

## Chapter 17 Tropical diseases: malaria and leprosy

### CASE STUDIES

#### Case study: beliefs about malaria in a farming community in southern Ghana

Agyepong<sup>11</sup> in 1992 described beliefs about fevers, including malaria, in a farming community of the Ga-Adangbe tribe in southern Ghana. She describes *asra*, which is a symptom complex that can include fever, but also some or all of the following: chills, headaches, bodily pains, yellow eyes, a bitter taste in the mouth, deeply coloured urine, loss of appetite, weakness, vomiting, pallor of palms and soles, and cold sores around the mouth. A more serious, less common, version was *asraku*, where the person has high fever, confusion, and 'acts like a madman'. Only a small minority believed that mosquitoes could cause *asra*. Almost all members of the community agreed that

*asra* was caused by contact with excessive external heat, especially from sunlight, but also from cooking, burning charcoal or standing too close to a fire. This heat causes *asra* by accumulating in the body, and upsetting the body balance by an effect on the blood. The prevailing view was that *asra* could not be prevented. It was an unavoidable fact of life, and of having to work outdoors in the harsh sunlight. Treatment for the condition mostly took place at home and only rarely at medical facilities. Home remedies included herbs to 'wash the blood of the illness', so that it was sweated out through the skin or else passed out in the urine. Only if these remedies failed did they resort to pharmaceuticals bought over the counter, such as analgesics or, occasionally, low doses of chloroquine.

#### Case study: stigma of leprosy patients in Banaras (Varanasi), India

Barrett<sup>28</sup> studied 72 leprosy patients attending a treatment centre and street clinic in Banaras, India, from 1999 to 2001. He found that the effects of the social stigma of leprosy were 'far worse than the disease itself', and that they exacerbated both the physical and psychological effects of the disease. This stigma was also more 'contagious' than the disease itself, since it usually affected the patient's family, leading them to seclude or reject the victim, especially when the disease could no longer be concealed. Even if the disease was completely cured by treatment, the social stigma for the victim might still last a lifetime. For this reason, the leprosy patients adopted a variety of strategies to conceal their disease from others – and from themselves. These included denial, not going for treatment, covering affected areas with clothing, travelling for

treatment to clinics many miles away, not adhering to the treatment prescribed or going to unofficial healers for treatment. Others tried to ignore their affected limbs, and spoke of them as if they were not really part of their body; speaking of 'the hand' (*haath*) rather than 'my hand' (*hamare haath*). As many of these diseased limbs had lost all touch and pain sensation, this often resulted in neglect, and 'dissociation' of a part of their body that required constant attention and care. Some tried to exaggerate their physical deformities even further – by surgery, self-mutilation, or wearing blood-stained bandages – in order to attract more money when begging. Overall, Barrett describes the circular relationship between stigma and physical disability, whereby stigma can cause delayed treatment, inadequate treatment or self-neglect, all of which may exacerbate even further the physical deformities caused by the disease.