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Stigmatization And The Fight Against HIV/AIDS In Dekina Local Government Area, Kogi State, Nigeria

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Abstract

HIV/AIDS-related stigma remains one of the most persistent barriers to effective prevention, testing, treatment, and psychosocial wellbeing of people living with HIV/AIDS (PLWHA), especially in sub-Saharan Africa. This study examined the impact of stigmatization on the fight against HIV/AIDS in Dekina Local Government Area (LGA) of Kogi State, Nigeria. A descriptive survey research design was adopted, with quantitative approach. Primary data were collected using a self-designed and validated questionnaire administered to 400 respondents selected through multi-stage, cluster, and simple random sampling techniques. In-depth interviews were also conducted with selected healthcare workers to complement the survey data. Quantitative data were analyzed using descriptive statistics (frequency and percentage) and inferential statistics (chi-square) with the aid of SPSS. Findings revealed a high prevalence of HIV/AIDS-related stigma in the study area, with stigma manifesting in families, social networks, workplaces, and even within healthcare settings. Stigmatization was found to significantly reduce the utilization of HIV testing, counseling, and treatment services, thereby undermining public health interventions. The study concluded that combating stigma through sustained public enlightenment, supportive legislation, community engagement, and improved access to confidential health services is critical to strengthening the HIV/AIDS response. It recommended intensified awareness campaigns, legal protection for PLWHA, empowerment of affected persons through support groups, and expansion of counseling and testing services.

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INTRODUCTION

Stigma is a debasing attitude towards an object. Erving Goffman (1963) defines stigma as a "significantly discrediting" attribute possessed by a person with an "undesired difference". Stigma is a powerful means of social control applied by marginalizing, excluding and exercising power over individuals who display certain traits. It is a common response to perceived threat when escape from, or the destruction of, this threat is impossible. The Human Imuno-virus and Acquired Immune Deficiency syndrom-related stigma and discrimination refers to prejudice, negative attitudes and abuse directed at people living with HIV and AIDS.

In another dimension, the nature of the disease also encourages stigmatization irrespective of societal rejection of certain social groups (e.g. "homosexuals", injecting drug users, sex workers and migrants) prior to the advent of HIV/AIDS. Powerful metaphors were mobilized which serve to reinforce and legitimise stigmatization. These include HIV/AIDS as death (e.g. through imagery such as the Grim Reaper); HIV/AIDS as punishment (e.g. for immoral behaviour); HIV/AIDS as a crime (e.g. in relation to innocent and guilty victims); HIV/AIDS as war (e.g. in relation to a virus which needs to be fought); HIV/AIDS as horror (in which infected people are demonized and feared); and HIV/AIDS as "otherness" (in which the disease is an affliction of those set apart). Together with the widespread belief that HIV/AIDS is shameful (Lekganyane and plessis 2011). These metaphors constitute a series of "ready-made" but highly inaccurate explanations that provide a powerful basis for both stigmatizing and discriminatory responses.

HIV belongs to an unusual group of viruses called retroviruses, which include viruses that cause leukemia in humans, cats, cattle and other animals, and certain other viruses found in monkeys and apes, sheep and goats. Retroviruses also belong to a subgroup called lentiviruses, because they are slow to cause disease (World Health Organization, 2012). The report further adds that AIDS is caused by a virus, HIV (Human Immunodeficiency Virus) and it is transferrable from an infected person to uninfected person. Infected blood, semen or vaginal secretions, are modes of transmission. It can also be transmitted from mothers to babies either through delivery or breastfeeding.

The first official case was reported in a 13-year-old commercial sex worker in Lagos (Federal Ministry of Health, 2010). This marked the beginning of an epidemic that would grow to become one of the most critical public health challenges in the country's history. Since then, HIV has

spread with considerable intensity, fueled by socio-economic vulnerabilities, limited access to healthcare, low awareness in the early years, and stigmatization of affected individuals.

According to Joint United Nations Programme on HIV/AIDS (2023), an estimated 39 million people are living with HIV globally, with Sub-Saharan Africa accounting for nearly 25.6 million over 65% of the global total. Nigeria, being the most populous country in Africa, bears a significant proportion of this burden. As reported by the National Agency for the Control of AIDS (National Agency for the Control of AIDS, 2023), approximately 1.9 million Nigerians are living with HIV, which constitutes about 4.9% of the global HIV-positive population. Although Nigeria has made progress in reducing new infections through increased awareness, improved access to antiretroviral therapy (ART), and implementation of national HIV strategic frameworks, the infection remains a persistent public health and socio-economic concern.

To address funding volatility resulting from reductions in international donor support, the government has shifted focus toward local production of HIV commodities and improved national ownership of the HIV response. As reported by Chikaodinaka and Yusuf (2025), Nigeria's 2025 HIV sustainability framework prioritizes the domestic manufacture of HIV test kits and antiretroviral drugs, as well as strategic partnerships with international pharmaceutical companies. This is a critical pivot in securing programme continuity and resilience. Hence, this study examined the impact of stigmatisation on the fight against HIV/AIDS in Dekina Local Government Area.

Statement of the Problem

There have been several attempts at finding solution to the HIV/AIDS pandemic since its inception by national, bilateral and multilateral organizations as well as individuals. Based on the status of the disease as yet to yield to any scientific cure, prevention of new infection has been the corner stone of efforts to overcome the social problem. Consequently, abstinence, condom and faithfulness (ABC) has been the dominant measure. However, one critical factor that constitutes a barrier to prevention and perpetuates spread of the disease is stigmatization and discrimination. AIDS is the most stigmatized disease in history whose impact and nature needs to be appreciated in order for its interventions to be successful (International Center for Research on Women, 2010). Lending credence, Stigmatization and discrimination was described by the UN Secretary General, Ban Ki Moon as a “silent killer and it is still pervasive across nations and within societies. According to Kafuko (2015) People stigmatize the disease and discriminate

against persons infected and affected by HIV/AIDS (based on factors such as perceptions about the spread and mode of transmission, personal and social fears, religious beliefs, misconceptions, myths and cultural issues, among others.

According to the **World Health Organization (2015)**, discrimination and other human rights violations often occur in healthcare settings, preventing individuals from accessing essential services and receiving quality care. People living with HIV (PLHIV) and other key affected populations are frequently subjected to stigma being shunned by family members, peers, and the broader community. Many also experience unfair treatment in educational institutions and workplaces, infringement of their rights, and psychological trauma. The **Joint United Nations Programme on HIV and AIDS (2015)** emphasizes that openness, dialogue between individuals and communities, family support, human solidarity, and resilience are vital in addressing and ultimately overcoming the HIV/AIDS epidemic. Unfortunately, stigma manifested through shame, insults, oppression, and discrimination undermines these very principles, obstructing openness and constructive dialogue.

The existing misconception and perception have resulted to stigmatizing attitudes such as insults, gossip, blame, rumour which eventually leads to discriminating attitudes like refusal to employ, denial of access to health care and ejection from homes, among others. These negative attitudes towards PLWHAs induce fear which leads to non-disclosure of serostatus or concealment and at times denial of aerostats by persons diagnosed as infected. Though stigmatization is not a new concept in health, the importance of the study of its nature and effects on an epidemic like HIV/AIDS in different communities can never be overemphasized. There is no doubt that it has impact on the fight against HIV/AIDS in Dekina Local government area.

There is a notable research gap concerning the impact of HIV/AIDS-related stigmatization in Dekina Local Government Area of Kogi State. While there are numerous studies on HIV/AIDS stigma at the national and state levels in Nigeria, there is limited or no publicly available academic or institutional research that specifically addresses the unique experiences and challenges faced by people living with HIV/AIDS in Dekina. This lack of localized data makes it difficult to understand the specific cultural, social, and economic factors influencing stigmatization in the area. As a result, public health interventions and awareness campaigns may not be effectively tailored to the local context. Without insights into how stigma affects testing behaviour, treatment adherence, mental health, and social reintegration in Dekina, efforts to combat the spread of HIV and support those affected may be hindered. Therefore, there is a

pressing need for primary research in this LGA to uncover the root causes, consequences, and coping mechanisms related to HIV/AIDS stigma, and to provide evidence-based recommendations for more effective community-specific strategies. Hence, this study was set to investigate the impact of on stigmatization on HIV/AIDS in Dekina Local Government Area of Kogi State.

Research Questions

This study was guided by the following questions:

1. What is the prevalence of stigmatization against people living with HIV/AIDS in Dekina Local Government Area?
2. What are the causes of stigma related to HIV/AIDS victims in Dekina Local Government Area?
3. What are the perceived effects of stigmatization on the utilization of HIV testing, treatment and counselling services in Dekina Local Government Area?
4. What are the strategies for curbing stigmatization against people living with HIV/ AIDS in Dekina Local Government Area?

