APPRAISAL OF STIGMATIZATION OF PEOPLE WITH LEPROSY AND OTHER HEALTH CONDITIONS IN NIGER STATE, NIGERIA

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Abstract

Leprosy remains highly stigmatized in Nigeria, and its social consequences persist despite biomedical advances and institutional efforts. This study investigates the cultural, social and structural drivers of leprosy-related stigma in Niger State and assesses the roles of government agencies, NGOs and community actors in stigma reduction. The theories of stigma, social identity and labeling were employed for the study. Using a mixed-methods design, data were collected from a survey of 360 respondents, 15 key informants and four focus group discussions, analyzed through descriptive statistics, regression and thematic analysis. Findings show that leprosy is perceived as one of the most stigmatized conditions, driven by misconceptions, supernatural attributions and entrenched cultural narratives, leading to human rights violations such as employment discrimination, social exclusion and unequal healthcare treatment. Institutional responses remain fragmented and under-resourced, while community attitudes especially in rural areas reinforce exclusion. The study concludes that effective stigma mitigation requires a culturally grounded, rights-based and multi-sector approach. As such, the study recommends integrating strengthened public health communication, expanded NGO advocacy, improved healthcare training and community-led efforts to challenge harmful beliefs among other recommendations.

1 Introduction

Stigmatization remains a significant yet under-examined social issue in Nigeria, where millions of individuals experience it from a broad array of characteristics including physical defects, age, occupational status, and social class (Hellandendu, 2000). Although stigma is a global phenomenon, its manifestations in Nigeria are uniquely shaped by cultural norms, inadequate legal protections, and persistent inequalities. Individuals living with stigmatized health conditions such as leprosy, epilepsy, mental illness, or Human Immune-deficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) are frequently subjected to negative stereotyping, exclusion, and acts of symbolic or physical marginalization. Despite the presence of constitutional guarantees and international human rights commitments, the plight of these populations has not been adequately addressed within national legislation or welfare frameworks. As observed by Hellandendu (2001), state responses often assume a palliative rather than structural form, failing to challenge the underlying social and institutional mechanisms that reproduce discrimination. The continued neglect of persons with stigmatized conditions reflects both weak state accountability and societal trivialization of their basic human rights.

Health related stigma, in particular, presents a multidimensional challenge. In its simplest sense, stigmatization involves attaching negative attributes to individuals due to a particular condition or identity, in ways that impair their social relationships and limit opportunities for full participation in communal life. Such processes have profound implications for health outcomes: stigma and discrimination can deter individuals from seeking treatment, undermine adherence to medical regimens, and intensify psychological distress (Akinyemi, Alabi & Odimegwu, 2017). Joint United Nations Programme on HIIV/AIDS (UNAIDS) (2015), similarly documents how exclusionary behaviours whether through verbal denigration, avoidance, refusal of services, or institutional neglect restrict access to care and reinforce cycles of vulnerability. Leprosy offers a striking illustration of these dynamics. Even with advances in biomedical treatment, many persons affected by leprosy continue to live in segregated colonies and endure deep social rejection, a pattern well documented in recent Nigerian studies (Pelumi, 2022).

The endurance of leprosy related stigma speaks to the ways in which health conditions acquire social meanings that far exceed their biomedical realities. Although modern science has established leprosy as a curable bacterial infection, its historical symbolism linked to impurity, divine punishment, and communicability continues to shape public perceptions (Goffman, 1963; Heijnders & Van der Meij, 2006). In many Nigerian communities, these beliefs become codified through labeling practices that mark affected individuals as morally compromised or socially dangerous. Such labels often persist even after successful medical treatment, demonstrating that stigma is sustained by cultural and social processes rather than biological facts. Moreover, such experiences underscore persistent gaps in public understanding of disease causation, transmission, and curability, as well as shortcomings in institutional responses.

