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Review

HIV/AIDS Discrimination in Nigeria: Challenges, Strategies, and Implications

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Nigeria continues to grapple with one of the largest HIV epidemics in the world, with approximately 1.9 million people currently living with HIV/AIDS (PLHIV) (UNAIDS, 2023). While the past decade has witnessed remarkable medical advances, including increased access to antiretroviral therapy (ART) and the implementation of the *HIV and AIDS (Anti-Discrimination) Act 2014*, stigma and discrimination remain persistent barriers to the realization of national and global targets. These social challenges not only undermine HIV prevention and treatment strategies but also perpetuate cycles of inequality, human rights violations, and poor health outcomes for affected populations. This paper investigates the manifestations, prevalence, and consequences of HIV/AIDS-related discrimination in Nigeria, with particular attention to how discriminatory practices shape healthcare utilization, workplace participation, and social inclusion. A mixed-methods design was employed, integrating quantitative survey data (n = 500 PLHIV across Lagos, Abuja, and Delta States), secondary data analysis from national HIV reports, and qualitative interviews with healthcare workers, policymakers, and PLHIV. Quantitative findings indicate that 34% of participants reported healthcare denial, 27% experienced workplace exclusion, and 42% faced community-level social isolation. Statistical analysis revealed a significant negative correlation ($r = -0.61$, $p < 0.01$) between experiences of discrimination and ART adherence, suggesting that stigma remains a structural barrier to effective treatment outcomes. The qualitative findings further highlighted gender disparities, with women disproportionately affected due to intersecting gender-based and HIV-related stigma, as well as the role of cultural and religious narratives in reinforcing discriminatory attitudes. The study concludes that while legal frameworks exist, weak enforcement, limited public awareness, and entrenched socio-cultural beliefs hinder progress toward stigma reduction. The findings underscore the urgent need for multi-sectoral interventions, including the strengthening of human rights protections, sustained community-based stigma reduction programs, improved training for healthcare providers, and robust monitoring of workplace compliance with anti-discrimination legislation. This research contributes to the broader discourse on HIV and human rights in Sub-Saharan Africa, with practical implications for Nigeria's progress toward achieving the UNAIDS 95-95-95 targets and the Sustainable Development Goal (SDG) of ending the AIDS epidemic by 2030.

Keywords: HIV/AIDS, Nigeria, stigma, discrimination, public health, antiretroviral therapy, human rights

INTRODUCTION

HIV/AIDS is not only a biomedical challenge but also a deeply social and structural issue that intersects with culture, religion, gender norms, and economic inequality. In Nigeria, the country with the second largest HIV epidemic globally, an estimated 1.9 million people are living with HIV/AIDS (PLHIV), with a prevalence rate of approximately 1.3% among adults aged 15–49 (NACA, 2022). Despite significant investments in prevention, testing, and treatment programs over the past two decades, stigma and

discrimination remain pervasive barriers to effective public health interventions (Okeke et al., 2021).

Stigma against PLHIV in Nigeria is often rooted in deeply entrenched cultural, religious, and moral perceptions. Individuals diagnosed with HIV are frequently labeled as promiscuous, morally corrupt, or socially "tainted," reflecting a broader societal tendency to moralize illness (Oladipo & Adebayo, 2020). Such perceptions extend into multiple spheres of daily life, including healthcare, education, employment, family dynamics, and community participation. In healthcare settings, PLHIV often report breaches of confidentiality, verbal abuse, and even denial of services, which discourage individuals from seeking timely testing or adhering to antiretroviral therapy (Adebajo et al., 2019). Educational institutions and workplaces have similarly been sites of exclusion, with some employers requiring HIV testing prior to employment and schools sometimes refusing enrollment to children affected by HIV, despite legal prohibitions (ILO, 2020; NACA, 2022).

Gender further complicates experiences of HIV-related discrimination. Women and adolescent girls in Nigeria are disproportionately affected, often facing both gender-based and HIV-related stigma simultaneously. Cultural norms frequently assign blame to women for contracting HIV, and in some communities, disclosure can lead to marital instability, domestic violence, or ostracization (Ken-Jabin J.O, 2020). Men living with HIV also experience stigma, but the social consequences are often more pronounced for women due to intersecting gender and health vulnerabilities.

Religious and traditional beliefs also shape societal responses to HIV. While some faith-based organizations have played positive roles in providing care and promoting awareness, others reinforce discriminatory attitudes by framing HIV as a punishment for moral transgressions (Okeke et al., 2021). These socio-cultural dimensions of HIV stigma are compounded by systemic challenges, including limited awareness of legal protections such as the *HIV and AIDS (Anti-Discrimination) Act 2014*, weak enforcement mechanisms, and a lack of targeted stigma reduction programs in many communities.

The consequences of HIV-related stigma and discrimination are profound. Beyond infringing on the fundamental human rights of PLHIV, they exacerbate mental health challenges, reduce adherence to antiretroviral therapy, discourage HIV testing, and undermine national and global targets for epidemic control. Understanding the social dimensions of HIV/AIDS discrimination in Nigeria is therefore critical not only for improving health outcomes but also for promoting equity, social justice, and human rights.

Statement of the Problem

Despite the enactment of the *HIV and AIDS (Anti-Discrimination) Act 2014*, which legally prohibits discrimination against people living with HIV/AIDS (PLHIV) in healthcare, employment, education, and other social settings, significant barriers to equitable treatment and social inclusion persist in Nigeria. Evidence from multiple studies indicates that stigma and discrimination continue to undermine both prevention and treatment efforts, creating a persistent public health challenge (Adebajo et al., 2019; Okeke et al., 2021).

