How to Cite:
Augustina, O. O., Egbe, I. B., Samuel, B. U., Takim, T. O., & Esther, U. E.-C. (2022). Discriminatory practices of health care providers and care of PLWHA in health facilities in cross river state, Nigeria. *International Journal of Health Sciences*, *6*(S6), 10516–10537. https://doi.org/10.53730/ijhs.v6nS6.12815

Discriminatory practices of health care providers and care of PLWHA in health facilities in cross river state, Nigeria

Onyema Okwu Augustina (Ph.D)
Department of Sociology, University of Calabar, Calabar, Nigeria
Email: luk4tinasly@gmail.com, augustinaonyema@unical.edu.ng

Isokon Brown Egbe (PhD)
Department of Social Work, University of Calabar, Calabar, Nigeria
Email: isokonegbe@unical.edu.ng

Bassey Ugo Samuel (PhD)
Department of Sociology, University of Calabar, Calabar, Nigeria
Email: ugoluoisa@gmail.com

Tiku Oru Takim (PhD)
Department of Social Work, University of Calabar, Calabar, Nigeria
Email: takimtiku@unical.edu.ng

Uzoh Esther E-C. (PhD)
Department of Social Work, University of Calabar, Nigeria
Email: ecuzoh@gmail.com

Abstract---The study examines the effect of discriminatory practices by health care providers on PLWHA in health facilities in Cross River State, Nigeria. This quantitative study utilizes survey design and a three stage sampling technique of 674 from the three senatorial districts that constitute Cross River State was used. The selection of participants was carried out per each health facility using simple random sampling method. The questionnaire used was field tested in the 14 health facilities used. It was further complimented with FGDs to draw data for the study. Analyses of items were descriptively carried out using tables and percentage, mean and standard deviations. The data entry and cleaning were done at each selected health facility after which they were combined into one data set and were further cleaned. The exploratory factor was also used to analyze the instrument. The result revealed that PLWHA were discriminated from accessing modern health care services due to health care provider's abrupt dismissive attitudes. Worthy of note is that most

health care providers did not know the coping strategies nor have the patience to deal with PLWHA. Because of their discriminatory practices it becomes practically impossible to give a holistic care to PLWHA. The study is useful for policy formulation and planning towards the care of PLWHA. It is therefore recommended that the Cross River State government embark on comprehensive HIV related training to change the attitude of health care providers.

Keywords---discriminatory practices, health care personnel, HIV/AIDS prevention, PLWHA, health facility.

Introduction

Over the years, the estimation of People Living with HIV/AIDS (PLWHA) in Nigeria was very high, precisely in 1980s about 3.6 million people were affected and this was a great concern (UNAIDS, 2012). Then, for ranking, she was rated the second on the number of people living with HIV/AIDS in Africa (Civil Society Legislative Advocacy Centre, (CISLAC) 2012). Recently, there has been an improvement in the treatment and prevention of HIV in Nigeria but discrimination has never ceased being a barrier to the ending of AIDS, a threat and challenge to health. HIV-related discrimination occurs in many styles and occasions but may have significant consequences in the health care sector. PLWHA suffer discrimination in places of work, communities, and from Health Care Personnel (HCP). Discriminatory practices by HCP against PLWHA as reported from other countries seem to affect the utilization of the health facilities. Discrimination and stigmatization may discourage people from getting HIV test and having access to useful information to protect them and others (Letaimo, 2005). It is imperative to note that so many people are not presenting themselves for voluntary testing not to talk of adhering to stipulated treatments from the targeted facilities due to the fear of being discriminated. Some people are never ready to disclose the sero-status of a family member if found HIV positive.

Generally in Nigeria, the attitude of health personnel especially nurses have been a great concern, some of them are rude, hash and only give quality care to known clients. Reis et al (2005) noted that a good number of health personnel displayed attitudes that are unethical to HIV patients. Again, authors remarked that past experience of some pregnant women was the main reason of non utilization of some hospitals. Neglect and wrong use of abusive words on patients equally amount to undue pressure on the sick. Basic attitudes expected from HCP, like, giving care, comfort and relief to the sick are rarely found especially in secondary facilities for PLWHA. The study looks at discriminatory practices that restrain care on PLWHA, how health care personnel relates to patients in the form of attitudes and behaviour, and make possible suggestions to curtail discrimination. The research work aimed at answering these questions;

- what are the discriminatory practices by HCP that affect the wellbeing and care of PLWHA?
- what causes discrimination on PLWHA?

To achieve the answers, questionnaire was designed and administered to the study population to get information on, attitude of staff on PLWHA and availability of working tools in the facilities. Again, to identify discriminatory practices certain factors need to be measured, for instance, attitudes of staff towards patients', with special reference to the Rights of the patients and availability of working tools in the facilities. There are attitudinal display among health personnel that suggested lack of care and discriminatory practices of PLWHA for example worrying about contagion during treatment for PLWHA, not seeking the consent of people living with HIV (PLWHA) before testing, and non supportive health facility environment. However, availability of working tools, training or retraining of staff will go a long way to motivate HCP giving comprehensive care.

Discrimination is widely practiced by medical, Para-medical and administrative personnel, but the study was limited to only health personnel who are actively involved in providing the day to day services of counseling, testing, and provision of ART, adherence counseling and follow up in the hospital/health centers. It was restricted to only health workers in the 12 secondary health facilities in Cross River State, Nigeria. Thus 11 hospitals (providing comprehensive ART services) and 1 hospital (providing PMTCT services) were included in the study. The independent variable was the discriminatory practices by health personnel and the dependent variable was caring for PLWHA.

Statement of problem

Discrimination of PLWHA has been noticed in the healthcare system. Such perceived discrimination could be discouraging so much so that the search for treatment, care and adherence or follow-up becomes difficult. Letaimo(2005). HIV/AIDS is a threat but discrimination is more threatening than getting infected by the disease. Discrimination and stigmatization are impediments to giving care to PLWHA and the search for reasons restraining PLWHA and other clients from seeking treatment; counseling and prevention at the available health facilities prompted this study. They discriminate, abuse and neglect their patients instead of exhibiting a high quality treatment they are known for. Unfortunately, there seem to be continuous discrimination on the part of health personnel through less thorough care. Persistent discrimination of HIV-infected people by health personnel may likely influence the utilization of services in Secondary health facilities in Cross River State.

