SYPHILIS IN THE UGANDA PROTECTORATE.

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Of England's more recent Colonial acquisitions, none is better known to the medical profession than the Protectorate of Uganda, made familiar to it as having been the locality almost devastated by sleeping sickness. Unfortunate as this outbreak would have been at any time, it was doubly so at the precise period when it made its appearance. Before its advent, another malady of even a more serious nature had begun to sap the life-blood of the tribes. Syphilis was very prevalent in the Protectorate, and the researches connected with sleeping sickness overshadowed all attention to the syphilitic outbreaks, attracted every interest and set back all investigations into the subject of syphilis in that part of the world. The consequence was that syphilitic disease was allowed to gain a footing in the Protectorate, and, being left to itself, caused devastation everywhere among the inhabitants. Syphilis assumed such a serious aspect that His Excellency the Governor, Mr. Hesketh Bell, C.M.G., applied to the Secretary of State for the Colonies for an inquiry to be made into the subject of syphilitic diseases in Uganda by an expert from this country, who should consult with the medical staff of the Protectorate and discuss the means which should be adopted to check the ravages of the disease. I was selected and proceeded to the Colony. Before detailing my experiences, a brief historical résumé of the country may be of interest.

In the first place I may say that there seems to be a certain amount of haziness as to the relations these two Protectorates, British East Africa and Uganda, bear to each other, both geographically and otherwise. The British East Africa Protectorate comprises the territories bounded on the south by German East Africa, on the east by the Indian Ocean, on the north by Italian Somaliland and Abyssinia, and on the west by Uganda.

Mombassa is the seaport town of East Africa. The Uganda Railway has opened up vast territories in the interior which are eminently fitted for European colonization. The climate, except on the coast, is very good—in fact, ideal in some places, such as Nairobi, Narvesha and Mau Escarpment.
Altitudes varying from 4,000 to 8,000 feet may be attained. The total area is about 120,000 square miles. The population is about 4,000,000, viz., 300 Europeans, 3,000 Asians, and 3,500,000 natives. The Uganda Protectorate is bounded on the east by British East Africa, as far north as the 6° N. latitude, on the south by the Anglo-German boundary and 1° S. latitude, on the west by the Congo Free State, and on the north by a line between Ladi and the White Nile.

Uganda is reached from Mombassa by the Uganda Railway, opened in 1901. This railway extends from Mombassa on the coast to Port Florence on Lake Victoria Nyanza, and is 584 miles long; in its course it passes through a varied description of country, from the arid land of the inhospitable Taru desert to the fertile highlands of Narvesha. It ascends and descends to various altitudes, reaching its maximum of 8,500 feet at the Mau ridge.

Among the sights seen on this railway journey none is more wonderful than the amount of large game; every description of game in hundreds can be seen from the railway carriage window.

Port Florence is situated at the south-east end of Lake Victoria (which latter is 320 miles long by 220 miles broad). This magnificent sheet of water is crossed in about twenty-four hours, when Entebbe, which is the official capital of the Uganda Protectorate, is reached, and here we are in Uganda.

