

EFFECTS OF TRADITIONAL RELIGIOUS BELIEF SYSTEM OF THE IGBO GROUP ON THE EFFECTIVENESS OF LEPROSY CONTROL PROGRAMMES IN ANAMBRA AND EBONYI STATES OF SOUTHEAST NIGERIA

Ignatius Uche Nwankwo

Abstract

The objective of this study is to verify the effects of religious belief system on the effectiveness of leprosy control programmes in Anambra and Ebonyi states of Southeast Nigeria. The complementary objective is to ascertain the dominant mode of disposition to leprosy among residents of the two states and to account for the role of religious belief system in shaping such disposition to leprosy among residents. The design for the study was cross-sectional survey method. Three instruments, questionnaire, focused group discussion (FGD) and in-depth interview (IDI) were combined for optimum results. There were four categories of respondents, namely, the general public, persons affected by leprosy, leprosy control staff and officials of World Health Organization (WHO) and the donor agency operating in the two states. All residents of the two states constituted the population of study but a sample size of 1116 adult /members, adequate for applicable statistical techniques were study participants on who a uniform set of structured questionnaire schedule were administered to generate quantitative data. They were selected through combination of cluster and random sampling methods. Qualitative data via FGD were generated from purposively selected persons affected by leprosy from State Leprosy Treatment Registers. Also, purposively selected Leprosy Control Staff and officials of WHO and the donor agency operating in the two states were respondents to IDI sessions. The Statistical Package for the Social Sciences (SPSS) software was employed in data analysis. Frequency tables, bar charts, chi-square and multiple regressions were used for analysis and hypothesis testing. It was found that religious belief system was a major socio-cultural factor affecting the effectiveness of leprosy control in the area. Other minor factors were lack of community participation, poverty, poor political commitment/ funding, low literacy level of both patients and the public. It was recommended that aggressive public enlightenment through public, private and local media and prohibition of socio-cultural practices that promote the spread of leprosy be adopted to enhance effectiveness of leprosy control in Anambra and Ebonyi states.

Key words: leprosy, leprosy control, religious belief system, stigmatization, disposition to leprosy

Introduction

Leprosy is one of the oldest diseases of mankind with very unique social dimension whereby victims and even their care givers are often rejected by society. The disease seldom kills, but has remained a public health problem in some developing countries. It is also one of the leading causes of permanent disability worldwide. Nigeria is ranked at the fifth position among 'high leprosy burden nations' in the world and second in Africa behind Republic of Congo (World Health Organization, WHO, 2008). The National Leprosy Control Programme was established in Nigeria in 1988 to achieve leprosy elimination and eradication. This goal seems to have become a mirage. This study is an attempt to assess the effects of religious belief system on the

effectiveness of leprosy control programmes in Anambra and Ebonyi states of South-east Nigeria.

There are five states namely, Anambra, Imo, Abia, Ebonyi and Enugu states that make-up the Southeast zone of Nigeria. Two of the states were randomly selected for study. The Igbo group, one of the three major ethnic nationalities in Nigeria is the main occupants of the area. According to Ifemesia (1979), the Igbo country covers an area of over 15,800 square miles.

Igbo groups are notable for their high commitment to industry reinforced by strong emphasis on achieved status. Contemporary Igbo societies have not deviated from agriculture, a major occupation of their fore fathers, in which the family served as basic unit of production. Accordingly, Anambra and Ebonyi states, rich in natural resources and arable soil also engage in land cultivation. Trading, arts and crafts, animal husbandry and civil service are other economic activities in the two states. However, people of Anambra state are more involved in entrepreneurship and commerce whereas Ebonyi state is notable for her agricultural prowess (Uzozie 2002; Onokala 2002).

In terms of governance, there is elected civilian government in Anambra and Ebonyi states whose functions are complemented by socio-political structures and pressure groups that characterize Igbo societies. These include village assembly, titled men, women groups and tendency towards gerontocracy, all of which are relevant to grass root administration.