Although the global prevalence of active leprosy has markedly declined due to advances in public health surveillance and the widespread availability of multidrug therapy, the social exclusion associated with the disease remains deeply entrenched (Emhokubun, 2019). Much of the Nigerian scholars and policy discourse continues to emphasize the biomedical or epidemiological dimensions of leprosy, leaving the socio-cultural, psychosocial and institutional aspects comparatively underexplored. In many communities across Niger State, inherited fears, derogatory labels and entrenched stereotypes continue to govern social relations with persons affected by leprosy, even when such individuals have been medically cured. This enduring disjunction between medical progress and societal acceptance underscores the fundamentally social rather than biological nature of health-related stigma.

Stigma, in its simplest expression, entails the attachment of negative attributes to an individual or groups based on a particular condition, identity or circumstance, in ways that diminish their social status or opportunities (Goffman, 1963). In Nigeria, millions of individuals experience stigmatization due to factors such as physical impairments, age, occupational identity or social class (Hellandendu, 2001). For those living with health conditions such as leprosy, the consequences of stigma are particularly profound, shaping patterns of exclusion that affect interpersonal relationships, access to services and overall life chances. Despite constitutional provisions affirming the protection and dignity of all citizens (Constitution of the Federal Republic of Nigeria, 1999, as amended), stigma-related concerns have not been fully integrated into national legislation or public policy. As scholars have observed, state responses tend to be palliative rather than structural, thereby failing to secure the basic rights of affected populations (Mowoe, 2008).

Leprosy occupies a unique place in the Nigerian social imagination, historically functioning as the epitome of degradation and as a metaphor for pollution and social rejection (Olasunkanmi, 2019).

The persistence of these perceptions contradicts contemporary biomedical knowledge, which clearly establishes that leprosy is only mildly contagious, has a long incubation period and can be effectively treated with WHO-supplied multidrug therapy (Emhokubun, 2019). Yet, affected individuals continue to face overt discriminatory practices such as avoidance, denial of employment, exclusion from communal participation, and even refusal of medical treatment due to unfounded fears of contagion. These experiences reflect a profound erosion of dignity and constitute violations of fundamental human rights.

Niger State offers a particularly relevant scenario for examining the sociological dynamics of stigma due to its cultural diversity and the presence of communities historically affected by leprosy. Despite improvements in diagnosis and multidrug therapy distribution by governmental and non-governmental actors, societal attitudes toward affected individuals remain largely negative. Persons Affected by Leprosy (PALs) frequently report being excluded from communal events, denied employment, restricted from marriage, or discouraged from participating in religious and social institutions. These practices amount to violations of fundamental human rights guaranteed by Nigerian law and supported by international health and human rights frameworks (World Health Organization [WHO], 2024).

Within Niger State, the inadequacy of institutional frameworks further exacerbates the marginalization of persons affected by leprosy. Although government agencies and non-governmental organizations have made efforts to improve detection and treatment, the mechanisms for protecting affected individuals from discrimination in employment, healthcare, housing and education remain inconsistent and insufficient. Community norms, often shaped by myths about contagion and moral impurity, continue to dictate social interactions, thereby reinforcing a cycle of exclusion.

Stigma remains a pervasive global phenomenon with profound social implications (Hellandendu, 2000). It manifests in the systematic devaluation of individuals who are marked by certain physical, health-related, or behavioural attributes, resulting in multiple forms of discrimination and social exclusion. In Nigeria, as in many other low- and middle-income settings, persons living with stigmatized health conditions including leprosy frequently encounter hostile social environments characterized by ridicule, denial of opportunities, and restricted access to essential services (Monjok, 2009; Akinyemi et al., 2017). Evidence indicates that individuals with conditions such as HIV/AIDS often suffer workplace discrimination, involuntary job loss, and strained family relationships, demonstrating how stigma is reproduced across institutional, interpersonal, and cultural domains (Akinyemi et al., 2017).

The persistence of such experiences is partly attributable to structural inadequacies. Political unwillingness to prioritize the rights of marginalized groups (Aljazeera, 2022), weak healthcare delivery systems, and the absence of strong legal and reporting mechanisms have made it difficult to monitor and address stigma in Nigeria (Hellandendu, 2000). Although the Constitution of the Federal Republic of Nigeria (1999, as amended) guarantees equality, dignity and non-discrimination, these provisions are seldom operationalized to protect people living with stigmatized conditions. Consequently, many affected persons resort to coping strategies such as concealment, dissociation, or normalization to navigate everyday life, often at great psychological and economic cost.