These discriminatory practices include absence of care to PLWHA, undignified way of approaching their personal belongings, even with the training and knowledge acquired on means of transmission. Revealing clients HIV status without their consent is another form of discrimination, which is breaching the rule of confidentiality by health personnel. It poses a significant barrier to care and utilization of the facilities provided. More so, lack of working tools and unfavourable environment or facility tends to increase the practice of discrimination by health personnel. Consequently, these practices result to status depreciation and lack of concern in containing the disease and so, seeking treatment at health facilities becomes difficult due to increased internalized fear of being discriminated. However, delay in accessing treatment due to fear of being

discriminated can be disastrous. In view of the foregoing problems therefore, this study examines the discriminatory practices of health personnel on HIV positive patients and its influence on care and utilization of Health facility in the study area.

Objective of the study

To ascertain whether discriminatory practices by healthcare providers affects the care of PLWHA

Hypothesis

Discriminatory practices by healthcare personnel does not significantly affects care of PLWHA

Literature review

Discriminatory practices by Health Care Personnel (HCP) and PLWHA

Use of extra infection precautions is visibly practiced among health workers, it is reported that wearing double gloves may serve as a protection against contraction of HIV and so, most health workers apply extra caution when attending to PLWHA. HCP fret over contagion as they provide care to PLWHA, their worrying increased as the virus invades. Scholarly article by Nyblade et al. (2013) showed that greater number of respondents indicated that HCP used abusive words on PLWHA. Again, HIV positive staff are rarely supported by the facility, majority of the staff who are HIV positive are relieved of their duties or apply for voluntary retirement as the case may be, just to avoid being discriminated at work place. Enabling environment with enacted laws in the facilities and standardized procedures of testing and treatment can give protection to PLWHA from being discriminated, but some work environment increases the practice of discrimination. However, provision of supplies like gloves and post-exposure prophylaxis, and a comprehensive re-training on confidentiality, making and implementing policies that can support and protect PLWHA, are various measures necessary to be taken to eliminate discrimination and stigma (Nyblade et al, 2013).

In many countries of the world discrimination and stigmatization in HIV/AIDS cases hinder prevention, treatment and care. Anderson, Elam and Gerver, (2008) opined that various attitude identified to be discriminatory include, displaying negative attitude, blaming the patients for contacting the virus, backing up policies that limits HIV patients and segregating from PLWHA. Using the three factor solution to measure HIV- related stigma, the study revealed that dishonor, reproach social isolation, discrimination had consistently experiences. The shame of assessing care, due to the blame on PLWHA for living irresponsibly keeps them isolated form health facilities. Anderson et al. (2008). According to Pearson et al (2008) noted that men of Zimbabwe were afraid of seeking care in a bid to avoid being stigmatized or discriminated. Even TB patients equally get discouraged in completing treatment because of fear of being discriminated (Pearson et al, 2008). Scholars in India reported the existence of discrimination primarily in health

services. Thus, PLWHA are denied medical care (Mulye et al. 2005; Marfatia et al. 2007).

UNAIDS and World Health Organization (WHO) identified fear of being discriminated as the primary reason for HIV patients refusing to disclose their status, get tested and take medication (ARV). In fact respondents in one of the surveys who reported a significant level of stigma were more likely to report lack of access to care. That is health care providers giving poorer quality of care to HIV patients than others. This gives rise to increase in the spread of the HIV epidemic and increase in death rate globally. (USAID, 2005). Famoroti et al. (2013), in a recent study observed that Healthcare workers unwilling to care for patient living with HIV specifically reported that it is necessary to avoid treating key populations like men who have sex with men, sex workers and people who inject drugs. Respondents indicated unwillingness to treat based on certain reasons; 1). Stigma experienced due to caring for PLWHA (e.g., being isolation by friends or family because of caring for PLWHA). 2) Stigmatization of staff who care for pregnant women with HIV positive status and those whose HIV status is not known. The study measured experienced attitudes and observed attitudes towards PLWHA and other patients (Famoroti et al. 2013, Nyblade et al. 2013).

Rule of Confidentiality and Health care personnel

According to Mahendra, Gilborn, Bharat, Mudoi, Gupta, George, Samson, Daly, and Pulerwitz (2007), observed that HIV/AIDS-related stigma and discrimination is especially apparent context and practices in the health care setting. The authors further stated that the healthcare setting is where PLWHA often find out their condition, and potentially where they gather information on caring for themselves, prevent transmission to others, and also where to get treatment and care. In studies like stigma and discrimination, various reports emerged from HIV positive people being given poor/indifferent care or not given care at all (Ogden & Nyblade, 2005). Examples have shown that attitudes of the greater society influence health care workers and predominant negative conditions of mind can result in discriminatory practices.

Stigma according to Famoroti, Fernandes and Chima (2013), is any attribute that is deeply discrediting and bring dishonor or tarnish some one's image. Stigmatization of PLWHA has been observed to result to patients on high risk suspending treatment (Famoroti, Fernandes, & Chima, 2013). Thus further contributing to the incessant spread of the virus within the environ. Evidence of such legal cases was that of "*Georgina Ahamefule v. Imperial Medical Centre* in the Lagos State High Court in 2012" where a Health Care Worker was tested for HIV without counseling nor her consent being obtained as result suspected AIDS-related opportunistic infection. Her employer promptly fired her after positive test leading to her suffering inexorable psychological and emotional injury and the abortion of her pregnancy. Because the doctors refused to offer her appropriate treatment, the client claimed "humiliated, stigmatized and discriminated" which resulted to her abortion due to her HIV condition. In her judgment, the Court averred that her removal from employment was not only illegal but also based on hate and ill-feelings. The Court also averred that decision of the employer constituted unlawful battery by putting the claimant through an HIV testing

without notifying the claimant, and professional negligence for not providing the claimant the needed pre or post-test counseling for HIV testing. In conclusion, for refusal of treatment and care on the basis of her HIV status the claimant right to health is guaranteed under article 16 of the African Charter on Human and People's Rights (African Union, 2004).

Similarly in South Africa, the Supreme Court of Appeal ruled that it amounted to a breach of doctor-patient confidentiality to disclose a clients' HIV status if consent is not given. In *Jansen van Vuuren v. Kruger* 1993, a doctor who in the process of playing a game of golf shared a "gossip" with other medical colleagues, who are not part of patient's care team that was diagnosed with HIV. According to Omosanya, Elegbede, Agboola, Isinkaye, and Omopariola, (2013) Discrimination of PLWHA by Health Care Providers (HCP) from studies is a common occurrence in health care settings in Africa and the world at large. In China, and world over, fear of stigma and discrimination and concerns about confidentiality significantly limits clients from HIV testing and adherence to treatments (Hardee, Clark, and Yuan, 2007). These discriminatory attitudes of some Chinese health professionals have been the major reason for low participation in Voluntary Counseling and Testing (VCT), prevention and treatment (Li, Zunyou, Yu, Chunqing, Roger, and Sheng, 2007). However, the government of China advanced a lot of regulations and policies on prevention and treatment of diseases that is contagious. Yet with all these available laws and guidelines from government, behaviour and attitude of health workers and HIV-positive patients was not clearly stated. The fear of being rejected or ill-treated at government designated hospitals hinder the treatment, care and control of HIV/AIDS in the society (Hardee et al, 2007).

