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Approved by

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Abstract

Cutaneous Leishmaniasis (which is locally known as *Shahign*) is one of the neglected tropical diseases that hamper the health condition of many poor people around the world. The disease is disseminating in a highest prevalence rate and is affecting most people in different parts of Ethiopia, leaving a disfiguring scar on the patient's body. However, there are no any studies that are conducted in this area to depict the major impact of the disease on the general wellbeing of the society. Hence, this study has explored the psycho-social impact of the disease on those infected people who are living at *Ankober Woreda, Mehal-Wonz Kebele.* The major scheme of the research is a qualitative method of exploratory purpose. Accordingly, ten participants from cutaneous leishmaniasis patients and five additional key informants from non-infected community members are selected using purposive sampling method. By doing this, qualitative data is gathered through in-depth interviews and observation. The finding of the study has also indicated that the disease of cutaneous leishmaniasis has brought major psycho-social impact on those patients, family members as well as their close relatives. One of these is the psychological problem of the disease on the patients which includes the problem of extreme fear and anxiety, poor self-disclosure, emotional sensitivity and disturbance, as well as disgrace and the feeling of gloomy future. The other is the social problem that are related to the views of the society such as stigma and discrimination, limited social participation, rejection of social ties as well as low quality of life.

Key Words: Ankober, Cutaneous Leishmaniasis, Disease, Impact, Kebele, Mehal-Wonz, Patient, Psycho-Social.

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Definition of Terms

Aetiology- the scientific study of the causes, origins, evolution and implication of disease (Farlex, Inc, 2012 p.1).

Cutaneous nodule- a small node which is solid and can be detected by touching (Farlex, Inc, 2012 p.1).

Epidemiology- the scientific study of the spread and control of diseases (Macmillan English Dictionary, 2007, p.494).

Infectious diseases- diseases that are caused by pathogenic microorganisms, such as bacteria, viruses, parasites or fungi; and that can be spread, directly or indirectly, from one person to another (Farlex, Inc, 2012 p.1).

Lesion-an area of damaged skin (Macmillan English Dictionary, 2007, p.862).

Mucosal tissue- a membrane lining all body passages or a thin layer of tissue that covers a surface, or divides a space or organ (Farlex, Inc, 2012 p.1).

Opportunistic infections- Infections that are associated with severe immunodeficiency and that can take the advantage of a weakened immune to be transmitted easily (Farlex, Inc, 2012 p.1).

Psychosocial- a term referring to the mind's ability to consciously or unconsciously, adjust and relate to the body to its social environment. Or can be understood as pertaining to a combination of psychological and social factors (Farlex, Inc, 2012 p.1).

Vector borne diseases- diseases, whose agents (parasites, viruses etc) are transmitted by insect vectors such as mosquitoes, and flies. Both their transmission and controlling mechanisms are also dependent on the social and environmental factors including climate change (Farlex, Inc, 2012 p.1).

Zoonoses- diseases that are infectious of animals and can be spread from animal to people (Farlex, Inc, 2012 p.1).

Background

Introduction

In Africa and in most developing countries of the world, there is the prevalence of a wide range of communicable and infectious diseases, opportunistic infections, as well as other vector-borne diseases and zoonoses (Hattingh , Dreyer & Roos 2006 p.249). From this category, the neglected tropical diseases have made adverse health effects over the poorest populations of the world. It is estimated that one billion people suffer from these diseases worldwide and most cases are found in Africa. Characteristically, some of the diseases are fatal; others leave physical deformity and affect intellectual and physical growth among children (Cooke, 2009 p.6).

According to Hunt, Steward, Mesquita and Oldring (2007, p.3) Leishmaniasis is one of the neglected tropical diseases. In Ethiopia, both forms of Leishmaniasis such as Cutaneous Leishmaniasis and Visceral Leishmaniasis are endemic and becoming a major public health concern (Edessa et al., 2008, p.1). The former which is mainly caused by *L. aethiopica*, is a widespread skin disease. *L. tropica* and *L. major* species also cause Ethiopian Cutaneous Leishmaniasis in the lowland regions. (Wossenseged et al., 2009, p.1).

The disease produces chronic ulcerative lesion on the face, arms, and legs. Apart from its detrimental health effect, the infection of cutaneous leishmaniasis leaves a disfiguring scar on the patient's body which permanently leads to a lifelong stigma and discrimination (Yanik, Gurel, Simsekt, & Kati, 2004, p. 464). Similarly, Kassi, Masoom., Kassi, Mahwash., Afghan, Rehman & Kasi stated that the infection of cutaneous leishmaniasis may cause psychological disorders and restricts social participation (2008, p.1). As a result, the disease creates very great psychosocial impacts on the patient's life when compared to other infectious diseases which have the highest morbidity rate in Africa like malaria and HIV/AIDS (Cooke, 2009, p.5).

The psychosocial impact of the disease connotes two different but related concepts. According to Kaplan (2005, p.19) the term 'psycho' stands for assessing the psychological and developmental issues. This includes different psychological factors that may have multitudes of role in the pain experience, in the influence of one's coping efforts, and in the sense of confidence to control oneself. Similarly, the social impact has various implications. Under this category, the cultural, social and religious belief of the society which influences the health behaviour is a major aspect. For instance the cultural values of using various traditional treatment practices, the societal understanding and attitudes towards specific problem, as well as the personal beliefs and prayers can dictate the individual attitudes towards different understanding. Besides it can put an effect on their illness experience (Anie, Egunjobi, & Akinyanju, 2010, p.2).

Statement of the Problem

The health situation of African continent is characterized by immense disease burden and weak health systems embedded by the context of poverty, underdevelopment and conflict (Cooke, 2009, p.1). In the same token, Ethiopia is not unique in this perspective as the case is testified by its poor health outcomes even by sub-Saharan Africa's standards. Consequently, there is the dissemination of various infectious diseases across the country due to the low spending of the government health care financing and the minimal participation of the private sector (Wamai, 2009, p. 279-281).

With this regard the category of neglected tropical diseases that affect almost exclusively the poorest populations in different parts of Ethiopia have been given lesser attention and further overshadowed by the major focus of HIV/AIDS, Tuberculosis and Malaria (Cooke, 2009, p.6). A case in point, cutaneous leishmaniasis is one of the infections which share neither the public eye nor better financial returns amongst the neglected tropical diseases (Piscopo & Mallia, 2006, p. 649). However it is a disease that needs an immediate intervention from the government and other concerned bodies. As notified by (WHO, 2007, p.2) the disease is rather a clinically recognized illness with a disfiguring and stigmatizing nature.

According to (Hunt et al., 2007, p.23) this is mainly because of the negative attitude attached to the societal understanding. Mostly the problem emanates from the results of the severe physical disabilities, including deformities and scarring. This has also in turn gives rise to social discrimination in the public and private settings.

In addition to this, other factors have also intensified the impact of the disease on the life of the society. One of these is the low level of priority and the passive intervention of the government in raising awareness about the nature of cutaneous leishmaniasis disease to the community. The other one is the society's and in some instances the patient's misunderstanding about the illness and its association to the poor people living in the peripheral areas of the country (Scientific Working Group, 2004, p.5).

In connection with this, few studies were conducted outside Ethiopia to depict the impact of cutaneous leishmaniasis disease. One of the study made by Kassi, et al. 2008, entitled as the stigmatization and the impact of cutaneous leishmaniasis in Pakistan and Afghanistan, revealed that there exist many erroneous beliefs about the disease of cutaneous leishmaniasis. For instance, it is believed that the disease can be transmitted by person to person physical contact. As a result of this, infected people are excluded from communal life and the level of exclusion may range from sharing plates to severe physical and emotional isolation.

Similar study was also made by Abazid, Jones, and Davies 2012, under the title of knowledge, attitudes and practices about leishmaniasis among cutaneous leishmaniasis patients in Aleppo, Syrian Arab Republic. The findings of the study attested that patients seek immediate treatment for the sake of preventing disfigurement, to limit the size of the spread of the wound and the multiplication of lesions.

These studies though showed the stigmatization and the impact of the disease as well as the reaction, attitudes and knowledge of the society, the place where the study was conducted is very different from the Ethiopian context in terms of culture, attitude, knowledge and awareness levels of the society. This fact is one of the reasons which instigated me to understand the existing situation in the study area.

In addition to this, my overall finding about the topic of cutaneous leishmaniasis disease and its psychosocial impact has shown that there is no any detailed research output that has been done so far in Ethiopia. This can show that there is the lack of sufficient epidemiological research outputs similar to this study and, this is one of the major drawbacks in the field of social science research. Thus I developed the interest to conduct such a pioneer study to address this gap which has been left from being a subject of study until recent times.

By this notion I explored the major psychological and social impact of cutaneous leishmaniasis on those people who are infected by the disease. Accordingly, the frequent psychosocial problems which are practically apparent in the Ankober woreda of Mehal-Wonz kebele are duly studied for the sake of making better intervention strategy and developing a coping mechanism for the existing problem.

Objectives of the Study

The general aim of the study is to identify the potential psychosocial outcome of cutaneous leishmaniasis on those victimised patients at Ankober Woreda of Mehal-Wonz kebele. Specifically the focus of the study was:

1. To examine the nature and level of psychological effects that victimized patients of cutaneous leishmaniasis have encountered.
2. To assess the effect of the disease on the social, cultural and moral value of the victimized patients.
3. To identify the coping mechanism of patients against the psychosocial problem of the disease.

Research Questions

The study is designed to answer the following research questions:

1. What are the major psychological, social, emotional and physical problems of people infected by cutaneous leishmaniasis disease come across?
2. How do patients react on the psychological and social problems they faced?
3. What will be the appropriate intervention mechanism in the fight against the psychosocial impact of cutaneous leishmaniasis disease?

Significance of the Study

This study can have the following contribution and significance in terms of:

1. Providing empirical evidence for practitioners in intervening to assist the victimised people.
2. Expanding the knowledge acquisition of health social work on the issue under investigation.
3. Documenting a systematic research output on the psychosocial problem of cutaneous leishmaniasis disease.

Limitation of the Study

Due to the absence of sufficient related literatures on the psychosocial impact of cutaneous leishmaniasis in the Ethiopian context, the study is limited only to use the primary data which were collected from the study participants. As the study was also employed at a selected kebele of Mehal-Wonz, the finding might not represent the general experiences of the remaining kebeles victimized patients which were not included in the study.

Literature Review

Cutaneous Leishmaniasis: A Brief Overview

According to Garnier & Croft (2002, n. p) Cutaneous Leishmaniasis is the most common form of Leishmaniasis disease, endemic in 88 countries with an annual incidence rate of 1 to 1.5 million cases. It is predominantly referred to as a group of diseases as a result of the varied spectrum of clinical manifestations that range from small cutaneous nodule to gross mucosal tissue destruction. In spite of its increasing incidence globally, the disease has become among the category of neglected diseases with little interest by researchers, and public health professionals for prevention and control (Reithinger et al., 2007, p. 581).

The three major clinical forms of Cutaneous Leishmaniasis that are recognized include Localized Cutaneous Leishmaniasis (LCL), which often heals without treatment, Diffuse Cutaneous Leishmaniasis (DCL), which is very difficult to treat, and Mucosal Cutaneous Leishmaniasis (MCL), which is the most severe form, producing disfiguring lesions and mutilation of the face (WHO, 2007, p. 2). It can be caused by several *leishmania* species and is transmitted to human beings and animals by sand flies (Reithinger, et al., 2007, p. 581).

