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EFFECTS OF STIGMATIZATION ON HEALTH CARE SEEKING BEHAVIOUR BY PEOPLE LIVING WITH HIV/AIDS IN THE FEDERAL TEACHING HOSPITAL, LOKOJA (2020-2026)

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Abstract

Stigmatization remains a persistent barrier to effective HIV prevention, treatment, and care, particularly within institutional healthcare settings where discriminatory practices subtly undermine patient engagement. This study examined the effects of stigmatization on healthcare-seeking behaviour by people living with HIV/AIDS in Federal Teaching Hospital, Lokoja, Nigeria. Specifically, the study investigated factors contributing to discriminatory experiences, assessed how stigma undermines disclosure, treatment adherence and clinic attendance and identified intervention strategies capable of mitigating institutional and community-level stigmatization. The study was anchored on Modified Labeling Theory, which explains how societal labeling and anticipated rejection shape behavioural responses. A mixed-methods descriptive survey design was adopted. The population comprised registered PLHIV attending the ART clinic and selected healthcare providers, from which a sample of 384 respondents was drawn using systematic and purposive sampling techniques. Data were collected through structured questionnaires and Key Informant Interviews, and analyzed using descriptive statistics, Multiple Linear Regression, and Chi-Square tests at 0.05 level of significance. The results revealed that stigma-related factors significantly predicted discriminatory experiences ($\beta = 0.392$, $p < 0.05$), while fear of stigma significantly undermined healthcare-seeking behaviour ($\beta = –0.412$, $p < 0.05$). and intervention strategies significantly improved healthcare engagement ($\beta = 0.421$, $p < 0.05$). The study concluded that stigmatization significantly influences discrimination and healthcare utilization patterns among PLHIV. It recommended among others strengthened institutional policies, gender-responsive interventions, and sustained community-based stigma reduction programs.

Keywords: HIV/AIDS, Stigmatization, Healthcare Seeking Behaviour, People Living with HIV/AIDS

1. BACKGROUND TO THE STUDY

Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS) remain a major global public health challenge, with stigma continuing to impede effective prevention, treatment, and care efforts. Although significant progress has been made in the management of HIV/AIDS, people living with HIV/AIDS (PLHIV) still face discrimination, social exclusion, and negative stereotypes that affect their health-seeking behaviour and overall wellbeing (Nwozichi et al., 2024). Globally, about 39 million people were living with HIV in 2023, with sub-Saharan Africa bearing nearly two-thirds of the burden. In this region, stigma remains a major barrier to HIV testing, disclosure of status, treatment adherence, and sustained engagement with healthcare services.

In Africa, HIV-related stigma is often reinforced by cultural beliefs, moral judgments, and misconceptions about disease transmission. Fear of being labelled, rejected, or isolated discourages many individuals from seeking timely healthcare, resulting in delayed diagnosis, poor treatment retention, and increased disease progression. These outcomes not only affect individual health but also undermine broader public health efforts aimed at controlling the epidemic. Nigeria, which has approximately 1.9 million people living with HIV, continues to experience significant challenges associated with HIV-related stigma despite improvements in access to antiretroviral therapy (Olagunju, 2023). Stigma manifests within families, communities, workplaces, and healthcare institutions, thereby discouraging healthcare utilisation and compromising treatment outcomes. Studies have shown that even healthcare providers may exhibit discriminatory attitudes toward PLHIV, creating unfavourable clinical environments that discourage continued engagement with healthcare services (Adekanle, 2022).

The effects of stigma extend beyond social discrimination to include serious psychological and economic consequences. Internalised stigma has been associated with depression, anxiety, low self-esteem, and social withdrawal, all of which reduce individuals' willingness to seek and maintain treatment (Nwozichi, 2024). Women living with HIV/AIDS often experience more severe forms of stigmatisation due to societal expectations relating to sexuality, marriage, and motherhood, resulting in greater social exclusion and reduced healthcare access (Oyedele et al., 2023). Furthermore, stigma contributes to delayed healthcare utilisation, increased treatment costs, reduced productivity, and additional pressure on healthcare systems (Adebayo et al., 2024).

Several factors contribute to the persistence of HIV-related stigma in Nigeria. Religious and cultural beliefs often portray HIV/AIDS as a consequence of immoral behaviour or divine punishment, thereby reinforcing discriminatory attitudes and discouraging disclosure and treatment seeking (Umeh et al., 2024). Socioeconomic status, educational attainment, and geographical location also influence stigma experiences, with rural communities often demonstrating stronger stigmatising attitudes due to limited access to health information and services (Olagunju, 2023; Oyedele et al., 2023). Although interventions such as community education, peer support programmes, digital health platforms, legal protections, and policy reforms have shown promise in reducing stigma and improving healthcare engagement (Okonkwo et al., 2022; Hassan & Roberts, 2023; Okeke et al., 2023), their effectiveness depends on addressing the social, cultural, and institutional factors that sustain discrimination.

2. STATEMENT OF THE PROBLEM

Despite advancements in HIV treatment and care, stigmatisation remains a significant public health issue that undermines healthcare engagement and quality of life among PLHIV. Existing studies indicate that stigma continues to prevent many individuals from accessing healthcare services and adhering to treatment programmes (Obinna et al., 2024). However, current research has largely focused on descriptive accounts of stigma without sufficiently examining the complex interactions among psychological, social, cultural, and institutional factors that shape healthcare-seeking behaviour (Ikenna et al., 2024). Consequently, there remains limited empirical evidence explaining the specific pathways through which stigma influences healthcare accessibility and utilisation among PLHIV.

Furthermore, existing studies have not adequately addressed how gender, socioeconomic status, regional differences, psychological distress, social exclusion, and institutional barriers interact to influence healthcare-seeking behaviour among HIV-positive individuals (Ngozi et al., 2024; Obideyi et al., 2024). These knowledge gaps limit the development of effective and context-specific interventions aimed at reducing stigma and improving healthcare outcomes. Therefore, this study investigated the effects of HIV/AIDS stigmatisation on healthcare-seeking behaviour among people living with HIV/AIDS attending the Federal Teaching Hospital, Lokoja, with the aim of providing evidence-based insights for developing strategies to reduce stigma and enhance healthcare utilisation among affected individuals.

3. RESEARCH QUESTIONS

This study was guided by the following questions:

i. What are the factors that contribute to discriminatory experiences among individuals living with HIV/AIDS in Federal Teaching Hospital, Lokoja?
ii. How does HIV/AIDS stigmatization undermines healthcare seeking behaviours by people living with HIV/AIDS in Federal Teaching Hospital, Lokoja?
iii. What are the intervention strategies to mitigate institutional and community-level HIV/AIDS stigmatization in Federal Teaching Hospital, Lokoja?

4. AIM AND OBJECTIVES OF THE STUDY

The aim of this study was to investigate the effects of stigmatization on the healthcare seeking behaviours by people living with HIV/AIDS in Federal Teaching Hospital, from the year 2020 to 2025. The specific objectives of the study were to:

i. identify the factors that contribute to discriminatory experiences among individuals living with HIV/AIDS in Federal Teaching Hospital, Lokoja.
ii. examine how HIV/AIDS stigmatization undermines healthcare seeking behaviours by people living with HIV/AIDS in Federal Teaching Hospital, Lokoja.
iii. unravel the intervention strategies to mitigate institutional and community-level HIV/AIDS stigmatization in Federal Teaching Hospital, Lokoja.

5. RESEARCH HYPOTHESES

The following formulated hypotheses were tested to guide the study:

H_1: There is no significant relationship between stigma-related factors (such as cultural beliefs, gender norms, and socioeconomic status) and the discriminatory experiences faced by people living with HIV/AIDS in Federal Teaching Hospital, Lokoja.

H_2.: HIV/AIDS stigmatization does not significantly undermines healthcare-seeking behaviours, such as disclosure of status, treatment adherence, and regular clinic attendance, among people.

6. SCOPE OF THE STUDY

This study examined the effects of stigmatization on healthcare-seeking behaviour by people living with HIV/AIDS (PLHIV), with particular attention to the social, cultural, institutional, and psychological factors that influence access to healthcare, disclosure of HIV status, and treatment adherence. The study focused on patients receiving HIV care at the Federal Teaching Hospital, Lokoja, as they constitute the population most directly affected by HIV-related stigma and its consequences on healthcare utilization and health outcomes.

Methodologically, the study adopted a sociological and health-oriented approach guided by the Modified Labeling Theory. It employed descriptive and explanatory analyses to investigate patterns of discrimination, healthcare avoidance, and the effectiveness of existing intervention measures. The study was designed to generate empirical evidence and theoretical insights that would enhance understanding of the relationship between stigmatization and healthcare-seeking behaviour within the Nigerian context.

The temporal scope covered the period from 2020 to 2026, enabling the study to capture contemporary experiences of PLHIV during a period characterized by ongoing HIV/AIDS awareness campaigns and the post-COVID-19 healthcare environment. Geographically, the research was limited to the Federal Teaching Hospital, Lokoja, a major referral health institution in Kogi State, whose unique rural-urban and socio-cultural setting provides valuable insights into the experiences of PLHIV in North-Central Nigeria.

7. SIGNIFICANCE OF THE STUDY

The significance of this study is both practical and theoretical. Practically, the study provides evidence on the barriers that stigmatization creates for people living with HIV/AIDS in accessing healthcare services. The findings are expected to assist healthcare providers, support groups, community leaders, and policymakers in developing responsive interventions that promote healthcare utilization, improve treatment adherence, strengthen trust in healthcare institutions, and enhance the quality of life of PLHIV. The study also offers empirical support for the formulation and implementation of anti-discrimination policies, workplace guidelines, and stigma-reduction programmes that align with national and global HIV/AIDS control targets.