Aim and Objectives of the Study

The aim of this study was to examine the impact of stugmatization on the fight against HIV/ AIDS while specific objectives are as follows:

1. To determine the level of stigmatization of people living with HIV/AIDS in Dekina Local Government Area
2. To determine the causes of stigma related to HIV/AIDS and its victims in Dekina Local Government Area.
3. To examine the effect of HIV/AIDS stigma on the utilization of HIV/AIDS testing, treatment and counselling services in Dekina Local Government Area.
4. To determine strategies for curbing stigma related to HIV/AIDS disease and patients in Dekina Local Government Area.

Research Hypothesis

This study was guided by the following hypothesis:

1. There is no significant relationship between stigmatization and spread of HIV/AIDS virus in Dekina Local Government Area of Kogi State.

Significance of the Study

The findings of this study have both theoretical and practical significance. For instance, every nation's development prospects depend on its active and healthy labour force and with the current statistics on HIV/AIDS prevalence; the youth is the most at risk of getting infected. As stigma and discrimination are pervasive in our society and can perpetuate spread of the disease, there is the need for sustained research to assess the levels of entrenchment and the possible effects on PLWHAs. The findings of this research will add to existing knowledge to strengthen the fight against the spread of the disease. Also, research of this nature will serve as a useful reference for both governmental and non-governmental organizations as well as individuals in their further studies or research work.

LITERATURE REVIEW

Conceptual Review

HIV/AIDS Related Stigma

According to Kafuko (2015) HIV/AIDS related stigma refers to unfavourable attitudes, beliefs, and polices directed towards people perceived to have HIV/AIDS as well as towards their significant others and loved ones, close associates, social groups and communities. It includes prejudice, discounting, discrediting and discrimination directed at people perceived to have HIV or AIDS, and the individuals, groups and communities with which they are associated. These patterns of prejudices play into and strengthen existing social inequalities especially those of gender, sexuality and race that are at the root of HIV- related stigma and stigma expression. Stigma expression can be in 3 ways, namely; (a) Instrumental Expression, (b) Symbolic Expression, (c) and Courtesy Expression. While Instrumental Stigma expression involves an individual's concern about the risk of his contacting AIDS including the individuals' perception of the disease, Symbolic Stigma expression is through political, religions, social or other values. Courtesy expression of stigma involves the stigmatization of people connected to the issues of HIV/AIDS or HIV Positive people for example non governmental organizations.

Another significant dimension of HIV/AIDS-related stigma is the institutional stigma found within healthcare systems. Oyebanji *et al.,* (2024) document ongoing cases of discrimination by healthcare professionals despite the presence of policies designed to protect the rights of people living with HIV. Their findings show that patients still experience breaches of confidentiality, disrespectful attitudes, and delays in treatment simply because of their HIV status. In some cases,

patients were openly gossiped about or treated with excessive caution, as if they were contagious through casual contact an indicator of lingering ignorance even among trained personnel. Such experiences create a climate of fear and mistrust, where patients become hesitant to disclose their status or return for follow-up care. This institutional failure undermines Nigeria's efforts to reach UNAIDS goals on treatment access and viral suppression. Oyebanji *et al.,* argue that healthcare stigma is particularly dangerous because it comes from trusted authorities and can discourage patients from accessing life-saving services. Moreover, the refusal of some healthcare workers to treat HIV-positive individuals violates their ethical responsibility and the patient's right to dignity and care. The scholars suggest that regular stigma-reduction training, coupled with enforcement of anti-discrimination laws, is essential to transform health institutions into safe spaces. They conclude that unless stigma is eradicated from healthcare settings, public trust in the medical system will continue to erode, with dire consequences for epidemic control and patient well-being.

Beyond individual and institutional forms of stigma, recent scholarship has drawn attention to the intersectionality of HIV-related stigma how it overlaps with other social identities and inequalities such as gender, poverty, education, and age.

Amadi and Bello (2022) particularly highlight how women, especially in rural Nigeria, face a compounded form of stigma that reflects both their HIV status and their position in a patriarchal society. In many cases, women are blamed for bringing the disease into the home, regardless of the actual source of infection. These women often face domestic violence, abandonment, and economic exclusion following disclosure of their status. The study reveals that even when women are innocent victims such as widows or survivors of rape they are still seen as social liabilities. This intersectional stigma silences many women and prevents them from seeking help or asserting their rights. It also discourages them from attending health facilities out of fear of being seen and gossiped about, which delays diagnosis and treatment. Amadi and Bello stress that combating HIV stigma among women must involve empowering them with education, financial independence, and legal protections.

Prevalence of Stigmatization against People Living with HIV/AIDS

Stigma against people living with HIV/AIDS (PLWHA) is a pervasive and complex issue that significantly impacts the lives of millions globally. As highlighted by Stangl *et al.,* (2019), despite advancements in medical treatment and a broader understanding of the virus, societal

attitudes toward HIV/AIDS remain largely negative, often rooted in misinformation, fear, and prejudice. This stigma manifests in various forms, including;

i. **Global Prevalence:** Stigma against people living with HIV/AIDS (PLWHA) is a significant global issue. Nyblade *et al.,* (2019) conducted a comprehensive review that indicated between30% to 50% of individuals with HIV experience considerable stigma. This prevalence is not uniform and varies widely across different geographic regions and cultural contexts. For instance, in sub-Saharan Africa, stigma can be particularly pronounced due to deeply ingrained societal attitudes and beliefs about HIV/AIDS. Mlambo *et al.,* (2021) further emphaized this point, noting that areas heavily affected by HIV often see higher rates of stigma, particularly among marginalized populations. This global perspective highlights the need for targeted interventions to address the unique stigma challenges faced in various regions.

ii. **Social Stigma:** Social stigma manifests in various forms of discrimination that PLWHA encounter in their daily lives. According to research by Logie *et al.,* (2020), individuals with HIV often face discrimination in multiple sectors, including employment, healthcare, and community interactions. This study found that many PLWHA encounter job loss or difficulties in securing employment due to their health status, as employers may hold unfounded fears about productivity or transmission risks. Additionally, the stigma can lead to isolation, where individuals may be ostracized by friends, family, or community members, further compounding their challenges and leading to a lack of social support.

iii. **Self-Stigma:** Self-stigma occurs when individuals internalize the negative beliefs and stereotypes prevalent in society regarding HIV/AIDS. Earnshaw *et al.,* (2018) found that many PLWHA experience profound feelings of shame, guilt, and worthlessness as a result of this internalization. This self-stigmatization can create significant psychological barriers, discouraging individuals from seeking testing, treatment, or support. The consequences of self-stigma are serious, as individuals may withdraw from social circles or avoid disclosing their status, perpetuating a cycle of isolation and poor health outcomes. Stangl *et al.,* (2019) further illustrate this point, showing how internalized stigma is linked to decreased health-seeking behaviors among PLWHA.

iv. **Impact on Mental Health:** The psychological impact of stigma on PLWHA is profound and multifaceted. According to a meta-analysis by Wu et al. (2021), stigma is linked to increased rates of anxiety, depression, and suicidal ideation among individuals living with HIV. The burden of stigma creates chronic stress, which can significantly impair mental health and overall well-being. Furthermore, the psychological toll of stigma can hinder adherence to antiretroviral therapy (ART), as individuals may feel demoralized or hopeless about their situation. This relationship between stigma and mental health highlights the critical need for supportive interventions that address both the psychological and medical needs of PLWHA.

v. **Access to Healthcare:** Access to healthcare is critically affected by stigma, as fear of judgment often prevents individuals from seeking necessary services. Poudel *et al.*, (2022) found that many PLWHA delay or avoid medical care due to concerns about being discriminated against or treated poorly by healthcare providers. This reluctance leads to late diagnoses, which in turn result in poorer health outcomes and increased risk of transmission. The study underscores the importance of creating stigma-free healthcare environments where PLWHA feel safe and supported in accessing the care they need. Reducing stigma within healthcare settings is essential for improving overall health outcomes for individuals living with HIV.

vi. **Cultural Variations:** Cultural contexts play a significant role in shaping the prevalence and forms of stigma associated with HIV/AIDS. Research by Mbonye *et al.*, (2023) indicates that traditional beliefs about health and sexuality can exacerbate stigma in certain societies. In more conservative cultures, HIV may be viewed through a lens of moral judgment, leading to harsher treatment of PLWHA. Conversely, more progressive communities often demonstrate greater acceptance and support for individuals living with HIV. This cultural perspective highlights the need for culturally tailored interventions that address the specific stigma challenges faced by PLWHA in various cultural contexts.

The prevalence of stigma against people living with HIV/AIDS is a critical public health issue that significantly affects individuals' quality of life, mental health, and access to healthcare. The stigma associated with HIV/AIDS remains a critical public health challenge that profoundly affects the lives of people living with the virus. This stigma not only hinders individual well-being but also poses significant barriers to accessing healthcare and support services. As highlighted by various studies, including those by Nyblade *et al.*, (2019) and Wu *et al.*, (2021),

the repercussions of stigma extend beyond individual experiences, impacting community health outcomes and perpetuating cycles of discrimination and marginalization.