Studies conducted by Edessa, et al. (2008, p. 2) suggest that in Ethiopia, Cutaneous Leishmaniasis is mainly caused by *L. aethiopica.* The disease is found mainly at high and mid altitudes ranging from 1400 to 2700 m above sea level which is most favourable for the proven vector sand flies species of *phlebotomus longipes* and *P. Pedifer.*, thereby limiting the distribution of Ethiopian Cutaneous Leishmaniasis. A lower level altitudinal limit of 1200 m also suspected to be the other potential area of Cutaneous Leishmaniasis distribution. The two species of Hyraxes *Procavia capensis* and *H.brucei*, are believed to be main host reservoir of *L. aethiopica* (Wossenseged et al., 2009, p. 2).

According to Piscopo & Mallia (2006, p. 651) the Mucosal Cutaneous Leishmaniasis may regenerate after many years of the initial Cutaneous Leishmaniasis healed. The disease typically affects the nose, oral cavity and pharynx. This causes great difficulties in time of eating, and carries considerable mortality. In case of Diffuse Cutaneous Leishmaniasis (DCL), as the relapse rate is quite common and high, it is hardly ever achieved a definite cure. Besides there is no precise figure on the number of Ethiopian Cutaneous Leishmaniasis cases, but based on the unofficial estimates, the total number of Cutaneous Leishmaniasis cases diagnosed in Ethiopia each year is around 20, 000 (Wossenseged et al., 2009, p. 2).

Psychosocial Aspects of Diseases

During the past century, the campaign to fight against infectious diseases has made great strides in saving millions of lives. This is mainly because of the dynamic changes of pharmacological innovations and the development of nations in prevention mechanisms. Despite such improvements, a quarter of all deaths in the world continue to occur because of the viral, bacterial, fungal and parasitic diseases. However, this doesn't account for the impact resulting in the psychosocial effect which ranges from stigma felt by individuals to regions ravaged through epidemic diseases (Akers, Blake, & Hanson, 2008, p. 181).

The above premise is counting the disastrous effects of diseases from the clinical aspect at the global context. But the moral, attitudinal, psychological and social chaos which deserves much attention is left unmentioned. On the contrary, other epidemiological studies also claimed that it is empirical to consider the psychosocial impacts of diseases while the subject of health care and illness is studied. A case in point Harding, Nettleton, and Taylor (1996, p. 121) emphasized that health and disease are not merely biologically determined phenomena.

The chances of becoming ill or healthy are often related to an individual's psychosocial circumstances. Hence diseases are not always associated with physiological changes but are mostly determined and influenced by the place where we live, and the way how we live, work, eat and by our own pattern of relationship with people living around us. Thus the line of argument goes to the inclusive thought of diseases with respect to the psychosocial patterns.

In these two prepositions, there is a clear stand of demarcation between the clinical and psychosocial aspects of diseases. Under these two contextual frameworks, still there is another argument which lays a foundation of links that alike between the disparities of the medical and psychosocial aspect of diseases. According to Schneidermann (2004, p. 248) a perfect causal pathway among the psychosocial variables of behavioural, psychological, societal approaches and diseases have not yet been mapped, but plausible biological pathways that have a seemingly effect to psychosocial patterns have been identified. For instance, these pathways involve lifestyle, stress, and psychological status. An example of pathway that links lifestyle and disease is diet system. Another pathway that exemplifies the psychosocial impact of disease is stress. In an environment which is very threatening, the degree of stress becomes high and brings an adverse health effect. It thus appears that psychosocial and bio-behavioural factors can contribute to disease's severity.

In support of the aforementioned ideas another argument also forwarded about the association between diseases and social circumstances that can be counted as part and parcel of the psychosocial component. For example a growing body of evidence is providing direction for the development of policies to reduce health inequities in modern societies. One of the evidence which is rightly pointed out is the socioeconomic environment as a powerful and potentially modifiable health-determining factor.

However, giving much emphasis on the socioeconomic environment does not imply that other factors such as genetics, lifestyles or health care do not figure significantly in determining health status; rather, the new knowledge supports a sector which, until recently, has not received much research attention from the epidemiological or health policy communities. Consequently, the new evidence offers additional proof of a direct and powerful link between the social environment and health by way of considering poverty, unemployment, education, living and working conditions, families, friends, workplaces, social support and physical environments all significantly affect health. These facts though lie in the ground and the evidence that has accumulated suffices that the relationship can no longer be denied, it has still been imperfectly understood (Canadian Public Health Association, 1997, P. v).

According to Ross and Deverell (2010, p. 5) the impact of psychological and sociological factors and the role they play in the progressive stages of the disease's cycle ranging from its aetiology, development, treatment and outcome are increasingly recognized. In all such processes, the situations of individuals living in the safe environment can not be the same to those who reside to refugees. Thus it will always remain that factors of the psychological situation and the social circumstances have a greater effect over the health status of individuals.

Across the study of diseases and its psychosocial impact on people, there are so many variables that come to discussion. One of this is social status which in turn has decisive element in the health setting in general and the psychological makeup of individuals in particular. For instance disparities in illness most particularly of chronic health problems can be grouped into social status or occupational class. In support of this, there are a number of theories that attempt to explain for this phenomenon.

Low socioeconomic status is linked to low pay, which produces inadequacies in every aspect of life standards. This has obviously affects the health status of the people. Such kind of permanent social and economic inequalities characterize the social structure in society, and this exposes people's to varying possibilities of ill health and injury (Ross & Deverell, 2010, p. 9).

In relation to this, one of the most striking epidemiological findings attested that individuals who are living in a low socioeconomic status have poorer health than individuals living in a higher socioeconomic status. Even with respect to stress, the same factor holds true. For example people may perceive a wide variety of negative impacts over health situations. Thus the level of stress one may experience highly depends on the socioeconomic status which in turn drives to the physiological exhaustion, and putting people at greater risk for a variety of disease (Chen, 2004, p. 112).

According to Schneidermann (2004, p. 248) each and every social variable such as education, income, occupation, social cohesion, ethnicity and race have been an integral part of health and illness. As a result of this, the relationship between social variables and disease life spans are complex. This will in turn make the requirement of detailed examination about the social context if societal contributions to health and illness are to be understood.

Major Psychosocial Problems Related to Cutaneous Leishmaniasis

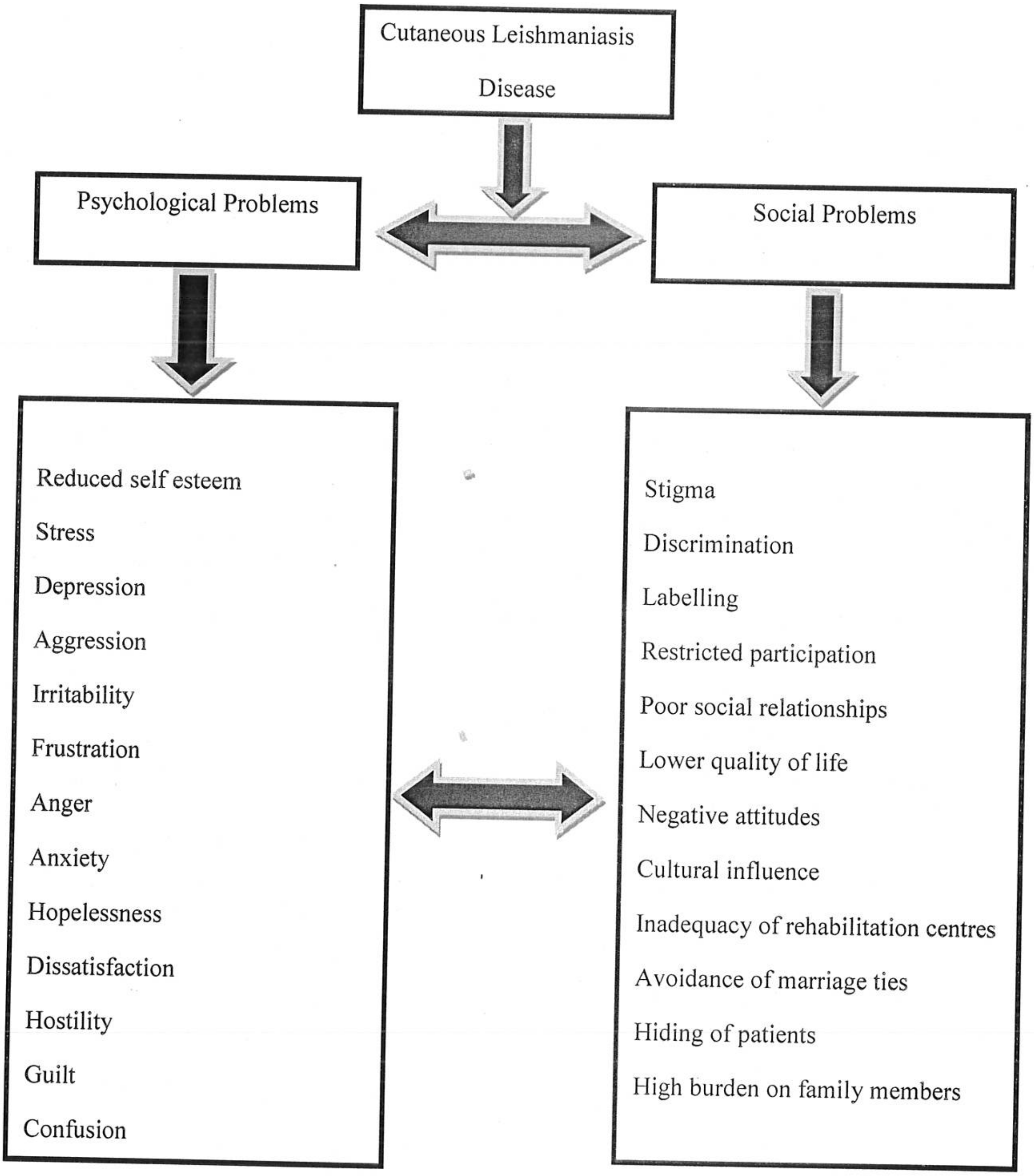
Many neglected tropical diseases are major causes of mortality and physical deformity, most commonly in areas where poor people are living in and health service provisions are scarcely available (Fischer & Macpherson, 2011, p. 18). The case of Cutaneous Leishmaniasis has the same kind of characteristics and prevalence rate in the Ethiopian context. Consequently, the problem has multitudes of health problems and psychosocial factors.

According to Yanick et al. (2004, p. 466) a Cutaneous Leishmaniasis disease patients experience high prevalence of psychiatric disorders. It is reported that there is a relationship between skin disease and psychiatric problems such as depression, anxiety, suicidal ideation, decreased self-esteem, lower quality of life, and poor body image satisfaction. Disfigurement and stigma due to severe skin disease are particularly the most frequent causes of psychiatric symptoms. These psychiatric disorders are often common in patients with unattractive lesions on exposed body parts of the face and hands compared to those with unexposed lesion sites. Besides, as the scars may not improve over time and may become permanent, there is a lifelong stigmatization problem. Moreover, patients are excluded from social groups since the disease's active period is one year long and people think that it may be a contagious disease.

The psychosocial impact of skin diseases like Cutaneous Leishmaniasis has been given very little attention, though it connotes negative attitudes and increases the likelihood of stigmatization. Hence, the problem should be measured not only in terms of symptoms, but also by physical, psychological, and social parameters. For this end, counseling and psychiatrist services can give massive benefits for patients with depression or anxiety related skin problems (Barankin &DeKoven, 2004, p.713).

