

**PERCEIVED STIGMATISATION RELATED EXPERIENCES PERPETRATED
BY HEALTH WORKERS TOWARDS PERSONS LIVING WITH HIV/AIDS IN
THREE SELECTED HOSPITALS IN IBADAN**

BY

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MATRIC. NO.: 130509

**A PROJECT SUBMITTED TO THE
DEPARTMENT OF HEALTH PROMOTION AND EDUCATION,
FACULTY OF PUBLIC HEALTH,
COLLEGE OF MEDICINE, UNIVERSITY OF IBADAN,
IBADAN**

**IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE DEGREE OF
MASTER OF PUBLIC HEALTH (POPULATION AND REPRODUCTIVE
HEALTH)
OF THE
UNIVERSITY OF IBADAN,
IBADAN, NIGERIA**

FEBRUARY, 2021

DEDICATION

This piece of work is dedicated to the Almighty God who gave me wisdom and supplied the fortitude required to be able to start and finish in spite of so many challenges.

To all my family members and friends that stood by me in the course of the programme.

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ACKNOWLEDGEMENTS

My profound gratitude goes to people whose efforts, encouragement and support have made this work a reality. Top on the list is my supervisors Dr. F. O. Oshiname, and Dr. M. A. Titiloye, both continually inspired, encouraged, supported and pardoned all misdeeds in the course of this work. They supplied all necessary information and drive needed to ensure this work is out and is worth presenting. Almighty shall continually crown their efforts with success in life.

I am also grateful to the Head of Department, Health Promotion and Education Dr O.E Oyewole for his relentless encouragements, advice and unquantifiable supports to see to the completion of this work.

Also worthy of note is the contributions of all the lecturers in the department who were supportive all through the course of my programme namely Professors O. Oladepo, Ademola J. Ajuwon and Oyedunni S. Arulogun, Drs. I.O. Dipeolu, Mojisola M. Oluwasanu, Adeyimika T. Desmennu and Yetunde O. John-Akinola, I am sincerely grateful.

I cannot but remember the contributions and help received from the Administrative staff of the Department: starting from the former Departmental Secretary, Chief O. A. Olubodun and the present one Mrs Bosede Pratt, Mr Lanre Quadri, Mr Oyeyemi, Mr Segun Bello, who were always there any time I needed their help during the study.

I am also indebted to Professor O. Oladepo who inspired me when it seems I was taking too much time to complete the work and see to the completion of course of study.

My gratitude also goes to my research assistants and respondents for their involvement, support and assistance all through the time of mobilization and data collection for the research work.

Last but not the least is the contributions of my husband; Mr. K. T. Olawoyin, who has been my backbone financially, emotionally and spiritually for years. He was very supportive till the end of this study. I am highly indebted and will forever be.

Finally, to God Immortal, invisible, the only wise God – to Him be honour and power forever and ever. He is indeed the Alpha and Omega: He started it for me and now He has helped to finish it.

CERTIFICATION

I certify that this work was carried out by **BILIKISU OLUWAKEMI, OLAWOYIN** in the Department of Health Promotion and Education, University of Ibadan, Ibadan under my supervision.

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ABSTRACT

The experience of stigma of People Living with HIV/AIDS (PLWHAA) when accessing care will diminish their confidence in the healthcare system and may adversely affect the efforts for the prevention and halting of the HIV epidemic. This study aimed to determine the perceived Stigmatisation related experiences perpetrated by health workers among persons living with HIV/AIDS in three selected hospitals in Ibadan.

Cross-sectional descriptive research design was adopted for the study. Simple random sampling technique was used to select two hundred and fifty-two (252) respondents that participated in the study from three selected hospitals. A semi-structured questionnaire which assessed socio-demographic characteristics, different types Stigmatisation, psychosocial and treatment challenges was used as instrument for data collection. Data were analysed using descriptive statistics. Correlation and logistic regression methods were used for test of significance at $p=0.05$ level of significance.

Respondents age was 36.5 ± 8.8 and 46.8% were within the age range of 30-39 years. Majority (82.1%) of the respondents were females. About 58.0% were Christians and 88.0% were married. Most (42.1%) had post-secondary education followed by secondary education holders (39.3%) and 47.6% were traders. Twenty-nine percent of the respondents reported that they have sexual partners. Many (54.4%) had been living with HIV/AIDS for up to four years. Reasons given by the respondents for taking the HIV test for the first time included: regular sickness (32.5%), referrals due to suspected HIV (11.5%) and regular Ante-Natal Care Investigations (10.3%). Respondents' reaction when they were first informed about their HIV status includes: fear of stigmatisation (79.8%), panic over death (77.8%). Concern about result disclosure to friends (77.4%), fear of discrimination (76.2%), concern about result disclosure to family members (76.2%). Majority (68.7%) had never experienced stigmatisation/discrimination from health workers and most common (48.0%) was among the nurses. Respondents' reported experience of derogatory treatment from health workers included: separation of seat from other clients/patients (42.1%). avoided contact (36.9%) and made to pay additional money for health care services (36.5%). Psychosocial problems faced by respondents following discrimination experienced from perpetrators included sadness (28.4%),

perplex/confusion (27.9%), worried (24.0%) and sleeplessness (22.1%). Respondents who had ever experienced reduction in social interaction recently were 32.7%, felt being a burden to family/people (44.9%) and experienced reduction in productivity were 35.9%. Challenges encountered by respondents during treatment uptake included: loss of confidence in health workers (43.2%), non-compliance to appointments (52.1%), and missed appointments (30.0%). Respondents' occupation ($p=0.031$), hospital setting ($p=0.000$); reported types - verbal stigmatisation ($p=0.000$); ridicule stigmatisation ($p=0.000$) and worthless stigmatisation ($p=0.024$); and psychological and treatment challenges were all significant with respect to experience of stigmatisation/discrimination.

People Living with HIV/AIDS still experience stigma and discrimination in health care setting perpetrated by healthcare workers and this has negative effect on their healthcare uptake. More sensitization programme is needed for the healthcare workers in order to reduce HIV-related stigma and discrimination.

Key words: Perception, HIV/AIDS, People Living with HIV/AIDS, Stigma, Health workers.

Word count: 465

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LIST OF ABBREVIATIONS

AIDS	-	Acquired Immune Deficiency Syndrome
ART	-	Antiretroviral Therapy
FSW	-	Female Sex Worker
HCW	-	Healthcare Worker
HIV	-	Human Immunodeficiency Virus
HPP	-	Health Policy Project
HTC	-	HIV Testing and Counseling
MoH	-	Ministry of Health
MTCT	-	Mother to Child Transmission
NACA	-	National Agency for the Control of AIDS
OR	-	Odds Ratio
PLWHA	-	People Living with HIV
PEPFAR	-	President's Emergency Plan for AIDS Relief
S&D	-	Stigma and Discrimination
STI	-	Sexually Transmitted Infection
UNAIDS	-	Joint United Nations Programme on HIV/AIDS

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Stigma and discrimination towards people with HIV have been associated with negative responses ranging from increased depressive symptoms to engaging in risky sexual behaviour (Kiene, Dove and Wanyenze, 2018). Furthermore, experiencing stigma or discrimination in a healthcare setting has been found to adversely affect the health behaviours of people living with HIV (PLWHA), such as accessing treatment, seeking testing for HIV or HCV, and adhering to medical regimes (Piatak and Jr, 2012; Masoudnia, 2015; Van Deventer and Wrigh, 2017; Polly, Zenobia and Loke, 2019).

According to the Global Network of People Living with HIV/AIDS, one of the biggest challenges facing people living with HIV today is stigma and discrimination (Odimegwu, Akinyemi and Alabi, 2017). HIV-related stigma in this context has been defined as discounting, discrediting and discriminating against people perceived to have HIV (Goffman, 2009). Stigma is a common human reaction to disease. Throughout history many diseases have carried considerable stigma including leprosy, tuberculosis, cancer, mental illness and many STDs. HIV/AIDS is only the latest disease to be stigmatized (Lisanne and Kate, 2011).

Overall, stigma continues to be prevalent in the context of HIV, whether measured in terms of the attitudes of those who are not infected or in terms of the experiences of those living with HIV (Earnshaw and Chaudoir, 2016). Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status. The health care sector is perhaps the most conspicuous context for HIV/AIDS-related stigmatisation, discrimination and denial. Fear of illness and fear of contagion is a common reaction among health workers, coworkers, and caregivers. Literature on caregiving shows that fear of contagion and fear of death have clear negative effects on health care workers' attitudes toward and treatment of PLWHAA (National Research Council, 2004; Adeyemo and Oyinloye, 2007; Patel, Srivastava, Sharma and Moitra, 2016). These attitudes range from mild disdain, through outright refusal to treat, to outright

abuse of PLWHAA. Negative attitudes from health care staff generate anxiety and fear among PLWHAA. Understanding the various dimensions of HIV-related discrimination in health settings is the first step in successfully meeting this challenge.

Effects of HIV related stigma and discrimination are often so severe that most members of societies are isolating them. Potential victims can prevent or avert stigma and discrimination by denying stigmatized condition such as HIV/AIDS. Denial is more pronounced in those that have tested HIV positive but fear the stigma attached to their HIV status (UNAIDS, 2017). Nigeria has the second largest HIV epidemic in the world (NACA, 2017). Although HIV prevalence among adults is much less (1.5%) than other sub-Saharan African countries such as South Africa (20.4%) and Zambia (11.3%), the size of Nigeria's population means 1.9 million people were living with HIV in 2018 (UNAIDS, 2017). Recent drops in prevalence estimates for the country has been attributed to better surveillance (PEPFAR, 2019).

Nevertheless, UNAIDS estimates that around two-thirds of new HIV infections in West and Central Africa in 2017 occurred in Nigeria. Together with South Africa and Uganda, the country accounts for around half of all new HIV infections in sub-Saharan Africa every year (UNAIDS, 2017). This is despite achieving a 5% reduction in new infections between 2010 and 2017 (UNAIDS, 2017). Unprotected heterosexual sex accounts for 80% of new HIV infections in Nigeria, with the majority of remaining HIV infections occurring in key affected populations such as sex workers (NACA, 2015). Prevalence ranges from 2% to 14.9% in the country's 36 states and Federal Capital Territory (FMOH, 2017).

People living with HIV/AIDS (PLWA) in Nigeria have been found to be subject to discrimination and stigmatisation in the work place, health care centers and by family and communities. Discriminatory attitude by health-care professionals against PLWA, as documented in other countries (JUMP, 2011), may create an atmosphere that interferes with effective prevention and treatment by discouraging individuals from being tested or seeking information on how to protect themselves and others from HIV/AIDS (Pub Med, 2015). Furthermore, discriminatory practices and violations of international principles of

medical ethics may serve to legitimize other forms of discrimination against people living with HIV/AIDS.

Discrimination & Stigmatisation could be physical or social. The physical types are insults, rejecting by locking, minimize contact with please, denial of medication, fling of patient's cards, and writing of HIV on the patient's cards. While the social types are isolation, judging, blaming denial to public, name calling, telling the patients that there is no hope for him/her (ICRW, 2016).

Stigma and discrimination against people living with HIV/AIDS is commonplace in Nigeria. Both Christian and Muslim see immoral behaviors as being the cause of the HIV/AIDS epidemic. This affects attitudes towards people living with HIV/AIDS (PLWHAA) and HIV prevention. PLWHAA often lose their jobs or are denied healthcare services because of the ignorance and fear about HIV and AIDS (WHO, 2017). Keeping in view the above facts, this study was planned to gain an insight into the situation of stigma and discrimination towards PLWHAA in health care sector in Ibadan.

1.2 Statement of the Problem

Stigma is a powerful instrument of social control. Stigma can be used to marginalize, exclude and exercise power over individuals who show certain characteristics, while the societal rejection of certain social groups (e.g. homosexuals, injecting drug users, sex workers) many predate HIV/AIDS, the disease has in many cases reinforced this stigma. (AVERT, 2015).

In many societies the infection is associated with minority groups or behaviors. Also in some societies, laws, rules, and policies can increase the stigmatisation of people living with HIV/AIDS. Such legislations may include compulsory screening and testing as well as limitations on international travel and migration (AVERT, 2015).

Before now, denial, stigmatisation and discrimination have fuelled the epidemic in Nigeria, and people appear not to be giving a 'human face' to the phenomenon of HIV infection (FHI, 2011). Many reports revealed the extent to which people are stigmatized against by health care systems. Many studies reveal the reality of withheld treatment;

non-attendance of hospital staff to patients, HIV testing without consent, lack of confidentiality, and denial of hospital facilities and medicines (UNAIDS, 2016).

As one of the oldest created municipalities in the country, we do not know the number of PLWHAAs in the municipality who face the challenge of stigma and discrimination, the type of stigma and discrimination commonly faced by these people, the manifestations as well as the coping mechanisms adopted by these people to enable them live a normal life in the society. Despite the fact that large numbers of PLWHAAs are found in Ibadan town, the situation of HIV stigmatisation and discrimination has not been well addressed in various literatures. Therefore, this study sought to assess the stigmatisation and discrimination experiences of HIV positive persons from health workers in Ibadan.

1.3 Justification of the Study

Although, there have been studies on stigmatisation and discrimination of PLWHAAs both within and outside the health sector, not much has been done for PLWHAAs narrate their experiences of stigmatisation by the health workers. More importantly, this problem has not been investigated in Ibadan. To date, fewer studies were ever done in Nigeria on this topic, targeting healthcare workers. This topic is of particular interest as increasing accusations are made through anecdotal reports and through various programmes especially the treatment and care programme about health care professionals stigmatizing and discriminating against People Living with HIV by refusing to provide care and treatment. It is my hope that this study will provide a baseline for future studies to be undertaken by other researchers and the Ministry of Health.

More importantly, the findings of this research will be useful to the HIV and counseling units of the hospital, non-governmental organizations working on HIV/AIDS programmes within the municipality and the Municipal Assembly in general in drawing new strategies for addressing problems of stigma and discrimination and also to improve on the existing programmes. The findings and recommendations based on this study will inform policy makers in the study area and the country as a whole.

1.4 Research Questions

1. What are the types of stigmatisation and discrimination of PLWHAAs attitudes perpetrated by health workers against PLWHAAs?
2. What are the reactions of PLWHAAs when first heard about HIV status?
3. What are the perceived stigmatisation and discrimination related treatment experienced by PLWHAAs from health workers?
4. What are the mental/psychological reactions/feeling by PLWHAAs as a result of stigmatisation and discrimination by health workers?
5. What are the psycho-social challenges experienced by PLWHAAs?

1.5 Objective of the study

1.5.1 General objective

To determine the perceived Stigmatisation related experiences perpetrated by health workers among persons living with HIV/AIDS in three selected hospitals in Ibadan, Nigeria.

1.5.2 Specific Objectives

The specific objectives are to:

1. identify different types of stigmatisation and discrimination passed to PLWHAAs by health workers.
2. examine the reactions of PLWHAAs when first heard about HIV status?
3. identify the mental/Psychological reaction/feeling by PLWA due to stigmatisation by Health Workers
4. investigate perceived stigmatisation and discrimination related treatment experienced by PLWHAAs from health workers
5. examine the psycho-social challenges experienced by PLWA due to being stigmatized by Health Workers

1.6 Hypotheses

- Ho1. There will be no significant relationship between respondents' socio-demographic characteristics (age, sex, religion, education, marital status) and PLWHAAs' experience of stigmatisation and discrimination from healthcare workers

- Ho2. There will be no significant relationship between types of stigmatisation & discrimination experienced and the reaction of PLWHAAs.
- Ho3. There will be no significant relationship between different challenges experienced by PLWHAAs and experience of stigmatisation and discrimination.

1.7 Definition of terms

Perception: This referred to the way in which something is regarded, understood, or interpreted. In this context, is the way in which patients regarded, understood or interpreted actions or attitude of health workers towards their HIV status.

People Living with HIV/AIDS: This set of individuals are those who have been tested to be positive to HIV and placed on antiretroviral therapy.

Stigma: stigma is the process of perceiving a characteristic of another, as deviant from the social expectations that are held by the majority.

Health workers: They are the people being satisfied to provide health care to patients at the health facility.

Experience: This referred to an event or occurrence which leaves an impression on someone. With regards to this study, this connote the occurrence discrimination or stigmatisation perpetrated by health workers which leaves an impression on PLWHAAs

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

The essence of this chapter is to review literature relevant to this research in order to establish what already exists especially on issues raised in the objectives.

