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**HEALTH CARE PROFESSIONALS AND PEOPLE LIVING WITH HIV/AIDS:  
DECONSTRUCTING THE DISCRIMINATORY ATTITUDE OF YOUNG  
CAREGIVERS IN NIGERIA.**

**By**

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***Abstract***

*Regardless of the cross-cutting edge and landslide achievements recorded in clinical management approaches of acquired immune deficiency syndrome (AIDS) in the 21st century and the correspondingly astounding chain of successes achieved in the production of drugs used effectively in transmuting AIDS status from a severe and deadly health issue to a life-long but manageable condition; people living with HIV/AIDS (PLWHA) are still stigmatised and heavily discriminated against in many parts of the world. Based on the preceding, this study assessed the knowledge and attitude of young healthcare professionals in the National Youth Service Corps (NYSC) toward HIV/AIDS patients using a descriptive cross sectional survey research design and a multistage sampling technique. A stratified sampling technique was adopted to select states across five geopolitical zones. Local Governments Areas (LGAs) within the states were selected using simple random sampling technique and the purposive sampling technique was employed for the selection of 325 participants. The results of the study indicated that there is a significant association between HIV/AIDS-related societal norms and region of origin  $X^2 (2, N = 102) = 10.91, p = 0.004$ . Also, there is a significant association between participants' personal and religious beliefs  $X^2 (2, N = 287) = 6.40, p = 0.041$ . Participants who were above 25 years old ( $108.3 \pm 14.66$ ), male ( $112.97 \pm 13.47$ ), had a high level of religiosity ( $105.68 \pm 13.98$ ), and participants of Northern origin ( $110.71 \pm 14.30$ ) had higher mean scores on the HPASS compared to their counterparts. The study concludes that associations between HIV/AIDS-related societal norms and region of origin, personal and religious belief, and significantly impact on the attitude of healthcare professionals towards persons living with HIV/AIDS.*

**Keywords:** People Living with HIV/AIDS, Youth Health care professionals, Knowledge, Community level beliefs, Attitudes

## **Introduction**

Over the years, the scourge of the Human Immunodeficiency virus and acquired immune deficiency syndrome (HIV/AIDS) has transmogrified from a minor global health issue to a significant global health crisis. Notably, in 2015, HIV/AIDS became the tenth-ranking cause of years with a disability-adjusted life expectancy. Indeed, HIV/AIDS is now recognised as the biggest threat to human survival because it has reversed the crucial gains in human health and life expectancy and has gradually destroyed several wellness efforts and investments made in the past decades. Nigeria is third on the list of nations having the most significant prevalence of HIV infection worldwide. According to the 2019 Nigeria National HIV/AIDS Indicator and Impact Survey, as of 2018, 1.9 million Nigerians were HIV and AIDS-positive. However, those in prison and high-risk drug users, particularly those who inject drugs (PWIDs), are much more likely to have HIV and AIDS.

Regardless of the cross-cutting edge and landslide achievements recorded in clinical management approaches of acquired immune deficiency syndrome (AIDS) in the 21<sup>st</sup> century and the correspondingly astounding chain of successes achieved in the production of drugs used effectively in transmuting AIDS status from a severe and deadly health issue to a life-long but manageable condition; people living with HIV/AIDS (PLWHA) are still stigmatised and heavily discriminated against in many parts of the world (Munro et al., 2017; Wagner et al., 2017; Nyblade et al., 2009).

Also, in the face of the notable success recorded through the adoption of the United Nations Programme aimed at strategically annihilating the global threat of AIDS by 2030 by ensuring that 90 of people living with HIV/AIDS are aware of their status, 90 of those who are aware of their status have access to antiretroviral therapy, while 90 of those receiving antiretroviral therapy achieve suppression (90-90-90 targets) by the year 2020, stigmatisation has negatively impacted the health and wellness of people living with HIV/AIDS (Mahy et al., 2019; UNAIDS 2014).

## **Stigmatisation and HIV/AIDS**

Stigma is negative attitudes and beliefs about a labelled group, e.g. those living with HIV. Stigma leads to discrimination, the behaviour and treatment of people living with HIV differently

than those without HIV. Right from the time the first cases of HIV/AIDS were diagnosed in the 1980s, stigmatisation and discrimination, such as fear and outright avoidance towards PLWHA, have been on ascendancy. Consequently, problems associated with HIV and AIDS-related stigma have not only stifled several HIV preventive efforts but also created an environment for its rapid spread in many parts of the world (UNAIDS/WHO, 2006). Specifically, stigma and discrimination have been identified in the literature as some/one of the factors preventing millions of people living with HIV/AIDS from all sorts of health-seeking behaviour such as testing, prevention and other treatment services (Grossman & Stangl, 2013; Stangly, 2013).

