

# Stigma, Discrimination and Associated Determinants Among People Living With Hiv/aids Accessing Anti-retroviral Therapy in Ikeja, Lagos State, Nigeria

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## Research Article

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# Abstract

Discrimination and stigma towards those living with HIV/AIDS (PLWHAs) pose serious obstacles to their ability to manage their disease and achieve overall wellbeing. These obstacles make it difficult to receive mental health assistance, prolong social isolation, and impede access to healthcare resources. The purpose of this study is to look into the types, prevalence, and factors that influence stigma and prejudice that PLWHAs in Ikeja, Lagos State, Nigeria, face when they seek antiretroviral therapy (ART). The study also aims to comprehend the ways in which these experiences impact PLWHAs' mental health and ability to receive healthcare.

Structured questionnaires were used in this cross-sectional study to gather data from 400 PLWHAs in Ikeja who were undergoing ART. Aspects of stigma such as negative self-image, disclosure concerns, personalized stigma, and public attitudes were all included in the questionnaire. The data were summarized using descriptive statistics, and significant predictors of discrimination and stigma were found using logistic regression analysis. The study also looked at how stigma affects mental health and healthcare access, with an emphasis on identifying important socio-demographic variables that influence these outcomes.

The results showed high prevalence of stigma against PLWHAs in Ikeja, in particular, 37.75% of respondents reported they have encountered stigma associated to HIV while seeking healthcare services, and 89.75% of respondents said they were aware of this stigma. Furthermore, 52% of respondents agreed that stigma is exacerbated by the media and societal views, and 45.5% thought that cultural and religious beliefs affected how PLWHAs were treated in their society. Gender, socioeconomic class, and educational attainment were found to be significant predictors of stigma.

In addition, 41.5% of respondents experienced unfavorable views from family or friends, and 48.75% of respondents felt ashamed or condemned due to their HIV status. Similarly, 64.25% of PLWHAs said stigma had a major negative impact on their social interactions and mental health, and 65% said stigma made them decide not to disclose their HIV status. While more than a third, 39.75%, of the respondents said that stigma made it difficult for them to get ART and other essential medical services, two-thirds, 67%, stated that the attitudes of healthcare providers influenced their desire to ask for assistance.

The study found widespread stigma and prejudice against PLWHAs with a negative influence on mental health and access to healthcare. The study suggests strengthening anti-discrimination laws, holding frequent training sessions for healthcare professionals, improving education and awareness campaigns, and increasing support services for PLWHAs in order to solve these problems. Stakeholders can improve the inclusive and supportive environment for people living with HIV/AIDS by putting these focused actions into practice, which will eventually improve health outcomes and quality of life. These initiatives are essential for reducing HIV/AIDS stigma and advancing a more equitable and compassionate society.

# INTRODUCTION

HIV/AIDS stands as a persistent and severe health condition with widespread implications for global public health. <sup>1,2</sup> recognized by the World Health Organization (WHO) as a worldwide public health emergency, HIV continues to pose significant challenges, marking over three decades since its emergence. This pandemic has inflicted devastating consequences, claiming the lives of millions globally and causing severe harm to countless others. The virus has affected over 75 million people since its onset. <sup>1</sup> In the year 2022 alone, 39 million individuals were living with HIV, and 1.3 million succumbed to AIDS-related causes worldwide. <sup>1</sup>

The impact of HIV/AIDS remains particularly pronounced in the Sub-Saharan region which continues to bear the brunt of the global HIV/AIDS burden, representing two-thirds of the total cases worldwide. <sup>3</sup> HIV which stands for human immunodeficiency virus leads to the disease AIDS (acquired immunodeficiency syndrome), if left untreated. <sup>4</sup> Presently, there are 25 million adults and children living with the virus in this region, constituting nearly 70% of the global figure. The statistics reveal an alarming scenario with approximately 1.9 million new HIV infections and 1.2 million AIDS-related deaths reported in Sub-Saharan Africa <sup>5</sup>. Nigeria, within this context, shoulders a significant portion of the epidemic, hosting an estimated 3.2 million individuals living with HIV, positioning the country among those with the highest HIV burden globally, second only to South Africa. In 2005, the international community embraced the goal of universal access to HIV prevention, treatment, care and support by 2010. <sup>6,7</sup> National HIV/AIDS programs must fortify their health systems and remove any obstacles to treatment and preventive initiatives in order to meet this objective. Nigeria has implemented several measures to stop the spread of disease. <sup>8</sup> People living with HIV/AIDS (PLWHAs) who have taken an HIV test and are on antiretroviral therapy (ART) have increased significantly as a result of international initiatives like the US Presidential Emergency Plan for AIDS Relief (PEPFAR) program. <sup>9</sup> In addition, there are many more antenatal women with HIV positivity who have received ART to prevent mother to child transmission of HIV. <sup>10</sup> The challenges many of these global and national programs face in a multi-diverse socio-cultural society like Nigeria are the problems of stigma and discrimination (S&D). <sup>11-14</sup> The issues of S&D described by Jonathan Man <sup>15</sup> as the third phase of the HIV pandemic poses a serious threat to prevention and treatment. Therefore, for Nigeria to achieve her national policy on HIV/AIDS, aimed at controlling the spread of the infection and its impact, the issue of S&D needs to be addressed. <sup>8,16</sup> Significant research and knowledge on HIV related S&D in many ethnic and cultural settings that constitute Nigeria, are important tool in understanding this “hidden factors” that are impediments to effective prevention and treatment. Incorporating these findings into national prevention strategies will go a long way in reducing the transmission of the virus in the population. <sup>17</sup>

In 2017, the demand for Anti-Retroviral Therapy (ART) in Nigeria was 1.9 million, with over 52% of those affected receiving treatment. The South-South region had the highest HIV prevalence at 3.1%, while Lagos state recorded 1.4%. Global efforts to curb HIV have significantly reduced infection rates, especially in developed countries, by extending the lives of those infected. Though no cure exists, Highly

Active Anti-Retroviral Therapy (HAART) has transformed HIV from a terminal illness to a manageable chronic condition.<sup>22-24</sup>

Over the past decade, Nigeria has witnessed notable advancements in curbing the HIV/AIDS epidemic.<sup>25,26</sup> The 2019 National AIDS and Reproductive Health Survey (NARHS) demonstrated a substantial reduction in the national HIV prevalence, decreasing from a peak of 5.8% in 2001 to 3.1%.<sup>27</sup> This accomplishment is largely attributed to impactful interventions such as Behavior Change Programs, HIV care and support initiatives, Prevention of Mother to Child Transmission (PMTCT), and the implementation of Highly Active Anti-Retroviral Therapy (HAART).<sup>19</sup> HAART treatment primarily aims to reduce the viral load to undetectable levels, fostering immune reconstitution and notable clinical improvement. Additionally, HAART has proven effective in preventing opportunistic infections.<sup>28-30</sup> Successful outcomes in the management of HIV/AIDS hinge significantly on adherence to HAART, as underscored by studies such as Shah (2007) and Giri et al. (2013).

