflicted with leprosy and other contagious diseases from escaping and having a guard posted day and night; closing the openings around the *hacienda* of the hospital which had been created by the lessees to enable them to go via the river to Tondo and Binondo, because they caused flooding in the *hacienda* with ruinous

effects; aggressively working to recover lands usurped from the hospital; appointing two Franciscan friars and two lay brothers, or at least three lay brothers to manage the hospital, as this task could not be carried out by only one Franciscan; and covering the deficit of P5,000.00 for the expenses of the hospital from solicitations or donations every Sunday in all towns of Tondo province.

The quandary faced by the Hospital de San Lazaro had a positive effect: it heightened the level of government consciousness of leprosy and the plight of the afflicted. Consequently, the government ordered the establishment of leprosaria in all the provinces of the Philippines and for these leprosaria to be located in the provincial capitals, particularly in isolated areas near a river to ensure cleanliness. Furthermore, these leprosaria were to be maintained through the work of the patients with support from public donations and the colonial government should deficits occur.[32]

ADJUSTMENTS IN THE HOSPITAL ALSO HAD TO BE MADE AS A RESULT OF ADVANCES IN SCIENTIFIC RESEARCH AND MEDICAL PRACTICE IN THE NINETEENTH CENTURY.

Adjustments in the hospital also had to be made as a result of advances in scientific research and medical practice in the nineteenth century. The changing concepts of sanitation, for instance, may be seen in the 1846 inspection by a Medical Commission which required higher standards of personal hygiene for patients.[33]

In 1859, the Franciscan friar Fr. Felix De Huerta became director. He made a great difference in the history of the Hospital de San Lazaro. He enthusiastically began upgrading the hospital. The pharmacy was improved and the hospital cemetery was relocated further away for better sanitation. At that time, the challenge for any Franciscan administrator of the hospital was the perennial shortage of funds because of the immense need for its services owing to the unrelenting spread of leprosy in the Philippines. The hospital was almost always full to capacity (by this time, patients with highly infectious diseases were also being admitted), thus accelerating the deterioration of the facilities. Maintenance costs were constantly rising due to the admission of new patients. Throughout its two-and-a-half centuries of existence, the hospital provided free services and medicine, a hallmark of the Franciscan Order. Fr. De Huerta was indefatigable in this respect. Consequently, by 1880 the Hospital de San Lazaro was truly the premier leprosarium in the country.[34]

It is a reflection of the Hospital de San Lazaro's admirable record and the Franciscan's reputation that by November 1861, two leprosaria were opened by the government in Laoag, Ilocos Norte and Vigan, Ilocos Sur, respectively. Both were named Hospital de San Lazaro.[35]

By 1865, the budget of the Hospital de San Lazaro in Manila had amounted to 4,000 pesos a year. As in previous years, these funds were largely generated by the *hacienda*, with 500 pesos coming from the Royal Tribunal and the rest from donations. The number of patients by this time was 130 (79 males and 51 females).[36]

Seven years later, the influence of the Hospital de San Lazaro in Manila was firmly established when the Bishop of Nueva Caceres, Fr. Francisco Gainza, O.P., successfully led the reconstruction of a similar leprosarium in Palestina, Camarines Norte. It was inaugurated on 23 September 1872. In his speech, the Provincial Governor likened the new building to the Manila Hospital de San Lazaro in 1784—spacious; with well-ventilated rooms, a chapel, rooms for infirmarians, and separate buildings for men and women; and with a capacity totalling 200 beds. A clear pattern had emerged. The Hospital de San Lazaro in Manila became the paradigm for hospitals for people with leprosy. Once again, the Franciscans were given charge of the new hospital.[37]

Tragedy struck in 1882, when a severe earthquake damaged Manila and the Hospital de San Lazaro there. The church and convent of the Franciscans next to the hospital collapsed. Nonetheless, this great challenge was met by Fr. De Huerta. Within a few years, he managed to reconstruct the hospital and other buildings[38] and even equipped these with better facilities. He also provided the same Franciscan care for the sick, poor and abandoned.

Although the hospital escaped destruction during the Philippine Revolution in 1896 and the Philippine-American War in 1898, the Franciscans lost the Hospital de San Lazaro. They were forbidden to return after hostilities ceased in 1898, since the Americans took over the facilities. Nevertheless, the hospital continued to be the premier provider of medical care for patients with leprosy in the first decade of American rule. It also pioneered in leprosy research[39] until the transfer of all the afflicted to Culion Island in Palawan.

An analysis of the 320 years of Franciscan connection to leprosy and the afflicted in the Philippines shows that their response was of two kinds: internal and external.

THE CHANGING FRANCISCAN RESPONSE

An analysis of the 320 years of Franciscan connection to leprosy and the afflicted in the Philippines shows that their response was of two kinds: internal and external. The long history and missionary experience of the Order in Europe and Latin America equipped them with a level of preparedness that was both capable of service and cognizant of continuous, even crucial adjustments, necessary in every situation in which they found themselves.

I. THE FRANCISCAN'S INTERNAL RESPONSE

Very early on, the Franciscans recognized that one of the most important initial adjustments involved the rules of the Order itself.

It is a fact that no one who needed medical care, specially those with leprosy, was refused by the Franciscans. Their hospitals were known to accept all those who sought relief from leprosy. Contrary to its name, the Hospital de Naturales (Hospital for Natives), where the first of the afflicted were admitted by the Order, welcomed all races without prejudice. In the sixteenth century when race, skin color, and even purity of blood were major bases for determining whether or not a man was suited for an ecclesiastical career and even for defining his social position, the Franciscans disregarded them. They took a step further by overlooking gender differences in leprosy treatment.

The Hospital de San Lazaro Hospital had two separate wings, one each for men and women. However, in practice this separation was not strictly followed. Although the Order's code of discipline specifically limited any contact with women, Franciscan doctor-surgeons were allowed to treat them. In the process, these Franciscans spoke with the women patients, which violated another rule, that members of the Order of Friars Minor were are not allowed to speak to women without the express permission of the Prelate.[40] The relaxation of rules went beyond the hospital premises. Another rule was that every Franciscan was not allowed to enter peoples' homes as it could cause rumors to the Order's detriment. Yet, Franciscan doctor-surgeons were allowed to make house calls when requested by a sick person, his family, or when the doctor-surgeon himself believed that it was necessary to do so.[41]

It is clear that the treatment of leprosy and alleviation of its attendant misery remained the top priority for the Franciscans in keeping with the vocation first practiced by their

FOUNDER, ST. FRANCIS.

It is clear that the treatment of leprosy and alleviation of its attendant misery remained the top priority for the Franciscans in keeping with the vocation first practiced by their founder, St. Francis. Service to the afflicted was not suspended, interrupted, delayed, or left undone so rules on enclaustration and segregation from women in their Constitution were eased. This was no easy matter to undertake as it required the permission and concurrence of the highest officials of the Order. Levelling the field of leprosy for every man, woman, or child in dire need of care at different physical, material, and spiritual levels could not be accomplished without the Franciscans realizing that the Order had to effect an interior transformation, hence the Order's internal response to leprosy and the afflicted.

II. THE FRANCISCAN'S EXTERNAL RESPONSE

This response involved a long and complicated process which lasted throughout the Franciscan involvement with leprosy. It can be divided into two phases, the Intramuros-Dilao-Balete Phase, (1578–1773) and Mayhaligue Phase, (1784–1898).

i. THE INTRAMUROS-DILAO-BALETE PHASE (1578–1773)

This period covered 205 years and involved the relocation of the hospital twice. (As mentioned earlier in this chapter, the first was from the Hospital of the Natives [1578] in Intramuros to the Sta. Ana de Dilao Hospital [1603], which eventually took the name Hospital de San Lazaro in 1632. This hospital was then transferred to Balete [1673] and remained there until its destruction in 1783.) Instead of charitable and philanthropic work which characterized most services to people with leprosy at that time, Franciscans chose medical care as part of their evangelization efforts. Within the first 15 years of their arrival, Franciscans founded five hospitals, all of which offered free treatment and medicine. These were the Hospital de San Lazaro in Manila (1580); Hospital de San Diego de Alcala in Naga, Camarines Norte (1586); Hospital del Espiritu Santo in Cavite (1591); Hospital de Aguas Santas in Los Baños, Laguna (1592); and Hospital de Caridad in Antipolo (1600).[42] Only the first two hospitals were leprosaria, but given the nature of Franciscan care for the sick, it is likely that those with leprosy were also accommodated in the other hospitals.

It is clear that the first response of the Franciscans to leprosy and the afflicted consisted of medical/physical services. Medical attention began with washing, cleaning, and binding the wounds of the afflicted, who had open sores or disfigurement of the extremities. After the cleaning and binding of wounds, a doctor-surgeon would examine the patient. Depending upon the stage of the disease, medical care also involved physically carrying patients who could not walk.[43] There is an account of a friar, Fr. Felipe de Leon, who took care of a Japanese man in an advanced state of leprosy. Fr. de Leon took the man in his arms and brought him to Church so he could attend mass, as the man requested. Then he washed the man and cut his nails.[44]

SPIRITUAL SERVICES WERE PROVIDED ALONG WITH MEDICAL CARE. THE PATIENTS IN THE FINAL STAGE OF THE DISEASE BENEFITED MOST FROM THE SPIRITUAL SERVICE OF THE FRANCISCANS.

Spiritual services were provided along with medical care. The patients in the final stage of the disease benefited most from the spiritual service of the Franciscans. The doctor-surgeons' task was to lessen the patient's pain and discomfort until his demise. This took many forms, such as consoling them with God's words, praying with and for them, saying mass for them, helping them have a good

death, and finally blessing and burying the dead. The Franciscans provided these services even if it entailed handling the sore-covered, foul-smelling patients.[45] On the other hand, relatively active patients whose cases were not serious may also have needed to hear Mass, go to confession, receive communion, get married, and have children baptized. All these were met by the Franciscans. Additionally, poor and rich patients were treated in the same way. If any bias was shown at all, it was towards the poor and abandoned who needed love and charity so they could bear the burden of their affliction.

IN THE COURSE OF CARRYING OUT THEIR TEMPORAL AND SPIRITUAL RESPONSIBILITIES TO THE AFFLICTED, THE FRANCISCANS BEGAN TO DEVELOP A SPECIAL INTEREST IN TRAINING TO BECOME DOCTORS AND SURGEONS.

In the course of carrying out their temporal and spiritual responsibilities to the afflicted, the Franciscans began to develop a special interest in training to become doctors and surgeons. This development became the hallmark of the Intramuros-Dilao-Balete Phase of the Franciscans' service history.

a. THE RISE OF FRANCISCAN DOCTOR-SURGEONS.

In the Franciscan Order, the role of the doctor-surgeon was fulfilled by lay brothers who spent most of their lives in infirmaries and hospitals assisting and curing the sick, and serving members of their own order. Like the friars, they were bound by vows of obedience to the Guardian of the Order and Franciscans in high positions. The service provided by the doctor-surgeons in the Philippines gradually expanded to include people outside the congregation and eventually to patients in China, Japan, Cambodia, and Vietnam.[46]

The severe lack of doctors and surgeons in the Philippines in the sixteenth to the seventeenth centuries compelled doctors to function as surgeons and vice-versa. Many also often assumed the role of pharmacists and infirmarians. Some of the most distinguished members of the Franciscan Order were doctor-surgeons. Examples include Fr. Juan Clemente, founder of the Hospital de Naturales; Fr. Blas de Madre de Dios, who converted every mission house he occupied into a hospital;[47] and Fr. Diego de Sta. Maria, who founded the Franciscan hospitals in Cavite, Los Baños, and Ternate, Indonesia.[48]

The majority of Franciscans who became doctor-surgeons did not receive training in medicine or surgery before joining the Order. Training began only after admission. All members of the Franciscan Order were required to observe the rule to spend a certain number of hours serving in hospitals every day. This, however, did not qualify as training for those who aspired to be doctor-surgeons. The only exception was Fr. Miguel Rubio, who was a trained doctor before he entered the Order.[49]

Formal training came in the form of mentorship and presumably by observation and application. An aspiring doctor-surgeon was under a senior and highly experienced doctor-surgeon. This was true of Fr. Antonio de la Concepcion, who trained under Fr. Blas Garcia, and Fr. Andres San Diego, who was trained by Fr Jose de Valencia.[50] The training period did not have a specified duration, but all trainees were closely observed and supervised by their mentors in the Royal Hospital in Manila. It was like a Franciscan school of medicine and surgery. Only the mentors could decide when the aspiring doctor-surgeon was ready to exercise his special ministry. The candidates who were determined fit enough to work on their own would be assigned to any of the Franciscan hospitals or infirmaries, depending on where they were deemed best suited to serve. The formal decision and

official announcement were usually arrived at during the chapters or periodic meetings of the Order. By today's standards, the training received by the doctor-surgeons may be regarded as severely inadequate. Nevertheless, during their time the Franciscan doctor-surgeons were said to be highly regarded by the people of Manila[51] as all the doctors-surgeons mentioned above had impressive records and reputations.[52]

> TO ALLEVIATE THE PERENNIAL SHORTAGE OF WESTERN MEDICINE, THE MEDICINAL PROPERTIES OF INDIGENOUS PLANTS, TREES, FRUITS, HERBS, AND EVEN VEGETABLES IN THE PHILIPPINES BECAME ANOTHER SPECIAL INTEREST FOR FRANCISCANS.

b. HARNESSING PHILIPPINE FLORA

Franciscan doctor-surgeons followed the standard Western medical practice in examining the patient, such as sweating out bad humors or bloodletting while at the same time developing better methods of diagnosing or monitoring the patient on their own. One such case was Fr. Andres de San Diego, who took the patient's medical history, like the previous ailments of the patient and his family. However, the reality is that these methods were dependent on medicines sourced from Spain and Mexico.[53] Nevertheless, working closely with natives in Luzon exposed Franciscans to local herbal medicine. Thus, to alleviate the perennial shortage of Western medicine, the medicinal properties of indigenous plants, trees, fruits, herbs, and even vegetables in the Philippines became another special interest for Franciscans.

Franciscans (not necessarily just the doctor-surgeons) began collecting a large number of tropical flora with the indispensable help of natives, whose knowledge of these flora was invaluable. Particularly effective for sores or wounds in advanced leprosy cases were coconut and tobacco. Coconut is indigenous to the islands, while tobacco was introduced by the Spaniards from the Caribbean. Both were readily available and considered panaceas by the natives. They were made into lotions or oils. Their leaves could be made into a poultice and applied directly on wounds.[54]Their extreme versatility and reported effectivity made them the mainstays in Fr. Clemente's practice at the Hospital de Naturales.

Honey was another cure for wounds. It was applied on the skin or ingested. *Niog-niogan* was another plant with the same medicinal value. Another example was jackfruit, which in powdered form was sprinkled over sores. Fr. Andres de San Diego applied it over a man's festering leg wounds which were deemed incurable by Spanish doctors and the wounds healed.[55] As early as 1587, Filipino use of herbs as medicine impressed Miguel de Loarca, who reported that there were good local doctors who could cure with simple herbs.[56]

Members of other orders—Dominicans, Augustinians, Recollects, and Jesuits—also devoted time and effort to collecting, identifying, and testing these plants by themselves or with the help of natives. Testaments to these efforts are the work of Fr. Blas de Madre de Dios, O.F.M; Fr. Jose Ignacio Alzina, S.J.; Fr. Jose de Valencia, O.F.M.; Fr. Hipolito Casiano Gomez, O.S.A.; Fr. Paul Klein, S.J.; Fr. Alejandro Cacho, O.S.A., Fr. Ignacio de Mercado, Fr. Fernando Sta. Maria, O.P., Fr. Juan de Viso, O.P.; Fr. Juan Belbi, O.P.; Fr. Julio Saldana, O.A.R.; and Fr. Mauricio Ferrero, O.A.R. Unfortunately, some of their manuscripts remain unpublished while others have been lost.[57]

From providing basic medical and spiritual needs, Franciscans took a step further to address the severe lack of doctors and surgeons by training members of their Order to fill that need. That step would have been futile without medicines. Thus, the Franciscans started using easily available local

medicinal plants, then collecting and testing them in search of possible cures to alleviate the perennial shortage of Western medicine in the islands. While each new development in the Franciscans' response to leprosy and the afflicted may seem already outstanding, the next phase of development would still set the bar higher.

ii. THE MAYHALIGUE PHASE (1784–1898)

The 114-year period of the Hospital de San Lazaro's existence in Mayhaligue was shorter than the period in Dilao, but the most serious challenges to its existence also occurred during this period. However, except for the takeover by the United States of America, all of these challenges were overcome by the Franciscans. They created a holistic program for people with leprosy way before modern public health practices were developed. This has not been given adequate acknowledgement in Philippine historiography due to the confluence of complex factors[58] all of which led to an incomplete understanding of what groups like the Franciscans accomplished.[59]

a. PHYSICAL/MEDICAL SERVICES

A clear distinction of the stage of infection among patients was done by this time, so only those with advanced cases were in the hospital, while those in the earlier stages were housed in a fenced-in community beside the hospital to separate them from the public and allay fears of contamination.[60] Even if it was acknowledged as incurable, leprosy was already known to be contagious only for those with close contact with the afflicted. It was not an airborne disease.[61] Medical knowledge had progressed to the extent that the afflicted did not need to be confined within the hospital for the rest of their lives, unlike in previous centuries. They were allowed to lead a relatively self-contained life undisturbed by most people.[62]

b. PSYCHOLOGICAL HEALTH

This involved giving the afflicted the opportunity to be useful. They were allowed to become self-supporting as long as they were physically able and to earn a living in a manner they knew. The hospital supplied only the rice while the rest was acquired by their own labor. The afflicted were allowed to raise poultry and weave for the town's needs as well as their own. Each house in the fenced-in compound had a vegetable garden with fruit trees. They consumed all their products themselves. The afflicted were also allowed to engage in small businesses.[63] In this way, they experienced a community life even in controlled conditions.

The most striking privilege that residents of the fenced-in community beside San Lazaro enjoyed was the permission to marry a fellow resident. It was seen as the answer to disorderly conduct among some of them. Marriage, having children, and a family life was definitely a boost to a healthy self-esteem. Many of the afflicted did not experience these rites of passage till the early nineteenth century in the Philippines. It gave them a feeling of companionship, belongingness, and security which were often overlooked when focusing mainly on the physical aspects of the disease.

c. SPIRITUAL FULFILMENT

The Franciscan commitment to spiritual matters continued during the Mayhaligue Phase. They ministered to the spiritual needs of residents and patients of the Hospital de San Lazaro leprosarium through the chapel attached to the hospital. The sacrament of marriage was open to the patients and residents, though it was questioned by some unnamed theologians. They argued that such unions were against Church tenets because they could only produce children infected with their parents' illness. On the contrary, the Franciscans viewed marriage between people with leprosy as "a mutual union of

a man and a woman to appease concupiscence and to beget children for heaven."[64] Fr. Zuñiga himself opined that the belief that marriage among the afflicted would result in having more infected people had no basis, because if that were the case, "Adam and Eve should not have entered into matrimony after they sinned, so we would not have procreated with Original Sin, which is much worse than leprosy."[65]

THE DISTINGUISHING CHARACTERISTIC OF FRANCISCAN LEPROSY CARE WAS THEIR CLOSE INVOLVEMENT WITH THE AFFLICTED DURING ALL THE STAGES OF THE ILLNESS, A CHARACTERISTIC WHICH TOUCHED MANY PEOPLE.

An effective public health plan involves the protection and improvement of the health of a community through preventive medicine and control of communicable diseases, and sanitary measures. The program developed by the Franciscans possessed these basic features. The people afflicted with advanced leprosy were segregated from the public by being confined in the hospital. Less advanced cases were placed in a separate community next to the hospital. This was a preventive measure that protected the public from infection. By conforming to the general directives from the Superior Government, particularly the 1830 regulations, the Franciscans followed strict sanitation requirements. At the same time, they gave the afflicted a better sense of self-worth by encouraging them to earn a living no matter how limited, socialize within their segregated community, live in their own homes, and tend gardens. For some, getting married and raising a family was finally possible. Many of these measures were associated with the U.S. government's policy on leprosy, but the Hospital de San Lazaro was on record for already practicing them at the beginning of the nineteenth century.

THE FRANCISCAN PARADIGM

The distinguishing characteristic of Franciscan leprosy care was their close involvement with the afflicted during all the stages of the illness, a characteristic which touched many people. It was not just the free medicine and services that the Franciscans gave to anyone who asked for it that brought comfort to the patient. It was the sincere, unconditional service, and spirit of charity which they showed to every person, as well as their constant devotion to their mission that many appreciated. The Franciscans healed not only the body but also the spirit with the balm of prayer. This special grace, called charism in Catholic theology, is regarded as a source of wisdom, faith, and the gift of healing. Institutionally, the Franciscan Order also readjusted rules on enclaustration and segregation so as not to compromise service to people with leprosy.

BY THE EARLY NINETEENTH CENTURY, THE FRANCISCANS EMBARKED ON A PROGRAM WHICH TODAY IS CALLED A PUBLIC HEALTH PLAN.IZATION OF A HOLISTIC PROGRAM.

Since the sixteenth century Franciscan hospitals always had a chapel attached to it. In the nineteenth century, these hospitals also separated persons with initial stages of leprosy from the terminal cases. The Hospital de San Lazaro in particular had separate wards for men and women as well as recreation areas. This gave rise to the segregated community which was supported by alms and other donations from the people, with government supplying the shortfall. The Franciscan hospital design was replicated in other leprosaria which were ordered to be constructed by the government after 1830. The Hospital de San Lazaro of Manila was truly "the institution most useful among those they

have in the Philippine Islands."[66]

The Franciscans also combined Western medicine with native medical practice, specially the use of herbal medicines. They built up collections of different kinds of medicine from as far as Mexico and Spain, in addition to those used in the Philippines. Consequently, they accumulated what was regarded as one of the most important pharmaceutical collections in this part of the world. Within the same period, Franciscans' skills as doctor-surgeons blossomed. However, these declined after two centuries and eventually disappeared in the eighteenth to the nineteenth centuries, not just in the Philippines, but even in the memory of the Franciscan Order. Nonetheless, the deployment of doctor-surgeons experienced in hospital administration and pharmacological practices inevitably spread to other countries in Asia like Japan, China, Vietnam, and Cambodia.

By the early nineteenth century, the Franciscans embarked on a program which today is called a public health plan. Their personalized attention and genuine concern for the afflicted gave the Franciscans a profound understanding of the patient's needs, which led to the conceptualization of a holistic program. Since it antedates the American program for leprosy, the Franciscan program could be regarded as the defining standard for such programs at the time. However, it was not regarded as such until a critical examination of the history of leprosy in the Spanish period was undertaken.

More than any of these, it was the Franciscans' unique Philippine experience which enabled them to develop a range of responses to the disease of leprosy and the afflicted, putting them at a distinct advantage when they established missions in other countries. This is the yardstick by which the rest of the medical institutions for leprosy established by the State and the Church during the Spanish colonial period in the Philippines were to be measured. The Franciscan Order's combined efforts in founding leprosaria; providing free medicine, medical attention and personalized nursing; training and supplying doctors-surgeons; raising funds for patients and leprosaria maintenance; researching on indigenous herbs; adjusting the order's rules; accepting all the afflicted regardless of race, gender or social status; and conceptualizing and realizing a holistic public health program which addressed the physical, spiritual, and psychological needs of the afflicted while safeguarding the health of the general public, long before the Americans introduced the practice with little or no cost to the Spanish colonial government—all these indubitably demonstrate the depth and breadth of their role in leprosy care. In hindsight, it is also evident that the Franciscans were inimitable in this respect. As exemplary servants to the afflicted in the Philippines, the Franciscans' deeds may be half-forgotten, but their legacy of faith and good works lives on in the continued existence of the Hospital de San Lazaro in Manila and its association with leprosy and the care of the afflicted. They are the indelible marks in the history of leprosy in the Philippines and symbolize the Franciscans' love for their fellowmen.

NOTES

1. Emma Blair and James Robertson, eds., *The Philippine Islands, 1498–1898* (Mandaluyong: Cacho Hermanos, 1973), 10:72.
2. *Cronica de Ciencias Medicas de Filipinas, Tomo 3, Año 3, Septiembre de 1897*, 281.
3. Francisco Guerra, *El Hospital en Hispanoamerica y Filipinas, 1492–1898* (Madrid: Ministro de Sanidad, 1992), 536576.
4. Ibid., 536–537.
5. Horacio Dela Costa and John N. Schumacher, *The Filipino Clergy* (Quezon City: Loyola House of Studies, 1982), 17.
6. Antonio Codorniu y Nieto, *Topografia Medica de las Islas Filipinas* (Madrid: Imprenta de D. Alejandro Gomez Fuentenebro, 1857), 45.

7. *Cronica de Ciencias Medicas de Filipinas, Tomo 2, Año 2, Febrero de 1896*, 33.
8. They were prohibited from hearing Mass with the Roman Rite for the Dead performed to signify their complete separation from society. (See more details in www2.kenyon.edu/projects/-margin/lepers.htm (accessed 26 January 2015).
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13. Blair and Robertson, *The Philippine Islands*, 21:140.
14. Ibid., 37:172.
15. Pedro Chirino, *Relacion de las Islas Filipinas y de lo que en ellos han trabajando los Padres de la Compania de Jesus* (Manila: Imprenta de D. Esteban Balbas, 1890), 153–154. See also Blair and Robertson, 16:60.
16. Blair and Robertson, 30:213.
17. Ibid., 10:72,
18. Juan Ferrando, O.P. and Joaquin Fonseca, O.P., *Historia de los PP. Dominicos en las Islas Filipinas y en sus misiones del Japon, China, Tung-kin y Formosa que comprende lo sucesos principales de lo historial general de este archipielago desde el discubrimiento y conquista de estas islas por las plotas de España hasta el año de 1840* (Madrid: Imprenta y Estereotipia de M. Rivadeneyra, 1870), 279–281.
19. Maria Lourdes Diaz Trechuelo, *Arquitectura Española en Filipinas (1565–1898)* (Sevilla: Escuela de Estudios Hispano-Americanos de Sevilla, 1959). Trechuelo obtained this floorplan from the Archivo General de Indias in Seville, Spain.
20. Pablo Fernandez, O.P., *History of the Church in the Philippines, 1521–1898* (Manila: National Bookstore, 1979), 68–69.
21. Severiano Alcobendas, O.F.M., "Medicos-Cirujanos de la Provincia de S. Gregorio Magno de Filipinas," *Archivo Iberoamericano (AIA), Tomo 34, Año 18* (1931), 261. For a full biography, see Eusebio Gomez Platero, *Catalogo Biografico de los Religiosos Franciscanos de la Provincia de San Gregorio Magno de Filipinas* (Manila: Imprenta del Real Colegio de Santo Tomas, 1880), 28–29.
22. In this section, most of the data on the hospitals is from Francisco Guerra, *El Hospital en Hispanoamerica y Filipinas, 1492–1898* (Madrid: Ministro de Sanidad, 1992), 536–576.
23. Alcobendas, "Medicos-Cirujanos de la Provincia," 28–29.
24. Guerra, *El Hospital en Hispanoamerica*, 540.
25. Lorenzo Perez, O.F.M., "Labor Patriotica de los Franciscanos españoles en el Extremo Oriente, particularmente en Filipinas en las obras de colonizacion, beneficiencia, y cultura, y en defensa del dominio patrio." in *AIA*, Tomo 32, Año 16 (Julio-Diciembre 1929), 190–191.
26. Ibid.
27. King Charles III of Spain ordered the expulsion of the Jesuits from all the territories of Spain in

1767. In the Philippines this occurred in 1768. Most of the Jesuit estates and buildings remained unoccupied and unused until the Spanish Crown awarded them to different religious orders.

28. Felix De Huerta, O.F.M., *Estado Geografico, Topografico, Estadistico, Historico, Religioso de la Sta. Apostolica Provincia de San Gregorio Magno de Religiosos Menores Descalzos de la Regular y mas estrecha observancia de N.S.P.S. Francisco, en las Islas Filipinas* (Binondo: Imprenta de M. Sanchez y Compania, 1865), 69–70.
29. Casero Nieto, as quoted in Guerra, *El Hospital en Hispanoamerica*, 561.
30. Miguel Rodriguez Berriz, *Diccionario de la Administration de Filipinas. Anuario de 1888* (Manila: Imprenta y Litografia de M. Perez, Hijo, 1888), 201.
31. Ibid., 203.
32. Guerra, *El Hospital en Hispanoamerica*, 561.
33. De Huerta, *Estado Geografico, Topografico*, 67–69.
34. Ibid., 565; Perez, Labor Patriotica, 190.
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36. Fermin Llorente, *Discurso de la bendicion del Hospital de Lazarinos del Obispado de Nueva Caceres en 23 de Setiembre de 1872.* n.d.
37. Lucio Gutierrez. O.P., *The Archdiocese of Manila: A Pilgrimage in Time (1565–1999)* (Manila: The Roman Catholic Archbishop of Manila, 1999), 166.
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39. Perez, Lorenzo, O.F.M "Constituciones de la Apostolica Provincia de San Gregorio Magno," *AIA*, Año 16, Num. 93, Mayo-Junio 1929, 339–264.
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41. Perez, "Labor Patriotica de los Franciscanos," 189–192.
42. Alcobendas, *AIA*, I, 52.
43. Ibid.
44. 46. Ibid., I, 53; II, 242.
45. Ibid., I, 1931, 49–50.
46. Ibid., 51.
47. Ibid., 58.
48. Gomez Platero, *Catalogo Biografico de los Religiosos Franciscanos*, 198.
49. Alcobendas, *AIA*, I, 61.
50. Ibid., 243.
51. For details on each doctor-surgeon, consult Gomez Platero, *Catalogo Biografico de los Religiosos Franciscanos.*
52. Franciscan chronicles do not give specific names of the Western medicine. See Ibid., 65.
53. Ignacio De Mercado, O.S.A., *Libro de Medicinas de esta Tierra y Declaraciones de las virtudes de los arboles y plantas que estan en las islas Filipinas*, vol. 4., n.d.
54. Alcobendas, 538–539.
55. Jose P. Bantug, "Recursores de la Farmacofitologia en Filipinas," *The Journal of the Philippine Pharmaceutical Association* 34, no. 6 (June 15, 1947): 218–222.
56. Francisco De las Barras y De Aragon, "La Botanica en los Conventos de Filipinas," *Boletin de la Real Sociedad Española de Historia Natural, Tomo 47* (Madrid: 1949), 235248.
57. The estrangement of Filipino scholars from the Spanish language has limited the sources from which contemporary Filipino historians examine the Spanish colonial period in Philippine

history. Some dependence on English translations and studies in English, written by a certain number of American scholars, inevitably occurs. These are further clouded by an extreme anti-Spanish stance in the early writings of American government officials, academics, businessmen, journalists, and others which are uncritically accepted and continue to influence current research in Philippine history.

58. The Franciscan holistic program for people with leprosy is well documented by the Augustinian Fr. Joaquin Martinez de Zuñiga in his *Estadismo de las Islas Filipinas.* It was written between 1803–1805 and it was based on expeditions which Fr. Zuñiga led around the Philippines from 1801–1802. His incisive assessment of the operations of the Hospital de San Lazaro reflected a system wherein the needs of people with leprosy were addressed. These included physical/medical services, psychological health, and spritual fulfilment.
59. Joaquin Martinez de Zuñiga, O.S.A., *Estadismo de las Islas Filipinas o mis viajes por esta pais* (Madrid: Imprenta de la viuda de M. Minuesca de los Rios, 1893), 327–328.
60. Ibid.
61. Ibid.
62. Ibid., 329.
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AT THE CROSSROADS: NEW DEVELOPMENTS IN LEPROSY CARE IN NINETEENTH CENTURY PHILIPPINES

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By the nineteenth century the care of people afflicted with leprosy in the Philippines had had over 200 years of implementation under the framework of charity as an integral part of the Christian evangelization of the Philippines. The Spanish Catholic Church, through the Franciscan missionary order, built hospitals where the afflicted were provided care, food, and clothing as well as spiritual guidance and sanctuary from public ridicule. As the nineteenth century began, leprosy care found itself at the crossroads as a result of two significant developments. The first was that while charity remained the founding principle for the care of those afflicted by the disease, it was no longer the monopoly of the Franciscans who were based in Luzon. This paper will present the undertaking of the bishops of the Diocese of Cebu to build a hospital for the afflicted in Cebu comparable to that in Manila—large, made of stone and hardwood, roomy, and comfortable—where the afflicted from Cebu and other islands in the Visayas were welcomed and nurtured. The second was the emergence of a new type of care providers for the afflicted, *medicos titulares* (medical practitioners who were duly authorized to take care of the sick), who differed greatly from the Franciscans in their treatment of leprosy. Graduates of medical courses in universities in Spain and in Manila, they were sent by the colonial government to the provinces to treat people afflicted with disease. Although they appeared rather late in the day, the deployment of medical professionals foreshadowed the more scientific approaches of the twentieth century.

LEPROSY IN CEBU

The province of Cebu in the nineteenth century had a population of more than 500,000. Older than Manila, the capital of Cebu was equally as populous. However, it had no civil hospital of its own. It had no appropriate budget to defray the cost of medicines of of the poor those who were injured.[1] Among the more numerous of the sick in Cebu in the nineteenth century were people afflicted by leprosy who wandered about in the streets.

Notwithstanding the absence of a cure for leprosy, the belief was strong among the afflicted in

Cebu that devotion to the Holy Child Jesus, endearingly called Santo Niño, would heal them. The image of the infant Jesus, believed to be the same that Ferdinand Magellan had given the wife of Rajah Humabon when she was baptized in 1521 and which Juan de Camuz, one of Miguel Lopez de Legazpi's men, found when the Spaniards sacked Cebu in 1565, was housed in the city's cathedral. Banking on the Santo Niño's miraculous powers, those afflicted by leprosy not only from Cebu but from the islands of Romblon, Masbate, Siquijor, Negros, and even Mindoro paid religious homage with the hope of a cure.[2]

A HOSPITAL IN CEBU FOR PEOPLE AFFLICTED BY LEPROSY

Among the Spanish religious orders, the Franciscans stood out for their care of persons afflicted with leprosy. However, their missions were focused on Luzon, particularly in the suburbs of Manila, such as San Francisco del Monte, Dilao, Sampaloc, Pandacan, and Santa Ana and the provinces of Laguna (the towns of Morong, Baras, Tanay, Pililla, Mabitac, Siniloan, Pangil, Pakil, Paete, Cavinti, Santa Cruz, Nagcarlan, and Liliw); Tayabas (the towns of Lucban, Tayabas, Pagbilao, Sariaya, Gumaca, and Atimonan); Camarines (the towns of Naga, Canaman, Quipayo, Milaor, Minalabac, Buhi, and Libmanan); and Albay (the towns of Libon, Polangui, Oas, Ligao, Guinobatan, and Cagsawa).[3] The responsibility for caring for the sick and leprosy sufferers in the Visayas instead fell upon the Diocese of Cebu, which was established on 14 August 1595 with the Latin name, *Nominis Iesu o Caebuanus*.[4] In addition to the province of Cebu, the administrative and episcopal responsibility of this diocese included the islands of Panay, Samar, Leyte, and the Calamianes in northern Palawan, as well as northern Mindanao and the Marianas Islands.[5]

The Diocese of Cebu built a hospital for the city's leprosy sufferers. Initially, it consisted of a small hut *(camarin)* built by Joaquin Encabo de la Virgen de Sopetrán, O.A.R., Bishop of Cebu (20 August 1804–8 November 1818), who took pity on the afflicted of the city. Diocesan support for the hospital was continued by Santos Gómez Marañòn, O.S.A., Bishop of Cebu (28 September 1829–23 October 1840).[6] The hospital was called San Lazaro Hospital, named after the Franciscan hospital with the same name in Manila that took care of those afflicted by leprosy.[7] It was located in Carreta, in the northern part of the city far from the area where the Spaniards lived. As was the practice at the time, hospitals, especially those caring for people believed to be afflicted with contagious diseases, were situated in areas far from the center of the town, where there were only a few houses and residents.[8]

The number of leprosy patients under the care of the San Lazaro Hospital of Cebu varied (see Table 1.)

THE PRIMARY RESPONSIBILITY OF THE DIOCESE TO THE HOSPITAL WAS TO ENSURE THAT THE TEMPORAL NEEDS OF THE LEPROSY PATIENTS WERE MET.

TABLE I. NUMBER OF LEPROSY PATIENTS
IN THE SAN LAZARO HOSPITAL OF CEBU, SELECTED YEARS

YEAR	NUMBER OF LEPROSY PATIENTS
1836	51
1844	53
1846	44
1847	44
1854	34

NOTE: The data from the above table were drawn from various sources.[9]

The Diocese administered the hospital through the parish priest of the Parian in Cebu City. Located northeast of the town center, the Parian was the original area of settlement of Chinese merchants in Cebu.[10]

The primary responsibility of the Diocese to the hospital was to ensure that the temporal needs of the leprosy patients were met. First of all, they needed a daily ration of food which consisted of rice and meat. Rice was usually purchased in bulk *(cavan)* for the hospital by local businessmen from nearby provinces like Capiz and Samar.[11] The meat which was usually served consisted of pork, though carabao was also a common dish at the dinner table.[12] The patients' clothing needs were modest shirts and pants for the men, and skirts and shirts for the women. An additional cost was the fee for the dressmaker. On 21 June, which was the feast day of Saint Lazarus, a new set of clothes was customarily distributed to the patients.[13] Aside from food and clothing, the hospital purchased salt and vinegar for seasoning of food, tar as sealant, and firewood for cooking.[14]

Adequate funds were also needed for contingencies. Prices of goods, such as cloth purchased from Bohol, fluctuated.[15] An adequate supply of rice in stock (at least 300 *cavanes*) was also necessary to cover periods of drought when the supply was lean and the price of rice was high. Prices also rose, such as the daily cost of meat: 2 *reales* in 1825 and 3 *reales* 6 *granos* by 1846.[16] Money also had to be allotted for repairs. For instance, the hospital's roof had to be repaired in September 1841.[17]

The San Lazaro Hospital of Cebu subsisted wholly on alms and donations. Among the generous benefactors of the hospital were the wealthy residents of the Parian. The practice was to leave money in trust to an executor for the maintenance of the people in the city who were afflicted by leprosy. Examples of such grants received by the hospital include 50 *pesos* each from Luis Suico, Placida del Rosario, and Mateo Gomez de Leon, and 18 *pesos* 6 *reales* from Maria Jazinta, who stipulated in her will that the money be spent by the hospital at three *reales* per month. Originally, Magdalena Marta, a widow who died in 1825, had wanted the poor and the destitute in the Parian to benefit from her pious grant amounting to 718 *pesos* in cash. She also left behind 1,000 *cavanes* of palay which she wanted to be distributed to the poor who went from door to door every Friday begging for food. However, in 1829 Bishop Santos Marañón persuaded Magdalena Marta's executor to give the money and palay to the leprosy patients of the San Lazaro Hospital of Cebu instead since they were also poor and destitute. Thus, the hospital was given a ration of 33 *cavanes* of palay every month and two *reales* worth of meat every day.[18]

Ordinary people also donated money, such as Seferino Hernandez, who gave 6 *pesos* 5 *reales* and Casimiro Soriano, who donated 4 *pesos*. Priests also gave money. Among them were R.P. Fr. Juan Soriano (20 *pesos*), R.P. Fr. Antonio Ubeda (10 *pesos*), Fr. Mateo Perez (2 *pesos* 6 *reales*), and Fr. Juan Quimbo (15 *pesos*). The Vicar of Iloilo, Fr. Jose Albares, sent 710 *pesos* 3 *reales* 6 *granos*, while the Vicar of Capiz sent 50 *pesos*.[19]

Alms amounting to 1,359 pesos 3 *reales* 9 *granos* came from various people: parish priests, coadjutors, and other ecclesiastics of various towns in northern Cebu; vicars of Bohol, Barili, and Siquijor; the parish priest of Dumaguete; and hundreds of nameless people who slipped in money in the small alms boxes conveniently placed in churches all over the province of Cebu.[20]

The provincial government also gave financial assistance to the hospital. When Francisco Ossorio was governor of Cebu from 1834 to 1840, he gave a total of 64 *pesos* 5 *reales* 6 *granos* to the hospital, which had come from various earnings of the province. Such assistance was continued by

the succeeding governor, Juan de la Guerra. In January of 1841, the first year of his term as governor, he gave the hospital 6 *pesos*, which came from the tax on raffles. In May of the same year, he gave the hospital 51 *pesos* 1 *real* from the income on stamping of weights and measures. In May of the following year, the hospital again received money from him amounting to 48 *pesos* 3 *reales* 6 *granos*, which was earned from the same source.[21]

Another source of funds for the hospital consisted of fees paid by 48 vendors who were allowed to put up stores in front of the Santo Niño convent. Each vendor paid a rental fee of 6 *granos* every month. However, funds from this source were not constant since the vendors did not always stay in Cebu City. Occasionally, they went to other towns like Danao, Naga, Carcar, and Argao to sell their wares when there were town holidays.[22] Nevertheless, funds from this source were used by the hospital to pay for the purchase of meat, salt, vinegar, firewood, and tar.[23]

Finally, fines from various kinds of infractions, such as those for conducting prohibited games, were another source of funding for the hospital.[24]

NEED FOR A NEW HOSPITAL

The San Lazaro Hospital of Cebu was a wooden structure which naturally deteriorated with the passage of time, especially because of strong winds and rain which buffeted the islands as well as the intense heat prevalent in a tropical country like the Philippines. By the mid-1840s the hospital had become dilapidated, cramped, and uncomfortable for the 55 leprosy patients it accommodated.[25] Because of its limited space, the hospital was unable to accommodate more patients even if it wanted to. Hence, leprosy patients in other places outside Cebu City were under the care of the parish priests of their towns, for example, Mandaue and San Nicolas.[26] At times, the hospital had to refuse people who sought admission owing to the lack of space, as was the case of six people from Bantayan who asked to be admitted in 1844. In the end, the hospital housed them in a place called Silagon, which was quite a distance away.[27] Even worse, some patients left the hospital and moved to other towns of the province.[28]

In view of this situation, the Diocese of Cebu embarked on an ambitious plan to construct a bigger and sturdier hospital for the leprosy patients of Cebu.[29] The construction of this new hospital was undertaken and completed when Romualdo Jimeno Ballesteros, O.P. became Bishop of Cebu (19 January 1846–17 March 1872).[30]

Cognizant of the needs of the new hospital, Bishop Ballesteros requested the Governor-General of the Philippines to place the construction of the hospital under the management of the Captain-Commandant of the Corps of Engineers of the Visayas, Felipe la Corte.[31] Accordingly, the latter appointed Lieutenant Colonel Jose Gimenes, Commandant of the Corps of Engineers, and Juan Tomas Calbo, a staff of the Military Hospital, to inspect the location of the old hospital.[32]

Based on their inspection, the two experts suggested building the new hospital in a different location for several reasons. First, they noted that the current hospital was located near a populated area, which facilitated contact between those who were afflicted by the disease and those who were not. Second, the hospital was located on the seashore and surrounded by trees that prevented the free flow of the wind, thus increasing the heat and humidity. Finally, there were no guards to prevent the patients from leaving the place.

BY BUILDING THE HOSPITAL ON AN ISLAND, THE AFFLICTED WOULD THUS BE PREVENTED FROM

The new site suggested by the experts was the island of Mactan near the passage across the port of Cebu City.[33] The popular notion then was that infection spread through contact. By building the hospital on an island, the afflicted would thus be prevented from wandering the city streets and infecting other people. Mactan was the perfect site because it provided the best means of isolating the afflicted.[34] The alternative was any small island near Mactan, like the island called Gapasgas located just in front of the town of San Nicolas.[35]

Another option was to build the new hospital near the old one. This was the suggestion of Bishop Ballesteros owing to the disadvantages of constructing the hospital in Mactan. First of all, building materials had to be transported from the city proper to Mactan. Secondly, workers had to travel daily to the construction site. Both entailed additional costs as well as extra time and effort that would affect the work schedule and even delay the completion of the construction. Finally, the daily travel by boat was not always easy because the body of water separating Mactan from the main island was not always navigable.

Conversely, there were advantages in building the new hospital near the current one. First, water could easily be acquired in the site of the current hospital. Second, because the current hospital would not be demolished while the construction of the new hospital was going on, the old building could still house the patients and meet their needs. Finally, building near the current hospital rather than in Mactan would facilitate visits to the construction site by officials who could contribute to the well-being of the patients. Bishop Ballesteros pointed out that in Manila the hospital for the leprosy patients was situated near the houses of those who were not afflicted by the disease, who even cultivated the fields next to the hospital. This indicated that there should be no fear of contamination.[36]

In the end, Bishop Ballesteros' suggestion prevailed. Narciso Claveria, Governor-General of the Philippines and Vice Royal Patron,[37] approved the construction of the new hospital near the current one.[38]

DESIGN OF THE NEW HOSPITAL

The two experts who were consulted for the project made several recommendations regarding the building itself, namely: the new hospital had to be bigger and sturdier to admit more patients in safety and comfort; the area had to be wide enough to accommodate a large veranda where the patients could pass their time; and the hospital had to be situated in a shaded place surrounded by fruit trees. The consultants also suggested providing the hospital with two or three wells and three or four large tanks of water to enable the patients to bathe and wash their clothes within the hospital premises. This would prevent them from going to the sea, where they would often gather sea shells as food which were believed at the time to cause leprosy.[39]

The new hospital was designed by Lieutenant Colonel Gimenes. It was a far cry from the current hospital. The building had two storeys as compared with the old hut which had only one storey. Unlike the old building, it was made of stone and reinforced by brick and hardwood, such as *tindalo*, *molave*, and *ipil*. The front part of the building opened to the entrance of the chaplain's quarters. A staircase led to the second floor where the chaplain's rooms, kitchen, and patio were located. Adjoining the quarters of the chaplain on the ground floor was the entrance to the hospital. Large patios and rooms for storage dominated most of the space. Towards the end of the ground floor, there

were wells and large cisterns for the storage of water. Two staircases led to the second floor where the dormitories for men and women were located. Wide corridors separated their quarters and between these corridors was a chapel. Directly above the cisterns were large patios and the kitchen.[40]

CONSTRUCTION OF THE NEW HOSPITAL

As was the practice at the time, the labor for public works construction was supplied by the local populace. It was compulsory in nature depending on certain conditions, such as age and distance from the work site. Called *servicio personal* (personal labor) or more popularly, *polo y servicio*,[41] the people who rendered this type of service were called *polistas*.[42] To construct the new hospital, the governor of Cebu assigned *polistas* from the towns nearest the construction site, as follows: 8 from the federation of natives and 4 from the federation of mixed-race of Cebu; 14 from the town of San Nicolas; 4 from Talamban; and 6 from Mandaue.[43]

The governor appointed as master builder for the project, Ludovico Marcial Salvador from Manila, the same master builder contracted for the construction of the new prison and commercial establishments in Cebu City. For his work on the hospital project, Salvador received a monthly salary of 25 *pesos* while the two stone masons whom he brought along with him were paid 12 *pesos* a month. The governor also provided the three workmen free travel to and from Cebu.[44]

THE GOVERNOR WAS FULL OF PRAISE FOR THE NEW HOSPITAL, DESCRIBING IT AS THE FINEST BUILDING OF ITS KIND IN THE ENTIRE PHILIPPINES. TO HIM THE BEST QUALITIES OF THE NEW HOSPITAL WERE ITS ELEGANCE AND COMFORT.

