UGANDA

I had the advantage of Dr. Ross Innes' company throughout my tour in Uganda and this was particularly helpful as he was well acquainted with the leprosy work. The Uganda Government has indicated its interest in leprosy by being the first territory which has appointed a territorial leprologist—Dr. J. A. Kinnear Brown —who has had many years of experience in West Africa and was the founder of the now famous Uzuakoli leprosy colony in Nigeria. On Dr. Brown's return from leave I was able to discuss matters fully with him.

The first institutions which I visited were Kumi and Ongino where Dr. Wiggins and Miss Laing did such good pioneer work in the early days.

Kumi is the children's section of the work and Ongino the adult colony. There are disadvantages in these two institutions being separated by several miles, but the policy of having a separate institution for children is a sound one, for children demand special care and attention, and facilities for mental and spiritual development are essential to the child's future development as a useful citizen. Now that sulphone therapy has given great hope it is expected that the great majority of children, in due course, will return to the villages from which they originally came.

Kumi and Ongino are understaffed, but recently through the action of BELRA the staff is being increased, and it is hoped as a result these institutions will develop their usefulness still further.

While at Kumi and Ongino I examined most of the patients. Here, as elsewhere, there were many with residual lesions, which were hypopigmented, but inactive. Such lesions should be given intradermal injections, for only in this way will many of these lesions repigment. A mark on the skin, no matter whether the lesion is healed or not, is unsightly to the patient and every attempt should be made to discharge patients with as few visible stigmata of the disease as possible. Here, as elsewhere, the main cause for

UGANDA AND NORTHERN RHODESIA

LEPROSY SETTLEMENT SCHOOL AND CHILDREN, BUNYONYI, UGANDA.

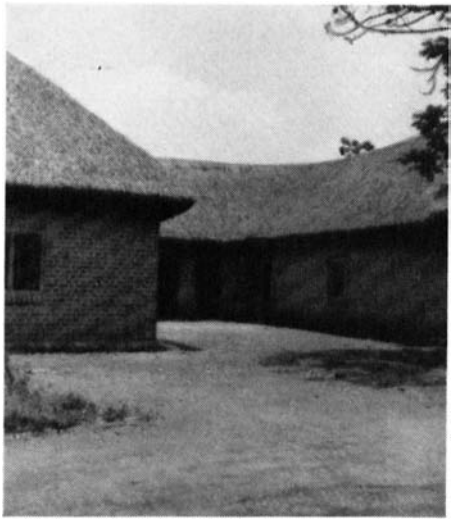
PATIENTS HOUSES, CHITOKOLOKI, N. RHODESIA.

SICK LINES, ALITA CENTRE, UGANDA.

LAKE BUNYONYI, FROM MAINLAND.

TANGANYIKA AND NYASALAND

GENERAL VIEW OF HOSPITAL AND TREATMENT CENTRE FROM HOUSE, CHAZI, TANGANYIKA.



NEW HOSPITAL, MAKETE, TANGANYIKA.

PATIENTS HUT AMONG BANANAS, MAKETE.

GENERAL VIEW OF HOUSES, MALAMULO, NYASALAND.

the delay in the full development of this institution is the lack of money. It is to be hoped that the plan for developing Kumi and Ongino, under Dr. Brown's scheme, into a good primary centre, will be hastened. As I have already indicated, it is good policy to encourage leprosy work, for the African Administration is keen on supporting all efforts towards leprosy control, and today it is well to take note of African sentiment in this respect. Further, as has been shown in India, leprosy is an excellent lever with which to open up the way to the tackling of other vital health problems. Not only this, but in leprosy settlements better methods of agriculture can be tried, and the results of such successful experiments passed on to the community at large.