The reported adherence rates to ART medication among people living with HIV (PLHIV) in Nigeria vary from 44–98%.<sup>11,31,32</sup> Factors shown to be associated with good adherence include text message as reminders, patient selected treatment partners, use of pill box, age and gender. On the other hand, psychiatric morbidity negatively had adverse impacts on adherence.<sup>11</sup> Despite this efforts, HIV/AIDS stigma continue to re-emerge as a formidable threat, particularly among many Nigerians who lack awareness of the realities surrounding HIV and AIDS, leading to avoidance and stigmatization of individuals affected by the virus due to misconceptions about its transmission. This misguided belief suggests that one can contract the virus through association or close contact with an infected person.<sup>33</sup> S&D as described by various sources, represent social barriers that significantly impact the life experiences of individuals. The stigma associated with HIV and AIDS tends to marginalize people within their communities, adversely affecting the overall quality of life for PLHIV. Stigma is often synonymous with social disgrace. Research indicates that individuals reporting high levels of stigma are more than four times likely to experience limited access to healthcare. Moreover, HIV and AIDS-related stigma can give rise to discrimination, such as restrictions on travel, healthcare facility usage, employment opportunities, and social interactions for PLHIV.<sup>13,34, 60</sup>

Although there have been few studies as regard stigma and discrimination against individuals living with HIV/AIDS,<sup>35-58</sup> it remains prevalent, impacting their access to care and quality of life. This research aims to comprehensively explore the knowledge, prevalence, types and determinants of stigma and discrimination among people accessing Anti-retroviral Therapy (ART) in Ikeja, Lagos State, Nigeria.

This research aims to fill a gap in the literature by exploring the relationship between stigma, discrimination, and factors affecting access to anti-retroviral therapy (ART) for people living with HIV/AIDS (PLWHA) in Ikeja, Lagos State, Nigeria. The geographical scope is limited to Ikeja, a prominent urban area, allowing for an in-depth exploration within a defined locale. It seeks to provide practical insights for the local healthcare sector, identifying cultural, socioeconomic, and healthcare-related

influences that impact PLWHA's well-being. The findings could guide policymakers and healthcare professionals in developing inclusive interventions to reduce stigma and improve healthcare practices. Additionally, the study aims to empower both PLWHA and the wider community by increasing public understanding and contributing to global efforts against HIV-related discrimination.

## **METHODOLOGY**

This study that was conducted in Lagos State in January 2024, focused on Ikeja, a major economic and healthcare hub. Despite being the smallest state by landmass, Lagos had a population of 12.7 million in 2019, with Ikeja being home to over 470,200 people.<sup>35, 61</sup> Overcrowding, rural-urban migration, and low-income earners characterize the state. Ikeja's diverse urban-suburban population and its healthcare infrastructure, including several busy Anti-Retroviral Therapy (ART) clinics, provide an ideal backdrop to examine stigma and discrimination among people living with HIV/AIDS (PLWHA). The study aims to highlight the socio-economic and healthcare challenges affecting access to ART services in this region.

A cross-sectional hospital-based study conducted at the Antiretroviral Therapy Centre (ATC) was employed. Among all adult clients on ART regimen, accessing treatment at any HAART clinic in Ikeja, Lagos state.

### **Inclusion criteria**

- Adult HIV patients 18 years and above
- Patients with confirmed HIV-positive status who had received Anti-Retroviral drugs for

at least 1 week prior to the study. This was to allow only established HAART clinic users in the study.

- Individuals accessing Anti-retroviral Therapy (ART) services in any HAART clinic within Ikeja, Lagos state.

### **Exclusion criteria**

- Pregnant women
- Terminally ill/debilitated patients
- Patients on admission

A sample size of 400 was selected using the fischer formula. A simple random sampling technique was used. Out of seven known ART centers, three hospitals were selected using simple random sampling. The names of all seven centers were written on separate slips of paper, placed in a container, and three slips were drawn randomly to select Lagos State University Teaching Hospital Ikeja, 661 Nigerian Air Force Hospital Ikeja, and Primary Health Centre Ogba. For patient selection, a list of all PLWHAs undergoing ART at these hospitals was obtained using a random number generator, 400 patients were chosen from these lists to participate in the study, ensuring an unbiased and representative sample.

Structured questionnaires was administered to individuals accessing ART in Ikeja to gather quantitative data on their experiences of stigma, discrimination, and related factors. These instruments include validated scales or items measuring stigma levels, discrimination experiences, and healthcare access barriers. The socio-demographic details of the participants was recorded using a pretested questionnaire schedule. Social stigma related to HIV was assessed using the Berger HIV Stigma Scale. During the process of patient interaction, queries/questions regarding HIV/AIDS/ART was clarified and solved. Any additional open-ended responses of the subjects was noted, without further probing.

The Berger Stigma Scale measures HIV-related stigma across four domains: Personalized Stigma, Disclosure Concerns, Negative Self Image, and Public Attitudes, totaling 40 items. Scores range from 40 to 160, with higher scores indicating greater stigma.<sup>62,63</sup> The scale has strong reliability (coefficients 0.90-0.96) and takes 15–25 minutes to complete. Knowledge of HIV was assessed through a separate scoring system, with scores over 60% classified as good knowledge. Ethical clearance was obtained from the Lagos state university teaching hospital Health Research and Ethics Committee with the Ref.No LREC/06/10/2499, and informed consent was obtained from participants. Participants were informed of their right to withdraw from the study at any time without penalty. Research assistants were trained to ensure confidentiality, and no personal identifiers were included in the data to prevent stigma.

Data was analyzed using STATA version 11.0, with statistical tests like Chi-squared, t-statistic, and logistic regression. A p-value of <0.05 was considered significant. Univariate analysis presented frequencies, percentages, means, and standard deviations. Knowledge scores were graded, and associations between stigma, discrimination, and ART accessibility were tested using Chi-square and logistic regression, with significance set at  $p < 0.05$ .

## RESULT

A total of 409 questionnaires were given out and 400 returned indicating a 98% response rate. Univariate analysis is expressed as frequency tables, mean and standard deviation while bivariate and multivariate was presented in tables.

The first section of the finding's presentation covered the respondents' demographic and socioeconomic details.

