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**KNOWLEDGE, ATTITUDE AND PRACTICE  
OF THE COMMUNITY**

**TOWARDS CLIENTS WITH LEPROSY**

**IN CHIBOMBO DISTRICT, ZAMBIA.**

**SIMON HAAMBOZI**

**OCTOBER 1995**

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# ABBREVIATIONS USED IN THE STUDY.

## DECLARATION

1. A.I.D.S - Acquired Immune Deficiency Syndrome.
2. W.H.O. - World Health Organisation  
presented in this study for a bachelor of science degree in nursing has not been
3. H.I.V. - Human Immune Deficiency Virus  
being currently submitted for any other degree.

SIGNED : .....  
CANDIDATE

APPROVED : .....  
LECTURER

STATEMENT  
**DECLARATION**

I hereby certify that this study is entirely the result of  
I hereby declare that the work presented in this study for  
a bachelor of science degree in nursing has not been  
presented wholly or in part for any other degree and is not  
being currently submitted for any other degree.

SIGNED : .....  
CANDIDATE

SIGNED : .....  
CANDIDATE

APPROVED : .....  
LECTURER

**STATEMENT**

DEDICATION

I hereby certify that this study is entirely the result of own independent investigations. The various sources to which I am indebted are clearly indicated in the text and in the references.

SIGNED : ..... *Stacow Shoji* .....  
CANDIDATE

## DEDICATION

This study is dedicated to my wife Mrs. I. Haambozi, James, Hamumba, Mum and Dad. Mr. and Mrs. Haambozi, my brothers and sisters.

## **ACKNOWLEDGEMENTS**

I would like to acknowledge my sponsors, the Directorate of Human Resource Development in conjunction with the Ministry of Health for making it possible for me to undertake a Bachelors Degree in Nursing. I am grateful to the World Health Organisation without whose sponsorship this study would not have been possible, and to my supervising lecturer Mrs. P. Ndele for the contributive knowledge, guidance and constructive criticism which made this study successful.

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# ABSTRACT.

The aim of the study was to determine the knowledge attitude and practice of the community towards clients with leprosy among the Liteta area residents following the resurfacing of the Leper Colony at Liteta Hospital Compound.

The ultimate objective was to determine the reasons why Leprosy patients discharged from Liteta Hospital are reluctant to go back home. Instead they opt to build their own houses around the Hospital compound; causing a resurfacing of a Leper Colony.

The study was conducted between August and September, 1995 using a systematically random sample of 100 respondents. 50 Units were former Leprosy Clients and 50 Units were household heads of chief Liteta's area.

A structured Interview Schedule was used to collect the data.

The study revealed that 100% of the respondents have heard about Leprosy but only 70% know that Leprosy is caused by a germ. The rest believe it is either caused by:- witchcraft 10% , curse from God 14% and hereditary 6% respectively.

Attitude is very positive as the respondents indicated that they can live, eat and drink with persons who had suffered from Leprosy (79%).

The study further revealed that 76% participants are against keeping away leprosy patients from the public. 80% of the christians are also in disagreement, but all the moslems 100% feel leprosy patients should be kept away from the public (Isolation).

The former Leprosy clients feel the community is not receptive, they indicated that <sup>having no</sup> lack of relatives, rejection and lack of skills are some of the contributing factors to their reluctance to go back to their respective homes upon discharge from Liteta Hospital.

# CHAPTER I

## 1.0 BACKGROUND

### 1.1 BACK GROUND INFORMATION

Leprosy remains one of the most chronic and disabling diseases of mankind. The World Health Organization (WHO) estimates that, there are 10-12 million cases of leprosy in the world (WHO - technical report series 768, 1988). However, as a result of fear, shame and social stigma associated with the disease; leprosy is greatly under reported and some countries are reluctant to reveal its true prevalence. The exact number of leprosy patients is therefore not known (Leprosy 1990).

Globally, India has the greatest number of people with leprosy, with about 4 million cases (WHO Epidemiology 1985); it is also common in Central and South America; and Brazil has the greatest number of leprosy cases in this part of the world.

In China, leprosy was first recorded in the Nel-Ting (400 BC). The earliest Japanese references to leprosy are also from the 4th Century BC (Clinical Leprosy 1984).

Leprosy is highly prevalent in Central Africa, although most leprosy patients live in Asia, the prevalence rate also is highest in Africa (Yawalkah 5, 1984). There are references amongst slaves from the Sudan, but the first confirmed report of leprosy in Zambia was from David Livingstone in 1869 from Western Province (de Sodenhoff 1987).

From the earliest times, leprosy has been a disease set apart from others. In many communities those with leprosy and those who cared for them had been rejected by Society (Bryceson 1990). Even during the time of Jesus, the Bible states clearly (Luke 17:11-19) that the ten leprosy patients, could not come close to where Jesus was, but asked to be healed from where they were at a distance; showing clearly how Society segregated the patients with leprosy.

The first leprosarium in Zambia was found by the London Missionary Society at Kawimbe Village in Mbala District in 1983. During those days the patients with leprosy were kept in a separate place by the missionaries; these segregated places were called leper Colonies where the leprosy patients lived on their own (Bwino on Leprosy Control P.4 1987).

Zambia before independence had 31 leprosaria around the country, it was not until 4 years after independence that most of them began to close down gradually; and by 1982 only 15 remained. This was due to the introduction of multi-drug therapy and change in the government policy towards isolating leprosy patients int

leper colonies, not only that but also the introduction of scientific investigation of leprosy brought about the discovery of the leprosy bacteria and the increased knowledge has contributed to a reduction in stigma (Bryceson 1980). There is no need therefore to regard leprosy as "special" because the well being of the patient with leprosy has become an integral part of the ordinary health service of many communities.

The leper colonies were leprosy homes isolated from the rest of the community, where leprosy patients used to stay; marriages and many cultural activities used to take place in these compounds: The doctors and the trained dressers were the only people who used to attend and visit the leprosy patients in these colonies, where as people without the disease were not allowed to mix with them.

Leprosy is unique in its psychological aspects: Apart from HIV/AIDS, there is no other disease that is associated with so much stigma and fear, (Ptaltzgraff 1990) -perhaps for this reason leprosy has commonly been considered to be a punishment from God. The negative attitude of society towards leprosy patients include unfortunate reactions such as, insults, rejection even murder:

The patients can even be deprived of food, clothing and access to medical care. Patients with leprosy respond in different ways to the attitudes of Society towards them; some submit and accept the ill treatment while others become aggressive and angry towards - mankind in general for the unjust persecution (Bryceson

1990).

There are about 1,692 registered leprosy patients in Zambia (less than 2 per 10,000 population) (Bulletin of Health Statistics 1982 - 1992) and probably at least the same number again who are not yet registered; more than 95% of these are out patients, 460 are admitted in different leprosy hospitals (de Sodenhoff 1987).

The types of leprosy patients who come for admission to Liteta hospital vary; The main reason for admission to a leprosarium are as follows:-

- (i) Complications such as chronic ulcers with Osteomyelitis.
- (ii) Severe leprosy reactions.
- (iii) Septic or reconstruction surgery.
- (iv) The last category, are the new patients who come for a short period of intensive health education while treatment is being started.

Hence, Liteta Leprosarium became a national centre for teaching, research co-ordination, referral curative and rehabilitation of leprosy Patients.

Rehabilitation initially was very effective because of availability of trained manpower who used to teach and rehabilitate leprosy patients in many skills before discharging them from the hospital. They were taught handcraft such as basket making, mats and use of sawing machine, all these activities prepared the leprosy patient psychologically and

physically to face the future in the community with confidence; but because of the social economic problems these activities are now extinct. Leprosy patients once admitted fear to be discharged from the hospital, may be as a result of the uncertainty of their future in the community especially when they have crippled hands and feet.

In Kabwe Rural, patients discharged from Liteta Leprosarium are reluctant to go back to their respective homes but instead choose to build their own houses in the periphery of Liteta Hospital Compound leading to resurfacing of a leper colony; that is why the researcher would like to study and determine the reasons why these patients do not want to go back to their villages and the response of the community to the new leper colony.