The costs and toll of discrimination and stigma are pretty enormous and counterproductive for PLWHA. These discriminatory activities associated with HIV/AIDS affect sufferers' self-concept, life satisfaction, quality of life and mental health in many unquantifiable ways (Gonzalez et al., 2009; Lee et al., 2002; Fife & Wright, 2000). Quite often, the fear of stigma and other related negative behaviours towards PLWHIV/PLWHA have gone beyond stifling preventive efforts to include reasons many HIV-positive individuals avoid disclosure (Brimlow et al., 2013). This explains why stigma and discrimination affect PLWHA, even in education, justice systems, families, workplaces, communities, and other humanitarian services and settings (UNAIDS, 2018).

Discrimination/stigma against people living with HIV/AIDS is usually a silent activity that has deleterious effects on people living with the virus. More often, it emanates from people's inbuilt fear about a virus they believe is infectious, terminal, and highly noxious. Social and health research findings have shown how PLWHA have consistently been targets of stigma and discrimination (Foreman et al., 2003). Literature is inundated with how stigmatisation and discrimination from individuals assumed to be HIV-positive have subjected PLWHIV/PLWHA to a potpourri of negative experiences such as loss of family, friends, work, housing, low self-concept, and physical and verbal abuse (Greeff et al., 2010; Holzemer et al., 2009; Foreman et al., 2003).

### **Beliefs and Knowledge of HIV/AIDS**

As amply evinced in health and social research findings, one factor determining people's attitude to PLWHA is their knowledge and understanding of the problem (HIV/AIDS). Two broad conclusions have been drawn to buttress this claim. The first is that most people that hold negative views about PLWHA are individuals with poor knowledge and understanding of HIV or people that are misinformed about HIV transmission. The second is the assertion that individuals who believe in casual contagion do not discriminate or hold negative attitudes towards PLWHA. Contrary to this claim, further studies have shown that knowledge does not always translate to attitudes. Beliefs concerning socio-demographic characteristics may likely affect attitude towards PLWHA (Chautrakarn1 (2023); Ademiju, P.U., Ayodele, O.T., & Balogun, S.A. (2010); Hossain, and Kippax, 2009; Umeh et al., 2008; Teshale & Tesema, 2002).

### **Health Care Professionals and Attitude to PLWHA**

Indeed, stigmatising attitudes and discriminatory behaviour OK have been found to cut across the broad spectrum of *health professionals*. In several studies that cut across continents and frontiers, PLWHA has described their experiences of stigmatisation/stigmatising attitude, discriminatory behaviour, and social rejection that were meted on them by *healthcare professionals* (Berezhnova et al., 2004; Herek et al., 2002; Lentine et al., 2000).

Some of the key factors attributed to such discriminatory attitude /stigmatising attitudes towards the PLWHA, particularly among health care professionals, are fear of contagion, associating HIV with immoral behaviour, not being aware of the impact of stigma, job stress related to AIDS and emotional labour (Akinbobola, 2020); Though, in recent times, there is growing evidence in the literature that supports a steady decline in discriminatory behaviours induced by the fear of contracting HIV/AIDS among health care practitioner. Moreover, such fear is still heightened among health professionals that work with patients that are homosexual and intravenous drug users (Sirota, 2013 & Rondahl, Innala, Carlsson, 2003). As well as among patients with overlapping stigmas (homophobia, ethnic discrimination, sexism, sex work and injection drug use (Akinbobola et al., 2021).

In Nigeria, like in many other Sub-Saharan African, various discriminatory attitudes/behaviours/stigmatising attitudes towards HIV/AIDS patients are widespread among healthcare professionals. The fact, however, that the prevalence of HIV in Nigeria is no longer troubling has not significantly helped stem the discriminatory attitudes/behaviours/stigmatising attitudes from health care professionals towards PLWHA. However, until recently, most empirical research on discrimination and stigmatisation towards PLWHA in Nigeria has surveyed the general public's attitudes and health professionals such as Nurses; surprisingly, not much has been done on youth healthcare professionals in the country. In an attempt to provide a comprehensive analysis of discrimination and stigmatisation targeted at PLWHA by young healthcare professionals, this study attempts to assess the belief and knowledge of young healthcare professionals on HIV and PLWHA and investigate the association of socio-demographic characteristics (region of origin and religiosity) with community level belief factors (societal norms, cultural values and biased belief) of young health care professionals. Also, the study examines the impact of socio-demographic characteristics (age, gender, religiosity, region of origin and region of service) on attitudes towards people living with HIV/AIDS among Nigerian youth healthcare professionals.