### **Table 1 Demographic characteristics of respondents. N= 400**

<b>Variable</b>	<b>Frequency</b>	<b>Percentage (%)</b>
<b>Age (in years)</b>		
<20	6	1.5
20-29	105	26.3
30-39	110	27.5
40-49	107	26.7
≥ 50	72	18.0
<b>Mean Age ± SD</b>	<b>39 ± 11</b>	
<b>Gender</b>		
Female	201	50.3
Male	199	49.7
<b>Marital status</b>		
Single	147	36.8
Married	195	48.8
Separated/Divorced	31	7.7
Widowed	27	6.7
<b>Ethnicity</b>		
Yoruba	120	30.0
Hausa	43	10.7
Igbo	121	30.3
Others	116	29.0
<b>Religion</b>		
Christianity	308	77.0
Islam	92	23.0
<b>Education status</b>		
None	8	2.0
Primary	11	2.8
Secondary	87	21.7
Tertiary	294	73.5

<b>Occupation</b>		
Civil servant	136	34.0
Artificer	20	5.0
Trader	168	42.0
Student	28	7.0
Others	48	12.0
<b>Average monthly income (₦)</b>		
<50,000	113	28.3
50,000-100,000	71	17.7
100,001-500,000	119	29.7
>500,000	97	24.3
<b>Average monthly income ± SD</b>	<b>301568.1 ± 318389.2</b>	
<b>HIV status Disclosure</b>		
Undisclosed	215	53.7
Disclosed	185	46.3
<b>Partner's HIV status</b>		
Positive	171	42.8
Negative	110	27.5
Unknown	119	29.7
<b>Duration on ART</b>		
< 5	211	52.7
≥ 5	189	47.3
<b>Mean duration on ART ± SD (in years)</b>	<b>5.3 ± 5</b>	
<b>Area of Residence</b>		
Within Ikeja	148	37.0
Outside Ikeja LGA	173	43.3
Outside Lagos State	79	19.7

From table 1, more than a quarter of respondents were in the 20-29years (26.3%), 30-39years (27.5%), and 40-49years (26.7%) with a mean of 39 ± 11. Gender distribution shows a near-equal split with 50.3%



female and 49.7% male. As regards the level of education, more than two thirds of participants (73.5%) have completed university education, with 2.0% having no formal education. The average monthly income of the participants varies; smaller proportion earn between ₦50,000 and ₦100,000 (17.7%), while the bulk earn between ₦100,000 and ₦500,000 (29.7%). The monthly average income is roughly ₦301,568 ± ₦318,389.

Concerning HIV status disclosure, more than one third of participants (46.3%) have declared their status, compared to over half (53.75%) who have not. For partners' HIV status more than one third (42.75%) of the participants reported having an HIV-positive spouse. With a mean of 5.3 ± 5 years, the participants' length of time on ART reveals more than half of participants (52.7%) have been on therapy for less than five years.

### Awareness and Knowledge of Stigma and Discrimination

**Table 2 Assessment of level of awareness and knowledge regarding stigma and discrimination. N=400**

Variable	Yes (%)
Are you aware of what stigma related to HIV/AIDS means?	359(89.7)
Have you received information regarding discrimination against PLWHAs?	232(58.0)
Do you know about support services available to address stigma and discrimination faced by PLWHAs?	187(46.7)
Have you participated in educational programs related to HIV/AIDS stigma and discrimination?	184(46.0)
Are you aware that reducing stigma could improve healthcare access for PLWHAs?	317(79.3)
<b>Knowledge</b>	
Good	<b>160(40.0)</b>
Poor	<b>240(60.0)</b>

Table 2: Among the respondents, 89.7% were aware of what stigma related to HIV/AIDS means, indicating high awareness levels. However, only 46.7% knew about support services available to address stigma and discrimination faced by PLWHAs. Additionally, 58.0% had received information regarding discrimination against PLWHAs, and 46.0% had participated in educational programs related to HIV/AIDS stigma and discrimination. Furthermore, 79.3% were aware that reducing stigma could improve healthcare access for PLWHAs. Despite high awareness, more than half (60.0%) of respondents had poor knowledge overall.

### Prevalence of Stigma and Discrimination

**Table 3 Determination of level of prevalence of stigma and discrimination encountered by respondents. N=400**

<b>Variable</b>	<b>Yes</b>
Have you ever been treated differently by healthcare providers due to your HIV status?	155(38.7)
Have you encountered negative attitudes or behaviors from family or friends because of your HIV status?	166(41.5)
Have you ever felt ashamed or judged because of your HIV status?	195(48.7)
Do you believe there is widespread discrimination against PLWHAs in Ikeja?	192(48.0)
Have you personally experienced verbal abuse or insults related to your HIV status?	127(31.7)
<b>Prevalence</b>	
High	<b>81(20.3)</b>
Low	<b>319(79.7)</b>

From table 3 above, more than a third of participants (38.7%) reported being treated differently by healthcare providers due to their HIV status. Negative attitudes or behaviors from family or friends were encountered by 41.5% of participants, 48.7% felt ashamed or judged because of their HIV status, and 48.0% believed there is widespread discrimination against PLWHAs in Ikeja. Personal experiences of verbal abuse or insults related to HIV status were reported by less than a third (31.7%) of respondents.

The prevalence of stigma and discrimination was generally low, with more than two third (79.7%) of respondents classified as experiencing low prevalence. This classification was based on scoring and grouping responses into low and high prevalence categories.

## **Forms of Stigma and Discrimination**

**Table 4 shows the different forms of stigma and discrimination experienced by respondents. N=400**

Variable	Yes (%)
Have you experienced stigma while accessing healthcare services for HIV/AIDS	151(37.7)
Have you encountered discrimination in educational or workplace settings due to	119(29.7)
Do you perceive media or societal attitudes contribute to stigma associated with HIV/AIDS	208(52.0)
Do religious or cultural beliefs influence the treatment of PLWHAs in your community	182(45.5)
Have you witnessed/experience instances where PLWHAs were excluded from community	129(32.3)
Do you believe poverty or socioeconomic status influences how PLWHAs are treated	224(56.0)
Have you experienced stigma or discrimination due to gender or sexual orientation	164(41.0)
Do healthcare provider attitudes affect stigma faced by PLWHAs	235(58.7)
Do you think education level or awareness impacts how people treat PLWHAs in Ikeja	278(69.5)
Are political or governmental policies contributing to discrimination against PLWHAs	209(52.3)
Do you perceive the community in Ikeja to hold negative attitudes towards PLWHAs	174(43.5)
Have you observed community-based programs aimed at reducing stigma against PLWHAs	174(43.5)
Do you believe media representations of HIV/AIDS contribute to negative perception	224(56.0)
Do you think healthcare provider attitudes affect PLWHAs' willingness to seek help	268(67.0)
Do PLWHAs in Ikeja face challenges accessing ART and necessary healthcare service	159(39.7)
Have you or others encountered barriers/difficulties accessing healthcare due to your HIV status?	163(40.7)
Are PLWHAs in Ikeja comfortable disclosing their HIV status to others?	89(22.3)
Does fear of stigma or discrimination influence the decision to disclose HIV status?	260(65.0)
Have you observed changes in your mental health or self-esteem because of your HIV status?	219(54.7)
Do you believe stigma significantly affects the mental well-being and social interactions of PLWHAs?	257(64.3)
Do you think poverty amplifies the stigma experienced by PLWHAs in Ikeja?	248(62.0)
Have you or others encountered barriers/difficulties accessing healthcare due to HIV/AIDS-related stigma?	163(40.7)
Does fear of stigma or discrimination influence the decision to disclose HIV status?	260(65.0)
Have you observed changes in your mental health or self-esteem because of your HIV status?	219(54.7)