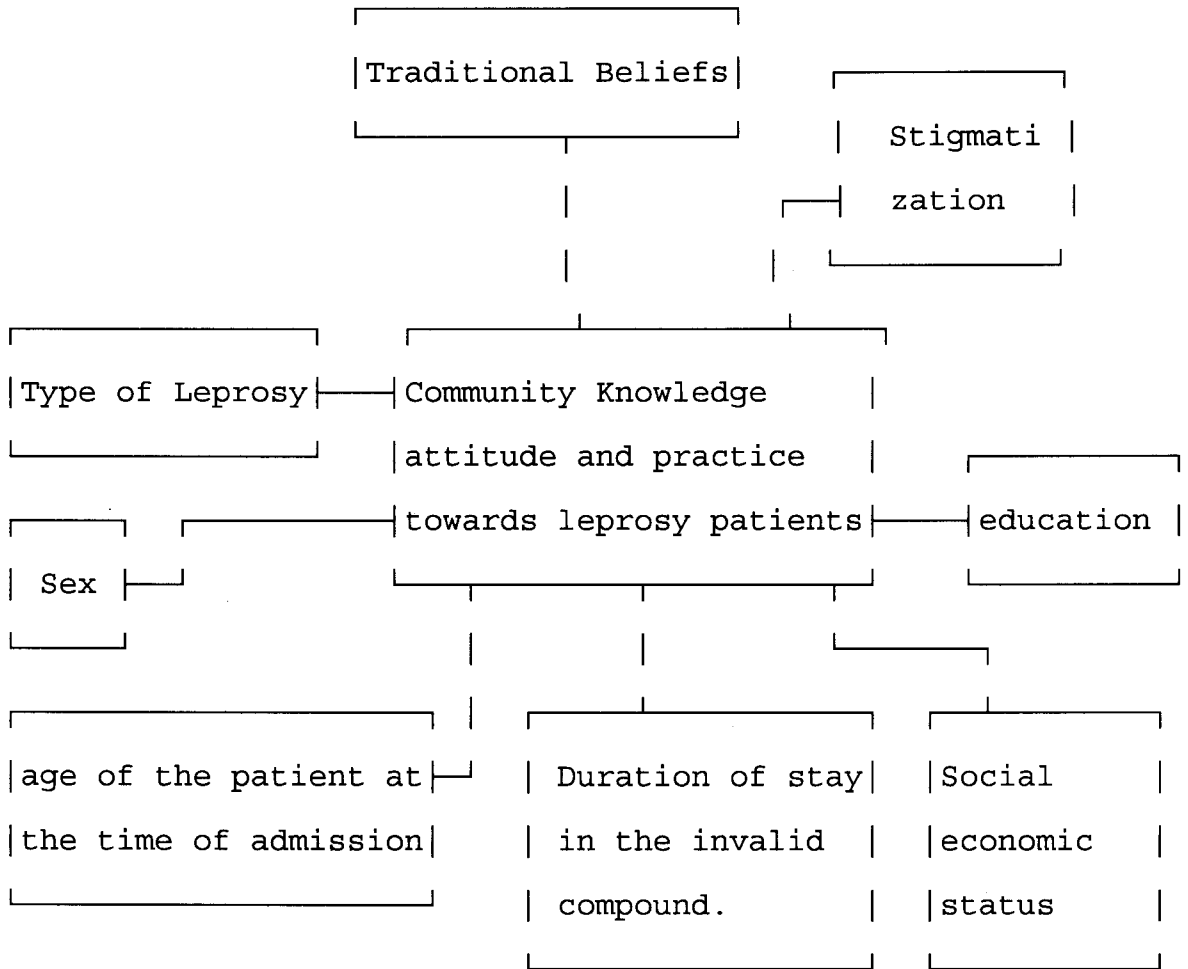
## **1.2 STATEMENT OF THE PROBLEM**

The incidence of leprosy is on the decrease in Zambia, this is reflected in the (1980 census project). There is a drastic decrease from 16,642 (1982) to 1692 (1992) of leprosy cases. An appreciated drop of 90% all this is attributed to increase in awareness, early detection and the effective short term treatment of multidrug - therapy (M.D.T.). Observations and experience have revealed that most of the leprosy patients admitted to Liteta Hospital are generally reluctant to go back to their respective homes of origin when they are discharged despite being given transport and money to take them back home.

Some of the possible reasons could be stigmatization that these patients are subjected to social economic factors may also contribute, traditional beliefs and witchcraft could be another factor. The way community reacts to these patients upon discharge could also contribute.

Although at the moment no research has been done in Zambia, on the community's knowledge, attitude and practice towards leprosy patients, related problems has been observed in Ethiopia where a leper colony is slowly resurfacing because of the former leprosy patients reluctance to join the community, as is the case at liteta Leprosarium.

**FIGURE I: Diagram showing core problem and the contributing factors.**



The researcher has observed that leprosy patients upon discharge from the hospital are happy to remain at the peripheral surrounding of Liteta Leprosarium instead of going straight to their respective villages. The reasons could be because there are many more people of their own kind and are able to socialize among themselves since they share the same affliction. This indicates that Society may not be receptive towards leprosy patients and may look at leprosy people as outcasts. Another contributing factor could be lack of knowledge about the disease by the community.

Leprosy is like any other disease, but the stigma attached to it make life difficult for the patient in the community. Leprosy patients in Liteta for example have there own graveyard separated from the community's, let alone when a leprosy patient dies the ones to bury are fellow leprosy patients: no person without the disease is allowed to touch the dead body of a leprosy patient. At the funeral house only those with leprosy will attend and sleep there as per custom. Those without the disease visit the funeral place only during the day, none of them do sleep at the funeral house; all these actions by the community clearly indicate the traditional beliefs the patient and the community have, towards leprosy. This could be one of the contributing factors as for the reluctance of patients to go back to their respective homes after discharge.

While some of the above mentioned assumptions may be true, there was no scientific evidence to prove these assumptions due to lack of a study carried out here in Zambia. As a result of this, the researcher felt it was necessary to carry out this study to determine the knowledge, attitude and practice of the community towards leprosy patients.

Findings and recommendations of the study will be made available to policy makers at Liteta District Hospital for use in decision making. Findings will also help the TB/Leprosy Unit of the Ministry of Health to evaluate the community awareness and effectiveness of the health education programme on leprosy. The Ministry of Community and Social Welfare will find the findings useful on how to collaborate better with the community in caring for leprosy patients.

The nurse will benefit from the findings by noting the areas of difference in the care of a leprosy patient before discharge. So that she can also know which areas to emphasise upon during the health education delivery.

### 1.3 LITERATURE REVIEW

#### INTRODUCTION

Leprosy is a chronic infectious disease, caused by mycobacterium laprae, discovered in 1873 by Dr. Hansen at Bergen in Norway. Before his discovery leprosy was thought to be a hereditary disease and a punishment from God. His discovery was accepted 6 years later by Albert Neigger who in 1879 stained the organism with fachin and violet: The organism closely resembles the bacillus that cause tuberculosis. It mainly attacks nerves and the skin. The nerves may be involved at any level from the peripheral cutaneous nerve twigs to the dorsal root ganglia. However, the mycobacterium leprea does not affect the spinal cord or the brain (Thangara and Yawlkar 1986).

Leprosy when diagnosed early and treated adequately can be cured with no adverse effects. However if left untreated it may cause severe physical disabilities which often causes severe emotional distress to patients and their families and may also seriously disturb their social life. (a guild to leprosy for field workers. Ross-1977).

## GLOBAL LEPROSY SITUATION

It is difficult to estimate accurately the number of cases of leprosy in the world, because the diagnostic criteria and definitions are not always clear or inconsistent and the enumeration of cases in many parts of the world is incomplete. Nevertheless estimates are given from available data time to time; the WHO estimated prevalence rate of 1966 and 1976 were 10.8 and 10.6 million cases respectively and currently the prevalence is estimated at 10-12 million cases (WHO technical report series 768, 1988).

India has the largest leprosy problem in the world, with an estimated 4 million patients. The number of registered cases in the country was 2.4 million by June 1990 (World health Statistics 1991).

Leprosy is also common in central and South America, Brazil having the greatest number of cases.

The disease is also seen in California, Florida and New York, chiefly among immigrants - (Leprosy Forth edition 1989).

It is highly prevalent in Central Africa, India and south-east Asia, Although most leprosy patients live in Asia, The prevalence rate is highest in Africa (Bryceson 1989).

Leprosy was a serious public health problem in Zambia, with over 16,000 cases in 1982; since then leprosy patients in the country have been put under multidrug therapy (MDT), as recommended by WHO with support from the Sasakwa Memorial Health Foundation.

By 1990 52 districts (93%) had been covered on multidrug therapy, with an overall coverage of about 70% of all patients. As a result the number of registered cases has come down steadily from 16,642 in 1982 (Steenbergen 1991) to 1,692 in 1992 (Census Project 1980).

Attitudes towards leprosy were stronger than those towards epilepsy, particularly with regard to marriage.

Apparently, there is no research done in Zambia on the community's knowledge, attitude and practices towards leprosy patients. However, similar studies have been done in Nigeria.

The research was on attitude of nurses towards leprosy patients in 1992, at the end of the study it was noted that nurses knowledge about the disease was lacking and that they actually feared to nurse leprosy patients. (Leprosy Review, 1992:p169).

This led to the recommendation that leprosy be included in the basic nursing curriculum in order to increase awareness and to decrease the fear amongst the Nigerian nurses. Experience and observation have shown that similar situation is prevailing amongst Zambian nurses, although no research has been done to prove the assumption.

pathic manifestations with the resultant disability and handicaps. The other type of stigmatization is due to social ostracism. This entails that the process of rehabilitation should begin from the moment the disease is diagnosed, and the earliest it is detected the better the prognosis for the patients.

In Ethiopia public attitudes towards leprosy patients was researched and it was discovered that majority of those interviewed (87%) were farmers, with an illiteracy rate of 84%. 95% of these farmers were not willing to employ or work with a person known to have leprosy. 75% would not allow their children to associate with a playmate known to be suffering from leprosy.

Comparative analysis of attitudes in the same community showed that negative attitudes towards leprosy were stronger than those towards epilepsy; particularly with regard to matrimonial associations, sharing of accommodation and physical contact with an infected person. The reason for these differences appeared to be the community's deep rooted belief that leprosy is both hereditary and contagious - expressed respectively by 48% and 53% of the respondents (Leprosy review 1992. P. 157)

In order to minimize the perpetuation of such negative attitudes, there is an urgent need to educate and impress on the community that leprosy, when detected early is a curable infectious disease; which is not congenitally acquired.

Leprosy gives rise to two types of stigmatization one from the disease and its neuropathic manifestations with the resultant disability and handicaps: The other type of stigmatization is due to social ostracism. This entails that the process of rehabilitation should begin from the moment the disease is diagnosed, and the earliest it is detected the better the prognosis for the patients.

The family unit to which the patient belongs plays a vital role in his social life, ensuring and enhancing his self respect and dignity in the society. In no circumstance should a patient be moved from his natural; home environment. hence the need for the community to be knowledgeable about leprosy, and get more involved in hastening the social assimilation of the patients. Communication plays an important role throughout the rehabilitation process, this helps to remove the stigma in the family and in the community and it also promotes good interaction between the staff, patients's families and community at large (Gershom 1992). *not listed*

In poor slum area in sub urban Bombay, a study of 129 leprosy patients with deformities revealed that only 46% were employed before the appearance of the deformities and most of them hand lost their jobs after deformities had appeared. This showed that health education on self care of anaesthetic extremities did not have desired impact on the patients, because they had to take up any kind of work in order to make a living. most of these patients were mostly poorly educated and lacked special skill. The only feasible alternative in this kind of situation appears to be a selective community based rehabilitation of leprosy patients with deformities (Chaturvedi: 1990). *not listed*

In India, all the programme personnel in leprosy were trained to seek cooperation of the public; expecting that sustained information campaign will bring about social acceptance of the leprosy patients and their rehabilitation within the community (Leprosy status report of India 1992 P. 67). In addition pamphlets on leprosy were distributed to promote treatment compliance and alleviate fear and shame arising out of misconception about the disease by the community (Leprosy status report of Myanmar 1991.)