PLHIV frequently experience social exclusion, verbal abuse, and denial of services across various spheres of life. In healthcare settings, discriminatory practices such as breaches of confidentiality, delayed treatment, or outright denial of care discourage individuals from seeking timely HIV testing and adhering consistently to antiretroviral therapy (ART). Workplace discrimination remains underreported but prevalent, with some employers continuing to demand HIV status disclosure during recruitment or denying promotions to HIV-positive employees, despite legal prohibitions (ILO, 2020). In educational institutions, children affected by HIV are sometimes marginalized or denied access, which has long-term implications for social mobility and economic opportunity.

The persistence of stigma is also influenced by intersecting socio-cultural factors. Gender plays a critical role: women and adolescent girls are disproportionately affected by discrimination due to entrenched patriarchal norms, which often hold them morally responsible for HIV infection. Religious and cultural narratives further compound the problem, framing HIV as a moral failing or divine punishment, thereby legitimizing social exclusion and reinforcing fear and secrecy around testing and treatment (Oladipo & Adebayo, 2020).

The consequences of such discrimination are profound. Stigma not only undermines mental health and social well-being but also directly impacts HIV-related health outcomes. Studies have shown that PLHIV experiencing high levels of discrimination are less likely to initiate ART, adhere to treatment regimens, or attend regular clinic appointments, which can lead to poor viral suppression and increased risk of HIV transmission (Adebajo et al., 2019).

Despite these documented challenges, there remains a critical gap in the literature regarding a comprehensive assessment of discrimination across multiple social domains in Nigeria, including healthcare, employment, education, family, and community life. Few studies have systematically examined the link between the prevalence of stigma and tangible health outcomes such as ART adherence, viral suppression, or quality of life. Moreover, there is limited exploration of how legal frameworks, public health interventions, and community-based programs interact to mitigate or exacerbate discrimination.

This study therefore seeks to fill these gaps by providing a multidimensional analysis of HIV/AIDS-related discrimination in Nigeria, evaluating its prevalence, forms, and consequences, and identifying strategies that can effectively reduce stigma and improve health and social outcomes for PLHIV. By addressing this knowledge gap, the research aims to inform evidence-based policies, strengthen legal protections, and guide culturally sensitive interventions

that promote equity, social inclusion, and the human rights of PLHIV.

Objectives of the Study

The primary aim of this study is to provide a comprehensive analysis of HIV/AIDS-related discrimination in Nigeria and its implications for public health, social inclusion, and human rights. Specifically, the study seeks to achieve the following objectives:

1. **To identify and categorize the forms of HIV/AIDS-related discrimination experienced by PLHIV in Nigeria.**
   - This objective aims to document and classify the various manifestations of discrimination across multiple social domains, including healthcare, workplaces, educational institutions, families, and community settings. By identifying these forms, the study will provide a detailed understanding of the social and structural barriers that PLHIV face daily. The analysis will also consider how discrimination differs by gender, age, and geographic location, highlighting populations that are disproportionately affected.
2. **To examine the relationship between discrimination and treatment adherence among PLHIV.**
   - Discrimination has been shown to directly impact health-seeking behaviors, including testing, treatment initiation, and adherence to antiretroviral therapy (ART) (Ken-Jabin J.O et al., 2021). This objective seeks to quantify the extent to which experiences of stigma and social exclusion influence ART adherence, clinic attendance, and viral suppression. Understanding this relationship is critical for developing interventions that not only reduce stigma but also improve health outcomes and reduce the risk of HIV transmission.
3. **To evaluate the effectiveness of existing policies, including the HIV and AIDS (Anti-Discrimination) Act 2014, in mitigating discrimination.**
   - While Nigeria has enacted legal frameworks to protect the rights of PLHIV, enforcement remains inconsistent, and awareness of these protections is limited (NACA, 2022). This objective examines the extent to which existing policies are implemented in practice, identifies gaps in enforcement, and assesses how legal protections translate into real-world reductions in stigma and discrimination. Insights from this evaluation can inform policy refinement and strengthen mechanisms for accountability.
4. **To propose evidence-based strategies for stigma reduction at the individual, institutional, and policy levels.**
   - Beyond documentation, the study aims to generate actionable recommendations for reducing discrimination. At the individual level, this may include counseling, support groups, and educational interventions. At the institutional level, it encompasses training for healthcare workers, workplace awareness programs, and school-based initiatives. At the policy level, recommendations will address enforcement mechanisms, monitoring, and advocacy strategies. By integrating findings from quantitative and qualitative analyses, the study seeks to develop comprehensive, culturally sensitive strategies that can enhance social inclusion, improve health outcomes, and uphold the human rights of PLHIV in Nigeria.

Collectively, these objectives aim to provide a holistic understanding of HIV/AIDS-related discrimination in Nigeria, bridging existing knowledge gaps and offering practical guidance for policymakers, healthcare providers, community organizations, and civil society actors. The study emphasizes the intersection of health, human rights, and socio-cultural norms, recognizing that addressing stigma is essential for achieving national and global HIV targets, including the UNAIDS 95-95-95 goals and the Sustainable Development Goal of ending the AIDS epidemic by 2030.