Construction of the new hospital commenced on 10 April 1849. Fr. Jose Morales del Rosario, the parish priest of the Parian, was appointed by Bishop Ballesteros to oversee the construction and ensure that the *polistas* performed the work assigned to them. He was also entrusted with the security of the construction materials,[45] which included timber, stone blocks, tiles, and bricks.[46]

A little over a year after construction began, the Diocese not surprisingly reported a shortage of funds. Although the budget estimated for the construction was 8,687 *Pesos* 2 *reales*, construction began even when the available funds amounted to only 4,505 *pesos* 11 *grams* or nearly half the required budget.[47] To aggravate the situation, the cost of construction grew since there were expenses that had not been included in the original budget. One such expense was the construction of a hut for the workers where they could take shelter whenever it rained. Another was the purchase of implements that the workers needed, such as a native cooking pot, a large pitcher, and some utensils for their use.[48] Fortunately, the colonial government intervened. On 21 December 1850, Governor-General Ramon Blanco ordered the governor of Cebu to use the surplus income of the towns outside the provincial capital and the earnings from the slaughter of cattle to finance the project.[49] Thus, by 6 September 1852 the construction of the hospital had progressed steadily. By the time he left his position, the governor reported that the roof had been attached, the staircases were set in place, and the wooden planks for the floors had been installed.[50]

Two years later, the succeeding governor proudly reported to the Governor-General that the construction of the new San Lazaro Hospital of Cebu was completed. On 1 April 1854, the hospital opened its doors to 30 leprosy patients. The governor was full of praise for the new hospital, describing it as the finest building of its kind in the entire Philippines. To him the best qualities of the

new hospital were its elegance and comfort. The new hospital, moreover, had a refreshing view of the sea and because of this he believed the new hospital would be able to provide the patients with a healthier environment.[51]

THE SUCCESSFUL CONSTRUCTION OF THE NEW HOSPITAL ALSO PROVED THAT FUNDS COULD ALWAYS BE SOURCED FOR THE BENEFIT OF THOSE AFFLICTED BY LEPROSY, SUCH AS ALMS AND SURPLUS EARNINGS FROM TAXES THAT THE PROVINCIAL GOVERNMENT COLLECTED.

In his report the governor expressed his great hope for the hospital. Now that it was bigger, the hospital could accommodate up to 100 patients, well beyond its estimated capacity of 60 to 70. The successful construction of the new hospital also proved that funds could always be sourced for the benefit of those afflicted by leprosy, such as alms and surplus earnings from taxes that the provincial government collected.[52]

Accordingly, in 1854 the Diocese prepared a budget that reflected the bigger work that lay ahead for the hospital. This entailed the hiring of personnel with commensurate salaries, such as a chaplain, a steward, three servants, and two young boys to assist in the chapel. The budget also included the purchase of medicines; nutritious food, such as rice, fresh meat, and vegetables; special food for the gravely ill; condiments, such as cooking oil, vinegar, and salt; other necessities, such as oil to light the lamps, wine, candles, and flour for making the hosts for Holy Communion; and two sets of clothing for the patients per year.[53]

PUBLIC HEALTH, A NEW GOVERNMENT PRIORITY

The San Lazaro Hospital of Cebu stands as a testimony to the concerted effort of the Catholic Church, the colonial government, and the local population to give the leprosy sufferers of Cebu a better life. This effort was bolstered by a new development toward the end of the nineteenth century—the rise of a new class of medical professionals called *medicos titulares*—made possible by changes in the colonial government structure. Although the direct impact on the care and treatment of leprosy patients was not large (since the changes came a decade or so before Spain's expulsion from the Philippines), the late nineteenth century Spanish efforts in creating a public health regime nonetheless signaled a change in the official approach to leprosy.

Health took on a new, albeit belated place in the colonial government's priorities. Leprosy sufferers began to be treated by *medicos titulares*, many of whom were Spaniards who went to the Philippines after finishing a medical course in Spanish universities. However, there were also *medicos titulares*—Spaniards and *mestizos*—who took the medicine course at the Faculty of Medicine of the University of Santo Tomas in Manila.

The post of *medico titular* arose as a result of the passage of the royal order of 31 March 1876, which aimed to provide skilled, knowledgeable doctors to attend to the needs of the sick in the Philippines.[54] In the nineteenth century the Spanish Crown recognized the unfortunate reality that many Filipinos were falling victim to a number of diseases. Though they varied in prevalence from province to province and year to year, these diseases could be classified under two categories: infectious diseases, such as malaria, typhoid fever, dysentery, measles, smallpox, and puerperal fever; and frequent ailments such as intestinal cold, tuberculosis, hepatitis, acute articular rheumatism, respiratory and circulatory diseases, and stroke.

THE *MEDICOS TITULARES* DID NOT JUST TREAT DISEASES; BUT THEY ALSO WANTED TO KNOW THEIR

CAUSES IN ORDER TO EXPLAIN THE FATALITIES THEY RECORDED.

The *medico titular* was assigned to address both categories of diseases in a particular province of the Philippines where for a period of one year he served as chief medical officer. As such, he treated illnesses, diseases, and other maladies affecting the people. At the end of his term, he wrote a report, *memoria medica*, in which he described the work he had carried out in the province. The *medico titular* also served as the eyes and ears of the colonial government in the provinces.

The *medicos titulares* did not just treat diseases; but they also wanted to know their causes in order to explain the fatalities they recorded. In the case of leprosy, they encountered various beliefs: that leprosy was hereditary, for instance, or that it was contagious. However, the more overwhelming explanation was religious: that leprosy was caused by sin and, therefore, a punishment from God; or that leprosy was a curse or caused by evil spirits or demons.[55]

Most *medicos titulares* believed, however, that *elefantiasis*, which was the other term used to denote leprosy, was not caused by sin or evil spirits. Rather, they attributed the disease to natural causes, one being certain foods in the Filipino diet. One such food was fish that Spaniards believed was already in the first stages of decomposition—presumably *bagoong* (shrimp or fish paste)—that Filipinos ate with gusto.[56] Another was pork from pigs that had not been properly fed. (In those days pigs normally roamed freely scavenging for food.) Beef and carabao meat, which were not desirable to the Spaniards since it had been dried up for several days already,[57] were a favourite of Filipinos.[58] Another natural cause was the perceived miserable way of life of Filipinos. According to the *medico titular* of Capiz, the houses of people in the province were very small and compact, supported only by four wooden stakes.[59] On the other hand, the *medico titular* of Leyte noted that those afflicted by the disease lacked cleanliness in their clothing.[60]

While the general population feared leprosy, the *medico titular* of the nineteenth century looked upon it as a disease of the skin. The *medico titular* of Leyte, for example, likened leprosy to dermatological diseases like herpes, scabies, psoriasis, and pitiriasis.[61] *Medicos titulares* also tended to be forward-looking. That of Ilocos Sur, for instance, proposed the establishment of a hospital or even a sanctuary to house those afflicted by leprosy in the province in anticipation of their growing number.[62] Some *medicos titulares* experimented on a possible cure. In 1896, for example, the *medico titular* of the Marianas Islands gave iodine and iron preparations to the leprosy patients there and applied astringents to their skin. He reported promising results in the *memoria medica* he submitted to the government at the end of his term.[63]

MEDICOS TITULARES ALSO TENDED TO BE FORWARD-LOOKING.

The efforts of the *medicos titulares*, however, were scattered and limited in impact for various reasons. Firstly, there were only a few of these doctors in the country. Secondly, the Faculty of Medicine of the University of Santo Tomas, the first school of medicine in the Philippines, opened only in 1872.[64] Thirdly, even as the appointment of doctors continued steadily by the last decade of the nineteenthcentury, and they reached nearly all the provinces in Luzon and the Visayas, the results of their work were uneven because conditions on the ground varied from place to place. Finally, Spanish rule in the Philippines was soon to end, cutting short the services of these professionals.

CONCLUSION

Leprosy care in the Philippines reached a turning point in the nineteenth century, marked by two important developments. The first was the construction of the San Lazaro Hospital of Cebu by the bishops of the Diocese of Cebu, which finally gave the leprosy sufferers of Cebu and other islands in the Visayas a hospital to take care for their temporal and spiritual needs. Patterned after its counterpart in Manila, the San Lazaro Hospital of Cebu was spacious, built of durable materials, restful, and well-ventilated. The hospital placed the care of the leprosy patients of the Visayas at par with that in Luzon. Also, the undertaking by the Diocese of Cebu to construct the hospital signalled the rise of the secular church in assuming the care of leprosy sufferers in the Visayas, which for centuries had been focused in Luzon with the Franciscans at the helm.

The second important development in the nineteenth century was the emergence of *medicos titulares*, professional medical practitioners who moved away from the religious orientation of earlier leprosy care and shifted toward a more studied approach to leprosy. As scientists, the *medicos titulares* were inquisitive, conscious not only of the treatment of diseases but also their causes and possible cure. Also, the deployment of *medicos titulares* to the countryside indicated a change in Spanish policy toward a more professional care of the sick throughout the colony and not just in Luzon.

By the end of the nineteenth century, the religious context of leprosy and the manner of caring for its sufferers that had prevailed in the previous 300 years ended. In 1906, the San Lazaro Hospital of Cebu closed its doors. Two coastguard cutters brought the afflicted to Culion, an island in the Calamianes group of islands in northern Palawan,[65] where the Americans set up their own leprosy program founded on segregation, medical cure, and control.[66] It was managed by doctors and other scientists who picked up from where the *medicos titulares* had left off.

NOTES

1. *Memorias medicas: Memoria escrita por el Medico Titular de la Provincia de Cebu en cumplimiento de lo dispuesto por el Gobierno Supremo dirigida al Excelentisimo Señor Gobernador General, Cebu, 20 Junio 1885.*
2. Report of the Governor General of the Philippine Islands for the Fiscal Year ended December 31, 1920 (Washington: Government Printing Office, 1923), 85.
3. Pedro Picornell, *The Philippine Chronicles of Fray San Antonio* (translation of Juan Francisco de San Antonio’s *Cronicas de la Provincia de San Gregorio Magno*) (Manila: Casalinda and Historical Conservation Society, 1977), 197–205.
4. Archdiocese of Cebu official website: www.catholic-hierarchy.org/diocese/dcebu.html (accessed 14 Oct. 2015).
5. Archdiocese of Cebu website, with particular information on the Cardinal, auxiliary bishops, diocesan curial, parishes, clergy, seminaries, and educational centers and institutions: www.cbcponline.net/cebu (accessed 14 Oct. 2015).
6. Spanish Manila 13846: *Oficio del Obispo de Cebu al Gobernador Yntendente de Visayas, Cebu, 21 Julio 1847*, 166.
7. The hospital’s name is derived from Lazarus (Lazaro), a poor man afflicted with *el mal lazaro* who is mentioned in the Bible.
8. Other examples are the hospital for leprosy patients in Manila, outside of Intramuros; the Hospital de Lazarinos de Palestina, outside Nueva Caceres (now Naga) in Camarines Sur *(Guia oficial de Filipinas: Anuario Historico-Estadistico-Administrativo* {Manila: Imprenta de Amigos del Pais, 1878), 103}); the hospital for leprosy patients in Santa Barbara, away from the

main town of Iloilo; (*Lazareto de Mariveles: Año de 1887: Expediente relativo al establecimiento de un Hospital de Lazarinos en la Diocesis de Jaro*); and the Hospicio de Sta. Ysabel at the outskirts of Laoag in Ilocos Norte (*Memorias medicas: Memoria acerca de la provincia de Ylocos Norte correspondiente el año 1876 elevada al Excelentisimo Señor Ministro de Ultramar por el Medico titular de la misma Don Gregorio Martin Blanco, Laoag, 2 Julio 1877*).

9. The data in the table were drawn from the following sources: 1836–Spanish Manila 13846: *Oficio del Cura parroco del Parian al Obispo de Cebu, Colegio Seminario de Zebu, 9 Noviembre 1843*, 25; 1844–Spanish Manila 13846: *Oficio del Administrador de Lazarinos al Obispo de Cebu, Colegio Seminario de Cebu, 2 Marzo 1844*, 154–155; 1846–Spanish Manila 13846: *Relacion del Diario i vestido de Lazarinos, 9 Octubre 1846*, 125; 1847–Spanish Manila 13846: *Oficio del Cura parroco del Parian al Obispo de Cebu, Casa parroquial del Parian, 9 Diciembre 1847*, 185–186; 1854–Spanish Manila 13846: *Relacion de los gastos que mensualmente irroga el Hospital de Lazarinos de esta ciudad por treinta enfermos que actualmente existen en el, Cebu, 7 Abril 1854*, 305.
10. Concepcion G. Briones, *Life in Old Parian* (Cebu City: University of San Carlos, 1983).
11. Occasionally, inter-island ships passed by Cebu selling goods such as rice. In 1841 the *Sta. Filomena* from Misamis dropped anchor in Cebu City and the hospital purchased from it 385 *cavanes* of rice worth 264 *pesos* 5 *reales.* (Spanish Manila 13846: *Cuenta de cargo y data que formo Yo el encargado por el Excelentisimo e Yllustrisimo Señor Don Fr. Santos Gomez Marañon, Obispo que fue de esta Diocesis y por el actual Excelentisimo e Yllustrisimo Señor Don Jayme Gil Orduña del Subministro del Hospital de San Lazaro de esta Ciudad; cuyo encargo me lo he tomado sin el menor interes, y solo por obedecer a mis Prelados desde el año 1837 por Julio, Cebu, 10 Febrero 1844*, 34 (hereinafter Spanish Manila 13846: *Cuenta de cargo y data ... Cebu, 10 Febrero 1844*).
12. Spanish Manila 13846: *Recivo y gasto del Hospital de San Lazaro de Zebu del presente año de 1834, en este mes de Agosto, en que me he hecho cargo del cobro de alquileres de las tiendas de la plaza de Sto. Niño por encargo del Señor Santos y Señores Alcaldes mayores y es la epoca en que empezaron a pagar*, 39 (hereinafter Spanish Manila 13846: *Recivo y gasto del Hospital de San Lazaro de Zebu*).
13. Spanish Manila 13846: *Cuenta de cargo y data ... Cebu, 10 Febrero 1844*, 34.
14. Spanish Manila 13846: *Recivo y gasto del Hospital de San Lazaro de Zebu*, 37.
15. Spanish Manila 13846: *Relation del Diario i vestido de Lazarinos, 9 Octubre 1846*, 125.
16. Ibid.
17. Spanish Manila 13846: *Cuenta de cargo y data ... Cebu, 10 Febrero 1844*, 34.
18. Ibid., 29.
19. Ibid., 30–32.
20. Spanish Manila: *Relacion de las limosnas recogidas de la obra del nuevo Hospital de los Lazarientos del Cebu, y de las cantidades que de ellas se han sacado para gastos de la misma obra, Cebu, 7 Setiembre 1850*, 238.
21. Ibid., 31.
22. Spanish Manila 13846: *Lista de las tenderas de la Plaza frente al Convento del Sto. Niño, Cebu, 9 Octubre 1846*, 124.
23. Spanish Manila 13846: *Oficio del Cura parroco del Parian al Obispo de Cebu, Colegio Seminario de Zebu, 9 Noviembre 1843*, 24.

24. Spanish Manila 13846: *Cuenta de Cargo i data que formo Yo el Encargado por el Excelentisimo e Yllustrisimo Señor Don Fr Santos Gomez Marañon Obispo que fue de esta Diocesis y por el Excelentisimo e Yllustrisimo Señor Don Jayme Gil Orduña del Subministro del Hospital de San Lazaro de esta Ciudad, cuyo encargo me lo he tomado sin el menor interes; solo por Dios y por obedecer a mis Prelados, Zebu, 31 Julio 1844*, 1141–16.
25. Spanish Manila 13846: *Oficio del Gobierno Eclesiastico de la Diocesis de Cebu al Excelentisimo Señor Governador y Capitán General de estas Yslas, Zebu, 3 Febrero 1844*, 145.
26. Spanish Manila 13846: *Oficio del Cura párroco del Parian al Obispo de Cebu, Colegio Seminario de Zebu, 9 Noviembre 1843*, 24.
27. Spanish Manila 13846: *Oficio del Administrador de Lazarinos al Obispo de Cebu, Colegio Seminario de Cebu, 2 Marzo 1844*, 154–155.
28. Spanish Manila 13846: *Oficio del Obispo de Cebu al Gobernador General de las Yslas Filipinas, Cebu, 7 Abril 1850*, 306–308.
29. Spanish Manila 13846: *Oficio del Gobierno Eclesiastico de la Diocesis de Cebu al Excelentisimo Señor Governador y Capitán General de estas Yslas, Zebu, 3 Febrero 1844*, 145.
30. Metropolitan Archdiocese of Cebu website: www.gcatholic.org/dioceses/diocese/cebuo.htm (accessed 14 Oct. 2015).
31. Spanish Manila 13846: *Oficio del Obispo de Cebu al Gobernador Yntendente de Visayas, Cebu, 6 Febrero 1844*, 147.
32. Spanish Manila 13846: *Decreto del Gobernador Yntendente de Visayas, Cebu, 14 Octubre 1846.*
33. Spanish Manila 13846: *Oficio de la Contaduria de Hacienda de las Yslas Visayas al Gobernador Yntendente de las Yslas Visayas, Cebu, 28 Febrero 1844.*
34. 34. Hospital de San Lazaro: *Ultima pieza del expediente instruido sobre la organization del Hospital de San Lazaro. Impreso en Sampaloc de orden del Gobierno y a expensas del Ayuntamiento, Año de 1823.*
35. Spanish Manila 13846: *Oficio del Alcalde mayor de Cebu al Gobernador Yntendente de Visayas, Cebu, 27 Noviembre 1846*, 135.
36. Spanish Manila 13846: *Oficio del Obispo de Cebu al Gobernador Yntendente de Visayas, Cebu, 16 Diciembre 1847*, 180–183.
37. Under the colonial set-up of the union of Church and State, the Governor-General was the highest official of the Catholic Church in the Philippines. (Teodoro Agoncillo, *History of the Filipino People*, 7th ed. [Quezon City: R.P. Garcia Publishing Co., 1987], 83–84.)
38. Spanish Manila 13846: *Oficio del Gobierno Yntendencia y Comandancia General de Visayas al Alcalde mayor de Cebu, Cebu, 2 Abril 1848*, 93.
39. Spanish Manila 13846: *Oficio del Juan Tomas Calbo al Gobernador Yntendente de las Yslas Visayas, Cebu, 18 Octubre 1846*, 128–134.
40. Spanish Manila 13846: *Proyecto de un Hospital de Lazarinos capaz de 60 a 70 Enfermos de ambos sexos con la debida separación, Cebu, 24 Noviembre 1846*, 136.
41. *Ley iij Libro 6 Titulo 12 (Del servicio personal), "Que a los Indios se pague el tiempo que trabajaren, con ida y buelta, y vayan de diez leguas,"* in *Recopilacion de las Leyes de los Reinos de las Indias*, sandramathews.wordpress.com
42. *Ereccion de Pueblos: Ilocos Norte e Ilocos Sur, 1807–1897*, Exp. 80, Fol. 308–309, *"Resumen*

por pueblos del numero de polistas en la provincia de Ylocos Norte durante el ultimo quinquenio de 1892–1896," Laoag, 8 Setiembre 1897; Ereccion de Pueblos: Ilocos Norte e Ilocos Sur, 1807–1897, Exp. 91, Fol. 330–331, *"Numero de polistas que podian haber en el pueblo de Batac, provincia de Ylocos Norte, correspondiente a los años de 1892–1896," Batac, 13 Setiembre 1897.*

43. Spanish Manila 13846: *Oficio del alcalde mayor de Cebu a los gobernadorcillos de la ciudad de Cebu, San Nicolas, Mandaue y Talamban, Cebu, 9 Abril 1849*, 196.
44. Spanish Manila 13846: *Oficio del Alcalde mayor de Cebu al Gobernador Yntendente de Visayas, Cebu, 12 Abril 1849*, 194.
45. Spanish Manila 13846: Oficio del Obispo de Cebu al Alcalde mayor de Cebu, Cebu, 19 Abril 1849, 198.
46. Spanish Manila 13846: *Relacion de las cantidades del ramo y pesos y medidas aplicadas durante el año de la fecha a los gastos de la obra del Hospital de Lazarinos de esta Ciudad, cuyos documentos de pago obran en poder del que subscribe, Cebu, 20 Setiembre 1850*, 232.
47. This amount came from the following: 2,090 pesos 6 reales 2 granos from the proceeds of the tax on restamping of weights and measures; 1,000 pesos from Bishop Ballesteros; 1,359 pesos 3 reales 9 granos from alms. (Spanish Manila 13846: *Cuenta general de las cantidades que se han reunido para la obra del Hospital de Lazarinos de esta Ciudad y de las que se ban invertido en la misma obra, Cebu, 22 Setiembre 1850*, 229.)
48. Spanish Manila 13846: *Oficio del Cura parroco del Parian al Obispo de Cebu, Cebu, 16 Setiembre 1850*, 241.
49. Spanish Manila 13846: *Decreto del Excelentisimo Señor Gobernador General, Manila, 21 Diciembre 1850*, 258.
50. Spanish Manila 13846: *Oficio del alcalde mayor al Gobernador General de Filipinas, Sta. Cruz, 6 Setiembre 1852*, 267.
51. Spanish Manila 13846: *Oficio del Alcalde mayor de Cebu al Gobernador General de Filipinas, Cebu, 7 Abril 1854*, 307.
52. Spanish Manila 13846: *Oficio del Alcalde mayor de Cebu al Gobernador General de Filipinas, Cebu, 1 Abril 1854*, 302–304.
53. Spanish Manila 13846: *Presupuesto de gastos ordinarios para el sostenimiento de cien enfermos en el Hospital de Lazarinos de esta Provincia; y demostracion de los medios con que se cuenta actualmente para cubrirlos, y de que para ello resulta, Cebu, 1 Abril 1854*, 299–301.
54. *Memorias medicas: Memoria dirijida al Excelentisimo Señor Director General de Administracion Civil por el Medico titular de la provincia de Leyte, Tacloban, 21 Febrero 1878.*
55. Turku, Finland senior secondary school website which posts school works and projects of students on various aspects of the Middle Ages such as everyday life, religion, science, technology, life attitudes, society, and arts: edu.turku.fi/tiimalasi/en/diseases.html (accessed 14 Oct. 2015).
56. Ambeth Ocampo, "Rotten Beef and Stinking Fish: Rizal and the Writing of Philippine History" in *More Hispanic Than We Admit: Insights into Philippine Cultural History*, ed. Isaac Donoso (Quezon City: Vibal Foundation, 2007), 223–261.
57. This is presumably *tapa* which is prepared by making thin slices of beef and then flavouring them with salt and garlic and allowed to dry for some time. The meat can be cooked either by

frying or grilling.

58. *Memorias medicas: Memoria anual escrita por el que subscribe en cumplimiento del Real Decreto de 31 de Marzo de 1876, Nueva Caceres, 31 Diciembre 1886.*
59. *Memorias medicas: Memoria anual que en cumplimiento del Real Decreto de 31 de Marzo de 1876 presenta a la Direccion General de Administracion Civil de estas Yslas, el Medico Titular interino de esta provincia de Capiz, D. Cornelio Mapa y Belmonte Licenciado en Medicina y Cirujia, Enero de 1887, Capiz 23 Enero 1887.*
60. *Memorias medicas: Memoria dirijida at Excelentisimo Señor Director General de Administracion Civil por el Medico titular de la provincia de Leyte, Tacloban, 21 Febrero 1878.*
61. Ibid.
62. *Memorias medicas: Memoria medica del medico titular de Ylocos Sur, Vigan, 7 Enero 1887.*
63. *Memorias medicas: Yslas Marianas, Vicisitudes de la salud publica en dichas Yslas en el año 1895, Agana, 8 Mayo 1896.*
64. 65. Zoilo Galang, *Encyclopedia of the Philippines* (Manila: McCullough Printing Co., 1950), 55–56.
65. Bureau of Insular Affairs, War Department, *Report of the Director of Health in the Sixth Annual Report of the Philippine Commission, 1903*, pt. 2 (Washington: Government Printing Office, 1906), 77–78.
66. Celestina P. Boncan, "America's Leprosy Control Program and Culion," *Historical Bulletin* 37 (January-December 2005): 27.

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______: *Memoria dirijida al Excelentisimo Señor Director General de Administracion Civil por el Medico titular de la provincia de Leyte, Tacloban, 21 Febrero 1878.*

______: *Memoria escrita por el Medico Titular de la Provincia de Cebu en cumplimiento de lo dispuesto por el Gobierno Supremo dirigida al Excelentisimo Señor Gobernador General, Cebu, 20 Junio 1885.*

______: *Memoria medica del medico titular de Ylocos Sur, Vigan, 7 Enero 1887.*

______: *Memoria anual que en cumplimiento del Real Decreto de 31 de Marzo de 1876 presenta a*

la Direccion General de Administracion Civil de estas Yslas, el Medico Titular interino de esta provincia de Capiz, D. Cornelio Mapay Belmonte Licenciado en Medicina y Cirujia, Enero de 1887, Capiz, 23 Enero 1887.

______: *Yslas Marianas, Vicisitudes de la salud publica en dichas Yslas en el año 1895, Agana, 8 Mayo 1896.*

Spanish Manila 13846: *Recivo y gasto del Hospital de San Lazaro de Zebu del presente año de 1834, en este mes de Agosto, en que me he hecho cargo del cobro de alquileres de las tiendas de la plaza de Sto. Niño por encargo del Señor Santos y Señores Alcaldes mayores y es la epoca en que empezaron a pagar.*

______: *Oficio del Cura parroco del Parian al Obispo de Cebu, Colegio Seminario de Zebu, 9 Noviembre 1843.*

______: Oficio del Gobierno Eclesiastico de la Diocesis de Cebu al Excelentisimo Señor Governador y Capitán General de estas Yslas, Zebu, 3 Febrero 1844.

______: Oficio del Obispo de Cebu al Gobernador Yntendente de Visayas, Cebu, 6 Febrero 1844.

______: *Cuenta de cargo y data que formo Yo el encargado por el Excelentisimo e Yllustrisimo Señor Don Fr. Santos Gomez Marañon, Obispo que fue de esta Diocesis y por el actual Excelentisimo e Yllustrisimo Señor Don Jayme Gil Orduña del Subministro del Hospital de San Lazaro de esta Ciudad; cuyo encargo me lo he tomado sin el menor interes, y solo por obedecer a mis Prelados desde el año 1837 por Julio, Cebu, 10 Febrero 1844.*

______: *Oficio de la Contaduria de Hacienda de las Yslas Visayas al Gobernador Yntendente de las Yslas Visayas, Cebu, 28 Febrero 1844.*

______: Oficio del Administrador de Lazarinos al Obispo de Cebu, Colegio Seminario de Cebu, 2 Marzo 1844.

______: Relacion del Diario i vestido de Lazarinos, 9 Octubre 1846.

______: *Lista de las tenderas de la Plaza frente al Convento del Sto. Niño, Cebu, 9 Octubre 1846.*

______: *Decreto del Gobernador Yntendente de Visayas, Cebu, 14 Octubre 1846.*

______: *Oficio del Juan Tomas Calbo al Gobernador Yntendente de las Yslas Visayas, Cebu, 18 Octubre 1846.*

______: *Proyecto de un Hospital de Lazarinos capaz de 60 a 70 Enfermos de ambos sexos con la debida separación, Cebu, 24 Noviembre 1846.*

______: *Oficio del Alcalde mayor de Cebu al Gobernador Yntendente de Visayas, Cebu, 27 Noviembre 1846.*

______: *Oficio del Obispo de Cebu al Gobernador Yntendente de Visayas, Cebu 21 Julio 1847.*

______: *Oficio del Cura parroco del Parian al Obispo de Cebu, Casa parroquial del Parian, 9 Diciembre 1847.*

______: *Oficio del Obispo de Cebu al Gobernador Yntendente de Visayas, Cebu, 16 Diciembre 1847.*

______: *Oficio del Gobierno Yntendencia y Comandancia General de Visayas al Alcalde mayor de Cebu, Cebu, 2 Abril 1848.*

______: *Oficio del alcalde mayor de Cebu a los gobernadorcillos de la ciudad de Cebu, San Nicolas, Mandaue y Talamban, Cebu, 9 Abril 1849.*

______: *Oficio del Alcalde mayor de Cebu al Gobernador Yntendente de Visayas, Cebu, 12 Abril 1849.*

______: *Oficio del Obispo de Cebu al Alcalde mayor de Cebu, Cebu, 19 Abril 1849.*

______: *Oficio del Obispo de Cebu al Gobernador General de las Yslas Filipinas, Cebu, 7 Abril*

1850.
______: *Relacion de las limosnas recogidas de la obra del nuevo Hospital de los Lazarientos del Cebu, y de las cantidades que de ellas se han sacado para gastos de la misma obra, Cebu, 7 Setiembre 1850.*
______: *Oficio del Cura parroco del Parian al Obispo de Cebu, Cebu, 16 Setiembre 1850.*
______: *Relacion de las cantidades del ramo y pesos y medidas aplicadas durante el año de la fecha a los gastos de la obra del Hospital de Lazarinos de esta Ciudad, cuyos documentos de pago obran en poder del que subscribe, Cebu, 20 Setiembre 1850.*
______: *Cuenta general de las cantidades que se han reunido para la obra del Hospital de Lazarinos de esta Ciudad y de las que se han invertido en la misma obra, Cebu, 22 Setiembre 1850.*
______: *Decreto del Excelentisimo Señor Gobernador General, Manila, 21 Diciembre 1850.*
______: *Oficio del alcalde mayor al Gobernador General de Filipinas, Sta. Cruz, 6 Setiembre 1852.*
______: *Oficio del Alcalde mayor de Cebu al Gobernador General de Filipinas, Cebu, 1 Abril 1854.*
______: *Presupuesto de gastos ordinarios para el sostenimiento de cien enfermos en el Hospital de Lazarinos de esta Provincia; y demostracion de los medios con que se cuenta actualmente para cubrirlos, y deficit que para ello resulta, Cebu, 1 Abril 1854.*
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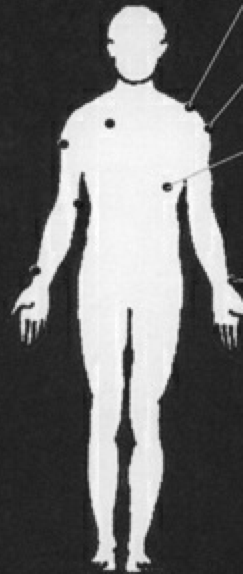
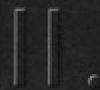


American Public Health Policy on Leprosy, 1898-1941

Spaces and Boundaries in Culion: Mobility amidst Segregation

Landscapes of Isolation: Selected Leprosaria in Luzon and the Visayas

From Collection to Release: Segregated Lives in the Culion Colony, 1906–1935



II. Controlling the Spread of Leprosy: Culion as a Prime Example

A carabao transporting American medical supplies (1899)

AMERICAN PUBLIC HEALTH POLICY ON LEPROSY, 1898–1941

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This study focuses on the evolution of American anti-leprosy policy from the time American forces arrived in the Philippines in 1898, when leprosy received little official attention, through the early decades of American rule, which constitute the peak of the anti-leprosy campaign, until the outbreak of the Pacific War in 1941, when American health officials gradually relaxed their centralized, segregation approach in the treatment of leprosy. The paper also explains the rationale of the American anti-leprosy policy and the reasons why adjustments were adopted in the course of its implementation. *Public Health Reports (1896–1970)* and memoirs of American colonials officials directly involved in containing leprosy serve as the principal sources of information.

GENEALOGY OF THE AMERICAN PUBLIC HEALTH POLICY

To the Americans, public health is an overriding concern. As taxpayers, they believe that the federal and state governments are duty-bound to promote the physical well-being of the citizenry. Their advocacy of public health started in the eighteenth century after the U.S. Congress enacted a law requiring the American President to assign medical practitioners who would take care of sick soldiers and seamen.[1] Originally, patients were confined in government-owned hospitals but as their number increased, federal officials decided to centralize and professionalize the service. At the height of the yellow fever epidemic in 1878, Congress tasked the Marine Hospital Service (1798–1912) with containing the spread of the disease. On 1 July 1902, Congress changed the name of the Marine Hospital Service to the Public Health Service (1902–1912). It then served as the lead agency in the prevention of cholera, yellow fever, smallpox, and plague in the different states.

The Public Health Service was originally under the Treasury Department with the Surgeon-General acting as its highest official. He administered the daily affairs of the bureau with the aid of an executive officer and seven division heads. Initially, the bureau's primary task was to prevent the spread of the aforementioned diseases, but as new health problems arose, it was designated to protect the population from all quarantinable and contagious diseases. Aside from hospital services, the other functions of the Public Health Service included the "protection of the United States from the introduction of disease from without, prevention of the interstate spread of disease, suppression of

epidemics, and cooperation with State and local boards of health on health matters and investigation of diseases."[2]

Leprosy was one of the diseases that caught the attention of the American public health officials. It had already been considered a serious medical problem long before Gerhard Henrik Armauer Hansen (1841–1914) discovered *Mycobacterium leprae.* As early as 1848, William Hillebrand[3] (1821–1886) had already noted the prevalence of leprosy among Chinese plantation workers in Hawaii. This prompted King Kamehameha V to enact on 3 January 1865 a law ordering the apprehension, detention, and segregation of people with leprosy. By separating the sick from the healthy, this order was one of the early measures in the United States to control the spread of leprosy.[4] On 13 November 1865, a small treatment hospital was opened in the neighborhood of Kalihi in Honolulu. However, it was abandoned after 10 years of operation because of financial reasons and its failure to isolate the contagious patients. Small detention homes for those afflicted with the disease were planned in the succeeding years but it was only in 1905 when health officials established a major leprosy settlement on the island of Molokai. The U.S. Congress appropriated US$100,000 for the Molokai hospital and laboratory, and another US$50,000 for their annual upkeep. A similar home for the afflicted was also built in Carville, Louisiana. From then on, the U. S. government kept tabs on those afflicted with the disease and adopted remedial segregation to eradicate leprosy or at least prevent it from spreading.

THE DEPLORABLE SANITARY CONDITION OF MANILA CAUSED BY CENTURIES OF NEGLECT GREETED THE AMERICANS WHEN THEY SET FOOT IN THE PHILIPPINES IN 1898.

In the Philippines, Spanish and American colonial administrators differed significantly in the way they regarded public health. The former viewed it as a minor problem that could be relegated to institutions like the Church while the latter considered it a major government concern. For the Spaniards, saving souls was more important than saving bodies. As a consequence, they built more churches than hospitals.[5] Thus, during the Spanish colonial period, very little progress was made in the field of preventive and curative medicine. Even the establishment of the San Jose Medical College in 1871 had minimal impact on the quality of medical services in the colony. For more than three centuries, Spanish and Filipino physicians never exercised effective control over leprosy and other infectious diseases that afflicted many Filipinos.

The deplorable sanitary condition of Manila caused by centuries of neglect greeted the Americans when they set foot in the Philippines in 1898. Col. Louis M. Laus, a medical doctor in the U.S. Army who was in the Philippines during the Filipino-American War, reported that the unhygienic situation of Manila at the turn of the twentieth century resembled that of European cities in the seventeenth century.[6] Victor Heiser, an American surgeon who worked in the U.S. Public Health and Marine Hospital Service,[7] on his part observed that Manila, with its population of over 200,000, had no sewer system. Disease-carrying human wastes were discharged into *esteros* (the drainage system) or buried directly in the ground. Street cleaning was not regularly carried out, so major thoroughfares were littered with uncollected trash. Moreover, hospitals lacked modern operating rooms and surgical equipment and there were no medical facilities for people with mental disorders. Heiser also noted that ready-to-eat food was sold in unsanitary conditions, and water reservoirs, pipelines, and artesian wells were either inadequate or contaminated. More importantly, no information campaign was ever conducted to teach the public how to combat and prevent the spread of contagious diseases. Consequently, health records showed that 40,000 Filipinos died annually from smallpox while 50,000

deaths were due to tuberculosis.[8]

American colonial officials initially thought that pacifying the Filipinos through "benevolent assimilation" was their only major problem in the Philippines. However, they realized later that "purifying" the colony was a necessity if they wanted to keep the Philippines as its colony. Hence, after the end of the Filipino-American War, they addressed the health and sanitation problems of the country. Many of the policies and programs that they introduced in the Philippines were patterned after what they used at home when they were preventing the spread of diseases like cholera, yellow fever, smallpox, and other contagious illnesses. These included hospital care for patients, quarantine measures, research, and values education.

THE AMERICAN OFFICIALS PAID SPECIAL ATTENTION TO PUBLIC HEALTH BECAUSE IT AFFECTED THE SUSTAINABILITY AND THE *RAISON D'ETRE* OF THE U.S. OCCUPATION OF THE PHILIPPINES.

INITIAL CHALLENGES CONFRONTED BY THE BOARD OF HEALTH

At the height of the Filipino-American War, American military officials prioritized sanitation and public health–two crucial areas that affected the American soldiers in the battlefields. Official records revealed that American casualties from tropical diseases were higher than those who died in actual battle. From 4 February 1899 to 30 June 1901, 3,499 American soldiers were killed in action,[9] while those who succumbed to tropical diseases during the same period totaled 3,693.[10] To prevent the Philippines from becoming the "white man's grave," the Surgeon-General ordered the medical officers of each military unit to enforce proper hygiene and isolate sick soldiers. Initially, the soldiers ignored these instructions because they thought they were resilient and immune to these diseases. However, after seeing their comrades contract various tropical diseases, they quickly complied with the sanitary regulations.

The American officials paid special attention to public health because it affected the sustainability and the *raison d'etre* of the U.S. occupation of the Philippines. They were aware that recruiting American bureaucrats and soldiers for deployment in the Philippines would be difficult if there was news of their countrymen dying of various diseases in the colony. As much as possible, the officials did not want a repeat of the "Cuban Round Robin"[11] in the Philippines. They realized that a successful clean-up of the colony and eradication of tropical diseases would give credence to their declaration that they came to the Philippines to improve the life of the Filipinos.

On 29 September 1898, the Provost Marshall of Manila issued General Order No. 15 which created the Army Board of Health, which was composed of three surgeons: Frank S. Bourns, C. L. Mullens, and C. E. Quisten. The military government also employed the services of Trinidad H. Pardo de Tavera and Ariston Bautista Lim, notable Filipino medical practitioners at the time, to help formulate health policies. The board's main task was to protect the health of the American troops and to sanitize Manila.[12] However, the measures that the board implemented were mostly reactive to the existing diseases at that time. It failed to come up with comprehensive and preventive solutions that would ensure the physical well-being of the Filipinos. Moreover, many of the health policies it suggested were not implemented because the board members as well as the military officials were so preoccupied with the war. Consequently, leprosy and the other diseases that had afflicted Filipinos for decades lingered until the end of the American military regime.

The health and sanitary conditions of the Philippines improved considerably after the military turned over the administration of the colony to the Philippine Commission. On 1 July 1901, the

Commission passed Act No. 157 which created the Board of Health.[13] Headed by the Commissioner of Public Health, the members of the Board included the City Engineer of Manila, Chief Surgeon of the U.S. Army in the Philippines, Chief of Health Inspector, Chief Officer of the Marine-Hospital Service, President and Vice-President of the Association of Physicians and Pharmacists of the Philippines, and the Secretary of the Board of Health.[14] The Act granted the board with legislative, executive, and judicial powers to effectively hurdle the country's health problems. The board was mandated to pass health and sanitary laws, supervise their implementation, and prosecute violators. All these tasks underscored the board's primary function of promoting public health and reducing the incidence of tropical diseases.

THE HEALTH AND SANITARY CONDITIONS OF THE PHILIPPINES IMPROVED CONSIDERABLY AFTER THE MILITARY TURNED OVER THE ADMINISTRATION OF THE COLONY TO THE PHILIPPINE COMMISSION.

In its first year of operation, the board was already aware of the risks posed by Filipinos who were afflicted by leprosy roaming the streets and other public places. However, this concern was set aside temporarily because of other health-related problems which were considered deadlier than leprosy. One such problem was the cholera outbreak that afflicted many Filipinos in 1902. The onset of the epidemic was recorded on 20 March 1902 when two confirmed cholera patients died in San Juan de Dios Hospital.[15] Health officials could not stem the spread of the disease and by the end of 1902, it had claimed 137,505 lives.[16] Eliodoro Mercado, a Filipino doctor who spent much of his time helping the government in its campaign against cholera and leprosy, recalled that at the height of the epidemic people avoided San Lazaro Hospital because of the stench from decaying bodies. It was also reported that roads leading to cemeteries were jammed with *carromatas* (carriages pulled by horses or carabaos), carts, and other vehicles transporting the corpses of cholera victims.[17]

The spread of cholera could not be controlled easily because Filipinos ignored the government's health warnings when the number of deaths had not yet reached alarming proportions. Some superstitious natives considered cholera, malaria, dysentery, and other communicable diseases as punishment for man's sinfulness, which could be remedied by asking God's forgiveness. To them, the best protection against cholera was not proper hygiene but a deep faith in God.[18] To counter this belief, the Bureau of Health conducted a massive education campaign to inform people of the nature of the disease and ways to prevent it. Health officials explained that it was in the best interest of the public if sick persons would be confined in hospitals and follow the prescribed measures.

The tragic memories of the Filipino-American War also made many Filipinos reluctant to cooperate with the American-sponsored anti-cholera campaign. When health officials accompanied by soldiers entered their houses and forcibly "arrested" household members manifesting symptoms of cholera, people were reminded of the time when the American soldiers were searching for insurgents. Filipinos did not see the quarantine policy of the government as being different from the reconcentration[19] policy of the army. They were also antagonized when they were prohibited from visiting sick relatives and when they learned that cholera victims were cremated, a practice that was detestable to most Filipinos at that time. News also circulated in Manila that the houses of the poor were razed to the ground to create space for the dwellings and warehouses of the Americans. These rumors fueled apathy and indifference to the anti-cholera campaign.

THE TRAGIC MEMORIES OF THE FILIPINO-AMERICAN WAR ALSO MADE MANY FILIPINOS RELUCTANT TO

COOPERATE WITH THE AMERICAN-SPONSORED ANTI-CHOLERA CAMPAIGN.

Another problem that confronted the American health officials was the rinderpest that plagued the colony when the incidence of cholera was on its downward trend. Rinderpest is a disease similar to cholera except that its victims are carabaos and cattle. It is characterized by a loss of appetite, drooping of the head, a generally dejected appearance, water discharge from the nostrils, and severe diarrhea. Ken DeBevoise, author of a book on Philippine epidemics in the nineteenth and twentieh centuries, considered the rinderpest epidemic “the single greatest catastrophe in the nineteenth century Philippines.”[20] To combat the disease the insular government adopted measures similar to those implemented to fight cholera, but it acted too late. In October 1902, an estimated 75 percent of the carabaos in the country had died and by the end of November, government records placed the figure at 90 percent.[21] In Pangasinan alone, 77,969 out of 93,244 carabaos and cattle died at the height of the epidemic.[22]

The rinderpest epidemic had devastating effects on the economy. First, the price of carabaos increased exorbitantly. Before the outbreak, a carabao cost only 20 Mexican dollars. At the height of the epidemic, the price went up to 200 Mexican dollars, making it impossible for ordinary farmers to replace the animals they lost.[23] Second, the death of many carabaos left vast tracts of land idle. Rural Filipinos lost their principal work animal so they could no longer cultivate as much land as before. The scarcity of carabaos reduced rice production by 75 percent. Governor General William H. Taft, civil governor of the Philippines in 1900–1903, saw the futility of relying on domestic revenues to offset the adverse effects of the epidemic. Thus, he appealed to President Theodore Roosevelt for a Congressional grant of not less than three million U.S. dollars. The U.S. Congress approved the request and the money was used to buy food supplies and import carabaos for the affected provinces.

By the end of 1903, new developments had unfolded in the Philippines. Governor-General William H. Taft was recalled to assume the position of Secretary of War, and he was replaced by Luke Wright. By this time, Aguinaldo had sworn his oath of allegiance to the United States and the threat posed by Filipino insurgents had been reduced to a manageable level. In the realm of public health, the battle against cholera and rinderpest had been won. In a way, the outbreak of cholera and rinderpest was a blessing in disguise for it served as wake-up call for Filipinos to discard some of their unhealthy cultural practices. It also encouraged them to take seriously the public health programs of the government and to be appreciative of the policies that the American health officials implemented. They realized that it was to their advantage to cooperate with the government to control the spread of cholera, rinderpest, and other contagious diseases. Taking all these into consideration, American health officials started to refocus their attention on leprosy.

IN A WAY, THE OUTBREAK OF CHOLERA AND RINDERPEST WAS A BLESSING IN DISGUISE FOR IT SERVED AS WAKE-UP CALL FOR FILIPINOS TO DISCARD SOME OF THEIR UNHEALTHY CULTURAL PRACTICES

THE CAMPAIGN AGAINST LEPROSY

The missionaries took care of the those afflicted by the disease in the colony. This practice in the Philippines was not a unique phenomenon because the Catholic Church worldwide regarded their service to these afflicted as a continuation of the work of “Christ the Healer.” However, their ministry was limited to providing spiritual comfort to the afflicted who were facing an impending death. In 1598, a lay brother of the Franciscan order founded the San Lazaro Hospital, where some wards were reserved for the afflicted. In 1839, the colonial government set up a similar facility in Cebu

(Hospital de San Lazaro of Cebu City), and in Camarines Sur (Hospital de Lazarinos de Palestina). In these hospitals, relatives were allowed to mingle with their afflicted kin provided the former lived in separate quarters. Friday was designated as "free day" when leprosy patients were allowed to go around the city begging at church doors, in streets and piers, and other public places.

The American authorities could not relegate to the *Casa Central de Sanidad* (Central Board of Health) and to the local *medicos titulares* (licensed physicians) the task of promoting public health because they considered the facilities, financial resources, and medical training of these local doctors inadequate for the job. Aside from the San Lazaro Hospital, San Juan de Dios Hospital, and a few medical centers in Manila, the other health centers in the countryside could not meet the needs of the people afflicted with leprosy because they were busy attending to patients with common illnesses. Similarly, the *curanderos* (native or local healers), *herbolarios* (medical practitioners who use medicinal plants to cure their patients), *mediquillos* (unlicensed medical practitioners), and faith healers could not offer alternative remedies because their incantations and rituals were proven ineffective in containing the spread of leprosy.[24] Hence, the American officials were left with no other option but to shoulder the responsibility.

The total number of people afflicted with leprosy in the Philippines at the advent of the Americans was estimated to be between 3,500 and 4,000.[25] The majority of them were confined at the San Lazaro Hospital[26] while the rest stayed at home with their families or lived as recluses in far-flung areas. The exact figure could not be determined because those suspected of having the disease were very mobile and diagnostic methods were not accurate. Their number was apparently small but the American health officials regarded leprosy as a serious public health menace that should not be taken lightly. They were particularly apprehensive about people afflicted with leprosy wandering around in American-controlled settlements. They were also worried about the reported growing number of Filipinos dying of leprosy. The Board of Health announced that from 1 October 1899 to 30 June 1900, there were 46 cases of death due to leprosy.[27] Hence, it waged a sustained campaign and allocated a considerable amount of money to control the disease. Furthermore, the board developed a comprehensive approach that included quarantine and segregation policies; established a colony for those afflicted with the disease; funded research teams in search for a cure; conducted an information campaign on leprosy; and formed linkages with international groups that were involved in the eradication of the disease.

THE TOTAL NUMBER OF PEOPLE AFFLICTED WITH LEPROSY IN THE PHILIPPINES AT THE ADVENT OF THE AMERICANS WAS ESTIMATED TO BE BETWEEN 3,500 AND 4,000.

Segregating people afflicted with leprosy was a common practice worldwide long before its implementation in the Philippines. In fact, the United States already had two leprosaria–one in Molokai, Hawaii and the other in Carville, Louisiana. The initial reaction of the Americans when they first saw people afflicted with the disease wandering in Manila was to gather them and limit their mobility within certain, ideally remote areas. They believed that segregating the afflicted would help stem the spread of the disease and eventually result in eradicating leprosy.[28]

SEGREGATING PEOPLE AFFLICTED WITH LEPROSY WAS A COMMON PRACTICE WORLDWIDE LONG BEFORE ITS IMPLEMENTATION IN THE PHILIPPINES.