Literature review so far indicates that the patients behaviour is influenced by the medical personnel, community and the social economic pressures; making it difficult for a maimed crippled patient to freely and happily join the community upon discharge from a leprosy hospital.

The zambian situation is not an exception to the problems faced by the other countries on leprosy patients. This situation makes it difficult for the patient to adapt to the environment where majority of these people do not have leprosy.

As stated earlier; with the introduction of new drugs which cure the disease within a short time there is no need for the community to continue fearing and isolating leprosy patients.

Community behaviour could influence the leprosy patients reluctance to join the community if the community still fears and looks at the leprosy patient as an outcast. These are some of the factors the researcher would like to investigate.

Reluctance of leprosy patients to go back to their respective villages after discharge from Liteta hospital has brought worry and dissatisfaction to the Government, it would like those patients to settle in their own villages, which is not the case.

The Government of the Republic of Zambia introduced the multidrug treatment in 1986 in order to reduce the years of treatment from life time to only 2 years maximum and 6 months minimum. This regimen leads to a patient being non infectious within a short period of time after initiation of treatment, hence be able to live together with the community without isolating the patient. This information should be included in the health education to the public in order to minimize the stigmazation and fear of leprosy patients.

#### **1.4 OPERATIONAL DEFINITIONS**

- LEPROSARIA:** A Special Hospital for caring and treatment of leprosy patients.
- RELUCTANCE:** Unwillingness of leprosy patients to go back to their respective villages upon discharge from Liteta Hospital.

**REHABILITATION:** Preparing a patient physically and mentally to take his place in the community again after developing disabilities, e.g. rehabilitation of an amputee.

**STIGMA:** Label or mark of disgrace against leprosy patients, for example regarding them as outcast.

**LEPER COLONY:** An isolated compound or village for former leprosy patients with with their families.

**NEGATIVE ATTITUDES:** Use of unkind words and lack of communication between the community and the patients.

**SOCIA-ECONOMIC STATUS:** Community's level of education or monthly earnings.

### **CONCLUSION**

Literature reviewed indicates that community's knowledge, attitude and practice influence the patients behaviour after discharge from a leprosarium.

## CHAPTER TWO

### OBJECTIVES

#### 2.1 GENERAL OBJECTIVES

To determine knowledge, attitude and practise of the community towards clients with leprosy and make recommendations to the relevant authorities for appropriate action.

#### 2.2 SPECIFIC OBJECTIVES

- 2.2.1 To determine the knowledge the community has on leprosy.
- 2.2.2 To determine the attitude the community has towards leprosy patients.
- 2.2.3 To determine the practice community has towards leprosy patients.
- 2.2.4 To determine the traditional beliefs the community has towards leprosy patients.
- 2.2.5 To determine whether the social-economic status of the community contribute to stigmatization.
- 2.2.6 To determine whether educational level of the community contribute to knowledge, attitude and practice positively or negatively towards leprosy.

- 2.2.7 To determine the traditional belief the patient has about leprosy.
- 2.2.8 To determine the reasons for reluctance.
- 2.2.9 To determine whether the educational level of the patient contribute to reluctance.
- 2.2.10 To identify areas for further research.
- 2.2.11 To determine the resource gaps arising from the above objectives and make recommendation for action.

**INDICATORS AND CUT-OFF POINTS OF VARIABLES AND OPERATIONAL DEFINITIONS THAT COULD NOT BE MEASURED.**

VARIABLES	INDICATORS	CUT OFF POINTS
DEPENDENT VARIABLES		
KNOWLEDGE	KNOWLEDGEABLE  NOT KNOWLEDGEABLE	3-5  0-2
ATTITUDE	POSITIVE  NEGATIVE	2-3  0-1
PRACTICE	GOOD  POOR	2-3  0-1

## CRITERIA FOR INDICATORS AND OPERATIONAL DEFINITIONS

- KNOWLEDGE:** The household member of the community :
1. Should be able to state what leprosy is.
  2. Should have been given leprosy advise by a professionally qualified worker.
  3. Should know that leprosy is caused by a germ nit a curse from God.
  4. Should know that leprosy is curable.
  5. Should be able to mention one sign of leprosy.

**ATTITUDE: POSITIVE:** The community should consider:

1. Leprosy is like any other disease
2. That leprosy patients should enjoy life like any other person, they should not be subjected to isolation.
3. That Leprosy patients can live together with the community members as long as they are receiving treatment.

**NEGATIVE:** Respondent should score 0-1 points of the set criteria.

**PRACTICE - GOOD:** The community should consider:

1. Eating with the leprosy patients.
2. Drinking beer together with the patient.
3. Living together in the same house.

**POOR:** Respondent should score 0-1 points of the criteria.

## CHAPTER 3

### **METHODOLOGY**

#### **3.1 RESEARCH DESIGN**

For the purpose of this study a descriptive and explanatory research design was used, because it involved a systematic collection and presentations of data in order to give clear picture concerning the community;s knowledge attitude and practice towards clients with leprosy.

The study was quantitative in that data collected was quantified in numerical values and later on analyzed statistically.

#### **3.2 RESEARCH SETTING**

The study was carried out in Chief Liteta area in Chibombo District because it is a known place where leprosy patients have settled. The area has a population of 44,557 people, mainly subsistence farmers and few commercial farms. it has 2 Secondary Schools with a lot of primary Schools.

The area is served by two Hospitals, Liteta Leprosarium and Mwachisompola demonstration zone. There are also 7 health centres in the area involved in the health care of liteta community.

The study included Liteta leprosarium Hospital Compound and 5 villages.

### **3.3 STUDY SAMPLE**

The study sample included two groups. The first study sample involved male and female households in the Liteta community above the age of 17 years. These household members were chosen to provide information on knowledge attitude and practice of the community towards clients with leprosy.

The second study sample was the former clients with leprosy in the Hospital compound these were included in the study because they are the ones who are reluctant to go back to their respective homes after discharge from Liteta hospital leading to resurfacing of a leper colony. They provided information on the attitude of the community towards them (clients with leprosy).

### **3.4 SAMPLE SIZE**

A total of 100 respondents was sampled. 50 units from the community and 50 units from former leprosy clients in the Hospital Compound.

### **3.5 SAMPLING METHOD**

#### **SAMPLING OF THE COMMUNITY**

Five villages were selected for the study out of 28 villages. These villages were randomly selected using the table of random numbers.

This method was used in order to give an equal chance of every household to participate in the study.

In each village 10 units were systematically and randomly selected using the Headman's registers until 50 units from the 5 villages was obtained.

### 3.6. SAMPLING OF THE CLIENTS WITH LEPROSY

A sample random sampling method was used to select 50 units out of a total of 75 former leprosy clients, because this provided an equal opportunity for member to be selected.

The method was also chosen because it is the best method to use when the population is concentrated in one area and it is less costly.

### 3.7 DATA COLLECTING TECHNIQUE

Data from the community and former patients with leprosy was collected using a semi structured interview schedule.

#### A SEMI STRUCTURED INTERVIEW SCHEDULE

This data collecting tool was used to collect data from both subject samples. Questions were written in English but were translated into 3 main Zambian languages. (Bemba, Tonga, Nyanja) appropriate to respondents being interviewed.

The interview schedule was chosen for collecting of data for the following advantages.

1. The interview allows for further probing of some questions to get correct response.
2. The researcher was able to replace some question without changing the original meaning since study elements included both literate and illiterate community household subjects and the former patients with leprosy.
3. The researcher tried to minimise the amount of incomplete response by ensuring that all questions are answered.
4. A high response rate was assured as the researcher and the research assistant conducted the interviews.

The disadvantage of this tool is that the presence of the researcher and the research assistant may have influenced on the subject response. This limitation was controlled by explaining the purpose of the study and introducing the interviewers.

### **3.8 ETHICAL CONSIDERATIONS**

Before conducting the study, written permission was sought from Liteta Hospital Director and chief liteta. The researcher also obtained verbal consent from individual community household members and the former patients with leprosy who participated in the study so that they understand the nature and purpose of this research and to assure them of confidentiality.

### 3.9 PILOT STUDY

A preliminary study done on the community households subjects outside the villages earmarked as sample villages and on patients in the wards with leprosy, using the same procedure of the research design.

This helped the researcher to identify problems that could be encountered during data collection.

This pilot study helped the researcher to test the feasibility of the data collecting tools and how to use them looking at their validity, time taken for the administration and the possible problems. In case of problems some changes were made to enhance accuracy in data collection.

### 3.10 LIMITATION

The study was conducted within the major limitation of time, finances and the busy schedule of a student so a large sample was not taken instead only 100 respondents.

The study was small and carried out in isolation with insufficient previous study evidence, this entails that the study result can only be generalised to people living in Kabwe rural.

# CHAPTER 4

## ANALYSIS AND PRESENTATION OF DATA

Data from the community and former leprosy patients was collected using a structured interview schedule.

All interview schedules were checked for accuracy, completeness and consistency in responses. Responses from open ended questions were categorised and loaded all responses to variables were coded using numerical codes in nominal and ordinal scales.

The coded data was entered on a coding sheet to create a data matrix record. Analysis of data was by computer using EPI-INFO software. Descriptive statistics using frequency distribution and percentages were used to ascertain the significance of cross-tabulation.