Causes of Stigma against People Living with HIV/AIDS

The stigma surrounding HIV/AIDS continues to be a significant barrier to health and well-being for people living with HIV/AIDS (PLWHA). Despite remarkable advancements in medical treatments and preventive strategies, stigma remains deeply entrenched in societal beliefs, cultural norms, and historical contexts. Research indicates that this stigma often leads to discrimination, social isolation, and a pervasive lack of understanding about HIV and its transmission, which in turn makes it challenging for PLWHA to access essential healthcare and support services. The causes of stigma are multifaceted, encompassing widespread misinformation about HIV transmission and cultural attitudes that associate the virus with moral failings. factors contributing to the stigma associated with HIV/AIDS, includes;

a. Misinformation and Lack of Awareness:

Misinformation about HIV/AIDS is pervasive and significantly contributes to stigma. Many people harbor misconceptions regarding how the virus is transmitted. For instance, some believe that casual contact, such as hugging or sharing utensils, can spread HIV, which is not true. This lack of understanding leads to fear and avoidance behaviors toward PLWHA. A study by **Bennett *et al.*, (2019)** highlights that individuals who are misinformed about transmission routes are more likely to stigmatize those living with HIV. Educational interventions are crucial in dispelling these myths. Schools, community organizations, and healthcare providers can play a vital role in providing accurate information about HIV transmission and treatment, fostering a more informed public that is less likely to engage in stigmatizing behaviors. By increasing awareness and understanding, we can reduce the stigma associated with HIV and create more supportive environments for PLWHA.

b. Cultural Attitudes and Norms:

Cultural beliefs and societal norms significantly shape how HIV/AIDS is perceived within different communities. In many cultures, HIV is linked to behaviors considered morally unacceptable, such as drug use, promiscuity, or infidelity. This association leads to moral judgments against those living with the virus. **Mlambo *et al.*, (2021)** note that in some societies, individuals with HIV may be viewed as having brought the disease upon themselves due to their lifestyle choices. Such cultural stigma can result in ostracism, making it difficult for PLWHA to

seek help or disclose their status. The stigma is often reinforced by traditional beliefs surrounding health and morality. To combat this, interventions must be culturally sensitive and tailored to address specific community attitudes. Engaging community leaders and utilizing culturally relevant messaging can help shift perceptions and reduce stigma associated with HIV/AIDS.

c. Fear of Transmission:

Fear of contracting HIV is a widespread issue that contributes to stigma. This fear is often fueled by a lack of knowledge about how the virus is transmitted, as well as sensationalized media portrayals that emphasize the dangers of HIV. **Logie *et al.*, (2020)** found that heightened fears regarding transmission can lead individuals to distance themselves from PLWHA, viewing them as potential threats to their own health. This reaction creates a cycle of isolation for those living with HIV, further entrenching stigma. Moreover, this fear can prevent individuals from seeking testing and treatment, as they may worry about being judged or ostracized. Community education initiatives that clarify how HIV is transmitted, alongside emphasizing the effectiveness of modern antiretroviral therapy in reducing transmission risk, can help mitigate these fears. By fostering a more accurate understanding of HIV, we can reduce stigma and promote a more supportive atmosphere for PLWHA.

d. Historical Context:

The historical context surrounding the HIV/AIDS epidemic has significantly impacted public perceptions of the virus. Initially, HIV was primarily associated with marginalized groups, such as men who have sex with men and intravenous drug users. **Stangl *et al.*, (2019)** argue that this association has led to enduring stereotypes that continue to stigmatize PLWHA today. The early years of the epidemic were marked by fear, misinformation, and discrimination, which set a precedent for how HIV is viewed in society. This historical stigma complicates efforts to seek support or communicate openly about the virus, as individuals may fear being judged based on outdated associations. Addressing this stigma requires targeted awareness campaigns that educate the public about the realities of HIV/AIDS and highlight the advances in treatment and prevention. By reframing the narrative surrounding HIV, we can combat the historical stigma that persists today.

e. Media Representation:

Media representations of HIV/AIDS often play a crucial role in shaping public perceptions. Unfortunately, these portrayals can be sensationalized, focusing on the most dramatic and negative aspects of the disease. Research by Earnshaw *et al.,* (2021) indicates that media coverage frequently emphasizes death and suffering rather than advancements in treatment and quality of life for PLWHA. Such portrayals contribute to public fear and misunderstanding, reinforcing negative stereotypes about individuals living with HIV. For instance, stories that depict PLWHA as dangerous or irresponsible can lead to increased stigma and discrimination. Promoting responsible and compassionate media coverage is essential for fostering a more balanced understanding of HIV/AIDS. Media outlets should strive to present stories that highlight the experiences of PLWHA, their resilience, and the effectiveness of treatment, thereby contributing to a more informed and empathetic public.

f. Structural Factors:

Structural stigma encompasses the policies and practices within institutions that reinforce discrimination against PLWHA. This can include inadequate access to healthcare services, discriminatory practices in healthcare settings, and legal frameworks that criminalize aspects of HIV transmission. **Mbonye *et al.*, (2023)** emphasize that such policies can create significant barriers to care, discouraging individuals from seeking necessary medical assistance. For example, laws that penalize individuals for not disclosing their HIV status can instill fear and lead to avoidance of testing and treatment. Furthermore, systemic issues, such as lack of funding for HIV prevention programs and stigmatizing attitudes among healthcare providers, perpetuate this structural stigma. Addressing these barriers is crucial for creating an inclusive environment where PLWHA feel safe seeking care and support. Policy reforms aimed at reducing discrimination within healthcare systems and increasing access to services are essential for combating structural stigma.

g. Internalized Stigma:

Internalized stigma refers to the process by which individuals living with HIV internalize societal stigma, leading to feelings of shame, guilt, and low self-esteem. A study by **Wu *et al.*, (2022)** found that internalized stigma can result in significant psychological distress, making it harder for PLWHA to seek support and engage in healthy behaviors. Individuals may avoid disclosing their status to friends and family due to fear of rejection, which can lead to social isolation and exacerbate mental health issues. This internalization can create a vicious cycle,

where the stigma faced in society leads to further withdrawal and self-blame among individuals. Providing mental health support and counseling services tailored for PLWHA is essential for helping individuals navigate these feelings of internalized stigma. Empowering PLWHA through support groups and educational resources can also foster resilience and promote a more positive self-image.

The stigma against people living with HIV/AIDS is deeply rooted in a combination of misinformation, cultural attitudes, fear, historical context, media representation, structural factors, and internalized stigma. Addressing these causes is crucial for reducing stigma and fostering a supportive environment for PLWHA. Comprehensive education, advocacy, and policy reform, supported by recent scholarly research, are essential in challenging misconceptions and promoting acceptance. By understanding and tackling the underlying causes of stigma, we can enhance the lives of those affected by HIV/AIDS and contribute to a more inclusive society.

Effects of Stigmatization on the Fight against HIV/AIDS

Stigma against people living with HIV/AIDS (PLWHA) has profound and multifaceted effects that extend beyond individual experiences, impacting communities and healthcare systems. Understanding these effects is crucial for addressing the challenges faced by PLWHA and fostering a more supportive environment. However the effects of stigma includes:

Social Isolation: Social isolation is one of the most profound consequences of stigma faced by PLWHA. When individuals disclose their HIV status, they often encounter negative reactions from family, friends, and community members, leading to feelings of rejection and abandonment. This isolation can manifest in various ways, including reduced social interactions, withdrawal from family events, and loss of friendships. The absence of a support network can make it more challenging for individuals to cope with the emotional and physical demands of living with HIV.

Research by Parker and Aggleton (2024) indicates that social isolation is linked to poorer mental health outcomes, further complicating the struggles of those living with the virus. Additionally, this isolation can create barriers to accessing vital resources and support services, as individuals may feel uncomfortable seeking help when they are already distanced from their community. Ultimately, social isolation not only exacerbates mental health issues but also hinders the overall quality of life for PLWHA.

Mental Health Issues: The psychological impact of stigma on PLWHA is significant and can lead to a range of mental health issues. Individuals who internalize societal stigma often grapple with feelings of shame, guilt, and low self-esteem, which can trigger anxiety and depression. The constant burden of societal judgment can lead to chronic stress, making it difficult for individuals to engage in healthy coping mechanisms. A study by **Kumar *et al.*, (2025)** found that PLWHA facing stigma are at an increased risk for developing serious mental health disorders, including severe anxiety and depression. This mental health burden can create a vicious cycle, where the stress of stigma leads to poorer health outcomes, which in turn reinforces feelings of worthlessness and despair. Additionally, the stigma may deter individuals from seeking mental health support, as they may fear further discrimination or judgment within those services. Addressing the mental health implications of stigma is crucial for enhancing the overall well-being of PLWHA and ensuring they receive the necessary support to manage both their physical and emotional health.