**Historical Résumé.**

The Kingdom of Uganda, which forms the nucleus of the Uganda Protectorate, was first brought to the notice of the world outside Africa in the year 1862 by an expedition under the command of the celebrated explorers Speke and Grant, who were at the time endeavouring to discover the source of the Nile. Previously, rumours of the existence of a powerful and semi-civilised African kingdom on the northern and western shores of the Victoria Nyanza had been brought to Zanzibar by Arab traders, but the country was not even heard of by the Arabs of Zanzibar before 1852. Yet Uganda is an ancient kingdom of considerable stability, which has been ruled for several hundred years by a single dynasty, having its reputed origin in a mixture of myth and tradition, and in all probability due to a conqueror of the north of that Hamitic race—the Bahima—which still forms the aristocracy of the western parts of the Protectorate. The Bahima were certainly of Hamitic stock, and closely related in origin to the Somali, and less closely, yet obviously so, to the Ancient Egyptian type. The Bahima at one time...
exercised widespread influence over the inner regions of East Central Africa. In Uganda proper, though the Hamitic invaders probably founded the dynasty, they did not remain to form the aristocracy as they had done in Unyoro, Toro, and the countries to the west of Uganda. They encountered in Uganda proper a very vigorous race of mixed negro type, sufficiently sturdy to hold its own, but equally prone towards civilisation to adopt the culture of the Hamites. This is the Baganda people. Great power radiated from this Kingdom of Uganda; the regular and abundant rainfall, the fertile soil, wealth of food and easily collected banana plantations caused this country to become the seat of a relatively dense and powerful population, which imposed its rule over a large portion of the present area of the Uganda Protectorate. Interest in the country was further excited by the visits of Sir H.M. Stanley in 1872. King Mutesa, the reigning monarch, had become interested in European civilisation since he had met Speke and Grant, and was in search of a religion superior to the worship of the earth, water, and ancestral spirits, and he was not satisfied with the tenets of Islam which had begun to attract a portion of his people. Stanley addressed a memorable appeal to the missionaries of England to introduce Christianity at the Court of Mutesa. The answer was immediate, and in 1876 the first British missionaries were on their way to Uganda. These were followed two or three years later by the emissaries of Cardinal Lavigerie, i.e., members of the mission of the White Fathers. In 1884 King Mutesa died, and after his death Christianity in its Roman and Anglican forms and Mahommedanism made such rapid strides that soon only a few pagans were left in the Kingdom of Uganda. In 1894 a British Protectorate over the Kingdom of Uganda was declared, and this was further extended in the course of a few years until it gradually came to comprise the five provinces now included within its limits, i.e., Central, Nile, Uganda, Western and Rudolph. The total area of the Protectorate is 130,000 square miles. The population is 3,000,000. The population of the Kingdom of Uganda is about 1,000,000, and 100,000 of them are Christians.

For the purpose of administration, the natives, especially those speaking Banta, are encouraged to govern themselves. For instance, the Kingdom of Uganda (16,000 square miles) is divided into twenty districts, each of which is placed under a chief appointed by the King of Uganda, subject, of course, to confirmation by the Imperial Government. These twenty chiefs are under the control of the King, who is assisted in his government by a Lukiko, a
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native parliament, elected on lines laid down by the British Government. Similar arrangements exist in the other provinces. Throughout, the King, or his chief, as the case may be, is encouraged to govern his people on humane principles, with only that amount of interference from the nearest European official as may protect the native from injustice.

Climate.—With perhaps the exception of the Nile and Rudolph Provinces, the climate of the Uganda Protectorate is not unhealthy, and large portions of it being 4,000 feet above the sea level, the heat is not excessive, even under the Equator, and it is very rarely disagreeably hot at any time of the year. Average maximum temperature 83° F., average minimum temperature 55° F. Parts of it, such as Toro and Ankole, have a climate resembling the month of June in England. I should say that the Protectorate has, as a whole, a healthy climate, although many parts of it are insalubrious, owing to the presence of mosquitoes and malaria.

Products.—It would be out of place to discuss, in any detail, the many products which this wonderfully fertile country is capable of bringing forth; suffice it to say that it needs no expert to see at a glance that almost anything in the way of vegetation flourishes. About one-fifth of the total area of the Protectorate is covered with rubber-producing trees and vines, gutta-percha is now extensively cultivated, cotton—introduced only a few years ago—is growing in the most wonderful way, as also is sugar, coffee and cocoa, in fact, the casual observer cannot help recognising what a jewel England possesses in holding this land, and what a splendid future is in front of it if we can but save the native from extermination by disease.