Given these challenges, there is a compelling need for sociological inquiry that bridges health, human rights and community dynamics. Understanding how stigma is produced, justified and sustained within households, institutions and broader social structures is crucial for designing effective interventions. This study therefore seeks to reorient public understanding and inform policy debates by emphasizing the necessity of inclusive development strategies that recognize persons with stigmatized health conditions as social agents rather than outcasts. By examining the interplay between stigma, identity, public policy and community norms in Niger State, the research contributes to broader efforts to advance social justice, collective responsibility and the reintegration of marginalized populations

Given these realities, a systematic inquiry into stigma related to health conditions particularly leprosy in Niger State becomes necessary. The socio-cultural terrain of the state, combined with historical misconceptions about leprosy, creates a complex environment where social exclusion endures despite medical progress. This study is therefore justified by the urgent need to generate empirical evidence that can guide community sensitization, support inclusive policy development, and strengthen institutional responses aimed at safeguarding the dignity and rights of individuals with stigmatized health conditions. Insights from this research are expected to contribute to more effective interventions and inform stakeholders including government agencies, NGOs and community leaders on how to reduce the social burden faced by marginalized populations in the state. The main objective of this study is to provide a comprehensive sociological appraisal of the stigmatization of individuals with stigmatized health conditions particularly leprosy in Niger State. The study also seeks to assess the role of government institutions, non-governmental organizations, community groups and other stakeholders in mitigating stigma and promoting social inclusion. Ultimately, the research aims to stimulate broader societal awareness and encourage collective responsibility toward upholding the fundamental human rights of persons living with stigmatized conditions. The specific objectives of the study are: to identify major stigmatized health conditions prevalent within Niger State; to examine the perceived and medical causes of leprosy within the study area; to assess the fundamental human rights of individuals affected by stigmatized health conditions; and to investigate societal attitudes and responses toward persons living with stigmatized health conditions.

2 Literature Review

2.1 Conceptual Clarification

Leprosy (Hansen Disease)

Leprosy medically known as Hansen's disease is a chronic infectious condition caused by Mycobacterium leprae, a slow growing bacillus that primarily targets the peripheral nervous system, the skin, and in advanced cases, the mucosa of the upper respiratory tract (WHO, 2022). Although global prevalence has declined due to Multidrug Therapy (MDT), the disease remains a major public health concern in several tropical and subtropical countries. The World Health Organization recorded 127,396 new cases globally in 2021, with approximately 80% of these reported in India, Indonesia, and Nigeria (WHO, 2022). Nigeria alone registers close to 1,000 new cases annually, making it one of the countries with persistent endemic transmission.

The clinical consequences of leprosy which includes nerve damage, loss of sensation, deformities, and skin discolouration, often contribute to profound social marginalization beyond biomedical impairment (Emhokubun, 2019). Nigeria currently hosts more than sixty-four leprosy hospitals and settlements, including the Minna settlement in Niger State, the Uzuakoli Leprosy Centre, the

Oji River Leprosy Settlement, the Leprosy and Tuberculosis Relief Initiative, and the National Tuberculosis and Leprosy Training Centre in Zaria. Although early diagnosis and MDT have made the disease curable, the persistence of cultural beliefs and misinformation sustains discrimination long after medical recovery (Olasunkanmi, 2019).

Stigmatization

Stigmatization refers to a process through which individuals are ascribed negative attributes based on a particular characteristic, health condition, or social identity, resulting in their devaluation and exclusion within society. Koschorke et al. (2014), conceptualize stigma as a form of "social devaluation," emphasizing its embeddedness in unequal power relations. The term itself originates from the Greek word stigma and was elaborated sociologically by Goffman (1963), who defined it as an attribute that is "deeply discrediting." Rather than residing in the attribute alone, stigma is produced through social interactions, cultural meanings, and institutional practices.

Goffman (1963), identified three major categories of stigma such as physical (bodily) stigmas, such as deformities or disabilities; Moral stigmas, linked to perceived character flaws; and tribal stigmas, associated with race, ethnicity, caste, lineage or group membership.