In general, the forefront problem that most patients have experienced in relation to the problems of skin related disease like cutaneous leishamniasis is stigma and discrimination. Stigma is a social construction and understanding that defines people in terms of a distinguishing feature and or mark, and treating people or certain member of a group with less respect. The stigma associated with disease may include serious disability, disfigurement, or disruption of social interactions (Johnson, Campbell, Bowers & Nichol, 2007, p. 680).

Conceptual Framework



Cutaneous Leishmaniasis Disease

Psychological Problems

Social Problems

Reduced self esteem
Stress
Depression
Aggression
Irritability
Frustration
Anger
Anxiety
Hopelessness
Dissatisfaction
Hostility
Guilt
Confusion

Stigma
Discrimination
Labelling
Restricted participation
Poor social relationships
Lower quality of life
Negative attitudes
Cultural influence
Inadequacy of rehabilitation centres
Avoidance of marriage ties
Hiding of patients
High burden on family members

Methods

Design

This study used a qualitative design for its main target is to generate a deeper understanding of the meanings of human experiences. Such an approach can also give great opportunities to formulate theoretically richer observations that are not easily reduced to numbers (Rubin & Babbie, 2010, p. 34). Thus using this method the psychosocial impact of cutaneous leishmaniasis on those infected people is explored. Besides, the reasons that make this study to be an exact fit for this approach is that, one it explores an issue which is little known before, and two for it is a topic of sensitivity and emotional depth (Padgett, 2008, p.15).

The purpose of the study is purely an exploration. According to York (1998, p.23) exploration is important to examine a new topic which is relatively unknown. For the qualitative design, I have used a case study as an approach. This is because cases can present valid interpretations that are sensitive to very peculiar social and historical contexts (Kreuger and Neuman, 2006, p. 134).

Scope of the Study

The study is confined to Ankober Woreda which is found in Semen Shoa zone of Amhara regional state in central Ethiopia. The study area is located at about 170 Kilometres to the North-East of Addis Ababa. The Woreda is divided into twenty three Kebeles having a total area of 672.8 square kilometer. Cutaneous leishmaniasis is widely prevalent in many Kebeles of the Ankober Woreda. Most particularly it is found in Gorgo, Derefo, Mehal-Wonz, Aliyu-Amba Zuriya and Daway Kebeles (CSA, 2007, p.3).

Amongst these areas, the study is conducted at Mehal-Wonz kebele through an informed decision. This is because most of the kebeles in the woreda are found at long distances and it was not possible to find transportation services as needed. Hence I chose the nearest kebele of Mehal-Wonz which would take me few hours of walking from Ankober to ease the process of data collection. By doing this, I collected the necessary information from the selected participants of the study.

Participants

The study included different categories of informants to gather important information. In the first place, ten different participants were selected from the community members who are infected by cutaneous leishmaniasis disease from both genders. In doing so, I assumed to minimize the number of participants on the basis of data saturation. Secondly, another five key informants from the community members who have lived in the area for long years and know about the disease of cutaneous leishmaniaisis were selected to participate in the interview.

Inclusion Criteria

Every participants of the research was required to be good Amharic speakers so that the process of obtaining the necessary information would be understood easily by the researcher. Besides, for the first ten participants infection by cutaneous leishmaniasis was the main criteria and their age limit were between 18-45 years. This would give the study the chances of exploring the psychosocial condition of the participants from their own point of experience, and made the study participants good representative of middle aged groups who are frequently exposed to psychosocial problems. Contrary to this, for key informant participants the inclusion criteria was the knowledge of the disease and the good understanding of the society's culture while they are living in the area for long years.

Sampling Techniques

The study has employed purposive sampling technique for the sake of meeting directly persons who are infected by cutaneous leishmaniasis disease. According to Padgett (2008) this is one of the sampling techniques in qualitative research that is deliberately made to select respondents based on their natural ability to give the required information (p.53).

Sources of Data

Both primary and secondary source of information were used to undertake this study. The primary data has included two in-depth interviews. One of the in-depth interviews used for cutaneous leishmaniasis patients, and the other in-depth interviews were for key informants. Integral to this observation was the other sources of data during the interview of both of the study participants. For the secondary data, published materials such as books, magazines, and journal articles were used to substantiate the overall findings of the study.

Data Collection Procedure

An official cooperation letter was written from the School of Social Work mentioning the status and mission of my visit at the study area. This was used for meeting the Ankober woreda health offices. Next by the help of the health bureau, I met the health extension workers and I was able to introduce myself to them and the purpose of my study. Finally, they facilitated my work schedule by appointing people who lives in the kebele and are victims of cutaneous leishmaniasis. Besides they introduced me to all the participants and told them the purpose of the study.

In doing so, firstly the health extension worker met five of the patients and arranged me a place for meeting and interviewing them. Secondly, I met the remaining participants of the study by visiting the place where they were found by the guidance of the health extension worker.

Similarly, they recruited me key informants from the kebele inhabitants who have lived for long years in the area and have good acquaintance to the society. Finally we had fixed a time to get the oral and written consent of all the participants before the actual interview was started. Having made the confirmation, we met for the interview. For the first five participants, the interviews were held at the health extension worker's office where as the remaining participants were interviewed at their home, and farm yards. The key informants were also interviewed at their villages and market places. During the time of the interview, I had used an audio recorder and also took notes.

Data Collection Tools

Interviews: As the major aim of the study is to understand the lived experience of people's infected by cutaneous leishmaniasis, an in-depth interview was employed to explore the psychosocial impact of the disease. The interview guide is unstructured and assessed the major psychological and the social effects of the patients. In the process of in-depth interview observing the feeling and reaction of the study participants were done simultaneously to help the interpretation of the findings. By doing this, I got ample information about the participants' experience and perception. For this purpose one major interview guideline with unstructured format was used.

key informant interviews. Another interview guide was also prepared to capture relevant information from the selected members of the study area whom they are believed to be knowledgeable and experienced about the culture and belief of the society. However the key informant's interview guide was brief since their participation in the study was made to add some more facts about the psychosocial condition of the cutaneous leishmaniasis patients in the study area. Besides the structure of the interview guide when compared to the main interview, it was focused for the sake of exploring the major understanding and attitudes of the society to the victimized patients of cutaneous leishmaniasis.

Observation: In combination with the process of in-depth interviews, observation was also used as an additional instrument of data gathering technique. The main advantage of this observation was to understand the expression, feeling and perception of patients' reaction towards the psycho-social impact of cutaneous leishmaniasis while they were participating in the interview. According to (Creswell, 2009, p.181) through qualitative observations it is possible that researchers can take field notes on the behaviour and activities of individuals at the research site.

Data Analysis Techniques

The data analysis task began immediately after I had completed the data collection. Firstly, the audio records of the interviews were translated from Amharic in to English language maintaining the actual meaning and the verbatim saying of the participants' response. Later I wrote all the translated interviews in the computer using word programme. Next by following an orderly fashion, I organized the data separately and generated categories, themes and patterns. As suggested by Yin (2003, p.111-114) I used a separate file folder to ease the process retrieving the data. Then based on the predefined categories, I coded the data, reviewing the emergent ideas and searching for alternative explanations. Finally by using cross case synthesis, I have examined each case separately and understand the general scene of the cases. Cross case synthesis is one of the techniques used to analyse data separately or collectively by merging all the possible cases and helps to draw a cross case conclusions (Yin, 2003, p.133). By doing this, answers are produced for what has been raised as major areas of the research question, and meet the objective set at the beginning of the session.

Ethical Consideration

As to the professional and ethical requirement of the research, the study has kept the names of the participants confidential by using pseudo names in place. As Creswell (2009, p.89) noted when researchers anticipate data collection, they need to respect the participant and sites of the research. Besides, researchers must avoid putting participants at risk and are expected to give value for vulnerable populations. For this sake, I made the signing of consent forms for an agreement with my participants. In view of this, (Creswell, 2009, p.89) stated that informed consent form acknowledges the participant's rights to be protected during the time of data collection. My ethical consideration in the study has thus clarify that participants were given a full mandate either to continue or terminate the interview session since their contribution in the study was purely voluntary.

Validation of the study

According to Creswell (2009, p.190) the validity of qualitative research is met by using certain procedures such as checking the accuracy of the findings. He recommends the use of multiple strategies should enhance the researcher's ability to assess the accuracy of the findings and to persuade the readers. With this format, I used triangulation as a major means for validating my study. Two in-depth interview guidelines with unstructured formats that were used during the data collection for the study participants were the prime major tool of the study. Additionally, the interpretative as well as the self reflection parts that based my closest observation in the interviewing time was the other tool that can demonstrate the validity of my study. Such kind of approach would add evidences from different sources and build a coherent justification for themes (Creswell, 2009, p. 191).

Findings

This chapter contains the findings of the investigation for the psychosocial impact of cutaneous leishmaniasis on people infected by the disease. The research findings are categorized into two major sections. First, the profile of research participants and key informants is explained briefly. Second, the discussion of themes and sub-themes that emerged from the transcribed data based on the interviews and observations are presented. Besides, the discussion is validated by the quoted extracts of participants' case stories and key informant interviewees. Table 1 below describes summary of the socio-demographic characteristics of participants.

Table 1. Socio-demographic information of participants

People	Age	Sex	Marital Status	Level of Education	Duration of Years in the Area
Participant 1	26	F	Unmarried	Grade 8	26
Participant 2	28	F	Unmarried	Grade 10	28
Participant 3	21	F	Unmarried	Grade 12	21
Participant 4	40	M	Married	Church Education	40
Participant 5	24	M	Unmarried	Grade 6	24
Participant 6	34	M	Unmarried	Diploma	13
Participant 7	22	F	Married	Grade 4	22
Participant 8	40	F	Married	Uneducated	40
Participant 9	33	M	Married	Grade 4	33
Participant 10	25	M	Unmarried	Grade 3	25

As indicated in the table, the study employed ten participants from both sexes who are infected by the disease of cutaneous leishmaniasis. Amongst them, there are three male and three female unmarried participants. On the contrary, the remaining two male and two female are married participants. Their age ranges from 21-40, and they have lived in the area for more than 20 years. However except two of the participants who completed college education and high school, none of them have attended their secondary education.

Table 2. Socio-demographic information of key informants

People	Age	Sex	Level of Education	Duration of Years in the Area
Key Informant A	38	M	BA Degree	29
Key Informant B	49	M	Grade 6	49
Key Informant C	26	F	Diploma	26
Key Informant D	54	F	Grade 8	54
Key Informant E	32	M	Diploma	32

In the above table, there are five key informant interviewees who participated in the study. Of these three are male and the other two are female respondents. All of them are free from the infection of cutaneous leishmaniasis disease. Except two of the participants who reached primary level, the remaining three are college graduates. Presently, they are working in different government and non-government organizations. They have also lived in the area for more than 25 years and have sufficient information about the culture of the people and the disease of cutaneous leishmaniasis.

Participants Disease History

As it is understood and observed from the study, all the participants have been faced with major health problems due to the infection of cutaneous leishmaniasis disease which is locally known as *shahign* in the study area. For instance, seven of the participants had suffered an earlier illness and get cured right now. From these, female participant 2, 7, and 8 are highly attacked by great ulcerative lesions and body damage at their nose, cheek, and facial parts respectively. Similarly all of them applied traditional medicines for treatment purpose. However, for both participants 2 & 8 the illness had stayed for about 4 years and for participant 7 it took only 2 years of time for complete healing.