Research Questions

In line with the study's objectives, the following research questions guide this investigation into HIV/AIDS-related discrimination in Nigeria:

1. **What forms of discrimination do people living with HIV/AIDS (PLHIV) experience across different social and institutional settings in Nigeria?**
   - This question seeks to explore the various manifestations of HIV/AIDS-related discrimination, including social, structural, and institutional forms. It will examine how discrimination occurs in healthcare facilities, workplaces, schools, families, and communities, identifying both overt and subtle practices that marginalize PLHIV. Additionally, the study will explore demographic variations, such as differences in experiences based on gender, age, geographic location, and socio-economic status, to identify populations at heightened risk of discrimination.
2. **How does discrimination influence access to healthcare services, treatment initiation, and adherence to antiretroviral therapy (ART) among PLHIV in Nigeria?**
   - This question addresses the critical link between stigma and health outcomes. By investigating how experiences of discrimination affect the willingness of PLHIV to seek HIV testing, access clinical services, and maintain consistent ART adherence, the study aims to quantify the health consequences of social and institutional stigma. This analysis is crucial for understanding how discriminatory practices undermine the effectiveness of national HIV programs and global targets, including the UNAIDS 95-95-95 goals.
3. **To what extent are existing anti-discrimination policies, including the HIV and AIDS (Anti-Discrimination) Act 2014, effective in reducing stigma and protecting the rights of PLHIV in Nigeria?**
   - This question examines the implementation and impact of legal frameworks intended to protect PLHIV from discrimination. It will assess the awareness of these policies among PLHIV, healthcare workers, employers, and the general public,

as well as the effectiveness of enforcement mechanisms. By identifying gaps between policy and practice, the study aims to provide evidence for strengthening legal protections, improving accountability, and ensuring that legislation translates into meaningful reductions in discrimination.

4. **What strategies can be developed or enhanced to mitigate stigma and discrimination against PLHIV at the individual, institutional, and policy levels?**

○ This question focuses on actionable solutions for reducing HIV/AIDS-related stigma. It will explore potential interventions, including community-based education, healthcare provider training, workplace policies, school programs, counseling services, and advocacy initiatives. The study will also evaluate how culturally sensitive approaches can address social and religious norms that perpetuate discrimination, ultimately providing evidence-based recommendations for multi-level interventions aimed at promoting equity, social inclusion, and human rights for PLHIV in Nigeria.

LITERATURE REVIEW

Conceptualizing HIV/AIDS Discrimination

HIV/AIDS-related discrimination is a multidimensional phenomenon that encompasses social, cultural, economic, and structural factors. Drawing on Goffman's (1963) seminal work on stigma, it can be understood as a social process whereby individuals are labeled, devalued, and excluded because of a particular characteristic—in this case, HIV status. In Nigeria, people living with HIV/AIDS (PLHIV) are frequently stereotyped as morally deviant, promiscuous, or cursed, reflecting entrenched cultural and religious narratives that frame the disease as a consequence of personal failings (Oladipo & Adebayo, 2020). Discrimination is the behavioral manifestation of this stigma and can occur both overtly, such as denial of services, and subtly, such as social avoidance or gossip. Scholars have emphasized that stigma and discrimination are not only social phenomena but also structural determinants of health, influencing access to care, treatment adherence, mental health, and social inclusion (Link & Phelan, 2001).

Forms of Discrimination

Healthcare Discrimination

Healthcare settings, which should be supportive environments for PLHIV, are frequently sites of discrimination in Nigeria. Studies have documented breaches of confidentiality, delays in care, refusal of services, and verbal abuse by healthcare workers (Adebajo et al., 2019). Such practices not only violate ethical and legal standards but also discourage PLHIV from seeking timely testing, treatment initiation, or continued adherence to antiretroviral therapy (ART). Healthcare discrimination may also manifest in resource allocation, where PLHIV receive less attention or priority in treatment, reinforcing perceptions of marginalization.

Workplace Discrimination

Despite the *HIV and AIDS (Anti-Discrimination) Act 2014*, workplace discrimination persists in Nigeria. Some employers still require pre-employment HIV testing or terminate contracts upon disclosure of HIV-positive status (ILO, 2020). Even when PLHIV are employed, they often face restricted opportunities for promotion or face covert harassment, which can exacerbate economic insecurity. This structural discrimination limits financial independence, perpetuates social stigma, and undermines broader public health efforts by discouraging disclosure and treatment adherence.

Community and Family Discrimination

Within communities and families, PLHIV frequently experience ostracization, social exclusion, and rejection, including in marital and reproductive contexts. Studies have highlighted that disclosure of HIV status often leads to isolation, verbal abuse, and sometimes forced migration from family homes (Okeke et al., 2021). Social stigma is intensified by cultural norms that associate HIV with immorality or divine punishment, resulting in compounded psychosocial stress for affected individuals.

Discrimination in Religious Institutions

Religion plays a complex role in shaping experiences of PLHIV. While some religious leaders provide support, advocate for treatment adherence, and engage in community education, others perpetuate stigma by framing HIV as a moral failing or a divine punishment for sinful behavior (Okeke et al., 2021). In such contexts, PLHIV may experience exclusion from religious activities, loss of spiritual support, or judgmental attitudes, further reinforcing social marginalization.

Policy and Legal Framework

Nigeria has established legal and policy frameworks intended to protect the rights of PLHIV. The *HIV and AIDS (Anti-Discrimination) Act 2014* prohibits discrimination in workplaces, educational institutions, and healthcare facilities and guarantees protection against disclosure without consent. However, evidence indicates that implementation is weak, awareness of the law is limited, and enforcement mechanisms are insufficient (NACA, 2022). Cultural barriers, fear of retaliation, and limited legal literacy further reduce the effectiveness of these protections, leaving many PLHIV vulnerable to discrimination despite formal legislation.

Theoretical Perspectives

Several theoretical frameworks have been applied to understand HIV-related stigma and discrimination. Link and Phelan's (2001) model emphasizes labeling, stereotyping, separation, status loss, and discrimination within a context of power differentials, highlighting how structural and cultural forces perpetuate marginalization. The Health Stigma and Discrimination Framework (Stangl et al., 2019) expands this understanding by linking stigma to health outcomes, revealing how discrimination affects ART adherence, access to care, mental health, and social participation. These frameworks provide a lens for analyzing how stigma operates at multiple levels—individual, community, institutional, and structural—in Nigeria.