Inhabitants.—The Baganda is the predominating tribe. They are a race of mixed negro type, sturdy in physique, extraordinarily intelligent, willing, hard working, and on the whole honest. They are brave and fought well in their own wars, and for us; but what struck me more than anything was their intelligence; personally, I never expected the negro to attain to the level that they have in this respect. Their eagerness to learn is also a marked feature. I cannot help here quoting the words of Sir Harry Johnston with reference to the Baganda: "In my opinion there is no race like

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1 On his return from Uganda in 1892, my old friend Sir F. Lugard spoke to me in the highest terms of these same Baganda people, but unless I had experienced it I could never have believed the negro capable of attaining such a high level of intelligence.
them among the negro tribes of Africa. They are the Japanese of the dark continent, the most naturally civilized, charming, kind, tactful, and courteous of black people."

Diseases.—(a) Malaria is prevalent along the coast at certain times in the year, especially during the wet season; (b) blackwater fever is, on the whole, rare; (c) spirillum fever has of late years made its appearance. It was apparently unknown until the introduction of the tick from the West Indies. It is conveyed by that insect. Of late years it has unfortunately become very prevalent, and is proving a real curse to Europeans especially. It has also in many cases assumed a very virulent type, sometimes leaving blindness and local paralysis as a sequel. This spirillum fever is causing anxiety among the authorities, as they fear its extension. But the two diseases which at present threaten to exterminate the whole population are: (a) sleeping sickness; and (b) syphilis. As regards the former, all that need be said here is that barely seven years ago it made its way from the Congo basin to Uganda, and in that time it is estimated that 300,000 of the inhabitants have perished from it.

The Consideration of Syphilis in the Protectorate.

As regards the latter, if the opening of Africa from the west has been responsible for the introduction of sleeping sickness, the opening up from the east has introduced, if possible, a more appalling visitation in the shape of syphilis. In saying this I do not intend to maintain that the disease was unknown in the land prior to its invasion from the east, for there is evidence of its having been present there for many years, and it is supposed to have been originally introduced during the Arab invasion some sixty years before, but that it existed only to a very small extent is also certain. About twelve years ago there was a more or less sudden outbreak of the disease among the Baganda tribe, since which time it has gone on increasing both numerically and in virulence, until at the present time more than half the population of the Protectorate is infected. In some districts, such as Ankole, it is estimated that 90 per cent. suffer from it. Infant mortality is as high as 50 to 60 per cent. owing to it, and it is the chief cause of the sterility which exists throughout the country. In fact, as things stand at present, through syphilis, the entire population stands a good chance of being entirely exterminated in a very few years, or left a degenerate race fit for nothing. In connection with this sudden outbreak, the question arises as to what was its cause or causes, and
investigation has convinced me that the causation has a two-fold origin, viz., (1) The introduction of Christianity; (2) the abolition of the punishments formerly meted out among the tribe for all immoral offences committed by either sex. With regard to the first cause, repugnant as it may seem to assert it, I fear it is none the less true that the introduction of Christianity, and the consequent abandonment of polygamy and old restrictions on the liberty of the women, was probably the chief cause of the outbreak. This conclusion is based on the evidence, not only of members of the Church Missionary Society and the White Fathers, but also on that of some of the most intelligent of the native chiefs, who themselves hold the Christian beliefs. The following are extracts taken from the summary of evidence of some of the principal witnesses: The Rev. J. Roscoe, C.M.S., Chief of the Theological College at Kampala, who has spent twenty-five years of his life in Uganda, states: “The cause of the outbreak was in my opinion the following: Among the Baganda, up to about twelve years ago, a custom prevailed of keeping the women belonging to it under strict confinement and surveillance; in fact, so strictly was this adhered to that they were more like prisoners than anything else, hence immorality and promiscuous intercourse did not exist. Corresponding with the time of the outbreak of syphilis, the chiefs of the Baganda tribe, the majority of whom had become Christians, decided to remove these restrictions, as being contrary to Christian teaching, and to set the women free. This was done, and from that time the women were released, henceforth to roam where and whither they willed and do as they liked. Other Christian tribes followed the example of the Baganda, and even those who had not embraced Christianity followed their example, as they usually do in almost all affairs of life, the Baganda being the predominant tribe. The result of the removal of those restrictions was exactly as one would have expected, i.e., promiscuous sexual intercourse and immorality. I consider the above to have been the main cause of the outbreak of syphilis among the tribes of the Protectorate.” The very Rev. Père Laane, Father Superior of the White Fathers, Entebbe, says: “As to the cause which has led up to this outbreak, I believe it to have been the emancipation of the Baganda women from the restrictions in which they were formerly held.” Sir Apolo Kagwa, K.C.M.G., the very enlightened native Prime Minister, remarks: “The probable immediate cause of the outbreak was the emancipation of the Baganda women from the surveillance to which they had hitherto been subjected.” The evidence of many others, as given
in the summary of evidence, is strong proof that the abolition of polygamy had at least a very great deal to do with the outbreak of the disease.