Tabulation data was presented in single and cross tabulated tables to conserve space, for easy interpretation and for the purpose of drawing meaningful inferences.

TABLE 1A: SEX OF COMMUNITY RESPONDENTS IN RELATION TO AGE

N=50

SEX	AGE OF RESPONDENTS					TOTAL	NUMBER
	17-24	25-31	32-40	40 & ABOVE	UNKNOWN		
FEMALE	23%	32%	23%	19%	5%	100%	22
MALE	25%	29%	14%	21%	11%	100%	28
TOTAL	24%	30%	18%	20%	8%	100%	50

Table 1a shows the sex and age distribution of the respondents

44% were females and 56% males with the majority in the age range of 25 - 31

TABLE 1B: SEX OF FORMER CLIENTS WITH LEPROSY RESPONDENTS IN RELATION TO AGE

N=50

SEX	AGE OF RESPONDENTS					UNKNOWN	TOTAL	NUMBER
	20-25	26-30	31-35	36-40	41 & ABOVE			
MALE	0%	0%	4%	8%	54%	33%	100%	24
FEMALE	0%	0%	0%	12%	62%	27%	100%	26
TOTAL	0%	0%	2%	10%	58%	30%	100%	50

Table 1b shows the sex and age distribution of the respondents. 52% were males and 48% were females with the majority in the age range of 41 and above and nothing in the range of 20-30 years

TABLE 2A: AGE OF THE COMMUNITY IN RELATION TO RELIGION

N=50

AGE	RELIGION				NUMBER
	BAHAI	CHRISTIAN	MUSLIM	TOTAL	
17-24	0%	100%	0%	100%	12
25-31	7%	93%	0%	100%	15
32-40	11%	89%	0%	100%	9
40 & ABOVE	10%	80%	10%	100%	10
DON'T KNOW	0%	75%	25%	100%	4
TOTAL	6%	90%	4%	100%	50

Table 2a shows the age and religion distribution of the respondents. Most of them 90% were christians and the muslims showed a low 4% with the majority in the age range of 25-32 years.

TABLE 2B: AGE OF THE FORMER CLIENTS WITH LEPROSY IN RELATION TO RELIGION

N=50

AGE	RELIGION					NUMBER
	BAHAI	CHRISTIAN	MUSLIM	OTHERS	TOTAL	
20-25	0%	0%	0%	0%	100%	0
26-30	0%	0%	0%	0%	100%	0
31-35	0%	100%	0%	0%	100%	1
36-40	0%	100%	0%	0%	100%	5
40 & ABOVE	0%	100%	0%	0%	100%	29
DON'T KNOW	0%	100%	0%	0%	100%	15
TOTAL	0%	100%	0%	0%	100%	50

Table 2b shows the age and religion distribution of the former clients with leprosy respondents. 100% were christians and none in other religion. Majority in the range age of 41 and above.

TABLE 3A: MARITAL STATUS ACCORDING TO SEX OF RESPONDENTS

N=50

MARITAL	SEX			NUMBER
	FEMALE	MALE	TOTAL	
DIVORCED	0%	11%	6%	3
MARRIED	73%	50%	60%	30
SEPARATED	5%	4%	4%	2
SINGLE	23%	32%	28%	14
WIDOWED	0%	4%	2%	1
TOTAL	0%	100%	100%	50

Table 3a shows the marital status according to sex of the community respondents. 60% were married and 28% single.

TABLE 3B: MARITAL STATUS ACCORDING TO SEX OF FORMER CLIENTS WITH LEPROSY RESPONDENTS

MARITAL	SEX			NUMBER
	FEMALE	MALE	TOTAL	
DIVORCED	8%	25%	16%	3
MARRIED	42%	38%	40%	30
SEPARATED	8%	13%	10%	2
SINGLE	15%	8%	12%	14
WIDOWED	27%	17%	22%	1
TOTAL	100%	100%	100%	50

Table 3B shows the marital status according to sex of the former clients with leprosy respondents. 40% were married.

TABLE 4: EDUCATIONAL LEVELS IN RELATION TO OCCUPATION OF THE COMMUNITY RESPONDENTS

EDUCATION	OCCUPATION						NUMBER
	BUSINESS	CASUAL WORKER	OTHERS	PEASANT	UNEMPLOYED	TOTAL	
COLLEGE	0%	0%	20%	0%	0%	4%	2
NONE	10%	0%	0%	18%	67%	12%	6
PRIMARY	50%	33%	20%	73%	33%	46%	23
SECONDARY	40%	67%	60%	9%	0%	38%	19
TOTAL	100%	100%	100%	100%	100%	100%	50

Table 4 shows that the community's respondents with primary education constituted the majority of the sample

TABLE 5: EDUCATIONAL LEVELS IN RELATION TO TRIBE OF THE FORMER CLIENTS WITH LEPROSY RESPONDENTS

EDUCATION	TRIBE						TOTAL	NUMBER
	LOZI	NYANJA	LENJE	TONGA	BEMBA	OTHERS		
COLLEGE	0%	0%	0%	0%	0%	0%	0%	0
NONE	0%	45%	75%	100%	40%	86%	2%	1
PRIMARY	100%	55%	25%	0%	50%	14%	36%	18
SECONDARY	0%	0%	0%	0%	10%	0%	62%	31
TOTAL	100%	100%	100%	100%	100%	100%	100%	50

Table 5 shows that most of the former clients with leprosy had never been to school 62% and none has attained college education. There is variety in the tribe distribution in relation to education.

TABLE 6: MONTHLY INCOME IN RELATION TO AGE OF THE RESPONDENTS

INCOME	AGE					TOTAL	NUMBER
	17-24	25-31	32-40	40 & ABOVE	DON'T KNOW		
K10,000-K20,000	0%	0%	0%	33%	67%	100%	3
K20,000-K30,000	60%	40%	0%	0%	0%	100%	5
LESS K10,000	25%	28%	25%	16%	6%	100%	32
OVER K30,000	10%	40%	10%	40%	0%	100%	10
TOTAL	24%	30%	18%	20%	8%	100%	50

Table 6 shows that most of the community respondents earned less than K10,000 with the majority in the range of 25-32

TABLE 7: AGE IN RELATION TO CAUSES OF LEPROSY AS PERCEIVED BY PARTICIPANTS

AGE	CURSE	GERMS	HEREDITARY	WITCHCRAFT	TOTAL
17-24	1 (8%)	10 (83%)	0 (0%)	1 (8%)	12 (100%)
25-31	0 (0%)	15 (100%)	0 (0%)	0 (0%)	15 (100%)
32-40	2 (22%)	5 (56%)	1 (11%)	1 (11%)	9 (100%)
40 & ABOVE	3 (30%)	3 (30%)	2 (20%)	2 (20%)	10 (100%)
AGE UNKNOWN	1 (25%)	2 (50%)	0 (0%)	1 (25%)	4 (100%)
TOTAL	7 (14%)	35 (70%)	3 (6%)	5 (10%)	50 (100%)

Table 7 shows that the majority of the respondents know that leprosy is caused by a germ 70%. Very few attribute it to hereditary 6%.

TABLE 8: SEX IN RELATION TO CAUSES OF LEPROSY AS PERCEIVED BY PARTICIPANTS

SEX	CURSE	GERMS	HEREDITARY	WITCHCRAFT	TOTAL
FEMALE	5 (23%)	14 (64%)	1 (4%)	2 (9%)	22 (100%)
MALE	2 (7%)	21 (75%)	2 (7%)	3 (11%)	28 (100%)
TOTAL	7 (14%)	35 (70%)	3 (6%)	5 (10%)	50 (100%)

Table 8 shows that 75% and the 64% of males and females respectively believe the germ cause leprosy. Predominantly witchcraft is believed to be the cause by males.

TABLE 9: EDUCATIONAL LEVEL IN RELATION TO PARTICIPANTS RESPONSES AS TO WHETHER LEPROSY IS CURABLE

EDUCATIONAL LEVEL	NOT CURABLE	CURABLE	TOTAL
COLLEGE	00%	02%	02%
SECONDARY	00%	19%	19%
PRIMARY	04%	19%	24%
NONE	3%	03%	06%
TOTAL	7 (14%)	43 (86%)	50 (100%)

Table 9 shows that all the participants who have attained college education say leprosy is curable. Of those who have never gone to school half say it is curable while half are saying it is not curable.

**TABLE 10: PARTICIPANTS' AGE AND RELATION TO EATING TOGETHER AND LIVING WITH A PERSON WHO HAD SUFFERED FROM LEPROSY.**

<b>AGE</b>	<b>CANNOT EAT/ LIVE TOGETHER</b>	<b>CAN EAT/ LIVE TOGETHER</b>	<b>TOTAL</b>
<b>17-24</b>	2(17%)	10(83%)	<b>12(100%)</b>
<b>25-31</b>	2(13%)	13(87%)	<b>15(100%)</b>
<b>32-40</b>	2(22%)	7(78%)	<b>9(100%)</b>
<b>40 &amp; ABOVE</b>	3(30%)	7(70%)	<b>10(100%)</b>
<b>AGE UNKNOWN</b>	4(100%)	0(0%)	<b>4(100%)</b>
<b>TOTAL</b>	<b>13(26%)</b>	<b>37(74%)</b>	<b>50(100%)</b>

TABLE 10: Shows that majority of the participants can live and eat with some who had suffered from leprosy . On the average 79% and the higher the age group the more the rejection to live or eat.

