The impact of gender discrimination and HIV stigma on women living in North Central Nigeria

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Abstract: Gender discrimination and HIV stigma among women living with HIV/AIDS are significant psychosocial and public health issues that influence health and well-being. Most adolescent girls exposed to early and forced marriages, sexual violence, and unwanted practices increase the risk of contracting sexually transmitted diseases like HIV and AIDS. The objective of this study is to explore the influence of psychosocial determinants of gender discrimination and HIV stigma on the health and well-being of women living with HIV/AIDS in North Central Nigeria. The study employs qualitative research using research protocol to interview participants and collect data with the approval of the National Health Research Ethics of the Ministry of Health. Forty participants, male and female aged 18 and above selected through purposive sampling technique from Dalhatu Araf Specialist Hospital (DASH) in Nasarawa State, North Central Nigeria. Data collected were analyzed through thematic analysis using ATLAS.ti software to code, transcribe, and present a graphical and words cloud frequency analysis. The findings indicate that forced marriage predominantly among the uneducated and low socioeconomic status is a socio-cultural practice that contributes to gender discrimination and HIV stigma. It leads to psychological problems like anxiety and depression in marriage. The study, therefore, concludes that community-based behavioral intervention strategies should advocate gender equality and anti-discrimination law. Also, public awareness on sex education, forced marriage, skills acquisition, and social support system be encouraged.

Subjects: Gender Studies - Soc Sci; Sociology & Social Policy; Feminist Psychology; Multidisciplinary Psychology; Social Psychology

Keywords: gender discrimination; HIV/AIDS; HIV stigma; stigma; women

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1. Introduction
HIV/AIDS has been a challenging historical disease in the entire universe. The global initiative on increased Antiretroviral Therapy (ART) among people living with HIV and AIDS (PLWHA) demonstrated a tremendously positive influence on the treatment response (Oladele et al., 2018). HIV stigma, however, affects the health and psychological well-being of HIV positive. The stigma of being HIV positive influences the attitudes of HIV positive towards early diagnosis, disclosing HIV status, consistent antiretroviral (ARV), attending antiretroviral therapy, and HIV treatment and prevention (Chan et al., 2020; Nkwo et al., 2019). The poor attitude of HIV positive towards ART and HIV testing (Hobkirck et al., 2015; Lorenz et al., 2016) requires the attention of trained psychologists and social workers to providing cognitive and behavioral interventions (Garofalo et al., 2016; Tobin et al., 2017).

In 2017, over 36.9 million people across the globe with HIV/AIDS (Girum et al., 2018). Sub-Saharan Africa accounted for 60% of the world’s HIV infections, two-thirds among women (Awofala & Ogundele, 2018; Kwent, 2018). HIV prevalence in Nigeria is predominantly among female sex workers and men who have sex with men (Awofala & Ogundele, 2018). There is an increased prevalence of 23% in 2016 among men who have sex with men, which accounted for 55% of all new country’s HIV infections (UNAIDS, 2019). The statement suggests that LGBT (particularly refers to the gay group) may suffer an increased HIV discrimination as more than half new infection was recorded from such a group in 2016. Furthermore, the socio-culture influences gender inequality in promoting HIV-related stigma (AVERT, 2018) and making women vulnerable to HIV infection (Anugwom & Anugwom, 2016). Also, society sees female sex workers as a high-risk group who transmit HIV/AIDS (Awofala & Ogundele, 2018). Culture, therefore, defines HIV as a women’s problem (Girum et al., 2018). According to Udeh et al., (2016), the consequences of socio-cultural and traditional beliefs on gender discrimination and HIV stigma make HIV healthcare a challenging public health issue in Nigeria. The implications of HIV stigma results in internalized and self-stigma (Turan et al., 2017; Zarei & Joulai, 2018) and encourages high-risk behavior among HIV positive women due to the socio-cultural stigma experienced for disclosing HIV status (Okafor et al., 2017).