Considering testing of HIV, discrimination and stigmatization were cited as primary barrier to using VCT. Findings from a survey reported that most women who refused to get VCT showed strong fear of being discriminated if they had tested positive. Again, some women rejected the test due to concern of confidentiality (Adeneye et al. 2006). According to a study conducted in Nigeria on 'the discriminatory attitudes of health workers against PLWHA' Letaimo (2005), opined that a good number of health providers practice discrimination and negative attitudes, even revealing test results to relatives without the patient's consent. Some equally reported denying to care for HIV patients or even refuse to admit them into the hospital.

Reason for discrimination by Healthcare Personnel

The fear of contagion are said to be the primary reason for the undesirable attitudes of health providers towards PLWHA (Daapaah, 2016). Studies have found that lack of knowledge about maintaining appropriate procedures for patient's confidentiality by HCP have been reported as part of the reasons for discrimination. Testing patients mandatorily, for "HIV prior to surgery or in the course of delivery of women in labour is considered a method of external stigma and discrimination against PLWHA (Daapaah, 2016). The use of protective gear should be limited to procedures with contact not for simple and routine examinations and or casual contact as doing otherwise is considered as form of stigma and discrimination, however, this may not be unrelated to instructions that direct HCP to utilize the universal precautions. Revelation of clients HIV

status to persons not involved in the patients' care without their approval, discussing the sickness of PLWHA with other colleagues in a degrading fashion, is a breach of confidentiality. Mitnick, Burris, Chesney, Devine, Fullilove, Fullilove, Gunther, Levi, Michaels, Novick, Pryor, Snyder and Sweeney, (1998) averred that circumstances as this affects the perception of the infected patient on himself. This may lead to stigmatized persons or groups acquiescing to the poor treatment and inequality, ensuring resistance to stigma and resultant discrimination becomes a difficult task. Externalized discrimination and stigmatization could also result to rejection by the family and community, disrespect, and even disparage or violence, humiliation and removal from place of work (USAID, 2005).

Dielema et al (2007) reported that other countries like Uganda, Taiwan and Zambia experienced fear of contagion as most common barrier preventing care givers from giving care. Sometimes inadequacy of basic items for protection may increase the fear of contracting infections. All these have implication for the fight against HIV/AIDS epidemic. Myth and wrong ideas about transmission of HIV contributes to the increase of discrimination and play a role in promoting discrimination; Most scholars further suggests educating the clinical staff on mode of transmission as a sure way to cub discrimination. Consequently, fear of HIV infection and lack of transmission knowledge result to avoidance attitudes towards PLWHA and key populations like the pregnant women with HIV positive status. In fact, healthcare workers in some facilities find it difficult to work with a co-staff with HIV positive regardless of their job specifications (Dielema et al 2007).

Re-training of Healthcare Personnel to cub discrimination

Studies undertaken previously according to Maman, Abler, Parker, Lane, Chirowodza, Ntogwisangu, Srirak, Modiba, Murima, and Fritz, (2009) stated that "stigmatization and discrimination of PLWHA by HCWs has become a global phenomenon". In that research, it was discovered that a greater number of Health Care Workers had prior training on HIV/AIDS (90.5 per cent). However, the total average knowledge is said to be moderate among these physicians (Adetoyeje, Bashir & Ibrahim, 2007). An attitudinal mean score of 110.6 amongst this cohort was recorded; the interpretation of this is "that group of medical professionals conceived ill-behaviour towards HIV patients and also refused to render health care services to them." The result justifies the findings of a negative attitude towards PLWHA was confirmed despite the training earlier had. (Adetoyeje, Bashir & Ibrahim, 2007).

Li et al, (2007), in his study had shown that more HIV related training of HCP had significantly lowered their prejudicial attitudes towards PLWHA. This study also indicated that doctors than nurses were more accommodating, comfortably interacting and partying with PLWHA. Similarly a Polish study concluded that "doctors and nurses with an exhaustive HIV training indicated less prejudice and equally condemned mandatory HIV testing of patients without consent when compared to their counterparts with a lesser training" (Gańczak, 2007). In a Similar vein, a study by Mahendra, et al. (2007), in their findings observed that HCWs showed less prejudice to PLWHA when they acquire more knowledge regarding HIV/AIDS with nurses being more prejudiced than doctors. Mahendra,

et al. (2007) “also reported that 68 percent of the HCP criticized their patients, blaming them for contracting the infection as a result of their promiscuous behaviour, indiscriminate in the choice of sexual partners and use of drugs. An overwhelming majority of Health Care Workers in the study in India (90 percent) approved the usage of HIV test mandatorily before surgery with 61 percent disagreeing with the mandate to obtain informed consent from patients before testing for HIV. Another pointer here is that hospitals where beds are labeled as "danger" confidentiality can be said to have been breached for PLWHA reports also indicated that it was noticed that nurses commonly wear cloves for procedures that require only casual contact such as administering drugs to HIV patients” (Mahendra, et al. 2007). Training and retraining of all health workers at all levels will actually reduce discrimination among care givers. To strengthen the services given to PLWHA the quality of care given should be accessed and motivated (Umar, Oche, Adeoso, 2012).

Theoretical framework

In the analysis of discriminatory practices of health care providers and care of PLWHA in secondary health facility in Cross River State, Nigeria, the patient satisfaction model was adopted for its background. The proponent of this model is Linder-Pelz (1982). This theoretical model considers the social-psychological determinants of clients’ satisfaction. Various fields of services are showing increasing attention on the ultimate result of patient contentment with healthcare. To get Patient satisfaction is the primary goal of health care delivery and it is an inevitable result of any negotiation regardless of the efficiency of the transaction. The widely held believe is that the client who is satisfied will definitely cooperate with instructions given by the doctor including keeping future appointments (Linder-Pelz, 1982). In building this theory Linder-Pelz draws its basic ingredients from theories such as “discrepancy theory which states that “satisfaction is perceived, not necessary, the actual-discrepancy between what an individual desires and what occurs”, and fulfillment theory which simply defines “satisfaction as the difference between results desired and those received”.

Expressions of satisfaction or dissatisfaction with an object or event “defines attitudinal expressions” that is people’s evaluation of affective responses to an object or event (Fishbein & Ajzen, 1980). The attitude of people towards a particular object or event is affected by the beliefs about this object or event which represent the information the people have about the object or event. (Fishbein & Ajzen, 1980). “Verbal communication from others” according to Linder-Pelz (1982) “basically determines attitudes. Cultural determinants of individual’s satisfaction are affected by social influence which can be traced to reference groups or significant others. Amongst the possible determinant of a person’s satisfaction with an object or event, is his or her understanding and attitude preceding the event or encounter with the object. Preceding attitudes are values people attach to different aspects of the object or event. Prior perceptions include but not limited beliefs about what the client is entitled to and expectations of the forthcoming encounter with object or event (Fishbein & Ajzen, 1980).