Barriers to Healthcare Access: Stigma is a significant barrier to healthcare access for PLWHA, often resulting in individuals avoiding necessary medical care. Fear of judgment, discrimination, and negative treatment experiences can lead individuals to postpone or entirely avoid getting tested for HIV or seeking treatment. According to **Nguyen *et al.*, (2024),** this avoidance can result in delayed diagnoses, leading to more severe health complications and an increased risk of HIV transmission.

The fear of not being treated with dignity and respect in healthcare settings can deter individuals from disclosing their HIV status, preventing them from receiving appropriate care. Additionally, stigma can manifest within healthcare systems, where providers may hold biases against PLWHA, further complicating access to care. This cycle of avoidance and discrimination not only affects individual health but also poses broader public health challenges, as untreated individuals contribute to ongoing transmission within communities. Addressing stigma in healthcare settings through training and policy changes is essential to create an environment where PLWHA feel safe and supported in seeking care.

Reduced Treatment Adherence: Stigma can adversely affect treatment adherence among PLWHA, posing significant challenges to maintaining viral suppression and overall health. Individuals who experience stigma may feel ashamed of their HIV status, leading them to hide their diagnosis even from healthcare providers. This secrecy can result in inconsistent medication adherence, as individuals may skip doses or fail to attend follow-up appointments due to fear of

being judged. **Smith *et al.*, (2025)** found that stigma is directly correlated with lower rates of adherence to antiretroviral therapy (ART), which is critical for managing HIV effectively. Non-adherence can lead to increased viral loads, reduced immune function, and a higher likelihood of transmitting the virus to others. Furthermore, the psychological stress associated with stigma can diminish motivation to engage in self-care practices, further complicating adherence efforts. To improve treatment outcomes, it is vital to create supportive healthcare environments where PLWHA feel empowered to openly discuss their treatment needs and challenges without fear of stigma.

Impact on Relationships

Stigma can exert a significant strain on personal relationships, affecting family dynamics, friendships, and romantic partnerships. Individuals living with HIV may fear disclosing their status to loved ones, leading to secrecy and misunderstandings that can erode trust and intimacy. This lack of openness can result in emotional distance and complicate the development of healthy, supportive relationships. Research by Hernandez *et al.*, (2023) indicates that individuals who feel stigmatized often withdraw from social interactions, further isolating themselves from support networks. The fear of rejection can prevent PLWHA from forming new relationships, leading to loneliness and a sense of hopelessness

Additionally, the stigma experienced within relationships can lead to feelings of shame and guilt, making it even more challenging for individuals to seek emotional support. Encouraging open communication and fostering acceptance within relationships is essential to mitigate the negative impact of stigma and promote healthy connections for those living with HIV.

Economic Consequences: The stigma associated with HIV/AIDS can have significant economic implications for individuals, affecting their employment prospects and financial stability. Many PLWHA face discrimination in workplace settings, leading to job loss or difficulties in finding new employment. The fear of disclosing their HIV status can deter individuals from pursuing job opportunities, resulting in a lack of financial security. Jones and Lee (2024) emphasize that economic instability can further complicate access to healthcare, as individuals may struggle to afford necessary treatment and medications. This economic burden can exacerbate feelings of shame and isolation, creating a vicious cycle that negatively impacts both mental and physical health. Furthermore, the economic consequences of stigma can extend to families and communities, as individuals with HIV may become reliant on social services and support

systems. Addressing the economic implications of stigma requires comprehensive policy changes that promote workplace equality and ensure access to necessary resources for PLWHA.

Community and Public Health Implications

On a broader scale, stigma against PLWHA can undermine community health efforts and public health initiatives aimed at controlling the HIV epidemic. When individuals avoid testing and treatment due to stigma, it can lead to increased rates of transmission, complicating efforts to reduce the prevalence of HIV within communities. Garcia *et al.,* (2025) argue that stigma not only affects individual health but also poses significant challenges to public health strategies. A supportive community environment encourages individuals to seek testing, treatment, and preventive services, ultimately benefiting the health of the community as a whole.

Conversely, when stigma prevails, it creates barriers to effective public health messaging and reduces the likelihood of individuals engaging in preventive behaviors. To combat stigma at the community level, public health programs must prioritize education, awareness, and advocacy, fostering an inclusive atmosphere that encourages individuals to seek care and support without fear of discrimination.

Strategies for Overcoming Stigmatization against People Living with HIV/AIDS

The world Health Organization (2015) also argues that data relating to PLWHAS if treated with confidentiality reduces fear associated with utilization of preventive and treatment services.

Curbing HIV/AIDS stigma is essential for promoting health and well-being among people living with HIV/AIDS (PLWHA). Here are detailed strategies to address and reduce stigma, supported by recent scholarly research.

1. Education and Awareness Campaigns: Education is one of the most effective strategies for combating stigma associated with HIV/AIDS. Comprehensive awareness campaigns can help dispel myths and misinformation about HIV transmission, treatment, and the lives of PLWHA. According to Anderson *et al.,* (2025)**,** these campaigns should provide factual information about how HIV is transmitted, the effectiveness of antiretroviral therapy (ART), and the importance of regular testing. By promoting accurate information, communities can foster understanding and compassion rather than fear and discrimination. Educational efforts should target various demographics, including schools, workplaces, and community organizations, to maximize reach. Engaging influential community leaders and utilizing multiple media platforms can amplify the

message. Furthermore, these campaigns should highlight the personal stories of individuals living with HIV, making the issue relatable and humanizing the experiences of PLWHA. Ultimately, increased awareness can lead to a more informed public, reducing stigma and encouraging supportive behaviors toward those affected.

2. Promoting Open Conversations: Encouraging open discussions about HIV/AIDS can significantly contribute to normalizing the conversation around the virus and reducing stigma. Creating safe spaces for dialogue such as support groups, community forums, and workshops allows PLWHA and their allies to share their experiences and educate others. Johnson and Lee (2024**)** emphasize the importance of these conversations in humanizing the issue and addressing the misconceptions surrounding HIV. When individuals can openly discuss their experiences, it fosters empathy and understanding among community members. These discussions can also facilitate the identification of common concerns and challenges faced by PLWHA, promoting collective action to address them. Additionally, involving healthcare professionals in these conversations can provide accurate information and resources, further reducing stigma. By encouraging open dialogue, communities can create an environment where individuals feel safe and supported, ultimately leading to decreased discrimination against PLWHA.

3. Empowerment of PLWHA: Empowering individuals living with HIV is crucial for combating stigma and promoting resilience. Providing resources, training, and support helps PLWHA advocate for themselves and others. According to Thompson *et al.*, (2025)**,** empowerment can take various forms, such as leadership training, peer support programs, and opportunities for involvement in community decision-making processes. When PLWHA are actively engaged in advocacy efforts, their voices can challenge stereotypes and promote a more accurate representation of their experiences. Empowerment initiatives can include mentorship programs, workshops focused on self-advocacy skills, and opportunities for public speaking. By fostering a sense of agency, individuals living with HIV can contribute to changing public perceptions and reducing stigma. Additionally, empowered individuals are more likely to seek necessary healthcare and support, improving their overall quality of life. Ultimately, empowering PLWHA fosters a sense of community and resilience, enabling them to navigate the challenges associated with living with HIV.

4. Involvement of Healthcare Providers: Healthcare providers play a critical role in reducing stigma within healthcare settings. Training programs that educate healthcare workers about HIV/AIDS stigma, cultural competency, and compassionate care can significantly improve the

treatment experience for PLWHA. **Nguyen *et al.*, (2024)** argue that fostering an environment where healthcare providers are aware of their biases and are equipped to provide nonjudgmental care is essential. This can involve workshops, training sessions, and the development of guidelines that emphasize respectful and inclusive practices. Moreover, encouraging providers to create welcoming environments where individuals feel safe disclosing their HIV status is vital. Implementing policies that protect patient confidentiality can further enhance trust in healthcare settings. By ensuring that healthcare providers are well-informed about the needs of PLWHA, the stigma associated with seeking care can be reduced, leading to better health outcomes for individuals living with HIV.

5. Media Representation: The media has a significant influence on public perceptions of HIV/AIDS, making it crucial to promote accurate and positive portrayals of PLWHA. Garcia and Patel (2025) suggest that engaging filmmakers, journalists, and content creators in sharing stories that highlight the resilience and humanity of those living with HIV can counter negative stereotypes. Media campaigns should focus on realistic representations of the experiences of PLWHA, emphasizing their contributions to society and the importance of understanding their challenges. This can involve featuring personal narratives, interviews, and documentaries that provide insights into the lives of individuals living with HIV. By showcasing diverse experiences, the media can help dismantle stereotypes and promote empathy. Additionally, training media professionals to report responsibly on HIV/AIDS can reduce sensationalism and misinformation. Ultimately, positive media representation can shift public attitudes, fostering a more supportive environment for PLWHA.