The Igbo group is very religious both in their traditional setting and in contemporary times. In this paper, religion refers to a set of theological beliefs and rituals performed by members of a social group (Peil, 1977). Religion is a part of human behavior manifested through verbal and non-verbal means. The verbal aspects consist of expression of belief, mythology, ethical standard and ideas of the supernatural, while the non-verbal aspects are embodied in the use of specific objects and persons to serve ethical ends.

The religious belief system of Igbo people are not without above attributes. Their traditional religious belief system was built around a spiritual supreme being '*Chiukwu*' who was responsible for all creations and on whom the continued existence of all things depended. Apart from the Supreme Being, the people also pay allegiance to a hierarchy of deities who are reached directly and serve as intermediaries to the Supreme Being. It is likely that their inability to fully comprehend the nature of the Supreme Being directs their attention to lesser deities. All deities are attended to by shrine priests who could offer explanations to the misfortunes that befall individuals and groups and the nature of sacrifices required to appease the deity to surmount the problems. Shrine priests are spokesmen of the deities and preside over applicable rites of worship.

Apart from the deities, adult males also house symbolical representations of their personal divinities (*chi*) in sacred huts called '*obu mmuo*'. The personal '*chi*' is like a guardian angel and is in constant communication with the person. It is normal for men to begin their day by breaking kola nut before their personal '*chi*' and seeking their guidance and protection.

The ancestors and dead relations who lived good life on earth and are accorded full burial rites were also respected and worshipped. They are believed to have successfully transited to the spiritual world and are therefore capable of helping the living.

The last element of the people's traditional religious belief system acknowledges the existence of evil forces that occupy the domain between the spiritual and visible world from where they launch regular attacks onto the living and cause them misfortune. The generic term '*ajo-muo*' represent all the evil forces but specific names like '*amosu*' (witch), etc do exist.

An important feature of the traditional religion of Igbo people is its tendency to view the world as in equilibrium. No occurrence is of natural course. Hence, enquiries must be made through diviners (*dibia afa*), seers and shrine priest to explain the cause of every occurrence.

Christianity, brought to the area by western missionaries has affected traditional belief systems of the Igbo people. Today the membership of the Christian religion in Igboland has grown tremendously that traditional religion is threatened not only by marked erosion of its tenets but also by the dearth of new entrants. Indeed, there has been continued conversion of the adherents of the old faith to the Christian family. Christianity now enjoys greater followership in the area but exists side by side with traditional religion which still has many adherents.

Both traditional religious belief systems of the Igbo and Christian religion have negative interpretations of leprosy. Consequently, persons afflicted with the disease are often perceived as if they have breached taboos of their locality, offended their gods or committed abominable offences in their present or previous existence. The Christian Bible contain verses that associated leprosy with being 'unclean' that requires spiritual bath or cleansing for those afflicted to be made whole

An individual's disposition to leprosy defined as his willingness or otherwise to maintain elaborate forms of social relationship with persons affected by leprosy and to participate in leprosy control activities is usually shaped by the content of belief systems and cultural practices of their area. Those who are keen to keep relationship and participate in leprosy control activities are considered as positively disposed to leprosy while those who cannot are negatively disposed to it.

Effectiveness of Leprosy Control programmes is measured in terms of several yardsticks or variables. These include number of cases detected over time (case finding prowess); ability to complete treatment for most cases detected (favourable treatment outcomes); low level of stigmatization of cases due to widespread knowledge and appropriate understanding of the disease by the people. Other indices of effectiveness are ability of the programme to fully rehabilitate and integrate those who completed treatment into the society (inclusive of socio-economic empowerment and absence of destitution on the part of victims) etc. This study interrogates the effect of religious beliefs on leprosy control.

Objectives of the Study

The core objective of this study is therefore to examine the effects of prevailing religious belief systems (deriving from both Christianity and traditional belief systems) on the effectiveness of

leprosy control programme at Anambra and Ebonyi states of Southeast Nigeria. The complementary objective is to ascertain the dominant mode of disposition to leprosy among residents of the two states and to account for the role of traditional religious belief system in shaping such disposition.