**TABLE 11: PARTICIPANTS' RELIGION AND RELATION TO EATING TOGETHER AND LIVING WITH A PERSON WHO HAD SUFFERED FROM LEPROSY.**

<b>RELIGION</b>	<b>CANNOT EAT/ LIVE TOGETHER</b>	<b>CAN EAT/ LIVE TOGETHER</b>	<b>TOTAL</b>
<b>BAHAI</b>	0(0%)	3(100%)	<b>3(100%)</b>
<b>CHRISTIAN</b>	11(24%)	34(76%)	<b>45(100%)</b>
<b>MUSLIM</b>	2(100%)	0(0%)	<b>2(100%)</b>
<b>TOTAL</b>	<b>13(26%)</b>	<b>37(74%)</b>	<b>50(100%)</b>

Table 11: Shows that 76% of the christians can live and eat with a person who had suffered from leprosy . Were as all Moslems can not eat and live with a person who had suffered from leprosy 100%.

TABLE 12: PARTICIPANTS' EDUCATION LEVEL IN RELATION TO EATING AND LIVING TOGETHER WITH A PERSON WHO HAD SUFFERED FROM LEPROSY

EDUCATION	CANNOT LIVE/EAT TOGETHER	CAN LIVE/EAT TOGETHER	TOTAL
COLLEGE	0%	2%	2%
SECONDARY	6%	0%	6%
PRIMARY	5%	18%	23%
NONE	2%	17%	19%
TOTAL	13%	37%	50%

Table 12 shows that all participants who have attained college education 100% can live/eat together with persons who had leprosy, on the other hand, it shows that all those who have never been to school cannot live/eat together with a person who had leprosy - 100%

**TABLE 13: PARTICIPANTS' AGE IN RELATION TO VIEW ABOUT QUARANTINE OF LEPROSY PATIENTS**

<b>AGE</b>	<b>NO</b>	<b>YES</b>	<b>TOTAL</b>
<b>17-24</b>	11(92%)	1(8%)	<b>12(100%)</b>
<b>25-31</b>	14(93%)	1(7%)	<b>15(100%)</b>
<b>32-40</b>	7(78%)	2(22%)	<b>9(100%)</b>
<b>40 &amp; ABOVE</b>	5(50%)	5(50%)	<b>10(100%)</b>
<b>AGE UNKNOWN</b>	1(25%)	3(75%)	<b>4(100%)</b>
<b>TOTAL</b>	<b>38(76%)</b>	<b>12(24%)</b>	<b>50(100%)</b>

Table 13: Shows that on average 76% participants are against keeping away leprosy patients from the public.

**TABLE 14: PARTICIPANTS' RELIGION IN RELATION TO VIEW ABOUT QUARANTINE OF LEPROSY PATIENTS**

<b>RELIGION</b>	<b>NO</b>	<b>YES</b>	<b>TOTAL</b>
<b>BAHAI</b>	2(67%)	1(33%)	<b>3(100%)</b>
<b>CHRISTIAN</b>	36(80%)	9(20%)	<b>45(100%)</b>
<b>MUSLIM</b>	0(0%)	2(100%)	<b>2(100%)</b>
<b>TOTAL</b>	<b>38(76%)</b>	<b>12(24%)</b>	<b>50(100%)</b>

Table 14: Shows that 67% of the Bahai participants feel leprosy patients should not be kept away from the public. 80% of the christians are also in disagreement, but all the Moslem 100% feel leprosy patients should be kept away from the public.

**TABLE 15: PARTICIPANTS' INCOME IN RELATION TO THEIR VIEW WHERE PERSONS WHO HAD SUFFERED FROM LEPROSY SHOULD SETTLE**

<b>INCOME</b>	<b>COMPOUND</b>	<b>HOME</b>	<b>WHEREVER</b>	<b>TOTAL</b>
<b>K10,000-K20,000</b>	2(67%)	1(33%)	0(0%)	<b>3(100%)</b>
<b>K20,000-K30,000</b>	0(0%)	3(60%)	2(40%)	<b>5(100%)</b>
<b>LESSK10,000</b>	5(16%)	19(59%)	8(25%)	<b>32(100%)</b>
<b>OVER K30,000</b>	1(10%)	6(60%)	3(30%)	<b>10(100%)</b>
<b>TOTAL</b>	<b>8(16%)</b>	<b>29(58%)</b>	<b>13(26%)</b>	<b>50(100%)</b>

Table 15: Shows that 65% of the participants who earn K10,000 - k20,000 feel persons who had suffered from leprosy should settle at Liteta compound. But on the average 48% feel they should settle at their homes.

**TABLE 16: PARTICIPANTS' EDUCATION LEVEL IN RELATION TO THEIR VIEW WHERE PERSONS WHO HAD SUFFERED FROM LEPROSY SHOULD SETTLE**

<b>EDUCATION</b>	<b>COMPOUND</b>	<b>HOME</b>	<b>WHEREVER</b>	<b>TOTAL</b>
<b>COLLEGE</b>	0(0%)	1(50%)	1(50%)	2(100%)
<b>NONE</b>	6(100%)	0(0%)	0(0%)	6(100%)
<b>PRIMARY</b>	2(9%)	17(73%)	4(17%)	23(100%)
<b>SECONDARY</b>	0(0%)	11(58%)	8(42%)	19(100%)
<b>TOTAL</b>	<b>8(16%)</b>	<b>29(58%)</b>	<b>13(26%)</b>	<b>50(100%)</b>

Table 16: Shows that all the participants who have never been to school said that persons who had suffered from leprosy should settle at Liteta compound whereas 50% of those who attained college education feel persons who had suffered from leprosy can settle at their homes.

TABLE 17: SEX IN RELATION TO PATIENTS' TRADITIONAL BELIEF TO WHETHER THE COMMUNITY IS RECEPTIVE TOWARDS AFTER BEING CURED

SEX	YES	NO	TOTAL
MALE	0 (0%)	26 (100%)	26 (100%)
FEMALE	2 (8%)	22 (92%)	24 (100%)
TOTAL	2 (4%)	48 (96%)	50 (100%)

Table 17 shows 100% male clients feel society is not ready to accept them after being cured as well as 92% female. Only 8% female feel society can accept them.

TABLE 18: CLIENTS REASONS FOR RELUCTANCE TO GO HOME IN RELATION TO AGE

REASONS	20-25	26-30	31-35	36-40	41 & ABOVE	UNKNOWN	TOTAL
NOWHERE TO GO	0 (0%)	0 (0%)	0 (0%)	1 (14%)	4 (57%)	2 (29%)	7 (100%)
NO RELATIVES	0 (0%)	0 (0%)	0 (0%)	1 (33 1/3%)	1 (33 1/3%)	1 (33 1/3%)	3 (100%)
REJECTED BY COMMUNITY	0 (0%)	0 (0%)	0 (0%)	2 (17%)	3 (25%)	3 (25%)	12 (100%)
I FEEL SAFE HERE	0 (0%)	0 (0%)	1 (4%)	1 (4%)	8 (32%)	8 (32%)	25 (100%)
OTHERS	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (33%)	1 (33%)	3 (100%)
TOTAL	0 (0%)	0 (0%)	1 (2%)	5 (10%)	15 (30%)	15 (30%)	50 (100%)

Total 18 shows that 57 % of the clients aged 41 had no where to go. 33 % had no relatives and those who said were rejected by community were 58% aged 41 years. 60% feel safe to be near the hospital.

TABLE 19: MARITAL STATUS IN RELATION TO LENGTHY OF STAY IN THE HOSPITAL COMPOUND

MARITAL STATUS	1/2 - 1 YEAR	2 - 5 YEARS	6 - 10 YEARS	11 YEARS & ABOVE	TOTAL
SINGLE	1 (12%)	1 (12%)	1 (12%)	5 (64%)	8 (100%)
MARRIED	1 (5%)	4 (20%)	2 (10%)	13 (65%)	20 (100%)
SEPARATED	0 (0%)	1 (17%)	0 (0%)	5 (83%)	6 (100%)
DIVORCED	0 (0%)	0 (0%)	1 (9%)	10 (91%)	11 (100%)
WIDOWED	0 (0%)	0 (0%)	1 (20%)	4 (80%)	5 (100%)
TOTAL	2 (4%)	6 (12%)	5 (10%)	37 (74%)	50 (100%)

Table 19 shows that 91% of the clients are widowed and have stayed for 6 years. 80% are separated and have stayed for 11 years and above. 83.5% are divorced and have stayed 11 years and above. Of the single 12% only have stayed 11 years and above.

TABLE 20: CLIENTS' PREFERENCE OF WAYS OF DISCHARGE FROM HOSPITAL IN RELATION TO THEIR SEX

DISCHARGE PREFERENCE	MALE	FEMALE	TOTAL
HOSPITAL TO HOME	1 (25%)	3 (75%)	4 (100%)
HOSPITAL TO COMPOUND	23 (53%)	20 (47%)	43 (100%)
COMPOUND TO HOME	2 (100%)	0 (0%)	2 (100%)
OTHERS	0 (0%)	1 (100%)	1 (100%)
TOTAL	26 (52%)	24 (48%)	50 (100%)

Table 20 shows that 25% male clients and 75% female clients preferred to be taken home when discharged. 53% male clients and 47% female clients preferred to be taken to the compound when discharged. 100% male clients preferred to be taken to the compound before being taken home. Only one female client preferred either way as the Hospital authorities may decide as proper.

## CHAPTER 5

### DISCUSSION OF FINDINGS, IMPLICATIONS TO THE HEALTH SYSTEM, SUMMARY AND CONCLUSION

#### 5.1. INTRODUCTION

In this chapter the findings of the research study will be discussed and appropriate Health System implications will be made. From the findings the researcher will draw up some relevant recommendations, to relevant authorities for action.

The objective for the study was to analyse the current knowledge, attitude and practice the community has in regards to clients who have under gone leprosy treatment; identify factors influencing former clients of leprosy reluctance to join the community upon discharge from Liteta leprosarium.

To meet this objective, data was collected from 50 former clients of leprosy and 50 respondents from the community in Chibombo District. Raw data was carefully analysed by computer to establish the causal effect of the independent variables on the dependent variables as a basis for making inferences.

## 5.2 DEMOGRAPHIC

The age range of the community participants was from (17) years and above and the majority 56% males were those from 25 - 31 years.