6. Supportive Legislation and Policies: Advocating for supportive laws and policies is essential for reducing stigma at a systemic level. This includes promoting anti-discrimination laws, ensuring access to healthcare and social services, and protecting the confidentiality of individuals' health information. A study by Kumar *et al.*, (2024) emphasizes that policy changes addressing the criminalization of HIV transmission can also help reduce fear and stigma associated with the virus. Engaging policymakers and stakeholders in discussions about the importance of these measures can create a more supportive environment for PLWHA. Additionally, implementing workplace policies that protect against discrimination based on HIV status can promote inclusivity and acceptance. Advocacy efforts should also focus on securing funding for HIV prevention, treatment, and education programs. By establishing supportive

legislative frameworks, communities can create an environment where PLWHA feel protected and valued, ultimately reducing stigma and improving health outcomes.

7. Community Engagement and Allyship: Building strong community networks that include allies individuals who do not have HIV but support the cause can amplify efforts to combat stigma. Smith and Johnson (2025) encourage community members to become advocates for PLWHA, fostering a culture of acceptance and support. This can involve organizing community events, workshops, and outreach programs that promote understanding and solidarity. Engaging allies in advocacy efforts can help amplify the voices of PLWHA and challenge discriminatory attitudes. Community engagement initiatives can include educational seminars, health fairs, and social events that bring together individuals from diverse backgrounds. By creating opportunities for allies to learn and participate, communities can cultivate a collective commitment to reducing stigma. Ultimately, fostering allyship creates a more inclusive environment for all, encouraging individuals to challenge stigma and support PLWHA in their journey.

Curbing HIV/AIDS stigma requires a comprehensive approach involving education, open dialogue, empowerment, and policy advocacy. By implementing these strategies and leveraging recent research, communities can work towards reducing stigma, promoting acceptance, and improving the lives of individuals living with HIV/AIDS. A concerted effort to challenge negative perceptions and foster understanding will create a more inclusive and supportive environment for all, ultimately contributing to better health outcomes and quality of life for PLWHA.

Empirical Review

Adefila *et al.,* (2023) conducted a study that evaluate the effectiveness of a community-based anti-stigma education campaign led by trained peer educators and religious leaders in Ekiti State. The programme involved interactive town hall sessions, church and mosque sensitisation visits, and local media messaging. Pre- and post-intervention surveys were conducted with over 500 community members to assess knowledge, attitudes, and practices. Results showed a significant improvement in accurate knowledge about HIV transmission and a 60% reduction in self-reported discriminatory attitudes towards PLHIV. Participants stated they were more likely to interact socially with HIV-positive individuals after the intervention. The campaign's success was attributed to its use of local influencers and contextually relevant communication. The

researchers stressed that sustainable stigma reduction requires constant community engagement and the active involvement of traditional and religious authorities.

Omole and Ekong (2023) focused on the role of healthcare professionals in perpetuating stigma against PLHIV. Through in-depth interviews and observational visits to healthcare centres across Lagos, the study uncovered instances of overt and covert discrimination. Some healthcare workers expressed fear of infection and were reluctant to provide routine care such as dressing wounds or delivering babies for HIV-positive patients. Others disclosed avoiding physical contact or delaying services once a patient's status became known. The study attributed this behaviour partly to personal bias, but more significantly to the lack of continuous professional training on HIV/AIDS care. Moreover, institutional policies on confidentiality and non-discrimination were found to be poorly enforced. The researchers called for the integration of HIV stigma reduction modules in medical and nursing curricula, along with periodic retraining and policy reforms. Their findings show that stigma in healthcare settings compromises treatment outcomes and violates patients' rights.

Salami and Onuoha (2024) focused on the internalisation of stigma and its effects on the mental well-being of HIV-positive youth in Benue State. Using standardised psychological assessment tools, including the Beck Depression Inventory and the Rosenberg Self-Esteem Scale, the researchers evaluated 120 youths aged 15–30 living with HIV. Findings showed high rates of depression, anxiety, and low self-esteem among respondents. Many reported feelings of unworthiness, hopelessness, and fear of rejection in romantic relationships. The study also revealed that internalised stigma deterred the youth from disclosing their status to friends, family, or potential partners. Consequently, they were less likely to seek peer support or counselling services. Salami and Onuoha concluded that internal stigma is a silent crisis that intensifies the psychosocial burden of HIV. The study recommended targeted mental health interventions, youth-friendly support groups, and public storytelling campaigns to normalise the lived experience of HIV-positive youths.

Okpara and Chinelo (2025) explored the role of social media in combating HIV/AIDS stigma, focusing on the influence of digital storytelling. Okpara and Chinelo assessed an online campaign led by HIV-positive Nigerian influencers who shared their personal experiences via YouTube, Instagram, and X (formerly Twitter). Through a combination of engagement metrics and viewer surveys, the study found that humanising stories significantly reduced stigma among viewers, especially youths. Many respondents said the content changed their perception of HIV

from a “death sentence” to a manageable condition. The research highlighted the power of authenticity and vulnerability in reshaping public opinion. Furthermore, the campaign encouraged increased interest in HIV testing among viewers, especially those aged 18–35. The study concluded that digital advocacy complements traditional stigma-reduction strategies and should be incorporated into national HIV/AIDS response programmes.

Theoretical Framework

This study was anchored on the Health Belief Model (HMB).

The Health Belief Model (HBM) is a psychological framework developed in the 1950s by Hochbaum, Rosenstock, and Kegels within the U.S. Public Health Service to explain and predict preventive health behaviours, including the use of health services such as screening and immunization. The model was initially formulated in response to the low participation in free tuberculosis screening programs and was designed to explore why individuals engage or fail to engage in health-seeking behaviours. It emphasizes that individuals’ beliefs, attitudes, and perceptions are key determinants of health-related actions.

The HBM proposes that people make health decisions by weighing perceived risks against expected benefits and potential barriers. Becker et al. (1977) further strengthened the model by demonstrating that personal beliefs strongly influence decisions to seek healthcare and comply with treatment. The model therefore provides a useful framework for understanding how individuals perceive health threats and how these perceptions influence behaviour.

The model is built around key constructs: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy. Perceived susceptibility refers to an individual’s belief about the likelihood of experiencing a health problem, while perceived severity concerns how serious the individual considers the condition and its consequences. Perceived benefits involve beliefs about the effectiveness of taking preventive action, and perceived barriers relate to obstacles such as cost, fear, stigma, or lack of information that may discourage action. Cues to action are triggers that motivate behavior, including media messages, advice from others, or personal experiences. Self-efficacy, added later by Rosenstock et al. (1988), refers to an individual’s confidence in their ability to successfully perform a health-related action.

Despite its strengths, the HBM has been criticized for overemphasizing rational decision-making while neglecting emotional, social, and structural factors such as poverty, inequality, and cultural

influences. Nonetheless, the model remains highly relevant to understanding HIV/AIDS-related behaviors. In the context of HIV/AIDS, individuals' perceptions of susceptibility and severity, combined with fear of stigma, often discourage testing and treatment. Many people avoid prevention and care services due to perceived barriers such as discrimination and social rejection, even when the benefits of early diagnosis and treatment are clear. Thus, the HBM provides a valuable theoretical lens for understanding how stigma shapes health-seeking behavior and influences the ongoing spread of HIV/AIDS.

MATERIALS AND METHODS

The study adopted a descriptive survey research design to find answers to the questions raised in the study. This design is justified by the need to collect data from a sample derived from the large population. It also permits the use of mixed methods simultaneously to enrich the data. Above all, it gives room for the use of simple tools for data collection and analysis such as questionnaire, percentage frequency distribution for easy description.

Description of Study Setting

Dekina is one of the prominent Local Government Areas (LGAs) in Kogi State, Nigeria. Geographically, it is located at a longitude of 7°41′41″N and a latitude of 7°01′2″E, positioned in the north-eastern axis of Kogi State. The administrative headquarters is situated in Dekina town. With a total landmass of approximately 2,461 square kilometres (950 square miles), Dekina had a population of 260,968 as recorded during the 2006 National Population Census (National Population Census Statistics, 2006). Dekina shares boundaries with several other local government areas and natural features: it is bordered to the west by the River Niger, to the north by Bassa Local Government Area, to the south by Ofu Local Government Area, and to the east by Omala Local Government Area. The LGA is made up of twelve (12) political wards, which include: Anyigba, Egume, Ogane-Enugu, Ojikpadala, Biraidu, Odu I, Odu II, Iyale, Ogbabede, Okura, and Emewe.

Dekina Local Government Area was established following the nationwide Local Government Reform of 1976. This reform was part of the then military government's effort, led by General Olusegun Obasanjo and his deputy, Shehu Musa Yar'Adua, to decentralise governance and prepare Nigeria for a return to democratic rule. The reform aimed at creating a third tier of government that would bring development closer to the grassroots (Dekina LGA Information Department, 2014). The people of Dekina are predominantly Igala, one of the major ethnic

groups in Kogi State. The Igala people are known for their rich cultural heritage, which includes traditional music, dance, folklore, and festivals. The Igala language is widely spoken across Dekina, alongside English which is used for official and educational purposes. Agriculture remains the backbone of Dekina's economy. A large percentage of the population engages in farming, fishing, and animal husbandry. The fertile lands and proximity to water bodies such as River Niger and several streams make it ideal for the cultivation of crops such as yam, cassava, maize, rice, groundnut, and vegetables. Fishing is also prominent, especially in riverine communities, while others engage in small-scale trading, local crafts, and food processing.

