SOCIO-ECONOMIC LIFE OF PEOPLE ASSOCIATED WITH LEPROSY: (THE CASE OF GELEMSO TOWN, WESTERN HARARGHE)

DEMEREW DAGNE YIRGU

A thesis submitted to the School of Graduate Studies of Addis Ababa University in partial fulfillment of the requirements for the Degree of Master of Arts in Social Anthropology

Addis Ababa

December 2004

Addis Ababa University

School of Graduate Studies

Socio-Economic Life of people Associated with Leprosy:

(The case of Gelemso Town, Western Hararghe)

by

Demerew Dagne Yirgu

College of Social Sciences

Approved by Board of Examiners:

Advisor

Examiner

Examiner

ACKNOWLEDGEMENT

Special acknowledgement goes to Dr. Assefa Tolera and Dr. Melese Getu for their constructive comments during the writing of the proposal and to my thesis advisor Dr. Santosh Mohapatra to his advice and critical comment both during the writing of the proposal and the thesis.

I also gratefully acknowledge financial support from The Graduate School of Asia and African studies (ASAFAS) of Koyoto University, Japan. I tank Dr.Gebre Yintso for his role in making these resources available to me especially to my previous research topic.

I am grateful to the former Ministry of Information and Culture and the current Ministry of Youth, Sports and Culture and especially to the heads and workers of the two cultural departments under the Ministry for the sponsorship and moral support for my graduate study.

I am also indebted to my friends especially to Ato Tenker Tereda, Getachew Senishaw and Girma Fikre for their valuable comment. I would like also to take this opportunity to extend my thanks to Ato Takele Fufa and his wife Kaabinesh Negeri who were always behind me in many ways. I am also thankful to all friends both in the ministry and outside whose names are not mentioned here.

Last but not least special gratitude goes to all my informants from the study community and the general public for their cooperation and patience to answer my questions.

CONTENTS

Chapter Three

ABSTRACT

The socio-economic life of the people associated with leprosy is one of the least explored subjects in Ethiopia. Thus, this thesis is an attempt to describe the socio-economic life of people associated with leprosy, which include leprosy sufferers as well as non-leprosy affected descendants. The general objective of the study is to describe survival strategies, social settings, and inter and intra community interactions. It examines the historical background of leprosy patients. It also explores and describes types of social change that occurred within and outside the community.

The study population has been living in the study site for more than three decades. The earlier settlers were exclusively leprosy sufferers and few in number. Then their numbers increased after other patients who took flight to escape social evils in their birthplaces joined them. Later with the newly born children their number increased. By now the number of leprosy patients is decreasing with the death of the older generation and the decrease in number of newly joining patients.

Leprosy has been surrounded by different beliefs and misconceptions and this in turn causes multi-faceted socio-economic hardships against leprosy associated people. Such hardships in turn were responsible to force leprosy sufferers to abandon their birthplaces, beloved families and property. So finally they have congregated with their fellows in isolated villages.

People associated with leprosy subsist on begging, cultivation of crops and vegetables and with other minor sources of income. Their means of livelihood has been diversifying through time. Besides, there have been social changes in the socio-economic life of people associated with leprosy. The changes are attributed to local, national and international factors. The achievement in the field of leprosy treatment is the result of international development in the field of medicine and the efforts of World Health Organization to end the suffering caused by leprosy. Their access to land for residence as well as for farmland resulted from the national land reform. The changes in the attitudes of the study population and the general public attributed to a combination of factors, which include formal and informal education, the role of media and the like are responsible for the change that took place among the study population and the general public.

Key words: Gelemso, Leprosy, or Hansen's disease, People associated with leprosy, Non-affected people, Migration, Begging, Stigma, Leprosy treatment, Traditional, Modern, Misconceptions.

PREFACE

This thesis deals with the socio-economic life of people associated with leprosy in Gelemso, Western Hararghe Zone, Oromia Regional State. The thesis is organized in six chapters.

The first chapter describes administrative history of Gelemso town, demographic features of Gelemso town, selection and the spatial position of the research site, statement of the problem, objectives of the study, significance and, fieldwork situations and data collection, research methodology and limitations of the study.

Chapter two reviews the available literature, which is divided into a brief history of leprosy, leprosy treatment, beliefs about the causes of leprosy, segregation policies and their implications, limitations associated with leprosy patients, and the survival mechanisms of people associated with leprosy.

Chapter three is the main body of the thesis. It deals with leprosy, the study community and social interactions, introduction to the study population, types of leprosy prevalent in the study area, origin and migration of leprosy affected people, beliefs about leprosy among the study population, traditional treatment and local healers, seeking modern treatment and the beginning of migration, seeking modern treatment as precipitating factor for migration, life condition of patients at an early stage, settlement at the present site, leprosy status of the study community, interactions within the community, interactions of the study community with the general public and interaction with other leprosy related people at two settlement sites.

Chapter four describes livelihoods and survival strategy of the population, begging as the survival strategy and farming as additional means of livelihood.

Chapter five describes people associated with leprosy and social change and the last chapter is the conclusion of the thesis.

Lists of Tables

ACKRONYM

Derg	The Ex-Military Regime in Ethiopia
ENAELP	Ethiopian National Association for Ex- Leprosy Patients
EPRDF	Ethiopian People's Revolutionary Democratic Front
EPRP	Ethiopian People's Revolutionary Party
GLRA	German Leprosy Relief Association
MAO	Mohammad Abdulahi Oxde
MDT	Multi-Drug -Therapy
MOH	Ministry of Health
MOLSA	Ministry of Labour and Social Affairs
NGO	Non Governmental Organization
OLF	Oromo Liberation Front
PA	Peasant Association
WHO	World Health Organization

Glossary

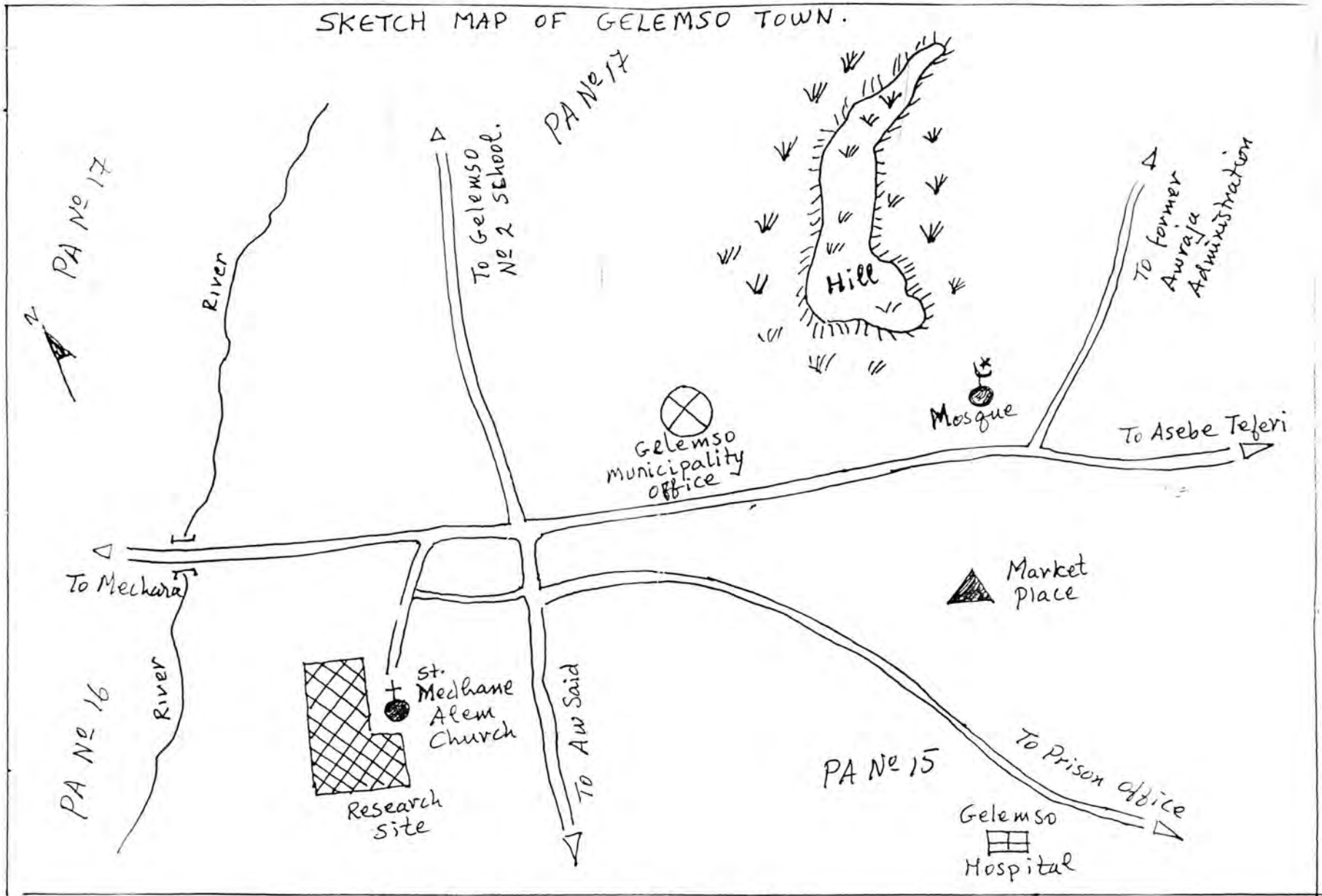
Abarsa gosati	A curse by a clan
Aqara	A bundle of ch'at
Attete	A supernatural power believed to determine the individual's destiny or fate
Awaqi	knowledgeable
Awraja	Former administrative division between province and Woreda
Beja	Syphilis
Berta	A spot appearing on parts of the body as the sign of leprosy
Buda	Evil eye
Chabssa	Marriage type
Chale yamiqotiru	Traditional healers believed to have the power to tell one's enemy and causes for suffering
Ch'at	Leaves with mild stimulant, which is chewed by people
Dajazematch	Traditional title given to an army general, a governor of a province
Darassa	A Muslim religious student
Dikuman	Handicapped
Dirrito	Patched clothes
Duaa	A form of prayer by Muslims
Dukkuba	Illness

Dukkuba hama	A serious or chronic disease or illness
Dukkuba qomatte	Illness of leprosy
Dulacha	Old person or thing
Elmaa	A child or an offspring
Fakata	Resemblance or likeability
Fakata kiyya	Some one like me
Faraqa	Communal labour exchange method
Felefala	Magic, sorcery
Ganda	Village
Gojjo	Small hut
Gudunfa	A bundle of material knot together
Guza	Communal labour exchange method
Hojja	Boiled coffee leaf sometimes mixed with milk to be drunk as tea
Ifdendeyi fuddi	Arrange a marriage at your own cost
Injera	The staple pancake, bread like food
Jarri	Evil spirit
Jinni	Evil
Jumata	Friday
Jummua solat	Friday prayer
Kabira	A religious title of Muslims
Kadda	To beg for alms or to pray
Kebele	The lowest administrative division

Kefitena	Administrative unit higher than kebele.
Kerkero	Warthog, a wild animal.
Kurfa	A spot appeared on the body as the sign of leprosy
Madab	An elevated ground inside a living room used to sit and sleep on
Miskin	Indigent
Oumatta bochola	People who strive to change the status quo
Penttee	Christian religious sect
Qalicha	Soothsayer
Qera	Slaughter house
Qertassa	A charm worn around the neck as a protection against evil spirit
Qilensa	Wind or air in a motion
Qita	Loaves of bread
Qomattee	A leprosy patients
Qumitina	Leprosy disease
Rabbi	A name used to refer God
Rabbi jee Sadaqa nubusi	For God's sake, give us alms
Ramadan	The ninth month of the year during which the Muslim fast
Rabitu nukenne	A gift by God
Rabi sii hakenu	May God reward you
Ras	Traditional title such as duke, lord
Robbi	A spot that appears on the body as the sign of leprosy

Sadaka	Alms given by a Muslim to the needy
Safar	District
Shanni	Ancestor
Shegoye	Traditional dance
Shek	A religious leader in Muslim religion
Simmuni	Quarter of a birr i.e. twenty five cents
Tanquai	Soothsayer
Tatare taye	Local healer who is consulted to identify the causes of any problem
Tee oluma	May you always prosper
Tej bet	House selling honey mead
Tella bet	House selling traditional alcoholic beer called tella
Timad	A pair of oxen
Tussi	A shrubs
Wadaja	A form of prayer
Wagesha	A person who provides traditional physiotherapeutic treatment
Waffa	A person who is believed to have special knowledge to tell the causes of a misfortune.
Woreda	Administrative division higher to Kebele
Yakal gudatena	An individual with physical disability or a handicapped person.
Yesiga dewe	Leprosy

Zaka	Alms offered by a Muslim to the destitute often during fasting seasons
Zar	Evil spirit
Zar prist	A person who possesses evil spirit



Source:- sketch Map by Demrew Dagne.

CHAPTER ONE

INTRODUCTION

This chapter provides description of the statements of the problem, objectives of the study, significance of the study, fieldwork situation and data collection, research methodology, limitations of the study, the administrative history of Gelemso town, selection of the research site and the spatial location of the site.

1.1 Statement of the problem

Leprosy, or Hansen's disease, named after Armauer Hansen, the Norwegian doctor who first detected the bacteria, of the disease in 1870s. It is a chronic infectious disease, caused by mycobacterium leprae. It mainly spreads via droplets from the nose and mouth. Its transmission is high during close and frequent contacts with untreated, infected individuals.

For century's leprosy remained a serious public health problem throughout the world with its cultural, social, economic and human right implications for its victims and their relatives. According to WHO special Ambassador, for South East Asian Region (SEAR) report (August 2003), in spite of WHO's effort to eliminate leprosy by the year 2005, by reducing the prevalence rate to a level of 1/10,000 cases, the report noted that currently around 600,000 new cases are reported every year as leprosy patients who need treatment. Furthermore, the report indicated that throughout the world there are tens of millions of ex-leprosy patients and their relatives who live encountering different forms of discriminations only because of their association with leprosy.

There are a number of leprosy victims in Ethiopia. Today, every year more than 5,000 new cases

are registered for leprosy treatment (MOH, 2002:46). Therefore, in Ethiopia like everywhere in the world the negative impacts of leprosy is not limited to public health alone but it has a social, cultural, psychological and economic implications as well.

People related to leprosy in this research include leprosy patients, people with arrested cases of leprosy and non-infected relatives or descendants of the patients. We find such people in and around special hospitals established to provide treatment to leprosy patients. Some live at settlement colony, in the outskirts of towns, and the backyards of churches. Leprosy as a contagious disease, causes many complications to the patients and their families. As is noted for its' prolonged incubation period. There is no consensus among scholars concerning the length of the incubation period. For instance, Price (1964:210) estimated the incubation period of the disease to be between 1-10 years. Stiller the then Director of Bisidimo Leprosy Relief Center, cited in Workafarahu (1970:130) estimated the incubation period to be between 1-20 years. Furthermore, Bryceson indicated that there is evidence, which shows 3 months-40 years as incubation period of the disease, but argues that the usual incubation period is from 2-4 years (Bryceson, 1979:13). The prolongation of the incubation period makes the life of the offspring of leprosy patients fearful and hazardous for two reasons. First, people who think that they are normal today fear that one-day may contract the disease. Secondly, they learned from the experience of others that encountering the disease would result in cultural and socio-economic difficulties.

Despite these problems, however, little is known about the factors affecting the socio-economic life of leprosy patients. This research is therefore, proposed for the following reasons:

First, although some scholars have produced materials on leprosy and leprosy patients in Ethiopia all of them are general of surveys, focusing on historical aspects of the disease (Price, 1964,1969; Giel and Luijk, 1969; Workafarahu, 1970; Senkenesh, 1972-73; Hagos, 1973; Girmay, 1973; Eyasu, 1983; Pankhurst, 1984; Motbainor, 1985; Tadele, 1988; Zargaw, 1992; Mesfin, 1992; Sofia, 1996;Tizita, 2000). Motbainor (1985) conducted his research under the title of "Survey of Socio-Economic Condition of Spontaneous Leprosy Settlements" in [former] Hararghe Administrative Region in which Gelemso is one, but his study was limited only to the area with a minimum description of 15 sites. Besides, there have been a number of changes since then. This research differs from the previous in many ways. This research has been conducted by focusing on one site and applying a qualitative research method. Above all information on the selected community is scarce. None of all the above-mentioned writers provide information on the survival strategy, intra- and inter community interactions of leprosy patients. Hence, the topic is chosen to fill this gap and contribute to our knowledge of the survival strategy, inter and intra community life of the research population.

Second, the research target population confined to the backyard of Gelemso Medhanealem Church is small in number, hence manageable and appropriate for in depth-qualitative study. Thus this research provides additional information about the survival strategy and the socio-economic conditions of the people associated with leprosy.

1.2 Objectives of the Study

1.2.1 General Objective

The general objective of the study is to describe survival strategies, social settings, and inter and intra-community relations of the people associated with leprosy.

1.2.2 Specific Objectives

The specific objectives of the study are:

1. To examine the historical backgrounds of leprosy patients.
2. To investigate different aspects of their relations with the wider community in historical perspectives.
3. To explore and describe types of social change that occurred within and outside the community in relation with the community.
4. To examine different survival strategies of leprosy patients, people with arrested leprosy and non-infected community members.
5. To explore the relations of the leprosy patients with their relatives, with those living with arrested leprosy and with those of non-infected members.

1.3 Significance of the Study

The result of this study can serve for various purposes. As I have pointed out earlier, information scarcity exists in the field no doubt data related with the life of such unfortunate section of society is well come. I hope this study will generate valuable data for academicians and policy makers. The results of the study may initiate others to conduct further researches on the socio-

economic life of leprosy patients and on the factors that affect their life in various parts of the country.

1.4 Fieldwork Situations and Data Collection

The fieldwork for this study was conducted between April and June 2004 i.e. a total of three months was devoted to the fieldwork. Before the actual fieldwork, review of the literature on leprosy and the socio economic life of leprosy sufferers were carried out in order to understand properly the subject matter.

The fieldwork was conducted at two phases. In the first phase, fifteen days, pilot survey was carried out. During the first phase rapport was established and preliminary data collected. The pilot survey enabled the researcher to identify the composition of the study community, which includes both patients and non-patient descendants living in the study village.

In the second phase, in addition to collecting qualitative data a questionnaire was distributed to collect information from health professionals and the general public. Additional data were gathered from the archives of Gelemso Municipal office.

I have encountered some difficulties at the very beginning of the field. The study population was in conflict with Gelemso Municipal officials for long years on the issues of land that was controlled by the study population as residential areas. The municipal officials had the intention of transferring the study population to somewhere else in order to distribute the area to the urban community. On the other hand, the study population whose number is increasing through natural

reproduction completely rejected the transfer and began to fight through forceful action and legal means. Among such action was repeated harassment of municipal officials when they attempt to measure the land under the pretext of visit. The community members commonly used to harass officials by throwing stones against officials. Besides, they presented their cases to local government officials including to officials in the Zone. They have also communicated with their national association which they secured letter in justifying their cases. At the time of my arrival in the field the issue was still fresh my presence was much suspected so as an outsider it took me some time to fully win the hearts of the study population.

The second constraint is related to the behaviors of the study population. The population is **ch'at** chewer; therefore sometimes I was forced to provide them money for **ch'at** and wait until they finish their **ch'at** and became ready for discussion. Those leprosy patients who secure their livelihood through begging are not available on Tuesdays, the market day in Gelemso, Friday morning, one of the major begging day of the week, Sundays and other ceremonial days. However, my past acquaintance with certain members of the study population has created an opportunity to establish rapport and win the confidence of the community members in general and to identify key informants in particular.

1.5 Research Methodology

This research has been conducted through a combination of different research methods to fulfill the objectives of the study. Besides the information obtained through observation, the main methods used for this research were document review, interviews including informal and semi-

structured interviews of key informants, survey questionnaires, focus group discussions and case histories.

1.5.1 **Document Review**:

Relevant documents were used to understand the background history of Gelemso town, the study area and the conditions of the people associated with leprosy. Documents from Gelemso Town Municipality, Habro Woreda Administrative office and Gelemso Hospital have been very important to understand the background of Gelemso Town and the conditions of the study population. Furthermore, it was equally important for identifying and understanding the nature of disagreements that exist among the study population, Gelemso Town Municipality and Gelemso Medehanealem Church.

1.5.2 **Observation:**

I have employed observation, as it is one of the most appropriate methods to gather valuable information in anthropological studies. Starting from the very first day of arrival the study site inhabited by people associated with leprosy, observation was used to collect primary data and notes were taken immediately after leaving the site.

Through out my stay in the field I have attended a weekly Wednesday meetings, two Muslim forms of prayer called duaa conducted at two occasions. In addition observation as a method of data collection was also used hand in hand with collecting information through other methods such as individual interviews, focus group discussions and recordings of case histories. The method helped me to capture significant data on the day-to-day activities of leprosy-associated

people. Accordingly, data regarding physical conditions of people affected by leprosy and the way they manage to perform some of their daily routine tasks such as eating food with mutilated fingers, dressing clothes and putting on shoes were also collected. Hence, their limitations were closely observed. My observation also helped me to obtain information concerning the interactions of leprosy-affected people with non- affected within and outside the village. Through personal observation, data regarding means of calling attention during begging and modes of interaction with the passers-by were collected. The observational method was supplemented by taking pictures.

1.5.3 **Key-informants**:

Before detailed and well-structured interviews were conducted with key informants, general issues relating to the socio-economic life of people associated with leprosy was discussed with different categories of the study population. In the informal discussions different categories of people associated with leprosy both old and young, women and men, highly affected and less affected, patients and non-patients, were asked about their socio-economic life as well as their views on the general public.

The informal interviews were not simultaneously supported either by taking notes or tape recording; the task of note taking was done immediately after the end of the day's fieldwork. In addition to the collection of valuable information through such methods, I was able to identify key informants. Nine key informants were selected for semi-structured interviews among the study population. The key informants were knowledgeable persons about the history of the research area, the history and condition of the study population. Key informants were selected

from different categories of the study population, which included early and late patient settlers in the site, non-leprosy affected members of the population, and leaders of the village association. Moreover, since the research has been designed to include the background information about Gelemso town and the perception of the general public towards the study population two key informants were selected from the general public on purposive selection. In -depth interviews with key informants were tape recorded with the consent of the informants in addition to taking notes.

1.5.4 Survey Questionnaire

Among the three methods well known under survey questionnaire techniques self administered questionnaire was employed to collect data from health professionals in Gelemso Hospital and other private health centers, from teachers and government employees as well as from individuals from other sectors. All the respondents were persons with educational background at least capable of reading and writing.

Health professionals were selected on purposive selection, while the rest informants were selected randomly. However, with the random selection I had to check that informants of different religious backgrounds were included.

Self- administered questionnaires were employed in order to obtain information regarding the perception and attitudes of the general public towards people associated with leprosy. Information was also obtained about the types of leprosy prevalent in the study area and modes of treatment available in the area. Some 38 informants were involved in self-administered

questionnaires. The questionnaires were dropped off and picked up later by myself.

1.5.5 **Focus group discussions**:

Focus group discussions were also conducted to supplement the information collected through other methods. Three focus groups were formed. Each group comprised 4 individuals. Male patients formed the first group and non-patients comprising of two men and two women formed the second and the third group was made up of female patients. Members of the three focus groups were among individuals who have been previously interviewed as individuals. In my research the formation of focus groups became necessary to get viewpoint of groups about the study area and the populations interaction with each other and with the general public.

By using this method, information mainly dealing with the survival strategies and livelihood of the population was collected. In addition information concerning the overall conditions of the study population was also collected. Here the focus was on village association and different networks such as idir, equb and faraqa.

1.5.6 **Case history**:

Detailed individual histories were recorded in order to understand past and present experiences of people affected by leprosy, and non-leprosy affected offspring's household strategies and changes that occurred within and outside the community in relation to social stigma, begging and the like. Using this method, attempts were made to secure information pertinent to the patients' early encounter with their relatives, friends and members of the general public, as well as their current status. Besides important data was collected related to traditional treatment, social stigma and

isolation after people afflicted in leprosy. In this study sixteen case histories are studied. The case histories disclosed different limitations and problems encountered by leprosy affected and their non- affected members.