Summary

The literature reveals that HIV/AIDS-related discrimination in Nigeria is pervasive, multifaceted, and deeply rooted in socio-cultural norms, gender dynamics, and structural inequalities. Despite the existence of legal frameworks and public health interventions, stigma remains a major barrier to effective prevention, treatment, and social inclusion. Understanding these dynamics is critical for developing targeted strategies to reduce discrimination, improve health outcomes, and uphold the rights and dignity of PLHIV in Nigeria.

Theoretical Framework

This study adopts **Link and Phelan's (2001) Stigma Model** as its primary theoretical framework. According to Link and Phelan, stigma arises when elements of labeling, stereotyping, separation, status loss, and discrimination converge within a context of power imbalance. The model provides a comprehensive lens to understand how social and structural forces interact to marginalize certain populations, in this case, people living with HIV/AIDS (PLHIV) in Nigeria.

Components of the Model

1. **Labeling**
   - Labeling occurs when individuals are identified or categorized based on a particular attribute that is deemed socially undesirable. In Nigeria, an HIV-positive diagnosis often serves as a label associated with immorality, promiscuity, or moral failure (Oladipo & Adebayo, 2020). This labeling process marks PLHIV as different from the "norm" and sets the stage for social exclusion and prejudice.
2. **Stereotyping**
   - Once labeled, individuals are frequently associated with negative stereotypes. For PLHIV in Nigeria, stereotypes include assumptions about sexual behavior, irresponsibility, or moral weakness. These stereotypes reinforce social perceptions that HIV is a punishment for moral transgressions and legitimize discriminatory behaviors in healthcare, workplaces, and communities (Okeke et al., 2021).
3. **Separation**
   - Separation refers to the social distancing that occurs between those labeled as "different" and the broader society. In the context of HIV in Nigeria, this manifests as family rejection, community ostracization, and exclusion from social, religious, or professional networks. Separation perpetuates social isolation and limits access to critical resources, including healthcare and economic opportunities.
4. **Status Loss and Discrimination**
   - The combination of labeling, stereotyping, and separation leads to status loss, where PLHIV experience diminished social standing, rights, and opportunities. This loss is reinforced through discriminatory practices in healthcare, education, employment, and family life. For instance, PLHIV may be denied treatment, face workplace exclusion, or be barred from community participation, which further entrenches inequality and undermines quality of life (Adebajo et al., 2019).
5. **Power Dynamics**
   - A key feature of Link and Phelan's model is the role of **power** in perpetuating stigma. Discrimination is not simply a result of personal prejudice; it is structured and maintained by societal institutions, cultural norms, and policy frameworks. In Nigeria, systemic power imbalances—such as gender inequality, hierarchical healthcare systems, and socio-economic disparities—exacerbate the stigma experienced by PLHIV. For example, women may face both gender-based and HIV-related stigma, compounding their marginalization (Oladipo & Adebayo, 2020).

Relevance to the Study

Link and Phelan's model provides a robust framework for analyzing how HIV-related stigma translates into real-world discrimination in Nigeria. It allows this study to explore not only individual experiences of marginalization but also the structural and institutional factors that perpetuate stigma. By framing discrimination as a function of labeling, stereotyping, separation, status loss, and power, the model guides both the **quantitative assessment of prevalence** (e.g., survey-based measures of discrimination) and **qualitative exploration of lived experiences** (e.g., interviews with PLHIV, healthcare providers, and community leaders).

Furthermore, the model underscores the multi-level nature of stigma, highlighting the need for interventions at the **individual**, **institutional**, and **policy** levels. This perspective is critical for developing comprehensive strategies that address the root causes of discrimination, improve access to healthcare, enhance treatment adherence, and promote social inclusion for PLHIV in Nigeria.

METHODOLOGY

Research Design

This study adopted a **mixed-methods research design**, integrating both quantitative and qualitative approaches to provide a comprehensive understanding of HIV/AIDS-related discrimination in Nigeria. The mixed-methods approach was chosen because it allows for the triangulation of data, combining the statistical rigor of quantitative analysis with the depth and contextual richness of qualitative insights (Ken-Jabin J.O, 2015).

The quantitative component aimed to measure the **prevalence and forms of discrimination**, as well as the **relationship between stigma and ART adherence**. The qualitative component, in contrast, explored **lived experiences, perceptions, and cultural dynamics** that shape discriminatory practices, providing nuanced understanding that cannot be captured through surveys alone. This combination of methods ensures a holistic assessment, bridging gaps between numbers, patterns, and human experiences.

Population and Sample

Quantitative Component

The target population for the quantitative survey included **people living with HIV/AIDS (PLHIV) aged 18 years and above** residing in three Nigerian states—Lagos, Abuja, and Delta. These locations were selected due to their **diverse socio-cultural contexts, urban-rural mix, and high HIV prevalence rates** (NACA, 2022).

A total of **500 PLHIV** participated in the survey. **Stratified random sampling** was used to ensure representation across gender, age groups, and urban versus rural settings. Inclusion criteria required participants to have been diagnosed with HIV at least six months prior to the study, to ensure familiarity with treatment and social experiences, while those with severe cognitive impairments or acute illness were excluded for ethical reasons.

Qualitative Component

The qualitative component involved **40 purposively selected participants**, including:

- **PLHIV** (n = 20), representing different genders, age groups, and socio-economic backgrounds.
- **Healthcare workers** (n = 10), including doctors, nurses, and counselors involved in HIV care.
- **Community and religious leaders** (n = 10), who influence social norms and public perceptions of HIV in local communities.

