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Survey to Explore Stigma and Discrimination Against People Living with HIV by Health Care Providers in Niger state, Nigeria

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Abstract

People living with HIV (PLHIV) often face stigma and discrimination in health care settings, significantly impacting their self-esteem and treatment adherence, leading to increased morbidity and mortality. This study aimed to assess the professional competence, and knowledge of health care workers about HIV. It also explored their attitudes and practices regarding stigmatization and discrimination against PLHIV. A cross-sectional survey using structured questionnaires was conducted, with data analyzed manually via Excel. Among the 195 respondents, 37% were aged 36–45, and 28.5% were 26–35 years old. Respondents included nurses (35%), doctors (18%), and medical records staff (20%). Findings revealed a high stigma prevalence, with 62% believing PLHIV should feel ashamed and 90% unwilling to provide services to men who have sex with men if given a choice. While 60% agreed that adequate infection prevention supplies were available, 51% still feared infection from touching PLHIV clothing. Alarmingly, 97% had not received training on addressing stigma and discrimination. The study recommends a health promotion multi-sectoral approach to combat stigma and discrimination in health facilities. Regular training and retraining of health workers on HIV prevention, infection control, and stigma reduction are essential to improve care for PLHIV.

Keywords: *Health Workers, People Living with HIV, Stigma and Discrimination.*

Background of the Study

One of the new targets under the Sustainable Development Goals (SDGs) is to end the AIDs epidemic by 2030. In achieving this, the National Agency for the Control of AIDs (NACA) has developed a national strategy in line with the Joint United Nations Program on HIV/AIDs to reduce the burden of HIV/AIDs in Nigeria [28]. Yet, stigma and discrimination against people living with human immunodeficiency virus (HIV) continue to be obstacles in the way of effective responses to HIV. Stigma and discrimination against people living with HIV has persisted across societies both in the community and at the health facilities despite efforts by Government and International community to improve on the knowledge, attitudes and behaviours of care providers and the populace. Therefore, strategies that would reduce discrimination and foster optimal HIV/AIDs medication at the facility level are urgently required in reducing the burden of HIV/AIDs in Nigeria.

It has been estimated that there are 37.7 million people living with HIV and over two thirds of whom are living in the African region. Sub-Saharan Africa bears a disproportionate share of all HIV cases globally. While Nigeria's national HIV prevalence is 1.4% among adults aged 15–49 years, women aged 15–49 years are more than twice as likely to be living with HIV than men (1.9% versus 0.9%.) according to the National Agency for the Control of AIDs, 2020[16]. Both international and national governments have been working to reduce HIV prevalence in Nigeria. But the national strategic

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framework identified reducing stigma and discrimination as key action point. Some of these pervasive stigma and discrimination are founded on misconceptions and wrong beliefs of local communities about HIV. For instance, before its discovery in Nigeria in 1981, HIV/AIDS had been peddled as a disease of the "white man" with the misconception that it was found in homosexuals only. There was scepticism and a lot of myths and misconceptions fuelled by ignorance. Some peddled ideas that it was the white man's way of discouraging sex and procreation. AIDS was termed "American way of discouraging sex. Some said it came from monkeys, mosquitoes, etc. These misconceptions have somehow affected scientific efforts to tackle the disease.

Notwithstanding, a lot of scientific research has since gone into documenting how certain beliefs regarding HIV and PLHIV can be addressed including stigmatization and discrimination [3][9]. HIV-related stigma and discrimination is a complex social process that interacts with, and reinforces, the pre-existing stigma and discrimination associated with sexuality, gender, race and poverty [9]. HIV/AIDS-related stigma and discrimination occur everywhere, but they may have more serious consequences in healthcare settings.

In the 21st century, the age of globalization when information, education and communication is at the touch of a button, societies can easily get information and educate themselves on ways of preventing HIV infection and caring for those infected. The government of Nigeria has taken positive actions to strategize on how to educate the populace, promote positive health behaviours in terms of safer sex practices, use of condoms etc. Health education messages through information, education and communication materials as well as use of interpersonal communication and mass media was embarked upon. Seen as a multi-sectoral approach, the government went into partnerships with international and National non-governmental and humanitarian organizations like the United Nations Children's Fund (UNICEF) and Society for Family Health (SFH) among others to implement primary prevention activities for in-school and out of school through mass media campaigns, interpersonal communication and other means of communication, all targeted at the vulnerable age group 13 to 24 years. By 2007, the National Youth Service Corps took ownership of the prevention program since they supervise the largest gathering of youths at the NYSC camps.

Statement of Problem

Service providers in healthcare institutions are expected to provide social and psychological support to persons living with HIV (PLHIV) in order to help them cope with stress and to reduce the stigma directed against PLHIV [9]. However, HIV/AIDS-related stigma and discrimination have been extensively documented amongst healthcare providers. There have been many reports from healthcare settings of HIV testing without consent, breaches of confidentiality, labelling, gossip, verbal harassment, differential treatment and even denial of treatment. People who feel stigmatized by healthcare providers face problems getting tested for HIV and accessing optimal healthcare services. The fear of stigma impedes prevention efforts, including discussions of safer sex.

Contributing to the problem of discrimination of PLHIV is lack of qualified personnel in health facilities. Qualified and motivated human resources are essential for adequate HIV care provision, but human resources shortages have now reached critical levels in many resource-poor settings, especially in rural areas. As a result, unqualified staffs are recruited who do not provide care according to standards and not being responsive to the needs of the patients. Insufficient staff seems to be a contributory factor to poor attitudes of health workers towards HIV patients as many of them are over-worked.

Nigeria is one of the countries with the largest number of PLHIV, with stigma and discrimination from health workers being constraints to efforts to curtail the epidemic [1]. Unfortunately, in spite of massive investment in HIV/AIDS prevention and treatment, People living with HIV face many challenges. The early (1990s) and peak years (mid-2000s) of the epidemic in Nigeria were characterized by various forms of stigma and discrimination at different levels of human interaction. As a result, they miss clinic and laboratory appointments, and do not adhere to their ARVs. Thus, there are interruptions in treatment probably because they do not understand the consequences of non-adherence or because they had not been adequately counselled by health care workers before treatment was started. They face all forms of discrimination both at home and health facilities [4] identified some of the stigma PLHIV face to include internalized stigma, lowered self-esteem, depression, and changes in behaviour (e.g., not using the available services) because of the fear of stigma. It was indicated that higher perceived HIV stigma scores amongst clients with HIV were significantly and negatively correlated with the quality of life. Stigma reduced participation in programs to prevent mother-to-child transmission of HIV (PMTCT). It also affects the attitudes of providers who deliver HIV-related care.