Do you believe stigma significantly affects the mental well-being and social interactions of PLWHAs?	257(64.3)
Do you think poverty amplifies the stigma experienced by PLWHAs in Ikeja?	248(62.0)
Have you noticed differences in the treatment of PLWHAs based on socioeconomic status?	196(49.0)
Can education and awareness programs substantially reduce stigma and discrimination related to HIV/AIDS?	283(70.7)
Have educational campaigns in Ikeja shown any impact on reducing stigma against PLWHAs?	232(58.0)
Have been gossiped about	96(24.0)
Verbally insulted/harassed or threatened	82(20.5)
Husband, spouse, or other household members have been discriminated against	75(18.7)
Sexual rejection	125(31.3)
Excluded from social gatherings	61(15.3)
Excluded from family activities	65(16.3)
Discriminated against by other PLWHAs	52(13.0)
Excluded from religious activities	42(10.5)

From table 4, two third (67.0%) of respondents believe that healthcare provider attitudes affect PLWHAs' willingness to seek help, highlighting a crucial factor in stigma and discrimination, 69.5% think that education and awareness impact how people treat PLWHAs in Ikeja. The perception that poverty or socioeconomic status influences the treatment of PLWHAs is shared by more than half (56.0%) of respondents, while the fear of stigma or discrimination affecting the decision to disclose HIV status was noted by 65.0% of participants. Furthermore, about two third (64.3%) of participants believe that stigma significantly impacts the mental well-being and social interactions of PLWHAs and 70.7% agree that education and awareness programs can substantially reduce stigma and discrimination related to HIV/AIDS.

**Table 4. 5 Subscale of stigma distribution with Gender**

Subscale	Mean Score	Male	Female	P (Independent t-test)
Personalized stigma	2.46 ± 2.04	2.29 ± 2.04	2.63 ± 2.02	0.0946
Disclosure concerns	1.43 ± 0.62	1.42 ± 0.60	1.44 ± 0.64	0.7391
Negative self-image	1.68 ± 1.02	1.61 ± 1.07	1.74 ± 0.96	0.1748
Public attitude	6.32 ± 4.43	6.48 ± 4.64	6.15 ± 4.42	0.4760

The table demonstrated the mean scores for the various HIV/AIDS stigma subscales among participants who were male and female, as well as the findings of an independent t-test comparing these scores.  $2.46 \pm 2.04$  was the mean score for personalized stigma. Although the mean score of females was slightly higher ( $2.63 \pm 2.02$ ) than that of males ( $2.29 \pm 2.04$ ), there was no statistically significant difference between the two groups ( $p = 0.0946$ ).

Participants' average score for disclosure concerns was  $1.43 \pm 0.62$ . Regarding these issues, there was no discernible difference between the male and female participants ( $1.42 \pm 0.60$  and  $1.44 \pm 0.64$ , respectively;  $p = 0.7391$ ).

The mean score for having a poor self-image was  $1.68 \pm 1.02$ . The mean score of females was  $1.74 \pm 0.96$ , somewhat higher than that of males ( $1.61 \pm 1.07$ ), although this difference was not statistically significant ( $p = 0.1748$ ). The mean score for public attitude was  $6.32 \pm 4.43$ . Regarding public attitude, there was no statistically significant difference between males ( $6.48 \pm 4.64$ ) and females ( $6.15 \pm 4.42$ ) ( $p = 0.4760$ ).

All things considered, these findings imply that there were no appreciable gender disparities in the participants' mean scores for personalized stigma, disclosure worries, negative self-image, or public opinion.

### Interpretation of Stigma Subscale Correlations

**Table 4. 6 Correlation between the different subscales of stigma.**

Stigma subscale	Personalized stigma	Disclosure concerns	Negative self-image	Public attitude
Personalized stigma	1			
Disclosure concerns	0.0296	1		
Negative self-image	0.5838	0.1195	1	
Public attitude	0.8012	0.0554	0.4698	1

The data reveals significant relationships between stigma subscales in the study. There is a moderate positive correlation between personalized stigma and negative self-image at 0.5838, indicating that higher levels of personalized stigma are associated with more negative self-perceptions. A strong positive correlation of 0.8012 exists between personalized stigma and public attitude, suggesting that personal stigma is closely linked to perceptions of societal attitudes. Disclosure concerns show a weak positive correlation with personalized stigma at 0.0296, and a weak positive correlation with negative self-image at 0.1195. The strongest correlation is between personalized stigma and public attitude. Meanwhile, public attitude and negative self-image have a moderate positive correlation of 0.4698, while disclosure concerns and public attitude show a weak correlation of 0.0554.

## Section E: Factors contributing to Experience of Stigma and Discrimination

### Table 4. 7 Association of socio-demographic parameters of study participant and stigmatization

Variable	Stigmatization			$\chi^2$	P value
	High (%)	Low (%)	Total (100%)		
<b>Age</b>					
<20	2(33.3)	4(66.7)	6		
20-29	34(32.4)	71(67.6)	105		
30-39	47(42.7)	63(57.3)	110	3.33	0.504
40-49	35(32.7)	72(67.3)	107		
>=50	25(34.7)	47(65.3)	72		
<b>Average monthly income (#)</b>					
<50,000	105(92.9)	8(7.1)	113		
50,000-100,000	38(53.5)	33(46.5)	71	290.74	<0.001
100,001-500,000	0(0.0)	119(100.0)	119		
> 500,000	0(0.0)	97(100.0)	97		
<b>Gender</b>					
Male	77(38.7)	122(61.3)	199	1.49	0.222
Female	66(32.8)	135(67.2)	201		
<b>Marital Status</b>					
Single	55(37.4)	92(62.6)	147		
Married	70(35.9)	125(64.1)	195		
Separated/Divorced	10(32.3)	21(67.7)	31	0.78	0.853
Widowed	8(29.6)	19(70.4)	27		
<b>Partner's HIV status</b>					
Positive	74(43.3)	97(56.7)	171		
Negative	30(27.3)	80(72.7)	110	8.12	0.017
Unknown	39(32.8)	80(67.2)	119		
<b>Ethnicity</b>					
Yoruba	45(37.5)	75(62.5)	120		
Hausa	14(32.6)	29(67.4)	43	0.97	0.808
Igbo	40(33.1)	81(66.9)	121		