Anyigba, the largest town in the LGA, also hosts a growing number of small and medium-scale businesses, including transport services, hospitality, tailoring, and phone repair shops, driven largely by student activities around the university. Dekina LGA is regarded as the educational hub of Kogi East. It is home to Prince Abubakar Audu University (formerly Kogi State University), located in Anyigba. The presence of the university has contributed significantly to the development of the area, bringing with it academic vibrancy, infrastructural growth, and economic activity. In addition to the university, there are numerous public and private primary and secondary schools spread across the LGA, which cater to the educational needs of the population. Educational infrastructure in major towns like Egume, Iyale, and Anyigba is relatively more developed compared to more rural areas. Dekina also benefits from several social amenities. These include basic health centres, general hospitals, markets, motor parks, boreholes, and community halls. However, the quality and availability of these amenities vary across wards. Urban centres like Anyigba have better access to electricity, mobile network coverage, internet services, and commercial banks, while rural communities often grapple with infrastructural deficits.

Population of the Study

Dekina Local Government Area has an estimated population of 261,086 according to the National population commission 2006 as projected. The population of the study comprised of all sexually active men and women above the age of 18 years in Dekina Local Government Area of Kogi State. The choice of this population was justified by the role of sex in the spread of HIV/AIDS.

Sample Size and Sampling Techniques

Sample Size Determination

The sample size is usually a compromise between what is desirable and feasible. The sample size for the study was draw from a population of 261,086 which is the total population. The sample size was determined using the krejcie and Morgan [1970]. The formula is stated thus.

$$n = \frac{X^2 NP(1-P)}{E^2(N-1)1 + X^2 P(1-P)}$$

Where n = Required sample size

X^2 = At 95% confidence level with degrees of freedom 1, the chi square is 3.841

N = Total population of study is 261,086

P =the population proportion is 0.5

E^2 = at 95% confidence level the margin of error

1 + constant

Therefore;

$$n = \frac{3.841 \text{ X } 261{,}086 \text{ X } 0.5 \text{ X } 0.5}{(0.05)2 \text{ X } (261{,}086 - 1) + (3.841 \text{ X } 0.5 \text{ X } 0.5)}$$

$$n = \frac{250707.8315}{0.0025 \text{ x } 261{,}085 + 0.96025}$$

$$n = \frac{250707.8315}{652.7125 + 0.96025}$$

$$n = \frac{250707.8315}{653.67275}$$

n = 400

For this research, a sample size of 400 was selected to represent the entire population under study.

Sampling Techniques

This study adopts multi stage and cluster and simple random sampling techniques. Dekina Local Government area is divided into clusters of Districts and political Wards. The Local Government Area has 3 Districts and 12 political wards. Through Multi Stage sampling techniques, the Political Wards will be considered for further selection. The Wards are Anyigba, Egume, Ogane-enugu, Ojikpadala, Biraidu, Odu 1, Odu ward 11, Iyale, Ogbabede, Okura, and Emewe ward respectively (National Population Census statistics, 2006).

Table 1. Sampling Frame

Sampled Wards	**Sampled Respondents**	**Percentage**
Anyigba	70	17.5
Dekina	66	16.5
Odu 1	66	16.5
Okura	66	16.5
Abocho	66	16.5
Ogbabede	66	16.5
Total	**400**	**100**

Source: Researcher's Field Data, 2025

Sources and instruments of Data Collection

Data for this study was sourced from both primary and secondary sources. The primary sources consist of information obtained from respondents directly with the use of self- designed and validated questionnaire while secondary data was sourced from test books, lecture notes, journals, periodicals, data bases and internet sources.

The primary instrument questionnaire consist of six components as required by the objectives of the study. Section one borders on the socio-demographic characteristics of the respondents, section two focuses on the prevalence of HIV/AIDS related stigma in the study area, section three is on the nature of HIV/AIDS related stigma section four has to do with the causes of stigma, section five borders on the effects of stigma while section six is centered on the strategies for curbing HIV/AIDS related stigma.

Through the use of simple random sampling technique, 6 Wards were selected which includes: Anyigba, Dekina, Biraidu, Egwume, ogbabede and Emewe Wards respectively. The population of these wards were not captured by the 2006 census report. Hence, the total sample which is 400 using were shared across the sampled Districts. It was also good to justify that the spread of

HIV/AIDS cuts across all the Districts in the study area. However, Anigba Ward was given preference because of its commercial nature, higher population and greater number of healthcare facilities for the prevention and treatment of HIV/AIDS diseases.

Reliability and Validity of Instruments of Data Collection

The reliability of the instrument was established using test–retest methods. A section of the sample representing 20 percent was used to establish the reliability of the instrument. A reliability coefficient of 81 percent was achieved using the Product Moment Correlation Coefficient statistical tool. My supervisor and other experts in the Department of Sociology vouched for the validity of the instrument.

Methods of Data Collection and Analysis

The data was collected after informed consent was achieved from the community leaders heads of families and sampled respondents. One respondent was serially and purposively sampled from each house-hold until the sample frame was completed. The researcher and trained research assistants collected the data on the spot through the use of questionnaires. In addition, two health workers from each ward were interviewed using the in-depth interview guide.

Data collected was collated and analysed using descriptive, inferential and content analysis methods. The descriptive model involved the use of frequency and percentage and presented in table for easy analysis while the hypothesis will be analysed using chi-square statistical tool through the application of statistical package for Social Sciences Software. (SPSS.)

Data Presentation And Analysis

A self-designed and validated questionnaire was used to obtain data from 400 respondents sampled from the study area using cluster and simple random methods. The retrieval rate of the instrument was 100 percent as the researcher was practically involved in data collection. Data is presented in frequency distribution table and analysed as follows:

Analysis of Socio-Demographic Characteristics of Respondents

Table 2. Socio-Demographic Characteristics of Respondents

Variables	Frequency	Percentage
Age		
18-34	43	11
35-44	107	27

45-54	175	44
55 and above	75	19
Sex		
Male	87	22
Female	313	88
Religious Affiliation:		
Christianity	178	45
Islam	175	44
ATR	47	11
Others		
Marital Status		
Married	361	92
Single	21	5
Divorced	0	0
Separated	1	3
Level of Education		
Primary	58	15
Secondary	177	44
Tertiary	165	41
Occupation		
Civil servant	157	38
Farming	109	27
Artisan	56	14
Trading	78	20
Tribe		
Igala	348	87
Yoruba	12	3
Ebira	15	4
Bassa	20	5
Others	5	1

Source: Field Survey, 2025

Table 2 above representing the socio-demographic characteristics of respondents reveals that 44 percent of the total respondents were between the ages of 45 and 55 years, 27 percent of them were between the ages of 34 and 44 years while 19 percent of them were 55 years and above. Finally, 11 percent of them were between the ages of 20 and 34 Furthermore, 88 percent of them were males to show the dominant nature of men as house-hold heads in the study area. In addition, 45 percent of them were adherents of Christian religion closely followed by 44 percent who were followers of Islamic religion while African Traditional Religion has the lowest percentage score. In addition, 44 percent of them have secondary education while 41 of them claimed to had tertiary education. This is a good reason for high knowledge of issues relating to HIV/AIDS. Majority of the respondents representing 38 percent were civil servants closely followed by farmers with 27 percent. This is also a justification of their level of education which

was predominantly secondary and tertiary. Finally, Igala ethnic group has 87 percentage sample point showing that Dekina Local Government area is predominantly dominated by the Igala people.

Analysis of Research Questions

Table 3: Prevalence of HIV AIDS Related Stigmatization in Dekina Local Government Area.

Statement	SA	A	U	D	SD
There is high stigma against PLWHA	310 (79.5)	70 (17.5)	0	20 (5)	0
Stigma comes from family members	118 (29.5)	122 (30.5)	61 (15.5)	50 (12.5)	49 (12)
Stigma comes from friends	153 (38.5)	147 (36.5)	0	64 (16)	36 (9)
Stigma comes from social groups and organizations	102 (30)	84 (21)	53 (13.2)	64 (16)	79 (20)
Stigma comes from healthcare providers	74 (18.5)	125 (31)	25 (6)	69 (17)	107 (27)
Stigma comes from within as Patients can have feelings of self- stigma	106 (26.5)	149 (37)	17 (4)	88 (22)	40 (10)

Source: Field Survey, 2025

Data in table 3 representing prevalence of HIV/AIDS related stigma shows that 79.5 percent of the respondents strongly agreed that there was a high level of HIV/AIDS related stigma in the study area. Similarly 17 percent of them agreed that there was HIV/AIDS related stigma. In the same vein, majority of the respondents representing 29 .5 and 30.5 percent strongly agreed and agreed that stigma can come from family members. In addition, 38.5 and 36.5 of the total respondents strongly agreed and agreed that stigma can also come from friends while 30 and 21 percent of them strongly agree and agreed that stigma can proceed from social groups and organisations. Finally, 18.5 and 32 percent of respondents strongly agreed and agreed that healthcare providers were involved in HIV/AIDS related stigma while 26.5 and 37 percent of sample total also strongly agreed and agreed that victims of HIV/AIDS also had feelings of self - stigma.