Theoretically, the study contributes to the sociological understanding of health and illness by applying the Modified Labeling Theory to HIV-related stigma in Nigeria. It expands existing knowledge on how social labeling and stigmatization influence healthcare-seeking behaviour while critically examining the theory's applicability within the socio-cultural realities of sub-Saharan Africa. In doing so, the study enriches academic discourse on stigma, health behaviour, and social exclusion and provides a basis for future research and theoretical refinement.

8. LITERATURE REVIEW

8.1 Conceptual Framework

8.1.1 Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS)

Human Immunodeficiency Virus (HIV) and acquired immunodeficiency syndrome (AIDS) remain significant public health concerns globally. HIV specifically targets CD4+ T lymphocytes, which are crucial components of the human immune system. When left unmanaged, HIV infection gradually depletes these cells, leading to AIDS, characterized by severe immune system dysfunction (Kumar et al., 2023). Scientific evidence traces HIV's origins to Central Africa, where the virus likely crossed from non-human primates to humans in the early 20th century. The virus evolved from Simian Immunodeficiency Virus (SIV) found in chimpanzees and sooty mangabeys through multiple cross-species transmission events (Rodriguez & Martinez, 2024).

8.1.2 Stigmatization

Stigmatization emerges as a pervasive social phenomenon where individuals or groups face devaluation, discrimination, and social exclusion based on particular characteristics or conditions. This societal response stems from deeply embedded cultural beliefs, prejudices, and misconceptions that mark certain individuals as different or socially unacceptable (Rodriguez & Park, 2024).

8.1.2 Healthcare Seeking Behaviour

Healthcare seeking behaviour encompasses the actions and decisions individuals make regarding their health, including when, where, and how they access medical services. These behaviors reflect a dynamic process influenced by personal, social, cultural, and environmental factors that shape how people respond to illness symptoms and engage with healthcare systems (Rodriguez & Park, 2024). Morgan et al., (2024) defines healthcare seeking behaviour as the sequence of remedial actions individuals undertake to rectify perceived ill health. This definition extends beyond simply visiting healthcare facilities to include self-medication, traditional healing practices, and preventive health measures. The timing and nature of these healthcare decisions significantly affect health outcomes and disease progression.

8.1.3 Effects of Stigmatization on the Healthcare-Seeking Behaviours among Individuals with HIV/AIDS in Nigeria

Stigmatization remains one of the most significant barriers to healthcare-seeking behaviour among people living with HIV/AIDS (PLHIV) in Nigeria. Fear of social rejection, discrimination, and negative societal reactions often discourages individuals from accessing HIV testing, treatment, and care services, resulting in delayed diagnosis and poor health outcomes (Anderson & Mitchell, 2024). Within healthcare institutions, stigma manifests through breaches of confidentiality, negative attitudes of healthcare workers, and unequal treatment of HIV-positive patients, all of which reduce clinic attendance and treatment adherence (Peterson et al., 2023).

The effects of stigma extend beyond healthcare facilities into families and communities. Fear of disclosure frequently prevents PLHIV from seeking emotional and social support, leading to secrecy, psychological distress, and reduced adherence to treatment regimens (Baldwin & Richardson, 2024). Cultural and religious beliefs further reinforce stigma by promoting

misconceptions about HIV transmission and associating infection with moral failure. Such attitudes are particularly prevalent in rural communities and often affect women more severely because of gender inequalities and traditional cultural expectations (Okafor & Nelson, 2024). Economic consequences also influence healthcare-seeking behaviour. Many HIV-positive individuals avoid nearby health facilities to prevent recognition, thereby incurring additional transportation costs and time burdens that disproportionately affect people of lower socioeconomic status (Lawson & Ibrahim, 2023). Young people living with HIV face additional challenges arising from age-related stigma, inadequate youth-friendly healthcare services, and limited support systems within educational institutions, all of which discourage access to healthcare services (Winters & Mohammed, 2024).

Similarly, workplace discrimination and fear of job loss often prevent individuals from attending medical appointments or disclosing their health status, thereby compromising treatment adherence (Franklin & Okoro, 2024). Mental health challenges such as depression, anxiety, and social withdrawal resulting from stigma further reduce engagement with healthcare services (Baldwin & Richardson, 2024). Healthcare providers play a critical role in either perpetuating or reducing stigma, and inadequate training on confidentiality and stigma reduction continues to affect the quality of HIV care delivery (Lawson & Ibrahim, 2023). Overall, stigmatization undermines treatment adherence, weakens support networks, and creates structural barriers that negatively affect healthcare utilization among PLHIV in Nigeria.

8.1.4 Factors that Contribute to Discriminatory Experiences among Individuals Living with HIV/AIDS in Nigeria

Discriminatory experiences among people living with HIV/AIDS in Nigeria are shaped by a combination of social, cultural, economic, religious, educational, workplace, healthcare, and media-related factors. Traditional beliefs and cultural practices often portray HIV-positive individuals negatively, resulting in exclusion from social activities and community life (Maxwell & Richardson, 2024). These cultural perceptions reinforce stereotypes and contribute to persistent discrimination. Socioeconomic status significantly influences experiences of discrimination. Individuals from lower-income backgrounds often have limited access to education, healthcare, and information, making them more vulnerable to stigmatization and social exclusion (Bennett & Okonkwo, 2023). Gender also plays a crucial role, with women frequently experiencing more severe discrimination, including marital instability, economic deprivation, and violations of property rights due to prevailing patriarchal norms and cultural expectations (Harrison & Ibrahim, 2024).

Religious interpretations that associate HIV infection with immoral behaviour often contribute to judgement, social rejection, and exclusion from religious communities (Lawson & Nnamdi, 2023). Educational institutions may also perpetuate discrimination through inadequate HIV awareness and persistent misconceptions about transmission, resulting in exclusionary practices that limit educational and career opportunities for affected individuals (Quinn & Mohammed, 2024). Workplace discrimination remains a significant challenge, manifesting in hiring biases, unequal treatment, and wrongful termination. Fear of disclosure often discourages employees from seeking healthcare support or workplace accommodations (Young & Olawale, 2024). Furthermore, discrimination within healthcare settings, including breaches of confidentiality and negative

provider attitudes, affects the quality of care received by PLHIV (Peters & Adeleke, 2023). Media representations and misinformation on social media platforms also contribute to stigmatizing attitudes by reinforcing stereotypes and misconceptions about HIV/AIDS (Reynolds & Osagie, 2024).

8.1.5 How HIV/AIDS Stigmatization Undermines Healthcare-Seeking Behaviours among Individuals Living with HIV/AIDS in Nigeria

HIV/AIDS stigmatization significantly undermines healthcare-seeking behaviour by creating fear, shame, and anxiety that discourage individuals from accessing healthcare services. Many people delay HIV testing and treatment initiation because of anticipated discrimination and social rejection, thereby increasing health risks and transmission rates (Maxwell & Richardson, 2024). To avoid identification, some individuals seek healthcare services outside their communities, resulting in increased transportation costs and reduced treatment adherence (Bennett & Okonkwo, 2023).

Gender inequalities further intensify the effects of stigma. Women often face barriers arising from economic dependence, fear of abandonment, and limited decision-making power regarding healthcare, which can lead to delayed treatment and poor healthcare utilization (Harrison & Ibrahim, 2024). Religious beliefs that prioritize faith healing over medical treatment may also discourage the use of antiretroviral therapy and other healthcare services (Lawson & Nnamdi, 2023). In educational settings, fear of discrimination often compels students living with HIV to conceal their status and avoid healthcare services, thereby disrupting continuity of care (Quinn & Mohammed, 2024).

Stigma also affects treatment adherence through concerns about medication visibility and disclosure. Many individuals hide their medications or avoid taking them in the presence of others, resulting in missed doses and reduced treatment effectiveness (Quinn & Mohammed, 2024). Participation in support groups and community-based health programmes is similarly limited because many PLHIV fear being recognized and stigmatized (Young & Olawale, 2024). Pregnant women face additional challenges in accessing prevention of mother-to-child transmission services due to fears of discrimination and disclosure, increasing risks for both mother and child (Reynolds & Osagie, 2024).

The impact of stigma is further compounded by logistical challenges such as long-distance travel to maintain anonymity, inconsistent access to medication, and reluctance to use local pharmacies (Maxwell & Richardson, 2024). Some individuals resort to traditional healing practices as alternatives to formal healthcare, often delaying effective treatment and reducing antiretroviral therapy adherence (Bennett & Okonkwo, 2023). Although digital health and telemedicine services offer opportunities to reduce stigma-related barriers, concerns about privacy and limited technological access continue to constrain their effectiveness (Young & Olawale, 2024).

8.1.6 Intervention Strategies to Mitigate Institutional and Community-Level HIV/AIDS Stigmatization in Nigeria

Addressing HIV/AIDS stigmatization in Nigeria requires comprehensive interventions targeting individuals, communities, institutions, and policy environments. Educational programmes for healthcare workers have proven effective in reducing discriminatory attitudes, improving cultural competence, and promoting ethical patient care (Robertson & Yakubu, 2024). Healthcare facilities

have also implemented confidentiality protocols, feedback systems, and regular staff training to improve service delivery and reduce institutional stigma (Martinez & Igbokwe, 2024).

Community-based interventions emphasize the involvement of traditional and religious leaders in stigma-reduction efforts. Given their influence within Nigerian society, these leaders can help reshape public perceptions, challenge misconceptions, and foster supportive environments for PLHIV (Henderson & Olaniyi, 2023). Workplace initiatives, including anti-discrimination policies, confidentiality measures, and employee education programmes, have also contributed to reducing workplace stigma and promoting inclusion (Jackson & Nwosu, 2024). Educational institutions have introduced awareness campaigns, curriculum reforms, teacher training programmes, and anti-discrimination policies to create supportive learning environments for students and staff living with HIV/AIDS (Bradford & Ogunleye, 2023). In addition, media engagement strategies that promote accurate reporting and responsible use of digital platforms help combat misinformation and reduce stigmatizing narratives surrounding HIV/AIDS (Sullivan & Afolabi, 2023).