Others	44(37.9)	72(62.1)	116		
<b>Religion</b>					
Christianity	106(34.4)	202(65.6)	308	1.04	0.308
Islam	37(40.2)	55(59.8)	92		
<b>Educational status</b>					
None	3(37.5)	5(62.5)	8		
Primary	4(36.4)	7(63.6)	11	6.57	0.087
Secondary	21(24.1)	66(75.9)	87		
Tertiary	115(39.1)	179(60.9)	294		

<b>HIV status disclosure</b>					
Undisclosed	76(35.4)	139(64.6)	215		
Disclosed	67(36.2)	118(63.8)	185	0.03	0.857
<b>Occupation</b>					
Civil servant	57(41.9)	79(58.1)	136		
Artificer	5(25.0)	15(75.0)	20		
Trader	54(32.1)	114(67.9)	168	4.21	0.379
Student	10(35.7)	18(64.3)	28		
Others	17(35.4)	31(64.6)	48		
<b>Area of Residence</b>					
Within Ikeja LGA	51(34.5)	97(65.5)	148		
Outside Ikeja LGA	58(33.5)	115(66.5)	173	2.31	0.316
Outside Lagos State	34(43.0)	45(57.0)	79		
<b>Duration on ART (in years)</b>					
<5	75(35.6)	136(64.4)	211	0.01	0.928
≥5	68(36.0)	121(64.0)	189		

The partner's HIV status was found to be a significant variable in the stigmatization analysis. With  $p = 0.017$  and  $\chi^2 = 8.12$ , there was clear statistical significance. This implies that a person's ability to avoid stigmatization is significantly influenced by the HIV status of their partners.



Additionally, there was an association between respondents' average monthly income and stigmatization ( $\chi^2 = 290.74$ ,  $p < 0.001$ , indicating that socioeconomic position is a key factor influencing stigmatization).

However, a number of factors had no statistically significant association with stigmatization. The  $\chi^2 = 3.33$  and the  $p = 0.504$  for age did not indicate an association.

The following factors did not significantly differ ( $p > 0.050$ ): gender, marital status, ethnicity, religion, educational status, disclosure of HIV status, occupation, place of residence, and duration on ART.

**Table 4. 8 Association of socio-demographic parameters of study participants and Discrimination**

Variable	Discrimination			$\chi^2$	P value
	High (%)	Low (%)	Total (100%)		
<b>Age</b>					
<20	0(0.0)	6(100.0)	6		
20-29	9(8.6)	96(91.4)	105		
30-39	12(10.9)	98(89.1)	110	1.50	0.826
40-49	12(11.2)	95(88.8)	107		
$\geq 50$	9(12.5)	63(87.5)	72		
<b>Average monthly income (#)</b>					
<50,000	20(17.7)	93(82.3)	113		
50,000-100,000	16(22.5)	55(77.5)	71	33.06	<0.001
100,001-500,000	0(0.0)	119(100.0)	119		
> 500,000	6(6.2)	91(93.8)	97		
<b>Gender</b>					
Male	18(9.0)	181(91.0)	199	0.89	0.345
Female	24(11.9)	177(88.1)	201		
<b>Marital Status</b>					
Single	12(8.2)	135(91.8)	147		
Married	23(11.8)	172(88.2)	195	2.52	0.471
Separated/Divorced	5(16.1)	26(83.9)	31		
Widowed	2(7.4)	25(92.6)	27		
<b>Partner's HIV status</b>					
Positive	31(18.1)	140(81.9)	171		
Negative	4(3.6)	106(96.4)	110	18.80	<0.001
Unknown	7(5.9)	112(94.1)	119		
<b>Ethnicity</b>					
Yoruba	17(14.2)	103(85.8)	120		
Hausa	4(9.3)	39(90.7)	43	3.79	0.285
Igbo	8(6.6)	113(93.4)	121		

Others	13(11.2)	103(88.8)	116		
<b>Religion</b>					
Christianity	28(9.1)	280(90.9)	308	2.83	0.093
Islam	14(15.2)	78(84.8)	92		
<b>Educational status</b>					
None	2(25.0)	6(75.0)	8		
Primary	0(0.0)	11(100.0)	11		
Secondary	9(10.3)	78(89.7)	87	3.08	0.379
Tertiary	31(10.5)	263(89.5)	294		

Table 4. 8 continued

Variable	Discrimination			$\chi^2$	P value
	High (%)	Low (%)	Total (100%)		
<b>Status disclosure</b>					
Undisclosed	16(7.4)	199(92.6)	215	4.63	0.031
Disclosed	26(14.1)	159(85.9)	185		
<b>Occupation</b>					
Civil servant	18(13.2)	118(86.8)	136	13.82	0.008
Artificer	6(30.0)	14(70.0)	20		
Trader	13(7.7)	155(92.3)	168		
Student	0(0.0)	28(100.0)	28		
Others	5(10.4)	43(89.6)	48		
<b>Area of Residence</b>					
Within Ikeja LGA	21(14.2)	127(85.8)	148	5.69	0.058
Outside Ikeja LGA	11(6.4)	162(93.6)	173		
Outside Lagos State	10(12.7)	69(87.3)	79		
<b>Duration on ART</b>					
<5	23(10.9)	188(89.1)	211	0.08	0.782
$\geq 5$	19(10.0)	170(90.0)	189		

The average monthly income has an association with discrimination among the factors analyzed. With  $p < 0.001$  and  $\chi^2 = 33.06$  there was clear statistical significance. This implies that people's experiences of discrimination are significantly influenced by their financial levels.

The presence of HIV in a partner was also significantly associated with discrimination ( $\chi^2 = 18.80$ ,  $p < 0.001$ ). This suggested that a person's ability to avoid discrimination is significantly influenced by their partner's HIV status. Another variable that showed statistical significance in relation to discrimination was status disclosure ( $\chi^2 = 4.63$ ,  $p = 0.031$ ). This suggests that a person's chance of facing discrimination is greatly impacted by whether they disclose their HIV status.

It was also found that discrimination was associated with occupation ( $\chi^2 = 13.8243$ ,  $p = 0.008$ ) indicating that occupational status has an effect on experiences of discrimination.