1.6 Limitations of the study

This thesis predominantly based on the qualitative data, mainly focuses on the perceptions of the people affected by leprosy, their non-leprosy affected descendants and members of the general public. However, I do not fully claim that my findings are complete. As a pioneer on the subject I have tried my best to contribute some points that can be showed better about the socio-economic life of people whom I prefer to call "people associated with leprosy" which include patients as well as non-patients. Although the focus is the social life of the study population within and with the general public, I have also tried to explore their economic life.

However, as the second research topic in one academic year 2003/2004 it has several implications to the researcher. The implications can be seen from time, financial and energy points of view. My first research topic, entitled "Conflict Resolution Mechanisms Among the Anyuaa of Gambela" was dropped with the eruption of serious conflict in December 2003 in the field area. That topic was abandoned after it costed me time, money and energy. It was after spending six months on the former topic that I have started to write a proposal for the present thesis. It took me three months to obtain the final approval because of change in advisor, semester break that made the meetings of Department Graduate Committee (DGC) to assign the second reader and an advisor difficult. I have submitted the first draft proposal for this thesis on 8, January 2004 and the final approval by the second reader came on 8, April 2004. However,

mentioning all this is not for any excuse or accuse of any one, rather I mentioned it to indicate the experience I have been through for the last one year. This time was devoted to collect extensive literature and designing the questionnaire for the actual fieldwork.

The other limitation, which needs mentioning in relation to this thesis, was the financial constraints. The second research proposal was not immediately supported by budget. I was left with the budget approved for the first topic, which I had already spent more than half on two times journey and during my stay in Gambela. Then a support came at the end of June that is a budget-closing month for government financial operation. So the finance department allowed me only a perdium for 23 days with a warning to settle it before the end of the month. As a result, I was sandwiched between conducting the fieldwork and settling the money, which I have been allowed on the time. As an experience, this was difficult encounter to me. Thus rushing for two things at the same time created financial as well as time constraint, which was the major problem.

The last but not least constraint is related with the non-availability of relevant materials, written on the topic by social scientists in general and by anthropologists in particular. So the researcher is resorted to argue that it is not the general public alone that avoids and stigmatizes leprosy patients, but academicians especially anthropologists have also ignored or lost interest in disclosing the socio-economic life of those unfortunate and isolated sections of the community. Except for such constraints, however, I have found the condition is conducive and encouraging for further research.

1.7 Administrative History of Gelemso Town

Gelemso town is located on **Char Char** highlands in the northwestern part of West Hararghe Zone of Oromia Regional State. It is located at the altitude of 1780 meters above sea level. There

is a mountain behind it in its northern direction. Three peasant Associations bound Gelemso. It is bounded in the north and east by PA number 15, in the south by PA number 16 and in the west by PA number 17.

Only a few authors have mentioned Gelemeso in their travel account and other works. Asme Giorgis (N.D); Gleichen (1898); Forbes (1925); Guida Dell (1938); Enrico (1939); Gebre Sellassie (1959); Pankhurst (1968); Alula Abate (1974); Darkwah (1975); Caulk (1975); Borelli (1980); Demerew Dagne (1988). Except the last author who wrote his BA senior essay on the history of Gelemso town other scholars have mentioned Gelemso in relation to its occupation in the second half of 19th century and its establishment as a garrison town. Others noted about Gelemso in relation to its strategic location both as trade route and also mentioned in relation to trade activities in 1920s and demographic information during the Italian period.

Gelemso emerged in the second half of the 19th century as a garrison town, which came into being after Menelik's expansion towards the east (Demerew, 1988:11). According to Darkwah, Gelemso was founded by one of Menelik's war leader, who led the first expanding army towards the east. He states " Gelemso, the **katama** of **Dajazmatch** Walda Gabriel, Boroma that of **Ras** Darge ... were all said to have been similarly garrisoned" (Darkwah, 1975:193). According to the above account the establishment of Gelemso as a **Katama** is attributed to Menelik's expanding force.

On the other hand, as it was mentioned by another writer Asme Giorgis Gelemso was later deserted by the force of **Dajazmach** W /Gabriel. Then the **Dajazmatch** transferred his seat to another place at about 25 km to the north of Gelemso. The new town is now serving as the seat

for another **Woreda** in the zone (Asme Giorgis, N.Y: 67).

In spite of its desertion by the **Dajazmatch** and his force immediately after its foundation, Gelemso steadily continued to grow to this day. Although it has a long history of foundation its growth was militated by different factors. The first factor emanated from its' geographical location. Gelemso was established on hilly areas surrounded by gorges, created by floods. This is one of the major factors, which militates its expansion and growth.

The second factor, which hindered its' growth in spite of its long history, is the landownership system in the country, which lasted until the 1975 land reform. The land in and adjoining Gelemso town was owned by feudal lords after its being occupied by the northern force. Subsequently, except a few areas around Gelemso Medhanealem Church, which was belonged to church servants the remaining area where Glemso town was established, belonged to a feudal lord known by the name Yirgu. Upon his death his son Zeleke Yirgu inherited the land and continued as a sole owner of the land in Gelemso town.

The third factor, which militates the growth of Gelemso town, is its' spatial location. Gelemso is located about 61 kms away from the major highway, which links Addis Ababa with eastern Ethiopia. Furthermore, although it has long history and is located in cash crop areas such as coffee and **ch'at,** it is still late for modern infrastructure. Its residents still get telephone service through operators. Although it has got hydroelectric power since 1984, the light falls several times. The first hospital in the area is established in recent years but is poorly equipped, and thereby provides poor service to the people.

There were different attempts to allocate land for its expansion before the Italian invasion and later on by government decision. However, the attempts faced difficulties from feudal lords who controlled land inside and in the adjoining parts of the town. The landlords refused any compensation or substitution of land for the area they loose. The struggle between the feudal lords and the town administration continued until 1957, when Gelemso came under municipal administration. However, the establishment of municipal administration could not solve the threat of feudal lords until the 1975 land reform in the country.

Traditionally Gelemso is divided into different **safars.** The **safars** have different names. Some of them are named due to the settlement patterns. Other names emerged after popular individual names lived in the area.

Some of the **Safars** took their names prior to Italian period. Among such names some have survived to this day. While others have remained only in the minds of old people. Some of the pre-Italian names include **Awsaid Safar, Silkbet Safar, Betechristian Safar**, **Ankober Safar**. The last name survives only in the minds of a few aged people. This name originated following the settlement of the Shoan force of Menelik. Ankober, an old town located in northern Shoa, is the birthplace of Menelik.

It is interesting to note here that my Oromo informants mentioned three of the **Safar** names but none of them mentioned the last one. The Oromo use the term **ganda** instead of **Safar, and** then they add the name of the institution or place. For instance they say **Ganda_Betskiana, Ganda Awsaid** and so on.

Three other **Safar /Ganda** names are noted to emerge during Italian and post Italian period. The first of the three is known as **Mesjd Safar.** This **Safar** took its name following the establishment of the first mosque in Gelemso town. The second **Safar** is known as **kara Safar,** derived from Oromo term called **kara** meaning an entrance. It took its' name due to its spatial location. Since it is a **Safar**, located at the eastern part of the town, where the major road crosses to the west. The third name **Mahal Safar** came into being with the establishment of new administration during post Italian period. In Amharic **mahal** literally means middle. The other **Safar,** which I shall elaborate later, is called **Yeqomatoch Safar / Ganda Qomate** (the village of leprosy patients). This is a **Safar** exclusively inhabited by ex-leprosy patients and their non-leprosy affected descendents. In recent years the town is expanding towards this **Safar.**

Furthermore, the emergence of new **Safar** names has continued in Gelemso town. There are two newly emerged safars. The first of the two is known as **Addis katama Safar** that has emerged with the expansion of the town and the other one is **Kosovo safar.**

The new **Safar** name, connected with its historical emergence is **kosovo Safar/Ganda kosovo**. According to my informant, the former Hararghe especially western and eastern Oromia Zones are well known as producers of quality coffee. The coffee from this part of the country has a good demand in world market particularly in the Middle East countries. Most of the time even during the **Derg** regime, the coffee from Hararghe was exported through Dire Dawa via Dijbuti to its destination. The major exporter for a long period of time has been an individual merchant known as Mohamod Abdulahi Oxde (MAO). Even at times when the price of coffee was falling at world market, the coffee from Hararghe continued to have a better demand and price.

However, my informants said that with the fall of coffee price in the country, individuals started buying coffee with low prices from Jimma, mixed it with coffee from Hararghe and then exported to the Middle East. Through such sabotage a number of people suddenly became rich. This profitable, but "illegal" activity attracted many people, and continued until it was stopped through government measures. Here we see two coincidences. One was the American bombardment in **Kosovo,** the other one was that of mixing low quality coffee with the quality coffee of the area. The local people could not find quality coffee even for home consumption, and then they said that they were invaded by low quality coffee in the way as the Americans did in **Kosovo.** Those individuals who accumulated money through the illegal trade of coffee started to invest their money in house construction and most of them have constructed houses at the new sites found between the village of leprosy patients and **Awsaid Safar,** which is as now known **Ganda Kosovo**.

The 1975 land reform had no immediate effect for Gelemso town. As I have tried to explain the problem posed by feudal lords like Zeleke Yirgu, continued until the 1975 land reform. Since then, Gelemso encountered another problem from three Peasant Associations such as number 15,16 and 17 that were established in the adjoing parts. The three PAs demarcated and started to administer some parts of confiscated houses and took a large number of Eucalyptus trees previously belonged to feudal lords and put under their own administration. At the same time the municipal officials claimed over the same houses and trees. This problem continued until Gelemso received its master plan in 1984, after which legal demarcation was made between the PAs and the town administration (Demerew, 1988:31).

Since its inception as a garrison town in 1870s Gelemso has been used as a seat of government administration. Before the Italian period it served as **Mikitil Woreda** (sub- Woreda.) The Italian period is noted for the construction of one huge Catholic Church, which still exists in northern part of the town and currently used as a government school. Besides there are a number of other houses built by Italians now used as government offices and individual residence. After 1941 Gelemso continued as the seat of **Habro woreda** and this has continued until it became the seat of **Habro Awraja** in 1970. Since 1995 it continued to serve as the seat of both **Habro woreda** and **Awraja** until it lost its' status as the seat of **Awraja** and became the seat of Habro **Woreda** under EPRDF. Gelemso since 1975 has been internally organized into two **kebeles** and one **Kefitegna** (higher) town council. Administrative wise, currently Gelemso is put under the Zone Industry and Town Development Bureau.

1.8 Demographic Features of Gelemso Town Over Time

Gelemso is inhabited by different ethnic groups of people. Unlike the adjacent rural areas Gelemso is multi-ethnic. The major ethnic groups living in Gelemso include the Oromo, the Amhara, the Gurages, the Tigre, and the Somali. During Italian period its' population was estimated to be at about 1,000. In 1966 the population were to be 3,400, whereas in 1971 it went up to 4,244 and a year later the figure rose to 5,708. A decade later in 1982 the population in the town was estimated about 7,854. In the first national population and housing census of 1984/85 the population in Gelemso town was estimated at about 10,253 (Demerew, 1988: 34-36). The 1994 Population and Housing Census of Ethiopia reported the population to be 10,849 (CSA 1994).

Table 1: Ethnic Compositions of Gelemso Town

S.No.	Ethnic Group	Number of persons	Percentage
1.	Oromo	5,739	52.9 percent
2.	Amhara	4,185	38.6 percent
3.	Sebat Bet Gurage	270	2.5 percent
4.	Siltie	178	1.64 percent
5.	Sodo Gurage	143	1.31 percent
6.	Tigraway	123	1.13 percent
7.	Somalie	89	0.82 percent
8.	Others	122	1.12 percent
	Total=	**10,849**	

Source: 1994 Census, Central Statistical Authority, 1994:240.

As shown in Table 1, the population of Gelemso Town comprises Oromo, Amhara, Seba Bet Gurage, Siltie, Sodo Gurage, Tigraway, Somalie and Others. The population of the town is predominantly Oromo (52.9 percent) followed by Amhara (38.6 percent).

1.9 Selection of the Research Site and Spatial Location of the Site

1.9.1 Selection of the Research Site

The selection of this research site is based on various fundamental reasons. The first reason is its difference with leprosy settlements in Bisidimo, Dire Dawa and Asebe Teferi. These sites were sponsored either by the government or other institutions like GLRA. Unlike these settlements the site in Gelemso was a "spontaneous settlement" site. This brought serious sufferings on leprosy patients because they were left to their own fate.

The second factor is its urban- rural settings. The research population currently living in Gelemso town has originated from rural areas within and outside Habro. Therefore it would have different advantages to explore the rural-urban interactions that existed before and after the settlement.

Besides leprosy victims and their non-leprosy affected descendants live together sharing the same utensil. Interactions exist between people having different health status and outside their community. These social interactions create a fertile ground for research. Although the study population lived shunned and stigmatized due to the disease, it has been able to utilize various means of living. How these diversified means of existence emerged and what impacts they exert on the psychological make up of leprosy-affected people together generated interest to carry on research in this locality.

The site, known with derogatory name "**ganda qomatte**" it literally means a "village of the leprosy patients", formerly was founded and located at the outskirt of Gelemso town and has recently became a focus area due to the potential expansion area for Gelemso town. This area used by the study population apart from using the area for residential purpose has also plantations such as coffee, **Ch'at** and eucalyptus trees. The area has now become field of dispute among three major forces. The first force is the people associated with leprosy who are currently in possession of the site and their number is increasing. The second force is the **Medhanealem Church**, which has land in adjoining the site and has interest to incorporate the site as the church's possession. The third force is the town administration. The town municipal officials strongly complain that, the leprosy patients owned a considerable land for plantation and as a garden with out any payment or rent to the municipality. Moreover, the municipal officials

complain because according to the master plan the site is allocated for the expansion of the residential area. However they say that when the municipality tried to distribute the land for the town resident, the people, in the site harassed municipal officials several times. Because of the triangular interest over the land it is more conductive to study.

The last rationale for the selection of the research site emanated from my literature review. A few of the written senior essays in the Departments of Sociology and Social Anthropology fully focused on leprosy patients and institutions engaged to rehabilitate leprosy patients in Addis Ababa. Hence, this research would be another contribution towards understanding and evaluating the cases of leprosy associated people in rural-urban setting.

1.9.2 The Spatial Location of the Research Site

Through out the world leprosy affected people have been forced to live isolated from their family and friends. Isolation of leprosy affected people in some cases emanated from what was mentioned in the Bible. Moreover, their isolation helps in controlling the spread of the disease, which was most feared because of its incurability and imprint left on its victims.

Compared to its' long history the medical science was too late to find medication for leprosy. Even after Armauer Hansen declared his finding of the bacteria in the 1870s, the world continued to act against leprosy victim. The good evidence for this was the world conference held in 1897 in Berlin, which conclusively decided leprosy as incurable disease, so isolation was adopted as the sole means of controlling leprosy (The Truth 2004:38).

Before and after then, leprosy afflicted people were forced either to live individually or in the

colonies established throughout the world. Ethiopia is not an exception. Since 1930s there have been such colonies for settlements of leprosy patients in Ethiopia. Among which Bisidimo near Harar, Settlement in Addis Ababa near Prince Zenbe Work Hospital (ALERT) and the Shashemene settlements are few of them. Leprosy victims and their descendents in Ethiopia commonly establish spontaneous settlements at the out skirts of towns and at church back yards and live isolated life. In former Hararghe there are two types of leprosy settlements. The first type is institutionally sponsored settlements. Such as Bisidimo, Dire Dawa and Asebe Teferi. The second type of settlement is known as " spontaneous leprosy settlement" which is created by leprosy victims themselves. The research site shares behaviors with both settlement types. Firstly, the site is found at church back yards. As informants from the research population and people serving in the church confirmed, the site where the study population inhabits formerly belonged to individuals who were servants of the church and the church still claims this land. Secondly, as the research population indicated the existence of the church has contributed and played as means of attraction to settlement at the present site because of the alms they obtain during holidays and other church celebrations. Furthermore, they stated that formerly after getting alms they passed the whole day begging and passed the night outside the town under trees. But after many years of interactions with the landowner near the church, one of them asked the landowner to lease a plot of land to erect a hut. Having his permission they constructed the first hut, which they used to live in groups. They paid 10-30 birr per month to the landowner as rent. Later with the increase of their number others followed and did the same. And such conditions continued until the 1975 land reform, which was a relief, also to the leprosy affected people in the site. Since then they expanded their possession and took control over the land previously cultivated by a feudal lord. The site is located in southwestern section of Gelemso town near Medhanealem Church.

CHAPTER TWO

2.Literature Review

INTRODUCTION

This chapter deals with the literature review part of the thesis. It provides the overall picture of leprosy and leprosy patients. It includes a brief history of leprosy, leprosy treatment, beliefs about the causes of leprosy, segregation policies and their implications, limitations associated with leprosy patients, and the survival mechanisms of people associated with leprosy.

2.1.1 A Brief History of Leprosy

2.1.1.1 History

Etymologically both the words library and leprosy have been derived from the same Latin term "liber" (Cochrane, 1964: 5). Mcneill argues, leprosy is a generic name, which stands as a name of numerous infectious skin diseases. He further noted that, in order to differentiate the leprosy bacilli from other infectious skin diseases the name Hansen's disease was in use since the bacteria was detected by the Norwegian Armauer Hansen (Mcneill, 1976: 164). However, this scholar did not tell us the particular name used in reference to the ancient disease, before the new name was coined either in late 1860s (Laidler and others, 1971: 427), or early 1870s (Schram, 1971:161; Mcneill, 1976:164).

Leprosy /Hansen's disease is also known by different names in different languages. Amharic English dictionary translates leprosy as **qumttina** (Leslau, 1972: 713). Among the Basutos of South Africa leprosy was known as the **Bushman's disease** (Mcneill, 1976: 164). Furthermore in

ancient Persia leprosy was known as **a Phoenician disease** (Emphasis mine.) Pankhurst (1984: 154) writes: "Leprosy had been known in Ethiopia, since early times, as **lamts**" added the term **kurchi** as Oromo word for leprosy.

There are three major forms of leprosy such as lepromatous, tuberculoid and borderline leprosy. The first type mainly targets skin, eyes, nerves, testes and upper respiratory tract. Tuberculoid mainly damages legs, arms, face and buttocks. The last type combines the characters of both lepromatous and tuberculoid and attacks various parts of human body (MOH, 2002: 141).

There are theories, which developed in relation to the causes of leprosy. The first theory was heredity theory. One of the proponents Dr. Sanghvi argues that, leprosy incidence was high among people who inhabited the same geographical area. He further added that, there were a number of studies, which supported his argument. Sanghvi mentioned an instance that leprosy was found high among the casts in India. Therefore, he concluded that the theory of heredity as a cause of leprosy is not totally to be rejected (Sanghvi, 1967:15).

The second theory which was communicated by Dr.Lapuz as cited by George M.Foster (1973:103) states "In the Philippines it is widely believed that chicken and squash eaten at the same meal produce leprosy". Furthermore there are proponents of fish theory, which was popular in 1870s in South Africa and is named as "fish theory". The proponent argues that, leprosy was caused after a people ate a rotten fish. This theory was formulated after the proponent found high incidence of leprosy cases among people who regularly ate fish and workers of fish canning industry (Mcneill, 1976:164).

According to Foster and Anderson (1978:53) illness is caused either by naturalistic or personalistic systems. And they define the former:

> In naturalistic systems illness is explained in impersonal, systemic terms. Naturalistic systems conform above all to an equilibrium model; health prevails when the insensate elements in the body, the heat, the cold, the humors or dosha, the yin and yang, are in balance appropriate to the age and condition of the individual in his natural and social environment. When this equilibrium is disturbed, illness results.

On the other hand, a personalistic system is defined "A personalistic system is one in which illness is believed to be caused by the active, purposeful intervention of a sensate agent who may be a supernatural being (a deity or a god) a nonhuman being (such as a ghost, ancestor, or evil spirit), or a human being (a witch or sorcerer)."

Murdock and others also mentioned the existence of natural and supernatural causation of illness. Under the former five types of illness are listed. The latter is further classified into three categories and number of illness types among which contagion is one of them. Leprosy, the concern of this thesis, according to these writers falls under contagion. They summarized their argument as follows: " Leprosy provides an interesting special case. Though it is recognized by modern medicine as a mildly infectious disease, the avoidance of its victims has closer parallels with that of such purportedly polluting categories of people as the ' untouchables' of India (Murdock and others, 1978: 451-454).

Leprosy is cited in different literature. The Holy Bible the sacred book of Christianity, has different references in relation to leprosy and "lepers" which imply the disease and those affected by it. These references are found both in the Old and New Testaments. For instance, we find such

references in II kings 5:1, in Leviticus 13:2. These and other mentions in the Bible, as we will see later have their own contributions in creating misconceptions towards the victims of the disease. However, scholars argue that the concept of leprosy referred in the Bible is different from leprosy or Hansen's disease of today (Cocharane, 1964:8; Bryceson, 1979:1).

Archeological findings also indicate that leprosy existed in ancient Egypt (Christensen and Hughes, 1960:243). Pankhurst, based on this archeological evidence concluded that it was Egypt from where leprosy started to spread to other parts of the world during the Exodus (Pankhurst, 1957: 137). However, there is another scholar who had refuted the above argument, and argues that although leprosy was confirmed as an ancient disease of mankind, there was no concrete evidence that showed its existence during the Exodus (Cocharane, 1964:4). In the Orient, especially in India and China, the earliest account of leprosy goes as far back as 600 BC. On the other hand, the earlier documentation of the Greeks on leprosy dates back to 150 AD (Ibid: 7).

The disease was prevalent in Europe between the first and the fourteenth centuries and even later. Evidences showed the existence of leprosy in France and Britain in the 6th century AD. Following the conversion of the Roman government to Christianity in the 4th century, leprosaria were mushroomed more than any time else before. However, it has been argued that the construction of leprosaria did not show the existence of leprosy patients, rather it emanated from the principles of Christianity in which the Roman government committed to perform (Mcneill, 1976: 138). Although leprosy declined in Europe after the fourteenth century, there were leprosy cases in countries like Norway until the mid of 1800s (Irgens, 1981: 150). Furthermore, Gill (1972: 430) indicated that there was leprosy and a number of isolated leprosy asylum between the

thirteenth and seventeenth centuries of Europe. Bryceson (1979:2) stated that leprosy persisted in countries like Iceland, Eastern and southern Europe where the poor lived in crowded situations.

With the spread of leprosy in Europe, hundreds of thousands of Lazar houses were established to provide food and other necessities to the victims of the disease (Irgens, 1981:150). According to one source the number of leprosaria or sometimes called " leper houses", built outside medieval towns, estimated were about 19,000 by the 13th century (Mcneill, 1976: 164). However, leprosy declined in Europe after the fourteenth century and for the decline of the disease different reasons are noted. One scholar summarized the case as follows.

> Why the disease subsequently faded in Europe is not known, but possibly was in part the result of the great plagues [some times referred as Black Death], which killed millions of persons, especially the already ill. However, this period was followed by an improvement in the standard of living, and this one factor is most responsible for its decline (Bryceson, 1979:2).

Mcneill, who confirmed the effects of Black Death for the decline of leprosy in Europe, argues "- - - but the notion that all infected individuals died, so that the disease [leprosy] therefore disappeared, is clearly wrong" furthermore he stated that after 1346, the year of a Black Death, there were leprosy cases at different parts of Europe, the only difference being the high reduction in the incidence rate (Mcneill, 1976:164). Besides, after the sixteenth century, leprosy became insignificant disease in Europe (Gussow and Tracy, 1971: 696).