Some studies like those of [9],[19] show that PLHIV felt discriminated against at the health facilities where they were enrolled for treatment and would prefer to go elsewhere to continue taking their drugs while some interrupt their treatment and prefer to seek help from spiritual houses and alternative medicine practitioners. Health Policy Project [11] discovered that stigma and discrimination within health facilities are serious barriers to healthcare access and engagement for people living with HIV. There is a need to understand the extent of stigma and discrimination against people living with HIV and the underlying causes so that we can develop strategies to reduce them. The study is aimed at accessing the current level of HIV/AIDS related stigma and discrimination trends among health care providers in health facilities in Niger state, Nigeria.

Objectives of the Study

The aim of the study is to assess the knowledge of stigmatization and discrimination against People living with HIV among healthcare workers, with a view to fostering strategies for effective HIV service delivery at health facilities. The specific objectives are to:

1. Examine the demographic and socioeconomic characteristics of health workers in the study area.
2. Determine the professional competence and level of knowledge of health care workers about the Human Immunodeficiency Virus
3. To find out attitudes and practices of stigmatization or discrimination against PLHIV by care providers in health facilities.
4. To suggest strategies of reducing stigma and discrimination against PLHIV by health care workers in the study area.

Significance of Study

HIV stigmatization and discrimination can pervade the lives of people with mental health problems and low self-esteem that robs people of social opportunities at community and health facility levels. Hence, the results of this study would lead to recommendations that will improve hospital-based care for HIV patients that would guarantee confidentiality and patient care without hampering routine clinical appointments and visits. Positive attitudes from healthcare providers can encourage infected persons to start ART early. By starting treatment in a specialized facility early, there is the possibility of adhering to medication, and staying in care for the desired results. By so doing, the virus can be kept under control, and people living with HIV can prevent their HIV infection from progressing to AIDS. The study would expose the wrong attitudes of health workers towards HIV patients at the health facility, thereby advising on the right practices. Therefore, the right attitudes towards PLHIV can encourage potential positive individuals to start HIV treatment as soon as possible. This would encourage people living with HIV to make their clinical appointments, exactly as recommended by the WHO. The findings of this study would provide insights on how improved care at the facility can support PLHIV in establishing a medication routine and adhering to it. It would assist policy makers in developing frameworks and policies aimed at effective service delivery to HIV patients, thereby achieving universal health coverage.

Literature Review

Causes of Stigmatization and Discrimination of People Living with HIV

Existing studies have shown several reasons for the stigmatization and discrimination of people living with HIV [21,26,27] declared that stigma and discrimination is not new to public health neither is it restricted to HIV/AIDS. Stigma and discrimination against people with certain diseases has always existed. For example, in Bible times, people with leprosy were taken outside the camp so that they do not contaminate or spread the diseases to others. This suggest that right from the beginning of time, people have been stigmatized and discriminated of many diseases. In recent times, studies have shown that there is a high level of stigma and discrimination against PLHIV in the Nigerian population. [7] explored stigma and discrimination towards PLHIV and noted that the lack of knowledge about HIV, fear of contracting HIV, social and moral perceptions about HIV and PLHIV were perceived facilitators or drivers of stigma and discrimination towards PLHIV.

Recent studies [3] reported that about half of the population discriminates against PLHIV. Younger persons, men including those without formal education and those within poor wealth index are more likely to have stigma towards PLHIV. Also, the study disclosed that married people are more likely to have stigma on PLWHA and are more likely to blame PLWHA for bringing the disease to the community. Further evaluation of the outcome of their study also showed that those with higher levels of education and those from higher wealth index seem to be more compassionate towards PLHIV. Notwithstanding, about 70 percent were willing to care for relative with AIDS, even more so among those with higher level of education. Their study provides important insights on the potency of education in tackling stigma and discrimination. Education seems to play a major role in the society with respect to HIV stigma and discrimination against PLHIV. Educating the population with factual information on HIV/AIDS is needed to reduce stigma and discrimination towards PLHIV in the community.

Furthermore, [29] studied stigmatized attitudes of healthcare providers as a barrier to inadequate healthcare delivery to HIV patients. The study identified the most dominant attitude of the health care providers toward HIV/AIDS patients to be related to fear. According to the results of their study, there was a significant relationship between stigmatized attitude of the health care providers and their religious beliefs, society stigmatized attitude, and knowledge of transmission routes. The relationship between social stigmatized attitude of health care providers and their knowledge of transmission routes, with their willingness to provide services to patients was significant. Almost half of the health professionals preferred not to provide services to the prostitutes and homosexual patients. The study concluded that fear of contamination and social stigmatized attitude were 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 ugly situation.

Characteristics of Stigmatization and Discrimination of People Living with HIV

Faruk, Hawke, Mwanri and Ward [7] explored stigma and discrimination towards PLHIV and noted that the findings showed that participants experienced stigma and discrimination across settings including family members and healthcare professionals. HIV stigma and discrimination were also identified as a process linked to the whole groups of people within families or communities, which occurred within social context in Yogyakarta and Belu. [3] reported that about half of the population discriminates against PLHIV. Younger persons, men including those without formal education and those within poor wealth index are more likely to have stigma towards PLHIV. Also, the study disclosed that married people are more likely to have stigma on PLHIV and are more likely to blame PLHIV for bringing the disease to the community. Evaluation of the outcome of their study also showed that those with higher levels of education and those from higher wealth index seem to be more compassionate towards PLHIV.