However, several factors (including age, marital status, religion, ethnicity, educational attainment, place

of residence, and duration on ART) did not show statistically significant differences from one another when it came to discrimination (p value > 0.05).

**Table 4. 9 Association of socio-demographic parameters of study subjects with Stigmatization (Logistic Regression analysis) N=400**

<b>Variable</b>	<b>Stigmatization</b>	
	<b>OR [95% Conf. Interval]</b>	<b>P&gt;z</b>
<b>Age (years)</b>		
<20	Reference	
20-29	50.41(1.66185 - 1529.633)	0.024
30-39	44.82(1.607253 - 1249.628)	0.025
40-49	7.56(0.335789 - 170.0604)	0.203
>50	5.92(0.256746 - 136.8447)	0.267
<b>Gender</b>		
Female	Reference	
Male	1.22(0.451968 - 3.295689)	0.694
<b>Marital Status</b>		
Single	Reference	
Married	2.30(0.494824 - 10.70581)	0.288
Divorced	2.14(0.313285 - 14.66395)	0.437
Widowed	1.68(0.088629 - 31.76929)	0.730
<b>Ethnicity</b>		
Yoruba	Reference	
Hausa	0.10(0.016882 - 0.619667)	0.013
Igbo	1.57(0.356462 - 6.931393)	0.550
Others	1.11(0.310046 - 3.975394)	0.872
<b>Religion</b>		
Christianity	Reference	
Islam	2.34(0.56546 - 9.66315)	0.241
<b>Educational Status</b>		
None	Reference	
Primary	0.06(0.000758 - 4.869785)	0.21
Secondary	0.28(0.007398 - 10.97426)	0.500
Tertiary	0.38(0.010955 - 12.88153)	0.587

<b>Occupation</b>		
Civil servant	Reference	
Artificer	0.83(0.024666 - 28.21668)	0.920
Trader	0.72(0.08047 - 6.462311)	0.770
Student	0.42(0.123071 - 1.40783)	0.159
<b>Place of residence</b>		
Within Ikeja	Reference	
Outside Ikeja LGA	1.39(0.478736 - 4.049149)	0.543
Outside Lagos State	4.75(1.085868 - 20.8087)	0.039
<b>HIV status disclosure</b>		
Undisclosed	Reference	
Disclosed	4.37(1.406066 - 13.56713)	0.011

Table 4. 9 continued

<b>Variable</b>	<b>Stigmatization</b>	
	<b>OR [95% Conf. Interval]</b>	<b>P&gt;z</b>
<b>Partner's Status</b>		
Positive	Reference	
Negative	0.61(0.18053 - 2.091202)	0.436
Unknown	0.70(0.138353 - 3.495726)	0.659
<b>Years you have been on ART</b>		
< 5	Reference	
≥ 5	0.88(0.276574 - 2.793859)	0.827
<b>Average monthly Income(₦)</b>		
< 50,000	Reference	
50,000-100,000	0.03(0.007962 - 0.110472)	<0.001
100,001-500,000		
> 500,000		

Table 4.9 highlights several statistically significant variables associated with stigmatization. Individuals aged 20-29 years have a significantly higher likelihood of experiencing stigmatization with an odds ratio (OR) of 50.41 (95% CI: 1.66 - 1529.63, P=0.024), and those aged 30-39 years have an OR of 44.82 (95% CI: 1.61 - 1249.63, P=0.025). Ethnicity also plays a role, as Hausa individuals are less likely to experience stigmatization with an OR of 0.10 (95% CI: 0.02 - 0.62, P=0.013). Those living outside Lagos State have an increased likelihood of stigmatization, with an OR of 4.75 (95% CI: 1.09 - 20.81, P=0.039). Disclosure of HIV status significantly affects stigmatization, with disclosed individuals having an OR of 4.37 (95% CI: 1.41 - 13.57, P=0.011). Additionally, individuals with an average monthly income of ₦50,000-₦100,000 are significantly less likely to experience stigmatization, with an OR of 0.03 (95% CI: 0.008 - 0.11, P<0.001).

**Table 4. 10 Association of socio-demographic parameters of study subjects with Discrimination (Logistic Regression analysis) n=400**



<b>Variable</b>	<b>Discrimination</b>	
	<b>OR [95% CI]</b>	<b>P&gt;z</b>
<b>Age</b>		
>20	Reference	
20-29	1.78(0.290562 - 10.88299)	0.533
30-39	0.70(0.178499 - 2.752831)	0.611
40-49	0.80(0.249451 - 2.565658)	0.707
>50		
<b>Gender</b>		
Female	Reference	
Male	0.33(0.136237 - 0.789087)	0.013
<b>Marital status</b>		
single	Reference	
Married	1.57(0.417577 - 5.88339)	0.505
Divorced	5.34(0.944528 - 30.16217)	0.058
Widowed	0.76(0.084505 - 6.916386)	0.811
<b>Ethnicity</b>		
Yoruba	Reference	
Hausa	0.21(0.040554 - 1.105638)	0.066
Igbo	0.39(0.120352 - 1.278844)	0.121
Others	0.59(0.213736 - 1.615236)	0.303
<b>Religion</b>		
Christianity	Reference	
Islam	1.59(0.596543 - 4.232781)	0.354
<b>Level of Educational</b>		
None	Reference	
Primary		
Secondary	0.13(0.013472 - 1.167885)	0.068
Tertiary	0.12(0.012748 - 1.041251)	0.054

<b>Occupation</b>		
Civil servant	Reference	
Artificer	11.28(2.180583 - 58.30819)	0.004
Trader		
Student	0.50(0.201388 - 1.217385)	0.126
Others		
<b>Area of residence</b>		
Within Ikeja	Reference	
Outside Ikeja	0.35(0.132875 - 0.904878)	0.030
Outside Lagos	0.76(0.265375 - 2.194287)	0.616
<b>Status disclosure</b>		
Undisclosed	Reference	
Disclosed	1.81(0.750922 - 4.386543)	0.186

**Table 4.10 continued**

Variable	Discrimination	
	OR [95% CI]	P>z
<b>Partner's status</b>		
Positive	Reference	
Negative	0.11(0.029828 - 0.441713)	0.002
Unknown	0.72(0.203469 - 2.543071)	0.609
<b>Duration on ART</b>		
<5 years	Reference	
>=5 Years	1.57(0.55778 - 4.428542)	0.392
<b>Average monthly Income(₦)</b>		
< 50,000	Reference	
50,000-100,000	1.28(0.516153 - 3.151279)	0.598
100,001-500,000		
> 500,000	0.13(0.032582 - 0.487093)	0.003

Table 4.10 highlights several statistically significant variables associated with discrimination. Males are less likely to experience discrimination with an odds ratio (OR) of 0.33 (95% CI: 0.14 - 0.79, P=0.013). Occupation as an artificer significantly increases the likelihood of discrimination, with an OR of 11.28 (95% CI: 2.18 - 58.31, P=0.004). Residing outside Ikeja is associated with a decreased likelihood of discrimination, with an OR of 0.35 (95% CI: 0.13 - 0.90, P=0.030). Having a partner with a negative HIV status significantly reduces the odds of discrimination, with an OR of 0.11 (95% CI: 0.03 - 0.44, P=0.002). Finally, an average monthly income of over 500,000 also significantly lowers the likelihood of experiencing discrimination, with an OR of 0.13 (95% CI: 0.03 - 0.49, P=0.003).