HIV stigma in Nigeria is significantly a psychosocial and public health issue that influences PLWHA and their family members (Odimegwu et al., 2017; Stockton et al., 2018). HIV stigma resulted in mental and psychological trauma to PLWHA, their close family members (CFM), and the health-care providers (HCP; O’Donnell et al., 2015). Society evaluated the infected persons with prejudice and stereotype of discrimination and stigmatization. The infected person also develops internalized or self-stigma as a coping strategy to manage HIV stigma (Odimegwu et al., 2018). In Nigeria, HIV stigma is related to devalued names like “gawa mai rai” meaning “living corpse,” “katangan mutuwa” meaning “dead wall,” “gama shika” meaning “bloodsucking snake,” “vampires,” and “zombies” among others (Doka et al., 2017).

Gender discrimination and HIV stigma in North Central Nigeria are associated with the patriarchal and polygamous structure where gender inequality and social differentiation against women on economic, educational, and healthcare are determined by the husband (Allanana, 2013; Attoh, 2017). The social structure restricts women from attaining higher education and seeking economic advancement and financial stability, thereby contributing to risk behavior and HIV infection (Ssewanyana et al., 2018). Odimegwu et al. (2018) revealed that ethnic differences are the primary determinant of HIV stigma and discrimination in Nigeria. Also, socio-cultural and religious ideology on gender inequality and social differentiation among gender contribute to high-risk behavior of transacting sex for money, food, shelter, and security, thereby increasing the vulnerability of HIV infection (Kilburn et al., 2018).

In Nigeria, there is a high rate of HIV/AIDS among women who experienced gender discrimination and HIV stigma compared to the men counterparts (Odimegwu et al., 2017). Studies confirmed that HIV stigma leads to discrimination, rejection, and isolation of PLWHA from the immediate society (AVERT, 2019; Famoroti et al., 2013; Srithananivisoonchai et al., 2017) with
negative implications to general welfare (Biraguma et al., 2018; Wabiri & Taffo, 2013). Also, PLWHA reported being stigmatized by close family members and health-care providers. This is due to the inadequate health policies and lack of implementation of legal Acts in Nigeria (World Health Organization, 2018), leading to a high level of fear of divorce and intimate partner violence among women, which affect early HIV diagnosis and disclosure rate among women in Nigerian (Paudel & Boral, 2015). Women develop a poor attitude towards antiretroviral therapy during the antenatal, delivery, and postnatal clinic check-ups (Adetokunboh & Oluwasanu, 2016; Omonaiye et al., 2018; Population Reference Bureau, 2014; Rawizza et al., 2017).

Further, exposure of most adolescent girls to early and forced marriages, sexual violence, and unwanted pregnancies increase the risk of contracting sexually transmitted diseases (STDs) like HIV/AIDS (Ivanova et al., 2018) and HIV stigma (Odimegwu et al., 2017, 2018). Women were denied freedom of education and prevented from earning income. Also, women are restricted from inheriting lands and properties and have limitation to freedom of association, movement, and expression (UNESCO, 2014). Gender inequality reduced women as mere housewives, daughters, mothers, and sisters with sole responsibility for childbearing and upbringing with little or no income. Women only engage in house-to-house cooperative money contribution and small-scale business, which adversely contribute to risk behavior and HIV (Asad et al., 2017). The trauma associated with stigma increases the physical pain, social phobia, and psychological distress in women living in North Central Nigeria (Akin-Odanye, 2018; Badejoko et al., 2014; Hassan et al., 2016).

Most behavioral-based researches on HIV stigma and gender discrimination centered on developed industrialized countries (Asad et al., 2017; Faust et al., 2017; Girum et al., 2018; Pantelic et al., 2018; Ssewanyana et al., 2018). Few studies that captured developing countries like Nigeria employ the quantitative approach with no reference to the phenomenological approach of the qualitative studies (Odimegwu et al., 2018; Okafor et al., 2017; Udeh et al., 2016; Uzochukwu et al., 2015). The current study employs a qualitative approach using the face-to-face in-depth interview to understand the psychosocial analysis of gender discrimination and HIV stigma among HIV patients using ATLAS.ti8, a Computer-Assisted Qualitative Data Analysis Software (CAQDAS) for thematic qualitative data analysis. The adoption of qualitative approach using ATLAS.ti8 software enables the development of HIV stigma intervention strategies against gender discrimination in North Central Nigeria.