Patient's satisfaction is the person's positive evaluation of distinctive dimensions of health care" (Linder-Pelz, 1982). The following are the determinant of patient's satisfaction";

- Expectations (subset of beliefs: the knowledge a person has concerning a quality of an event or object);
- Value (attitude: estimation either good or bad of a quality of healthcare engagement);
- Occurrences' (the perception concerning an aspect of a healthcare engagement) and
- Interpersonal comparisons (a person's assessment of what takes place, example, the healthcare engagement) by putting it side by side with all other such engagements known or experienced by him / her.

Applicability/relevance: As far as this study is concerned, patient's satisfaction in Cross River State government and private health institutions is seen in terms of the positive manpower utilization in addressing HIV/AIDS. From the above view on satisfaction, the theory implies that patient satisfaction depends on the attitude of HCP for example, doctors and nurses and the system as a whole in combating HIV/AIDS. When health care recipients develop favourable attitude towards implementers of HIV/AIDS in the state, this will imply acceptance of such services. This will be manifested by positive attitudinal change towards the direction advised by health care providers. Unfavourable attitude from patients could result to non – adoption or utilization of HIV/AIDS services such as counseling, testing, anti-retroviral drugs use etc could result from a negative attitude by the people (patients).

The model though examines health manpower utilization in combating HIV/AIDS, gives a clue to the understanding of those factors that may enable us know why combating HIV/AIDS could be successful or why it could fail. The model implies that among government and private institutions in Cross River State, there appears to be factors that could be used in evaluating why people or patients are satisfied or dissatisfied with health manpower in combating HIV/AIDS (which could also be used to evaluate health manpower utilization in fighting HIV/AIDS). These are health manpower factors such as quality of health personnel, suitability of training received by health professionals, availability of health professionals, availability of health facilities and equipment, and health practitioner's knowledge of health issues etc. these factors are likely to hamper effective health human resource utilization in combating HIV/AIDS and thus directly affecting the people or patient's level of satisfaction. Patient's satisfaction theory provides a convenient point of departure for understanding the effects of the above objectives on combating HIV/AIDS.

Methods

The study used a three stage sampling technique to select the sample from the three Senatorial Districts that constitute Cross River State. In the first stage, a list of all tertiary and secondary health facilities in Southern Senatorial District was made and the total number of tertiary facilities was 3 while the number of secondary health facilities was 6. Whereas, all the three tertiary facilities were

used for the study, only 3 out of the six secondary health facilities in the area were randomly selected using the simple random sampling method (balloting method). In the second stage, there was no tertiary facility existing in the area. Therefore, a list of all secondary health facilities in the Central Senatorial District was made and this gave us a total of 6 facilities. Out of this number, 4 were selected using simple random sampling.

Also, in the third stage, there was no tertiary facility existing in Northern Senatorial District, so that a list of all secondary health facilities in the area was made and this gave us a total of 6 facilities. Out of this number, 4 were selected using simple random sampling. On the whole, out of a total number of eighteen secondary health facilities in Cross River State, eleven facilities were selected and 3 tertiary facilities were used in the study. (i.e. tertiary health facilities = 3 and Secondary health facilities = 11), which gave us a total of 14 health facilities used for the study. The selection of participants was first carried out per each health facility using simple random sampling method. That is, in each facility, eligible participants were selected, by means of the Hat and Draw method. This involved writing "YES" and "NO" on pieces of papers. The , the written YES and NO was thoroughly shuffled in a hat. Respondents were told to pick a paper but will not return same to the basket. Only those who picked YES were given questionnaire, therefore, 674 respondents filled the questionnaire for the study. A breakdown of the sample distribution is shown in Table 1

Table 1
Sample distribution of respondents by Senatorial districts and health facilities

S/n	Senatorial districts	Health facilities	Number of respondents		Total number of respondents
			Tertiary health facility	Secondary health facility	
1	Southern	St. Lawrence hospital, Calabar South	36	-	36
2		UCTH, Calabar	38	-	38
3		General hospital, Calabar	-	54	54
4		General hospital, Akamkpa	-	40	40
5		Psychiatric hospital, Calabar	38	-	38
6		General hospital, Oban	-	68	68
7	Central	General hospital, Ugep	-	52	52
8		Eja Memorial hospital Itigidi	-	44	44
9		General hospital, Boki	-	39	39
10		General hospital, Ikom	-	37	37
11	Northern	General hospital, Yala	-	52	52
12		General hospital,	-	49	49

		Obudu			
13		Specialist hospital, Ogoja	-	61	61
14		General hospital, Bekwara	-	66	66
15		TOTAL	112	562	674

Source: Field survey, 2021

Item pool from Focus Group Discussion (FGD)

Twelve FGD sessions, in each of the twelve local government areas (where the health facilities were situated) was held. Each session composed of 10 health care providers and it lasted for about one hour. Also, membership of the FGD was purposively selected without bias in order to build confidence in the study. Each session had a moderator who was appointed by the discussants to moderate the discussions and were assisted by a research assistant who took notes and records of both verbal and non-verbal discussions. All respondents were given equal opportunities to contribute to the discussions.

The FGD guide comprised eight predetermined open-ended questions used to generate information on discriminatory practices of health care providers and care of PLWHA in health facilities in Cross River State, Nigeria, while their responses were recorded.The, audio-taped discussions from each of the FGDs was transcribed verbatim by a research expert. The thematic analyses were also used to organize the data in relation to the research objectives and level of patterned response or meaning within the data set as well as their content using ATLAS. ti 8 software for windows. In each FGD, the discussants were asked to assess seven key areas of discriminatory practices based on the following criteria:

- Attitude related to discriminatory practices.
- Percentage of health care providers involved in the practice.
- Perceived response or reaction of PLWHA.
- Level of interaction between health care providers and PLWHA.
- Category of healthcare providers with positive and those with negative attitudes.
- Factors that triggers discriminatory practices.
- Measures towards the reduction of discriminatory practices against PLWHA.

Using these criteria, each discussant in each FGD was asked to present his opinion and ratings of each item to the group for further discussion. Discussants were required to discuss gaps if any in the item pool and to fill them with new ones.