## DISCUSSION

This study assessed the level of knowledge and HIV-related stigma and discrimination faced by people living with HIV/AIDS in Ikeja local government, Lagos state. The report reveals that majority (89.75%) of participants are aware of the stigma associated with HIV/AIDS, 60% possess only a limited understanding of the issue. This aligns with previous studies showing that although awareness is high, detailed comprehension of stigma and active involvement in educational programs remain low. The high rate of stigma and discrimination against people living with HIV/AIDS (PLWHAs) in Ikeja highlights the complex interactions between institutional operations, cultural norms, and societal views.<sup>61, 62, 64, 65</sup>

A significant portion of participants reported experiencing stigma in healthcare settings, which reflects ongoing challenges faced by PLWHAs in accessing healthcare services.<sup>66, 67</sup> These findings are consistent with prior research, indicating that negative attitudes from healthcare providers discourage PLWHAs from seeking medical attention, worsening their healthcare outcomes.<sup>57,68–70</sup> Discrimination is also widespread in the workplace and educational institutions<sup>71</sup>, which echoes research demonstrating how HIV stigma infiltrates multiple areas of life, affecting the opportunities and well-being of PLWHAs.<sup>73,74</sup>

Media portrayals were also cited as contributors to HIV stigma, reinforcing negative stereotypes and societal prejudices. This underscores the role of public perception in perpetuating stigma. Religious and cultural beliefs were identified by many respondents as significant factors influencing attitudes toward PLWHAs. These cultural stigmas pose serious barriers to acceptance and support, further isolating PLWHAs from social and community activities. This social isolation is a recurring theme in HIV stigma studies, as it exacerbates the emotional and psychological toll on affected individuals.<sup>74–78</sup>

Economic factors were also identified as contributors to stigma. Many participants believed that poverty worsens the stigma associated with HIV, a viewpoint supported by research indicating that PLWHAs with lower socioeconomic status are more vulnerable to discrimination. The report highlights the potential of educational initiatives to reduce stigma, with respondents recognizing that increased awareness and understanding can foster more accepting attitudes and behaviors toward PLWHAs. This reinforces previous findings showing that educational efforts can challenge stereotypes and improve public perceptions.<sup>74-79</sup>

The study's findings align with broader research on HIV-related stigma and discrimination, emphasizing the importance of continuous efforts in community support, legislative reform, and education to address these issues. The regularity of stigma and discrimination reported by participants reflects the broader dynamics of HIV-related stigma. Family, friends, and healthcare providers were common sources of stigma, which can lead to feelings of guilt, rejection, and condemnation among PLWHAs. These experiences have a significant impact on their quality of life and mental health, underscoring the critical need to address stigma in HIV/AIDS care.<sup>80,81</sup>

Interestingly, the study found a lower prevalence of overt discrimination and verbal abuse, which contrasts with some literature suggesting these forms of discrimination are more widespread. This discrepancy may stem from cultural differences in how stigma is perceived and expressed, as well as potential improvements in Ikeja's efforts to reduce stigma. However, the mixed views on stigma indicate the complexity of HIV-related discrimination, highlighting the need for ongoing research and locally tailored solutions.<sup>83</sup>

The report provides valuable insights into the different dimensions of stigma faced by PLWHAs, as shown by the stigma subscales in Tables 4.5 and 4.6. These subscales—Personalized Stigma, Disclosure Concerns, Negative Self-Image, and Public Attitude—offer a comprehensive understanding of the stigma

phenomenon and its impact on PLWHAs in Ikeja. This subscale measures internalized stigma, also known as self-stigma, which is the experience of feeling guilty, ashamed, or having a bad self-image due to one's HIV status. Studies on self-stigma in HIV-positive communities in Abeokuta, Nigeria; Tamil Nadu, India, confirms the idea that women may internalize negative societal attitudes more thoroughly than men, as seen by the somewhat higher ratings among females <sup>36,59,85</sup>.

Perceptions of how the general public perceives and handles individuals living with HIV/AIDS are measured by this subscale. A strong conviction that the public has negative attitudes towards people living with HIV, which are a result of social prejudice and misinformation, is indicated by high scores on this subscale. Numerous studies support these conclusions, showing that stigma from the public still poses a serious obstacle to the quality of life for those living with HIV <sup>56,86,87</sup>.

The findings from the subscale analysis are logical and align with current research on HIV stigma. Personalized Stigma, Disclosure Concerns, Negative Self-Image, and Public Attitude are all critical dimensions that impact the lives of individuals with HIV. These dimensions help to pinpoint areas where interventions can be most effective, such as public education to reduce societal stigma and supportive services to help individuals cope with internalized stigma. The gender differences observed, though not always statistically significant, highlight the need for gender-sensitive approaches in addressing HIV-related stigma. These insights are invaluable for developing comprehensive strategies to combat stigma and improve the well-being of people living with HIV/AIDS <sup>88,89</sup>. The data showed that, in comparison to people under 20, those in the 20–29 and 30-39 age groups are substantially more likely to encounter stigma. This result is in line with the theory that widespread assumptions and misconceptions regarding the lifestyles of younger PLWHA contribute to their increased social stigma. Youth are sometimes unfairly condemned for imagined acts that may have contributed to their HIV status in many nations, including Nigeria. Cultural norms that stigmatize drug use and premarital sexual activity, both of which are frequently (and often incorrectly) linked to HIV transmission, may be the root cause of this age-related stigma <sup>90</sup>.

Additionally, younger PLWHA may lack the social support systems that older individuals might have, exacerbating their vulnerability to stigma. The absence of strong family or community support can leave younger individuals feeling isolated and more susceptible to negative societal attitudes. This pattern aligns with previous research indicating that younger people with HIV face more pronounced stigma, making targeted interventions for this age group crucial.

Gender emerged as a key influence in discrimination but not in Stigma. It was discovered that the likelihood of discrimination was far lower for men than for women. This demonstrates the relationship between gender-based discrimination and HIV-related stigma. HIV-positive women frequently bear a dual burden: they are discriminated against because of their gender identity and stigmatized for having the virus <sup>91,92</sup>.