Brief Review of Literature on Leprosy and the Problems of Belief Systems and Social Labels

The word 'Leprosy' was derived from a Greek word 'Leptos' which means scaly (Ezekpeazu, 2000). Nigeria's Federal Ministry of Health (FMOH, 2004) defined leprosy as a chronic, infectious disease that mainly affects the skin, peripheral nerves and mucous membrane of upper respiratory tract caused by *Mycobacterium leprae*.

The problem of leprosy in society had been with society before, during and after the days of Jesus Christ. Rees (1994) noted that leprosy is certainly one of the oldest scourges of mankind. On his part, Ezekpeazu (2000) observes that although the causative organism of leprosy was discovered only in 1873 by Norwegian doctor named Armaeur Hansen, the disease (which is also called Hansen's disease after him) probably originated several centuries ago in India. He maintained that the first authentic description of different types of leprosy and their treatment with Chaulmoogra oil was documented in a treatise written in India around 600BC by an eminent surgeon named Sushruta. The Indians called leprosy 'Kushta'.

Aside from medico-scientific conceptualization of leprosy, studies across cultures show that the disease has also been conceived in derogatory terms quite distinct from other diseases. This gives leprosy a special but negative reckoning in human history (see Ogbeiwi 2005; Stiger, Geus & Heyenders 2000; Scott 2000 etc).

Similarly Brycesson and Pfaltzgraph (1990) contended that although the descriptions of leprosy in the Bible do not correspond to the clinical picture of the disease in our times, and may have merely encompassed a varied group of skin conditions; such Bible references nevertheless compounded contemporary social reactions to leprosy due to uncomplimentary description of its victims as 'unclean'.

Nwankwo (2000) notes that even in the present era of science and technology, the definition of leprosy as a curse from gods and the attachment of extreme social stigma to it remain crucial elements of the conceptualization of the disease especially across sub-Saharan Africa. Kaufman, Neville and Miriam (1993) similarly observed that leprosy is conceived with loathing and aversion and that attitude toward the disease is the same in many eastern and western cultures alike. To them, low awareness and fear of the disease have remained part of characteristic social attitude towards it right to the present day.

Against the above background, Stiger, Geus and Heyender (2000), taking a clue from Robinson (1990) explained leprosy in three related terms as disease (bio medical perception), illness (self-perception) and sickness (social perception). They opined that in the tripartite, it is the term "sickness" (social perception) that reflects the social stigma.

Valencia (1989) summed up the argument. He posited that while the ‘illness’ leprosy is experienced by the person and shaped by social and cultural influences; the ‘sickness’ leprosy encompasses the problem as perceived and named by the society, expressed into social stigma. In Nigeria, Adagba (2011) laments that advocacy and awareness creation about leprosy is still low, and that misconceptions also exist.

The above modes of conceptualizing and belief systems about leprosy has significant implications and must be taken into adequate consideration by any control programme that wants to achieve meaningful results. This is particularly worrisome because persons affected by leprosy often perceive themselves within the framework or template provided by their society with devastating effects on their self concept and socio-economic survival.

Materials and Methods

The study which is located in Anambra and Ebonyi states, randomly selected out of five Igbo speaking states of Southeast Nigeria, adopted cross-sectional survey design. The study participants consisted of adults, aged 18 years and above. There are about 3,515,370 of such adults in the area which represented 57.2% of the area’s total population of 6,354,775 (National Population Census, 2006)

Three instruments (questionnaire, focused group discussion and in-depth interview) were combined for optimum results. There are four categories of respondents, namely, the general public, persons affected by leprosy, leprosy control staff and officials of World Health Organization and the donor agency operating in the two states. All residents of the two states constituted the population of study but a sample size of 1116 adult /members (about 0.32% of the study population), considered adequate for applicable statistical techniques were the study participants on who a uniform set of structured questionnaire schedule, containing closed and open ended items were administered on a one-on-one (other administered) basis to generate quantitative data. The sample also accommodated geographical spread and rural-urban bias at the ratio of 2:1. They were selected through a combination of cluster and random sampling methods. Qualitative data via focused group discussion (FGD) were generated from purposively selected 52 persons affected by leprosy from State Leprosy Treatment Registers. There were four sessions of FGD (two in each state) with 6-12 participants per session segmented along gender. The moderator of each FGD was of the same sex with their FGD group. Also, purposively selected 10 Leprosy Control Staff and 2 officials of World Health Organization and the donor agency operating in the two states were respondents to In-Depth Interview (IDI).