This study explores the influence of psychosocial determinants of gender discrimination and HIV stigma on the health and well-being of women diagnosed with HIV/AIDS in North Central Nigeria. The following questions guide the objective of this study: Do patriarchal and polygamous system influence gender discrimination and HIV stigma in North Central Nigeria? How do gender law of inheritance influence the prevalence of HIV and HIV stigma by gender? To what extent do force and child marriage increase risk of HIV? How can the implementation of HIV anti-discrimination law on gender in every workplace reduce unprotected sexual and HIV infection? Does social differentiation influence gender inequality and HIV?

2. Materials and methods

2.1. Study design

The study adopted a phenomenological (Davidson, 2013) qualitative research (Sandelowski, 2000) using an in-depth interview (Olanrewaju, 2018) to explore gender discrimination and HIV stigma among HIV patients in North Central Nigeria. The study employs qualitative research to enable interaction using the semi-structured interview to generate textual data such as field notes “first-hand note taking”, audio recording, transcribing, and translating verbatim. As shown in Figure 1, the thematic analysis enables the transcription of information in the audio recorder and field notes into codes and graphical representation of the analyzed codes. Also, as shown in Figure 2, the thematic analysis is presented using word cloud analysis.
2.2. Population
The population centered on diagnosed and admitted outpatients from Dalhatu Araf Specialist Hospital (DASH) Lafia, Nasarawa State, North Central Nigeria. The population of 3508 has access to health-care facilities in the study area (Akawu & Charles, 2018). As shown in Figure 3, the rationale for the choice of the population based on the 2015 HIV/AIDS prevalence state statistics recorded 8.1% for Nasarawa State (National Agency for the Control of AIDS, 2015). Also, the population covers aged 18 years and above who voluntarily signed the informed consent to participate in the study.

2.3. Sample and sample size
As shown in Table 1, forty (40) samples selected through the purposive sampling technique (Burns & Grove, 2013) from selected hospitals handling HIV/AIDS cases in Nasarawa State, North Central Nigeria. The purposive sampling technique was adopted because it allows the preselection of participants based on relevant criteria and characteristics to answer research questions in a particular area of interest. Gender and HIV stigma have become these preselected research areas.

2.4. Interview protocol and data collection
A designed interview protocol of semi-structured questions guided the interview session to explore gender discrimination and the stigma of being HIV positive. Data collected through audio recorder and field notes were transcribed, coded, and analyzed using ATLAS.ti8 software, a Computer-Assisted Qualitative Data Analysis Software (CAQDAS).

2.5. Procedure
The National Health Research Ethics of the Ministry of Health, Nasarawa State, Nigeria, provided approval for the study. At every point of the interview, the volunteered participants signed an informed consent form indicating a willingness to participate in the study. Each interview session allocated 50 minutes. The researcher provided confidentiality by securing all personal information from the field notes and audio recorder with a password in a removable hard drive.

2.6. Data analysis
The study employs a thematic data analysis technique using ATLAS.ti8 software, a Computer-Assisted Qualitative Data Analysis Software (CAQDAS) transcribe, code, and analyze data from field notes and audio recorder (Vaismoradi et al., 2016). As shown in Figures 1 and 2, the coded data
were represented graphically and analyzed word frequency counts through word clouds using thematic network analysis, respectively.

2.7. Results
A participant associates HIV stigma and gender discrimination with women counterparts. A woman working as a laundrywoman (dry cleaner in Nigeria) felt stigmatized as being HIV positive in her community because of her gender. Her narrative described her experience in the statement below (participant 1);

The HIV disease in my place is seen as a woman’s sickness oooooo. It is believed that any lady infected with HIV/AIDS has been an evil woman who has been sleeping from one man’s bed to another. Also, women are just like a commodity that people go to the market to buy and sale. Being a woman, you are at risk of contracting directly or indirectly merely because you are a woman.