Health officials looked for a place that had enough land for agriculture, an existing harbor, a small

local population, and an inaccessible entry-exit point to prevent people afflicted with the disease from leaving the area. They also preferred a place not far from Manila so that transporting supplies would not be problematic. Lastly, they wanted a wide open space where the government could build hospital wards, residential houses, recreational facilities, and other amenities. After exploring different places nationwide, Culion, an island off the northern coast of Palawan, was chosen. Its land area, location, and distance were ideal for the purpose. The conversion of Culion into a leper colony started in 1902 after the Philippine Commission appropriated USD50,000 for the project. On 22 August 1904, Gov. Gen. Luke E. Wright issued Executive Order No. 35 which formally declared Culion a leper colony reservation.

Before becoming a leper colony, there were already habitable houses, a church, and a town hall in Culion. Thus, the government simply added 125 new nipa houses, water and sewer systems, a hospital with 100 beds, as well as expanded harbor facilities. Building a leprosarium in Culion was a long arduous process. It took almost four years before it could accommodate the first batch of segregated people who were afflicted by the disease. This was because before the structures could be built, the local residents had to be relocated. Besides, the shortage of skilled workers and the difficulty of transporting construction materials from Manila to Culion contributed to the delay.

The Philippine Commission enacted Act. No. 1711 on 12 September 1907 to formalize the implementation of the segregation policy.[29] It provided the legal basis for the compulsory apprehension and detention of people suspected of having leprosy for treatment and segregation in Culion. The law extended enormous powers to the Director of Health so that he could effectively enforce the program. Under Section 1, health officials and all other insular, provincial, and municipal officials were given police powers to apprehend, detain, isolate, segregate, or confine all leprous persons in the Philippines.[30] Likewise, the law mandated them to build hospitals and detention centers for those afflicted by the disease and to hire medical practitioners who would manage these institutions. The detained people who were suspected of having the disease were to be examined first by competent physicians before they could be sent to Culion. The law also obliged all police officers to report to health officials the residents of their locality who manifested signs and symptoms of leprosy. Finally, it also stated that concealing and harboring persons afflicted with leprosy were punishable by law.[31]

The problems that health officials encountered when they were battling cholera resurfaced as soon as they implemented the segregation policy. People suspected of having the disease and their loved ones defied the authority of health officials notwithstanding the apparent benefits of the segregation policy. Filipinos became depressed when they learned that their loved ones who were afflicted with leprosy would be separated from them. They could not accept the possibility that they would not be at their loved ones bedside in their dying moment.[32] Consequently, whenever news of a round-up would leak, those afflicted with the disease would hide in the forests so they had to be hunted down like common criminals. Others opted to commit suicide rather than be confined in the leprosarium.[33] Sometimes sanitary inspectors were even assaulted, disarmed, and stabbed when they were rounding up those who were suspected of having the disease.

THE PROBLEMS THAT HEALTH OFFICIALS ENCOUNTERED WHEN THEY WERE BATTLING CHOLERA RESURFACED AS SOON AS THEY IMPLEMENTED THE SEGREGATION POLICY.

When the Americans realized that ignorance was one of the reasons why the local population

opposed the segregation policy, they launched an extensive information campaign. They briefed the Filipinos on the nature of the disease and the latest preventive measures. They justified that their intruding into the private life of those afflicted and restricting their movements were done in good faith and motivated by noble intentions. They also argued that some of the cultural practices and habits of the Filipinos had to be discarded because these practices posed risks to the well-being of the afflicted and their healthy relatives. Medical experts lectured on leprosy and showed photographs and films that instilled fear of the disease. Repeatedly, they stressed that the afflicted who concealed their disease were a deadly menace to the community where they lived.[34] They also recounted the successful healing of some people who had been afflicted with the disease in the United States who, after several years of confinement and treatment in the leprosarium, were discharged and given a clean bill of health. They indicated that these encouraging results could also be achieved in the Philippines if Filipinos would cooperate and comply with the prescribed treatment. Hearing about these cases, Filipinos were gradually convinced that cooperating with the American health officials could stem the spread of leprosy in the Philippines.

The processing of people suspected of having leprosy started from the municipal level and eventually up to the provincial level. Local health officers were required to examine the patients waiting for the ship that would ferry them to Culion. Upon arrival of the ship, experts from the Bureau of Science would re-examine the patients. Those confirmed to have the disease were asked to board the ship while those who tested negative were advised to go home.

On 27 May 1906, the first batch of afflicted people (370 patients) from the Visayas arrived in Culion aboard two Coast Guard cutters. Many of them were already crippled, blind, mentally disturbed, and horribly disfigured by boils and swollen skin. Since most patients were already in the advanced stage of the disease, around 30 percent of them would die before the end of the first year. By the end of 1910, a total of 5,403 leprosy patients had been admitted to Culion. With attrition caused by deaths, escapes, and releases, 2,172 remained in the island. The high mortality rate of the leprosy patients earned Culion the reputation of the "land of the living dead."[35]

THE PRIMARY CONSIDERATION IN ESTABLISHING CULION AS A LEPER COLONY WAS THE WELL-BEING OF PEOPLE WHO DID NOT HAVE THE DISEASE. THE WELFARE OF THE PATIENTS WAS NOT A PRIORITY.

SEARCH FOR A CURE

The primary consideration in establishing Culion as a leper colony was the well-being of people who did not have the disease. The welfare of the patients was not a priority. In fact, many of them thought that Culion would be their final destination and the prospects of leaving the island alive were nil. Nevertheless, health officials realized in time that their anti-leprosy policy should not be limited to segregating and preparing the patients for their eventual death. Thus, the vigorous search for a cure for the disease became an essential component of their anti-leprosy program. Gradually, Culion became a huge laboratory where medical experts conducted research on leprosy. It became the ideal place for clinically and expeditiously testing the efficacy of a particular drug because the island was under government control and the subjects were readily available. Doctors carried out trials on experimental drugs which were used in other leprosaria overseas. Thus, towards the latter part of the American period, Culion was a mecca for scientists doing research on leprosy. Both the medical experts and the public had high expectations that the leprosarium could produce a cure for leprosy. Even among patients, there was hope rather than despair.

BOTH THE MEDICAL EXPERTS AND THE PUBLIC HAD HIGH EXPECTATIONS THAT THE LEPROSARIUM COULD PRODUCE A CURE FOR LEPROSY.

After the Norwegian physician Gerhard H.A. Hansen (1841–1912) discovered the germ that caused leprosy, researchers rushed to produce an antidote for the disease; however, they failed because they could not transmit the leprosy bacilli to an animal. Consequently, leprosy patients were used in the clinical trials; hence, leprosaria worldwide served not only as hospitals but also as research centers for leprosy studies and medical research. American researchers joined the worldwide search for a cure by conducting studies and experiments on drugs and practices which were purportedly effective against leprosy. It was more convenient for them to conduct clinical tests in Culion and San Lazaro Hospital than in Hawaii and Louisiana because of the colonial set up in the Philippines. However, these American researchers were emotionally detached from their Filipino subjects. They remained stoic even when their experiments ended badly or adversely affected their subjects. Additionally, Culion and San Lazaro Hospital had numerous patients whose predispositions they could freely manipulate and easily control. Thus, the researchers and physicians had an unlimited supply of subjects for their studies.

There were already a number of anti-leprosy drugs being tested elsewhere in the world before the Americans colonized the Philippines. For instance, it was known for several years that chewing the bark and leaves of the chaulmoogra tree had curative effects on leprosy. Pharmacological experiments and applications had been conducted on this drug but the results were not conclusive enough to warrant its endorsement as a cure for leprosy. Oral testing was difficult because chaulmoogra had an extremely unpleasant taste and numerous side effects, such as vomiting after taking its bark and leaves.

In 1907, Heiser tested the efficacy of oral chaulmoogra oil with strychnine (Dyer oral method) in Culion. However, because of its foul taste only a few patients opted to take the concoction long enough for it to be effective. To make it taste more palatable to patients, pharmaceutical companies converted chaulmoogra oil into coated pills. They also produced it in the form of an injectable liquid.

Another attempt to make chaulmoogra oil into a cure was done by Eliodoro Mercado, a resident physician at San Lazaro Hospital, and a member of his research team. They produced a chemical concoction called the “Mercado Mixture” which used chaulmoogra oil as a base. Their formula consisted of 10 percent camphorated oil, 60 ml pure and sterile chaulmoogra oil, 4 grams resorcin, and 2.5 ml purified ether.[36] This solution was injected intramuscularly. The treatment was tried in the Culion leprosarium under the supervision of Herbert Windsor Wade, the Medical Director of the leprosarium from 1922 to 1959. Initial testing showed promising results among those who took it consistently for a long period of time.

Further studies revealed that chaulmoogra’s capacity to cause fever in the patient was the reason why it was effective against leprosy.[37] As a consequence, hot baths and immersion in hot springs began to be recommended for those afflicted by the disease. By the 1920s, chaulmoogra was extensively used in Culion under different preparations and the results were encouraging as evidenced by the following report:

> On May 3, 1920, 500 patients given Chaulmoogra were divided into four groups, each receiving a different preparation. By the end of 1921, ethyl esters given IM had proven to be the most effective and with fewer side effects. By 1922, treatment was shifted to ethyl ester. By end of the year, 4,485 patients were receiving it. At the end of 18 months, the

following were reported: 55.9% improved; 36% stationary; 6% worsened; 1.7% died. For 7 years, ethyl ester was used as the main treatment of leprosy. In 1923, Culion used ethyl ester of Chaulmoogra oil with .5% iodine as main and standard treatment. They reported 77.8% improvement with 10.7% negative.[38]

Brookmen Wilkinson, the physician in charge of San Lazaro Hospital and one of the pioneering American researchers in the Philippines conducted a clinical trial which involved exposing the affected parts of the body to X-ray radiation to kill the leprosy bacilli.[39] The results showed a positive response in patients who were in the early stage of the disease.[40] However, X-ray ceased to be a routine treatment later on because of the side effects of excessive exposure to radiation. Wilkinson also experimented with Leprosin serum, which came from Japan, but he discontinued the experiment because of the erratic supply of the serum.[41] Other drugs were clinically tested in the Philippines but many did not have curative effects. These included potassium iodine, mercury, creosote, salicylic acid, gurgon oil, leprol, Nastin "B," and experimental sera.

TABLE I
NUMBER OF PEOPLE AFFLICTED WITH LEPROSY IN THE PHILIPPINES, 1906 AND 1909

PROVINCE	1906	1909
ABRA	11	3
ALBAY	47	2
AMBOS CAMARINES	68	10
ANTIQUE	116	N.D.
BATAAN	23	N.D.
BATANGAS	29	N.D.
BENGUET	43	N.D.
BOHOL	133	N.D.
BULACAN	42	15
CAGAYAN	94	20
CAPIZ	50	N.D.
CAVITE	66	N.D.
CEBU	701	10
CULION	N.D.	1,741
ILOCOS NORTE	118	5
ILOCOS SUR	235	5
ILOILO	151	9
ISABELA	12	2
LAGUNA	25	N.D.
LEPANTO BONTOC	19	15
LEYTE	58	N.D.
MASBATE	23	N.D.
MISAMIS	56	2
MORO	220	220
NEGROS OCCIDENTAL	34	N.D.

NEGROS ORIENTAL	99	N.D.
NUEVA ECIJA	47	47
NUEVA VIZCAYA	6	N.D.
PAMPANGA	24	2
PANGASINAN	69	N.D.
RIZAL	90	2
ROMBLON	13	N.D.
SAMAR	258	2
SORSOGON	117	1
SURIGAO	3	N.D.
TARLAC	37	N.D.
TAYABAS	23	3
LA UNION	47	N.D.
ZAMBALES	50	2
SAN LAZARO HOSPITAL	236	155
TOTAL	3,494	2,273

N.D. – NO DATA
SOURCES: The data for 1906 are from Association of Schools of Public Health,"Status of Leprosy in the Islands," *Public Health Reports, (1896–1970)* 21, no. 50 (Dec. 14,1906): 1492–1493. The data for 1909 are from Association of Schools of Public Health, "Philippine Islands: Lepers in the Philippine Islands" Public Health Reports (1896-1970), 24, no. 43 (Oct. 22, 1909): 1602.

Heiser was personally convinced that the segregation policy was a big success.[42] As shown in Table 1, the population of those afflicted with leprosy dropped by almost 35 percent three years after the implementation of the segregation policy.[43] In some provinces, the decrease in the number of afflicted was dramatic. For instance, in Cebu it decreased from 701 to 10 and in Samar it was from 258 to 2. Health officials also noticed that the majority of the afflicted brought to Culion during the first few years of its operation were in the advanced stage, but after a decade of operation, the patients admitted in Culion consisted mostly of non-advanced cases. Moreover, the success of the drugs introduced in Culion and San Lazaro Hospital, albeit limited, burnished the image of these two dreaded institutions. Increasingly more people were convinced that leprosy was curable and that the latest developments offered better and brighter prospects for the those afflicted by the disease and their loved ones. They were further elated to see some Culion patients leaving the island and rejoining their family and friends. Culion's reputation as an island of sorrow (*la isla del dolor*) was transformed into an island of hope (*la isla de la esperanza*).

DECENTRALIZING THE SEGREGATION POLICY

Two decades after the establishment of Culion as a colony for leprosy patients, American health officials started to assess the effectiveness of their segregation policy. This was prompted by some developments abroad and in the local scene. Towards the middle of the 1920s, medical knowledge about the disease continued to advance, and health experts worldwide acquired new information on how the disease could be transmitted and the ways to cure it. Health officials started to realize that leprosy was not that contagious and deadly. All these new developments coming from contemporary research forced colonial officials to re-examine their rigorous segregation policy and institute new approaches on how to deal with leprosy patients.

NEW DEVELOPMENTS COMING FROM CONTEMPORARY RESEARCH FORCED COLONIAL OFFICIALS TO RE-EXAMINE THEIR RIGOROUS SEGREGATION POLICY AND INSTITUTE NEW APPROACHES ON HOW TO DEAL WITH LEPROSY PATIENTS.

As years went by, local politicians and concerned citizens became less appreciative of the American anti-leprosy policy. Some Filipino politicians criticized the policy for being financially burdensome and wrongly prioritized. They could not understand why the Bureau of Health was spending huge amounts of money on a disease that affected only a few Filipinos. Manuel L. Quezon disclosed that the budget for the 6,000 leprosy patients under government care was bigger than the allocation for the prevention of tuberculosis, which was killing 30,000 Filipinos a year.[44] According to him, it would be more prudent for the government to channel the scarce resources of the government to the prevention of leading killer diseases like tuberculosis, smallpox, beri-beri, cholera, and a few other contagious diseases.

There were also ordinary citizens who were disenchanted with the way American authorities implemented compulsory segregation and the continuous banishment of those afflicted to Culion. They considered the approach cruel and anti-Filipino. To them Culion and other leprosaria were "prison-like." They demanded to make the existing leper hospitals more open, humane, caring, and attractive to patients. They also petitioned for new leprosaria that were more accessible to the patient's relatives and friends.

To prevent the anti-leprosy sentiment from becoming a political issue, health officials reconsidered their segregation policy in the light of these new developments. Since leprosy was already proven to be a not-so-contagious disease, they relaxed the segregation policy somewhat. They also realized that maintaining a centralized, big, and exclusive leprosarium was an expensive undertaking. Hence, by the late 1920s, they started to scale down the segregation of those afflicted by the disease in Culion and San Lazaro Hospital and planned the building of small regional leprosaria in strategic locations throughout the country. Although these would entail new capital expenditures, these institutions would end up more sustainable, cheaper to maintain, and acceptable to Filipinos who wanted to remain in touch with their sick loved ones. With the establishment of regional leprosaria, the admission of new patients in Culion declined significantly. The average number of new patients dropped from 800 a year to around 240.[45]

Likewise, health officials decided to prioritize the establishment of leprosaria in regions with bigger populations afflicted with leprosy. In 1927, the first regional leprosarium was built on the land donated by Rosario Gonzaga de Jeseña in Santa Barbara, Iloilo. It served the patients from Western Visayas, particularly those who were confined at the Iloilo Provincial Jail. Years later, Gonzaga de Jeseña donated more land. The government also purchased additional parcels of land until the sanitarium occupied a total of 22 hectares.

In 1928, a committee headed by Culion leprosarium doctors, Herbert Wade and Vicente Kierulf, went on an ocular inspection of Cebu for a possible site of another regional leprosarium. They chose a place in Mandaue, Cebu which was owned by the provincial government of Cebu. When Senator Sergio Osmeña, Sr. learned that the government land would be converted into a leprosarium, he donated his property contiguous to it. Situated 150 meters above sea level, the land was studded with coconut trees and mangroves. It had a sloping terrain and a large spring nearby. Construction commenced after Eversley Childs, a New York philanthropist, donated USD2 million for the project, which consisted of buildings made of steel and concrete that could house more than a hundred patients. It was named the Eversley Childs Treatment Station (ECTS) in honor of its principal donor and inaugurated on 29 April 1930. People in the Visayas welcomed these two leprosaria because the

afflicted could now be treated without being separated from their loved ones.

The establishment of small leprosaria in Luzon started after the National Assembly passed Commonwealth Act No. 161, which allotted half a million pesos for the building of three leprosaria, one each in Manila, Cagayan Valley, and in the Ilocos region. Years later, the Commonwealth Government inaugurated two more leprosaria in Luzon—one in Bongabong, Nueva Ecija for thse afflicted by the disease in Central Luzon and the other one in the rolling hills of the Talá Estate in Rizal. These new projects were undertaken to provide care and treatment to the afflicted in places where they could be visited by their relatives. These innovations calmed down the anti-segregation feelings of many Filipinos. Consequently, the decentralized approach against leprosy would continue in the next succeeding decades.

ASIDE FROM EDUCATION, AMERICAN COLONIAL RULE SIGNIFICANTLY IMPACTED PUBLIC HEALTH IN THE PHILIPPINES.

CONCLUSION

Studies in the past dealing with the American period generally consider education as the United States' single most important and successful achievement in the country. This explains why, in the grand narrative of the period, the other institutional programs were cursorily mentioned, downplayed, or even intentionally overlooked for several decades. This study maintains, however, that aside from education, American colonial rule significantly impacted public health in the Philippines. The organizational structure and budgetary allocations which the government had for public health could match the instrumentalities and resources which it also provided for education. On a broader historical perspective, the attention, dedication, and support demonstrated by the American health officials in battling leprosy, cholera, rinderpest, and other major diseases could not be equaled by the efforts of the Spanish colonial administration. Consequently, under U.S. governance, the sanitary condition of the colony improved considerably and the number of people afflicted with leprosy and other deadly diseases decreased dramatically.

Likewise, the preceding analysis attests that initially, altruism and promoting the well-being of the Filipinos were not the motivational springboards of the Americans when they implemented their public health policies. They sanitized Manila and launched a sustained campaign against tropical diseases to safeguard the health of the American soldiers waging war against Filipinos revolutionists. Moreover, they wanted to make the Philippines a safe haven for Americans interested in settling in the colony. While sanitizing the places where Americans went or settled in, they unintentionally and inevitably cleaned the places where Filipinos resided as well. At the end of the Filipino-American War, the American health officials deliberately included the Filipinos as intended beneficiaries of their public health policies. This move was unavoidable because if Filipinos were not "sanitized," they would remain carriers of the contagious diseases that Americans feared. They also ascertained that fostering the health of the Filipinos could also justify their continued stay in the Philippines.

INITIALLY, ALTRUISM AND PROMOTING THE WELL-BEING OF THE FILIPINOS WERE NOT THE MOTIVATIONAL SPRINGBOARDS OF THE AMERICANS WHEN THEY IMPLEMENTED THEIR PUBLIC HEALTH POLICIES.

Compared to cholera, tuberculosis, beri-beri, and other dreadful diseases, leprosy was given special attention by the American health officials. In their reports, Worcester,[46] Heiser, and Wood[47] are not clear as to the reason for the special attention to leprosy. Suffice it to say that during their

tenure the Americans launched a comprehensive and vigorous campaign against leprosy. They spent huge amounts of money in gathering those who were afflicted and in maintaining Culion and other leprosaria all over the country. The colonial government also recruited health workers who not only spent much of their time in Culion but also exposed themselves to this contagious disease, hoping that they could produce a permanent cure someday. While implementing the segregation policy, health officials encountered violent reactions from the local population, which never discouraged them. Because of their constancy and dedication, they succeeded in reducing the number of people afflicted by leprosy in the Philippines. In particular, the scientific treatment of leprosy in Culion is attributed to Victor Heiser.[48]

The success of the anti-leprosy program and its attendant policies could partly be attributed to the colonial set-up of the Philippines. Policy implementors overcame the difficulties they encountered because the colonial government controlled the country. The program was backed by laws, resources, manpower, infrastructure, and technical assistance to ensure its smooth implementation. The government also linked the local health officials with international groups who were likewise dealing with leprosy. Moreover, the Interior Department recruited competent and dedicated health officials fully committed to the eradication of leprosy at all costs. All these factors contributed to the success of the campaign against leprosy. The American course of action during this period could serve as paradigm or model of an effective response to a similar health problem at present and in the future.

This study also affirms that colonial rule does not always unilaterally favor the colonial power. As colonizers pursue their interests, the colonized benefit as well. Sometimes the colonized are the deliberate or intended beneficiaries, but there are also cases when they became accidental recipients of the policy's benefits. In the case of the American anti-leprosy policy in the Philippines, the Filipinos were not the target beneficiaries in the beginning. However, as the policy was implemented, the Filipinos were taken into account and eventually they became the major beneficiaries. By expanding the program to include the search for a cure, the intended beneficiaries not only comprised the Americans and the Filipinos but also those similarly afflicted elsewhere in the world. Americans transformed Culion into a huge laboratory where possible cures for leprosy could be shared with other research centers seeking a cure for the same disease. Anti-leprosy drugs were tested in Culion and the results validating or disproving their efficacy were published in medical journals. Indeed, Culion contributed not only to the anti-leprosy campaign in the Philippines, but also to the global fight against the dreaded disease.

INDEED, CULION CONTRIBUTED NOT ONLY TO THE ANTI-LEPROSY CAMPAIGN IN THE PHILIPPINES, BUT ALSO TO THE GLOBAL FIGHT AGAINST THE DREADED DISEASE.

NOTES

1. Association of Schools of Public Health, "The United States Public Health Service: Its Evolution and Organization," *Public Health Reports (1896–1970)* 36, no. 21 (1921): 1165.
2. Ibid., 1167.
3. William Hillebrand was a German physician who settled in Hawaii in 1850. He was one of the founders of the Hawaiian Medical Society and he was commissioned by King Kamehameha V to help contain the spread of leprosy. In 1865 he was appointed to the King's Privy Council, the Board of Health, and the Bureau of Immigration.
4. Chapman H. Binford, "The History and Study of Leprosy in Hawaii," *Public Health Reports (1896–1970)* 51, no. 15 (1936): 416.

5. Michael Worboys, “The Colonial World as Mission and Mandate: Leprosy and Empire, 1900–1940,” *Osiris,* 2nd ser. 15, *Nature and Empire: Science and the Colonial Enterprise* (2000): 209.
6. U.S. Philippine Commission, *Report of the Philippine Commission,* pt. 1 (1902): 310.
7. Victor G. Heiser was assigned to the Philippines first as Chief Quarantine Officer for the Philippine Islands and later on appointed as Director of Health.
8. Victor G. Heiser. “American Sanitation in the Philippines and Its Influence on the Orient,” in *Proceedings of the American Philosophical Society* 57, no. 1 (1918): 61.
9. John Foreman, *The Philippine Islands: A Political, Geographical, Ethnographical, Social and Commercial History of the Philippine Archipelago* (New York: Charles Scribner’s Sons, 1906): 553.
10. Ken De Bevoise, *Agents of Apocalypse: Epidemic Disease in the Colonial Philippines* (Quezon City: New Day Publishers, 1995): 42.
11. “Round Robin” refers to the letter sent by the commanding officers at Santiago, Cuba during the Spanish American War to General William Rufus Shafter demanding the immediate repatriation of American troops in Cuba. They reported that the army was already “disabled by malarial fever to such an extent that its efficiency is destroyed,” (Theodore Roosevelt, *The Works of Theodore Roosevelt,* vol. 2 [New York: P.F. Collier and Sons, Publishers, 1899]: 295) and likely to be “entirely destroyed by the epidemic of yellow fever sure to come in the future” (Ibid., 300).
12. Victor G. Heiser, *An American Doctor’s Odyssey* (Quezon City: CGF Books, 1988): 20.
13. U.S. Philippine Commission. *Public Laws Passed by the Philippines Commission,* vol. 1 (Manila: Bureau of Printing, 1902): 295–298. On 26 October 1905, the Philippine Commission passed Act No. 1407, otherwise known as “The Reorganization Act of 1905.” Section 5 (e) of this Act abolished the Board of Health and replaced it with the Bureau of Health to be headed by the Director of Health.
14. They were merely honorary members of the board who were allowed to participate in the deliberation but not allowed to vote.
15. *Report of the Philippine Commission,* pt, 1 (1902): 267.
16. U.S. Bureau of Census, *Census of the Philippine Islands,* vol. 3 (1905): 52.
17. Dean Worcester, *A History of Asiatic Cholera in the Philippines* (Manila: Bureau of Printing, 1908): 10.
18. William Cameron Forbes, *The Philippine Islands* (Cambridge, MA: Harvard University Press, 1945): 156.
19. “Reconcentration” refers to the practice of some American officers of forcing Filipinos to stay in a specific zone while military operations were being conducted. Movements of people inside the zone were restricted and they were not allowed to mingle with those living outside the zone, who were considered enemies of the colonial government.
20. De Bevoise, *Agents of Apocalypse,* 158.
21. Peter Stanley, *A Nation in the Making: The Philippines and the United States, 1899–1921* (Cambridge, MA: Harvard University Press, 1974): 97.
22. De Bevoise, *Agents of Apocalypse,* 160.
23. *Report of the Philippine Commission,* pt. 1 (1902): 5.
24. Ken De Bevoise, “Until God Knows When: Smallpox in the Late-Colonial Philippines,” *Pacific Historical Review* 59, no. 2 (1990): 153–154.

25. Victor G. Heiser, “Leprosy in the Philippine Islands,” *Public Health Reports (1896–1970)* 24, no. 33 (1909): 1,155. Heiser also asserted that the wild estimate ranging from 10,000 to 30,000 was bloated and had no credible basis.
26. In 1900, San Lazaro Hospital had an average of 80–100 patients afflicted with leprosy. See Simon Flexner and Lewellys F. Barker, “The Prevalent Diseases in the Philippines,” *Science,* New Series, vol. 11, no. 275 (1900): 523.
27. J. C. Perry, “Philippine Statistics of Deaths Occurring in Manila from October 1, 1899 to June 30, 1900,” *Public Health Reports (1896–1970)* 15, no. 36 (1900): 2240.
28. Angel Aparicio, *First International Conference on the History of Medicine in the Philippines* (Manila: University of Santo Tomas Miguel de Benavides Library, 2008): 250. See also Warwick Anderson, *Colonial Pathologies: American Tropical Medicine, Race and Hygiene in the Philippines* (Quezon City: Ateneo de Manila Press, 2007): 164.
29. Act No. 1711, “An Act providing for the apprehension, detention, segregation and treatment of lepers in the Philippine Islands,” U.S. War Department, *Acts Passed by the Philippine Commission* (1907): 363–364.
30. Ibid., 363.
31. Violators of these provisions would be punished by a fine not to exceed 200 pesos or imprisonment not to exceed six months or both. See Section 6 of Act No. 1711.
32. Roberta Romero, *Research on Leprosy in the Philippines* (Manila: Philippine Council for Health Research and Development, 1988:5.
33. Aparicio, *First International Conference,* 251.
34. Anderson, *Colonial Pathologies,* 166.
35. Aparicio, *First International Conference,* 251.
36. Romero, *Research on Leprosy in the Philippines,* 5.
37. Victor G. Heiser, “Recent Progress in the Control of Leprosy,” in *Proceedings of the American Philosophical Society* 71, no. 4 (1932): 167–171.
38. Aparicio, *First International Conference,* 256.
39. Ibid., 255.
40. Heiser, “Leprosy in the Philippine Islands,” 1158–1159.
41. Aparicio, *First International Conference,* 255.
42. Heiser, “Leprosy in the Philippine Islands,” 1156.
43. The statistics for 1907–1909 are found in Association of Schools of Public Health. “Status of Leprosy in the Islands,” *Public Health Reports (1896–1970)* 21, no. 50 (Dec. 14, 1906): 1492–1493 and in Association of Schools of Public Health, “Philippine Islands: Lepers in the Philippine Islands,” *Public Health Reports (1896-1970)* 24, no. 43 (Oct. 22, 1909): 1602.
44. Anderson, *Colonial Pathologies,* 176.
45. Aparicio, *First International Conference,* 240.
46. Dean C. Worcester was one of the most prominent American officials during the first decade of American rule of the Philippines. He was a member of the First and Second Philippine Commission. After the establishment of the civil government, he was appointed Secretary of Interior which at that time had direct supervisory control over the Bureau of Health. It was during this period, when he became actively involved in the campaign against leprosy, cholera, rinderpest, and other diseases.
47. Leonard Wood was a medical doctor who became governor-general of the Philippines in 1921. His administration was actively involved in the campaign against leprosy. He increased the

budget of Culion Leprosarium and made the eradication of leprosy a top priority in his administration.

48. Ibid., 167.

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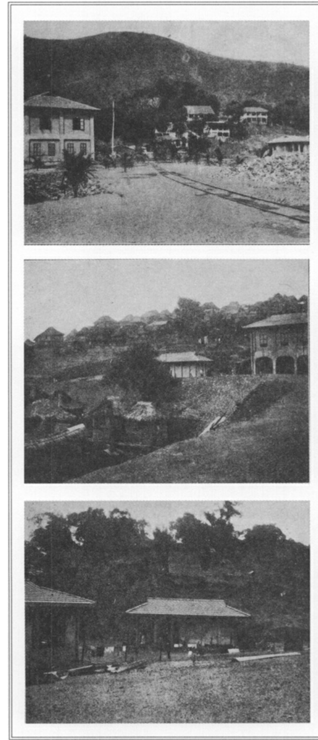

Scenes from Culion: Doctors' residences and other buildings outside of the balcony fence (top), Concrete dormitory and native shacks (middle), Concrete kitchen, lavatory, and native residences (bottom)
(The Open Court, "Tay Tay and the Leper Colony of Culion", 1917)

SPACES AND BOUNDARIES IN CULION: MOBILITY AMIDST SEGREGATION

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When the American colonial policy of segregating people afflicted with leprosy in the early twentieth century was enforced, leprosy sufferers in every municipality, province, and island were sent to Culion, a remote island north of Palawan, to isolate them from the healthy population. There was spatial segregation in Culion. Boundaries were designated to delineate the settlements of the *leprosos* (those afflicted with leprosy) and the *sanos* (those who were not, like the doctors, nurses, nuns, priests, and other colony personnel), but for both communities, life was made as normal as possible. Houses were built of indigenous materials and simulated the architecture of the rural areas where the inmates had come from. The inmates could pursue their livelihood, even earning enough to send some money to their families. While the hospital sheltered the infirmed and the elderly, patients who were able to move about had their regular check-ups at the hospital and clinics. The laboratory had competent doctors who searched for a cure to the dreaded disease, leprosy.

Even through the patients' quarters were separated from those of the staff, they had many opportunities for daily contact within the colony. Patients could meet at the hospital where they had wound dressings changed, or the clinic where they got their chaulmoogra shots, at the church to hear daily mass, at the open field for a game of softball, or at the colony theater to watch the latest movie.

That the patients were allowed to practice their trades or earn their living meant that they had certain privileges for mobility within the island. Such was the case of farmers who tilled the land in the farming stations. Fishermen were also allowed to fish but they had to go back to the island with their day's catch to earn their wages.

Culion was an island for the segregation of leprosy sufferers in the Philippines, but within the island, and even as there were boundaries within the spaces, there was mobility for both *sanos* and the *leprosos*.

BACKGROUND

When the Americans occupied the Philippines in 1898, they observed with concern the large number of people afflicted with leprosy in almost all the major towns in the Philippines, especially in Manila and Cebu. The Americans noted that although the Spanish government had established

hospitals for leprosy sufferers in Manila, Cebu, and Nueva Caceres, the care of patients reflected more of a concern for their spiritual well-being rather than a concern for treating their illness. Moreover, there was no effort to restrict contact between leprosy sufferers and healthy people. The afflicted wandered about as beggars or were driven away from towns and obliged to inhabit caves and inaccessible places. American officials were appalled that some were employed to prepare and handle food. American health officials concluded that the treatment of leprosy was inadequate. No systematic effort had been made to stamp out leprosy in the Philippines, the care of the afflicted was insufficient, and the existing hospitals were poorly maintained.

THE CARE OF THE AFFLICTED WAS INSUFFICIENT, AND THE EXISTING HOSPITALS WERE POORLY MAINTAINED.

The American government decided to establish the Culion Leper Colony on an island in the Calamianes group, north of the island of Palawan based on three considerations:

- an assumption that leprosy was hereditary and highly contagious,
- recommendations made during the First International Conference on Leprosy in Berlin in 1897 urging the segregation of those afflicted with leprosy to prevent the spread of the disease to healthy populations, and
- American health officials' success in isolating leprosy sufferers in colonies at Kalaupapa on the Hawaiian island of Molokai and in Carville, Louisiana.

Officials chose Culion for its healthful climate, rich soil, extensive cattle ranges, abundant water supply, good harbors, isolated location, natural drainage, wide stretches of open country, refreshing breezes, and the small population that inhabited the island. These officials intended to establish the colony as a place "where persons in the early stages of leprosy can have their homes, cultivate the soil, and in general, lead a free out-of-door life, instead of being practically imprisoned and compelled to pass their days in the company of fellow unfortunates in the last stages of this horrible disease."[2] People afflicted with leprosy from difference parts of the country were identified by the local health workers, segregated, and sent in batches to Culion.

The total area covered by the colony proper was about 40 acres. To establish a colony on the island, an appropriation of US$50,000 was included in Act No. 389 for the erecting a warehouse on Halsey Bay, constructing a road to the proposed site of the colony, and building the superintendent's house and a hospital.[3] One hundred houses were built before the first batch of inmates arrived on 26 May 1906. The number was increased to 1,000 houses to accommodate new arrivals two months later. By the 1920s, Culion's inmate population reached its highest number of more than 6,000 patients. By that time, a number of internationally renowned specialists in the treatment of leprosy had visited the colony and noted that Culion was the largest and one of the best institutions of its kind in the world. It was also regarded as an interesting sociological and medical experiment.[4]

"WE WANT THE LEPROSARIUM TO BE A CHEERFUL VILLAGE, HAPPY, FULL OF HYGIENE AND EVEN A CERTAIN BEAUTY."
—DR. VICTOR HEISER

The Culion Leper Colony was situated to isolate its inmates from healthy populations like other late nineteenth and early twentieth century leprosaria. However, the colony was laid out like typical Philippine villages with the objective of letting the inmates live as normally as possible, given the

circumstances of their disease. Dr. Victor Heiser, Director of the Bureau of Health for the Philippine Islands, wrote:

> Do not suppose that we want a leprosarium of the penitentiary type...We want the leprosarium to be a cheerful village, happy, full of hygiene and even a certain beauty. Simple modest houses, but with considerable charm, nurseries, gardens, lots of flowers and trees, plenty of water, a house for recreation, commercial establishments, workshops, in short, a combination of circumstances that make the sick forget about their misfortune and misery."[5]

The world of Culion was divided into two: the colony proper or the inner colony for those afflicted with leprosy and a settlement outside the colony for the *sanos* (those not afflicted with leprosy).

THE COLONY PROPER: THE WORLD OF THE *LEPROSO*

The colony proper was located on a 150-foot hill that sloped in nearly all directions to the sea. Before the first group of inmates arrived in 1906, houses and a hospital were built for them and laid out on regular streets, just like any Philippine town. In later years, a street and park system was added, and the colony and its surroundings were beautified.

Like typical Filipino houses of the era, the inmates' houses were built with nipa and bamboo on hardwood frames and elevated from the ground. Each nipa house was large enough to accommodate five to seven persons. The government built some housing. However, inmates could opt to build their own houses with materials provided by the government or with hardwood sourced from the island's interior. The bamboo for the houses was cut on the other side of Culion Island, about 25 minutes distant by water.

To make living in the colony like living in their home towns, the authorities put the Tagalogs with each other, Ilocanos with each other, Visayans with each other, Moros with each other, and so forth. The inmates would mix during the day but at night they were with their own kind.[6]

In 1914, a new standard of construction was adopted to lessen the risk of fire caused by the use of light building materials. Houses were to be erected with a five-meter clearance on all sides. To conform to this standard, a number of houses had to be torn down and rebuilt. Where necessary, the colony administration paid some inmates from a gratuity fund to assist other inmates in renovating their houses if they did not conform to the housing regulations.[7]

In 1919, to meet the housing demand, the government started constructing tenement houses for the inmates, which were then regarded as model sanitary housing. Each tenement contained five units. Each unit was 10 by 16 meters in size and had four ample rooms that could accommodate 12 persons each, four small rooms, and four cooking areas. The front part of the building was provided with a two-meter veranda[8] as the afflicted needed access to good ventilation to prevent the festering of their wounds.

The tenements had *tiza* brick roofing, which matched the roofs of the theater and Colony Hall (the administrative center of the colony proper). The plaza fronting the tenements, then known as Worcester Plaza, was later called Tiza because of the roofing material. The open space allowed the inmates opportunities for social interaction with other inmates.

In 1919, construction of a "Get Well Club" residence was started and completed one year later. It was a wooden frame building with a living room, kitchen, pantry, and a small room for a caretaker, and galvanized iron roofing. The front part of the building had a veranda.[9] All patients were welcome in the residence.

As the anti-leprosy injections began to have some positive effects in later years, a building, known as the Negative House, was constructed to isolate inmates who tested bacteriologically negative more than once for a two-year period. The Negative House was situated halfway down the northern slope of the hill below the church. The two-story building had six rooms. Each room opened on to an arched balcony 2.5 meters wide along the front. The lower floor contained lavatories for both sexes and a large kitchen with fireplaces in the native style, but constructed of concrete and firebrick.[10]

AMERICAN HEALTH OFFICIALS ASSUMED... THAT LEPROSY WAS HEREDITARY AND HIGHLY CONTAGIOUS.

Clinically and bacteriologically negative inmates were released and permitted to return to their home towns with the condition that they would report to the district health office of their provinces every six months for a period of two years to determine whether they were permanently free from leprosy.[11]

Because Culion was constantly receiving patients from the provinces and housing them was a constant problem, the resulting housing shortage compelled authorities to use the Negative House as well as the Quarantine House, where all incoming inmates to the island were temporarily quartered, as housing.[12]

SEPARATION WITHIN THE COLONY

American health officials assumed, like most medical professionals of the day, that leprosy was hereditary and highly contagious. This assumption led them to discourage marriage and cohabitation in order to prevent the proliferation of babies who would be vulnerable to leprosy. Despite the obvious difficulties in stopping the inmates from leading normal social and sexual lives, the American authorities conducted educational campaigns, used moral persuasion, and separated minors and adults by gender.[13] They also sought the help of the Jesuit parish priests to counsel their parishioners and ordered the colony police force to maintain separation of the sexes.

Upon arrival at the colony, the inmates were lodged in the Quarantine House. After quarantine, the men selected the places where they wanted to live, and the boys, aged 8 to 15,were placed in the Angelitos dormitory run by the Jesuit priests “to do away with the possibility of frequent cases of corruption of minors and to provide for better care of these children who were practically orphans in the colony.”[14]

The Sisters of St. Paul de Chartres housed the girl and women inmates. Girls below 18 years old were placed in the Hijas de Santa Maria and Santa Teresita dormitories while women went to the Cinco Llagas dormitory.

However, many inmates ignored the authorities, and the colony police force could not be depended upon to keep the inmates in their respective quarters at night.[15]

Forcible separation from spouses and families, a low probability of a cure, and the strict enforcement of the isolation policy led many inmates to justify seeking a lifetime partner from among the colonists since it was unlikely that they could go back to the world beyond Culion.

There was also another kind of separation by nationality. Although the population of Culion was made up generally of Filipinos, there were other nationalities. In 1912, in accordance with an Act of Congress, 18 Chamorros, who were ill with leprosy were transported to the Culion Leper Colony on the naval ship *Supply.* The cost of maintaining these inmates was paid by the United States Navy Department, which had jurisdiction over Guam.[16] No report was made if any of the Chamorro inmate

ever returned to Guam, but some Chamorro deaths were recorded in Culion. The inmates from Guam as well as one American had quarters separate from Filipino inmates.

SANITATION

The colony had an excellent water and drainage system because of its hilltop location. The drainage system worked on gravity while the water system used gravity and a gasoline water pump to bring water to the colony from a reservoir (Denney Spring) that was over 230 feet above sea level.[17] There was abundant water for the numerous bathhouses, latrines, and laundries in the colony.

The colony also had a modern sewer system, discharging waste into septic vaults and then into the sea. Inmates were employed by the colony administrators to collect garbage daily. In the early years, the combustible garbage was burned in an incinerator. Then the residue was placed on rafts and towed out to sea to be thrown overboard. In later years, this method of disposal was regarded as unsatisfactory. A concrete and brick garbage incinerator was built where garbage was burned to slag, which was utilized for street foundations.[18]

Public toilets were constructed throughout the colony. These were either cast-iron raised bowls or squat bowls on the concrete floor. Embedded on the floor were water service pipes for flushing the toilet bowls. The floor surface sloped toward the bowls from all directions. This allowed the toilets to act as floor drains when the floors were washed down.[19] The public toilets were flushed, cleaned, and sanitized twice daily by cleaners suffering from leprosy.

A medicated bathhouse was introduced in 1918, The bathhouse, adjoining the electric plant, had facilities for six bathers at a time in separate cement tubs. The building was three by six meters, with three bathrooms at each end of the building. A cement reserve water tank occupied the middle third of the floor. Seawater was pumped into the reserve water tank to a depth of about 20 feet. The water was then heated to the desired temperature and run into individual tubs to allow patients to submerge up to their necks. Sodium bicarbonate and sulphur were added when prescribed by the physicians for special cases. An attendant was in charge of regulating the temperature of the baths and making sure that bathers spent their prescribed time in the bathtub.[20]

MEDICAL FACILITIES

The first hospital was built from nipa and bamboo in 1906 to provide temporary accommodations for the early patients. However, to handle the increasing number of patients, the hospital was expanded over the years with the addition of reinforced concrete wings and annexes. However, construction work was slowed down by two factors. First, the hospital was situated on a high point of solid rock that needed to be blasted, and second, it was difficult to get workers for projects because they feared close proximity to those afflicted with leprosy.[21]

In 1913, the renovated hospital's head nurse described it as

> a concrete, one-storey building, facing the sea, designed for the tropics, with wide porches front and back, and with both sides built in such a way that the wards can be entirely thrown open, leaving only a roof and floor. This ensured coolness, and the ventilation which is so necessary where all the patients had the same evil-smelling disease."[22]

The hospital was 75 meters long and had separate wings for male and female patients.
It had a central administration area, operating and sterilizing rooms, separate baths, and lavatories

and toilets for males and females.[23] The annexes also housed the different hospital sections such as the pathological section for routine examination of patients, autopsies, and special work; and the chemical section which manufactured all the anti-leprosy preparations used for patient injections. The preparations used, the precursors of today's multi-drug therapy, were plain and iodized ethyl esters of chaulmoogra oil and, on a small scale, ethyl esters of cod liver oil and the Mercado mixture.

In 1916, the two-story hospital annex was completed. The first floor housed an outpatient surgical dressing room for men, a similar one for women, a storeroom for the attending Sisters, a room for the chaulmoogra clinic, and a sterilizing room. The second floor was the general ward. Dispensary consultations were available at the special dispensary in the general hospital for those who were not in the treatment lists for the chaulmoogra injections.

Fifty-bed (or less) emergency hospitals were established in the colony to treat cases resulting from negative reactions to the injections (e.g., choking and shock) and intercurrent diseases.[24]

To avoid overcrowding, only advanced cases requiring intensive medical attention were admitted to the hospitals. Usually these were cases that were complicated by other illnesses, such as tuberculosis and chronic nephritis. Crippled persons who did not require medical care were discouraged from occupying beds meant for the ill.[25]

In 1927, the 25-bed Yangco dormitory was built with a donation from the philanthropist Teodoro R. Yangco, for invalid patients. The dormitory was situated to command a good view of the bay and to ensure good ventilation.[26] The site selection was also dictated by its proximity to Emergency Hospital No. 2 that allowed personnel from the hospital to be utilized for the care of the invalids.

In 1919, two treatment clinics, separate from the general hospital, were set up in the colony. There was a daily line of patients ready to receive intradermal and intramuscular injections of Mercado-mixture chaulmoogra oil or Wightiana ethyl esters.[27]

These injections gave the patients much hope that their illness could be cured. Patients were assigned their own doctors and nurses, and they were given injections once a week, or twice a week if they were strong enough. If patients failed to present themselves to their doctors for an injection without a justifiable reason, they could not get their food ration tickets.[28] Physicians countersigned the tickets to entitle holders to receive their weekly raw rations from the General Kitchen. This procedure forced all patients to receive treatment.

Field dispensaries were established for the care and treatment of patients who opted to live in the distant barrios or farming stations in Palumpong, Baldad, Guitna, and Pilapil. Two dispensary attendants with supplies of dressings and medicines went to these barrios three times a week and stayed there to render treatment. One resident physician visited the barrios at least twice a month.[29]

THE COLONY HALL WAS THE ADMINISTRATIVE CENTER OF THE COLONY PROPER.

A laboratory was established in 1917 to develop effective treatments of leprosy. The administration of the chaulmoogra oil mixture by injection had considerable success, and those given the mixture were discharged after intensive treatment. With the arrival of Dr. Herbert Wade in Culion in 1920, the Leonard Wood Memorial Research Laboratory pursued intensive research work on leprosy control and anti-leprosy injections.

ADMINISTRATIVE FACILITIES

Constructed in 1932, the Colony Hall was the administrative center of the colony proper. This was

where the Chief of Colony, who was the chief physician, and the Culion Advisory Council held office. It also served as the courtroom of the Chief of Colony, who was also the colony's justice of peace and notary public. The Superintendent of Agriculture, who advised colonists in matters pertaining to the natural resources of the colony, held office in the Colony Hall as well.

The post office occupied the ground floor of the Colony Hall. Every piece of mail leaving Culion was thoroughly disinfected by formaldehyde.

During Culion's operation as an isolation colony, relatives and friends of a patient were authorized to send a package of food, clothing, tobacco, letters, pictures, and documents free of charge, up to a total gross weight of 100 pounds once every three months. District health officers were required to receive such articles, give receipts, and ship the packages by the first available transportation to Culion at the expense of the Bureau of Health.[30]

The library was also located at the ground floor of the Colony Hall. It was outfitted with some 7,000 volumes, collected largely by civic and religious organizations in Manila.