Health related stigma, such as that associated with leprosy, HIV/AIDS or mental illness, emerges from a combination of fear, misinformation, religious interpretations, and cultural beliefs. In many Nigerian communities, labels attached to individuals with leprosy reproduce centuries-old misconceptions about contagion, spiritual impurity, and hereditary taint (Jadhav, 2007). These labels often lead to exclusion from employment, marriage, educational opportunities, and social participation, reaffirming stigma as a social process rather than a medical inevitability.

While interventions such as public enlightenment, rehabilitation, anti-discrimination legislation and biomedical treatment can reduce stigma, their impact in Nigeria has been limited. Many individuals who could be productive citizens remain confined to the margins of their communities, hindered by fear, superstition and entrenched cultural norms (Monjok, 2009).

Fundamental Human Rights

Fundamental human rights are constitutionally guaranteed entitlements that safeguard the dignity, equality and liberty of all persons. In Nigeria, these rights are established under Chapter IV of the Constitution of the Federal Republic of Nigeria (1999, as amended). For individuals living with stigmatized health conditions, several of these provisions have direct relevance: Right to Life (Section 33) – Every person has the right to life, which obligates the state to protect individuals from neglect and harmful treatment. Right to Dignity of the Human Person (Section 34) – This prohibits degrading or inhuman treatment, affirming that all persons are born free and equal in dignity and rights. Right to Freedom from Discrimination (Section 42) – No citizen shall be subjected to restrictions, disabilities, privileges or disadvantages based solely on community, sex, ethnicity, religion, or circumstances of birth.

Section 42 further emphasizes that no Nigerian shall be deprived of rights "merely by reason of the circumstances of his birth," a clause that implicitly protects individuals whose stigma arises from hereditary or congenital conditions. Additionally, Chapter II, Section 15(2) mandates active promotion of national integration and prohibits discrimination based on place of origin, ethnic affiliation, religion, or status.

Mowoe (2008), notes that any disadvantage imposed on individual's based on these classifications constitutes discrimination and, in effect, a form of social stigmatization. In principle, these provisions require the state to ensure that persons living with stigmatized conditions including leprosy are protected from societal exclusion and institutional neglect. Yet, practical implementation remains weak, necessitating strengthened state responsibility, rights-based interventions, and inclusive social policies (Araromi, 2008).

Ultimately, the effective realization of these rights is central to achieving inclusive development. Addressing stigma is therefore not only a moral imperative but also a constitutional obligation and a prerequisite for sustainable social integration.

2.2 Empirical Review

Empirical scholarship over the last decade demonstrates that, despite significant improvements in early detection and multidrug therapy, leprosy continues to provoke entrenched social stigma in many Nigerian communities. This stigma frequently persists well after medical cure and shapes the life-course trajectories of persons affected. Drawing on a life-course ethnographic design, Ebenso et al. (2019), examined the experiences of individuals affected by leprosy in Western Nigeria and showed how societal arrangements such as segregated settlements, service delivery structures, and long-standing organizational routines produce and reinforce stigma. Their study illustrates that social labeling permeates critical aspects of everyday life, influencing marriage prospects, occupational opportunities and interpersonal relationships. The ethnography underscores how stigma is simultaneously embedded in institutional practices and expressed through intimate social interactions, thereby demonstrating its multidimensional and enduring nature.

Complementary findings have been generated in northern Nigeria, where stigma intersects with region-specific cultural and religious belief systems. A qualitative inquiry conducted by Dahiru, Iliyasu, Mande, van't Noordende and Aliyu (2022), in Kano State revealed widespread misconceptions regarding leprosy aetiology and transmission. Many community members believed that leprosy is linked to spiritual forces, hereditary contamination or persistent contagion, thereby legitimizing avoidance behaviours and moral judgment. The authors show that stigma is sustained by gaps in health communication, the influence of religious teachings and the authority of local leaders. Their study therefore calls for behaviour-change interventions that reflect local epistemologies, social norms and modes of community deliberation.