Item pool from Literature review

A literature review was thoroughly carried out with Pub Med and complemented with bibliographic databases. The review covered various articles, reports and questionnaires constructed by other scholars which measures the discriminatory practices of health care providers and care of PLWHA in health facilities with

focus on factors that induced discriminatory practices such as fear of HIV infection transmission, bias and stereotypes, prejudice and fear of stigmatization as well as negative attitudes towards PLWHA and other barriers to effective delivery of health care to PLWHA. The literature review used the inclusion criteria to draw 14 peer-reviewed articles, 5 reports from secondary and third health facilities, and 3 different questionnaires (unpublished). The peer reviewed articles were drawn online. Of the 5 reports, 2 were check list while 3 were health facility monthly reports. The 3 unpublished questionnaire collected data from health care providers in both tertiary and secondary health facilities. These include 13 medical doctors, 23 health care providers drawn from various health disciplines.

Measured-tested items

With the comprehensive literature review and the thematic analysis of the FGD, a questionnaire was systematically developed to collect data for the study. The instrument covered the substantive issues involved in discriminatory practices of health care providers and care of PLWHA. These included demographic features of respondents, their duties and responsibilities, type of facility, access and availability of health equipment, factors induced discrimination, discriminatory practices against PLWHA, perceived implications, and willingness to take risks, precautionary measures taken by health care providers. Opinions and observations of respondents were equally required, especially on the behaviors of PLWHA when a health care provider discriminates against them and whether PLWHA also avoided health care workers. A summary of the measured tested items is shown in Table 2.

Table 2
Summary of field tested measures

Category	Number of questions	Description
Demographic features	7	Age, sex, marital status, destination, position, religion, education
Duties and responsibilities	9	Health care, referrals, counselling, drug administration, advocacy, drawing blood, bathing patients, etc.
Type of facility	8	Tertiary, secondary, IDH, UCTH, Neurological center, General hospital, Private specialist hospitals, etc.
Access and availability of health equipment	7	Hand gloves, prophylaxis, health infrastructures, drugs, etc. Retroviral drugs, etc.
Factors induced discrimination	9	Fear, worry of contraction, stigma, stereotyping, real or perceived experience, negative stories about HIV/AIDs and lack of protective equipment, religion or cultural consideration and shame
Discriminatory practices against PLWHA	11	Negative attitudes: dismissiveness, abusive acts, selecting patients to care for, abandonment and neglect of PLWHA, showing bias, stigmatizing PLWHA, distancing from PLWHA, refuse contact with PLWHA, stay clear of PLWHA

Perceived implications	4	Staff safety is in danger, staff will be infected, staff will die, will be avoided by friends and family members, etc.
Willingness to take risk	4	Question on whether Health care provider is willing to take risk of rendering health care for PLWHA. Four items measured
Precautionary measures	5	Use of hand gloves, sterilization of equipment, etc. five items measured
Opinion	2	The behaviors of PLWHA when a health care provider discriminate against them (two items measured)
Observation	1	Whether PLWHA avoid health care workers; Measures 3 different items

Source: Field survey, 2021

Field testing

The questionnaire was field tested in the selected fourteen health facilities in Cross River State as shown in Table 2. The field test was carried out between January and June, 2021. A consolidated questionnaire was distributed to 674 respondents, comprising medical doctors, medical directors, nurses, midwives, dentists, pharmacists. There were variations in the population sizes of health care providers in the selected health care facilities as well as the sample sizes chosen per each facility (See Table 1). Copies of the questionnaire were administered to the respondents after informed consent was obtained from them. The purpose was to ensure informed decision. Pseudonyms were also used to assure them of anonymity. The respondents were informed of their right to voluntarily participate in the study without deleterious effect. Administration of the research instrument was carried out by the researchers with ten research assistants. The research assistants were well trained on the required standard for administering research instruments. Furthermore, the data obtained from the respondents were treated with utmost confidentiality and no one was penalized for not being part of the study. Ethical clearance was got from the Cross River State Health Research Ethics Committee, Department of Clinical Governance, Servicom & E-Health, Ministry of Health Calabar, Cross River State.

Data analysis

The data entry and cleaning were first done at each selected health facility after which they were combined into one data set and were further cleaned. Data were entered into the SPSS version 21.0 for windows, analyzed using descriptive statistics of frequency counts, simple percentages, mean, median and standard deviation. The survey items at each health facility were assessed and their psychometric properties and other contextual issues examined. The analysis was conducted by the research team, taking into consideration the variability in responses, experiences of respondents from each health facility. The exploratory factor was used to analyze the instrument to ascertain the practices of health care providers towards PLWHA. Thus, responses to items that related to discriminatory practices by health care providers were selected and used for the study. To determine the reliability of the instrument Cronbach's alpha was used. Thus, a reliability co-efficient of 0.7 was considered acceptable to establish the internal

consistency of the scale. Next, a comparison of the health facilities was done and we have a cut off of 0.6 (3032) for the attitudinal scale at each facility.

Result

Health care providers' attitudes towards care of PLWHA

The result of Table 3 shows that the mean scores of standard deviation of each of the ten items on discriminatory practices by health care providers towards PLWHA. The item mean scores and standard deviations for ten items on discriminatory practices by health care providers towards PLWHA ranges from 1.8 (SD = 70) to 3.67 (SD=69). The result shows that 3 items had mean scores above 3.5 which is the scale critical mean, while 7 items had mean scores below 3.5. The finding shows that discriminatory practices by health care providers is high. Health care providers who had high scores are those who freely interact with PLWHA (Mean 3.67, SD = 0.99), followed by those who believe that their facilities have provided policies to protect PLWHA from being discriminated (Mean 3.56, SD 0.69); and those who provide health care for people whether they are living with HIV/AIDS or not (Mean 3.36, SD=0.49).

The 7 items are as follows: Those who wear personal protective equipments only when caring for PLWHA (Mean 1.87, SD= 1.01). Other health care providers who like caring for people without HIV/AIDS only (Mean 1.77, SD=0.97). Discriminating persons suspected to be living with HIV/AIDS is not easy to avoid (Mean 1.43, SD= 0.82). Those who said the care for PLWHA is a waste of time and resources (Mean 1.38, SD=0.83), While others who don't like doing anyting with PLWHA because they are harmful to their health (Mean 1.37, SD= 0.76). only 3 items narrated above had mean greater than 2.5, this is considered as health care providers' positive attitude towards care for PLWHA while 7 items M<2.5 showed health care providers' negative attitude towards care for PLWHA,

Table 3
Responses to health care providers' attitudes towards care of PLWHA (n = 674)

