

Attitudes of rural people in central Ethiopia towards leprosy and a brief comparison with observations on epilepsy

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Summary To find out public attitudes toward leprosy a door-to-door survey was carried out in 1546 sampled households in the rural farming community of Meskan and Mareko in central Ethiopia, where the prevalence of leprosy is estimated to be 1:1000. Attitudes toward leprosy were compared with attitudes to epilepsy, studied in a previously performed survey in the same community. Eighty-seven per cent of the respondents were above the age of 25, and 59.5% were females. There were slightly more Muslims (54%) than Christians. The majority of the interviewees (87%) were farmers, with an illiteracy rate of 84%. Ninety-five per cent and 83%, respectively, were not willing to employ or work with a person having the disease. Seventy-five per cent would not allow their children to associate with a playmate suffering from leprosy. Comparative analysis of attitudes in the same community showed that negative attitudes toward leprosy were stronger than those toward epilepsy, particularly with regard to matrimonial associations, sharing of accommodation, and physical contact with an affected person. The reasons for these differences appear to be the community's deeply entrenched belief that leprosy is both hereditary and contagious, expressed respectively by 48% and 53% of the respondents. In order to minimize the perpetuation of negative attitudes, there is a need to educate and impress on the population that leprosy is a treatable infectious disease which is not congenitally acquired, and that it is even curable if detected early. The study reinforces previously proposed suggestions that, in developing countries such as Ethiopia, leprosy care should be integrated into the general health services.

Introduction

About 10 million people in the world, mainly in developing countries, are infected by

leprosy; 12% are found in Africa.¹ Situated in the north-eastern part of Africa, Ethiopia covers an area of 1.25 million sq km and has a population of 46,000,000.² It belongs to the leprosy-endemic regions of the African continent. A review of the leprosy control programmes in the country (1976–89) revealed that the cumulative national average prevalence rate was 2.6 per thousand.³ Although a decline in the detection rate has been noticed since 1982, coinciding with the introduction of multiple drug therapy (MDT), leprosy remains a serious public health problem in the country.

Besides the physically disfiguring and disabling effects of the disease, its victims and their families suffer a great deal from social prejudices and isolation. The situation in Ethiopia is similar to that recorded from other developing countries. As Giel wrote in 1968, 'Among the outcasts of the society, concentrated around the churchyards and cemeteries of Ethiopia, lepromatous lepers are the most easily recognized'.⁴

The objective of the present study is to evaluate the knowledge and traditional beliefs and attitudes toward leprosy in a rural Ethiopian community. An attempt will also be made to compare the attitude toward leprosy with that previously recorded for epilepsy in the same community.⁵

Subjects and methods

Between 1986 and 1988 an epidemiological study of neurological disorders was carried out in the rural subdistrict of Meskan and Mareko (population 181,883) in the Shoa Administrative Region of central Ethiopia. At the time of the survey, the subdistrict comprised 6 town-dwellers' associations and 82 peasant associations. There was a total of 40,000 households in the subdistrict, with an average family size of 4.5 members. The study was undertaken in a random selection of 30% of the associations, involving 60,820 inhabitants. The majority of the inhabitants (89%) were from the Gurage ethnic group, while the rest were from the Oromo, Amhara, Tigre and Kembata ethnic groups. In the survey, trained lay health workers were employed to administer specially designed questionnaires to detect neurological symptoms and signs;⁶ the questionnaires were those used for a community-based study of neurological disorders in the same area.

Concomitant with this survey, the lay health workers were also trained to interview adults, mainly heads of households, on their opinions of common neurological disorders that may carry significant negative and unfavourable attitudes in the community. These disorders included mental retardation, physical handicap, leprosy and epilepsy. In order to avoid confusion, every fourth household of all the randomly selected villages in the study area was interviewed on each of the disorders. This resulted in the inclusion of 1546 households each for the attitudinal surveys of leprosy and epilepsy.

The questionnaire used for this study and shown in the Appendix was translated into Amharic, the 'official' Ethiopian language. Local dialects were used in the interviews whenever required. Before the administration of the questionnaire, the aims and purpose of the study were clearly explained to the respondents, and their consent was obtained. There was a 94% and 95% participation in the interviews on epilepsy and leprosy respectively.

The chi-square test (with Yates' correction) was used as a test of independence between two variables.