More recent cross-sectional and mixed-methods studies offer quantitative and triangulated support for the persistence of discriminatory attitudes. National and community-level KAP (knowledge, attitudes and practices) surveys report that unfavourable perceptions of persons affected by leprosy remain widespread across endemic communities. For instance, Murphy-Okpala et al. (2024), demonstrate that negative attitudes correlate strongly with delayed health-seeking behaviour, diminished utilization of formal care and adverse psychosocial outcomes, including depression and internalized stigma. These studies also document forms of institutional discrimination, such as exclusion from employment opportunities and inequitable treatment in public services, showing that stigma extends beyond interpersonal avoidance to include structural and bureaucratic forms of disadvantage.

Further granular evidence is provided by studies focused specifically on leprosy settlements. Oke et al. (2024)**,** drawing on qualitative and mixed-method approaches, argue that residents of these settlements face layered vulnerabilities, including economic precarity, inadequate rehabilitation services, limited social protection and entrenched self-stigma. Their findings suggest that segregationist policies of previous decades continue to shape present-day experiences of marginalization, reinforcing stigma and undermining the effectiveness of biomedical interventions alone. These studies collectively reveal that they lived realities of individuals in leprosy settlements are shaped by a combination of historical path dependencies and contemporary institutional neglect.

Evidence from intervention research, especially studies conducted in South Asia, provides insights into strategies that may reduce stigma in comparable contexts. Van't Noordende et al.(2021) evaluated community-based education, participatory dialogues and poster-driven awareness campaigns, showing that culturally attuned and participatory interventions can significantly improve knowledge and reduce discriminatory attitudes. Although conducted outside Nigeria, these findings underscore the importance of multilevel community engagement co-created with religious leaders, traditional authorities and civil society actors in dismantling structural and interpersonal stigma. Given the socio-cultural heterogeneity of Nigerian communities, the literature recommends careful localization and context-specific adaptation of such interventions, particularly those integrating livelihood support, disability-inclusive messaging and rights-based narratives.

2.3 Theoretical Framework

The analytical foundation of this study is anchored in classical and contemporary sociological theories of stigma, identity, and social control. These frameworks illuminate how individuals with stigmatized health conditions particularly persons affected by leprosy become socially marginalized not solely because of biomedical impairment, but through cultural meanings, institutional practices, and power relations that shape public responses.

Goffman's Theory of Stigma

Erving Goffman's (1963) seminal work provides the primary theoretical lens. Goffman conceptualizes stigma as an attribute that fundamentally disqualifies an individual from full social acceptance, transforming them from a "whole and usual person" into a discounted and discredited one. Stigma, in this sense, is not inherent in the condition but embedded in the social processes that assign negative meanings to the condition. Through mechanisms of "discredited" and "discreditable" identities, individuals attempt to navigate social interactions using various impression management strategies to conceal or negotiate their stigmatized status.

Labeling Theory (Becker, 1963)

Complementing Goffman's framework is Becker's (1963) Labeling Theory, which posits that deviance is not a quality of an act or condition but a consequence of the societal reaction to it. The theory suggests that individuals become "deviant" when influential social actors like medical institutions, community leaders, or the state label them as such. For persons with leprosy, the disease becomes a master status, overshadowing all other social identities and shaping how others perceive and interact with them. Thus, deviance and exclusion arise less from the pathology and more from the stigmatizing gaze of society.

Social Identity Theory (Tajfel & Turner, 1986)

Social Identity Theory further enhances this analysis by explaining how group dynamics sustain stigmatization. Tajfel and Turner (1986) argue that individuals derive part of their self-concept from group membership, and groups with higher power or prestige often maintain boundaries by stigmatizing those perceived as lower in status. In many Nigerian communities, persons with leprosy occupy a socially devalued category, and stigma becomes a tool for reinforcing group hierarchies, protecting perceived social purity, and maintaining cultural boundaries.

Stigma as Social Control

Goffman's perspective is extended in literature that views stigma as a form of social regulation. According to this perspective, stigma operates as a mechanism of social control by enforcing conformity to social norms (Goffman, 1963). The assumptions of this approach include: Stigma functions to discipline behaviour; Stigma reinforces normative expectations; Stigma legitimizes the marginalization of individuals or entire groups who fall outside societal ideals.