2.1 Stigmatisation and discrimination in health facilities

Stigma

The concept of stigma is the process of perceiving a characteristic of another, as deviant from the social expectations that are held by the majority. Classic social psychological theory provides a useful framework in which to examine the foundation and expression of stigma. Stigma has been defined as a trait that is deeply disreputable to an individual or a group of people (Goffman, 1963). Stigma arises in various spheres of life, including relationships with other people, in feelings we have about ourselves, and throughout various interactions we might have with the broader community, such as in the workplace or health services. Stigmatized people are labeled as different and structures are put in place to protect the majority from whatever negative attribute they are believed to possess (Crosby, 2012). Nyblade, Srinivasan, Mazur, Raj, Patil, Devadass, Radhakrishna and Ekstrand, (2018) further expanded upon Crosby (2012) description of the stigmatized by describing it as a means to reinforce social power.

This is accomplished by marking and establishing social inequalities through the use of boundaries or 'norms', such as ethnicity, gender, sexuality, and socio-economic status. Research on stigma broadly differentiates between enacted and internalized stigma, referring to the source of the stigmatisation. Enacted stigma is stigma one experiences from an external source, such as an individual or organization. By contrast, internalized or self stigma stems from within and occurs when an individual internalizes the dominant cultural norms as part of being a member of a stereotyped minority group (Mark, 2016). Stigma is also understood in terms of institutional or structural stigma, which is stigmatisation of a group of people through the implementation of policy and procedures

(ASHM in partnership with National, Centre in HIV Social Research (NCHSR), 2012; Neuman Obermeyer Group, 2013; Mark, 2016; Nyblade, Stockton, Giger, et al., 2019).

2.1.1 Discrimination

Stigma becomes discrimination when thoughts, beliefs or attitudes evolve into direct action. Discrimination is defined as any unfavorable treatment of an individual based solely on their membership of a certain group (Crosby, 2012; Macdonald, and Daniel, 2013; Statistics Canada. 2013; Jaurique, Humboldt Ryan, Smith, and Paolucci-Callahan, 2019). Discrimination involves exhibiting a negative behaviour towards members of a social group, other than one's own, and can result in limiting members of one group from opportunities that are available to others. It is the unfair treatment of someone based on a particular characteristic that defines discrimination. Particular characteristics include; race, sexual orientation, or particular physical attributes, and lead ultimately to some form of rejection or exclusion (Crosby, 2012; Macdonald, and Daniel, 2013; Statistics Canada. 2013; Jaurique, Humboldt Ryan, Smith, and Paolucci-Callahan, 2019).

2.1.2 Manifestations and ramifications

There are many ways in which HIV-related stigma manifests in health care settings. A study in Tanzania documented a wide range of discriminatory and stigmatizing practices, and categorized them broadly into neglect, differential treatment, denial of care, testing and disclosing HIV status without consent, and verbal abuse/gossip (Synergy, 2015). Similarly, a study in Ethiopia found that common forms of stigma in health facilities were designating patients as HIV positive on charts or in wards, gossiping about patient's status, verbally harassing patients, avoiding and isolating HIV-positive patients, and referring patients for HIV testing without counseling (Heijnders, 2016).

In Indian hospitals, stigma and discrimination manifested as health workers informing family members of a patient's HIV status without his or her consent, and doing the following only with HIV-positive patients: burning their bedding upon discharge, charging them for the cost of infection control supplies, and using gloves during all interactions, regardless of whether physical contact occurred (Heijnders, 2012). Stigma and discrimination in the health care setting and elsewhere contribute to keeping people,

including health providers, from adopting HIV preventive behaviours and accessing needed care and treatment. Fear of being identified as someone infected with HIV increases the likelihood that people will avoid testing for HIV, disclosing their HIV status to health care providers and family members, or seeking treatment and care, thus compromising their health and wellbeing.

With its potentially devastating consequences on care-seeking behavior, stigma represents a major "cost" for both individuals and public health. Both experienced and perceived stigma and discrimination are associated with reduced utilization of prevention services, including programmes to prevent mother to child transmission, HIV testing and counseling, and accessing care and treatment (Kiene, Dove and Wanyenze, 2018; Phung Bach, Cuong, Nu, Thao, et.al., 2019).

In addition, research has demonstrated that the experience or fear of stigma often results in postponing or rejecting care, seeking care far from home to protect confidentiality, and non-adherence to medication. For example, studies in Senegal and Indonesia documented that men who have sex with men and injecting drug users, respectively, often avoid or delay accessing HIV-related services, including treatment for other sexually transmitted diseases, for fear of public exposure and discrimination by health workers (Niang, 2013). Likewise, researchers in Botswana and Nigeria found that stigma leads many people to seek testing and treatment services late in the progression of their disease, often beyond the stage of optimal drug intervention (Wolfe, 2016). To conceal use of antiretroviral medications, HIV-positive individuals in South Africa reported grinding drugs into powder and not taking medication in front of others, which can result in inconsistent dosing (Niang, 2013).

As mentioned, health care providers themselves may be reluctant to access the same testing, care and treatment they provide to their patients due to fear of stigma in the workplace and in the communities they serve (Gupta, 2013). A study in South Africa and Botswana found that health workers struggle with self-stigma regarding a potential HIV diagnosis, as well as fear of stigmatizing attitudes and behaviours from their colleagues, which contribute to a lack of uptake of HIV testing and early treatment, if needed

(Wolfe, 2016). Similarly among health care workers, research suggests that fear of casual contact and moral judgments contributes to stigma and discrimination directed at clients living with HIV. Studies in Nigeria (Nyblade, 2013) have found high levels of fear of contagion among health workers, which is related to a lack of understanding of how HIV is and is not transmitted, and how to protect oneself in the workplace through universal precautions.

2.2 Attitudes and discriminatory practices of healthcare worker towards HIV

Research suggests that health care workers often hold negative views of people with HIV and that their views tend to mirror those of the general public (Ahsan, 2011). Furthermore, when compared to other illnesses, biases towards HIV are far more negative (Li et al., 2007). Prejudicial attitudes of health care workers towards other stigmatized groups, such as PWID, have been shown to have a negative impact on treatment adherence (Monjok, Smesny and Essien, 2009), while satisfaction with a healthcare provider has been shown to increase medication and appointment adherence in adults with HIV (Schwebela and Larimerab, 2018; Omosivie, 2019).

In a study that examined the attitudes of nurses towards HIV positive patients (Pisal, Sutar, Sastry, Kapadia-Kundu, Joshi, et.al., 2007), found that issues surrounding homophobia, injecting drug use, fears of transmission and knowledge of HIV/AIDS all contributed to stigma and discrimination among nurses. Even though research has shown that the majority of healthcare workers understand how HIV is transmitted, they still revealed fears of the disease and those who were more fearful were more likely to hold stigmatizing views (Pisal, et al., 2007; Chan et al., 2009; Vance and Denham, 2008; Hossain and Kippax, 2011). Previous research has also found that negative attitudes towards people with HIV among healthcare workers were associated with age, whether they ranked religion as important in their lives, and if they were not doctors (Hossain and Kippax, 2011). Furthermore, it has been shown that doctors, when compared to other staff members, are less likely to discriminate based on HIV status (Mahendra, et al., 2007). Another study found that nurses tended to provide differential care based on HIV status, while doctors were more likely to violate privacy by disclosing status and testing without consent (Andrewin and Chien, 2008). The differences between the level of

stigma and discrimination displayed by doctors and nurses or other staff members could be explained by research suggesting that people with higher levels of education demonstrate lower levels of stigma (Pisal, et.al., 2007; Barkey, 2010).

However, stigma and discrimination should not be solely affiliated with level of education. Aside from attitudes, research has reported on specific stigmatizing or discriminatory behaviours among healthcare workers. Research illustrates some of the ways in which stigmatizing attitudes of healthcare workers are transformed into discriminatory practices and behaviours. Vorasane, Jimba, Kikuchi, Yasuoka, Nanishi, Durham and Sychareun, (2017) found that lack of eye contact, clipped or brusque speech and differential precautions were all attributed to HIV-related stigma, when describing the experiences of HIV-positive patients in the US (Oscar and Daniel, 2017)..

They also found more overt forms of discrimination, such as blaming patients for their status, physical abuse and the denial of care, and that many of the patients reported being very upset and even emotionally scarred (Vorasane, Jimba, Kikuchi, Yasuoka, Nanishi, Durham, and Sychareun, 2017; Oscar and Daniel, 2017). Patients also reported experiencing substandard care, ranging from an inadequate time spent on their needs, to being left in extreme pain for an extended period of time.

2.2.1 The value of a supportive, stigma-free environment

There is increasing evidence of the value of supportive and de-stigmatizing HIV services in different HIV prevalence and socio-cultural settings. In China, health care workers who provide medical and emotional support are viewed favorably by HIV-positive patients and as critical to their ability to stay healthy, especially in the light of family isolation due to intense HIV stigma (Chen, and Starks, 2014). Makoae, et.al., (2007), describes new forms of citizenship and socio-political inclusion among low-income people living with HIV in Brazil, a country lauded for its policy of free universal access to antiretroviral therapy. Close and supportive relationships between health practitioners and their clients; between the health system and community non-governmental organizations that offer meetings, workshops, legal advice and support groups are also emphasized. Through de-stigmatizing care and treatment services they receive from the

health system and related services in the community, clients are encouraged to claim further rights to be involved in decision-making processes, to achieve greater social inclusion, and to challenge stigma in the workplace and within families.

2.3 Reducing stigma in health facilities a focus on the individual, environmental and policy levels

Although stigma is a pervasive and daunting problem in the health care setting, much can be done to address its causes and consequences. A key lesson that has emerged from recent research and field experiences is that to combat stigma in the health care setting, interventions must focus on the individual, environmental and policy levels (Mahendra, 2016).

2.3.1 Individual level

At the individual level, increasing awareness among health workers of what stigma is and the benefits of reducing it is critical. Raising awareness about stigma and allowing for critical reflection on the negative consequences of stigma for patients, such as reduced quality of care and patients' unwillingness to disclose their HIV status and adhere to treatment regimens, are important first steps in any stigma-reduction programme. A better understanding of what stigma is, how it manifests and what the negative consequences are can help reduce stigma and discrimination and improve patient-provider interactions (Nyblade, 2013).

Health workers' fears and misconceptions about HIV transmission must also be addressed. Fear of acquiring HIV through everyday contact leads people to take unnecessary, often stigmatizing actions. Thus programmes need to provide health workers with complete information about how HIV is and is not transmitted and how practicing universal precautions can allay their fears. In addition to basic HIV epidemiology, health workers must be able to understand the occupational risk of HIV infection relative to other infectious diseases that are more highly transmissible and commonly found in health care settings.

2.3.2 Environmental level

In the physical environment, programmes need to ensure that health workers have the information, supplies and equipment necessary to practice universal precautions and prevent occupational transmission of HIV. This includes gloves for invasive procedures, sharps containers, adequate water and soap or disinfectant for hand washing, and post-exposure prophylaxis in case of work-related, potential exposure to HIV. Posting relevant policies, hand washing procedures or other critical information in key areas in the health care setting enables health workers to maintain better quality of patient care.

2.3.3 Policy level

The lack of specific policies or clear guidance related to the care of patients with HIV reinforces discriminatory behaviour among health workers. Health facilities need to enact policies that protect the safety and health of patients, as well as health workers, to prevent discrimination against people living with HIV. Such policies are most successful when developed in a participatory manner, clearly communicated to staff, and routinely monitored after implementation. Several studies have shown that stigma reduction activities in hospitals, based on the principles we have outlined, have led to positive changes in health providers' knowledge, attitudes and behaviours, and better quality of care for HIV-positive patients (Ngozi, 2011; Odimegwu, Akinyemi, and Alabi, 2017; Nair, Kumar, Pandey, Harshana, Kazmi, et.al., 2019).

For example, following a stigma reduction intervention in four Vietnamese hospitals (Oanh, Ashburn, Pulerwitz, Ogden, and Nyblade 2008), the mean score on both a fear-based and a value-based stigma index decreased significantly among hospital workers ($p < 0.05$). Additionally, there was a significant reduction in reporting of discriminatory behaviours and practices by hospital workers. For example, the percentage of hospital workers reporting the existence of labels indicating HIV status on files declined from 56% to 31% ($p < 0.001$) in one hospital, and from 31% to 17% in another ($p < 0.002$). During monitoring visits, various positive changes were observed (e.g., improvements in the use of universal precautions, increased voluntary HIV testing of patients and informing patients of their HIV status, and a reduction in the marking of files and beds with the patient's HIV status).

The intervention accomplished this reduction in stigma and discrimination within six months through the following programmatic steps:

- Implementation of a brief survey to document the need for action to reduce stigma and guide the design of the intervention
- Establishment of a steering committee to plan the intervention.
- A flexibly scheduled 2½ day participatory training for all hospital staff (from cleaners to clerks to doctors), which focused on increasing knowledge and awareness of HIV, universal precautions, and fear-based and value-based stigma, including what stigma looks like in the health care setting.
- Participatory drafting and negotiation by all staff of a hospital policy to foster staff safety and a stigma-free atmosphere.
- Provision of materials and supplies to facilitate the practice of universal precautions.

This and other intervention studies in hospitals (Samson, 2015) suggest a number of promising pathways and approaches for tackling the problem at the individual, environmental and policy levels. Stigma reduction fundamentals for the hospital setting, outlined below, are also applicable in other health care settings, such as primary care clinics and health posts.

2.4 Types of HIV-related stigma and discrimination

According to Lekganyane and du Plessis (2011), stigma can be felt (anticipated or internal) which leads to an unwillingness on the part of diagnosed persons to seek help and to access resources. It can also be enacted (external stigma), leading to discrimination on the basis of one's HIV status. Stigma can either be external or internal. External stigma refers to the actual experience of discrimination whereas internal stigma (felt or imagined stigma) refers to the shame associated with HIV/AIDS and PLWHAAs' fear of being discriminated against. Internal stigma, as further indicated by Mbonu, Van Den Borne and De Vries (2009), serves as a powerful survival mechanism that helps one to protect him or herself from external stigma which often results in thoughts or behaviour such as refusal or reluctance to disclose one's HIV positive status, denial of HIV/AIDS

and unwillingness to accept help (Ngozi, Mbonu et al., 2011; Odimegwu, Akinyemi, and Alabi, 2017).

A research conducted by UNAIDS (2010) in Uganda and India on HIV and AIDS related stigmatisation, discrimination and denial revealed that HIV-related stigmatisation, discrimination and denial may appear in a variety of contexts. Central among those are the family and local community, employment and the workplace, and the health care system. In majority of developing countries, families are the primary care givers and play an important role in providing support and care for PLWHAAs. Infected and affected family members may experience stigmatisation and discrimination within the home. The family's efforts to "manage" stigmatisation within the wider community also have consequences for quality of care. Families may shield affected members from the wider community by keeping them within the house or by protecting them from questioning.

Additionally, although HIV is not readily transmitted in the majority of workplace settings, employment and workplace stigmatisation and discrimination has been enacted through termination or refusal of employment by many employers. In countries where employer sponsored insurance schemes that provide medical assistance and pensions for employees have come under increasing pressure in countries that have been seriously affected by HIV/AIDS, some employers have used this pressure to deny employment to PLWHAAs (UNAIDS, 2010).

It is further reported by UNAIDS (2010) on the extent to which individuals are stigmatized and discriminated against by the health care system. Many accounts also proliferate of withheld treatment, non-attendance of hospital staff to patients left lying in their beds, HIV testing without consent, breaches of confidentiality and denial of hospital facilities and medications.

2.5 Coping Mechanisms adopted by PLWHAAs

In a study involving 43 focus groups comprising 251 participants that was conducted on coping with HIV/AIDS Stigma in Five African countries, 17 coping strategies were identified. Out of this number, 6 were labeled emotional coping strategies whereas 11

were labeled problem-focused coping strategies (Lucia, Makoae, Greeff, René, Phetlhu, et.al., 2018).

The emotional coping strategies identified in the study by Makoae et.al., (2017) were activities that were personally done by the stigmatized individual which involves emotional self-management. Problem solving coping strategies on the other hand involved how the problem of stigma could be addressed directly whiles engaging with other people. The emotional strategies identified were: rationalization where respondents focused on positive thinking and had alternative meanings for their illness; seeing self as being okay, that is seeing one's self as normal or as okay and courageous in the face of the illness or stigma. Also, letting it be, a situation where stigmatized people avoid confrontation and passively accepting or ignoring stigmatizing behavior.

In addition to the above mentioned emotional strategies is turning to God which focuses on spiritual aspects and includes activities such as praying, joining religious groups, depending on and building hope in God in response to the illness. More so, hoping, where references to hope were not linked to any specific source, rather, the hope that all would change without any intervention and humor, this involved the use of joking words about the illness or stigma in order to lessen the fear and seriousness associated with HIV.