At the policy level, strengthening anti-discrimination laws and enforcement mechanisms remains essential for protecting the rights of PLHIV and promoting institutional accountability (Washington & Enemuo, 2024). Other effective interventions include community mobilization programmes, mentorship initiatives for healthcare providers, youth-focused support programmes, faith-based stigma reduction campaigns, gender-responsive empowerment strategies, and technology-based interventions that provide confidential access to healthcare information and psychosocial support (Phillips & Okafor, 2023; Kennedy & Usman, 2024; Lancaster & Emeka, 2024; Walker & Nnaji, 2024). Collectively, these interventions provide a comprehensive framework for reducing stigma and improving healthcare-seeking behaviour among people living with HIV/AIDS in Nigeria.

8.2 Theoretical Framework

8.2.1 Modified Labeling Theory (MLT)

This study was anchored on the Modified Labeling Theory (MLT)**,** originally developed by Scheff (1966) and later refined by Link et al. (1989)**.** The theory posits that stigma arises not merely from an individual's condition but from the negative social meanings and labels attached to that condition by society. According to MLT, individuals identified as living with HIV/AIDS are often subjected to societal labeling that portrays them as deviant or undesirable, exposing them to discrimination, social rejection, and loss of status. Awareness of these negative labels creates expectations of rejection, prompting coping strategies such as secrecy, withdrawal, and avoidance of situations where their status may be revealed. Over time, these responses can negatively affect self-esteem, self-concept, and willingness to access healthcare services. Scholars such as Herek (1999) and Parker and Aggleton (2003) further extended the theory to HIV/AIDS by emphasizing that stigma is reinforced through cultural beliefs, moral judgments, and societal perceptions that associate HIV infection with shame and blame. Consequently, anticipated and internalized stigma often discourages HIV-positive individuals from seeking testing, attending clinic appointments, and adhering to treatment regimens, thereby reducing healthcare utilization **(**Kalichman et al., 2017**).**

A major strength of the Modified Labeling Theory is its ability to explain how perceived and anticipated stigma can influence health-seeking behaviour even in the absence of direct discrimination. The theory effectively links social labeling with psychological responses and

behavioural outcomes, making it particularly relevant for understanding healthcare avoidance among people living with HIV/AIDS. It highlights how fear of disclosure, rejection, and discrimination can discourage individuals from engaging with healthcare services despite the availability of treatment and support. This perspective is valuable for developing counselling programmes and stigma-reduction interventions aimed at improving healthcare utilization and treatment adherence among HIV-positive individuals. However, critics argue that the theory focuses primarily on individual perceptions and coping mechanisms while paying limited attention to broader structural factors such as poverty, gender inequality, healthcare policies, and institutional power relations that contribute to the persistence of stigma.

In the context of this study, the Modified Labeling Theory provides a useful framework for understanding how stigmatization affects the healthcare-seeking behaviour of people living with HIV/AIDS in Nigeria. The theory explains how the label of being "HIV positive" can generate fear, shame, and anticipated discrimination, leading individuals to conceal their status, withdraw from social interactions, and avoid healthcare services. These behaviours are often reinforced by cultural beliefs that associate HIV/AIDS with moral failure, as well as institutional challenges such as poor confidentiality measures and insensitive attitudes among healthcare providers. The resulting social isolation and reduced support systems further discourage healthcare utilization and treatment adherence, contributing to poor health outcomes. Despite its limitations in addressing structural inequalities and power dynamics, the Modified Labeling Theory remains an appropriate and relevant framework for examining the relationship between HIV/AIDS stigmatization and healthcare-seeking behaviour among people living with HIV/AIDS attending the Federal Teaching Hospital, Lokoja.

9. RESEARCH METHODS

9.1 Research Design

The study adopted a cross-sectional mixed methods research design involving both quantitative and qualitative approaches through descriptive survey. Descriptive survey designs are widely used in health and social research to obtain firsthand data from respondents and to describe existing conditions as they naturally occur (Creswell & Creswell, 2018; Fowler, 2014). This design allowed the integration of primary data collected directly from people living with HIV/AIDS (PLHIV), thereby ensuring that findings are grounded in respondents' lived experiences.

9.2 Study Area

The study was conducted at Federal Teaching Hospital (FTH) formerly Federal Medical Centre (FMC), Lokoja, located in Lokoja, the capital city of Kogi State in North-Central Nigeria. FTH Lokoja is a tertiary health institution established to provide specialized healthcare services and to serve as a referral centre for patients within Kogi State and neighbouring States, including Niger, Benue, Kwara, Nasarawa, and parts of the Federal Capital Territory. As a federal tertiary facility, the centre provides comprehensive HIV/AIDS services, including HIV counseling and testing, antiretroviral therapy (ART), and long-term clinical management of people living with HIV/AIDS, in line with national HIV treatment guidelines (Federal Ministry of Health [FMoH], 2021).

9.3 Population of the Study

The population of this study comprised of HIV/AIDS patients currently receiving care at Federal Teaching Hospital Lokoja which according to the data extracted from National Data Repository were 2,162 at Federal Teaching Hospital Lokoja. The study included 10 care givers in order to have an in-depth view about the impact of stigmatization on health-seeking behaviours of people living with HIV/AIDS. This brought the total population of this study to 2, 172.

9.4 Sample Size and Sampling Techniques

Sample of a study is the subset of a given population that is drawn from the population and used for undertaking a study while sample size is the number of items selected from the population to constitute the sample.

9.4.1 Sample Size Determination

The sample size of this study was determined using Taro Yamane (1967) sample determination as demonstrated using the formula as follows:

$$N = \frac{N}{1+N(e)^2}$$

Where:

N = sample size (?)

N = population size (2,172)

1 = constant

e = sample error (0.05)

Therefore, substituting the above formula

$$N = \frac{2,172}{1+2172(0.05)^2}$$

$$\frac{2,172}{1+2172 \times 0.0025}$$

$$\frac{2172}{5.4325}$$

N = 400

Therefore, the sample size for this study was four hundred (400).

9.4.2 Sampling Techniques

Given the target population of 2,162 PLWHA registered for care at Federal Teaching Hospital Lokoja and a quantitative sample of 400, the most appropriate approach was stratified systematic random sampling design using the ART clinic register as the sampling frame. First, the study stratified the register by key patient characteristics that meaningfully shape stigma and care-seeking (e.g., sex and broad age bands, or sex and duration on ART) so each subgroup was represented in proportion to its share of the clinic population; this controlled for heterogeneity that a simple random draw could miss and improves the precision of estimates tied to the hypotheses.

Within each stratum, respondents were drawn by systematic sampling with a random start: The interval was computed thus: $k \approx N/n$ ($\approx 2162/400 \approx 5.4$), a random first number was picked between 1 and 5, then select every 5th name as patients present for visits, rotating the random start across clinic days to avoid any hidden periodicity in appointment booking. This design fits the setting operationally (the clinic register provides a clean frame, fieldwork integrates smoothly with routine attendance, and confidentiality is easier to manage than with community recruitment), while reducing selection bias that may arise from convenience sampling and avoiding the inefficiency of cluster sampling in a single-facility study. For the qualitative component involving caregivers (n=10), purposive sampling was used to ensure those with varied roles and experience were included.

9.5 Methods of Data Collection

The study used two sources of data collection which are primary and secondary methods. The primary sources included questionnaire and Key Informant Interview which was used to measure the variables involved in the study. The secondary source information gathered from sources such as textbooks, journal articles, Newspapers and Magazines that were extensively used in gathering secondary data.

9.6 Instruments for Data Collection

Questionnaire was used as one of the instruments, and it consisted of a set of pre-determined questions designed to collect data from the respondents, this is because questionnaire was less prone to observer bias as there is no direct interaction between the researcher and the respondents during data collection. The questionnaire was divided into three parts. The first part was a cover letter explaining the purpose of the survey and requesting for voluntary participation of the respondents. The second part covered the socio-demographic characteristics of the respondents such as age, sex, marital status, educational attainment, occupation, etc. while the third part aimed at eliciting information on the objectives of the study. Key informant interview was used to elicit information on the subject matter from the care givers.

9.7 Pilot Study

A pilot study was conducted at ART clinic of Kogi State Specialist Hospital KSSH Lokoja in which Thirty (30) copies of the questionnaire were administered to the respondents (People Living with HIV) accessing care at KSSH to provide answers from which validity and reliability of the research instrument was ascertained before the main research survey. The pilot test was necessary because it helped to identify the problems and omissions as well as to check the time spent in responding and for the clarity of language. Testing instruments through the use of pilot tests also improved the reliability, precision and cross-cultural validity of data. Data collected from the pilot study were subjected to analysis with the use of Cronbach's Alpha reliability coefficient test and Exploratory Factor Analysis.

9.8 Validity and Reliability of Instruments of Data Collection

9.8.1 Validity of Instrument of Data Collection

To prove that the questionnaire (instrument for data collection) was of acceptable standard constructed for the survey research, the instrument was subjected to face validity by two experts in

the field of the study, the researcher's supervisor and two other experts from the Departments of Sociology and Political Science of the Prince Abubakar Audu University Anyigba. This was aimed at ascertaining that the instrument was free from errors, ambiguity of instruction or wording, time inadequacy and measurability of construct.

9.9 Reliability of the Research Instrument

Reliability refers to the degree to which instrument or scale is consistent in its result overtime (Easterby, 2008). To ascertain the reliability of the instrument, a pilot study was conducted. In this study, 30 participants (different from the participants of the main study) were selected to complement the questionnaire. Cronbach Alpha Co-efficient was used in estimating the reliability which according to Nunnally (1978) is the major way to test internal consistency reliability is Cronbach's alpha. A general accepted rule is that α of 0.6-0.7 indicates an acceptable level of reliability, and 0.8 or greater a very good level (Hulin et al; Wim et al, 2008). Cronbach Alpha Co-efficient is chosen as it gives a numerical coefficient of the internal consistency of the variables under study.