In a study [3], most health-care professionals reported being in compliance with their ethical obligations despite the lack of resources even though discriminatory behaviour and attitudes toward patients with HIV/AIDS exist among a significant proportion of health-care professionals in the surveyed states. Their study reported that nine percent of professionals claimed to have refused to care for an HIV/AIDS patient, and 9% indicated that they had refused an HIV/AIDS patient admission to a hospital, others also think that people with HIV/AIDS should be on a separate ward, and 40% believed a person's HIV status could be determined by his or her appearance. Their study also disclosed that staff and health-care professionals in health facilities want to be informed when a patient is HIV-positive so they can protect themselves, and that health-care professionals with HIV/AIDS should not be allowed to work in any area of health-care that requires patient contact.

Socioeconomic and Health Consequences of Stigmatization and Discrimination of People Living with HIV

The concept of stigma and discrimination as experienced by patients in the hands of health care providers is rampant though not documented. The issue of HIV/AIDS stigma and discrimination is a significant component that may affect patient-care-provider interaction and that patients perceive that stigma is existent and tangible in health care facilities.

Stigma is an undesirable or discrediting attribute that an individual possesses, thus reducing that individual’s status in the eyes of society [10]. While discrimination is the prejudicial treatment of different categories of people or things, especially on the grounds of race, age, health status or gender. Discrimination plays out for PLHIV as hostility by family members, partners, caregivers and health care workers etc. denying them equal access to essential services [15]. [5] studied self-stigmatization among people living with HIV at Kumbe health and found that almost half of the people felt ashamed because of their HIV status, and exhibited self-guilt, while others blamed themselves for being HIV positive. Sometimes, HIV positive persons blame others for their condition and decided to stop childbearing for fear of transmitting the disease to their unborn children. The study by [5] disclosed that infected women feared that they might no longer have sexual partners. The study identified external stigma as follows: feeling of being gossiped, verbal insults, and internal stigma to include feeling ashamed, self-guilt, self-blame, blame others, and fear of having more children. [6] noted that stigmatization creates an unnecessary culture of secrecy and silence based on ignorance and fear of victimization.

Studies have shown that stigma and discrimination experienced (or perceived) by PLHIV at the health facilities may be particularly detrimental to their health outcomes. In a study conducted by [23] physician-patient relationship quality was a potentially important factor of intervention to improve patients' medication adherence. Similarly, [24,25] found discrimination in healthcare settings to be negatively associated with optimal ART adherence. When PLHIV perceive discrimination against them at health care facilities, it leads to internalization of the stigma which in turn may lead to depressive symptoms.

In a study conducted by [19] at the Federal Capital Territory, Nigeria people living with HIV (PLHIV) faced stigma through decrease in quality of health services and outright denial of services apart from stigma faced at work and within the family. Also, [5] conducted a study using mixed approach and reported that **i**nternal stigma was common among PLHIV. Though stigma and discrimination cannot be elicited by going through clients’ folders, the study found that other factors that affected the level of stigma was younger age group while, lower level of education increased the level of stigma among PLHIV. [9] found that higher levels of stigma and discrimination against PLHIV were associated with lack of in-depth knowledge on HIV and there was a need for orientation about policies against stigma and discrimination. The Joint United Nations Programme on HIV and AIDS (UNAIDS, [25] was set to achieve the goal of 90% of people getting tested and knowing their status, 90% on treatment and adhering to their ART and 90% achieving viral suppression by the year 2020. PLHIV may be placed on treatment as per the 2nd 90, however, they may not adhere to treatment due partly to the stigma they may face on the health sector and viral suppression compromised.

The UN indicators [12] used to track Stigma and Discrimination in the AIDS epidemic include (1) Discriminatory attitudes towards people living with HIV, (2) Experience of HIV-related discrimination in health-care settings, (3) Accepting attitudes towards those living with HIV (4) Fear of HIV transmission through casual contact with a person living with HIV (5) Avoidance of health care due to stigma and discrimination of people living with HIV and (6) Negative manifestations of HIV-related stigma. These indicators form part of the questions in the survey instrument. Health behaviors such as adherence to antiretroviral therapy (ART) and all clinic appointments, drug pick up and laboratory tests, result in maintenance of viral load suppression, prevention of the development of treatment-resistant HIV strains, and reduction of the risk of transmission leading to improved quality of life. It is therefore important to provide an enabling environment for the persons living with HIV (PLHIV) to ensure they practice adherence as stated on the health belief model of perceived susceptibility, perceived severity, health motivation, perceived benefits, perceived barriers and the need to take action. PLIHV can be motivated by social and environmental factors such as attitude of health care workers and the availability of quality care at health facilities.

Methodology

Study Design

A survey design was used in this study. This type of research design studies sample of a large population by selecting representatives from the population and studying them; and their characteristics will be used to generalize for the entire population. This design was applied because it is not feasible to study the whole population. On this note, the survey design was chosen because it accommodates both small and large population and it is devoid of social desirability and manipulation of variables. It is inferential because it involves the drawing of conclusions or making predictions based on the analysis of observed data.

Study Area

The research was carried out in 4 health facilities in Bida, Lavun and Mokwa local government areas (LGAs) in Niger state. This study was carried out in Niger State, Nigeria. The research was conducted in the following hospitals: General Hospital, Bida, General Hospital, Kutigi Lavun LGA, General Hospital, Mokwa, Mokwa LGA, and Federal Medical Center, Bida.

Niger state lies on latitude 3.20^0 East and longitude 11.30^0 North. Minna is the capital city of Niger State, Nigeria. The state has a population of 3,950,249 and land mass of 29.484sqm. The area is largely occupied by the Nupes, Hausas and Gbagyis [18]. Niger State shares boundaries with Kebbi and Zamfara states in the north, Kaduna State in the northeast, Federal Capital Territory in the east, Kogi and Kwara states in the south, and Benin Republic in the west. These manifold boundaries including an international boundary with the attendant fluidity contribute to the heterogeneous nature of the state with the attendant problem of interstate and international trade, which could be favourable for cross-infections such as sexually transmitted infections including HIV/AIDS [20]

As at 2015, Niger state was ranked 20th in terms of HIV infection prevalence among the 36 states and the Federal Capital Territory (FCT) that make up Nigeria, with a prevalence of 4.0 percent which is slightly below the national average of 4.1 percent [20] However, by 2018, the Nigeria AIDS indicator and impact survey NAIIS put the prevalence for Nigeria at 1.9% and for Niger state as 0.7% [12]. A previous study in the area has established that the prevalence of HIV is highest among non-pregnant women, literates, full housewives, women in polygamous marriages, and younger people. And that there was significant association between HIV infection and other factors such as pregnancy, education status, occupation, marriage type, and age [2]. Although it is now classified as low prevalence, it is pertinent that government and non-governmental organizations step into the scene to curb further reinfection as a result of globalization, migration, insecurity and displacement due to internal conflict through improved health promotion and health communication strategies.