All instruments used in the study were pre-tested outside the study locations by the researcher and five Field Assistants trained for the research This was to ensure reliability and suitability of instruments to meet study objectives. The language of administration of the questionnaire and FGD was Igbo, spoken in the area, because there were many respondents who could not read, write or understand English language. Nonetheless, English was used where any respondent showed preference for English language. The instrument which was originally in English was translated into the local language, which is Igbo and retranslated into English, to provide both Igbo and English versions. Same sex administration of questionnaire was carried out to prevent any cultural barriers and permit free discussion or responses to questionnaire items. All IDI sessions were conducted in English because respondents were all very literate.

Quantitative data gathered in the course of research were analyzed with the help of the Statistical Package for the Social Sciences (SPSS) soft ware. Descriptive statistics like frequency distribution tables, mean, median, percentages and bar-charts were used to interpret data. One correlation analysis (the chi-square) was employed in hypothesis test. On the other hand, qualitative data generated through FGD and IDI were transcribed and organized under different aspects of the discussion and used to explain quantitative data where applicable.

Research Findings

Out of 1116 questionnaires distributed, only 1104 were properly filled and returned, and were thus used for analysis.

(a) **Socio-Cultural Factors and Religious Belief Systems Affecting Leprosy Control:** The findings are shown in Table 1 and Figure 1 below.

Table 1: Distribution of Respondents by their view on whether there are Socio-cultural factors that affect Effectiveness of Leprosy Control in their Area.

Response	Frequency	Percent
Yes	842	76.3
No	240	21.7
Don't know	22	2.0
Total	1104	100

Table 1 shows that more than three-quarters of the respondents or 76.3% agreed that there are socio-cultural factors associated with leprosy which affects its control. They identified them to include belief system about leprosy (33.7%), lack of community participation (19.7%), poverty (14.9%), negative social definition of leprosy (12.9%), lack of political commitment (11.5%) and low literacy level of patients and general public (6.9%). With regard to belief, it was found that there were many religious and cultural beliefs about leprosy which respondents subscribed to (see fig 1 below).

Which of these is a major religious and cultural belief about leprosy in your community?

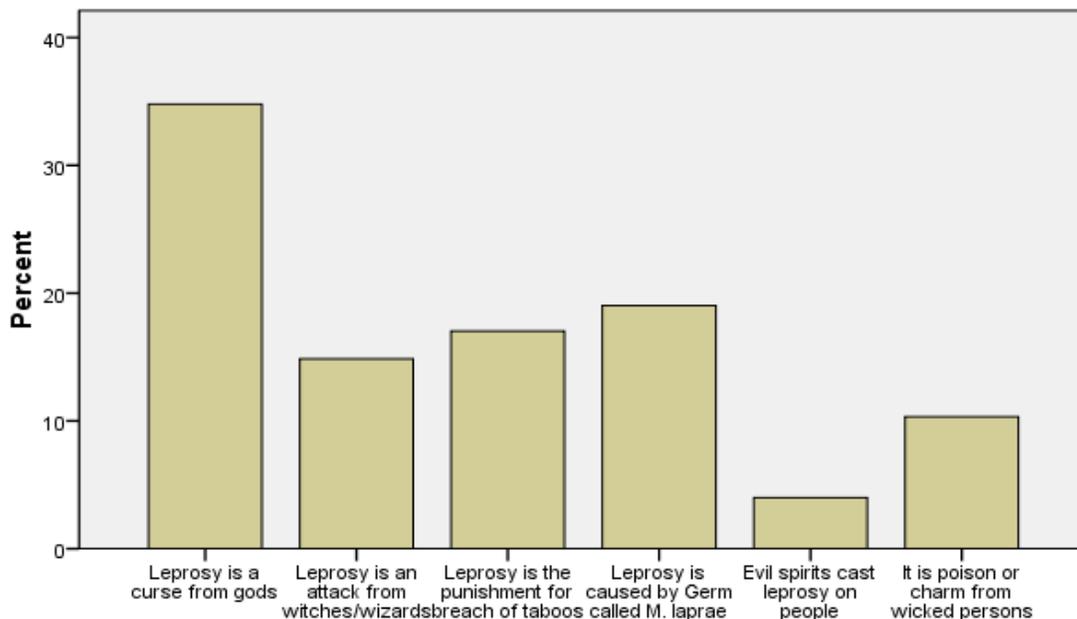


Fig 1: Respondents views about major Religious / Cultural Beliefs about Leprosy in their area