Leprosy has a long history in the African content and it has been a continuous public health problem in many parts of the continent until recently. There are different evidences, which indicate the existence of leprosy in Africa. Schram indicates that the prevalence of the disease in

Nigerian as far back as 200 BC (Schram, 1971: 161). The disease was common in South Africa in 18th century (Laidler and others, 1971: 58). Besides, South Africa under apartheid is noted for implementing her policy to leprosy patients as well. As in elsewhere, South Africa had a segregation policy against leprosy patients from the general public. But the Africans and non-African leprosy patients were kept at different leprosaria (Ibid, 427).

As Ralph Schram (1971:356) stated, Africa constituted about half of the world leprosy cases. He estimated the cases between 2-5 million. He noted Nigeria as having the highest number, i.e. about 650,000. Furthermore, he mentioned countries with high prevalence rate: Siera Leone, Congo and Nigeria with 48/ 1000, 22/1000 and 19/1000 respectively.

Ethiopia is not an exception among African countries. References of leprosy cases are cited in the accounts of early foreign travelers in the country. As it is cited in Pankhurst (1984:151-52), Alvares in the sixteenth century and a number of other foreign travelers in the nineteenth and early twentieth century noted the existence of leprosy patients in the northern, north western and southern provinces of the country. The travelers mentioned the provinces of Gojjam and Shoa and to cities like Addis Ababa, Desse, Gore and Harar. They also mentioned different figures of leprosy cases in the country.

The Spread of leprosy to the New World is mainly associated with Columbus and his Sailors, European immigrants to America and later to slaves taken from West Africa (Skinned, 1973:225).

Throughout the world, leprosy affected a considerable number of people. WHO's report for 1980 suggested that there were more than 3,500,000 leprosy infected people. The report added that the number of people infected but not detected exceeded twice than the registered ones (WHO, 1980:70). However, figures are sometimes very confusing, for instance, according to one scholar there were 15 million leprosy-infected people throughout the world (Mchenry, 1993:602). On the other hand the same figure, i.e. 15 million, was mentioned in the document appeared in 1997(Priff Nancy and Margaret Eckmand, 1997:140). Therefore figures must be taken with caution.

2.1.1.2 Leprosy Treatment

Leprosy, or Hansen's disease is ancient disease, which is known to afflict mankind. Leprosy is mainly spread via droplets from the nose and mouth. Its transmission is high during long and frequent contact with untreated and infected person. As Price (1964:210) argues, its ways of transmission through repeated skin-to-skin contact, which is unavoidable fact of life for most of the members of the community. It is the worst for those poor and destitute sections of the community, which live in crowd, and poor hygienic situation in slums and settlement colonies.

In relation to the spread of the disease Cochrane (1964:11-12) identified two patterns, the village and the house pattern. He wrote:

> The determining factor, then, in producing either the village pattern of the disease or the house pattern depends upon the opportunity of contact. Where the contact is confined largely to the household which is infected, and the village as a whole may have a relatively low incidence of the disease; ---.

However, even after the bacteria were detected the medical science has been too late to prepare the first drug of its kind.

The available literature show the earlier attempt to prepare medicine for leprosy treatment was started in the second decade of the twentieth century. Two scholars Leonard Rogers from India and Dr.Heiser from the Philippines were the pioneers in trying "Chaulmoogra oil" as a medicine to treat leprosy (Cochrane, 1964:188).

Since the modern medical drug was too late, patients tried and sought to cure or get relief from the disease through traditional means. The traditional ways vary from place to place and from culture to culture. Seeking treatment is also influenced by family structure, because treatment costs resources of various kinds. The following citation from Foster makes this clear. " Medical care involves expenditure of time and energy by the patient's relatives and friends. Money for doctors and medicines comes from the common family purse; many of a sick person's duties are performed during the period of illness by other members of his social group" (Foster, 1973:120-121).

By personal efforts or with the consent of family members, it was common among leprosy patients to consult indigenous healers including herbalists, witchdoctors and many others. Besides starting from the Biblical references the holy water was sought and used to cure from leprosy and other diseases.

For instance, "Naaman the leper" "---- dipped himself seven times in Jordan, --- his flesh came again like unto the flesh of a little child, and he was clean" (II kings, 5:14). Pankhurst (1984:165) argues that in Ethiopia people talk about miraculous cures of the disease and towards that end

swear to present gifts if they get cured, he adds it was common to wear a charm around their neck to protect themselves from the evil of the disease.

On the other hand, the patients also used to apply butter and plant leaves on the affected parts of the body. Patients also consulted indigenous healers such as **Tanquai, Wegesha, Kalicha** and **Zar priest** in the hope of curing from leprosy (Girmay, 1973:5; Motbainor, 1985:80). Furthermore, Pankhurst (1984:166) argues different parts of plants such as bark, seeds, roots; leave and fruits are also used as a means of leprosy treatment. Laidler and others (1971:172) argue that leprosy patients in South Africa who did not get modern medicine used to put salt and a blue stone on their wounds.

In the history of modern medicine the year 1941 was a breakthrough for leprosy treatment. As Eyasu stated it was in 1941 that sulphone appeared as a treatment for leprosy patients. For sometime this drug proved effective against the causative bacteria of leprosy (Eyasu, 1983:2). However, its effectiveness did not last long because the patients started to develop resistance. Then, since 1981 there has been a drug, which proved its effectiveness to fight against mycobacterium leprae. The new drug which was recommended by WHO (World Health Organization) is known in short as MDT (Multi- Drug -Therapy).

MDT consists of three drugs called dapsone, rifampicilin and clofazimine. Based on the conditions of the patients, MDT is prescribed for six or twelve months. WHO described MDT as: ' Safe, effective, economical and easy to administer under field conditions' (WHO, 1988:4).

Treatments for patients were provided at two places. The first one was in special hospitals and colonies purely organized to treat patients. The second one was home treatment that is a type of ambulatory treatment. Like in Thailand with an estimated 150,000-200,000 leprosy patients a research was conducted to compare the costs of institutional and home care treatments. According to the finding institutional care was more expensive than home care. The research showed that to take care of an individual patient in a hospital cost hundred dollars, while to take care at home cost eleven dollars per year (Bryant, 1969:120). Another aspect of treatment conducted for leprosy patients fall under medical rehabilitation. Such a treatment has a considerable effect on the patients physical appearances and consequently on social and other aspects of the patients life. Schram (1971:356) summarized the effect of medical rehabilitation as follows:

> ... not only the drugs which gave impetus to leprosy control, but the new surgical rehabilitative measures: tendon transplants, muscle and bone grafts, scalp transplants for eyebrow restoration, and other measures of restoring hands, feet and faces-with this methods many disfigured and useless people were restored to work and home.

But except for a few who have an opportunity for surgical makeups the majority of the disfigured, poor and destitute members of leprosy victims could not return to whole again (Wulff, 1966:62).

Another aspect of leprosy treatment emanated from prejudice against patients. Bryceson (1979:116) suggested that integrating the health service for leprosy patients into general public health centers were a major step in the history of treatment. Furthermore, leprosy treatment and control has been affected by migration and ways of mobility. For instance among herders who

have been continuously on mobility in search of water and grazing for their herds it was found difficult to provide effective treatment. Peoples' migration also affected regular follow up of infected people, and such ways of life contributed to the spread of the disease (Ibid, 142). As stated above leprosy patients have been found using both traditional as well as modern treatments to cure themselves from leprosy. Moreover we have seen how the use of traditional or modern forms of treatment would be influenced by ones culture.

2.1.2 Beliefs About the Causes of Leprosy

Leprosy or Hansen's disease is surrounded by myths, fear, beliefs, misconceptions and superstitions. All these in turn affect the socio-economic life of leprosy victims more than the harm the disease causes.

There are different beliefs as a cause of leprosy. Some beliefs have religious connotations and others are considered as superstitious. For instance, the Bible attributes the cause of leprosy as a divine punishment for misdeed (Numbers, 12:10,171). The accounts in the Bible had a significant influence in shaping peoples' belief towards the disease and the victims. Risse (1999:175) wrote: " By the Middle Ages, leprosy had come to be mainly associated with sin and vice, and medieval culture connected its causes with sinful behaviour, attributing its appearance to divine punishment for immoral behaviour."

Moreover, many people believe that leprosy is a hereditary disease (Girmay, 1973:8; Amakelew, 1973:6; Eyasu, 1983:7; Tadele, 1988:252; Mesfin, 1992: 15). Study among the Nyamwezi of Tanganyika further indicates that leprosy is considered as hereditary illness and people having

such disease are avoided from marriage arrangement (Read, 1966:32).

Besides, Evans-Pritchard's account among the Azande revealed that incest is believed to be the major cause of leprosy (Pritchard, 1937:720). Furthermore, Schaller (1961:29) noted that the people in northern Nigeria attributed the cause of leprosy as God given disease.

As cited by Mesfin (1992:15-16) a number of other reasons are stated as causes of leprosy. The Chinese believe that sexual intercourse with prostitutes is a cause to contract leprosy. The Greece believes that sexual intercourse with a woman during her menstruation period causes leprosy. In Zambia people attribute leprosy to a witch. Furthermore, people in Uganda attribute leprosy to a misdeed done against leprosy patients. Leprosy patients in Pakistan believe that they contracted the disease after they ate fish mixed with milk.

Furthermore, as cited in Motbainor (1985:7), Merab (1921-29) summarized 'Ethiopian beliefs' as 'a thousand and one causes, each as a fantastic as the other-among them, a blow from the Devil, entry to a church sanctuary reserved exclusively for priests, violation of marriage contracted by moon light.'

Merab's argument is confirmed by different studies conducted in Ethiopia. As it is already mentioned, a considerable number of people in Ethiopia still believe that leprosy is an inheritable disease.

On the other hand, as Giel and Luijk (1969:3) stated, the local "**zar-priest**" also attributed the

disease to different reasons. The **Zar-priest** told to leprosy patients various causes of leprosy. Some were told that they were contracted the disease after they struck by sun light while sleeping in the open air. Others were told that they were exposed to leprosy after they walked on a wet grass early in the morning and consequently created a crack on their feet. Still others were told as they contracted the disease after they practiced sexual intercourse in the open air. Moreover, one's appearance near a river and a number of other reasons are also told to patients as reasons for contracting the disease.

As a result of all the above accounts and a number of other misconceptions and beliefs the victims of leprosy throughout the world are forced to lead life full of misery. They live in isolation from their own fellow beings. They are often shunned because of the disease.

On the other hand, although all the above accounts as well as many other beliefs not mentioned here explain the causes of leprosy, a scientific identification of the disease remained in the dark until Armauer Hansen identified the cause of the disease in the second half of the 19th century. In spite of Hansen's achievement and later advances in the field of medicine, traditional beliefs still prevail among many people about the disease. Such beliefs remained widespread in undeveloped nations where culture, traditions and beliefs still play dominant role instead of modern scientific thinking.

2.1.3 Segregation Policies and their Implications

Throughout the ages, as literature show the leprosy patients were kept in isolation. This is true everywhere in the world. Consequently, tradition has created outcasts labeled as "lepers" who

often formed isolated communities. Isolation of leprosy patients is also referred in the Bible. "...the leper in whom the plague is, ...he shall be defiled; he is unclean: he shall dwell alone; without the camp shall his habitation be." (Leviticus, 13:45-46).

Scholars explain the causes of the segregation from different angles. Gill indicates that leprosy patients do not appear pleasant because they are physically disfigured as a result people develop fear not to contract the disease through contact with leprosy patients. Citation from Richardson and others (1961:242) makes this clear: "Evidence from a variety of sources suggests that a person's physical characteristics and appearance strongly influence the judgment of those who perceive him". Therefore, the victims are forced to live in isolation. Many misconceptions and superstitions such as associating the disease with curse from God played a significant role for the ostracism. Even if the disease is as old as human kind, it remained without proper treatment for centuries afflicting its victims. Therefore, people believed that the disease is incurable and so every one accepted the segregation policy as a rule (Gill, 1972:69).

Gill also noted the effects of segregation on the social, economic and psychological life of leprosy patients. He points out that the segregated patients are found in depressed conditions. They become blunt and mechanical beings loosing all their individuality. Loneliness is a common feature observed among segregated patients and they loose faith in other communities and develops hatred against outsiders as well as their fellows. He furthermore, explains that such people are indifferent with happiness, pleasure and humor. They become aggressive and hot-tempered. They loose confidence to live by themselves and develop dependency due to it (ibid, 71). Segregation with various forms has been observed throughout the globe. Here are a few of

them. As Schram (1971:161) stated among the Yoruba and the Ibo of Nigeria, there existed a tradition to expel leprosy victims and kill their children. The purpose was to eradicate leprosy from the country. Another instance of this from South Africa indicate that a woman called Maria Marce a leprosy patient contracted leprosy in 1757 and later conceived from a solider. At delivery her child was taken away and the soldier was expelled from the Cape although he was found to be free from the disease (Laidler and others, 1971:58). Furthermore, in Japan it was common to shoot and throw leprosy patients into rivers and lakes. Similar actions were reported from China during the revolution. The Kuomintang used to deport leprosy victims to a top of mountains and to leave them die starved and frozen (Horn, 1969:38).

According to Frist, segregation of leprosy patients has been institutionalized in the west. He summarized his view as follows: "Throughout history, many minority groups have been the victims of such forced isolation. Perhaps more than any of these minorities, the 'leper' has become a symbol of this ostracism-at least in the west"(Frist, 1980:174).

Such segregations and consideration of leprosy patients as outcasts resulted from the biblical references. Frist reported that leprosy victims lived in leprosaria and the colonies. The leprosaria have been used to keep the victims in one place for the well being of other community members and to provide the victims with their life necessities. In addition to this he states that segregation policies could have a negative effect on the over all life of victims. He noted that as a result of segregation the victims lost their jobs and experienced family breakdowns. This in turn forced the victims of the disease to become a burden on other societies. Frist in his account stressed that the psychological effects of segregation policies have far reaching consequences on the victims'

overall life (Ibid, 175).

Sigerist (1965:75) however argues from a different point of view. According to his argument, segregation has economic and social advantages to leprosy patients.

> There are economic reasons for segregation. The majority of lepers are indigents and it is cheaper and more effective to keep them together in a leprosarium than to treat them individually in their homes or to have them run around as beggars. In the leprosarium, moreover, they live with fellow patients and escape the social ostracism that would inevitably befall them as soon as the disease reached an advanced stage.

2.1.4 Limitations Associated with Leprosy Patients

As various researchers have indicated limitations of people associated with leprosy are multi-dimensional. The limitations are cultural, social and psychological by nature. Some scholars stated the limitations emanate from their physical appearance. Because the patients are physically disfigured, they don't appear pleasant to others, therefore people develop negative attitudes towards them. As a result of such attitudes and wrong misconceptions about the incurability of the disease, the leprosy patients were forced to live in isolation from their fellows. Moreover, they are shunned and stigmatized by the other community members. Some of the limitations (or sometimes referred as social stigma) are institutional while others are not. However, the limitations or social stigma have threatening and damaging effects more than the disease itself.

As scholars argue the first limitation against leprosy patient began when different countries adopted an idea "... of isolation and segregation as the appropriate treatment. [Thus] a number of nations, starting with Norway and including New South Wales, South Africa and many others, established compulsory segregation laws..."(Gussow and Tracy, 1971:702). Other writers argue

that the social stigma became widespread as a result of lack of information and misconception about the disease (Hagos, 1973: 20).

Isolation and segregation in turn caused several complicated effects on patients and their relatives. Such effects can be explained as economic, social and psychological. The patients everywhere were found in depressed conditions. Loneliness and loss of trust on others were observed. The patients were alienated from happiness, pleasure and humor. Furthermore isolated patients have lost all their confidence to live by themselves and developed dependency (Gill, 1972:69-71).

On the other hand, as stated by Friest (1980:175) it was common to lose ones job after contracting the disease. Unemployment followed by family break down and many other problems. Another scholar also noted that patients' loss of major intra human communication means such as hand, feet, face and eye were responsible for other consequent sufferings of leprosy victims (Gonzalez, 1980:201).

We can enumerate various forms of limitations. For instance in some areas their free movements were restricted by law. Hence they were forbidden to enter to churches, market places, bakery, mill and other public places (Sigerist, 1965:73). They experienced limitations on their ways of dressing. According to the rule the patients were required to wear a special dress designed to them before leaving their residence (Ibid, 74; Pankhurst, 1957:137). Limitations were also imposed on their manners of speech. Whenever they wanted to talk with non-leprosy affected person they had to turn back their face against the person (Sigerist, 1965:74). And in other cases

the patients were expected to speak with low voices only (Pankhurst, 1957:137). They were also ordered to make sound using a clapper whenever they approached non-leprosy affected people (Ibid).

Leprosy is also noted to limit interactions of family members. In many instances a seriously incapacitated family heads fell to act according to status and perform their assigned roles. Such failure endangered family interactions. Family heads lost respect; their children gave birth before marriage and frequently quarreled with one another (Gill, 1972:31). Limitation on leprosy patients also appeared in another form. Different source of the patients' livelihood was further threatened when other community members refused to trade with them. As Gill stated people refused to buy any produce that belonged to leprosy patients (Ibid, 49).

Furthermore, different scholars confirmed that leprosy patients were forbidden to marry with other community members. In some countries, it was restricted by law (Pankhurst, 1957:137). In other areas, for instance in Ethiopia, the community refused to make marriage arrangement with people related to leprosy (Price, 1964:210). As cited in Mesifin (1992:13), Gerochi (1986) indicated that in the Philippines, leave alone to have marriage arrangement, the people do not let their children to play with the children of leprosy patients.

The following report from India shows another form of social stigma against leprosy patients, who were forced to lead an unfortunate life in many respects:

> In India, some years ago there was a movement for land reform and reallocation. One of the workers was addressed and requested to consider the needs of leprosy-disabled persons. His reply was, 'why should I go out of my way to give land to a person who is not physically fit to make the

> maximum use of the land, when there are plenty of strong able bodied, landless persons who can make better use of it (Saui, 1980:940).

A study conducted in Karachi, Pakistan showed how terrible the life of leprosy patients in a camp was. Because their shelter was made of poor materials, it only served them against sun - shade but failed to protect them from rain. Clean water and sanitation were out of question. All were physically incapacitated. He concluded his observation by saying, "What was worse, their lives were also deformed"(Gill, 1972:19). Besides, Gill argues that those leprosy patients in isolated settlement camps were commonly exposed to alcohol, gambling and narcotics (Ibid).

In Ethiopia, as one writer noted, social stigma towards leprosy patients is expressed by covering mouth and nose sharing the same bus for transportation (Giel and Luijk, 1969:80). In some countries, leprosy patients were not allowed to use public transport (Appel, 1980:210).

2.1.5 The Survival Mechanisms of People Associated with Leprosy

The problem of people affected by leprosy or Hansen's disease is complex in nature. Unless the disease is diagnosed and treated at its early stage it causes disabilities on its victims. Leprosy patients who are treated for leprosy bacilli and released from treatment are known as ex-leprosy patients. These people do not discharge leprosy bacilli when they cough, spit, sneeze or during breast-feeding. Most of ex-leprosy patients are crippled. Loss of fingers, sight, and deformities on the face are common marks of leprosy. These and other effects of the disease make its victims incapacitated in many ways, and consequently the ex-patients and their families are forced to lead a life full of hardship compared to those community members considered normal physically and socially.

During treatment leprosy patients stay in leprosarium hospitals or other special centers established for this purpose. During their stay they survive through aid, helps mainly from welfare institutions (Dharmendra and Cochrane, 1964:606-607). Certain countries have a policy of rehabilitation for the ex-patients following their release from treatment centers and hospitals. In such countries the ex-leprosy patients survive by the resources they obtain from income generating schemes. In some countries like Brazil there is a private society organization, established to help leprosy patients and their family members (Cochrane, 1964:608). On the other hand, some countries have no rehabilitation policy for ex-leprosy patients. Therefore, the ex-leprosy patients are released without rehabilitation and for survival they depend either on their relatives or on the larger community by begging (Gill, 1972:49; Eyasu, 1983:6).

Some people associate begging with leprosy related people. However, some scholars argue that begging is looked as the only alternative left as survival strategy for leprosy patients. Dharmendra and Cochrane (1964:609) argue that:

> .... Persons afflicted with leprosy may be deprived of all sources of livelihood and may be forced to take to begging. This is especially likely to occur in the presence of marked crippling incapacitation produced by the disease; but in some persons, because of their psychological background, the mere presence of the disease serves to provide an excuse for taking to begging. There is another category namely, the ordinary beggars and their children getting the disease.

Other scholars argue that it is not the leprosy that takes an individual to beg, but it is either his/her fate or a push by the community which forces him/ her to resort to begging (Fritsch and others, 1980:193).

Furthermore, a survey conducted among leprosy patients in the former Hararghe Administrative Region (which includes the present west and east Hararghe of Oromia Regional State, Harari Regional State, Dire Dawa Council and larger parts of Somali Regional State) indicates, how leprosy patients in spontaneous settlements survive. Some are full time beggars, others subsist on part- time begging and farming while the rest survive as self-employed in handcrafts and farming (Motbainor, 1985:26).

CHAPTER THREE

3. Leprosy, the Study Community and Social Interactions

INTRODUCTION

This chapter provides description of the major parts of the thesis. It presents discussions on leprosy, the study community and social interactions. It includes the introduction to the study population, types of leprosy prevalent in the study area, origin and migration of leprosy- affected people, contracting leprosy, beliefs about leprosy among the study population, traditional treatment and local healers, seeking modern treatment and the beginning of migration, seeking modern treatment as precipitating factor for migration, early style of living of the study population, settlement at the present site, description of the village, early settlement in the village, the present condition of leprosy associated people's village, leprosy status of the study community, non-leprosy affected section of the community, interactions within the community, family based network, neighborhood based network, **Mahabara Chafe kuffa** as village network, interactions of the study community with the general public, beliefs about leprosy and leprosy related people by the general public, **duaa** (a form of prayer) as a means of social interaction, interaction in market exchange, interaction with other leprosy related people at two settlement sites, and inter-settlement marriage.

3.1 Introduction to the Study Population

According to the 1994 Population and Housing Census of Ethiopia there were 12,536 leprosy patients in Oromia Regional State. Out of these 323 were found in Western Hararghe Zone. Among which, 108 (33.43 percent) dwelt in urban areas, while the remaining, 215(66.6 percent) resided in rural area (CSA, 1994:30).

On the other hand, a data, which is obtained from the Western Hararghe Zone Labour and Social Affairs Bureau, indicates that there are nine leprosy settlement sites in the zone, namely Chiro, Meso, Hirna, Mesela, Doba, Bedesa, Gelemso, Mechara, and Guba Qoricha. In these sites 383 leprosy-affected persons inhabit, out of which are 212 men and 171 are women. The data does not include the rural dwellers, children and non-affected relatives. As indicated by Tadele (1988:256) in the former Hararghe Administrative Region, there were already 6,342 reported cases of leprosy in 1984. Additional 471 new cases were reported before the end of the year.

Table 2: Disabled Persons Composition of Western Harerge Zone.

S.No.	Type of Disability	Rural	Urban	Percentage
1.	Totally Blind	1,493	189	10.43 percent
2.	Partially Blind	2,268	264	15.70 percent
3.	Hearing Problems	3,578	212	23.50 percent
4.	Hearing and speaking problems	786	69	5.30 percent
5.	Leg problems	2,627	284	18.07 percent
6.	Hand / Arm problem	1,073	180	7.8 percent
7.	Leprosy	215	108	2 percent
8.	Mental Problem	1,323	240	9.7 percent
9.	Other types of disability	449	45	3.06 percent
10.	Multiple disability	323	64	2.40 percent
11.	Not stated	239	92	2.05 percent
	Total=	14,374	1747	

Source: 1994 Census, Central Statistical Authority, 1994:404.

As shown in Table 2, disabled persons found in large numbers (89.16 percent) in rural areas of the zone. Hearing problems of disability constitutes the largest number of disability (23.50 percent) and followed by leg problems (18.07 percent), leprosy, which is the concern of this

thesis, constitutes the least disability cause, that is (2 percent). However, the researcher argue that leprosy which is known in causing most complicated disability besides the observable mutilation it also causes blindness, hand/ arm problem, leg problem, other types of disability that are not stated, and multiple disability, only to mention among the variables appeared in the table. Besides leprosy, which has social implications and causes a number of social isolation, people commonly hide patients and even the disease itself. Therefore, I conclusively argue that the figures must be seen only with caution because identification of the victims is not an easy task, and I also suspect that the disability condition caused by leprosy was either under scored or statistics workers were not properly understand it to disclose and made the data available.

