LEPROSY

The 60th survey of a series begun in 1950 was completed and analysed during the year. The surveys consisted of the examination of every person resident in well defined but widely scattered areas. The incidence range obtained was 0.0%—4%, with an average lepromatous rate of 10% and a child rate of 20%.

The age distribution showed that the heaviest incidence was not in childhood, but after the age of 20. The disease occurred equally among males and females. Climate and population density did not appear to be related to the incidence. The higher values were obtained in the smaller tribal groups such as the Bwamba, Bakonjo, Bachopi, Banyuli and Badama. The evidence suggests that susceptibility is of primary importance and in such people, contact at any age can produce leprosy with the age frequency in a community, depending on the age at which the social pattern makes contact more likely. It was not uncommon to find large areas with many tuberculoid patients, but not a single lepro-

matous case. The surveys suggest that tuberculoid cases are infectious. They may be less infectious than lepromatous cases, but if such cases are mobile they will have greater opportunities of contact with other people.

The survey provided opportunities to discuss local measures to introduce treatment in the simplest manner. The response has been encouraging and at the end of the year 20 treatment villages were in operation and others were projected.

In 1951 treatment was only available on any large scale at five settlements maintained by missionary societies but subsidised by annual grants by Protectorate Government, District Councils and the British Empire Leprosy Relief Association. The average number of patients resident in the settlements at that time was approximately 2,000 and out-patient treatment was being given at the settlements to about 2,000 more. The result of the efforts by the District Councils has been to increase the total number of lepers under in-patient treatment to more than 3,000.

In addition, out-patient clinics have been opened as pilot schemes, so that including the 2,000 attending settlements, the total number of out-patients registered is now in the region of 4,000.

Treatment villages are preferable to out-patient clinics because they help to guarantee continuity of treatment. It has been found that in the course of a year most out-patients put in only half the attendances possible, whether treatment is given weekly, twice weekly, or fortnightly.

The average incidence appears to be higher in the Eastern Province and about half the cases in Uganda are in that province.

The main treatment used has been diamino-diphenyl sulphone by tablet and, in a few cases, sulphetrone. The results have been gratifying but unfortunately patients have a tendency to discharge themselves as soon as they find their lesions disappearing and their general health improving. For this reason the number of those discharged is not mentioned in the report as it would not reflect the value of the treatment given. The major part of the work of leprosy control in Uganda has still to be begun but the outlook is good and progress to date has been reasonably satisfactory.