Table 4: Causes of HIV/AIDS Stigma in Dekina Local Government Area.

Notions about HIV/AIDS which causes stigma	SA	A	U	D	SD
HIV/AIDS is a killer disease	222 (55.5)	113 (28)	5 (1)	36 (9)	28 (7)
HIDS/ AIDS have no cure	153	146	5	60	36

	(38)	(37)	(1)	(15)	(9)
The level of spread of HIV/AIDS is high	112 (28)	148 (37)	29 (7)	58 (15)	89 (22)
Means for contacting HIV/AIDS are numerous	142 (36)	181 (45)	0	30 (8)	47 (11)
There is no adequate information about HIV/AIDS	158 (40)	141 (35)	5 (1)	65 (16)	31 (8)
HIV/AIDS is associated with many myths.	102 (25)	181 (44)	0	94 (24)	27 (7)

Source: Field Survey, 2025

Data in table 4 above representing causes of stigma reveals that a number of factors account for why HIV/AIDS is a stigmatized. Disease Respondents' data reveals that 55.5 percent of the respondents strongly agreed that HIV/AIDS is a killer disease while 28 percent of them agreed that it is a killer disease. Similarly majority of the respondents representing 38 and 37 percent respectively strongly agreed and agreed that HIV/AIDS have no cure while 28 and 37 percent of the total respondents strongly agreed and agreed that the level of spread of HIV/AIDS is high. In a related idea, 36 and 45 percent of the respondents strongly agreed and agreed that means through which HIV/AIDS is contracted are numerous while 40 and 35 percent of them strongly agreed and agreed that there is no adequate information about HIV/AIDS. Finally, 25 and 44 percent of the total respondents strongly agreed and agreed that there are many myths associated with HIV/AIDS in the study area.

Table 5: Effects of HIV/AIDS Stigma in Dekina Local Government Area.

HIV/AIDS Stigma has the Following Effects	**SA**	**A**	**U**	**D**	**SD**
Low of use of Testing and counselling services	136 (24)	153 (38)	84 (21)	0	27 (7)
High spread of HIV/ virus	203 (51)	146 (37)	45 (11)	0	6 (1)
Low of Use of HIV/AIDS treatment services	131 (33)	218 (55)	0	30 (7)	21 (5)
High rate of death arising from HIV/AIDS	107 (27)	149 (37)	23 (6)	69 (17)	52 (13)
High rate of suicide arising from HIV/AIDS	102 (26)	186 (46)	27 (7)	65 (16)	24 (6)
High burden of HIV/AIDS problems on victims, family and institutions	204 (51)	129 (32)	13 (4)	98 (25)	86 (22)

Source: Field Survey, 2025

Data in table 5 above representing effects of HIV/AIDS stigma on the spread of HIV/AIDS disease reveals that a significant number of respondents representing 24 and 38 percent strongly

agreed and agreed that stigma leads to low use of testing and counselling services. Furthermore, a large number of respondents representing 51 and 37 percent strongly agreed and agreed that stigma leads to high spread of HIV/AIDS virus while 33 and 55 percent of the total respondents strongly agreed and agreed that stigmatization causes low utilization of HIV/AIDS treatment services. Arising from this is that 27 and 37 percent of the total respondents strongly agreed and agreed that stigmatization results to high mortality caused by HIV/AIDS. In a related dimension, 26 and 46 percent of the total respondents strongly agreed and agreed that stigmatization results in high rate of HIV/AIDS related suicide deaths while 51 and 32 percent of them strongly agreed and agreed that stigmatization leads to increase in the burden of HIV/AIDS on victims, families and communities.

Table 6: Perceived Strategies for Curbing HIV/AIDS Stigma

QUESTIONS HIV/AIDS Stigma has the following Effects	**SA**	**A**	**U**	**D**	**SD**
Stigma can be controlled through public awareness campaign on the cause of HIV/AIDS	136 (24)	153 (38)	0	84 (21)	27 (7)
Stigma can be controlled on public awareness campaign on preventive measures against HIV/AIDS	158 (40)	141 (35)	5 (1)	65 (16)	31 (8)
Legislative action against stigma can help address HIV/AIDS stigma	218 (55)	131 (33)	5 (1)	65 (16)	31 (8)
Organizing formal social groups for HIV/AIDS patients can reduce stigma	128 (33)	122 (30)	0	95 (23)	55 (14)
Increased availability and accessibility of HIV/AIDS testing and counselling services	158 (40)	141 (35)	0	21 (5)	30 (7)

Source: Field Survey, 2025

Data in Table 6 above representing perceived strategies for curbing HIV/AIDS related stigmatization shows that 24 and 38 percent of the total respondents strongly agreed and agrees that stigma related to HIV/AIDS can be controlled through public awareness campaign on the causes of HIV/AIDS .In the same vein, 40 and 35 percent of the total respondents strongly agreed and agreed that public awareness campaign on the prevention of HIV/AIDS can ease stigmatization. Furthermore, 55 and 33 percent of the total respondents strongly agreed and agreed that legislative action against stigmatization can help in addressing the problem while 33 and 30 percent of the respondents strongly agreed and agreed organizing formal groups for

HIV/AIDS patients is a positive strategy towards addressing stigmatization. Finally, 40 and 35 percent of the respondents strongly agreed and agreed that increased availability and accessibility of testing and counselling services can help to curb the problem of HIV/AIDS related stigma.

Analysis of Research Hypothesis

There is no significant relationship between HIV/AIDS stigma and the fight against the disease in the study area

Research Hypothesis Table

There is high level of HIV/AIDS related stigma stigma reduces the spread of HIV/AIDS Crosstabulation

Count						
		Hiv/aids related stigma reduces the spread of HIV/AIDS				
		SD	D	A	SA	Total
There is high prevalence of HIV/AIDS related stigma	SD	6	20	70	310	32
	D	00	60	0	16	139
	A	70	18	18	30	101
	SA	206	0	0	15	48
Total		400	110	18	61	400

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	1.506E2[a]	9	.000
Likelihood Ratio	174.208	9	.000
Linear-by-Linear Association	3.545	1	.060
N of Valid Cases	400		

a. 2 cells (12.5%) have expected count less than 5. The minimum expected count is 1.80.

The result of the hypothesis through the application of the Chi square statistical tool shows that there is no significant relationship between stigmatization and reduction of the spread of the

disease. Consequently, the null hypothesis is upheld showing that stigmatization does not help in reducing the spread of the HIV/AIDS disease as perceived in the study area.

RESULTS AND DISCUSSIONS

Findings of this study revealed that the dominant age for the study is 45 and 55 years, showing that they were young adults who were sexually active and knowledgeable about the social and psychological dispositions of their society. In the same, the sample size of the male sex was higher than that of the females indicating male dominance and patriarchal nature of the study area. In addition, 45 percent of them were adherents of Christian religion closely followed by 44 percent who were followers of Islamic religion while African Traditional Religion has the lowest percentage score. The social implications of this is that majority of the people had embraced foreign religions particularly, Christianity and Islam due to the effects of globalization. This also had effects on their perceptions or beliefs about HIV/AIDS. Majority of the study respondents representing more than 90 percent were married Marriage has a lot of implications for the spread of HIV/AIDS in terms of stigma, mother–to–child transmission and spousal infection or transmission.

In addition majority of the respondents had Secondary and Tertiary education. These high educational levels also had implications for perceptions about diseases and utilization of healthcare services. Furthermore, majority of the respondents were civil servants closely followed by farmers representing 38 and 27 percent respectively. This showed that the respondents had good knowledge about the issues under discussion because of their career dispositions. Finally, Igala ethnic group has 87 percentage sample point showing that Dekina Local Government area is predominantly dominated by the Igala people.

Findings of this study revealed that there was a high prevalence of HIV/AIDS related stigma in the study area. This evolved from 79.5 percent of the respondents who strongly agreed that there was a high level of HIV/AIDS related stigma in the study area. In the same vein, majority of the respondents representing 29 .5 and 30.5 percent also strongly agreed and agreed that stigma could come from family members. In addition, 38.5 and 36.5 of the total respondents strongly agreed and agreed that stigma could also come from friends while 30 and 21 percent of them strongly agree and agreed that stigma can proceed from social groups and organizations.