Precisely, the study was designed to answer the following questions:

1. What is the knowledge and belief of young healthcare professionals about HIV and PLWHA?
2. How do young healthcare professionals get their beliefs about HIV?
3. What are the attitudes of Nigerian youth healthcare professionals towards people living with HIV/AIDS, and how is this differentiated by their socio-demographic characteristics (age, gender, religiosity, region of origin and region of service)?

## **Methods**

### **Study Design**

The study utilised primary data from a cross-sectional survey of healthcare professionals across five geographical zones in Nigeria. Selected locations for the study include Owerri, Imo

State (South East Nigeria), Port-Harcourt, Rivers State (South-South Nigeria), Ipaja, Lagos State and Ado-Ekiti, Ekiti State (South West Nigeria), Ilorin, Kwara State (North Central Nigeria), Sokoto, Sokoto State (North West Nigeria) and the Federal Capital Territory, Abuja. Data was collected between 2017 to 2018 as part of a comprehensive study on the associations between HIV/AIDS and the practices of healthcare professionals in Nigeria.

### **Participants**

The study participants comprised National Youth Service Corps (NYSC) healthcare professionals. The NYSC comprises graduate members of all ethnic groups in Nigeria who are graduates aged 30 years or below. The choice of NYSC health care professionals as participants are because they are new entrants into the health profession and represent a group that could be targeted for early stigma reduction interventions.

When the study was conducted, the general population of NYSC corp members was 318 474 (NYSC, 2018). Hence, the Araoye (2003) sample size calculation formula for a population greater than 10,000 was adopted to calculate the sample size for this study. Based on this, a sample of three hundred and twenty-five (325) male and female participants was adopted for the study.

### **Sampling Technique**

The study adopted a multi-stage sampling method to select study participants. The states were selected across five geopolitical zones using stratified sampling. The local government sample within the state was selected using a simple random sampling technique. Participants were purposively selected.

### **Inclusion-Exclusion Criteria**

Graduate healthcare professionals aged 30 and below, serving NYSC corp members at the time of the study, were included. Healthcare professionals included in the study were limited to laboratory scientists, nurses, doctors, physiotherapists, social workers and psychologists who are in good physical condition (self-reported) and willing to spend about 15 minutes on the study and provide written informed consent. Those not meeting these criteria were excluded.

## Data Collection

The survey data were obtained through standardised scales and face-to-face interviews. The survey data included socio-demographic, HIV/AIDS-related societal norms, cultural values, personal/biased belief scale, and the attitude towards people living with HIV/AIDS (PLWHA) scale.

The HIV/AIDS-related societal norms, cultural values, and personal biased-belief scale is a questionnaire developed by Akinbobola (2020). This measure was developed based on a preliminary interview with the study population. Pilot testing was carried out to ensure readability and clarity.

Attitude towards people living with HIV/AIDS (PLWHA) was measured with the Health Care Provider HIV/AIDS Stigma Scale (HPASS) developed by Wagner, Hart, McShane, Margolese and Girard (2014). It is a 30-item scale with three subscales: prejudice, stereotypes, and discrimination. The authors indicated that the total scale has an internal consistency (Cronbach's alpha) of .94 while each of its three subscales, namely prejudice, stereotypes, and discrimination, has Cronbach's alphas of .91, .82, and .92. Items were scored on a 5-point Likert-type scale with the following anchors: 1 = extremely uncharacteristic; 2 = somewhat uncharacteristic, 3 = uncertain, 4 = somewhat characteristics, and 5 = extremely characteristic. Some items are "I worry about contracting HIV from HIV patients" and "I would rather not come into physical contact with HIV patients". A high score indicates a high attitude of prejudice, stereotype and discrimination towards PLWHA. Low scores indicate a low attitude of prejudice, stereotype and discrimination towards PLWHA. (HPASS measures stigma, which reflects a negative attitude). The present study found reliability estimates (Cronbach's  $\alpha$ ) for the three subscale Prejudice, Stereotype and Discrimination to range from 0.70 – 0.86. The total scale has a good measure of internal consistency (Cronbach's  $\alpha$  of 0.882).