In the case of leprosy, stigmatization historically functioned to spatially segregate persons affected through leprosaria, settlements, and colonies as a way of maintaining social order and minimizing perceived threats.

Modified Labeling Theory (Link & Phelan, 2001)

Link and Phelan (2001) re-conceptualize stigma as a dynamic process emerging from the intersection of labeling, stereotyping, separation, status loss, and discrimination in a context of unequal power. This perspective highlights how structural forces legal systems, healthcare institutions, economic relations, and cultural norms shape stigmatization. Their model assumes that: Stigma is produced through labeling processes embedded in social structure; Power determines who assigns labels and how labels are enforced; Stigma can be challenged through collective action and advocacy.

This is particularly relevant to leprosy in Nigeria, where institutional practices (e.g., discriminatory healthcare encounters, exclusionary housing policies) reproduce stigma even after medical cure, and where power disparities restrict the ability of affected individuals to resist or reframe their identity.

Stigma as a Dynamic, Structural Process

Contemporary stigma theory advances the argument that stigma is not static but continually reproduced through interpersonal interactions and structural arrangements such as laws, policies, and cultural narratives (Phelan, Link & Dovidio, 2008). Stigma becomes especially harmful when linked to health conditions such as HIV/AIDS, mental illness, and leprosy because it creates barriers to accessing healthcare, employment, education, and adequate housing. These structural exclusions exacerbate marginalization and intensify the social suffering experienced by affected individuals.

Implications for Persons with Stigmatized Health Conditions

Drawing on these theoretical perspectives, the experiences of individuals living with leprosy, HIV/AIDS, or mental health disorders can be conceptualized as products of both structural and interpersonal stigma. Common consequences include: Discrimination in employment, education, housing, and healthcare; social exclusion and community-level ostracism; delayed or denied medical care due to provider bias or inadequate knowledge; internalized stigma, manifesting as shame, guilt, or diminished self-worth; exposure to violence and abuse because of perceived danger or impurity; legal and policy limitations that restrict full citizenship; economic deprivation, resulting from systematic exclusion; cultural silencing, which erases the lived experiences of affected persons; limited access to information that could counter misconceptions; weak support systems, especially in mental health and social services.

These consequences affirm the need for a rights-based and sociologically grounded approach to understanding stigma. The theoretical frameworks collectively demonstrate that stigmatization is not simply a matter of individual prejudice but a socially and structurally embedded process shaped by power relations, cultural histories, and institutional practices.

3 Methodology

3.1 Research Design

The study adopts a mixed-methods research design to provide a comprehensive analysis of stigma in Niger State. Quantitative techniques were used to measure the prevalence of stigmatizing attitudes and discriminatory behaviours, while qualitative methods enabled a deeper understanding of the cultural logics and personal narratives that shape these attitudes (Creswell & Plano Clark, 2018). The integration of these approaches strengthens the validity of the findings.

3.2 Study Area and Population

The study was carried out in Minna metropolis and Chanchaga Leprosarium in Niger State to capture community and institutional variations in stigma. Participants included **Persons Affected by Leprosy (PALs)**, **household respondents**, **healthcare workers**, **traditional and religious leaders**, and **policymakers/Non-Governmental Organisations representatives** involved in disability and public health advocacy. This diverse sample enabled a holistic assessment of how stigma is produced and reproduced at individual, community and institutional levels, and how these dynamics shape the daily experiences and rights of affected persons.

3.3 Sampling and Sample Size

A multistage sampling approach was adopted to ensure analytical robustness and representativeness. **Purposive sampling** was used to recruit persons affected by leprosy and NGO officials, given their direct experiential knowledge of stigma and intervention processes. **Stratified sampling** was implemented to capture variation across urban and rural communities, while **simple random sampling** guided the selection of household respondents. Overall, **360 participants** were drawn using Taro Yamane formula. The respondents were surveyed quantitatively, complemented by **15 key informant interviews** and **four focus group discussions** that enriched the study with qualitative insights.