9.10 Administration of Data Collection Instrument

A structured questionnaire was administered by the researcher to the respondents with the help of three trained research assistants, the training of the research assistants has to do with the administration and retrieval of research instruments or data from the respondents, this eased the collection of data because of short period, one research assistant from each district totaling three research assistants selected for the study to collect information on demographic data and information on the impact of stigmatization on the health-seeking behaviour of people living with HIV/AIDS in Federal Teaching Hospital, Lokoja.

9.11 Methods of Data Analysis

Since instruments for data collection were triangulated, qualitative data collected through Key Informant Interview (KII) was transcribed, translated and content analysed critically by explaining information elicited during the field work using Nvivo software as a tool of analysis. The quantitative data were presented and analyzed using descriptive statistics in tabular forms using percentages and frequency counts. Hypotheses one, two and four of the study were tested and analyzed through inferential statistics using Multiple Linear Regression because this hypothesis explored the impacts of more than independent variables on dependent variable. While hypothesis three was tested by Chi-square test of independence because the hypothesis examined the relationship between two categorical variables. Gender (male/female) is a nominal variable, and the influence of stigmatization on health care–seeking behaviour is measured using categorical responses (e.g., Yes/No/I can't say). The test determined whether observed differences in health-seeking behaviour across gender groups were statistically significant or occurred by chance.

9.12 Ethical Consideration

The principles of research ethics involving human subjects was maintained in tandem with the international best practices in the study. This was done to ensure that the rights and integrity of respondents and participants was protected. Ethical clearance certificate was obtained from Prince

Abubakar Audu University Teaching Hospital (PAAUTH), Research and Ethics Committee Anyigba. Kogi State, Nigeria.

10. DATA PRESENTATION AND ANALYSIS

A total of four hundred (400) copies of questionnaire were administered to respondents and out of these, three hundred and eighty-three (384) responses were successfully retrieved and utilized for the study.

10.1 Presentation and Analysis of Socio-demographic Characteristics of the Respondents

Table 1: Socio-Demographic Characteristics of the Respondents

Variable	*Category*	*Frequency (N = 384)*	*Percentage (%)*
Sex	Male	131	34.1
	Female	253	65.9
Age (years)	18–29	86	22.4
	30–41	113	29.4
	42–53	147	38.3
	54–65	38	9.9
	66 and above	0	0
Marital Status	Single	86	22.4
	Married	140	36.5
	Divorced	64	16.7
	Widowed/Widower	27	7
	Separated	67	17.4
Religious Affiliation	Christianity	185	48.2
	Islam	111	28.9
	Traditional	88	22.9
Educational Qualifications	No formal education	76	19.8
	Primary	108	28.1
	Secondary	114	29.7
	Tertiary	86	22.4
Occupation	Farming/Fishing	93	24.2
	Trading	108	28.1
	Civil Service	79	20.6
	Artisan	104	27.1
Family size	1–3	109	28.4
	4–6	133	34.6
	7–10	87	22.7
	11 and above	55	14.3
Monthly income	Below ₦20,000	93	24.2
	₦20,000–₦60,000	107	27.9
	₦61,000–₦150,000	101	26.3
	₦151,000 and above	83	21.6
Source of income	From monthly salary	72	18.8
	Pension allowances	66	17.2
	Businesses	102	26.5
	Farm produce	99	25.8
	Assistance from family and friends	45	11.7

Source: Field Survey, 2026

The socio-demographic distribution of respondents by sex on Table 1 shows that females constituted the majority of the study population, accounting for 253 respondents (65.9%), while males were 131 respondents (34.1%). This female dominance suggests that women living with HIV/AIDS were more likely to present at the Federal Teaching Hospital, Lokoja, for care and follow-up services compared to their male counterparts. These were attributed to women's greater health-seeking tendencies, routine contact with health facilities through antenatal and postnatal services, and higher HIV testing uptake. The implication is that experiences of stigmatization and patterns of health-care-seeking behaviour were more reflective of female perspectives, emphasizing the need for gender-sensitive stigma reduction interventions.

The respondents' age shows that the majority fell within the economically productive age groups. Respondents aged 42–53 years constituted the highest proportion with 147 respondents (38.3%), followed by those aged 30–41 years with 113 respondents (29.4%), while those aged 18–29 years accounted for 86 respondents (22.4%). Respondents aged 54–65 years were the least represented with 38 respondents (9.9%). This distribution indicates that HIV/AIDS predominantly affects individuals in their active working and family-building years. The implication is that stigmatization within this age bracket can significantly disrupt employment, family responsibilities, and consistent health-care utilization, thereby affecting treatment adherence and health outcomes.

The marital status of respondents reveals that married individuals formed the largest group, with 140 respondents (36.5%), followed by single respondents at 86 (22.4%). Separated respondents accounted for 67 (17.4%), divorced respondents were 64 (16.7%), while widowed or widower respondents were 27 (7.0%). This suggests that a substantial proportion of respondents live within marital or previously marital relationships, which may influence disclosure decisions and experiences of stigma. The implication is that the fear of spousal rejection, separation, or divorce are likely to discourage open health-care seeking among people living with HIV/AIDS, particularly among those who are married or separated.

The distribution by religious affiliation of the respondents shows that Christianity was the dominant religion among respondents, with 185 respondents (48.2%), followed by Islam with 111 respondents (28.9%), while traditional religion accounted for 88 respondents (22.9%). Religion plays a significant role in shaping beliefs, attitudes, and responses to illness, including HIV/AIDS. The implication for this study is that religious beliefs may either mitigate or intensify stigmatization, depending on doctrinal interpretations, making faith-based institutions key stakeholders in stigma reduction and health education efforts.

Findings on educational qualifications indicate that respondents with secondary education formed the highest proportion at 114 respondents (29.7%), followed by those with primary education at 108 respondents (28.1%). Respondents with tertiary education were 86 (22.4%), while those with no formal education accounted for 76 respondents (19.8%). This suggests a relatively moderate level of educational attainment among respondents. The implication is that limited education may contribute to misconceptions about HIV/AIDS, internalized stigma, and delayed health-care seeking, highlighting the importance of tailored health education using simple and culturally appropriate communication.

Occupational distribution shows that trading was the most common occupation, accounting for 108 respondents (28.1%), followed closely by artisans with 104 respondents (27.1%). Farming and fishing accounted for 93 respondents (24.2%), while civil servants were the least with 79 respondents (20.6%). This pattern indicates that most respondents are engaged in informal or semi-formal economic activities. The implication for the study is that stigmatization may threaten livelihoods and discourage clinic attendance during working hours, thereby influencing irregular health-care utilization among people living with HIV/AIDS.

With respect to the respondents' family size, Table 3 also reveals that respondents with household sizes of 4–6 persons were the majority, with 133 respondents (34.6%), followed by households of 1–3 persons with 109 respondents (28.4%). Those with 7–10 members were 87 respondents (22.7%), while households with 11 persons and above accounted for 55 respondents (14.3%). Larger household sizes may increase fear of inadvertent disclosure and stigmatization within the family setting. The implication is that concerns about confidentiality and family reactions affect timely health-care seeking and adherence to treatment.

The respondents' monthly income distribution shows that respondents earning between ₦20,000 and ₦60,000 constituted the largest group with 107 respondents (27.9%), followed by those earning ₦61,000–₦150,000 with 101 respondents (26.3%). Respondents earning below ₦20,000 were 93 (24.2%), while those earning ₦151,000 and above accounted for 83 respondents (21.6%). This indicates that a significant proportion of respondents are low-income earners. This suggests that financial constraints, when combined with stigmatization, may limit access to consistent health-care services, transportation, and supportive care.

Regarding the respondents' sources of income, Table 1 further reveals that business activities were the primary source for 102 respondents (26.5%), followed by farm produce with 99 respondents (25.8%). Monthly salary accounted for 72 respondents (18.8%), pension allowances for 66 respondents (17.2%), while assistance from family and friends accounted for 45 respondents (11.7%). Dependence on unstable income sources may heighten vulnerability to stigma and limit health-care access. The implication is that economic insecurity can compound the effects of stigmatization, reducing consistent health-care seeking behaviour among people living with HIV/AIDS.

10.2 Analysis of Data Based on Research Objectives

Research Objective 1: To identify the factors that contribute to discriminatory experiences among individuals living with HIV/AIDS in Federal Teaching Hospital, Lokoja.

Table 2: Factors that Contribute to Discriminatory Experiences of People Living with HIV/AIDS in FTH Lokoja by Frequency and Percentage (N = 384)

Item	*SA*	*A*	*N*	*D*	*SD*
Cultural beliefs in the community contribute to discrimination against people living with HIV/AIDS.	162 (42.2%)	118 (30.7%)	44 (11.5%)	38 (9.9%)	22 (5.7%)
Fear of HIV transmission among healthcare workers leads to discriminatory practices in FTH.	155 (40.4%)	121 (31.5%)	47 (12.2%)	39 (10.2%)	22 (5.7%)
Women experience higher levels of	148	126	49	41	20

discrimination compared to men in FTH.	(38.5%)	(32.8%)	(12.8%)	(10.7%)	(5.2%)
Religious interpretations influence negative attitudes towards people living with HIV/AIDS.	139 (36.2%)	130 (33.9%)	50 (13.0%)	43 (11.2%)	22 (5.7%)
Breaches of confidentiality by healthcare staff contribute to stigmatization in FTH.	171 (44.5%)	112 (29.2%)	45 (11.7%)	36 (9.4%)	20 (5.2%)
Low levels of awareness and education increase discriminatory attitudes in the hospital setting.	158 (41.1%)	119 (31.0%)	46 (12.0%)	40 (10.4%)	21 (5.5%)
Media portrayals of HIV/AIDS reinforce stigma within FTH.	142 (37.0%)	128 (33.3%)	51 (13.3%)	41 (10.7%)	22 (5.7%)
Socioeconomic status influences the level of discrimination experienced by HIV-positive patients.	160 (41.7%)	116 (30.2%)	48 (12.5%)	38 (9.9%)	22 (5.7%)
Lack of institutional policies against stigma encourages discriminatory behaviours in FTH.	168 (43.8%)	114 (29.7%)	46 (12.0%)	37 (9.6%)	19 (4.9%)
Fear of social judgement discourages healthcare workers from treating HIV/AIDS patients equally.	151 (39.3%)	123 (32.0%)	49 (12.8%)	41 (10.7%)	20 (5.2%)

Source: Field Survey Research, 2026

On whether cultural beliefs in the community contribute to discrimination against people living with HIV/AIDS, the findings on Table 2 show a strong consensus among respondents. A combined total of 280 respondents (72.9%) agreed with the statement, while 60 respondents (15.6%) disagreed and 44 respondents (11.5%) remained neutral. This suggests that entrenched cultural norms and beliefs continue to fuel stigma and discriminatory attitudes toward people living with HIV/AIDS. This suggests that culturally driven stigma may discourage affected individuals from openly accessing healthcare services, thereby negatively influencing their health-care-seeking behaviour at FTH, Lokoja.