The statement indicated that women are more vulnerable to contracting HIV because they signify a commodity that can be bought and used. Conversely, one of the male participants identified unprotected sex with multiple partners as the most contributing factor across gender;
I know a man who dated and had unprotected sex with more than one lady before marriage is at risk of contracting HIV. So, it is possible my gender as a man make it possible one of those times.
Poverty and financial stability are two different factors that increase the risk of HIV among males and females. A financially stable man uses his money to acquire many poor women. Also, poverty can make women engage in unprotected sexual relationships with multiple sex partners. Participant 4 shared his experience below;

As a local rich man in the village, many families are willing to give their daughters for me to marry or to have as a concubine because I will be supporting the family. I have many children within the neighboring villages from different women I come across during the sales of animals across other villages.

Most women who are HIV positive suffered difficulties managing their health as a result of their gender. Participant 1 described her experiences below;

I have difficulty as a woman convincing people, even the health workers that I have lived a good life, and I do not know how this illness comes about. People believed that every lady infected had played a dirty lifestyle; as such, they must be handled without human pity.

Many participants viewed HIV as a social stigma experiencing stereotypes and discrimination. People perceived social rejection from various sources, including society, friends, family, partners, health-care workers, and colleagues. A man experienced rejection and discrimination in his workplace because he had an HIV infection (participant 5);

My boss will always remind me please Mr ‘this’ we will call you if we need your impact, you know you need to stay at home to take care of yourself. The direct and indirect frustration forced me to submit my resignation because I discovered that I was dying silently, and my health is getting worse whenever I think of the insult I will always receive whenever I go to work. I do not have any source of money, though my health has been better since I left the job. It has not been easy because I do not have any specific source of money at the moment.

An NGO serves as one of the intervention strategies for managing and controlling the spread of HIV. A participant described his experience as stated below (participant 6);

An NGO came here, tested us, and registered us to an NGO clinic where we usually go to collect ARV free. Also, I have received material gifts and cash from this organization to help with transportation and other things.

The experiences of harmful family practice of early marriage in North Central Nigeria recorded a severe family crisis, including extramarital affairs and drugs. Young girls of 12 years arranged and betrothed forcefully to a rich man of 50 to 60 years. The age difference and social exposure increase the risk of contracting HIV infection. Participant 7 narrative described the content above;

Being a woman makes my parents arranged forced marriage for me with Alhaji. My beauty also attracts Alhaji. Being the only female graduate also attracts suitors, including my late husband.

Another participant experienced forced marriage by her father, who wants her to marry a rich man to take care of her younger ones. The narrative of participant 7 below described her experience;

My father said his first daughter must be a degree holder. Moreover, she will marry a rich man to enable her to take care of her younger ones. I got a degree because I am the first daughter of the family. Also, I was forced to marry Alhaji. I end up marrying an HIV positive.

Other participants presented some phrases to describe those experiences that fit into the definition of gender inequality. Participant 7 suggested the following:
Early marriage, forced marriage, social inequality, no education, or being educated but stopped from being gainfully employed.

The problem of forced marriage, arranged marriage, and early marriage contribute to psychosocial issues challenging the many married homes in North Central Nigeria. Gender inequality is another contributing factor because the dichotomy between male and female indicated domination, subjugation, and discrimination against women. A female participant described her experiences in the following statement:

The gender of boys alone reinforces their power (masculinity). It automatically forces women to be submissive even in sexual affairs without resistance, although I think this can increase the risk of HIV infection. My father married a wife for me, the daughter of one of his childhood friends who live in Lagos. We got married two years ago when they came home for the Sallah celebration. I divorced her before getting admission in Singapore. She was caught at different times, having extramarital affairs with different men in the village. My guess is that I contracted HIV from her.

Another concern is gender inequality and the economic law of inheritance, where women are denied inheritance of any material and landed properties. The women are left stranded with no source of income to sustain themselves. Most women resort to any risky social behavior to enable them to survive. One of the participants shared a similar experience below:

I was denied my husband’s property because I gave birth to only three daughters. The issue of gender inequality makes me think of doing everything possible to get money, including trading sex for food and money. Even my daughters became angry and started misbehaving.