The research population in Gelemso settlement site is estimated to be 200. This figure includes both male and female members of the first generation affected by leprosy. In general explanations the patients are fathers and mothers of the members of the second generation. They are also husbands and wives. Furthermore, all of them participate in begging either on full- time or part- time bases. As Motbainor (1985:19) noted that there were 108 people in 1985 in the village of leprosy patients in Gelemso. Tadele (1988:256) added that in Habro Awraja there were 468 reported cases of leprosy and in addition 26 new cases were found in the same year (1988).

Except three Christians, the study population is predominantly (98.5%) Muslim. Except the three individuals who claimed to have Amhara origin, all the rest (98.5%) are Oromo people. Consequently except a few who speak, Amharic and Oromifa, the members of the first generation and all the other members of the study population speak Affan Oromo (the language of Oromo people).

Only five household members of the study community live in iron-corrugated houses. While the rest of them live in huts. The huts have partial internal partitions. The partitions are used for different purposes such as a place to sleep, to boil hot drinks as well as to keep at night small stock like goats. Despite its location in urban settings, the village looks like a typical rural village. People keep cows and bulls at the backyard and in front of their houses. Inside their house they build an elevated ground called **madab,** which is covered with plastic, clothes and goats' skin, so that it can serve as a sleeping and sitting place for the household members and their guests and it is also the ideal place to chew **ch'at**.

The households include husband, wife and small children. The remaining members of the community especially adolescent males build small huts locally known as **gojjo**. Except the difference in size **gojjo** and other huts are similar.

3.2 Types of Leprosy Prevalent in the Study Area

In spite of the existence of various religious, cultural and superstitious beliefs as a cause of leprosy and consequent stigma and isolation of patients, Armauer Hansen, the Norwegian detected the bacteria that cause leprosy in 1870s (The Truth, 2003:25). Since then there have been a number of advancements in the medical science which includes, identifying forms of leprosy and the types of damage each leprosy form can cause and the preparation of effective medication for leprosy treatment.

Accordingly, there are different forms of leprosy. These are multibacillary (MB), lepromatous (LL), tuberculoid (TT) and borderline lepromatous (BL). Although it is the most dreaded disease, leprosy is also found to be less contagious disease. As one source indicates, out of ten people who contracted the bacteria that causes leprosy, only one person developed the disease and the remaining have possessed natural resistance (Priff and others, 1997:141).

As information from Gelemso hospital indicates, in the Woreda where the research site is located there are three forms of leprosy. These are lepromatous, tuberculoid and borderline/ or dyamorphos leprosy. Among the three forms tuberclouid and borderline leprosy are mostly found in the study area.

According to the information from Gelemso hospital, where leprosy treatment was conducted, the treatments for leprosy and tuberculosis have been provided simultaneously. The treatment center in the hospital is known as Leprosy and TB clinic. A nurse is responsible to provide medicine for both diseases, after the patient diagnosed by the doctors in the hospital. As the nurse in the clinic indicates, before patients start taking medicine they were required to bring a contact person. In case the patient stopped or disappeared before completing the treatment, the contact person would be called and informed to bring the patient to the hospital.

The patients are advised about the nature of the disease and its treatment. The advice is necessary because the treatment of leprosy bacilli takes from six to twelve months based on the forms of leprosy afflicted a particular person. The nurse provides the advice to the individual patients before handing over the drugs. The advice does not take the nature of the disease and its

consequent socio-economic effects on the patients and their families into consideration. As a result, the advice by the nurse is seen as any daily routine task rather than serious psychological treatment hand in hand to the medical treatment. Furthermore, the orientation given to the patients also failed to address the ways of tackling difficulties, which arise from the community members, they have been living with.

3.3 Origin and Migration of Leprosy Affected People

3.3.1 Contracting Leprosy

Leprosy patients felt that they have passed through different experiences after afflictions in leprosy. All of my informants from leprosy-affected section of the study community conclusively argue that at the beginning neither they themselves nor their immediate family members were aware of affliction in leprosy.

The study population informed that, earlier different terms were given to the disease, which affected them seriously. Informants also explain the sign of leprosy they saw for the first time a spot appeared as some people say on their face, others say on their leg and still others say on their back. They compare that particular spot with the size of what they call **simuni** meaning twenty-five cents coin. Locally such spots are known with the following terms **robbi** (mole), **kurfa** and **bertta.** All the three terms are used to refer to the first sign or spot appeared on different parts of their body. It was only after they were diagnosed that they became aware of leprosy contraction. The patients during my interview continued to use the above terms to refer to the disease. Another term used in references to leprosy is **"dukkubba Juuzam"** the first term stands for an illness and the second refers to the disease. The latter term has Arabic origin.

According to Hamilton (2000:246) "... the Arabian medical writer al- Majusi, substituted the word lepra for the Arabic **judham**, which denoted the specific disease leprosy." Furthermore, Dols, as cited by Motbainor (1985:11) confirmed that, the terms "judham and baras" are employed in reference to the disease leprosy. Therefore, the study population and other informants, who are predominantly Muslim by religion, used the term **juzzam** to refer leprosy. In addition to the above terms using **dukkba komatte** literally meaning the illness of leprosy.

Leprosy is a disease, which has positive correlation with age and sex. Thus, children, youth and adults are more susceptible to the disease than others (Cochrane, 1964:76). Besides Cochrane (1964:17) argues that males are predominantly affected by the disease than females, this was mainly explained in relation to biological fact, which indicates that human male is the weaker sex Cochrane writes " ... this has been explained on the basis of the X- chromosomes in the male which exposes recessive deleterious and lethal genes, in contrast to the female who has two X-chromosomes which provide protection to recessive genes in single does."

Thus, scholars provided different ages groups as easily susceptible to leprosy. Accordingly Roger and Muir (1946) as cited by Cochrane (1964:76) argue that leprosy afflicted a person before he/ she reached the age of 20, Cochrane on the other hand argued that people contracted the disease before they reach the age of 15. Furthermore, Bryceson (1979:130) indicated that, among the Hawaii 45 percent of leprosy patients were contracted the disease before they reached the age of 20 and in southern U.S.A a study showed that 24 percent of leprosy patients were affected by leprosy while they were under the age of 20. Another source in Ethiopia indicated that people

between 15 to 45 years are vulnerable to leprosy (MOH, 2002:45).

Bryceson (1979:130) also indicated that the male female ratio in hospital was more than 1 for Africa, and 3:1 for Malaysia.

As this study shows, out of 25 leprosy-affected people surveyed 17(68%) afflicted leprosy while under the age of 21, 5 individuals (20%) between the age of 21 and 30, 3 people (12%) contracted the disease while they were above 31 years of age.

Table 3. Age at Contracting Leprosy

Age during Leprosy Affliction	Respondents	Percent
Under 21	17	68
21-30	5	20
Above 31	3	12
	25	100

Source: compiled from field notes

Therefore, both age and sex factors have their own implication for the people related to leprosy. High incidence of the disease among children and the youth is related mainly to the fact that they make repeated and direct household contact, which increases the risk of contracting the disease. This in turn has long lasting effects on the immediate and future life of those who contracted the disease and it has complicated effects on their families. On the other hand, when an individual contracts the disease at his adult age, things get more complicated to the individual concerned as well as to the community he lives in. Consequently, his/ her economic, social, cultural and

political role could be endangered. Things become worse when men, who dominate the economic basis of the household, contract the disease.

3.3.2 Beliefs About Leprosy Among the Research Population

The followers of the major world religions view leprosy as a special disease caused by sin. In the three major religions of the world Islam, Christianity and Judaism which all derive their principles from the Old Testament, conclusively have taken leprosy as punishment of God against wrong doers. Furthermore, leprosy has remained as the most feared disease among the Hindus, Buddhists and followers of Confucius (Cochrane, 1964). In addition to the religious thought and beliefs, leprosy is surrounded by superstitious and cultural explanations.

As studies from different corners of the world showed, leprosy is surrounded by mythology, superstitions, misconceptions and wrong beliefs. All such beliefs emanated mainly from the nature of the disease, which changes its victims to incapacitated, deformed and crippled being. Other sources of misconception and mythology emanated from religious thoughts and beliefs. The religious beliefs still prevail and may continue in the future. Furthermore, different beliefs and misconceptions surrounding leprosy emanated from lack of proper knowledge about the causes of leprosy and its level of contagious. This latter reason still widely prevails among the general public in the study area. Here we will assess the types of beliefs that exist among people associated with leprosy.

In most cases superstitious beliefs had immediate effects on leprosy patients and their families. Leprosy patients were immediately shunned after they contracted the disease. To ostracize

patients is common everywhere. Furthermore, patients were forced to take annual leaves if they were employed and consequently expelled from their work. The families of the patients were also threatened in one way or the other. In some cases the family of the patients faced social isolation. They were avoided from marriage arrangements; people stopped sharing food and drink with the family of patents. Others insulted them. Their children were forbidden to join with other children to play. With loss of the sources of livelihood by leprosy-affected people, family break down was common. Students of such a family were forced to leave schools.

Families of leprosy patients commonly hide patients behind the door. Besides, they put different pressure on their own fellows telling their fear particularly in getting marriage partners to the rest of the children and the like. Consequently patients used sometimes to commit suicide and in some cases they leave their families and migrate.

In this study area a number of beliefs about the causes of leprosy exist. Consequently leprosy patients had encountered difficulties from their own families and other members of the community. They were shunned, isolated, and ostracized and finally forced to leave their birthplace, their property and their own children's and finally forced to lead a destitute life in settlement villages. Informants argue that almost all of them sought and consulted local "healers" such as **Tanquai** (soothsayer) and **Muslim shek** (religious leader in Muslim religion). These traditional healers tell to patients and their families a number of conditions that cause leprosy. They also suggest and provide a variety of traditional treatments, which I will discuss in the following section.

The **Shek** and **Tanquai** (soothsayer) told the clients various reasons as a cause of leprosy. One of widely known causes of leprosy is a **felfela** (magic, sorcery) used to refer any thing like dead fowl put or thrown on someone's door, entrance or paths aimed to harm an enemy after contact with the thing. The following two cases can make this clear.

Case one. Halima Ousso, F, is 29, leprosy patient.

> Halima Ousso, is 29. She is leprosy patient. She contracted the disease at the age of 15. Just like her other age mates, she used to play **shegoye** during the night. **Shegoye** is a traditional Oromo dance young boys and girls used to play at night. **Shegoye** also serves for boys and girls to select future mates. Halima had a boy friend. Halima had a brother who was unmarried by then, Halima's brother married a wife through **Chebsa** that is type of marriage which the individual gets his wife in one or two days. Following the marriage of Halima's brother the in - laws who had unmarried young boy sent elders to Halima's parents to ask marriage arrangement. Halima's parent accepted the request without the consent of Halima. Then she told her friend the intention of her parents. Halima's parents forbid Halima from **shegoye.** However, she did not stop. Before the arrangement of the new marriage, Halima fell sick and this illness later became leprosy. The local Shek told that she became ill because she stood on **felfela** (magic, sorcery) put by her ex-friends.

Case two. Yusuf Abdulahi, M, is 70, leprosy patient.

> Yusuf contracted leprosy at the age of 22; he was married and had two wives and three children. Like Halima Yusuf, also attributed his affliction to leprosy to **felfela.** Yusuf argues that, as usual, he went to assist his friend in agricultural work called **guza** (communal labour exchange method). Then Yusuf says while digging he encountered a slaughtered black colored fowl and immediately cried and jumped with surprise. Then for Yusuf that was a **felefela,** which some one had put to harm him. After that he was frustrated and sometime later he saw a reddish spot spread on his body. He sought traditional treatment and tried a variety of medicines but he said that his hand, leg continued to loss sensation and went for modern treatment and he was diagnosed and found with leprosy.

From the above two illustrations we can see that superstitious beliefs still prevailed and have socio-economic impacts in the peoples day- to -day life.

In addition to **felfela,** (magic, sorcery) people belief that leprosy is caused by **Qilensa** literary meaning air or wind. Such explanations are very common in the study area after some afflicted with leprosy in October. People also attribute to a disease like tuberculosis with **qilensa.** According to leprosy patient informants leprosy is unknown in history of their family. But they attributed leprosy as a disease caused by heredity. Among my informants I found a female who claims to have leprosy history in her family. The following case illustrates this.

Case three, Kedija Oumer, F, is 50, leprosy patient.

> Kedija afflicted by leprosy at the age of 20, was born and lived in an area called Wene. She was married and had 4 children before she contracted leprosy. Among her family members her elder brother had afflicted leprosy before her. According to Kedija after she contracted the disease she encountered different difficulties from her neighbours and finally she was taken first to Gelemso and then to Bisidimo for treatment. She stayed in Bisidimo for a year. While she was in Bisidimo her husband died. When she returned home after the death of her husband, the relatives of her husband took her children and property. They also cultivated her land. And she says she completely shunned by every one and so she returned back to Gelemso and joined people affected by leprosy. Finally she married a leprosy patient and now lives in the leprosy patients village. Kedija knows nothing about her children and relatives fate since she left her birthplace.

The other widely spoken belief as a cause of leprosy is a curse by a clan member. In local terms this is called **Abarssa gossati**, **gosatu abare,** which literally means a curse by a clan. Others attribute leprosy to what they call **Jarri** (evil spirit). My informants assert that their failure to perform a ritual previously performed by ancestors which annoyed **zar** priest and in turn the **zar** priest revenged them by inflicting leprosy. Still others attribute leprosy to performing sexual intercourse in the open air. Others tell that washing with polluted water causes the disease.

Despite all the explanations mentioned above, through repeated probing, informants finally resorted to attribute their disease to God. In highlighting their argument they ask again and again why only they contracted leprosy. So they conclude by saying " **Rabitu nukenne**" literally to say, it is a gift from God.

According to the result of the research, there are a number of beliefs about the causes of leprosy even among the leprosy patients who became aware of the cause of the disease after their repeated visit and exposure to information from medical personnel. The study population attributed leprosy to a single or a combination of factors. Their explanation emanated from what they have been told by traditional healers such as **Shek** (a religious leader in Muslim religion) and **Tanquai** (soothsayer) and what they have heard from other community members. People in the study area use different traditional medicines, which is the concern of the following sub section.

3.3.3 Traditional Treatment and Local Healers

As a study from India disclosed people like to use indigenous medicine rather than western medicine. As Horn (1969:250) asserts: "Indigenous village medical services are overwhelmingly preferred to western medicine. Their strength is due in larger part to their successful adaptation to the fundamentals of village social organization." Horn also found that there were different local medical experts within a village: " Indigenous medical specialists in an Indian village such as Kishan Garhi are extremely varied. They include priests, exorcists, magicians, and secular physicians as well as numberless minor technicians such as bone - setters, charm - sellers, cuppers, cultists, surgeons, and thorn - pullers." (Ibid). Horn further noted that, there were a variety of medicines used by people belonging to the same family or living as neighbors, for the

same kind of injury or any other illness. On the other hand, it is not uncommon for the Ethiopian population to consult traditional healers and use indigenous medicine. One source estimated that about 90 percent of the population involves in such activities (Ethiopian Herald, 2003:1).

According to the leprosy patient informant, they used a multiple types of traditional medicine to treat leprosy. The traditional treatment includes rituals performed in the name of patients. The medicine provided by traditional healers is mainly prepared from roots, leaves and bark of trees. The medicine is partly applied in the nose, partly rubbed on the body and consumed. Holy water was also used for treatment. A number of informants mentioned that they visited the holy water in **Erer Gota**. The patients also use goats' blood to wash their body as a means of treatment. On the other hand, as Assefa (1992:72) disclosed children's blood also used by leprosy patients. Assefa writes: "It is said that some [leprosy] afflicted individuals washed their bodies with the blood of children especially that of children with connected eyebrows, but whose ears were not pierced." Furthermore, one informant said that against his will and religious belief he was forced to eat the meat of porcupine and an animal locally known as **kerkero** that is warthog.

Still other informants said that they make use of **qerrtassa** that was given by Muslim traditional healers. **Qerrtassa** has equivalent meaning with charm, which people wears around the neck or tie on their hand or waist to protect themselves against evils.

The traditional treatment, include ritual performances such as **Attete, Wadaja** (a form of prayer) and **Duaa** (a form of prayer). The rituals take place at the home of the patient's or at that of local healers. The ritual involves Muslim **Sheks, deressa**, (a Muslim religious student) elders as well

as members of the clients. At the ritual the Muslim scholars read citation from the Holy Quran and pray surrounding the patient. As it is a Muslim dominated area, in addition to Muslim **sheks**, the **Kebira,** (religious leader in Muslim religion) **Tanquai**, (soothsayer) **Weffa**, (traditional healer) **Tattar Taye** and **Chale Yamikotiru** (traditional healers) are also known as traditional healers. Patients at early and later stages of their sickness consult the traditional healers one after the other. However, as my research shows patients who have been exhausted with traditional treatment, resort to modern treatment. The next subsection focuses on patients seeking modern treatment and their subsequent migration.

3.3.4 Seeking Modern Treatment and the Beginning of Migration

According to the leprosy patient informants before they sought modern treatment they had been visiting a number of times traditional healers in and around their villages. They moreover argue that, their visits cost them considerable resources of money, energy and time. Almost all patient informants have visited the major leprosy treatment center in eastern Hararghe, popularly known as Bisidimo, at least once in their lifetime. In seeking modern treatment the experience of one patient differs from the others. Some of them had been taken to treatment center by their families and relatives, while others had undertaken the task themselves. Seeking modern treatment has different implications for the victims of leprosy as well as their family. The following illustration makes this clear:

Case four, Mohamod Ousman, M, age 70.

> Mohamad Ousman afflicted leprosy when he was 23. He was a farmer, married and had two children when he contracted leprosy. Before, he sought modern treatment he spent about a year trying local medicines. Mohamad after being unable to see improvement sold coffee beans for 500 birr and left for modern treatment accompanied by his brother. According to Mohamad his journey was not as smooth as he thought it. His brother

later disappeared at a place called Bordede and so Mohamad became lonely. Then he traveled to Dire Dawa by Train. In Dire Dawa he lost some of his money. Then he continued his journey until arrived at Bisidimo after some days. He stayed for one year in Bisidimo and returned home with hope. But it was unfortunate that he found his wife married to another husband and his property lost. Then he became angry and started to fight with his in - laws who were responsible for the harms done against his family and property. His father in-law who undermined Mohamad asked him the following in the local language " **Nemaa qebda moo neffi qebda"** and Mohammad responded "**nemma enqebbu neffi wanddebu**" literally meaning "do you have some one who guarantee you", or "do you have the power" and Mohammad responds "I do not have any one to rely on, but I do have the means." Then Mohammad put on fire the house of his in - laws and escaped and never returned home. Now Mohammad is married to leprosy-affected woman and have children and live as part- time beggars and have coffee, **ch'at** and crop fields in Gelemso leprosy associated peoples' village.

As the above case clearly shows getting modern treatment by itself is not an easy task for leprosy victims. The treatment costs various resources of the patients and their families. Furthermore, leaving ones home have negative consequences on the patients' later life. In this research, there are a number of similar cases.

3.3.4.1 Seeking Modern Treatment as Precipitating Factor for Migration

There are different theories dealing with migration and migration patterns. According to migration theorists' migration follows a variety of patterns. Some of the patterns are rural-rural, rural- urban, urban-rural, and urban-urban. Patterns of migration have been influenced by different variables. Some of the variables include rapid population increase, employment opportunities and level of incomes. The patterns of migration follow from the areas of high population growth to less pressurized ones. People also migrate from where income is less and employment opportunities are limited to better areas in both conditions (Permi, 1976:103-104).

Scholars mention different causative factors of migration: " Bad or oppressive laws, heavy taxation, an unattractive climate, uncongenial social surroundings...." (Bouvier, 1976:25). Foster who was a proponent of push and pull factors in migration also contributed towards the literature of migration and writes "...those men who run afoul of the law, usually as a consequence of murder, and who, with their families, flee the village...[in] fear of vengeance by relatives of the victims" (Foster, 1973:46).

Graves and Graves (1974:118-120) further enriched the literature on migration and they wrote: " Migration itself can be viewed as both an individual and community responses to limited resources, social deviance, and personal dissatisfaction." They further noted that, three types of migration patterns were identified. These were foraging, circular and permanent migration. Foraging as pattern of migration mainly focused to maintain the natal community by pooling resources outside the home areas. Two features were associated with foraging migration. First, some were found returning home with the resources and remaining at home while others emigrate again. Second, they were also found maintaining their rural identity in spite of their exposure to urban ways of life.

Circular migration was characterized by the migrants' dual nature of identity. Unlike foraging, the migrants here were found with both rural and urban identity. They were also found supporting the natal community by maintaining the ties between themselves and their natal community. The migrants in the permanent migration pattern lost their rural identity and adapted and integrated to urban identity.

The proponents of migration theorists argue that, although there are different causative factors of migration, the economic factor serves as the major one (Naim, 1976:161; Bauvier, 1976:25).

It is not uncommon for leprosy victims to migrate. According to Bryceson (1979:115) " In some communities, for example in parts of India and south America, the patient deliberately leaves his family in order to avoid the rejection of society which encompasses the rest of the family as well as the sick individual"

Leprosy is a disease, with social, economic, cultural, political and economic implications especially to the patients. We have seen how patients are shunned, stigmatized and isolated. All such evils against patients are done by their own relatives as well as by the surrounding communities. Leprosy serves also as a pretext to fulfill ones own interest at the expenses of the patients. Bryceson (1979:130) argues that the relatives of leprosy patients employed different pretexts to expel leprosy patients and consequently took the land and other belongings of patients.

The family and relatives of patients who themselves have experienced different social problems from the community in turn put pressure against patients. Some patients are closed behind the door without treatment. Some are taken for treatment after the chance of curing is very minimal. The families also tell to the patients the problems that other siblings face in getting marriage partners because of their existence in the family. Such continuous pressure, isolation and stigma, force patients to leave their home and migrate. Furthermore, the incapacitated and crippled

patients have different limitations to survive in rural areas, because, they cannot play their role as husbands, as wives, as fathers and the like.

The following cases can indicate the reasons leprosy patients migrate from their birthplace to urban areas and finally congregate in settlement sites.

Case five. Fatuma Ousso, F, is 45, leprosy patient.

> Fatuma contracted leprosy when she was 18. She was married and had her first child by then. Leprosy affected her fingers and toes. Fatuma said that she passed through different problems until she joined the leprosy patients village in Gelemso. After she was rejected by her husband, she had to return to her natal family. At her parents' home Fatuma faced two unforgettable incidents. The first incident happened before she left for modern treatment. One day her brother Jamal arranged a **guza** (communal labour exchange method). Jamal and his parents prepared food and drinks for their guests who came to share their labour. When lunch was ready the participants refused to eat. Jamal became confused and furious with his parents accusing Fatuma. After that Fatuma's life became worst. At one time she even wanted to commit suicide but as a Muslim she felt that was wrong. Then her parents took her for medical treatment. When she returned home the stigma and isolation became worse than before. The second unforgettable incident occurred at that time. Her brother Jamal was planned to marry and she arrived at the eve of his marriage day. Jamal was anxious at his parents and threatened to quarrel. However Fatuma asked permission to be allowed to stay only until the day of the wedding. She passed the whole day hiding and sweeping in a **tussi,** that is, a shrub. Then she had returned at night and the next day she had left and never returned. She went to Gelemso leprosy village, as she previously knew a woman who was afflicted with the disease and lives in the village. So she went to the site asking where about the village was since then resided in the village.

Case six Tadese Yimer, M, age 53, leprosy patient.