## Ethical Consideration

The researcher got ethical approval from Redeemer's University Ethics Committee (RUNIREC) before data was collected for this study. The research assistants also received letters

of introduction from the Department of Behavioural Studies at the same University. All respondents remained anonymous, as no identifier questions were included.

### Data Analysis

Data were analysed using SPSS 23. Descriptive statistics (mean, standard deviations, frequency counts and simple percentages) and inferential statistics (chi-square, t-test and ANOVA) were computed. Descriptive statistics were utilised to present information on the participants' socio-demographic characteristics. Inferential statistics were used to analyse the study hypothesis.

## RESULTS

**Table 1**  
*Socio-demographic Characteristics of Participants*

Variables	Level	Frequency	Percentage
Age	Mean±SD	25.68±2.23	
	<25 years	99	30.5
	>=25 years	205	63.1
	Not Reported	21	6.5
Gender	Female	180	55.4
	Male	145	44.6
Religion	Christianity	289	88.9
	Islam	33	10.2
	Traditional	03	0.9
Level of Religiosity	Low	23	7.07
	High	279	85.8
	Not Reported	23	7.07
Geopolitical Zone of Origin	North	88	27.1
	Central/FCT		
	North West	11	3.4
	North East	03	0.9
	South West	131	40.3
	South East	68	20.9
	South South	17	(5.2
	Not Reported	7	2.2
Region of Origin	North	102	31.4
	South	216	66.4
	Not Reported	7	2.2
Geopolitical Zone of Service	North	165	50.8
	Central/FCT		
	North West	21	6.5



	South West	85	26.2
	South East	33	10.2
	South South	21	6.5
Region of Service	North	186	57.2
	South	139	42.8

The study included a total of 325 young healthcare professionals as participants, of which 180 individuals (55.4) were female, while 145 individuals (44.6) were male. Regarding age distribution, the majority of participants, comprising 205 individuals (63.1), were at least 25 years old, while 99 individuals (30.5) were under age 25. The average age of the participants was 25.68 years, with a standard deviation of 2.23.

Regarding religious affiliation, a majority of participants, 289 individuals (88.9), identified as Christians. Additionally, 33 (10.2) professed Islam, and 3 (0.9) followed traditional beliefs. Regarding religiosity levels, 279 participants (85.86) reported a high level of religiosity, while 23 participants (7.07) reported a low level of religiosity.

Regarding regional origin, more than half of the participants, 216 individuals (66.4), hailed from the South, while 102 individuals (31.4) were from the North. Further dividing the regions into geopolitical zones, the most participants, 131 individuals (40.3), originated from the South West. The North Central region, including the Federal Capital Territory (FCT, Abuja), accounted for 88 participants (27.1), while 68 participants (20.9) were from the South East. A smaller number of participants came from the South-south region (17 individuals, 5.2), the North West region (11 individuals, 3.4), and the North East region (3 individuals, 0.9).

Moving on to the region of service, a majority of the participants, 186 individuals (57.2), served in the North, while 139 individuals (42.8) served in the South. Like the regional origin, the service region was divided into geopolitical zones. Among the participants, 165 individuals (50.8) provided their services in the North Central region/FCT, 85 individuals (26.2) in the South West, 33 individuals (10.2) in the South East, and 21 individuals (6.5) in both the North West and South-South regions.

**Table 2**  
*Beliefs and Knowledge about HIV/AIDS and PLWHA*

Variables	Yes (%)	No (%)
My societal norms frown on HIV/AIDS	85.8	14.2
My cultural values are against HIV/AIDS	97.8	2.2
My belief is based on HIV/AIDS	68	32.0
HIV/AIDS is not curable	51.1	48.9
HIV/AIDS cannot be eradicated	32.9	67.1
HIV/AIDS is a natural punishment for human beings	4.6	95.4
People living with HIV/AIDS (PLWHA) are promiscuous	7.4	92.6
Time spent on treating PLWHA is a waste	5.8	94.2
Money spent on treating PLWHA is a waste	13.8	86.2
People should keep off PLWHA	18.2	81.8

Table 2 summarises the beliefs and knowledge about HIV/AIDS obtained through a semi-structured interview. The participants, who possessed knowledge and training in healthcare, demonstrated a high level of awareness regarding HIV/AIDS-related information. A significant majority, ranging from 81.8 to 95.4 of the participants, acknowledged that HIV/AIDS is not a natural punishment, emphasised the importance of not stigmatising people living with HIV/AIDS (PLWHA), recognised that time and money spent on treating PLWHA is not a waste, and rejected the notion that PLWHA is inherently promiscuous.

