‘Money is the vehicle of interaction’: Insight into social integration of people affected by leprosy in Northern Nigeria

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Summary

Objective: This paper proposes a mechanism by which socio-economic rehabilitation (SER) reduces stigma in northern Nigeria following a re-analysis of the transcripts of interviews conducted to evaluate the impact of SER on leprosy-related stigma.

Design: The evaluation combined quantitative questionnaire (P-scale) with qualitative interviews of 20 individuals affected by leprosy, five focus group discussions and 10 key informant interviews. From our data, we developed a leprosy-related stigma framework by integrating emerging themes with the construct of threat to group functioning to describe stigma processes experienced by people affected by leprosy in northern Nigeria.

Results: Findings revealed people affected by leprosy are less likely to be stigmatised because of leprosy impairments than for their incapacity to contribute to family/community finances. We also identified micro-credit loans and vocational training as elements of SER for reducing stigma through the mechanism of protecting individuals against the loss of social value, and by facilitating their continued engagement in daily social roles in the family/community.

Conclusion: We propose that SER stimulates attitudinal change towards, and inclusion of people affected by leprosy by protecting individuals against the loss of social value and increasing their contributive capacity. We recommend further empirical testing of the proposed framework to ascertain its utility in other cultures.

Introduction

A recent report of retrospective evaluation of the impact of socio-economic rehabilitation (SER) on leprosy-related stigma in northern Nigeria showed how SER improved self-esteem, financial contribution, and skills acquisition, access to public institutions by people affected...
The findings led the authors of the report to conclude SER stimulated attitudinal change towards, and social interaction of SER participants through the above improvements in living and economic conditions of the participants. Nevertheless, the authors did not explore how improved economic and living conditions stimulated access to public institutions or social interaction of people affected by leprosy. Therefore, following a re-analysis of transcripts of interviews conducted for that retrospective evaluation, this paper argues that micro-credit loans and vocational training components of SER reduce stigma by protecting individuals against the loss of social value, thereby facilitating their continued engagement in daily social roles in the family and community.

Contemporary scholars regard stigma as a social construction that exists when processes of labeling, negative stereotyping, exclusion, discrimination and low status co-exist in a power situation that allow these processes to unfold. Furthermore, Parker and Aggleton state that stigma and discrimination function, quite literally, at the point of intersection of culture, difference and power – social, economic or political power. They contend that understanding stigma and discrimination in these terms encourages a focus on the political economy of stigmatisation and its links to structural inequalities and exclusion.

Consistent with Parker and Aggleton’s proposition for understanding stigmatisation as central to producing and reproducing relations of power and structural inequality, evolutionary researchers consider the root of stigmatisation to be the human need to avoid the pitfalls that accompany group living. Neuberg et al. argue that the universal practise of stigmatisation is rooted in the basic human need to live in effective interdependent groups. They further argue that successful group living depends upon establishing norms for reciprocity and trust, for truth-telling, for teaching competencies, and for creating a group identity and stable bonds between members. They maintain that in order to minimise intra-group threats that often accompany group living, societies devise cognitive mechanisms for identifying and excluding members who possess qualities that threaten successful group functioning. Threatening qualities include poor reciprocal contribution to group activities; physical disability or carrying a parasitic infection; and membership of minority group(s) that can be exploited for the majority-group’s advantage. Neuberg et al. claim that stigmatisation is the mechanism designed to prevent threats to members’ ability to derive benefits from group living. Group benefits that could be threatened include group security, shared knowledge, food, communication and health etc.

An extension of Neuberg et al.’s proposition implies, for instance, that people with disabilities will be more likely to be excluded than those who are healthier or do not carry infectious diseases. Further, the extent to which individuals with disability are stigmatised is likely to increase, especially when material and behavioural resources are scarce. In such situations, unreciprocated investment becomes unaffordable, and the group is likely to resent dependency of such disabled individuals.

Interestingly, leprosy possesses qualities that threaten successful group functioning in many social contexts. The widespread pattern of stigmatisation of leprosy emerges from the disease’s tendency to produce distinct physical impairments when left untreated. Further, most societies regard leprosy as an incurable, highly contagious, and chronic disfiguring disease of questionable aetiology. The combination of visible impairments, fear of contagion and incurability cause people to separate themselves from those affected by leprosy in order to reduce their own risk of acquiring the stigma. As stigmatisation is frequently believed to be permanent, this paper identifies a mechanism by which socio-economic rehabilitation triggers positive attitudes and stimulates social inclusion of people affected by
leprosy into society in northern Nigeria. The paper also develops a leprosy-related stigma framework by integrating themes from our data with the construct of threat to group functioning to describe stigma processes experienced by people affected by leprosy in northern Nigeria.