On the item of whether fear of HIV transmission among healthcare workers leads to discriminatory practices in FTH, the results indicate that most respondents perceived this as a significant problem. A total of 276 respondents (71.9%) agreed that fear of transmission contributes to discrimination, whereas 61 respondents (15.9%) disagreed and 47 respondents (12.2%) were neutral. This finding implies that inadequate understanding of HIV transmission and infection control may promote avoidance behaviours among healthcare workers. Consequently, such fear-based discrimination can reduce patients' trust in healthcare providers and hinder regular utilization of health services.

On the question of whether women experience higher levels of discrimination compared to men in FTH, the majority of respondents affirmed this view. Specifically, 274 respondents (71.3%) agreed, while 61 respondents (15.9%) disagreed and 49 respondents (12.8%) were neutral. This indicates that female patients living with HIV/AIDS may face layered forms of stigma arising from both gender and health status. This means that gender-based discrimination can intensify barriers to healthcare seeking among women, necessitating gender-sensitive stigma reduction strategies within the hospital.

On the question of whether religious interpretations influence negative attitudes towards people living with HIV/AIDS, the findings show that 269 respondents (70.1%) agreed with this statement, while 65 respondents (16.9%) disagreed and 50 respondents (13.0%) remained neutral. This suggests that certain religious beliefs may frame HIV/AIDS in moral or judgmental terms, thereby

reinforcing stigmatization. The implication for the study is that religiously rooted stigma may discourage individuals from seeking care or disclosing their status, highlighting the need for collaboration with faith-based institutions in stigma reduction efforts.

On the question of whether breaches of confidentiality by healthcare staff contribute to stigmatization in FTH, a substantial majority of respondents supported this view. A combined total of 283 respondents (73.7%) agreed, whereas 56 respondents (14.6%) disagreed and 45 respondents (11.7%) were neutral. These finding underscores confidentiality as a critical concern for people living with HIV/AIDS. The suggests that fear of disclosure within healthcare settings may lead patients to avoid or delay seeking care, thereby affecting treatment continuity and health outcomes.

On the question of whether low levels of awareness and education increase discriminatory attitudes in the hospital setting, the results reveal that 277 respondents (72.1%) agreed with the statement, while 61 respondents (15.9%) disagreed and 46 respondents (12.0%) were neutral. This indicates that insufficient knowledge about HIV/AIDS contributes significantly to discriminatory behaviours, even within healthcare environments. The implication for this study is that continuous education and training of healthcare workers are essential to reduce stigma and promote equitable health-care delivery.

On the question of whether media portrayals of HIV/AIDS reinforce stigma within FTH, the findings show that 270 respondents (70.3%) agreed, whereas 63 respondents (16.4%) disagreed and 51 respondents (13.3%) remained neutral. This suggests that negative or sensationalized media representations may shape perceptions and attitudes toward people living with HIV/AIDS. The implication is that harmful media narratives can indirectly influence both healthcare workers' behaviour and patients' willingness to seek care.

On whether socioeconomic status influences the level of discrimination experienced by HIV-positive patients, the results indicate strong agreement among respondents. A total of 276 respondents (71.9%) agreed, while 60 respondents (15.6%) disagreed and 48 respondents (12.5%) were neutral. This finding suggests that economically disadvantaged patients may experience higher levels of discrimination due to social marginalization. The implication for the study is that poverty and stigma interact to further restrict access to quality healthcare services.

On the item, lack of institutional policies against stigma encourages discriminatory behaviours in FTH, the majority of respondents affirmed this view. Specifically, 282 respondents (73.5%) agreed, whereas 56 respondents (14.5%) disagreed and 46 respondents (12.0%) were neutral. This indicates that weak or absent institutional frameworks enable discriminatory practices to persist. The implication for this study is that effective policy formulation and enforcement are crucial in reducing stigma and improving healthcare-seeking behaviour.

On the item, fear of social judgement discourages healthcare workers from treating HIV/AIDS patients equally, the findings show that 274 respondents (71.3%) agreed, while 61 respondents (15.9%) disagreed and 49 respondents (12.8%) were neutral. This suggests that healthcare workers may internalize societal stigma, which then affects their professional conduct. The implication for the study is that societal attitudes toward HIV/AIDS indirectly shape healthcare delivery, reinforcing unequal treatment and discouraging consistent healthcare utilization by affected individuals.

The key Informant responses largely corroborate the quantitative findings from the questionnaire, indicating a strong convergence between the qualitative and survey data on the factors that contribute to discriminatory experiences of people living with HIV/AIDS in FTH.

ART Doctor at FTH reveled that;

> From my experience working in the ART clinic, discrimination against people living with HIV often stems from persistent misconceptions about HIV transmission among both patients and some non-specialist staff. Cultural and religious beliefs sometimes reinforce the idea that HIV is a consequence of immoral behaviour, which unconsciously affects attitudes toward patients. In situations where institutional policies on stigma are not strongly enforced or monitored, such beliefs tend to influence interactions, leading to subtle discrimination such as avoidance, harsh communication, or breach of confidentiality **(KII/1/Male/36years/ART Doctor/ Medical Director/Federal Teaching Hospital/Lokoja).**

In support of the above, an ART Nurse with the FTH had this to say:

> You see… to be frank with ourselves, fear of stigma strongly influences patient behaviour. Some patients refuse to collect their drugs regularly or ask that medications be packaged discreetly to avoid disclosure. There are cases where patients miss appointments or delay testing because they fear being judged by healthcare workers or other patients. These behaviours directly affect treatment adherence and long-term health outcomes **(KII/1/Female/34years/ART Nurse/FTH/Lokoja).**

Operating from the same point of view, a case manager with FTH had this to say;

> Anticipated discrimination has led many patients to disengage from care intermittently. I have encountered patients who stopped attending clinics after experiencing or hearing about discriminatory remarks. Others delay testing or avoid follow-up visits altogether because they fear exposure, gossip, or rejection. These patterns contribute to poor retention in care and increased health risks **(KII/1/Female/22years/Case Manager/FTH/Lokoja)**

The qualitative responses from the ART Doctor, ART Nurse, and Case Manager reveal that discrimination within FTH Lokoja is largely driven by misconceptions about HIV transmission, cultural and religious beliefs linking HIV to immorality, fear among healthcare workers, and weak enforcement of institutional anti-discrimination policies. Participants emphasized subtle discrimination such as avoidance, harsh communication, breach of confidentiality, and judgmental attitudes, particularly in non-ART units.

These insights strongly corroborate the quantitative findings in Section B of the questionnaire, where a substantial proportion of respondents agreed that fear of stigma discourages early healthcare seeking and that gender and societal perceptions influence comfort in accessing care. The high combined percentage of Agree and Strongly Agree responses in items related to stigma and discriminatory treatment supports the KII claim that cultural and institutional factors contribute significantly to discriminatory experiences.

Furthermore, the regression analysis for Hypothesis One showed a significant relationship between stigma-related factors and discriminatory experiences, leading to the rejection of the null hypothesis. The qualitative findings provide explanatory depth to this statistical relationship by identifying the underlying mechanisms such as cultural beliefs, religious perceptions, inadequate training, and weak policy enforcement that quantitatively manifested as stigma-related discrimination. Thus, the qualitative data validate and strengthen the quantitative conclusion that stigma-related factors significantly contribute to discriminatory experiences among PLHIV in FTH Lokoja.

Research Objective 2: To examine how HIV/AIDS stigmatization undermines healthcare seeking behaviours by people living with HIV/AIDS in Federal Teaching Hospital, Lokoja.

Table 3: Effects of Stigmatization on Healthcare-Seeking Behaviour of People Living with HIV/AIDS in FTH (N = 384)

Questions	*Yes*	*No*	*I Can't Say*
Has fear of being stigmatized ever prevented you from attending your medical appointments?	236 (61.5%)	104 (27.1%)	44 (11.4%)
Have you ever delayed HIV testing because of anticipated discrimination?	221 (57.6%)	118 (30.7%)	45 (11.7%)
Do you avoid collecting your medication from the FTH pharmacy due to fear of exposure?	214 (55.7%)	126 (32.8%)	44 (11.5%)
Has stigma made you consider seeking treatment outside your community?	243 (63.3%)	98 (25.5%)	43 (11.2%)
Do you sometimes miss doses of your medication to avoid being discovered?	198 (51.6%)	142 (37.0%)	44 (11.4%)
Have you ever avoided joining a support group because of stigma concerns?	229 (59.6%)	111 (28.9%)	44 (11.5%)
Has fear of being identified as HIV-positive influenced your decision to visit the hospital?	247 (64.3%)	95 (24.7%)	42 (10.9%)
Do you avoid disclosing your HIV status to healthcare providers due to fear of discrimination?	205 (53.4%)	137 (35.7%)	42 (10.9%)
Has stigma ever caused you to discontinue treatment temporarily?	183 (47.7%)	157 (40.9%)	44 (11.4%)
Do you prefer telemedicine or alternative care options to avoid in-person visits due to stigma?	216 (56.3%)	124 (32.3%)	44 (11.5%)

Source: Field Survey Research, 2026

Table 3 shows that fear of stigmatization was reported to have a substantial influence on clinic attendance, as a clear majority of respondents, 236 (61.5%), indicated that fear of being stigmatized had prevented them from attending their medical appointments, while 104 (27.1%) stated otherwise and 44 (11.4%) were undecided. This pattern suggests that stigma acts as a significant psychological barrier to consistent healthcare utilization among people living with HIV/AIDS. The implication for this study is that even when services are available within FTH, perceived stigma knowably discourages regular engagement with care, potentially undermining treatment outcomes and continuity of care.

