LEPROSY CONTROL IN NIGERIA

TO THE EDITOR:

Some of those interested in leprosy control in Nigeria may not be familiar with the present political structure of the country, and find such words as "Region", "Province", and "Division" confusing. It also appears that some aspects of the organisation of leprosy control work are sometimes not fully understood, and I write now to clarify these matters.

At the present time Nigeria is divided into three Regions, Northern, Western and Eastern. The Northern Region with a population of about 17 millions is very much the largest of the three in area, and some parts are sparsely populated. The Western Region, population about 7 millions, and the Eastern Region, population about 8 millions, together make up the southern part of the country, and population is dense, especially in the East. All three Regions have considerable autonomy, with a Federal Government responsible for external affairs and certain essential services.

Each of the three Regions is divided into Provinces, and these again are divided into county areas or Divisions, which though they vary a great deal in size, make convenient administrative units, with a population varying between 100,000 and half a million. At the present time a number of boundaries are in a state of flux.

Leprosy control is now organised separately in each Region, but experience gained through intensive work in the Eastern Region during the past 18 years has proved useful elsewhere. It is undertaken in some Provinces by Missionary Societies aided by Government grants, and in some heavily infected Provinces by the Government Leprosy Service, working in cooperation with Missionary Societies. In almost every case a Settlement is associated with a definite "Area" for which it is responsible, and although this "Area" often coincides with the Province in which the Settlement is situated, there are several exceptions to this. The essential point is the definite responsibility accepted by those engaged in this work to pursue active leprosy control measures throughout the area based on each Settlement, and as a result, definite and often intensive control work is proceeding simultaneously throughout the greater part of the country.

The success of this work depends on how close it gets to the people in each locality. It is not enough to provide treatment facilities under a tree by the roadside. The aim is to establish in every locality where it is needed, a definite centre in which the local community has a share of responsibility, and which a trained leprosy control worker can use as the local centre for his activities. These include not only the giving of free treatment, but propaganda, surveys, and follow-up work of all kinds. Many of these local centres are very simple in construction, but the casual visitor who witnesses treatment in progress does not see behind the scenes all the patient preparatory work that was necessary before the visible centre materialised, the friendly visits to the people, the breaking down of prejudice, the winning of their support so that they provided the site for their local centre, and so on. This approach is fundamental in leprosy control work in Nigeria, and is the secret of its prosperity.

In the Eastern Region it has been found useful to associate local leprosy control centres with segregation villages for which the local community is also responsible, and which care for open cases from that locality only.

Formerly, treatment consisted of injections of hydnocarpus oil, and staff necessary for this were established at every local clinic. The advent of oral DDS treatment simplified matters greatly, but it is worth placing on record that among the millions

of injections given, cases of tetanus were exceptionally rare. It is undoubtedly possible to organise mass treatment on a basis of administration by injection. Nevertheless, after several years experience with DDS given orally on a very large scale through the medium of local leprosy control workers, it can be stated that the oral method has everything to commend it in the circumstances prevailing in Nigeria. Our experience is that by and large patients do get their treatment everywhere, and any wastage or irregularity that goes on is on so small a scale in relation to the total effort as to support no reasonable criticism of the methods adopted.

At all local centres detailed records of all treatment are kept, and checked against DDS supplies to that centre from time to time by responsible persons. Dosage of DDS is standardised on a basis of twice weekly or weekly treatment, with a maximum dose of 400 mgm. twice weekly or 600 mgm. weekly. The patient is given his treatment in the presence of witnesses, and takes it then and there. He is not given any to take home. Apart from the regular visits of the doctor, any local centre is liable to be visited without warning by the doctor or his deputy and all its activities reviewed, while the work of the local worker (or Leprosy Inspector as he is called), is gone into in detail. By such methods reasonable control of both treatment and other activities can be maintained, and their success is evidenced by the thousands of patients now discharged symptom free, the rapidly growing proportion of patients now attending in the very early stages of the disease, and the fact that survey after survey demonstrates that only a small minority of patients fail to attend their local clinic, once this is firmly established and its purpose understood by the people. One cannot speak too highly of the work of Leprosy Inspectors as a group in leading to such results.

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