> Tadese is an Amhara. He contracted leprosy at the age of 30.When he became afflicted with leprosy he was living in a place called Qore 10 kms north of Gelemso town. At that time he was already married and had three children. As Tadese was seriously affected by the disease he lost his fingers and toes and certain deformity could be observed on his face. Hoping to get cured from leprosy he spent six months trying different traditional medicines at home. He estimated his expense to be the same as the cost of two oxen. Later Tadese sought modern treatment but it was too

late and he only succeeded to stop the spread of the disease. Then Tadese returning home sent his wife and children to her parent. Then he left his birthplace and joined leprosy patients in Gelemso. Since then he lives, as full time beggar and he never saw his wife and children again. Tadese later married another wife but has no child from the second wife. According to Tadese the main reason for leaving his birthplace was his disease that made him incapacitated being. He mentioned the stigma and isolation as another pushing factor to completely abandon his birthplace.

Case seven. Abduselam Sani, M, age 36, leprosy patient.

Abduselam contracted leprosy at the age of 25. Then he had wife from first marriage. He tried a variety of traditional medicines and he spent more than 200 birr visiting one traditional healer after anothers. Then he encountered difficulties. His wife left him. His friends shunned him. For instance he was invited as a **Guza** but at lunch people hesitated to eat with him. The pressure caused him to encounter with difficulties from his own family. Later he sought modern treatment but it was late to get cured with out effect. Then he returned home but he was not in a position to work as before. Although he felt cured, isolation and stigma were further strengthened. When he was not able to work his field, his brothers shared his land and they told him to leave the area and join " **Fekkatta kettee**" literally meaning "people like you." Then he had left home with anger and found a patient in Gelemso. Here he says he feels full freedom. According to Abdusalam, he has no relation with his natal family since he left his birthplace. Now he is married with a leprosy patient woman and has three children. During my fieldwork in June, Abdusalam was taking leprosy treatment in Gelemso hospital after a relapse of leprosy. His wife was previously treated while the three kids are not diagnosed or they are not taking treatment currently.

As the above illustrations show, leprosy affected people leave their home for different reasons. What is common to all is that, after they are afflicted with leprosy they were shunned, stigmatized and isolated both by their own kin as well as non-kins. Besides, as incapacitated and crippled being they have barriers and limitations to continue life in their birthplace. The limitations emanate from the fact that, they are not in a position to plough or dig their farm as a result they became dependents. Besides their personal incapacity, their parents put pressure

against them to avoid social isolation of themselves like in getting marriage partners for their children. Thus, the patients facing such evil act either try to commit suicide or to abandon their home and migrate. The psychological impacts of the disease play their own role in worsening the lives of leprosy patients mainly when they are in their birthplaces. This will be discussed in detail later. Bryceson (1979:117) stated that, among agricultural communities leprosy was not a stigmatized disease. Therefore, he argued that leprosy patients with different disability status would survive among other community members. On the contrary, this study indicates that leprosy patients were shunned, stigmatized and finally pushed out of the community, hence, according to the findings of this research patients could not survive among the natal community after afflicted with leprosy.

3.3.5 Life Condition of Patients at An Early Stage

Leprosy patients' early style of living is very miserable. Their early life can be characterized by wandering as the following citation from Hamilton (2000:247) proves "Most lepers [leprosy patients] lived as wandering vagrants, begging for alms on the outskirts of towns, forbidden to dwell among the healthy population...."

As this research reveals most of the study population have passed through either individual or group wandering life experiences. According to some informants such style of living emanated from the type of disease they had contracted which has social, psychological and economic implications against the victims. Most of the patients left their home with out destination. Among the reasons for leaving home include, seeking modern treatment, stigma, loss of friends, pressure from family members. Still others mentioned limitations to survive in rural areas as their fellow

beings playing the role as farmers, fathers, and husbands. The limitations mainly emanated from their incapacitation and crippled features, which are caused by the disease. A few others argue that they left home because they found themselves as unwanted and degraded person after they afflicted leprosy.

At early days of their life mobility is very high. Inter- regional, inter- **Awraja** and inter- district as well as mobility from town to town and from one rural area to another is very common. They travel both by car and on foot. They have a number of fascinating stories to tell about both means of travel. According to some informants they were forbidden to use public transport. Sometimes they were denied to use public transport under a pretext that their car did not yet arrive. When they were allowed a public transport they have been ordered to sit at the rear. That chair is known **k-ormatti** literally it means belonging to the unmentionable leprosy patients.

Hence, to travel on foot was not uncommon. This was the case when there was no transport service in the area or they could not afford the expense in addition to denial as mentioned above. Traveling on foot had also different problems. Those patients who were seriously affected by the disease had a problem to walk long distances. At the night they encounter harassment because the patients were looked as the sole transmitter of the disease. Besides, people also suspected them as cattle thieves. People used to dig and remove the upper soil of the place where they sat on after the patients leave the area. This emanated from fear of the transmission of the disease. Therefore, in order to avoid such risks they spend the night near cemeteries, at places far away from residential areas, in the open air or under trees.

Male informants also stated that at an early day of contact they faced shortage of women to accompany them. Out of a group of ten people not more than two women were found. This in turn exposed them for mockery and backbiters. Sometimes people asked them how a woman or two could be able to satisfy their sexual need. Most of the time the male patients responded by saying that they were their sisters or they helped them in preparing food.

The following illustrations can also show clearly the wandering life of leprosy patients at early days of their life.

Case eight. Rashid Mussa, M, is 57, leprosy patient.

> Rashid was afflicted with leprosy when he was 21. Unlike other patients he did not seek traditional treatment at first. However, he was not sought modern treatment immediately either. As a result he was affected by leprosy. When he was ready to seek modern treatment he sold an ox and went to a town called Abomsa. After diagnosed he was advised to go to Shahemene to get proper medication. Then he went to Shahemene and stayed there for a month and returned back home. However, the disease relapsed after a while. This time he was taken to a local healer called **Awaki** literally it means "knowledgeable." As he was told a **zar** priest caused his illness. Then his family ordered to perform a ritual locally known as **wadaja**. But Rashid could not be cured. Then some people started to talk that he was contracted **dukkuba hamma** literally to say the bad disease. One day he encountered **fakata kiyya** literally meaning "the one like me" when he asked for its meaning he was told that **wanni kun dibdee senni** literally means "yours was the sign of that disease." The term is used instead of the unnamed bad disease, leprosy. After confirmation Rashid collected about 300 birr and left for Bisidimo. He first arrived at Dire Dawa and met leprosy patients with whom he joined. In Dire Dawa he was socialized for begging. After sometime he went to Bisidimo where he stayed for six months. Then, returned to Dire Dawa and later traveled to Gelemso. After sometimes he left for Mechara 70Kms away from Gelemso. There he was put in jail suspected as thief. Following his release, returned to Gelemso. He traveled almost for a decade until he finally settled in the present village in Gelemso. Rashid married a leprosy patient woman and now has four children. He lives as part time beggar and as a farmer of **ch'at** and other crops near the settlement site.

Case nine Alisho Abdulahi, M, is 70, leprosy patient.

> Alisho Abdulahi was afflicted with leprosy when he was 25 years old. He was born and brought up at a place called Tulo. According to Alisho the main factor that pushed him to leave his home was family pressure. His family frequently told him to leave home because of the social problems they encountered due to his presence. Alisho says that not only his friends but also neighbours stopped to visit their home, to share drinks like **hojja** and food. They refrained from lending utensils to his family. His parents worried about the fate of his siblings in getting marriage partners, so they often told him all the difficulties they had to face. So he decided to disappear leaving everything behind. He first went to Asebe Teferi where he stayed for about 3 years wandering in rural as well as in urban areas. He then left for Bedessa and lived there for about 5 years. At last he went to Gelemso where he is living currently. Alisho whose fingers and toes withered away and some deformities appeared in his face and now have been living in Gelemso as a wanderer and permanent settler. He is one of the earlier few settlers in Gelemso leprosy village. Alisho had been married to a leprosy-affected woman and has three children who have already married and live in the same village. Alisho now lives as full time beggar.

3.4 Settlement at the Present Site

3.4.1 Description of the Village

As literature on leprosy show leprosy was the most feared disease. Patients were shunned and suffered from stigma, ostracism and isolation. Throughout the world leprosy patients were kept in colonies and lazar houses. In areas where they were leading a wandering life patients had been forbidden from entering certain public institutions. They were also forbidden to touch certain things without gloves.

Lasar houses were common in medieval Europe while colonies were common in Africa and Asia. In most cases isolating leprosy patients from the general public had the intention of controlling

the disease from spreading, however as one study from Philippines disclosed such an attempt became futile. Citation from Buker (1965:211) makes this clear:

> For many years a leprosy colony or Sanatorium or home was considered the logical approach for getting rid of leprosy in a given area. This seemed logical here was a contagious disease, the natural thing to do was to isolate the cases and the disease would disappear. Unfortunately the majority of government officials still have this limited and unscientific view of leprosy. Perhaps the classical example, which really disproved its value, was the trial in the Philippine Islands - - - -A law was enacted that all leprosy cases should be removed to Culin Island well isolated from the rest of the islands. Cases could not swim back to their homes and clandestine shipping could be fairly well controlled. - - - - After over ten years of trial it was realized that the plan was a failure so far as eradicating leprosy from the Philippines. Every year there was approximately the same number of new cases being found and sent to Culion. Two important factors made the scheme impossible. The first is the long time which leprosy takes to develop in a given case before it can be recognized; the latter part of this period may, many times, be infectious. The second factor is human nature no one is going to submit to being transported from home, loved ones, familiar surrounding to an outcast life among the forsaken ones....

As Buker noted keeping leprosy patients in the Colonies or Sanatorim or in similar institutions proved ineffective to stop or control the spread of leprosy. In addition to the institutions mentioned above there existed what some scholars called leprosy village, which Robert Wulff defines as follows "- - - By a leprosy village we mean a group of leprosy patients who live together in a village exactly as do the people of that area" (Buker, 1965:222). Leprosy village proved effective in Asian countries. Such villages were commonly established by non-governmental institutions with the consent of government officials. The effectiveness of leprosy villages emanated from the psychological satisfaction they provided to the patients. Unlike colonies or other institutions here the movement of leprosy patients are not restricted. Besides, unlike colonies leprosy villages were established near to the dwellings of non-leprosy affected people. Furthermore if non-affected people chose and asked to reside in leprosy villages he/she

was allowed to do so (Ibid, 220-221). Although the researcher could not get relevant literature dealing with leprosy village in Africa, Buker (1965:218) states"- - - in Africa leprosy village formation would be easier than in many countries." The Leprosy village in Gelemso is not an institutional sponsored village. According to informants the first nucleus of today's village started in late 1960s and early 1970s that was during the imperial regime. The earlier settlers of the village were very few. It was their interactions during begging and a visit to drinking places such as **tella** and **teje** houses, which helped them to create a network which later enabled them to rent a plot of land and to erect the first hut at the site. The village is found exactly at the south of Gelemso Medhanealem Church. The village is bounded in the north by a cemetery and eucalyptus trees, in the east by a footpath, and in the west by urban residential houses. There is no clear demarcation between the residential houses and farm fields of the study population. In the village people who have blood relations live in adjacent houses.

3.4.2 Early Settlement in the Village

The site where leprosy associated people live today was previously found at the outskirt of Gelemso town. Until the leprosy patients had settled there, the area was fully covered with eucalyptus trees and shrubs. Formerly the general public knew this area as **Qera** that is the place where animals slaughter places in open air. As a result the area is not suitable for people to reside. However, such area is the only place left for those abandoned leprosy patients. Through interactions they secured land from individuals like Ato Areru and Ato Dayas who were controlling the land at the site. Then they got permission from Ato Areru to build a hut and in return to pay him 30 birr per year. By then they were very few in number and their group constituted only patients. At times when other members joined the group they built new huts with

the permission of the owner of the land and that tradition continued until the 1975 land reform.

3.4.3 The Present Condition of Leprosy Associated Peoples' Village

The 1975 rural land reform had a direct impact on leprosy-associated people in Gelemso. Following the reform they immediately reacted in many ways. Patients who were previously living crowded in groups expanded their positions by constructing new houses. They also controlled a farmland, which belonged to a feudal lord, known as Zeleke Yirgu. This farm field is still controlled by them, which will be discussed in chapter four in relation to survival strategy. The previous condition of the village has been changed in many ways. Until recently, two non-leprosy affected people had a plot of land within the village later claimed by leprosy associated people. At present the land is fully controlled by leprosy associated people. A few children of leprosy-affected people have already constructed iron-corrugated houses within the village. Furthermore, the village is no more the outskirt of Gelemso town. Residents of non-leprosy associated people rather surround it. It is only a footpath that separates the village and the newly built houses in three directions. The northern and northwestern part of the village is still used for cemetery and the rest covered with eucalyptus trees.

With the expansion of Gelemso towards the village inhabited exclusively by leprosy associated people face two challenges. The first is that, the municipal officials already started to question ownership of the land currently used by the study population. The officials argue that, the area controlled by leprosy-associated people is too extensive and used as a farm field while the town has a shortage of land for its expansion. The officials emphasize that leprosy associated people

owned the urban land without any payment to the municipality. An attempt, which did not become effective until the end of my fieldwork was made by municipal officials to take some part of the land and distribute it to urban dwellers. The municipal officials were harassed by the study population, and reverted the attempt, and finally the interference of the district officials' stopped the pressure. The other challenge comes from the urban population who started to lobby some members of the study population to buy land. This pressure is in process. The second challenge according to informants has serious implications for the unity and integrity of the study population. The members of the old generation who are in their 50s and above have a firm stand to maintain the status quo and they have a strong concern for the future of their descendants. The members of the second generation who are moderate in their interaction with the outside community intended to compromise with the pressure from the municipal authorities and the attractive price promised by urban dwellers. This has been to create a crack between the members of the two-generations. The effect will be seen in the future.

3.5 Leprosy Status of the Study Community

The study population can be divided into two groups: those with leprosy cases and their descendants. The latter group itself can be divided into two sections. Among the members of the second generation I found only one individual who was afflicted with leprosy and treated at its early stage.

3.5.1 Leprosy Affected Section of the Community

The people with leprosy cases include both sexes. Members of the section can be grouped into different sub-sections according to their health status. Some of them seem so healthy that no

one except the patients themselves can associate them with the disease because they do not have any imprint left on their bodies. Such members can be taken as a sub section. But they state to have problems in freely manipulating their hands and legs because of loss of sensation. The other section of leprosy-affected people is those patients whose fingers and toes are not wither away but they faced muscular contractions and have claw fingers. Such patients have a serious problem to manipulate their fingers. Besides, such people have also different burnt imprints on their hands, faces and legs. Further, the researcher also found an individual by the name Gadisa Abdo, who was afflicted leprosy when he was 12 and then attended treatment for six months and cured. The last section that falls in leprosy-affected group constitutes those individuals who are seriously affected and those with permanent imprint of the disease. The members include patients those who have lost fingers and toes completely and those with facial deformities also. One woman has faced complicated problems on her hand, feet, and facial deformity and loss of sight.

Periodically Patients are called to Gelemso hospital to take shoes and Vaseline. As the hospital officials confirmed there is no mechanism even to identify a relapse cases or any other ways of transmission in the village. The health workers only used to treat those who have reported to the hospital. That is the method of sits and waits to the problem rather than going out to reach the problem at the spot.

Leprosy affected section of the community have not only physical barriers but also social and economic problems. Their perception towards themselves is very complicated. They believe themselves to be very disgusted persons; even they say that are not different from the dead. In-group discussion one of them mentioned that, since they live beside the grave, so the outsiders

consider us as dead. They consider themselves also as cursed persons. Even though they do not have a history of leprosy in their family, and were born free of leprosy but have suddenly afflicted with it. They are disturbed when they memorize the life they have passed through. The rejection by their own family and relatives makes them more irritable when they talk about it. They feel sad for their children whom they had left behind after being contracted leprosy. The patients talk about loss of respect by the younger generation as well in their own village. The members of the older generation argue that, they had passed through different hardships to up bring their children, but now the children neither give them respect nor take care. Of course, the members of the second generation have their own views, which will be discussed in the following sub topic. The patients are unhappy about social environment, which prevented them from playing their role. For instance, they argue that although they have been teaching their children they have never been to the schools as parents either during registration or at any time even when the children are told to bring their parents. Rather, they ask other people to take their position. Besides, their poor economic status also makes difficult to teach their children. For instance, the following illustrations are the case in point:

Case ten Abdo Ousso, M, is 50.

Abdo Ousso is a leprosy patient and has four children. His wife became insane and deserted him with all the children. By then two of his sons were already enrolled in the primary school and every task both at home and outside fell on his shoulder. Then with the increasing hardship he forced his eldest son, Gadisa Abdo to quit his education at grade six and share tasks with his father. But his second son, Mehadi Abdo, has continued his education and graduated from Alemaya University with BA degree a year before. Now Mahadi who has joined government civil service in Somali Regional state has taken his sister to teach her in Jijiga. The researcher of this study asked Abdo what he feels today and he said is very happy to see the success of his son despite all hardships he passed through, at the same time he feels unhappy by the decision he made against his eldest son, Abdo's

fourth son is now in grade 8 living with his father.

Case eleven, Fatuma Ousso, F, is 45, leprosy victim.

The second impression is about a woman patient called Fatuma Ousso. Fatuma has two sons; her first son is at grade 11 and the second at grade 8. According to Fatuma she had never accompanied her sons until they reached their present stage. The children have different fathers who have abandoned her. Fatuma as a full- time beggar has been living hard life. As she says, after getting breakfast, for her sons, she could not succeed to fulfill their lunch. Above all, she feels sad when she remembers the time her children were forced to return home, because of her inability to buy them school uniform. In order to help her children she had been married to many "**Dulacha**" one after the other literally meaning an old man. But after a short stay the **dulachas** left her by saying that why they should suffer to help some one's child. Now in spite of all difficulty she came through, Halima thanks **Rabi** that is God, because she says one of her son is transferred to grade12.

Despite the patients discontent about their life, the researcher found that the earlier settlers particularly those at old age have controlled the major sources in the village. These sources can be divided into four. The first is the farmland, which the patients have been controlling since 1975. The second source is their status as fathers, elders and founders of the village. The third source is the indigenous knowledge, which attracts many clients from the general public. They have also another source of power, which emanated from their association known as "**Mahabra Chaffee kuffa**" literally means the association of the village of the prosperous. This Association is a member of the Ethiopian National Association for EX-Leprosy Patients. The Association leaders claim that it was their effort that enabled the association to get grain mill, water pumps for irrigation and other periodical support in the material as well as financial forms.

3.5.2 Non - Leprosy Affected Section of the Community

This section constitutes the members of the second generation, which are the children and grand children of leprosy patients who are now in their early10s and late 20s and early 30s of

ages. Besides, it is interesting to note that three families of non-leprosy associated people live in the village with leprosy-associated people. One of them is an ex-militia who was seriously wounded during the Ethio-Somalia war of 1977. The second one is an old widow who lives with her children. The third one is a farmer who lives among the leprosy-associated people. I also found three individuals one married, one is 9th grade student and a third one is a newly born infant. The last one is found after he had been left by the unknown mother and taken by the **Woreda** Labor and Social Affairs Bureau and handed over to one of a leprosy affected woman. The remaining two were found by leprosy patients, after they had been left as infants and adopted by them. As I have mentioned above the descendants of leprosy patients constitute two sub-groups. One of the sub-groups is made up of their (the members of the second generation) immediate children. Some members of this sub group are school dropouts. They have mentioned different reasons to stop schooling. The following cases are good examples:

Case twelve. Chaltu Nure, F, is 18, non- leprosy affected.

> Chaltu Nure is 18 years old. She was born from patient parents. She was married and has 4 children in four years marriage life. She is the only child to her parents. Chaltu was forced to stop school when the Ormo Liberation Front, (OLF) controlled Gelemso and it's environ in 1992. The time was insecure because of lawlessness of the urban youngsters who had joined OLF. Then her parents forbidden her to go to school and she had married four years ago. Since then she lives adjacent to her parents' house. Chaltu as a child of leprosy-affected parents has certain limitations. As Chaltu said her father Nure is a full time beggar. He begs sitting along the road. To avoid stigma by identification with leprosy affected people she has never greeted or talked with her own father. Association with her father would inhibit her social interaction with the general public.

Case thirteen. Jabir Ahemad, M, is 29, non-leprosy affected.

> Jabir Ahmad is another instance among the second generation. He is 29 years old, married from the same village and has 3 children. He attended school up to grade 5. Jabir is a second child to his leprosy-affected father.

Jabir's house is located adjacent to his father. His reason to stop schooling was lack of support. As Jabir explains his father supported three sons via begging. Jabir himself used to beg accompanying women beggars when he was a child. But he says when he grew up he was ashamed of begging and stopped. His father's income has not been enough to fulfill all his needs as a student. Then Jabir stopped his education and joined a patient woman who trading contraband using her deformed physical appearance as a pretext. But that did not last long. Then Jabir became engaged in daily labor and later he got a chance to join an NGO called Care Ethiopia in Gelemso. There, Jabir was trained as carpenter. But he was not given necessary materials to apply and benefit from his training. Later he secured the necessary materials but it was difficult to work and subsist his life out side the village. Jabir associated his difficulty in getting work because of his association of leprosy-affected people.

The perception of the members of the second generation towards themselves as well as to the outside world is more or less similar with the leprosy-affected people. The perception towards the outside world is shaped by the experience they passed through as leprosy affected parents' children. Besides, their perception has been affected by the outsiders' misconception towards them and causes of leprosy transmission. As they affirm no one believes them, to be free from leprosy, rather people continue to believe that, they would afflict it in the future. Furthermore, this sub-section of the community recognized to have different limitations. For instance, when they encounter their own leprosy-affected parents in public they escape to talk with them in fear of social identification and consequently stigma and ostracism. On the other hand, the members of the second generation who are poor themselves are not happy by the "**Jarsota's**" engagement on begging. The term **Jarsota** literally means elders. So they say that they feel ashamed of themselves by not helping their aged beggar parents. In short, I found that the members of the second generation are not satisfied with their over all life they have been leading

Some of the members of the second generation were already married and have children. Most of

the children, except those who are under 7 years, have joined schools. Those small kids have not been able to join any kindergarten until the end of my fieldwork, but I have seen a house constructed by the public intended for kindergarten.

3.6 Interactions Within the Community

3.6.1 Family Based Network

"... all people in all societies are born into networks of kinsmen and acquire complex sets of obligations, privileges, and expected reciprocities with their kinsmen" (Cohn, 1969:106). As the above statement shows clearly no one is born without kinsmen and every member of all societies has expected to play role and get benefit from it. Similarly the individual members of the research community were born into networks but lost these networks later. After a while they have reformed it with a new networks. Such networks begin with the family.

It is a well-known fact that different types of families exist. Nuclear family is a basic type of family. Nuclear family is composed of the household head, wife or wives and their children. Sometimes the type referred as elementary family. As Radcliffee-Brown argues "We may regard the elementary family as the basic unit of kinship structure" (Brown, 1950:5). The other type is commonly known as extended family. This second type is noted for keeping the people of various generations together (Harries and Alfred, 1964:125). Compound family came into being with the remarriage of a widow and a widower with their children from the previous marriage and new children added by the remarriage (Brown, 1950:5).

However, the ideal type does not always fit to the empirical data. In this research, the nuclear

family is the predominant form. Families formed in two ways. The first family type is formed through the remarriage of a widower and a widow in leprosy affected section of the community. Most patients of both sex had their first marriage at their birthplaces. Some of them have had children from their first marriage. However, due to the disease they were abandoned by a partner. Therefore, there is no compound family formation in my research cases due to the reasons mentioned above. The children of leprosy patients form the second type of family. They reside in the same village with their parents. Thus both the patients and their non-leprosy affected children form the community.

The leprosy-affected section of the community has several limitations. The limitations emanate from the disease. Physical limitations surrounded by several social and cultural impacts, are the major ones, which are observed among the study population. Due to the limitations patients are incapable of performing certain tasks. Therefore in order to tackle all the difficulties and survive as a family unit the patients have employed the family based network in the village. The patients especially those who have resided in the village from the very beginning have farmlands in their possessions. However, they are not capable of cultivating due to their physical limitations. In this case children are at their disposal to perform all agricultural tasks. The following illustration is a case in point.