As to the second cause, doubtless the custom which had previously existed among the tribes of administering punishment for immoral offences had a deterring effect, and in this way acted as a safeguard. The abolition of these punishments encouraged the commission of these crimes, and lent itself to the propagation of the disease among the people.

Spread: the Main Cause.—With regard to the spread of the disease, with its consequent intensification, there can be little doubt as to what was the main cause. The country has been opened up from the East. This allowed of free ingress of the Indian-Swahili traders from the coast, who not only acted as mediums for the spread of syphilis in their wanderings throughout the country, but also introduced into the Protectorate much fresh disease. The evidence on this point is unanimous.

Other causes are alluded to as aiding the spread of syphilis. The first is, in my opinion at least, a "doubtful" one. It is said that the Bahima were, to a great extent, responsible for its dissemination. This tribe, otherwise known as the "Cow" tribe, are shepherds, and live a wandering or bedouin life. The Rev. J. Roscoe, C.M.S., who has made a special study of this people, says in his evidence: "There is another medium through which I think syphilis has widely spread, viz., the presence in Uganda of a certain number of the Bahima tribe (the Cow people of Ankole), a migratory tribe, amongst whom some curious customs exist. Thus, after a woman is married, all sexual restrictions are thrown to the winds. She may welcome to her bed any of her husband's friends or relatives with impunity. When a friend visits a man, he sleeps in the same bed with him and his wife, and the rules of hospitality are such that the host must leave his wife to his friend in the early morning. When a man is absent from home, and a visitor arrives, the wife must entertain him, and, if he should so desire it, act as his wife. It may well be imagined, then, what a fruitful source for the dissemination of syphilis and other venereal diseases the Bahima are." Lieutenant-Colonel Will, R.A.M.C., remarks: "In the province of Uganda, the Bahima (Cow tribe), who are migratory, are responsible in a great measure for spreading the disease."

In the course of my investigation I discovered the existence of a third and much more real cause for the spread of syphilis. I had
heard rumours of a practice which was said to exist in some of the provinces of deliberate vaccination of healthy infants with the syphilitic virus from affected persons, the rationale being that syphilis communicated in this way during infant life conferred immunity from it to the adult. As stated, investigation proved that this dreadful state of things does exist, and to a very great extent in some of the Provinces. The following are extracts from the summary of evidence of some of the witnesses as regards this:

The Rev. Père Laane, Father Superior of the White Fathers, says: “Undoubtedly a practice exists in some parts of the country of deliberately inoculating infants with syphilitic virus to prevent a repetition of the disease in grown-up life. This is especially the case in and about Hoima, in the Province of Unyoro. The people there have told us over and over again about this. The practice is to wrap the infant, when only a few days old, in clothes which have been smeared in syphilitic discharges. Of the existence of this practice I have no doubt whatever, and have had to make it the subject of my sermon on more than one occasion.”