Women may experience more severe societal repercussions and are frequently held responsible for HIV transmission within their families in many countries, including Nigeria. This social guilt can show up as a variety of discriminatory experiences, such as being neglected in medical settings or being shunned by the community. This research emphasizes how gender-sensitive strategies are necessary to combat HIV-related prejudice and make sure that women's particular needs are met.

Looking at different forms of stigmatization across gender distribution females living with HIV/AIDS in Ikeja experience slightly higher personalized stigma (mean score: 2.63) compared to males (2.29), though the difference is not statistically significant ( $P = 0.0946$ ). This might be due to societal expectations placing more pressure on women. Disclosure concerns were nearly identical for both genders, suggesting a shared fear of stigma ( $P = 0.7391$ ). Negative self-image scores were also similar, indicating internalized stigma affects both sexes equally ( $P = 0.1748$ ). Public attitude scores were high across the board, reflecting widespread societal stigma ( $P = 0.4760$ ). These rational conclusions are consistent with recent research showing that stigma associated to HIV affects men and women in a similar way, highlighting the widespread nature of stigma irrespective of gender<sup>93,94</sup>.

While marital status was not significantly associated with stigma or discrimination in this study, divorced individuals had higher, though not statistically significant, odds of experiencing both. This points to an intricate relationship in which other variables, such as social support and financial stability, interact with married status to predict stigma and discrimination rather than stigma or discrimination alone<sup>95-97</sup>.

PLWHA who are divorced or alone may face more stigma and discrimination as a result of losing their spouse's support, which can be an important defense against negative societal perceptions. Furthermore, societal standards that stigmatize divorce or singlehood may make it harder for PLWHA to overcome these obstacles.

Religion and ethnicity were significant factors in stigma experiences. Those who identified as Hausa were much less likely than Yoruba people to face stigma. This might be explained by the different cultural perspectives that various ethnic groups have on HIV/AIDS. Communities that have more robust support networks within the community and less judgmental views towards disease, for instance, may create more conducive circumstances where stigma is less common.

Religion, although not significantly associated with stigma or discrimination in this study, still showed trends where individuals practicing Islam had higher odds of stigma. This finding suggests that religious beliefs and community practices might influence how HIV/AIDS is perceived and how individuals are treated. Previous studies have shown mixed results regarding the role of religion, indicating that it can either mitigate or exacerbate stigma depending on the religious context and its teachings about illness and morality<sup>76,77,98</sup>.

Higher educational attainment was significantly associated with lower odds of experiencing discrimination. This suggests that education can serve as a protective factor, possibly because educated individuals are better equipped to understand HIV/AIDS, advocate for their rights, and navigate

healthcare systems. Education might also foster more progressive attitudes towards HIV, reducing the likelihood of discriminatory behavior from others.

This is consistent with the larger body of literature that emphasizes the value of education in empowering people and lowering stigma and discrimination associated with health issues. Additionally, those with higher levels of education might have easier access to social networks and resources that help lessen the negative effects of discrimination <sup>34,99</sup>.

Experiences of prejudice were strongly influenced by occupation, with artisans experiencing much greater odds than civil servants. This draws attention to the occupational vulnerabilities that some occupations have, especially those that are less stable and have a lower social status, which might make people more vulnerable to discrimination.

Workplaces with pervasive prejudice toward HIV/AIDS or without policies protecting PLWHA can provide as fertile grounds for discrimination. This research highlights the significance of workplace interventions and regulations that safeguard the dignity and rights of PLWHA, guaranteeing equitable support for all occupational groups <sup>71,76,100</sup>.

Both stigma and discrimination were influenced by geographic location. Outside of Ikeja, people were more likely to face stigma than outside of Lagos State, where prejudice was less likely to occur. This regional discrepancy may result from differing HIV/AIDS knowledge, resources, and support networks in various areas.

It's possible that urban regions like Ikeja have stronger support networks and healthcare infrastructures, which lessen discrimination. On the other hand, stigma associated with HIV/AIDS may be higher in rural or less urbanized areas due to stronger traditional beliefs and limited access to factual information <sup>101,102</sup>.

Disclosure of HIV status was substantially linked to increased risk of stigma. This research emphasizes the two-edged sword of disclosure: although it is necessary to obtain assistance and medical care, it can also subject people to stigma from society. People frequently avoid declaring their status out of fear of stigma, which can make it more difficult for them to get the support and treatment they need <sup>56,103</sup>. This conclusion supports the necessity for safe disclosure contexts that shield people from stigma. Previous research has shown that disclosure can have detrimental societal implications.

The likelihood of facing stigma and discrimination was much decreased if one's partner's HIV status was unknown or negative. This implies that the social dynamics and support networks accessible to PLWHA can be impacted by the partner's status. Partners who do not know their status or who are HIV-negative may offer stronger support, lessening the negative effects of discrimination and stigma in society. The suffering of having been infected by a positive spouse may, despite the appearance of normalcy, intensify discrimination and stigma amongst Sero concordant couples <sup>104,105</sup>.

There was a strong association found between higher income and a decreased likelihood of discrimination and stigma. This emphasizes how stable economies provide protection against stigma and discrimination, since those with higher wages may have better access to healthcare, social services, and educational opportunities.

In line with the larger body of research on the protective benefits of socioeconomic position, economic empowerment can give PLWHA the means to stand up for their rights, get better healthcare, and create supportive social networks <sup>106,107</sup>

## **CONCLUSION**

The study concludes that stigma and prejudice against PLWHAs are still pervasive in Ikeja and have an impact on their general well-being, social inclusion, and access to healthcare. The difficulties that PLWHAs confront are mostly caused by socioeconomic issues, stigmas associated with culture and religion, and unfavorable attitudes from healthcare professionals. Even though stigma-related problems are becoming more widely recognized, there is still a significant need for improved education and focused treatments to deal with these problems. The results are consistent with previous research, which emphasizes the necessity for a multifaceted strategy to counteract stigma and discrimination connected to HIV.

## **Abbreviations**

AIDS Acquired immune deficiency syndrome

ART Anti-Retroviral Therapy

ATC Antiretroviral Therapy Centre

HAART Highly Active Anti-Retroviral Therapy

HIV Human immunodeficiency virus

NARHS National AIDS and Reproductive Health Survey

PEPFAR US President's Emergency Plan for AIDS Relief

PLHIV People Living with HIV

PLWHA People Living With HIV/AIDS

PMTCT Prevention of Mother to Child Transmission

## **Declarations**



Ethical Approval and Consent to participate: ethical approval was obtained from the health research and ethics committee Lagos state university teaching hospital (LASUTH)

Consent for publication: All authors agreed to publish this article

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