Fig 1 shows that whereas only 19% of the respondents correctly identified germ as the cause of leprosy, 894 respondents representing 81% held unto diverse local beliefs. The breakdown shows that 34.8% attributed the disease to curse from gods, 17% to punishments for breach of taboos, 14.9% to attack from witches/wizards, 10.3% to poison or charm and 4% to evil spirits. The large number of respondents who attributed leprosy to curse from gods agrees with observation by Valsa (1999) that leprosy is globally attributed to curse from gods. This study has therefore shown that the Igbo group is not an exception in that regard, particularly with reference to their traditional belief system. There was no remarkable difference between respondents from the two states in respect of their attachment to belief systems about leprosy in their areas.

There were strong indications that such belief systems constitute obstacles to leprosy control. This is because majority of the respondents (61%) accepted them as correct and will rather take actions along that line. Similarly, 44.3% of the respondents acknowledged that the prevailing belief systems on leprosy in their area have great influence on their responses or what they do. More of the respondents who accepted the belief systems as correct and those who acknowledged that such beliefs have great influence on them were from Anambra state. About 17.8% and 14.2% stated that the belief systems have moderate and little influences respectively on what they do. Only 11.5% of the respondents claimed that local beliefs about leprosy have no influence on them. Most of the respondents also attributed delay in commencement of treatment to fear /shame of disclosing problem to others. This fear could also be associated to the belief system and prevailing negative definition of leprosy in the area.

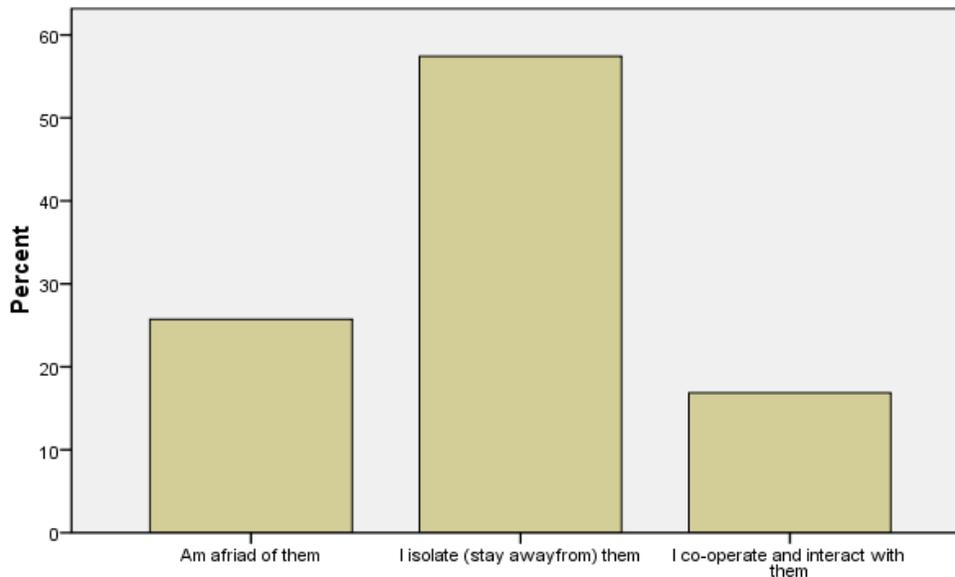
During the four FGD sessions conducted, participants recounted local belief systems on leprosy. A number of them were however philosophical and do not want to join the debate about whether belief systems on leprosy are factual. A male FGD participant at Fr. Damian Hospital Nnewi/Amichi simply asserted that *'there are local beliefs on leprosy but when someone is healed; people will no longer treat him badly. I depend on God Almighty to heal me. That's all I want'*.