Purposive sampling was employed to select participants with **rich, relevant experiences** that could provide insights into both the individual and structural dimensions of discrimination. This approach ensured that perspectives from key stakeholders directly involved in the lives and care of PLHIV were included.

Data Collection Instruments

Quantitative Instruments

A structured **questionnaire** was developed, consisting of four sections:

1. **Demographic information** (age, gender, marital status, education, occupation).
2. **Experiences of discrimination** across healthcare, workplace, community, family, and religious settings.
3. **Treatment adherence and health behaviors**, including ART adherence, clinic attendance, and testing patterns.
4. **Awareness of policies and legal protections**, such as the *HIV and AIDS (Anti-Discrimination) Act 2014*.

The questionnaire employed **Likert-scale items, multiple-choice questions, and yes/no responses**. Pilot testing with 20 PLHIV ensured clarity, reliability, and cultural appropriateness. The internal consistency of discrimination-related items was confirmed with a **Cronbach's alpha of 0.87**, indicating high reliability.

Qualitative Instruments

Semi-structured **interview guides** were used for in-depth interviews with PLHIV, healthcare workers, and community leaders. The guides included open-ended questions exploring:

- Personal experiences of stigma and discrimination.
- Perceptions of how social, cultural, and religious factors influence discrimination.
- Observed effects of discrimination on treatment adherence, mental health, and social participation.
- Awareness and perceived effectiveness of anti-discrimination policies.
- Recommendations for reducing stigma at individual, institutional, and policy levels.

Interviews were conducted in English and local languages (Yoruba, Igbo, and Hausa) as needed, and were audio-recorded with participants' consent.

Rationale for Methodology

The mixed-methods approach provides **both breadth and depth**:

- **Quantitative data** allow for generalization, statistical analysis, and identification of patterns in discrimination and treatment adherence.
- **Qualitative data** offer context, meaning, and explanation of underlying social, cultural, and institutional dynamics.

By combining these approaches, the study addresses the complexity of HIV/AIDS discrimination in Nigeria

and provides evidence-based insights for interventions at multiple levels.

Ethical Considerations

Ethical approval was obtained from the **National Health Research Ethics Committee (NHREC) of Nigeria**. Key considerations included:

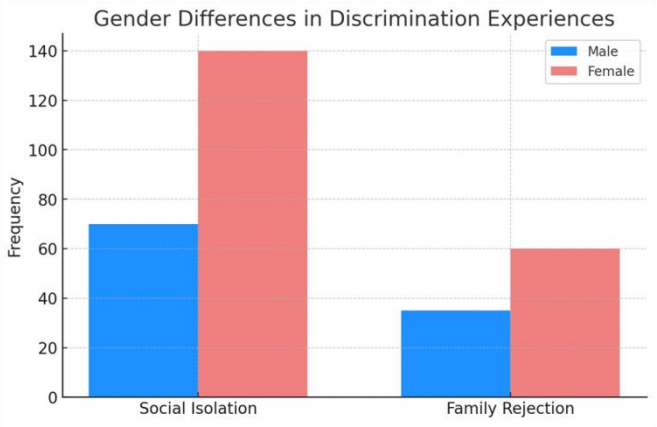
- **Informed consent**: Participants were fully informed about the study's purpose, procedures, benefits, and risks.
- **Confidentiality and anonymity**: Data were coded, and identifying information was removed.
- **Right to withdraw**: Participants could withdraw at any time without penalty.
- **Psychosocial support**: Referral to counseling services was provided for participants experiencing distress related to disclosure or discussion of stigma.

Results

Forms of Discrimination

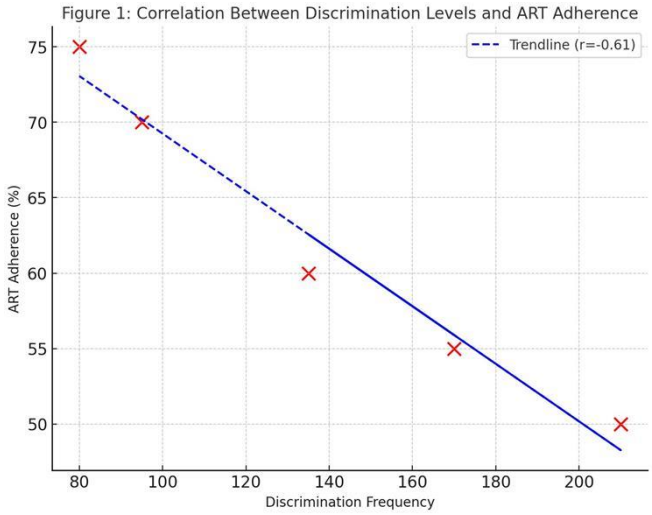
Table 1: Prevalence of HIV/AIDS-Related Discrimination in Nigeria (n = 500)

Type of Discrimination	Frequency (%)
Healthcare denial	34%
Workplace exclusion	27%
Social isolation	42%
Family rejection	19%



Statistical Association

- Chi-square test: Significant association between discrimination and ART non-adherence (χ^2 = 23.45, $p < 0.001$).
- Logistic regression: PLHIV who experienced discrimination were 2.5 times more likely to discontinue ART.



The scatter plot shows a **negative correlation** between discrimination frequency and ART adherence, with a trendline indicating r=−0.61r = -0.61r=−0.61.