The age range of the former clients of leprosy participants was from 20 years and above out of which the majority were 62% male were those from age range of 41 and above more in the range of 20 - 30 years. (Table 1b).

The majority of the community's participants were Christians 90% and Muslims showed a low 4% with the majority in the age range of 25 - 32 years. Where as the former clients of leprosy showed 100% all Christian respondents and non in other religion. (Table 2a) and (Table @b) respectively.

Married status of the community respondents. 60% were married and 28% single. Marital status according to sex of the former clients with leprosy respondents 40% were married, and 22% widowed. (Table 3a) and (Table 3b).

Educationally the community's respondents constituted primary education as the majority of the sample. (Table 4) where as former clients of leprosy most of them had never been to school 62% (Table 5) and none has attained college education. There is variety in the tribe distribution in relation to education.

Economic status of the community participants shows that most of them carried less than K10,000 per month, with the majority in the age range of 25 - 32 years, (Table 6).

### 5.3. KNOWLEDGE OF THE COMMUNITY ABOUT LEPROSY

The findings from the study revealed that a total of 35 (70%) out of 50 respondents showed that they know about leprosy. 14% stated that the cause is a curse from God. 10% indicated that it is by witchcraft and only 6% hereditary. (Table 7). All the research participants have heard of leprosy 22 female 100% and 28 male 100%. It is evident from the study that most of the respondents, whether educated or not had knowledge about leprosy. An indicator that health education has been effective in this area.

These findings are contradicting the findings of a study done in Nigeria which revealed misconception and gaps in knowledge of the nurses in relation to leprosy. It was noted that nurses knowledge in the disease was lacking to an extent of fearing to nurse a leprosy patient, leprosy review, (992p 169).

One may assume from these findings that despite the knowledge being 100% it is unlikely to expect them to have a positive attitude towards clients with leprosy and good practices that support leprosy prevention and control strategies. This could be attributed to many reasons given as to the cause of leprosy.

Table 8 shows that 75% and 64% of males and females respectively believe the germ causes leprosy. But 11% believe it is witchcraft predominantly believed to be the cause by males; this can have an adverse effect on the future generation given that the father is the head of the house hold and commands good respect according to traditional and customs. These factors should be remembered when giving the health education about leprosy, to the community.

#### **5.4. ATTITUDE OF THE COMMUNITY TOWARDS CLIENTS WITH LEPROSY**

The findings from study revealed that majority of the participants can live and eat with some one who had suffered from leprosy. The higher the age group the more the rejection to live or eat together, this could be attributed to the traditional belief in this age group compared to the new generation with the scientific knowledge of the cause of leprosy and how it can be transmitted. (Table 10)

Participants religion in relation to eating and living together (Table 11) shows that 76% of the Christians can live and eat with a person who had suffered from leprosy, were as all Moslems can not eat and live with a person who had suffered from leprosy 100%, these findings are in line with a study that was done in Sudan which showed that religion influences the attitude of the community towards

leprosy, in this case negatively.

Participants educational level in relation to eating and living together with a person who had suffered from leprosy. (Table 12) shows that all participants who have attained college education 100% can live/eat together with persons who had leprosy. Those that had never been to school can not live/eat together with persons who had leprosy. It is inconsistency with the study done in India where it was found that laboratory technicians had the highest (74.6%) desirable attitude and health educators had the lowest (57.5%), while the rest of the team members fell in between. The stigma shown towards leprosy was higher among doctors when compared to the rest of the team members, but this is not the case in Zambia, leprosy review 65 (I): 66 - 77 1994 March.

#### **5.5 PRACTICES OF THE COMMUNITY TOWARDS CLIENTS WITH LEPROSY**

Participants age in relation to view about quarantine of leprosy patients, table 13 shows that 38 respondents out of 50 are against keeping away leprosy patients from the public only 12 (24%) are in favour.

In accordance with the religion, the study shows that (Table 14) 67% of the Buhai participants feel leprosy patients should not be kept away from the public 80% of the Christians are also in disagreement, but all the Muslim

100% feel leprosy patients should be kept away from the public. It is evident here that religion is taking some significant influence on the attitude and practice of the society towards leprosy patients.

Analysis of respondents level of education in relation to view where persons who had suffered from leprosy should settle (Table 16) shows that all the participants who have even been to school said that persons who had suffered from leprosy should settle at Liteta compound where as 50% of those who attained college education feel persons who had suffered from leprosy can settle at their homes.

#### **5.6. FORMER CLIENTS OF LEPROSY RESPONSE TOWARDS THE COMMUNITY**

The findings from the former clients of leprosy revealed that most of the clients who are reluctant to go back home are those who feel society is not ready to accept them after being cured. 100% male, and 92% female (Table 12) only 8% feel society can accept them.

Analysis of the reasons for staying in Hospital Compound revealed that of the clients who said they had no where to go, 14% were aged 35 to 40 years. 57% were aged 41 and above, 83% stated that community rejected them and the majority 92% felt safe to be near the hospital despite having relatives or some one to take care of them. Analysis of clients preference of ways of discharge from hospital in relation to get revealed that 25% male clients and 75% female clients preferred to be taken home

when discharged, as opposed to 53% male clients and 47% female clients preferred to be taken to the compound when discharged.

Further analysis of the type of skills acquired during the stay in the hospital revealed that only 23% of the clients who had never been to school acquired a skill to enable them live a manageable life at home while 77% did not. 39% who acquired skills attained primary education. The only client who had attained secondary education acquired a skill. Out of the total of the 50 clients 26 were female and 24 male, analysis of acquired skills in relation to sex revealed that 65% male clients did not acquire any skill while 35% did. 75% female clients did not acquire any skill while 25% did. This is a very good evidence to assume that reluctance of clients to join the community is contributed to lack of skills to help them start a manageable life.

The findings on type of skills acquired from rehabilitation centre in relation to sex revealed that 75% male clients and 25% female clients acquired basket making skill. One male client acquired blacksmith skill. 20% male clients and 80% female clients acquired sewing and only one male client acquired shoe repair skill. These findings clearly indicates that there is not much that has been done on the rehabilitation of leprosy patients no wonder they are not confident to face

the future in the community. Hence the need for the Ministry of Health in conjunction with the none governmental organisation to reorganise this part of leprosy therapy.

#### 5.7 HEALTH SYSTEM IMPLICATION

The study revealed that most respondents had very high knowledge about leprosy, but their practice prevents former leprosy clients to join the community. The study also revealed that some respondents though that leprosy is hereditary disease, can be caused by witchcraft and even a curse from god, these beliefs should be remembered when giving health education to the community. There is need for health workers to clarify the misconceptions respondent have on leprosy, both the former clients and the community. During the leprosy day respondents should be involved in the control programmes and rehabilitation. For if they are well informed, they will in turn teach others as revealed by the study. Health education should be continued despite having a reduction in the number of leprosy incidence so far in Zambia; so that all can be educated about leprosy and the respondents can be receptive toward clients who had leprosy. This will reduce the number of those that need to be staying near the hospital compound hence dismantle the leper colony that is resurfacing at Liteta leprosiuim.

## 5.8 SUMMARY

The purpose of this study was to establish knowledge attitude and practice the community has towards clients with leprosy. Results in this study are based on responses from a randomly selected sample of 50 former clients of leprosy and 50 community households of Chibombo District. The study revealed that all the community respondents has knowledge about leprosy 100% they have also indicated that they can be able to live, eat and even drink with the cured clients without any problems but when it came to religious affiliation, the study revealed that Muslims would not eat, live nor drink with someone who had suffered from leprosy. As a result of interaction such behaviour by the Muslims can be misconceived by the other clients indicated willingness to join the community they do not have relatives to go to some are afraid of being away from the hospital in case of a problem they feel other hospitals can not be able to attend to them because of their condition. Hence the need for re-enforcement of integrated health services throughout the country so that it is easy to refer a client from one hospital to another without showing some resentment by medical personnel. Despite the community's willingness to stay with the clients the stigma the clients have to mingle with community makes it difficult to join the community especially if the client has deformities and no skill to enable him/her start a challenging life in the community. Social economic problems also could be assumed to be contributing.

Educational level has shown that it has a positive influence on the acceptance of former clients with leprosy were as all the participants who have never suffered from leprosy should settle at Liteta compound, those who attained college 50%, secondary 73% and primary 73% feel they should settle at their homes.

## CHAPTER 6

### CONCLUSION

The study was aimed at determining the knowledge, attitude and practice of the community towards clients with leprosy in Kabwe rural, Chibombo District. At the same time, the researcher also wanted to know if the community's knowledge, attitude and practice contribute to the reluctance of former clients with leprosy to go back home upon discharge from Liteta Leprosium so as to prevent the resurfacing of the leprosy colon.

Data was collected using a structured interview schedule. The sample consisted of 100 respondents.

The study revealed that most of the respondents had knowledge of leprosy. 70% of those who have heard about leprosy are all the respondents 100% (Table 7).

The study also revealed that clients who stayed longer in the hospital tend to have a negative attitude towards discharge to home than those who stay for a short duration.

The study revealed that the more education one is the more positive he/she is towards clients with leprosy. Social economic factors also contribute to the reluctance of the former clients to go back home.

The study revealed that most of former clients who are reluctant to go back to their respective homes have sighted lack of relatives, rejection by the society and above all they feel safe being near the leprosiium because that is where the expert are when it comes to development of complications or relapse than any other hospital. Some feel since they have this chronic disease it is the responsibility of the government to keep them.

## RECOMMENDATIONS.

The study results showed that lack of skills by the patients contributes greatly to the reluctance of former clients to go home upon discharge from Liteta Hospital, hence the need to revamp the Rehabilitation Centre.