The effect of socio-cultural factors on leprosy control appears to be compounded by the fact that community attributes and social resources like social groups (e.g. families, age grades and women groups) and festival rites etc were poorly exploited. About 76.3% of the respondents were of the view that these attributes were inadequately explored by the control programme. In the words of a female FGD participant from Mile 4 Hospital Abakaliki- *'When one is afflicted with leprosy, all groups turn their back against you. One's family, spouse and children often begin to maintain some distance and do not assist much. Other groups completely avoid you. Our hope for help is here (Mile 4 Hospital) and in God'*

(b) Social Problems faced by Persons Affected by Leprosy (PAL)

Table 2: Distribution of Respondents by their Opinion on the Major Social Problem faced by Leprosy Patients in their Communities.

How would you describe your relationship with persons affected by leprosy?

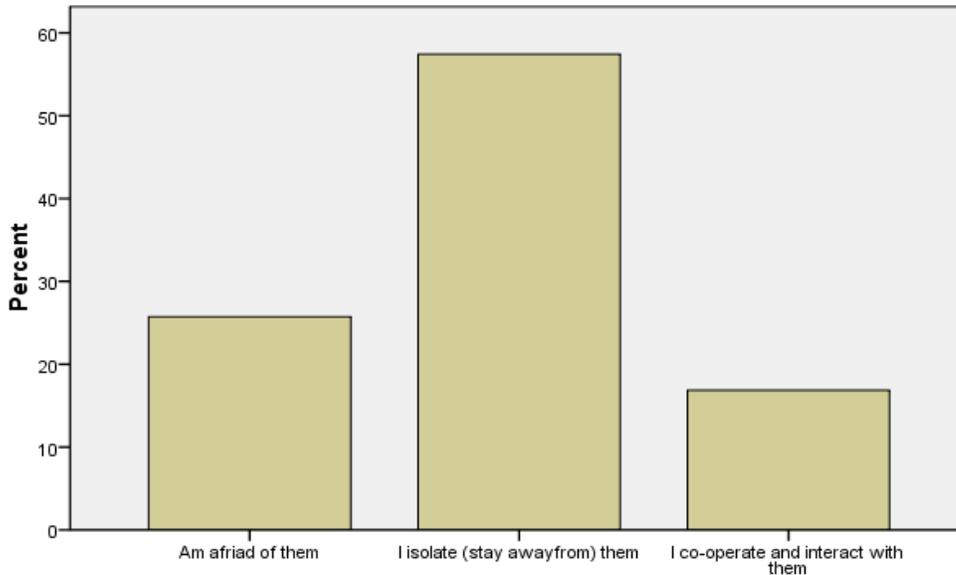


Response	Frequency	Percent
They do not live with their families	156	14.1
They are treated as outcasts	417	37.8
Lack of support from community	168	15.2
Desertion by spouse or inability to find spouse to marry	113	10.2
Violations of their human rights	140	12.7
Loss of lands, properties and titles	66	6.0
Others (specify)	44	4.0
Total	1104	100

Table 2 above shows that most respondents (37.8%) perceived the major social problem of leprosy patients in their communities to be that they are treated like outcasts. Other problems are lack of support from community (15.2%), and not being allowed to live with their families (14.1%) etc. About 35.8% of the respondents attributed these social problems to low level of awareness about leprosy and belief systems in the area. Furthermore, 57.4% of the respondents acknowledged that they personally isolate or stay away from persons affected by leprosy (see fig 2 below).

Fig. 2: Respondents Description of their Relationship with Persons Affected by Leprosy

How would you describe your relationship with persons affected by leprosy?



On how members of the community relate with persons affected by leprosy, 43.8% of the respondents were of the view that communities reject/isolate them. About 23.9% and 13.0% respectively stated that Persons Affected by Leprosy (PAL) were discriminated from job offers and could not buy or sell to others. This study has shown that the reason for the reactions toward patients was particularly due to the belief system/cultural view of leprosy (38.7%). Other reasons include that the disease is seen as curse from gods (27.7%), and that many are scared of contracting leprosy (22.5%). The problem of community rejection/isolation of persons affected by leprosy appears to be more severe in Anambra state where 64.3% of respondents from the state identified it as such, whereas at Ebonyi state, only 23.6% of the respondents considered it a problem.