The inmates were provided their daily subsistence by the government at the General Kitchen (later known as the Distribution Center). Fish and vegetables were given every day, while beef was issued every Tuesday. Rice, mongo beans, lard compounds, sugar, tea, coffee, garlic, onions, canned tomato, condensed milk, and other food supplies were distributed once a week from a distribution shed nearby.[31] Children received half of the adults' ration.[32]

Clothing for men, women, and children plus bedding were issued twice a year. The clothes consisted of khaki, drill, percale, chambray, *sinamay,* gingham, and ready-made shirts and *kimonas.* Beddings consisted of flannel blankets, *buri* mats, and *kapok* pillows.[33] During World War II, these provisions were exchanged for food from nearby islands where the harvest was good. A pair of khaki pants fetched a sack of*palay* (rice).[34]

Near the Colony Hall was a cooperative store operated by employees who were also inmates. The store sold additional necessities and comforts to other inmates at reasonable prices. It also accepted consignments of goods which inmates produced[35] so that they could be encouraged to become partly self-supporting.[36]

T o alleviate the monotony of life and to provide entertainment for the inmates, a theater was constructed in 1913. Theatrical performances and literary programs in local dialects were presented and enjoyed by both inmates and *sano* staff, with the help of an advisory board and the members of the *sano* staff. Tagalog, Cebuano, Ilonggo, and Ilocano groups were very active in these affairs.

In 1914, a movie projector and a dynamo connected to a 2.5 horsepower gasoline engine were delivered to the colony. Films were sent regularly on a commercial steamer. In one night, two films were shown. These were then reshown on another night so that all the inmates had an opportunity to watch them. Because the films had to be returned to Manila, inmates were not allowed to handle the films or the equipment for showing them. Only volunteer staff members could operate the apparatus. For the first two months, the Chief of Colony himself had to personally supervise each night's entertainment.[37]

The theater was also the venue for phonograph concerts, political debates, dances, receptions, and graduations. There was free seating in the theater, which was unlike that in Carville in Louisiana where the inmates sat on benches in sections separated from those reserved for the medical personnel.

In 1922, the theater was the venue for an experimental feeding program conducted by Hartley Embrey, a consultant for the Philippine Health Service, to demonstrate the physiological effects of a

better-balanced diet.[38] Two hundred inmates were selected from a group of volunteers as the subjects of the program. The theater was converted into a large dining room and a kitchen was set up at the side of the building. The selected volunteers were restricted to eating only the food served to them in the kitchen. They were enjoined not to eat additional food. Their weights were recorded each week. After a month, the results were reviewed: several of the volunteers gained weight, others retained their weight, while a few lost weight.

RELIGIOUS FACILITIES

Recollect missionaries constructed a Roman Catholic church in 1618 on top of a hill overlooking the bay. The church was designed with a stone fort surrounding it to protect the local inhabitants from invaders. When the American government converted Culion into a colony for people suffering form leprosy, the church became an important element in the daily life of the inmates, who were mostly Catholic. To accommodate a growing population, there was a need to enlarge the church. In 1933, the side walls were moved to increase the width of the church.

The church occupied such a scenic site that people would usually gather in front of the church after attending mass to take in the panoramic view of the colony and the calm waters of the bay.

When Fr. Jose Tarrago, who was assigned in Culion (1910-1917), was diagnosed with leprosy, a Cebuano inmate immediately gave Fr. Tarrago his house in front of the church. Fr. Tarrago did not say mass until the Sisters of Charity provided him with special vestments and a chalice. Meanwhile, he received communion with the inmates. After some time, a house was constructed for him, close to the church. He was also provided the day services of a houseboy living in the colony.[39]

Fr. Teodosio Agcaoili, an Ilocano priest who had contracted leprosy and was sent to Culion, ordinarily said his Sunday mass at Baldat, a barrio where many inmates lived. His weekday masses were said at a side altar, which the head priest, Fr. Hugh McNulty, had constructed for him within the sanctuary of the newly enlarged Culion Church. Fr. Agcaoili also had his own confessional near the entrance of the church.[40]

The construction of the Protestant chapel in 1918 fulfilled a long felt need among the Protestant inmates who had held their religious services in a nipa shack on the waterfront for a number of years. The building was centrally located on the third level of the colony just above Worcester Plaza. The floor plan consisted of one large assembly room with a pulpit, a square partitioned off for the use of non-leprous visitors, and a small anteroom for the pastor. The assembly room could seat 100 people.[41]

> WITHIN THE TOWN, THE INMATES WERE GIVEN ALL POSSIBLE FREEDOM TO MOVE ABOUT. THEY WERE CONTROLLED BY THE REGULATIONS WHICH THEY THEMSELVES OR THEIR REPRESENTATIVES LEGISLATED.

THE SANITARY BARRIO

Inmates who became bacteriologically negative after a series of tests but were not yet recommended for permanent release were transferred to the Sanitary Barrio to make way for new batches of inmates who needed housing in the colony proper. The Sanitary Barrio was on the flat land below the colony proper. The site was surveyed so that building lots would conform to the colony’s building code. Hence, house lots in the Sanitary Barrio were nine by six meters, with a space of five meters between houses. Each house lot had 2.5-meter long areas at the back and the sides for gardening. A “town square” or “city block” was composed of four houses.[42]

The Sanitary Barrio was planned as a model settlement on the island. Streets were graded. Acacia, palm, and coconut trees were planted at regular intervals to complement the home gardens that nearly all house owners started as soon as they settled in.[43] Home gardens were encouraged by the authorities for the colonists to supply vegetables to the General Kitchen and augment their diet. Tools and seeds were given to colonists who volunteered to cultivate home vegetable gardens. To give impetus to this program, home vegetable garden contests were organized, and prizes were given out.[44]

Public toilets were likewise constructed in the Sanitary Barrio. These were two meters wide, four meters long, and two meters deep. The walls were made of concrete about six inches thick at the bottom and gradually tapered to four inches at the top. The sidings of the toilets were made of *sawali* and the roof was galvanized iron.[45]

LIFE IN THE COLONY PROPER

Within the town, the inmates were given all possible freedom to move about. They were controlled by the regulations which they themselves or their representatives legislated. Their local government consisted of a president and ten *consejales,* nine of whom represented colonists from the following major regional groups of inmates—Cebuano, Tagalog, Ilocano, Bicolano, Ilonggo, Samar-Leyte, Pampanga-Tarlac, Moro, and Zamboanga. A tenth *consejal* represented inmates from the smaller regions.

A police force composed of twelve inmates, later fifteen, maintained peace and order, arrested offenders, enforced discipline, and ensured the sanitary conditions of the colony. They were unarmed and under the charge of an ex-constabulary inspector.[46] While on duty, they wore regulation khaki uniforms; for special occasions, they wore white.[47]

AS IN ANY PHILIPPINE TOWN, CIVIC AND RELIGIOUS OCCASIONS WERE CELEBRATED WITH FERVOR AND ENTHUSIASM.

A group of inmates was also organized as a corps of volunteer firemen and drilled in simple fire-fighting techniques.[48] No fires were reported in Culion during its operation as a colony. The destruction of buildings and houses was mostly caused by typhoons.

Musically inclined inmates composed the colony's brass band. The band greeted newcomers to the colony and gave concerts on special occasions. There was also a string orchestra which provided music for dances and receptions.[49] Both bands played alternately on Sundays and Thursdays in the main plaza.[50]

Track athletics, tennis, volleyball, and baseball games were frequently played in the colony. A great deal of interest was manifested in baseball. One visiting doctor noted that the inmates demonstrated the American baseball spirit at one of the games when both teams attacked the umpire with bats.[51]

Cockfighting was permitted on Sundays and holidays, but heavy betting was prohibited. A few pool and billiard tables were operated privately.

During the Christmas holidays, inmates were given gifts collected in Manila from school children and merchants by the Philippine Anti-Leprosy Society. Manila school children were entitled to credit for gathering together the Christmas presents. On one occasion, the government purchased over two tons of candy and popcorn, oranges, and other fruits for distribution to all inmates.[52]

As in any Philippine town, civic and religious occasions were celebrated with fervor and

enthusiasm. Rizal Day was considered the most brilliant affair, complete with parades and speeches. One inmate proudly recalled that he was once selected to make a speech honoring Jose Rizal.[53] Feast days of saints were celebrated too with the feast day of San Lazaro, the patron saint of those afflicted with leprosy, being a special day. Every holiday was a reason to stage dramas, *zarzuelas*, musical programs, *balagtasan* (debates), and sports events such as indoor baseball, volleyball, table tennis, and track-and-field races.[54]

When the Rizal monument was started in 1924, the cornerstone laying was considered the biggest civic event of that year.[55] The construction of the monument was funded by voluntary contributions of the inmates. In 1927, an octagonal bandstand facing the monument was constructed, again, with funds raised by the inmates.[56]

In 1917, when government appropriations failed to yield sufficient funds to build a clubhouse, the inmates collected money from among themselves and the *sano* staff. Carpenters from the colony under the supervision of a foreman from outside the colony did all the labor.[57] The clubhouse was completed and inaugurated in March 1918. The building had a large assembly room, a reading room, a library, and a three-meter veranda all around. The clubhouse was the venue of well-attended biweekly dances, afternoon teas, and other social events.

The inmates were encouraged to pursue their occupations or engage in other kinds of work of their choice. However, because of their illness, many could not do so. Their bodies were not able to take the physical demands of occupations like farming and fishing. The government employed semi-invalids as street cleaners, garbage collectors, construction workers, litter bearers, and fabricators of beds and furniture.[58]

Many of the inmates spent a large part of their time in fishing, using rafts of lashed bamboo poles. Others were engaged in farming. They sold their fish and farm produce to the government, which in turn distributed them to the inmates.

The government paid a weekly gratuity of twenty centavos to each child, woman, and incapacitated adult male with special aluminum coins used exclusively in the colony.[59] By mutual agreement, the gratuity was not paid to able-bodied men, and the savings generated was used to pay miscellaneous inmate labor. Inmates were engaged in other remunerative occupations such as carpentry, tailoring, bamboo craft, shoemaking, baking, and tending to small stores.[60]

COLONY VISITORS

The colony's health officials strictly enforced a policy forbidding relatives and friends to accompany patients to Culion, the stated reason being that "isolation was for the best interests of all concerned, for the benefit of the patients, and for the protection of the public."[61] However, relatives and friends could arrange to visit inmates after they settled in. The trip involved taking a scheduled government boat to Culion. Once there, visitors were not allowed to stay overnight, but had to stay on the nearby island of Busuanga.

TO CORRECT THE PUBLIC'S PREVAILING IDEAS ABOUT THE CONDITIONS AT THE COLONY, THE GOVERNMENT ARRANGED FOR HOLIDAY VISITS.

In the later years, the policy became less rigid. To satisfy the inmates' desires to see their relatives and friends and to correct the public's prevailing ideas about the conditions at the colony, the government arranged for holiday visits. From time to time, coastguard cutters chartered by the

Philippine Health Service brought families, relatives, and friends to Culion, leaving Manila and stopping at the ports of Cebu, Iloilo, and Mindanao. A few times, the Yangco Steamship Company offered their boats to bring in contingents of visitors to Culion.[62] The visitors' arrival signaled festivities in the colony that included concerts, baseball games, the competitive decoration of houses, parades of decorated rafts, and the staging of plays at the theater.[63]

Visits lasted from 24 hours to one week. Everybody enjoyed these activities and being together with friends and relatives. Then, visitors would leave Culion on the same cutters that brought them in. While in Culion, visitors did not live within the colony proper but were provided sleeping quarters in Balala which was outside the colony.

Americans and other foreigners were also welcome to visit the island, some to look at the progress of the leprosy campaign, others to look into charity work, and for medical officers working in leprosaria in other parts of the world, a comparison of facilities. One foreigner observed that doctors did not hesitate to touch the inmates.[64]

Governor General Leonard Wood often visited Culion during his administration. He would go to the clinic, laboratory, and hospitals and ask the patients if there was anything they wanted him to do for them.[65] Culion received its biggest annual budget for the construction of facilities and the deployment of medical personnel during his administration. So loved was he by the inmates that they erected a monument at the plaza fronting Colony Hall after he died.

THE GATES

The inmates were not permitted to pass two specified points that divided their world from the outside world. These were the colony gates. They were known as the Upper Gate and the Lower Gate, indicating their elevation in the colony. The gates separated the colony from Balala, which was reserved for the priests, nuns, health officials, and other staff members.

The construction of the Lower Gate started in April 1919 and it was completed by the end of the year. It was a reinforced concrete structure provided with a small room from which the disbursing officer paid gratuities and salaries to colonists who were employed in the construction of roads, garbage disposal, and other jobs. The gate had a strong iron fence with a small window and a cement basin containing a disinfecting solution where all money was disinfected.[66] The gate also served as a shelter for inmates while they transacted business with vendors who had not contract leprosy.[67]

At the Lower Gate, the medical personnel disinfected themselves in the morning before going to the hospital area, and again in the afternoon, when they returned to their homes. The Sisters of St. Paul de Chartres likewise had to dip their hands and wipe their slippers or shoes in antiseptic at least twice a day. The Sisters also changed into fresh habits and shoes upon entering the convent or nursery at the end of the day.

Inmates who had to go to Balala for official or personal transactions, or to Malaking Patag, the *destino* (agricultural area), had to go through the gates and show the guard on duty a pass signed by their medical officer authorizing them to leave the colony. The pass indicated the duration of their absence from the colony. In later years, inmates who had to leave the colony had their arms stamped upon leaving the gates.

OUTSIDE THE COLONY: THE WORLD OF THE *SANOS*

The *sanos,* that is, staff who did not have leprosy, lived about a quarter of a mile outside the colony on the opposite side of the hill in the adjoining village of Balala. this was the main contact point with

the outside world where boats docked to unload supplies and mail.

The *sano* staff consisted of the Chief of the Colony and administrative, medical, and religious personnel (Jesuits who volunteered as parish priests and Sisters of St. Paul of Chartres).

Because of the steep lay of the land in Balala, the settlement was divided into Upper Balala and Lower Balala. A series of steps connected the upper section to the lower section.

Initially, the Chief of the Colony lived about two miles across the bay. Each day, he reported for work in the colony by a small gasoline launch.[68] In 1917, a new house for the Chief was constructed about one-eighth mile from the colony on the hillside above Balala next to the Sisters of Charity's house. The house was made entirely of *ipil* wood and cement, and it was considered the most handsome structure in Colon. It contained two bedrooms, each with a bath and closet, one large *sala* (living room) and dining room combined, a kitchen, and a storeroom. The house was surrounded by a three-meter veranda. The Chief moved in a year later.[69]

FOR EVERY FACILITY IN THE COLONY PROPER FOR THE INMATES THERE WAS A COUNTERPRT IN BALALA FOR THOSE WITHOUT LEPROSY.

The concrete house for the Sisters of St. Paul of Chartres, which was started in 1915, was completed in June 1916.[70] Further up was the Jesuit House, constructed in 1926.[71]

The other structures in Balala were the administration building, hospital, a general kitchen and mess hall, laundry sheds, dormitories for the medical staff, bachelors' quarters, nurses' homes, clerks' quarters, storehouses for supplies, quarters for carpenters and mechanics, the colony's wharf, a basin for small boats, and the Bureau of Posts' radio tower. On the hillside above Upper Balala were the residences of the senior doctors, a hospital for those without leprosy, and the house of the Protestant missionary.

For every facility in the colony proper for the inmates, there was a counterpart in Balala for those without leprosy.

Although all those connected with the care of leprosy sufferers in the Philippines regarded sex between men and women a natural aspect of life, they also regarded the separation of sexes and refraining from having children as necessary because leprosy was assumed to be hereditary and communicable. However, it was admitted that the complete separation of the sexes was impracticable, if not impossible. During the first decade, officials left the management of this problem to the persuasive power of the Catholic Church.[72]

Health officials attempted to separate children and parents from the beginning of the colony's operation. A few children were transferred to the Negative Children's Home, but most of the infants died, so most parents refused to give up their children. Those who were given up were transferred to the Hospicio de San Jose in Manila. The Negative Children's Home was rebuilt as the Nursery in Upper Balala in 1916.

The babies remained with their mothers for six months, and were then placed in the nursery for two years. The toddlers who became affected with leprosy during that period were returned to their parents. Those who remained free of leprosy were given to relatives outside Culion or were put up for adoption and sent to Welfareville in Mandaluyong, south of Manila.

On Thursdays and Sundays, from three to five o'clock in the afternoon, the inmate parents were allowed to visit their babies in the nursery.

A GLASS WALL DIVIDED THE NURSERY: THE CHILDREN WERE PLACED IN CRADLES ON ONE SIDE OF THE

WALL AND THEIR PARENTS LOOKED AT THEIR INFANTS FROM THE OTHER SIDE TO PREVENT ANY PHYSICAL CONTACT.

A glass wall divided the nursery: the children were placed in cradles on one side of the wall and their parents looked at their infants from the other side to prevent any physical contact. The parents were allowed to give presents like fruits and vegetables. However, these were received by the attendants on duty, who disinfected and cleaned them thoroughly before giving them to the child.

Department B of Welfareville was the home for healthy children of inmates on Culion or parents who had been discharged from Culion but who were too poor to provide for their children.[73] As the children were considered potential carriers of the disease, they were thoroughly examined and isolated for about two weeks. Only then were the children permitted to have contact with other orphans.

The children in Welfareville visited their parents on Culion yearly. The Philippine Health Service inspected and gave injections to these children regularly, and monthly reports on the children's health were given to the parents. If a child was discovered to have leprosy, he or she was immediately transferred to San Lazaro Hospital.[74]

CONCLUSION

The social stigma associated with leprosy was deeply entrenched in the late nineteenth and early twentieth centuries. In countries where leprosy was prevalent, the segregation and isolation of those afflicted with leprosy was looked upon as the only solution to protect the country. Hence, colonies were designed as places of exile where the afflicted were forcibly sent with the hope that the disease would eventually die along with the exiles.

With their fate sealed in their segregation and isolation, Culion inmates left their destiny to the authorities, who provided them with homes, created a socio-physical environment that simulated aspects of village life in the world beyond the colony, constantly attempted to improve the colonists' welfare, and carried out scientific research to prevent and cure leprosy.

Throughout the American period, reports justified the policy of isolating people afflicted with leprosy by pointing out that the greater majority of the inmates had better houses, better clothing, and better food in the colony than they had enjoyed before their transfer to the island. Quite a number of colonists confirmed this fact.

THE INMATES WERE VERY MUCH AWARE THAT THEY WERE UNLIKELY TO LEAVE CULION.

In Culion, neither rigid walls nor barbed wire confined the colonists, which were the standard physical features ofthe leprosaria in other countries. Culion's colony gates, the Upper and Lower Gates, were the only manifestations of their separation from the world of those who did not suffer from leprosy.

Even with the separation of the living quarters of the *sanos* and inmates, many facilities in the colony proper were programmed for the communities to congregate and socialize during the day. There were several plazas, open spaces, and social and religious halls which provided opportunities for a diverse range of social interactions and pursuits that supported community health. The open fields and rolling terrain allowed them to interact with the natural environment and provided physical activity. Inmates were permitted go to any part of the island, subject to rules and regulations which they themselves formulated.

The inmates were very much aware that they were unlikely to leave Culion. Leprosy had scarred them for life, and if they were cured of their affliction, they bore physical deformities which were repulsive to people without leprosy. Cured inmates who returned to their provinces begged to come back because their families and friends had disowned them. Their life was in Culion and they would gladly die and be buried there.

For the doctors, nurses and religious staff, having daily contacts with the *taga-loob* was part of their tour of duty. It could also be the fact that they realized that leprosy was not as communicable as perceived by the outside world. While only the most persevering ones accepted the Culion assignment, many of them served the afflicted inmates for several decades. Dr. Wade, the eminent pathologist, arrived in Culion in 1920 to head the Leonard Wood Memorial Research Laboratory and stayed on the island until his death in 1968. His remains as well as that of his wife, Dorothy Wade, are buried in the cemetery of Culion reserved for those without leprosy.

Life in Culion for both *taga-loob* and *taga-labas* was far from ideal, but with the situation at hand, both communities strove to make their lives as normal as possible. In all aspects of life—physical and mental health, economic, leisure, social and cultural well-being—all residents of Culion Island interacted. There was mobility within the segregation of Culion.

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Front of the old stone "hospital" for persons afflicted with leprosy in Cebu.

LANDSCAPES OF ISOLATION: SELECTED LEPROSARIA IN LUZON AND THE VISAYAS

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INTRODUCTION

Leprosy is a worldwide disease whose symptoms have led people to treat leprosy victims as outcasts—"unclean" individuals who imperil the well-being of society and who, thus, must be isolated so they cannot transmit the disease. This impulse was manifested by late nineteenth and early twentieth century government policies that forcibly isolated victims of leprosy in leper colonies and leprosaria in order to stop them from infecting their communities and to provide the medical treatment needed to prevent the disease's devastating progression. Such policies did not go unopposed. Critics pointed out the undesirable consequences of isolating leprosy victims—usurpation of individual freedom, disruption of family life, and disturbance of relations between the individual and society.[1] Nevertheless, such objections did not deter late nineteenth and early twentieth century American colonial officials in the Philippines from developing policies to isolate and segregate those infected with leprosy to curtail the spread of the disease. Drawing from their experiences of containing leprosy in the National Leprosarium located in Carville, Lousiana and Kalaupapa Peninsula at Moloka'i, Hawaii, the American authorities decided to build similar institutions in the Philippine Islands.

While the Amercian policy isolation and segregation is well documented, less documented are the shaping of landscapes to aid the implementation of this policy. This chapter examines how changes to the landscapes of four selected leprosaria in Luzon and the Visayas mirrored the American policy of isolating people with leprosy front "healthy" populations. The four leprosaria are the Culion Leper Colony (1906), the Western Visayas Treatment Station in Sta. Barbara, Iloilo (1927), the Eversley Childs Treatment Center in Jagobiao, Mandaue, Cebu (1930), and the Central Luzon Sanitarium in Tala Novaliches, Rizal (1940). The paper two points.

1. The four leprosaria exhibited a set of common landscape-related elements designed to contribute to the general well-being of the leprosy sufferers: situated on rolling or sloping terrain, a town with complete basic infrastructure, organized political and socio-civic organizations, and a fervent practice of religion.

2. However, these elements changed in reaction to changes in scientific and medical knowledge about leprosy which occured between 1900 and 1940.

LANDSCAPES COMMUNICATE THE VALUES BELIEFS, AND PRACTICES OF THEIR MAKERS

The term, landscape, is an essential concept in the disciplines of geography and history. Proponents of landscape analysis and interpretation define this concept in various ways.[2] However, there is general agreement that the term encompasses two ideas about landscapes: (1) they are physical environments; and (2) "a comprehensive product of human action such that every landscape is a complex repository of society."[3] Landscape analysis and interpretation focus on describing the ways in which landscapes communicate the values, beliefs, and practices of their makers and proceeds from three principles: (1) the builders of a landscape must be understood in terms of their own historical context; (2) elements of a landscape must be studied within its geographical context; and (3) the reading of a cultural landscape presupposes some basic knowledge of physical landscape.[4]

LEPROSY IN THE PHILIPPINES UNDER THE UNITED STATES: A HISTORICAL BACKGROUND

At the turn of the twentieth century, American colonial officials considered leprosy as a top public health problem. Although a census conducted by the American colonial government estimated that the total number of leprosy victims did not exceed 10,000,[5] the government was determined to prevent the further spread of this disease. Two colonial officials, Dean C. Worcester (Secretary of the Interior) and Victor G. Heiser (Director of the Bureau of Health) conducted a series of long deliberations that resulted in implementing an already established, but controversial, policy of compulsory segregation of persons with leprosy by isolating them on an island. The American government would build a leper colony in the Philippines as it had done in Kalaupapa on the island of Moloka'i, Hawaii.[6]

The decision to implement compulsory segregation was largely influenced by international guidelines that were in place at that time. The First and Second International Leprosy Congresses which were held in 1897 and 1909 in Berlin and Bergen, respectively, stated that leprosy was highly contagious and proposed isolation as the best means to contain the disease.[7] In the Philippines, American colonial authorities argued that if persons who were suffering from the early stages of leprosy could be convinced to settle in a colony, "they could have their own homes, cultivate the soil, and in general lead a free out-of-door life, instead of being practically imprisoned and compelled to pass their days in company with fellow unfortunates..."[8]

CULION LEPER COLONY, CULION ISLAND, NORTHERN PALAWAN

Culion Leper Colony was the first facility established by the American colonial authorities to isolate and treat victims of leprosy, although it was not their first choice. By December 1901, a military board had identified the island of Cagayan de Joló as a favorable location. However upon inspection of Cagayan de Joló, a committee comprised of the Secretary of the Interior, Commissioner of Public Health, and the Sanitary Engineer from the Bureau of Health rejected the island because of a "lack of a favourably situated supply of drinking water, the absence of any port, and the presence in the island of some 3,000 Moros."[9] Instead, the committee chose Culion Island as the site for the colony, due to "Its healthful climate, rich soil, extensive cattle ranges, abundant water supply, good harbours and small population."[10]

CULION LEPER COLONY WAS THE FIRST FACILITY ESTABLISHED BY THE AMERICAN COLONIAL AUTHORITIES TO ISOLATE AND TREAT VICTIMS OF LEPROSY, ALTHOUGH IT WAS NOT THEIR FIRST CHOICE.

Culion is situated 200 miles south of Manila, deep in Coron Bay and surrounded by small islands. The remoteness of the site was perfect for the isolation of persons suffering from leprosy from centers of population.

On 22 August 1904, Civil Governor Luke Wright issued Executive Order 35 declaring Culion as a government property, leper colony, and stock farm.[11] The colony was situated on the northeast coast of the island with the colony proper (the area where the inmates would be confined) located in a hilly area 30 meters above sea level. Construction work commenced in 1905. Despite the difficulties encountered, these were overcome. When the colony opened in May 1906, streets from the harbor leading to the colony proper, cottages for the patients, and quarters for the hospital staff and employees had been completed as well as a hospital, town hall, dining hall, open-air theater, public toilets and baths, and a cemetery.

Physically fit patients were soon hired as employees to do menial jobs like bearing litters to bring sick patients to the hospital and burying the dead.[12] Others worked as sanitary inspectors, nursing assistants, kitchen assistants, firemen, carpenters, and post office and telegraph office staff, etc. A police force of 15 to 18 members dealt with minor altercations among patients.[13] The patients were given the freedom to earn a living either by growing corn and vegetables, raising pigs, or fishing.

Opportunities for the patients to live a normal life were planned and developed. For example, patients who were musically talented became members of a brass band that welcomed new groups of patients to Culion. They played also on special occasions, such as dances, celebration of holidays, wedding receptions, and concerts which were held in an open-air theater, located at the center of the colony. Here, patients also enjoyed watching movies, phonograph concerts, as well as occasional indoor baseball games. Cockfighting and drinking were favorite leisure activities among male patients.

As the population of the colony grew, the systems for supplying food and water were improved and expanded to meet the demands of a growing patient population. For example, an experiment conducted in 1922 by a team of nutritionists and dieticians resulted in changes in the patients' food rations to include more locally grown vegetables like eggplants, *pechay* (Chinese cabbage), radishes, tomatoes, sweet potatoes, etc.[14] Food, clothing, and goods like cigarettes, candies, and reading material were gathered from private benefactors and organizations from the United States and the Philippines, largely due to the efforts Governor-General Leonard Wood and Dorothy Paul Wade, which greatly benefitted the patients. The initial water supply in the colony proved to be inadequate, especially at the onset of the dry season, so a team of hydraulic engineers looked for additional sources of potable water in the nearby areas. Government subsidies were considerably increased over the years and used not only for the maintenance of the colony but for developing more effective medical treatments that benefited all the patients.

By the 1920s, Culion island was considered to be the largest facility of its kind in the world. The colony proper encompassed around 40 acres (16 hectares) of land.

At odds with the idea of colony as a good place to live and work while receiving treatment for leprosy was the fact that leprosy sufferers were forcibly separated from their communities, families, and friends. The likelihood of being cured and returning to their former lives was very low. Permanent isolation from wider world was the default outcome of being sent to Culion. This was marked by the division of island into two domains: the realm of the *sanos* (healthy persons, that is,

mostly the hospital staff and employees) and the realm of those afflicted with leprosy. The landscape of these two realms had common elements that reinforced the idea of separation: each realm had its own hospital, theater, post office, and cemetery.[15] It is interesting to note that as the years passed the expansion of the two realms maintained their separateness. The realm of the afflicted expanded to include three nearby barrios—Tiza, Rizal, and Osmeña. Likewise, the realm of the *sano* expanded to include barrios of Jardin, Balala, and Culango located on the other side of the island.

AT ODDS WITH THE IDEA OF COLONY AS A GOOD PLACE TO LIVE AND WORK WHILE RECEIVING TREATMENT FOR LEPROSY WAS THE FACT THAT LEPROSY SUFFERERS WERE FORCIBLY SEPARATED FROM THEIR COMMUNITIES, FAMILIES, AND FRIENDS.

ESTABLISHMENT OF REGIONAL TREATMENT STATIONS

The 1920s saw a broader understanding of how leprosy was transmitted and might be cured. The Third International Leprosy Congress held at Strasbourg, France in July 1923, passed several resolutions, the most notable of which was the call for a more humane form of isolation that would permit those afflicted to be near their families.[16]

In the Philippines, politicians, concerned citizens, policy makers, and members of the medical profession began to criticize the American policy of segregation. They called for sweeping changes to the laws governing the treatment of patients, based on recent studies and research about leprosy. For example, Dr. Jose Albert opined that the Culion experiment "...is a failure... because the propagation and diffusion of leprosy have not diminished to any perceptible degree" and proposed that "lepers with open lesions be segregated in appropriate hospitals whenever their isolation at home is considered by competent authorities as unsatisfactory and unsafe."[17] Likewise, Dr. Luis Guerrero recommended in 1925 that "sanatorio-hospitals be established in the most central points of the principal regions in the Philippines in order that the patients will be more easily accessible to their friends and relatives."[18] The Philippine press published critical news articles, editorials, and opinion pieces about the situation in Culion. The segregation policy was dubbed as "cruel, inhuman and unscientific" and it was also alleged that a "large group of patients are being subjected to different cures... [T]hose who happen to be subjected to a cure which proves to be fatal represent the extremely unfortunate." Other "anomalies" in Culion were exposed with the ultimate objective of convincing the legislature to conduct an investigation. The idea of constructing provincial treatment stations and hospitals was also floated as a better option rather than banishing leporsy sufferers to a faraway island against their will.[19]

IN THE PHILIPPINES, POLITICIANS, CONCERNED CITIZENS, POLICY MAKERS, AND MEMBERS OF THE MEDICAL PROFESSION BEGAN TO CRITICIZE THE AMERICAN POLICY OF SEGREGATION.

Colonial health officials were convinced, however, that discontinuing the segregation policy on Culion and building smaller regional hospitals "should be discouraged from both an economic and sanitary standpoint, since it would be susceptible to abuses which would tend to defeat the object of segregation, the benefits of which are already in sight."[20] In 1925, the Culion Medical Board argued that segregation "could not easily be dismissed as a total failure although it did not also yield a satisfactory result."[21] Nevertheless, the board presented initial plans for revising the treatment and care of "cases who are found responding to treatment [should] be assigned in Treatment Stations developed as an asylum so that they will be available at all times to treating physicians... [T]hese

multiple treatment stations must be located in the principal leprous regions."[22]

Although leprosy patients could still be confined to these stations, they would be closer to their families and friends than patients committed to the Culion colony.

These plans for constructing regional leprosaria led to the establishment of the Western Visayas Treatment Station in Santa Barbara, Iloilo (1927); the Bicol Treatment Station in Legazpi, Albay (1929); the Eversley Childs Treatment Center in Mandaue, Cebu (1930); the Zamboanga Leprosarium (1930); and the Central Luzon Sanitarium in Tala, Novaliches, Rizal (1940).

THE WESTERN VISAYAS TREATMENT STATION IN STA. BARBARA, ILOILO

Between 1906 and the 1920s, a significant number of leprosy sufferers had been forcibly brought to Culion from the province of Iloilo in the Visayas. However, awareness of new findings about how leprosy was transmitted and could be treated grew among people concerned with the patients' welfare. This led Ilonggo speaking residents from Iloilo Province in 1924 to call upon the Philippine Legislature to support the establishment of a hospital in Iloilo for leprosy patients.[23] In 1926, Leonard Wood visited the province and appointed a committee to obtain funds to purchase a site for a local treatment station.[24]

Local philanthropists donated funds and property among the rolling hills of Santa Barbara just outside Iloilo to establish the Western Visayas Treatment Station in 1927. Most of the early patients admitted to the institution were patients who had been formerly confined in the Iloilo Provincial Jail.[25] In 1932, Rosario Gonzaga de Jesena, who had donated the initial land on which the treatment station was built, donated more land. The government also purchased additional parcels of land until the treatment station occupied a total of 22 hectares.

LOCAL PHILANTHROPISTS DONATED FUNDS AND PROPERTY AMONG THE ROLLING HILLS OF SANTA BARBARA JUST OUTSIDE ILOILO TO ESTABLISH THE WESTERN VISAYAS TREATMENT STATION IN 1927.

The treatment station had a small medical staffs—some of whom came from the Culion colony—to care for patients from the province of Iloilo and the neighboring provinces on Panay Island. By 1932, the treatment station was nearing full capacity.[26] From 1937 onwards, major construction work commenced. Small hills were levelled and roads were constructed. A plaza was laid out which included not just an open space but a playground as well. Separate quarters for male and female patients were added to the existing ones. A school was also opened, which came under the direct supervision of Pastor Alberto Franco, a Baptist minister. The station's fertile soil made the site an ideal place for agriculture. Soon, some physically fit patients engaged in the cultivation of rice and vegetables and the raising of poultry.[27] The health authorities praised these activities as good examples of how to gradually train the patients to be self-sufficient.[28]

When the Pacific War broke out in 1941, the treatment station was abandoned by the employees. The patients were relocated to a safer place—the mountainous area of Tinago, Alimodian about 19 kilometers from the town of Santa Barbara. They were able to return to the treatment station in late 1943. However, the institution only resumed operations after the liberation of the Philippines in 1945. Because new patients were admitted to the treatment station, additional dormitories were built using light construction materials. The community of patients now extended up to Purok Milagrosa, which was a kilometre away from the original site of the treatment station. Economic programs from the late 1930s like hog raising, poultry raising, and vegetable gardening were revived to help patients

generate modest incomes.

Aside from concentrating on the rehabilitation and improvement of the treatment station's physical facilities, the social well-being of patients became one of the paramount concerns of the authorities so that the patients would feel that they were part of a typical community. An orchestra, which played music on all occasions, was organized by the Chief of the Sanitarium, Dr. Jesus Puno. Engagement in sports was strongly encouraged not just as a form of leisure but also as a part of medical therapy. As a result, several sports teams were organized and competed in athletic meets with the surrounding communities. The recreation hall was repaired and new structures such as a library, cooperative store, school building, infirmary, and basketball court were constructed. Slowly, the treatment station recovered from the ravages of war.

THE SOCIAL WELL-BEING OF PATIENTS BECAME ONE OF THE PARAMOUNT CONCERS OF THE AUTHORITIES SO THAT THE PATIENTS WOULD FEEL THAT THEY WERE PART OF A TYPICAL COMMUNITY.

EVERSLEY CHILDS TREATMENT CENTER IN JAGOBIAO, MANDAUE, CEBU

The construction of the Eversley Childs Treatment Center was tied to the long history of treating leprosy in Cebu. Existing historical records indicate that in the early nineteenth century, the disease had spread rapidly. The Bishop of Cebu, Joaquin de Sopetran, decided to build the Hospital de San Lazaro in 1817 to house people afflicted by leprosy who freely roamed the streets of Cebu. However, the hospital eventually became crowded because Spanish colonial officials in the province sent patients from all over the Visayas to the hospital, which resulted in some patients moving out and settling in the outskirts of the city and on the island of Mactan.[29] In 1854, Bishop Romualdo Gimeno had another structure of concrete and high-quality wood built to accommodate 100 patients. Male and female patients were segregated in the wards separated by a partition.[30] However, patients were mostly free to come and go. When the Americans came to Cebu on 21 February 1899, they found that the Hospital de San Lazaro, had

THE CONSTRUCTION OF THE EVERSLEY CHILDS TREATMENT CENTER WAS TIED TO THE LONG HISTORY OF TREATING LEPROSY IN CEBU.

> two hundred and forty lepers living in one hospital composed of a stone building and two nipa barracks. The former was unsanitary and unfit for the purpose and the latter were in the last stages of decay and ruin. There was no fence around the place and no way of keeping the inmates confined and since the hospital was found on the outskirts of Cebu, patients mixed freely with the people.[31]

American officials launched a campaign to gather and confine those suffering from leprosy in the old hospital. These people were eventually deported to Culion island when it opened in 1906. However, "collectors" continued their job of rounding up leprosy victims for deportation to Culion. In 1922, the Cebu Leper Detention Camp was established "to serve solely as a preparatory station for patients to be transported to Culion Leper Colony in Palawan."[32]

Modern leprosy treatments in the early 1920s resulted in the discharge of over 1,000 patients from the Culion colony. In view of this development, the American colonial government's policy of compulsory confinement was modified. The establishment of skin dispensaries, where incipient cases of leprosy could be detected and treated, were highly favored by other health officials. Similarly,

establishing regional treatment stations was proposed by some health authorities so that patients could be treated, but at the same time they would not be totally separated from their families. By 1928, the Philippine Health Service had piloted the operations of a skin dispensary in Cebu, where leprosy was prevalent. The Cebu Skin Dispensary that was established in Cebu, Cebu treated around 200 patients with incipient leprosy in its first year of operation.[33]

The Bureau of Public Health set up a committee headed by Dr. Herbert Wade and Dr. Vicente Kierulf to find a site for a treatment station in the province of Cebu. In June 1928, they chose a hilly and sloping site in Jagobiao, Mandaue. The site was situated 150 meters above sea level, located near a big spring, and studded with coconut trees and mangroves. The Provincial Government of Cebu purchased 27 hectares of high ground and 26 hectares of swamp lands. Senator Sergio Osmeña donated some adjoining parcels of land on which to build the treatment station and Mr. Eversley Childs of New York donated USD2,000,000 for its construction. The treatment station's steel and concrete buildings were designed to accommodate more than 100 patients from the old hospital. The institution was formally opened on 30 May 1930 and named Eversley Childs Treatment Center after its donor.

The treatment station had the standard features and structures of a regional treatment station: separate quarters for male and female patients; residences for medical staff and hospital employees; and an administration building, kitchen, recreation areas, school, chapel, cemetery, etc. The management of the center made the physical and social well-being of the leprosy patients its first priority. To this end, the management facilitated the community-building activities of various groups. Musically talented patients organized an orchestra, which provided music for special occasions and celebrations. The children could go to an elementary school, the Leonard Wood Elementary School, which was run by the Bureau of Public School. When they finished primary school, they could go to Mabini High School, managed by the local government, with subsidies coming from Cebu Friends of Hansens, Inc. The patients held elections for the positions of mayor, vice mayor, and three councillors. These elected officials protected the interests of all of the patients confined in the institution by serving as intermediaries between the hospital administration and patients. Indeed, life inside the sanitarium was "perfectly normal, full of activity and delightfully interesting...but in order to attain a state of contentment in confinement, it is very necessary for one to be detached from pride...to accept with calm and resignation the fate which the Lord prepared for us."[34] Regarding this last point, Catholic groups, like the Legion of Mary and the Confraternity of the Most Sacred Heart of Jesus, played an important role in the lives of the leprosy patients as they provided extension and community services inside the center, like catechism classes and training in the art of "fellowshipping."[35]

TOWARDS A LIBERAL POLICY ON SEGREGATION

In 1935, the Philippine Legislature proposed Senate Bill Number 101 to radically alter the existing system of controlling leprosy in light of the newest findings about the disease—especially that the assumption that leprosy was highly contagious was not factually accurate. The U.S. Governor General, Frank Murphy, vetoed the bill. However, he organized a Leprosy Commission on 23 July 1935. The principal objective of the commission was "to make a thorough study of the scientific, public health, social and economic aspects of the problem."[36] In September 1935, the committee submitted its recommendations, the most significant of which were the following: (1) the program of segregating persons with leprosy should be continued through the implementation of group

segregation (patients would be confined to regional colonies and treatment stations near their homes); (2) regional treatment stations should be increased so that early cases could be detected and treated immediately; and (3) the Leper Department of the San Lazaro Hospital in Manila should be closed and patients from northern and central Luzon should be sent to a regional treatment station to be established near Manila.

In 1935, the Philippine Legislature proposed Senate Bill Number 101 to radically alter the existing system of controlling leprosy in light of the newest findings about the disease

Commonwealth President Manuel L. Quezon spoke before the First National Assembly on 30 September 1936 to call on the legislators to appropriate PHP500, 000 for the establishment of three leprosaria in Luzon near Manila, the Cagayan Valley, and the Ilocos region. The Assembly passed Commonwealth Act No. 161 which allocated the asked for appropriation for the three leprosaria.[37] In November 1936, the president issued the final approval for their construction. This move aimed to lower the number of patients being sent to Culion and to make possible the eventual transfer of patients in the San Lazaro Hospital to the three new regional facilities.

The leprosarium nearest to Manila was located in the rolling hills of the Tala Estate in Rizal Province, covering a land area of 788 hectares.[38] The plans to establish leprosaria in Cagayan Valley and the Ilocos region never materialized.[39]

CENTRAL LUZON SANITARIUM IN TALÁ NOVALICHES, RIZAL (NOW NORTHERN CALOOCAN)

Construction of the Central Luzon Sanitarium (CLS) commenced in 1938 when the area was cleared, and the Novaliches-Ipo provincial road was paved with stone and gravel. A paved road was cut across the hills to connect the colony to the provincial road. The institution opened on 17 May 1940 as the CLS, with 30 officials and employees and 40 single male patients.[40] The CLS was conceived as an agricultural colony that should be

> located near the city of Manila, and should be operated in connection with a treatment station for the segregation of lepers who are not colonists. This combined colony and treatment station would provide for the segregation of all patients from northern and central Luzon. [41]

When the Pacific War broke out, the number of patients admitted to the hospital had risen to 600. However, due to the difficulties of the times, the management had to send home some patients until only 83 remained by 1945, which now included female patients [42]

From 1947 to 1949, the patient population of the CLS increased abruptly, due to the relocation of former patients of the San Lazaro Hospital in Manila to the CLS. There was a dire need for additional funds to build new dormitories for patients and quarters for doctors. Requests for appropriations from the government were approved, along with donations from the Philippine Charity Sweepstakes Office. In a short while, the housing problem was solved.

The establishment of Tala Advisory Council in 1949 gave patients the right to participate in decision-making processes that involved issues concerning the management of the institution. The council's primary responsibility was "...to help promote and protect the interest and welfare of the Hansenites." [43] As the council's name implies, it advised the Chief of the Hospital, particularly on

issues concerning the moral, physical, and material needs of the patients.

> THE ESTABLISHMENT OF TALA ADVISORY COUNCIL IN 1949 GAVE PATIENTS THE RIGHT TO PARTICIPATE IN DECISION-MAKING PROCESSES THAT INVOLVED ISSUES CONCERNING THE MANAGEMENT OF THE INSTITUTION.

Like the other regional treatment stations established in the late 1920s and 1930s, the CLS featured several buildings and areas intended for different purposes: administration building, main hospital, social hall, post office, chapel, cemetery, and recreational areas like the small park *(glorietta)*, basketball court, and improvised theater. In the early 1950s, Father Anthony Leo Hofstee, an American chaplain formerly attached to the U.S. 13th Air Force, decided to settle in Tala. Aside from ministering to the spiritual needs of patients, he also founded a school and ensured that the social and psychological well-being of patients were attended to. He encouraged the formation of a string band that visited wards to entertain disabled and bedridden patients. Several religious groups became active, like the Legion of Mary and the League of the Sacred Heart. The Franciscan nuns maintained the nursery where babies born to leprosy victims were taken care of.

Other private and civic organizations came to Tala to support the patients and their families by teaching them to be self-reliant instead of depending on the meager rations provided by the government. For example in 1968, the Philippine Association of the Sovereign Military Hospitaller Order of Malta purchased a 24 hectare parcel of land adjacent to the Tala community and set up livelihood programs to teach people how to start small businesses, vegetable farms, and piggeries so that they would be able to make a modest living.[44]

The Central Luzon Sanitarium served its stated purpose, that is, to become the new home to leprosy patients, where close relatives could easily visit them because of the accessibility of its location.

CONCLUSION

The four leprosaria in Luzon and the Visayas were situated in landscapes of isolation, which reflected the assumptions that American policy makers and most Filipinos held—leprosy was a highly contagious disease and the most effective way to its spread is the segregation and isolation of those ill with leprosy.[45] Despite their remoteness at the time they were built, they were made relatively accessible through regular visits by ships in the case of the Culion colony and the construction of rough roads in the case of the Luzon and Visayan treatment stations.

While the present study has focused on a particular geographic context within a historical period, the larger picture of international development of scientific and medical knowledge about leprosy and the establishment of leprosaria cannot be ignored. The establishment of Culion as a leper colony was a product of the prevailing notions at that time—isolation and segregation were deemed as the most efficient way to prevent the spread of leprosy, as dictated by international guidelines. Culion's landscape was shaped by American colonial policy-makers, who slightly differed from their European counterparts in combating the dreaded disease. Eventually, the colony at Culion became the "model landscape" for the regional treatment statation that were established in the 1920s and 1930s. There were common elements and characteristics—they were built on rolling or sloping terrain, often associated with a salubrious environment; an entire community or town was created; political and socio-civic organizations were organized; and the general well-being of the patients was given paramount attention.

> THE COLONY AT CULION BECAME THE "MODEL LANDSCAPE" FOR THE REGIONAL TREATMENT STATATION

THAT WERE ESTABLISHED IN THE 1920S AND 1930S.

Another striking commonality of the four leprosaria was that patients practiced their religion fervently. In the Philippines where Christianity has been traditionally practiced, religious men and women, coming from different orders and denominations dedicated their lives to succor the patients who were confined in the leprosaria. Through the pursuit of religion, the patients held on to the belief that if they continue to be pious individuals, they would ultimately be redeemed from their sufferings.

In time, patients gradually learned how to peacefully accept their fate, partly because they were in the company of their fellow sufferers and partly because they settled in a community where they enjoyed a life, as close to normal as possible to the life that they were used to.

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Culion Coins from 1913, 1920, 1922, 1925

From Collection to Release: Segregated Lives in the Culion Colony, 1906–1935

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INTRODUCTION

At the beginning of the American occupation of the Philippines in the twentieth century, colonial authories regarded leprosy as a serious medical and health problem.[1] In its 1900 report to the President of the United States, the War Department indicated that out of a total population of 7 million people, 30,000 were afflicted with leprosy.[2] This figure was noteworthy to the Americans when compared with figures from Cuba and Puerto Rico—the other newly acquired territories of the United States from the Spaniards—that had only 500[3] and 35 cases, respectively.[4] The Americans adopted a policy of segregating persons afflicted with leprosy in the Philippines in order to contain the disease, especially in the absence of an effective cure.

Persons diagnosed with leprosy in the Philippines were to be identified, arrested, and isolated from their communities to protect the public from infection. To legalize this policy of exclusion, the Insular Board of Health—the institution that supervised leprosy control in the Philippines—drafted and recommended laws for the Philippine Commission to adopt in order to address the leprosy problem in the country. Culion Island north of Palawan was identified as the ideal site for the leper colony[5] as it was presented to have a healthy climate, rich soil, extensive cattle range, adequate water supply, and a good harbor.[6]

Act No. 490 mandated the establishment of the Culion Leper Colony in 1902. When construction was about to commence, however, a malaria outbreak occurred in Manila that prompted the authorities to temporarily stop the construction of the leper colony. This was due to the fact that the sanitary engineer responsible for the construction had to return to Manila to help the Bureau of Health fight a malaria outbreak there. By the time the engineer returned to Culion, Act No. 490 had elapsed, and a new law needed to be passed to resume the construction of the colony. Thus, Executive Order No. 35 was enacted on 22 August 1904. The order strengthened Act. No. 490 by declaring Culion not only to be a leper colony, but also government property.[7] Consequently, all the residents of the islands were evicted and transferred to the nearby island of Busuanga. Additionally, the government bought private property on the island. Buildings in satisfactory condition were transformed into housing for the arriving patients. A sewage system, network of roads, hospitals, and dormitories were constructed. The Culion Leper Colony was officially opened in 1906, ushering a new era in the history of leprosy in the Philippines.