Data Types and Sources

The study used a number of data on demographic, socioeconomic characteristics, HIV care, stigma and discrimination related services to achieve the objectives of the study. These data include demographic and socioeconomic characteristics of respondents such as age, sex, current job, years of experience in healthcare services. HIV care and stigma and discrimination was considered based on HIV prevalence (high or low), ever worked in HIV care unit, number of trainings on HIV attended, HIV infection concerns among health workers, quality of care to HIV patients, health facility policies concerning people living with HIV as well as the opinions of healthcare providers on how HIV patients should feel. These variables were culled from the standard brief questionnaire for measuring HIV stigma and discrimination among health facility staff prepared by the Health Policy Project. All the data used in this study are primary data collected through questionnaire and interviews and Focus Group Discussions (FGDs).

Sample Size and Sampling Technique

The study sample was purposively determined based on the list of staff employed in the health facility comprising Doctors, Nurses, Laboratory Scientists/technicians, Data entry clerks, Pharmacists, Community Health

Extension Workers, Case Managers, Cleaners and security guards (Gate men). A set of 120 well structured pretested questionnaires was administered on health care workers in units where HIV intervention care was provided.

Data Collection Methods

Four health facilities providing care to HIV patients in three Local Government Areas were purposively selected across the state for the cross-sectional survey. These LGAs are Bida, Lavun and Mokwa local government areas (LGAs) in Niger state. In each of these 3 LGAs, at least one health facility was sampled. The mixed method approach comprising of qualitative and quantitative methods were used in the data collection process. For the qualitative method, personal interviews were conducted for 10 health workers per health facility while one focus group discussions (FGDs) per facility were conducted to elicit responses on HIV stigmatization by care providers. To effectively conduct the Focus Group Discussions (FGD), a purposive sampling technique was used to select ten (10) respondents for each of the four FGDs from all the health facilities with a representative sample of male and female irrespective of whether they had participated in filling the survey questionnaire or not.

Two field assistants were trained in terms of carrying out the interview and also how to take notes. The interviews were recorded with the aid of a tape recorder. To start the interview, the issues for discussion were introduced and representatives were encouraged to treat each topic with utmost seriousness. The participants were informed of what was required both in terms of content and process, and the time required. For the interviews, the key informant interview guides were handed to each of the Key Informants before the actual interview took place in order for them to familiarize themselves with the issues and obtain additional information that they may not have off-hand. The interview was set to allow flexibility and to explore new and unanticipated issues which were relevant to the study. Apart from the recording device, detailed notes were also made by the researcher. These were later compared to ensure that all issues discussed had been documented. Both the FGD and interviews were necessary to explain the perceptions, knowledge, attitudes, and pattern of HIV/AIDs related stigma and discrimination against PLHIV and to discover reasons and intentions for some of the results obtained from the quantitative study.

For the quantitative method, a questionnaire survey was conducted among the health workers in the 4 facilities. A sampling was done after the list of staff of the health care facility was obtained from the Human Resource department of the health facilities as the sampling frame. A random sample table was then used with a table of random numbers to select the staff who would participate in the study. A structured questionnaire was developed from the Health Policy Project, which was developed for eliciting stigma and discrimination against PLHIV by health care workers and used for data collection. The questionnaire measures programmatically actionable drivers of HIV-related stigma and discrimination among healthcare facility staff. It also captures observations of HIV-related stigma and discrimination within the facility and the extent to which providers experience stigma and discrimination as a result of providing care to people living with or believed to be living with HIV [11].

Data Analysis

The data collected from the field was analyzed using both descriptive and inferential statistics. The descriptive statistics include frequency distribution, simple percentage, tables and graphs, whereas the inferential statistics such as correlation analysis and multiple regression analysis were used to test significant relationships. The recorded interviews were processed and their contents analyzed and used to discuss the results.

Ethical Considerations

Ethical approval for the study was obtained from the Ethics Committee of the State and a permission letter was obtained from the State Ministry of Health and the respective healthcare facilities where the study was conducted. A written informed consent was also obtained from each study participant. The right of the study participants to refuse participation or withdraw from the study at any point was respected. All data obtained from the study were confidentially kept. The names of the respondents were replaced with codes to ensure confidentiality.

Results and Discussions

Demographic and Socioeconomic Characteristics of Health workers (Respondents)

One hundred and ninety-five (195) health care providers with a response rate of 97.5% participated in the survey. The result obtained is shown in Table 1.

Table 1. HIV-Positive Patients did you Provide with Care or Services

S/N	No. of HIV+ clients	Frequency of Repondent	Percentage%
1	0-10	70	35
2	11-20	56	28
3	21-30	20	10
4	31-40	11	5.5
5	41-50	17	8.5
6	51 and above	38	19
	TOTAL	195	100

Source: Researcher's Fieldwork, 2024

The result in Table 1 showed that 125 (62.5%) were males, while 46.2% were females. The dominance of males is anticipated because they are mostly the administrative heads of the sampled departments /units. Information on the age of respondents showed that respondents within the ages of 36-45 years dominated the survey (37%), followed by those within the ages of 26-35yrs with a percentage value of 28.5%, while those >25yrs had the lowest proportion of respondents of 15% respectively. The pattern that emerged shows that majority (65.5%) of the respondents are within the ages of 26 – 45yrs implying that adult medical personnel dominated the study. The respondents who are between 26 – 45 years are likely to have requisite experience of how to provide care and support to PLHIV without stigmatizing them and vice versa.

