

LEPROSY IN NIGERIA

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Nigeria is the largest of the British West African possessions, the approximate area being 372,000 square miles. In extent the territory stretches, roughly, from latitude 4° to 14° North, and eastward from longitude 3° to 8.5° East at the coast to just over 14° East in the region of Lake Chad at the northeast corner of the country. (See Text-fig. 1.)

The country is divided naturally into four main zones, which differ in their characteristics: (1) A belt of swamp and mangrove forest which follows the coast line and varies from ten to sixty miles in width. (2) A belt of dense tropical forest from fifty to one hundred miles wide intersected by rivers and streams and very rich in oil palms. (3) A belt of more open country which gradually becomes clearer, being followed by open expanses covered with high grass. (4) A vast undulating plateau with occasional hills of granite and sandstone. This becomes less wooded and more sandy towards the borders of the Sahara; this portion lies within the limits of the Western Sudan.

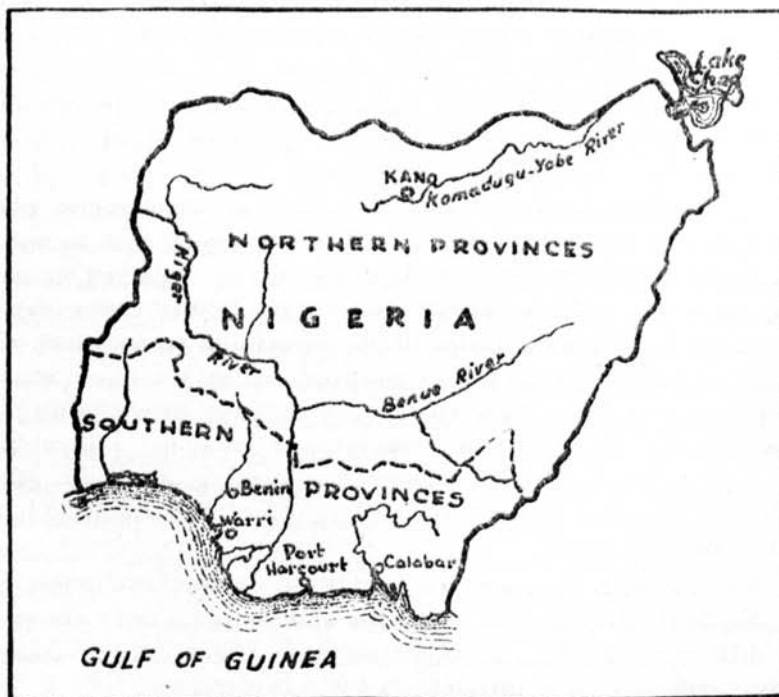
The Southern Provinces lie mainly in the first two zones, and the Northern Provinces in the third and fourth zones. Owing to the differences in climate, population and religion, the problem of leprosy control is very different in these two regions.

LEPROSY IN THE SOUTH

In the Southern Provinces the country is densely populated, mainly by the Ibo, Yoruba and Ibibio tribes and off-shoots from them. For the most part they are pagans, though a large number of them have been converted to Christianity.

The incidence of leprosy is high, and in most places victims of the disease are dreaded and avoided as much as possible, especially those suffering from the advanced cutaneous types of the disease. Until recently such cases were dealt with by being driven off into the bush and left until they died, or by poisoning, or even by

burial alive. In spite of these drastic methods of avoiding contagion the incidence of the disease is still high, and one suspects that in a country where the incidence of predisposing diseases such as yaws, venereal disease, hookworm and malaria is as high as it is here every case of leprosy should be considered infective, and if possible segregated and treated. This is also necessary for another reason, and that is that it is impossible to keep most cases under observation unless they have been segregated in a settlement.



TEXT-FIG. 1. Outline sketch of Nigeria.

For this reason numbers of leper settlements have been started in this region, most of them being run by medical missionaries with support from the Government or Native Administration of the province which they serve. Until recently these settlements were mostly places of refuge for pauper lepers—lazarettos where the inmates were allowed to live without much organization, though at some of them various types of treatment were given by the nearest doctors, and in some cases a weekly allowance was given them with which to buy food. Now, however, following the lead given at Itu in Calabar

Province, large farm colonies are springing up in the Southern Provinces, and at the present time there are three of these working satisfactorily. One of these is at Itu, run by the Scottish Mission with financial aid from the Government. One is at Uzuakoli, near Port Harcourt, run by the Methodist Mission with financial aid from the Native Administration. The third is at Ossiomo, in Benin Province, supported by grants from the Native Administration of the Benin and Warri Provinces.

It would take too long to describe these farm colonies in detail, but their primary object is to attract early cases to come for treatment. All able-bodied patients are provided with work, mostly of an agricultural nature, though each man is encouraged to ply his own trade for the common good. The idea is as far as possible to make each colony self-supporting as regards food. To further this object those who can afford it are expected to pay up to £2 towards their keep for the first year, and they are given a plot of land on which they can grow their food, which consists mostly of yams and cassava. At the same time each able-bodied patient is expected to work a certain number of days each week on large communal farms where the necessary food is grown for the more advanced and helpless cases.

In these farm colonies the patients live under conditions as natural as they can be made. The houses are built of mud, and the camps are divided up into quarters for the males, females, married couples, advanced and crippled cases, etc. In addition there is a hospital for cases of acute disease, with in most cases a modern operating theater, a laboratory, and also a ward where uninfected children can be brought up without risk of infection from their parents. As far as possible all the nursing and routine medical work is carried out by trained patients.

In all of the colonies the patients are treated with injections of hydnocarpus oil and its derivatives. Great care is taken to see that all concurrent and predisposing diseases are adequately treated. More important still, the psychological aspect of the disease is treated by the restoration of self respect which results from the happier outlook on a rather hopeless prospect. This is brought about by religious teaching and the discipline resulting therefrom.

LEPROSY IN THE NORTH

In the Northern Provinces conditions are very different. The natives are mostly Hausas and Fulanis. They are Mohamedans, and

consequently unprogressive and fatalistic in their outlook. At the same time they appear to have none of the horror and dread of leprosy which characterizes the natives in the South. Lepers are allowed to live and beg in the villages and towns, though most of these beggars are hopelessly advanced cases. These people actively resent being segregated in a settlement, as this interferes with their begging activities.

At the present time there is a number of leper settlements in which treatment is carried out, though most of them tend to attract the advanced and disabled cases. However, an attempt is being made at Kano to establish a farm colony on the lines of those in the south with a view to attracting early cases.

It will possibly appear from this account of leprosy in Nigeria that too much is being done for the individual cases of leprosy, and not enough for prevention of it in future generations, which after all is the more important side of leprosy relief work. However, the first thing in any campaign against a disease is to obtain the confidence of the native, for only in this way will the early case be encouraged to appear for treatment. Meanwhile the best preventive side of the campaign will go forward by general medical and sanitary work in preventing and treating the endemic predisposing diseases, and by education in improving the standard of living among the natives.