**General Background of Study Area**

This research was conducted in five northern states of Nigeria namely Kebbi, Kogi, Niger, Sokoto and Zamfara with a combined 2005 population of 16 million people. The majority of people affected by leprosy in these states live in seven rural leprosy settlements. Approximately 5000 people, including those unaffected by leprosy, live in the leprosy settlements with about 1500 (36.3%) of residents suffering visible deformities. Residents of these leprosy communities are mainly petty traders, farmers, and beggars, who live in mud houses with thatched roofs, dusty floors and poor ventilation. Compared to the average national socio-economic conditions, inhabitants of the study area are more likely to be Muslim (80% vs. 50%), unemployed (>34% vs. 30%), uneducated (56% vs. 73%), rural farmers (80% vs. 70%) with a lower household income (GDP per capita US$ 300 vs. US$ 1000).

With regard to the general attitude to leprosy, inhabitants of northern Nigeria view the disease as one of many afflictions which are a part of life, differing mainly in its chronic duration and crippling deformities than many of their diseases. Although there is recognition of possible contagion, people affected by leprosy are not utterly rejected from society any more than for other diseases. They remain a part of the social milieu, surrounded by kinsmen and fellow-villagers, and enjoy privileges and obligations which are a part of these relationships. For these reasons, people affected by leprosy in northern Nigeria may lead relatively normal lives for years until the advanced stages of their disease leaves them ulcerated or grossly deformed. Notwithstanding this general convention of tolerance, those who maintain poor personal hygiene or fail to seek anti-leprosy treatment to render them non-infectious are shunned by community members.

**Organisation of Leprosy Work**

Between 1910 and the early 1930s, leprosy work in northern Nigeria was almost entirely in the hands of voluntary agencies – Christian missions – who devoted great effort to treating cases segregated in leprosaria (or central settlements) and leprosy villages (or clan settlements) according to conceptions of the most effective methods then generally available. Unfortunately, very few Hausa -the dominant tribal people of the study area – could accept, in their opinion, the draconian medical practice of isolating leprosy patients. To have family members, particularly women and children, taken away by the *Baturai* (white man), and segregated for months and years, was a form of treatment they perceived as a tragedy. By 1952, cultural unacceptability of segregation villages to the Hausa had instigated the refinement of anti-leprosy efforts to consist predominantly of out-patient treatment. This coincided with the employment of Dapsone tablets, widely used at the time for treatment on the grounds of efficacy, ease of administration and low cost.

This arrangement continued until 1962, when northern state governments took over responsibility for leprosy work from Christian missions. According to a 1961 annual report of
the Northern Nigeria Leprosy Service, there were 264,000 patients on treatment, with >75% of them treated in out-patient clinics. While out-patient treatment remarkably reduced the population of residents in leprosy villages, these settlements have survived to become home to families of patients who settled there prior to reorganisation of leprosy work. However, in 1991 the Federal Government of Nigeria (FGN) established a country-wide leprosy programme using multidrug therapy (MDT), tagged the National Tuberculosis and Leprosy Control Programme (NTBLCP). From its inception, the NTBLCP aimed to reduce the national prevalence to a level where leprosy was no longer a public health problem. The FGN sought the assistance of four international anti-leprosy (ILEP) organisations to achieve its goal of reducing the disease burden to <1 case per 10,000 population by the year 2000.

The Leprosy Mission (TLM) was thus contracted by the NTBLCP to fund leprosy control activities in five states where this study was conducted. Activities funded by TLM included case detection and treatment organised on an out-patient basis; prevention and management of disabilities; community awareness and socio-economic rehabilitation (SER). This paper focuses on the SER activity only. TLM commenced funding SER interventions in leprosy settlements in northern Nigeria in 1997. SER interventions implemented in Nigeria consist largely of the provision of wells and water pumps, construction of schools, shelters, scholarship schemes, loans for small scale businesses, and vocational training. These interventions have been implemented primarily to alleviate socio-economic problems.