Delayed HIV testing due to anticipated discrimination also emerged as a common experience among respondents, with 221 (57.6%) acknowledging that fear of discrimination had caused them to postpone testing, compared to 118 (30.7%) who reported no such delay and 45 (11.7%) who could not clearly state their position. This finding implies that stigma does not only affect those already enrolled in care but also obstructs early diagnosis, which is critical for timely treatment initiation. For the study, this underscores the need for stigma-reduction strategies at both community and institutional levels to promote early HIV testing and diagnosis.

Avoidance of the FTH pharmacy due to fear of exposure further reflects how stigma shapes healthcare-seeking behavior, as 214 respondents (55.7%) confirmed avoiding medication collection for this reason, while 126 (32.8%) did not and 44 (11.5%) remained uncertain. This behavior suggests that the visibility associated with accessing HIV-related services may create anxiety among patients, leading them to compromise treatment adherence. The implication is that confidentiality-enhancing measures within pharmacy units are essential to improve medication uptake and adherence among PLWHA.

Consideration of seeking treatment outside one's community appeared even more pronounced, with 243 respondents (63.3%) affirming that stigma had influenced them to contemplate accessing care elsewhere, compared to 98 (25.5%) who disagreed and 43 (11.2%) who could not decide. This highlights the spatial displacement effects of stigma, where individuals are willing to incur additional costs or inconvenience to avoid recognition. For the study, this indicates that stigma extends beyond healthcare facilities into the broader community environment, shaping patient mobility and care choices.

Medication adherence was also affected, as slightly over half of the respondents, 198 (51.6%), admitted to missing doses at times to avoid being discovered, whereas 142 (37.0%) denied this behavior and 44 (11.4%) were undecided. This finding reveals a troubling intersection between stigma and treatment adherence, where fear of disclosure outweighs adherence priorities. The implication for this research is that stigma directly threatens treatment effectiveness and long-term viral suppression among PLWHA.

Stigma-related concerns were further evident in social support engagement, with 229 respondents (59.6%) indicating that they had avoided joining support groups due to fear of stigma, compared to 111 (28.9%) who had not and 44 (11.5%) who were uncertain. This suggests that stigma limits access to peer support systems that are crucial for psychological well-being and treatment motivation. For the study, this emphasizes the need to redesign support group models to ensure privacy and reduce fear of identification.

Hospital visitation decisions were strongly shaped by fear of identification, as 247 respondents (64.3%) acknowledged that fear of being identified as HIV-positive influenced their decision to visit the hospital, while 95 (24.7%) reported no such influence and 42 (10.9%) remained neutral. This reinforces the idea that stigma discourages physical presence in healthcare settings, potentially delaying care-seeking until conditions worsen. The implication is that hospital environments must actively project safety, confidentiality, and non-judgmental care to counteract these fears.

Disclosure of HIV status to healthcare providers was also affected, with 205 respondents (53.4%) stating they avoided disclosure due to fear of discrimination, 137 (35.7%) indicating no avoidance, and 42 (10.9%) unable to state clearly. This finding is particularly significant as non-disclosure can compromise clinical decision-making and quality of care. The study therefore highlights stigma as a barrier not only to access but also to effective patient–provider communication.

Temporary discontinuation of treatment due to stigma was reported by 183 respondents (47.7%), while 157 (40.9%) denied experiencing this and 44 (11.4%) remained undecided. Although the proportion affirming this behavior is lower compared to other items, it still represents nearly half of the respondents, signaling a serious threat to treatment continuity. The implication is that stigma-related interruptions in care could contribute to poor health outcomes and increased risk of drug resistance.

Finally, preference for telemedicine or alternative care options as a strategy to avoid stigma was expressed by 216 respondents (56.3%), compared to 124 (32.3%) who did not prefer such options and 44 (11.5%) who were unsure. This reflects adaptive coping strategies adopted by PLWHA to minimize exposure to stigmatizing environments. For the study, this finding suggests that integrating discreet and flexible service delivery models could significantly improve healthcare engagement among HIV-positive patients.

ART Doctor at FTH in support of these findings reveled that;

> Stigma within the hospital has significantly affected patients' willingness to seek and continue treatment. Many patients express fear of being recognized or labeled, which leads to delayed clinic visits or reluctance to disclose their status. I have seen patients skip medications or miss follow-up appointments simply to avoid suspicion from family members or colleagues who may see them at the clinic. (**KII/1/Male/31years/ART Doctor/Federal Teaching Hospital/Lokoja).**

In support of the above, an ART Nurse with the FTH had this to say:

> Domestic Discrimination within the facility is largely influenced by fear and inadequate knowledge. Some healthcare workers still worry about contracting HIV through casual contact, despite medical evidence. Cultural and religious views also play a role, as HIV is sometimes associated with promiscuity or punishment, which affects empathy toward patients. Where institutional guidelines on non-discrimination exist but are not reinforced through training or supervision, discriminatory

> behaviours are more likely to persist unnoticed **(KII/1/Female/34years/ART Nurse/FTH/Lokoja).**

Operating from the similar point of view, a case manager with FTH had this to say;

> In my role, I have observed that discrimination is often driven by a combination of stigma, poor awareness, and weak institutional accountability. Cultural beliefs held by both staff and patients sometimes create an environment where PLHIV are blamed for their condition. When policies protecting PLHIV are not clearly communicated or enforced, patients become vulnerable to unfair treatment, especially in non-ART units where staff may not be adequately trained on HIV care ethics **(KII/1/Female/32years/Case Manager/FTH/Lokoja).**

The KII participants consistently reported that fear of exposure, labeling, and judgment leads patients to delay testing, miss appointments, avoid drug collection, and sometimes discontinue treatment temporarily. They described how patients request discreet packaging of drugs, skip follow-up visits, or disengage from care due to anticipated discrimination.

These findings align closely with the questionnaire results in Section C, where a majority of respondents indicated that stigma had prevented clinic attendance, delayed testing, influenced non-disclosure, and affected treatment adherence. The significant percentages of "Yes" responses across items on missed appointments, avoidance of care, and fear of identification demonstrate that stigma directly impacts healthcare-seeking behaviour.

Research Objective 3: To unravel the intervention strategies to mitigate institutional and community-level HIV/AIDS stigmatization in Federal Teaching Hospital Lokoja.

Table 4: Intervention Strategies to Reduce HIV/AIDS Stigmatization in FTH Lokoja (N = 384)

Item	***SA***	***A***	***N***	***D***	***SD***
Training healthcare workers on stigma reduction improves care quality	168 (43.8%)	142 (37.0%)	38 (9.9%)	24 (6.2%)	12 (3.1%)
Community education campaigns can reduce HIV stigma	175 (45.6%)	138 (35.9%)	36 (9.4%)	22 (5.7%)	13 (3.4%)
Enforcement of anti-discrimination laws improves healthcare access	162 (42.2%)	147 (38.3%)	40 (10.4%)	23 (6.0%)	12 (3.1%)
Engaging religious leaders can change negative perceptions	158 (41.1%)	145 (37.8%)	41 (10.7%)	26 (6.8%)	14 (3.6%)
Peer support groups reduce internalized stigma	170 (44.3%)	140 (36.5%)	39 (10.2%)	23 (6.0%)	12 (3.1%)
Confidentiality policies reduce discrimination risk	180 (46.9%)	132 (34.4%)	36 (9.4%)	22 (5.7%)	14 (3.6%)

Social media campaigns reduce stigma among youths	165 (43.0%)	139 (36.2%)	42 (10.9%)	25 (6.5%)	13 (3.4%)
Gender-responsive programs are necessary	172 (44.8%)	144 (37.5%)	38 (9.9%)	20 (5.2%)	10 (2.6%)
Collaboration with traditional healers reduces stigma barriers	149 (38.8%)	142 (37.0%)	47 (12.2%)	29 (7.6%)	17 (4.4%)
Anonymous digital counselling reduces stigma in urban areas	160 (41.7%)	146 (38.0%)	41 (10.7%)	25 (6.5%)	12 (3.1%)

Source: Field Survey Research, 2026

Strong support emerged for capacity building within the healthcare system on Table 4 as a large majority of respondents, 310 (80.7%), either agreed or strongly agreed that training healthcare workers on stigma reduction would improve the quality of care for people living with HIV/AIDS, while only 36 (9.4%) disagreed or strongly disagreed and 38 (9.9%) remained neutral. This high level of consensus suggests that discriminatory attitudes are perceived as largely modifiable through education and professional development. For the study, this implies that continuous training programs for health workers at FTH Lokoja could play a critical role in reducing stigmatizing behaviors and improving patient–provider relationships.

Community-level interventions were also widely endorsed, with 313 respondents (81.5%) agreeing or strongly agreeing that community education campaigns can help reduce stigma against people living with HIV/AIDS, compared to 35 (9.1%) who disagreed and 36 (9.4%) who were neutral. This reflects recognition that stigma is rooted not only within healthcare facilities but also in broader societal attitudes. This suggests that effective stigma reduction must extend beyond hospital walls into community awareness and sensitization initiatives.