The problem focused coping strategies that were identified also included joining a group (support group). Disclosing i.e. openly disclosing HIV status to reduce gossip and rumours. Moreover, problem focused coping strategies include going for counseling from health workers or peer counselors in order to feel better and understand the illness better. Other problem focused coping strategies are talking and chatting to others i.e. informal socializing and talking; helping others i.e. give help to other HIV positive persons; educating others; changing lifestyle; keeping busy; acquiring more knowledge and learning from others i.e. learning from others who are infected (Makoae, et.al, 2018).

In Cloete's et.al., study in Cape Town, as a way of coping with stigma, PLWHAAs keep quiet about their status while some keep away from the public eye. HIV positive mothers go as long as breastfeeding their babies even when they know that it is not right to do so

all because of fear of denial and rejection by spouses, families and community (Cloete, Strebel, Simbayi, van Wyk, Henda and Nqeketo, 2010; Madiba and Letsoalo, 2013).

In his study conducted in Ghana, Awusabo (2015) noted that, for fear of being stigmatized and isolated by family members, some PLWHAAs have to keep their sero-status as a secret from family members. This is due to the breakdown of the social 'safety net' which was once provided by the corporate clan to individual family members. This 'safety net' no longer makes provision for such support systems. Barkey (2010) mentioned in another study conducted in Nigeria that PLWHAAs and their family members have different methods and strategies that enable them to cope with stigmatizing behaviour in society. The study stated that some PLWHAAs cope by disclosing their status to their family members and colleagues in order to get support from them whereas others either conceal or deny their sero-status as a coping mechanism. Another coping mechanism for some PLWHAAs is their association with area networks or support groups to have a sense of belonging. While some PLWHAAs do not disclose their status, others also relocate as a way of coping with HIV related stigma and discrimination. The study further revealed that some PLWHAAs and their families' explanation for HIV diagnosis as a result of bewitching provide them with some form of protection against societal stigma and discrimination.

2.6 Conceptual framework: HIV stigmatisation & discrimination (Ahiadeke, 2010)

A Conceptual framework according to Ahaideke is an outline of possible relationships between concepts (Ahiadeke, 2010). The conceptual framework showing how stigmatisation and discrimination of people living with HIV/AIDS affect prevention and spread is represented in the figure below.

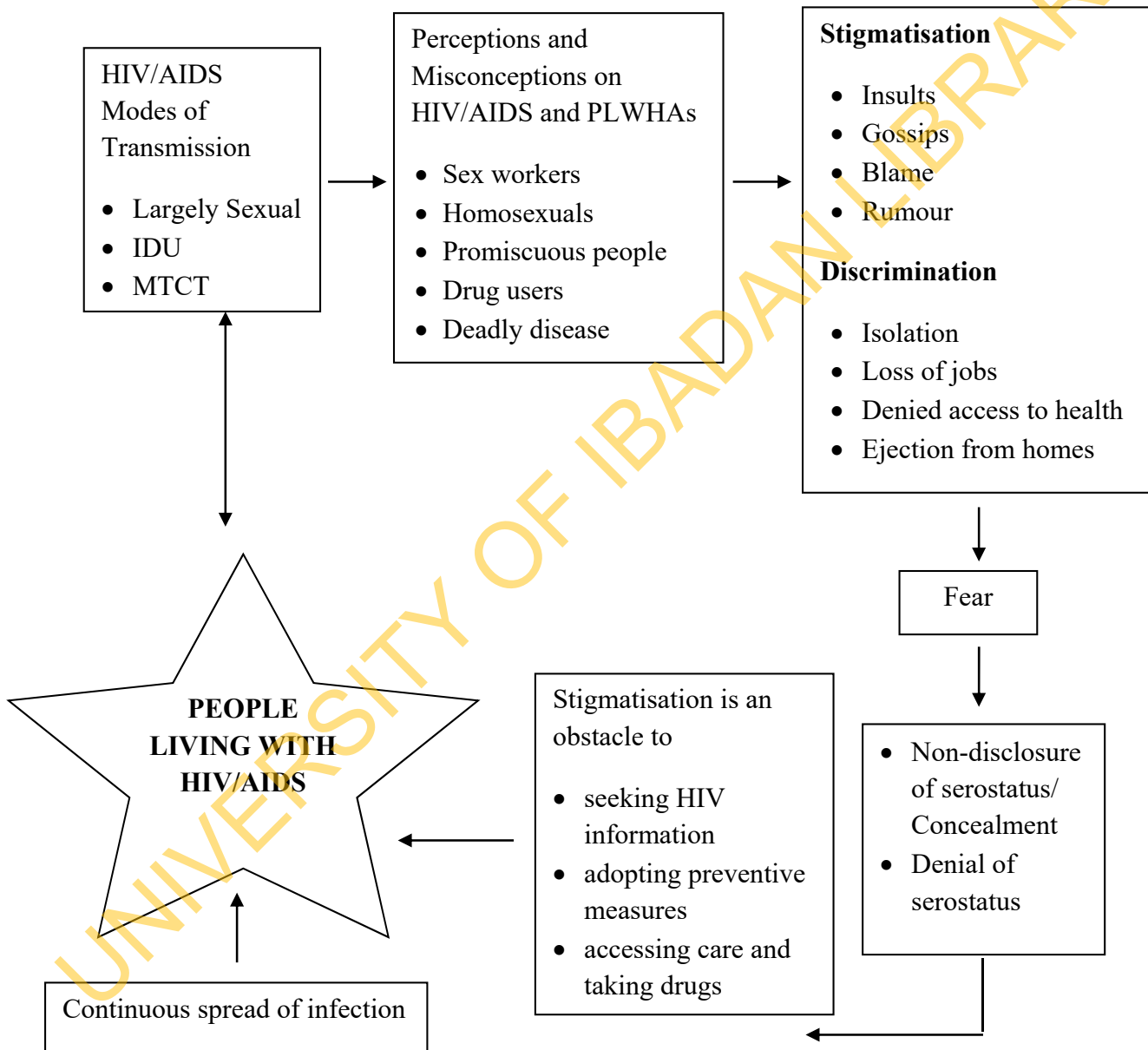


Figure 2.1: HIV stigmatisation and discrimination (Ahiadeke, 2010)

2.6.1 Application of the conceptual frame work

As shown by the conceptual framework above, earlier reports on HIV/AIDS as a deadly disease with its main mode of transmission being sex which affected populations such as sex workers, homosexuals and injection drug users has created certain misconceptions and perception of persons living with it to be in either one or more of these category of population. The existing misconception and perception have resulted to stigmatizing attitudes such as insults, gossip, blame, rumour etc. which eventually lead to discriminating attitudes like refusal to employment, denial of access to health care, and ejection from homes, among others. These negative attitudes towards PLWHAAs put some kind of fear in them which leads to non-disclosure of sero-status or concealment and at times denial of sero-status by persons diagnosed as infected. This as noted by many studies and international bodies like the United Nations serves as an obstacle to PLWHAAs to seek information on HIV, adopt preventive measures as well as take drugs which eventually leads to continuous spread of the disease.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter explains the research methodology underpinning the current study and looks at the procedures used to achieve the objectives of the study. Sections discussed in this chapter include: the study area, research design, research setting, target population, the sample size determination, the sampling procedure, research instrument, validity and reliability of instrument, data collection procedure, data analytical techniques and ethical considerations related to the study.

3.1 Research design

A cross sectional study design was used. A cross sectional study examines the relationship between disease (or other health related state) and other variables of interest as they exist in a defined population at a single point in time or over a short period of time. The researcher opted for this study design because:

- Relatively quick and easy to conduct (no long periods of follow-up).
- Data on all variables is only collected once.
- Able to measure prevalence for all factors under investigation.
- Multiple outcomes and exposures can be studied.
- Good for descriptive analyses and for generating hypotheses.

3.2 Study area

Ibadan is the largest city in West Africa and the third largest in the world. Ibadan, the capital city of Oyo State, lies roughly on latitude 7⁰N and 4⁰S. Situated in South Western Nigeria, the last known population is \approx 3 160 200 (year 2015). This was 1.734% of total Nigeria population. If population growth rate would be same as in period 2006-2015 (+4.14%/year), Ibadan population in 2021 would be: 4 031 840*. and the metro area population of Ibadan in 2020 was 3,552,000, annual increase rate of a 2.54% (United Nations 2021). Ibadan formerly consisted of Ibadan metropolitan city, i.e. the municipality and the surrounding hinterland. The municipality/metropolitan area was reformed in August 27, 1991 during Gen. I.B. Babangida regime. This reform resulted

into the division of Ibadan into five local governments within the city and the already existing 6 local governments in the surrounding predominantly rural hinterlands. The 5 local government areas located in Ibadan city include:

last known population is $\approx 3\,160\,200$ (year 2015). This was 1.734% of total Nigeria population. If population growth rate would be same as in period 2006-2015 (+4.14%/year), Ibadan population in 2021 would be: 4 031 840* (United Nations - World Population Prospects, 2021).

- i. Ibadan North Local Government Area
- ii. Ibadan North-West Local Government Area
- iii. Ibadan North-East Local Government Area
- iv. Ibadan South-West Local Government Area
- v. Ibadan South-East Local Government Area

The other 6 local government areas in the hinterland consists of

- i. Akinyele Local Government Area
- ii. Lagelu Local Government Area
- iii. Egbeda Local Government Area
- iv. Ona-Ara Local Government Area
- v. Ido Local Government Area
- vi. Oluyole Local Government Area

The total landmass of Ibadan metropolitan area is $3,124.6\text{km}^2$ out of which about 15% falls within the urban area, while the remaining 85% constitute the rural area of Ibadan (SIO, 1996). With regards to health facilities, the city has one teaching hospital, (the University College Hospital, Ibadan), 7 State Hospitals, 409 Primary Health facilities and many private clinics, hospital and maternity homes. There is a state-own central blood bank and a number of private laboratories scattered all over the city. In addition, some non-governmental organizations and charity bodies also have health facilities providing varying degree of services.

The indigenous non-governmental organization working with PLWHA in Ibadan include the Family Health and Population Action Committee (FAHPAC), Aperin- Oniyere; The

People Living with HIV/AIDS Association in Nigeria 9 (PLAN), Samonda; The Network on Ethics/Human Rights, Law on HIV/AIDS prevention and support (NELA) Old Ife Road; The Positive Life Association of Nigeria, Yemetu; Hope for Positive Couples, Onireke; Ireti-International Alliance, Orita-Aperin; The Positive Women Empowerment Responses (POWER) Sango; and Sisters for Hope Bodija.

These organizations have care and support programs ranging from associating PLWHAs to form social support groups, to training and health education, home based visitations, community awareness and publicity, financial empowerment, vocational training and medical services.

3.3 Target population

The target population for the study were the People living with HIV/AIDS in 3 selected hospitals in Ibadan.

3.4 Study population

The study population consisted of all volunteering HIV positive persons, attending support group meetings. These will be the people who have been infected with the virus and know their HIV status, having done the appropriate blood test, both male and female within the young adult age of 15 to 24 years and adults of 25years and above. The PLWHAs (those that have declared their status), usually have support groups in these organizations, where they carry out various activities such as training and health education, access to ARV, promotion of food and food supplements, care for the critically ill, among other things. In Oyo State, there are 200,000 PLWHAs (NACA, 2017).

3.5 Inclusion criterion

All consenting PLWHA within the selected centers in Ibadan were included in the study.

3.6 Sampling procedure and sample size determination

3.6.1 Sampling procedure

The purposive or judgmental sampling technique was adopted for this study. This approach was considered appropriate because the target group was a rare population that

was difficult to reach and to interview. Subsequently their selection did not lend itself to probability sampling as pre-selected samples might never have been found or might have refused to be interviewed.

3.6.2 Sample size determination

A sample is a small proportion of the population or a subset of the whole which is to be investigated and whose findings can be generalized to the entire population (1987). A sample is a selected group of elements from entire population that has the same characteristics.

The sample was determined using the Leshile Kish formula for calculating size for single proportion.

$$n = \frac{z^2 pq}{d^2}$$

n = Sample size

z = confidence interval (1.96)

p = Proportion of PLWHA who had ever experienced stigmatisation or discrimination treatment (being incarcerated even more than once) in hospital setting (81.5%) (Ebrahimi, et.al., 2019)

q = 1-p = 0.5; z = 1.96; p = 0.82.

d = level of significant 0.05

$$n = \frac{1.96^2 \times 0.82 \times 0.18}{0.05^2}$$

$$n = \frac{1.96^2 \times 0.82 \times 0.18}{0.05^2}$$

$$n = \frac{3.8416 \times 0.56702016}{0.05^2} = 226.808$$

The estimated sample size calculated was ≈ 227 .

Making allowance for non-response rate, the sample size =

$$n = \frac{226}{0.9}$$

n = 252.01 was approximated to 252.

3.7 Instrument for data collection

A semi-structured Questionnaire was developed based on the study objectives and review of literature. It incorporates major variables (as described above). The questionnaire consists of six sessions.

1. Section A: Social demographic characteristics of respondent
2. Section B: Involvement in HIV testing and related experience.
3. Section C: Stigmatizing Experiences
4. Section D: Psychological Challenges.
5. Section E: Social Challenges
6. Section F: Treatment Challenges

3.8 Validity of Instrument

Validity describes the ability of an instrument to measure what it is expected to measure. The instrument was pre-tested among persons living with HIV/AIDS attending Adeoyo Maternity Teaching Hospital, Ibadan. The hospital and respondents have similar characteristics to the actual study population to determine how effective the developed instrument was in collecting appropriate data relevant to the research objectives. The objective opinions of supervisors and experts in the Department of Health Promotion and Education were sought to find out the face and content validity of the developed instrument.

3.9 Reliability of Instrument

Reliability describes the accuracy or precision of a research-measuring instrument. The returned questionnaires were coded and analysed using Cronbach's Alpha correlation coefficient Statistical Package for Social Science (SPSS). Alpha (Cronbach's) is a model of internal consistency, based on the average inter-item correlation (<http://www.spss.com>). This was done to ascertain the psychometric properties of the instrument. According to this approach, a result showing correlation coefficient equal to or greater than 0.7 is said to be reliable. The result of the analysis of the data collected during the pre-test is 0.934 which shows that the instrument is very reliable.

3.10 Data collection method

3.10.1 Training of Research Assistants

Six Research Assistants (RAs) (three males and females) (aged 18-40 years) were recruited for the study. The six research assistants were post-secondary education certificate holders. They were fluent in English, Yoruba and Pigin languages. The research assistants were trained for two days. A time table was drawn for this period, with each day lasting 5 hours (10 a.m-3p.m). The training commenced with a self-introduction of the trainees, the investigator and the trainee, followed by the background of the study and objectives. Contents of the training focused on interview techniques, interpersonal and communication skills. Demonstrations and role-play was used to transfer skills. A copy of the instrument was given to each of the trainees to take home and read over for better understanding with the intention that issues generated should be discussed the following day.

3.11 Procedure for Data Collection

The questionnaire was administered by the researcher and research assistants. Six research assistants were recruited and trained on data collection instrument, correct and complete filling of the questionnaire. Ethical clearance certificate was shown to the heads of each hospital who served as entry point and guides to the units. The PLWHAs were selected by simple random sampling at the clinic as earlier. Consent was obtained after explanation and willing participants were administered questionnaire. The questionnaires were retrieved upon completion. Data collection took a period of three weeks as the researcher and research assistants rotated round the three hospitals ensuring that at least a week is used in each hospital in order to achieve the desired sample size. Each hospital runs clinic thrice per week.

3.12 Data Management and Analysis

The completed questionnaires were collected, coded, cleaned and data entry was done with the use of Statistical Package for Social Sciences (SPSS) software for windows version 21. Variables were analyzed using descriptive and inferential statistics. Results were presented in tables, diagrams and figures. Statistical significance was set at p-value ≤ 0.05 .

3.13 Ethical Considerations

Ethical clearance was sought and obtained from the Oyo State Ethical Review Committee. Before embarking on the study, consent from Directors and Coordinators of the NGOs and participants were obtained. Assurance was given to all respondents on the confidentiality and anonymity of the data collected, and protection of their interests, since there was no requirement to include names in the questionnaires.

3.14 Scope and Limitation of the study

Due to time, financial limitation, I chose only Ibadan for easy coverage.

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CHAPTER FOUR

RESULTS

This chapter focuses on the analysis of data from the respondents and interpretation.

4.1 Socio-demographic characteristics of the respondents

The age of the respondents' ranged from 18 – 70 years. Respondents mean age was 36.5 ± 8.8 and 46.8% were within the age range of 30-39 years. Majority (82.1%) of respondents were females. More than half (57.9%) were Christians and 73.0 % were married. Many (42.1%) among the respondents had above secondary education before the study while only (39.3%) had secondary education (Table 4.1). Many (47.6%) of the respondents in the study were traders (Figure 4.1). Less than one-third (29.0%) of them, reported that they have sexual partners.