Commenting on socio-cultural factors and problems affecting leprosy control, an interviewee from WHO Southeast Zonal Office noted that “*what society call leprosy is ‘deformity’. If deformity is avoided, social isolation and erroneous belief systems will cease*”

Another interviewee from Anambra State reported that at Amansea community, an isolated PAL felt so angry and frustrated about his situation that he went about contaminating cassava soaked at the stream for fermentation by villagers with his leprosy sore. Some male FGD participants at Fr. Damian TB and Leprosy Hospital Nnewi/Amichi expressed their problems and agonies these ways:

- *‘The community asked me to move away from their midst until I am fully cured. But I have completed treatment, yet they cannot accept me back because of my shortened toes and fingers. I am all alone now. I depend on charity’*
- *‘Once a leprosy patient has sores or wounds, the family and community avoid the person completely’.*

- *'Health workers do not attend clinic again. No doctor comes here. It is up to five months since they last attended. They are afraid of getting leprosy from us'.*

The above facts suggest that 'disposition to leprosy' in the areas studied was generally poor. This is to be expected given high level of stigma about the disease and discrimination/social isolation which its victims encounter. Binary logistic regression was further employed at the multivariate level to predict the simultaneous effect of independent variables including age, gender, religion, education, income and residence on 'disposition to leprosy'. In the analysis, disposition to leprosy was considered as a categorical variable which takes the value of 1 if the respondent is positively disposed to leprosy and 0 if negatively disposed. Table 3 below shows the result of the regression analysis.

Table 3: Logistic Regression Predicting the Influence of Socio-Demographic Variables on Disposition to Leprosy.

	B	S.E.	Wald	Df	Sig.	Exp(B)
Age	-.672	.071	88.568	1	.000	.511
Gender	-.352	.165	4.578	1	.032	1.423
Religion	-.536	.136	15.561	1	.000	.585
Education	.340	.067	25.451	1	.000	1.405
Occupation	.076	.044	3.054	1	.081	1.079
Income	-.182	.038	22.386	1	.000	.834
Residence	-.272	.082	10.958	1	.001	.762
Constant	1.066	.473	5.085	1	.024	2.905

According to the distribution in the table, five variables, age, religion, education, income, and residence were statistically very significant ($p < 0.000$). The exponential of the distribution shows that older respondents are 51% more likely to be positively disposed to leprosy than younger ones. Also, respondents resident at urban areas are 76% more likely to be positively disposed than their rural counterparts. Furthermore, respondents with higher income are 83% more likely to be positively disposed to leprosy than those with low income, while those with higher education are 140% more likely to be positively disposed than those with lower level of education. Therefore age, religion, education, income and residence are good predictors on disposition to leprosy with education being the best predictor.

Test of Research Hypothesis

Male respondents are more likely to accept religious and cultural belief systems of their community on leprosy than female respondents.

To test this hypothesis, a cross-tabulation between gender and acceptance of belief systems on leprosy was carried out (Table 4 below).

The computed value of chi-square is 27.323. The tabulated value of chi-square at 0.05 level of significance with a degree of freedom (df) of 2 is 5.991. Having observed that the calculated value of chi-square is greater than the table value the researcher consequently accepted the alternative hypothesis. This implies that there is a significant relationship between gender and acceptance of community belief system on leprosy.

Table 4: Distribution of Respondents according to Gender and their Acceptance of Belief Systems on Leprosy.