While the medical reasons for the policy of segregation have been explained by the architects of the policy and examined by various researchers, the social history of the policy has not been as fully explicated, especially from the viewpoint of people who were forcibly brought to the island. Hence, this paper has two objectives.

- The paper provides a narrative of the experience of the Hansenites who formed the colony of the afflicted in Culion during the period from 1906 to 1935. The narrative describes how they were “collected” from their communities and how the Culion Leper Colony was transformed into a community.
- The paper describes the establishment of the colony as a part of the Americans’ colonial project to transform Filipinos socially, economically, and politically. Unlike other Philippine communities that were being integrated into a single colony in which this transformation would be accomplished, the Culion colony was different in that it was intended to be both a part of, but segregated from, the larger

Philippine colony. The system of segregation both within and outside Culion and the kind of community that resulted from this system is the second focus of the paper.

"COLLECTION" AND THE SEGREGATION POLICY

The aim of the "collection" campaign was to eradicate the dreaded disease from the islands. This was the first necessary step in implementing a policy of segregation consistent with the First International Congress on Leprosy in Berlin (1897) that recommended isolation as the most appropriate measure against leprosy. According to then Director of Health Victor Heiser, it became necessary to project the collection of patients afflicted with leprosy as different from the other public health campaigns launched in the archipelago several years before. Learning from the lessons of earlier cholera campaigns that saw the application of colonial public health measures being perceived by the local population with great suspicion, enmity, and animosity that prevented the health authorities from fully implementing the measures to control the epidemic, the collection tours for Culion were preceded by a campaign to educate the public. Photographs and movie reels were shown to potential colonists to entice them to voluntarily go to Culion without resistance.[8]

THE AIM OF THE "COLLECTION" CAMPAIGN WAS TO ERADICATE THE DREADED DISEASE FROM THE ISLANDS

The actual plan for the "collection" of patients afflicted with leprosy was envisioned as early as 1901, with the legalization of the move taking effect as a result of the passage of the Segregation Law of 1907 (Act No. 1711), entitled "An Act providing for the Apprehension, Detention, Segregation and Treatment of Lepers in the Philippine Islands." As archivist-historian Ricardo Punzalan[9] notes, the terms of the act reflects the criminalization of leprosy in the eyes of the state. Apprehension, detention, and segregation were part of the discourse on criminality and correction of the late nineteenth and early twentieth centuries and penetrated the discourse of colonial medical and public health policies in most parts of the world during that period. At the same time, the last provision of the act, which called for the treatment of leprosy patients, was more of a future direction of the policy, as a real treatment of the disease had yet to be found, and treatment of the disease had yet to pass the experimental stage.

The act also provided strong state powers not only for the central government, through the Bureau of Public Health, but also to the local municipal government.

> The Director of Health and his authorized agents are hereby empowered to cause to be apprehended, and detained, isolated, segregated, or confined, all leprous persons in the Philippine Islands, and upon application of the Director of Health it shall be the duty of every Insular, provincial or municipal official having police powers to cause to be arrested and delivered to the Director of Health, or his agents, any person alleged or believed to be a leper...[10]

The health authorities were given wide judicial and police powers to implement the law, through their authority to enlist the help of all relevant local and national authorities to the campaign. It gave the director of health almost absolute power to implement the law and compelled the other authorities to follow it. Failure to do so was a punishable offense. The law also charted the evolution of colonial health policy, in general, and the policy of containing leprosy in particular. (See Rene Escalante's paper in this volume.)

THE HEALTH AUTHORITIES WERE GIVEN WIDE JUDICIAL AND POLICE POWERS TO IMPLEMENT THE LAW, THROUGH THEIR AUTHORITY TO ENLIST THE HELP OF ALL RELEVANT LOCAL AND NATIONAL AUTHORITIES TO THE CAMPAIGN.

In order to lure the afflicted into positively accepting the "collection" program, the Americans depicted the leper colony, Culion, as a paradise (Figure 2) with modern sanitary hospital facilities for treating leprosy and a place with free food, shelter, and arable land. Additionally, colonists were promised that they would have a free hand in running the colony. By offering all these benefits, the American officials hoped that the colonists would not oppose the segregation policy and voluntarily segregate themselves on the island of Culion.

MOBILIZATION AND ITS PROBLEMS

Mobilizing local officials for collecting patients afflicted with the disease eventually exposed the limitations of implementating the program. The colonial authorities soon learned that some local politicians were reporting the relatives of their political rivals as afflicted with the disease for collection by the authorities so as to pose serious problems to one's political opponents. There were also instances when people suspected of being afflicted were forewarned of the collection day so that they could leave their villages and await the departure of the collection teams before returning.

Resistance to the collection trips were noticeable even by the implementers of the program themselves. In some of these collection trips, families of the afflicted would hide those being hunted in the rice fields until the collection tours had passed their areas. At times, even after being "collected", afflicted patients would rather fatally jump off the ships in the Culion Harbor outside of the reefs and drown themselves rather than be brought into the colony.'[11]

FAMILIES OF THE AFFLICTED WOULD HIDE THOSE BEING HUNTED IN THE RICE FIELDS UNTIL THE COLLECTION TOURS HAD PASSED THEIR AREAS.

Eustaquio Montalbo, a patient from Lucena, Tayabas described what could have been a common experience of the afflicted who hid from the authorities in order to escape "collection" as he narrated his experience as follows:

> For four years, I hid (from the authorities). As a result, my right hand totally crippled, and my left hand were (*sic*) fast becoming crippled too. My nose and ears and even my face became very large indeed and swelled greatly until I could hardly breathe. I became desperate, and nothing seemed sweet, but to be laid in the grave."[12]

Some of the afflicted individuals resorted to violent resistance. For example, rather than submit to the authorities, patients in Cebu would flee their villages to nipa swamps and fight the collection teams with *bolos* (machetes).[13]

The initial Filipino resistance to collection was due to what the patients perceived as possible consequences of segregation.[14] Firstly, there was no assurance that they would be able to return home. Secondly, the length of incarceration was uncertain. Rather than being frightened by the illness, the Hansenites feared the eventual separation from their families. Thirdly, social relations and community life in the colony were uncertain. Culion was a new community consisting of people from different ethnolinguistic groups with diverse backgrounds, social status, beliefs, values, norms, and standards. The patients worried whether these groups could live harmoniously be in constant conflict in the

Culion Leper Colony given the strong regional rivalries between these groups. The colonists were, therefore, uncertain about how the government would manage the individual differences and the regionalistic tendencies of the people in this new community. Sufferers within a particular province were gathered together before they were carried by the coast guard cutters *Polillio* and *Mindanao* to the island of Culion.

ARRIVAL OF THE COLONISTS

On 27 May 1906, the *Polillo* and the *Mindanao*—arrived in Culion island with the first batch of patient colonists after a series of "collection trips" from various parts of the archipelago. These trips were aimed at collecting patients afflicted with leprosy, segregating them from the rest of the population, and isolating them in a remote island far from the other centers of human population. It was the beginning of a new era in the campaign at eradicating leprosy in the islands, with the hope that the social and medical experiments that will be applied in the island will eventually lead to the total eradication of leprosy not only in the Philippines, but also the entire world.

When the *Polillo* and the *Mindanao* docked in Culion, the Philippine Bureau of Public Health's collection program was deemed to be institutionally initiated. Although the patients came from all over the Philippines, the largest numbers were from Cebu.[15]

The collected patients were welcomed by towering ten-foot quarantine fences. Seeing the fences must have been a terrifying sight for the patients. It may brought home the realization that they were not only miles away from home, but cast upon a far flung island possibly for good—separated from the outside world by the inescapable barbed wire surrounding the colony. This was a very different sight from the picturesque haven presented to them by the authorities prior to their deportation and which had promised them that they could freely move aroundin the island and bathe and fish in the sea. Thus some responded by demanding to be brought back home while others attempted to swim against the strong sea current even before reaching the shore. However, most of them accepted their fate of staying in the island despite the poor conditions that they found themselves in.

THE COLLECTED PATIENTS WERE WELCOMED BY TOWERING TEN-FOOT QUARANTINE FENCES. SEEING THE FENCES MUST HAVE BEEN A TERRIFYING SIGHT FOR THE PATIENTS.

SETTLING IN THE COLONY

In 1906, the colonial authorities and religious leaders of the Culion Leper Colony were theoretically in a position to engineer the social institutions around which the community was being built; that is, they had the authority to shape all aspects of life in the colony to conform with the beliefs, values, and practices that they assumed would best contribute to eradicating leprosy in the Philippines. And, they had the legal power to enforce their authority. However, they found in reality that the policy of segregation and its underlying assumptions would need to be re-evaluated and reoriented following conditions set by the people who were meant to accept, and not challenge, the rightness of segregation. One such set of conditions revolved around the rights to have families, sex, and a married life. These became ongoing flash points of discontinent with which people challenged the colonial officials' authority to prevent them from having sexual relations in and out of marriage and having children, as measures to prevent the transmission of leprosy.

FAMILY, SEX, AND MARRIAGE IN CULION

One of the first issues confronting the authorities was their decision to restrict patients' sexual

relationships with each other. From the beginning, the authorities wanted to not only segregate patients from non-patients but also men from women in order to reduce their opportunities to infect (or re-infect) each other and children resulting from these relationships. To this end, the Culion planners and administrators built separate dormitories for men and women on separate sides of the colony with high barbed wire fences around the women's complex.[16] Moveover, couples were not allowed to marry.

Despite these measures, social relations between men and women could not be controlled. The patients felt that they had a right to sexual relations. This was, in their view, a natural part of life, and this was a view that they pushed.

SOCIAL RELATIONS BETWEEN MEN AND WOMEN COULD NOT BE CONTROLLED THE PATIENTS FELT THAT THEY HAD A RIGHT TO SEXUAL RELATIONS

When the colony started in 1906, the only personnel supervising the 734 patients were four French nuns from the Sisters of Charity of St. Paul of de Chartres and a Jesuit chaplain. Opportunies for men and women to meet were apparently not hard to create. Although the chaplain was aware of the prohibitions, it seems that he was persuaded by the patients, who wanted to marry, to intercede with the civil authorities to let them marry. Protesting women threatened to lynch Director of Health Heiser during one of his visits to Culion unless he issued a statement lifting the policy of gender segregation. This he did and promised to make the proper representations to the Governor General to change the policy on housing and gender segregation in Culion. Housing rules and social prohibitions on the relationships between the members of the opposite sex were consequently relaxed.

In response to the patients' demands and to the fact that they were engaged in widespread concubinage anyway, patients were allowed to marry in 1910. Between 1910 and 1935, a total of 1,419 couples were married in the colony with an average of 54 couples getting married a year (see Table 1).

TABLE 1. NUMBER OF MARRIAGES RECORDED BY THE JESUIT MISSION FROM 1910–1935

YEAR	NUMBER OF MARRIAGES
1910	13
1911	100
1912	75
1913	75
1914	43
1915	19
1916	36
1917	62
1918	82
1919	87
1920	46
1921	76
1922	35
1923	41
1924	39
1925	60

1926	54
1927	42
1928	N.A.
1929	N.A.
1930	N.A.
1931	N.A.
1932	17
1933	244
1934	87
1935	86
TOTAL	1,419
AVERAGE	64.5

SOURCE: Fr. Carl Hausman, "The Culion Leper Colony."

A total of 13 couples wed in 1910, followed by 100 in 1911. Marriage between patients would be allowed until 1928 when once again it was prohibited until 1932. Thereafter, the colony officials did not prohibit marriage in the colony between patients again. The unusually high number of marriages in 1911 and 1933 is probably due to a buildup of couples wanting to marry but were prohibited from doing so.

Victor Heiser relates that

> [The Culion administrators] had discouraged marriage because we did not want the lepers to contract lasting relationships which might entail suffering later if one partner should be cured and dismissed from Culion. But when they produced offspring without benefit of clergy, moral necessities obtruded upon medical ones, and our religious advisers insisted they must marry. Our concern before had been to prevent propagation, but now the birth rate began to increase.[17]

However, the rising number of children resulting from these unions led the colony administrators to take newborn babies away from their parents, placed them in the care of the nuns, and arrange for their adoption (by relatives whenever possible) or for their transfer to an orphanage in Manila. A marriage tax was imposed on the colonists who wished to get married while on Culion, but this was discontinued in 1933.[18] Various other proposals were discussed but not implemented due to opposition from the Catholic clergy. These proposals included compulsory male sterilization before marriage; introduction of contraceptives; and the liberalization of divorce laws in favor of the patient colonists.[19]

> THE RISING NUMBER OF CHILDREN RESULTING FROM THESE UNIONS LED THE COLONY ADMINISTRATORS TO TAKE NEWBORN BABIES AWAY FROM THEIR PARENTS

The 1930s saw another protest over gender separation and marriage. Colony officials revoked the right to marry in 1928 in order to stem the rising birth rate in the colony. Additionally they strictly enforced restrictions on men's rights to visit women and girls in their dormatories. These restrictions required men with leprosy to register every time they visited the women's dormitories, indicating their name, civil status, and relationship to the woman they were visiting. They were also required to carry and show to the authorities a *novio* (boyfriend) permit issued by the family of the woman,

indicating the latter's agreement to the relationship, and the ultimate recognition of marriage of the couple if necessary.[20] In 1932, three gangs of 800 colonists, broke into the women's dormitory, forcefully took away their girlfriends, and burned down the dormitory.[21] After the incident, most of the women did not return to the dormitory but lived with their boyfriends. In 1933, colony officials reinstated the right of marriage, and most of the couples involved in the raid on the women's dormitory wedded that year to legalize their unions.

CHILDREN OF CULION

Aside from the issue of sexual relations between, and marriage among, patient colonists, the issue of children of these liaisons would time and again be a persistent concern for both the colony's civil administrators and the religious leaders. Both Keck and Arcilla discussed the topic of marriage among patients afflicted with leprosy, the children born to colonist parents, and the campaign for adoption of these children as they were brought to Welfareville in Manila.[22] Initially, marriage was disallowed primarily because the authorities never wanted to see children born to parents who were suffering from the disease. Consequently, the issue of care, education, and socialization of these children became important in this regard.

INITIALLY, MARRIAGE WAS DISALLOWED PRIMARILY BECAUSE THE AUTHORITIES NEVER WANTED TO SEE CHILDREN BORN TO PARENTS WHO WERE SUFFERING FROM THE DISEASE.

From 1906 to 1927, there was an increase in the birth rate in the colony. From 5 babies in 1906, the number rose to 72 in 1927. The highest number (96 births) was recorded in 1926 (see Table 2). All in all, from 1906 to 1927, a total of 1,114 children were born in the colony with an average of 51 children born yearly.

TABLE 2. CHILDREN BORN IN CULION, 1906–1927

YEAR	NUMBER OF CHILDREN BORN
1906	5
1907	18
1908	16
1909	16
1910	37
1911	22
1912	36
1913	23
1914	51
1915	69
1916	65
1917	74
1918	75
1919	48
1920	72
1921	46
1922	57
1923	69

1924	65
1925	82
1926	96
1927	72
TOTAL	1,114
AVERAGE	50.6

SOURCE: *Annual Report of the Bureau of Health, 1906–1927* (Manila: Bureau of Printing, 1907–1928).

It was both a popular and official belief of the Culion administrators that these children were more highly susceptible to contracting the disease due to constant exposure. Thus, it was recommended that these children not be allowed to live with their Hansenite parents and that they be separated from them as soon as possible. Further, these children should stay in the nursery of the colony for eventual adoption by other parents upon being brought to Manila.[23]

The first attempts at transporting the children of Hansenite parents were documented in the memoir of Victor Heiser. Once, when 26 babies were being transported from Culion to Manila for adoption, a tragic-comic incident occurred. On the way to Manila, their boat encountered rough waters in the middle of a stormy night. Heiser narrated how he took care of the children while the sailors were occupied with navigating the boat through the storm. Upon their arrival in Manila, they discovered that most of the babies' name tags were missing. Heiser had to recall the names of all 26 babies whom he had just met 48 hours earlier. He picked up each baby and gave it a name as he remembered it, based on a numbered list in his possession. He then scratched the number of each baby on its finger nail so he wouldn't forget it. Thus, he claimed that long before they reached Manila the names and corresponding numbers of the 26 babies were "engraved in his memory."[24]

Children who were born and raised in Culion but were not put up for adoption attended a primary school established in 1906 for the colonists. The school had 64 boys and 27 girls as its first enrollees[25] Administrators proudly noted how baseball was always played by the colonists. A dramatic circle was also organized, as well as a 40-piece band that played American songs.[26]

CULION POLITICAL ADMINISTRATION

The medical, civil, and religious authorities of Culion established a political and administrative structure to promote patient-colonist participation in the colony's administration. A police force was organized to handle the peace and order situation in the colony. Numbering 28 men (including the chief of police and three sergeants), the force was composed entirely of patient colonists. They were given the freedom to maintain the peace and order in the community.[27] A Fire Department comprising 23 members who were all patients afflicted with leprosy was also organized.

A significant feature of the Culion administration was its own municipal government. It had a president, a vice-president, and eight councilors, all elected by the colonists themselves.[28] The Culion Advisory Board (CAB) was also established in 1914. The CAB was authorized to hear out grievances that patient colonists might wish to air or constructive advice they might offer. It was composed of ten patient colonists or regional representatives from one of the following groups: Cebuano, Tagalog, Ilocano, Bicolano, Ilongo, Samar-Leyte, Pampango-Tarlac, Moro, Zamboanga, and other regions. These representatives were elected by constituents of their respective regional or ethnic groups, often in hotly contested and tight electoral battles, which occurred every two years. The ethnic division of voting groups also reflected the domicile of colonists. Residents were grouped

according to their ethnolinguistic identities, and they were only allowed to socialize with other groups in the daytime. They were required to return to their dormitories at night.[29]

A SIGNIFICANT FEATURE OF THE CULION ADMINISTRATION WAS ITS OWN MUNICIPAL GOVERNMENT. IT HAD A PRESIDENT, A VICE-PRESIDENT, AND EIGHT COUNCILORS, ALL ELECTED BY THE COLONISTS THEMSELVES.

Sister Damien of the Sisters of St. Paul de Chartres, one of the first nuns who took care of patients in Culion, noted that in 1909 the influx of Tagalog and Ilocano speakers in Culion had become a challenge to the already settled Cebuano community.[30] Consequently, the CAB was established to resolve the issues arising from regionalism in the community. Constituting the board on the basis of regional affiliation ensured that no group would be favored over others. This was important since there was a tendency among the personnel in charge of managing the colony to favor the original settlers, i.e. the Cebuanos, or the group with great influence on the government, i.e. the Tagalogs. The CAB's primary responsibility was only to the patient colonists. The bulk of the administrative control rested on the predominantly foreign personnel managing the colony—the priest was Spanish; the nuns were French and the directors of the colony were Americans.

While Filipino women in other parts of the country had no right of suffrage until the Commonwealth period, the CAB constitution allowed women to vote. In particular, men and women between the ages of 18 to 60 who were of sound mind were given the right to vote for their representative in the CAB.[31] Heiser noted that granting women the right to suffrage in Culion was a first in Asia, adding that the women "were influential in elections, and invariably picked out the best looking man for president, no matter what his qualifications."[32]

Aside from the political and police administration of the colony, there was also a significant number of bureaucratic and medical employees working in the island. By the late 1920s, there was a total of 234 non-afflicted employees and 275 afflicted patient employees. In the medical section alone, there were 77 non-afflicted employees and 192 employees afflicted with leprosy.[33]

One must note that notwithstanding the colonists' participation in electoral exercises and in the organization of the police force, real political power rested in the hands of the medical administrators of the colony. The government director of Culion held extensive power among the colonists, occupying the posts of justice of the peace, captain of the port, provincial physician, and police administrator.[34] The Director of Public Health also held considerable powers, covering not only the administration of the Culion colony, but also the power over police and local government authorities in other provinces in so far as the campaigns at local collections of afflicted patients were concerned.[35]

NOTWITHSTANDING THE COLONISTS' PARTICIPATION IN ELECTORAL EXERCISES AND IN THE ORGANIZATION OF THE POLICE FORCE, REAL POLITICAL POWER RESTED IN THE HANDS OF THE MEDICAL ADMINISTRATORS OF THE COLONY.

CULION ECONOMY WITHIN A COLONIAL ECONOMY

Despite the fact that leprosy did not distinguish social and economic status for its victims, many of the patients who went to Culion came from the lower classes. As late as the 1930s, a major benefactor of the anti-leprosy campaign, Mrs. H. W. Wade, stated that "leprosy is a disease of poverty; you find lepers among the poor and the ignorant and the unenlightened."[36] Based on this idea, officials exerted efforts tried to project Culion as a viable settlement site to those who wanted to

pursue economic activities despite their illness. Moreover, the design of Culion was such that it entailed the promotion of economic activities to sustain the community as a self-contained and sustainable colony.

> DESPITE THE FACT THAT LEPROSY DID NOT DISTINGUISH SOCIAL AND ECONOMIC STATUS FOR ITS VICTIMS, MANY OF THE PATIENTS WHO WENT TO CULION CAME FROM THE LOWER CLASSES.

A store was in operation in the islands, together with a post office. Each colonist was allowed to use the coins specifically minted for use in Culion only, over and above the 50 cents given to them by the government every month.[37] These newly minted coins eventually became known as Culion coins, with values according to the currency exchange rate relative to the Philippine currency which was itself determined by its value relative to the US dollar. The coins could be used only in the colony, but could be exchanged for Philippine currency if the colonists wanted to remit funds to their families on other islands.

Patients, both skilled and unskilled, did practically all construction work within the colony. Farming, fishing, and preparation and distribution of food were undertaken by the patients themselves.[38] The most viable occupation, of course, was related to the medical professions. Those who were not badly afflicted were given a training course for volunteer patients to become nursing aids, with government salaries.[39]

The Culion Ice, Fish and Electric Co. was initially organized with government support. Later on, patients were offered stock certificates for them to have a stake in the company. The company initially produced ice to keep the colonists' fish catch fresh. Later on, it was expanded to include the supply of electricity to the island.[40] The inclusion of the electricity component to the company's operations presented particular challenges for the campany. The company was unable to pay the engineer who designed and executed the electricity infrastructure of the island, forcing the company to sell almost half of its shares to the engineer, therefore diluting the colonists' control of the company. Financial challenges also made the company unsustainable in the latter years of its existence.[41]

Aside from the Culion Ice, Fish and Electric Company, other businesses were established. Under the guidance of certain religious organizations, patients started a bus service, a general store, and a bakery. All of them experienced different degrees of financial success and failure.[42]

CHURCH-STATE RELATIONS

The narrative of Culion is a narrative of church-state relations at the micro level. Various Catholic missionary orders had treated leprosy during the earlier Spanish colonial occupation of the Philippines. (See the chapters by de Viana, Boncan, and de Castro in this volume.) During the American colonial period, the involvement of the Catholic church in the administration of the colony was an integral part of the Culion story. The parish priest of Culion also held the position of chaplain to the colony as an appointee of the Director of Health Services. The first chaplin was Fr. Manuel Valles, S. J., who was appointed by Victor Heiser on 4 April 1906, a month and a half before the first boat of patients arrived.[43] The first group of the assisting nuns were members of the Sisters of Charity of St. Paul de Chartres from France who arrived on 25 May, giving them two days to prepare for the arrival of the colonists on 27 May.[44] The government required the religious in Culion to attend to the religious and spiritual needs of the colonists.[45] As employees, they received a government salary from the government to help implement its projects in the colony. However, relations between the

colony officials and their church-related employees were strained by disputes over church property; differences between the Catholic Church's teachings on sex and marriage and the Culion administrators' methods for limiting births in the colony; and the Culion adminstrators' permission for Protestant groups to establish church communities in the colonly.

DURING THE AMERICAN COLONIAL PERIOD, THE INVOLVEMENT OF THE CATHOLIC CHURCH IN THE ADMINISTRATION OF THE COLONY WAS AN INTEGRAL PART OF THE CULION STORY.

The issue over Church property revolved around the parish church of Culion, the *convento* (priest's quarters), and an old Spanish fort plus its surrounding wall, all of which had been built before the arrival of the Americans in the Philippines. When the American government expropriated all public and private land and structures on Culion, it did so with the understanding that the owners of private property would be compensated for the losses. Church officials claimed that it owned all the abovementioned structures and should, therefore, be compensated for them. American officials claimed that the fort and wall were not Church property.[46] The issue was not resolved until 1912 when eventually the Church lost legal possession and ownership of the fort while retaining full control of the church building.[47] The parish priest assigned to minister to the colonists and the health employees was given government compensation similar to the government compensation granted to military chaplains of government troops.[48]

As discussed in the previous section, there were also disagreements on a number of proposals mooted by the Culion administrators to control of the number of children born in and out of wedlock: contraception, sterilization, and liberalized divorce laws. These methods were forbidden based on Catholic notions of morality.

Like other parts of the Philippines, Culion also became an area where Catholics and Protestants competed with each other to increase membership in their churches because the American colonial government allowed Protestant and Aglipayan groups to set up church communities in the colony from the outset. The Jesuit priest, Fr. Valles, responded by enforcing existing rules about who should be allowed to participate in the rites of the Church. For example, only Catholics in good standing could stand as baptismal sponsors to children being baptized in Culion, and only Catholics in good standing could be buried in the consecrated ground of the Catholic cemetery of the island.[49] Local groups of afflicted patients were formed according to these religious lines, with the Kapisanan being part of the Protestant group, while the different Catholic organizations, namely the Angelitos, Cinco Llagas, Teresitas, and the Apostleship of Prayer, comprising the majority.[50]

ESCAPE, PAROLE, AND RELEASE: END OF THE CULION EXPERIENCE

Different colonists reacted differently in their lives as segregated patients in Culion. Suicide, escape, parole, and the expectation to be released were regarded as means to end one's stay in the colony. In 1925 and 1927 the Philippine Health Service reported two suicide incidents; the first victim killed himself by strangulation while the second drowned himself in the sea after seeing the life in the colony. There were also cases of escape from the colony. From 1906 to 1927, an average of 27 escapees were recorded in the colony annually (see Table 3). When segregation started in 1906, there were 9 escapees from the population of 615 patients, which increased to 50 by 1908. It was during 1914 when the government recorded the highest number of escapees at around 95, followed by the 84 escapees in 1912, and 62 cases in 1911. Most patients escaped in the years 1921, 1923, and 1927 while they were at San Lazaro Hospital in Manila for medical and other reasons.

DIFFERENT COLONISTS REACTED DIFFERENTLY IN THEIR LIVES AS SEGREGATED PATIENTS IN CULION. SUICIDE, ESCAPE, PAROLE, AND THE EXPECTATION TO BE RELEASED WERE REGARDED AS MEANS TO END ONE'S STAY IN THE COLONY.

TABLE 3. NUMBER OF ESCAPEES IN CULION, 1906–1927

YEAR	ESCAPED
1906	9
1907	13
1908	50
1909	22
1910	53
1911	62
1912	84
1913	18
1914	95
1915	23
1916	20
1917	37
1918	22
1919	0
1920	30
1921	10
1922	0
1923	6
1924	0
1925	11
1926	7
1927	12
TOTAL	584
AVERAGE	26.5

SOURCE: *Annual Report of the Bureau of Health, 1906–1927* (Manila: Bureau of Printing, 1907–1928).

Dr. Jose Albert pointed out in 1921 that

> the course taken by Culion in its existence is well known to us. Administered with the best of wishes, without sparing any expense to make life in the colony more attractive, the institution has never succeeded in gaining the sympathies of its sick inmates or the approval from the people. This is well known by the repeated evasions and instances of suicide from the island, the many cases of concealment, and continuous censure of the press.[52]

This statement questioned the veracity and credibility of the reports made by the Philippine Commission, War Department, and Public Health on the positive reception of the afflicted patients and their families regarding segregation. The reports made it appear that the patients took segregation positively implying that the colonial project was triumphant and successful.

For the patients, the primary goal in the Culion leper colony was eventually to be cured of the disease of leprosy and be given the opportunity to return home through a government parole program. In this program, patients who were tested negative of the bacterium were eventually sent back home by the government. This was the ultimate goal of the government in order to justify the policy of segregation as an effective method in containing and eradicating the problem of leprosy in the Philippines. In 1927, at the end of Leonard Wood's term as Governor General of the Philippines, 155 patients were granted parole and sent back home by the government to their families and loved ones.

However, there were cases of relapse among the patients who had been previously paroled. This raised questions about the desirability of the parole system, doubts about the efficacy of methods for treating leprosy, and the danger of exposure to families of the patients. The uncertainty raised by such questions intensified the stigmatization of patients afflicted with leprosy. This forced some patients to remain in Culion even after successful treatment because family members did not want to take them back home. This became the reason why the director of the colony would write to the patients' relatives asking if they were willing to accept their relative who had been cured of the disease, before release and parole orders were signed.

RELEASE FROM THE COLONY: INTERSECTING DISCOURSES ON PENOLOGY AND LEPROSY

Analysis of the late nineteenth and early twentieth century documents that recorded the American efforts at controlling leprosy in the Philippines reveals a language that parallels the language of criminality and criminology, as well as the language used to describe systems of punishment correction and penology. The San Lazaro Hospital and its leprosy ward was referred to as a "detention service," while the efforts at establishing the involvement of local hospitals entailed the location of treatment "stations" in various localities, somewhat parallel to the establishment of local prisons as institutions established to complement the national prison system. Those who exhibited negative manifestation of the disease after hospitalization or stayed in the colony of patients afflicted with leprosy were "restored" to society. At times, patients who were found to be bacteriologically negative were released "on probation"[55] or on "parole",[56] which metaphorically likened patients to convicts on parole.

ANALYSIS OF THE LATE NINETEENTH AND EARLY TWENTIETH CENTURY DOCUMENTS THAT RECORDED THE AMERICAN EFFORTS AT CONTROLLING LEPROSY IN THE PHILIPPINES REVEALS A LANGUAGE THAT PARALLELS THE LANGUAGE OF CRIMINALITY AND CRIMINOLOGY

Though the authorities were careful in projecting Culion as a place for treatment and cure, and not imprisonment of afflicted patients,[57] patients were considered as "inmates" whose release was premised on the community's decision to pardon or discharge them.[58] And just like most prisons, those who were captured during collection trips were regarded as inmates of Culion, that is, as people with a tendency to escape. Government reports regularly provided statistics not only on the number of "collected patients" but also the number of those who escaped, were recaptured, and were not recaptured.[59] It was said that in Culion, one of three fates awaited inmates—obtain a pardon, escape, or die in the colony.

CONCLUSION

Patients exhibited various reactions towards segregation, which included flight, violent resistance,

accommodation, acceptance of one's fate, escape, suicide, and hope of government parole. Some of these reactions became localized and concentrated mainly on the island of Culion.

The American experience in Culion provided the opportunity for American public health officials to socially, politically, economically, and culturally shape a colony of people afflicted with leprosy. Culion became a colony within a colony with its own government, social norms, economic institutions, religious communities, international relations, and policing powers that reflected the institutional norms and practices of the larger Philippine colony under the United States. But more than that, Culion was also a community to be viewed by the world. It was not only presented as a showcase of American achievement in science and medicine, Culion also provided the institutional impetus for the networking of like-minded internationalist medical practitioners whose self-avowed mission was to find a cure for the dreaded disease. Science and society intersected in Culion with most of its colonists living their lives as subjects of the American empire and objects of its scientific inquiry.

SCIENCE AND SOCIETY INTERSECTED IN CULION WITH MOST OF ITS COLONISTS LIVING THEIR LIVES AS SUBJECTS OF THE AMERICAN EMPIRE AND OBJECTS OF ITS SCIENTIFIC INQUIRY.

The criminalization of the disease and the application of the terms of penology were both evident in the discourse that was used to justify the anti-leprosy campaigns at the beginning of the American colonial period and the creation of a new community of patients on Culion. The discourse of criminology was used to represent those infected with leprosy as people with lesser rights to be free. Being healthy and unstigmatized allowed the colonizers to segregate and isolate from the mainstream. Like most criminals, the patients afflicted with leprosy were classified, catalogued, studied, and categorized in order to place them into the institutional stuctures and routines of the colony.

Immediately upon arrival, the inmates and colonists were classified according to a number of social characteristics: gender, ethnolinguistic identity, religious affiliation, occupation in the colony, skill in work, and if applicable, position in the administration and bureaucracy. These would have particular ramifications to the site of habitation, social and sexual relations, and status within the colony. Once the social classification was completed, patients were medically classified to measure the progress (or regression) of their disease in order to whether they should remain or be relased from the colony. The inmates were further were made to determine provide medical technologists with blood samples to classify them according to the level of infection, types of debilitation, and possibility of becoming bacteriologically negative in the future to make them eligible for pardon or probation.

The intersection of biomedical and social categories with catagories used to measure criminality formed a language that was used to understand and treat the patients in Culion, the San Lazaro leprosy ward, and the leprosy stations that would be established later in other localities of the archipelago.

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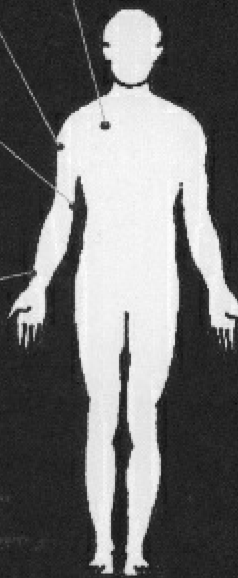
Hansen's Disease and International Public Health in the Philippines, 1900–1930s

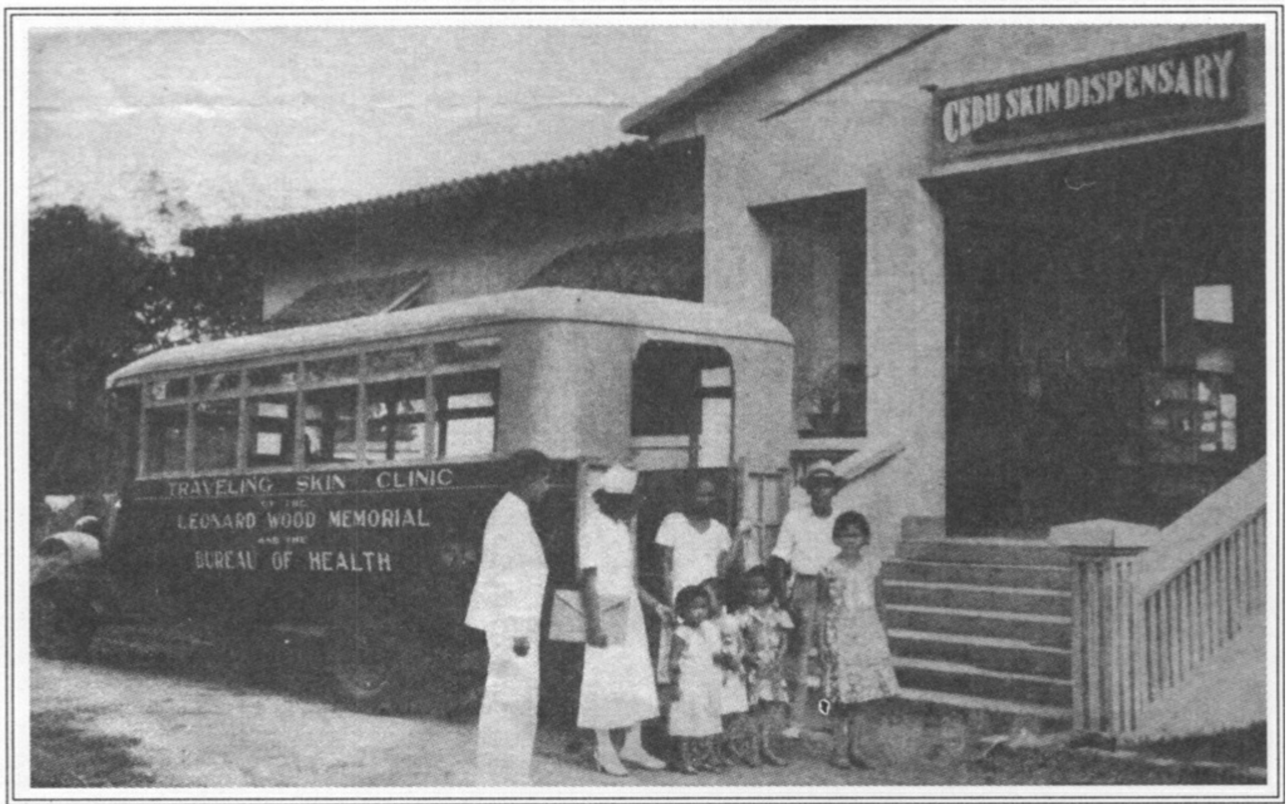
Leprosy Control Since 1946

Women of Culion: Their Voices

Identity and Stigma: Life Stories of Afflicted Men in Culion



III. TOWARD DESEGREGATION: THE WORLD OF HANSENITES



Cebu Skin Dispensary (The Literary Digest, 12 October 1935)

Hansen's Disease and International Public Health in the Philippines, 1900–1930s

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INTRODUCTION

This paper seeks to contribute to the growing interest in the global history of medicine and health and the role of international health organizations in Southeast Asia. It also seeks to locate the development of medicine and public health in the Philippines' changing social, political, and economic structures and relations.[1] These will be undertaken through an examination of American colonial public health efforts to address Hansen's disease in the Philippines from the first decade of the twentieth century until the 1930s, as part of the American civilizing mission. Crucial to the American Hansen's disease program in the Philippines were institutions supporting medical and scientific work, particularly two international health organizations, the Far Eastern Association for Tropical Medicine (FEATM), a transnational organization which was founded in Manila in 1908, and the International Health Commission (IHC), a public health arm of the Rockefeller Foundation (RF) founded in 1913, to promote public sanitation and the spread of knowledge of scientific medicine through campaigns against malaria, yellow fever, and hookworm throughout Europe, Latin America, the Caribbean, and the Philippines. In 1916, the IHC was restructured and renamed the International Health Board (IHB), and eventually, in 1927, the International Health Division (IHD), which initiated similar programs in over 80 countries. From 1918 to 1927, Victor Heiser, Director of Health in the Philippines (1905–1915) and one of the major architects of the American public health system in the Philippines, headed the IHB.

Three works on Southeast Asia, all edited, present a comparative and regional/international view of the history of medicine in the region: Norman Owen's (1987) *Death and Disease in Southeast Asia: Explorations in Social, Medical and Demographic History*; Harold J. Cook and Laurence Monnais' (2012) *Global Movements, Local Concerns: Medicine and Health in Southeast Asia*; and Sunil Amrith and Tim Harper's (2014) *Histories of Health in Southeast Asia: Perspectives on the Long Twentieth Century.* Employing a multidisciplinary approach, Owen's work shows how the study of sickness and death in Southeast Asia may contribute to a fuller comprehension of the region's history.[2] A rejoinder in many ways to Owen's book, Cook and Monnais' work portrays a general history of Southeast Asia through medicine, arguing that the development of medicine in the region was a complex and negotiated process between local and foreign actors.[3] For Cook and Monnais, L.S.A.M. Von Römer's, *Historical Sketches: An Introduction to the 4th Congress of the Far Eastern Association of Tropical Medicine*, a volume which came out of the association's Fourth Congress in Java in 1921, and which emphasizes the Dutch contribution to the medicalization of Southeast Asia, presents a holistic treatment of the region through the history of medicine.[4] While this is correct, the book's focus on Dutch medical contributions to Indonesia as a means to interpret the Southeast Asian region medically is tangential to the study of the history of medicine as the work primarily serves to highlight the Dutch and their achievements in Indonesia. Thus, the book can be classified mainly as colonial history.[5] Nevertheless, Von Römer's book allows the possibility of tracking the development of modern medicine in Southeast Asia and provides a glimpse of the medical world of Southeast Asia from a colonial perspective. Arnrith and Harper's *Histories of Health in Southeast Asia* examines health in the widest possible sense by viewing the different dimensions of health, that is, social, cultural, demographic, and political, through a multidisciplinary and interdisciplinary approach that is anchored in the comparative method.[6] The varied approaches and perspectives of the contributors in the volume, which range from the empirical to the theoretical and applied, involve disciplines and

areas of study such as epidemiology and public policy that go beyond the social science disciplines and the social sciences broadly defined. In this regard, the book presents a holistic view of the region in the modern period. While these books are significant contributions to the history of medicine and Southeast Asian studies in general, it is noteworthy that they are all edited, indicating to a large degree, that while there are strong efforts to study the history of medicine and its development in Southeast Asia and there are specialists who have written on the subject, the lack of single-authorship work indicates the vastness of the field and its young stage.

This paper has three main arguments. First, the choice to address Hansen's disease and the consequent building of public health infrastructures to address this disease in the Philippines amidst more crucial public health concerns, such as cholera, beriberi, smallpox, and tuberculosis during the period under consideration is particularly woven into the American rhetoric of exceptionalism and civilizing mission. Second, the American campaign against Hansen's disease, while in large respects a chronicle of the American civilizing mission, also highlights the national politics of health in the Philippines. Third, the campaign against Hansen's disease shows not only the development of modern medicine in non-Western countries but also how modern medicine is mediated within the network of governments, international health organizations, as well as a wide range of health agents.[7] These health agents may include professionals and non-professionals who have functioned in both the "formal" and "non-formal" sectors, and they may be Western-trained or traditional.[8] They may also include the unexpected intermediaries, such as colonial administrators, missionaries, traditional healers, political reformers, migrants, the local population, public health agents, and family members, among others.[9] In this regard, this paper asserts, along with Cook and Monnais (2012), that the influences on both medicine and how it is practiced, as well as on local ideas on health and its transformation in Southeast Asia, "is marked both by the region's extensive connections to the rest of the world as well as by local and even personal histories and knowledges."[10]

THE CAMPAIGN AGAINST HANSEN'S DISEASE SHOWS . . . HOW MODERN MEDICINE IS MEDIATED WITHIN THE NETWORK OF GOVERNMENTS, INTERNATIONAL HEALTH ORGANIZATIONS, AS WELL AS A WIDE RANGE OF HEALTH AGENTS.

Heir to the great traditions of China, India, and the Pacific, Southeast Asia is home to the spiritual legacies of Buddhism and Hinduism. It is also a living legacy of the Austronesians who undertook one of the greatest migrations in world history. Beginning in the sixteenth century to the height of western colonialism in the nineteenth century, Southeast Asia was the scene of colonial expansion by the Portuguese in East Timor; the British in British Malaya, Burma, and Northern Borneo; the Dutch in Indonesia; the Spanish and Americans in the Philippines; and the French in Indochina (Cambodia, Vietnam, and Laos), with Thailand as a buffer state. Indeed, from the sixteenth century onward, the region was the object and site of European colonial and, in the twentieth century, imperialist ambitions, which propelled it to become even more globalized as western interests in the region accelerated population movements, exchange of ideas, as well as ethnic and socio-cultural exchanges that paved the way, to a large extent, for the formation of Southeast Asia's multi-ethnic societies. At the same time, Southeast Asia's long history of population movements and human exchanges acquired new legacies and traditions which have been adapted locally, particularly the religions of Christianity and Islam, specifically for the Philippines, the only Catholic country in Asia, and Indonesia, now the world's most populous Islamic country.

FROM THE SIXTEENTH CENTURY ONWARD, THE REGION WAS THE OBJECT AND SITE OF EUROPEAN

Southeast Asia, as a contemporary and distinct geopolitical reality and entity, both diverse and vast among the regions of Asia, is composed of 11 countries (Brunei, Cambodia, Indonesia, Laos, Malaysia, Myanmar, the Philippines, Singapore, Thailand, Timor Leste, and Vietnam). It is a product of centuries of interaction within countries in the region, within Asia, and with the West. North American scholars and anti-Japanese allies during the Second World War were the first to use the term "Southeast Asia" as an intellectual construct that gained more salience towards the period of the Cold War and beyond through concerted efforts against communist hegemony in the fifties.[11]

From its linked histories with the West, Southeast Asia became a theater of imperialism in the twentieth century, which culminated in the Second World War, and continued to the Cold War Era in the late forties to the period of decolonization and post-independence. With the Americans as a new imperial power in the region by the end of the nineteeth century, colonial regimes were reorganized. The British, French, Dutch, and American colonial regimes eventually dominated and flourished throughout Southeast Asia until the first half of the twentieth century.

While colonialism in the sixteenth century saw the dynamics of exchange in Southeast Asia, the reorganization of power in the region in the nineteenth century did not only strengthen the region's interaction with the international community but also fuelled imperial rivalry. This rivalry, however, was tempered by similar public health concerns, which brought the unintended effect of fostering a shared purpose among the colonial powers as public health matters necessitated cooperation and collaboration, and the exchange and dissemination of scientific, medical, and technical ideas, information, practices, and experiences.[12] These shared purposes, or what David Arnold refers to as, "tropical governance," eventually led colonial regimes to transform their respective colonies into areas that were productive and profitable as well as conducive to the health of the colonizers.[13]

Expanding on the idea and practice of tropical governance, Hong Kong Governor Sir Frederick Lugard, in his address to the second congress of the Far Eastern Association for Tropical Medicine (FEATM) in Hong Kong in 1912, stated that the "progress of the world, of civilization, and of all that ennobles the human race [lay chiefly] in the hands and the energies of the races that inhabit the temperate zones, [whether in] Europe, Asia or America." Lugard was Britain's most famous colonial official in Africa. At once a soldier, explorer, and colonial administrator who wrote the *Dual Mandate*, which expressed the fundamental principles of European imperialism in Africa, Lugard was also described as a mercenary who had little or altogether no regard for colonial subjects in general. Thus, Lugard's 1912 address to the FEATM was not only bound by his personal disposition; these were personal views that were solidified during his almost two decades of tenure in Africa. It was in keeping with Lugard's disposition then when he expressed in the same speech that "progressive races" were increasingly reliant on the products of the tropics, but that the tropics could never be developed without "external assistance" because:

"PROGRESS OF THE WORLD, OF CIVILIZATION, AND OF ALL THAT ENNOBLES THE HUMAN RACE [LAY CHIEFLY] IN THE HANDS AND THE ENERGIES OF THE RACES THAT INHABIT THE TEMPERATE ZONES, [WHETHER IN] EUROPE, ASIA OR AMERICA." – SIR FREDERICK LUGARD

> ...though this development of trade in the tropics is ... a necessity thrust upon the races of the temperate zones, by the law of progress it can be raised above the sordid level of mere material benefit by the recognition of responsibility towards the peoples of the tropics, to

> whom in return for material products we should bring higher standards of material comfort, and above all higher standards of morality, and the benefits which science has conferred on humanity.[14]

With these statements Lugard had laid the essence of tropical governance as a colonial project[15] with tangible objectives: to make the tropics habitable for the white man and best manage "subject races" for the interest of the metropole.[16] As individual colonies were not uniform, colonial efforts varied. Nevertheless, transformations were generally undertaken in areas such as a) reproduction and nutrition to create healthier future generations; and b) supervision/establishment of institutions whose confined populations seemed to present peculiar problems for tropical health and sanitation.[17] In the Philippines, beginning in the Spanish through the American colonial periods, prisons, hospitals, and asylums were established. It was during the American colonial period, however, that the quarantine method, as the most *crucial* element in the search for a cure for Hansen's disease, was institutionalized. In particular, the work of Orillos in this volume titled "Landscapes of Isolation: Selected Leprosaria in Luzon and the Visayas" provides a concrete picture of the institutional imperative that determined the establishment of leprosaria in the Philippines.

