

LEPROSY IN WOMEN: CHARACTERISTICS AND REPERCUSSIONS

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Abstract—“Health is often measured in terms of low mortality; nevertheless, merely being alive is not a measure of the quality of life” H. Méndez Castellanos.

Physiological, socioeconomic and cultural factors play important roles in the response of women to *Mycobacterium leprae* and in the impact of leprosy on their lives. They appear to develop stronger immunological responses to *M. leprae* than men, as suggested by lower incidence and less severe clinical forms of disease in most areas of the world, as well as stronger reactions of cell-mediated immunity after prophylactic vaccination. Genetic factors and physiological status including pregnancy, intercurrent infection and malnutrition might be among the factors which modulate this response. Women in leprosy-endemic areas of the world, with few exceptions, suffer from marked economic and social dependency and inferiority which can only be heightened by the social stigma associated with leprosy. Nevertheless, they bear an enormous responsibility for the health of their families, often as head of the household, and they often possess a unique capacity to influence community opinion. With the introduction of multidrug therapy, leprosy control throughout the world is no longer an unrealistic goal. Active vaccination may constitute the other factor necessary for eventual eradication of the disease. The incorporation of women at all levels into active roles in health care programs may constitute one of the decisive factors in the success or failure of leprosy control.

Key words—leprosy, women, gender

INTRODUCTION

Among tropical diseases, leprosy is especially characterized by social stigma. Other diseases, of which mucocutaneous and diffuse cutaneous leishmaniasis and onchocerciasis (river blindness) are examples, cause profound incapacity and disfigurement, but none is associated with the ostracism and sense of fear and repulsion inspired by leprosy throughout much of the world.

Women bear much social and cultural responsibility for maintaining the framework of the society in many developing countries. They may be partially protected by well-intentioned but often unenforced legislation, but their real situation is often characterized by lack of opportunity, extreme dependency and subtle or even blatant discrimination in nearly every aspect of their lives. Many of the elements associated with social stigma, including low self-esteem and self-destructive acceptance of relegation as a second-class member of society, are reflected in the current situation of women in many parts of the world where leprosy is endemic.

In the following pages, we will try to explore both biomedical and social aspects of leprosy among women, their status in the recent past and present, and perspectives for the future. Many of the data and observations which follow are based on our experience in Venezuela. This country clearly occupies a privileged economic position within Latin America

because of the abundance of its natural resources, and our experience does not represent the more severe situations found in many under-developed and developing countries.

The ethnic composition of the Venezuelan population is relatively uniform, with a creole mixture of Spanish, African and native American components. Small groups of African descent and of native Americans are found in the national territory, but the data relevant to leprosy in these groups will not be discussed here. Recent studies reveal that 80% of the population lives under conditions of poverty or critical poverty. The national birth rate has declined by 50% in the last 15 yr, but the birth rate, and morbidity and mortality rates are three times as great in the 80% living in poverty, compared to the other 20% of the population (unpublished data, Foundation Center for Biological Studies of Growth and Development of the Venezuelan Population, Caracas).

The incidence of leprosy has been in exponential decline since 1951 [1]. The current number of active cases under treatment is about 9100, with 12,000 under post-treatment surveillance; this represents less than 3% of the 330,000 registered active cases in the Americas in 1988 [2]. The disease has been the objective of a very active control program and of basic and applied research activities for many years. The observations made during the course of these programs reflect many basic characteristics of the disease and its impact on women which we find

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