Methods

As this was the first evaluation exploring people’s perception of the effect of SER on their experience of stigma in Nigeria, we adopted a retrospective, combined quantitative-qualitative approach to the research. The study combined semi-structured interviews of SER participants, focus groups and key informant interviews with a quantitative assessment of the level of participation-restriction of SER participants using a questionnaire called the Participation Scale. Findings comparing the quantitative and qualitative findings have been reported elsewhere. Only the qualitative data is reported here. The research is based on interviews conducted with 65 adults in September 2006, to determine their perceptions of the usefulness of SER for stigma reduction in leprosy. Twenty of the 65 adults consisted of SER participants randomly selected from a list of 131 beneficiaries in five leprosy settlements in northern Nigeria. Thirty-five of the 65 respondents were neighbours/family members of SER participants who constituted five focus groups. The remaining 10 people were community members (teachers, village/religious leader, health workers etc.) selected for possessing valuable contextual information about the SER project or the study area. After gaining their consent to be interviewed, the 20 individual SER participants were selected to enhance the variation in their account of experiences of stigma using characteristics including visible deformity, gender, religious persuasion, ethnicity, and literacy status. Key informants were selected using the snow-ball technique. This is a technique whereby we relied on rehabilitation facilitators at the research sites to locate the initial two key informants. Thereafter, the key informants were asked to assist us in locating other potentially knowledgeable persons to interview.
**DATA ANALYSIS**

Qualitative interviews and group discussions, each lasting about 30 minutes, were recorded with a Dictaphone, transcribed verbatim, and translated into English to facilitate data analysis. Analysis involved: (i) repeated examination of the contents of the interview transcripts for statements about discriminatory practices and usefulness of SER for social inclusion; (ii) developing themes around emerging patterns regarding these topics, building analytic categories from themes and linking the categories into a coherent process, and (iii) comparing categories and themes with our research questions and literature for logical linkages. Lastly, the findings of our inquiry were integrated with the concepts of ‘threat to group functioning’ to illustrate leprosy-related stigma experiences in northern Nigeria. Qualitative analysis was done manually without the use of computer software. The research was approved by the Research Ethics Committee of The Leprosy Mission.

**Results**

Table 1 shows the socio-demographic characteristics of 20 SER participants whose mean age was 54·3 years and 85% of whom suffered visible deformities.

Seventeen of them (or 85%) benefited from micro-credit loans or housing only, while three persons benefited from combinations of loans, housing, vocational training or adult education.

A re-analysis of interview transcripts identified six themes, namely: (i) prejudicial attitudes, (ii) independence and income generation, (iii) access to public institutions, (iv) desire for acceptance, (v) dignity, and (vi) components of SER that stimulate social interaction. The interview excerpts are referenced as follows: (P3 Female) indicating a quote by a female participant No 3; (R1-FG5 Male) indicates a quote by a male respondent No 1 in focus group 5; and (KI 8 Female) indicating a quote by a female Key informant No 8.

### PREJUDICIAL ATTITUDES

The commonest negative attitudes identified by people affected by leprosy during the study were avoidance, devaluation, and segregation by family. Fear of contagion appears to have

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Value (n = 20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age range</td>
<td>18–80 Yrs</td>
</tr>
<tr>
<td>Female</td>
<td>10 (50%)</td>
</tr>
<tr>
<td>Treated &amp; Released from MDT</td>
<td>20 (100%)</td>
</tr>
<tr>
<td>Literate (primary/Arabic/adult education)</td>
<td>4 (20%)</td>
</tr>
<tr>
<td>Married</td>
<td>16 (80%)</td>
</tr>
<tr>
<td>Separated/Widowed</td>
<td>4 (20%)</td>
</tr>
<tr>
<td>Visible deformity</td>
<td>17 (85%)</td>
</tr>
<tr>
<td>Muslim</td>
<td>15 (75%)</td>
</tr>
<tr>
<td>Christian</td>
<td>5 (25%)</td>
</tr>
<tr>
<td>Ethnicity-Hausa/Fulani</td>
<td>16 (80%)</td>
</tr>
<tr>
<td>Yoruba/Igbira</td>
<td>4 (20%)</td>
</tr>
</tbody>
</table>
been the root of prejudicial attitudes. These attitudes were corroborated by focus groups (who were family members of people affected by leprosy) and key informants (who were predominantly people not affected by leprosy). Typical examples of prejudicial attitudes and discriminatory practices included: ‘They look down on people affected by leprosy. Even in my father’s family, they did not want to see me. My mother’s people separated themselves from me, so that they will not contract the disease’ (KI 3 Female).