HANSEN'S DISEASE REDISCOVERED

After the fall of the Roman Empire, Christianity became the sole monolithic entity that united all of Europe. This dominance of the Catholic Church became crucial in the historical and institutional understanding and treatment of Hansen's disease in Europe. As such, Catholics were bound by the moral responsibility to provide help and succor to those who were afflicted by the disease and were either segregated in special institutions called *lazarettos, leprosaria* or *sanitaria* or who wandered outside the communities but were assured of Christian charity through alms.[18] Because of its religious association, providing comfort and assistance to Hansen's disease patients became a defining mission for both Catholics and, later on, for Protestants. As Hansen's disease is linked with Christianity, the history of Hansen's disease is, in many respects, also a history of Christianity itself.[19]

AS HANSEN'S DISEASE IS LINKED WITH CHRISTIANITY, THE HISTORY OF HANSEN'S DISEASE IS, IN MANY RESPECTS, ALSO A HISTORY OF CHRISTIANITY ITSELF.

By the fourteenth and fifteenth centuries, Hansen's disease declined in Europe and ceased to be a vital medical problem even as it remained a theological concern for the religious.[20] The lack of sufficient knowledge about Hansen's disease, however, allowed for notions of social evolution or the extinction of weak individuals and the rise of civilization as the strongest explanations for Hansen's disease's decline, even as its historical and biblical associations with disfigurement, dirt, the isolation of sufferers – in short, Hansen's disease's religious association – persisted.[21] This binary but mutually sustaining view of Hansen's disease would continue with the advent of European colonial expansion beginning in the fifteenth century, when Europeans once again encountered Hansen's disease and they were forced to confront it. Thus, while "continental Europe had seen the closing of the leprosaria in the early modern period, the colonies of Europeans in this era would see leprosaria opening."[22] In the Philippines, Hansen's disease was confronted by the Spaniards and Americans in the seventeenth and twentieth centuries, respectively.

Prior to the Spanish colonial regime in the Philippines, there was no system of medical care for the

afflicted outside of the family and the community. It was the Spaniards who established hospitals for these people, such as Hospital de San Lazaro in Manila (1784) and Cebu (1817), and Palestina in Ambos, Camarines Sur (1801)[23] which were all under the administration of the Catholic Church.[24] Information on how the Spaniards addressed Hansen's disease may be gleaned from the accounts of missionaries who were involved in Hansen's disease care. As there was inadequate scientific knowledge about Hansen's disease at the time, these accounts are essentially stories of miraculous cures that promoted Christian conversion.[25] In this regard, the Spanish missionary Francisco Colin's *Labor evangelica de los obreros de la Compania de Jesus en las islas Filipinas* published in the early twentieth century, is the first accurate description of a Hansen's disease case and the first definitive record of systematic care for people afflicted by the disease in Philippine history, although the section on Hansen's disease is embedded within the larger missionary enterprise of the Jesuit missionaries in the Philippines.[26] Given the myriad concerns of the Spanish colonial government in the Philippines, the reality that Hansen's disease was not considered a threat to public health, and that Christian conversion was the main imperative of Spanish colonialism, it can be concluded that a missionary enterprise, rather than a public health or scientific endeavor, drove the initial Spanish Hansen's disease control efforts in the Philippines. Most important, care and succor rather than finding a cure for Hansen's disease were the primary objectives of Spanish efforts. In his thesis titled, "History of Medicine: A Historical Perspective," Enrico Azicate writes that "the point of the religious was to provide care. The religious did not entertain the possibility, except through miraculous means, for any cure for their charges."[27]

In the nineteenth century, the Spanish government undertook substantial governmental reforms in Spain and extended these reforms to its colonies, including the Philippines. These efforts also generally coincided with significant developments in medicine and public health in the West. In 1873, for example, Gerhard Armaeur Hansen discovered the Hansen's disease causative agent, the *Mycobacillus leprae*, which provided a scientific explanation for the nature, transmission, and causes of Hansen's disease. In the Philippines, the reforms expanded the concerns of the Spanish health service or the *Inspeccion general de beneficience y sanidad* to include Hansen's disease, when previously the disease was largely a matter of Church concern. In 1892, the Spanish colonial government surveyed possible sites to expand the already existing leprosaria as a means to control Hansen's disease through segregation and isolation under the auspices of the state. In 1895, Laguna and Iloilo were identified as areas where the new leprosaria could be constructed. While largely a result of the developments in science and public health in the nineteenth century, these plans may have also been influenced by the increased public agitation against the growing number of those afflicted by the disease who were allowed to roam freely. In his work titled, *Lepra en Bisayas*, the Spanish writer Manuel Lebres criticized what he perceived to be the apathy brought about by a lack of scientific knowledge of both Spanish health officials and Filipinos regarding Hansen's disease in the Visayas region.[28] In 1896, however, the Philippine Revolution broke out and the *Inspeccion General* collapsed even before the Spaniards were able to implement their public health agenda, which included Hansen's disease. Through the Treaty of Paris, the Americans acquired the Philippines and plans to further the Spanish Hansen's disease campaigns did not materialize. Nevertheless, the institutionalization of Hansen's disease as a state responsibility under the Spanish colonial regime had been established. This idea was concretized under the American public health efforts to address Hansen's disease.

> In the nineteenth century, the Spanish government undertook substantial governmental reforms in Spain and extended these reforms to its colonies, including the Philippines.

CIVILIZING MISSION ON THE GROUND[29]

Sanitation problems and epidemics were among the general health concerns that confronted the Americans when they first entered Manila at the height of the Philippine Revolution in August 1898, and subsequently when they occupied it.[30] Manila, which was the Spanish capital in the Philippines, was crowded with refugees and suffered from critical food and water shortages. Garbage that had accumulated during its siege littered the streets, which were also flooded due to the absence of drainage. People afflicted with Hansen's disease roamed the streets and begged in the markets.[31] Dean Worcester, Secretary of Interior, relates how the afflicted roamed through the towns freely, "spreading the disease broadcast."[32] Sometimes they would even be hired to arrange food in small retail stores, a job which required minimum effort and thus well-suited for them.[33]

> Sanitation problems and epidemics were among the general health concerns that confronted the Americans when they first entered Manila. . .and subsequently when they occupied it.

As American and Filipino forces were gearing up for the attack on Intramuros, smallpox broke out. Since 1896, smallpox vaccination which the Spaniards had initiated at the beginning of the nineteenth century had been discontinued because of the Philippine Revolution against Spain. It was not until the beginning of the twentieth century, when the Philippine Revolution had ended and the Filipinos had rightfully won their independence, that vaccination was systematically resumed. Smallpox peaked during the outbreak of the Philippine-American War when the population had lowered immunity and continued for three years, spreading in areas following the war within and outside of Manila, such as Guimaras, Panay, and Negros Island in the Western Visayas.[34] The Philippine-American War officially ended in 1901, with the capture and surrender of Emilio Aguinaldo, the leader of the Philippine Revolutionary troops, although resistance against the Americans continued.

Prior to the formal establishment of American military rule in the Philippines on 21 December 1898, trained medical officers serving with the American troops had already taken charge of public health. Because of the problem of sanitation and the lack of infrastructure which aggravated public health conditions and contributed to the spread of epidemics, American public health efforts were geared towards these concerns. There were no sewer systems or sanitary water supplies; the drains did not work, and the canals were exposed. For Victor Heiser, Chief Quarantine Officer then, it seemed that Manila might sink into the water anytime.[35] There were also no building codes. The unsanitary disposal of human waste aggravated the regular occurrence of cholera, smallpox, and plague epidemics. Beriberi, dysentery, malaria, and tuberculosis were also rampant. The generally poor sanitary conditions bred rat infestations. Disregarding the fact that the Spanish colonial government had built several hospitals during the Spanish regime apart from the Hansen's disease hospitals, Heiser recorded the lack of a proper hospital, trained medical personnel, and an asylum for the insane during the Spanish regime.[36]

On 10 September 1898, following the American occupation of Manila, Frank S. Bourns, Major and Chief Surgeon, United States Volunteers, was appointed head of public health matters. He was also in charge of the creation of a public health service and a board of health for the city of Manila.[37] On 29

September 1898, through General Order No. 15, the Board of Health was formally organized, and "infectious and contagious diseases" such as anthrax, chicken pox, cholera, diphtheria, glanders, Hansen's disease, measles, membranous croup, smallpox, typhus, typhoid fever, and spotted, relapsing, yellow, and scarlet fevers, as well as any other disease of an infectious, contagious, or pestilential nature, or those declared by the Board to be dangerous to public health, were identified.[38] As the military government extended to the provinces, the services of the Board of Health were also extended to these areas. Continuing the work of Bourns, Guy Eddie, who replaced him in 1899, maintained a municipal dispensary to control the spread of smallpox.[39] On 1 July 1901, the Philippine Commission passed Act No. 157 which created a permanent Insular Board of Health for the Philippine Islands until local health boards where established in the provinces on December 1901, in order to extend better public health services to the local areas. On the same day, 1 July 1901, the Philippine Commission passed Act No. 156 establishing a Bureau of Government Laboratories. This laboratory served as a venue for biological and chemical studies, as well as vaccine production.[40] Paul Freer, the first dean of the Philippine Medical School, which eventually became the University of the Philippines' College of Medicine, became its first director.

As the Americans perceived that conditions in the Philippines were stabilizing, the Philippine Commission passed Reorganization Act 1407 on 26 October 1905, which created the Bureau of Health for the Philippine Islands. Heiser was appointed as Director of Health while simultaneously retaining his post as Chief Quarantine Officer of the Philippine Islands. Heiser would also be the central figure throughout the American Hansen's disease campaigns. The Reorganization Act placed the following under the Bureau of Health: (a) the civil hospital and civil sanitarium in Benguet in Northern Luzon; (b) prisoners in Bilibid prison and the insular and penal settlements, and the supervision of all provincial and municipal prisons; and (c) supervision of the transfer of the veterinary division to the Bureau of Agriculture. The Bureau also consisted of 11 divisions, namely, (a) provincial health; (b) inspection; (c) clerical work; (d) property; (e) statistics; (f) sanitary engineering; (g) the San Lazaro Hospital in Manila; (h) civil hospitals; (i) prison sanitation; (j) the Benguet sanitarium; and (k) the Culion leper colony division.[41]

Despite these efforts, American colonial public health officials wrote that during the initial stages of the American occupation of the Philippines, public health was not a priority. In 1899, Henry Hoyt, Major and Chief Surgeon of the United States Volunteers, called the attention of the colonial authorities to the health conditions in the country. In his 17 August 1899 statement, Hoyt said: "As near as I can learn, with the exception of Manila and a very few of the other larger cities, very little attention has been paid by the {American} authorities to sanitation, hygiene or the prevention of preventable diseases."[42] Hoyt emphasized the importance of public health in the attainment of peace in the archipelago. He also recommended the establishment of a central or general department of health, a recommendation which was implemented in 1901, or two years later. William Cameron Forbes, the American Governor-General in 1908-1913, wrote that the revenues of the colonial government were "extremely small," particularly in comparison with the budget appropriated for Cuba and Puerto Rico. Forbes cited that from 1905 to 1913, the total annual expenditure for public health service averaged less than seven cents per capita.[43] Despite the limited funding and the lack of priority given by American colonial health officials to public health, the Board of Health appropriated US$50,000 for the establishment of the Culion Leper Colony on 27 October 1902, prior to the reorganization of the Board of Health and a year after the end of the Philippine-American War.[44]

AMERICAN COLONIAL PUBLIC HEALTH OFFICIALS WROTE THAT DURING THE INITIAL STAGES OF THE AMERICAN OCCUPATION OF THE PHILIPPINES, PUBLIC HEALTH WAS NOT A PRIORITY.

The context of establishing a colonial state amidst continuing resistance to American rule, the public health concerns that had to be addressed, the lack of medical personnel and public health infrastructure, and the lack of funds not only for public health but also for the colonial state in general, form the backdrop of the American Hansen's disease campaign in the Philippines.

FROM CULION TO THE WORLD: THE AMERICAN HANSEN'S DISEASE CAMPAIGN

Compared to other public health concerns in the Philippines, especially during the initial stages of the American regime, the Americans prioritized Hansen's disease, a disease which has been referred to as the "Cinderella" of tropical medicine. Tropical medicine during this time concentrated on the control of parasitic diseases, principally malaria, sleeping sickness, smallpox, yellow fever, bilharzia, and hookworm.[45] Such programs began in the late nineteenth century. They were first promoted by scientists and colonialists with the primary objective of preventing tropical colonies from being the "white man's grave," in order to consolidate imperial rule and promote trade.[46] Thus, initial histories of medicine reflect little attention to Hansen's disease. Compared with tuberculosis which killed more Filipinos than any other disease in the Philippines or with beriberi and cholera which threatened the local population as well as the Spanish and American colonial regimes, Hansen's disease was never considered a threat.[47]

COMPARED TO OTHER PUBLIC HEALTH CONCERNS. . . THE AMERICANS PRIORITIZED HANSEN'S DISEASE, A DISEASE WHICH HAS BEEN REFERRED TO AS THE "CINDERELLA" OF TROPICAL MEDICINE.

In his 2002 seminal work titled, *Agents of the Apocalypse: Epidemic Disease in the Philippines*, Ken De Bevoise identifies five major diseases that have either reached alarming heights or have developed into epidemics, such as venereal diseases (gonorrhoea and syphilis), beriberi, cholera, malaria, and smallpox. De Bevoise begins his account in the late nineteenth century, when diseases and epidemics spread as he narrates how the Spanish *medico titular* (licensed physician) feared the demise of the local population. De Bevoise eventually takes us to the peak of epidemiological heights during the Philippine-American War. Interestingly, however, Hansen's disease never figures in De Bevoise's accounts. The imbalance between De Bevoise's work that relies strongly on archival materials and the American prioritization of Hansen's disease is reconciled in Warwick Anderson's, *Colonial Pathologies: American Tropical Medicine*, *Race and Hygiene in the Philippines.* Anderson explains that the American obsession with Hansen's disease and its singling out is significant because of the notion that as American efforts transformed Culion and its leprous residents into, "progressive citizens...products of progressive colonial officials' work of civilization..." they were also transforming Filipinos in general and showcasing to the world the ultimate example of the American civilizing mission.[48] Albert Jenks, former chief of the Bureau of Ethnology and whose thinking ran on parallel lines, also thought that the transformation of Culion and its residents was against the Filipinos' natural "inertia."[49] As the Americans were better equipped to deal with Hansen's disease compared to the Spaniards because of the developments in medicine and public health which coincided with their acquisition of the Philippines, the American transformation of Culion, according to Anderson, was designed to disturb this inertia.[50]

Prior to the formal occupation of the Philippines in 1898, the Americans had already conducted a survey which determined the number of those afflicted to be about 3,500 to 4,ooo.[51] By 1901, the Americans had surveyed the Hansen's disease cases in the country; scrutinized the Spanish attempts to address Hansen's disease; and proposed the segregation and isolation of the afflicted at a central location. Having concluded that the Spaniards were unable to set up a centralized Hansen's disease program, the Board of Health appropriated funds for a Hansen's disease settlement in 1902.[52] In the same year, a campaign was initiated to find a suitable place in which to establish a colony for those afflicted with the disease. Based on his studies of available medical literature on Hansen's disease, along with the knowledge of fear of contamination among those who encountered the disease, Heiser, the main architect of the American Hansen's disease control program, recommended that only isolation and experimental treatment could accomplish the eradication of Hansen's disease.[53] Unlike the Spaniards who viewed their Hansen's disease campaigns in religious terms and undertook these campaigns as a means to provide comfort and care until the reforms in the nineteenth century which reoriented Spanish views, the American campaign to address Hansen's disease, from the very beginning of the America acquisition of the Philippines, was intended to provide a cure for the disease.

THE. AMERICAN CAMPAIGN TO ADDRESS HANSEN'S DISEASE. FROM THE VERY BEGINNING OF THE AMERICA ACQUISITION OF THE PHILIPPINES. WAS INTENDED TO PROVIDE A CURE FOR THE DISEASE.

Along with a committee of inquiry in 1902, Worcester, the Secretary of the Interior, surveyed a number of locations and concluded that Culion, "afforded an ideal site for the proposed colony, and furnished abundant and suitable lands for agriculture and stock raising." The committee also believed that, "nowhere else in the archipelago can there be found an island so healthful, extensive, and fertile, which has so small a population."[54] Thus, Heiser recorded that the actual building of the colony began in 1905, the same year that his policy of segregation became compulsory. In May 1906, the 365 inmates of the San Lazaro Hospital in Cebu were transferred to Culion. Through Heiser's efforts, the Philippines earned the distinction of being, "the only oriental country where complete segregation is being attempted."[55]

INTERNATIONAL COLLABORATION FORMALIZED

Prior to the introduction of sulfones in the 1940s, and with the exception of chaulmoogra oil, generally recognized for years as a valuable treatment for Hansen's disease, almost all substances (i.e., potassium iodide, arsenic, antimony, copper, sera, vaccines, and aniline dyes) utilized to treat Hansen's disease were worthless.[56] Chaulmoogra oil as a treatment for Hansen's disease had a long history in Asia, particularly in traditional Ayurvedic medicine in India as well as in Burma and China. It was not until the turn of the twentieth centuiy, however, that the medical profession in Europe and the United States paid attention to the possibility of chaulmoogra oil being a cure for Hansen's disease.[57] Chaulmoogra oil's nauseating effect limited its efficacy such that physicians were compelled to find the best form to administer it to persons afflicted with Hansen's disease. In 1901, Isadore Dyer of the Louisiana Leper Home in Carville, Louisiana, was the first to use orally-administered chaulmoogra oil in the form of drops. Heiser had supervised the use of chaulmoogra oil at the San Lázaro Hospital for the afflicted in Manila since the early years of the American occupation of the Philippines but with limited success. In 1908, he visited the Leper Home in

Carville to learn better techniques.[58]

> PRIOR TO THE INTRODUCTION OF SULFONES IN THE 1 940S, AND WITH THE EXCEPTION OF CHAULMOOGRA OIL… ALMOST ALL SUBSTANCES… UTILIZED TO TREAT HANSEN'S DISEASE WERE WORTHLESS.

Upon his return to the Philippines in 1909, Heiser arranged for the Louisiana method to be given a thorough trial at the San Lázaro Hospital in Manila under the supervision of the resident physician, Elidoro Mercado. The new method, while more successful, still resulted in nausea; therefore, patients remained resistant to taking the drug. Finally, having learned that some physicians had tried hypodermic injection, Heiser and Mercado experimented with the procedure and added camphor to a prescription of chaulmoogra oil and resorcin. Typically given orally, Heiser and Mercado found that the camphor-resorcin solution of chaulmoogra oil was readily absorbed.[59] For the first time, Heiser became hopeful that a permanent cure might actually be found for what he described as the, "most hopeless disease."[60]

News of Heiser's success with the chaulmoogra oil solution in the Philippines spread in the medical community throughout the world and spurred further research in Africa, Calcutta, China, Hawaii, as well as several places in japan, among others. As many other remedies were soon being tested, the benefits of international collaboration, not only in Hansen's disease work but also in public health matters in general, became recognized. In this regard, Heiser's accomplishment goes beyond finding a cure for Hansen's disease.

Heiser's accomplishment in finding a cure for Hansen's disease, as well as his other accomplishments as Director of Health in the face of similar public health issues that confronted the different colonial powers, provided the initiative for the United States Medical and Sanitary Administration in the Philippines to move for the establishment of the Far Eastern Association of Tropical Medicine (FEATM). Founded in Manila in 1908, the FEATM aimed to promote the science and art of tropical medicine alongside friendly international dialogue between physicians and scientists. Additionally, it sought to: (a) raise the standard of medical education in the East; (b) enlighten and direct public opinion regarding the problems of hygiene; (c) form habits conducive to the prevention of disease among the native populations; and (d) present to the world the results of scientific investigations.[61] In its First Congress in 1910, the FEATM and its participants from other Asian colonies acknowledged that the American sanitary regime in the Philippines, "worked miracles" and that it was a model for tropic-wide emulation. While the FEATM provided a platform for research on tropical medicine in general, its first three congresses—in Manila (1910), Flong Kong (1912), and Saigon (1913)—were devoted to beriberi as FEATM's central concern, even as the Governor-General of Saigon in 1913 emphasized the need to conquer Hansen's disease, among many other "myriad evils" that continuously threatened the tropics.[62] On his part, Heiser viewed the FEATM as an international venue in which delegates armed with the authority of their respective government would be able to make binding decisions on international health policy.[63]

> BY THE END OF THE FIRSY DECADE OF THE TWENTIETH CENTURY CULION HAD BECOME FAMOUS FOR THE CHEMOTHERAPY OF HANSEN'S DISEASE.

By the end of the first decade of the twentieth century Culion had become famous for the chemotherapy of Hansen's disease. Alongside this distinction, however, were several changes in

ideas and policy on Hansen's disease. In 1910, the identification of biological and etiological similarities between the Hansen's disease and the tubercle bacilli as well as the notion that European anti-tuberculosis measures might be suitable for Hansen's disease control prompted doctors in India, the Philippines, and French Indo-China to call for new approaches to Hansen's disease.[64] In 1915, Heiser visited Sir Leonard Rogers of the Indian Medical Service in Calcutta, who was one of the pioneers in setting up the Calcutta School of Tropical Medicine in 1914, as well as a founding member of the Royal Society of Tropical Medicine and Hygiene (RSTMH). Founded in 1907, the RSTMH positioned itself as the, "army of humanity against disease."[65] A distinguished physician who made solid contributions to tropical medicine, Rogers' involvement and collaboration with Heiser attests to the value and significance of Heiser's work and his cause for Hansen's disease. Through Heiser's insistence, Rogers developed new derivatives of the chaulmoogra oil, which ensured continued progress in Hansen's disease work.[66] Heiser and Roger's collaboration did not only lead to the continuity and sustainability of Hansen's disease research. More significantly, it showed the strength of research efforts and collaborative work in the colonies. As such, it was a demonstration of the vitality of polycentric colonial research networks which crossed political and geographical boundaries, but was unhampered by the "tyranny of distance."[67]

> HESSEN AND ROGER'S COLLABORATION DID NOT ONLY LEAD TO THE CONTINUITY AND SUSTAINABILITY OF HANSEN'S DISEASE RESEARCH. MORE SIGNIFICANTLY, IT SHOWED THE STRENGTH EFFORTS AND COLLABORATIVE WORK IN THE COLONIES.

In 1912, the Republican Party lost to the Democrats, and Woodrow Wilson became president of the United States. While the Philippines was retained, Filipinos were allowed increased participation in government. They also enjoyed greater domestic autonomy and control of certain government offices as a practical and realistic measure to prepare them for eventual self-rule. On 6 October 1913, President Wilson appointed Francis Burton Harrison as Governor-General of the Philippine Islands replacing Forbes. Advocating Wilson's liberal policy, Harrison was devoted to the cause of Philippine independence. He implemented the policy of Filipinization, whereby American personnel would gradually be replaced by educated and trained Filipinos, starting from the lower positions to the higher posts.

In 1916, the Democrats again won the presidency. On 29 August 1916, the United States Congress passed the Jones Law, the first formal and official declaration of the United Sates' intention to grant independence to the Philippines. Americans in the insular government, who could not reconcile Harrison's policies with their own or were motivated either by anxiety, pride, or despondency, opted to resign. Some also resigned because they could not face the prospect of having a Filipino as head. Worcester, who never tried to hide his low opinion of Filipinos became even more vocal of his contempt for them.[68] At the Manila Merchants Association banquet in his honor, Worcester remarked that the "new policy was a mistake", as "the Filipino politicians are like the horse-leech's daughters crying, 'Give, give!' They will not cease constantly to demand powers which they are as yet wholly unfit to exercise until something has been taken away from them."[69]

For both Heiser and Worcester, the achievements and gains in public health work would be lost once Filipinos took over. Having isolated themselves from the Harrison administration because of their opposition to Filipinization, Worcester resigned in 1913, and Heiser on 28 February 1915, eventually joining the Rockefeller Foundation in 1916, as Director for the Far East of the Rockefeller

Foundation's International Health Board (IHB).[70] Partly inspired by the experiences of the Rockefeller Sanitary Commission in 1909, the IHB, which aimed to promote sanitation and spread the knowledge of scientific medicine in the world, was formed on 27 January 1913.

INTERNATIONALIZING THE HANSEN'S DISEASE CAMPAIGN

Heiser brought to the IHB the same conviction and strength that he showed as Director of Health in the Philippines. At the same time, as the IHB's representative in Asia and a prominent figure in the FEATM for 30 years of its existence (1908–1938), Heiser retained if not revitalized, "the unshaken view that American sanitary reform in the Philippines had transformed (or had the capacity to transform) the outlook of colonial health officers across Asia and provided a suitable template for interventionist action against the diseases that blighted the region as a whole."[71] In a visit to survey the health conditions and the public health efforts of the Dutch in Java in 1916, Heiser wrote:

> American entrance into the Orient has been a tremendous stimulation to other countries in promoting education and health measures among the masses. Until the Americans came it was very generally held throughout the East that efforts to help the native would prove futile.[72]

After resigning as Director of Health in 1915, Heiser remained involved in public health matters and often returned to the Philippines as Director of the IHB. He continued to pursue a cure for Hansen's disease; however, it was not an IHB priority. In 1916, for example, Wickliffe Rose, Director of the IHB, indicated beriberi as a second priority of the IHB next to hookworm.[73] Rogers, then head of the Calcutta Medical School, lobbied Heiser to have the IHB take up Hansen's disease and develop a program for its eradication.[74] Unable to interest either colonial governments or the Rockefeller Foundation, Rogers established the British Empire Hansen's disease Relief Association (BELRA) upon his retirement in 1921. The BELRA was a charitable organization whose goal was to collect funds to enable and coordinate new approaches to the control of Hansen's disease.[75] In a correspondence between Richmond K Anderson, Associate Director of the Rockefeller Foundation, and Professor Smith A. E. Wilder of the Farmakolisk Institute, Bergen, Norway, Anderson indicated that, "Hansen's disease and tuberculosis have for some years been regarded as lying outside our [IHB] main programme interests." The RF/IHBs reluctance to support Hansen's disease would continue towards the third decade of the twentieth century and the peak of Leonard Wood's governor-generalship in the Philippines.[76] Nevertheless, Heiser pursued his agenda for Hansen's disease.

In the 1920s, Heiser became especially attentive to developments in the Philippines, especially with the appointment of his old friend and ally, Governor-General Leonard Wood, former Governor of the Moro Province. As Heiser and Wood were friends and political allies during their previous political posts in the Philippines, Heiser saw Wood's appointment as a means to remain continuously involved with affairs in the Philippines. He eventually convinced Wood to focus on Hansen's disease work. Thus, in 1922, the 6,000 residents in Culion received more than one-third of the country's health budget in an archipelago of more than ten million.[77] While the rest of the other hospitals in the country had meager resources, Warwick Anderson notes how medical staffing was increased in Culion and treatment became more rigorous and sophisticated. Largely opposed to Filipinization, Wood's bias for leprsosy would eventually contribute to the Cabinet Crisis of 1923, when Filipino members of his cabinet resigned after accusing Wood of autocracy.[78]

Wood visited Culion 16 times and became very engaged with the prospect of rehabilitating its inmates. His bias for Culion eventually irked many Filipino politicians who felt that the money poured in Culion was being spent on a whim, “a peculiar American extravagance in a poor and needy archipelago,” to which Wood responded that unless Filipino politicians could take care of their people who were afflicted by Hansen’s disease, Filipinos would never be fit for independence.[79] Manuel L. Quezon, the Senate President and eventually the Commonwealth President of the Philippines, felt that the prioritization of Hansen’s disease was at the expense of more pressing needs, such as tuberculosis, which claimed almost 30,000 deaths a year among the Filipinos.[80] For Wood, however, “there was nothing noble and redeeming about a disease as mundane as tuberculosis, and Quezon’s indictment of the Governor-General fell on unheeding ears.” According to Ronald Fettes Chapman in his book titled, *Leonard Wood and Hansen’s disease in the Philippines: The Culion Leper Colony, 1921–1927,* “Wood’s self-appointed mission was to turn the biggest leper colony in the world into the best.”[81]

MANUEL L. QUEZON, THE SENATE PRESIDENT AND EVENTUALLY THE COMMONWEALTH PRESIDENT OF THE PHILIPPINES. FELT THAT THE PRIORITAZATION OF HANSEN’S DISEASE WAS AT THE EXPENSE OF MORE PRESSING NEEDS, SUCH AS TUBERCULOSIS

Wood’s battle for Hansen’s disease was waged with Herbert Windsor Wade, a United States pathologist who was appointed member of the Hansen’s disease Investigation Committee of the Bureau of Health in Manila in 1920, and who would eventually be both the Chief Physician and Chief Pathologist in Culion. Wade’s wife, Dorothy Paul Wade, who was supportive of Wade, also took up his cause for Hansen’s disease.[82] Eventually, Wade would establish the Leonard Wood Memorial Foundation American Hansen’s disease Society in 1928, a non-profit organization that resulted from Wood’s Hansen’s disease campaign. In 1931, the International Hansen’s disease Association (ILA) was established as an international effort to eradicate Hansen’s disease primarily by identifying a cure for the disease, helping to channel public funds towards this effort, as well as providing proper care for the welfare and treatment of patients and their families. By working on all fronts - scientific, economic, and social - these efforts to eradicate Hansen’s disease bore the imprints of the American civilizing mission and of the Philippines as a modern nation under American stewardship.

BY WORKING ON ALL FRONTS – SCIENTIFIC, ECONOMIC, AND SOCIAL – THESE EFFORTS TO ERADICATE HANSEN’S DISEASE BORE THE IMPRINTS OF THE AMERICAN CIVILIZING MISSION AND OF THE PHILIPPINES AS A MODERN NATION UNDER AMERICAN STEWARDSHIP.

CONCLUSION

The American Hansen’s disease campaign in the Philippines is of interest for three main reasons. First, American involvement with the Hansen’s disease problem demonstrates that the American colonial regime in the Philippines may have had its over-arching agenda, but within this agenda were individuals and networks that were crucial not only in furthering the goal of the colonial regime but also in furthering particular interests. The latter shows the importance of scientific research as justification for promoting an agenda in order to command support among medical experts or to impel governments to adopt an interventionist policy, even if the scientific research is not sufficient to justify this support. Second, American public health efforts were a significant node in regional and international cooperation that presented opportunities for medical/colonial service as a conduit for

the deployment of medical ideas, practices, and institutions, which laid the foundations for modern medicine in the Philippines, Southeast Asia, and Asia. Third, the recognition of the central role of the state in protecting the health and welfare of both the colonial and the local population illuminates the complex relations among the individuals and the state. Within this frame, the history of medicine and public health, particularly during the period under consideration, is also a history of nation-building in the Philippines.

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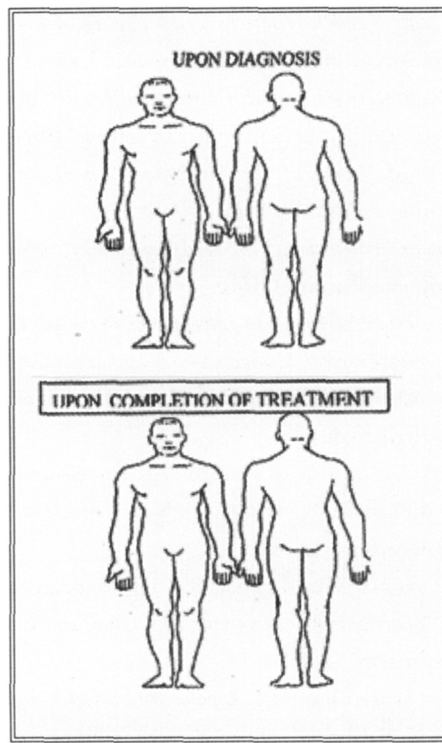

Body chart for diagnosis and treatment of leprosy.

CONTROL OF HANSEN'S DISEASE SINCE 1946

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INTRODUCTION

The era from 1946, the onset of formal political independence for the new Philippine republic, until the present has certainly been the most exciting period as far as Hansen's disease control in the Philippines is concerned. This chapter looks at modern Hansen's disease control by tracing its development from the time of segregation or institutional care of patients in leprosaria during the American colonial era to the breakthrough in the treatment of the disease; scrutinizing the policies for Hansen's disease control undertaken by the Philippine government; and documenting the support services provided by non-state actors. This paper highlights the state's search for modes of curing Hansen's disease, such as the introduction of early detection methods and the use of more potent drugs. Of importance to the search for this cure was the assistance given by international health organizations, primarily the World Health Organization (WHO), and the critical support provided by private foundations and religious organizations.

The paper focuses on two periods. The first period, from 1946 to 1986, traces the early development of Hansen's disease control in the late 1940s, the entry of international organizations and other support institutions, and the vigorous Hansen's disease control measures instituted by the Philippine government until the seeming decline of state capacity during the late 1970s and early 1980s under the Marcos administration. The second period, from 1987 to 2010, looks at the revived Hansen's disease control measures not only due to support from international health partners but also the Philippine government's stress on community participation and good governance. In addition, focus is given to the important role played by non-state actors in Hansen's disease control. These include philanthropic or charitable foundations, religious organizations, and not the least, the patients themselves.

HANSEN'S DISEASE AND THE STATE, 1946–1986

Philippine independence from the United States happened on 4 July 1946 with Manuel A. Roxas as president of the new republic. However, the timing was far from ideal as the destruction brought about by the Japanese Occupation took a heavy toll on lives and infrastructure such that the challenges of rebuilding the country were almost insurmountable. Likewise, the health situation was in dire straits. The Department of Health and Public Welfare, the government arm responsible for public health, was faced with inadequate funds, shortage of personnel, and lack of supplies, materials, and equipment.

Initially, Filipino medical workers were assisted by the US army personnel in treating patients and

providing other essential medical services. After American military medical personnel were demobilized and sent home, the US Public Health Service assisted the Philippine government under its Philippine Public Health Rehabilitation Program. However, rehabilitation of the public health system was anchored on the overall rehabilitation of the country as stipulated in the Philippine Rehabilitation Act of 1946. In effect, the rehabilitation of the public health system was dependent on the passage of this law, which among other things sought to grant parity rights to US citizens.

As stipulated in this Act, an initial amount of USD 5 million was allocated for the purpose. This was later augmented with an additional USD200,000, after which the Philippine War Damage Commission reimbursed the Department of Health and Public Welfare the amount of USD33,000 for emergency reconstruction procedures,[1]

On 17 July 1946, a meeting was held between American and Filipino health officials on the matter of communicable diseases. Priority was given to malaria, tuberculosis, venereal diseases, and Hansen's disease. However, the rehabilitation of these priority programs was anchored on the overall health situation in the country. The control of these communicable diseases could not be separated from policies and measures related to sanitation, nutrition, quarantine, rehabilitation of health facilities, and the training of health workers.[2]

An assessment of the Hansen's disease control program revealed that pre-war measures had deteriorated greatly or they were almost non-existent. It was noted that segregated patients from the Culion and Tala leprosaria had escaped and roamed the streets of Manila begging for food and other necessities. The physical infrastructure in the Culion and Tala leprosaria was mostly intact, but most of the property had been looted. As an initial step, the U.S. Public Health Service restored water services in the leprosaria and reactivated segregation measures. Later, a new set of health personnel and equipment was sent first to Culion and then to other leprosaria. A nursery for children born of parents infected with Hansen's disease or those separated from their parents at birth was established in Culion on 1 April 1948. To further boost the health capabilities of the government, President Roxas decoupled public health from public welfare on 4 October 1947, thus giving birth to a reorganized Department of Health (DOH) and ensuring that its budget would be intended only for public health.[3]

PRESIDENT ROXAS DECOUPLED PUBLIC HEALTH FROM PUBLIC WELFARE ON 4 OCTOBER 1947, THUS GIVING BIRTH TO A REORGANIZED DEPARTMENT OF HEALTH (DOH) AND ENSURING THAT ITS BUDGET WOULD BE INTENDED ONLY FOR PUBLIC HEALTH

Developments in public health from the 1950s to the 1960s could be considered the advent of bilateral and multilateral assistance as this era saw the entry of international agencies which would assist the Philippine government in the task of rehabilitating public health in general and eliminating Hansen's disease in particular. Agencies such as the U.S. Official Mission Economic Cooperation Agency (USOM-ECA, forerunner of the United States Assistance for International Development or USAID), the World Health Organization (WHO), and the United Nations International Children's Emergency Fund (UNICEF), just to name a few, offered their services. It is significant to note that on 15 August 1951, the WHO moved its regional headquarters from Hong Kong to Manila, in effect a recognition of the Health Department's capabilities, but also for easier access to the agency.

The Division of Sanitaria, a unit within the Bureau of Disease Control was set up. It was assigned the tasks of formulating policies, programs, and operational procedures; conducting continuous research on Hansen's disease with focus on its therapeutic, histopathological, and bacteriological aspects; supervising technical support over field units; and training of personnel assigned to Hansen's

disease control work. The Division of Sanitaria continued the operations of the eight sanitaria nationwide[4] which comprised the following: Bicol Sanitaria (Cabusao, Sipocot); Cotabato Sanitarium (Cotabato City); Culion Sanitarium (Culion, Palawan); Eversley Childs Sanitarium (Mandaue City, Cebu); Mindanao Central Sanitarium (Zamboanga City); Sulu Sanitarium (Jolo); Tala Sanitarium (Caloocan); and Western Visayas Sanitarium (Sta. Barbara, Iloilo).

One of the key observations made by leprologists was that despite more than four decades of compulsory segregation, the practice failed to arrest the increasing number of Hansen's disease cases. Thus, it was deemed necessary to modify the law in order to test case home treatment or ambulatory care. In 1952, Republic Act 753 was passed in order to liberalize the practice of segregation. It permitted home isolation provided that the patients were regularly visited by private physicians and certain conditions were followed. However, many patients chose instead to stay in leprosaria as they could be saddled with economic and social problems if they returned home.[5]

ONE OF THE KEY OBSERVATIONS MADE BY LEPROLOGISTS WAS THAT DESPITE MORE THAN FOUR DECADES OF COMPULSORY SEGREGATION, THE PRACTICE FAILED TO ARREST THE INCREASING NUMBER OF HANSEN'S DISEASE CASES

In 1955, the DOH entered into a tripartite agreement with the UNICEF and WHO to seek equipment and technical and advisory services for its skin clinics.[6] Although skin clinics were presented as dermatological clinics, the real intent was to detect undiagnosed cases of Hansen's disease. These mobile and stationary clinics were deployed in cities or municipalities where the incidence rate was high, in the hope that Hansen's disease cases could be detected during their early stage. These skin clinics also conducted seminars or educational modules in Hansen's disease control.[7]

The mobile clinic pilot project was successful. Consequently, in 1957 three travelling skin clinics were added. Two years later, five more units were added in Luzon and Mindanao. Thus, by the end of the year the number of travelling and stationary skin clinics reached 13 and 6, respectively. The locations of these skin clinics are presented in Tables 1 and 2.

TABLE 1. LOCATION OF STATIONARY SKIN CLINICS IN THE PHILIPPINES

STATIONARY SKIN CLINICS	LOCATION
LEPROSY RESEARCH AND TRAINING CENTER	MANILA
CEBU SKIN CLINIC	CEBU CITY
ILOCOS SUR SKIN CLINIC	VIGAN, ILOCOS SUR
BICOL SKIN CLINIC	LEGASPI CITY
ILOILO SKIN CLINIC	ILOILO CITY
ILOCOS NORTE SKIN CLINIC	LAOAG CITY

SOURCE: DOH, *Annual Report for the Fiscal Year 1968-1969 of the Division of Sanitaria* (1970).

TABLE 2. TRAVELLING SKIN CLINICS IN THE PHILIPPINES

TRAVELLING SKIN CLINICS	LOCATION
BOHOL TRAVELLING SKIN CLINIC	TAGBILARAN CITY
WESTERN VISAYAS TRAVELLING SKIN CLINIC	MAMBUSAO, CAPIZ
LA UNION TRAVELLING SKIN CLINIC	SAN FERNANDO, LA UNION
PANGASINAN TRAVELLING SKIN CLINIC	DAGUPAN CITY
LEYTE TRAVELLING SKIN CLINIC	TACLOBAN CITY

SAMAR TRAVELLING SKIN CLINIC	CATBALOGAN CITY
SOUTHERN TAGALOG TRAVELLING SKIN CLINIC	STA. CRUZ, LAGUNA
BICOL TRAVELLING SKIN CLINIC	NAGA CITY
EASTERN MINDANAO TRAVELLING SKIN CLINIC	DAVAO CITY
WESTERN MINDANAO TRAVELLING SKIN CLINIC	CAGAYAN DE ORO CITY
NORTHERN TAGALOG TRAVELLING SKIN CLINIC	PASIG, METRO MANILA
WESTERN LUZON TRAVELLING SKIN CLINIC	LUBAO, PAMPANGA
CAGAYAN VALLEY TRAVELLING SKIN CLINIC	TUGUEGARAO, CAGAYAN

SOURCE: DOH, *Annual Report for the Fiscal Year 1968-1969 of the Division of Sanitaria* (1970).

As a means to further liberalize Hansen's disease control and treatment, President Diosdado Macapagal signed into law Republic Act 4073 in 1964, with the end in view of eliminating segregation in the sanitaria except those who were in need of institutional care. The law was meant to relax the rather stringent measures of Republic Act 753. However, one of the primary motivations was to reduce government expenditures in the operation of these sanitaria, where only those who needed institutional care were to be cared for. Others were encouraged to either seek treatment from private physicians or the stationary and mobile clinics. The law also provided the legal framework for the structural reorganization of the Department of Health (DOH). Because the emphasis was on home care, the Hansen's disease control program was integrated into the rural health centers at the provincial and municipal levels. In addition, the authority of the health secretary over the Culion leprosarium was withdrawn.[8]

As shown in Table 3 and Figure 1, from 1946 to 1965, the prevalence rate was characterized by a seeming decline, although this increased dramatically from the middle until the end of the period. From 154 cases in 1946, the rate decreased to 85 in 1952. However, the following year it rose to 6,521, a thirty-fold jump in recorded cases. In fact, the trend would peak in 1962 with 7,610 cases and it would remain high until 1965 even though there was a slight decrease in the number of recorded cases. The sudden and sharp increase in the trend may be attributed to the detection of new cases of Hansen's disease. However, detection did not automatically lead to cure even if Dapsone, a new and promising drug against Hansen's disease, was introduced in the 1950s.

The same trend may be said of deaths due to Hansen's disease (mortality rate). From 38 in 1946, the number of recorded deaths did not change much in 1952 with 35 cases. In the following year, however, mortality jumped to 170, a five-fold increase. The rate peaked in 1963 with 210 deaths, though it registered a slight decrease to 194 in 1965. Improved capabilities in tracking new cases and better record keeping reflected the extent of Hansen's disease and its lethal effects despite the dire numbers.

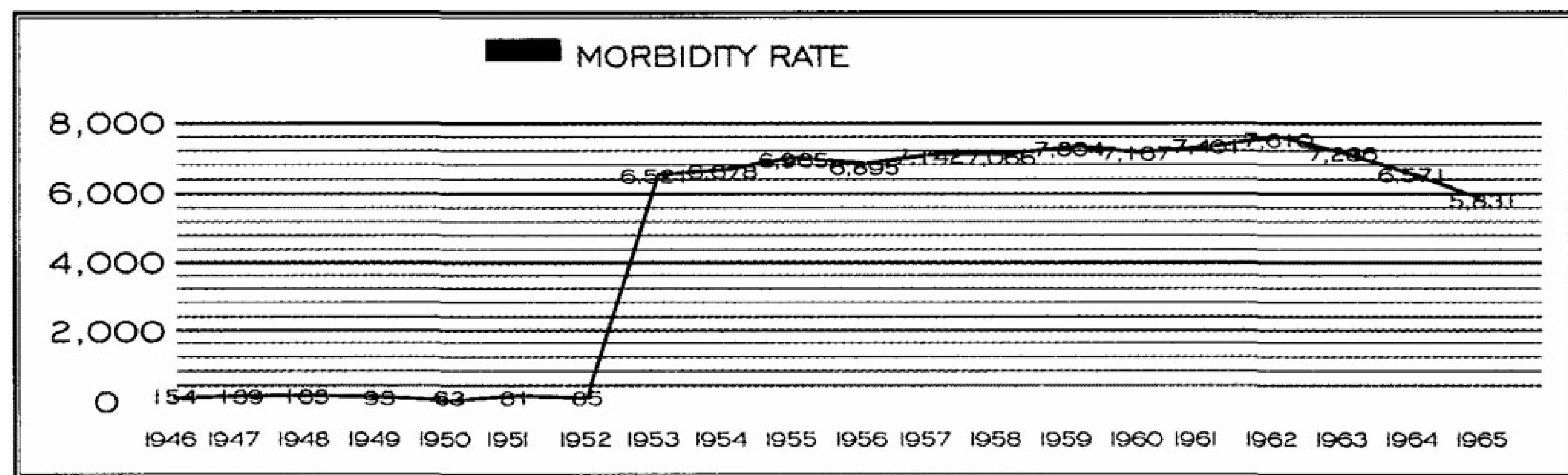
TABLE 3. PREVALENCE AND MORTALITY RATES OF HANSEN'S DISEASE, PHILIPPINES, 1946–1965

YEAR	POPULATION	PREVALENCE		MORTALITY	
		CASES	RATE	DEATHS	RATE
1946	18,434,400	154	0.83	38	0.21
1947	18,785,700	139	0.74	60	0.32
1948	19, 143,800	163	0.85	104	0.51
1949	19,689,800	93	0.48	52	0.27

1950	20,315,800	63	0.32	31	0. 16
1951	20,961,800	81	0.40	35	0.19
1 952	21,628,300	85	0.41	35	0.17
1953	22,216,000	6521	29.2	170	0.76
1954	23,025,500	6678	29.0	123	0.53
1955	23,757,600	6965	29.3	125	0.53
1956	24,513.000	6825	27.8	143	0.58
1957	25,292,400	7142	28.2	138	0.55
1958	26,096,600	7066	27.1	179	0.69
I 959	26,926,400	7304	27.1	171	0.64
1960	27,410,000	7167	26.1	150	0.55
1961	28,313,000	7401	26.1	167	0.59
1962	29,257,000	7610	26.0	209	0.71
1963	30,241,000	7236	23.9	210	0.69
1964	31,270,000	6571	21.0	205	0.66
1965	32,345,000	5831	18.0	194	0.54

SOURCE: Bureau of Health, *Annual Report of the Division of Sanitaria* (1966).

FIGURE 1 TREND OF PREVALENCE DUE TO HANSEN’S DISEASE IN THE PHILIPPINES (1946–1965)



SOURCE: Bureau of Health, *Annual Report of the Division of Sanitaria* (1966).

Compared to other countries, the Philippine experience of Hansen’s disease control is quite unique. For one thing, it was the only country that had skin clinics, a practice not seen anywhere else. In the immediate post-war period, many Asian countries had higher prevalence rates. South Korea had the highest rate at almost 126 followed by Hong Kong (100). Taiwan and Japan ranked sixth and seventh, respectively, higher than the Philippines at eighth place. In Southeast Asia, the prevalence rate was highest in Thailand followed by Indonesia.