Results

As summarized in Table 1, the characteristics of the respondents for the leprosy and epilepsy interviews were very similar. Taking those who responded to the questionnaire on leprosy, 85% were above the age of 25, and the majority (87%) were farmers. There were slightly more Muslims (54%) than Christians. Eighty-two per cent were married, and of those 89% had children. The rate of illiteracy were very high (84%). As the men in the community were often in the fields during the door-to-door visits of the lay health workers, there was a slight preponderance of females (59.6%) among the respondents to the interview on leprosy, similar to that experienced in the study of epilepsy.

Those who were literate obtained their skill from church and regular schools, as well as through participation in the literacy campaign. Less than 2% had received secondary school education. The vast majority in the community (94%) had incomes at subsistence level (\$US 120 per annum), and only 1% could be classified as well-to-do.

Table 1. Characteristics of respondents

Characteristics	Epilepsy		Leprosy	
	No.	%	No.	%
Age (years)				
14-25	206	14.2	195	13.4
26-35	377	26.0	420	29.0
36-45	338	23.3	368	25.4
46+	531	36.5	468	32.2
Sex				
Male	606	41.6	586	40.3
Female	850	58.4	865	59.6
Religion				
Christian	674	46.3	666	45.9
Moslem	781	53.7	785	54.1
Marital status				
Married	1147	78.8	1183	81.5
Widow/Widower	162	11.2	125	8.6
Single	76	5.2	84	5.8
Divorced	70	4.8	59	4.1
Level of education				
Illiterate	1240	85.2	1223	84.3
Read and write	120	8.2	93	6.4
Grade 2-8	75	5.2	109	7.5
Grade 9 and above	21	1.4	26	1.8
Occupation				
Farmer	1267	87.0	1265	87.2
Housewife	75	5.1	85	5.9
Merchant	37	2.5	40	2.7
Labourer	29	2.0	15	1.0
Dependant	27	1.9	20	1.4
Student	13	0.9	12	0.8
Government employee	9	0.6	14	1.0

In Ethiopia leprosy is commonly referred to as qumtina, an Amharic word denoting 'the state of amputation or mutilation'. Likewise, a person with leprosy is called qwomata. These terms were used by 70% of the respondents, in spite of the fact that only 7% of them were from the Amhara ethnic group. The preferred term for leprosy in Amharic is sega dewe, which literally translates as 'the disease of the flesh'; this term was used by only 0.3% of the respondents. Other less commonly-used terms for leprosy within the study population were buska, gegehu yelegode and yajamoy in the Mareko, Meskan and Silti dialects of the Gurage language, and shishera was used by the Hadiya language-speakers. All these terms have equivalent meanings and connotations similar to the Amharic word qumtina.

As shown in Table 2, the proportion of respondents that had heard of, or, in a few cases, read about leprosy and epilepsy was equal. However, a higher percentage of respondents had seen a sufferer from leprosy. Interestingly, a significantly higher proportion of respondents believed that leprosy is hereditary and contagious, as compared to epilepsy. The negative attitude towards leprosy is further demonstrated by the unwillingness or intolerance of the respondents to employ, work or live with a person

Table 2. Public response to attitudinal questions

Question	Response number	Answer (%)			p value
		Yes	No	Don't know	
Have you heard or read about leprosy?	1365	90.3	9.7	—	
..... epilepsy?	1441	89.0	11.0	—	>0.10
Have you seen someone with leprosy?	1351	95.9	4.1	—	
..... epilepsy?	1338	86.2	13.8	—	<0.001
Do you have a family member with leprosy?	1347	2.3	97.7	—	
..... epilepsy?	1332	14.3	85.7	—	<0.001
Is leprosy hereditary?	1328	47.8	52.2	—	
Is epilepsy hereditary?	1274	4.9	95.1	—	<0.001
Is leprosy contagious?	1324	53.1	43.8	3.1	
Is epilepsy contagious?	1269	44.6	53.4	2.0	<0.001
Is leprosy a form of insanity?	1321	1.0	99.0	—	
..... epilepsy?	1265	1.9	98.1	—	0.01 < 0.05
Would you employ a leper?	1316	3.8	95.1	1.1	
..... an epileptic?	1254	25.0	75.0	—	<0.001
Are you willing to work with a leper?	1317	15.6	83.3	1.1	
..... an epileptic?	1257	52.7	46.1	1.2	<0.001
Would you house a person with leprosy under pressure?	1314	0.4	98.9	0.7	
..... epilepsy?	1260	67.2	32.2	0.6	<0.001
Do you think a person with leprosy should be hidden from public view?	1314	3.6	96.4	—	
..... epilepsy?	1262	1.8	98.2	—	0.001 < 0.01
Would you allow a leper to use public transport?	1314	97.2	2.8	—	
..... an epileptic?	1262	90.1	9.1	0.8	<0.001
Would you shake hands with a leper?	1314	22.5	77.5	—	
..... an epileptic?	1262	90.8	9.2	—	<0.001
Would you have a person with leprosy as a friend?	1308	9.3	90.7	—	
..... epilepsy?	1259	40.6	58.3	1.1	<0.001
Would you allow your child to play with a child having leprosy?	1311	25.2	74.8	—	
..... epilepsy?	1254	65.1	33.9	1.0	<0.001