Sir Apolo Kagwa says: “Yes, it is well known that in certain Sasas this practice does exist, in Buyagu, Bugangadai, and Hoima. The people vaccinate infants with the virus of syphilis with a view to preventing them getting the disease in adult life. The consequence is that in these countries probably 90 per cent. of the population is affected.”

The Rev. Father Moulin, of the White Fathers, says: “I am in a position to say that this practice does exist to this day among the Bunyoro—not so with the Baganda.”

Chief Mugwanya, Second Regent, remarks: “Deliberate vaccination with syphilitic virus is common in some of the Sasas, especially Buyagu.”

Dr. Goodliffe, Colonial Surgeon, says: “I have heard it stated, and, although I have no direct evidence of it, I have reason to believe it is true, that in some parts of Unyoro Province a practice exists of deliberately inoculating infants with the syphilitic virus, to protect them from again contracting the disease.”

**Incidence of the Disease.**

Unfortunately the statistics are of such a meagre description that no accurate conclusion can be arrived at as regards the actual incidence of syphilis in the Protectorate as a whole.

*Syphilis as it Exists.*—Syphilis, as seen to-day in Uganda, presents the usual picture of what it has always done when the
disease is implanted on virgin soil and allowed to run riot without treatment. It is the same picture which was depicted by William Ferguson (afterwards Sir William Ferguson) of what he saw under similar circumstances in 1813, whilst in Portugal, viz., mutilation everywhere. He said then of Lisbon that more cases of mutilation from syphilis could be seen in that city in one day than would be observed anywhere else in a year, and I imagine the same can be said of almost any station in the Uganda Protectorate to-day. Under the circumstances, the disease has assumed its well-known characteristic virulence. In the primary form, the true Hunterian chancre is the rule, and this as often as not takes on a phagedenic character, resulting in wide destruction of the surrounding soft parts. The second stage of the disease is characterised by intense and confluent eruptions, ulcerations of the mucous membranes, laryngitis, iritis, periostitis, and joint affections, profound anemia, cachexia, and general disturbances of the nutrition. In some cases, the principal secondary manifestations are of a nervous kind, as exemplified by neuralgic pains, asthenia, paralysis and analgesia. The tertiary stage is represented by early rupial syphilides, which extend rapidly and deeply over the body and limbs; osteo-arthritis manifestations, with severe nocturnal pains, periostitis, necrosis of femur, tibia, clavicle, and bones of forearms; the joints become distended with fluid and sometimes become ankylosed. Gummatous ulceration destroys the eyelids, nose, and ears, bringing about varieties of mutilation which it is one's lot to see in Uganda day by day.

Saddest of all is the number of cases of hereditary syphilis. One is constantly coming across, in every part of the country, boys and girls between 8 and 10 years of age affected in one way or another, one of the commonest affections being osteo-arthritis of both knees. Caries of the bones of the face and base of skull are common, whilst it need not be said that blindness due to interstitial keratitis is a common occurrence. With regard to the effect syphilis has on the child-birth and infant mortality, Dr. A. C. Cook, C.M.S., makes the following statement: "From statistics based on obstetrical (confinement) out-patients, I calculate that 75 per cent. of the pregnancies among the Uganda women ended either in abortion or miscarriage, premature labour, or still-births, or the infants die within the first week of life. This latter is mainly due to syphilis, which in this connection the Baganda called "Munyo."

Parasyphilitic affections are not very commonly seen. In fact,
they are rare, the reason probably being that the disease has not existed, at least to any extent, in the country for a long enough time. Further, we would hardly expect to find syphilitic nervous affections existing to any extent among the class of patients under consideration. A certain number of cases showing early tabetic symptoms came under my notice, and quite a number of young able-bodied men, with syphilitic histories, who suffered from complete loss of sexual power.

Proposed Method for Checking the Disease.