Case fourtinnen. Nure Ebro, M, is 70, leprosy affected person.

> Nure has a land previously belonging to the association and later distributed among members. He has a daughter from his second marriage and a son by adoption. His son Bultum Nure has been performing all agricultural tasks for Nure's family until he married years ago. Even after his marriage he has continued to help. Nure's daughter has also married four years ago. Her husband residing adjacent to Nure's house has taken over all the tasks in the field and provides Nure and his wife with all food crops from the field.

So the patients have used family based networks in such a way. There are a number of other similar cases as well.

As leprosy affected informants have stated, family based networks are also used to tackle their various difficulties during their interactions with the general public. For instance, the patients have a problem in trading in market areas. Hence they send their children with marketable things.

Therefore family based networks have different importance for leprosy-affected section in particular and the non-leprosy affected section of the community in general.

3.6.2 Neighborhood Based Network

The type of neighborhood of the population affects the ways of network establishment among the people. As Mitchell (1987:303) states "The characteristics of village life were that individuals were in contact with one another at practically 'all points of their lives'; everyone knew everything about everyone else..."

Among the study population there are different networks, which serve as a means of interactions both in social and economic support. **Idir** is one of them. People use **Idir** as a means of social security when they face immediate difficulties as a burial association in the village, as well as when they are informed the death of relatives outside the village either at their birthplace or in other leprosy settlements. **Equb** is another neighborhood-based network in the village. Through **Equb** people use to pool resources turn by turn. Among the study population leprosy affected

women have a weekly-based **Equb**, which takes place on Fridays immediately after the morning begging. Like the women, men also have **Equb**, on the same day.

Neighborhood based network is also used to form labour organizations which serve to perform different agricultural tasks. Such labour sharing is locally called **faraqa** literally meaning working turn by turn. Therefore, like that of family based network neibougrhood based network also has several forms and importance for the study community.

3.6.3 Mahabara Chafe Kuffa as Village Network

This sub-title is the name of the local association of leprosy-associated section of the research population. The local association is a member to the Ethiopian National Association for Ex-Leprosy patients (ENAELP). Each family or household is a member to the local association. To become a member a family has to pay 9 birr registration fee and 50 cents membership fee per month. Three non-leprosy associated families living in the village are also members. They pay 1 birr instead of 50 cents as a monthly membership fee otherwise every thing is equal to all the members.

The association serves as sole coordinator of all members in the village. Weekly meetings are held on every Wednesday. The members discuss various issues which include problems encountered in the week around the village, health issues such as family planning, common property and the like. Experts from the Woreda Labour and Social Affairs Bureau and the leaders of the association facilitate the meetings.

Using this village based network members succeeded to tackle different threats directed against them. Their cooperation during the municipal officials attempt to take part of their land can be mentioned as a good example. The attempt was stopped by the harassment of the officials. Besides, during their difficulties they use their organization to ask for help from local officials.

On the other hand, the village-based network is used for other purposes as well. For instance, when one of the members wants to sell a portion of his land for an individual outside the community he presents his request to the association. Then his case is decided by the general meeting of the members. Furthermore, the people also use the village-based network to organize labour to construct houses for those people who have no kinsmen support.

Moreover, informants argue that through their association they could succeed in creating awareness of their members as well as the general public about leprosy. When elected members participated in the meeting held at the national level they brought with them different posters and magazines related with leprosy. Then they distributed the materials to different government offices which they believe have impacts on peoples attitude towards them. After they became the member of the national association they also used to celebrate the annual leprosy day by public rally. Thus village-based network has a number of other advantages for the study community in general.

3.7 Interactions of the Study Community with the General Public

3.7.1 Beliefs About Leprosy and Leprosy Related People by the General Public

As Cohn (1969:103) writes "... inter-and intragroup relations are in constant feedback; neither exists independently of the other...." The point in Cohn's statements is that, there is always a

relation within and between groups and the existence of one implicitly indicates the existence of the other.

Leprosy associated people in Gelemso has maintained different interactions with the general public. In this sub-section the general public's beliefs about the causes and transmission methods of leprosy and their socio-economic interactions with people associated with leprosy has been examined and analyzed.

Despite the fact that leprosy associated people has been living at the present site for more than three decades, the general public has been found employing different names in reference to the village inhabited by the study population. Out of the total informants from the general public covered by survey quessitionaire 38.9 percent call the village "**Ganda Qomattee**", while 27.8 percent call the village "**Yqomatta Safar**" the literal meaning of both terms, the former in Oromo and the latter in Amharic language is the village of leprosy patients. Other 16.7 percent call the village "**Ydikuman Safar**" literally to say the village of the destitute especially those who have physical, social, cultural and economic difficulties. Moreover 11.11 percent call the village "**Ganda Miskin**" literal meaning the village of the indigent. The rest 5.55 percent call the village where leprosy associated people live "**Betekiristian Safar**" literally to say the village around the church. Furthermore, through informal conversation I found also one additional name often used to refer to the village of the study population. This name is **03.** There is no such officially known name. The town where the study site is found has only two **Kebeles** i.e. 01 and 02. So the last name that is 03 is a name attached to the study community to differentiate it from the two **Kebeles** of the general public.

Table 4. Names employed by the general public in reference to the village inhabited by the study population.

Name Employed	Respondents	Percent
Ganda Qomattee	14	38.9
Yqomatta Safar	10	27.8
Ydikuman Safar	6	16.7
Ganda Miskin	4	11.11
Betekirstian Safar	2	5.55
	36	100

Source: compiled from field notes

Thus, the existence of at least five names in reference to a single village indicates that the general public has no clear picture of leprosy-associated people.

Informants from the general public also found in use of different names to refer the disease, leprosy. Besides employing several names in reference to the disease I found among informants that there is a problem of differentiating the name of the disease with the patients. In reference to the disease 38.9 percent use the name "**Qomattee**", 33.33 percent "**Qumitina**", 5.55 percent "**Dikuman**", another 5.55 percent "**Jusum**", still another 5.55 percent "**Yesiga dewe**", further 5.55 percent "**Yeakal gudatenna**" while the rest of 5.55 percent use the term "**Beja**". The last term is an Oromo term for syphilis.

Table 5. Names employed by the general public in reference to leprosy.

Name employed	Respondents	Percent
Qomattee	14	38.9
Qumitina	12	33.33
Dikuman	2	5.55
Jusum	2	5.55
Yeakal Gudatenna	2	5.55
Yesigadawe	2	5.55
Beja	2	5.55
	36	100

Source: compiled from field notes

Therefore, as I have mentioned in the literature section it is not uncommon to find different local names in reference to the most feared disease i.e. leprosy. On the other hand, among the terms mentioned above the term **Dikuman** and **Yeakal Gudatenna** are terms used to refer to the persons rather than the disease. Besides, the term **Beja** as mentioned above is the name of another disease, which was confused for a long period of time with leprosy in many literatures.

It is not also uncommon to attribute leprosy to several factors. Thus 44.44 percent attribute leprosy to heredity, while 22.22 percent beliefs that leprosy is caused by long period of intimate contacts with the infected person. Bacteria are also stated by 11.11 percent. The first 5.55 percent and the rest of 5.55 percent attributed leprosy to virus and punishments of God respectively.

Table 6. Factors attributed as causes of leprosy

Assumed cause	Respondents	Percent
Heredity	16	44.44
Contact with the patients	8	22.22
Bacteria	4	11.11
Virus	2	5.55
Punishment by God	2	5.55
No response	4	11.11
	36	100

Source: compiled from field notes

Moreover, informants were asked whether leprosy is transmittable disease or not. In their responses 77.8 percent said it is transmittable disease while the remaining 22.22 percent argue in the contrary.

Table 7. Knowledge about the transmission of leprosy

Response	Respondents	Percent
Transmittable	28	38.9
Non-transmittable	8	22.22
	36	100

Source: compiled from field notes

Informants were also asked to mention ways and agents of transmission of the disease. Some informants mentioned sweat, flies, and contact with lesion of the patients. Others stated that leprosy is only transmitted from parents to children. Those who noted intimate contact as a means of transmission further argue that leprosy takes as long as 20 years to be transmitted. A few

others mentioned breast-feeding, hand shaking and eating food with leprosy patients as a causative factor for leprosy transmissions.

From all the responses given above, it is possible to note that educational background and informants exposures on health issues in general, leprosy in particular have affected informants beliefs about leprosy related information. On the other hand, although some of the responses seem similar with scientific explanations of leprosy related information it is noted that informants have developed wrong perception. For instance, transmission by hand shaking, by contact to lesion and eating food with the patients are not scientifically proved reasoning. In short, leprosy is still surrounded by wrong beliefs and misconceptions.

On the other hand, informants from the general public state that the socio-economic interactions of leprosy associated people with the general public are considered as almost non-existent. Thus, 72.22 percent said that they excluded people associated with leprosy from all kinds of social life while 16.7 percent state that they underestimated people associated with leprosy. Moreover, 11.11 percent of respondents looked people associated with leprosy as a burden to the general public.

Table 8. The views of the general public towards leprosy associated people.

Response	Respondents	Percent
Avoiding from all types of social life.	26	72.22
Underestimating leprosy associated people.	6	16.7
Considering as a burden on the general public.	4	11.11
	36	100

Source: compiled from field notes

Therefore, from the above explanations one can understand that leprosy associated people still live not only in physical isolation but also in social and psychological isolation. The consideration of leprosy associated people as a burden, also emanated from unbalanced interactions of the study population with the general public. The beliefs of the general public towards leprosy-associated people are affected by different reasons. The first reason is that the leprosy-associated people live in isolated village, which, in turn has created a barrier for frequent interactions and proper understandings of one another. The second reason emanated from lack of sufficient knowledge about the causes and transmission way of leprosy. Not less important point is that considering leprosy-associated people generally as beggars and dependents emanates from information barriers about the social, economic and cultural lives of the people associated with leprosy.

Another interesting point given to the general public was on their willingness about having marriage engagement and sitting in a round table and share food with leprosy associated people. 50 percent of informants stated that they are not willing to eat food together with leprosy associated people, while 27.8 percent said that they have no problem to eat food with leprosy associated people and the rest 22.22 percent of informants refrained from responding the question. Concerning marriage engagement, the response is interesting. For instance, some say "let not happen", others say "I never do it" and still others say "I do not want" and the like. Thus, 16.7 percent argue by saying that they have no problem to engage in marriage, the rest 83.30 percent are not willing to have marriage with leprosy associated people. Among their reasons for not being willing to have marriage is that, it will pollute and harm their descendents. A few others state that their mind would not allow them to perform such things with leprosy-associated people.

Moreover, informants from the general public are not willing to share food, drinking material or sleeping places with people contracted leprosy even if the infected person is their own kinsman. The reason they forwarded is that they do not want to lose their comfortable or happy life and others reasoned out that they do not want to risk their positive social interactions with other friends and consequently encounter ostracism.

Last but not least point in this sub- section is the case of behavior during interpersonal contact of the members of the general public with leprosy-associated people. In this respect, the respondents are more moderate in their responses. Some 66.7 percent say that they would entertain all the

issues posed, and the rest 33.33 percent say that they would immediately avoid leprosy-associated people by giving them cents as alms. This has the implication that the general public is not free from shunning and ostracizing of the victims of the disease.

3.7.2 Duaa As a Means of Social Interaction

People associated with leprosy especially those members of the community who are old and affected by leprosy have maintained certain roles which in turn serve as pulling factors of the members of the general public towards them. Among such roles **duaa** (a form of prayer) is the major one. There are also other roles, which serve as a means of social interaction between people associated with leprosy on the one hand, and the general public on the other. According to Abraraw (1998: vi) "**Du'a** [is] a form of prayer organized by Muslims to seek the help of Allah in order to resolve health related or any other problems." There is another ritual ceremony known with another term but seems has similar functions. This ritual is known as "**wadaja**". As Demissie (1974:51) defines " **Wadaja** is a ritual ceremony held when somebody dies, when there is lack of rain, when somebody is seriously sick for a long time." Almost similar but an elaborated definition of the term also goes like this " **Wodaja** [is] a group ritual ceremony carried out in many houses of Muslim traditional healers, whereby a person with health or any other problems is helped through prayers and songs" (Abraraw, 1998: vii).

As both definitions indicate the rituals involve more than one individual or it is a group performance. Besides traditional societies use such rituals for variety of purposes in their wordily life.

According to informants from the study population and the general public, **duaa** is conducted not only among the Muslims but among the Christians as well. **Duaa** is found to have different functions in this research. People organize **duaa** when members of a family fall sick, when a pregnant woman faces difficulty to deliver a child. Besides following a death of a person **duaa** is commonly organized by the survival members of the deceased. Furthermore, **duaa** is conducted in other occasions as well. For instance, in the past people used to organize **duaa,** when their children were harassed by **kebele** officials for national services. In recent years it has been very common for youth to migrate via Kenya to America and Canada. Thus, before children leave home the parents organize **duaa**. These two latter cases indicate us the diversifications of the use of rituals with the increasing of the socio-economic difficulties of the people.

The researcher of this study got a chance to attend **duaa** in the study village. The following illustration is the case in point:

Case fifteen. Rashid Musa, M, is 57, leprosy victim.

> Rashid arranged **duaa** when his child was sick. Before calling the elders in the village he prepared things like three bundle of **ch'at** people call **aqarra**, three home made loaves of bread people call **qitta** and **hoja** that is boiled dried coffee leaf mixed with milk. The **madab** that is where the people sit is a well-prepared floor covered with green straw. A charcoal is seen burnt. Then the participants summoned for the ceremony sat surrounding the sick child. Among the elders one of them started the ceremony by slicing the **qitta** putting at the head of the sick he has thrown certain parts in different directions. Then the sliced **qitta** is distributed among participants. **Ch'at** is also distributed among participants and chewed and then every-one spite on the sick child. Under the leadership of one of the elders prayer is conducted wishing health for the sick. The logic behind organizing **duaa** is that the sick person becomes healthy after **duaa** because, the ritual damages those evils that caused the illness such as **jinni** that is a disease believed to be caused by satanic possession and **buda** literally it means evil eyes. Every saying and activity in the ritual has its own meaning which is difficult to understand in a short period. So this will be left for future research.

Therefore, **duaa** serves the members of the study community to maintain a social interaction with the larger public. **Duaa** also has immediate benefit for leprosy-affected people. They entertain with **ch'at** at the expenses of their clients who organize the particular ritual. Furthermore, they serve food before starting to chew **ch'at**. Some clients provide them money as a reward for their services. But the point here that needs to be clear is that why people prefer those unfortunate leprosy victims to summon in their home to organize **duaa.** The reason seems more of psychological. According to informants from the general public, this people were the victims of God. They live by begging in the name of God, so they say, " God would hear their prayer more than any normal individual." So, that is their reasons why they look for leprosy victims for **duaa**.

On the other hand, the actors argue that God gave to every one roles to play, thus the teacher teaches, government rules, so they are allowed to live by "**keddaa**", meaning to beg and to pray. This is their perception towards their role.

The other means of interaction emanates from the existence of certain leprosy patients who have been believed to have special knowledge. These include local soothsayer or better known as **Tanquai.** In the village there is one blind leprosy affected woman, frequently visited by the members of the general public for consultation and get solution to their problems. Moreover, there are also about three aged leprosy affected men known as herbalists. As a reward they receive money. Therefore, **duaa** and other means of interaction serve the leprosy-associated people as a means of social interaction. Besides, its immediate economic benefit for the destitute and poor leprosy associated people, such means of interaction have social values as well, which serve as a social integration of the members of the study community in the long run into the

general public.

3.7.3 Interaction in Market Exchange

Traditional market serves as a place where people with different social, economic and cultural backgrounds hold interactions. In market areas complex and variety of interactions are easily observed. However, market interaction does not always provide equal opportunities to all actors. In Habro **Woreda** there are different traditional markets hold at different days of the week. The study population visits markets not only to buy and sell but also to beg. In this discussion only the aspects of trading is dealt with. As it is mentioned in the literature section, studies indicate that non-leprosy affected people were found not willing to buy things from the patients.

The leprosy-associated people in Gelemso argue that their market interaction is surrounded with difficulties. To the local market, they present pumpkin, sweet potatoes, maize, sorghum, onions, **injera** and the like. As informants say until their children grew and started to help them in selling and buying materials from markets with their normal status they personally used to appear in markets with their goods. But whatever quality their materials may have no one asked them. Even when they send their children, those who knew the children created problems by informing to. When strangers asked to buy others informed them through signs such as claw fingers.

When the leprosy affected individuals wants to buy things they were not allowed to touch and test the quality of things they want to buy. Sometimes they were forced to buy things if they once touched. Some shopkeepers and other people as well, receive money by covering clothes on their palm in order not to touch the money. Women informants told me that sometimes they cover all their body to avoid such stigma. As a result, women patients refrained from going to markets they

send either their children or the members of the community who have not been affected by leprosy. Sometimes as male informants tell when they do not have money to buy things like **ch'at** they ask the owners to give them freely, if they are refused they touch it and the owners throw that part and so then the patients took it and chew it. All the above interactions show that leprosy associated people have a problem in their market interactions. Such difficulties mainly arise from wrong beliefs and misconceptions about leprosy.

3.8 Interaction with Other Leprosy Related People at two Settlement Sites

3.8.1 Inter-Settlement Marriage

As studies from different parts of the world show leprosy was noted making marriage arrangement difficult. It affects not only the marriage of leprosy-affected individuals but also for siblings of the victims. It is mentioned that leprosy also causes divorce among spouses. There are many instances of rejection or abandon of wives or husbands after one of them is afflicted to leprosy. Consequently parents are prohibited getting contact with their own children. A family whose child is afflicted to leprosy puts pressures against him/her to leave home in order not to affect in getting husbands or wives for the rest of children.

Informants claim that at the time when the leprosy-affected population began to settle down at the present site males vastly outnumbered females. This created shortage of wives. They have used different means to make the sex ratio proportional. No doubt males had to look for leprosy affected females because the non-leprosy affected people were not willing to have marriage with leprosy victims. They had to visit different places; such as medical treatment centers to look to what they call "**fekata keena**" literally it means someone like us, and neighbouring settlement

areas, where such females could be found. They have also approached women who have been abandoned by their former husbands and those shunned by the community. Through such means males tried to have their marriage partners.

However, with the increasing in numbers of leprosy associated people in the settlement through birth and joining by other patients, the means also has been established to tackle their shortage for women. Those men and women patients married to each other. The newly born children of leprosy patients not affected by the disease started to arrange intra village marriage for some time. But that did not last long as a mechanism. Later with the interests of the three villages in Gelemso, Bedesa and Chiro had been established inter settlement marriage earlier between patients and later on with their non leprosy affected children. In the study site there are leprosy affected and non-affected women who joined the village as a result of marriage arrangements both from Bedesa and Chiro settlements. There are also parents whose daughters were married either to Bedesa or Chiro. As informants explain they have established inter settlement marriage only with the two settlements because of proximity of the site. Some of the leprosy-affected people who by now live in Gelemso previously spent some years either in Chiro or Bedesa. That helped them to have friends and continue to visit each other periodically and later strengthened with inter settlement marriage arrangement. Such marital relations have created further ties between settlements. For instance, when death occurred it was common to visit one another especially relatives of the diseased.

For marriage arrangements it was easy to ask and count genealogical relations because people in the three settlements are predominantly an Oromo. According to informants this is done because

it is a custom, otherwise most of them left home individually after afflicted with leprosy and the probability of having blood relation are very rare.

The children of leprosy patients practice two types of marriage. The first is a marriage arranged by the parents. The second is almost similar but known with the term **Chabsa.** The term in Oromo language means to break. The difference between the two is that the latter one is a kind of ad hoc marriage arrangement while the former takes some days or months.

Marriage in the study population is simpler than in other communities. There is no well-known kind of bride wealth or marriage payments. When the two families settle the proposal the parents of the bridegroom present gifts to the parents of the bride. The first present is given when elders are first sent to the family of the girl. At this time the elders bring a couple of things, known as **Gudunfecha.** It comprises a small amount of raw coffee beans, some amount of tobacco, 3-4 bundles of **Ch'at** and 6 birr. Except the money all are consumed by the elders and other participants on the same day. The money is exchanged into 10 cents coins. Then the mother of the girl or any other woman on behalf of the girl distributes the cents to all neighbors. Those who received the cents later bring different utensils as a gift to the bride during marriage ceremony. The ceremony and the feast are also very simple. If the father of the girl is not in a position to prepare the feast he tells to the parents of the boy that he has allowed his daughter and he finally says to them "**ifdendeyi fudi**" literally it means arrange marriage at the expenses of your cost. Then the parents of the boy bring about 1-3 bucket of grounded flour for porridge and 5-10 liters of food oil for the feast. The bridegroom also buys clothes, shoes and other materials to the girl. That is all.

In relation to marriage, leprosy associated people except those who have married and later divorced or rejected by husbands or wives after afflicted of leprosy, there is only one woman who was married to non-leprosy associated individual and now is divorced because of stigma and insult by members of her in-laws and neighbors. All others have married either within the village or from the other settlements. As some non-leprosy affected members of the study population say when they are not married many girls and boys from the general public were approach them for marriage but they never accept it in fear of future disagreement and insult they would encounter such as **elmma** or **shnni qomatta** literally it means the children of leprosy patients and the leprosy descendants. Besides the parents also could not advise them in concern of future incidents. Therefore, the researcher argue that there are no marriage arrangements between the study population and the general public and this does not seem to happen in the near future as well. Besides, it is also found out that when people are in difficult conditions, they create ways of tackling their difficulty. Last but not least point that needs to be noted is that leprosy associated people have developed certain negative out looks towards the general public in relation to marriage arrangement.

CHAPTER FOUR

4. Livelihood and Survival Strategy of the Population

INTRODUCTION

This chapter deals with the survival strategy of the study population. It presents a detailed exposition of two major means of livelihood of the study population. The chapter covers the following sub-titles: begging as the survival strategy (begging in rural areas, begging on market days, Friday begging, begging in other days) and farming as additional means of livelihood.

4.1 Begging as the Survival Strategy

Begging which has been a common phenomenon in many societies, for some it is a social problem while for others it is a means of making a living and a sources of livelihood. As a social phenomenon, it involves the receiver on the one hand and the givers on the other. It has been stated that begging was non existent in primitive societies and it is a phenomenon which came into being with the coming of private property: "Begging as a phenomenon - a social problem - came into existence with the emergence of private property" (Encyclopedia of Social Work In India, 1968:46). However, for the purposes of this thesis, the researcher use a definition appeared in one of the Ministry of Labour and Social Affairs (MOLSA's) documents. As the document defines ".... Begging is a method of earning one's living from the income obtained by other sectors of the society using age, health and economic conditions as a means for gaining sympathy..." (MOLSA, 1992:2).

The statement points out that there are "a better off sectors" which supports the unfortunate sectors or people with physical disabilities. In this case there are the impoverished sections of the community due to factors related to age, health and economic situations. There are also many other reasons not mentioned in the definition, which force certain sections of the community to resort to begging. As cited in Woubishet (2003:33) Bevan and Ssewaya (1995) begging serves as one of the survival strategies '... Many poor individuals or households adopt three general survival strategies: selling their labour or sexual services, selling assets or resort to begging.' As cited in Pankhurst (1984:161), Pearce (1831) characterized leprosy patient beggars as ' great beggars'.

The study population, which is the main concern of this thesis, consists of beggars and non-beggars in wider perspectives. The beggars are those leprosy-affected people who have been engaged in begging as a full and part -time beggars to obtain a living for themselves and their dependants. The group constituting beggars in turn can be divided into two. The first group of beggars is those who have additional sources to support their livelihood and the second group of beggars is those people who have no other means and exclusively rely on begging as a means of livelihood.

The members of the study population who are not currently beggars constitute almost two groups in relation to begging. The first group is the immediate children of leprosy patients who had a history of begging in the past. The second group is that of small children who are sometimes found begging particularly in the holidays accompanying their grand parents.