The remaining male participant 4, 5, 6, and 10 alike to the female participants have damaged body and scar at the upper lip, whole face, nose and eyelash, as well as cheeks and forehead respectively. Accordingly, all used different plant medicines but participant 6 and 10 treated the illness after 3 years and participant 4 cured after 5 years of illness. Different from others, participant 10 seriously suffered for about 11 years to get a complete remedy.

The other three people who have still been suffering from the infection of cutaneous leishmaniasis are 2 females and 1 male participant. Both female participant 1 and 3 are experiencing serious illness at the forehead, and cheek respectively. The former has faced the problem 6 months before while the later has encountered the illness for about 10 months. Both these patients are applying the plant medicines of *Kinchib* and *Yeazo Hareg*. Participant 9 is also the only male patient who is currently feeling the illness of the infection at his ear. He has 2 years of illness and applied a heated nail to treat the disease.

Thematic Areas from Data Collection and Analysis

The following paragraphs state the two broad themes of the study result followed by their sub-themes that are arising from the case analysis. These are the psychological and the social impact of cutaneous leishmaniasis disease on those infected people.

The Psychological Impact of Cutaneous Leishmaniasis: The psychological impacts are the result of various physical injuries and imbalanced recognition of illness by the patients themselves. The situation presented in the case studies vividly testified that the psychological problems have occurred in multifaceted contexts. For example most participants stated that their problems start from the day of serious illness to the time of complete treatment. Consequently, they are highly exposed to different levels of traumatic experiences in their life time. Each of these sub-themes is in turn presented below under specific classification patterns.

Extreme fear and anxiety: All of the research participants believed that the disease has a very disastrous health effect and can completely damage the patient's body unless prompt medication and treatment is made. Hence in fear of these ill effects, they have applied various plant medicines which are locally produced by traditional healers. The most common of these are the plant leaves of *Kinchib* and *Yeazo Hareg*. All key informants have also observed that patients have great fear and worry in relation to the cutaneous leishmaniasis infection.

According to the information gathered from participant 1, when the first node of cutaneous leishmaniasis wound grow at her forehead, she began to use different plant medicines particularly those of *Kinchib* and *Yeazo Hareg* from the traditional healers. This has rather brought more suffering and serious major health problems as the wound continued to secret a fluid and resulted with a serious pain. But after a passage of time, the wound spread out and cover the whole part of her forehead. Similar to participant 1, participant 3 used the plant medicine to treat the wound that appeared on her cheek, but it made her weak for several days and brought great pain.

As to the cases of the participants that are presented during the interview, the symptoms vary upon the individuals' experience. For instance, when participant 5 used the plant medicines for treating the wounds on his whole face, he is totally cured but the wounds remained with spots for life. Participant 6 also used the medicines for treating his nose and he hardly gets cured. The infection of the disease rather deformed his nose. Participant 7 had also the same effect of remedy like that of participant 5 despite a big scar is left on her cheek.

On the contrary, the fate of participant 8 became quite unusual. This is because of the severe damage of facial shapes. As she reported,

> I had tried all the possible medicines that were plausibly helpful to cure my illness. But I have still got nothing out of it. Now I feel that I myself aggravated the illness. Due to the extreme fear and anxiety, I applied medicines all the time to

> avoid the ill effect of the disease. But as you see, my shape is totally deformed and no one identifies me who I am.

Thus the participants confessed that their own extreme fear and anxiety had exacerbated the illness into its worst form. If they hadn't felt such an extreme fear or anxiety about the illness, all the participants would have enabled to treat the disease better than the present situation. Since they rush to get immediate cure before their body damaged, they had applied over doze medicines and use different plant leaves on their body.

There are also the possibilities of using other types of medicines which are believed to be good in giving immediate relief for the wound and that are believed to avoid the illness from further transmission in the patient's body.

A case in point is participant 2 who stated what she used for her wounded nose.

> I saw the bad effects of the plant medicines of *kinchib* and *Yeazo hareg* on the patients face as enlarging the wound than ever before. Thus I applied excreta or faeces on the wound despite it didn't bring any likely change. In time of great illness while I scratched the wound until it became bloody, I usually spread the flour of coffee for treatment purpose.

The shift of applying another medication or treatment approach is the result of fear. She used to put excreta and coffee powder to get a relief from the pain and most importantly to minimize the growing nature of the wound.

Participant 4 used other medicinal plants such as *Antarfa*, and *Beles* but it was impossible to protect the injury of his upper lip. Different from others, participant 9 put heated nail on the wound to destroy the illness from its root. Participant 10 also visited many traditional healers in the countryside and Addis Ababa. However the report states none of the participants efforts have brought the desired cure without leaving a disfiguring scar and a stride of bruises on their face. Thus for most of the cutaneous leishmaniasis patients, the fear and high level of anxiety disorder resulted in ill effects such as body damage, severe pain, large wound and lifelong scar.

Poor self disclosure: The stories of participants revealed that many of them have the failure to discuss about their illness and infection of cutaneous leishmaniasis to the community members, neighbours, and friends. It is rather common to hide the infection as well as the scar using handkerchief, scarf and white clothes. Key informant B and D added that patients show great reluctance to meet people and vanish from their common places during their illness. Others also choose to spend their time at home compound until the wound will show progressive remedy. Participant 2 reported:

> Due to the infection of cutaneous leishmaniasis, I put on scarf to cover my nose. I also never disclosed my problem to any one from the community except trying to treat the illness by myself and family members. I felt that this is the result of my own stress, depression and dissatisfaction.

Participant 4 had the illness from cutaneous leishmaniasis five years before. He made the treatment secretly for long years, but the wound changed very drastically from time to time. As a result, his illness became so painful and complex that the upper part of his lip is cut. When asked about his illness and recent feelings he responded:

> I always regret for what I did during the time of my illness. For one thing I wouldn't suffer this much if I disclosed my illness. Secondly, I would rather normalize the situation than cover the removed part of my upper lip through handkerchief. As a result of this, I have a great problem of stress, depression and dissatisfaction in my daily activities.

For participant 6, the degree of disclosure is not as simple as people may think. This is because he believed that the problems couldn't be stopped easily. Therefore he totally avoided the disclosure for the sake of protecting himself and his family from gossip, verbal abuse and underestimation. He said:

> During my illness, I used to cover the wound by a scarf. Since my sister had the illness before me, I was very eager to conceal the situation from people's recognition and view. Otherwise the illness of my sister and my case would be associated as a hereditary problem which may also be a source of disregard and shame to all of my family.

Key informant A, C, and E share the view of the participant. According to these key informants the community would rather impart what has happening on him to other people than make a support for the illness. So avoiding the disclosure is good to the patients. It is also clear that the remaining cases of participants have the same kind of problem with the aforementioned one. However, the degree of the disclosure is different between them. This is entirely due to the place of the wound it grew up on the body. For instance, the cutaneous leishmaniasis infections which appear at the nose and mouse part mostly cut and deform this smooth body parts in an ugly manner. On the contrary, the infection that grows at the forehead, cheek and eye part remained scarred. Therefore patients infected at their noses and mouths are afraid to expose themselves. Contrary to this, if the infection appeared different from nose and mouth, patients are relatively able to disclose themselves better than participant 2, 4, and 6 who have an infection and damage of nose and lip part. But this doesn't mean that patients had sufficiently disclosed themselves since the level of stress, depression and dissatisfaction still persist on them.

Generally, poor disclosure of the disease by the patients has reduced the possibility to get the proper treatment and denied them from cure time. This exacerbated the situation of the illness. As indicated above, the situation of some of the participants is more dangerous and devastating than others since the illness has stayed for long period on these patients body.

Emotional sensitivity and disturbance: In addition to the loss of part of the body and an everlasting scar at one's face, most of the research participants suffered the additional ordeal of emotional trauma. Participant 3 told that she had hostility to her friends while they came to visit during her illness of cutaneous leishmaniasis. One day her friend came to see her and sat at a distance. But the patient was not able to control her anger seeing the unusual act of the visitor. This strange behaviour made the patient to insult her friend which later times set bitter confrontation between them.

Participant 4 face the same thing. Being a patient of cutaneous leishmaniasis, he has encountered major behavioural problem. This has also emanated from the reaction and view of the community. He stated the situation as:

> One day my young son came home crying. He told me that his friend was insulting him saying *'yemelata lij.'* (you are a son of a man whose body is disfigured by a scar due to cutaneous leishmaniasis illness) I was shocked about the moment and felt bad for I have become a source of disregard and shame even for my family. From that day on wards, I became very aggressive and hostile. When people decline my view and proposal at different moments, I started to construe it as for I am a patient of cutaneous leishmaniasis. All these things brought on me odd emotional behaviours, such as high anger, irritability, hostility and aggression.

Different from the prior cases, participant 2 used to cry all day long and had greatest irritation on her mother due to the illness. Consequently, there were times where she didn't have good appetite, and sleep. In terms of friendly relationships and outgoing activities she was as normal as the other days, and hadn't felt anything bad by the illness. But her continuous disturbance and compliance began when the wound develops new nodes of wound round the injured body. This time is so acute that the patient greatly itched to the wound until it was bleeding.

The story told by six different participants in the case study further attested that their major source of emotional disturbance is related to great injury of facial bodies. For instance, all share commonly the problems of anxiety, sadness, angriness, wariness, and self hatred. The view of key informant B, D, and E further strengthened the idea by stating that patients have been seen with the problem of high depression, and a sign of unpredictable behaviour.

The other claim of emotional disturbance is presented by participant 10. He supported his serious challenge by the fact that his step mother's frequent outbursts against him were a source of disorder. He explained the situation as follows:

> My step mother cruelly disgraces me due to my illness of cutaneous leishmaniasis. She used to say me that the scars and bruises of your face is the result of your sin. You will be beaten more in the remaining time of your life.

His temporal disagreement to his step mother was a source of insult. But he felt that he developed an aggressive and hostile behaviour because of the continuous dispute with his step mother. Other story similar to this one demonstrates that, it is frequently observed that patients are insulted by their friends and neighbours as *'lemtsam',* (a person with a disfiguring scar due to cutaneous leishmaniasis illness) and *'korata'* (a person whose part of the body is cut due to cutaneous leishmaniasis illness) if there is quarrel or disagreement amongst people (Key Informant A and D).

Disgrace and the feeling of gloomy future: According to the information contained from the interview, most of the participants are confronted with the problem of low self esteem, hopelessness, frustration, guilt and confusion. This has been examined after the ill effect of cutaneous leishmaniasis is seen on the patients' general physical appearance, and social integration. In relation to this, participant 1 told that her situation was so worst and members in the community make her a subject of discussion for long. This has been disgracing herself and the family members. She stated the situation as:

> I am an exemplary patient in the community as the infection of cutaneous leishmaniasis is considered. As a result of this, many people in the community sympathise me seeing the great infection, severe pain and secretion of fluids from the wound. Certainly, I will not have any bright future as the illness may impede my plan, and wish.

During the interview it is apparent that participant 2 and 10 share the same kind of view. The former explained that for a young girl like her the damage of nose would mean a lot. She reiterates that she lost her beautiful appearance due to the illness. The later also stated that he felt sad for his disfiguring scar at his younger age and regrets about it for his entire life. Hence both of them stated that they feel shame whenever they look at themselves.