- The District Health management board should ensure collaboration between the Social welfare officers in the districts, to ensure consistence support of the former clients of leprosy wherever they may be.
- The District Health Management Board should work hand in hand with the Headmen in chief Liteta's area through meetings. These meeting would facilitate communication and sharing knowledge on how best leprosy patients can be intergrated in the community.
- All health workers should collectively intensify health education on the cause, treatment, prevention and control of leprosy so that both patients and the community are aware of the cause of the disease and seek treatment early enough when they suspect they have leprosy to prevent complications.
- All newly appointed members of staff to Liteta Hospital should undergo an Induction training in Leprosy before they are Intergrated in the workforce of the Hospital.

- The District Health Management Boards through their health centre supervisors should ensure equity distribution of trained health workers in each health centre in order to ensure continuity of services.
  - Since the study has not been exhaustive in itself, a similar study could be conducted particularly to investigate the quality of Nursing Care and Health Education given by nurses while the patient is in the ward.
1. Achola, P.P.W., Sless, C., Fundamentals of Social Research: An African Approach, UNZA, 1990, pp. 1-37.
  2. Abel, G. Van, A.H., Psychological Difficulties in the serdanic country, 1971, 39: pp.429-432.
  3. Brunner and Suddarth, The Textbook of Medical Surgical Nursing, W.B. Saunders Company, pp. 1054-1055.
  4. Browns, S.G., Some Aspects of the History of Leprosy, 1975, pp. 485-495.
  5. Elycaron, A.R., Medicine in the Tropics: Leprosy Longman Group, London, 1979.
  6. Cook, A., An Urban Community's thought about Leprosy: A Survey in Guyana Leprosy Review, 1982, 53, pp. 285-294.
  7. Davidson, J.M., Principles and Practice of Medicine, London Longman Group, pp. 756-762, 1986.
  8. De Solderhoff, R., Swing: On Leprosy Control, Ministry of Health, Lusaka, pp. 23-28, 1987.
  9. Goffman, E., Stigma: Notes on the Management of Spoiled Identity. Prentice - Hall, Inc, London, 1963.
  10. Gokhale, S.D., Rehabilitation of People with Leprosy. International Leprosy Union, India, pp. 17-29, 1992.
  11. Hastings, R.E., Medicine in Tropics, Leprosy Longman Group, London, pp. 183-189, 1995.
  12. Health System Research Training Services, The Technician Working Group, Vol. 2 and 1, Canada, IRDC.
  13. Htoo, S.W., Leprosy status report of Myanmar, International Leprosy Union, India, pp. 10-12, 1992.

*Answer  
quotes are  
acknowledged*

*2. Correct & uniform  
documentation?*

## BIBLIOGRAPHY

1. Achola, P.P.W., Bless, C., Fundamentals of Social Research Methods. An African Approach, UNZA, 1990 pp. 1-37.
2. Abel, G., Van, A.H., Psychological Difficulties in the Treatment of Leprosy Patients in a non-endemic country, 1971, 39: pp.429-432.
3. Brunner and Suddarth, The Textbook of Medical Surgical Nursing, Toronto 1970, J.B. Limpcott Company, pp. 1054-1055.
4. Browne, S.G., Some Aspects of the History of Leprosy 1975, pp. 485-495.
5. Bryceson, A.R., Medicine in the Tropics: Leprosy Longman Group, London, 1979.
6. Cook, A., An Urban Community's thought about Leprosy: A Survey in Guyana Leprosy Review, 1982, 53. pp. 285-296.
7. Davidson, J.M., Principles and Practice of Medicine, London Longman Group, pp. 758-762, 1986.
8. De Soldenhof, R., Bwino: On Leprosy Control, Ministry of Health, Lusaka, pp. 23-28, 1987.
9. Goffman, E., Stigma: Notes on the Management of Spoiled Identity. Prentice - Hall, Inc. London, 1963.
10. Gokhale, S.D., Rehabilitation of People with Leprosy, International Leprosy Union, India, pp. 17-29, 1992.
11. Hastings, R.E., Medicine in Tropics, Leprosy Longman Group, London, pp. 183-189, 1995
12. Health System Research Training Services, The Technician Working Group, Vol. 2 and 1, Canada, IRDC.
13. Htoo, S.W., Leprosy status report of Myaumar, International Leprosy Union, India, pp. 10-12, 1992.

- 14 ILEP, Guideline for Campaign against Leprosy, London, 1982.
- 15 Imorth, R.M., Is it Safe to treat the Lepromatous patient at Home? A study of home exposure in Hongkong. Leprosy review 36, pp. 296-302, 1968.
- 16 Jobling, W.H., A continuing miracle: A report of Syoung Women with Hansen Disease. The Star, 1981 (MoH): 3-4.
- 17 Jobling, W.H., Leprosy in Textbook of Dermatology. Oxford Blackwell Scientific Publications, 1986 pp. 823-838.
- 18 Kanfmann, A., et al The Social Dimension of Leprosy. ILEP, London, Review, 1972 (42) MoH.
- 19 Karat, S., Preventive Rehabilitation in Leprosy, Leprosy Review, 39-44, 1968a.
- 20 Karat, S., Preventive Rehabilitation in Leprosy, 3 principles of practical application. Leprosy Review 39: 75-78, 1968 b.
- 21 Kelly, E.D., Physical Therapy in Leprosy for Para-Medicals Level I, II and III Inc, 1981, American Leprosy Mission.
- 22 Lennon, S.A., A Review of Health Education in Leprosy, 1988: 56  
(4) 611-618.
- 23 Margraith, A., Tropical Medicine for Nurses, London, 1980, pp. 87-97.
- 24 Mendis, M., Physiotherapy in Leprosy, John Wright and Sons, Bristol, 1965.
- 25 McDougall, The Medical Student and Leprosy, Leprosy Review 1986, pp. 97-100.
- 26 Neylon, T.C., et al Illness Beliefs of Leprosy Patients Use of Medical Anthropology in Clinical Practice, 1988. pp. 271-277.
- 27 Meville, P., A Guide to Health Education in Leprosy, German Leprosy Relief Association, Wurzburg, 1980.

- 28 Meville, P., Foot wear manual for Leprosy Control Programme Number I and ii Wurzburg, 1983.
- 29 Skinsnes, O.K.E., Leprosy in Society, and Leprosy in Accidental literature, 1970 pp. 294-307.
- 30 Skinsnes, O.K.E., Leprosy in Society II, the pattern of concept and reaction to leprosy in oriental antiquity leprosy review, 1964, pp. 105-122.
- 31 Srinivason, H., To Care for Leprosy as if the Patient Mattered India Journal of Leprosy, 1984, pp. 386-395.
- 32 Tatitari, S., Leprosy Status Report of Brazil, International Union of India, pp. 2-5, 1982.
- 33 Thangaraj, R. <sup>3</sup> h, Leprosy: for all Medical Practitioners and Para-medical Workers. CIBA Geigy Limited. Switzerland, pp. 80-86, 1986.
- 34 Turk, J.L. Leprosy Review: Volume 63 Number 2, June, 1992. British Relief Association, London, pp. 171-179, 1992.
- 35 Treece, E.W., Treece, J.W., (1986), Elements of Research in Nursing. The C.V. Musby Company Toronto, pp. 13-365.
- 36 Mittol, B.N., Leprosy Status Report of India, pp. 4-7, 1992.
- 37 Wood, M.J., Basic Steps in Planning Nursing Research from question to proposal, Boston, Inc. 1988.
- 38 Wright, E.M., Leprosy Villages are they all outdated? A Survey to two leprosy communities, Leprosy review, 47, pp. 303-311, 1976.

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REPUBLIC OF ZAMBIA

## MINISTRY OF HEALTH

OFFICE OF THE MEDICAL SUPERINTENDENT  
LITETA LEPROSARIUM

DEPARTMENT OF POST BASIC NURSING

P.A. LITETA  
KABWE

8th August, 1995.

Mr. Haambozi Simon,  
The University of Zambia,  
P.O. Box 50170,  
LUSAKA.RE: 10th July, 1995

Reference is made to the above mentioned subject.

The District Medical Officer  
The Liteta Hospital  
P.O. Box 81605  
KABWE  
wishes to grant you per-  
mission to conduct interviews at the institutions  
as per request.

Wish you all the best.

*H. A. S.*  
u.c.s. Head - Post Basic Nursing*Shwartz*  
Dear Sir,Dr. H.A. S. S. S.  
MEDICAL SUPERINTENDENTre: RESEARCH STUDY

HAS/mcz

I am a final year student at the School of Medicine, University of Zambia. I am required to submit a Research Study in the **area** of my interest as part of the course requirements. My Research topic is "A Study to Determine the Knowledge, Attitude and Practice of the Community Towards Clients with Leprosy in Chief Liteta's Area", **Chibombo District.**

I would be very grateful if you will kindly grant me permission to conduct interview in your Institution, specifically invalid compound and former leprosy patients surrounding the invalid compound. This will enable me to collect information required for the study. Collecting of data will be between July 1995 and August 1995.

Your *favourable* response to my request will be greatly appreciated.

Yours faithfully, .

*Haambozi*  
Haambozi Simon  
BSC. STUDENT NURSE

MED/SUPT

LL/101/1/4

Telephone: 222792



REPUBLIC OF ZAMBIA

# MINISTRY OF HEALTH

OFFICE OF THE MEDICAL SUPERINTENDENT  
LITETA LEPROSARIUM  
P.A. LITETA  
KABWE

8th August, 1995.

Mr. Haambozi Simon,  
The University of Zambia,  
P.O. Box 50110,  
LUSAKA.

RE: RESEARCH STUDY

Reference is made to the above mentioned subject.

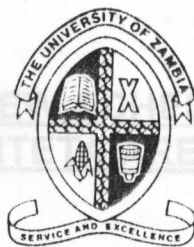
The Hospital Management wishes to grant you permission to conduct interviews at the institution as per your request.

Wish you all the best.

A handwritten signature in cursive script, appearing to read 'Simwanza'.