3.4 Instruments

Data were collected using multiple research instruments, including structured questionnaire, in-depth interview guides and focus group discussions. The reliability of the survey instrument was confirmed through Cronbach's alpha values exceeding 0.70, indicating strong internal consistency (Tavakol & Dennick, 2011).

3.5 Data Analysis

Quantitative data were processed using **SPSS version 26**, consistent with standard analytical procedures in sociological research (Bryman, 2016). Descriptive statistics were used to summarize demographic and stigma-related variables, while **Chi-square tests** and **logistic regression models** were employed to examine significant associations between socio-demographic factors and stigma outcomes (Agresti, 2018).

Qualitative data from interviews and focus groups were **transcribed verbatim**, **coded**, and analyzed using **thematic analysis**, following the iterative procedures outlined by Braun and Clarke (2006). This approach enabled the identification of recurring meanings, social interpretations and patterned narratives that reflect participants lived experiences within broader socio-cultural structures.

4 Results

Table 1: Community Perceptions of Stigmatized Health Conditions

Health Condition	Percentage Perceiving Condition as Highly Stigmatized (%)
Leprosy	87
Mental Illness	79
Epilepsy	62
HIV/AIDS	59

Source:

As shown in Table 1, leprosy emerged as the most stigmatized health condition (87%), reinforcing findings from earlier literature that leprosy carries an enduring symbolic and moral burden in many African societies (Goffman, 1963; Ebenso et al., 2019). High levels of stigma toward mental illness (79%) and epilepsy (62%) align with research describing persistent misconceptions and cultural fears surrounding neurological and psychiatric disorders (Atilola, 2016). The continued stigmatization of HIV/AIDS (59%) also reflects lingering moral and behavioural attributions associated with the disease (Akinyemi et al., 2017). These insights highlight that stigma is socially constructed and embedded within cultural narratives, confirming theoretical positions by Goffman (1963) and Link & Phelan (2001) on the social reproduction of stigma.

Table 2: Perceptions of Causes of Leprosy

Attributed Cause	Percentage (%)
Bacterial / Medical cause	41
Supernatural causes (curse, witchcraft, spiritual pollution)	48
Other / Unsure	11

Source: Authors Computation

Table 2 indicates that although 41% correctly recognized the biomedical cause of leprosy, nearly half of respondents (48%) attributed it to supernatural forces. This reflects longstanding cultural interpretations of illness rooted in spiritual causation, which continue to influence behaviour and social attitudes (Heijnders & Van der Meij, 2006). These misconceptions reinforce avoidance behaviours, mirroring empirical findings from northern Nigeria where spiritual explanations increase stigma and social exclusion (Dahiru et al., 2022). Such patterns demonstrate how stigma persists not because of the disease's biomedical characteristics, but due to socially constructed beliefs (Becker, 1963; Tajfel & Turner, 1986).

Table 3: Reported Human Rights Violations Linked to Stigmatization

Type of Rights Violation	Percentage (%)
Employment discrimination	56
Exclusion from community events	43
Unequal treatment in healthcare settings	32

Source: Authors Computation

Table 3 shows that stigma generates measurable human rights violations, with more than half of respondents (56%) reporting employment discrimination. These findings correspond with national studies demonstrating that PALs and individuals with other stigmatized conditions face systemic constraints in accessing work, social participation and healthcare (Murphy-Okpala et al., 2024). Exclusion from communal activities (43%) and unequal treatment within healthcare systems (32%) reflect the institutional dimensions of stigma described in Modified Labeling Theory (Link & Phelan, 2001). Qualitative narratives also indicate that concealment of illness is a common coping strategy, consistent with Goffman's (1963) concept of "information control."

Table 4: Roles of Stakeholders in Stigma Reduction

Stakeholder Group	Observed Roles / Limitations
NGOs	Educational campaigns, rehabilitation programmes; limited coverage and irregular funding
Government agencies	Acknowledged gaps in public health messaging; weak integration of stigma mitigation
Community members	Mixed reactions; stronger stigmatizing attitudes among rural dwellers and older populations

Source: Authors Computation

Table 4 summarizes the institutional and societal dynamics shaping stigma mitigation efforts. While NGOs provide important awareness and rehabilitation services, their impact is constrained by funding instability, echoing findings from other low-resource settings (van't Noordende et al., 2021). Government efforts remain limited, with stigma reduction insufficiently integrated into mainstream public health communication. Community responses vary significantly by age and location, consistent with evidence that socio-cultural context strongly influences stigma beliefs (Jadhav, 2007). These findings reinforce that stigma is sustained through structural, cultural and interpersonal processes, requiring multi-level interventions.