Table 4.1: Socio-demographic characteristics of the respondents (N=252)

Variable	Frequency (N)	Percent
Age in years		
<20	5	2.0
20-29	49	19.4
30-39	118	46.8
40-49	62	24.6
50-59	12	4.8
≥60	6	2.4
Mean age = 36.5±8.8years with age range between 18 to 70		
Sex		
Male	45	17.9
Female	207	82.1
Religion		
Christianity	146	57.9
Islam	99	39.3
African Traditional Religion	5	2.0
Others+	2	0.8
Highest level of education		
No formal education	16	6.3
Primary	31	12.3
Secondary	99	39.3
Tertiary++	106	42.1
Marital status		
Single	28	11.1
Married	184	73.0
Cohabiting	1	.4
Divorced	13	5.2
Widowed	14	5.6
Separated	12	4.8

+ - Free thinker and pagan

++ - NCE, OND, HDN, B.Sc., M.Sc. & Ph.D

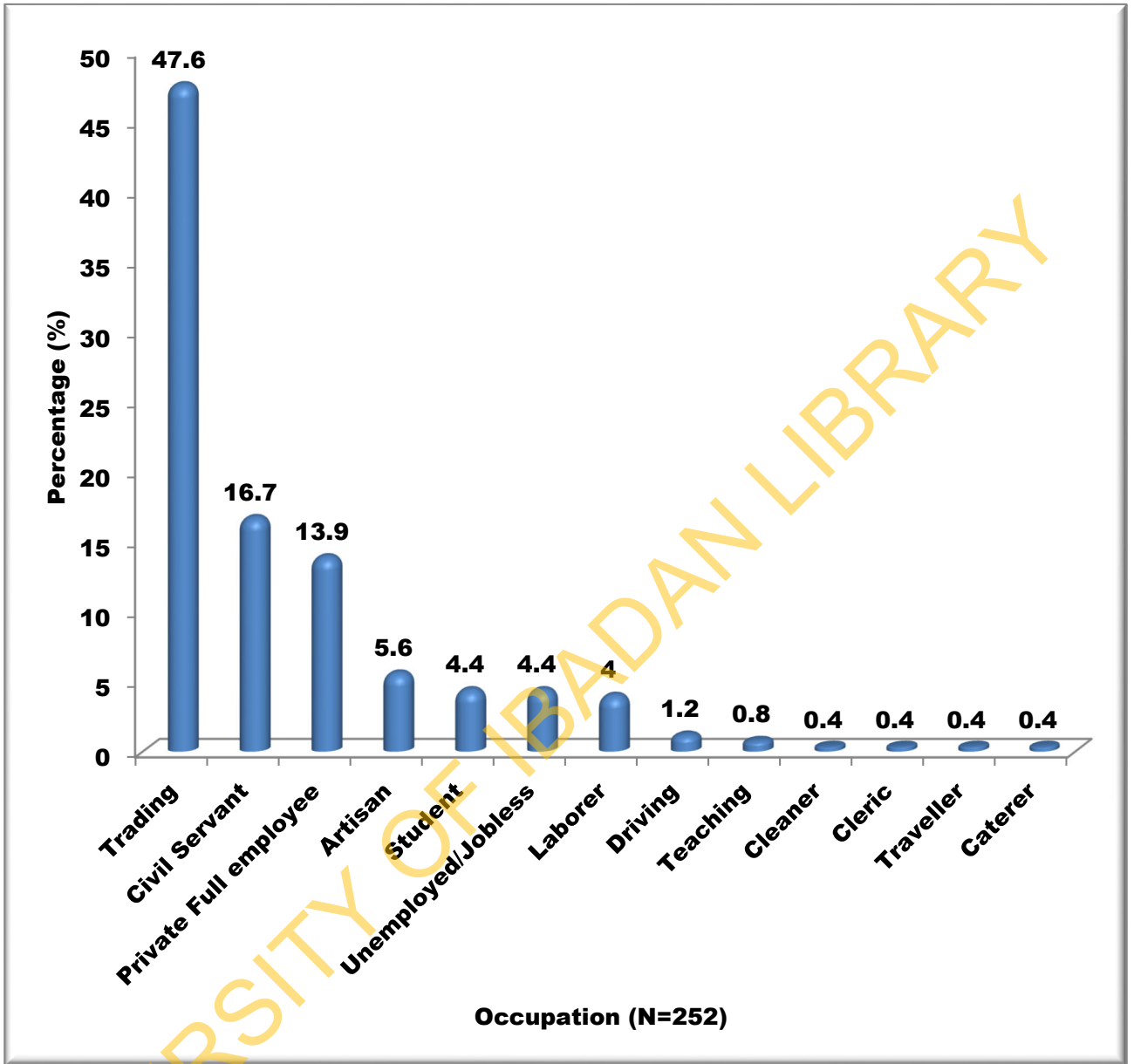


Figure 4.1: Respondents' occupation

4.2 Respondents' involvement in HIV testing and related experience

Many (54.4%) among the respondents declared less than five years of having been living with HIV/AIDS with mean age of 5.1 ± 4.0 years. Reasons given by the respondents for undergone HIV testing for the first time included: regular sickness (32.5%), recommendation due to suspected HIV (11.5%), regular Anti-Natal Care Investigations (10.3%), just wanted to know my status (8.7%) and preparation for marriage (6.3%).

Reactions put up by the respondents when first heard that they were positive to HIV test included: Fear of stigmatisation (79.8%); Panic that death is near/at hand (77.8%); Concern about how to disclose result to friends (77.4%); Stunned (77.0%); Fear that people will start to discriminate against me (76.2%); Concern of how disclose result to family members (76.2%); Angry (76.2%); Lost confidence in myself (74.2%) and Feeling of uselessness (73.8%) (Table 4.3).

Table 4.2: Respondents' involvement in HIV testing and related experience
(N=252)

Variable	Frequency (N)	Percentage (%)
Years and months having been living with HIV/AIDS		
<5	137	54.4
5-9	77	30.6
≥10	38	15.1
Mean age = 5.1±4.0years with age range between 1 to 25		
Reason(s) for HIV testing for the first time		
Regular sickness	82	32.5
Recommendation due to suspected HIV	29	11.5
Regular Anti-Natal Care Investigations	26	10.3
Just wanted to know my status	22	8.7
Preparation for marriage	16	6.3
Doctor's instruction	12	4.8
Family advice	12	4.8
Spouse/partner/family member was found to be having HIV	12	4.8
Nurse's advice	9	3.6
Wanted to donate blood	8	3.2
Because Spouse/partner/family member died of HIV	8	3.2
Followed friend's advice	6	2.4
Sister/relations' advice	5	2.0
Preparation for sexual relation	5	2.0

Table 4.3: Respondents' reactions when informed of HIV status for the first time (N=252)

Reasons for reaction taken*	Frequency	Percent
Sad	33	13.1
Angry	192	76.2
Stunned	194	77.0
I was not convinced /uncertain of test result.	179	71.0
Panic that death is near/ at hand	196	77.8
I became Hopeless	178	70.6
Fear of being lonely	181	71.8
Fear that people will start to discriminate against me	192	76.2
Fear of stigmatisation	201	79.8
Fear of losing my job	168	66.7
Lost confidence in myself	187	74.2
I was humiliated	171	67.9
Feeling of uselessness	186	73.8
Segregate self from societal functions	175	69.4
Concern of how disclose result to family members	192	76.2
Concern about how to disclose result to friends	195	77.4

* Multiple responses

4.3 Respondents' experience of ever being treated in a dislike manner by the health worker

From the figure 4.3 below, it was revealed that 68.7% of respondents reported that they had sometime and somehow experienced been treated in a dislike manner by the health worker.

Relating the table 4.4 below with result in figure 4.3, less than half (49.2%) of the respondents declared that they had been blamed for being responsible for your HIV Status by someone among healthcare worker sometime. Other reported stigmatisation experienced by the respondents included gossip about their status with coworker or other health worker 79(31.3%), Irregular or winking of eye at them disrespectfully 77(30.6%), and called bad/derogatory names 73(29.0%) although they were less than half of those who declared their experiences yet they were somehow significant to reckon with (Table 4.4).

Considering the perpetrators of each reported types of stigmatisation by the respondents, nurses (48.0%) took a lead in each category of stigmatisation experiences followed by those who doctors (23.0%) as the perpetrator in each category (Table 4.4).

Table 4.4: Stigmatizing Experiences and its perpetrator

Stigmatizing experiences	Ever Experienced	Perpetrator					
		Doctor No.(%)	Nurses No.(%)	Lab. Scientist No.(%)	Social Worker No.(%)	Dentist No.(%)	Record Officer No.(%)
Blamed for being responsible for your HIV Status	124(50.8)	32(25.8)	55(44.4)	24(19.4)	8(6.5)	0(0.0)	5(4.0)
Gossip about your status with coworker or other health worker	79(31.3)	23(29.1)	37(46.8)	10(12.7)	4(5.1)	2(2.5)	3(3.8)
Called Bad/ derogatory names	73(29.0)	10(13.7)	35(47.9)	12(16.4)	9(12.3)	0(0.0)	7(9.6)
Irregular or winking of eye at you disrespectfully	77(30.6)	15(19.5)	39(50.6)	12(15.6)	7(9.1)	0(0.0)	4(5.2)
You were used as example of somebody living with HIV to newly HIV positively confirmed person(s)	41(16.3)	8(19.5)	23(56.1)	3(7.3)	4(9.8)	1(2.4)	2(4.9)
Total*		88(23.0)	189(48.0)	61(15,5)	32(8.1)	3(0.8)	21(5.3)

* Multiple responses

4.4 Respondents' experience of ridicule by health care providers

Little above one-third (33.7%) of respondents reported that they had experienced being laughed disrespectfully at by someone among the health workers. Approximately 37.0% said that they were mocked and 46.8% of them expressed that they had been sometimes shunned by health workers. Those who retorted that they had the experience from nurses (43.2%) were many and followed by those who experienced such ridiculed from Laboratory scientists (16.6%) (Table 4.5).

Table 4.5: Respondents' experienced of ridicule from health care providers

Ever experience ridiculing	Ever experienced	Perpetrator					
		Doctor No.(%)	Nurses No.(%)	Lab. Scientist No.(%)	Social Worker No.(%)	Dentist No.(%)	Record Officer No.(%)
Laughed disrespectfully at you	85(33.7)	10(11.8)	42(49.4)	12(14.1)	6(7.1)	1(1.2)	14(16.5)
Mocked you	93(36.9)	7(7.5)	42(45.2)	20(21.5)	9(9.7)	5(5.4)	10(10.8)
Try to shun you	118(46.8)	31(26.3)	44(37.3)	17(14.4)	6(5.1)	5(4.2)	15(12.7)
Total*		48(16.2)	128(43.2)	49(16.6)	21(7.1)	11(3.7)	39(13.2)

* Multiple responses

4.5 Respondents' account of various derogatory treatment/actions by health workers due to HIV status

Respondents' reported experience of derogatory treatment from some health workers included: Separated their seat from other clients or patients 106(42.1%); Avoided contact with them 93(36.9%); Made to pay additional money 92(36.5%); Used unnecessary personal protection wear (e.g. additional gloves, goggles, face mask etc.) 80(31.7%); Informed other health workers that they are HIV positive without their permission 70(27.8%); Placed sign near their beds while on admission to indicate that they are HIV+ 67(26.6%); Served medication by dropping the medication into their mouths or palms without allowing their body to touch them 50(19.8%); Treated or dealt with them without respect 48(19.0%) and Made them the last person to be attended to 47(18.7%) (Table 4.6).

Table 4.6: Respondents ever treated as countless / worthless somebody

Ever treated as countless / worthless somebody - Perpetrator	Ever experienced	Doctor No.(%)	Nurses No.(%)	Lab. Scientist No.(%)	Social Worker No.(%)	Dentist No.(%)	Record Officer No.(%)
Informed other health workers that you have HIV without your permission	70(27.8)	16(22.9)	20(28.6)	23(32.9)	6(8.6)	4(5.7)	1(1.4)
Informed your husband/ wife about your HIV status without your permission	25(9.9)	10(40.0)	7(28.0)	2(8.0)	2(8.0)	2(8.0)	2(8.0)
Informed your family member(s) about your HIV status without your permission	25(9.9)	8(32.0)	12(48.0)	4(16.0)	1(4.0)	0(0.0)	0(0.0)
Refused to treat you because of your HIV status	25(9.9)	6(24.0)	13(52.0)	6(24.0)	0(0.0)	0(0.0)	0(0.0)
Ordered for HIV testing without approval	27(10.7)	10(37.0)	15(55.6)	1(3.7)	1(3.7)	0(0.0)	0(0.0)
Refused admission because of your HIV status	17(6.7)	10(58.8)	4(23.5)	3(17.6)	0(0.0)	0(0.0)	0(0.0)
Left in the corridor or side ward	30(11.9)	9(30.0)	10(33.3)	7(23.3)	2(6.7)	1(3.3)	1(3.3)
Made you the last person to be attended to because you have HIV	47(18.7)	12(25.5)	16(34.0)	8(17.0)	5(10.6)	5(10.6)	1(2.1)
Discharged home to seek care from elsewhere on learning that you have HIV	28(11.1)	21(75.0)	3(10.7)	3(10.7)	0(0.0)	0(0.0)	1(3.6)
Tested you for HIV without any pre or posttest counselling	29(11.5)	5(17.2)	10(34.5)	14(48.3)	0(0.0)	0(0.0)	0(0.0)
Used you for research without informed consent	19(7.5)	5(26.3)	4(21.1)	7(36.8)	1(5.3)	1(5.3)	1(5.3)
Served medication by dropping the medication into your mouth or palm without allowing their body to touch you	50(19.8)	9(18.0)	22(44.0)	17(34.0)	1(2.0)	1(2.0)	0(0.0)
Used unnecessary personal protection wear (e.g. additional gloves, goggle, face mask etc.)	80(31.7)	20(25.0)	24(30.0)	24(30.0)	4(5.0)	2(2.5)	6(7.5)
Treated or dealt with you without respect because of your HIV status	48(19.0)	13(27.1)	16(33.3)	12(25.0)	5(10.4)	0(0.0)	2(4.2)
Placed sign near your bed while on admission to indicate that you are HIV+	67(26.6)	28(41.8)	37(55.2)	0(0.0)	0(0.0)	2(3.0)	0(0.0)
Avoided contact with you because of your HIV status	93(36.9)	19(20.4)	38(40.9)	24(25.8)	7(7.5)	2(2.2)	3(3.2)
Made to pay additional money for health care services as a result of HIV status	92(36.5)	45(48.9)	24(26.1)	18(19.6)	1(1.1)	1(1.1)	3(3.3)
Separated your seat from other clients or patients because of your HIV status	106(42.1)	31(29.2)	40(37.7)	23(21.7)	6(5.7)	4(3.8)	2(1.9)
Total*		277(31.5)	315(35.9)	196(22.3)	42(4.8)	25(2.8)	23(2.6)

* Multiple responses

4.6 Respondents' experience of psychosocial problems as a result of stigmatisation

Table 4.7 revealed different psychosocial problems faced by the respondents as a result of different stigmatisations experienced from the perpetrators. Those who had sleeplessness were 136(54.0%) and those who still having it were 30(22.1%). Out of 134(53.2%) who felt sad then, 38(28.4%) recently had it. Above half 129(51.2%) were worried among whom 31(24.0%) them recently experienced it. Those who were perplexed/confused were 129(51.2%) and among them were 36(27.9%) recently it. Feeling as one who was dreaming (Delusion) were 124(49.2%) among which 23(18.5%) recently experienced such.

Among respondents who had ever experienced reduction in social interaction 98(38.9%), about one-third 32(32.7%) of them presently experiencing it. Those who felt being a burden to family/people were 89(35.3%) of which 40(44.9%) of them reported that they were still experiencing it. Among those who experienced reduction in productivity 78(31.0%), less than half 28(35.9%) of them still experiencing it. Few 80(31.7%) of the respondents said that they had experienced withdrawn from habitual activities among which 50(62.5%) of them were still experiencing it (Table 4.8).

Table 4.9 below revealed the challenges countered by the respondents relating to their treatment uptake. From the table was shown that few of the respondents had experienced loss of confidence in health workers 44(17.5) of which 19(43.2) declared of such experience recently. In the manner, 48(19.0) admitted that they had shown non-compliance to their appointments and 25(52.1) did such recently. Less than one-quarter 60(23.8) of respondents admitted that they had ever missed appointments while among 18(30.0) recently missed it too. Among few 34(13.5) respondents who said they had sometimes ever loss of confidence in the treatment given to them, 9(26.5) experienced same recently. Those who had ever non-adherence to treatment were 20(7.9) out of which 8(40.0) did same recently (Table 4.9).