When been asked, gender inequality can influence the widespread HIV/AIDS, a woman narrative suggested a case of gender inequality and girl-child education. Most women diagnosed HIV positive in North Central Nigeria have no educational opportunities, making them vulnerable to high-risk behavior and HIV. A young lady denied sponsorship into the College of Education, Akwanga, narrated the following:

I only finished secondary education and got admission into the College of Education, Akwanga, but was refused to be sponsored because my father had to pay my brothers’ school fees. As a woman, you get involved in one or two relationships and seek assistance from you guys to help take care of your primary needs.

The above statement indicated that a lack of proper education places women at risk of engaging in an unprotected sexual relationship. Another participant’s narrative supported the above assertion;

Ohooo. I know some of my lady friends we grew up together who sell their body for sex just to pay their school fees. Moreover, the doctors and nurses told us that sex is the primary point where you can get infected.

Also, most participants confirmed that they engage in risk behaviors during school days. A participant shared his experiences of behaving arrogant and engaging in risky behavior while at the university;

As the firstborn and the only male child of the family, my father makes sure I went to the University before he died. My father overprotected and spoiled me with luxuries. It makes me arrogant about playing a risky lifestyle. I became attracted to women, and I lost control. My first wife I impregnated while at the University. I joined my father’s business soon after graduation and wasted the money on women.

Another participant shared his experiences as a privileged man who enjoys more priority than his sisters because of his gender. His narrative suggests that gender inequality, in terms of male
superiority, will affect the development of man’s self-esteem, self-concept, and self-control towards the opposite sex. Providing good education to the male child is good, but over-pampering him with additional resources will lead him to high-risk behaviors such as drugs and multiple sexual relationships.

I grew up under the watch of a cultured father who insists on making his male children to assume leadership responsibilities as well as develop themselves academically. That leadership charisma and male superiority ego attract women around you, and in the process, you get involved, and many things happen. Being among the few educated men in my community, the women and the entire society accord respect and dignity, which enables you to privilege to have access to meeting and dating the pretty ladies.

The statement above also suggested a case of gender inequality and male ego superiority. A participant shared his experiences;

I am the only male child of the family. The culture demands that I inherit all my father’s wealth. I maltreat my younger sisters as strangers. My male ego increases my risky lifestyle.

Another participant indicates that poverty and poor education influences risk behavior. Most commercial sex workers and those having unprotected multiple sexual relationships are having a low educational background and poor socio-economic status;

When you do not acquire education, you automatically do not have access to good jobs. You become illiterate and ignorant that you have to do anything to survive, including risk behavior. I do smoke and drink any drug. I used to sleep with more than three different men in a day. It contributed to my contracting HIV.

Gender inequality and the economic law of inheritance against women is another major contributing factor to gender discrimination and HIV stigma among women. One of the participants provided the following statement:

Women do not inherit land even they are the only surviving child of the parents. They must get married to a man who will inherit that land. Women cannot inherit the throne, except they get married to a man who will inherit the throne for them. Some ladies who are formerly rich with assets end up going to the cities for prostitution and other harmful behaviors. Women are denied inheritance to land and properties. They are only useful as an inheritance to a man.

3. Discussion
In the present study, findings indicate that gender discrimination and HIV stigma originate from the patriarchal and polygamous system where discrimination, stigmatization, and gender inequality against women are justified as a marital obligation. Women were discriminated against in social, economic, political, religious, and cultural settings. The stigma of being discriminated against due to HIV status made most women develop low self-concept (Povedano-Diaz et al., 2020), low self-esteem (Stuppy et al., 2020), and an absence of self-reliance (Regmi et al., 2020). Mostly, women experienced HIV stigma in workplace harassment, employment, and job discrimination and denied negotiating for safe sex during a sexual relationship, thereby increasing the risk of contracting and transmitting HIV and AIDS (Eilami et al., 2019). As shown in Figure 2, the word cloud analysis of the study finding indicates high-frequency counts on words such as women, HIV, and status. The word cloud analysis suggests that the under-representation and segregation of women in technical education due to cultural and religious ideologies have significantly increased vulnerability to risk behavior and HIV infection. In North Central Nigeria, women attend only religious schools (Ahmadiyya) to acquire Arabic knowledge through Quranic recitation. The religious practice restricted women to acquiring vocational skills and home-based economic activities such as street hawking and domestic chores to improve the family income.
In 2014, Nigeria signed the Anti-Discrimination Acts into law, but lack of implementation has posed a severe challenge to why HIV stigma continue to develop aiming women in Nigeria over the years (Odimegwu et al., 2017; Onyemekukwe, 2017). At the 2018 World International Workers’ Day, the Director-General of NACA calls for the implementation of HIV anti-discrimination law workplace on gender in every workplace. Also, socio-cultural values and religious beliefs influence the perception of health, which affect the implementation of the law (Anugwom & Angwom, 2016; Udeh et al., 2016; Ugwu & De Kok, 2015). Society teaches values and beliefs that directly or indirectly controls the individual’s understanding of HIV/AIDS, thereby making PLWHA feel guilt, shame, and fear (AVERT, 2019; Hutchinson & Dhairyawan, 2018).