However, the participants highlighted community-level belief factors that act as barriers to combating HIV/AIDS. Biased beliefs were reported by 68 of the participants, indicating the existence of prejudices or preconceived notions in their communities. Cultural values were cited by a significant majority, 97.8 of participants, as influential factors contributing to the challenges associated with HIV/AIDS. Additionally, 85.8 of participants recognised societal norms as a hindrance.

While more than half of the participants (51.1%) believed that HIV/AIDS is incurable, a majority (67.1) expressed their belief that HIV/AIDS can ultimately be eradicated. This indicates a hopeful outlook among the participants regarding the long-term possibilities of addressing and eliminating the disease.

## Hypotheses Testing

**Hypothesis 1:** There will be a significant association of HIV/AIDS-related societal norms, cultural values and personal beliefs with the region of origin of Nigerian youth healthcare professionals.

**Table 3**

*Bivariate Analysis of Association between HIV/AIDS-related Societal Norms, Cultural Values and Biased beliefs with Region of Origin*

Variables	Region of Origin			Degree of Freedom (df)	Chi-Square (P-value)
	North	South	Not Reported		
My societal norms frown on HIV/AIDS.				2	10.914 (0.004)
	No	21 (20.59)	22 (10.23)		3 (42.86)
	Yes	81 (79.41)	193 (89.77)		4 (57.14)
My cultural values are against HIV/AIDS.				2	0.533 (0.766)
	No	3 (2.94)	4 (1.87)		0 (0.00)
	Yes	99 (97.06)	210 (98.13)		7 (100.00)
My personal belief is negatively biased on HIV/AIDS.				2	0.396 (0.820)
	No	32 (31.37)	69 (32.24)		3 (42.86)
	Yes	70 (68.63)	145 (67.76)		4 (57.14)

The Bivariate Analysis, as shown in Table 3, explores the association between HIV/AIDS-related societal norms, cultural values, and biased beliefs with the participants' region of origin. The results presented in Table 3 indicate that most of the participants' societal norms disapprove of HIV/AIDS, and this relationship is statistically significant  $X^2(2, N = 102) = 10.91, p = 0.004$  concerning their region of origin. However, the analysis reveals that there is no significant relationship between the participants' cultural values  $X^2(2, N = 287) = 0.53, p = 0.766$  or biased beliefs  $X^2(2, N = 287) = 396, p = 0.820$  and their region of origin. All analyses were conducted with a significance level set at 5.

**Hypothesis 2:** There will be a significant association of HIV/AIDS-related societal norms, cultural values and personal beliefs with the religious affiliation of Nigerian youth healthcare professionals

**Table 4**

*Bivariate Analysis of Association between HIV/AIDS-related Societal Norms, Cultural Values and Personal beliefs with Religious Affiliation*

Variables	Religion			Degree of Freedom (df)	Chi-Square (P-value)
	Christianity	Islam	Traditional		
My societal norms frown on HIV/AIDS.				2	2.566 (0.277)
	No	44 (15.28)	2 (6.06)		
	Yes	244 (84.72)	31 (93.94)		
My cultural values are against HIV/AIDS.				2	0.190 (0.909)
	No	6 (2.09)	1 (3.03)		
	Yes	281 (97.91)	32 (96.97)		
My personal belief is negatively biased on HIV/AIDS.				2	6.403 (0.041)
	No	91 (31.71)	10 (30.30)		
	Yes	196 (68.29)	23 (69.70)		

The Bivariate Analysis, as presented in Table 4, investigates the association between HIV/AIDS-related societal norms, cultural values, personal beliefs, and religious affiliation. The results indicate that most respondents reported having personal beliefs that are negatively biased towards HIV/AIDS, and this relationship is statistically significant  $X^2(2, N = 287) = 6.40, p = 0.041$  about their religious beliefs. However, the analysis reveals that there is no significant relationship between the participants' societal norms  $X^2(2, N = 287) = 2.57, p = 0.277$  or cultural values  $X^2(2, N = 287) = 0.19, p = 0.909$  and their religious beliefs.