The Jobs/Profession of the 195 participants indicated that 30% were Nurses, 20% were medical records officers, 17.5% were Doctors and 15% were Laboratory technicians as well as Pharmacists, Ward attendants, and Cashiers. This result indicates that Nurses, Doctors and Pharmacists constitute 62.5% of the care providers in the sampled health facilities. In the provision of Care for PLHIV in the health sector, Nurses, Doctors and Pharmacists are in the forefront as they are responsible for counselling on adherence, providing psychosocial support and drug refill, among others. With respect to years of experience in health care, 45% of respondents have worked in healthcare for over 21 years, 17.5% have between 6 to 10 years of experience in healthcare and only 15% have worked in the health sector for 16 to 20 years. The result implies that the study participants have the cognate experience to provide care and support to PLHIV. The results also revealed that majority (58 %) of the respondents have cared for or are currently for PLHIV, 35% of respondents have attended to about 10 clients in the last 12 months while 28% have attended to 11 to 20 HIV positive clients within the period as shown in Table 1 below.

Professional Competence and Level of Knowledge of Health Care Workers about HIV

In an attempt to probe into the skills of care, treatment and support health facilities of health providers, we asked '*Did you ever receive training in related subjects?'*. The results showed that participants received training on stigma and discrimination. Of the 195 participants, only 87% answered the question out of which 56% admitted to have been trained. Another related area that respondents affirmed to have received training was on infection prevention and universal precaution.

Table 2. Number of Trainings Attended on HIV Care

S/n	**Training**	**Frequency**				**Respondents**
		YES	%	NO	%	**Total**
1	HIV stigma and discrimination	95	56%	75	44%	170
2	Infection control and universal precautions	101	68%	47	32%	148
3	Patients' informed consent, privacy, and confidentiality	97	56%	77	44%	174
4	Key population stigma and discrimination	71	37%	119	63%	190

Source: Researcher's Fieldwork, 2024

A total of 148 respondents answered the question; however, only 68% said they have been trained. On patients' consent, privacy and confidentiality, 56% have received training; and only 37% have been trained concerning stigma and discrimination against key population. This analysis depicts that the participants have received Training on every aspect of HIV prevention, treatment, care and support. This is key to the success of reaching impact and epidemic control. Expectedly, all health care workers will benefit from regular capacity building sessions, i.e., on the job, non-residential or residential training and refresher training every year.

Table 3. Quality of Care Provision for PLHIV

Touched the clothing of a patient living with HIV	**Frequency**	**Percent**
Not worried	77	43
A little worry	12	7
worried	51	28
Very worried	17	10
Not applicable	21	12
Total	**178**	100
Dressed the wounds of patient living with HIV		
Not worried	32	18

A little worry	45	25
worried	15	8.7
Very worried	18	10.2
Not applicable	67	38.1
Total	**177**	100
Drew blood from a patient living with HIV		
Not worried	40	21.4
A little worry	27	14.4
worried	30	16.0
Very worried	15	8.0
Not applicable	75	40.2
Total	**187**	100
Took the temperature of a patient living with HIV		
Not worried	93	51.0
A little worry	13	7.2
worried	21	11.6
Very worried	5	2.7
Not applicable	50	27.5
Total	**182**	100

Source: Researcher's Fieldwork, 2024

Table 3 above, shows the level of knowledge or awareness of infection prevention and control of health care providers. The result shows that 43% affirmed that they are not worried if they touched the clothing of patients with HIV. However, 28% said that they will be worried and 7% expressed a little worry for touching the clothing of patients with HIV. This result indicates that 57.0% are worried, have a little worry and become very worried for touching the clothing of an HIV positive person, suggestive of discrimination against PLHIV. Results of the FGD also shows that in the context of care for people living with HIV, who are also facing self-stigmatization, the expression on the faces of the health care providers is very important as the PLHIV may feel stigmatized even when the care provider does not express it.

The result in Table 3 also shows that 18% are not worried if they dress the wounds of patients with HIV. However, 25% expressed a little worry and 8.7% are worried for dressing the wounds of patients with HIV. This result indicates that 10.1% are very worried for touching the clothing an HIV positive person and 38.1 said it not applicable. This result implies that 43.9% of the respondents develop fear of being infected if they dress the wounds of patients with HIV. This attitude from care providers is likely to make PLHIV feel bad or stigmatized. With respect to drawing blood from a patient living with HIV, 21.4% said they are not worried, 14.4% expressed a little worry, 16.0% are worried and 8.0% are very worried whenever they take blood samples from a patient with HIV. A dissimilar pattern of result was observed with health workers in the temperature checks of patients. The majority (51.0%) of the respondents are not worried if they check the temperature of a patient with HIV and 27.7% said it is not applicable. Overall, these results show that some health workers fear of being infected if they are providing services related to dressing of wounds and drawing blood of HIV positive persons.

Table 4. Discriminatory Practices in Health Facilities

Variable	**Never**		**Once or**	**Twice**	**Several**	**Times**	**Most**	**Times**
	Freq	%	Freq	%	Freq	%	Freq	%
Health worker unwilling to care to a patient living with or thought to be living with HIV	74	69.2	12	11.2	21	19.6	0	0
Healthcare workers providing poorer quality of care to a patient living with or thought to be living with HIV, relative to other patients	34	50.7	25	37.3	8	11.9	0	0
Healthcare workers talking badly about people living with or thought to be living with HIV	57	41.6	28	20.4	32	23.3	20	14.6

Source: Researcher's Fieldwork, 2024

In an attempt to further probe into the attitude of health workers towards PLHIV table 4 above, respondents were asked how often they have observed certain negative behaviours by care providers in the health facility in the past 12 months. The result in table 4 shows that 69.2% have never seen health worker unwilling to care for a patient living with or thought to be living with HIV, 11.2% said they have seen health worker unwilling to care for a patient living with or thought to be living with HIV once or twice and 19.6% claimed to have seen health worker unwilling to care for a patient living with or thought to be living with HIV several times. In terms of healthcare workers providing poorer quality of care to a patient living with or thought to be living with HIV, relative to other patients, the result depicts that 50.7% never saw this happen, 37.3% said it has happened once or twice and 11.9% disclosed that they have seen healthcare workers provide poor quality care to a patient living with HIV several times. The study also found that Healthcare workers talk badly about people living with or thought to be living with HIV. The result is shown in Table 4. The result shows that 41.6% have never spoken bad against a patient living with HIV, 20.4% said they have seen and heard once or twice and 23.3% claimed to have seen healthcare workers talk badly about people living with or thought to be living with HIV several times and 14.6% indicated that they have seen healthcare workers talk badly about people living with or thought to be living with HIV most times.