The change in policy from segregation to home care necessitated changes in the government’s health infrastructure. Hansen’s disease control work was thus devolved and integrated into the general public health services.[9] As envisioned in the government’s Reorganization Plan, Hansen’s disease control work would now be handled by rural health workers. These efforts were met with resistance. For one, rural health workers were not prepared psychologically and physically to handle Hansen’s disease cases. In addition, while some leprosaria units were only too willing to devolve their tasks, they were nevertheless hesitant when it came to doing the same with their funds for this

purpose. As a result, Hansen's disease workers in the field had to look for other fund sources to fulfill their tasks.[10]

Just as this reorganization was taking root, another reorganization was undertaken in order to streamline Hansen's disease control operations. If previous thrusts were towards decentralization, this reorganization now sought the reverse, to centralize Hansen's disease control. The establishment of the Dermatology Research and Training Center, mandated to do intensive research, conduct training programs, and provide medical services, became the nerve center of all Hansen's disease control activities as per Administrative Order No. 48. To avoid duplication and overlapping of functions, line functions that were previously transferred to the Bureau of Health Services were now given back to the new Center. In effect, the eight sanitaria and skin clinics became part of the new Center's extension services.[10]

The numerous reorganizations inside the department took its toll on Hansen's disease control work. Hansen's disease control became the lowest priority and specialized Hansen's disease control units were aligned with regional health offices. Case finding and regular treatment activities succumbed to budgetary cuts as did anti-Hansen's disease drugs. Even if there were enough supply of medicine these could still not be transported to remote areas for lack of funds. As demoralization set in, some field offices did not give regular reports, while a few units stopped reporting altogether. Eventually, the government's overall Hansen's disease control program was marked by a decline in the overall quality of services.[12] Thus, many leprologists saw the Marcos period, particularly during the martial law regime, as one marked by confusion and even irrationality.[13]

MANY LEPROLOGISTS SAW THE MARCOS PERIOD, PARTICULARLY DURING THE MARTIAL LAW REGIME, AS ONE MARKED BY CONFUSION AND EVEN IRRATIONALITY.

It is estimated that the government and private allocation per patient annually during this time was roughly 15,000 pesos. Although around 40 percent of the patients were already negative, that is, they were no longer capable of spreading the disease even if the *lepraea* microbe lay dormant in their bodies, many refused to leave the sanctuary of the leprosaria because of the uncertainties of life outside these sanctuaries. What was needed, leprologists argued, was a halfway house where patients could be physically and psychologically rehabilitated to prepare them for life after confinement. Prolonged institutional care, they observed, bred complete dependence on the government and reinforced the feeling of stigmatization.[14]

HANSEN'S DISEASE AND THE STATE AFTER 1987

The Aquino government in 1986 breathed new life into the government's health policy. Dr. Alfredo Bengzon, a known anti-Marcos activist and primary health care advocate, was appointed Health Secretary. Dr. Bengzon brought with him into the Department like-minded activists such as Drs. Jaime Galvez-Tan and Mario Taguiwalo as well as personnel from health-oriented non-government organizations who saw the participation of communities and other non-state actors as integral to the improvement of the overall health situation. Dr. Bengzon established the National Leprosy Control Program (NLCP) in 1986 with the goal of increasing state capacity in eliminating Hansen's disease as a public health hazard. Furthermore, Hansen's disease control during this period received a big boost with the introduction of the wonder drug Sulfone which formed part of the so called the multi-drug therapy (MDT) that effectively proved to be the cure for Hansen's disease. Dr. Bengzon was succeeded by an even more charismatic and popular secretary, the affable Sec. Juan T. Flavier, who

spent many years as a rural doctor, ensuring the continuity of these reforms.

Immediately, the DOH went to work and outlined its objectives. In the short term, or by the end of 1987, the target was to fully implement the MDT regimen on 2,000 patients at the leprosaria and to partially implement this regimen in high endemic areas. For its three-year Medium-Term Plan, the DOH prioritized the delivery of MDT blister packs nationwide and a complete treatment of 90 percent of all Hansen's disease cases. A 90-day treatment of paucibacillary cases (PB) and a 180-day treatment of multibacillary (MB) cases rendered people afflicted with Hansen's disease negative. The DOH's long-term objectives included intensifying detection activities through skin clinics and health centers; further operational research for Hansen's disease eradicating drugs, and forging functional linkages with non-state actors. In its initial year, the DOH allotted 33.3 million pesos for its Hansen's disease control program, and for its Five-Year Plan (1987–1991) it allotted 80 million pesos, a far cry from previous budgets.[15]

TABLE 4: PROVINCES WITH THE HIGHEST INCIDENCES OF HANSEN'S DISEASE, 1987

PROVINCE	TOTAL REGISTERED CASES	PREVALENCE (1/1,000)
ILOCOS SUR	1,935	3.8
SULU	1,576	3.74
ILOCOS NORTE	1,348	3.06
METRO MANILA (NCR)	14,538	1.97
BATANES	26	1.94
SOUTHERN LEYTE	483	1.37
ABRA	237	1.29
LA UNION	683	1.23
PALAWAN	489	1.05

SOURCE: Philippine Council of Health Research and Development, *State of the Art: Leprosy in the Philippines* (1988).

Table 5 shows the progress made in the 1990s. From a prevalence rate of 2.76 per 10,000 population in 1991, this rate was down to just 0.49 by the year 2001. From a high of 17,347 registered cases in 1991, there were only 3,816 cases, or a 450 percent drop in cases after only a decade. New cases also registered a 270 percent drop from 7169 to 2669, even if the total population increased by more than 14 million in the same period.

TABLE 5: HANSEN'S DISEASE INDICATORS IN THE PHILIPPINES

Year	Population (in millions)	Registered Cases	Prevalence	Detection	New Cases	MB Detection (%)	Disability	Child (%)
1991	62895	17347	2.76	7169	11.4			
1992	64342	15317	2.38	5896	9.16			
1993	65065	15441	2.37	3442	5.29			
1994	65000	16486	2.54	4450	6.85			
1995	67581	11674	1.73	3988	5.9	78.8		
1996	68226	8659	1.27	4081	5.98	83.7	0	8.3
1997	71389	8749	1.23	4942	6.92	80.6	5.1	8
1998	73717	7005	0.95	3490	4.73	82.4	5.5	7.6
1999	75892	4786	0.63	3736	4.92	82.8	4.8	7.7
2000	76348	4320	0.57	3379	4.43	86.6	7.2	6.3
2001	77131	3816	0.49	2669	3.46	89.2	2.3	5.1

SOURCE: WHO, *Leprosy: Overview and Epidemiological Overview in the WHO Western Pacific Region in 2001* (2003).

In late 1996, the WHO issued World Health Assembly Resolution No. 44.9 which called for the global elimination of Hansen's disease as a public health problem by the year 2000. As a country with a high incidence of Hansen's disease and being a signatory to the Resolution, the Philippine government formulated objectives to meet this obligation. One was to set the bar for its implementation. The DOH set as its target a prevalence rate of less than 1/10,000 by 1998 at the national level and by 2000 at the sub-national levels (regions, provinces, cities / municipalities). This target was two years ahead of the global target. To assuage the public and encourage treatment for suspected *lepraea* carriers, the DOH launched an information campaign about the true nature of Hansen's disease – that it is the least communicable disease; that Hansen's disease can be cured by taking the MDT regimen; and, that Hansen's disease patients are rendered non-infectious after only one week of taking MDT.[16]

A major initiative to achieve this goal was to again reorganize the DOH anti-Hansen's disease units. This time, the eight leprosaria became the lead agencies in the implementation of the National Leprosy Control Program. They were given the tasks of providing leadership to the field units and providing the necessary drugs and other supplies. Each sanitarium was given a specific catchment area.[17] Another task was the production of a Manual of Procedures (MOP) which clearly stipulated the duties and responsibilities of health workers at different implementing levels.

In March 1992, Hansen's disease control was further boosted with the passage of Republic Act 7277 or the law for persons with disabilities (PWDs).[18] Among other provisions, persons afflicted with the disease were considered PWDs and thus entitled to more assistance from the state. In a sense, Hansen's disease was no longer a disease relegated to the fringes. Rather, persons afflicted with the disease were now placed in the mainstream alongside those afflicted with other ailments, which were not necessarily contagious nor considered a public health hazard. Under the law, the

DOH was tasked to:

- institute a national health program for PWDs;
- establish medical rehabilitation centers in provincial hospitals; and
- adopt an integrated and comprehensive approach to the health care development of PWDs, which would make essential health services available to them at an affordable cost.

A new and improved detection campaign was launched with the Kilatis Kutis (Skin Check) Campaign. This activity is a week-long campaign held every third week of February, and designed to raise awareness on skin care and prod those with skin lesions to check with health authorities. Still another innovation was community participation through the Community Action Project for the Elimination of Leprosy (CAPEL) wherein influential or respected non-health personnel in a community such as teachers, priests or pastors, and barangay officials were trained to spot suspected lesions on persons and refer them to health centers.[19] All in all, the goal of eliminating Hansen's disease as a public health disease was achieved with grit and determination in observing and implementing policies and procedures set by the DOH – intensive case finding, improved treatment, extensive health education, community participation and involvement, active case monitoring, continuous supply of medicines (MDT blister packs) or logistics, and accurate recording of all cases. Hansen's disease control may well be considered a success. From 38,750 registered patients and a prevalence rate of 7.2 percent in 1986, the number of patients was dramatically reduced to just 2,041 and a prevalence rate of only 0.31 percent by 2010.[20]

THE GOAL OF ELIMINATING HANSEN'S DISEASE AS A PUBLIC HEALTH DISEASE WAS ACHIEVED WITH GRIT AND DETERMINATION IN OBSERVING AND IMPLEMENTING POLICIES AND PROCEDURES SET BY THE DOH

HANSEN'S DISEASE AND NON-STATE ACTORS

As discussed in previous chapters, the pioneers in Hansen's disease work in the Philippines were religious organizations. This was true before the Japanese Occupation. However, in the post-war period, an increasing number of support services came from so-called private groups, such as philanthropic foundations, charity organizations, and religious orders. This section focuses on the support services given by both religious organizations and private foundations, later referred to as non-government organizations (NGOs).

IN THE POST-WAR PERIOD, AN INCREASING NUMBER OF SUPPORT SERVICES CAME FROM SO CALLED PRIVATE GROUPS, SUCH AS PHILANTHROPIC FOUNDATIONS, CHARITY ORGANIZATIONS AND RELIGIOUS ORDERS.

Nowhere is the presence of NGOs more felt than in the largest of all the sanitaria, Culion. Upon its establishment in the early part of the twentieth century, two Catholic religious congregations made their presence felt – the Sisters of St. Paul de Chartres (SPC) and the Society of Jesus (or Jesuits). The SPC Sisters arrived in Culion as early as 1906. There was only one doctor in the island and some of the SPC Sisters served as the only nurses (they were nurses before joining the congregation). At times, they had to fill in for the lack of medical staff, and even carried out amputations and minor dental work. In the 1950s, these sisters applied to join the hospital nursing staff and they were readily accepted by the Bureau of Health. In this way, they became paid government workers and permanent

settlers.[21]

The most remarkable Jesuit of the post-war era was the Spanish Fr. Javier Olazabal or simply Fr. Ola to the people of Culion. Fr. Ola was already 60 years old when he started work in Culion in 1971. Aside from ministering to the spiritual needs of Catholics, Fr. Ola worked tirelessly to improve the living conditions of both patients and medical staff with the help of the Fundacion Anesvad *(A Nuestro Enfermos Servicios Veindo A Dios* or We Get to Know God by Serving the Sick), a Spanish philantropic institution based in Bilbao, Spain. Because of stress from overwork and poor nutrition, Fr. Ola died in 1988. He was buried inside the Immaculate Conception church. This is uncommon for there is only one burial place for Jesuits in the Philippines—their novitiate in Novaliches which incidentally is within the vicinity of the Tala Sanitarium.[22]

The Philippine Leprosy Mission (PLM) began its work in Culion in the 1920s. Known then as the Philippine Evangelical Leprosy Mission (PELM), American and Filipino pastors were sent to Culion to cater to the spiritual and temporal needs of Hansen's disease patients by setting up an educational system and introducing Protestantism. The PLM sent two Filipino doctors to India on a scholarship to study reconstructive surgery and physiotherapy on the condition that they render service in Culion with these acquired skills. The PLM has since shifted to supporting local government units (LGUs), the DOH, and other government agencies in capacity-building activities, such as training as well as supporting patients' organizations towards rehabilitation.

Fr. Javier Olazabal, S.J. invited Anesvad whose president then was his former student, to work in Culion in 1971, and it did so until it terminated its operation in 1997. Culion was Anesvad's first international engagement. Its primary work in Culion was to provide funds for many of the sanitarium's medical, administrative, and support services. Aside from funding drug purchases in support of intensive MDT implementation and augmenting salaries of doctors and administrative staff, Anesvad also funded the renovation of hospital wards and purchases for new medical equipment. Grants were likewise given for socio-economic projects and infrastructure assistance. Anesvad's experience in Culion was used as a template for its operations in China, Cambodia, Vietnam, Myanmar, India, Ecuador, and Nicaragua.

From the 1970s onwards however, the majority of support services for Hansen's disease control came from the Sasakawa Memorial Health Foundation (SMFH). The SMHF is the brainchild of two prominent Japanese—Ryoichi Sasakawa, then the Executive Director of The Nippon Foundation, and Prof. Morizo Ishidate, considered the father of chemotherapeutic cure in Japan. Together, they set up the SMHF in May 1974 in Tokyo.

The principal objective of the SMHF is to work with governments, international health organizations, and NGOs for the global elimination of Hansen's disease. Rather than taking the traditional dole out approach, the SMHF is of the belief that the final responsibility in Hansen's disease control rests with the government. Thus, its express aim is to generate resources and expertise in assisting concerned actors. The SMHF also believes that Hansen's disease is not a separate and distinct phenomenon, but rather a dire symptom of the overall health situation that afflicts developing countries.

RATHER THAN TAKING THE TRADITIONAL DOLE OUT APPROACH, THE SMHF IS OF THE BELIEF THAT THE FINAL RESPONSIBILITY IN HANSEN'S DISEASE CONTROL RESTS WITH THE GOVERNMENT.

Among SMHF's major accomplishments is aiding the development of the breakthrough the MDT regimen. With the help of the SMHF, the Philippines pioneered the use of the MDT in areas with high

prevalent rates. The SMHF also funded major Hansen's disease control projects including research, training, seminars, and exchange programs. For example, during Fiscal Year 1997, out of the total Philippine government budget of 24.525 million pesos for Hansen's disease control, the SMHF contributed 2.38 million pesos for drugs, 480,000 for training, and 300,000 for equipment, or a total of 3.16 million pesos, which accounted for 13 percent of the country's total budget for Hansen's disease control.[23]

The Culion Foundation Inc. (CFI) was established in 1976 in partnership between the Jesuits and Sovereign Military Order of Malta. The CFI served as the conduit that channeled funds from foundations or international partners into the rehabilitation of Culion and its patients. The CFI extended its services to areas with high endemic rates, among them Cebu, Siquijor, and Tawi-tawi.

A late comer in the scene is the Korean Sorok-Uni Foundation, Inc. (SUFI), which was founded only in 2002. The foundation is named after the famous leprosarium in Sorok Island, South Korea. Sorok-Uni provides three shelters or sanctuaries for out-patients unable to support themselves or receive support from their families. These shelters, located in San Antonio in Quezon province, Tala in Caloocan City, and in Cotabato City, provide physical therapy and rehabilitation, adult literacy programs, and livelihood projects.

Patients have organized themselves into associations or cooperatives as a way of assisting their communities in personal development and rehabilitation. This is recognized as one strategy in empowering patients towards wellness. Among these groups are the Bicol Sanitarium Association of Persons with Disability, Inc. (BSAPWDI); Grupo ng mga Registradong Pasyente ng may Mahusay na Oryentasyon, Inc. (GRUPO or Group of Registered Patients with Upright Orientation); Hansen's Club; Bagong Pagasa (Renewed Hope) Cooperative (BPC); Cotabato Sanitarium Hansenites Multi-Purpose Cooperative (CSHMPC); Persons Affected with Leprosy Organization in Mindanao Area, Inc. (PALOMA); and the Interactive Society Leprosy Association of Muslims (ISLAM). Likewise, former patients have banded together to help those undergoing the social, financial and psychological stress from having Hansen's disease and assist in their social and psychological needs. Some of these are area-based, such as the Association of Culion Hansenites, Inc. (ACHI, Inc); Negative Barrio Welfare Association in Cebu; and the Sulu Women's Negative Hansenites Cooperative, Inc. At present, NGOs and patients' organizations are grouped under the Coalition of Leper Advocates of the Philippines (CLAP).[24]

PATIENTS HAVE ORGANIZED THEMSELVES INTO ASSOCIATIONS OR COOPERATIVES AS A WAY OF ASSISTING THEIR COMMUNITIES IN PERSONAL DEVELOPMENT AND REHABILITATION.

CONCLUSION

Although Hansen's disease has been eliminated as a public health problem, still its stigma continues. Hansen's disease has a strong psychological impact not only on the patients but also on their family members and the communities where they belong. Despite the fact that Hansen's disease is less deadly than other diseases, leprosy patients face hostility as they are feared and rejected due to their skin ailment. This is why the struggle to mitigate the impact of stigma is being carried out even at the international level.

ALTHOUGH HANSEN'S DISEASE HAS BEEN ELIMINATED AS A PUBLIC HEALTH PROBLEM, STILL ITS STIGMA CONTINUES.

A number of international legal and humanitarian instruments have been ratified, from the 1948 Universal Declaration of Human Rights to the United Nations Convention on the Rights of Peoples with Disabilities signed in 2008, that places greater inclusivity in development. This mandated right is crucial in protecting the rights of afflicted persons. The year 2008 also saw the unanimous approval of the UN Human Rights Council Resolution on the "Elimination of discrimination against persons affected by Hansen's disease and their family members."[25]

In June 2010, the WHO hosted a meeting of experts and patients to draw up strategies that would increase the inclusion of persons afflicted by Hansen's disease in different aspects of community life and decision-making. Like human rights, Hansen's disease also affects the issue of gender. Women have suffered more negative consequences of Hansen's disease compared to men so that putting greater emphasis on gender with regards to training health professionals has led to improved awareness of and sensitivity to gender concerns and disparities.[26]

NOTES

1. Teodora V. Tiglao, *Seven Decades of Public Health in the Philippines* (Tokyo: Southeast Asian Medical Information, 1975), 96-97.
2. Ibid., 98.
3. Ibid., 99.
4. These sanitaria are still in operation today, but they no longer serve Hansen's disease patients exclusively. After they were integrated into the basic health service delivery structures, each leprosarium was renamed "sanitarium," meaning they are now both hospitals and leprosaria. For example, the Bicol Sanitarium is a Level II hospital with a 450-bed capacity. It covers not only the entire Bicol Region (Region V) but also the adjacent provinces of Rizal, Quezon, and Eastern Samar. Tala Leprosarium is now called the Dr. Jose N. Rodriguez Memorial Hospital; it has been elevated to a general hospital.
5. Domingo Disini, M.D., "Leprosy Control in the Philippines," *Philippine Journal of Leprosy* 12, no. 1 (1966): 8–9.
6. Stationary Skin Clinics were located at the Leprosy and Research Training Center in Manila, Vigan, and the cities of Cebu, Legaspi, Iloilo, and Laoag. Travelling skin clinics were stationed in the cities of Tagbilaran, Dagupan, Tacloban, Catbalogan, Naga, Davao, and Cagayan de Oro and in the municipalities of Mabusao in Capiz, San Fernando in La Union, Sta. Cruz in Laguna, Lubao in Pampanga, Tuguegarao in Cagayan, and Pasig in the former Rizal Province (now the National Capital Region).
7. Department of Health (DOFI), *Annual Report for the Fiscal Year 1967-1968 of the Division of Sanitaria* (1969), 23-25.
8. Ma. Ceres P. Doyo, "Toward Healing: 1946–1986," in *Culion Island: A Leper Colony's 100-Year Journey Toward Healing*, ed. Ma. Cristina V. Rodriguez (Quezon City: Culion Foundation, Inc. & Fundacion Anesvad, 1998), 119.
9. Clinics and hospitals at the primary (city or provincial), secondary (regional), and tertiary (national) levels.
10. Division of Leprosaria, Bureau of Disease Control, *Annual Report for the Fiscal Year 1968-1969,* (1969).
11. DOH, Office of the Minister. Administrative Order 48, s.1979, October 22 1979.
12. For an assessment of the overall public health condition of this period, see AKAP Research, *Health and Human Rights in the Philippines: A Report by AKAP and KAAKBAY* (Quezon City:

Dept. of Health, 1984).

13. Ernesto Villalon M.D. (Program Director for Leprosy, Office of Infectious Diseases, Disease Prevention and Control Bureau, Department of Health), in discussion with author, June 30, 2014.
14. DOH, *National Leprosy Control Program, Communicable Disease Control Service, Division of Sanitaria* (1987), 3–4.
15. Ibid., 6–7.
16. DOH, Office of the Secretary. Administrative Order 26-A, s.1997. November 5, 1997
17. In the Department of Health Department Order No. 72, s.1994, Bicol Sanitarium was given the whole of Region V as its area of operation; Culion for Palawan and the Calamianes Island Group; Cotabato Sanitarium for Regions X, XI, and XII; Eversley Childs Sanitarium for Regions VII and VIII; Tala Leprosarium for NCR and Regions III and IV; Zamboanga Sanitarium for Region IX; Sulu Sanitarium for Sulu and Tawi-Tawi; and Western Visayas Sanitarium in Iloilo for Region VI.
18. It was titled "An Act Providing for the Rehabilitation, Self-Development and Self-Reliance of Disabled Persons and their Integration into the Mainstream of Society and other Purposes."
19. DOH, November 5,1997.
20. For an appraisal of the gains made in Hansen's disease control during this period, see World Health Organization, *Global Strategy for Further Reducing the Leprosy Burden and Sustaining Leprosy Control Activities, 2006-2010* (Regional Office for Southeast Asia, New Delhi: 2011).
21. Doyo, 127-128.
22. Ibid., 132-133.
23. DOH, Department Circular 248, s.1997, September 23, 1997.
24. For a listing of foundations and organizations in partnership with the government in Hansen's disease control in recent years, see DOH, *A Handbook of Leprosy Control in the Philippines, 2006–2010* (2010), 30–32.
25. World Health Organization, *WHO Expert Committee on Leprosy, Eighth Report* (2012), 29.
26. Ibid., 30.

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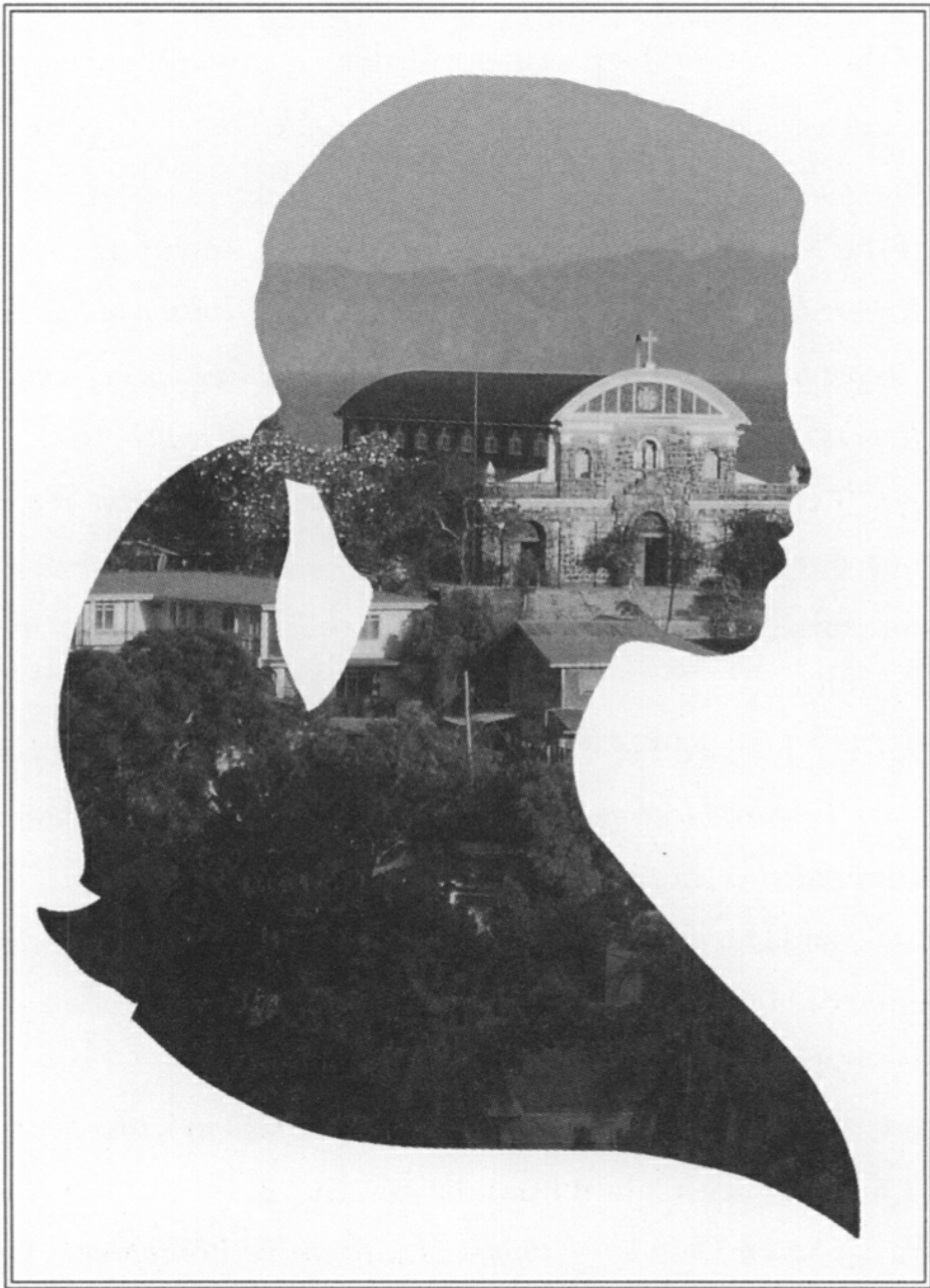

La Imaculada Church, Culion, Palawan

Women of Culion: Their Voices

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INTRODUCTION

Previous studies on leprosy in the Philippines have focused on the disease and its treatment, the history of leprosaria in the Philippines, notably the Culion Leprosarium in Palawan which showcased an efficiently-run institution during the American period, and the policies adopted by the Spaniards and Americans regarding the control of the disease. Unlike previous studies, however, this study documents the social dimension of the disease, particularly the experiences of women afflicted with leprosy.

The documentation of leprosy in the Philippines started during the American period when medical doctors began writing articles published in the *Journal of the Philippine Islands Medical Association* (JPIMA). One of these was an article written by Jose Albert, Professor of Medical Jurisprudence and Pediatrics at the College of Medicine of the University of the Philippines in 1921. Titled "The Experiment of Leper Segregation in the Philippines," the article was a response to an assertion by Milton Rosenau, then Assistant Surgeon of U.S. Public Health, that the number of patients admitted to the Culion Leprosarium had declined by 90 percent in 1906–1921. Upon examining the admission statistics, however, Albert concluded that the rate of admission had not changed and that Rosenau simply wanted to show that Americans had succeeded in controlling leprosy in the country by adopting a segregation policy for those afflicted by the disease. The JPIMA consequently became the venue for many other articles on leprosy written by Filipino doctors. Their topics included the topographical distribution of leprosy in the Philippines,[1] diagnostic problems of leprosy,[2] early leprosy in children,[3] segregation of people afflicted by the disease, and the treatment of leprosy.[4] Nonetheless, a survey of scientific papers written during the period [5] shows that none of them focused on leprosy from a social perspective. Recently however, there has been an interest in investigating the gender dimension of the leprosy.

LEPROSY IN WOMEN IS A MORE COMPLICATED PROBLEM BECAUSE UNLIKE MEN, WOMEN CONTEND WITH HORMONAL CHANGES, CHILDBEARING, AND BREASTFEEDING.

Leprosy in women is a more complicated problem because unlike men, women contend with hormonal changes, childbearing, and breastfeeding. Additionally, women who are generally breadwinners feel that their health is not a priority in their lives so they delay the diagnosis and treatment of the disease. Socially, women who are infected with leprosy are more likely to face

isolation and stigma than men. Studies attribute this to the low status of women, illiteracy, limited mobility, and poor knowledge of leprosy.[6]

This paper documents the experiences of women with leprosy, not only about how they faced the disease but also its impact on them and their lives

THE STUDY

Data for this study was drawn from oral histories of selected women in the municipality of Culion which were obtained through personal interviews conducted during two visits there. The interview focused on four turning points in the life of a woman patient, namely: before being diagnosed, after being diagnosed, living with leprosy, and hopes for the future.

DEMOGRAPHIC PROFILE OF THE WOMEN

A total of 24 women were interviewed. Their ages ranged from 43 to 85. Their age distribution is shown in Table 1.

TABLE I : AGE DISTRIBUTION OF INTERVIEWEES

AGE	HUMBER
40-49	5
50-59	5
60-69	2
70-79	8
60-89	4
TOTAL	24

Except for one, all the women had gone to school. One even had a college degree in education. The rest finished high school, Grade VI, and Grade IV.

Six of the women were born in Culion and the rest came mostly from the Visayas region (seven from Cebu, two each from Sorsogon and Manila), and one each from Rizal, Palawan, Samar, Antique, Zamboanga, and Leyte.

The women's marital status varied. Eight were married, ten were widows, two were separated, two were in a live-in relationship, and two were single.

Finally, some of the women were young (e.g. six years old) when the symptoms of leprosy appeared. For others, the symptoms came out when they were adolescents (12–15 years old). Only one showed symptoms of leprosy in her twenties.

MOST THE WOMEN WERE DIAGNOSED WITH LEPROSY AT AN EARLY AGE, ALTHOUGH THEY HAD LED NORMAL LIVES AS CHILDREN BEFORE THE SYMPTOMS APPEARED.

LIFE BEFORE DIAGNOSIS

Most the women were diagnosed with leprosy at an early age, although they had led normal lives as children before the symptoms appeared. These symptoms came in various forms. Some women said that white spots appeared on their face, which they mistook as *an-an/anan* or *ap-ap*[7]. Others said they had *pula-pula* (red spots)), which initially swelled before becoming blisters, while for others nodules *bukol-bukol* (nodules) appeared in different parts of their body, such as their ears and elbows. One woman said that she had callouses on the soles of her feet, but these felt numb.

Consequently, when she got hurt in these areas, she would not feel it. For example, once she was on a see-saw when her playmates noticed that she had skinned her feet. She, herself, was unaware of the abrasion. A woman recalled that she experienced pain and tingling sensations, while another said she kept dropping things and leaving behind her slippers.

When they were children, the women were subjected to traditional methods of dealing with leprosy. These included being buried in a hole on the ground with the head uncovered; applying leeches on the skin; being prohibited from eating fish and chicken, as the rashes were considered as an allergic reaction; bathing in the sea; and eating cat meat. Home cures included drinking ginger infusions and those of leaves from *pitogo*[8], *makabuhay na baging*,[9] and *suha.*[10] Bathing with water in which *tanglad* (lemon grass) leaves had been boiled was another home remedy. Finally, leaves of certain herbs were also applied directly on the rashes or wounds.

FOR THE MAJORITY OF THE WOMEN WHO WERE INFECTED WITH THE DISEASE AT A YOUNG AGE, CONTRACTING THE DISEASE WAS PART OF GROWING UP, AS CHILDREN, THE GRAVITY OF THEIR ILLNESS NEVER DAWNED ON THEM.

Most of the women (22 out of 24) had family members who were also infected with leprosy when they were children. Sometimes, it would be both set of parents; at other times, it was either the father or the mother, or a sibling. Only two women said that no member of her family was infected with leprosy.

For the majority of the women who were infected with the disease at a young age, contracting the disease was part of growing up. As children, the gravity of their illness never dawned on them. It was their admission to medical care and the practice of segregation that signaled a departure from a normal life. However, their resiliency was best expressed by one woman when she said that as a child she did not mind the disease. In fact, she eventually got used to it.

LIFE AFTER DIAGNOSIS

The women found themselves in Culion under various circumstances. Some came from other leprosaria in the country, such as the Tala Leprosarium, Cebu Leprosarium, Albay Leprosarium, Zamboanga Leprosarium, and San Lazaro Hospital in Manila. They arrived in Culion with one or both of their parents, or siblings who were also infected with leprosy. Those whose parents were admitted into the leprosarium earlier were born in Culion. Interestingly, these women proudly introduced themselves as “Culion-born.” Some women were brought to Culion after they were “captured” by sanitary inspectors in their locality. This was true for the adolescents.

Those who arrived in Culion as children recalled the care of Casimiro Lara, a physician who served as the Chief of the Colony in 1947. *Reconocer was* the term they used to refer to the physical examination to which they were subjected. *(Reconocer* is a Spanish word which means to examine closely.) Standing on a platform with a revolving center, Dr Lara would take note of signs of the disease. Pricking different parts of the body, he would ask the child to count the number of pricks to ascertain whether or not a particular part of the body was numb. Fondly remembered by the women were the chocolate candies and powdered milk given to them by Dr Lara after the *reconocer.*

When queried about how they thought they got infected with leprosy, the women gave a variety of answers. Some said they were infected by their parents who were similarly afflicted. One believed that it was due to her genetic make-up, while another thought that she must have gotten the disease from her mother’s milk. Another felt that she must have gotten it from *pasma* or *espasmo* (Spanish for

spasm). In her words, “This illness is believed to be caused by an attack of ‘cold’ on someone who is too ‘hot’ or vice versa.”[11] Traditionally, it is recommended that a person not take a bath, (the cold element) after a strenuous exercise (the hot element) to avoid *pasma.* Similarly, women are advised not to take a bath (the cold element) when they have their menstruation (the hot element). One symptom of *pasma* is numbness, which also happens to be a symptom of leprosy. Echoing the *pasma* belief, another woman stated that she must have been infected with leprosy because of alternating weather conditions of sun and rain, and the onset of menarche. Finally, one woman attributed her leprosy to eating dried *kurot* (a kind of seaweed).

BEING SEPARATED FROM THE FAMILY AND ADMITTED TO AN INSTITUTION WAS AN IMPORTANT TURNING POINT IN THE LIVES OF ALL THE WOMEN.

LIVING WITH LEPROSY

Being separated from the family and admitted to an institution was an important turning point in the lives of all the women. Most of them vividly remember the time when they were admitted to a leprosarium as a child, regardless of whether or not they were accompanied by a parent who was also afflicted by the same disease. To them being uprooted from the warmth of home was unforgettable. The fact that they were separated from their parents within the Culion leprosarium mattered to them. (The children were sent to dormitories while their parents were admitted to the hospital.)

Even when the entire family arrived in Culion together, it did not guarantee that they would stay together. Children were often separated from the parents who were infected with the disease. When they were children, the women were entrusted to the care of the Sisters of Charity who ran a dormitory called Santa Teresita. Here, the women recalled following a strict schedule of doing household chores and going to school. Four of the women recalled being assigned to be *encargadas* or *bodegeras* (people who took care of distributing food rations or supplies to be used in the dormitory.)

The Sisters of Charity managed two dormitories—the Hijas de Maria for the older women and the Santa Teresita for the young girls. The Sisters were strict disciplinarians and they prohibited contact between men and women. As a result, they incurred the wrath of the men of Culion. On the evening of Holy Thursday, 25 March 1932, men armed with *bolos* and sticks surrounded the Hijas de Maria dormitory and took away about 30 of their women friends. Fearful that another attack could be staged, the rest of the women in the dormitory left with friends and relatives. By Saturday night only the house mother, a dozen young girls, and few policemen remained in the dormitory.[12]

MARRIAGE BECAME A FORM OF ESCAPE FROM THE STRICT SUPERVISION OF THE NUNS.

Marriage became a form of escape from the strict supervision of the nuns. One woman mentioned that after staying for a year in the dormitory she married a *leproso* (a man afflicted by leprosy) and they had 13 children. Another woman remarked that “life in the dormitory was difficult and rules were strict. I wanted to be free.” Consequently, she escaped from the dormitory.

However, for some women there was gratitude for the care given by the nuns. One woman remembered how the nuns consoled her by saying that God loved her despite her condition, while another was grateful to the nuns for giving her an education and kindling her religious faith. Knowledge in crafts such as crocheting and making paper flowers as well as developing talents in

singing or playing the piano was also attributed to the Sisters of Charity nuns.

Most of the women who were educated attended the Loyola College of Culion which was run by the Jesuit fathers.

There were cases among the Culion-born women being sent to Welfareville.[13] In 1925 babies who remained healthy until they were three years old were sent to Welfareville, where there was a special place for children from Culion. It had three houses—one for older boys, one for young boys, and one for the girls. Two of the women, both in their seventies, were sent to Welfareville. One stayed there for five years and the other for three years. Both eventually returned to Culion. One of them said that her mother who was left in Culion insisted that she be reunited with her daughter.

Other women from Culion spent some years in Tala Leprosarium,[14] which enabled them to attend school. One was even able to obtain a college degree in education, while another finished two years of high school. Like the women who were sent to Welfareville, the ones who went to Tala Leprosarium also returned to Culion.

THE EMOTIONAL PAIN WHICH THE WOMEN EXPERIENCED REVOLVED AROUND THEIR NOT KNOWING WHY THEY WERE STRICKEN WITH LEPROSY.

PAINS OF LEPROSY

The women spoke of the pain attendant to being afflicted with leprosy, both physical and emotional. Excruciating is the word that would best describe the physical pain they suffered. They frequently described their blisters and their whole body as *masakit* (painful). One of them recalled that she stopped schooling when she was in Grade Four because her skin hurt. She could not play because she felt pain, for example, whenever a ball hit her. Another said that she often felt feverish and she had wounds on her body that were painful. One woman mentioned that she was often confined in the hospital, while others spoke of alternating bouts of chills and fever. Another experienced agonizing pain when blister-like wounds appeared all over her body. Since the blisters soiled both one's clothes and bed linen, sometimes banana leaves were used as bed sheets so that blood from the blisters would not soil them. The leaves were also used to provide a cooling effect on the body. Finally, the inability to sleep because of the throbbing pain was also experienced by most of the women.

It was noted that the older women (those in their 80s and 70s) experienced more pain than the younger ones (60s to 40s). Perhaps this was because the older women were given the early forms of leprosy medication, not the Multiple Drug Therapy (MDT) which was only introduced in 1981. MDT is a combination of three bacterial drugs—Rifampicin, Clofazimine, and Dapsone. It is considered the most effective regimen to treat leprosy. Unlike the older women, the younger ones had the advantage of undergoing MDT in the earlier stages of the disease, hence the shorter duration of their treatment and possibly less pain.

The emotional pain which the women experienced revolved around their not knowing why they were stricken with leprosy. *Lungkot* (sadness) was the word they used to describe their feeling upon being diagnosed with leprosy. The source of this sadness differed among the women. One said that she was sad because her parents were ashamed of her. This feeling was aggravated when she was sent to Culion and lost contact with her parents. She bravely declared "I am all alone."

The emotional pain also stemmed from unfulfilled desires. One woman declared that aside from the physical pain she experienced, she felt sad about not being able to finish school because she was always sick. This woman had persevered and even continued to go to school even if she was older

than her Grade Four classmates. A similar desire was articulated by another woman who said she lost interest in pursuing a college education with a major in social work.

THE STIGMA OF BEING AFFLICTED BY LEPROSY SADDENED THE WOMEN. IT WAS MORE RAINFUL WHEN THEY WERE SHUNNED BY PEOPLE TO WHOM THEY WERE ENTRUSTED.

The physical deformities resulting from leprosy also caused most of the women emotional pain. Being stared at because of the scars of leprosy such as nose collapse, claw fingers, muscle atrophy, and amputated legs was painful. One woman narrated that once someone attempted to embarrass her by giving her the "give me five" gesture. She responded by showing him a clenched a fist. Another said she hides her claw fingers with a towel or tucks her hands in her pocket. One woman has special shoes to cover an amputated foot.

The stigma of being afflicted by leprosy saddened the women. It was more painful when they were shunned by people to whom they were entrusted, such as the nuns. One woman confided that it hurt her to be considered an outcast by the nuns. "I was loathed by the nuns," she said.

Being avoided by people out of fear of being contaminated brought pain to the women. They reported that neighbors shunned them. Even asking a neighbor for water for cooking or fire to kindle the stove was viewed by neighbors as an occasion for transmission of the disease. Most of the women reacted by distancing themselves. However, one woman was defiant. She did not consider herself an outcast. She was not ashamed to be labeled a *leprosa* (a woman afflicted by leprosy). In fact, she was proud to be one. In her belief, God wanted her to be a person afflicted by the disease. She said, "Who are they to consider me an outcast? I am a human being just like them." These words summed up her courageous stance.

The shame of being afflicted with leprosy brought pain to most of the women. For one of them, being diagnosed with leprosy was the most painful part of the disease. She added that she had lost hope in life. Another confided that she wanted to end her life upon learning she had leprosy. She felt that she did not deserve to be afflicted by the disease. One woman questioned God as to why she contracted the disease.

ACCEPTING ONE'S FATE

The initial pain and self-pity of all the women would slowly turn into acceptance of their condition. Different circumstances caused them to come to terms with leprosy. One woman accepted her fate when she saw other patients whose condition was worse than hers. Others were consoled by the nuns from the Sisters of Charity dormitory with whom they stayed for some time. The women were reassured when the nuns told them "Do not be sad and ashamed. God loves you." Such assurances made it easier for some women to accept their condition.

RELIGION, PARTICULARLY THE CATHOLIC FAITH, WAS A STRONG SOURCE OF HOPE AND COURAGE FOR THE MAJORITY OF THE WOMEN.

Religion, particularly the Catholic faith, was a strong source of hope and courage for the majority of the women. Although at the onset, they questioned God's wisdom for allowing them to suffer from leprosy, eventually their acceptance of God's will made them resigned to their condition. As one woman said, "It is the will of God. One should never blame God for one's fate." Another consoled herself by saying that her fate was the wish of the Almighty.

While religion was the source of solace for most of the women, two mentioned that it was their families' love and support that gave them the strength to accept their fate. Additionally, others accepted their condition when they recognized that having family members who were also stricken with leprosy, such as their parents, was the cause of their affliction. "It is in our genes," was their rationalization.

It is interesting to note that one woman indicated that she had no regrets in life despite her affliction.

LIFE AS A MOTHER

Leprosy took a toll on the health of women in ways that were different from the afflicted men. For instance, pregnancy posed particular difficulties for the women. One woman said she had blisters all over her body and she became bedridden when she was pregnant with her eldest child. Another mentioned that she had to be very careful when breastfeeding her baby because the doctor cautioned against having the baby touch her open wounds.

Some women spoke of a relapse, which is defined by the World Health Organization as "a patient who successfully completes an adequate course of MDT, but subsequently develops new signs and symptoms of the disease during the surveillance period or thereafter."[15] One woman mentioned that she suffered a relapse when she gave birth to her twins. Her relapse took the form of a fever. She was *lagnatin* (prone to having a fever) and just generally felt feverish. Although pregnancy increased the chances of a relapse from leprosy, this did not deter the women who had suffered a relapse from having many children. One woman had n children, while two other women had seven and five children each.

Besides having difficult pregnancies, the women also suffered being separated from their children. The practice of segregating babies from their mothers was experienced by the older women. One woman who had 13 children mentioned that eight of her children were put in the nursery, and she missed them terribly. She raised the remaining five children herself. Another woman remarked that of her seven children, three were entrusted to the nursery while four were raised by her.

THE WOMEN WERE NOT AVERSE TO GETTING INTO ANOTHER RELATIONSHIP WHEN THE FIRST RELATIONSHIP DID NOT WORK.

It seems that most of the children of the women were not infected with leprosy. For instance, the 13 children of the woman mentioned previously were not afflicted by the disease. Another woman had eight children who were all free from the leprosy. For these women, it was a relief to know that their children were not ill and they were thankful to God for this blessing. Nevertheless, two women were not so fortunate. One of them had 10 children. The eldest was confined at Tala Leprosarium and eventually committed suicide. The other woman had seven children and one was "suspected" of having leprosy.

AS WIFE OR PARTNER

Except for one, all of the women had either been married in church or had a live-in arrangement with a man. Their partners included *leprosos* (men infected with leprosy) and *sanos* (men not infected with leprosy). Most of the women met their partners in Culion.

The women were not averse to getting into another relationship when the first relationship did not work. For instance, the husband of one woman left her for another woman while she was in Tala

Leprosarium. When she returned to Culion, she entered into a relationship with a *sano* who was 26 years her junior.

It was not uncommon for the women to have partners younger than themselves, as in the previous case. Similarly, a 44–year old woman who was separated from her husband lived-in with a 31 year old man.

The live-in arrangement seemed to be an acceptable practice among the women. One of them married when she was 53 years old. She had lived-in with her husband for seven years prior to their marriage. Another woman became a live-in partner of a widower who had three children. She had been employed as household help in the family and wanted to leave, but the widower prevailed on her not to go. According to her, she pitied the children so she stayed. Finally, one woman lived with a *leproso* whose wife had abandoned him because of his illness. The woman did not marry him because he was married to somebody else. As she explained, “1 am telling you the truth because I am not one who is ashamed of things like this.”

ALL OF THE WOMEN REMAINED HOPEFUL. THEIR OPTIMISM STEMMED FROM THE FACT THAT THEY HAD ACCEPTED THEIR ILLNESS, THEY HAD BEEN CURED. AND THEIR SPIRITUAL FAITH WAS STRONG.

HOPES FOR THE FUTURE

Despite the many setbacks in their lives, all of the women remained hopeful. Their optimism stemmed from the fact that they had accepted their illness, they had been cured, and their spiritual faith was strong. Thus, it was not surprising that they had aspirations for the future.

When queried about their future, most of the older women (70–80 years old) were hopeful, though their aspirations were simple. Foremost among these were to be comfortable, eat good food, and stay healthy. Perhaps this was the doctor’s recommendation in order to avoid a relapse. Some aspirations were social in nature, like to be able to see their grandchildren grow up, finish school, and lead their own lives or even for them to be able to teach their grandchildren skills in crafts, farming, and selling; to resolve problems with their children; and to visit other places and reconnect with relatives there. One woman specified that she wanted to live long enough to enjoy the privileges of being a senior citizen.

Nevertheless, a few of the older women were not as optimistic. Having experienced much hardship in their lives, they wished for an early death. One of these women had a problematic marriage and the other one had a marriage that was never consummated. The onset of diseases related to ageing also affected the health and outlook of one woman in her eighties. She suffered from arthritis and hypertension, and she had periods of poor health as well as good health.

In contrast to the older women, the younger ones (40–60 years old) were more optimistic. For them there was a future to look forward to. Having been cured of the disease at an early stage gave them hope and they felt useful to society. To them being employed was the most tangible sign of their usefulness. Many of them worked in the Culion hospital as nursing attendants or as staff of the laundry and kitchen sections. Though they were not regular employees, they received a gratuity for their services. They felt useful because they had some form of gainful employment. Other women felt useful because they engaged in farming, accepted laundry, raised pigs, or worked as household help.

One woman stood out because she has remained very busy. She is the federation president of Persons with Disability and secretary of the Association of the Culion Hansenites, Inc. She is also a choir member of the church. She confessed that initially she was sad and lost hope because of her affliction, but now she declares that while she is strong and alive, she would like to serve her

community. She also derives strength and self-fulfillment when she shares her story with others.

SEGREGATION AND THE STIGMA ATTACHED TO THE DISEASE WERE TURNING POINTS IN THEIR LIVES.

Like their older counterparts, some younger women wanted to visit their relatives. Among them was a Tausog mat weaver who wanted to see her relatives in Zamboanga del Sur because their houses were destroyed by typhoon "Yolanda."

The only unmarried woman in the younger group said that she was resigned to stay in the Yangco Pavillion[16] because she was assured of medical care and nutritious food there. To her, institutional care was better than life outside. Though she had family members living in Culion, she preferred to be cared for by the hospital rather than her family.

CONCLUSION

The life journeys of all the women interviewees have been interesting. Before being diagnosed with leprosy at a young age, they all had a happy childhood, though most of them had parents who had the disease. In fact, most of the women thought it was part of growing up. The resiliency of the youth infected with leprosy is summed up by the remark of one woman: "When I was a child, I did not mind being sick with leprosy."