The finding of the current study has an association with previous studies conducted by Malinga and Modie-Maroka (2020) and Mensah (2020) indicate that some women studying in tertiary institutions engage in high-risk behavior transacting sexual relationships with multiple partners to sponsor their education. Also, women who graduated experienced sexual harassment from the secondary school teachers and lecturers at the tertiary institutions (Imonikhe et al., 2011). A recent study conducted by Igbkokwe and colleagues indicates that uneducated women lack knowledge of Family Life and HIV/AIDS Education (FLHE) designed to enlighten students on sex education and HIV/AIDS (Igbkokwe et al., 2020). Badru et al. (2020) assert that a decline in comprehensive HIV knowledge increases the risk of contracting HIV among young adolescent girls. As shown in Figure 2, the presented word cloud analysis shows high-frequency counts on words including women, risk, sex, HIV, education, and infection, suggesting lack of formal education increases women’s risk-behavior and HIV infection.

The current finding reveals that the gender law of inheritance has been a determinant factor to the continued existence of gender discrimination and HIV stigma in North Central Nigeria. Previous publication by the Immigration and Refugees Board of Canada (IRB) reveals that Nigerian law protects widows of the right to inherit their deceased husband’s properties (IRB, 2020). The finding of this study indicates that the traditional communities of North Central Nigeria operate the patrilineal descent systems and coordinated by the customary law where women have no direct right to inheritance of lands and properties. Women can benefit indirectly the inherited lands and properties of their late husband if having a surviving son who is the next of kin to the dead husband. The girl-child experienced difficulties requesting rights of inheritance of properties in their parent’s house because they get married out of their father’s house into another family.

Further, the boy-child and men exercise all privileges and rights of inheritance from their father, grandfather, and the lineage of their father, including inheriting wives from their late brothers. Therefore, in the patrilineal descent system, the right to inheritance is traced to the blood relatives and the father’s ancestral lines. The practice indicates that the right of inheritance and the use of family surnames are related to the man and his blood relatives. The research conducted by Oba (2019) supports the current finding by indicating that the Nigerian constitution recognizes three heritage laws to include statutory, Islamic, and customary law. The woman can inherit everything with or without children under the statutory law, while she gets only one quarter in the case of Islamic law, and the customary laws do not allow the woman right to inheritance but allow her to stay in her husband’s family as an inheritance for the member of the family. The finding suggests that the patrilineal system has created grounds for gender discrimination, thereby increasing risk behavior and chances for contracting and transmitting HIV and experiencing HIV stigma.

The finding of the current study indicates that forced marriage is predominantly a socio-cultural practice among uneducated ethnic groups, especially those with low socioeconomic status living in rural areas of North Central Nigeria. Young girls below the age of 15 are forcefully married to a financially stable old man who can spend money on the parents or guardians of the bride. Most victims of child marriage develop severe medical complications such as rectovaginal fistulae (RVF) and vesicovaginal fistulae (VVF) during childbirth and experienced psychological issues like anxiety.
and depression in marriage (Timothy & Bello, 2020). Also, most old men with many wives increase vulnerability to HIV and AIDS among young married women (Akullian et al., 2017).

