ABSTRACT OF A FURTHER REPORT ON THE OJI RIVER, LEPROSY SETTLEMENT, NIGERIA.

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This report on six years work from 1938 to 1943, on the work of the Oji River Leprosy Settlement in Nigeria, gives the following information in addition to that contained in Dr. Money's report for 1941 and 1942, recorded in *Leprosy Review*, Vol. XV, p. 15.

The Settlement was founded in 1936 by the Church Missionary Society in conjunction with the Nigerian Government and Native Administrations, to provide for the institutional care of 250 leprosy patients of the Onitsha Province, with an area of 5,000 square miles and a population of 1,107,745, giving the high density of 224 per square mile. It is an isolated agricultural area and the people are mainly peasant farmers of the Ibo tribe. Between October, 1935 and July, 1936, nearly 2,000 applications for admission were received and in 1938 arrangements were made to provide clinics for out-patient treatment in the areas around the central settlement, financed by the Church Missionary Society and other charitable bodies and the Native Administration. A doctor and a nurse were supplied by the C.M.S. and two Toc H lay workers through the B.E.L.R.A. Educated Africans were employed and trained as assistants. The people were leprosy conscious, but they were mostly illiterate and their confidence had to be gained. The object was to control leprosy in the province as a whole with a view to its eventual eradication by means of a central settlement, out-lying clinics to treat as many cases as possible and surveys and preventive service to determine the extent of the problem and to investigate as far as possible the isolation of the highly infective patients. Training some of the more intelligent of the patients to enable them to assist in the work has been made good use of. Schools for educating child patients have also been organised; a number of them have eventually been recruited to add to the native staff. They are also taught useful arts and crafts, such as carpentry and making soap, pottery, etc.

Disabled, but non-infective cases present a difficult problem, as treatment is no longer curative, but humane considerations necessitate a certain number of them being cared for in the central settlement for a time at least. The cost of the work is kept down

by making the resident patients responsible for their own food, clothing and personal necessities and the charge of a small admission fee. All able-bodied patients are also required to work without remuneration for twelve hours weekly, including collective farming. The patient staff receive a low wage. Children are either paid for in advance by their relatives, or from some charitable source, such as the B.E.L.R.A. Child Adoption Scheme, in the case of about 100 of them. They live in a special compound and food is issued to them. They may also become wards of guardians. Married patients are separated from healthy mates. Games and a library for literate patients are also provided.

Clinics. These were steadily increased between 1938 and 1941 and each visited weekly by a medical officer and his assistants, with from several hundred up to one thousand cases attending at each. In 1942 it was decided to operate the clinics with resident staffs working five days a week and visited weekly as before, by a medical officer to inspect and issue supplies. This plan allowed the clinics to be increased from six in 1941 and 1942 to eleven in 1943, records of the cases being kept and slides taken when necessary for bacteriological examination.

Surveys. It was not found possible to examine 100 per cent. of the population during local surveys, but the evidence indicates that few cases of active leprosy fail to attend the clinics for the sake of the free treatment provided in them. Many open lepromatous cases are thus brought to light and important information is gained regarding the incidence of the disease and the social conditions influencing its spread in the area dealt with.

Prevention. The way is thus paved for the introduction of preventive measures to reduce the contact between infectious cases and susceptible persons of their households, or near neighbours, especially healthy children. Propaganda is required to convince the population of the necessity for isolating in some way the more infectious cases by residence in the central settlement with the most efficient treatment, in villages established by the people in which only infectious cases reside, so that they cannot infect others, or by isolation when feasible in a separate room or house in or near the family compound. Leprosy villages have been established in the Ibo country, Ogoja, Owerri and Benin Provinces; only one has been founded in the Onitsha Province, but family isolation is a widespread custom in the latter area. Ex-patients have been employed to induce the infected patients to adopt isolation. By these various measures suspicion has been reduced and more willing co-operation of the people

in preventive measures has been obtained. Special Leprosy Control Officers are in charge of the Survey and Preventive measures in each area. Accurate diagnosis and classification of the cases is essential to success. Selective segregation of the infective lepromatous type of case is the only practical method on account of the large total number of cases. It is estimated that there are from 20,000 to 25,000 active cases of leprosy in the Onitsha Province, 15 to 20 per cent. of these, or a total of 3,000 to 5,000, are highly infectious ones which require to be segregated. The much larger number of neural are so little infective that their rigid segregation is unnecessary as well as impracticable; this reduces the problem to practical proportions. Thus, since 1939 it has been the practice to allow closed, little, if at all infective female cases to retain infants at the breast and none of the infants has contracted leprosy.

Research. Reference is made to work of Dharmendra and Lowe in Calcutta in improving greatly on the old Mitsuda or lepromin test, opportunities for clinical tests of which are great in Nigeria, although it has not yet been possible to make full use of them. Two series of cases illustrating the progress between 1938-43 and 1941-43 respectively, as regards their bacteriological condition are recorded.

	1938-43		1941-43	
	No.	Per cent.	No.	Per cent.
Negative to bacteria throughout ...	582	79.5	295	79.2
Positive to bacteria throughout ...	59	8.0	35	9.4
Becoming negative	55	7.5	34	9.2
Becoming positive	36	5.0	8	2.2
Total cases	732		372	

It is concluded that the great majority of the cases coming to the clinics do not become positive or open cases to the danger of the community, so negative or closed cases can safely be treated at clinics.

Extensive statistics are included in appendices. The more important data for 1940 to 1942 have already been given in our issue of January, 1944. Those for 1943 show increases of 202 in the patients resident in the central settlement to reach 1,187; in attendances at clinics of 100,711 to reach a total of 305,793; and of treatments given by 64,375 to reach 341,684. The work of the Oji River Settlement has thus steadily increased in spite of wartime difficulties.

[EDITOR].