Preventive Measures.—One's first idea was that the most effectual method of combating such a widespread syphilitic outbreak would be compulsory legislation. A Contagious Diseases Act, for instance. Under the circumstances, this measure could not be entertained, owing to the strong concensus of opinion—medical, clerical and lay—which was opposed to it. Doctors and laymen object to a Contagious Diseases Act on the ground that the state of civilisation in the Protectorate did not lend itself to any such measure. The Anglican Church Mission strongly urged objections of a moral character. The only body with whom the suggestion found favour was the White Fathers, and they were unanimous for its adoption. I was consequently obliged to look in other directions for means of dealing with the prevention of the dissemination of syphilis, and fortunately one method gave great prospects of success. I have already pointed out that, for the purposes of government, the various provinces are divided into districts, each of the latter being under a chief, appointed by the King and Government. The influence this chief exercises over the people in his district is very great. He can do almost what he chooses with them. It struck me that, by enlisting the sympathy of these powerful chiefs for the stricken people under their charge, great assistance could thereby be obtained, and I formulated in my mind a scheme for gaining their co-operation and powerful aid in this matter. This enabled me to trust to prolonged treatment, both for the prevention and cure of the disease. The chiefs could influence the people to report their sickness and attend at suitable places for regular treatment. This I thought preferable to any legislative measures. This object being in view, I proposed to limit the experiment in the first instance as a tentative measure to the Kingdom of Uganda. I suggested that throughout the districts of this part of the country small rooms, which I term “Treatment
Rooms,” should be established and be situated within reasonable access of all patients. Each of the “Rooms” would be placed under the charge of a medical subordinate, and visited once a week by a medical officer for the purpose of carrying out continuous treatment. Syphilitic patients would attend once a week for treatment and observation. Reliance in this way would be placed on the influence and sympathy of the chiefs for ensuring regular attendance of the afflicted. In each “Room” a register would be kept in which the names of all syphilitic patients would be entered and forwarded to the respective chiefs, who would enter them on registers which they would also keep. A card should be given to each patient, on one side of which important details as to the nature of the disease from which the patient is suffering, its dangers to himself and others, with the necessary precautions which he ought to take, would be printed. On the other side, instructions as to the day for attendance for treatment would be set out. Should a patient fail to attend on more than one or two occasions, without sufficient excuse, the fact would be notified to his respective chief. By means of this “continuous treatment,” the patient would have a chance of being cured of his disease, and in any case he and his offspring would be safeguarded against its future ravages, and, whilst undergoing the treatment, he would be rendered harmless to others.

Everything in this method of dealing with the Uganda outbreak depends on the sympathy of the chiefs. In view of this, I had private interviews with a great many of them, including the Prime Minister and the two other Regents, and soon discovered that all of them not only took the greatest interest in the subject, but were most willing to assist. They took a most comprehensive view of the syphilis question, and quite appreciated the necessity of long-continued treatment. The official summary shows how greatly the chiefs appreciated this scheme which I proposed, and how they concluded it could be easily carried out. On January 6th, 1908, I gave an address before the young King of Uganda and his assembled Parliament, the object being to explain to them the nature of the disease we had to deal with, the ravages it had committed and was still doing, and to lay before them the scheme which I proposed to adopt to check its further progress. The address was listened to with the greatest interest and attention, but nothing surprised me more than the speeches which followed, and which were delivered by some of the chiefs, showing as they did the most complete and intelligent grasp of the subject under discussion as well as a thorough knowledge of the ravages which syphilis had
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already perpetrated among the tribes, and which, if left unchecked, would ultimately end in practically complete racial extermination. Listening to these speeches, one could hardly believe that one was hearing them from the lips of the black men in the centre of Africa. In the end, I found I had the entire intelligent sympathy of the assembly of chiefs, as they were prepared at once to do their share in carrying out the proposals of my scheme. I may add that the whole population showed interest in the subject. Previously, losses from syphilis had come to be regarded as Kismet. The fresh proposal gave them fresh hope, at which these poor people eagerly grasped. This meeting under the King of Uganda in Lukiko will, I feel sure, turn out to be as important an event as it will be memorable to me.