Items	Agree	Disagree	Don't know	Mean	Std
I wear personal protective equipments only when caring for PLWHA.	194	258	222	1.87	1.01
I like caring for people without HIV/AIDS	180	265	229	1.77	0.97
I like interacting with PLWHA **	332	168	174	3.67	0.99
I don't like doing anyting with PLWHA because they are harmful to my health	173	301	200	1.37	0.76
Discriminatory practices against PLWHA is ideal when one perceives danger	176	282	216	1.38	0.70
Discriminating persons suspected of living with HIV/AIDS is not easy to avoid	172	290	212	1.43	0.82
My health facility has policies to protect PLWHA from discrimination **	289	171	214	3.56	0.69
I provide health care for people whether they are living with HIVor not **	331	174	169	3.36	0.49

As far as I am concern the care for PLWHA is a waste of time and resources	178	310	186	1.38	0.83
If I had a choice, I will avoid giving care to PLWHA	197	259	218	1.71	0.89

Source: Fieldwork 2021

Mean> 2.5 is regarded as health care providers' positive attitude while M < 2.5 is considered as health care providers' negative attitude.
** implies positively worded statements

Discriminatory practices by health care providers towards care of PLWHA

Table 4 presented the discriminatory practices by health care providers. A greater percentage of respondents agreed that health care providers were engaged in the following practices: refusal to show enough care and concern, ignoring PLWHA, refusing to spend adequate time with PLWHA, refusal to draw blood from any person living with HIV/AIDS and referring any person living with HIV/AIDs to another healthcare provider because of fear of contraction as well as out-rightly refusing PLWHA treatment. Some health care providers neglect PLWHA in some health facilities, PLWHA were denied care while some got low quality care. They also refused to touch the personal properties of PLWHA such as clothes and food. Some of these health care providers go about disclosing the HIV/AIDS status of patients which is against ethical guidelines to maintain the confidentiality of the patient. However, analysis of data showed that health care providers did not abuse PLWHA.

Table 4
Responses to discriminatory practices by health care providers towards care of PLWHA (n = 674)

Items	Agree	Disagree	Don't know
Refusal to show concern	494(73.3%)	158(23.4%)	22(3.3%)
Ignoring PLWHA	580(86.1%)	65(9.6%)	29(4.3%)
Refusal to spend time with PLWHA	432(64.1%)	168(24.9%)	74(11%)
Refusal to draw blood from PLWHA	473(70.2%)	101(15%)	100(14.8%)
Undue referrals made because of PLWHA HIV status	576(85.5%)	82(12.2%)	16(2.4%)
Health care providers neglect PLWHA	572(84.9%)	90(13.3%)	12(1.8%)
Health care providers abuse PLWHA**	71(10.5%)	589(87.4%)	14(2.1%)
PLWHA were given low quality care	435(64.5%)	170(25.2%)	69(10.2%)
Health care providers refused to touch the personal properties of PLWHA such as clothes and food.	478(70.9%)	110(16.3%)	86(12.8%)
Some health care providers disclose HIV/AIDS status of patients	497(73.7%)	159(23.6%)	18(2.7%)

Source: Fieldwork 2021
** implies non-discriminatory practice

Instigators of discriminatory practices toward PLWHA

Table 5 presents instigators of discriminatory practices of health care providers towards PLWHA. The analysis showed that out of the ten items analysed, 9 items present the actual instigators of discriminatory practices among health care providers. These include items 1-9 while item 10 alone was not considered capable of instigating discriminatory practices among primary health workers. In other words, the fear of contracting the virus, fear of stigma, poor working conditions, fear of death, unfavorable environment, lack of working tools, fear that the virus is incurable, lack of training and the fear of being castigated immoral were the actual instigators of discriminatory practices by health care providers towards PLWHA. The analysis however indicated that fear of divine judgment had low response and therefore not considered as a strong indicator of discriminatory practices.

Table 5
Responses to instigators of discriminatory practices toward PLWHA (n = 674)

S/n	Items	Agree	Disagree	Don't know
1	Fear of contracting HIV/AIDS	394(58.5%)	158(23.4%)	122(18.1%)
2	Fear of stigma	129(19.1%)	465(69%)	80(11.9%)
3	Poor working conditions	492(73%)	108(16%)	74(11%)
4	Fear of death	273(40.5%)	351(52.1%)	50(7.4%)
5	Unfavorable environment	376(55.8%)	182(27%)	116(17.2%)
6	Lack of working tools	390(57.9%)	172(25.5%)	112(16.6%)
7	Fear that the virus is incurable	181(26.9%)	389(57.7%)	104(15.4%)
8	Lack of training	341(50.6%)	264(39.2%)	69(10.2%)
9	Fear of being castigated immoral	110(31.1%)	478(56.1%)	86(12.8%)
10	Fear of facing divine judgement **	209(31%)	347(51.5%)	118(17.5%)

Source: Fieldwork 2021

** implies item that do not instigate discriminatory practices

Negative effects of discriminatory practices towards PLWHA

Table 6 presented the negative effect of discriminatory practices towards PLWHA. It was observed that discriminatory practices discouraged PLWHA from further seeking health care while it causes some of them to lose trust in the system. Their dismissive attitude alone had deterred most of them from visiting any health care facilities. This indeed had affected the utilization of health services in the health facilities studied. Discriminatory practices also induce low self-esteem, low morale, lack of interest in obtaining health care, fear of stigma and of death for PLWHA. Analysis of data also showed that induces low perceptions of the health care systems as well as affected the productive ventures of PLWHA

Table 6
Responses to negative effects of discriminatory practices towards PLWHA (n = 674)

S/n	Items	Agree	Disagree	Don't know
1	Discourages PLWHA from seeking health care	594(88.1%)	57(8.5%)	23(3.4%)
2	Causes PLWHA to lose trust in the health care system	529(78.5%)	85(12.6%)	60(8.9%)
3	Leads PLWHA to patronize TBAs	592(87.8%)	74(11%)	8(1.2%)
4	Affect utilization of health care services	573(85%)	81(12%)	20(3%)
5	Induces low self-esteem	576(85.5%)	83(12.3%)	13(1.9%)
6	Leads to low morale	590(87.5%)	72(10.7%)	12(1,8%)
7	Leads to negative perceptions about health care	481(71.4%)	189(28%)	4(0.6%)
8	Leads to stigmatization of PLWHA	541(80.3%)	94(13.9%)	39(5.8%)
9	Leads to premature death for PLWHA	510(75.7%)	118(17.5%)	46(6.8%)
10	Affects PLWHA" productive ventures	509(75.5%)	147(21,8%)	18(2.7%)

Source: Fieldwork 2021

** implies item that do not instigate discriminatory practices

Curbing discriminatory practices among health care providers towards PLWHA

Table 7 revealed respondents' opinion on how to curb discriminatory practices among health care providers towards PLWHA. Analysis of data shows that greater percentage of respondents agreed that health care providers should be sensitized from discriminating against PLWHA. Majority also held the opinion that standard precautions should be adopted in the care of PLWHA and that training of health care providers to care for patients regardless of their status is a critical element for quality health care delivery. It further shows that majority of respondents agreed that wearing protective equipments is the most effective measure of ending discriminatory practices towards PLWHA and that effective monitoring of health care providers will stem the tide of discriminatory practices towards PLWHA. Respondents further agreed that health care providers found to discriminate against PLWHA should be penalized.