Table 3. Question: Would you allow someone from your family to marry a person with epilepsy/leprosy?

Results	Respondents				
	Epilepsy 1257		Leprosy 1313		Value
	No.	%	No.	% <i>p</i>	
Yes	327	26.0	39	3.0	< 0.001
Would not tolerate (reason not specified)	422	33.6	213	16.2	< 0.001
No, the sufferer is unable to earn a living	292	23.3	185	14.0	< 0.001
No, contagious	148	11.8	302	23.0	< 0.001
No, genetically inadvisable	49	3.9	563	42.9	< 0.001
Don't know	18	1.4	11	0.8	

having the disease. Similarly, fewer respondents were willing to be friends with or allow their children to be associated with a person suffering from leprosy; 78% of the interviewees were unwilling to shake hands with a leprosy sufferer, compared with 9% that expressed the same attitudes to a patient with epilepsy.

When asked if they would accept a successfully treated and cured case of leprosy, nearly 42% of the interviewees responded with 'once a leper, always a leper'.

When the attitudes to marriage were evaluated (Table 3), only 3% expressed probable consent to a family member undertaking a matrimonial relationship with a person affected by leprosy. On the other hand, there was a 26% positive response on the same question concerning epilepsy. The main factors contributing to the strong reluctance concerning marriage with a leprosy sufferer were the fear of contagion and hereditary considerations, as well as the feeling that a person with leprosy is incapable of being gainfully employed. Whereas 38% of those interviewed on epilepsy thought that evil spirits and punishment from God were responsible for the disorder, only 13% of respondents implicated these reasons for leprosy. The respondents considered genetic

Table 4. Question: What do you think is the cause of epilepsy/leprosy?

Results	Respondents				
	Epilepsy 1270		Leprosy 1329		<i>p</i> value
	No.	%	No.	%	
Don't know	655	51.6	266	20.0	< 0.001
Evil spirit	381	30.0	97	7.3	< 0.001
Punishment/curse from God	102	8.0	70	5.3	< 0.001
Physical contact	64	5.0	333	25.0	< 0.001
Born with it	63	5.0	514	38.7	< 0.001
Febrile disease	3	0.2	44	3.3	
Accident	1	0.1	5	0.4	
Lightning	1	0.1			

Table 5. Question: How should society take care of persons with epilepsy/leprosy?

Results	Respondents				<i>p</i> value
	Epilepsy 1214		Leprosy 1314		
	No.	%	No.	%	
Don't know	554	45.6	175	13.3	
Give alms	415	34.2	877	66.7	<0.001
Medicine to be provided	199	16.4	184	14.0	<0.001
Let own family help	20	1.6	25	1.9	<0.001
Government to take care	18	1.5	47	3.6	
Pray for them	6	0.5	1	0.1	
Give sacrifices to the spirits	2	0.2	1	0.1	
Employ them to be independent	—	—	4	0.3	

transmission and contagion as the factors most commonly associated with the causation of leprosy. This was significantly different ($p < 0.001$) from the beliefs found with epilepsy (Table 4).

The respondents' attitude on what society should do for the sufferers of leprosy and epilepsy was very revealing (Table 5). The need to provide conventional treatment was expressed by a modest 14–16% of respondents in both interviews. However, more interviewees (67%) thought that victims of leprosy should be dealt with by the offer of alms, as compared with 34% who had the same belief for the epileptics ($p < 0.001$).

