LEPROSY CONTROL IN UGANDA*

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The modern era in leprosy treatment and control dates back thirty years to the preparation of Alepol, a solid compounded from hydnocarpus oil, by Sir Leonard Rogers. That discovery, and Sir Leonard's work with Dr. E. Muir, resulted in an expansion of leprosy services both within and without the British Commonwealth, an expansion which might otherwise have been considerably delayed. The fact that Alepol did not eventually prove superior to the oil and its ester is of little moment. It provided a drug which could be sent to inaccessible places, and overcame what had been the very formidable difficulty of getting bulk supplies from the place of extraction to other countries and continents.

At the same time, public opinion was changing about the advisability or practicability of compulsory segregation. Isolation of all recognisable patients had been the world-wide traditional approach to the prevention of the disease. Nations differed only in the vigour with which they applied it. Apart from the inhumanity of the method, the results achieved did not justify its continuation; for it was only successful where every patient was strictly isolated or every suspect, infected or not, ruthlessly exterminated. The compulsory element drove the disease underground, and only those were caught who were obviously affected or who could no longer hide its signs. The early cases remained at large, spreading the infection among the community.

Voluntary settlements promised to achieve far more. In the hands of Missions and of those who were not easily discouraged by slow or disappointing results of treatment, such settlements were extremely popular. Knowing that they could come and go almost as they wished and that during their residence they would not be treated as criminals but allowed to enjoy reasonably normal lives, patients travelled long distances to obtain treatment. The difficulty of tracing patients under a compulsory scheme was reversed; the new problem was to accommodate all who came.

Before examining the position in Uganda, it may be of comparative interest to take a glance at the other side of Africa. The first settlement of any size in West Africa was built at Itu, on the

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Cross River in Nigeria. It developed from an out-patient clinic at the Church of Scotland Mission Hospital. The patients came in canoes from up and down the river and its creeks. Unable to make the journey every week, or to return to their villages because their homes had been burned, they settled on a sandbank. When the rains came, the river rose, submerging their temporary shacks and compelling the patients to move across to the shore, much to the resentment of the local population. The Government intervened when the situation was becoming tense, provided the necessary assistance, and enabled Dr. A. B. MacDonald to direct this motley and forlorn crowd while they laid the foundations of what ultimately became the largest settlement in the whole of Africa.

The success of Itu encouraged further ventures, one of which was Uzuakoli, in the Owerri Province. It was not, like Itu, an accidental development. It was planned from the beginning, but the experience at Itu was repeated and quotas of patients had to be allotted to the various administrations according to their financial contributions. Patients were admitted through their political and medical officers, but there were always more applicants than vacancies. To increase the capacity of the settlement, additional patients were accepted if they were able to support themselves; but even here, the number of these had to be regulated. It soon became apparent that with the best of intentions only the fringe of the problem could be touched unless there was some modification of general policy. Voluntary settlements alone could have little effect on the incidence of the disease in areas of high density. The annual cost of Uzuakoli was between two and three thousands pounds. There was accommodation for one thousand patients. The Owerri Province was but a small part of Nigeria, yet it alone would have required more than twenty settlements with the necessary staff to make any appreciable impact on the disease. This was a financial and practicable impossibility, and in 1935 the author published the outlines of a scheme of control for the Southern Provinces.

Patients were beginning to create their own compounds or villages. Marriage between a patient and a non-patient was forbidden. The appearance of leprosy in a husband or wife automatically created a divorce. Intermarriage between patients, many of whom were closely related, was the logical sequence, and for this reason the incidence in small, heavy infected compounds increased. Those who were not infected moved out, leaving behind

a " Leper Village." In other places, either because they were ostracized or driven from their homes, patients settled together, petitioning for treatment to be taken to them. However they began, small leper communities were springing up. It appeared reasonable to weave this natural thread into an organised scheme of control based on provincial settlements, using volunteers and ex-patients to survey outlying parts and to encourage the formation of similar communities under the guidance of the local chiefs.

Uganda is quite unlike Nigeria; it has a different social pattern. The people do not live in villages. Their houses are widely scattered, a natural barrier to the spread of epidemics but a disadvantage to the provision of rural medical service. It is probably responsible for the fact that the incidence of leprosy is everywhere less in Uganda than in the villages of Southern Nigeria. Surveys are more difficult to organise, and the creation of treatment facilities is less easily arranged. With few exceptions, the incidence is higher where the population is more dense, and it is in these areas of greater need that less land is available for larger settlements.