The result also shows that 20.5% of the health care providers have never experienced people talking badly about them because they care for patients living with HIV, and 15.2 said they have experienced people talking badly about them once or twice; and 34% said they have never been avoided by friends and family because they care for patients living with HIV. Also, 22% said they have never been avoided by friends and family because they care for patients living with HIV. And 20% said they have been avoided once or twice by colleagues because of they work caring for patients living with HIV? And 10.2% have been avoided once or twice by colleagues because of the work caring for patients living with HIV.

Table 5. Discrimination Against Healthcare Providers

Variable	**Never**	**%**	**Once or twice**	**%**	**Several times**	**%**	**Most of the time**	**%**
Experienced people talking badly about you because you care for patients living with HIV?	45	20.5	34	15.2	10	0	1	2/89
Been avoided by friends and family because you care for patients living with HIV?	36	34	22	10.2	34	16	3	6/92
Been avoided by colleagues because of your work caring for patients living with HIV?	48	20	21	10.2	33	0	0	0/102

Source: Researcher's Fieldwork, 2024

In order to confirm whether health workers comply with health facility policies concerning HIV treatment, we explored the guidelines, standards of practice and procedures in the health facilities. To the question: In my facility, it is not acceptable to test a patient for HIV without their knowledge, 179 (92%) out of 195 responded. The result shows that 48% of them strongly disagreed with this statement, 28% disagreed and 7% strongly disagreed. This is a pointer to the fact that some health care providers are not aware of the policy on HIV testing services in Nigeria generally and especially in low prevalence areas like Niger state. The result also suggests some health workers might be aware but would not comply with operational procedures and this calls for concern.

Table 6. Showing Knowledge of PITC Policy in the Facility

S/N		**Frequency**	**Percentage**
i.	Strongly Agree	86	48
Ii	Agree	30	17
Iii	Disagree	51	28
iv	Strongly Disagree	12	7
	TOTAL	179	100

Source: Researcher's Fieldwork, 2024

Based on this result, it is important to stress that in prevention, treatment, care and support services for HIV and AIDS, HIV Testing Services (HTS) is an important strategy and this servers as an important entry point to behaviour change. WHO/UNAIDS and the CDC all recommend provider-initiated testing and counselling (PITC) for HIV especially in areas with high HIV prevalence. In the same vein, Nigeria recommends PITC on all health facilities using the opt-in and opt-out approach [16]. In Niger state, although prevalence is said to be low, medical services will be improved if PITC is carried out in the face of STI, TB, and for pregnant women in antenatal clinics.

Fear of the Consequences of Practicing Stigma and Discrimination

To ascertain if there are disciplinary measures for health care providers who stigmatize or discriminate against PLHIV, the question asked was "*I will get in trouble at work* *if I discriminate against patients living with HIV*", all 195 respondents answered the question with 56% agreeing that they would get into trouble. The 43% who responded in the affirmative are either ignorant of the standard of practice in their facility or the rules are not adhered to. This is likely the reason for the pervasive stigma and discrimination of PLHIV in health facilities.

The result also reveals that 41% and 37% agreed and strongly agreed to be confident that the facility has adequate supplies to ensure that workers do not get infected with HIV respectively making a total of 78% majority responses compared to the 22% that disagreed of not having confidence on the adequacy of the facilities to guard against health workers infection. This result implies that not all health care providers in the area of study were confident that the facility has adequate supplies to ensure that workers do not get infected with HIV. However, two of the respondents declined answering this question probably because they are not in a position to know due to the peculiarity of their duties or afraid to answer though they had been assured that their responses were anonymous. From this result, it can be deduced that some health workers do not provide the best care to HIV patients because of inadequate facilities. It is important that health workers are provided with the right facilities to ensure compliance with standard operating procedures. Standard Operating Procedures (SOPs) describe who, what, where, when and how to operate in a functional area such as the laboratory, clinical unit, pharmacy, etc. Every health facility should provide health care providers with SOPs to minimize errors in patient care and maintain quality care for its clients.

Concerning availability of standard operating procedures, guidelines and job aids was test using the statement "*There are standardized procedures/protocols in my health facility that reduce my risk of becoming infected with HIV*". The result shows that 21% of the total respondents strongly agreed and 76% agreed that there are standard procedures/protocols that guide the delivery of care to HIV patients. However, 3% disagreed and reasons why some declined is not known. But the 76% that agreed and 21% strongly agreed sufficient suggest that that there are availability of guidelines and SOPs.

The evidence from this result is commendable because having the SOPs and Job aids is good. However, using them is much more important to reduce the rate of clients dropping out of the HIV program or interrupting their treatment which affects rate of transmission to sexual partners, morbidity and mortality. This is an area that must be given a huge priority. Similarly, we sought to ascertain availability of written guidelines that would protect people living with HIV from discrimination. An overwhelming majority of 80% answered in the affirmative. Interestingly, all 195 (100%) answered this question, a suggestive that PLHIV are protected by law and policy from being discriminated.

Table 7. Availability of Guidelines and SOPs

S/N		Strongly Agree	%	Agree	%	Disagree	%	Strongly Disagree	%	Total
a.	There are adequate supplies in my health facility that reduce my risk of becoming infected with HIV.	71	37%	80	41%	42	22%	0	0	193

Ii	There are standardized procedures/protocols in my health facility that reduce my risk of becoming infected with HIV.	37	21%	134	76%	5	3	0	0	176