In the remaining cases major painful memories of disgrace, despair, and confusion are surfaced. Participant 3 stated that her illness will have the possibility to occur in every member of the family. She substantiated her claim in that she is the second person from the family who are infected by the disease. Therefore she always makes this as curse of the family and this will always down her hope.

Contrary to the above views, participant 4, 6, 8, and 9 relate their cases with despair and shamefulness due to their physical scar. Still others give different connotations for their disgrace. A case in point is the statement made by participant 5. Participant 5 was considered as a source of disgrace by his family. He stated the following to strengthen his point of view.

> My family had a shame on me. That's why they hid me for long years from the view of the community. I was also forced to drop my schooling for about 10 years until my wound get a complete remedy. Presently, I have a meagre hope of achieving what I have been aspiring for.

Particularly, participant 8 explained her situation with a grief. As she stated, the illness has laid a severe impact on her life for the last past five years. Besides, she has never seen any progressive change the same to other patients whom she knew. She said "I have applied all the possible mechanisms to get relief from my sickness but none of such mechanisms brought me a change. I'm a hopeless woman who is created for misery".

In a nutshell, the psychological impact of cutaneous leishmaniasis on patients' life has been profound and show varying degrees of results. As indicated in detail under the categorical thematic areas, the facet of problems patients have been encountering in their life time are multitude and complex.

The Social Impact of Cutaneous Leishmaniasis: The study under the social arena sought to examine generally the entire outlook of the society for the problem of cutaneous leishmaniasis disease. In doing so a particular emphasis is paid on the state of the community's view, level of awareness, understanding, culture as well as social support and togetherness. All these investigations have been backed by the authentic life time experience of participants and the critical observation of the current study. Therefore the following sub-themes are generated from the social impact are presented in different schemes.

Stigma and discrimination: An overwhelming number of participants both from the patients of cutaneous leishmaniasis and key informants described that the state of stigma and discrimination has varying features. For instance the ideas presented by participant 1, 5, 9, and 10 stress that when the effect of the disease became worst at their body, it cuts and disfigures the place where the wound grows. This time it is common to see stigma and discrimination within the community. These are manifested when friends start breaking the usual intimacy and failed to spend time together, as well as way out for other relationships. Community members also down the skills and potentials of the patient and thereby give priority for others who are not infected by the disease. In support of this the claim from key informant C and D ascertained that the community make the stigma and discrimination by looking at the injured body of the patients. Most particularly the labelling and dishonour are evident if the injured part is exposed at facial part.

Contrary to this, the cases of participants 2, 3, 7, and 8 show different manifestation of stigma and discrimination. The time where the wound is at an extreme stage of pain, there is no one who would reach around the patient. This is due to the secretion of fluid and pus as well as the stinking nature of the wound. According to key informant A, many people retreat patients seeing the ugly nature of the wound at their face during the time of acute illness.

The view forwarded from key informant B, and E is different in that the stigma and discrimination associated with the illness of cutaneous leishmaniasis is the result of the patients themselves. In connection with this participant 4 added his experience as follows.

"The community give me full respect but I stigmatize and discriminate myself due to the ill effect of the disease." However, different from others participant 6 believes that the stigma and discrimination is minimal and expressed verbally. Mostly it is said, "Where did you get this evil? It is so catastrophe, Let God sends you his mercy".

Limited social participation: The other social impact which is exhibited from the finding is restricted social participation and poor social relationships among the patients and the healthy people. Most particularly, after the severe effect of cutaneous leishmaniasis is recognized, there is a major threat of infection and low societal integration which is being apparent among the members of the community in response to the disease.

As indicated by participant 1, 2, and 3 patients have poor attachment and relationship with the community member. The major reason for this is the society's negative attitude and poor understanding about their infection. Key informant A, B, and C has also justified that the community members neither spend times with patients nor appreciate working together with them. This is because of their bad feeling and understanding that the disease would be transmitted on them. Others may also consider patients as incapable of performing things and their illness of cutaneous leishmaniasis would be aggravated if they engaged to perform in different types of work the same to the non infected people.

On the other hand participant 4 and 7 restricted their social relationship deliberately. For one thing they didn't get any relief and recess to participate in every social activity in time of illness. Secondly, they have little contribution in time of team work and conferences. Case in points, the former has a problem of stuttering to give his view in the community session. The later also fails to perform basic home chores due to the physical injuries brought to her by the disease. Contrary to the above mentioned participants, the fundamental reason of social detachment for participant 5 and 6 was the long year's treatment of the disease.

From the cases of participant 8, 9, and 10, it is understood that the view of the community have been a major impediment for the patients to have active participation and relationship. They explained the situation of the community as unattractive and disregarding. Participant 8 said:

> I quit my frequent contact and active participation in the social festive after I encountered a personal problem. People used to leave the place where I was sitting. I haven't seen anyone who dares to eat with me. I also felt that people gossiped me during my presence. After a time these experiences became a sufficient reason for me to abandon my participation in the social gatherings until I get cured.

In relation to this, key informant B and E justified that the community members are usually disrespecting patients and dislike to make keen relationships in time of social gatherings because of the fear and discomfort of the illness.

Rejection of social ties: Cultural view, improper understanding, and traditional speculations about the disease of cutaneous leishmaniasis have become a major reason for the avoidance of marriage ties in the life of the society. This phenomenon has been exemplified in a different manner as understood from the case studies presentation. Besides, it became an additional burden for the normal life of the patients from being free and able to treat the illness.

The prime scene of rejection which is investigated in terms of social ties is marriage alliance. Most participants witnessed that the negative health effect of cutaneous leishmaniasis has become a major obstacle for marriage formation and discontinuity of prior love affairs. As to participant 1, 2, and 3 they are unable to form marriage ties due to the hideous scar found at their face. Three of them have got a physical injury at the forehead, nose and cheek side of their face respectively. In support of this, the ideas of key informant A, B, and C further elaborated that during the time of marriage people would look at the facial beauty of their mates. If the bad scars are not exposed at the facial part, mates have the tolerance to form the marriage ties.

Another case presented by participant 5 shows a unique experience. The plan and offer made to form marriage alliance came to total disagreement after his illness is cured. He explained the facts he encountered as follows:

> I had 3 years of relationship with the girl. That time I was totally cured from my illness. However, there is still the sign of bold scar in my whole face and some stride of bruises are scattered around. When I proposed to form the marriage ties, she rejected the idea and told me that her parents are not interested to do so. The reason for their decline was my facial injury and the fear of the society's gossip.

The reason to avoid the marriage ties emanates not only from the facial injury but also the fear of infection through heredity. Participant 6 and 9 stated that the community are very much reserved in making marriage alliance with people who are infected by the disease of cutaneous leishmaniasis.

Hence there is the practice of hiding the illness to overcome such societal outlooks. For example participant 9 has a plan to send his daughter to another area where people didn't consider the problem as hereditary. He believed that his illness will be a setback to his daughter in forming marriage ties. According to key informant E, he strongly believes that such kinds of decisions are the result of lack of courage and despair.

Even others see the problem from different perspectives. For example the ideas of participant 10 and key informant D assured that the making of marriage alliance is a lifelong process. Thus whatever physical injuries and societal discriminations are put over, the determinant factors are laid down from the couples themselves. Hence there are times either physically injured people or an injured and non-injured people make marriage alliances in the community.

In opposition to the views reflected above, there is a stance from participant 4 and 8which devalues the drawback of the disease in terms of marriage alliance. According to them, physical injuries can not be the factor for poorly practiced marriage alliance in the community. They are adamant in their idea that there would be some other reasons that must be understood which become a soul reason for the change of the society's view and that limit the couple's interest to reach marriage formation.

Low quality of life: Patients of cutaneous leishmaniasis have encountered many complex situations. One of these which makes great impact in their life time is the illness and treatment approaches that could be directly associated with their poor socioeconomic status. This is measured in terms of their work, level of awareness, access to basic health services, adequacy of rehabilitation centres as well as integrity of the societal relationships.

The cases of the participants and key informants interviews revealed that many patients of cutaneous leishmaniasis are lacking a better quality of life due to the above mentioned factors.

According to participant 1, 2, and 9 the area is devoid of any form of health and rehabilitation centres. Most importantly, patients lack awareness and negligent about the disastrous effects of cutaneous leishmaniasis. As to Key informants A and B, the disease is seen simply as '*yekola kusil*', (a wound that is frequent to the lowland area) and patients consider it as simple and easily curable. Participant 4, 7, and 8 also stated that they ignore the seriousness of the disease and start to apply some form of traditional medication only if they feel the illness is high. This is mostly true because of the lack of understanding, shortage of treatment centres and financial constraints. With this notion all key informants forwarded their idea that patients neither aware of the disease nor have health centres nor financial capacities to get proper medication.

However, the disease has great impact both in the social and economic status of the patients. As explained in the aforementioned paragraphs, the poor social effects are mostly related to the illness and the patients' general status. According to the view of participant 3 and 5 the patients are given little attention both from the government and the society due to their poor class status. Apart from this both the key informant B and D as well as participant 5 and 10 underlined that the disease is a multiple challenge for their existence. Firstly it adds great burden of work in time of one of the member of the family illness. Secondly, it disrupts them from major works of farming, and domestic chores. These have made a profound negative effect over their productivity and there by lead them to the poor quality of life.

Discussion

The study which is devoted to analyse the psychosocial impact of cutaneous leishmaniasis has undergone different steps to examine the effect of the disease on those infected people. The findings revealed that the psychological impacts are associated with fear, poor self disclosure, emotional disturbance, disgrace as well as despair. The social impacts have also shown the result of stigma and discrimination, restricted social participation, avoidance of social ties and poor quality of life.

In support of this Mckenzie and Pinger (1997) explained that "The health of a community can be affected by a great deal of factors such as the major ones that are depicted in this regard include physical, psychological, social and cultural aspect" (p.5). As a result of this the health status of every community will remain to show the existence of unique differences.

According to the major findings of the study, extreme fear and anxiety is considered as major reasons that spoil the health condition of a patient. As indicated in the findings, patients have the rush to get prompt cure for their physical damage that happened due to the illness of cutaneous leishmaniasis. However, major side effects are governed when they apply traditional plant medicines on the wounded part of their body.

According to (Ross & Deverell, 2010, p.56) generalized feeling of panic and anxiety mostly occurred while people are confronted with the reality of losing something significant in their life. Under these circumstances people show different actions. For instance some become super dedicated to overcome the existing problem, while others tempted to run away for a psychological flight in the form of geographical escape. This kind of understanding is dangerous in that it will conceal the good lives beyond the problem.

Poor self-disclosure is the other manifestation of psychological impact. As to the finding of the participants' interview, the cutaneous leishmaniasis patients deliberately skip from making disclosure fearing the negative attitude of the society. They feel that they will be traumatized more whenever they expose their problems for others. Studies also show that the fear of individuals' disclosure is usually explained by rejection and denial mechanism. Therefore individual patients use the aforementioned mechanism as a means to defend the psyche from trauma. But the moment where they get inner strength and external support the problem come to an end (Ross & Deverell, 2010, p.56). As it is described during the interview, most of the patients are denying the status of their illness and make a seemingly effect to healthiness. This traversing approach has brought the effects of long years of injury and a chance for complexity in the nature of the illness.