A male member of a focus group—R6-FG1, said: ‘Some people think that if they sit beside a person affected by leprosy, the disease will jump on them. They will not want to sit closer to you. If you stop a vehicle/bus and you enter it, they will withdraw from you’. A female respondent of a focus group—R4-FG3 said: ‘The benefits of SER extend to us the children of people affected by leprosy. People used to say we were unfit for marriage because we were children of people affected by leprosy. We could only marry children of other leprosy-affected people. But now...we are uplifted, there are marriages between our families and those of people not affected by leprosy’.

**FINANCIAL INDEPENDENCE AND INCOME-GENERATION**

During this research, independence denoted a situation where SER participants ‘did not rely on the financial support of others for survival’. Financial independence was closely linked to income generation. A majority of participants (seven men and seven women) reported becoming financially independent from families and friends following SER interventions. Participation in SER enabled respondents to meet basic family needs and stop begging. A statement describing independence by a female participant—P7 is: ‘The loan has increased my independence. In the past, I used to wait for my husband before I could buy something, but now because of the loan that I use for trading, I can do some things on my own, I don’t have to wait for my husband to do all the things again and it has also brought wealth for enjoyment’.

**ACCESSIBILITY TO LOCAL SERVICES**

The participants’ perceived accessibility to local services and public institutions was an indication of social interaction. A majority of participants (eight women and five men) reported improved accessibility to hospitals, schools, and places of worship following their participation in micro-credit loans. An unexpected finding was the indigenous perspective that money facilitated access to public institutions, as described in the words of the following male participant—P3: ‘It has improved my access to places. Where I couldn’t go before, I can now go; you know ‘money is the vehicle of interaction’. I am now going to places like church and contribute my own share’. Another male respondent—P5 said: ‘Yes I can now enter many places in the community, but in the time past I was not allowed into some places because of lack of money to contribute to community activities’.

The foregoing accounts depict a landscape of attitudinal barriers to social contact and cultural barriers to social institutions and services experienced by people affected by leprosy prior to the positive experiences with SER intervention.
DESIRE FOR ACCEPTANCE

The central feature of the stigmatised individual’s situation in life lies in efforts made to achieve what is often, if vaguely, called ‘acceptance’. The stigmatised individual responds by making direct and indirect attempts to correct the basis of his/her failing. Direct attempts of people affected by leprosy to correct the objective basis of their situation include seeking drug treatment to cure the disease, and undergoing surgery to correct resulting physical impairments. Indirect adaptations to stigmatisation include re-training in a new vocation/employment or attending remedial education to increase one’s chances of attaining acceptable levels of literacy. A poignant account by a female petty trader—P10 exemplifying a desire for acceptance was: ‘Although we enjoyed the previous loans, we think more loans will increase our recognition with people, so that when they talk, we can talk too...we can be like other people. You know a little more money like N20 000–30 000 [US$150–200] will uplift us’. Additionally, a male focus-group participant – R1 FG5 said: ‘A lot of changes are noticeable. We and the ‘healthy’ can now sit in the same place to eat together. Our interactions are like those of ‘healthy-to-healthy’...when we travel to neighbouring towns, we are not shunned any longer’. These quotes reveal an aspiration for acceptance on equal terms with other members of society. The narrative of the female petty trader portrays the belief that maintaining one’s livelihood could protect one’s place in society. By her estimation, continuous acceptance could be guaranteed by obtaining extra capital for sustaining her petty trade which is the basis of her new social identity in society.

DIGNITY

For this research, dignity denoted a sense of self-worth. A majority of participants (17 people) claimed SER improved their dignity through: (a) acceptance in society, (b) increased capability of meeting family needs such as feeding or children’s education, and (c) increased ability to work like others in society. A key statement depicting dignity is ‘It has increased my dignity because I am now able to send my children to school and I am able to work like other women in society’ (P1 Female). This statement exemplifies the free will of people affected by leprosy to remain respectable by engaging in productive work and fulfilling social roles and obligations.