Table 4.7: Respondents' experience of psychosocial problems as a result of stigmatisation (N=250)

Psychological Problems	Ever Experienced	Currently experienced	
		Yes(%)	No(%)
Sleeplessness	136(54.0)	30(22.1)	106(77.9)
Feeling being useless/worthlessness	102(40.5)	20(19.6)	82(80.4)
Worry	129(51.2)	31(24.0)	98(76.0)
Feeling as one is dreaming (Delusion)	124(49.2)	23(18.5)	101(81.5)
Low self-esteem	110(43.7)	25(22.7)	85(77.3)
Feeling Sad	134(53.2)	38(28.4)	96(71.6)
Being absent Minded	104(41.3)	20(19.2)	84(80.8)
Inability to remember things easily	108(42.9)	37(34.3)	71(65.7)
Perplexed/ Confused	129(51.2)	36(27.9)	93(72.1)
Feeling like taking your life	70(27.8)	41(58.6)	29(41.4)

Table 4.8: Social problems experienced by the respondents' as a result of stigmatisation

Social Challenges	Ever Experienced	Currently experienced	
		Yes(%)	No(%)
Withdrawn from habitual activities	80(31.7)	50(62.5)	30(37.5)
Reduced Productivity	78(31.0)	28(35.9)	50(64.1)
Reduced social interaction	98(38.9)	32(32.7)	66(67.3)
Feeling of being a burden to family/people	89(35.3)	40(44.9)	49(55.1)
Reluctance / fear to seek / apply for job / vacancy	74(29.4)	26(35.1)	48(64.9)

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Table 4.9: The negative consequences of feeling of stigmatisation on the behaviour of the respondents' regarding hospital care

Challenges being experienced	Ever Experienced	Currently experienced	
		Yes(%)	No(%)
Loss of confidence in Health workers	44(17.5)	19(43.2)	25(56.8)
Non-compliance to appointments	48(19.0)	25(52.1)	23(47.9)
Missing of appointments	60(23.8)	18(30.0)	42(70.0)
Loss of confidence in the treatment given	34(13.5)	9(26.5)	25(73.5)
Non-adherence to treatment	20(7.9)	8(40.0)	12(60.0)

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4.7 Hypotheses

Hypothesis one

Ho1. There will be no significant relationship between respondents' socio-demographic characteristics (like: respondents' age, sex, religion, education, marital status, occupation and sexual partner) and PLWHAAs' experience of stigmatisation and discrimination from healthcare workers

Table 4.10. The results revealed that, of all the socio-demographic characteristics variables (respondents' age, sex, religion, education, marital status, occupation and sexual partner) tested with PLWHAAs' experience of stigmatisation and discrimination from healthcare workers, statistically, only respondents' occupation ($p = 0.031$) was significant to experience of stigmatisation and discrimination. Other variables were statistically significant ($p > 0.05$).

Based on the result shown in Table 4.18, the null hypothesis, which stated that there will be no relationship between respondents' socio-demographic characteristics (like: respondents' age, sex, religion, education, marital status and sexual partner) and PLWHAAs' experience of stigmatisation and discrimination from healthcare workers is therefore not rejected ($p > 0.05$) although occupation was significant but could not be counted because some variables with cell count less than 5.

N.B: Fisher exact test was used in some chi-square tables below because of those variables with cell count less than 5.

Table 4.10: Relationship between socio demographic characteristics and experience of stigmatisation/discrimination

Socio Demographic Characteristics	Experience of stigmatisation/discrimination			Chi-square (χ^2)
	No (n=79)	Yes (n=173)	Total (N=252)	
Age in years in group				
<20	1(1.3)	4 (2.3)	5 (2.0)	$f = 3.693$
20-29	15 (19.0)	34 (19.7)	49 (19.4)	$p = 0.606$
30-39	34 (43.0)	84 (48.6)	118 (46.8)	
40-49	20 (25.3)	42 (24.3)	62 (24.6)	
50-59	6 (7.6)	6 (3.5)	12 (4.8)	
≥ 60	3 (3.8)	3 (1.7)	6 (2.4)	
Sex				
Male	17 (21.5)	28 (16.2)	45 (17.9)	$\chi^2 = 1.052$
Female	62 (78.5)	145 (83.8)	207 (82.1)	$p = 0.305$
Religion				
Christianity	47 (59.5)	99 (57.2)	146 (57.9)	$f = 6.366$
Islam	27 (34.2)	72 (41.6)	99 (39.3)	$p = 0.060$
African Traditional Religion	3 (3.8)	2 (1.2)	5 (2.0)	
Others*	2 (2.5)	0 (0.0)	2 (0.8)	
Highest level of education				
No formal education	6 (7.6)	10 (5.8)	16 (6.3)	$\chi^2 = 0.758$
Primary	9 (11.4)	22 (12.7)	31 (12.3)	$p = 0.860$
Secondary	33 (41.8)	66 (38.2)	99 (39.3)	
Tertiary	31 (39.2)	75 (43.4)	106 (42.1)	
Marital status				
Single	8 (10.1)	20 (11.6)	28 (11.1)	$f = 2.334$
Married	57 (72.2)	127 (73.4)	184 (73.0)	$p = 0.841$
Cohabiting	0 (0.0)	1 (0.6)	1 (0.4)	
Divorced	6 (7.6)	7 (4.0)	13 (5.2)	
Widowed	5 (6.3)	9 (5.2)	14 (5.6)	
Separated	3 (3.8)	9 (5.2)	12 (4.8)	
Have sexual partner				
Yes	25 (31.6)	48 (27.7)	73 (29.0)	$\chi^2 = 0.401$
No	54 (68.4)	125 (72.3)	179 (71.0)	$p = 0.527$
Occupation				
Civil Servant	10 (12.7)	34 (19.7)	44 (17.5)	$f = 13.404$
Private full employee	11 (13.9)	25 (14.5)	36 (14.3)	$p = 0.031^*$
Labourer	1 (1.3)	9 (5.2)	10 (4.0)	
Trading	39 (49.4)	81 (46.8)	120 (47.6)	
Student	1 (1.3)	10 (5.8)	11 (4.4)	
Unemployed/Jobless	6 (7.6)	5 (2.9)	11 (4.4)	
Artisan	11 (13.9)	9 (5.2)	20 (7.9)	

f - Fisher's Exact Test;

* Significant at 0.05

Table 4.11. The results revealed that, hospital setting and experience of stigmatisation/discrimination. Statistically, there was significant relationship between respondents' hospital facilities and experience of stigmatisation and discrimination (p=0.000).

Table 4.11: Relationship between hospital setting and experience of stigmatisation/discrimination

Hospital setting	Experience of stigmatisation/discrimination			Chi-square (χ^2)
	Yes (n=79)	No (n=173)	Total (N=252)	
University College Hospital	27(34.2)	99(57.2)	126(50.0)	$\chi^2 = 19.881$
Adeoyo Maternity Teaching Hospital	24(30.4)	52(30.1)	76(30.2)	p = 0.000*
Jericho General Hospital	28(35.4)	22(12.7)	50(19.8)	

* Significant at 0.05

Ho2. There will be no significant relationship between respondents' reactions of PLWHAAs when first heard about HIV status and experience of stigmatisation and discrimination

Table 4.12. The results revealed that, despite majority of respondents who reacted depressingly at first heard about HIV status also experience of stigmatisation/discrimination, statistically, there was no significant relationship between respondents' reactions of PLWHAAs when first heard about HIV status and experience of stigmatisation and discrimination ($p=0.142$).

Based on the result shown in Table 4.12, the null hypothesis, which stated that there will be no significant relationship between respondents' reactions of PLWHAAs when first heard about HIV status and experience of stigmatisation and discrimination is therefore not rejected ($p>0.05$).

Table 4.12: Relationship between respondents' reactions of PLWHAAs when first heard about HIV status and experience of stigmatisation and discrimination

Reaction when first heard about HIV status	Experience of stigmatisation/discrimination			Chi-square (χ^2)
	No (n=79)	Yes (n=173)	Total (N=252)	
Verbal stigmatisation				
No	14 (17.7)	19 (11.0)	33 (13.1)	$\chi^2 = 2.156$
Yes	65 (82.3)	154 (89.0)	219 (86.9)	$p = 0.142$

* - Significant at 0.05

Hypothesis three

Ho3. There will be no significant relationship between types of stigmatisation & discrimination experienced and experience of stigmatisation & discrimination by PLWHAAs.

Table 4.13. The results revealed that, statistically, there was significant relationship between reported types - verbal stigmatisation (100.0%; $p=0.000$); ridicule stigmatisation (84.1%; $p=0.000$) and worthless stigmatisation (78.0%; $p=0.024$) (verbal, ridicule and worthless) of stigmatisation & discrimination experienced and experience of stigmatisation & discrimination by PLWHAAs.

Based on the result shown in Table 4.13, the null hypothesis, which stated that there will be no relationship between types of stigmatisation & discrimination experienced and experience of stigmatisation & discrimination by PLWHAAs is therefore rejected ($p<0.05$).

Table 4.13: Relationship between types of stigmatisation experienced and experience of stigmatisation/discrimination

Types of stigmatisation Experienced	Experience of stigmatisation/discrimination			Chi-square (χ^2)
	No (n=79)	Yes (n=173)	Total (N=252)	
Verbal stigmatisation				
No	79 (100.0)	0 (0.0)	79 (31.3)	$f = 0.000$
Yes	0 (0.0)	173 (100.0)	173 (68.7)	$p = 0.000^*$
Ridicule Stigmatisation				
No	54 (68.4)	41 (23.7)	95 (37.7)	$\chi^2 = 46.046$
Yes	25 (15.9)	132 (84.1)	157 (100.0)	$p = 0.000^*$
Worthless Stigmatisation				
No	28 (35.4)	38 (22.0)	66 (26.2)	$\chi^2 = 5.096$
Yes	51 (64.6)	135 (78.0)	186 (73.8)	$p = 0.024^*$

f - Fisher's Exact Test;

* Significant at 0.05

Hypothesis four

Ho4. There will be no significant relationship between different challenges experienced and experience of stigmatisation & discrimination by PLWHAAs

Table 4.14. The results revealed that, statistically, there was significant relationship between reported psychological and treatment challenges faced by respondents due to stigmatisation/discrimination and experience of stigmatisation/discrimination. This was shown in the result as majority of respondents (90.8%) who reported psychological stigmatisation and 43.4% who reported treatment challenges were found among those who had ever experienced stigmatisation/discrimination ($p=0.000$ and $p=0.024$) respectively. However, the result was not the same to social challenges faced by respondents and ever had experienced stigmatisation/discrimination ($p = 0.064$).

Based on the result shown in Table 4.14, the null hypothesis, which stated that there will be no relationship between reported different challenges experienced and experience of stigmatisation & discrimination by PLWHAAs is therefore partially rejected ($p<0.05$).

Table 4.14: Relationship between challenges faced by respondents due to stigmatisation/discrimination and experience of stigmatisation/discrimination

Challenges	Experience of stigmatisation/discrimination			Chi-square (χ^2)
	No (n=79)	Yes (n=173)	Total (N=252)	
Psychological				
No	25 (31.6)	16 (9.2)	41 (16.3)	$\chi^2 = 19.970$ $p = 0.000^*$
Yes	54 (68.4)	157 (90.8)	211 (83.7)	
Social				
No	39 (49.4)	64 (37.0)	103 (40.9)	$\chi^2 = 3.436$ $p = 0.064$
Yes	40 (50.6)	109 (63.0)	149 (59.1)	
Treatment				
No	56 (70.9)	98 (56.6)	154 (61.1)	$\chi^2 = 4.627$ $p = 0.031^*$
Yes	23 (29.1)	75 (43.4)	98 (38.9)	

* - Significant at 0.05

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DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Discussion

The sample population of this current study consisted of those who were within the 18 – 70 years with mean age was 36.5 ± 8.8 . The age range had many within the age of 30-39 years. This imply that the victims of HIV/AIDS were much among the youths and this could be associated with the fact that youths are more sexually active who most do not consider the consequences of unprotected sex or being promiscuous but preferred to damn the consequence. This result was in line with the study result of Nooshin, Hassan, Elahe and Mohammad (2015). This result also have sex pattern with Nooshin, et.al., (2015) which featured females as majority. Most of the participants in this study who were women, were probably in unequal sexual relationships because of financial reasons. This inequity may have exposed them to an increased risk of acquiring HIV infection and post-infection depression, both likely to accelerate the progression of their disease, as well as their chances of infecting others as it was reported in Hatcher, Tsai, Kumbakumba, et al., (2012)

Many of the respondents who were married in this study implies that acceptance of errors instead of shifting blames among the couples encourages reduction or mitigation of Stigmatisation and discrimination both in the family and in the community where healthcare facilities belong to. This is also reflected in the less numbers of respondents who reported having sexual partners as an evidence of reduction in infidelity. These results conformed with previous studies (Hatcher, Tsai, Kumbakumba, et al., 2012; Zamudio, Keovongchith, Boisson, Crepey, Bagshaw, Phongdeth, et al., 2013; Stringer, Turan, McCormick, Durojaiye, Nyblade, Kempf, Bronwen and Turan, 2016)

Majority of the respondents declared that they had been living with HIV/AIDS more than one year. This implies the vast majority of PLWHAA interviewed had a reasonable chance of coming into contact with the health care system which would allow them to share valuable experience (if any) related to HIV stigma and discrimination. Through their responses it was obvious that they had come into contact with the health care system many times (countless times). Because all the PLWHAA interviewed had come into

contact with the health care system countless times, it was likely that a proportion of them would have experienced HIV related stigma and/or discrimination if at all it ever existed in health care setting providing HIV and/or family planning services. The age of living with HIV would definitely count in recent studies for the fact that prevalence of HIV has been long in existence.

Reasons given by the respondents for HIV testing for the first time in this study included: regular sickness, recommendation due to suspected HIV, regular anti-natal care investigations, just wanted to know my status and preparation for marriage was in consistent with other observations and studies on the main reason for people testing for HIV in health care setting; it is usually because they are feeling unwell or say they are sick. For example an assessment on HIV testing conducted in San Francisco in 2006 revealed majority of those who delayed HIV testing received their first positive HIV test in a medical setting (2007: HPPC Needs Assessment HIV Prevention Council). They received testing due to illness or disease-related symptoms. Another study, a cross country analysis based on the people living with HIV stigma index in Asia by a consortium of organizations namely UNAIDS, Global Network of People Living with HIV/AIDS (GNP+), International Community of Women Living with HIV/AIDS, and the International Planned Parenthood Federation also demonstrated that high percentages of respondents tested because they had symptoms related to HIV (International Planned Parenthood Federation 2010; Asia Pacific Regional Analysis, 2011).

Among reactions found as consequence of first time hearing of being positive to HIV test in the study were: Fear of stigmatisation; Panic that death is near/ at hand; Concern about how to disclose result to friends; Fear that people will start to discriminate against me; Concern of how disclose result to family members; Angry; Lost confidence in myself and Feeling of uselessness. These were in consonant with previous studies by Campbell, Nair, Maimane and Sibiya, (2008); Ahsan, (2011) where it was shown that fear of disclosure of HIV due to stigma is the main obstacle for seeking care, resulting in lack of access to minimum care and support. AIDS-related stigma can have negative impact on medication adherence and use of health services (Rao, Kekwaletswe, Hosek, et al., 2007; Pulerwitz, Michaelis, Lippman, et.al., 2008; Rao, Feldman, Fredericksen, et.al., 2012), and for

health professionals and patients, it is a significant obstacle in the treatment course and services and its postponing (Feyissa, Abebe, Girmaand Woldie, 2012; Bogart, Chetty, Giddy, et.al., 2013; Wayne, Bharat, Ramakrishna, et.al., 2013). In addition, internal stigma, negative self-image, and public perceived attitudes and stigma lead the patients to hide the disease, their depression, and suffering a low quality of life (Charles, Jeyaseelan, Pandian, et.al., 2012).

In a Nigerian study on attitudes of health care workers towards PLWHAA, 91.0% all respondents agreed that staff and health care workers should be informed when a patient is HIV-positive so that they can protect themselves; 57.0% believed that relatives and sexual partners of patients with HIV/AIDS should be informed of the patient's status even without consent; 38% reported giving confidential information to a patient's family member without the patient's consent and 53% had observed the behavior (Reis et al. 2012).

Report in this study that majority of respondents had been sometime and somehow experienced treated in a dislike manner by the health worker corroborated the findings in some previous studies that shown reported experiences of stigma and discrimination from healthcare providers in a variety of contexts. While previous studies demonstrated that most Iranian healthcare providers report fairly positive attitudes towards PLWHA (Aghamolaei, Tavafian, Hasani and Zare, 2009), some other study participants' experiences and perceptions of the attitudes and behaviours of healthcare providers tell a different story. Therefore, it is imperative to engage PLWHA in designing effective interventions targeting healthcare providers.