The emotional disturbance and sensitivity which includes anger, irritability, aggression and hostility come out from the psychological disorder of patients. During illness, the worries as well as the pain can bring a change in behaviour. Some influential theoretical aspects ascertained that aggressive behaviour can be the result of social construction which can be acquired through individual experience. "Not only this can be the manifestation of aggression but also there are times where aggression can be seen as a reaction to frustration" (Mummendey, 1997, p. 266). The same is true for patients of cutaneous leishmaniasis that they developed the behaviour of aggression after they get infected by the disease. Anger or rage is also an integral part of mourning. For example some participants of the research have been shown being anger against the people as the situation and environment lead them to the grievance.

The above mentioned points are all the facts that are arisen from the major psychological impacts of cutaneous leishmaniasis. Hence it is clear that the collective effect of these problems has made patients to develop despair and depressing future. This is aggravated more by long time illness, negative societal attitudes, and the failure to understand the patients' situation as well as lack of proper understanding about the nature and cause of the disease.

From the social aspect of cutaneous leishmaniasis disease, four different sub-themes that patients have been encountering as an impact are emerged. The foremost one is stigma and discrimination. According to Ross and Deverell stigma is an identification and recognition of bad happenings. From the types of stigma, felt stigma and enacted stigma are very devastative of the patients' life. As the former is associated with the fear of the patients that discrimination may occur, the later is understood as the real experience of prejudice against the person who are injured or affected (2010, p.106).

The stigma and discrimination related to the disease of cutaneous leishmaniasis are apparent in two forms. One is when the illness reaches the stage of an extreme pain and, two at the time where the wound is totally cured. This time the community's attitude towards the patients can be described as complete negligence and avoidance of relationship.

However compared to the time of illness, the degree of stigma and discrimination after patients remedy is said to be minimal. Most importantly when the facial beauty is destroyed and scars around the injured parts of the body are spread, patients are neglected in time of marriage and are easily identified by disfiguring lesion of the disease and are given nicked names for identification in a secret manner.

In time of various social gatherings, ceremonial day of events, and the celebration of festivals, patients of cutaneous leishamaniasis are restricted from making active participation as freely as other non-patient people. The main reason for this is basically the negative attitude of the society in relation to the infection of the disease. The community believes that the participation of patients in any kind of social activities will contribute nothing worth due to their illness. As a result, there are a growing number of detachments among members of the society in meeting each other at the social gatherings of Idir, Iqub, wedding and funeral days. The patients' self-hiding and retreat is also further intensified by the views of the community members. Hence, the status of neighbourhood attachment, togetherness, coffee ceremony and other cultural assets are deteriorating. Studies also asserted that the loss of social relationship and participation is a major source of stress, depression and other forms of disorder. Bodily health, recovery from operations, and length of life has all been affected by the quality of supportive relationships. However, those people who are accustomed to the weakest social attachments are very likely to face harmful impacts in their life (Argyle, 1997, p. 266)

The fear to make marriage alliance and the discontinuity of love affairs with people infected by the cutaneous leishamaniasis disease is the other manifestation of social impact. Apart from the people who are involved directly to the life of marriage and love affairs, members of the community as well as family and close relatives have a say on the process of mate selection, interaction and feeling. Mostly the ties among couples with a problem of cutaneous leishmaniasis are condemned through direct attack, negligence, gossip, fear of infection, and a threat of physical damage. These influences have the power of convincing the individuals and pressurizing them to reject the marriage alliance. However, the findings indicate that there are some moments whereby some individuals decline this kind of belief and place their interest forward. This is mostly true when the following conditions are met. For instance, there are patients whose lesion of the wound is not exposed to any parts of the facial body very boldly. This time a considerable degree of agreement among couples as well as a positively inclined attitude towards the marriage ties are structured in the view of the society. On the contrary others who have faced serious physical damages feel that their marriage life is remaining at stake. Therefore they seem to develop a feeling of relationship with a person who passed through the same kind of experience. It is also common to see that in friendship and love people find a mate who is similar to themselves in many aspects. This will help to ease their relationships in terms of having similar interests, beliefs, values and social backgrounds (Argley, 1997, p.229). Thus the ill effect of this societal outlook may deter and tear apart familial relationships thereby bring a crisis of societal integration.

Patients of cutaneous leishmaniasis have faced with social impacts. This is witnessed when their standard of living and quality of life is measured. As mentioned earlier in the findings, patients are enjoying little support from the community as a result of disregarding and negative outlook mainly due to the poor awareness of the disease. In addition to this, the lack of available health and rehabilitation centres, as well as financial constraints has been a major setback from meeting their basic needs. Consequently, most patients are forced to lead a low quality of life.

At times when the patients laid on the physical injuries, they are obliged to disrupt their major work and spend their time in search of treatments thereby expending more money. Thus any segments of the community having the lowest socioeconomic status have the poorest health and face great difficulties in gaining access and provision to basic health care services (Mckenzie & Pinger, 1997, p.9). Thus it is understood that socio-economic condition has a direct link to health condition.

Conclusion and Implication

Conclusion

The study is aimed to explore and attain an in-depth understanding about the psycho-social impact of cutaneous leishmaniasis disease patients. Therefore this chapter provides the conclusion about the findings of the study. In view of this, a concise overview of the result of the existing body of literature; the findings stemming from the analysis of case studies and the conclusion drawn from the findings are noted. There after implications for social work intervention and strategies are discussed.

Primarily the study has found out that cutaneous leishmaniasis is known in the study area by a different name as *Shahign.* As it is understood and observed from the research participants, the disease has made its highest detrimental health effects by damaging most frequently the facial parts of the body, and to a lesser extent the arms and legs of patients. This in turn places an enormous burden of psychosocial problems on those infected people.

The study has revealed that the problem primarily affects the psychological state of patients in various ways and later develops to the undesired societal misconceptions. The problem also goes far beyond the patients' illness and has put profound impacts on those people who have familial relationship, and closest intimacy to the patients.

Regarding the psychological perspectives, patients have developed negative attitudes towards themselves and feel despair for their future life. This is apparent from the onset of their infection by the disease to the aftermath of the treatment. The situation is clearly demonstrated in the study during the interview and observation time. Most patients feel very guilty of their illness and devalue themselves due to the severe effect of the illness.

The same to the psychological effect, they are also suffering to various social problems. For instance the relationships of patients with neighbours are deteriorating from time to time. It is also exhibited in the study that patients were spending most of their time at their home in fear of exposing the wound and the scar from the communities view.

In support of the major findings, the other theoretical lessons which were given due emphasis in the study was the review of the literature. This part states in detail the concepts of psychosocial health and the disease of cutaneous leishmaniasis. According to the literatures, cutaneous leishmaniasis is one of the prominent neglected tropical diseases that are affecting many poor people around the world. However, it has been rarely given the focus of prevention both from the government and non-governmental organizations. As a result, its negative effect is heightened both from the state of physical health and psychosocial condition. Most particularly, it is underlined in the review of the literature that poor psychosocial circumstances can power the situation of health into greatest jeopardy. For instance it may deter timely treatment and lead the diseases nature into the complex unit. Besides, it becomes a mainstay of many psychosocial problems such as depression, anxiety, suicidal ideation, decreased self-esteem, lower quality of life, stigma, discrimination, and exclusion from social groups. Thus the theories are underpinning first, the major influence of psychosocial problems on the general condition of health and second, the importance of psychosocial wellness in the fight against the dissemination of the neglected tropical diseases of cutaneous leishmaniasis.

The findings and analysis of the study where the participant and key informant interviews are involved is the other integral part of the study. Therefore issues that stood out for worth mentioning are identified and summarized into two major categories. One of which is the psychological impact of cutaneous leishmaniasis. This is defined from the perspectives of the patients' perception about the physical injuries and the low level of understanding for the nature of the disease and its infection. Thus the study explored the areas of vulnerability whereby patients of cutaneous leishmaniasis are facing into four major sub sections. These include extreme fear and anxiety, poor self-disclosure, emotional sensitivity and disturbance as well as disgrace and the feeling of gloomy future. The second is the social impact of cutaneous leishmaniasis which is understood from the context of the social recognition. Hence, major problems that are related to the society's view are put under four major sub-themes as stigma and discrimination, limited social participation, rejection of social ties, and low quality of life.

Finally the general conclusion of the study is drawn by tracing collectively the major findings, the literature reviews, and the sub theme presentation of the case study analysis. In doing so, the study revisited the results in the light of the study objectives and research questions. On the basis of these findings it is possible to say that patients of cutaneous leishmaniasis have encountered major psychological and social problems in the course of their illness. This has been seen in the conclusion sections of the major findings of the study, the review of literature output, and the case story analysis.

The different facets of psychological and social disorders such as fear, emotion, self hatred, frustration, anger, depression, stress, stigma, discrimination, poor social ties, labelling, limited participation, ignorance, underestimation are all the major result of the study. This has also proved that each of the psychological and social impacts influence one another. A case in point, the effect of the psychological problem has made great losses on the patients' social life in terms of their view towards life and social cohesiveness. The same is true on the social impact of the disease. The view of the society's negative attitude towards the disease of cutaneous leishmaniasis affects adversely the situations of the patients' psychology. For example patients show great reluctance for treatment, and develop aggressive behaviours due to the illness.

Social Work Implication

As indicated in the findings, the experiences of cutaneous leishmaniasis patients show great psycho-social problems. This is mainly due to the physical damages caused by the illness and the attitudes imposed over patients by the society as a result of the little understanding about the nature of the disease. Furthermore the situation is aggravated by the fact that the area is devoid from the access of basic health services and rehabilitation centres. As a result great endeavours and immediate intervention mechanism are required to overcome the problems that patients of cutaneous leishmaniasis are encountering in their daily life.

With this regard, a pivotal role can be played by the government and non-government organizations. Most particularly, the problem seeks major intervention focus from the social work perspective. Case in points, in the field of research it is possible to conduct many more epidemiological studies. Similarly different initiatives and contributions can also be made in policy making as well as in the practice areas in a macro and micro level. Thus in light of this the following are proposed activities that have direct implication to social work.

Research

The disease of cutaneous leishmaniasis has been given lesser attention by those major stakeholders including media, government and organizations that are working in the health sector. A critical reason for this has been the lack of funding to advance research and development in neglected disease control (Pokhrel, Reidpath, & Allotey, 2010, p.1). Consequently, the situation coupled with poverty and inadequate treatment it is increasing its psychosocial impact and deprivation against the community. As indicated in the findings, there is stigma and discrimination, poor societal relationships, fear for marriage ties, the uses of traditional healing drugs and plant medicines for treatment purpose and others.

All the above problems are still practiced and prevalent in the area. Therefore, this study can generally be a good exemplary work to do the following activities; (1), it helps to consider those mentioned points to be taken into further social science researches. For instance a study can be conducted on the issue of the health belief of the society; (2), it gives a way to carry out similar researches in different kind of pandemic diseases that have an adverse health effect on the community the same to cutaneous leishmaniasis ; and (3), it develops the acquisition of health social work by documenting a systematic research output on the effect of cutaneous leishmaniasis.

Policy

This research output shows the existing situations of health coverage in Ethiopia. Most particularly in the areas where the provision of basic health services and clinical centres are scarcely found, the situation can have the worst form. Thus, from this research output it is possible to present the direction for policy makers and program managers to analyse the seemingly effect of neglected diseases in Ethiopia, more particularly in the area where the study is conducted and in other places that have alike features to it.