In addition to the "Treatment Rooms," I proposed that in each Province a large hospital for the treatment of venereal diseases should be established for the treatment of hospital cases, each to be placed under the charge of medical men specially qualified in venereal diseases.

As regards the question of any special line of treatment which should be followed, that, of course, would be optional for medical officers to select as they thought best; but for continuous treatment I believe it will be found that the only feasible method to carry out effectually in the circumstances under consideration is the "intramuscular injection" treatment.

Here I may mention an interesting fact. When I arrived in Uganda I found that both there and in other parts of East Africa, the medical men were prejudiced against administering mercury in any shape or form to the natives. They assured me that the natives were most peculiarly susceptible to its action, and became salivated after minute doses. Dr. A. C. Cook, C.M.S., whose experience among the natives is, to say the least, unique, told me that such was his experience and he had been giving mercury of late years only when forced to do so, and even then only in the smallest doses. In spite of all precautions, salivation occurred, and he warned me to be on my guard with mercury as regards the African natives. However, I felt confident from old experience that given intramuscularly the drug would be far better borne than when given by the mouth. At a demonstration at the Church Missionary Hospital I gave a number of native patients injections of half my usual dose, viz., grain $\frac{1}{2}$ (metallic mercury), and not one was followed by any untoward effect, and the following week I gave a number of full dose injections, with similar results.
Since then Dr. Cook and many other district surgeons have continued the injections for both syphilis and sleeping sickness, and have had no bad effects.

The conclusions arrived at may be set forth as follows:—

(1) That up to within recent years syphilis existed in Uganda only to a very limited extent, and was of the mildest type.

(2) About twelve years ago there was a more or less sudden outbreak of the disease.

(3) That the causes of this outbreak were probably: (a) The emancipation of the Baganda women. (b) The abolishment of punishments hitherto meted out for immoral crimes.

(4) That it was spread through: (a) The opening up of the country generally, allowing of free ingress and egress. (b) The doing away of the custom of isolation as regards syphilitics, which had hitherto been in vogue among the tribes.

(5) That syphilis was spread mostly by Swahili and East Indian native traders from the coast, and to a lesser extent by members of the Bahima tribe.

(6) That the disease has spread and continues to do so throughout the land.

(7) That its incidence varies in different places, being placed as high as 90 per cent. in certain districts, the inhabitants of which it threatens to decimate.

(8) That syphilis is the chief cause of the high infant mortality, as is seen from the rough figures showing the deaths from “Munyo,” by which name the native knows infantile syphilis.

(9) There is every reason to think that syphilis is the chief cause of miscarriage and abortion among the native women.

(10) There is at least strong presumptive evidence that a practice exists in some of the districts of deliberate syphilitic vaccination.

(11) With regard to prevention and treatment it was recommended: (a) That the present state of civilisation in the country does not permit of any legislative preventive measures. (b) That for the present reliance must be placed more on the better and more thorough treatment of the disease.

(12) For this purpose it is recommended that: (a) “Treatment Rooms” should be established, and be so situated as regards distance as to be within reasonable reach of all patients. Then syphilitic patients could attend once a fortnight for treatment. (b) Each Treatment Room should have a resident medical subordinate (Indian native) in charge, and should be visited regularly once a week by a medical officer. (c) That in each room a syphilitic register should be kept, in which would be entered the names
of all syphilitic patients. (d) That a similar register should be kept by each chief. (e) On a patient reporting sick and his case being diagnosed syphilis, his name should be entered in the "Room" Register, and also sent to his respective chief for entry in the chief's register.

(13) Non-regular attendance on the part of a patient should be reported to his respective chief.

(14) Much reliance would be placed on the influence of the chiefs to insure regular attendance.

(15) That a special venereal hospital be established in each province for the reception of hospital venereal cases. That such a hospital be placed in the charge of a medical man with special knowledge of venereal diseases. It would also serve as a venereal clinique for the medical staff of the Protectorate, a thing to be very greatly desired.