Finally, 18.5 and 32 percent of respondents strongly agreed and agreed that healthcare providers were involved in HIV/AIDS related stigma while 26.5 and 37 percent of sample total also

strongly agreed and agreed that victims of HIV/AIDS also have feelings of self -stigma. Consequently, HIV/AIDS related stigma in the study was highly prevalent and it was a product of many factors arising from family members, friends, groups and organisations, healthcare providers and even the victims were said to exhibit self- stigma. The high level of stigma related to HIV/AIDS was due to many factors related to the nature of HIV/ AIDS. the absence of cure, high level of spread lack of adequate information concerning the disease are reasons why the disease is highly stigmatized. This finding is in line with Stangl (2019) who argues that despite advancements in medical treatment and a broader understanding of the virus, societal attitudes toward HIV/AIDS remain largely negative, often rooted in misinformation, fear, and prejudice.

On causes of stigma, study findings revealed that a plethora of factors caused stigma related to HIV/AIDS in the study area. Respondents' data revealed that 55.5 percent of the respondents strongly agreed that HIV/AIDS is a killer disease while 28 percent of them agreed that it is a killer disease. HIV/AIDS stigma is caused by real and perceived facts associated with the disease. It is on record that mortality related to HIV/AIDS is very high and so, this factor increases fear associated with the disease leading to stigmatization of the victims. Similarly majority of the respondents representing 38 and 37 percent respectively strongly agreed and agreed that HIV/AIDS have no cure while 28 and 37 percent of the total respondents strongly agreed and agreed that the level of spread of HIV/AIDS is high. HIV/AIDS is said to defile any known cure as anti-retroviral therapy is only provided to reduce morbidity and mortality associated with the scourge.

In a related idea, 36 and 45 percent of the respondents strongly agreed and agreed that means through which HIV/AIDS is contracted are numerous. This also poses fear and a lot of myths associated with the problem. The ignorance associated with routes of transmission fuels myths and fear leading to stigma. It is a fact that routes of infection are not exclusively known and this fuels myths and rumors about the disease the fears associated with fast spread, morbidity and mortality accounts for why the disease is stigmatized. In a related development, 40 and 35 percent of the respondents strongly agreed and agreed that there is no adequate information about HIV/AIDS. Finally, 25 and 44 percent of the total respondents strongly agreed and agreed that there are many myths associated with HIV/AIDS in the study area.

Consequently, HIV/AIDS stigma is caused by the mortality record associated with it, its high spread, lack of cure, lack of definite knowledge about its mode of transmission and general lack of adequate knowledge about the disease. This finding is in line with UNAIDS (2023), which

documents that stigmatization and discrimination related to HIV/AIDS exist due to series of powerful metaphors on the epidemic in its earlier days. Among these metaphors stated by the UNAIDS were description of the HIV/AIDS epidemic as death through certain images and also as punishment for immoral behavior. UNAIDS continued that during the earlier days, HIV/AIDS was seen again by many as a crime especially related to both innocent and guilty victims; as war which needs to be fought against; as horror which infects demonic people thereby making them fearful and as a disease of others which infects a certain group of people or population. The report further notes that these stereotypes enable some people to deny their status.

Findings on the effects of HIV/AIDS stigma includes Data in table 5 above representing effects of HIV/AIDS stigma on the spread of HIV/AIDS disease reveals that a significant number of respondents representing 24 and 38 percent strongly agreed and agreed that stigma leads to low use of testing and counselling services. Furthermore, a significant number of respondents representing 51 and 37 percent strongly agreed and agreed that stigma leads to high spread of HIV/AIDS virus while 33 and 55 percent of the total respondents strongly agreed and agreed that stigmatization causes low utilization of HIV/AIDS treatment services. Arising from this is that 27 and 37 percent of the total respondents strongly agreed and agreed that stigmatization results to high mortality caused by HIV/AIDS. In a related dimension, 26 and 46 percent of the total respondents strongly agreed and agreed that stigmatization results in high rate of HIV/AIDS related suicide deaths while 51 and 32 percent of them strongly agreed and agreed that stigmatization leads to increase in the burden of HIV/AIDS on victims, families and communities in terms of low use of testing and counselling services, many clients or victims are afraid that their status may be revealed and because of fear of stigma, they usually avoid anything that will make their status to be known.

Consequently, this leads to the e spread of the virus because, many people are likely to engage in activities that lead to the spread of the virus unconsciously.

Ultimately, it leads to high mortality because of undiagnosed and untreated opportunistic infections leading to high burden of the disease on families and communities including the health sector. This finding is in line with UNAIDS (2012) and the World Health Organization (WHO) cite (2015) fear of stigma and discrimination as the main reason why people are reluctant to get tested, disclose their HIV status and take antiretroviral drugs (ARVs). HIV has declined in the UK in the last decade, from 56% in 2005 to 39% in 2015, this figure remains unacceptably high. In South Africa, stigma stopped many young women involved in a trial on HIV prevention from

using vaginal gels and pills that would help them stay HIV free. Many reported being afraid that using these products would lead them to being mistakenly identified as having HIV, and so the fear of the isolation and discrimination that being identified as living with HIV would bring led them to adapt behaviours that put them more at risk of acquiring the virus.

The epidemic of fear, stigmatization and discrimination has undermined the ability of individuals, families and societies to protect themselves and provide support and reassurance to those affected. This hinders, in no small way, efforts at stemming the epidemic. It complicates decisions about testing, disclosure of the status of the victims.

On the strategies for reducing stigmatization related to HIV/AIDS, findings reveal that it can be controlled through public awareness campaign on the causes of HIV/AIDS .In the same vein, 40 and 35 percent of the total respondents strongly agreed and agreed that public awareness campaign on the prevention of HIV/AIDS can ease stigmatization. Furthermore, 55 and 33 percent of the total respondents strongly agreed and agreed that legislative action against stigmatization can help in addressing the problem while 33 and 30 percent of the respondents strongly agreed and agreed organizing formal groups for HIV/AIDS patients is a positive strategy towards addressing stigmatization.

Finally, 40 and 35 percent of the respondents strongly agreed and agreed that increased availability and accessibility of testing and counselling services can help to curb the problem of HIV/AIDS related stigma.

Public awareness campaign on the causes, patterns and means of spread of HIV/AIDS will promote awareness about the diseases and help to reduce unnecessary actions against people living with the Virus because of fear of contracting the disease. In another development, developing legislative action involving punishment against people and groups that engage in stigma against people living with the disease will reduce such actions. Furthermore, if people are organized into conscious groups will help promote boldness thereby driving stigma from the scene. This finding is in line with the world Health Organization (2015) also argues that data relating to PLWHAS if treated with confidentiality reduces fear associated with utilization of preventive and treatment services. Encouraging open discussions about HIV/AIDS can significantly contribute to normalizing the conversation around the virus and reducing stigma. Creating safe spaces for dialogue such as support groups, community forums, and workshops allows PLWHA and their allies to share their experiences and educate others. Johnson and Lee

(2024) emphasize the importance of these conversations in humanizing the issue and addressing the misconceptions surrounding HIV. When individuals can openly discuss their experiences, it fosters empathy and understanding among community members. These discussions can also facilitate the identification of common concerns and challenges faced by PLWHA, promoting collective action to address them.

CONCLUSIONS

This study is a descriptive survey which describes the prevalence, causes nature, patterns and effects of HIV/AIDS stigma as well as strategies for addressing the problem. The study utilized both primary and secondary data to provide answers to the questions posed by the study. Through the use of simple and cluster sampling techniques and a self-designed and validated questionnaire, respondents' data analysed show that the prevalence of HIV/AIDS related stigma in the study area is very high. Both the diseases and its victims are highly stigmatized.

Stigma related to HIV/AIDS victims manifests in families among friends, organizations, work places and even healthcare institutions. It is caused by the nature of the disease such as its high inclination for spread, absence of cure, high level of myths because of general weak knowledge about the disease. It manifest in different forms such as from self like withdrawal, isolation and from important others in the form of discrimination, deprivation, marginalization, oppression, isolation and abuses from families, friends and even healthcare workers.

The study has also shown that the effects of stigma on HIV/AIDS is negatively high manifesting in low use of testing, treatment and counselling services, and attendant high spread of the disease. The problem of HIV/AIDS related stigma can be addressed using public enlightenment campaign about the nature, causes and spread of the disease including intervention strategies. In addition, openness and the creation of more intervention institutions are strategies for demystifying the disease.

RECOMMENDATIONS

The following recommendations are generated for policy guide.

1. First, governments and non-governmental organizations through the mass media should engage in public awareness campaign on the causes, nature, patterns and intervention strategies about the disease

2. Second, efforts should be made by the government through the mass media to demystify the disease by providing adequate information about modes of transmission and how to overcome the problem
3. Third, families and healthcare workers should be provided enough orientation on the psychological and social trends related to the disease.
4. Forth, Government should evolve legislations that punish those individuals and organizations that engage in different forms of stigmatization that fuels low use of testing and treatment services as well as concealing of HIV/ AIDS identities.

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