WHAT COMPONENTS OF SER STIMULATE STIGMA-REDUCTION?

Stigma-reduction denotes the situation where people who were previously excluded are included in family or community life. Asked which elements of SER were useful for stimulating stigma-reduction, a majority of respondents claimed micro-credit loans was the foremost component of SER for stimulating positive community attitudes and social interaction. A male key informant—KI 9 said: ‘In my opinion, no other intervention reduces discrimination like having something [loans] to trade with. As many people are aware. .people shun those who are ill, poor and without a means of livelihood. .But if he makes a living and has some money. .people would interact with or approach him whether he has a disease or not. .as long as he is not dirty’. Furthermore, a female key informant—KI 6 said: ‘I am satisfied especially with the loans and vocational training which have brought many changes in the life of these people. It is amazing to see how we now interact with them’.
From the foregoing, we surmise that micro-credit loans and vocational training are the dominant ingredients of SER for stimulating stigma-reduction in northern Nigeria. These ingredients increased clients’ chances of self-employment, income-generation, and their capability for contributing financially to family and community activities.

**HOW DOES SOCIO-ECONOMIC REHABILITATION REDUCE STIGMA?**

From the narratives of our respondents, we created a framework of leprosy-related stigma to aid the understanding of stigma processes and identify the mechanism by which SER reduces stigma in northern Nigeria (Figure 1).

The framework consists of three parts—upper, middle and lower. The upper part depicts the disease leprosy and its distinctive impairments that evoke fear of contagion and fear of association with people affected by leprosy. The middle part illustrates two columns depicting the outcomes of prejudicial attitudes and discriminatory practices experienced by respondents including reduced access to employment, exclusion from family/social activities and reduced access to public institutions (see the right column). Below these columns are the consequences of exclusionary practices that are manifested as the loss of income, diminished capability to fulfill normal social roles, loss of social identity and further exclusion of from society. Where the outcomes of discriminatory practices and their consequences are left uncorrected, they result in low self-esteem, poor self-care, powerlessness and destitution (see the left column), that result in a vicious cycle of increased impairment-exclusion-further impairment.

![Figure 1. Conceptual framework of leprosy-related stigma derived from narratives of respondents.](image-url)
Reidpath et al. contend that community membership is determined by the perceived social value of groups/individuals and that stigmatisation is the marking of people who are unworthy of social association or investment. Individuals judged to be poor financial contributors, carriers of infections or physically disabled become more socially excluded than good contributors, and ‘healthy’ people. Interviews conducted for this research lead us to infer that stigmatisation of leprosy in northern Nigeria can be understood using Reidpath et al.’s concept of threat to group membership and social/financial contribution. Consistent with this view, we speculate that those who are employed and capable of income-generation or financial contribution are judged to be of higher social value and embraced by society; while disabled people who are unemployed or poor reciprocators are socially excluded. This might, in part, explain the social exclusion of people affected by leprosy with visible disfigurement in northern Nigeria.

Further to marking leprosy impairments for exclusion, a plausible link between social value and stigmatisation might be the overarching poverty in Nigeria. Despite high income from crude oil sales and high external reserves between the years 2002–2007, there is still a high incidence of poverty in Nigeria. The problem is further complicated by the impact of structural adjustment programmes (SAPs) imposed by the World Bank and International Monetary Fund throughout the 1990s to ensure the servicing of national debts. SAPs stipulated low government investment in health, education and social infrastructure. For instance, the incidence of poverty in northern Nigeria where this research was conducted is >71% compared to a national average of 54% in 2007. The high incidence of poverty has led to increasing numbers of youths and adults who are unemployed. Families and immediate communities who struggle to meet their needs are forced to neglect members unable to contribute to group sustenance. In a growing climate of differential neglect, disabled people gravitate to the great cities, both to form communities of their own and to participate in a sub-economy of poverty—begging/dependence on alms for sustenance.

The relationship between stigmatisation and poverty is illustrated by a quote from a male respondent—KI 7 that says: ‘Poverty on its own is a kind of disease. No one associates with you if you have nothing [no means of livelihood]. Yes, rehabilitation is reducing stigma. . .because the people now have something doing. People are not stigmatised if they have something or a trade’. This quote suggests that the social value of people without a productive means of livelihood or who are perceived as a net drain on community resources is low.