Dr. H.A. Simwanza  
MEDICAL SUPERINTENDENT

HAS/msz\*



SEMI-STRUCTURED INTERVIEW SCHEDULED FOR THE COMMUNITY

IN LITETA AREA

QUESTIONNAIRE NUMBER.....

DATE.....

INSTRUCTIONS TO THE INTERVIEWER

# THE UNIVERSITY OF ZAMBIA

## SCHOOL OF MEDICINE

Telephone: 252641

211440 (UTH) 254824 (Pre-Clinical) Ridgeway Campus

Telegrams: UNZA, LUSAKA

Telex: UNZALU ZA 44370

Fax: + 260-1-250753

DEPARTMENT OF POST BASIC NURSING

P.O. Box 50110

Lusaka, Zambia

Your Ref:

Our Ref:

4. Tick in the space provided according to respondent given answer.

5. Please 12th July 1995 questions are answered.

15/8/95

✓ Senior Chief Liteta  
P.O. Box Chibombo  
KABWE

*NO Objection  
carry on S.C.L.*

U.F.S. Head - P.B.N.

*rebo  
for*

Dear Sir,

re: RESEARCH STUDY

I am a final year student at the School of Medicine, University of Zambia. I am required to submit a research study in the area of my interest as part of the course requirements. My research topic is a study to determine the knowledge, attitude and practice of the community towards clients with Leprosy in Chief Liteta's area, Chibombo District.

I would be very grateful if you will kindly grant me permission to conduct an interview in your area. This will enable me to collect information required for the study. Collecting of data will be between July 1995 and August, 1995.

Your favourable response to my request will be greatly appreciated.

Yours faithfully,

*Haambozi*

Haambozi Simon  
BSC STUDENT NURSE

**SEMI-STRUCTURED INTERVIEW SCHEDULED FOR THE COMMUNITY  
IN LITETA AREA**

QUESTIONNAIRE NUMBER.....

DATE.....

**INSTRUCTIONS TO THE INTERVIEWER.**

- 1. Introduce yourself to the respondent.**
- 2. Explain purpose of interview, and that of all responses will be treated in strict confidence.**
- 3. Ensure respondent are free when answering questions through-out the interview.**
- 4. Tick in the space provided according to respondent given answer.**
- 5. Please ensure that all the questions are answered.**

BACKGROUND INFORMATION.

FOR OFFICIAL U

1. SEX

- (1) Male
- (2) Female


2. HOW OLD ARE YOU?

- (1) 17--24
- (2) 25--31
- (3) 32--40
- (4) 40--and above
- (5) Not know


3. WHAT IS YOUR MARITAL STATUS?

- (1) Single
- (2) Married
- (3) Divorced
- (4) Widowed
- (5) Separated


4. WHAT IS YOUR RELIGION?

- (1) Christian
- (2) Bahai
- (3) Moslem
- (4) Others specify.....


5. WHAT LEVEL OF EDUCATION DID YOU REACH?

- (1) Primary
- (2) Secondary
- (3) College
- (4) University
- (5) Never been to school


6. WHAT IS YOUR OCCUPATION?

- (1) Peasant famer
- (2) Casual worker
- (3) Business
- (4) Unemployed
- (5) Others specify.....


7. HOW MUCH DO YOU EARN FOR YOUR LIVING PER MONTH?

- (1) Less than K 10,000
- (2) K10,000—K20,000
- (3) K20,000—K30,000
- (4) K30,000—and above


KNOWLEDGE ATTITUDE AND PRACTICE.

8. HAVE YOU EVER HEARD ABOUT LEPROSY?

- (1) Yes
- (2) No


9. IF YES TO QUESTION 8, WHAT CAUSES LEPROSY?

- (1) Germs
- (2) Witchcraft
- (3) Curse from God

(4) Any other specify.....

FOR OFFICIAL USE

10. HOW CAN SOME ONE KNOW THAT HE/SHE HAS LEPROSY?

- (1) A lesion with loss of sensation
- (2) Nerve pain
- (3) Disabled
- (4) Chronic ulcer

11. CAN LEPROSY BE CURED?

- (1) Yes
- (2) No

12. HAVE YOU EVER SEEN A PERSON WITH LEPROSY?

- (1) Yes
- (2) No

13. CAN YOU EAT WITH A PERSON WHO HAD SUFFERED FROM LEPROSY?

- (1) Yes
- (2) No

14. CAN YOU LIVE WITH A PERSON WHO HAD LEPROSY IN THE SAME HOUSE?

- (1) Yes
- (2) No

15. CAN YOU DRINK BEER WITH THEM?

- (1) Yes
- (2) No

16. DO YOU THINK A PERSON WITH LEPROSY SHOULD BE KEPT AWAY FROM THE PUBLIC?

- (1) Yes
- (2) No

17. IF YES WHY?.....

.....

18. DO YOU THINK PEOPLE WITH LEPROSY BEHAVE DIFFERENTLY?

- (1) Yes
- (2) No

19. IF YES EXPLAIN.

- (1) Aggressive
- (2) Reserved
- (3) Shy
- (4) Others specify

20. WHEN PATIENTS ARE DISCHARGED FROM LITETA HOSPITAL WHERE DO YOU THINK THEY SHOULD GO?

- (1) Back to their respective home where they came from.
- (2) Remain in the compound.
- (3) Go settle where ever they want.

END OF QUESTIONNAIRE  
3

**INTERVIEW SCHEDULE FOR FORMER CLIENTS WITH LEPROSY  
AT LITETA INVALID COMPOUND.**

QUESTIONNAIRENUMBER.....  
DATE.....

**INSTRUCTIONS TO THE INTERVIEWER.**

- 1 Introduce yourself to the respondent.
- 2 Explain purpose of interview , and that of all resposes will be trated in strict confindece.
- 3 Ensure respondent are free when answering questions through-out the interview.
- 4 Tick in the space provided according to respodent given answer.
- 5 Please ensure that all the questions are answered .

BACKGROUND INFORMATION

FOR OFFICIAL USE

1. SEX	(1) Male (2) Female	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
2 AGE	(1) 20--25 (2) 26--30 (3) 31--35 (4) 36--40 (5) 41---and above (6) Don't know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
3 MARITAL STATUS	(1) Single (2) Married (3) Divorced (4)Widowed (5) Separated	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
4 WHAT LEVEL OF EDUCATION HAVE YOU ATTAINED?	(1) None (2) Primary (3) Secondary (4) University	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
5 TRIBE	(1) Lozi (2) Nyanja (3) Lenje (4)Tonga (5) Bemba (6) Others specify.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
6 RELIGION	(1) Christian (2) Bahai (3) Moslem (4) Budduism (5) Others specify.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
<u>KNOWLEDGE ATTITUDE AND PRACTICE.</u>			
7 WHEN WERE YOU TOLD THAT YOU HAVE LEPROSY?	(1) 2--3 years ago (2) 4--6 years ago (3) 7--10 years ago (4) 11--and above years ago	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
8 WHEN DID YOU COMPLETE THE TREATMENT	(1) 6 months ago (2) 1--2 years ago (3) 3--5 years ago (4) 6--and above years ago	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>

9 WHAT DISABILITIES DO YOU HAVE?

- (1) Anaesthesia
- (2) Loss of upper extremities
- (3) Loss of lower extremities
- (4) Blindness
- (5) Claw fingers
- (6) None
- (7) Other specify.....



10 HAVE ACQUIRED ANY SKILLS FROM THE REHABILITATION CENTER TO ENABLE TO LIVE A MANAGEABLE LIFE AT HOME?

- (1) Yes
- (2) No



11 IF YES TO QUESTION 10 WHAT SKILL?

- (1) Basket making
- (2) Blacksmith
- (3) Sewing
- (4) Shoe repair
- (5) Others specify



12 WHAT CAUSES LEPROSY?

- (1) Germ
- (2) Babel fish eating
- (3) Witchcraft
- (4) Curse from God
- (5) Family disease



13 DO YOU THINK THE TYPE OF LEPROSY YOU HAVE REQUIRES YOU TO STAY IN THE HOSPITAL COMPOUND EVEN AFTER COMPLETING TREATMENT?

- (1) Yes
- (2) No



14 DO YOU BELIEVE THAT THE SHORT DURATION OF TREATMENT BEING PRACTICED IS STRONG ENOUGH TO CURE LEPROSY?

- (1) Yes
- (2) No



15 WERE YOU HAPPY WHEN YOU WHERE DISCHARGED FROM HOSPITAL TO HOME?

- (1) Yes
- (2) No



16 HOW WOULD YOU PREFER TO BE DISCHARGED?

- (1) Hospital to home
- (2) Hospital to compound
- (3) Compound to home
- (4) Others specify.....



17 DO YOU THINK THE COMMUNITY IS READY TO ACCEPT YOU AFTER BEING CURED?

- (1) Yes
- (2) No



18 DO YOU FREE TO MIX WITH OTHER PERSONS IN THE COMMUNITY?

FOR OFFICIAL USE

- (1) Yes
- (2) No



19 IF NO TO QUESTION 18, WHY NOT?.....  
 .....  
 .....

20 DO YOU THINK A PERSON WHO HAS BEEN CURED FROM LEPROSY SHOULD BE ISOLATED FROM THE PUBLIC?

- (1) Yes
- (2) No



21 IF YES TO QUESTION 20 WHY?.....  
 .....  
 .....

22 HOW LONG HAVE YOU STAYED IN THE INVALID COMPOUND?

- (1) 6 Months to 1 year
- (2) 2-5 years
- (3) 6-10 years
- (4) 11-and above



23 WHAT HAS MADE YOU TO STAY IN THE INVALID COMPOUND?

- (1) No where to go
- (2) No relatives
- (3) Rejection by the community
- (4) I feel safe here.
- (5) Others specify.....



THANKYOU  
END OF QUESTIONNAIRE.