Source: Researcher's Fieldwork, 2024

Attitude of People Living With HIV

The result further shows that 32% strongly disagreed or disagreed that most people living with HIV do not care if they infect other people and only 46% agreed to this statement. Respondents claimed that they can only determine whether PLHIV care or not passing on the virus to others if they had face to face discussion with them. Also, 64% strongly agree or agree that people living with HIV should feel ashamed of themselves. Similarly, 40% either disagree or strongly disagree that most people living with HIV have had many sexual partners, and 60% strongly agree or agreed. This is a pointer to the low level of knowledge of HIV transmission and high level of stigma among the total of 98% who answered the question. With respect to the fact that people get infected with HIV because they engage in irresponsible behaviours, 54% strongly agree or agree and 46% disagree or strongly disagree to this assertion. The analysis shows that 90% strongly disagree that HIV is punishment for bad behaviour. This result indicates that health care workers in this study area do not allow religion to affect their perception of method of infection with HIV. However, of the total respondents of 195, only 57% answered the question. It is possible that those who did not answer the question agreed with the statement but did not want to say so. Inference from these results has shown that ignorance, myths and misinformation have continued to increase stigma and discrimination against people living with HIV. Health care providers especially in secondary health facilities in the study area are expected to have higher level of knowledge compared to others who do not have their level of knowledge. It is assumed that in this age of information, communication and technology, these service providers would have availed themselves of internet access to learn more about HIV infection and prevention instead of continuing to believe in the myths and misinformation still being peddled. It is unfortunate that social media is still peddling wrong information about the people who live with HIV.

Table 8. Healthcare Level of Stigmatization Against PLHIV

S/N		Strongly Agree	%	Agree	%	Disagree	%	Strongly Disagree	%	Total
a.	Most people living with HIV do not care if they infect other people.	56	32	81	46	10	6	30	17	177
B	People living with HIV should feel ashamed of themselves.	86	47	32	17	22	12	43	23	183

c	Most people living with HIV have had many sexual partners.	72	38	51	27	10	5	58	30	191
d	People get infected with HIV because they engage in irresponsible behaviors.	40	23	54	31	81	46	2	1	177
E	HIV is punishment for bad behavior.	4	4	10	9	7	6	90	81.0	111

Source: Researcher’s Fieldwork, 2024

In line with the rights-based approach, every woman has a right to have babies when she wants to (see table 9 below). To the question “*women living with HIV should be allowed to have babies if they wish*, a majority (83%) of the respondents strongly agreed or agreed. It is interesting to know that 12% disagreed and 5% strongly disagreed. This is likely to be due to lack of empathy or ignorance. In the health care setting, provision is made for family planning services so that all women whether infected with HIV or not could have access to different methods of family planning services and the women could select their choice and based on their health condition.

Table 9. Whether Women who are HIV+ have Rights to have Babies

S/N		Frequency	Percentage
i.	Strongly Agree	97	52
Ii	Agree	57	31
Iii	Disagree	22	12
iv	Strongly Disagree	10	5
	TOTAL	186	100

Source: Researcher’s Fieldwork, 2024

Stigma Against Key Populations

If I had a choice, I would prefer not to provide services to people who inject illegal drugs (PWID). This question was answered by 185 respondents out of which 51% strongly agreed and 30% agreed bringing the total of those who would not provide services willing to PWID at 81%. Reasons given for unwillingness to provide services to PWID by respondents are presented in table 10. The result shows that 39% agreed and 61% disagreed that providing drugs to PLHIV puts them at higher risk of infection. Also, 56% agreed that unwillingness to provide drugs could be as a result of immoral behaviour of this group of patients that has exposed them to the virus. Similarly, 80% attributed unwillingness to provide services to lack of training on care for PLHIV. This result agrees with previous finding in Sub Saharan Africa where means of infection is usually attributed to infidelity, promiscuity or sex work. Health care providers in this study were asked questions that border on stigma and discrimination against key populations namely men having sex with men (MSM), female sex workers (fsw) and people who inject drugs. There is an obvious gap in training of health care providers for key populations as 80% of the respondents say they have not been trained and 56% said this group of people "engage in immoral" behaviour.

Table 10. Showing Reasons for Unwillingness to Provide Services to PWID

S/N	**Illegal Drugs**	**Agree**	**%**	**Disagree**	**%**	**Total**
a.	They put me at higher risk for disease.	67	39	104	61	171
B	This group engages in immoral behavior.	91	56	71	44	162
c	I have not received training to work with this group.	141	80	35	20	176

Source: Researcher's Field work 2024

Despite the lack of training of respondents, 70% agreed that even though they have the training they would prefer not to provide services to men who have sex with men and 20% strongly agreed to this assertion. This result indicates that 90% of the respondents discriminate against PLHIV. Stigma against MSM is very high in the area of study as 90% of the respondents agree that they would prefer not to provide services to them. The reasons why health care providers would not want to provide services to MSM is that it put them at higher risk (47%) and 53% disagreed against this statement. Also, 43% agreed that unwillingness to provide services is as a result of immoral behaviour of MSM. However, 57% of the respondents disagreed to this statement. Similarly, 57% attributed unwillingness to provide services to lack of training on care for PLHIV and 43% disagreed. An extract from a FGD on discrimination shows that:

I feel like not attending to men who have sex with men, sex workers, people who inject drugs because they sin against God and man as well as the society. This kind of negative and discriminatory attitudes towards men who have sex with men and people who inject drugs hampered the provision of adequate HIV prevention services for these groups of population.

Table 11. Choice to Provide Service to MSM or Not

S/N		**Frequency**	**Percentage**
i.	Strongly Agree	89	20
Ii	Agree	51	70
Iii	Disagree	24	4
iv	Strongly Disagree	31	2
	TOTAL	195	100

Researchers' Field work 2024

Table 12. Reasons why Health Care Providers Discriminate Against MSM

S/N	**MSM**	**Agree**	**%**	**Disagree**	**%**	**Total**
a.	They put me at higher risk for disease.	75	47	85	53	160

B	This group engages in immoral behaviour.	69	43	91	57	160
c	I have not received training to work with this group.	81	57	60	43	141

Researcher's Field work 2024

Obviously, lack of training is the major reason for their answer depicted in table 12 above. For respondents who have been on the job for more than one year, they should have received training on key populations. Respondents were asked: If they had a choice, whether or not they would provide services to sex works (*male or female or both)*. The result in Table 13 indicates that 80% of the respondents would not provide services to sex workers because they have not received training to work with this group. Also, 45% believe this group engage in immoral behavior showing that religious consideration is uppermost in their minds and 60% claimed that it puts their lives at higher risk for the disease.