**Hypothesis 3:** There will be a significant relationship between socio-demographic characteristics (age, gender, religiosity, region of origin and service) on attitudes towards people living with HIV/AIDS among Nigerian youth healthcare professionals.

**Table 5**

*Mean Score Difference of Attitude towards PLWHA by Socio-demographic Characteristics*

Variables	N	Mean	±SD	df	t test/ ANOVA	(P-value)
Age				2, 322	9.366	(<0.001)
	<25 years	99	103.04			
	>=25 years	205	108.36			
	Not Reported	21	96.38			
Gender				323	8.385	(<0.001)
	Female	180	100.32			
	Male	145	112.97			
Level of Religiosity				2, 300	3.214	(<0.001)
	Low	23	95.70			
	High	279	105.68			
	Not Reported	23	119.70			
Region of Origin				2, 322	8.618	(<0.001)
	North	102	110.71			
	South	216	103.58			
	Not Reported	7	110.29			
Region of Service				323	0.913	(0.352)
	North	186	106.63			
	South	139	105.07			

Table 5 presents the differences in mean scores of the Attitude Towards PLWHA Scale (HPASS) among the participants concerning their socio-demographic characteristics. The mean scores of HPASS were compared between two groups within each socio-demographic characteristic using independent t-tests. The analysis revealed that the mean score of respondents on the Attitude Towards PLWHA Scale (HPASS) differed significantly based on their age ( $p < 0.001$ ), Gender ( $p < 0.001$ ), Level of Religiosity ( $p < 0.001$ ), and Region of Origin ( $p < 0.001$ ).

Participants who were above 25 years old ( $108.3 \pm 14.66$ ), male ( $112.97 \pm 13.47$ ), had a high level of religiosity ( $105.68 \pm 13.98$ ), and participants of Northern origin ( $110.71 \pm 14.30$ ) had higher mean scores on the HPASS compared to their counterparts.

## **Discussion**

The present study aimed to explore the deconstruction of the discriminatory attitudes of young healthcare professionals in Nigeria. An overview of socio-demographic characteristics, including age, religious affiliation, religiosity level, region of origin and service, was explored in Table 1. Essential insights into the socio-demographic characteristics of the participants, including the presence of more females, the predominance of participants aged 25 and below, more Christian religious affiliation, high levels of religiosity, and more participants from the Southern region of origin and Northern region of service.

The findings align with previous research on the predominance of women in healthcare professions (Smith & Braunack-Mayer, 2011), highlighting the youthfulness of the participants (Agampodi et al., 2009), emphasising the role of religiosity in shaping beliefs (Nguyen et al., 2013; Obermeyer, 2008), and underscoring the significance of regional variations in origin and service (Obermeyer, 2008). These socio-demographic variations serve as a basis for exploring the relationships with HIV/AIDS-related factors in subsequent analyses.

Table 2 provides significant insights into the beliefs and knowledge of the participants regarding HIV/AIDS. Most participants demonstrated accurate knowledge and positive attitudes towards HIV/AIDS. This finding aligns with previous research demonstrating that healthcare professionals generally possess accurate knowledge about HIV/AIDS and exhibit positive attitudes towards PLWHA (Nyamathi et al., 2018), which can improve patient outcomes and reduce stigma (Daher et al., 2020).

However, societal norms, cultural values, and biased beliefs pose challenges to addressing HIV/AIDS effectively. These factors can perpetuate stigma and discrimination, hindering prevention efforts and impeding access to treatment and support services (Pulerwitz et al., 2010).

Addressing these belief systems and promoting accurate information is crucial in reducing stigma, improving access to treatment, and achieving the goal of eradicating HIV/AIDS.

Furthermore, approximately half of the participants believed HIV/AIDS is not curable. The presence of almost half of the others who believe the contrary may reflect a gap in knowledge or misconceptions about advancements in HIV/AIDS treatment. Efforts should be made to disseminate accurate information and raise awareness about the effectiveness of antiretroviral therapy (ART) in managing HIV/AIDS and improving the quality of life for PLWHA (UNAIDS, 2020). On a more optimistic note, most participants (67.1) believed that HIV/AIDS could be eradicated. This finding underscores the participants' hope for an AIDS-free future and their recognition of the importance of prevention and control measures. It aligns with global efforts and initiatives to eliminate new HIV infections and achieve an AIDS-free generation (UNAIDS, 2016).