Discussion

The study population in the rural sub-district of Butajira consists of mainly illiterate farmers who have very little exposure to scientific knowledge on diseases like leprosy and epilepsy. The prevalence of leprosy in the community was found to be 1/1000.⁶ It is also an interesting point that 2.3% of the respondents in this survey admitted that a family member or a relative suffered from leprosy.

Less than 15% of the interviewees possess radios, the only means of access to mass media available to the community. It must also be pointed out that the Ethiopian mass media offer only limited programmes on health education. Thus, the views that the respondents express on leprosy and epilepsy represent largely the beliefs and practices which are indigenous and prevalent in the rural community, without much outside or foreign influence. It is quite obvious from this study that the rural community has stronger and more negative feelings toward leprosy compared with those toward epilepsy, particularly on such matters as physical contact and marriage with victims. What is indeed at the root of this strong social stigma toward leprosy?

The Ethiopian Amharic word *qumtina* used for leprosy is very similar in concept to the Arabic word *judham* derived from *jadham*, with the literal meaning of 'cutting', denoting the outcome of the disease.⁷ The Amharic terms for leprosy the disease, and for the person with the disease, although widely used in the country, have derogatory and deeply entrenched discriminatory and stigmatizing connotations. For what it is worth,

the less pejorative new terminology *sega dewe*, 'the disease of the flesh', is fortunately gaining wider acceptance. In this connection it is worth mentioning that, as part of the programme of destigmatization, Dogliotti proposed the replacement of the 'opprobrious term—leprosy' with the eponym 'hanseniasis',⁸ though we are all aware that changing the name is not certain to change an attitude.

Nevertheless, in the rural farming community surveyed, it was our experience that leprosy patients do not in fact face outright segregation and ostracism. They seem in general to get a sympathetic reaction from their community. In a survey undertaken in the same community to detect neurological cases including leprosy,⁶ we were impressed by the way leprosy patients were mixing and intermingling freely with others who did not openly discriminate against or reject them. This is very unlike the unfriendly reception that leprosy patients receive in the big towns and cities in Ethiopia.

It is also a common practice that in the peasant associations farmers with leprosy are allocated pieces of land equal to those of other peasants: they can cultivate these on their own or, if unable to do so, hire others to do the work for them. Like all other farmers, they can build their huts within the allocated village boundaries without any restriction or segregation. These conditions and observations suggest that leprosy patients in the rural community are better accepted or tolerated than in the towns, where they are invariably treated as outcasts.

In this attitudinal study on leprosy 13% of the respondents were from Butajira, the main small rural town, and from two other satellite towns within the study area. The attitudes of the respondents from these semiurban centres to different aspects of leprosy was not statistically different from that recorded in the rural villages.

As evidence in Table 5, the majority of the respondents are convinced that leprosy sufferers should depend on alms, which may explain why we find so many of leprosy sufferers among the multitudes of beggars around places of worship.

In a *Leprosy Review* editorial of 1977, Antia appropriately referred to leprosy as the 'disease which affects the body of the patient and the morale of the public'.⁹ Indeed, leprosy has a profound effect on the patient, and carries a strong stigma in all cultures and societies.

In his analysis of the psychological aspects of leprosy, Davey identified the following main sources of stress in the leprosy patients: the stress of inherited idea, the stressful experience of leprosy related to its physical disabilities; and the stress of home and family life emanating from the threat of unemployment and problems of marriage.¹⁰

As evidenced in this study, there is a widely held concept that leprosy is congenital. Nearly half of the respondents in this survey thought that the disease was inherited, as compared to 5% who expressed the same belief about epilepsy. Such congenital transmission of leprosy is believed to extend through several generations, very similar to what has been documented among Hong Kong Chinese.¹¹ Traditionally, in many parts of Ethiopia, marriage with a leprosy sufferer would be allowed only after the families of each of the partners have independently convinced themselves that leprosy has not occurred for seven generations. Although this study did not address itself to the attitudes of the leprosy patients to their own disease, it was quite clear from our experience in the study area that those with leprosy face both rejection and isolation, particularly if they exhibit obvious amputations, ulcerations and disfigurement.