A 2012 study conducted in Nigeria regarding the attitudes and practices of health care workers towards patients with HIV/AIDS revealed that providers who reported less adequate training in HIV treatment and ethics were more likely to demonstrate negative attitudes and practices across the different health professionals surveyed (Reis et al. 2012).

Respondents' stigmatisation experiences; like being blamed for being responsible for their HIV Status sometime by healthcare worker, gossip about their status by coworkers or other health worker, Irregular or winking of eye at them disrespectfully and called bad/derogatory names although were less than in this study, yet they were somehow significant to reckon with. These findings supported the findings conducted by Vorasane, Jimba, Kikuchi, Yasuoka, Nanishi, Durham, and Sychareun, 2017; Oscar and Daniel, 2017). They also found more overt forms of discrimination, such as blaming patients for their status, physical abuse and the denial of care, and that many of the patients reported being very upset and even emotionally scarred. Patients also reported experiencing substandard care, ranging from an inadequate time spent on their needs, to being left in extreme pain for an extended period of time.

Considering the perpetrators of each reported types of stigmatisation by the respondents in this study, nurses took a lead in each category of stigmatisation experiences and followed by those who reported doctors as the perpetrator in each category. This implies that stigmatisation coming from these two leading medical professionals could be as a result of being immediate care givers to patients on the ward. This result buttressed the reports from the participants in a qualitative study conducted by Rahmati-Najarkolaei, Niknami, Aminshokravi, Bazargan, Ahmadi, Hadjizadeh, and Tavafian, (2010):

Indeed, a patient indicated that to make sure that his dentist took precautionary measures, he usually told his dentist that he has been diagnosed with hepatitis B or C. (A 29-year-old housewife said):

“I begged them (dentists) a couple of times to take care of my bad tooth. However, they did not do anything but instead asked me to leave their clinic. After that experience, I did not tell them, dentists or others, any more about my HIV status”.

Low self-esteem accompanied by a diminished motivation to stay healthy

Several patients claimed that because they had been mistreated by their providers, they had lost their motivation to stay healthy. A 31-year-old male street worker said:

“You know, after my doctor mistreated me, I left his office angry. I told myself that my life is over; I really do not have any reason to take care of myself. This is the last page of my life; my life no longer has any meaning”.

A 22-year-old unemployed male indicated:

“My own doctor has no respect for me. This makes me very upset. I felt as though I do not deserve any care. I am worthless. I do not know ... maybe I should go somewhere else, another country”.

Reported being laughed disrespectfully at by someone among the health workers and mocked by health workers as well as those who expressed that they had been sometimes shunned by health workers could be denied by the health workers like nurses and doctors always being in contact with patients on the wards. These sometimes come from fatigue and stress encountered by these medical practitioners. This was reflected in the percentages of perpetrators recorded such as had the experience from nurses and followed by those who experienced such ridiculed from Laboratory scientists.

Many of the reported experiences of derogatory treatment from some health workers as being persons with HIV/AIDS as if they were worthless or they no longer count in this study such as separated seat of PLWHAs from other clients or patients because of their HIV status; Avoided contact with; Made to pay additional money for health care services as a result of HIV status; Used unnecessary personal protection wear (e.g. additional gloves, goggles, face mask etc.); Informed other health workers that they have HIV without their permission; Placed sign near their beds while on admission to indicate that they are HIV+; Served medication by dropping the medication into their mouths or palms without allowing their body to touch them; Treated or dealt with them without respect because of their HIV status and made PLWHA the last person to be attended to because their HIV status were in conformity with the study conducted among patients in an Indian hospitals, where stigma and discrimination manifested like health workers informing family members of a patient's HIV status without his or her consent, burning their bedding upon discharge, charging them for the cost of infection control supplies, and

using gloves during all interactions, regardless of whether physical contact occurred (Heijnders, 2012).

Even though research has shown that the majority of healthcare workers understand how HIV is transmitted, they still revealed fears of the disease and those who were more fearful were more likely to hold stigmatizing views (Pisal et al., 2007; Vance & Denham, 2008; Chan, Rungpueng, and Reidpath, 2009; Hossain & Kippax, 2011). Previous research has also found that negative attitudes towards people with HIV among healthcare workers was associated with age, whether they ranked religion as important in their lives, and if they were not doctors (Hossain & Kippax, 2011).

Furthermore, it has been shown that doctors, when compared to other staff members, are less likely to discriminate based on HIV status (Mahendra, et al., 2007). Another study found that nurses tended to provide differential care based on HIV status, while doctors were more likely to violate privacy by disclosing status and testing without consent (Andrewin & Chien, 2008). The differences between the level of stigma and discrimination displayed by doctors and nurses or other staff members could be explained by research suggesting that people with higher levels of education demonstrate lower levels of stigma (Pisal, et.al., 2007; Barkey, 2010). However, stigma and discrimination should not be solely affiliated with level of education. Aside from attitudes, research has reported on specific stigmatizing or discriminatory behaviours among healthcare workers. Research illustrates some of the ways in which stigmatizing attitudes of healthcare workers are transformed into discriminatory practices and behaviours. Vorasane, Jimba, Kikuchi, Yasuoka, Nanishi, Durham, and Sychareun, (2017); Oscar and Daniel, (2017), found that lack of eye contact; clipped or brusque speech and differential precautions were all attributed to HIV-related stigma, when describing the experiences of HIV-positive patients in the US.

In a qualitative study conducted by Rahmati-Najarkolaei, Niknami, Aminshokravi, Bazargan, Ahmadi, Hadjizadeh, and Tavafian, (2010), majority of discussants stated that healthcare providers sometimes refused to provide needed services, and perceived that

healthcare providers did so because of their fear of becoming infected with HIV. A 29-year-old female patient, a hairdresser, reported:

Yes, it happened to me when my ovarian cyst ruptured and I needed an immediate operation. The surgeons did not operate on me. They never wanted to. They just came and went. I was examined by several surgeons.

A 25-year-old patient, a housewife, reported that she was denied post-delivery care when the emergency room (ER) doctor became aware of her HIV status. She indicated:

I had excessive bleeding for a few days after I had delivered my baby. I had to go to the ER. I told them that I am HIV positive. The ER doctor told me, "You have excessive bleeding. I cannot examine you. I could be easily infected with the HIV. Look, you have HIV.. ... Sorry, go somewhere else."

A 27-year-old used car dealer spoke of a similar circumstance in which a nurse had refused to provide services:

I knew a nurse [at the infection ward] who was scared of us. No nurse really wants to take care of PLWHA admitted to this ward. Some of the nurses in particular refused to take blood or give injections to the patients.

Different psychosocial problems faced by the respondents as a result of different stigmatisations experienced from the perpetrators reported in this study like having sleeplessness felt sad, being worried, perplexed/confused and feeling as one who was dreaming (Delusion) were similar to those reported in other studies. The progression of the disease and the ability to infect others may have generated anxiety, depression, external stigmatisation and self-stigmatisation for the study participants (Nambiar and Rimal, 2012; Herrmann, McKinnon, Hyland, et.al., 2013). The experience of reduction in social interaction could have been attributed to ever or recently psychosocial problems experienced by the respondents.

The challenges reported by the respondents relating to their treatment uptake in this study were supported by the previous studies conducted on stigmatisation and discrimination

experiences by PLWHA. In addition, research has demonstrated that the experience or fear of stigma may often result in postponing or rejecting care, seeking care far from home to protect confidentiality, and non-adherence to medication. For example, studies in Senegal and Indonesia documented that men who have sex with men and injecting drug users, respectively, often avoid or delay accessing HIV-related services, including treatment for other sexually transmitted diseases, for fear of public exposure and discrimination by health workers (Niang, 2013). Likewise, researchers in Botswana and Nigeria found that stigma leads many people to seek testing and treatment services late in the progression of their disease, often beyond the stage of optimal drug intervention (Wolfe, 2016). To conceal use of antiretroviral medications, HIV-positive individuals in South Africa reported grinding drugs into powder and not taking medication in front of others, which can result in inconsistent dosing (Niang, 2013).

As mentioned, health care providers themselves may be reluctant to go for the same test, care and treatment they provide to their patients due to fear of stigma in the workplace and in the communities they serve (Gupta, 2013). A study in South Africa and Botswana found that health workers struggle with self-stigma regarding a potential HIV diagnosis, as well as fear of stigmatizing attitudes and behaviours from their colleagues, which contribute to a lack of uptake of HIV testing and early treatment, if needed (Wolfe, 2016). Similarly among health care workers, research suggests that fear of casual contact and moral judgments contributes to stigma and discrimination directed at clients living with HIV. Studies in Nigeria (Nyblade, 2013) have found high levels of fear of contagion among health workers, which is related to a lack of understanding of how HIV is and is not transmitted, and how to protect oneself in the workplace through universal precautions.

5.2 Summary

Fear of contamination and social stigmatized attitude are the main impediments to dealing with patients and providing services to them. Hence, it seems that creating an effective knowledge about transmission and correcting the socio-cultural beliefs of health providers are two key strategies to tackle this problem.

Given the prevalence of fear as the most common behaviour of the personnel in dealing with the patients, increased knowledge can be an effective step in reducing stigmatized attitude toward patients. This not only reduces inappropriate fear of dealing with patients, but also decreases HIV-associated stigmatized attitude. Modified attitude toward AIDS patients can lead to improved health services to them. Given the dominant role of religion in countries like Iran, stigmatized attitude toward AIDS is associated with unethical behaviors. Thus, the role of the clergymen in eliminating AIDS taboo may be very impressive. Taboo of the disease and the unequal social behaviour with the patients not only do not solve the problem, but may result in patients' isolation and their deprivation from their minimum rights of treatment.

5.3 Conclusion

The results in this current study imply that PLWHA in Nigeria continue to experience HIV-related stigma and this has an impact on their quality of life. Verbal abuse and negative self-perception are the major forms of stigma in this region, whereas fewer PLWHA experienced health care neglect and social isolation. This study identified verbal stigma and derogative words from health workers as the main forms of stigmatisation that persist among PLWHA in this study centres. These high levels of stigma and discrimination resulted in delayed access to care, maladaptive coping, and delayed disclosure of their relapse to health workers, family, and sexual partners. This finding is useful for developing future interventions aimed at empowering PLWHA and hence improving their quality of life. It is also propose interventions such as re-training of health workers in our health care facilities to gear them up in their humanitarian services to generality and be concerned to reduction of negative self-perception of PLWHA and the community.

5.4 Recommendations

1. PLWHA support groups in this South-west, Nigeria have been found to provide a supportive environment in which HIV-infected people feel connected to a larger community because they receive emotional support as they learn to cope with their diagnosis. This should be more encouraged and well-funded by the Government directly or through NGO in HIV intervention programme.

2. Long-term counseling and psychosocial support programs for PLWHA in northern Uganda assist PLWHA gain self-acceptance and skills necessary to successfully cope with HIV. This type of programs should be established in Nigeria.
3. It is important for health managers to note that the mode of delivery of antiretroviral therapy may contribute to the stigmatisation of PLWHA. This problem may be resolved or mitigated through confidentiality policy and practice in the delivery of HAART programs and in all AIDS clinics in the countries.
4. Future monitoring of stigma and discrimination still mentioned by respondents in this study would enable an evaluation of the impact of HAART and other interventions on stigma in this PLWHA population.
5. At the individual level, increasing awareness among health workers of what stigma is and the benefits of reducing it is critical. Raising awareness about stigma and allowing for critical reflection on the negative consequences of stigma for patients, such as reduced quality of care and patients' unwillingness to disclose their HIV status and adhere to treatment regimens, are important first steps in any stigma-reduction programme.
6. Health workers' fears and misconceptions about HIV transmission must also be addressed.
7. Health facilities need to enact policies that protect the safety and health of patients, as well as health workers, to prevent discrimination against people living with HIV.

REFERENCES

- Adeyemo, D. A. and Oyinloye, A. A. 2007. Predispositional Factors in Stigmatisation and Discrimination Against HIV/AIDS Seropositive Persons in the Workplace: A Case Study of Osun State, Nigeria. *J. Soc. Sci.*, 15(3): 279-292
- Aghamolaei T, Tavafian SS, Hasani L, Zare S. 2009. Attitudes of healthcare providers towards patients with HIV/AIDS in Bandar Abbas. *Archives of Iranian Medicine.* ;13:298–301.
- Ahsan U., 2011. The Discriminatory Attitudes of Health Workers against People Living with HIV. *PLOS Medicine*, 2 (8): p. 715- 716.
- Ahsan U.A.K., 2011. HIV/AIDS-Related Stigma and Discrimination: A Study of Health Care Providers in Bangladesh. *The International Association of Physicians in AIDS Care.* ;10:97–104.
- Andrewin, A., & Chien, L. Y. 2008. Stigmatisation of patients with HIV/AIDS among doctors and nurses in Belize. *AIDS Patient Care and STDs*, 22(11), 897-906. Retrieved June 18, 2019, from <http://www.jstor.org/page/info/about/policies/terms.jsp>
- ASHM in partnership with National, Centre in HIV Social Research (NCHSR), 2012. Stigma and Discrimination around HIV and HCV in Healthcare Settings: *Research Report*; www.ashm.org.au/publications.
- AVERT, 2015. Women and HIV/AIDS. Available from: <http://www.avert.org/women-and-hiv-aids.htm>. Accessed June 1, 2015.
- Awusabo A. 2015. People Living with HIV Stigma Index Cambodia. geneva: UNAIDS;. Available from: <http://www.stigmaindex.org/sites/default/files/reports/>.
- Barkey, G. A. 2010. Once It's your sister, they think it's in the Bloodline: Impact of HIV/AIDS- Related Stigma in Ghana. Doctor of Philosophy Dissertation. Manhattan, Kansas.
- Bogart LM, Chetty S, Giddy J, et al. 2013. Barriers to care among people living with HIV in South Africa: Contrasts between patient and healthcare provider perspectives. *AIDS Care*; 25:843–53.
- Bos, Arjan E. R 2001. HIV STIGMA AND SOCIAL INTERACTION: Examining Strategies to influence Perceivers' Emotional and Behavioural reactions in initial encounters. Netherlands: *Maastricht Research Institute for Prevention and Care*.
- Brown, L., Trujillo L. and Macintyre K. 2001. Interventions to Reduce HIV/AIDS Stigma: What have we learned? Washington, D.C: Horizons Program, Tulane University.

- Campbell C, Nair Y, Maimane S, Sibiyi Z. 2008. Supporting people with AIDS and Their cares in rural south Africa: possibilities and challenges. *Health and place*;14:507–18.
- Campbell-Yesufu, O.T. and Rajesh T. G., 2011. 'Update on human immunodeficiency virus HIV-2 infection.' *Clinical infectious diseases* 52.6: 780-787.
- Centers for Disease Control and Prevention. 2013. HIV/AIDS: HIV Basics. Retrieved May 29, 2013, from <http://www.cdc.gov/hiv/resources/qa/definitions.htm>
- Central Statistical Agency. Ethiopia Demographic and Health Survey; 2011. Available from: <http://www.stigmaindex.org/sites/default/files/reports/EthiopianPLWHA%20Stigma%20Index%20Country%20Report%202011.pdf>. Accessed May 20, 2015.
- Chan, K. Y., Rungpueng, A., & Reidpath, D. D. 2009. AIDS and the stigma of sexual promiscuity: Thai nurses' risk perceptions of occupational exposure to HIV. *Culture, Health and Sexuality*, 114, 353-368.
- Charles B, Jeyaseelan L, Pandian AK, et al. 2012. Association between stigma, depression and quality of life of people living with HIV/AIDS PLWHAA in South India—a community based cross sectional study. *BMC Public Health*.;12:463.
- Chen W-T, Starks H, 2014 HIV/AIDS Stigma, Denial, Fear and Discrimination: Experiences and Responses of People from African and Caribbean Communities in Toronto. Toronto, Ontario: The African and Caribbean Council on HIV/AIDS in Ontario (ACCHO), and The HIV Social, *Behavioural and Epidemiological Studies Unit*.
- Cloete, A., Strebel, A., Simbayi, L., van Wyk, B., Henda, N. and Nqeketo., A., 2010. Challenges Faced by People Living with HIV/AIDS in Cape Town, South Africa: Issues for Group Risk Reduction Interventions. *AIDS Research and Treatment*; Volume 2010, Article ID 420270, 8 pages; <http://dx.doi.org/10.1155/2010/420270>
- Crosby, E.M., 2012. Exploring Stigma, Identity Gaps, and Consumption. A Dissertation Submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Business Administration in the Graduate College of the University of Illinois at Urbana-Champaign; 21-215
- Cummings, E., Gobin, R., Narine, V., Ramlall, A., Pasram, R., Glasgow, S., Reddy, D., Conway, M. and Sue-Chee, S. 2005. Attitudes and Perceptions among Medical Practitioners, Nurses, Other Health Workers and the General Population towards Persons Affected with HIV/AIDS in Georgetown, Guyana.
- Doitsh, G; Greene, WC 2016, Discrimination and Prejudice against HIV/AIDS Patients by the Health Care Workers in Guyana. Guyana.