Table 7
Respondents' opinion on how to curb discriminatory practices among health care providers towards PLWHA (n = 674)

Items	Agreed	Disagreed
Health care providers should be sensitized from discriminating against PLWHA	592(87.8%)	82(12.2%)
Standard precautions should be adopted in the care of PLWHA	572(84.9%)	102(15.1%)
Training of health care providers to care for patients irrespective of their HIV/AIDS status	390(57.9%)	284(42.1%)
Wearing protective equipments is the most effective measure of ending discriminatory practices towards PLWHA	467(69.3%)	207(30.7%)
Effective monitoring of health care providers will stem the tide of	408(60.5%)	266(39.5%)

discriminatory practices towards PLWHA		
Health care providers found to discriminate against PLWHA should be penalized	392(58.2%)	282(41.8%)

Source: Fieldwork, 2021

Discussion

The study found that the discriminatory practices by health care providers had significantly affected the care of PLWHA in secondary health facility in Cross River State, Nigeria. This result validates the findings of Sohler & Cunningham (2007), Umar, Oche & Adeoso (2012) which observed discriminatory practices to be prevalent among health workers thereby affecting the fight against the virus, especially with PLWHA. The results in Tables 3 demonstrated that discrimination was commonly practiced by health care providers in all the secondary health facilities studied. As a result of these discriminatory practices, majority of health care providers (78%) were unwilling to care for PLWHA in their facility. Only few (22%) reported that they use to care for PLWHA and only when they wear gloves and other protective apparatus.

As observed in Table 4, discriminatory practices ranged from refusal to show enough care and concern, ignoring PLWHA, refusing to spend adequate time with PLWHA, refusal to draw blood from any person living with HIV patient and their referrals to another healthcare provider. Even out-right refusal of treating PLWHA all because of fear of contraction. Some health care providers neglect PLWHA. In some health facilities, PLWHA were denied care while some got low quality care. They also refused to touch the personal properties of PLWHA such as clothes and food. Some of these health care providers go about disclosing the HIV/AIDS status of patients which is against ethical guidelines to maintain the confidentiality of the patient.

It was also found that there were instigators of discriminatory practices toward PLWHA as found in Table 5. These include the fear of HIV transmission which is prevalent among the health care providers. Another excuse for the discriminatory practices is the fear of stigma which tended to have the second highest response after HIV/AIDS transmission. Others includes poor working conditions, fear of death, unfavorable environment, lack of working tools, fear that the virus is incurable, lack of training and the fear of being castigated immoral (i.e., having multiple sex partners). The fear of divine judgment was not considered by the respondents as potent enough to cause discriminatory practices by the health care providers.

The negative effect of discriminatory practices towards PLWHA as presented in Table 6 indicated that discriminatory practices discourage PLWHA from further seeking health care while some refused to adhere to treatment. It also causes some of them to lose trust in the health care system. Dismissive attitude of most of these health professionals had deterred some of them from visiting any health care facilities. This indeed had affected the utilization of health services in the health facilities studied. Discriminatory practices also induce low self-esteem, low morale, low trust in obtaining health care and fear of being stigmatized. It was further observed that the discriminatory practices induce low perceptions of the

health care systems as well as affected the productive ventures of PLWHA. In other words, it causes PLWHA not to be free to associate with people in the outside world and to do business and to fend for them.

The findings of the study also revealed that discriminatory practices among health care providers towards PLWHA can be curbed. This is shown in Table 7. It was agreed by a higher percentage of respondents that health care providers should be sensitized from discriminating against PLWHA and that standard precautions should be provided to health care providers for the care of PLWHA. The training of health care providers to care for patients is also considered a critical element for quality health care delivery to PLWHA. The wearing of protective equipments was also considered to be the most effective measure of curbing discriminatory practices towards PLWHA and that effective monitoring of health care providers will stem the tide of discriminatory practices towards PLWHA. Finally, penalizing health care providers found to discriminate against PLWHA was recommended.

Limitations

This study has some limitations. For example, there was no comparative analysis of the secondary health care facilities used in the study. Despite the fact that the secondary health facilities varied by their location and sizes, their mode of operations and administration were the same. Because there were all owned and controlled by government, the health care providers were occasionally transferred or posted from one facility to another. For instance, during the process of administering the research instruments, some key informants working at Ikom General Hospital were suddenly transferred to Akamkpa General Hospital. In all the facilities, the health care providers use the same template and manual.

Conclusions

The study investigates the extent to which health care providers indulge in discriminatory practices and how it affected the care of PLWHA in secondary health facility in Cross River State, Nigeria. The findings revealed that discriminatory practices towards PLWHA are common and wide spread in Secondary health care facilities. The study identified some discriminatory practices of the health care providers, such as the conscious neglect of their assigned responsibilities, dismissive attitudes and their inability to provide the needs of PLWHA. Such discriminatory practices were principally instigated by the fear of contracting the virus and stigmatization. The result had been the negative effect it has on PLWHA. These discriminatory practices cause some of the PLWHA to loose confidence in the health system and had affected utilization of the services of the Secondary health facilities. The discriminatory practices also induces low self-esteem, low morale, lack of interest in obtaining health care, induces fear and stigma as well as untimely death for PLWHA. It also affected the productive ventures of PLWHA. In other words, it causes PLWHA not to be free to associate with people in the outside world and to do business and to fend for them.

Recommendations

Considering the findings, recommendations were given thus; health care providers need to be sensitized from discriminating against PLWHA and that standard precautions should be provided to health care providers for the care of PLWHA. The training of health care providers is also imperative on the need to care for patients irrespective of their HIV/AIDS status. Besides, effective monitoring of health care providers will stem the tide of discriminatory practices towards PLWHA. Finally, penalizing health care providers found to discriminate against PLWHA was recommended.

Competing interests

There is absence of competing and conflicting interest.

Authors' contributions

Onyema, O. A. was responsible for conceptualizing and drafting of the manuscript. Isokon, B.E. handled the data analysis. Bassey U.S. did the coordinating and drafting of the manuscript. Okolie U.C. and Tiku O.T implemented the field testing they equally reviewed the manuscript. The final work on the paper has been read and approved by all the authors.