Edwards proposed that the origin of the social stigma of leprosy was a primitive fear evoking a guilt complex in both the sufferer and the observer, a rational fear of contagion, and the religious fear of divine punishment.¹²

In previous studies of leprosy within the religious context, we come across persistent allegations of mistranslation and misinterpretations of writings on leprosy in holy scripture. References to leprosy are certainly made in the Bible. However, Browne, for one, argues that leprosy, as the currently well-defined clinical entity, is not explicitly or beyond doubt referred to in the Bible, although the word 'leprosy' and its cognates occur in translations from the original scriptures in Western languages.¹³ In his review of the same subject, Mohamed in 1985 found that leprosy is also not mentioned in the Quran. What was erroneously translated from the Quran as leprosy was vitiligo. He further argues that the medieval type of persecution, isolation and segregation of leprosy patients, still practised in many Moslem communities, has no religious justification.⁷

Similarly, Skinsnes has cast serious doubts on the suggestion that the negative social reaction to leprosy is the result of biblical teachings, including possible mistranslation. Based on our experience and as confirmed by this study, we tend to agree with his conclusions that the negative social reactions encountered are largely derived from a 'wrongly perceived picture of a contagious, incurable disease which progresses and eventually results in deformities and mutilation'.¹⁴

In Zambia, witchcraft was believed to be an important cause of leprosy, and the disease was often believed to be a punishment, reminiscent of the beliefs in medieval Europe.¹⁵ Yet these beliefs were not very prevalent in the Ethiopian rural community we surveyed. Only 12.6% implicated evil spirits and punishment from God as the cause of the disease. On the other hand, as mentioned earlier, the hereditary factor was considered very important. The fear of contagion was expressed by 48% of the respondents. Direct contact was believed to be the main method of transmission, while a minority also considered sexual contact to be a means. Similar strong fears of contagion have been documented in studies from communities in Mangalore, in south-west India.¹⁶

The conclusion to draw from this study is that the rural community as a whole needs to be provided with correct information on the cause and outcome of leprosy. There is a real need to impress on the public that the disease is not genetically transmitted. This necessitates intensive health education to convince the population that, as an infectious disease, leprosy can be cured, and if detected very early can be cured without deformities. The absence of strong negative religious beliefs, and the observed tolerance and understanding of the community toward leprosy sufferers would certainly contribute positively to the success of such health education. A campaign of education should, as Dogliotti suggested, extend to medical, paramedical, social, religious and educational institutions.⁸ It is emphasized that the education of those in the medical profession should precede that of the general public.

The integration of leprosy care into the general health services would help to reduce the segregation of leprosy patients. In this connection, we subscribe to the views of Antia that the specialized treatment of leprosy patients in isolation encourages the perpetuation of the stigma in the minds of the public and the medical profession.⁹ The present existing leprosy control programmes, with better resources and trained manpower, should therefore help to strengthen the basic health delivery centres in the country, and also actively participate in the health stations in order to ensure that the follow-up of leprosy patients is not neglected.

While we educate communities in endemic areas to avoid being victims of the disease and to report when they experience the first sign of leprosy, it is absolutely vital that we also find ways of re-integrating those that have been successfully treated. In the context of

developing countries, it is common knowledge that a disabled person with a skill has better chances of overcoming prejudices and getting social acceptance. As Frist has emphasized, attention must be given to create integrated vocational rehabilitation opportunities for leprosy patients.¹⁷