When at Kumi we visited Lira, about a hundred miles away, where Dr. Wheate and I stayed with the Provincial Commissioner, and Dr. Ross Innes with Dr. Murray Short, the District Medical Officer. Lira is the headquarters of the Lira District of the Eastern Provinces. Dr. Murray Short was formerly at Itu and is now in the East African Medical Service. Dr. Short has organised a most interesting experiment in village segregation. The Leprosy Control Camp, approximately 30 miles from Lira, the Medical Headquarters of the district, is at Atan or Alita and consists of 162 patients (59 men, 31 women, 45 boys, and 27 girls). Of these 50% are lepromatous cases. There are well organised " weak lines " for those needing special care, huts for patients, and mud and thatch sheds for treatment, and another shed which will be used for simple laboratory work. The land is divided into three plots, and the patients cultivate these. It is anticipated that when all the land available is under cultivation the settlement will be self-supporting. The soil appears to be excellent and the crops in good condition. The local African Government meets the running costs and those of hospital supplies, medicine and dressings. A trained Kumi worker supervises the camp and there is excellent discipline and morale.

I was greatly impressed with the whole set up and leprosy dealt with in this way is capable of control. All lepromatous cases should be isolated in such centres and communal life devel
This will give scope for experiments in agriculture and animal husbandry, and be a centre where training for better citizenship (the sociological side of leprosy is of great importance) under village conditions can be achieved. I feel very strongly that this type of satellite centre should be greatly encouraged. Admittedly, further developments will be necessary, e.g., treatment centre, school, and small laboratory. Land cultivation and cattle should keep patients busy and help greatly towards support. The great advantages are that:—

1. The centre is linked to a district hospital, which can cater for the acutely ill.
2. The District Medical Officer and District Commissioner are both enthusiastic.
3. The Agricultural Officer and Veterinary Officer are also ready to give their support.
4. The children are separated and looked after by Catholic Sisters.

A well trained African from Kumi, with the help of local Chiefs, the D.M.O., and the D.C., would be able to maintain an efficient centre. A BELRA-type of worker would be invaluable in such centres.

This type of work emphasises to Medical Officers that leprosy in endemic areas should be linked, as with other endemic diseases e.g. tuberculosis, trypanosomiasis, bilharzia etc.,—to the Government Hospital. Missions and voluntary organisations can help with personnel and in a limited way institutional work, but the control of leprosy is primarily a Government responsibility.

I should mention at this point that I regret very much I was unable to visit Arua where Dr. Williams started the first experiment of this kind. The organisation of the Arua centre has been described in an article in *Leprosy Review* (Vol. 24—No. 2—April 1953).

From Kumi I went with Dr. Ross Innes to Buluba. This is a Roman Catholic institution and is fortunately well staffed, and one of the Sisters is a trained laboratory technician. Records are well kept and biopsy work attempted. Dr. Blenska, who is very keen and enthusiastic, deserves to be encouraged, and as this is the only institution which has the facilities and the staff able to undertake biopsy work, I should like to see some £100 spent to equip the laboratory so that good routine histological work could be undertaken.

The general routine treatment, as in most institutions, is Dapsone (DDS) given orally. Great care is being taken in its administration. There has been one case of severe dermatitis and one mild case, although twice-weekly dosages were given, indicating the need for careful supervision. Parenteral Sulphetrone has been found useful, particularly as a preliminary course for 1-3 months prior to oral DDS being given. There appeared to be a greater number of ulcers and septic conditions than at Kumi. This may be due to the fact that operative and reconstructive work is being done on a larger scale and, owing to a larger staff, more attention can be given to the general medical aspects of the work.

En route for Kampala we called in at the other Roman Catholic institution at Nyenga. This institution, which is also given medical oversight by Dr. Blenska, is well arranged, and, while the laboratory is smaller, the operating facilities are very much better. This institution, along with Buluba, make a centre which deserves every encouragement, for the work is not only excellent, but, being relatively nearer Makerere College, Kampala, has great potentialities. In Nyenga there was another severe case of sulphone dermatitis, which was on only two tablets of DDS twice a week. The Mother Superior was of the opinion that the patient must have procured an extra supply from outside the institution. That is always a possibility which has to be guarded against.

On the way to Kabale, via Kampala, we called at Nsambya, the headquarters of the Catholic Order (St. Francis) which is responsible for the management of Buluba and Nyenga. Mother Kevan, who founded the leprosy work, was most anxious for these institutions to develop along the best possible lines.