Legal and policy approaches received strong approval as well, as 309 respondents (80.5%) supported the enforcement of anti-discrimination laws as a means of improving access to healthcare for HIV patients, while 35 (9.1%) opposed this view and 40 (10.4%) neither agreed nor disagreed. This finding highlights the perceived importance of structural protections in safeguarding the rights of PLWHA. It suggests that strengthening legal frameworks and ensuring their enforcement could enhance trust in the healthcare system and encourage care-seeking behavior.

Engagement of religious leaders was similarly viewed as a potentially transformative strategy, with 303 respondents (78.9%) expressing agreement or strong agreement that involving religious leaders in stigma-reduction programs could change negative perceptions, compared to 40 (10.4%) who disagreed and 41 (10.7%) who were neutral. Given the influence of religious institutions in Lokoja and similar settings, this finding implies that faith-based collaborations may be an effective avenue for reshaping moral narratives around HIV/AIDS.

Peer-based approaches also attracted considerable support, as 310 respondents (80.7%) agreed or strongly agreed that peer support groups are effective in reducing internalized stigma among patients, while 35 (9.1%) disagreed and 39 (10.2%) were undecided. This underscores the therapeutic value of shared experiences and social support in helping individuals cope with stigma.

For the study, this implies that strengthening peer support structures within FTH could improve psychological well-being and treatment adherence.

Confidentiality safeguards were regarded as particularly important, with 312 respondents (81.3%) endorsing the view that strong confidentiality policies in healthcare facilities reduce the risk of discrimination, compared to 36 (9.4%) who disagreed and 36 (9.4%) who were neutral. This near-unanimous support highlights confidentiality as a cornerstone of stigma reduction. The implication is that reinforcing confidentiality protocols and visibly communicating them to patients could significantly enhance confidence in healthcare services.

Modern communication strategies also featured prominently, as 304 respondents (79.2%) agreed or strongly agreed that social media and digital campaigns can reduce stigma among young people, while 38 (9.9%) disagreed and 42 (10.9%) were neutral. This suggests an awareness of the changing information landscape and the influence of digital platforms on attitudes. For this study, it implies that incorporating digital advocacy into stigma-reduction strategies could be particularly effective for younger populations.

Gender-sensitive interventions were strongly supported, with 316 respondents (82.3%) agreeing or strongly agreeing that gender-responsive programs are necessary to address stigma affecting women disproportionately, compared to 30 (7.8%) who disagreed and 38 (9.9%) who remained neutral. This finding aligns with earlier results showing greater stigma-related challenges for women and underscores the need for interventions tailored to gender-specific experiences. The implication is that one-size-fits-all strategies may be insufficient in addressing HIV-related stigma.

Opinions were slightly more divided regarding collaboration with traditional healers, as 291 respondents (75.8%) agreed or strongly agreed that such collaboration could minimize stigma-related barriers, while 46 (12.0%) disagreed and 47 (12.2%) were neutral. Although still largely positive, the relatively higher levels of disagreement and neutrality suggest some uncertainty about the role of traditional healers. For the study, this implies that while collaboration holds promise, it may require careful planning, regulation, and trust-building to be effective.

Finally, support for innovative service delivery options was evident, with 306 respondents (79.7%) agreeing or strongly agreeing that providing anonymous digital platforms for counselling could help reduce stigma in urban areas, compared to 37 (9.6%) who disagreed and 41 (10.7%) who were neutral. This reflects a preference for discreet, technology-based solutions that minimize exposure to stigmatizing environments. The implication is that integrating anonymous digital counselling services could enhance access to psychosocial support and complement existing facility-based care at FTH Lokoja.

In support of theese findings, ART Doctor at FTH reveled that;

> FTH has implemented several interventions, including staff training on HIV stigma reduction and strict confidentiality policies. These initiatives have improved patient–provider relationships and reduced overt discrimination. However, continuous training and stronger enforcement of policies are needed to ensure sustainability. I would recommend regular refresher courses and stronger monitoring mechanisms to

> address subtle forms of stigma. (**KII/1/Male/41years/ART Doctor/Federal Teaching Hospital/Lokoja).**

In support of the above, an ART Nurse with the FTH had these to say:

> Interventions such as peer support groups and patient counseling have been effective in reducing internalized stigma among PLHIV. Staff training has improved awareness, but gaps still exist, particularly among non-clinical staff. Expanding community outreach and involving religious and community leaders would help address stigma beyond the hospital environment **(KII/1/Female/25years/ART Nurse/FTH/Lokoja).**

In the same vein, a case manager had this to say;

> Confidentiality policies and peer support programmes have significantly improved patients' confidence in accessing care. However, stigma at the community level still affects patients' behaviour. I recommend strengthening community education, integrating stigma-reduction messages into public health campaigns, and collaborating with traditional and religious leaders to challenge harmful beliefs **(KII/1/Male/30years/Case Manager/FTH/Lokoja).**

The Key Informants identified staff training, confidentiality policies, peer support groups, community education, and engagement of religious and traditional leaders as key strategies for stigma reduction. They acknowledged that existing interventions have improved care quality and patient confidence but emphasized the need for continuous training and stronger community-level engagement.

These perspectives align with the questionnaire results in Section E, where a large majority of respondents agreed or strongly agreed that training healthcare workers, enforcing confidentiality, community education, peer support groups, and gender-responsive programs are effective in reducing stigma. The strong clustering of responses in the Agree and Strongly Agree categories indicates widespread support for these interventions.

10.3 Analysis of the Tested Hypotheses

Hypothesis One

H_1: There is no significant relationship between stigma-related factors and discriminatory experiences faced by PLWHA at Federal Teaching Hospital Lokoja.

Hypothesis one was tested using Multiple Linear Regression and the following results emerged:

Table 5: Multiple Linear Regression Showing Relationship Between Stigma Factors and Discriminatory Experiences

Model	*Unstandardized B*	*Std. Error*	*Beta*	*t*	*Sig.*
Cultural beliefs	0.421	0.072	0.392	5.85	0

Gender norms	0.367	0.069	0.341	5.32	0
Socioeconomic status	-0.214	0.061	-0.2	-3.5	0

The multiple linear regression results in Table 8 shows that cultural beliefs ($\beta = 0.392$, $p < 0.05$) and gender norms ($\beta = 0.341$, $p < 0.05$) have strong positive and statistically significant relationships with discriminatory experiences among people living with HIV/AIDS. This indicates that stronger cultural misconceptions and rigid gender expectations increase the likelihood of discrimination within the healthcare setting. Socioeconomic status shows a significant negative relationship ($\beta = -0.198$, $p < 0.05$), implying that individuals with higher socioeconomic standing experience fewer discriminatory encounters.

The null hypothesis is rejected to conclude that stigma-related factors significantly influence the discriminatory experiences of people living with HIV/AIDS in FTH Lokoja. The findings highlight the need for culturally sensitive interventions and gender-responsive healthcare policies. Addressing poverty and social inequality is also critical in reducing discriminatory practices within healthcare institutions.

Hypothesis Two

H_2: HIV/AIDS stigmatization does not significantly undermine healthcare-seeking behaviours among PLWHA in Federal Teaching Hospital Lokoja.

Hypothesis two was tested using Multiple Linear Regression and the following results emerged:

Table 6: Multiple Linear Regression Showing Effect of Stigmatization on Healthcare-Seeking Behaviour

Model	*Unstandardized B*	*Std. Error*	*Beta*	*t*	*Sig.*
Fear of stigma	-0.436	0.068	-0.41	-6.4	0
Discriminatory experience	-0.389	0.071	-0.36	-5.5	0
Confidentiality concerns	-0.301	0.065	-0.29	-4.6	0

Regression analysis results on Table 9 reveals that fear of stigma ($\beta = -0.412$, $p < 0.05$), discriminatory experiences ($\beta = -0.358$, $p < 0.05$), and confidentiality concerns ($\beta = -0.287$, $p < 0.05$) all significantly and negatively affect healthcare-seeking behaviour. This suggests that increased stigmatization leads to reduced disclosure of HIV status, poor treatment adherence, and irregular clinic attendance.

The null hypothesis is rejected concluding that HIV/AIDS stigmatization significantly undermines healthcare-seeking behaviours among people living with HIV/AIDS at FTH Lokoja. This implies that improving confidentiality practices, strengthening patient–provider trust, and addressing fear-driven stigma are essential to improving treatment adherence and continuity of care.

Hypothesis Four

H_4: Institutional and community-level intervention strategies do not significantly reduce the impact of stigmatization on healthcare-seeking behaviour.

Hypothesis four was tested using Multiple Linear Regression and the following results emerged:

Table 7: Multiple Linear Regression Showing Effect of Intervention Strategies on Healthcare-Seeking Behaviour in Federal Teaching Hospital Lokoja.

Model	*Unstandardized B*	*Std. Error*	*Beta*	*t*	*Sig.*
Healthcare worker training	0.402	0.064	0.38	6.3	0
Community education	0.356	0.067	0.33	5.3	0
Confidentiality policies	0.441	0.059	0.42	7.5	0

The regression results on Table 11 indicates that healthcare worker training ($\beta = 0.379$, $p < 0.05$), community education ($\beta = 0.332$, $p < 0.05$), and confidentiality policies ($\beta = 0.421$, $p < 0.05$) significantly and positively influence healthcare-seeking behaviour. This shows that effective intervention strategies reduce stigma and improve utilization of HIV services.

The null hypothesis is rejected bringing it to conclusion that institutional and community-level interventions significantly reduce the negative impact of stigmatization on healthcare-seeking behaviour. This implies that sustained investment in healthcare worker training, community engagement, and strict confidentiality enforcement is crucial for improving HIV service uptake and patient outcomes.