The above reasons for stigmatisation namely: (i) leprosy and its impairments, and (ii) lack of employment or incapability of financial exchange, correspond to two of three criteria for exclusion from community groups earlier proposed by Neuberg et al. Although SER was originally implemented to increase financial capacity and functioning, and not to reduce stigma, nevertheless, by addressing the important social values (self-employment, and income-generation) that people affected by leprosy lacked, we realised the visible impairment and stigma that previously defined their social identity became a non-issue. From the proposed framework, SER might be implemented both to prevent individuals from deleterious outcomes of discrimination and to salvage those suffering consequences of exclusion (see broken arrows in Figure 1).
Discussion

Whereas some reports extol SER for improving social and economic conditions of people affected by leprosy,24,25 there is a paucity of reports evaluating the impact of SER on stigma-reduction.1,26,27 Studies that indicate SER reduces stigma through improvements in economic conditions and social interaction do not identify the mechanism(s) by which economic improvements stimulated acceptance and social interaction.1,24,28 Our research explored whether exposure of people affected by leprosy to SER led to stigma-reduction. We integrated themes of discrimination with the constructs of threat to group functioning and reciprocity to provide a framework for describing the cycle of stigmatisation experienced by people affected by leprosy in northern Nigeria. This framework showed that discriminatory practices resulted in exclusion from employment, family and social institutions e.g. hospitals and mosques. The consequences of discriminatory practices resulted in the loss of income, incapability of fulfilling normal social roles, reduced capacity for financial reciprocity, social devaluation, worsening impairments and further stigmatisation. Contrary to literature depicting people affected by leprosy as doomed to stigmatization,19,29 the narratives of our respondents indicate leprosy-related stigma was partial rather than total. These accounts from northern Nigeria suggest there is nothing inherent in leprosy impairments that interfere with the potential fulfillment of social roles. The accounts further underline the flexibility of communities to embrace individuals that demonstrate a capability for engaging in productive work, and financial contribution to family/community activities. Our data revealed reintegrated respondents worked hard to protect their place in society by maintaining their livelihoods. We propose that SER breaks the cycle of stigmatisation by protecting people affected by leprosy against the loss of social value by facilitating their participation in daily social roles in the community, and in turn protecting their ability to engage in financial exchange.

Conclusion

Using concepts of threat to group survival and financial reciprocity, we developed a framework from the narratives of our respondents for understanding stigma processes and the place of SER in stigmatisation in Nigeria. While analysis revealed a tendency for excluding people affected by leprosy in times of economic hardship, there was flexibility towards reintegrating productive and contributive individuals. This suggests stigmatisation is partial rather than permanent. We identified micro-credit loans and vocational training as components of SER that triggered stigma-reduction through the mechanism of protecting people against the loss of social value by facilitating their continuous engagement in daily social roles and participation in financial exchange in the community. We propose that through this mechanism, SER stimulates positive attitudes, social inclusion of people affected by leprosy in northern Nigeria. We recommend empirical testing of the proposed framework to ascertain its utility in other cultures.

Study Limitations

First, whereas we identified distancing, devaluation, and segregation by family as the commonest negative attitudes experienced by people affected by leprosy, we acknowledge
that our question regarding the usual public reaction to leprosy in northern Nigeria may have elicited synoptic accounts from respondents that were geared to the perceived needs/wants of the researcher. While these negative practices may have been corroborated by focus groups and key informants, we are aware that perceived negative responses to leprosy may not always reflect actual negative behaviour especially in social contexts that actively encourages tolerance for the unfortunate or impaired.

Secondly, while we identified employment, income-generation and financial contribution as social values for inclusion in northern Nigeria, we acknowledge there are cultures where dimensions of leprosy-related stigma may be explained by concepts such as sin, religious purity and moral transgression. Further, we recognise leprosy is not universally stigmatised. In societies with a more egalitarian structure, stigma might be less, although societal expectations and responses to leprosy, and thus stigma construction may be linked to particular historical and cultural conditions of specific societies. For instance, in West Sepik province of Papua New Guinea, there is a lack of leprosy-related stigma as practical considerations lead inhabitants of the province to regard leprosy much less serious than several other unpleasant skin diseases that assail them. Although the contexts may differ from northern Nigeria, we believe utilising the concept of threat to group survival might facilitate analysis and identification of culturally appropriate stigma-reduction interventions.

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