- Earnshaw VA, Chaudoir SR. 2016. Factors associated with perceived stigma among people living with HIV/AIDS in postconflict northern Uganda. *AIDS Educ Prev.* 2011;23(3):193–205.
- Ebrahim Masoudnia 2015 Public perceptions about HIV/AIDS and discriminatory attitudes toward people living with acquired immunodeficiency syndrome in Iran, SAHARA-J: *Journal of Social Aspects of HIV/AIDS*, 12:1, 116-122, DOI:10.1080/17290376.2015.1123644.
- Ebrahimi Kalan M, Han J, Ben Taleb Z, Fennie KP, Asghari Jafarabadi M, Dastoorpoor M, Hajhashemi N, Naseh M and Rimaz S, 2019. Quality Of Life and stigma among People Living with HIV/AIDS in Iran. *Journals HIV/AIDS Research and Palliative Care* 11(2)287—298. DOI <https://doi.org/10.2147/HIV.S221512>
- Esbjörnsson, Joakim, et al. 2018. ‘Long-term follow-up of HIV-2-related AIDS and mortality in Guinea-Bissau: a prospective open cohort study.’ *The Lancet HIV*.
- Falk, G. 2001. *STIGMA: How We Treat Outsiders*. NY: Promeyheus Books.
- Feyissa GT, Abebe L, Girma E, Woldie M. 2012. Validation of an HIV-related stigma scale among health care providers in a resource-poor Ethiopian setting. *Journal of Multidisciplinary Healthcare.*;5:97–113.
- Global Network of People Living with HIV/AIDS. HIV-related stigma. 2011. Late testing; Late treatment
- Global tuberculosis report 2015. Geneva: World Health Organisation; 2015 (http://www.who.int/tb/publications/global_report/en/, accessed 21 June 2019).
- Goffman E 2009. Stigmatisation and shame: consequences of caring for HIV/AIDS patients in China. *AIDS Care.* 2007;19(2):258–263.
- Goffman, E. 1963. *Stigma: Notes on Management of spoiled identity*. Englewood Cliffs, NJ: Prentice-Hall.
- Green, J. and Browne, J. 2005. *Principles of Social Research*. London:
- Gupta G, 2013. *HIV/AIDS Stigma, Denial, Fear and Discrimination: Experiences and responses of people from African and Caribbean Communities in Toronto*. Canada: University of Toronto.
- Hatcher A, Tsai A, Kumbakumba E, et al. 2012. Sexual relationship power and depression among HIV-infected women in rural Uganda. *PloS one.*;7(12):e49821.

Health and Development Networks and the AIDS –Care Watch Campaign 2006. Unveiling the truth, Shedding light on HIV stigma and Discrimination, A report from the XVI International AIDS Conference: Toronto, Canada.

Heijnders M, 2016. Symbolic prejudice or fear of infection? A functional analysis of AIDS-related stigma among heterosexual adults. *Basic and Applied Social Psychology*, 20: 230-241.

Herrmann S, McKinnon E, Hyland N, et al., 2013. HIV-related stigma and physical symptoms have a persistent influence on health-related quality of life in Australians with HIV infection. *Health Qual Life Outcomes*;11:56

Hossain, M. B., & Kippax, S. 2011. Stigmatized attitudes toward people living with HIV in Bangladesh: Health care workers' perspectives. *Asia-Pacific Journal of Public Health*, 23(2), 171-182.

International Center for Research on Women 2006. HIV/AIDS Stigma: Finding solutions to Strengthen HIV/AIDS Programs. Washington DC: Author.

International Planned Parenthood Federation 2010. Reports of work undertaken to further that process include Global Network of People Living with HIV 2010 and International Planned Parenthood Federation. Interview with Person Living with HIV on August 21, 2008

Jaurique, A., Humboldt Ryan, D.A., Smith, H.J. and Paolucci-Callahan, M., 2019. Social Issues and Policy Review, Vol. 13, No. 1, 2019, pp. 125--153DOI: 10.1111/sipr.12050 Observing Discrimination: Implications for Group-Based Respect and Organizational Morality.

Joint United Nations Programme on HIV/AIDS 1999. Gender and HIV/AIDS: Taking stock of research and programmes. Switzerland: Author.

Joint United Nations Programme on HIV/AIDS 2001. Uganda: HIV and AIDS-related Discrimination, Stigmatisation and Denial. Geneva: Author.

Joint United Nations Programme on HIV/AIDS 2005a. A scaled-up response to AIDS in Asia and the Pacific. Geneva, Author.

Joint United Nations Programme on HIV/AIDS 2005b. A Report of a Theological Workshop focusing on HIV-and AIDS-related Stigma. Geneva: Author.

Joint United Nations Programme on HIV/AIDS 2007. Reducing HIV Stigma and Discrimination: a critical part of national AIDS programmes. Geneva: Author.

Joint United Nations Programme on HIV/AIDS 2007. UNAIDS'

- Joint United Nations Programme on HIV/AIDS 2008. Report on the global AIDS epidemic 2008. Geneva. Author.
- Kiene, S.M., Dove, M., Wanyenze, R.K., 2018. Depressive Symptoms, Disclosure, HIV-Related Stigma, and Coping following HIV Testing among Outpatients in Uganda: A Daily Process Analysis AIDS Behav. Author manuscript; available in PMC 2019 May 1. Published in final edited form as: *AIDS Behav.* May; 22(5): 1639–1651. doi: 10.1007/s10461-017-1953-9
- Lekganyane, R., and Plessis, G. d. 2011. Dealing with HIV-Related Stigma: A Qualitative Study of Women Outpatients from the Chris Hani Baragwanath Hospital. *Journal of the association of nurses in AIDS care*, 1-8. doi:10.1016/j.jana.2011.05.003
- Li, L., Zunyou, W., Sheng, W., Yu, Z., Manhong, J., and Zhihua, Y. 2007. HIV-Related Stigma in Health Care Settings: A Survey of Service Providers in China. *AIDS patient care and STDs*, Vol. 21(10): p.753-762.
- Lisanne B and Kate M 2011. Experiences of stigma in healthcare settings among adults living with HIV in the Islamic Republic of Iran. *J Int AIDS Soc.* 2010;13:27.
- Lucia N. Makoae, Minrie Greeff, René D. Phetlhu, Leana R. Uys, Joanne R. Naidoo, Thecla W. Kohi, Priscilla S. Dlamini, Maureen L. Chirwa and William L. Holzemer, 2018. The People Living with HIV Stigma Index. Addis Ababa: nEP+;
- Macdonald, and Daniel, 2013, Poverty or Prosperity: Indigenous Children in Canada Ottawa, Canadian Centre for Policy Alternatives. Retrieved April 16, 2014 from http://www.policyalternatives.ca/sites/default/files/uploads/publications/National%20Office/2013/06/Poverty_or_Prosperty_Indigenous_Children.pdf
- Madiba S, Letsoalo R. 2013, HIV disclosure to partners and family among women enrolled in prevention of mother to child transmission of HIV program: Implications for infant feeding in poor resourced communities in South Africa. *Glob J Health Sci.* 2013. July;5(4): 1 10.5539/gjhs.v5n4p1
- Mahendra VS, 2016. Knowledge and attitudes toward AIDS among female college students in Nagasaki, Japan. *Health Education Research: Theory and Practice.* *Health Education Research, Theory and Practice*, 15(1), 5-11.
- Mahendra, V.S., Gilborn L., Bharat S., Mudoi R., Gupta I., George B., Samson, L., Daly C., Pulerwitz, J. 2007. Understanding and measuring AIDS-related stigma in health care settings: A developing country perspective. *Journal of Social Aspects of HIV/AIDS.* 4 (2): p. 616-625
- Makoae LN1, Greeff M, Phetlhu RD, Uys LR, Naidoo JR, Kohi TW, Dlamini PS, Chirwa ML, Holzemer WL., 2007. Coping with HIV-related stigma in five African

- countries. *J Assoc Nurses AIDS Care*. 2008 Mar-Apr;19(2):137-46. doi: 10.1016/j.jana.11.004.
- Mark L.H., 2016. Structural Stigma and Health Inequalities: Research Evidence and Implications for Psychological Science. *Am Psychol*. Nov; 71(8): 742–751.
- Mc Lean, R., 2004. Baseline Assessment of Minibus Operators and Riders' Attitude Towards People Living with and Affected by HIV/AIDS in Guyana: Follow Up Phase. Arlington VA: Family Health International.
- Ministry of Health 2006. Behavioural Surveillance Survey. Guyana: Author. Ministry of Health 2006. National HIV/AIDS Strategy 2007-2011. Guyana: Author.
- Monjok, E, Smesny, A. and Essien, E.J., 2009. HIV/AIDS - Related Stigma and Discrimination in Nigeria: Review of Research Studies and future directions for Prevention Strategies. *Afr J Reprod Health*. Author manuscript; available in PMC 2010 Aug 11. Published in final edited form as: *Afr J Reprod Health*. Sep; 13(3): 21–35.
- NACA 2015 'Nigeria GARPR 2015' [pdf]
- NACA 2017 'National Strategic Framework on HIV and AIDS: 2017 -2021' [pdf]
- Nair, M., Kumar, P., Pandey, S., Harshana, A., Kazmi, S., Moreto-Planas, L., Burza, S., 2019. Refused and referred-persistent stigma and discrimination against people living with HIV/AIDS in Bihar: a qualitative study from India. *BMJ Open*. 2019; 9(11): e033790. Published online 2019 Nov 25. doi: 10.1136/bmjopen-2019-033790
- Nambiar D, Rimal R., 2012. Duty and destiny: psychometric properties and correlates of HIV-related stigma among youth NGO workers in Delhi, India. *AIDS Care*; 24(11):1384–91.
- National AIDS Committee. 2006. Revised National Policy Document on HIV/AIDS in Guyana. Guyana. Author.
- National AIDS Committee. 2008. Survey of Stigma and Discrimination Experiences of HIV+ Guyanese. Guyana. Author.
- National Research Council. 2004. Measuring Racial Discrimination. Panel on Methods for Assessing Discrimination. Rebecca M. Blank, Marilyn Dabady, and Constance F. Citro, Editors. Committee on National Statistics, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press.

- Neuman M., Obermeyer C.M., Group M.S., 2013. MATCH Study Group Experiences of stigma, discrimination, care and support among people living with HIV: A four country study. *AIDS Behav.* ;17(5):1796–1808. doi: 10.1007/s10461-013-0432-1.
- Neuman, W. L., 2003. *Social Research Methods: Qualitative and Quantitative Approaches*, 5th Edition. USA: Pearson Education, Inc.
- Ngozi C. Mbonu, Bart Van Den Borne and Nanne K. De Vries, 2011. Societal Beliefs and reactions about People Living with HIV/AIDS. Submitted: November 30th 2010 Reviewed: July 6th 2011 Published: October 26th 2011. DOI: 10.5772/23911
- Niang C.I., 2013. Development of a brief scale to measure AIDS-Related Stigma in South Africa. *AIDS and Behaviour*. 9(2): p.135-143.
- Nooshin Z, Hassan J, Elahe D, Mohammad F, 2015. Stigmatized Attitude of Healthcare Providers: A Barrier for Delivering Health Services to HIV Positive Patients. *Int J Community Based Nurs Midwifery*; 3(4): 292–300.
- Nyblade L, 2013. Stigma of People with HIV/AIDS in Sub-Saharan Africa: A Literature Review. *Journal of Tropical Medicine*, 2009, 14 pages. doi:10.1155/2009/145891
- Nyblade L, Srinivasan K, Mazur A, Raj T, Patil DS, Devadass D, Radhakrishna K and Ekstrand ML 2018 HIV Stigma Reduction for Health Facility Staff: Development of a Blended- Learning Intervention. *Front. Public Health* 6:165. doi: 10.3389/fpubh.2018.00165
- Nyblade, L., Stockton, M.A., Giger, K. et al., 2019. Stigma in health facilities: why it matters and how we can change it. *BMC Med* 17:25 doi:10.1186/s12916-019-1256-2
- Oanh KTH, Ashburn K, Pulerwitz J, Ogden J, and Nyblade 2008. Levels and Spread of HIV Seroprevalence and Associated Factors: Evidence from National Household Surveys. Calverton, Maryland: *Macro International Inc*.
- Odimegwu, C.O., Akinyemi, J.O. and Alabi, O.O., 2017. HIV-Stigma in Nigeria: Review of Research Studies, Policies, and Programmes. *Review Article*. Volume 2017, Article ID 5812650, 13 pages. <https://doi.org/10.1155/2017/5812650>
- Office of National AIDS Policy. 2010. national HIV/AIDS strategy for the United States. Available from: <http://www.whitehouse.gov/sites/default/files/uploads/nHAS.pdf>.
- Office of the United Nations High Commissioner for Human Rights 2006. *International Guidelines on HIV/AIDS and Human Rights*. Geneva: Author.
- Okoror TA, Falade CO, Olorunlana A, Walker EM, Okareh OT. 2013 Exploring the cultural context of HIV stigma on antiretroviral therapy adherence among people

living with HIV/AIDS in southwest nigeria. *AIDS Patient Care STDS*. 2013;27(1):55–64.

- Omosivie M., 2019. Investigating client satisfaction with antiretroviral treatment services in South-South Nigeria. *SAHARA-J: Journal of Social Aspects of HIV/AIDS; An Open Access Journal*; Volume 16, - Issue 1, 243-9
- Online Medical Dictionary 2000. Student Nurse. Retrieved September 13, 2008 from Google Website <http://cancerweb.ncl.ac.uk/cgl/bin/omd> Open University Press.
- Oscar, L and Daniel,T., 2017. The Persistence of Stigma Linked with HIV/AIDS in Health-Care Contexts: A Chronic Social Incapacity, HIV/AIDS - Contemporary Challenges, Nancy Dumais, IntechOpen, DOI: 10.5772/66654. Available from: <https://www.intechopen.com/books/hiv-aids-contemporary-challenges/the-persistence-of-stigma-linked-with-hiv-aids-in-health-care-contexts-a-chronic-social-incapacity>
- Pan American Health Organisation (n.d). 2008. World AIDS Day; Fighting HIV Discrimination in the Health Sector. Retrieved February 12, 2008 from Google Website http://www.paho.org/English/DD/PIN/hiv_factsheet.htm. para 21-23.
- Pantaleo G 2015. Attitudes and responsibilities of nurses towards the HIV sero-positive client: a literature review. Retrieved February 12, 2008, from Google Website: <http://www.ciap.health.nsw.gov.au/hospital/stvinc> ent,1991/a06.html.
- Patel BH, Srivastava RK, Sharma R, Moitra M. 2016. A Qualitative Study on Experience of Stigma and Discrimination in Health Care Sector among PLHA Attending VCTC of New Civil Hospital and GSNP+ of Surat. *Ntl J Community Med*; 7(2):82-87.
- PEPFAR 2019. 'Large National Survey Shows Smaller HIV Epidemic in Nigeria Than Once Thought and Highlights Key Gaps Toward Reaching HIV Epidemic Control' [Accessed April 2019].
- Phung Q.T.T., Bach, X.T., Cuong, T.N., Nu, T.T., Thao, P.T.T., Carl, A.L, Cyrus, S.H. and Roger, C.M., 2019. Stigma against patients with HIV/AIDS in the rapid expansion of antiretroviral treatment in large drug injection-driven HIV epidemics of Vietnam. *Harm Reduct J.*; 16: 6. Published online 2019 Jan 17. doi: 10.1186/s12954-019-0277-7.
- Piatak, M. and Jr, Saag 2012. The AIDS Crisis: A United States health care perspective. *Soc Sci Med*, 26: p. 979-988.
- Pisal, H., Sutar, S., Sastry, J., Kapadia-Kundu, N., Joshi, A., Joshi, M., Leslie, J., Scotti, L., Bharucha, K., Suryavanshi, N., Phadke, M., Bollinger, R., & Shanker, A.V.