Begging among the study population has regular and periodic features. It is conducted both in urban and rural settings involving members of both sexes.

4.1.1 Begging in Rural Areas

Here I mean by rural areas all places except the capital of the **woreda** and other small towns, having market days once in a week and are visited by beggars for alms. Begging in rural areas is conducted in inter- **Woreda** bases. It has periodic features. Furthermore, beggars in this kind of begging are stay for days out of their residential areas. Both sexes take part in rural begging.

According to informants, begging in rural areas is mainly conducted during and after the harvest season. It is conducted on group bases. A minimum of two and a maximum of five beggars form a group in rural begging. However, members of the group are not necessarily from the same family. The beggars take with them donkeys to load alms. Most of the time beggars are given agricultural produces such as maize and sorghum. They get also **ch'at** and prepared food during their travel from village to village. Ritual ceremonies such as wedding, **wadajas and duuas** created good opportunity for the beggars to get food, **ch'at** and other gifts. The rural areas visited by beggars are not necessarily inhabited by kinsmen. As some beggars argue they would not prefer such areas because of bad experiences they passed through, after afflicted to leprosy, while others stated that their kinsmen were not around rural areas roamed by them.

According to beggar informants rural begging involves different difficulties. Some of the difficulties they encountered emanated from the political situation that existed in the area. During the serious struggle between the **Derg** and the Ethiopian Peoples' Revolutionary Party (EPRP)

and later between the **Derg** (the ex-military regime) and the current EPRDF (the Ethiopian Peoples' Revolutionary Democratic Front) with the Oromo Liberation Front (OLF), the beggars faced difficulties from both sides. Government supporters suspected them as agents of opposition forces inquired them and sometimes they put them in **Kebele** prisons for days. On the other hand, when the members of the opposition forces found them traveling in rural areas, they suspect them as government spies and sometimes they also create difficulty in begging. The following illustration is the case in point.

Case sixteen. Rashid Musa and Yuya Abdule, M, 57 and 60, respectively.

> In 1992/93, both beggars went to a place called Hardim for rural begging. By the time Hardim was under the forces of Oromo Liberation Front (OLF.) After one day of their arrival at Hardim, Yuya fell under armed force of OLF. They captured him suspecting him to be as Tigre spy. Then Yuya's arms were chained together and seriously flogged. But later, Yuya was given a chance to verify himself. Then Yuya found someone who knew him as leprosy victim and beggar and then he was released and returned to Gelemso. Since he was seriously flogged he spent about 60 birr to treat his wound caused by the flogging.

Therefore, begging in rural areas has such dangers and costs for beggars. The alms they get from rural begging is divided only among members participated in person.

As beggars argue, in recent years there has been a considerable decrease in begging and in the amount of alms in rural areas. Some of them attributed the decrease to age and deteriorating health conditions. Others mentioned, recurrence of drought, which seriously affected the region and changed the rural community to food aid seekers than givers. Furthermore, a few others stated that when the weather condition was good, they are busy in taking care of their own farms, which in turn affect the frequency of travel to rural areas for begging.

Begging in rural areas especially in the past have had a considerable importance in supporting the livelihood of beggars and their dependants. Begging in rural areas has been affected by natural as well as man-made factors. The availability of other means of livelihood for beggars also has its own impacts on begging in rural areas.

4.1.2 Begging on Market Days

As mentioned earlier in the study area, there are different market days, which fall may be on the same days of the week or on different days of the week. For instance, Tuesday is the market day in Gelemso; Thursday is the market day in Belbelti and Karakurkura almost 20-25 km to the west and east of Gelemso town respectively, along the same road crossing the towns. Saturday is the market day in Mechara and Bedessa almost 35-40 km to the west and east of Gelemso town respectively along the major roads and, the market day in Hardim 15 km to the northwest of Gelemso town is held on Saturdays. Furthermore, the market day in Watchu 10 km to the east of Gelemso is held on Sundays. All these markets are potential areas for beggars.

On market days the beggars sit in-groups of 3-5 along streets where passers-by walk to the market sites in the towns. Groups are formed on gender base, thus men and women grouped separately. The beggars chew **Ch'at** at the place they sat for begging. When passers-by approach them, the beggars appeal commonly in the Oromo language and say, **"Rebi jee sadak nubusi"** meaning " in the name of God give us alms ". After receiving alms, they immediately respond in blessing and say **"Rebi sii hakenu, te oluma"** meaning, "may God give you, may you prosper" and the like. Some unique features are observed on market days begging. At the end of the day when people start to return home the beggars who have been begging at different sites gather

together to share their daily earnings. This is because alms are collective property of the beggars' community. For the same reason beggars who remained at home because of sickness or had to take part in a mourning ceremony, share the earnings of the day equally.

Therefore, beggars who participated in begging on market days besides fulfilling their own livelihood, they use the alms they get to support their friends who failed to accompany them as a result of problems mentioned above. This has positive implications since it is an indirect way of saving for the future. However, there is no any written agreement but only mutual understanding among the members.

4.1.3 Friday Begging

Friday begging is conducted only in Gelemso town where the population lives. As Muslim dominated area the beggars relate the Friday begging with Muslim holiday. The Muslim conduct the major weekly **solat** on Friday.

Like begging on market days, Friday begging is also conducted on group basis. The begging takes place in the morning between 8-10 am. Beggars on Friday visit non-residential houses such as shops, tearooms, hotels etc.... Although Friday begging is related with Muslim holidays, beggars ask for **sadaka** meaning alms from the Muslims as well as Christians. On Fridays, the beggars beg by walking from house to house until they visited all houses along the major street where business houses are found.

It is observed that on Fridays, men walk in a group followed by a group of women. Among the groups of beggars a man and a woman were assigned to receive alms. On Fridays' begging, the

amount of alms given by individuals range from 1 to 10 birr.

Like begging on market days, those beggars who failed to accompany friends on Fridays' begging with the reasons mentioned previously also get their share equal to those participated in begging.

The interesting point related with Friday begging is the existence of **iqub**, which was established based on the money they earned on that particular begging day. Thus, men contribute 5 birr each while women contribute 3 birr and each person gets in rotation. The difference between men and women emanated from the amount they earn. Informants were not willing to tell the amount of money they earn because they beg in-groups and the number of members in a group show variation consequently their income. Therefore, Friday begging besides supporting the livelihood of beggars and their dependants, serves beggars to establish **iqub** for the purpose of money saving.

4.1.4 Begging on Other Days

By "other days" is meant all days of the week except market days and Friday. Begging on other days mainly depends on Christian and Muslim ceremonial holidays as well as on other days. On holidays mainly on Sunday and other yearly-commemorated saint days, beggars sit together along the street leading to Gelemso Medhanealem church and beg. Later beggars congregate near the church and receive food and drink. On Christian holidays, children also take part in begging accompanying their grand parents.

Muslims are the other source of alms for beggars. Besides the well - known yearly Muslim holidays including **Ramadan** there are other Muslim celebration. The Muslims in Gelemso town

celebrate additional holidays because of the existence of well-known **Mesjid** named after the founder. The founder was Shek Omur Aliy, buried in the compound of the **masjid** he founded. The Muslims from **Habro** and other **Woredas** come to celebrate the day of his death. For beggar, this was additional Muslim holiday where they used to beg. Besides, whenever the uncertainty of rain and threatening of drought, the rural people used to congregate with food and **Ch'at** in the mosque to pray, which enables beggars to get the left over in alms from the community, congregated to celebrate the ceremony.

Furthermore, the Muslims who have dominated in the trade in Gelemso town also serve as periodical sources of alms for beggars. The Muslims based on the teaching of the Holy Quran, provide the poor and the needy with some resources in the name of **zekat.** According to beggar informants except one Gurage merchant who brings and distributes **zekat** in their village the rest Muslims provide **zekat** when the beggars go to their houses for begging. Moreover, in addition to begging on holidays, every morning beggars move from house to house to beg for left over food.

Therefore, begging on other days involves two features: firstly alms received on religious holidays; and secondly, begging on other days is conducted only in Gelemso town on individual basis to get left over food. Furthermore, begging on the Christian holy days especially on Sundays and other ceremonially celebrated saint days involve small children besides the regular elder beggars. Beggars get alms both in cash and kind.

4. 2 Farming as Additional Means of Livelihood

For agricultural communities, land is the major source of wealth. Among the study population

some have farmlands while others have no farmland of their own. Those who have possessed land have obtained it during the rural land reform in1975. The land currently being controlled by some of the members of the study community previously belonged to a feudal lord. Those who have been controlling the land include leprosy patients who have settled in the study village in the early 1970s and those who had joined the group in late 1970s and early 1980s. Until the fall of the **Derg** regime, the land was being controlled and managed as communal land. Because of in equal contribution but equal distribution, the disagreement emanated which caused land fragmentation and distribution among members. Those who have children participated more in farming and other related activities, while those without children contributed less labor but shared the products equally. Those patients who have children gave out a portion of their possession of land to their children at their marriage. Therefore, the land is further parceled.

Non-leprosy affected members of the community have a serious shortage of farmland. Therefore, in order to tackle this problem, they either resort to sharecropping or cash rent method. Through both ways farmland is available in Peasant Associations (PA) number 16 and 17, which adjoin the farmland of the study population. Land is the main source of income for widows and other aged widowers also. But because of different problem they cannot cultivate their farmland. So widows and widowers have two alternatives: they have either to give the land for rent or allow the landless to cultivate it in the form of sharecropping. According to informants from the study population a parcel of land, which can be, cultivated in a day with two oxen **(timad)** costs 200 birr per year. As informants state land in cash rent has more advantage than sharecropping, because when the harvest is good, they pay only the money selling the residues of the crops like fodder and fuel and keep all the rest products for themselves. Therefore, presently the members

of the new generation have such mechanisms to have access to land at present but this does not seem a dependable means in the long run.

Among the study population, particularly among the patients there are people who have no land to cultivate and solely live through begging.

Those people who have land at their possession and those who have obtained land in the form of sharecropping and rent mainly produce two crops: maize and sorghum. They also sow haricot beans intercropped with maize and sorghum. Moreover, pumpkins and sweet potatoes make parts of their produces. Some of them have coffee and **ch'at** and a few of them eucalyptus trees in their yard stead, which they use for their own consumption as well as for sell.

Leprosy affected people and their children, usually grow crops during winter while during the summer time using a water pump they have received from German Leprosy Relief Association (GLRA), grow a variety of vegetables such as onion, tomato, carrot, cabbage and the like. However, they have still problems to sell their vegetables in retail, thus other retailers buy them all their produce at wholesale and take it to the market.

As informants argue since their control of the land after the 1975 land reform the members of the study community do not pay any government tax so they have such an advantage over other peasants of the surroundings.

It is very difficult to compare the income earned through begging with the income earned from

ırming activities because of various reasons. This is because there are people who are engaged ı begging and have plantations as additional means of livelihood. Secondly, there are people vho only live through begging. There are also people who live with the income they earn in gricultural produce and working as daily labourer. Furthermore, as disclosed in the previous ections, there was credit service and one individual was found a carpenter among the ommunity. On the other hand, beggars were not willing to disclose the size of their income from egging. Therefore, the existences of these variables make comparison difficult.

There is also the credit service available with low interest rate for the study population. Both ndividuals from patients and non-patients have an opportunity to take 600 birr credit. One woman has been engaged in a petty trade and investing the money on goats. Two leprosy patients who have obtained a credit invested the money to buy donkeys and given to others on rental basis.

Moreover, non-leprosy affected members of the community have get additional income working as a daily laborer in agriculture. As I have already mentioned one individual was trained as carpenter. However, his income has not been viable as he argues because of his association with eprosy-affected people.

Last but not least means of survival strategy for study population in general have been nstitutional support and a common property they administer. As it is mentioned above, GLRA provided to the study population water pump, which was bought at a cost of 6,000 birr. People ıse it to irrigate their land and to produce vegetables. They also get income by letting other people rent the water pump. Members are only required to buy fuel to use the pump and as some

ıformants stated this has created management problem concerning its proper usage. GLRA also :ovided them with grain mill. Concerning this grain mill there are two contradictory views. .ccording to informants from the study population, following its establishment until it stopped 'orking three years ago, it had served the community as an income-generating scheme. After it 'as closed for some time until it resumed operation after being contracted to a man outside the ɔmmunity. However, the man failed to fulfill his commitment and it was closed again after a ear. Although three years have elapsed it was not open until the end of my fieldwork in June 004.

ıs informants from the general public argue, the grain mill was not successful for different easons. The first reason is that except provision of the grain mill by the donor the beneficiaries vere not properly organized and trained to maintain and use the grain mill. Secondly, although ome rural people used the grain mill, others hesitated to use it after they have been informed that he grain mill belongs to people associated with leprosy. Besides, the location of the grain mill, vhich is at one corner of the town, affected its' profitability. So now the grain mill stopped for hree years without any function. Besides, the study population commonly owns eucalyptus trees, vhich helps as an additional income generating means.

Therefore, it is noted that the common property provided to the study population has a ıanagement problem, which emanated from improper empowerment of the community by ;LRA. Had GLRA made more efforts in training personnel, in management and finance, besides ıe provisions of the grain mill and the water pump, the people could have benefited better from ıe provisions and could have supported the community better.

CHAPTER FIVE

5. People Associated with Leprosy and Social Change.

INTRODUCTION

This chapter deals with changes and continuity that have been observed in the socio-economic life of people associated with leprosy.

The socio-economic life of people associated with leprosy is slowly changing as a result of a combination of factors. As Etzioni and Etzioni (1964:405) indicate:

> Viewing the initiation of processes of social change-either revolutions or reforms- largely as a response to social disorganization, caused either internally or externally, implies that change is the outcome of an interplay among a variety of factors. Some factors are mere background conditions, while others are more closely related to the initiation of change.

Starting from its early history, leprosy has been known as the most dreaded disease, which changes its victims into mutilated and crippled, and socially isolated beings. The general public committed multiple evils against patients on the ground of religious thought, superstitious beliefs and cultural explanations in connection with the causes and transmission of the disease.

As in the past people associated with leprosy both patients and their non-patient descendants have continue to live in a village known by the larger public as the village inhabited by leprosy patients. Although in the village are found not only patients but also non-patients even members from the general public. The members of the study population talk about psychological satisfaction and senses of freedom by living in the village exclusively inhabited by people associated with leprosy. One can also see changes in the types of houses the study population use

the village. In the past not a single iron corrugated house in the village was found but now most seven iron-corrugated houses are observed belonging to the study population. The huts ed by the rest of the community are almost similar with the huts that the average peasants in the gion are used to live in.

he other factor of change observed during the fieldwork was the expansion of Gelemso town wards the village inhabited by the study population. The factor has long lasting effects on the opulation. As Motbainor (1985) saw the village was located at the outskirts of the Gelemso wn. The present researcher is also a witness because he knew the village almost 19 years ago as cated in the outskirts of the town isolated from any other village inhabited by the general ublic. But now the village is almost surrounded in all sides by the newly constructed houses. As is already mentioned, one of the members of the study population had sold the land previously his possession to an individual outside the community. Many other people have continued to pproach the study population to secure land by promising attractive prices. There is also a otential threat coming from the municipal officials who have already started to question about ne land controlled by the study population free of charge while the demand for land by urban opulation is increasing.

n spite of the existence of a variety of beliefs about the cause and transmission of leprosy, it is nown that bacteria cause leprosy and that it is less contagious disease. After a number of other nedicines had been used, medical advancement at last succeeded to introduce multi -drug- herapy (MDT) in the 1980s as effective medicine for leprosy treatment. Therefore, achievement n the medical science field is one of the factors that caused change in the socio-economic life of people associated with leprosy.

The introduction of MDT has many effects on people associated with leprosy. For instance, compared to pre MDT medicines, which were taken through out one's lifetime, MDT is taken only between 6-12 months. Further MDT proved its effectiveness to cure new patients diagnosed early and treated very properly. MDT was introduced to Ethiopia in 1983. Beginning from two years after its introduction until 2002 about 82,640 leprosy patients had been treated and left with "cured" status all over Ethiopia (MOH, 2002:46). The section of the study population who were patients has taken the medicine and finally was released with "cured " status. This, in turn, has created new hope and psychological satisfaction for patients and their children. Although there might be a possibility of relapse, the patients were not a threat to transmit the disease to their non-infected children. Even though leprosy left permanent imprints in different forms on their bodies, the patients were found with better appearance without sores and pus, whose presence may cause discomfort on the larger public. Here the efforts of World Health Organization (WHO) deserve appreciation, which provided the medicine free of charge. Although the organization has shifted its target year from 2000 to 2005, it has been working to eliminate the disease by reducing its' prevalent rate to less than one out of 10,000. Therefore, WHO's effort combined with medical advancement in the field are factors responsible for the slow improvements observed in the socio-economic life of people associated with leprosy.

According to patient informants there is also change in the use of certain public services. For instance, in the past, the patients were allowed to seat only at the rear seat of the bus. But now they are free to sit wherever they find open seats. In this regard, the patients also have taken measures to change their appearances when they have to travel with others. For example, the patients have abandoned their untidy clothes, which other community members associate with

beggars called **dirrito,** meaning patched clothes, which produces bad smell unless washed properly. Instead of **dirrito,** they started to wear properly washed clothes during their travel ıses. Thus, they have developed the sense of self-confidence through time.

e is also a change in their interaction with government officials. In the past, they used to ent their cases to government officials standing outside. But now, as any other person, they r to any office to discuss their cases. From their viewpoint this change has emanated from a bination of factors. The improvement in the socio-economic life of the patients, the role ed by the mass media in creating awareness on the part of the general public concerning the se and ways of transmission of the disease which made their interaction more easier than ever ore.

the other hand, their access to land both for residential as well as for farming purposes has tributed to the steady change observed in the socio-economic life of people associated with rosy. Their access to land has enabled the patients to establish their residence without any rictions and enabled them to grow different crops for domestic consumption as well as for rket. Therefore, this has great implications for the people who have been earning their elihood by begging. This factor is a result of a national policy.

e population access to credit service is also a new dimension of change for the people who ve been seen as beggars and dependents for a long period of time. Although currently only a v people are involved in the credit service, it is a good beginning to improve the impoverished e of people associated with leprosy. Besides, access to credit service, it also contributes in

building better image of the people by demonstrating as they can work and succeed to support their own life as any other individual if they get the opportunity.

The role played by the association of the study population is also important for the change observed. The local association, which is a member to the Ethiopian National Association for Ex-Leprosy Patients, has played significant roles, which in turn contributed to changes observed in the socio -economic life of the people. Both patients and their non-patient descendants are members of the association. All of them are registered, pay membership fee to the association and have identification cards. Through this association, they distribute posters, magazines and leaflets dealing with leprosy to government offices as well as to other community members. Moreover, they celebrate the annual leprosy day in public rally and meetings. As they argue, they have been able to see changes in their interaction with the general public from time to time after they have organized themselves in association.

Another not less important reason for the observed changes is the contribution of education. Many of the study population have been found sending their children to schools. In the past, children from such a community usually have encountered many difficulties in their schooling. Quitting education due to lack of proper support, insult from other students and the like were the problems they used to experience. As one student says when they scored better grades in class performances, other students mock at them by saying that" they got a good grade because they eat food coming from different houses", that is to refer to the left over food brought to them by their beggar parents. Although it seems a very simple argument it was very disturbing issue for the children born from patients. However, according to informants there is change in students'

interaction and attitude of students from the general public. Now they play different games together in school and outside. They study together in the study rooms of students from the general public, though not vice-versa. The success of one patient in educating his son to college level and the student's employment create a good hope and inspiration for other families in the community to send their children to school. The success of the student stimulated interest and led to a positive academic competition among students of the community.

There is also a change in begging. In the past, rural begging had been contributing a lot to beggars in securing their living. However, with the factors related to age and health conditions their visit to the rural area for begging has experienced a considerable decrease. As informants argue, the recurrence of drought in the region has also contributed to the decrease in alms due to the incapacity of the former potential alms-giver. Moreover, in relation to begging they also mentioned change that occurred with the increase in members of the followers of protestant group commonly known as "**penttee**" among the Orthodox Christians and "**Wahabis**" among the Muslims**.** Beggar informants call these two groups commonly as "**Oumata Bochola**" meaning people who are disturbers. The Protestants sometimes react negatively to the beggars who appeal for alms in the names of the saints. Besides, the **wahabis** are against traditional ceremonies and rituals such as **wadajas** and **duaas**, which the beggars see as opportunities to get alms in the form of food and **ch'at.** Beggars also talk other changes, with the decrease in the amount of alms they earn by begging sitting in one permanent site, to tackle such problem they frequently change the site where they sit in order to get sympathy and attract new alm givers. They also started to sit along the road used by people who knew them before they afflicted to leprosy and who look them with regret, show sympathy, and give them alms.

Furthermore, beggars say that in the past if they touched any material people would not take back the materials in fear of contagion, but now people take back the materials even after the beggars eat on it.

Avoiding leprosy patients from marriage arrangement by the larger public has been still persistent among the study population. Only one girl born from a member of the study community was married to a member of larger public after she had been lived with her uncle far away from the village of the study population. But the marriage ended in divorce, after the husband heard of about the background of the girl. As non-leprosy affected male informants argue, they were approached by girls from the general public for marriage, but none of them agreed with the girls on the fear of future contradiction and consequent insult. So intermarriage between people associated with leprosy and the general public is non-existent.

Therefore, it can be said that social changes are occurring gradually but surely. Generally, the changes that are observed by the researcher, although some are minor, in the long run will change the socio-economic life of the people associated with leprosy. These changes observed now are the beginning. The researcher believes that they can serve as a step forward hopefully for a better future.

CHAPTER SIX

6. Conclusion

The thesis has discussed the socio-economic life of people associated with leprosy, which include both leprosy patients and non-leprosy affected descendants. The study populations, who are predominantly Oromo ethnic group and Muslim by religion, have been living in the site for more than three decades. The first settlers were a few in number but later had been joined by other leprosy-affected persons of both sexes, and further their numbers have been increasing with natural reproduction, and also with others joining the group through marriage from other two settlement sites in the zone. The number of leprosy-associated people was estimated to be 108 in 1985 (Motbainor, 1985), and now after two decades is estimated to be 200.

Among the study population leprosy- affected people came to the site, except three of whom one is from Wollo and the other two from Arsi, from different places in the former Hararghe Administrative Region, and today's Eastern and Western Hararghe Zones of Oromia Regional State. Besides, except one person who claimed as he was born in Wollo, then lived in Addis Ababa and Dire Dawa and finally came to Gelemso leprosy settlement site, all the rest had rural background. As informants stated the major reason, which forced them to abandon their birthplaces was their affliction with leprosy. Leprosy caused them multi faceted problems. The first problem emanated from the nature of the disease itself. Leprosy is a disease, which changes the sufferers into incapacitated and crippled being unless it is diagnosed and properly treated at its early stages. However, as this study disclosed early diagnoses and treatment was not possible for various reasons. As informants argue they had spent a considerable period of time before they

sought modern treatment. Except for two informants, for all others modern treatment was their second option next to traditional one.

Traditional treatment became their first choice because they found it at easy access in their locality. Besides, it is less expensive both in time, energy and finance, compared to modern treatment, which is found in urban areas far away from the residences of the patients. Further leprosy treatment in the past was confined to specialized treatment center. For instance, Bisidimo is the only leprosy treatment center in the whole of Eastern Ethiopia, until finally the treatment for leprosy integrated in other health center. Therefore, this was also a hindering effect to seek treatment at early stage of the disease.

Moreover, leprosy as socially stigmatized and the most fearful disease not only affects the socio-economic life of patients but also threatens that of their family. The families of the patients who are horrified by all social evils in turn put different pressures against the patients. Among the action taken by the family members include hiding the patients behind the door. This in turn creates conducive conditions for mycobacterium leprae, the bacteria that are responsible for causing leprosy, for affecting the patient severely. Besides, leprosy patients shunned, stigmatized and isolated by family members and friends were pressed and advised to leave home for the well being of the rest of the family. Then follows leaving home first for treatment, which in turn had many consequences for future life of leprosy-affected people.

