Letter to the Editor

WHAT IS THE ACTUAL MALE/FEMALE SEX RATIO IN LEPROSY PATIENTS?

There is evidence demonstrating a wide range of social, cultural and economic variables determining if and when those with leprosy present for diagnosis and treatment. Just what these factors are, and how they influence the campaign for control of leprosy remain questionable.

During a period of 30 years, carrying out leprosy treatment in North Eastern Nigeria, ending in 1982, we noted a puzzling pattern of male/female ratio in the outpatient and inpatient populations.

We were in charge of the Gongola State Leprosy Hospital in Garkida mentioned by van de Weg and Post in their review. Then in 1976, I was appointed in charge of the State Leprosy Control Programme of Gongola State. This outpatient project at that time had 240 treatment centres in dispensaries, health units and leprosy treatment clinics treating > 16,000. In this outpatient programme 56-7% of the patients were women. This is quite different from the figures given in the majority of treatment programmes elsewhere, even in other parts of Nigeria. We have been puzzled as to the reasons for this difference, but I think there are at least four possible motives on the part of the women. First, although there was not a great deal of stigmatization of persons with leprosy, it was difficult for a woman with the disease to get a husband. On the other hand, there did not seem to be a problem for a man with leprosy to find a wife. Thus it was important for a woman to seek treatment. Second, there was a very widespread belief that dapsone had some effect in suppressing malaria, which was ubiquitous. Chronic malaria tends to cause abortion at an early stage of pregnancy, and thus may have been prevented by taking dapsone. There was a great demand for dapsone on the ‘black market’, and it was even in demand by men who believed that it promoted fertility. Third, in much of Africa women are suppressed and relegated to a position inferior to men. That did not seem to be so marked in this area that was predominantly non-Moslem and holding animistic beliefs. Thus women took some leadership roles so that in a few instances the community appointed ‘chief’ or leader in an outpatient clinic was a woman. Fourthly, frequently a small market was established on treatment days. This also encouraged women to come for trading and socialization.

On the other hand, the ratio of admission to the leprosy hospital showed a male dominance. Survey of the records reveals that from 1929 to 1979, over a period of 50 years, there had been 10,972 admissions. A study done in 1969 of 6691 patients revealed that 74.3% of patients were male, 32.6% female. Thus there is a preponderance of males of 2:3. My conclusion from this is that leprosy involves men more severely. I do not have the figures, but there were far more type II (ENL) reactions in men, and they were also more severe on average. The type distribution in this study was:

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<th>Male</th>
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<td>BT</td>
<td>66%</td>
<td>34%</td>
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<td>BL</td>
<td>72%</td>
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These differences do not appear to be significant. However, the disease in males was more severe.
Might this be due to genetic differences? Although one might say that the difference may be attributed to the fact that men do more physical labour, in this culture both sexes worked equally hard at farming.

Thus the conundrum: Why in this setting are roughly two-thirds of outpatients female, while two-thirds of in-patients are male?

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References