Besides, the social workers can have great contribution in the process of health advocacy by making different programmes. For instance, it is possible to make event organizations that can promote public- private partnership to control the epidemic of cutaneous leishmaniasis and thereby raise awareness. It is also possible to enforce the government bodies or significant others in the health sector to add cutaneous leishmaniasis to the list of notifiable diseases in the country.

Still it is possible to strength and facilitates the systems for the sake of reconstructing national control programs to eradicate the dissemination of the disease.

Finally, as indicated in the Health Policy of the Transitional Government of Ethiopia, there is a clear statement that supports the health advocacy process. The health legislation section under general strategies guideline of 14.2 has stated, "Developing new rules and legislation to help in the implementation of the current policy and addressing new health issues" (September, 1993, p.10). Though such guideline is stated, the implementation of this kind of policies has not gained full attention. Therefore social workers who are practicing in the health setting are expected to design different programmes and strategies in line with the policies and follow the proper implementation.

Practice

The disease of cutaneous leishmaniasis is making major disabling conditions in the life of the society. Therefore it is imperative to begin addressing the problem through a professionally guided intervention mechanism. With this regard health social workers have the leading role to provide various services across the continuum in the form of health education, crisis intervention, supportive counseling and case management (National Association of Social Workers (2005, p.5). Apart from this, the study has implied the application of different health belief models that are so vital in the practice areas. One of this is the bio-psychosocial and spiritual model.

The bio-psychosocial and spiritual model is one of the strength based perspectives in social work practice. This model states the importance of recognizing the physical state of human beings in (bio), the emotional or psychological aspects in (psycho), the sociocultural, socio political and socioeconomic conditions in (social), and finding the meaning of lives in (spiritual). This model can rebuild the skills and strengths of clients to overcome their own problem (National Association of Social Workers 2005, p.5).

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Annex 1

Consent Form for Cutaneous Leishamaniasis Patients

Good morning/Good afternoon dear participants.

My name is Getnet Semeneh. I am a post graduate student of School of Social Work in Addis Ababa University. Currently, I am studying the psycho-social impact of cutaneous leishmaniasis at *Mehal-Wonz kebele* in *Ankober Woreda* for the partial fulfillment of the requirement for the Degree of Master of Social Work. For this purpose, I need to gather information from the *Kebele* inhabitants who are infected by the disease. I therefore, kindly request your willingness to respond for some of the questions I have prepared on the psycho-social impact of cutaneous leishmaniasis.

The participation with this research is purely voluntary and you might not have any immediate benefit. However your response to each question is very essential for the study purpose. If you are willing, I will contact you at a convenient place and conduct the interview. The session of the interview will take a maximum of 50 minutes. If it is appropriate, I will use the tape to record the conversation and will be deleted up on the completion of the study. In doing so, any of your personal profile and name will not be indicated rather it will remain confidential.

Thank you for your kind cooperation!

If you are agreed, put your signatures,

Participant	Researcher
Signature ____________________	Signature____________________
Date________________________	Date ________________________

Annex 2

Consent Form for Community Members

Good morning/Good afternoon dear participants.

My name is Getnet Semeneh. I am a post graduate student of School of Social Work in Addis Ababa University. Currently, I am studying the psycho-social impact of cutaneous leishmaniasis at *Mehal-Wonz Kebele* in *Ankober Woreda* for the partial fulfillment of the requirement for the Degree of Master of Social Work. For this purpose, I need to gather information from the selected *Kebele* inhabitants who know a lot about the problem. I therefore, kindly request your willingness to respond for some of the questions about the psycho-social impact of cutaneous leishmaniasis.

The participation with this research is purely voluntary and you might not have any immediate benefit. However your response to each question is very essential for the study purpose. If you are willing, I will contact you at a convenient place and conduct the interview. The session of the interview will take only a maximum of 25 minutes. In doing so, any of your personal profile and name will not be indicated rather it will remain confidential.

Thank you for your kind cooperation!

If you are agreed, put your signatures,

Participant	Researcher
Signature ____________________	Signature______________________
Date______________________	Date _________________________

Annex 3

The Psychosocial Impact of Cutaneous Leishmaniasis

Interview Guide for Cutaneous Leishmaniasis Patients

1. Personal Information
    a. Age
    b. Sex
    c. Marital Status
    d. What is the level of your education?
    e. How long have you been in the area?
    f. Which part of your body is infected?
2. Psychological Problems of Cutaneous Leishmaniasis
    a. What do you feel about your infection of cutaneous leishmaniasis with respect to your health condition? How do you see the ill effects of the disease in terms of making relationship with the society, family, and relatives?
    b. How severe and chronic is the illness of cutaneous leishmaniasis in your futurity, plan, and wish is concerned? What measures have you taken to overcome the problem?
    c. How much the disease is interfering with your daily functioning in performing normal activities, making good relationships, and supporting the family members? Is it specific to certain situations or does it occur across situations?
    d. Have you ever told about your illness of cutaneous leishmaniasis to your friends, or people living in your locality? If yes, what is their attitude? If no, why didn't you share your problem?

  e. What negative events have occurred recently at home as a result of your infection by cutaneous leishmaniasis? If yes what is that?
  f. What ongoing stressors are present in your life due to the infection of cutaneous leishmaniasis?
  g. How do you explain your general behaviour in terms of self efficacy in overcoming the problem of cutaneous leishmaniasis?

3. Social Problems of Cutaneous Leishmaniasis
   a. How does the culture you grown up or the people living around you influence to react for the illness of cutaneous leishmaniasis? What basic problems you have encountered?
   b. What does it seem the cultural as well as scientific beliefs of the society in making impacts against the patients of cutaneous leishmaniasis?
   c. How do you explain your experience in relation to the views of the society since you have the physical complications such as scarring and deforming due to the illness of cutaneous leishmaniasis? What kinds of issues are more irritating? Can you tell me some of the problems you have faced with?
   d. What would you think will be the reaction of the society if enough awareness raising programme about the disease of cutaneous leishamniasis is made? Does that have some worth contribution? If yes how?
   e. What major problems are frequent among people infected by cutaneous leishmaniasis? In relation to this what are the most common negative manifestations of the society for people infected by cutaneous leishmaniasis? Which one of these aggravates the situation of patients more intensely?

f. How do you evaluate the interaction of the society with victim people of cutaneous leishmaniasis in time of cultural festive such as wedding, iddir, iqub, mahiber, and lamentation? Where do you think the problem emanates more? Is it from the society or the patients themselves?

g. What looks like your recognition in the working place, in the school, in the family, in the neighbourhood as you are infected by cutaneous leishmaniasis?

h. How often the government as well as the non government organization helped you to overcome this problem? How do you collaborate together with the society to overcome this problem?

Annex 4

The Psychosocial Impact of Cutaneous Leishamaniasis

Interview Guide for Community Members

1. Personal Information
    a. Age
    b. Sex
    c. Marital Status
    d. What is the level of your education?
    e. How long have you been in the area?
2. a. What do you know about the infectious disease of cutaneous leishmaniasis?
    b. Can you describe the most common behavioural problem of cutaneous leishmaniasis patients? What do you think is the reason for this?
    c. What does it look the society's approach to the victim's of cutaneous leishmaniasis ? Do they make some support or ignorant of the patient? Why?
    d. How does the society understand the scarring resulted from cutaneous leishamaniasis?
3. a. Is that common to see a home to home visit to take care of people infected by cutaneous leishmaniasis? If no, why?
    b. How many people in the society are aware enough to the problem of the disease?
    c. Are there any chances that patient's of the disease viewed as unfavourably by the society? If yes, Why? What kind of problem are mostly facing?
    d. Do you think the society make difficulty in making relationships? If yes, why?

Annex 5

Informed Consent Form for Cutaneous Leishmaniasis Patients (Amharic Version)

የስምምነት ቅፅ ለኩታኒየስ ሊሽማኒያሲስ ህመምተኞች

ወድ የጥናቱ ተሳታፊ እንደምን አደሩ/እንደምን ዋሉ?

ጌትነት ስሜህ እባላለሁ፡፡ በአዲስ አበባ ዩኒቨርስቲ የሶሻል ወርክ ትምህርት ክፍል የድህረ ምሪቃ ፕሮግራም ተማሪ ስሆን ለሁለተኛ ዲግሪ መሚቂያ የሚሆን የማሟያ ጥናት በማድረግ ላይ እገኛለሁ፡፡ ጥናቱ በአንኮበር ወረዳ የመሀል ወንዝ ቀበሌ ላይ በሚገኙ የኩታኒየስ ሊሽማኒያሲስ ህመምተኞች ላይ የደረሰውን የስነልቦናና የማህበራዊ ተፅዕኖ ልምድ ለማንዘብ ትኩረት ያደረገ ነው፡፡ በመሆኑም ለጥናቱ ግብአት አላማ ሲባል በዚህ ቀበሌ ነዋሪ ከሆኑ የበሽታው ተጠቂዎች ጋር መረጃ ማሰብሰብ ስለምፈልግ ላዘጋጀኋቸው ጥያቄዎች ተገቢ ምላሽ በመስጠት እንዲተባበሩኝ ፍቃደኝነትዎን በአክብሮት እጠይቃለሁ፡፡

በዚህ ጥናት ላይ የሚኖረው ተሳትፎ በፍቃደኝነት ላይ የተመሰረተ ሲሆን ምንም አይነት የገንዘብ ክፍያ አይኖረውም፡፡ ሆኖም ግን የእርስዎ ተሳትፎ በጥናቱ ላይ አብይ አስተዋፅኦ ይኖረዋል፡፡ ስለዚህ በጥናቱ ለመሳተፍ ፈቃደኛ ከሆኑ አመቺ ጊዜና ቦታ በመምረጥ ከ50 ደቂቃ በማይበልጥ ሰአት የድምፅ መቅጃ መሳሪያ በመጠቀም ቃለ ምልልሱን እናደርጋለን፡፡

በጥናቱ ጊዜ የሚያካፍሉኝ ማንኛውም አይነት መረጃ ሚስጥራዊነቱ የተጠበቀ ከመሆኑ ባሻገር መመለስ ያልፈለጉትን ጥያቄ ያለመመለስ፣ ጥያቄና ማብራሪያ የማድረግ፣ ከጥናቱም እራስዎን የማግለል መብት ያለዎት መሆኑን እየገለፅኩ በተጠቀሱት ነጥቦች ዙሪያ የሚስማሙ ከሆነ ከዚህ በታች ስምና ፊርማዎን በማኖር ስምምነትዎን እንዲገልፁልኝ እጠይቃለሁ፡፡

የጥናቱ ተሳታፊ	ጥናቱን ያካሄደው
ፊርማ________________	ፊርማ________________
ቀን________________	ቀን________________

Annex 6

Informed Consent Form for the Community Members (Amharic Version)

የስምምነት ቅፅ ለአካባቢው ነዋሪዎች

ውድ የጥናቱ ተሳታፊ እንደምን አደሩ/እንደምን ዋሉ?