At the treatment center, besides getting modern treatment, the patients were exposed to information. It was also a chance for patients to know exactly what type of disease they were afflicted with. Further, the patients came into contact with other patients either at treatment

center, settlement sites, roaming around or sitting for begging along the streets. As informants argue when they returned home after months they faced more difficulties. They were more shunned, stigmatized, sometimes robbed all their properties and abandoned by partners. They being compelled by unfavorable socio-economic environment, they abandon their home and migrate to their ultimate destination where they join their fellow patients. This study showed such experience of the patients. Therefore, this research result does not fully support the argument made by some scholars who asserted that leprosy patient with different disability status would survive among agricultural community.

The cause of leprosy was attributed among the study population to multiple reasons. As this study shows the causes of leprosy attributed to culturally justified causes than scientific reasonings. It is attributed to **fella**, **qilensa**, curse by clan members, annoyed **zar** priest, and finally to God. On the other hand, as this research shows there are different local healers who were visited by patients. These are Muslim **shek, kebiras, tanquai, weffa, deressa, tattar taye,** and **chale yamiqotiru.**

Traditional treatments include conducting rituals such as **Attete, Wadaja** and **Duaa**; wearing **qertassa**, using holy water, washing one's body with the blood of goats and eating the flesh of wild animals. Others tried to cure themselves from leprosy by taking medicines prepared from plant roots, leaves and the like.

Roaming and wandering from town to town, from woreda to Woreda and from one rural area to the other characterized the early style of living of the study population. During their journey, they have experienced different difficulties in getting and using public transport even if they could

afford the payments. Further, the general public who feared leprosy were used to remove the soil where the patients had sat or slept.

This study shows that among the study population there are community- based voluntary associations, which include mainly **Idir** and **Equb**. There is also labor-sharing organization called **fereqa.** The voluntary associations and the labour sharing organization comprise only members from the study population and three households from the general public who have been living in the village. Moreover, the study population was also organized in an association, which in turn enables them to be a member of the Ethiopian National Association for Ex - Leprosy Patients. These institutions give to the study population social and economic support.

The perception of the general public towards the study population, as this study shows, is a multifaceted one. There is no consensus among the general public even in referring to the name of the village inhabited by people associated with leprosy. The Oromos call the village " **Ganda qomattee**" and "**Ganda miskin**" while Amharic speakers call it " **Yaqomatta safar**", "**Yadikuman safar**", "**betekiristian safar**" and others call the village 03.

On the other hand, informants from the general public are found that some people using different names without differentiating the disease from the patients. These terms are "**Qomattee**", "**Qumitina**", "**Dikuman**", "**jusum**" "**Yeakal gudatenna**", and "**Beja**."

As this study shows, leprosy affects all-social interaction of the study population with the general public. Marriage arrangement is non-existent among the general public and the study population. The opinions of both communities are found diametrically opposing in this regard. However, in order to tackle their problem in this regard the study community has found arranging marriage

with the community in the village and also established marriage ties with other similar leprosy associated people's settlement.

Interaction of the general public with the study population in market areas reflects two features. The first feature can be seen during the selling and buying of things and the second feature of market interaction takes place while the general public acts as alms giver while certain section of the study population as beggars. The market interaction in buying and selling has a problem for the study community. The problems identified include refusing to buy things from leprosy affected people, forbidding to touch things that leprosy affected people want to buy from the general public, and refusing to take money from the leprosy affected people in order to avoid direct contacts.

As this research shows, begging constitutes the major bases of livelihood for leprosy-affected section of the community. Some leprosy-affected people exclusively depend on begging and use begging as their survival strategy. Other leprosy sufferers supplement their livelihood from income they obtain from agriculture, a few others from credit. Beggars beg both in rural and urban areas, on market days and other days of the week. Non-leprosy affected section of the study population secure their livelihood from agriculture, wage labour in agriculture and a few others supplement their livelihood with an income from petty trade and other activities.

As this research indicates, there are certain changes in the socio-economic life of the people associated with leprosy. The changes emanated from the combination of three major factors. One of the factors of change is related with the medical advancement especially in treatment of leprosy. Consequently leprosy treatment period dropped to 6-12 months compared to life long

treatment in the past. The other factor of change observed among the study population has resulted from the national land reform of 1975. This reform helped the study population to get land for residential purposes as well as for farmland. The other determinants of change came with changes in the attitude of the general public as well as in the study population concerning the nature and ways of transmission of the disease. This change is the result of informal as well as formal education. The role of the media in this regard is also important. This latter change in turn has contributed to the creation of certain positive interactions between the general pubic and the study population. Further, begging, which has been contributing to the living of beggars also showed change as a result of factors related to natural as well as man made.

Last but not least change that have occurred in recent years largely come from the expansion of Gelemso town towards the village inhabited by the study population. This change will have long lasting effects on the study population for the better or for the worse.

This thesis based on qualitative data, tries to reflect the perception of the study population towards their own socio-economic life, and towards the general public and vice versa.

Finally, concerning the socio-economic life of people associated with leprosy social science students have done not much research. Therefore, the researcher hope this research as a pioneer work in the field, will initiate others for further investigation to disclose the socio-economic life of people stigmatized, shunned, rejected and isolated because of their affliction with the age old horrific disease, and their children who suffered different evils simply because they have been born into leprosy affected families.

BIBLIOGRHPY

Abraraw Tesfaye (1998) "Traditional Medicine in An Urban Center: Beliefs and Practices (The case of Dessie Town, Northern Ethiopia") Unpublished MA Thesis, Addis Ababa University.

Alula Abate (1974) "The growth and Development of Small and Medium-Sized Katama Settlement in the Harar Highlands." Rome Academia Nazionali Dei Lincei.

Amakelew Cherkosie (1973) "Opinion Study on the Problem of Leprosy" BA Senior Essay, HSIU.

Asme Giorgis (N.D) "Ya Galla Tarik" (Unpublished Amharic MS).

Assefa Balcha (1992). "Traditional Medicine its Nature and History", Unpublished MA Thesis, Addis Ababa University.

Apeel, Reverend George E. (1980)"Social Aspects of Leprosy In Para State Amazon Vally" in F.Latapi and others (eds.) Leprocy. Proceedings of the XI International Leprosy Congress, Mexico City, November 13- 18,1978. Oxford: Amsterdam.

Bauvier, Leon F. (1976) "Toward a Framework for the analysis of Differential Migration" in Daniel Kubat and Anthony H.Richmond (eds.) International Migration the New World and the Third world. London: Sage Publications Ltd.

Borelli, Jules (1980) Ethiopian Meridionale, Paris: N.P.

Brotto, Enrico (1939). Governo Del Harar, Ic Regime delle Terre Nel Governo del Harar. Addis Ababa: Sevizio Tipografico Governo Generale H.O.I XVI.

Bryant, John (1969) Health and the Developing World. Ithaca: Cornell University Press.

Bryceson, Anthony (1979) Leprosy. Edinburgh: Longman Group Limited.

Buker, Richard S. (1965) "Analysis of Leprosy Control Methods" in Robert Wulff (1966) Village of the Outcasts. New York: Doubledy and Company, Inc.

Caulk, R.A. (1971) " The occupation of Harar January 1887" Journal of Ethiopia Studies. Vol. IX. No.2.PP 1-20.

Christensen, V.Moller and D.R.Hughes (1960) "An Early Case of Leprosy from Nubia " in A.C Mayer (ed) Man Vol.1.No1.

Cohn, Yehudi A. (1969)" Social Boundary Systems" Current Anthropology 10:103-117.

Central Statistical Authority (1984) The 1984/85 Population and Housing Census of Ethiopia Addis Ababa.

Central Statistical Authority (1994) The 1994 Population and Housing Census of Ethiopia Results from Oromia Region Vol.1 Part 1. Addis Ababa.

Cochrane, R.G. (1964). "The History of Leprosy and its Spread Throughout the World" in R.G Cochrane and others. Eds Leprosy in Theory and Practice. Bristol: John Wright and Sons Ltd.

Cochrane,R,G. and Dharmendra(1964). "Leprosy in Relation to its Impact on Society" in Leprosy in Theory and Practice. Bristol: John Wright and sons Ltd.

Darkwah, R.H.K. (1975) Shewa, Menelik and the Ethiopian Empire 1813-1889. London: Helnemann.

Demerew Dagne(1988) "A Short History of Galamso Town from its Foundation Until 1974 " BA Senior Essay, Addis Ababa University.

Demissie Gebre Michael (1974) The Kottu of Hararrghe:An Introduction to the eastern Oromo Experiment Station Bulletin No.68.

Etzioni, Amitai and Eva Etzioni. Eds. (1964) Social Change . New York: Basic Books.

Eyasu Gebru (1983). "Types and Qualities of Services Provided to Leprosy Patients in Addis Ababa with Particular Reference to Alert center." BA Senior Essay, Addis Ababa University.

Forbes, Rosita (1925) From the Red Sea to Blue Nile, A Thousand miles of Ethiopia. London: Cassell and Company Ltd.

Foster, George M. (1973) Traditional Societies and Technological Change. New York: Harper and Row publishers.

Foster, George M. and Barbara Gallatin Anderson (1978). Medical Anthropology. New York: John Wiley & Sons, Inc.

Frist, Thomas F. (1980) "Community Factors influencing the Hansen's disease Patients and His Treatment" in F.Latapi and others (eds.) Leprosy. Proceedings of the XI International Leprosy Congress, Mexico City, November 13-18, 1978. Oxford: Amsterdam.

Fritsch and others (1980)"Employment and Re-Employment." in F.Latapi and others. Leprosy Proceedings of the XI International leprosy Congress, Mexico City, November 13-18,1978. Oxford: Amsterdam.

Gebre Sellassie (1959) Tarika Zamana Zadagmawi Menelik. Addis Ababa: N.P.

Gill, I.k. (1972). Friends, Not Outcast A Social Rehabilitation of Leprosy Patients. New York: Helios Books Publishing Company, Inc.

Girmay Berhie (1973) "A Study of Influencing the Concentration of Lepers in the Neighborhood of Ketchene Area." H.S.I University, Addis Ababa.

Gleichen, Count (1898) With the Mission to Menelik 1897.London: Edward Arnold.

Gonzalez,S (1980) "Stigma and Leprosy" Leprosy in Proceedings of the XI International Leprosy Congress, Mexico City, November 13-18,1978. Oxford: Amsterdam.

Graves, Theodore D. and Nancy B.Graves (1974) " Adaptive Strategies in Urban Migration" Annual Review of Anthropology.3: 117-147.

Guida, dell (1938) "Africa Orientale Italian" Milano

Hagos Yohannes (1973) "Some Aspects of Leprosy as a Social Problem." School of Social Work. H.S.I.U.Addis Ababa.

Hamilton, Bernard (2000) The Leper King and His hears: Baldwin and the Crusader Kingdom of Jerusalem.Cambridge.

Harries, Grace and Alfred (1964)"Property and the Cycle of Domestic Groups in Taita (Kenya)" in Robert F.Gray and P.H. Gulliver (Eds) The Family Estate in Africa. London: Routledge and Kegan paul.

Horn, Joshua S. (1969) Away with All Pests . New York: Monthly Review Press.

Laidler, P.W. and Others (1971) South Africa its Medical History 1652-1892 a Medical and Social Study. Cape Town: C.Struik (pty) Ltd.

Leslau, Wolf (1972) English -Amharic Context Dictionary. Los Angeles.

Luijk,J.N.Van and R.Giel(1969) "Leprosy In Ethiopian Society"(Mimeographed)

Mchenry, Robert. Ed. (1993) The New Encyclopaedia Britanica Vol.9. Chicago: Encyclopedia Britannica, Inc.

Mcneill, William H. (1976) Plagues and Peoples. Harmondsworth: Penguin Books Ltd.

Mesfin Addisse (1992). "Historical and Social Aspects of Leprosy in Ethiopia." Unpublished MA Thesis, Addis Ababa University.

Ministry of Health (2002). Manual Tuberculosis and Leprosy Prevention and Control Program Printed by United Printer Plc. Addis Ababa.

Ministry of Labour and Social Affairs (1992) "Study on Begging in Addis Ababa Action-Oriented"

Mitchell, J.Clyde (1987). Cities, Society and Social Perception. Oxford: Clarendon Press.

ıor Abera (1985) "Survey of Socio-Economic Conditions of Spontaneous Leprosy
lements in Hararghe Administrative Region." BA senior Essay, Addis Ababa University.
k, George Peter and others (1978) "World Distribution of Theories of Illness" in Arthur
en. Ed. Ethnology Vol.XVII No.4, 441-470.
Mochtar (1976) "Voluntary Migration in Indonesia" in Daniel Kubat and Anthony H.
hmond. Eds. Internal Migration the New world and the Third World. London: Sage
lications Ltd.
,P.Jane (1980)"Non-Medical Objectives of Leprosy Control Programme" in F.Latapi
others (eds.) Leprosy Proceedings of the XI International Leprosy Congress, Mexico
y, November 13-18, 1978.Oxford: Amsterdam.
ırst, Richard (1968) Economic History of Ethiopia 1800-1935. Addis Ababa: HSIU press.
ırst, Richard (1984) " The History of Leprosy in Ethiopia" in Medical History. London:
28. P. 57-72 (Mimeographed)
ırst, Sylvia. Ed (1957). "Efforts to End Leprosy the Need for Fuller International
ɔperation" in Ethiopian Observer Vol.1. No.4.
Mahendra K. (1976) "Out-Migration from Urban Areas" in Daniel Kubat and
thony H. Richmond. Eds. Internal Migration the New World and the Third
ɔrld. London: Sage publications Ltd.
E.W.(1964) " 'The new Outlook In Leprosy" in Ethiopia Medical Journal. Vol II.No.3.
ddis Ababa: Artistic Printing Press.
E.W. (1969) Leprosy in Ethiopia. Addis Ababa.
Nancy and Margaret Eckman. Eds. (1997) Diseases. Pensylvania: Spring House
ɔrporation.

Pritchard, E.E.Evans(1937) Witchcraft, Oracles and Magic Among the Azande. Oxford: The Clarendon press.

Radcliffe, A.R. Brow (1964) "Introduction" in Radcliffe, A.R. Brown and Daryll Forde Eds African Systems of Kinship and Marriage. London: Oxford University press.

Read, Margaret (1966) Culture, Health, and Disease. Social and cultural Influences on Health Programmes in Developing Countries. London: Travistock publications.

Richardson, Stephen A. and Others (1961) "Cultural Uniformity in Reaction to Physical Disabilities" in American Sociological Review Vol.26.No.2.

Risse, Guenter B. (1999) Mending Bodies, Saving Souls: A History of Hospitals. New York.

Saui,A.F.Latapi. Eds. (1980) "Leprosy" in Proceedings of the XI International Leprosy Congress, Mexico City, November 13-18,1978. Oxford: Amsterdam.

Schaller, K.F. (1961) "Leprosy Control in East and West Africa" in K.F. Schaller. Ed. Report of the Second National Leprosy Conference of Ethiopia. Addis Ababa.

Schram, Ralph (1971) A History of the Nigerian Health Services. Ibadan: Ibadan University press.

Sigerist, Henry E. (1965). Civilization and Disease. Chicago: The University of Chicago Press.

Sister Senkenesh G.Mariam (1972-73) "A study of the Socio-Economic Problems of Leprosy Patients in a Spontaneous Leprosy Settlement in Ethiopia and the problems of their Rehabilitation." University College of Swansea. Department of Social Administration.

Sofia Mogas (1996) "An assessment of Rehabilitation Services for Ex-Lepers in Woreda 23, Addis Ababa. A case Study on Chereka Leprosy Patients Multi-Purpose Workers Association" BA Senior Essay, Addis Ababa University.

adele Tedla "Leprosy" in Zein Ahmed Zein and Helmut Kloos. Eds (1988) The Ecology of Health and Disease in Ethiopia. Addis Ababa: EMPDA

anami, Tatsuya .Ed (2003) "WHO Special Ambassador's Newsletter for the Elimination of Leprosy" Publisher Yohei Sasakawa.

he Encyclopedia of Social Work in India 1968. New Delhi: Publication Division, India.

he Ethiopian Hearald. 23 December 2003.

he Holy Bible. London: Cambridge University Press.

he Truth (2003) "A Bilingual Bulletin Published Annually by the Ethiopian National Association for Ex-Leprosy Patients." No.4.

he Truth (2004) A Bilingual Bulletin Published Annually by the Ethiopian National Association for Ex-Leprosy Patients. No.5.

izita Abate (2000) "An Assessment on the Effort of Medhin Social Center to Tackle the Socio-Economic Problems of Women Affected by Leprosy." BA Senior Essay, Addis Ababa University.

Gussow, Zachary and Georges Tracy. (1971) "The use of Archival Materials in the Analysis and Interpretation of Field Data: A case Study in the Institutionalization of the Myth of Leprosy as Leper" in American Anthropologist 73: 3. 695-709.

WHO (1980) A Guide to Leprosy Control. Geneva.

WHO (1988) Multi Drug Therapy for Leprosy an End in Sight, WHO: Geneva.

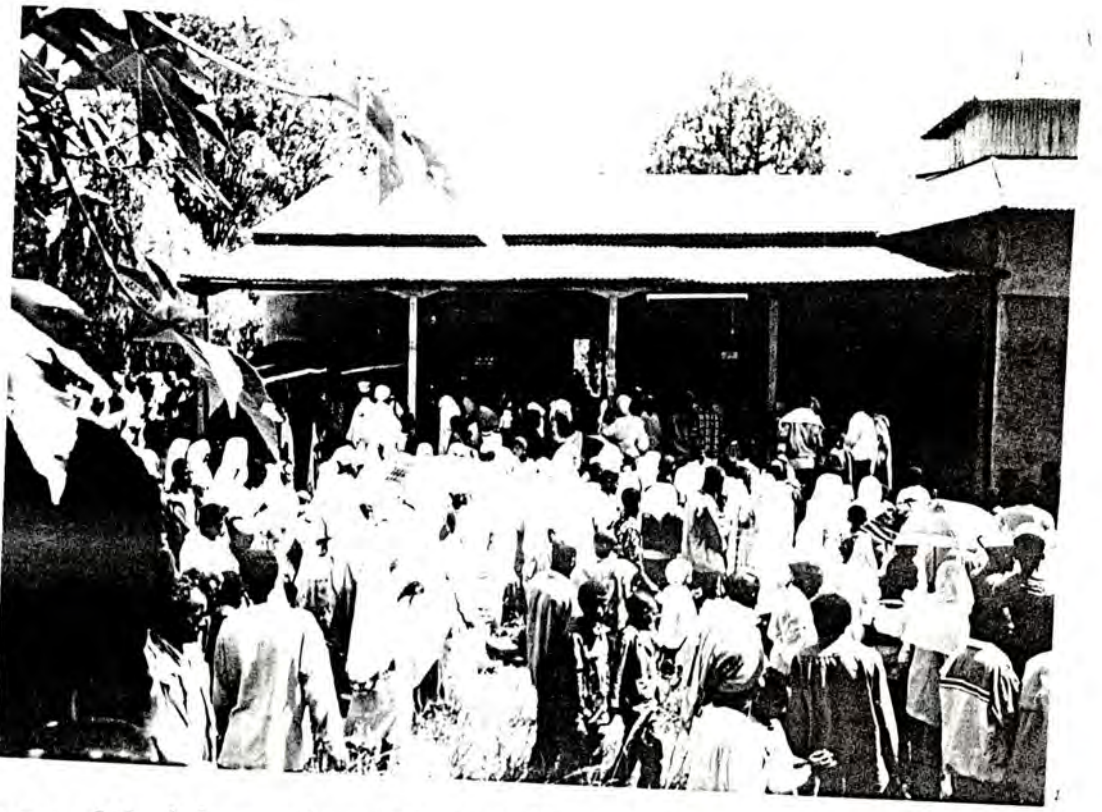
Workafarahu Kebede(1970) "Leprosy an Age Old Problem" in Yacob Woldemariam. Ed. Addis Reporter. vol.2.No.5. Addis Ababa: Artistic Printers.

Youbishet Demewozu (2003) " Begging As a Survival Strategy: Conferring with the Poor at the Orthodox Religious Ceremonial Days in Addis Ababa." Unpublished MA Thesis, Addis Ababa University.

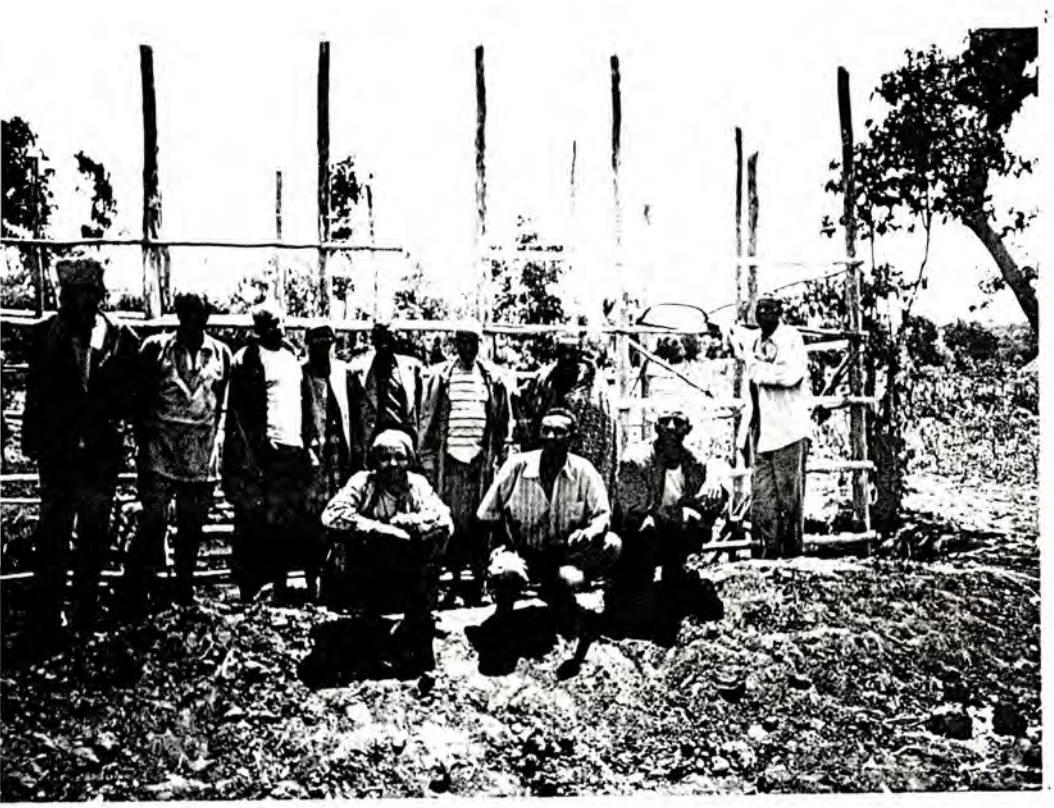
Wulff, Robert M. (1966) Village of the Outcasts. New York: Doubleday and Company Inc.

Yergaw Lemesa (1992) "Rehabilitation of Ex-Leprosy Patients. A Case Study of Addis House and Office Furniture Enterprise." BA Senior Essay, Addis Ababa University.

Partial view of Gelemso town



emso Medehanealem Church People congregated for a
early celebration in Meyazia (April) 27/1996 E.C.



Some members of the study population in front of the office in the process of construction

Some members of the study population congregating for **duaa** following a death of a father of one of their leprosy affected member.

women and a child of the study population in front of the office in the process of construction.

) Abdulahi, leprosy affected patient, in front of him is
sack of maize after taking it from the ground store.

eprosy affected women, one of them with two of her children in the village.

ad Ousman leprosy affected patient and his family
in the study village.

nen with calabash in the open-air market in Gelemso.

Market day in Gelemso.

DECLARATION

ndersigned, declare that this thesis is my original work and that

rces of material used for the thesis have been duly acknowledged.

Demerew Dagne Yirgu

ture: 

December 2004