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References

- ¹ WHO. *A Guide to Leprosy Control*. WHO: Geneva, 1988.
- ² Ethiopia, Central Statistical Office. *People's Democratic Republic of Ethiopia: Facts and Figures*. 1986.
- ³ Berhe D, Tekle-Haimanot R, Tedla T, Tadesse T. Epidemiological pattern of leprosy in Ethiopia: a review of the control programmes. *Lepr Rev*, 1990; **61**: 258–66.
- ⁴ Giel R. The problem of epilepsy in Ethiopia. *Trop Geogr Med*, 1970; **22**: 439–42.
- ⁵ Tekle-Haimanot R, Abebe M, Forsgren L, Gebre-Mariam A, Heijbel J, Holmgren G, Ekstedt J. Attitudes of rural people in central Ethiopia toward epilepsy. *Soc Sci Med*, 1991; **32**: 203–9.
- ⁶ Tekle-Haimanot R, Abebe M, Gebre-Mariam A, Forsgren L, Holmgren G, Heijbel J, Ekstedt J. Community-based study of neurological disorders in rural central Ethiopia. *Neuroepidemiology*, 1990; **9**: 263–77.
- ⁷ Mohamed HAA. Leprosy—the Moslem attitude. *Lepr Rev*, 1985; **56**: 17–21.
- ⁸ Dogliotti M. Leprostigma in hanseniasis. *S Afr J*, 1979; **55**: 102.
- ⁹ Antia NH. Editorial: The people we fail to reach. *Lepr Rev*, 1977; **48**: 155–7.
- ¹⁰ Davey TF. Physiological aspects of leprosy. *Lepr Rev*, 1976; **47**: 71–4.
- ¹¹ Skinsnes OK. Leprosy in society. I. 'Leprosy has appeared on the face.' *Lepr Rev*, 1964; **35**: 21–4.
- ¹² Edwards RHT. Leprosy today. *Lepr Rev*, 1964; **35**: 3–13.
- ¹³ Browne SG. *Leprosy in the Bible*. 1970.
- ¹⁴ Skinsnes OK. Leprosy in society, III. The relationship of the social to the medical pathology of leprosy. *Lepr Rev*, 1964; **35**: 175–81.
- ¹⁵ Griffiths PG. Leprosy in the Luapula Valley, Zambia: History, Beliefs, Prevalence and Control. *Lepr Rev*, 1965; **36**: 59–67.
- ¹⁶ Shetty JN, Shivaswamy SS, Shirwadkar PS. Knowledge, attitude and practice of the community and patients regarding leprosy in Mangalore. *Ind J Lepr*, 1985; **57**: 613–19.
- ¹⁷ Frist TF. Employer acceptance of the Hansen's disease patient and other handicapped persons. *Int J Lepr Mycobact, Dis* 1980; **48**: 303–8.

APPENDIX

Attitude Questionnaire

Date	Farmers/Urban Association	House No.	Interviewer
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TO BE ANSWERED BY ONE MEMBER OF THE HOUSEHOLD, PREFERABLY BY THE HEAD OR WIFE

Name of informant..... Age..... Sex.....
 Marital status: Married..... Single..... Divorced..... Widow.....
 Number of children: Male..... Female..... Total.....
 Occupation..... Income per month:.....
 Education: Illiterate..... Read and write..... Grade.....
 Religion: Christian..... Moslem..... Other.....

ATTITUDES TO LEPROSY

Have you heard or read about leprosy? Yes..... No.....
 If yes, where?

How would you recognize a person with leprosy?

Is there in your language/dialect another name for a person with leprosy?
 Yes..... No..... If yes, specify:

After giving a full description of the different manifestations of leprosy (skin lesions, deformities and amputations due to nerve damage), the enumerator tells the respondent: WE CALL THIS *LEPROSY (SEGA DEWE)* AND THAT IS THE TERM WE WILL USE IN THE QUESTIONS TO FOLLOW.

Have you ever seen a person with leprosy? Yes..... No.....

Have you among your relatives anyone with leprosy?
 Yes..... No..... If yes, specify relationship

Do you think you know the cause of leprosy? Yes..... No.....
 If yes, explain

Do you think that leprosy is inherited? Yes..... No.....
 If yes, how?

Do you think that leprosy is contagious? Yes..... No.....
 If yes, how?

Do you think leprosy is a form of insanity? Yes..... No.....

Do you know what to do for a person with leprosy?
 Yes..... No..... If yes, how?

If a person with leprosy has been treated and his disease has been cured will you consider him/her to be an ordinary healthy person?
 Yes..... No..... If no, why?

If you had the opportunity, would you employ someone with leprosy?
 Yes..... No..... If no, why?

Are you willing to work with a person having leprosy?
 Yes..... No..... If no, why?

Would you allow your child to play with a child having leprosy?
 Yes..... No..... If no, why?

What would you do if you were forced to share accommodation with someone with leprosy?

.....

Do you have a friend who has leprosy? Yes..... No.....

Would you be a friend of someone with leprosy?

Yes..... No..... If no, why?

May anyone in your family marry someone with leprosy?

Yes..... No..... If no, why?

Are you afraid of someone who has leprosy?