ጌትነት ስሜነህ እባላለሁ፡፡ በአዲስ አበባ ዩኒቨርስቲ የሶሻል ወርክ ትምህርት ክፍል የድህረ ምረቃ ፕሮግራም ተማሪ ስሆን ለሁለተኛ ዲግሪ መሚቂያ የሚሆን የማሟያ ጥናት በማድረግ ላይ እገኛለሁ፡፡ ጥናቱ በአንኮበር ወረዳ የማህል ወንዝ ቀበሌ ላይ በሚገኙ የኩታኒየስ ሊሽማኒያሲስ ህሙማኖች ላይ የደረሰውን የስነልቦናና የማህበራዊ ተፅዕኖ ልምድ ለማንዘብ ትኩረት ያደረገ ነው፡፡ በመሆኑም ለጥናቱ ግብአት ሲባል በዚህ ቀበሌ ነዋሪ ከሆኑና ስለበሽታው በቂ ግንዛቤ ካላቸው ሰዎች መረጃ ማሰባሰብ ስለምፈልግ ላዘጋጀኋቸው ጥያቄዎች ተገቢ ምላሽ በመስጠት እንዲተባበሩኝ ፍቃደኝነትዎን በአክብሮት እጠይቃለሁ፡

በዚህ ጥናት ላይ የሚኖረው ተሳትፎ በፍቃደኝነት ላይ የተመሰረተ ሲሆን ምንም አይነት የገንዘብ ክፍያ አይኖረውም፡፡ ሆኖም ግን የእርሰዎ ተሳትፎ በጥናቱ ላይ አብይ አስተዋፅኦ ይኖረዋል፡፡ ስለዚህ በጥናቱ ለመሳተፍ ፈቃደኛ ከሆኑ አመቺ ግዜና ቦታ በመምረጥ ከ25 ደቂቃ በማይበልጥ ሰአት የድምፅ መቅጃ መሳሪያ በመጠቀም ቃለ ምልልሱን እናደርጋለን፡፡

በጥናቱ ጊዜ የሚያካፍሉኝ ማንኛውም አይነት መረጃ ሚስጥራዊነቱ የተጠበቀ ከመሆኑ ባሻገር መመለስ ያልፈለጉትን ጥያቄ ያለመመለስ፣ ጥያቄና ማብራሪያ የማድረግ፣ ከጥናቱም እራስዎን የማግለል መብት ያለዎት መሆኑን እየገለፅኩ በተጠቀሱት ነጥቦች ዙሪያ የሚስማሙ ከሆነ ከዚህ በታች ስምና ፊርማዎን በማኖር ስምምነትዎን እንዲገልፁልኝ እጠይቃለሁ፡

የጥናቱ ተሳታፊ	ጥናቱን ያካሄደው
ፊርማ____________	ፊርማ____________
ቀን____________	ቀን____________

Annex 7

An Interview Guide for Cutaneous Leishmaniasis Patients (Amharic Version)

ለኩታኒየስ ህመምተኞች የሚቀርብ

የቃለ መጠይቅ መመሪያ

1. የተጠየቂው መረጃ
   - 1.1 እድሜ
   - 1.2 ፆታ
   - 1.3 የጋብቻ ሁኔታ
   - 1.4 የትምህርት ደረጃ
   - 1.5 በአካባቢው ለምን ያህል ጊዜ ኖረዋል?
   - 1.6 ጉዳት የደረሰብዎት የአካል ክፍል የትኛው ነው?
2. ከስነልቦና ጋር የተገናኙ ጥያቄዎች
   - 2.1 የኩታኒየስ ሊሽሜኒያሲስ ህመምተኛ በመሆንዎ የደረሰብዎት ዋና የጠፍ ችግር ምንድን ነው? ከማህበረሰቡ፣ ከቤተሰብ፣ ወይም ከቤተ ዘመድ ጋር ባለዎት ግንኙነት ላይስ ያሳደረብዎ አሉታዊ ጎን ምን ይመስላል?
   - 2.2 የኩታኒየስ ሊሽሜኒያሲስ ህመም በወደፊት አላማዎ፣ ፍላጎትዎና ምኞትዎ ላይ ያሳደረው የከፋ አደጋ ምንድን ነው? ችግሩን ለመቋቋምስ የወሰዱት የመፍትሔ እርምጃ ምንድን ነው?
   - 2.3 በዚህ በሽታ በመጎዳትዎ በዕለት ተዕለት የኑሮ ሒደት ውስጥ ያጋጠምዎት ችግር ማለትም በስራ አቅም፣ በማህበራዊ ተሳትፎ፣ ቤተሰብን በመርዳትም ሆነ በማስተዳደር ምን ይመስላል? የችግሩስ አይነትና መጠን ጊዜና ወቅት ጠብቆ የሚከሰት ነው ወይስ በቀጣይነት የሚያስቸግር ነው?
   - 2.4 የኩታኒየስ ሊሽሜኒያሲስ ህመምተኛነትዎን ለቅርብ ዘመድ ወይም ለቅርብ ጓደኛዎትና ለአካባቢው ነዋሪ ሰው ነግረው ያውቃሉ? ከሆነስ የሰዎች አመለካከት ምን ይመስላል? ካልሆነስ ለምን መናገር አልፈለጉም?
   - 2.5 በርስዎ የኩታኒየስ ሊሽሜኒያሲስ ህመምተኝነት ምክንያት ከቤተሰብዎ መካከል ተፅዕኖ የደረሰበት አለ? ካለስ ምንድን ነው?
   - 2.6 የኩታኒየስ ሊሽሜኒያሲስ ህመምተኛ ከሆኑ ወዲህ በራሴ ያየኋቸው ያልተገቡ ባህሪያትና መለጫዎች የሚሏቸው ነገሮች ምንድናቸው?
   - 2.7 በህመሙ ምክንያት የመጡ ችግሮችን ለመቋቋም የወሰዱት ወስጣዊ ማሳሳት ምንድን ነው?

3. ከማህበራዊ ጉዳይ ጋር የተገናኙ ጥያቄዎች

3.1 በአካባቢው ነዋሪዎች የተለመደው ባህላዊ አመለካከት የኩታኒየስ ሊሽማኒያሲስ ህመምተኞች ላይ ያሳደረው ተፅዕኖ ምንድን ነው? ማኅረታዊ ችግሮችን ቢገልጹልኝ::

3.2 የአካባቢው ነዋሪዎች ባህላዊም ሆነ ሳይንሳዊ እምነት በኩታኒየስ ሊሽማኒያሲስ ህመምተኞች ላይ ያለው አሉታዊ ጎን ምንድን ነው?

3.3 ህመምተኞች በሆናችሁ ግለሰቦች የሰውነት ክፍል ላይ ለሚታዩ ህመምና አካላዊ ጠበሳዎች (ጉዳቶች) ምክንያት የማህበረሰቡ አመለካከት ምን ይመስላል? በአስቸጋሪነቱ ወይንም በመጥፎነቱ የሚታወቀው የትኛው አይነት ችግር ነው? የሚያስታውሱትን አጋጣሚ ቢነግሩኝ?

3.4 ለማህበረሰቡ የግንዛቤ ማስጨበጫ ትምህርት ቢሰጥ የማህበረሰቡ ምላሽ በኩታኒየስ ሊሽማኒያሲስ ህመም ዙሪያ ምን ይመስላል ብለው ያስባሉ? ስለጠቀሜታውስ ምን ይላሉ?

3.5 በአካባቢው ነዋሪ በዋናነት የሚታዩና በእናንተ የኩታኒየስ ሊሽማኒያሲስ ህመምተኞች ላይ የሚፈፀሙ ማኅረታዊ ተፅዕኖዎች ምንድን ናቸው? ከነዚህ ወስጥስ የህመምተኞችን ችግር የበለጠ የሚያባብሱ ችግሮች የትኞቹ ናቸው?

3.6 በማህበረሰብ ኑሮ ወስጥ ቁርኝትን (አብሮነትን) ከሚፈጥሩት የዕቁብ፣ የዕድር፣ የሀዘንና የሰርግ ሥነስርዓት ወስጥ የኩታኒየስ ሊሽማኒያሲስ ህመምተኞችና የአካባቢው ማህበረሰብ ግንኙነት ምን ይመስላል? የጎላ ችግር የሚታየው ከማህበረሰቡ ወይሥ ከእናንተ ከህመምተኞች ነው?

3.7 የኩታኒየስ ሊሽማኒያሲስ ህመምተኛ በመሆንዎ በስራ ቦታ፣ በትምህርት ቤት፣ እንደዚሁም ከቤተሰብና ከጎረቤት ጋር አብሮ ለማስራትና ለመኖር በሚያደርጉት ሁኔታ ወስጥ ያጋጠምዎት ችግሮች ምንድን ናቸው?

3.8 ከመንግስታዊና መንግስታዊ ካልሆኑ ድርጅቶች ሊገኝ የሚችልን ማንኛውንም አይነት ድጋፍ ለማበረታታት ከእናንተ ከበሽታው ተጠቂዎችና ከማህበረሰቡ የተደረገው እንቅስቃሴ እንዴት ይገለፃል?

Annex 8

An Interview Guide for Community Members (Amharic Version)

ለአካባቢው ነዋሪዎች የሚቀርብ

የቃለ መጠይቅ መመሪያ

1. የተጠየቂው መረጃ
    1.1 ዕድሜ
    1.2 ጾታ
    1.3 የጋብቻ ሁኔታ
    1.4 የትምህርት ደረጃ
    1.5 በአካባቢው ለምን ያህል ጊዜ ኖረዋል?
2. ስለኩታኒየስ ሊሽማኒየሲስ በሽታ ያለዎት ግንዛቤና አመለካከት ምንድን ነው?
3. በአካባቢው ነዋሪ ከሆኑ የኩታኒየስ ሊሽማኒያሲስ ህመምተኞች ላይ የሚታዩ አብይ የባህርይ ችግሮች ምንድናቸው? ዋና ዋና ምክንያቶቹስ ምን ይመስልዎታል?
4. የአካባቢው ማህበረሰብ ለኩታኒየስ ሊሽማኒያሲስ ህመምተኞች ያለው አመለካከት ምን ይመስላል? ለህመምተኞችስ ያላቸው አስተዋፅኦ በድጋፍ ወይስ በቸልተኝነት ይገለፃል? ለምን?
5. በህመምተኞች ሰውነት ላይ ለሚታየውና ለሚደርሰው አካላዊ ጉዳት የማህበረሰቡ አመለካከት እንዴት ይገለፃል ?
6. የኩታኒየስ ሊሽማኒያሲስ ህመምተኞችን ለመርዳት ቤት ለቤት እየሄዱ ዕርዳታ የሚያደርጉ የአካባቢው ነዋሪዎች/የመንግስት ሰራተኞች አሉ? ከሌሉ ለምን?
7. የአካባቢው ነዋሪ በርስዎ ግምትና ዕውቀት ለኩታኒየስ ሊሽማኒያሲስ ያለው ዕውቀት ምን ይመስላል?
8. የኩታኒየስ ሊሽማኒያሲስ ህመምተኞች በማህበረሰቡ ዘንድ በንቀትና ዝቅ ባለ አክብሮት የሚታዩበት አጋጣሚ አለ? ካለ ለምን? አብይ የሚባሉት ችግሮችስ የትኞቹ ናቸው?
9. የአካባቢው ነዋሪ ከኩታኒየስ ሊሽማኒያሲስ ህመምተኞች ጋር ማህበራዊ ግንኙነትን ለመፍጠር ያላቸው አቅም እንዴት ይገለፃል? ይህን ማድረግ የማይፈልጉ ከሆነስ ምክንያቱ ምንድን ነው?

Declaration

I declare that the study entitled "The Psycho-Social Impact of Cutaneous Leishmaniasis on People Infected by the Disease" is my own work and that all the sources I have used or quoted have been indicated and acknowledged by means of complete reference.

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This thesis has been submitted for examination with my approval as an advisor for the candidate.

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