Gender	Acceptance of Communal Belief System on Leprosy as correct			
	Yes	No	Don't know	Total
Male	350 (52%)	135 (35.7%)	20 (37.7%)	505 (45.7%)
Female	323 (48%)	243 (64.3%)	33 (62.3%)	599 (54.3%)
Total	673 (100%)	378 (100%)	53 (100%)	1104 (100%)

$X^2 = 27.323$, $df = 2$, $p = 0.000$

Discussion of Findings

Several socio-cultural factors were identified to have united with limited knowledge about the disease to compound challenges experienced by the control programme. The most important of such factors is the belief system about leprosy. This observation agrees with the Health Belief Model (HBM) adopted as the theoretical thrusts for this study. The HBM explains behaviour (preventive and curative health behaviour and responses) in relation to belief systems, knowledge, attitude and perceptions held by individuals which ultimately affect their actions toward problems and disease situations. Given strong perceptions of susceptibility and severity of leprosy among the study population (which ordinarily should trigger appropriate responses), HBM locates poor community participation, low uptake of leprosy control services and poor compliance to treatment to socio-cultural beliefs and reactions that stimulate a preference to cover up the disease by victims. The issue of belief system is particularly worrisome to leprosy control in the area because there were several of such beliefs. Although, these beliefs are not consistent with scientific realities of leprosy, yet the people have held tenaciously unto them.

Accordingly, such beliefs serve as templates that negatively structured responses or activities of individuals in the context of leprosy control. It is therefore not surprising that most of the respondents accepted such beliefs as correct and acknowledged that they have great influence on what they do. In the light of the foregoing, fear of leprosy, discrimination and social isolation of victims are products of beliefs that suggest that leprosy is a curse from gods or punishment for breach of taboos. So strong are these beliefs that they generate delay in commencement of treatment due to fear /shame of disclosing problem to others. This type of situation has also been found to be true in both Eastern and western cultures where fear of leprosy has existed from ancient times (Nicholls, 2000).

Valsa (1999) has also observed that the belief that leprosy is a curse from gods is a global phenomenon. This study has therefore shown that the Igbo group is not an exception in that regard. It is therefore pertinent, as Kaufman, Neville and Miriam (1993) suggested that shared meanings of a social group about leprosy and other cultural factors ought to be understood by leprosy control programmes. Unfortunately, this is the exception rather than the rule in the control programmes of Anambra and Ebonyi states.

The above viewpoint is similar to phenomenological viewpoint on leprosy. On his part, Scott (2000) had stressed the need for commensurate emphasis on social aspects of leprosy as is the case with its bio-medical component. This is against the backdrop of emerging evidence, amplified by this study, to the effect that social factors like belief systems affect leprosy control.

Conclusions and Recommendations

Based on the findings from the present study, the following recommendations can be made:

1. The use of traditional media like town criers as effective tools for sensitizing community members about leprosy should be adopted. This will complement the efforts of the western form of media and ensure a more extensive coverage of the area with appropriate leprosy related information.
2. The support of traditional and religious institutions must be sought and won. To this end, there should be extensive advocacy visits by leprosy control staff to traditional rulers, religious leaders and other opinion leaders in the communities that make-up the two states. This is to improve their understanding of issues related to leprosy and to enable them to be at the fore-front of the crusade to change people's perception and beliefs about leprosy.
3. There is immense need to improve the level of community involvement, ownership and participation in the programme which is currently very low. The involvement of community leaders, age-grades, women groups, clubs and faith-based associations will positively affect decisions toward ameliorating the effects of socio-cultural factors like belief system on leprosy control programme. With the support and participation of the community, socio-cultural practices and beliefs that negatively affect leprosy control should be abolished.
4. Existing legislations should be enforced and new ones enacted to adequately protect persons affected by leprosy from forms of stigmatization, discrimination, and violations of their fundamental human rights. Such measure of protection will encourage them to live normal lives devoid of social seclusion or withdrawal and to positively respond to their problem.
5. Government at all levels should demonstrate strong political will and commitment toward leprosy control. This should be done through adequate funding, provision of infrastructure, logistics, training and motivation of leprosy control staff via prompt payment of entitlements and allowances.
7. Because of observed negative impact of socio-cultural factors like belief system on leprosy control, there is need to enhance the capacity of health workers to understand socio-cultural factors related to leprosy. This could be achieved through on the job trainings to equip them about behaviour change techniques. Furthermore, social scientists that are likely to better understand and plan interventions against such socio-cultural dimensions should be part of leprosy control teams in the spirit of inter-disciplinary co-operation and better results.

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