The findings of hypothesis one reveal that most persons frown at HIV/AIDS based on their social norms, which are linked with their region of origin. Previous studies have highlighted the influence of societal norms and cultural contexts on HIV/AIDS-related attitudes and behaviours (Li et al., 2020; Logie et al., 2011). According to Odimegwu et al. (2018), knowledge of HIV/AIDS was significantly associated with lower odds of discriminating attitudes among the Hausa and Fulani ethnic groups. Also, Faust et al. (2017) posit that the odds of common knowledge of MTCT are highest among the Fulani and lowest among the Ijaw ethnic groups. There also appear links between HIV/AIDS-related social norms and state of origin. Using females to entertain guests in the North-Central, particularly among the Tiv people, may foster more accommodating viewpoints towards risky sexual behaviours, which may be a precursor for higher rates of HIV/AIDS within the region (Timiun, 2017).

The findings of hypothesis two show that most participants have a personal bias towards HIV/AIDS based on their religion. Previous studies have explored the influence of religious beliefs on HIV/AIDS-related attitudes and behaviours, indicating that certain religious doctrines and cultural interpretations can contribute to stigma, discrimination, and negative attitudes towards PLWHA (Genberg et al., 2013; Parker, 2014; Visser et al., 2019). As opposed to the study findings, Mullens et al. (2018), societal norms that associate HIV with moral culpability, death and disease may be more likely linked to stigmatisation. However, in a related study by Supa (2005), 52.6

participants indicated that culture and religion did not significantly influence their provision of HIV and sexuality education.

The findings of Hypothesis 3 indicated that participants above 25 years, male, high level of religiosity and whose region of origin is the North have a negative attitude towards people living with HIV/AIDS. These findings supported Hossain and Kippax's (2009) study, which identified that higher age and rating religion as correlates of stigmatised attitudes toward people living with HIV (PLHIV) among Health Care Workers. Also, it corroborated Ademiju et al. (2010) findings that there is a significant difference in mean attitude scores among people of different age groups and religions. Again, Chautrakarn et al. (2023) substantiated that factors associated with discriminatory attitudes toward PLWHA were age, religion, and region among adults. The findings are confirmed by Teshale and Tesema (2002) that being from the western SSA region was significantly associated with higher odds of discriminatory attitudes towards people living with HIV/AIDS among adults in Africa.

### **Conclusion**

The study assessed the attitudes of healthcare professionals towards persons living with HIV/AIDS. The study findings revealed the socio-demographic characteristics of the participants, including gender, age, religion, region of origin, and region of service. They highlighted the participants' knowledge and beliefs about HIV/AIDS. The study further demonstrated a significant relationship between HIV/AIDS-related societal norms and the participants' region of origin, indicating the influence of regional context on attitudes towards HIV/AIDS.

The study also uncovered a significant association between personal beliefs and participants' religious affiliations, suggesting the role of religion in shaping attitudes towards HIV/AIDS. Findings also indicated significant differences in attitudes towards PLWHA based on socio-demographic characteristics such as age, gender, level of religiosity, and region of origin.

### **Limitations of the Study**

This study examined discriminatory attitudes of healthcare professionals towards PLWHA. The study's limitation is its non-consideration of other research elements in assessing discriminatory attitudes from specific socio-demographic variables, social norms, cultural values



and personal values. In addition, the study may have benefited from a larger sample size for generalisation. Furthermore, the study's use of a cross-sectional survey design limits the ability to infer causal relationships or assess variable changes over time. Moreover, the data collected through self-report measures may be subject to inherent limitations. Despite these limitations, ethical considerations implemented in the study help mitigate the potential impact of these identified pitfalls on the overall quality of the research.

### **Recommendations**

Reducing discriminatory attitudes towards PLWHA among healthcare professionals is pertinent to the provision of care for persons living with HIV/AIDS, as the presence of stigma may hamper the quality of and access to care. This study, therefore, suggests the need for periodic interventions tailored to sensitise healthcare professionals on the likely implications of social norms, personal bias, ethnicity and religious dispositions on the stigmatisation of persons living with HIV/AIDS. Also, socio-demographic characteristics should be given due consideration in such sensitisation efforts.

Also, further research is needed to explore healthcare professionals' attitudes towards persons living with HIV/AIDS using larger samples across the understudied regions in Nigeria. Further studies may also adopt varied research designs to explore possible variability in research findings.

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