Uganda has a leper population in the region of 80,000 spread over a general population of more than 5,000,000 and an area of 93,000 square miles. There are five voluntary settlements, four of them between twenty and twenty-five years old. Together they accommodate rather less than 2,500 patients. It is possible that the older ones may have reduced the incidence in their immediate vicinity. In some cases, however, the long distances have led to extensive squatting by patients, and this has altered the picture. It appeared logical to take advantage of this immigration into the environment of a curative centre and to link it to a community effort throughout the country to establish nationwide treatment and control.

During the last two and a half years more than sixty leprosy surveys have been carried out. Such surveys provide the essential groundwork on which a rational control scheme can be based. They have involved considerable preparation and planning in order that the results should be significant. These examinations would not have been possible without the co-operation of the administrative and medical staff of the country and the goodwill of the peope. An integral part of the surveys has been conferences with the County Councils and the District Teams. At these meetings the local incidence has been discussed and plans suggested which have taken into account particular circumstances or difficulties.

The main argument has been that even if the large staff necessary were available, which it most definitely was not, it would

still cost the whole of the money spent on the medical services of the Protectorate to control this one disease by a series of large-scale settlements. On the other hand, the establishment of small treatment villages within a reasonable distance of rural medical units is economically possible by community effort especially if assisted by community and general funds. If patients are willing to submit to some limitation of their private lives to obtain treatment and to give some protection to the community, the community in return should accept the responsibility of providing the necessary simple accommodation.

Patients cannot travel long distances every week, especially if sick or if the weather is severe. Small treatment villages make continuity possible and secure some measure of segregation. One hundred per cent segregation is the ideal. This is pressed in grossly infectious cases, but it is not suggested that it should be applied too rigorously to the less infectious lest the whole object be defeated. Allowing the patients to visit their homes enables them to obtain food and keep in touch with their families. If eighty per cent segregation results, that and treatment by the sulphone drugs should effectively interrupt the normal spread of the disease. The main problem is to get the right number of tablets into the right mouths at correct intervals. The solution is not easy, even in more highly-developed societies. The man who has obtained benefit from one medicine for one condition does not hesitate to recommend it, but often for something entirely different. Nor is it certain that every dose of medicine is taken as prescribed. It has been known to be thrown away. In less developed communities, the abuse or indiscriminate use of potent drugs may be highly dangerous. Much of the organisation necessary for a leprosy control system is due to the necessity for safeguarding people from their own folly or ignorance, through which they may omit to take the drug regularly, or take overdoses, or give or sell it to their friends.

The community response in Uganda has so far been encouraging. Early in 1952 in the Northern Province three large units were established by the District Councils in Lango, Acholi and West Nile. A fourth, rather smaller, was built in the Madi sub-district in 1953. In the Western Province in Bunyora, the District Council provided a similar village, whilst in Tora quite an amazing effort was seen. In a matter of weeks the local population cleared a site, made a road two miles long, and provided accommodation for a large number of patients. In three weeks from its opening four hundred were accommodated and treatment

was begun. A second such centre, in the same district, is under construction.

The Eastern Province of Uganda is more densely populated and has problems peculiar to itself. Two of the major voluntary settlements are in this Province. A small unit has been provided by the District Council of Busoga near the Buluba settlement, and two others in the north-westerly part of Busoga built by the local population show great promise. In Teso, a similar centre is being built and a scheme linking community effort with the expansion of the settlement at Ongino is under discussion. This will include the provision of a separate village within the settlement by each district in the area.

Very satisfactory progress has also taken place in Buganda, the largest province in the Protectorate. Recent happenings have brought this part of the country very much in the limelight, but not every movement in Buganda is political, either in its origin or its general trend. Four small villages have been built in the district of Mubende, and patients are receiving treatment. A fifth has been completed in the district of Mengo at Mityano and will be opened by the Katikiro, the Prime Minister of the country. Two villages are growing rapidly in more remote areas, and others are on the drawing board. All this work has been done by "Bulungi Bwansi," a form of communal labour whereby each male adult is required to work certain days on community projects when called upon by his Chief.

By some standards, and when measured against what it is hoped to achieve, progress might be considered slow. However, a large machine takes time to gather momentum, and what has been acomplished has taken a comparatively short time. It is early yet to speak of results. There is every reason, however, to believe that this community work begun in so many parts of Uganda will be multiplied, and that by means of it, a disease which has defied treatment for centuries may in a few years become an incident of history.