On the evening of October 25th we arrived at Kabale on the shores of Lake Bunyoni. At 10 a.m. the following morning we were picked up by Dr. Sharp, in his motor boat, and taken over to the island on which the Leprosy Settlement was situated. This island is set in very attractive natural surroundings, and as a result of propaganda and the willingness of local Chiefs to persuade their leprosy cases to isolate themselves, the incidence of leprosy over the past 20 years has shown a marked decline.

The staff on Lake Bunyoni consists of Dr. Sharp, two nursing sisters and a lady missionary, who is a trained technician. There is another doctor, Dr. Parry, who was away relieving at another mission station. Dr. Sharp, as so often is the case, has to spend much time in general duties, and until there are two doctors permanently stationed in this area it will be impossible to develop this institution to the full. Again the routine treatment is oral DDS. There have been no serious difficulties with treatment. The administration of the drug is very carefully supervised and under such conditions, in the dosages now recommended, there should be no difficulty. One disquieting feature was the tendency to discharge cases too early, and this resulted in early relapses. Because clinical improvement is much more dramatic than bacteriological improvement, it is desirable that a patient should be negative for at least one year before being discharged.

I arrived back at Entebbe on October 26th. Dr. Ross Innes returned to Kenya on the 27th and I paid a visit to Makerere College, where I had the opportunity of discussing matters of mutual interest with members of the staff. I was most favourably

impressed with the whole set-up. There are great possibilities, and it should not be many years before this college becomes one of the outstanding medical institutions in tropical Africa. The staff at Makerere College assured me of their giving whole-hearted support to the proposed leprosy research project for East Africa.

On my return to Entebbe, I met Dr. J. A. Kinnear Brown, whom we had seen for a short while in Nairobi before starting on my safari. Dr. Brown has just taken over as Leprologist to the Uganda Government, and he is making a careful study of the whole situation.

There is no question that Dr. Brown's long-term scheme is sound, but there is also no doubt that there has been a considerably increased public interest in leprosy, and to hasten the development of leprosy institutions and make available finances would, I am sure, pay handsome returns in the form of goodwill and gratitude.

From Entebbe I enplaned for Mwanza and spent two days in this area. As this is in Tanganyika Territory I shall leave its consideration until I describe the work in Tanganyika. I left Entebbe on the 29th for Nairobi and found the tension in that city greater than when I left some three weeks previously.

While in Entebbe I had the privilege of an interview with His Excellency the Governor, and also had discussions with Dr. Hennessey, D.M.S. and Dr. Kinnear Brown, the territorial leprologist. Dr. Kinnear Brown outlined his scheme for the development of primary and secondary residential centres. The policy of the future development of leprosy in Uganda is based on sound principles. It must be remembered that while leprosy is only one of the endemic diseases of the country, and must not receive an undue proportion of attention, yet up to now it may be said that the organisation of preventive schemes has fallen behind the over-all public health programme. As a result of the recent advances in therapy a greater incentive has been given to the development of such schemes, and the Medical Department of the Uganda Government is alive to these issues. It is hoped that the application for assistance for the organisation of primary and secondary residential centres which has been made to the Cotton Association Fund will receive a generous response.

It is generally recognised that, as in Nigeria so in Uganda, the preliminary steps in the development of leprosy work leading up to the point when real advances in the control of leprosy in Uganda can take place, would have been impossible without the help of the BELRA. The contribution BELRA has made in personnel has guaranteed the continuation of the work. As I have said BELRA is essentially a bridge builder and the Association is ever

ready to undertake its share in encouraging sound leprosy work and in initiating research. Governments have accepted the fact that it is their primary duty to control leprosy; the possibility of this has been very much greater owing to the fact that leprosy has now entered the domain of scientific medicine, and greater interest has thereby been created. It is encouraging to know that the Uganda Government is fully alive to its responsibilities in this matter, and it is confidently expected as in many other fields that the Protectorate of Uganda will lead East Africa in organising a comprehensive anti-leprosy scheme which will, in due season, result in the conquest of leprosy as effectively as malaria and other tropical scourges have been controlled.