References

Adeneye, A. K, Briege W. R., Mafe, M. A., Adenye A. A.(2006). Willingness to seek HIV testing and counselling among pregnant women attending antenatal clinics in Ogun State, Nigeria. *International Quarterly of Community Health Education* 26(4): 337-353

Adetoyeje, Y.O., Bashir, O.O., & Ibrahim, S.B. (2007). Physicians and HIV and does knowledge influence their attitude and comfort in rendering care.*African Journal of Health Science*, 14**:**37-43.

African Union (2004). *African Charter on Human and Peoples Rights,* 2004. (Ratification and Enforcement) Act, Cap. A9, Vol. 1, Laws of the Federation of Nigeria.

Ajzen, I. & Fishbein, M. (1980). *Understanding Attitudes and Predicting Social Behaviour.*Englewood Cliffs, NJ: Prentice-Hall.

Anderson, M., Elam, G., Gerver, S., (2008). HIV/AIDS-related Stigma and Discrimination: Account of HIV- positive Caribbean people in the United Kingdom. *Social science and medicine* 1-9 doi:10.1016/j.socscimed. 2008.05.003

China, Dominica,Egypt, Kenya, Puerto Rico and St. Christopher & Nevis.*Journal of*

CISLAC (2012). *Policy Brief on Nigeria's Progress towards Achieving Millennium Development Goals of Combating HIV/AIDS, Tuberculosis & Malaria.* Accessed from http://www.cislacnigeria.net/wp-content /and%20Malaria.pd f 5 May, 2019.

Daapaah J. M. (2016). Attitudes and Behaviour of Health Workers and the Use of HIV/AIDS Health Care Services. *Nursing Research and Practice* vol. 2016/Article ID 51724971

Dielema M., Biemba G., Mphuka S., Sichunga-Sichali K. (2007). We are also dying like any

Discrimination and Voluntary Disclosures. *The Indian Journal of Social Work*

Famoroti, T.O, Fernandes, L. and Chima, S.C. (2013). Stigmatization of People Living with HIV/AIDS by Healthcare Workers at a Tertiary Hospital in KwaZulu- Natal, South Africa: A Cross-Sectional Descriptive study. *BMC Medical Ethics*, 14(1):S6.

Gañczak, M. (2007). Stigma and Discrimination for HIV/AIDS in the Health Sector: A Polish Perspective.*Interam J Psychol*, 41:57-66.

Hardee, K., Clark Y, Yuan V., (2007). HIv and AIDS Stigma and Discrimination in China: Results from a National Survey. *Asia- Pacific Population Journal* vol. 24 No 2.

http://www.jiasociety.org/index.php/jias/article/view/18718

Letaimo G. (2005). The Discriminatory Attitudes of Health workers against People Living with HIV. *PLoS Medicine* 2(8) e261

Li, L., Zunyou, W., Yu, Z., Chunqing, L., Roger, D., & Sheng, W. (2007). Using case vignettes to measure HIV related stigma among health professionals in China.*Int. Journal of Epidemiol*, 36:178-184.

Linder-Pelz, S. (1982). Towards a theory of patient satisfaction. *Social Science &Medicine,* Vol 16(5), 1982, 577-582. Retrieved from http://dx.doi.org/10.1016 /0277-9536(82)90311-2

Mahendra, V.S., Gilborn, L., Bharat, S., Mudoi, R., Gupta, I., George, B., Samson, L; Daly, C., & Pulerwitz, J. (2007). Understanding and measuring AIDS-related stigma in health care settings: A developing country perspective. *Journal of Social Aspects of HIV/AIDS*, 4(2): 616-625.

Maman, S., Abler, L., Parker, L., Lane, T., Chirowodza, A., Ntogwisangu, J., Srirak, N., Modiba, P., Murima, O., & Fritz, K. (2009). A comparison of HIV stigma and discrimination in five international sites: The influence of care and treatment resources in high prevalence settings.*Soc Sci Med*, 68:2271-2278.

Measuring HIV-related stigma amonghealth facility staff: results of field testing in

Mitnick, L., Burris, S., Chesney, M., Devine, P, Fullilove, M.T., Fullilove, R., Gunther, H.C., Levi, J., Michaels, S., Novick, A., Pryor, J., Snyder, M., & Sweeney, T. (1998). AIDS and stigma: A conceptual framework and research agenda. *AIDS Publ Pol J.*, 13:36-47.

Mulye, R., T. Raja, M. Menon, J. Pereire and B. L. Barnes (2005). Confidentiality, Sigma,

Nyblade, L., Jain, A., Benkirane M., Li, L., Lohiniva, A., (2013). Brief, standardized tool for

Ogden, L.D. & Nyblade, R.E. (2005). Models of Care for Patients with HIV/AIDS. AIDS 11 (Suppl. B): S99-S106.

Omosanya, O.E., Elegbede, O.T., Agboola, S.T., Isinkaye, A.O., & Omopariola, O.A . (2013). Effects of stigmatization/Discrimination on Antiretroviral Therapy Adherence Among HIV-infected Patients in a Rural Tertiary Medical Center in Nigeria. *J Int Assoc Provid AIDS Care*, **00:**1-4.

other people, we are also people. Perception of the Impact of HIV/AIDS on Health Workers in 2 District of Zambia Health Policy Plan. 22(3): 139-148

Pearson S.and Makadzanga P. (2008). Help Seeking Behaviour for Sexual-Health Concerns: A Qualitative Study of Men in Zimbabwe. *An International Journal for Resaerch, Intervention and Care* 10(4). Pp. 361-376.

Reis C, Amowitz L. L, Heister M, Moreland R. S, Mafeni J. O, et al (2005). Discriminatory Attitudes and Practices by health workers towards patients with HIV/AIDS in Nigeria. *PLoS Medicine* vol. 2 no. 8: e 246

Sohler, N., Li, X and Cunningham C., (2007). Perceived discrimination among severely disadvantaged people with HIV infection. SAGE Journal vol. 122 issue: 3 pages 347-355

the International AIDS Society 2013, 16(2):18718

Umar A. S. Oche M. O. and Adeoso A. A. (2012). Discriminatory Practices of Health Workers towards People Living with HIV/AIDS in Sokoto, Nigeria. *Journal of AIDS and HIV Research* 4(9) pp. 223-228.

UNAIDS, (2012). Attaining higher goals in HIV treatment: the central importance of Adherence. Retrieved from http://www.unaids.org/en/ media/unaids/content assets/documents/unaidspublication /2011/20110609_JC2137_Global-Plan- Elimination-HIV-Childrenen.pdf.

United Nations (1976). *International Covenant on Economic, Social and Cultural Rights*, 1976. Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966 entry intoforce 3 January.

USAID (2005). *Working Report Measuring HIV stigma: Results of a Field Test in Tanzania*. Washington DC: USAID. Retrieved from http://www.icrw.org/ publications/measuring-hiv-stigma