2007. Nurses' Health Education Program in India Increases HIV Knowledge and Reduces Fear. *Journal of the Association of Nurses in AIDS Care*, 18(6), 32-43.
- Polly H. X. Ma, Zenobia C. Y. Chan, Loke, A.Y., 2019 Self-Stigma Reduction Interventions for People Living with HIV/AIDS and Their Families: A Systematic Review. *AIDS and Behavior* 23:3, pages 707-741.
- Pulerwitz J, Michaelis AP, Lippman SA, et al. 2008. HIV-related stigma, service utilization, and status disclosure among truck drivers crossing the Southern borders in Brazil. *AIDS Care*.;20:764–70.
- Rahmati-Najarkolaei, F, Niknami, S., Aminshokravi, F., Bazargan, M., Ahmadi, F., Hadjizadeh, E. and Tavafian, S., 2010. Experiences of stigma in healthcare settings among adults living with HIV in the Islamic Republic of Iran. *J Int AIDS Soc.*; 13: 27.
- Rao D, Feldman BJ, Fredericksen RJ, et al. 2012. A structural equation model of HIV-related stigma, depressive symptoms, and medication adherence. *AIDS Behav.*;16:711–6.
- Rao D, Kekwaletswe TC, Hosek S, et al. 2007. Stigma and social barriers to medication adherence with urban youth living with HIV. *AIDS Care*.;19:28–33.
- Reis, C., et al., 2012. Discriminatory Attitudes and Practices by Health Care Workers for People Living with HIV/AIDS in Nigeria.
- Samson L, 2015. HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action. *Social Science and Medicine* (57), 13–24.
- Schacker T 2016. Understanding HIV-Related Stigma and Discrimination in a “Blameless” Population. *AIDS Education and Prevention*, 18(6): p.518-528.
- Schwebela, F.J. and Larimerab, 2018. M.E., Using text message reminders in health care services: A narrative literature review. *Internet Interventions*; Volume 13, September 2018, Pages 82-104
- Statistics Canada. 2013. “Immigration and Ethnocultural Diversity in Canada: National Household Survey, 2011” *Statistics Canada Catalogue* no. 99-010-X2011001. Retrieved April 15, 2014, from <http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-010-x/99-010-x2011001-eng.pdf>.
- Stringer, K.L., Turan, B., McCormick, L., Durojaiye, M., Nyblade, L., Kempf, M.C., Bronwen L. and Turan, J.M., 2016. HIV-Related Stigma among Healthcare Providers in the Deep South. *AIDS Behav. Jan; 20(1): 115–125.*

- Tzemis D, Forrest JI, Puskas CM, et al. 2013. Identifying self-perceived HIV-related stigma in a population accessing antiretroviral therapy. *AIDS Care*. 2013;25(1):95–102.
- UNAIDS 2013. GARPR and UNAIDS modeling Spectrum HIV and AIDS 2012 estimates.
- UNAIDS 2017 Data Book [pdf].
- UNAIDS 2017. The global AIDS program gAP report. Beginning of the end of AIDS epidemic. 2014. Available from: http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2014/UnAIDS_gap_report_en.pdf. Accessed May 20, 2015.
- UNAIDS 'AIDSinfo' [Accessed October 2018].
- UNAIDS 'AIDSinfo' accessed August 2019.
- UNAIDS, 2013. global summary of the AIDS epidemic. AIDS epidemic update. 2013.
- UNAIDS/WHO Technical Guidance Note. 2011. Global Fund HIV Proposals 2011: Reduction of HIV-related stigma . Geneva, Switzerland: UNAIDS/WHO.
- UnAIDS, 2010. Family Planning Association Sri Lanka and Partners. People living with HIV stigma index in Sri Lanka. Available from: http://www.unaids.org/sites/default/files/media_asset/jc1521_Stigmatisation_en_1.pdf; <http://www.stigmaindex.org/sites/default/files/reports/>.
- United Nations - World Population Prospects, 2021. Ibadan, Nigeria Metro Area Population 1950-2021. [Ibadan, Nigeria Metro Area Population 1950-2021](https://www.macrotrends.net/cities/21990/ibadan/population). [www.macrotrends.net](https://www.macrotrends.net/cities/21990/ibadan/population). Retrieved 2021-02-13.
- United States Agency for International Development USAID. 2011. USAID/PEPFAR HIV Stigma and Discrimination Activity. Washington, DC: USAID.
- Van Deventer C, Wright A., 2017. The psychosocial impact of caregiving on the family caregivers of chronically ill AIDS and/or HIV patients in home-based care: A qualitative study in Zimbabwe. *S Afr J HIV Med.*;181, a718. <https://doi.org/10.4102/sajhivmed.v18i1.718>
- Vance, R., & Denham, S. 2008. HIV/AIDS related stigma: Delivering appropriate nursing care. *Teaching and Learning in Nursing*, 3(2), 59-66.
- Visser MJ, Kershaw T, Makin JD, Forsyth BW. 2008. Development of parallel scales to measure HIV-related stigma. *AIDS Behav*. 125: 759–771.

- Vorasane, S., Jimba, M., Kikuchi, K., Yasuoka, J., Nanishi, K., Durham, J. and Sychareun, V., 2017. An investigation of stigmatizing attitudes towards people living with HIV/AIDS by doctors and nurses in Vientiane, Lao PDR *BMC Health Serv Res.*; 17: 125. Published online 2017 Feb 10. doi: 10.1186/s12913-017-2068-8
- Wayne T, Bharat SS, Ramakrishna J, et al. 2013. Stigma Is Associated with Delays in Seeking Care among HIV-Infected People in India. *Journal of the International Association of Providers of AIDS Care.*;12:103–9.
- White, R. C. and Carr R. 2005. Homosexuality and HIV/AIDS Stigma in Jamaica. *Culture, Health and Sexuality*, Vol. 7 (4): p 347-359.
- WHO 2017 Stigma interventions and research for international health. Background paper, Stigma and Global Health: Developing a Research Agenda: An International Conference.
- Wolfe W, 2016. Knowledge, attitudes and practices on the acquired immune deficiency syndrome (AIDS) among health workers in (Nyeri) a district in Kenya. *Kenya Nurs J.* 18 (1): 28-30.
- World Health Organisation. 2012. World Health Organisation. Retrieved from World Health Organisation website: <http://www.who.int/hiv/about/hiv/en/>
- Zamudio AR, Keovongchith B, Boisson D, Crepey P, Bagshaw K, Phongdeth K, et al. 2013. Results of the people living with HIV stigma index in Lao PDR: documenting the HIV stigma and discrimination situation in the country and disentangling the layers of stigma in marginalized populations. Boston, MA: *American Public Health Association 141st Annual Meeting*;

**APPENDIX I
QUESTIONNAIRE**

**PERCEIVED STIGMATISATION RELATED EXPERIENCES PERPETRATED
BY HEALTH WORKERS AMONG PERSONS LIVING WITH HIV/ AIDS IN
IBADAN**

Dear Sir/Madam,

This questionnaire is designed to gather information relating to the experiences which HIV positive persons have ever had in hands of Health Workers in Ibadan. The findings of this study will be helpful for designing clinic-based interventions for persons living with HIV from being stigmatized and/or discriminated against by the HIV and counseling units of the hospitals, non-governmental organisations working on HIV/AIDS programmes within the municipality. Your candid responses to the questions in the questionnaire will be highly appreciated. All information given by you will be treated with outmost privacy and confidentiality and your participation is voluntary.

Please sign below if you desire to respond. If you do not want sign, please thumb print in the box provided at the right hand side. Thank you.

Signature.....

Place of Interview.....

Serial No......

SECTION A: Socio demographic Characteristics of Respondents. (✓)Tick appropriately or complete the blank spaces provided in respect of each of the following questions.

1. Age (in years as at last Birthday):
2. Sex : (1) Male (2) Female
3. Religion: (1) Christianity (2) Islam (3) African Traditional Religion
(4) Any others (Specify).....
4. (a) Highest level of education: (1) No formal education (2) Primary
(3) Secondary (4) Tertiary
- 4(b) If Tertiary, please Specify: (1) NCE (2) OND (3) HND
(4) BSc (5) MSc (6) PhD (7) any other (specify)

5. Marital status: (1) Single (2) Married (3) Cohabiting (4) Divorced
(5) Widowed (6) Separated
6. Do you have a sexual partner (i.e. Boyfriend / Girlfriend/ Concubine if presently divorced, widowed, separated or single) (1) Yes (2) No
7. What is your profession or occupation: (1) Civil Servant
(2) Private Fulltime employee (3) Laborer (4) Trader (5) Students
(6) Unemployed/Jobless (7) Other Specify).....

SECTION B: Involvement in HIV testing and related experience.

Please tick (√) the appropriate box or complete the blank spaces provided

8. Please for how long have you been living with HIV/AIDS: Years...../
Months.....
9. Who or What encouraged you to go for HIV testing for the first time:
 - (1) Recommendation due to suspected HIV
 - (2) Just wanted to know my status
 - (3) Spouse/partner/family member was found to be having HIV
 - (4) Preparation for sexual relation
 - (5) Because Spouse/partner/family member died of HIV
 - (6) Regular Anti-Natal Care Investigations
 - (7) Preparation for marriage
 - (8) Sickness
 - (9) Family Advice
 - (10) Other specify

**10. How did you react when you were first told that you were having HIV?
Kindly tick (✓) as appropriate in table 1.**

Table 1

S/N	How reacted	Yes	No
10.1	Sad		
10.2	Angry		
10.3	Stunned		
10.4	I was not convinced /uncertain of test result.		
10.5	Panic that death is near/ at hand		
10.6	I became Hopeless		
10.7	Fear of being lonely		
10.8	Fear that people will start to discriminate against me		
10.9	Fear of Stigmatisation		
10.10	Fear of losing my job		
10.11	Lost confidence in myself		
10.12	I was humiliated		
10.13	Feeling of being useless		
10.14	Segregate self from societal functions		
10.15	Concern of how to disclose result to family members		
10.16	Concern about how to disclose result to friends		
10.17	Other reactions:		

Section C:

11 (a) Has any health worker ever treated or related to you in a way you do not like? (i.e Stigmatize you, discriminate against you, abuse you, ridicule you or look down on you as if you do not matter? Yes No

11. (b) Table 2 contains a list of stigmatizing verbal/ non-verbal abuses or experiences. For each tick (✓) the health worker that has / have perpetrated it against you because you have HIV / AIDs.

Table 2

S/N	Stigmatizing Experiences	Ever Experienced it		Who did it to you? (Tick (✓))						
		Yes	No	Doctor	Nurses	Lab. Scientist	Social Worker	Dentist	Record Officer	Others
11.1	Blamed for being responsible for your HIV Status									
11.2	Gossip about your status with coworker or other health workers									
11.3	Called Bad/ derogatory names									
11.4	Irregular or winking of eye at you disrespectfully									
11.5	You were used as example of somebody living with HIV to newly HIV positively confirmed person (s)									

12. Table 3 contains some forms of ridicule that can be perpetrated against persons with HIV /AIDs. For each, tick (✓) the health worker that has / have ever done it to you.

Table 3

S/N	Ever ridiculed	Ever Experienced it		Who ever did it: (Tick (✓))						
		Yes	No	Doctor	Nurses	Lab. Scientist	Social Worker	Dentist	Record Officer	Others
12.1	Laughed disrespectfully at you									
12.2	Mocked you									
12.3	Try to shun you									

13. Table 4 contains a list of the various ways some health workers treat persons with HIV/ AIDs as if they are worthless or they no longer count. For each, tick (✓) the health worker(s) that has / have ever done it to you.

Table 4

S/N	Ways ever treated as if you do not count (i.e. that you are worthless	Ever Experienced it		Whoever did it: (Tick (✓))						
		Yes	No	Doctor	Nurses	Lab. Scientist	Social Worker	Dentist	Record Officer	Others
13.1	informed other health workers that you have HIV without your permission									
13.2	informed your husband/ wife about your HIV status without your permission									
13.3	Informed your family member(s) about your HIV status without your permission									
13.4	Refused to treat you because of your HIV status									
13.5	Ordered for HIV testing without your approval									
13.6	Refused admission because of your HIV status									
13.7	Left in the corridor or side ward									
13.8	Made you the last person to be attended to because you have HIV									
13.9	Discharged home to seek care from elsewhere on learning that you have HIV									
13.10	Tested you for HIV without any pre or posttest counselling									
13.11	Used you for research without informed consent									
13.12	Served medication by dropping the medication into your mouth or palm without allowing their body to touch you									
13.13	Used unnecessary Personal protection wear (e.g. additional gloves, goggle, face mask e.t.c.)									
13.14	Treated or dealt with you without respect because of your HIV status									

S/N	Ways ever treated as if you do not count (i.e. that you are worthless	Ever Experienced it		Whoever did it: (Tick (√))						
		Yes	No	Doctor	Nurses	Lab. Scientist	Social Worker	Dentist	Record Officer	Others
13.15	Placed sign near your bed while on admission to indicate that you are HIV+									
13.16	Avoided contact with you because of your HIV status									
13.17	Reduced contact with you because of your HIV status									
13.18	Made to pay additional money for health care services as a result of HIV status									
13.19	Separated your seat from other clients or patients because of your HIV status									

14. SECTION D: Psychological Challenges. Kindly tick (√) appropriately.

This section contains a list of psychological problems that persons with HIV / AIDs experience as a result of the Stigmatisation perpetrated against them by health workers. For each tick whether you have ever experienced it. If yes, also state whether you still experience it.

Table 5

S/N	Psychological problems ever experienced	Ever experienced it		If Yes, are you currently experiencing it	
		Yes	No	Yes	No
14.1	Sleeplessness				
14.2	Feeling being useless/worthless				
14.3	Worry				
14.4	Feeling as one is dreaming (Delusion)				
14.5	Low self-esteem				
14.6	Feeling Sad				
14.7	Being absent Minded				
14.8	Inability to remember things easily				
14.9	Perplexed/ Confused				
14.10	Feeling like taking your life				

15. SECTION E: Social Challenges

Table 6 contains some social challenges that persons with HIV /AIDs often experience as a result of the Stigmatisation perpetrated against them by health workers. For each, tick (√) whether you have ever experienced it; also tick (√) whether you are currently experiencing it.

Table 6

S/N	Social Challenges	Ever experienced it		If Yes, are you currently experiencing it	
		Yes	No	Yes	No
15.1	Withdrawn from habitual activities				
15.2	Reduced Productivity				
15.3	Reduced social interaction				
15.4	Feeling of being a burden to family/people				
15.5	Reluctance / fear to seek / apply for job / vacancy				

16. SECTION F: Treatment Challenges

Table 7 contains a list of treatment related challenges you have ever experienced as a result of the Stigmatisation that you experienced in the hands of health workers. For each, tick (√) whether you have ever experienced it; also tick (√) whether you are currently experiencing it.

Table 7

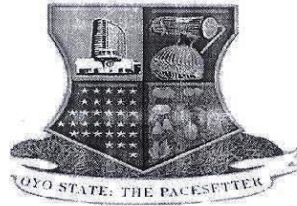
S/N	Challenges being experienced	Ever experienced it		If yes, are you currently experiencing it	
		Yes	No	Yes	No
16.1	Loss of confidence in Health workers				
16.2	Non-compliance to appointments				
16.3	Missing of appointments				
16.4	Loss of confidence in the treatment given				
16.5	Non-adherence to treatment				
16.6	Others				

APPENDIX II

LETTER OF ETHICAL REVIEWER'S APPROVAL

TELEGRAMS.....

TELEPHONE.....



MINISTRY OF HEALTH
DEPARTMENT OF PLANNING, RESEARCH & STATISTICS DIVISION
PRIVATE MAIL BAG NO. 5027, OYO STATE OF NIGERIA

Your Ref. No.

All communications should be addressed to

the Honorable Commissioner quoting

Our Ref. No. AD 13/479/ 1440

16th September, 2019

The Principal Investigator,
Department of Health Promotion and Education,
Faculty of Public Health,
College of Medicine,
University of Ibadan,
Ibadan.

Attention: Olawovin Bilikisu

**ETHICS APPROVAL FOR THE IMPLEMENTATION
OF YOUR RESEARCH PROPOSAL IN OYO STATE**

This is to acknowledge that your Research Proposal titled: "Perceived Stigmatization Related Experiences Perpetrated by Health Workers among Persons Living with HIV/ AIDS in Ibadan." has been reviewed by the Oyo State Ethics Review Committee.

2. The committee has noted your compliance. In the light of this, I am pleased to convey to you the full approval by the committee for the implementation of the Research Proposal in Oyo State, Nigeria.

3. Please note that the National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations, in line with this, the Committee will monitor closely and follow up the implementation of the research study. However, the Ministry of Health would like to have a copy of the results and conclusions of findings as this will help in policy making in the health sector.

4. Wishing you all the best.


Signature & Date
Dr. Abbas Gbolahan

Director, Planning, Research & Statistics
Secretary, Oyo State Research Ethics Review Committee