Of our chances of being able to grapple successfully with syphilis in Uganda I am very hopeful, as I consider the general conditions are favourable. In the first place we have a naturally healthy and sturdy race to deal with, who are intelligent enough to recognise the dangers of the disease, and the ravages it has already committed among them and their children, who are desirous of being rid of the disease, and willing to undergo any treatment with that object.

For the successful treatment of syphilis, experience has taught us that complete control of out-patients, so as to insure regular attendance, with consequent regular treatment, is an absolute essential. In the Army in India, through having this control of our patients, and by means of the intramuscular method, the invaliding rate for syphilis has been reduced some 70 per cent.

Now in the Uganda Protectorate I believe we can count on even a more complete control of our patients than in India, for the influence of the chief over the people is remarkable, and his word is law; hence, with his sympathy on our side, complete and regular attendance can be relied upon, so that there is every reason to think, without being too optimistic, that our chances of being able to deal successfully with syphilis in Uganda are at least as good as they were ten years ago in India, and if we can bring about anything like the brilliant results achieved in that country we shall have cause for congratulation.

DISCUSSION.

Captain Dorgan related his experience in a large station in India, and considered that an average of 2 grammes might be given. In a large series of injections he never found any harm result. Several relapses
might occur even with large doses if treatment was discontinued. In
injecting it was difficult to give sufficient without giving too much. He
thought that a great deal of reduction of syphilis in India was due to
prevention of infection.

Major French said he had used the mouth, inunction, and injection
methods of treating syphilis extensively during a period of fifteen years
in large military hospitals. In early syphilis—i.e., during the chancre and
early rash stage, and before the disease had become established—he was
convinced that the inunction method of administering mercury was
infinitely preferable to the injection of insoluble salts such as grey oil.
He had conducted a close research on this point during the past nine
months, and found that when inunctions of ung. hydrarg. were judici­
ously used, the induration of the chancre and of the lymphatic glands was
much more rapidly and thoroughly dissipated, and that a gain of several
pounds in weight was the rule and not the exception. He found severe
relapses and loss of weight to be much more common after the use of
insoluble grey oil, and the lymphatic glands were not nearly so beneficially
affected.

We were chiefly concerned in the Army with arresting syphilis of
hospital patients in the chancre and rash stage. At Woolwich, in the
year 1903, the intramuscular injection of grey oil was used for in­
patients. There were 477 admissions for syphilis. In 1904 there were
331 admissions, regular out-patient attendances commencing in that year.
In October, 1905, he initiated inunctions for in-patients, grey oil in­
jections being reserved for out-patients. In 1906 there were only 129
admissions for syphilis, and in 1907, 87 admissions. In October, 1905,
there were some 150 men attending as out-patients for syphilis.
Average number of out-patients now was 61. The method of inunction
prevailing at Woolwich was on the general lines of Aix-la-Chapelle,
modified by Service conditions. Hot baths were essential before rubbing.
The groins and arm-pits were closely shaved to prevent pustulation—
these places were selected owing to the greater frequency of glandular
orifices, which regulated absorption. The abdomen and back were also
rubbed. The dose was 3l. ung. hydrarg. B.P., compounded with lanoline
or other substances. Forty inunctions formed the first course; this was
most important. He usually gave twenty-five and stopped for a week,
and gave potassium iodide during the week’s interval, then fifteen more.

In the JOURNAL OF THE ROYAL ARMY MEDICAL CORPS for May, 1908,
Colonel Lambkin’s article attributed the brilliant results obtained in the
British Army in recent years to the injection of insoluble grey oil
(Lambkin cream).

Inspector General Bentham, Dr. Power and Surgeon-General Sloggett
also took part in the discussion, and Colonel Lambkin replied, and a
hearty vote of thanks was accorded to him on the motion of the President.