MOBILE ANTI-LEPROSY TREATMENT CENTRES GHANA

by JOHN H. ELDON

Senior Leprosy Control Officer, Ghana Leprosy Service

Until the middle of 1957, anti-leprosy treatment in Ghana was offered at static clinics. Treatment was given by the Ghana Leprosy Service, Government Hospitals, Local Council Dispensaries and by various Missionary organisations. The big disadvantage of this form of treatment was that patients would present themselves for treatment for a number of weeks and then fail to report again. The reasons given for this persistent absenteeism were many but the principal one was economic; the patient did not have the money to pay for the return lorry fare from his home to the clinic. Another reason was that lorries ran so infrequently that the patient had to sacrifice a day away from work to receive treatment.

To overcome these difficulties the Ghana Leprosy Service, through the Ghana Government, asked UNICEF for a number of Land Rovers to start a series of mobile treatment centres throughout Ghana. UNICEF agreed to the request and not only arranged to supply nine Land Rovers but also to supply a two years stock of tablets DDS. Approval of the request came in during the latter part of 1956, with a promise that the Land Rovers would be delivered in Ghana about March, 1957. In order to facilitate the introduction of such a scheme, a pilot mobile treatment centre was inaugurated at Wa in the western region of Northern Ghana. A circular itinerary was arranged and treatment started in areas where previously static treatment centres had been employed. The Leprosy Control Officers in other areas were also asked to give serious thought to the planning of itineraries in their areas. The aim was the treatment of the largest possible number of new and old cases with the most profitable running time. Wherever possible circular itineraries were arranged although in some areas back tracking was necessary due to the road systems.

In March, 1957, the Land Rovers arrived and drivers were engaged at Cape Coast, the largest town near the Ankaful Leprosarium. After an initial period of training, the drivers with their vehicles were posted to the regions where they would be working. Each driver, when engaged, was told that he would be expected to assist the Leprosy Control Assistant in charge of each Land Rover with the distribution of tablets. This they willingly undertook to do and have proved, in the main, to be of great use to the centres. One criticism which was made by the Leprosy Control Officers was that they would have preferred to have engaged drivers from the areas in which they were to work because of the language and housing difficulties. This is a very real criticism as in certain areas of Ghana, particularly in the north, a stranger has great difficulty in making himself understood. Drivers who were engaged locally also had

settled domestic arrangements whereas the drivers engaged at the Ankaful Leprosarium had to uproot their families and transport them to the areas where they would be working.

The Land Rovers are staffed by a Leprosy Control Assistant and a driver with, in one or two cases, a Clinic Attendant. The Leprosy Control Assistant is in charge of the vehicle and responsible for the efficient treatment of all patients suffering from leprosy on his circuit. On appointment to the Ghana Leprosy Service the Leprosy Control Assistant undertook a two-year period of apprenticeship during which time he was trained at the Ankaful Leprosarium and was also in charge of a group of clinics under the close supervision of the Leprosy Control Officer in charge of the region where he was working. The pupil whilst at the Ankaful Leprosarium is given instruction in the diagnosis of leprosy, differential diagnosis, the accurate keeping of records such as would affect him when posted to the field and dealing with the welfare of the patients in residence at Ankaful. In the field he is expected to run efficiently ten or twelve clinics during the course of a week. Periodically reports on the pupils are submitted and their progress assessed. At the end of their training period and subject to satisfactory reports, they are recommended for appointment to the grade of Leprosy Control Assistant.

The Land Rovers travel on circuits which vary from 300 miles to 500 miles each week. As far as possible the period away from base is confined to Monday to Friday which leaves Saturday morning free for maintenance, replenishing supplies, and record work. During the course of the week the Land Rover stops at each village on the route and treatment is given to every patient. The number of patients treated varies greatly from area to area but during 1958 approximately half the total registered patients in Ghana were receiving treatment from the mobile treatment centres. In addition the absentee rate fell considerably. At last the patients did not have to spend money on transport and the Land Rovers arrived regularly each week with their treatment. The keeping of a fixed schedule is one of the most important factors contributing to the popularity of the mobile treatment centres and it is of the utmost importance, if the Land Rover is to be delayed, that the patient should be notified beforehand. One big disadvantage of the mobile treatment centre is that when a Medical Officer visits the circuit to examine the patients the schedule must, of necessity, be delayed. If, however, the patients are warned in advance that the doctor is to visit them they are prepared to wait patiently until the Land Rover arrives.

In order to provide for continuity of treatment one Land Rover was to be held in reserve to enable each Land Rover working on a circuit to be relieved and sent to the main agents for a thorough check over. Circumstances prevented this programme from being put into operation; one circuit was disrupted by a broken bridge, with

the Land Rover on the wrong side of the bridge. As there were no alternative roads the spare vehicle had to stand in for three months until the rains ceased and the bridge was repaired. To replace each vehicle in turn consequently became impossible and to enable much needed maintenance to be done the circuits were closed down for three weeks in August, 1958. The vehicles were sent to the agents, checked over and repaired where necessary. All required fairly extensive repairs, mainly to the engine (new piston rings, etc.), the propeller shafts and brakes.

The close-down of the mobile treatment centres for a three week period also enabled the crews of the vehicles to proceed on leave. In Ghana new leave regulations stipulate that all Ghanaian officers should take leave during the year and that accumulation of leave will not, as a general rule, be permitted. In order to provide an efficient leave roster it has been decided that the mobile treatment centres will close down completely again in 1959 thus enabling all officers working in the field to enjoy their leave at the same time. July has been chosen for the close-down period as the rainy season will be half way through during this month and attendances at the stopping places will be low.

So successful have the mobile treatment centres proved in Ghana that UNICEF have agreed to provide an additional fleet of ten Land Rovers. Eight of these vehicles will be put into circuits and two will be held in reserve. These circuits will come into operation in March or April, 1959, and will make seventeen mobile treatment circuits in Ghana. These seventeen circuits will cover the highly endemic areas of Ghana bringing treatment based on oral DDS to the majority of cases suffering from leprosy.

The following table shows the number of cases under treatment in Ghana at the end of 1958 and the number of cases treated by the mobile treatment centres:

	Number Registered	*Mobile Treatm. Centres*	*Number of Vehicles*
Eastern Region North Ghana	11053	7454	4
Western Region North Ghana	3885	1443	1
Ashanti	4652	1130	1
Eastern Region South Ghana	2991	1269	1
Western Region South Ghana	2014	1118	2
Trans-Volta Togoland	1422	—	
Total	26017	12414	9

My thanks are due to Dr. E. Akwei, Permanent Secretary and Chief Medical Officer, Ministry of Health, Ghana, for permission to publish this article.