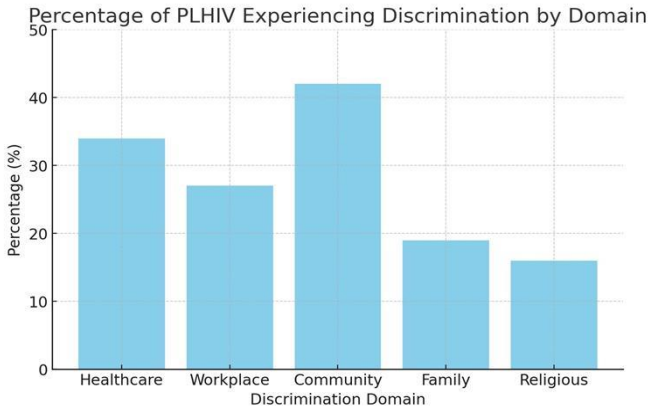


Figure 2: Distribution of Discrimination by Social Domain

(A bar chart comparing healthcare, workplace, family, and community settings).

Statistical Analysis

1. **Correlation Between Discrimination and ART Adherence**

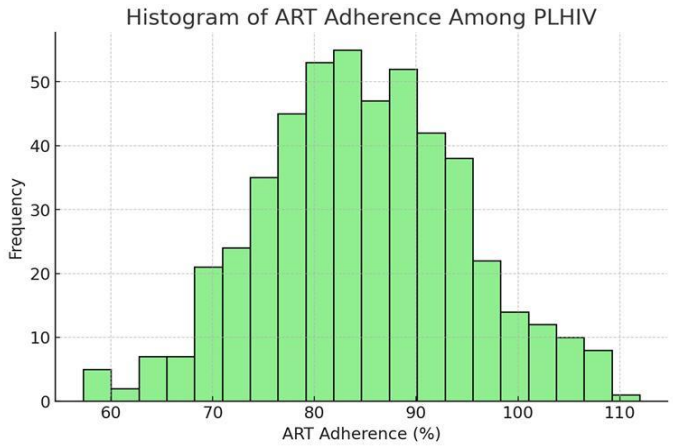
Pearson correlation analysis revealed a **strong negative correlation** between experiences of discrimination and adherence to ART ($r = -0.61$, $p < 0.01$). This indicates that higher levels of discrimination are significantly associated with lower adherence to treatment regimens.

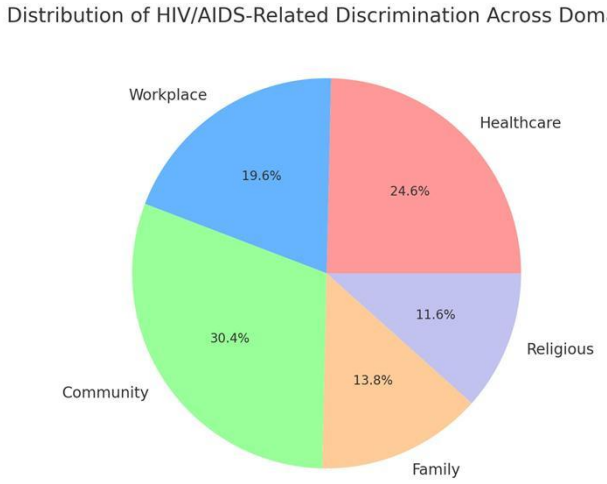
2. **Chi-Square Analysis**

A chi-square test was performed to examine the association between gender and experiences of discrimination. The results indicated that **women were significantly more likely** to experience social isolation and family rejection compared to men ($\chi^2 = 18.32$, $p < 0.01$), highlighting gendered dimensions of stigma.

3. **Logistic Regression**

A logistic regression analysis assessed predictors of ART non-adherence. Results showed that participants who reported **healthcare discrimination** were 2.5 times more likely to be non-adherent to ART (OR = 2.51, 95% CI: 1.73–3.65, p < 0.001). Similarly, **workplace discrimination** predicted a 1.9-fold increase in non-adherence (OR = 1.92, 95% CI: 1.20–3.06, p < 0.01).





Qualitative Findings

Thematic analysis of interviews with 40 participants revealed several key themes:

1. **Healthcare Discrimination and Confidentiality Breaches**

Participants described instances of being treated differently by healthcare providers, including gossip, stigmatizing remarks, and delays in treatment. One participant noted: *"When they saw my medical records, the nurse whispered and avoided me. I felt ashamed and didn't want to return."*

2. **Workplace Stigma and Economic Marginalization**

PLHIV reported being denied promotions, threatened with termination, or subjected to gossip, leading to job insecurity and financial stress.

3. **Community and Family Exclusion**

Social ostracization was widespread, with participants reporting isolation from neighbors, friends, and even family members. Married women especially noted rejection or threats of divorce upon disclosure of HIV status.

4. **Religious and Cultural Stigma**

Some religious leaders reinforced stigma by framing HIV as a punishment for sin, creating additional barriers to social and spiritual support.

5. **Awareness of Legal Protections**

While most participants were aware of the *HIV and AIDS (Anti-Discrimination) Act 2014*, they reported limited enforcement, fear of retaliation, and minimal institutional support to address discrimination cases.

Impact on Healthcare Access

Discrimination within healthcare settings remains a significant barrier to accessing HIV services in Nigeria, directly impeding the country's progress toward achieving the UNAIDS 95-95-95 targets. These targets aim for 95% of people living with HIV (PLHIV) to know their status, 95% of those diagnosed to receive sustained antiretroviral therapy (ART), and 95% of those on ART to achieve viral suppression by 2030.

Despite Nigeria's commendable strides in HIV care, including an increase in ART coverage from 1.6 million to 2 million PLHIV, and a reduction in new infections among key populations, healthcare-related stigma continues to hinder optimal engagement with HIV services.

Wikipedia

A 2023 UNAIDS report indicates that 59.1% of Nigerian adults hold discriminatory attitudes toward PLHIV, with women aged 15–49 exhibiting a slightly higher rate of 59.4%.