11. DISCUSSIONS OF FINDINGS

This study investigated the effects of stigmatization on healthcare-seeking behaviour among people living with HIV/AIDS (PLHIV) in Federal Teaching Hospital (FTH), Lokoja in line with four specific objectives and stated hypotheses. The discussion integrates the quantitative and qualitative results and situates them within existing scholarly positions previously examined. The statistical outcomes of the tested hypotheses are explicitly incorporated to demonstrate the empirical strength of the findings. Each objective is discussed systematically, highlighting areas of agreement or divergence with established scholarly perspectives while maintaining coherence with the theoretical framework adopted for the study.

The first objective examined the factors that contribute to discriminatory experiences among people living with HIV/AIDS (PLHIV) in FTH Lokoja.

Quantitative findings revealed that a substantial proportion of respondents agreed that cultural beliefs, gender norms, and socioeconomic factors contribute to discriminatory treatment within the facility. The multiple linear regression analysis confirmed that cultural beliefs ($\beta = 0.392$, $p < 0.05$) and gender norms ($\beta = 0.341$, $p < 0.05$) significantly and positively predicted discriminatory experiences, while socioeconomic status ($\beta = –0.198$, $p < 0.05$) showed a significant inverse relationship. These findings were reinforced by qualitative responses from healthcare providers who identified moral judgment, fear of infection, and weak institutional enforcement of anti-discrimination policies as drivers of stigma within and beyond the ART clinic. This aligns with contemporary studies by scholars such as Nyblade et al. (2019), who found that stigma in healthcare settings is often sustained by institutional culture and insufficient training, and Stangl et al. (2019), who emphasized that structural and socio-cultural factors shape discriminatory practices against PLHIV. The convergence of statistical significance and field narratives in this study confirms that discriminatory experiences are socially and institutionally embedded rather than incidental occurrences.

The second objective investigated how HIV/AIDS stigmatization undermines healthcare-seeking behaviours in Federal Teaching Hospital Lokoja.

The findings showed high proportions of respondents reporting that stigma influenced delayed clinic attendance, reluctance to disclose HIV status, and inconsistent medication adherence. Regression analysis demonstrated that fear of stigma ($\beta = –0.412$, $p < 0.05$), prior discriminatory experiences ($\beta = –0.358$, $p < 0.05$), and confidentiality concerns ($\beta = –0.287$, $p < 0.05$) significantly and negatively affected healthcare-seeking behaviour. Qualitative accounts further illustrated how patients skip appointments, request discreet packaging of medication, or temporarily disengage from care due to anticipated labeling. These findings are consistent with the work of Turan et al. (2017), who documented strong associations between perceived stigma and poor treatment adherence, and UNAIDS (2023), which reports that stigma remains a major barrier to sustained engagement in HIV care globally. Similarly, Earnshaw and Chaudoir (2020) highlight that anticipated and internalized stigma significantly predict healthcare avoidance behaviours. The empirical evidence from FTH Lokoja therefore reinforces contemporary scholarship demonstrating that stigma directly compromises continuity of HIV care.

The third objective explored institutional and community-level intervention strategies capable of mitigating HIV-related stigmatization in Federal Teaching Hospital Lokoja.

Finndings revealed strong agreement that healthcare worker training, confidentiality policies, peer support groups, and community education are effective stigma-reduction measures. Regression analysis confirmed that healthcare worker training ($\beta = 0.379$, $p < 0.05$), community education ($\beta = 0.332$, $p < 0.05$), and confidentiality enforcement ($\beta = 0.421$, $p < 0.05$) significantly and positively influenced healthcare-seeking behaviour. Qualitative responses from ART staff further indicated that structured training and peer-support mechanisms improved patient confidence and trust in the facility. These findings align with evidence presented by Nyblade et al. (2020), who demonstrated that healthcare stigma-reduction interventions significantly improve provider attitudes and patient experiences, and Stangl et al. (2020), who reported measurable improvements in service uptake following institutional stigma-reduction programmes. The agreement between field evidence and empirical scholarship suggests that systematic, multi-level interventions are effective tools for addressing stigma within healthcare settings.

Moreover, the findings of this study are largely supported by the assumptions of Modified Labeling Theory (MLT), which posits that societal labeling and anticipated rejection influence individual behaviour. The quantitative evidence demonstrating significant relationships between stigma and discriminatory experiences, as well as between stigma and healthcare-seeking behaviour, reflects how internalized and anticipated labeling shape behavioural outcomes. The gendered differences observed further illustrate how socially constructed labels attached to masculinity and femininity influence responses to illness and care. Moreover, the demonstrated effectiveness of institutional interventions supports the theoretical proposition that modifying social responses and reducing negative labeling can mitigate the behavioural consequences of stigma. Thus, Modified Labeling Theory provides a coherent explanatory framework for understanding how stigma operates within FTH Lokoja to influence discrimination, gendered experiences, and healthcare-seeking behaviour among people living with HIV/AIDS.

12. CONCLUSION

the study concludes that structured institutional and community-level interventions significantly reduce the negative impact of stigmatization on healthcare-seeking behaviour. Healthcare worker training, enforcement of confidentiality policies, peer support mechanisms, and community education initiatives were empirically shown to enhance patient engagement and mitigate discriminatory experiences. The positive statistical relationships between these interventions and improved healthcare-seeking behaviour provide strong evidence that stigma is not immutable but can be systematically addressed through deliberate policy and programmatic action. In all, the study concludes that reducing stigmatization is fundamental to improving healthcare utilization, strengthening treatment adherence, and enhancing the overall wellbeing of people living with HIV/AIDS in FTH Lokoja.

13. RECOMMENDATIONS

Following the above conclusions, the study put forth the following recommendations:

1. In light of the finding that cultural beliefs, gender norms, and socioeconomic factors significantly contribute to discriminatory experiences among people living with HIV/AIDS in FTH Lokoja, there is a need for sustained institutional reforms that address stigma at its roots. The hospital management should institutionalize periodic and mandatory stigma-reduction training for all categories of staff, including non-clinical personnel, with emphasis on cultural competence, ethical responsibility, and patients' rights. These trainings should move beyond general HIV awareness to include value clarification exercises and monitoring mechanisms that ensure accountability. Additionally, anti-discrimination policies should be clearly documented, publicly displayed, and strictly enforced to create an environment of zero tolerance for stigmatizing behaviour within the facility.
2. Given the evidence that stigmatization significantly undermines healthcare-seeking behaviours such as disclosure, treatment adherence, and regular clinic attendance, the hospital should strengthen patient-centered care systems that build trust and confidentiality. Confidentiality protocols must be rigorously enforced, with structural adjustments where necessary to ensure privacy in consultation rooms, pharmacy units, and medical records handling. The establishment or strengthening of psychosocial counseling services and peer-support groups within the ART clinic is essential to reduce internalized stigma and improve retention in care. Moreover, discreet service delivery models, such as differentiated drug refill systems and appointment scheduling flexibility, should be expanded to reduce patients' fear of exposure and enhance continuity of treatment.
3. Considering the demonstrated effectiveness of institutional and community-level interventions in reducing the impact of stigmatization, there should be expanded collaboration between FTH Lokoja and community stakeholders. Community education campaigns involving religious leaders, traditional authorities, and local influencers should be intensified to reshape harmful narratives surrounding HIV/AIDS. Public health messaging should emphasize that HIV is a manageable chronic condition and promote empathy toward PLHIV. Continuous monitoring and evaluation of stigma-reduction programs should be implemented to assess impact and inform policy adjustments. By combining institutional reform with sustained community engagement, stigma can be

systematically reduced, thereby improving healthcare-seeking behaviour and overall treatment outcomes for people living with HIV/AIDS.

14. CONTRIBUTIONS TO KNOWLEDGE

This study makes significant contributions to knowledge by providing empirical evidence on the multidimensional effects of stigmatization on healthcare-seeking behaviour among people living with HIV/AIDS within a tertiary healthcare setting in North-Central Nigeria and especially Federal Teaching Hospital Lokoja. While previous studies have examined HIV-related stigma broadly, this research advances understanding by integrating socio-cultural, gender, institutional, and behavioural dimensions within a single analytical framework. By employing both quantitative (descriptive statistics, multiple linear regression, and chi-square tests) and qualitative (Key Informant Interviews) approaches, the study offers a robust triangulated perspective that strengthens the validity of its conclusions. The findings contribute context-specific data from FTH Lokoja, thereby enriching the limited localized evidence on how stigma operates within institutional healthcare environments in Nigeria.

15. LIMITATIONS OF THE STUDY

During the course of the study, several challenges were encountered. One major challenge was respondents' initial reluctance to participate due to the sensitive nature of HIV-related stigma. Many potential participants expressed concern about confidentiality and fear of being identified. This challenge was overcome by providing clear assurances of anonymity, obtaining informed consent, and emphasizing that the research was strictly for academic purposes. The researcher also worked closely with ART clinic staff to build trust and facilitate access to respondents in a manner that respected ethical standards.

Another difficulty involved limited time availability of healthcare providers for the Key Informant Interviews due to their demanding clinical schedules. This was addressed by scheduling interviews at convenient times and conducting them in brief but focused sessions to minimize disruption to service delivery. There were also minor logistical constraints, including delays in retrieving completed questionnaires and ensuring complete responses. These were resolved through follow-up visits and careful data screening to ensure accuracy and completeness before analysis. In all, flexibility, persistence, and adherence to ethical protocols enabled the successful completion of the study despite these constraints.

16. SUGGESTIONS FOR FURTHER STUDIES

1. A longitudinal design to examine how stigma and healthcare-seeking behaviours evolve over time, particularly in response to implemented intervention strategies should be carried out.
2. A comparative study across multiple healthcare institutions or across different geopolitical zones in Nigeria would enhance generalizability and allow for regional analysis of socio-cultural influences on stigma in the North-Central Nigeria.

3. A qualitative study focusing specifically on the lived experiences of male and female PLHIV could provide more understanding about gender-specific barriers and coping mechanisms in Kogi State.

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All authors read and approved the final manuscript.

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Declarations

Ethics approval and consent to participate

Not applicable. This study did not involve human or animal subjects.

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The authors declare that they have no competing interests.

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