Yes..... No..... If yes, why?

Should a family having a member with leprosy hide him/her from outsiders?

Yes..... No..... If yes, why?

Do you think a person with leprosy should use public transport?

Yes..... No..... If no, how should he/she travel?

Would you shake hands with a person known to have leprosy? Yes..... No.....

How should society take care of persons with leprosy?

.....

At the end of the interviews health education on leprosy is given to the respondent and his/her family by the enumerator.

Attitude des populations rursales à l'égard de la lèpre dans le centre de l'Éthiopie et brève comparaison avec certaines observations sur l'épilepsie

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Résumé Pour connaître la réaction du public face à la lèpre, un sondage porte à porte a été effectué auprès de 1546 foyers dans les communautés rurales d'agriculteurs de Meskan et de Mareko dans le centre de l'Éthiopie, où la fréquence des cas de lèpre est estimée à 1 pour 1000. Les attitudes à l'égard de la lèpre ont été comparées aux attitudes vis-à-vis de l'épilepsie, étudiées lors d'une précédente enquête dans la même communauté. Quarante-sept pour cent des personnes interrogées ont plus de 25 ans, et 59,5% sont des femmes. Le groupe étudié se compose d'un peu plus de musulmans (54%) que de chrétiens. La majorité des personnes interrogées (87%) sont des fermiers, et le taux d'analphabétisme est de 84%. Respectivement 95% et 83% ne souhaitent pas employer ou travailler avec une personne souffrant de la maladie. Soixante-quinze pour cent ne permettraient pas à leurs enfants de fréquenter un camarade de jeu atteint de la lèpre. Une analyse comparative, dans la même communauté, a montré que les attitudes négatives à l'égard de la lèpre étaient plus marquées que celles à l'égard de l'épilepsie, notamment en ce qui concerne les relations matrimoniales, le partage du logement et le contact physique avec une personne atteinte. Il semble que ces différences s'expliquent par le fait que la communauté croit profondément que la lèpre est à la fois héréditaire et contagieuse, opinion exprimée par 48% et 53% des personnes interrogées, respectivement. Pour mettre un terme à ces attitudes négatives, il faut éduquer la population et lui inculquer que la lèpre est une maladie infectieuse que se soigne, qu'elle n'est pas congénitale et qu'elle est guérissable si elle est décelée tôt. Cette étude renforce les propositions déjà formulées pour intégrer le traitement de la lèpre aux programmes généraux de santé, dans les pays en développement comme l'Éthiopie.

Actitudes de los habitantes rurales de Etiopía Central a la lepra, y una breve comparación con la epilepsia

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Resumen Se realizó un estudio de las actitudes públicas a la lepra, de casa en casa en 1546 residencias muestreadas en las comunidades agrícolas rurales de Mesken y Mareko, en Etiopía Central, en donde se calcula la frecuencia de la lepra en 1 por 1000. Se compararon las actitudes a la lepra con las actitudes a la epilepsia determinados en un estudio anterior en la misma comunidad. 87% de las personas interrogadas tenían más de 25 años, y un 59,5% eran mujeres. Habían pocos más Musulmanes (54%) que Christianos. La mayoría de personas entrevistadas eran agricultores, con un nivel de analfabetismo de 84%. 95% y 83% respectivamente no estaban dispuestos emplear ni trabajar con una persona que padecía de la enfermedad. Un 75% no permitía que sus hijos se asocien con un compañero que sufría de la lepra. Un análisis comparativo de las actitudes en la misma comunidad indicó que las negativas a la lepra eran más fuertes que las contra la epilepsia, especialmente respecto a las asociaciones matrimoniales, la distribución de acomodación y los contactos físicos con un enfermo. Las razones por estas diferencias parecían ser debidas a la creencia intensa que la lepra era tanto hereditaria como contagiosa, expresada por 48% y 53% de los entrevistados respectivamente. Para reducir a un mínimo la perpetuación de las actitudes negativas, es necesario educar y convencer la población que la lepra es una enfermedad infecciosa tratable, que no se adquiere por razones congénitas, y que es hasta curable si se detecta temprano. El estudio refuerza las sugerencias propuestas anteriormente que en los países en desarrollo, como la Etiopía, se debe integrar el cuidado de la lepra a los servicios sanitarios generales.