Discussion of Findings

The findings of this study demonstrate that leprosy-related stigma in Niger State is produced through a complex interplay of social beliefs, cultural interpretations and structural weaknesses. The persistence of supernatural explanations such as witchcraft, curses or spiritual pollution for the causes of leprosy reflects broader socio-cultural logics documented in sub-Saharan African health belief systems (Adhikari et al., 2014). These belief patterns not only shape community perceptions but also reinforce symbolic boundaries that separate “healthy” individuals from those with stigmatized conditions, thereby sustaining social exclusion. Similar misconceptions have been widely reported in northern Nigeria and other endemic regions, where incomplete biomedical knowledge fuels fear, avoidance and deep-rooted stigma (Dahiru et al., 2022; Heijnders & Van der Meij, 2006).

The evidence of human rights violations, including employment discrimination, exclusion from communal events and unequal treatment within healthcare settings, highlights the structural dimension of stigma. These findings mirror earlier sociological analyses showing that global and national human rights frameworks frequently fail to translate into meaningful protection for marginalized groups in local contexts (Ezeilo, 2019). In line with Goffman’s (1963) conceptualization of stigma as a “spoiled identity,” affected persons resort to concealment strategies to manage social risk, an adaptive but psychologically burdensome response also documented in other Nigerian studies (Murphy-Okpala et al., 2024).

Institutional responses, while present through NGOs and government programmes, are fragmented, inconsistent and insufficiently integrated into mainstream health communication channels. These limitations resonate with studies arguing that stigma reduction efforts in Nigeria often suffer from inadequate funding, weak coordination and limited cultural adaptation (van’t Noordende et al., 2021). The observed variation in stigma by age and rural–urban location further underscores the importance of contextualizing interventions within local cultural and demographic dynamics (Jadhav, 2007). Collectively, these patterns affirm that stigma is not merely an interpersonal issue but a multi-level social process influenced by institutional arrangements, historical narratives and community worldviews (Link & Phelan, 2001).

In all, the findings reinforce a central consensus in contemporary stigma scholars: biomedical interventions alone are insufficient. Sustainable reduction in leprosy-related stigma requires continuous community engagement, culturally informed communication, empowerment of affected persons and stronger institutional accountability. Addressing these interconnected layers is essential for transforming public attitudes, enhancing social inclusion and safeguarding the rights and dignity of persons affected by leprosy in Niger State.

5 Conclusion and Recommendations

The study shows that leprosy-related stigma in Niger State persists largely because cultural beliefs, structural inequalities and gaps in public health communication continue to shape community perceptions. Despite biomedical progress, misconceptions and supernatural explanations remain widespread, reinforcing exclusion and rights violations in employment, social participation and healthcare. Institutional responses though present are fragmented and insufficiently integrated into broader health and social policies. Addressing this challenge requires more than medical intervention; it demands coordinated, culturally informed and rights-based action across community, institutional and policy levels.

The study recommends as follows; Government Action: Integrate stigma reduction into state health communication strategies and enforce anti-discrimination laws protecting persons affected by leprosy. Strengthen NGO Engagement: Expand community education and rehabilitation programmes using culturally sensitive approaches, with improved funding stability. Community Leadership Involvement: Mobilize religious and traditional leaders to reshape narratives, correct misconceptions and support community acceptance. Healthcare System Improvement: Train healthcare workers to deliver stigma-free, rights-based services and ensure equitable treatment for affected individuals. Research and Monitoring: Promote longitudinal studies to track reintegration outcomes and assess the effectiveness of stigma-reduction interventions. Multi-sector Collaboration: Foster stronger coordination among government agencies, NGOs, community groups and academic institutions to sustain long-term impact.

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