The implications of this finding indicate that most victims of early and forced marriage have little or no knowledge of using a condom as a contraceptive that can reduce chances of contracting STIs like HIV/AIDS. Although there are laws and policies in Nigeria against child marriage, weak legislative policy and contradicting laws hinder the successful arrest and prosecution of the perpetrators of this crime against the girl-child. For example, the contradiction includes the Child Right’s Act 2003 indicating a child as a person below the age of 18 years; Article 2 of the Children and Young Persons Act (CYP) defined a child as a person under the age of 14 years; S3(1)(e) of the Matrimonial Causes Act 2004, must be 21 years. Based on the research findings, the multiplicities of these laws account for the weak legislative policies making it difficult to apprehend and prosecute offenders. Other studies established an association between child marriage among men, low level of education, and lack of comprehensive knowledge of HIV (Misunas et al., 2019; Nwonu & Oyahiromen, 2014).

Further, the study finding indicates that socioeconomic status contributes to gender discrimination and the stigma of being HIV positive. People migrate to cities and towns for greener pastures due to the high rate of poverty, hunger, food insecurity, and low socioeconomic status. The finding suggests that gender discrimination has created economic imbalance and facilitated intimate partner violence in relationships, making it difficult for women to negotiate to use condoms for protection against HIV during sexual relationships. Most women engage in unprotected sexual intercourse with multiple partners, making women vulnerable to STIs, including HIV and AIDS. Other studies also suggested an association between unprotected sexual intercourse and HIV prevalence in Nigeria (Ankomah et al., 2011; Eluwa et al., 2019).

The current finding indicates that educated men have economic privileges to earn a high income but spend the money marrying many women and engaging in multiple sexual relationships, thereby increasing vulnerability to HIV and AIDS. Other studies indicate that a high level of education, poverty, and family status reduces the chances of contracting HIV/AIDS (McMahon et al., 2011; Oladele et al., 2018). A recent study suggests that young girls face disadvantages due to gender inequality, and they likely do not attain formal education, making it difficult to access information and knowledge related to sexuality and the reproductive system (George et al., 2020).

The study finding also reported social differentiation as a product of gender inequality across social institutions, including community, education, ethnic or cultural groups, political and religious organizations. In North Central Nigeria, people tend to value cultural rights than human or women’s rights; hence, men and women accept social differentiation. For example, society discriminates and stigmatizes young girls and women confirmed being victims of harmful cultural practices like female genital mutilation, early marriage, and in some cases, having sexual intercourse during menstruation as a cultural means of cementing blood covenant and safeguarding faithfulness in a relationship. The risk of these harmful cultural practices has health implications, including vesicovaginal fistulae (VVF), rectovaginal fistulae (RVF), and an increased risk of HIV and psychological trauma. Other studies established an association with the current findings (Klein et al., 2018; Parent Magazine Africa, 2020; Petroni et al., 2019; Schaffnit et al., 2019). It indicates that society had legitimized social differentiation and gender discrimination in terms of gender roles and opportunities in social, education, political and economic empowerment.

Gender discrimination and HIV stigma are challenging psychosocial issues for HIV patients living in Nigeria. In North Central Nigeria, gender discrimination and HIV stigma originate from the patriarchal and polygamous system where discrimination, stigmatization, and gender inequality against women are an acceptable norm. The patrilineal descent system coordinated by the customary law contributes to the law of inheritance where women have no right to inheritance of lands and properties. Men enjoy all social, economic, cultural, political, and religious privileges against women who experienced
unequal treatment of gender inequality in North Central Nigeria. Also, forced marriage predominantly among the uneducated and low socioeconomic status is a gender discrimination-based socio-cultural practice that contributes to severe medical complications such as rectovaginal fistulae (RVF) and vesicovaginal fistulae (VVF) during childbirth and experienced psychological problems like anxiety and depression in marriage. Also, harmful cultural practices include female genital mutilation, sexual intercourse during menstruation, and blood covenant increase gender discrimination and HIV stigma in North Central Nigeria. This study recommends a collaborative community-based approach by psychologists and social workers in creating awareness and enhance understanding of gender discrimination and HIV stigma at a macro level. