

The History of Sexually Transmitted Diseases. No 8 in a series edited by Milton Lewis and Michael Waugh.

# Sexually transmitted diseases in the history of Uganda

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## Abstract

**First noticed in Uganda in 1863 by a European explorer, sexually transmitted diseases (STDs) were cited as a major cause of morbidity and mortality throughout this century. In 1908 the venereal diseases campaign was launched marking the real introduction of western medicine. By the mid-1920s, the campaign was combined with the medical service but throughout the colonial period (1901-1962) venereal diseases were considered intractable. A 1991 survey revealed alarming incidence rates and in light of the importance of STDs as a co-factor in the transmission of HIV, it is of paramount importance to implement more effective control measures.**

(*Genitourin Med* 1994;70:138-145)

## Introduction

Uganda became a British Protectorate in 1894 and within a decade sexually transmitted diseases were being cited as a major cause of infertility, morbidity, and mortality.<sup>1</sup> Their deleterious effects on population size were perceived as a major threat to colonial notions of development. The record abounds with references to the "ravages" of these diseases which would "exterminate" whole populations. Present projections of HIV prevalence and AIDS mortality remind us of the decades-long fear of a dying population in Uganda while present medical discourse, like its antecedent, often minimises the broader context of disease.

Have sexually transmitted diseases been intractable for generations of Ugandans, and if so, do they bear any relation to the present epidemic of HIV/AIDS in that country? Yoweri Museveni, the president of Uganda, recently described AIDS as a "developmentally linked" disease which resonates with the history of sexual diseases in this country. He said that while

*"AIDS is the pre-eminent public health threat of our time, socio-economic factors, crucial in the transmission of AIDS and other sexually transmitted diseases, have deep historical roots. In Africa, sexually transmitted diseases such as gonorrhoea and syphilis were a big health hazard before the advent of modern Western medicine".<sup>2</sup>*

## *Sexually transmitted diseases in Uganda*

Venereal disease was first noted in 1863 by

the explorer John Speke who "hinted at seeing syphilitic lesions".<sup>3</sup> By 1879 it was said to be widespread in the two dominant kingdoms, Buganda and Bunyoro.<sup>4</sup> Venereal disease continued to be regularly cited throughout the colonial period (1894-1962) as widespread and the authorities believed that it constituted a grave threat to the population and "development" of the colony. Dr. Albert Cook of the Church Missionary Society began keeping statistics on sexually transmitted diseases in 1897 and he soon concluded that about 80% of the Baganda<sup>5</sup> had at one time or other had syphilis. According to Cook the "drive against venereal diseases" was the second great medical campaign against diseases threatening the population of Uganda, the first having been against sleeping sickness.<sup>6</sup>

## *The investigation*

By 1906 the situation was so worrying that Governor Hesketh Bell appealed to the Secretary of State for the Colonies and in 1907, Colonel F J Lambkin, an expert venereologist of the Royal Army Medical Corps, was commissioned to study the situation. Lambkin's report, *An Outbreak of Syphilis on Virgin Soil* alarmed the authorities.<sup>7</sup> Venereal diseases were widespread and included syphilis, gonorrhoea and soft chancre. Gonorrhoea was said to "exist to a fearful extent" and was thought to be the cause of very high miscarriage and infant mortality rates.<sup>8</sup>

In some areas, such as Ankole District, in the southwest, it was estimated that 90% of the population was infected with syphilis and infant mortality was said to be as high as 50% to 60%. Lambkin warned that unless steps were taken the

*"population stands a good chance of being entirely exterminated in a very few years, or left a degenerate race fit for nothing".<sup>9</sup>*

Dr A C Rendle reported that during 1907 at the Kampala Government Dispensary, there had been 11,787 new cases of which 2,112, or 17.9%, were suffering from some form of venereal disease and she believed that many ulcer and skin conditions due to syphilis escaped statistics.<sup>10</sup> Notes kept by Cook for Buganda between 1914 and 1920 indicated 67,988 births, 93,035 deaths and 7,111 still births which "startled men" into realising that the Baganda were in danger of becoming extinct through disease and ignorance.<sup>11</sup>

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*Theories on origin and spread*

Early theories on the origin and spread of venereal diseases included a range of cultural, social and economic factors. Most informants agreed that gonorrhoea was a very old disease and well-known by the population. There was overall consensus that syphilis had been present for a long time, introduced by traders from the East Coast of Africa who first arrived in Uganda in the 1860s. Medical investigators dated the epidemic to the mid-1890s and believed it had been caused by increased mobility of population as a result of the completion of the Uganda Railway linking Kampala with Mombasa in 1899. Another cause was believed to be the introduction of Christianity at which time large numbers of converted Bagandan men "emancipated" their women who were formerly kept under strict surveillance and confinement. A prominent Bagandan leader, Apolo Kagwa, added that the abolition of the punishments which used to be given to both men and women for "crimes of immorality" was yet another factor for the spread of venereal diseases. Missionaries were annoyed at the implication that Christianity was cited as a cause of venereal diseases. At the insistence of the Church Missionary Society Cook wrote to *The Lancet* in 1908.

*"I must give emphatic denial to the assumption that Christianity has been the chief cause of this epidemic. It has been all the other way round. Read 'civilisation' for 'Christianity' and there may be some amount of truth in it."*

And, echoing the moral debate today in Uganda concerning the cause of AIDS, Cook added

*"Christianity . . . is indeed, when intelligently accepted, the only true prophylaxis to this terrible scourge."*<sup>12</sup>

One chief added that sexual diseases had spread during the series of wars between Buganda and Bunyoro which ended with the arrival of the British. Several cultural practices were cited as causes for the spread of sexual diseases. Among the Bahima of Ankole, the practice of husbands sharing wives with their brothers was thought to explain widespread venereal disease. (It is noteworthy that at present, with AIDS, this practice is still condemned by health workers.) Other cultural practices included vaccination of infants with syphilitic discharge, wrapping infants in cloths soaked in discharge or placing them to sleep in beds with syphilitic victims in an attempt to convey a form of immunity.

It is important to note that such practices argue long familiarity with a treponemal disease. The experts' chronology of the introduction and spread of syphilis taken together with the obviously very old cultural practices mentioned highlight a contradiction in Lambkin's analysis of a "virgin soil epidemic", a point I shall return to later.<sup>13</sup>

*The campaign*

In December 1908, a commission of three Royal Army Medical Corps officers headed

by Captain W M B Sparkes arrived in Kampala to begin the venereal diseases campaign as suggested by Colonel Lambkin. Medical staff concurred that "the present state of civilization of the country does not permit any legislative measures with a view to prevention". Thus, no ordinance was considered. Instead, a few small treatment rooms were to be established and staffed by African medical subordinates and visited weekly by a medical officer. Initially, treatment consisted of a twenty-one month course of intramuscular injections of one grain doses of mercury administered weekly, together with the application of mercury ointment and calomel cream. At his first treatment session, in order to reassure the sceptics, Sparkes had himself injected in the buttocks with a full dose of mercury in front of a large crowd which was reported to be "greatly impressed".<sup>14</sup> The Colonial Office warned Sparkes that there would be no additional funding for the next year even though "If we were to tackle every case of syphilis that exists within the country, we should find work for 40 doctors at least."<sup>15</sup>

By June 1909, the Colonial Secretary was concerned that only 2,482 patients had attended the treatment centre. "I cannot think that...represents anything like the number who require treatment round Kampala. The chiefs ought to have their attention drawn to this."<sup>16</sup> It soon became clear that Africans were avoiding the injections which in many caused mercury poisoning (salivation) and which had resulted in the death of eight or nine patients.<sup>7</sup> In June, Sparkes altered the regime to doses of between one-quarter and one-half grain but since the full treatment took nearly two years, the non-attendance after a few doses was alarming. People simply refused to return for injections once visible signs of disease disappeared. Others were frightened away by rumours that the European medicine was an injection of fire which removes the blood and causes miscarriages.<sup>18</sup> By August with only forty-four new patients, Sparkes again altered the treatment regime. In cases of old tertiary lesions, he shortened the course of treatment to ten injections over four or five months but he doubted patients in primary and secondary stages would continue the required lengthy treatment. In spite of the difficulties, there were 3,851 attendances at the Kampala treatment room and during its first year, the programme was expanded to three "treatment rooms" at Kampala, Busimbi and Budu with plans for another at Masaka. The centrepiece was the Venereal Diseases Hospital built in 1913 in Kampala, which later became the major government hospital, Mulago, and which would serve as the central treatment centre and a "teaching venereal clinic".

*African responses*

Many Bagandan and Banyoro leaders responded to the campaign enthusiastically. Some, like the ruler of Bunyoro in 1911, pleaded for European medical assistance. "Sir, We beg most respectfully to inform you

*that we find that the disease of syphilis is increasing in our country. It grows worse; a lot of children are born dead from syphilis. It also causes the women miscarriage. It is found in some villages, though not in all. We should be very glad if some arrangement could be made by the Govt. to send a Doctor to cure that disease."*

The District Commissioner added that *"the letter together with general opinion that population of Unyoro is considerably decreasing, specially so by infantile mortality, shows that if something is not done in the near future to allay this disease, there is every probability of a not too well populated District becoming decimated"*.<sup>19</sup>

*"All natives of any influence or education know of, and profess to sympathise with, the efforts being made by Government to combat venereal disease"* according to Dr Jack Cook, Albert Cook's brother.<sup>20</sup> In 1913, Cook reported that 84% of the Banyoro, neighbours of the Baganda, either had or had had syphilis and it was reported that there were on average 2,052 syphilis-related deaths annually [1.3/1000 pop] with one in seven or eight deliveries resulting in stillbirths. The relation between sexually transmitted diseases and productivity was clearly understood. *"How far the surviving population is reduced in vitality and usefulness from this cause may be conjectured."*

The establishment of the first treatment centres marked the beginning a long campaign which by the 1970s had earned Uganda the reputation of having the "finest STD programme in all Africa".<sup>21</sup> Closed during the First World War, the Venereal Diseases Hospital in Kampala was reopened in 1921 when a compulsory examination and treatment ordinance was passed. The Venereal Disease Ordinance of October 13, 1921 prohibited treatments for syphilis, gonorrhoea or soft chancre by unregistered, unlicensed medical practitioners for it had come to the notice of the authorities a large number of Africans were "extorting enormous sums from natives for so called cures".

Dr Webb, director of the venereal diseases campaign, using statistics of 1913-14 and 1921, considered 10% to 20% of the total population to be infected with acute gonorrhoea or acute syphilis and between 70% to 90% to be suffering from chronic or latent forms of these diseases.<sup>23</sup> The campaign now consisted of Mulago Hospital and five subsidiary treatment centres within a radius of ten or twenty miles which meant, in practice, that the venereal diseases campaign covered only a small fraction of the Protectorate. In addition to specialised treatment centres, however, there were many small, government dispensaries and sub-dispensaries throughout the country as well as hospitals and dispensaries run by missionaries. By 1909, there were already 17 mission dispensaries in Uganda. By 1903 Mengo Hospital in Kampala, where the Church Missionary had begun its medical work in 1897, reported syphilis to be a common cause of admission "amounting to about 10% of patients".<sup>24</sup>

In 1923, the "vertical" campaign against

venereal disease was merged with general medical work. The change in policy arose from a number of factors including a scandal in 1921-22 which had drawn attention to Uganda and which greatly alarmed the Colonial Office. The *London Daily News* on 17 February 1922 reported the Colonial Office's attempt to introduce Contagious Diseases Acts in Uganda. The article initiated an exposé of events in the small, distant colony. At the request of a number of concerned organisations in Britain, the National Council for Combating Venereal Diseases began an enquiry into the matter. Interested parties included the Catholic Women's League, The Federation of Medical Women, The Association for Moral and Social Hygiene and the International Woman Suffrage Alliance.

In July 1921, Dr Lamont, a female, had been engaged as a "Venereal Medical Officer" to treat Ugandan women and children. She was fired in December that year after accusing senior medical officers, all members of the Royal Army Medical Corps, of applying regulations unacceptable anywhere else in the world and of degrading and humiliating African women during physical examinations.

*"I found I was called upon to assist in working venereal disease laws and regulations which are far worse than any Contagious Diseases Acts ever in force in any country. . . [which] apply to the whole native population; they involve the compulsory examination and treatment of whole villages of people and this at regular intervals."*

Major Keane, Specialist Officer in the Venereal Diseases Campaign, summarising the programme in July 1922 in reply to the allegations of abuse admitted that *"It is probable that the compulsory measures of Uganda are the most rigorous and far reaching that have ever been enacted in any country in the world."*<sup>25</sup> But Dr Lamont's allegations were indeed disturbing. She described *"The most repulsive form of genital inspection of these women... [which was] often done on a hillside behind a fence with no apparatus whatever and with men undergoing a similar examination in close proximity."*

She was expected to examine some fifty to sixty women an hour, the women bending double, presenting their gluteal regions to the doctor while native attendants pulled the women's clothes up.

According to Lamont, African chiefs were encouraged and rewarded with small payments, for reporting any of their subjects whom they reasonably suspected of having venereal disease. She described how *"The women are driven up like cattle in groups of fifty or so, and the chiefs get 6d a head for each one they send in for examination."*<sup>26</sup>

In his rebuttal, Keane argued that *"Compulsory examination owes its origin entirely to native wish and native conception as to how VD measures should be conducted. . . In considering coercion it is essential to divest one's mind of European conditions. Coercion is recognised as the customary method of introducing new ideas"*

and advancing progress in this country.”

According to him, Ugandans preferred compulsory examination to the notification system which placed “house-owners and land-owners in a difficult position and laid them open to charges of espionage and liable to have houses burned”. And, he insisted, it was astonishing that not one Ugandan had ever complained about the system.<sup>27</sup>

Compulsory examination had become necessary, he reasoned, when early in the campaign it became clear that the majority of those who came for treatment were the elderly, in advanced stages of the disease suffering chronic, tertiary syphilitic ulceration of legs and arms and even these people tended not to follow through a whole course while the younger, freshly infected and, therefore, more infective victims did not come to the treatment centres. This fact, combined with the custom of “visiting” kin and friends in the villages even when covered with severe genital lesions, well-developed rashes, and contagious sores had led the authorities to press for legislation to compel people to come forward for treatment.

The first legislation concerning venereal diseases had been the 1913 “Native Law” passed by the *Lukiko*, or parliament, of the Baganda and it applied only within Buganda and at Entebbe, the administrative headquarters some 25 miles distant. The law required chiefs to notify authorities of infected persons and to send them to government treatment centres for attention. In addition, Township Rules, beginning in 1903, sanctioned compulsory examination and detention of persons, male or female, thought to be infected with dangerous diseases.

Although exonerated through the efforts of a large number of supporters of the campaign in Uganda, the small specialist venereal establishment was soon amalgamated within a larger, unitary colonial medical establishment. The Principal Medical Officer felt that the venereal diseases campaign had developed too rapidly between 1921 and 1923 and had become antagonistic, even detrimental, rather than complementary to other medical work in the Protectorate. This in spite of the fact that the campaign operated within a circumscribed area of the Protectorate representing not more than 5% of the total population.<sup>20</sup>

Restructured within the colonial medical department, the programme against venereal diseases continued, fuelled by the perception of their impact on fertility and morbidity. With ever-increasing demands for labourers, this was a major concern to the authorities. Following the publicity in England of the campaign in Uganda, the National Council for Combating Venereal Diseases invited the Protectorate Government to send representatives to a series of Imperial Social Hygiene Congresses throughout the 1920s. These were held for the benefit of “Dominion and Colonial Governments, Health Authorities from the Empire and National and Imperial Social Organisations” with the aim of “formulating constructive schemes for still more effective means

of reducing the incidence of venereal disease.”

Incorporated within the colonial medical service, the campaign against sexually transmitted diseases functioned until nearly a decade after Uganda’s political independence in 1962. Statistics indicate that by 1963 syphilis had decreased in incidence while gonorrhoea increased considerably. While government and mission hospitals and dispensaries offered treatment for sexually transmitted diseases, a very large proportion of Africans preferred to seek medical attention from either their own traditional practitioners or in the numerous private clinics which by the 1970s proliferated; thus official statistics give us only an indication of the true scale of these diseases.

By 1953 treatment of venereal diseases was provided by 227 government medical units and in most general outpatients departments. Additionally, missions operated 45 medical units. But in spite of the medical establishment, reports of alarming incidence rates continued. Astonishingly, there was not one venereal diseases expert in the country although it was recognised that “Venereal disease in the form of syphilis and gonorrhoea has constituted one of the most intractable problems which the Medical Department of Uganda had had to deal with during the last thirty years.”<sup>31</sup> Eight percent of all hospital admissions were for sexual diseases, mainly gonorrhoea, syphilis and granuloma inguinale and while prevalent throughout the country, the highest incidence was in the southern half.

It was believed that, “the transmission of venereal disease is facilitated by lack of any marked social sanction against promiscuity. . . [making] the chances or reinfection within a short period following cure of an infection. . . generally high”.<sup>32</sup>

Officials were particularly alarmed to discover that “at Mulago Hospital, 15% of 2,763 patients were school children, and 70% were unmarried. Many had been ‘cured’ three or four times before”.<sup>33</sup>

Europeans had always argued that the primary cause of widespread venereal diseases was the uncontrolled sexual activity of Ugandans which coupled with their lack of social sanctions was a recipe for disaster. Readers will recognise the argument which appears repeatedly throughout the history of sexual diseases.<sup>34</sup> In light of the widely-held European opinion that Africans were morally deficient and that this class of diseases was caused by weakness of character, it is not surprising that a large proportion of patients sought cures outside the colonial sector. Colonial records reiterated as a continuing problem the reluctance of patients to present at recognised treatment centres preferring instead to see private practitioners, many of whom were only half trained or quacks. “The result is that in many instances the causative germs of the diseases become resistant to the known drugs or antibiotics”.<sup>35</sup> In 1955, Uganda requested the World Health Organisation to conduct a nationwide survey of sexually transmitted diseases. It was hoped to launch a

Table 1 Syphilis, gonorrhoea and yaws in Uganda reported in government hospitals 1939–1960

Year	Syphilis	Yaws	Gonorrhoea	
1939	57,542	76,427	—	
1940	20,138	24,665	7,178	
1941	18,951	22,942	7,347	
1942	19,692	24,069	8,669	
1943	23,599	26,769	11,415	
1944	24,021	27,655	—	
1945	31,549	33,697	14,936	
1946	38,444	35,185	20,098	
1947	45,464	37,803	30,111	
1948	47,854	35,913	33,160	Other VD
1950	41,089	—	30,900	
1951	36,857	—	32,271	
1952	29,780	—	23,381	5,487
1953	23,680	—	16,659	3,894
1958	11,866	—	43,185	
1960	6,430	—	39,150 <sup>30</sup>	

Sources: Uganda Protectorate, Medical Department. Annual Reports and Uganda National Archives. File GCW 3, 30 April 1955, Proposed Survey of Venereal Diseases.

new prevention initiative through education and use of the radio. Special VD clinics would be set up at each government and mission hospital in the country and treatment should be free. All schoolchildren would be examined at the beginning of each term and employers would be responsible for regular examinations of all employees. Prostitutes would be examined and those found infected would be offered alternative forms of labour.

Unfortunately, in 1955 the volatile political situation in central Uganda forced the authorities to request a postponement of the survey together with the proposed new campaign.<sup>36</sup> The whole idea was dropped in 1956 with explanations from the World Health Organisation that the continuing political difficulties in Uganda combined with the growing consensus that funds would be better spent on a “continental offensive against the endemic treponematoses in Africa” made such a survey unlikely.<sup>37</sup>

Not all medical staff concurred that venereal diseases were the major health problem in Uganda. Some, for instance, cautioned that there was much misdiagnosis of other conditions as syphilis. For example, one medical officer, reporting in 1951, complained that “Many people think that every sick child in this country is emaciated, pale and very irritable because of syphilis, and there is discontent on the part of parents when a doctor informs them that the child suffers from kwashiorkor. This department must plead guilty to over-facile diagnosis of ‘syphilis’ and erroneous interpretation of hospital data in the past. In a pamphlet published in 1922 it was claimed that two-thirds of all pregnant women in Buganda suffered from syphilis

and it is evident that many other diseases of childhood were in those days confused with syphilis. Enthusiastic concentration on a single disease is liable to override discrimination.”<sup>38</sup>

#### Venereal diseases, 1960 to the present

In his Policy Speech for 1963, the Ugandan Minister of Health reiterated the now familiar refrain that “Needless to say these two diseases [gonorrhoea and syphilis] are very common and cause a great deal of sickness among the population of this country.”<sup>39</sup>

And in the same year there was yet another application for a survey of sexually transmitted diseases which, to date, had not yet been accomplished. “VD is a very big problem which I believe Uganda cannot afford to eradicate single handed”. This was accompanied by a plea that “Something new, and perhaps drastic steps, must therefore be taken to stamp out the VD scourge”.<sup>40</sup>

In the late 1960s and 1970s a series of studies of venereal disease among university students and the army provide further evidence of incidence rates. O P Arya and F J Bennett who studied the subject extensively had no doubt that “Venereal disease is one of the major health problems of college life”. In 1966 23% of all male attendances at the health clinic were related to venereal disease while by 1968 about 25% of university students were infected.<sup>44</sup> They called for a modern health education programme which would “fit the changing sexual mores of today rather than reliance on traditional and now unrealistic moral principles.”<sup>42</sup>

By the late 1960s gonorrhoea was believed to be the most prevalent venereal disease with disastrous impact on female fertility. Sterility was common among Bagandan women and estimates of rates ranged from 30% in 1948 to a 1963 estimate that 50% of all women were made sterile by gonorrhoea.<sup>44</sup>

Dr W D Foster, Professor of Medical Microbiology at Makerere University College between 1963 and 1967, found that specific serological tests for syphilis were positive for some 15% of apparently healthy adults while the incidence of acute gonorrhoea was “very high” and late complications of this disease were one of the commonest causes of death.<sup>45</sup>

An experienced Ugandan nurse described the late 1960s and 1970s when sexually transmitted diseases were widespread in Uganda. Impressed into service with Amin’s army [1971–79], this nurse said there was “so much STD with the soldiers. . . it was horrible. . . it was mostly gonorrhoea”. And later, in eastern Uganda between 1971 to 1987 she observed much venereal disease involving penile sores.<sup>46</sup>

In 1986 the long civil war in Uganda ended with the victory of the National Resistance Movement and the establishment of the present government under the leadership of President Yoweri Museveni. The National Resistance Movement published its political programme two years later in 1988 and under the heading of health they described how during 1979 while fighting in

Table 2 Sexual diseases in Kabale District, Southwestern Uganda

Year	Early syphilis	Late syphilis	Gonorrhoea
1981	159	179	4007
1983	268	410	4451
1984	335	663	5919
1985	208	156	4817
1986	232	153	4291
1987	570	230	10280 <sup>48</sup>

Source: Ministry of Health, Monthly and Annual Mortality and Morbidity Statistics, Kabale District.

central Uganda, they had discovered that syphilis was very rampant.

*"The most pathetic aspect, however, is the fact that the population are relatively unconcerned about it; you can find somebody with syphilitic skin marks completely unaware that he is still sick, arguing that this is due to the past sickness and that it is normal."*<sup>47</sup>

#### *Sexually transmitted disease in Uganda at present*

It is clear that sexually transmitted diseases remain a major health problem in Uganda today although by late 1991 there was only one government STD clinic in the country. Evidence from interviews and surveys corroborates this observation. A recent retrospective study of sexually transmitted diseases over the period 1986 to 1990 at nine sentinel sites (hospitals located along the major east-west trade axis) revealed that in some hospitals they accounted for 16% of all admissions. A small set of statistics from the government hospital at Kabale reveals a similar increase in venereal diseases.

Testing for syphilis antibody during the National Serosurvey for HIV in 1988 revealed that 17.5% of random specimens were antibody positive. The Serosurvey also discovered that in some areas of Uganda 15% to 30% of those infected with HIV had a history of genital ulcer disease [GUD] within the past 5 years<sup>48</sup>; for example, 30% of the outpatients at Mulago's sexually transmitted diseases clinic present with genital ulcers. Bohenga Hospital located in Fort Portal, western Uganda, reported that in 1989, 24.3% of paediatric visits to outpatients were related to congenital syphilis. A most disturbing discovery is the fact that well over 90% of gonorrhoea in Uganda is resistant to penicillin.<sup>50</sup> At Kabale Government Hospital near the Rwandan border, syphilis, gonorrhoea, penile ulcers and staphylococcal infections were reportedly rampant until recently.<sup>51</sup>

#### *A controversy*

When discussing the history of venereal diseases in Uganda, it is necessary to consider the oft-posed question, "was there ever an epidemic of syphilis?" Before continuing, however, I would like to emphasise that for this paper, it is not relevant whether or not syphilis was truly epidemic earlier this century. My concern is the contemporary perception of disease and the policies which were based on those perceptions. Nevertheless, there are convincing arguments to support the question.

*"The modern view is that syphilis is but one of the manifestations of infection with Treponema pallidum and that there is a group of diseases, differing considerably in their clinical features and geographical distribution, which are all caused by organisms which are indistinguishable and, therefore, probably the same species. The exact clinical picture in the treponematoses seems to depend upon climatic and social factors."*<sup>52</sup>

J N P Davies, a physician who worked in Uganda, has described the possible confusion

of the two forms of syphilis, endemic and venereal in early colonial Uganda.<sup>53</sup> While agreeing that by mid-century true venereal syphilis was widespread in Buganda, he postulated that the so-called earlier epidemic was in fact endemic non-venereal syphilis. Endemic syphilis is not a sexually transmitted disease but a contagious disease mainly of children which "evolves into venereal syphilis as civilisation modifies the environment and factors of transmission".<sup>54</sup> Davies suggested that "there had been an endemic form of syphilis in southern Uganda with yaws common in other areas and that at the turn of the century this original endemic form of syphilis was replaced by true venereal syphilis".<sup>55</sup> The endemic form conveys a degree of immunity against the venereal form.<sup>56</sup> In agreement with this view, another expert, J Orley postulated that there had been an endemic form of syphilis or yaws present for many centuries in Uganda and that the so-called epidemic of the early century "may have been due to increased awareness of the disease and decreased immunity to venereal syphilis as endemic syphilis diminished".<sup>56</sup> In the 1950s yaws was virtually eradicated in Uganda.

#### *HIV and AIDS*

It is of considerable relevance to consider the relationship of the history of sexually transmitted diseases to the present epidemic of HIV/AIDS in Uganda. By June 1991, it was estimated that nearly one and a half million Ugandans were infected with HIV. It was also estimated in 1991 that in some urban hospitals, like Mulago, about 40% of beds were occupied by patients with AIDS or AIDS-related illnesses.<sup>58</sup> A level of infection that high in a population of 16,582,700 is a clear indication of a dramatic epidemic of a sexually transmitted disease.

By 1985, AIDS was declared to be epidemic although it had first been noticed by many practitioners in 1981-2. Many epidemiologists believe that AIDS probably appeared in Uganda in the late 1970s, perhaps introduced and spread by 45,000 Tanzanian soldiers during their invasion and occupation of the country in 1979 and 1980. That upheaval was followed by a protracted guerilla war between 1981 and 1986 which led to the virtual destruction of much of the country and displacement of many thousands of people. It is believed that during those turbulent years, the new virus, HIV, percolated through southwestern rural regions like Rakai and Masaka Districts, or urban centres like Kampala and Jinja. No public health programme could begin until 1986 when the present government was established.

There can be no doubt that the political upheavals and civil wars in Uganda from the mid-1970s until 1986 are implicated in the spread of a sexually transmitted disease and the present epidemiological view of the introduction of HIV through the Tanzanian army in 1979 is also a reasonable explanation, in part, for the epidemic. I believe, however, the long history of high incidence of other sexu-

ally transmitted diseases combined with the fact that treatment and prevention, while commendable efforts in Uganda, never achieved the scale necessary to eliminate venereal diseases, provide a better explanation for the wildfire spread of HIV. There is good evidence that the presence of other sexual diseases, particularly those like syphilis and chancroid which involve genital ulcer disease, enhance the transmissibility of HIV.

### Conclusion

I have outlined the medical and scientific assessment of sexually transmitted diseases in Uganda over most of this century. The medical authorities repeatedly described venereal diseases in Uganda as an intractable medical problem. Retrospective diagnosis is difficult, and a dangerous exercise for the non-specialist. My concern is not the incorrect diagnoses caused by the confusion between endemic and venereal syphilis earlier this century. We must accept the contemporary perception that venereal diseases constituted a demographic threat. The threat was expressed in medical terms and it was believed that the solution would be found in science. There is no question, however, that since mid-century sexually transmitted diseases have been prevalent in Uganda and recent studies such as the survey of nine sentinel sites between 1986 and 1990 leave no doubt that these diseases are widespread.

We need to know much more about the history of sexual diseases in Uganda; nevertheless, it remains clear that they were present when the Europeans arrived in the last century, continued during the colonial period to afflict the health of large numbers of the population and remain widespread today. On the grounds alone of our knowledge that a clinical history of venereal disease is an important co-factor in the transmission rate of HIV, an understanding of the *medical* history of sexual diseases is relevant to understanding the contours and intensity of the AIDS epidemic in Uganda.

- 1 Muwazi EMK, Trowell HC, Davies JNP. 'Congenital syphilis in Uganda', *East African Medical Journal* (1947):152-170:152.
- 2 16 June 1991, President Museveni's Opening Speech at the Seventh International AIDS Conference in Florence.
- 3 Davies JNP. 'History of syphilis in Uganda', *Bulletin of the World Health Organization* 15:1043.
- 4 Davies JNP. 'The history of syphilis in Uganda', *Bulletin of the World Health Organization* 15 (1956):1041-55.
- 5 *Buganda* is the country; *Baganda* is plural for people while a *Muganda* is an individual. Many Bantu languages employ a similar pattern of prefixes.
- 6 Cook A. 'The medical history of Uganda: Part II', *East African Medical Journal*, 13 (1936-37):99-110:99.
- 7 Colonial Office, Africa No. 917. Uganda. Lambkin, Colonel FJ, *Prevalence of venereal diseases in the Uganda Protectorate*.
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- 20 Uganda National Archives. Secretariat Minute Paper No. 1862. 5 May 1911, Principal Medical Officer to Chief Secretary, Entebbe re: 'Inoculation of children with Syphilis' enclosing Dr JH Cook.
- 21 20 April 1990, Stephen Fitzgerald, WHO Consultant from Centers for Disease Control. Draft report for 16 January-20 April 1990, Ministry of Health, Sexually Transmitted Disease Control Programme, Republic of Uganda.
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- 23 Uganda National Archives. File C. 637, Medical: Anti-venereal work in Uganda. 11 April 1921, Interview of Dr Webb by Mrs Rolfe. See also 14 July 1922, Major Keane, Venereal Diseases Campaign, summary of venereal disease in Uganda enclosed in File C.637.
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- 40 WHO Proposal for a Venereal Diseases Survey. SMP No. GCW.3 1963.
- 41 Arya OP, Bennett FJ. 'Attitudes of college students in East Africa to sexual activity and venereal disease', *Br Venereal Dis*, 1968;44:160.
- 42 Arya OP, Bennett FJ. 'Venereal disease in an elite group (university students) in East Africa', *British Journal of Venereal Disease* (43) 1967:275-79:276-279. A study of the military in 1968 revealed that a third of the cohort of 712 individuals gave a history of venereal diseases.

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- 43 Richards A, Reining P. *Report on fertility survey of Buganda and Bahaya*, East African Institute of Social Research, Kampala, 1952:35. The estimates of fertility were based on the 1948 Census which also indicated that 18% of all women in the entire colony were childless (calculated as a percent of all women over 45 years). During this survey, it was not possible to persuade every adult to be examined for venereal disease. Audrey Richards said that "Venereal disease is openly discussed by the Baganda and little stigma is attached to infection. All the women were asked if they had had syphilis or gonorrhoea and twenty-nine percent reported that they had had one or the other of these diseases but the figures are not reliable because the women tended to call an undiagnosed illness, especially those producing skin rashes by the general name of *kabotongo* or syphilis. p. 30
- 44 Griffith HB. Gonorrhoea and fertility in Uganda, *Eugenics Review*; 1963;55:103-8.
- 45 Foster WD. *The Early History of Scientific Medicine in Uganda*, Kampala, Uganda Literature Bureau, (1970) 1980:78-9.
- 46 29 September 1990, Interview of Victoria Sembajwe, Mulago Hospital.
- 47 Uganda National Archives. 1988 booklet entitled, *Political programme of the NRM: Two years of action*, compiled and edited by the Department of Information and Mass Mobilisation, NRM Secretariat, pp. 16-17.
- 48 Ministry of Health. Monthly and Annual Mortality and Morbidity Statistics, Kabale District.
- 49 20 April 1990, Stephen Fitzgerald, WHO Consultant from Centers for Disease Control. Draft report for 16 January-20 April 1990, Ministry of Health, Sexually Transmitted Disease Control Programme, Republic of Uganda. GUD has been identified as an enhancing factor for HIV transmission rates. GUD occurs with diseases such as syphilis and chancroid. On GUD and HIV transmission, see Greenblatt RM *et al.* 'General ulceration as a risk factor for human immunodeficiency virus infection', *AIDS*, 2 (1)February 1988:47-50.
- 50 20.4.90, Fitzgerald S. Interview and report to CDC. In the US, penicillin resistance is in the region of 1%. Resistance probably came about through indiscriminate use of the drug. As of April 1990, the only government STD clinic in Uganda was Ward 12, Mulago Hospital, Kampala.
- 51 20 December 1990, Interview of Kaggwa Adson, Medical Laboratory Technologist, Kabale Hospital. He speculates that the rates may have fallen recently because people "are not coming forward because of AIDS".
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- 53 Carman JA. The relationship of yaws and syphilis. Are they two diseases or one?, *The East African Medical Journal* 12(1935-36):135-49.
- 54 Willcox RR. *Textbook of Venereal Diseases and Traponematoses*, London, William Heinemann Medical Books, 1964:263.
- 55 Davies JNP. *Bulletin of the World Health Organization* 15 (1956):1041 and Bennett FJ. "Venereal diseases and related spirochaetal infection", pp. 66-68 in Ministry of Health, East African Community Medical Research Institutes and Makerere University College Medical School, *Uganda Atlas of Disease Distribution*, Makerere University, Department of Geography, Occasional Paper No. 12, 1968.
- 56 Some Ugandan peoples inoculated their babies by "wrapping them in a cloth which had on it the discharges from secondary syphilitic ulcers". Orley, 'Concepts of infectious disease amongst the rural Ganda—with special reference to yaws and syphilis', *Nkanga: Special Edition on Medicine and Social Sciences in East and West Africa*, Bennett FJ (ed). Makerere Institute for Social Research, 1973, pp. 60-66, p. 62.
- 57 Orley J. Concepts of infectious disease amongst the rural Ganda—with special reference to yaws and syphilis, *Nkanga: Special Edition on Medicine and Social Sciences in East and West Africa*, Bennett FJ (ed). Makerere Institute for Social Research, 1973, pp. 60-66. Orley suggests the high child mortality witnessed by the early STD investigators was probably due to malnutrition, malaria and other parasitic diseases and not congenital syphilis. p. 62.
- 58 Ministry of Health, AIDS Control Programme, *Progress on the AIDS epidemic in Uganda*, August 1991.