Table 13. Reasons why they would not Provide Services to Sex Workers

S/N	Sex Workers	Agree	%	Disagree	%	Total
a.	They put me at higher risk for disease.	117	60	78	40	195
B	This group engages in immoral behaviour.	81	45	99	55	180
c	I have not received training to work with this group.	127	80	31	20	158

Source: Researcher's Fieldwork, 2024

Discussion

The study has shown that males within the ages of 26 – 45years dominated the survey. This result indicates that most of the administrative departments /units especially where HIV services are provided are headed by males. This is likely to have some impact on the quality of care provided to HIV positive persons as opposed to female headship due to attitudinal differences. Inadequate services may manifest in the masculinization of HIV related responsibilities, but women may provide the most desired services to HIV patients due to their roles as women or mothers. The health facilities studied also have a good proportion of skilled personnel involved in the provision of HIV care. The result indicates that Nurses, Doctors and Pharmacists constitute 62.5% of the care providers in the health facilities. Almost half of the respondents have worked in the health sector for over 21 years and therefore possess the cognate experience to provide care and support to PLHIV without discrimination. This is likely to have positive impact on the quality of services and may be a reason why 58.0% of the respondents have cared for or are currently caring for PLHIV. These categories of staff are likely to develop positive attitude towards PLHIV due to years of experience. This will encourage PLHIV to visit the health facilities, keep to appointments and adhere to treatment guidelines.

The study has shown that health care workers involved in HIV care benefit from regular capacity building training. The study revealed 56.0% health workers to have been trained, especially on infection prevention and universal precaution. Others received training on patients' consent, privacy and confidentiality (56%) and 37% have been trained concerning stigma and discrimination against key population such that 38% affirmed that they are not worried if they touched the clothing of patients with HIV. The result of this study corresponds with the work [22] that most health-care professionals reported being in compliance with their ethical obligations despite the lack of resources even though discriminatory behaviour and attitudes toward patients with HIV/AIDS exist among a significant proportion of health-care professionals in the health facilities where their study was based.

On the other hand, 43.9% of the respondents developed a fear of being infected if they dress the wounds of patients with HIV. This negative attitude is likely to make persons with HIV feel bad about visiting the health facility. This study corroborates the finding, as the FGDs with some health workers revealed that they have witnessed colleagues providing poorer quality services to PLHIV. Other consequences listed by ICRW are loss of income and livelihood, loss of marriage and childbearing options, withdrawal of caregiving in the home, loss of hope and feelings of worthlessness and loss of reputation. Although 48.0% agreed it is not acceptable to test a patient for HIV without their knowledge, some health care providers are not aware of the guidelines on HIV testing services. A large part of the respondents were not aware that they can get into trouble if they test patients without consent or discriminate against PLHIV. This is likely the reason for the pervasive stigma and discrimination of PLHIV in health facilities.

The results of the study confirmed that there are adequate measures put in place to protect health workers from HIV infection. For instance, almost 80% of the respondents were confident that the health facilities have adequate supplies to ensure that workers do not get infected with HIV. This is likely to encourage the health workers to render services to HIV patients without fear. It is worrying to note that a total of 64% of the health workers strongly agreed or agreed that PLHIV should be ashamed of themselves. This shows a high stigma index among the health care workers in the study area. A similar observation was made by [5] that almost half of the HIV positive persons felt ashamed because of their HIV status, and exhibited self-guilt, while others blamed themselves for being HIV positive. Also, a situation where 90% strongly disagree that HIV is a punishment for bad behavior serves to highlight the fact that the respondents are aware of the cause of HIV among populations.

Stigma and discrimination against key population was observed. Stigma and discrimination is evident by the way health workers show that they are afraid of getting infected thereby taking extra precautions when providing services. This result agrees with previous studies like those of [3] that about half of the population discriminate against PLHIV and are more likely to blame PLHIV for bringing the disease to the community. Also, stigma and discrimination are obvious from their reluctance to provide services to key populations – men having sex with men, people who inject drugs and sex workers. For instance, 81% provided reasons for unwillingness to provide services to PWID and men who have sex with men (70%). This result suggests that stigma against MSM and other key populations is very high in the area of study. This may be a result of ignorance. This result corroborates the findings of [7] that the lack of knowledge about HIV, fear of contracting HIV, social and moral perceptions about HIV and PLHIV were the reasons for discrimination. The study noted that one of the consequences of stigma and discrimination against people living with HIV includes poor care within the health sector. This attitude towards PLHIV is likely to slow down progress in achieving universal coverage. Some health workers agreed that they have witnessed other colleagues providing poorer quality services to PLHIV.

Conclusion

There is stigma and discrimination against People Living with HIV in the health facilities sampled. This is due to the lack of training of health workers and inadequate knowledge of HIV. Although a good number of the health care providers reported that there SOPs, the compliance with ethical obligations spelt out by management of the health facilities is a major issue. There are inadequate resources and guidelines on stigma and discrimination. The results of this study clearly show that discriminatory behavior and attitudes toward patients with HIV/AIDS exist among some of the health-care providers in the surveyed facilities. Some of the health care providers have not received adequate training on some aspects of HIV care and support and some fear they might get infected due to inadequate supplies of protective materials, so they try to avoid having to provide care. Hence, urgent actions are required to reduce this ugly trend.

Recommendation

It is recommended that more training should be conducted for other health care providers in the health facilities besides those working in the ART unit. Training and retraining of health care providers be it on the job training, seminars, conferences etc. will go a long way to increase knowledge and improve practices and skills in HIV care. These trainings should be organized for small groups of about 30 to 40 people so that participation of all can be guaranteed. At the point of hiring new staff, irrespective of status, an orientation session should be given on basic facts on HIV and prevention, stigma and discrimination. Provision of Standard operating procedures, job aids and guidelines with copies made available to staff is crucial in ensuring compliance with ethical obligation. Effective supervision to ensure compliance with SOPs is essential for best practices. Above all, holding defaulters accountable is one surest way of compelling health care providers to be careful and serious with their job. This would go a long way in reducing stigma and discrimination against people living with HIV to a minimal proportion.

Conflict of Interest

I, Catherine Gana, hereby declare that I have no known competing financial interest or personal relationships that could have appeared to influence the work reported in this article

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