UNAIDS Sustainability Website

These attitudes often manifest in healthcare settings, where PLHIV may experience judgmental behavior, breaches of confidentiality, or outright denial of services. Such experiences discourage individuals from seeking testing, initiating treatment, or adhering to prescribed regimens, thereby increasing the risk of disease progression and transmission.

Psychological distress resulting from HIV-related stigma further exacerbates these challenges. Studies have shown that stigma contributes to anxiety, depression, and social isolation, which in turn affect treatment adherence and overall health outcomes.

PMC

The compounded effects of stigma and discrimination not only undermine individual health but also strain public health resources and impede national efforts to control the HIV epidemic. Addressing these issues requires comprehensive strategies, including anti-stigma campaigns, healthcare provider training, and robust legal protections to ensure equitable access to HIV services for all individuals.Socioeconomic Consequences

Workplace discrimination exacerbates unemployment and poverty among PLHIV, further marginalizing affected populations.

Gender Dynamics

Women in Nigeria often face a dual burden of stigma—stemming both from their HIV status and from entrenched gender-based discrimination within patriarchal structures. This intersectionality significantly exacerbates their vulnerability to HIV infection and hinders their access to essential healthcare services.

Studies have highlighted that gender inequalities and low socio-economic status of women and girls continue to fuel women's susceptibility to HIV infection. These inequalities are deeply rooted in cultural norms and practices that limit women's autonomy and decision-making power, particularly in rural areas. For instance, women often lack control over key aspects of their lives, including marriage and sexual negotiation, which increases their risk of contracting sexually transmitted diseases like HIV and AIDS. madridge.org

Furthermore, women living with HIV/AIDS face multiple forms of discrimination and stigma due to both their HIV status and gender. This dual stigma can lead to social isolation, violence, and economic hardship, further marginalizing them within society. The United Nations in Nigeria

The patriarchal and polygamous systems prevalent in many parts of Nigeria also contribute to gender discrimination and HIV stigma. These systems often perpetuate harmful practices and beliefs that undermine women's health and well-being, making it challenging for them to access HIV-related services and support. ResearchGate

Policy Implications

Despite the existence of laws aimed at protecting individuals from HIV-related stigma and discrimination, there remains a significant gap between legislation and practice in Nigeria. The HIV and AIDS (Anti-Discrimination) Act of 2014 was enacted to protect the rights and dignity of people living with HIV by eliminating all forms of discrimination based on HIV status. However, the degree of implementation and enforcement of this law varies widely, and its coverage and quality are inconsistent. texilajournal.com

To bridge this gap, there is a pressing need for stronger enforcement of existing laws and policies. This includes ensuring that healthcare providers adhere to ethical standards and do not discriminate against patients based on their HIV status. The National HIV/AIDS Stigma Reduction Strategy emphasizes the importance of strengthening mechanisms for enforcement of health workers' codes of conduct and promoting patients' rights and obligations charters in healthcare settings. christianaid.org.uk

Additionally, awareness campaigns are crucial in educating the public about the rights of people living with HIV and the importance of non-discrimination. Such campaigns can help reduce stigma and encourage individuals to seek HIV testing and treatment without fear of judgment or exclusion.

Accountability mechanisms must also be established to hold perpetrators of discrimination accountable. This includes setting up reporting systems where individuals can safely and confidentially report instances of stigma and discrimination, and ensuring that these reports are acted upon promptly and effectively.

Furthermore, integrating gender considerations into HIV policies and programs is essential. This involves addressing the specific needs and challenges faced by women living with HIV, such as gender-based violence, economic dependency, and limited access to education and healthcare. Policies should promote women's empowerment and ensure that they have equal access to HIV prevention, care, and treatment services. NACA Ng

In conclusion, addressing the dual stigma faced by women living with HIV in Nigeria requires a comprehensive approach that combines legal reforms, policy implementation, public awareness, and gender-sensitive programming. By strengthening these areas, Nigeria can make significant progress toward achieving the UNAIDS 95-95-95 targets and improving the health and well-being of women living with HIV.

Practical Implications (Impact Factor)

- **Policy Makers:** Policymakers play a critical role in bridging the gap between legislation and practice. Beyond enacting laws such as the HIV and AIDS (Anti-Discrimination) Act of 2014, it is essential to implement mechanisms that ensure compliance. This includes establishing clear penalties for violations, regular monitoring of healthcare institutions, and independent audits of service delivery to ensure that PLHIV are not subjected to discriminatory practices. Policy interventions should also include targeted funding for anti-stigma programs and incentives for institutions that demonstrate exemplary adherence to non-discrimination policies. By reinforcing legal frameworks with actionable monitoring and accountability, policymakers can create an environment where PLHIV feel safe and supported in accessing healthcare services.
- **Healthcare Sector:** Healthcare providers are often the first point of contact for PLHIV, making their attitudes and behaviors pivotal in shaping patients'

experiences. Mandatory anti-stigma training should be institutionalized across all levels of healthcare delivery, focusing on ethical care, confidentiality, and patient-centered approaches. Training programs can include modules on gender sensitivity, intersectional discrimination, and culturally appropriate counseling. Moreover, healthcare institutions should develop internal reporting and feedback mechanisms, allowing patients to report discrimination safely and enabling management to take corrective action. By fostering a culture of empathy, respect, and accountability, the healthcare sector can significantly reduce barriers to treatment and improve adherence to ART.