The pain and sadness caused by leprosy occurred when the women were separated first from their families and then from their own children. Segregation and the stigma attached to the disease were turning points in their lives. Henceforth, they experienced disappointment and discouragement until they learn to accept the disease and to be resigned to their fate. The rationalization that heredity must have been the reason for their illness or that it was the Lord's will made acceptance easier. Their faith in God, particularly among the Catholics, was a source of solace. There was only one instance when the thought of ending one's life was articulated.

Living in the midst of other leprosy patients in the Culion leprosarium lessened the stigma for the women, though they experienced it when they interacted with people who were not infected with leprosy both inside Culion and outside. This stigma was pronounced when they displayed their physical impairments such as claw fingers, nose collapse, drop feet, amputated feet, and facial disfigurements. Indeed, leprosy has scarred them both physically and emotionally. However, one can marvel at how they have overcome such impairments. Their claw fingers can still crochet, do the laundry, and engage in productive work with the use of the hands.

To deal with the stigma, some of the women practice self stigmatization. In other words, they themselves keep their distance from others. Some are grateful to family members who explain to friends and other relatives that leprosy is a non-communicable disease, as ignorance of the disease contributes to the practice of stigmatization.

All of the women were all treated with Multiple Drug Therapy (MDT). This drug has facilitated the cure of the disease and given hope to all the women.

In conclusion, these oral histories have documented the experiences of women with leprosy and the effect of the disease on them. In particular, these histories have revealed a social dimension of leprosy, particularly the underpinnings of pregnancy and lactation among these women.

It has been asserted that detection of leprosy among women is lower compared to men.[17] This is because women generally have a lower status in society, and consequently lack access to health services. Thus, "one of the present challenges in leprosy services is to improve or enhance accessibility for the diagnosis and MDT treatment of women early to prevent disabilities and to

diminish or remove social stigma."[18] Additionally, the issue of gender in leprosy studies should be investigated further. More studies on the experiences of women afflicted with leprosy and their journey towards a new lease in life will enhance our understanding of this disease.

NOTES

1. Luis Guerrero, "Topographical Distribution of Leprosy in the Philippines," *Journal of the Philippine Islands Medical Association* 7 (March 1927).
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4. Culion Medical Board, "Leper Segregation and the Treatment of Leprosy," *Journal of the Philippine Islands Medical Association* 5 (December 1923); C.B. Lara, "Progress of Leprosy Treatment at the Culion Leper Colony," *Journal of the Philippine Islands Medical Association* 10 (November 1930).
5. These include Carol Shieh, Hsiu-Humg Wang, and Ching-Feng Lin, "From Contagious to Chronic: A Life Course Experience with Leprosy in Taiwanese Women," *Leprosy Review* 77 (2006) and Corlien M. Varevisser et al,, "Gender and Leprosy: Case Studies in Indonesia, Nigeria, Nepal, and Brazil," *Leprosy Review* 80 (2009).
6. Corlien M. Varevisser et al. "Gender and Leprosy."
7. *An-an* and *ap-ap* are local terms that refer to a fungal infection which appears on the skin. *An-an* is Tagalog, while *ap-ap* is the Visayan equivalent.
8. *Pitogo* is a tree whose scientific name is *cycas wadei.* It was introduced in Palawan by H. W. Wade, a physcian who worked in the Culion Leprosarium during the American period.
9. *Makabuhay* is a vine which belongs to the family *Menispermacaea.* Its stem was used as a cleanser for skin ulcers and wounds.
10. *Suha* is the Tagalog word for *Citrus decuman.* Its leaves are used for aromatic baths.
11. Michael Tan, *Revisiting Usog, Pasma, Kulam* (Diliman, Quezon City: University of the Philippines Press, 2008), 94.
12. *Culion Island; A Leper Colony's 100-Year Journey Towards Healing* (Culion Foundation Inc., and Fundacion Anesvad [Accion Sanitaria y Desarollo Social], 2003), 88–89.
13. This was a place in Mandaluyong, Rizal where various welfare institutions such as orphanages were housed.
14. Tala Leprosarium, formerly known as the Central Luzon Sanitarium, was founded in 1940. It is located in Tala in present-day Caloocan City, Metro Manila.
15. Judy Maripet Cruz-Cataquis and Arturo C. Cunanan, *Culion*, (publication funded by the Sasakawa Health Foundation, n.d.) 216.
16. The Yangco Pavillion is part of the Culion Hospital which houses the elderly patients who have been abandoned by their families.
17. Cruz-Cataquis and Cunanan, *Culion,* 222
18. Ibid.

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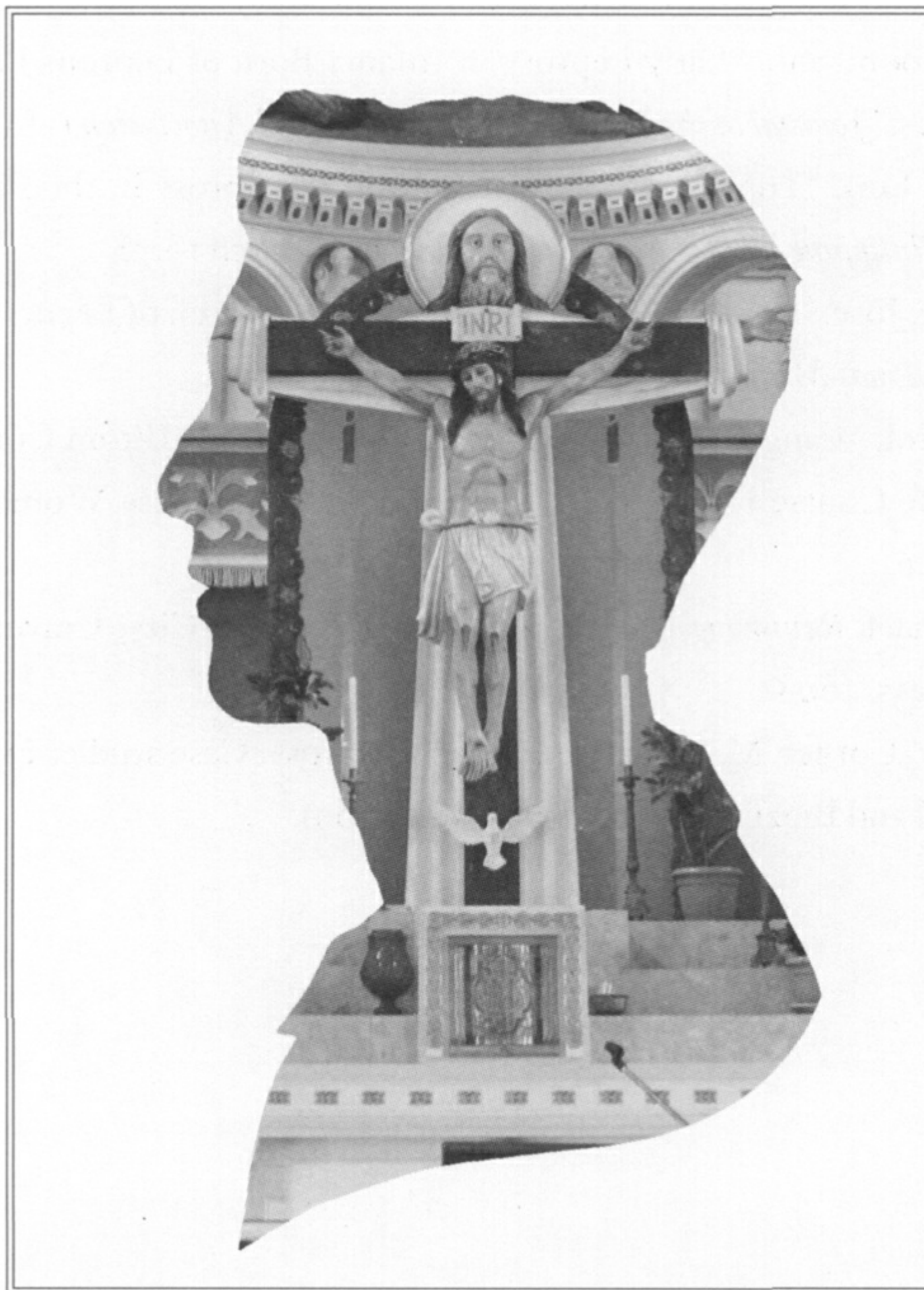

Altar of La Imaculada Church, Culion, Palawan

IDENTITY AND STIGMA: LIFE STORIES OF AFFLICTED MEN IN CULION

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Stigma is the possession of a devalued attribute considered to be undesirable by society. It is dehumanizing since "a person who is stigmatized is (one) whose social identity or membership in some social category calls into question his or her full humanity"[1] and excludes the person from acceptance by and entry into society.[2]

Stigma has identifying signs which mark the possessor as clearly different or deviant from the larger group. While what is considered to be a stigmatized condition may vary across groups and time periods, other conditions may have an evolutionary basis for the stigmatization[3] so that attitudes and perceptions regarding a particular condition remain relatively stable across time and across large groups of people.

> STIGMATIZED PERSONS ARE USUALLY OSTRACIZED, MARGINALIZED, AND SOCIALLY EXCLUDED. . . THE EFFECTS OF SUCH NEGATIVE REACTIONS CAN BE DEVASTATING.

In the psychological literature, Jones et.al.[4] identified six aspects of stigma which influence the reactions of others. These include concealability, social disruptiveness, aesthetics, personal responsibility for the condition or for its progression, and the severity of threat it holds for others. Thus, a person will be shunned if he is considered to have caused or to have had a part in bringing about the condition and its progression, if the condition is either highly visible or repugnant, or if the condition is such that it limits the person's social interactions and relationships largely because of the threat it poses to the life and health of these others.

Leprosy is a stigmatized condition. Evaluated against the six aspects that Jones et.al. identified, it would fare badly. In its advanced stages, the disease is difficult to conceal and it disrupts social relations on various levels (interpersonal, family, and community) because of strong adverse reactions from others. Oftentimes, the condition is blamed on something which the individual may or may not have done. It is often feared because of the disfigurement it causes, which may result in strong primal fears of contagion.

Hence, stigmatized persons are usually ostracized, marginalized, and socially excluded. Given that

people are considered to have a social nature, the effects of such negative reactions can be devastating. The person may experience poor mental health, low self esteem, depression, poor social relationships, and feelings of powerlessness and helplessness All these may lead to low academic achievement and poverty, among others.[5] Thus, Dovidio et al. conclude that “stigmatization is personally, interpersonally, and socially costly.”[6]

Despite the fact that medical advances have blunted the damaging effects of leprosy, it remains a condition whose very mention evokes dread, revulsion, or despair. Widespread misconceptions and myths abound regarding the disease and those afflicted by it. Some of the earliest references to leprosy are found in the Bible wherein the afflicted were considered to be “unclean” and “defiled,” shunned and cast off from the rest of society because of their disfigurement. They were often blamed for their condition, which was considered a divine punishment for their sins.

But what is the situation like today? Have there been changes in the responses of those who are or have been afflicted with the condition? What about the responses of the people around them?

This study scrutinizes the lives of a small group of males who had been diagnosed with and treated for leprosy. In particular, it examines how their lives and appraisals of self and identity have been affected and shaped by their condition.

Given the depth of emotional response which the disease evokes, as well as the strong negative evaluation associated with it, it is hypothesized that diagnosis will not only shape the way in which the person afflicted with it will see himself. It will also affect the way he interacts with others as well as the manner in which these others will perceive and respond to him.

The question of identity—how it is constructed, its maintenance and stability as well as its attendant aspects of self-worth and self-esteem—are thus the focus of this study.

METHODOLOGY

Given the exploratory nature of this study, a qualitative approach was deemed most appropriate to elicit the desired data. Hence, the study utilized the in-depth interview which enabled the respondent to express himself more fully, at his own pace, and in his own manner. Using a conversational tone and manner, designed to put the respondents at their ease, the interviewer made it clear at the outset that the focus of the encounter would be their life story and experiences as these were affected by leprosy.

I. DATA GATHERING

In-depth interviews were conducted with 16 men who had been treated with Multi-Drug Therapy (MDT) in the Culion Sanitarium. Many described themselves to be negative for the disease at the time of the interviews while there were also those who appeared to be active cases, judging from their stories and/or their appearance.

The interviews explored the men’s early lives and personal histories, focusing on the effects of discovering they had leprosy and how this influenced their relationships with their families, friends, and spouses; their self-appraisals; and the course of their lives over time. Each person was met individually and his permission to record the interview was obtained. The interviews were conducted in Pilipino and loosely followed an interview schedule, though the men were allowed to relate their stories in their own way. The tone of the interview was kept light to maintain the appearance of a conversation. The interviews were conducted in the men’s homes, an office in the Sanitarium, and in the deserted dining room of the hotel where the researcher was staying. Generally, the main body of the interview took about an hour to complete.

II. THE INTERVIEWEES

Many of those who were interviewed were elderly. The oldest was an active 86, with the rest of the group clustering in the 40s to 60s age group. Only one was young at 18 years of age. The average age of the interviewees was 55.6 years.

They had grown old in Culion, they recounted, with one respondent describing their group as currently an endangered species. There were hardly any new cases diagnosed in the recent past, and over time, the number of names recorded in the registry of those with the disease had decreased. He estimated that there were only about 100 or so of them left and soon, there would be none, he added.

Five of the men were born and raised in Culion since they had parents who were *leprosos* (males afflicted with leprosy). Six were from the Visayas, four were Muslims from Mindanao, and one was from Luzon. All eventually found their way to Culion, with most coming by way of previous institutions in Zamboanga, Cebu, and Metro Manila. Apart from those born on the island, the men had lived in Culion for an average of 26.75 years, with the longest period of residence at 60 years and the most recent at 4 years.

All the men came from a low socio-economic background. Indeed, there were those who spoke of being given away as children to relatives to be raised by them because their parents could not afford to keep them. Once in the care of these relatives, they spoke of benign neglect, which they believed could have contributed to contracting the disease. Most blamed poverty for their failure to seek treatment when the first signs appeared or for their inability to afford the medication prescribed. Except for two who finished college and two who graduated from high school, the rest had barely any schooling because of the need to work to supplement the family income or because their condition kept them out of school. What work they found was mainly in fishing or in low paying manual jobs. One spoke of working as a houseboy when he was 10 years old, helping out in a sari-sari store, and driving a tricycle at 14. The two who finished college went on to become public school teachers.

They came from large families of 5 to 6 children, though one had 9 siblings and another had 11. Seven had family members, oftentimes siblings, with leprosy; five had parents with the condition. These parents met while undergoing treatment in Culion. They married soon after and raised a family. The nine others admitted that they were the only ones in their families with leprosy, if the accounts of their families and relatives were to be believed.

Many of the men were diagnosed as children. For five of them, discovery of the first signs happened during a routine weekly examination of children of *leprosos.* For the others, it happened by chance. They were bathing (skinny-dipping) in the river so that others saw and pointed out the symptoms. The youngest was diagnosed when he was three years old while the others said that they were about six or seven years of age when the symptoms first appeared. Three were diagnosed when they were adolescents (14, 15, and 18 years, respectively) while three others were already adults (26, 27, and 36 years) at the time of discovery.

RUNNING THROUGH THESE ATTRIBUTIONS WAS THE IMPLICATION THAT THEY WERE VICTIMS, UNDESERVING OF THEIR CONDITION AND, THEREFORE, NOT TO BE BLAMED FOR IT.

BELIEFS REGARDING THE CAUSES OF LEPROSY

Upon being diagnosed with leprosy, the question which bedeviled the men was how they were infected. Those who had parents or relatives with leprosy often asked why. Why them? Why not their other siblings? Why only them?

Their search for answers often led them to consider either internal or external factors. When they

believed that the disease was because of something they did, an internal cause was implicated. Otherwise, it was something that happened to them, outside of their control. More of the men believed that their condition was because of external factors, hence absolving them from blame.

The most common causal factor identified was spiritual in nature. God punished them with the condition, they believed, and while they couldn't understand why God singled them out for this punishment, there had to be a reason for it. All they could do was to accept it.

A former fisherman attributed his condition to being cursed by sea spirits (*bati-bati*) whom he might have inadvertently angered while fishing. Another said it might have been due to an airborne virus which swept through their barangay while he was a child, so that several persons, including himself, found themselves to have leprosy.

Running through these attributions was the implication that they were victims, undeserving of their condition and, therefore, not to be blamed for it.

However, some of the men eventually conceded that they may have contributed to their condition because of a previously unhealthy lifestyle, which included excessive drinking, carousing with women late into the night, and using drugs—all of which could have weakened their constitution, rendering them more susceptible to contracting the disease. Others pointed to a family history of leprosy, believing it to be hereditary in nature and thus fearing for their own children. However, one man was careful to clarify that it takes two *leprosos* to pass the condition on to at least one child. The chances of this happening when one was a *leproso* and the other a *sano* was almost nil.

Another common explanation which the men gave was having weak blood or a weakened constitution at the time of infection. This weak blood could have been a latent family condition manifesting in the weakest family member or earlier exposure to a *leproso* by the weak family member. One man remembered giving alms to a leper in his neighbourhood as a child. Could this act of past generosity have been the reason for his present condition, he wondered.

Another issue which the men grappled with during the interview was whether or not their condition was contagious. Most of them denied the contagious nature of their condition; if this were true, then all the people they had come in contact with should also have contracted leprosy. Nevertheless, they did not believe in taking any chances, so they voluntarily limited their social interactions and they were always careful in their behavior.

ONCE ACCEPTED, THE LABELS WHICH OTHERS USED FOR THEM, BEGUN TO SHAPE THEIR SELF-IMAGE.

LABELS AND IDENTITY

The men referred to themselves as *leprosos*, or less commonly, as *lepras*. One said that among the Visayans they were said to have *sanla* (leprosy) or were *sanlahun* (afflicted with leprosy), while another said that the Tagalogs referred to them as *may ketong* (afflicted with leprosy). It was not easy for them to accept these labels and the stigmatized identity that came with them. Accepting these labels came only after a long and difficult struggle. However, once accepted, the labels which others used for them, begun to shape their self-image.

Many of the men struggled with these labels. They spoke of the process of acceptance as one marked by denial and attempts to hide or explain away the symptoms, followed by anger which was oftentimes directed outward, then by depression, and finally, after the passage of several years and the onset of more symptoms, by an uneasy acceptance. Essentially then, their struggle and the process they went through seem to mirror the different stages of grieving which Kubler-Ross identified.[7]

THROUGH MANY OF THE MEN ARE NOW CONSIDERED NEGATIVE FOR LEPROSY, THEY CONTINUE TO ASSUME THE IDENTITY OF *LEPROSOS*.

The red spots, white patches, and urticaria (*pantal-pantal*) which often marked the early onset of the condition were initially ignored until these were forcibly brought to their attention by family members or by the people around them who counselled medical attention. These white spots were usually passed off as skin conditions called *an-an* or *ap-ap*[8]. Oftentimes, the process of identification was delayed by misdiagnosis—their symptoms passed off as an allergy by the first doctors they consulted and whose treatments often exacerbated the condition. In a few instances, the resistance to going for treatment was reportedly because of poverty, though further discussion often revealed an anxiety over what might be found. In several instances, the men had to be brought forcibly and accompanied by others to see a doctor.[9]

They spoke of being angry for a long time, usually about two years, on the average. This anger was often initially directed at God, since many regarded the condition as God-given though they failed to understand His purpose. Others denied this anger at God and directed it towards themselves (self-blame), saying that they might have had some hand in bringing about this condition. They spoke of indulging in undesirable behavior in the past which weakened their resistance, rendering them susceptible to infection. They implicated a family history which predisposed them towards the disease. Indeed, the most common explanation for their leprosy was inherited weak blood. One man spoke of his father vainly trying to protect him by plying him with vitamins as a child. At present, they claimed to have given up all vices and unhealthy behavior and now take very good care of themselves since they feared the return of the disease.

Though many of the men are now considered negative for leprosy, they continue to assume the identity of *leprosos*. They called themselves *nega* (for negative) or *ex* (for the condition), but never once did they refer to themselves as "normal" or "well" during the interviews. One man reported that his family wanted him back with them after being pronounced negative. However, he told them he could never go back, because "*Iba na ang mundo ko*" (I have a different world/life now) and "*Iba na ako*" (I am different now). This man had been physically and emotionally scarred by leprosy and though now negative for the disease, he could not change his stigmatized identity and self-concept.

The men make a clear distinction between those who never had leprosy and those who have/had it. This is so even if there were no visible marks from the condition, or if there were, such marks could be easily concealed. Examples given were scarred legs covered by long pants and disfigured feet hidden by closed shoes. Such marks served as constant reminders of their identity as *leprosos*. While these marks could be concealed from others, they were always aware of them.

Additionally, other people never let them forget their identity as *leprosos*. Two spoke of friends who constantly counselled them to take care of their health so as not to suffer a relapse. Another spoke of those who cautioned him to restrict his activities, avoid mingling too much with others, and keep the welfare of those he encountered in mind. While well-meaning in intent, these reminders only served to maintain and strengthen their stigmatized identity, the men concluded with some bitterness. Even when they were considered recovered, the marks of leprosy could be concealed, and the men could well pass as healthy and normal, they continued to be perceived by others as *leprosos*.

Thus, the men came to believe that one is never cured or finally free of leprosy. There were the marks as a constant reminder—the disfigured hands and feet, the stumps of what used to be fingers or toes, the lack of sensation (*inosente*) in the extremities, and the scarred legs and body. There was also the weakened state of health, so one was more vulnerable to infections, kidney problems, and urinary

tract infections (UTI), among others. According to one of the men, “Leprosy does not kill; it is these by-products which do.”

ALL OF THE MEN REPORTED PAINFUL PERSONAL EXPERIENCES BECAUSE OF THEIR CONDITION. MOST HURTFUL OF THESE EXPERIENCES WAS THE REJECTION BY THEIR PARENTS AND FAMILY MEMBERS.

PERSONAL EXPERIENCES WITH PREJUDICE

All of the men reported painful personal experiences because of their condition. Most hurtful of these experiences was the rejection by their parents and family members. They became emotional or deliberately dismissive when they spoke of how their parents turned from them in disgust and revulsion (*nandidiri*) when their condition was first diagnosed and especially when the symptoms became more pronounced. They were driven away from home to protect the other members from contagion and because of their frightful appearance. Once in Culion, all contact with family members was severed, though not by them. One recalled writing his siblings a letter and receiving no response. Maybe, he commented wryly, they were afraid of catching the disease by merely opening his letter. They had no communication with their friends or neighbors. In fairness, however, they also spoke of how they and their family members kept their diagnosis a secret and lied about their present whereabouts. As far as his friends were concerned, one said, he had relocated to a far-off place.

There were also their neighbours who begged them to stay away or to leave the area and never come back because of their condition. These neighbors also advised their families against visiting them, lest they transmit the disease to others upon returning home to the barangay.

Two men reported abandonment by their wives. One wife simply said she was leaving for a while to look for a job. However, she never came back and her husband never heard from her again. Another wife was pressured by relatives to leave her husband of 20 years because of his condition.

All the men detected a change in the behavior of others towards them when news of their condition spread. Neighbors and friends remained friendly but took pains to keep their distance and avoid all physical contact. There were averted glances and surreptitious whispers when the men walked by. These muted responses became more open and vicious during drinking sessions when alcohol disinhibited the need to be polite. People laughed and made fun of them when they dropped things or when they could not get a firm grip on objects because of their non-functional hands. At home, they noticed their possessions were kept apart from those of others and all the utensils they used or touched were boiled in water after every use. Those who were diagnosed as children reported being teased and taunted by their classmates, especially when their symptoms became more pronounced, or of being kept away from school (and hidden at home) to spare their families from shame.

Two men spoke of multiple past humiliations when people refused to get on the same public vehicle with them when they were undergoing treatment in Tala Leprosarium. People preferred to crowd together in other public vehicles rather than share a ride with any *leproso.* While this made for spacious, comfortable rides for the men, this public repudiation was very hurtful and humiliating for them.

All the men were familiar with and recounted stories regarding children of *leprosos* who left Culion as soon as they could and thereafter denying their place of origin, all because of the strong association of Culion with leprosy. They spoke of children disowning their parents, of failing to invite them to or even to inform them of important milestones such as marriages and christenings in these children’s lives, and of refusing to return to Culion for the wakes and burials of *leproso* parents. The men spoke longingly and emotionally of wanting to see their families and their children and to be

with them, or even to meet and hold grandchildren who were kept away from them.

THE MEN SPOKE LONGINGLY AND EMOTIONALLY OF WANTING TO SEE THEIR FAMILIES AND THEIR CHILDREN AND TO BE WITH THEM, OR EVEN TO MEET AND HOLD GRANDCHILDREN WHO WERE KEPT AWAY FROM THEM.

The men recalled how, in the past, Culion was divided into two sections: Balala (the *sano* side) and their side. These two sections were kept separate so much so that a permit was required to enter either side. Violators of the curfew imposed or the restrictions noted on their permits were actively hunted.

In earlier times, *leprosos* were routinely rounded up for containment and those trying to escape were shot. (One added with bitterness that the guard who did the shooting was then hailed as a hero.) Another spoke of his own experience when a group of them were rounded up in their area for transport to Culion. All were frightened because rumors of what awaited them in Culion were rampant. At the last moment, several escaped, believing that once in Culion, they would be burned alive.

Perhaps the most heartrending was the story of one man who lived through the early days of the Segregation Law. He was born in Culion to *leproso* parents and was among the first batch of children who were forcibly taken from their parents and settled in Welfareville. He was two at the time, he says, and was comforted only by knowing that he was with his other siblings. However, he developed symptoms when he was 15 years old, so he was abruptly separated from his siblings and transferred to Tala Leprosarium. Just as before when he had no chance to say goodbye to his parents in Culion, he had no chance to say goodbye to his siblings. Neither could he take any personal belongings with him. Although he was finally reunited with his mother when he made his way back to Culion, he regrets the time away from his parents and never knowing what it was like to be with and to be loved by his parents. There was bitterness and pain in his voice when he spoke of finding out that his father had died while he was in Welfareville. He now spends much of his time thinking of his siblings, wondering whether they are still alive, and if so, whether or not they still remember him.

All the men said that once they arrived in Culion, they were effectively alone. They had no contact with family and friends. Perhaps it would be more accurate to say that they were cast off and forgotten by these people. It is as if they had ceased to exist once they became *leprosos*.

ANGER AND BEWILDERMENT WAS A COMMONLY REPORTED RESPONSE TO BEING DIAGNOSED WITH LEPROSY.

RESPONSE TO DISCRIMINATION

Anger and bewilderment was a commonly reported response to being diagnosed with leprosy.

When the first symptoms of leprosy emerged, the men adopted various guises to hide them from sight. Thus, hair was grown longer to cover droopy ears; shirts with long sleeves or jackets were the preferred apparel to hide reddish spots or white patches on the arms; long pants were used to hide scarred legs; and closed shoes were used to cover swollen and disfigured feet. One man recalled slathering pomade on his arms and legs to lubricate and make them look shiny. When asked why they went through this elaborate camouflage, the men replied that they were ashamed to have people see them with those symptoms.

Several men recalled being hidden by their parents when they were younger so that no one would

know they had a family member with leprosy. As a young man, another recalled having to do his courting in places far from his hometown where no one knew of his condition. This was the only way he could get close to the girls, he said. As young men, many courted and fathered children with *sano* women who were kept ignorant of their condition. One only revealed his condition to his wife when his symptoms re-emerged after marriage, hoping her marriage vows would keep his wife from abandoning him.[10] These fears of repudiation and abandonment were real and terrifying for the men. It was not without basis as neither marriage vows nor a long married fife with a *leproso* kept two of the wives from eventually abandoning their husbands.

The two men who had been abandoned by their wives said that they had not dared to enter into any intimate relationships afterwards, despite great loneliness and prodding from their friends. One said that he could not go through the pain of falling in love and being rejected again because of his condition.

When they had children of their own, many counselled these children to keep quiet about their fathers, hoping to spare their children the adverse reactions of others. One man said their children deserved good lives, which might not be possible if it was known that their fathers were *leprosos.*

One spoke of being so ashamed to face others and being so depressed at his situation that he refused to leave his house for three months. Another confided that he made brief surreptitious visits to his family, even after he had apparently left them and the barangay for good. Once there, he hid in the house, forbidding his family to reveal his presence to anyone. His family also nurtured the fiction that he was well, successful, and living in Cebu, but too busy to visit or communicate with his old friends.

Late into the interviews, four men finally revealed suicidal intentions and/or attempts in the early days of their condition. One methodically planned his death by poison when he was a child of 11 because he could no longer bear the taunts, whispers, and finger-pointing that followed him everywhere he went. Another tried to drown himself at sea as he contemplated his condition and unhappy future, but he was prevented from doing so by his fellow fishermen. He was subsequently subjected to a suicide watch for the rest of the voyage. One man recalled talking to himself about suicide and building up his courage to do so. He was only prevented from killing himself by a nun who overheard him and lectured him about the great fortune of having leprosy. Upon his death, the good nun confided, he would go straight to heaven since he had already suffered so much here on earth. While he did not believe this, it did stop him from any further thoughts of suicide.

All the men agreed that suicide was always an option, one which many in their situation had chosen to take. Many in fact knew *leprosos* who had chosen this way out.

They opened up about their anger and bitterness at the cruelty of others, which was sometimes unthinking, but often deliberate. They had already suffered enough, they said, and were not to blame for their condition. Therefore, why should they be punished?

Because of their histories of constant rejection by loved ones, friends, and strangers, the men learned to be hypersensitive to cues which they associated with rejection. They walked with heads down, averted gazes, or lowered eyes so as to avoid seeing others react at the sight of them. Nevertheless, they continued to feel these glances and hear the whispers. According to one man, when people glanced his way, he could feel them looking at his shod feet and seeing the swollen stumps concealed therein. Over time, they learned to anticipate the reactions of others and to act on these anticipations; they retreated into themselves or kept to what they knew to be safe.

ALL THE MEN AGREED THAT SUICIDE WAS ALWAYS AN OPTION, ONE WHICH MANY IN THEIR SITUATION HAD CHOSEN TO TAKE.

FEELING SAFE IN CULION

The men considered Culion a safe place. Here they could live without shame or fear. They could walk around the place in their shorts, undershirts, and slippers, with their scars and disfigurements in fall view of everyone, and not be rejected. This they could not do anywhere else.

Nevertheless, the men were divided when asked whether there was truly no prejudice and discrimination in Culion. Some said that they were accepted in Culion and they had friends among the *leprosos* and *sanos*. Others disagreed, saying that the new settlers (*dayos*) regarded them with fear or revulsion. They spoke of the same whispers and averted glances, which they encountered outside Culion.

Many had already mustered enough courage to leave Culion, but they had only gone as far as Coron, the next island, and usually only for special occasions, such as fiestas. Outside Culion, they covered themselves up from head to foot—using long sleeves, long pants, closed shoes, and a small towel or handkerchief wrapped around their hand to cover their gnarled or swollen hands. More often, they would walk with their hands in their pants pockets, effectively keeping their give-away hands from view. They walked quickly, keeping to the side of the road with heads down and refusing to look people in the eye. When people noticed their hands and asked why, they lied. They would say that they lost the fingers in an accident or because of dynamite fishing. Gnarled hands were explained away as *pasma*.[11]

IN A WAY, THE MEN HAD ESTABLISHED NEW LIVES IN CULION. MANY HAD REMARRIED, FORMED NEW FAMILIES, AND DEVELOPED GOOD RELATIONSHIPS WITH OTHERS IN THE PLACE.

CULION IN THEIR FUTURE

At the end of the interview, the men were asked whether they saw a future for themselves in Culion. Most of the men said that they would probably end their days on the island. Given how much time had already passed, their parents and siblings were probably dead and they would be strangers to the younger generations. The friends from their early years would have died or forgotten about them as well. There was nothing to go back to, they concluded. Additionally, there were too many associations of pain and shame with their lives before Culion.

In a way, the men had established new lives in Culion. Many had remarried, formed new families, and developed good relationships with others in the place. They had acquired lands, which they farmed. Some occupied their days doing odd jobs and part-time work, but all had stayed because of the regular stipend they received.

Because they were officially registered[12]—though where exactly was a cause of some confusion—they received a monthly allowance which provided for their daily needs. Some said that the money came from Dr. Arturo Cunanan, Jr., the director of the hospital in Culion while others said it was from the Department of Social Welfare and Development (DSWD). Still others made vague mention of the government. They received PHP200 every Monday and PHP750 every 15th and 30th of the month. All were grateful for this help, though some complained that it was proving increasingly difficult to survive on that amount.

At the end of the interview, several men confided that they had plans of leaving Culion in the future to settle elsewhere. They had discussed this with their wives and were already saving money for this purpose. When pressed for specifics, however, they gave vague and uncertain responses as to where they would go or even when they would leave the island. Thus, it seems that such plans are goals that sustain them and provide hope, but which they do not really believe to be possible.

LEPROSY IS MORE THAN JUST A DISEASE THAT ATTACKS THE BODY AND LEAVES IT DISFIGURED. IT IS A CONDITION THAT DAMAGES THE PERSON ON THE PHYSICAL LEVEL, AND MORE IMPORTANTLY, ON THE EMOTIONAL AND PSYCHOLOGICAL LEVEL AS WELL.

CONCLUSION

Leprosy is more than just a disease that attacks the body and leaves it disfigured. It is a condition that damages the person on the physical level, and more importantly, on the emotional and psychological levels as well. It can even be said to change him completely—his body image, self-appraisal, relationships, and perceived future.

At the core of all these appraisals is the identity the person holds of himself. Very simply, identity may be defined as the thoughts and feelings a person has of himself. A large part of this identity would be from those experiences with others and the environment which the person has processed and accepted as part of himself.

Swann and Bosson contend that identity development and maintenance are negotiated processes.[13] One's self-identity must be affirmed and nourished by others. This presupposes that we enter each encounter holding an idea of our self which the other either supports and, therefore affirms, leading to a stronger identity or is not affirmed. However, what happens when one has not yet had time and sufficient experience to develop a self-concept to offer others?

This is what happened to those who were diagnosed with leprosy when they were as young as three or five years old. What happens when the social environment perceives and behaves towards the person according to a label because of a diagnosis, stereotypes, or one's appearance?

For the very young, there is the inevitable acceptance and internalization of a stigmatized identity such as the *leproso* role and identity. Other male respondents spoke of the *leproso* identity that others held of them, keeping this identity nourished with each encounter. So, despite being pronounced negative for leprosy, the constant reminders from others to be careful of one's health lest a relapse occurs and to be mindful of contact with others, constantly refresh and nourish the *leproso* identity, leading the person to accept that "*Iba na ako.*" Just as the respondents believe that one is never truly free of leprosy, so are they never permitted to shed the *leproso* identity.

As a universal stigmatized condition, leprosy is, as Dovidio et.al. believe, "personally, interpersonally, and socially costly."[14]

NOTES

1. J. Crocker, B. Major and C. Steele, "Social Stigma," in *Handbook of Social Psychology,* vol. 2, 4th ed. ed. Gilbert et al. (Boston: McGraw Hill, 1998), 504–553.
2. E. Goffman, *Stigma: Notes on the Management of a Spoiled Identity* (Englewood Cliffs, NJ: Prentice Hall, 1963).
3. R. Kurzban and M. Leary, "Evolutionary Origins of Stigmatization: The Functions of Social Inclusion," *Psychological Bulletin* 127 (2001): 2, 187–208.
4. E. Jones, et al. *Social Stigma: The Psychology of Marked Relationships* (NY: Freeman, 1984).
5. J. Crocker and B. Major, "Social Stigma and Self Esteem: The Self Protective Properties of Stigma," *Psychological Review* 96, no. 4. (1989): 608–630; J. Crocker, "Social Stigma and Self Esteem: Situational Construction of Self Worth," *Journal of Experimental Social Psychology* 35 (1999): 89–107; B. Major and L. O'Brien, "The Social Psychology of Stigma," *Annual Review of Psychology* 56 (2005): 393–421.
6. J. Dovidio, B. Major, and J. Crocker, "Stigma: Introduction and Overview," in *The Social*

Psychology of Stigma, eds. Heatherton et al. (NY: The Guilford Press, 2000), 1–28.

7. In the course of working with terminally ill patients, Elizabeth Kubler Ross identified five stages of dying which have since guided physicians, nurses, psychiatrists, clinicians, and others who work with critically ill patients. These five stages are (1) denial – "No, not me;" (2) rage and anger – "Why me;" (3) bargaining – "Yes me, but...;" (4) depression – "Yes, me;" and (5) acceptance – "It's all right." Over time, this model has developed to explain the process of grieving as well. It has been used in work with persons (and their families) who have gone through a traumatic situation.
8. *An-an* is the common term for a skin condition usually found in hot climates. More precisely termed *tinea flava* or *tinea versicolor*, it is a skin problem caused by fungal infection. Characterized by skin discoloration which is usually white in color, it may also be a dark reddish tan. Its patches are fine and scaly and it usually attacks the face, chest, shoulders, chest, stomach, and feet; it may also be accompanied by severe itching. Young men and adolescent boys are its usual targets. *Ap-ap* is the Visayan term for *an-an.*
9. The language used for diagnosis could have affected the understanding of the men. Two of them agreed that the doctor informed them they had leprosy. However, because the doctor spoke in English, which they didn't understand, they ignored what he said. However, they assured the interviewer that if the doctor had told them they had *sanla* or *ketong*, they would have understood and taken measures to deal with it.
10. Since his wife accompanied the man being interviewed, the interviewer asked her if she would have married him, had she known of his condition beforehand. After a pause, she replied, "Probably not."
11. *Pasma* is a condition brought on by an imbalance of the hot and cold energy in a person. It is one of a group of folk illnesses which may loosely (and unsatisfactorily) be translated to English as rheumatism or joint pains. In his 1987 classic work "*Usug, Kulam, Pasma:* Traditional Concepts of Health and Illness in the Philippines," anthropologist Michael Tan speaks of a theory of humoral pathology "represented by beliefs about interactions between the hot and the cold" as a theory of illness causation. For instance, a person who has just engaged in strenuous activity would be "hot" and should not expose himself to cold by bathing or drinking cold liquids, lest this result in *pasma.* Common symptoms of *pasma* include severe recurrent migraine, sweaty palms, numbness and pains, hand tremors, body pains, or stomach pains.
12. The government keeps a registry consisting of the names of all those with leprosy. The people in this registry receive a small monthly subsidy.
13. W. Swann, Jr. and J. Bossum, "Identity Negotiation: A Theory of Self and Social Interaction," in *Handbook of Personality Theory and Research,* 3rd ed., ed. John et.al. (The Guilford Press, 2008): 448–471.
14. .Dovidio, Major, and J. Crocker, "Stigma: Introduction and Overview," 1–28.

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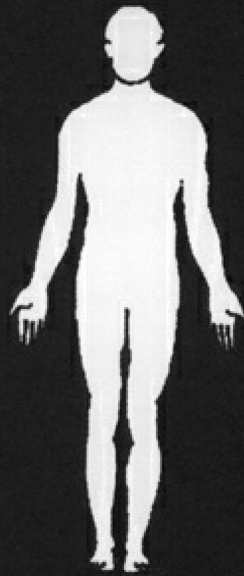

Index

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INDEX

A

Act No. 156, ref1
Act No. 157 *also referred to as* “Leper Law,” ref1, ref2, ref3
Act No. 1711 *also referred to as* “Segregation Law of 1907,” ref1, ref2, ref3, ref4
Act No. 490, ref1
Albert, Jose, ref1, ref2, ref3
Alcina, Francisco Ignacio, ref1

B

Balala, ref1, ref2, ref3, ref4
Ballesteros, Romualdo Jimeno, ref1, ref2
Bengzon, Alfredo, ref1
Board of Health *also referred to as* “Bureau of Health” or “Board of Public Health,” ref1, ref2, ref3, ref4, ref5, ref6, ref7, ref8, ref9, ref10, ref11, ref12, ref13, ref14
British Empire Hansen’s Disease Relief Association (“BELRA”), ref1

C

Calbo, Juan Tomas, ref1
Carville, Louisiana, ref1, ref2, ref3, ref4, ref5, ref6
Cebu Leper Detention Camp, ref1, ref2
Cebu Skin Dispensary, ref1, ref2
Central Luzon Leprosarium *also referred to as* “Tala Leprosarium” or “Tala Sanitarium,” ref1, ref2, ref3, ref4, ref5, ref6, ref7, ref8, ref9, ref10, ref11
Chaulmoogra *also referred to as* “chaulmoogra oil” or “chaulmoogra tree,” ref1, ref2, ref3, ref4, ref5
Childs, Eversley, ref1, ref2
Chirino, Pedro, ref1, ref2

Cholera outbreak, ref1, ref2, ref3, ref4
Clemente, Juan, ref1, ref2
Clofazimine, ref1, ref2
Collection (policy of), ref1, ref2, ref3, ref4, ref5, ref6
Community Action Project for the Elimination of Leprosy, ref1
Community-based health infrastructure, ref1
Consejales, ref1
Culion Advisory Council, ref1, ref2
Culion Foundation Inc., ref1

D

Dapsone, ref1, ref2, ref3
De Huerta, Felix, ref1
De Sopetran, Joaquin, ref1
De Zuñiga, Joaquin Martinez, ref1, ref2
Del Rosario, Jose Morales, ref1
Dermatology Research and Training Center, ref1
Divine punishment, ref1, ref2, ref3, ref4, ref5, ref6, ref7
Division of Sanitaria, ref1
Doctor-surgeon, ref1, ref2, ref3
Dyer oral method, ref1

E

Elephantiasis *also referred to* as “elefantiasis,” ref1
Ethyl esters, ref1, ref2
Eversley Childs Leprosarium or Treatment Center, ref1, ref2, ref3, ref4, ref5, ref6, ref7
Exceptionalism, ref1
Executive Order No. 35, ref1, ref3, ref4

F

Far Eastern Association for Tropical Medicine (“FEATM”), ref1, ref2
First International Conference on Leprosy *also referred to as* “First International Congress on Leprosy,” ref1, ref2, ref3
Francis of Assisi, ref1, ref2

Franciscan Order *also referred to as* “Order of Friars Minor” or “Franciscans,” ref1, ref2, ref3, ref4, ref5, ref6, ref7
Fundacion ANESVAD, ref1

G

Gimenes, Jose, ref1, ref2

H

Hansen, Gerhard Henrik Armauer, ref1, ref2, ref3, ref4
Heiser, Victor G., ref1, ref2, ref3, ref4, ref5, ref6, ref7, ref8, ref9, ref10, ref11, ref12, ref13, ref14, ref15, ref16
Hijas de Maria, ref1
Home-based health infrastructure *also referred to as* “home isolation” or “home segregation,” ref1, ref2, ref3, ref4, ref5, ref6, ref7, ref8, ref9, ref10, ref11
Hospital de Lazarinos de Palestina, ref1
Hospital de Naturales *also referred to as* “Hospital for Natives,” ref1, ref2
Hospital de San Lazaro, Cebu *also referred to as* “San Lazaro Hospital, Cebu,” ref1, ref2, ref3, ref4, ref5
Hospital de San Lazaro, Manila *also referred to as* “San Lazaro Hospital, Manila,” ref1, ref2, ref3, ref4, ref5, ref6, ref7, ref8, ref9, ref10, ref11, ref12, ref13, ref14
Hospital de Sta. Ana, ref1

I

International Health Board *also referred to as* “International Health Commission,” ref1, ref2, ref3
Intramuros-Dilao-Balete Phase, ref1, ref2
Ishidate, Morizo, ref1

K

Kalaupapa/Molokai *also referred to as* “Molokai, Hawaii,” ref1, ref2, ref3, ref4
Kilatis Kutis Campaign, ref1
Korean Sorok-Uni Foundation, ref1

L

Lara, Casimiro, ref1
Lazariento, ref1
Leper coins *also referred to as* "Leper money," ref1, ref2, ref3
Leper Law, ref1, ref2, ref3
Leproso/s, ref1, ref2, ref3, ref4, ref5, ref6, ref7, ref8
Louisiana method, ref1
Lower Gate, ref1, ref2, ref3
Lugard, Frederick, ref1

M

Mactan, ref1, ref2
Mayhaligue Phase, ref1, ref2
Medico-cirujuano, ref1
Medicos titulares, ref1, ref2, ref3, ref4
Mercado mixture, ref1, ref2
Mercado, Eliodoro, ref1, ref2
Mindanao, ref1
Mobile clinic *also referred to as* "skin clinic," ref1, ref2, ref3
Multidrug Therapy *also referred to as* "multidrug therapy" or "Multiple Drug Therapy" or "MDT," ref1, ref2, ref3, ref4, ref5, ref6, ref7, ref8
Mycobacillus leprae also referred to as "Mycrobacterium leprae," ref1, ref2, ref3

N

National Leprosy Control Program, ref1, ref2
Nolasco Bill *also referred to as* "Senate Bill No. 101," ref1, ref2

O

Olazabal, Javier, ref1

P

Pasma also referred to as "espasmo," ref1, ref2, ref3
Philippine Board of Health *also referred to as* "Bureau of Health," ref1, ref2, ref3, ref4, ref5, ref6, ref7, ref8, ref9, ref10, ref11, ref12
Philippine Commission, ref1, ref2, ref3, ref4
Philippine Leprosy Mission *also referred to as* "Philippine Evangelical Leprosy Mission," ref1
Philippine Rehabilitation Act of 1946, ref1
Polillo, ref1, ref2

Q

Quezon, Manuel L., ref1, ref2, ref3, ref4

R

Reconocer, ref1, ref2
Regional leprosaria *also referred to as* "regional treatment stations," ref1, ref2, ref3, ref4, ref5, ref6, ref7
Relapse, ref1, ref2, ref3, ref4, ref5, ref6
Reorganization Act 1407, ref1
Republic Act 4073, ref1, ref2
Republic Act 7277, ref1
Republic Act 753, ref1, ref2, ref3
Rifampicin, ref1, ref2
Rinderpest *also referred to as* Rinderpest epidemic, ref1, ref2, ref3
Rockefeller Foundation, ref1, ref2, ref3
Rogers, Leonard, ref1, ref2

S

Sano/s, ref1, ref2, ref3, ref4, ref5, ref6, ref7, ref8, ref9, ref10, ref11, ref12, ref13
Santa Teresita, ref1, ref2
Sasakawa Memorial Health Foundation, ref1, ref2
Sasakawa, Ryoichi, ref1
Segregation Law of 1907 *also referred to as* "Act No. 1711", ref1, ref2, ref3, ref4,
Segregation of sexes *also referred to as* "gender segregation" or "sexual segregation", ref1, ref2, ref3

Self-stigmatization, ref1, ref2
Sisters of Charity *also referred to as* “Sisters of Charity of St Paul de Chartres” or “Sisters of St Paul de Chartres,” ref1, ref2, ref3, ref4, ref5, ref6, ref7, ref8, ref9, ref10
Society of Jesus *also referred to as* “Jesuits,” ref1, ref2, ref3, ref4, ref5, ref6, ref7, ref8
Spiritual districts, ref1
Sta. Ana de Dilao Hospital, ref1, ref2
Stigma, ref1, ref2, ref3, ref4, ref5, ref6, ref7, ref8, ref9, ref10, ref11, ref12, ref13, ref14
Sulfone, ref1, ref2

T

Tala Advisory Council, ref1
Tropical governance, ref1, ref2

U

United Nations Human Rights Council Resolution *also referred to as* “UN Human Rights Council Resolution,” ref1
Upper Gate, ref1, ref2

W

Wade, Dorothy Paul, ref1, ref2, ref3
Wade, Herbert, ref1, ref2, ref3
Wade, Herbert Windsor *also referred to as* “H.W. Wade,” ref1, ref2, ref3
Welfareville, ref1, ref2, ref3, ref4
Wilkinson, Brookmen, ref1
Wood, Leonard, ref1, ref2, ref3, ref4, ref5, ref6, ref7, ref8
Worcester, Dean, ref1, ref2, ref3, ref4, ref5
World Health Assembly Resolution No. 44.9, ref1
World Health Organization, ref1, ref2, ref3
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