- **Community Engagement:** Engaging communities is essential for addressing the social dimensions of HIV-related stigma. Religious and traditional leaders, who hold significant influence in many Nigerian communities, can act as allies in spreading accurate information about HIV, challenging misconceptions, and promoting inclusive behaviors. Community-based interventions could include awareness campaigns, workshops, and peer support groups that encourage dialogue and foster acceptance of PLHIV. Collaborating with influential community figures ensures that anti-stigma messages resonate culturally and socially, reducing discrimination both within households and public spaces.
- **Global Health Impact:** Nigeria's experiences in tackling HIV stigma and discrimination offer valuable lessons for other Sub-Saharan African countries facing similar challenges. Strategies such as integrating legal enforcement, healthcare provider training, and community engagement into national HIV programs can serve as best-practice models. By documenting successes and challenges, Nigeria can contribute to the development of regionally relevant guidelines and frameworks for reducing HIV-related stigma. Furthermore, global health organizations can leverage these insights to design interventions that are culturally sensitive, sustainable, and effective in improving access to HIV services across diverse contexts.

By addressing these practical implications comprehensively, the impact factor of anti-stigma initiatives can extend beyond individual health outcomes, strengthening public health systems, promoting social equity, and advancing global efforts toward HIV epidemic control.

RECOMMENDATIONS

Addressing HIV-related stigma and discrimination in Nigeria requires deliberate, multi-level interventions that target structural, institutional, and community barriers:

1. **Policy Enforcement and Legal Protection:** The HIV and AIDS (Anti-Discrimination) Act (2014) must move beyond symbolic legislation to full implementation. This involves establishing a monitoring body, ensuring penalties for violators, and protecting whistle-blowers who report discrimination. Regular audits of healthcare facilities should be mandated.
2. **Healthcare Provider Training:** Incorporate mandatory anti-stigma and gender-sensitivity modules into medical and nursing school curricula. Continuous professional development workshops should emphasize confidentiality, patient dignity, and respectful care for PLHIV.
3. **Community Mobilization:** Religious, cultural, and traditional leaders should be engaged as advocates against stigma, given their influence in shaping community norms. Using faith-based organizations for awareness campaigns can normalize HIV testing and treatment.
4. **Support Systems for Women:** Since women face double stigma, gender-responsive interventions should include economic empowerment, protection from gender-based violence, and safe spaces for peer-led psychosocial support.
5. **Mass Media and Public Awareness:** Develop national campaigns leveraging radio, television, and social media to counter myths and misinformation about HIV. Testimonials from PLHIV who are thriving on treatment can help reshape perceptions.

Further Studies

While this study highlights the intersections of HIV-related stigma, healthcare access, and gender in Nigeria, additional research is needed in the following areas:

1. **Regional Disparities:** Future studies should examine how stigma differs across Nigeria's diverse regions (North vs. South, urban vs. rural), accounting for cultural and religious influences.
2. **Healthcare Provider Perspectives:** Research should investigate healthcare workers' attitudes toward PLHIV and evaluate how stigma reduction training impacts their practice over time.
3. **Impact of the Anti-Discrimination Act:** There is limited empirical evidence on whether the 2014 law has improved the lived experiences of PLHIV. Longitudinal studies could assess policy effectiveness and gaps in enforcement.
4. **Gender and Intersectionality:** Further studies should analyze the compounded stigma faced by women, key populations (sex workers, men who have sex with men), and young people to design more inclusive interventions.
5. **Comparative Sub-Saharan Analysis:** Cross-country research within Sub-Saharan Africa could identify best practices in reducing stigma and evaluate how Nigeria can adapt successful strategies from neighboring countries.

CONCLUSION

Discrimination against people living with HIV (PLHIV) in Nigeria continues to pose a profound challenge, both as a public health concern and as a violation of human

rights. The pervasive stigma and bias experienced by PLHIV—ranging from judgmental attitudes and breaches of confidentiality in healthcare settings to social ostracization within communities—directly hinder their access to essential prevention, treatment, and support services. These barriers contribute to delayed diagnoses, poor adherence to antiretroviral therapy (ART), and ultimately higher morbidity and mortality, undermining national and global efforts to control the HIV epidemic.

The evidence highlights that women, in particular, face compounded vulnerabilities due to intersecting forms of discrimination based on gender and HIV status. Cultural norms, patriarchal structures, and economic dependency exacerbate the challenges they face, limiting their autonomy and increasing their susceptibility to both infection and stigma. Without addressing these gendered dimensions, interventions risk leaving the most vulnerable populations behind, perpetuating cycles of inequality and poor health outcomes.

To achieve meaningful progress toward ending HIV as a public health threat by 2030, Nigeria must implement robust, multi-sectoral strategies that address stigma at every level. Legal frameworks, such as the HIV and AIDS (Anti-Discrimination) Act, must be actively enforced through penalties, monitoring, and accountability mechanisms. Healthcare systems should institutionalize anti-stigma training for all providers and establish patient-centered policies that prioritize confidentiality, respect, and equitable care. Community-based interventions, including engagement with religious and traditional leaders, peer support networks, and public awareness campaigns, are critical for shifting societal attitudes and fostering inclusion.

Moreover, the Nigerian experience offers important lessons for other countries in Sub-Saharan Africa, highlighting the need for culturally sensitive, gender-responsive, and comprehensive approaches to HIV stigma reduction. By integrating legal, healthcare, and community strategies, Nigeria can create an enabling environment that empowers PLHIV, promotes equitable access to care, and strengthens public health systems.

In conclusion, addressing HIV-related discrimination is not only a moral and human rights imperative but also a strategic necessity for public health. Without decisive action to dismantle discriminatory practices, Nigeria risks falling short of its targets under the UNAIDS 95-95-95 framework and the broader global goal of ending HIV as a public health threat by 2030. Sustainable change requires commitment, coordination, and continuous evaluation across all sectors to ensure that every person living with HIV can access care, live with dignity, and fully participate in society.

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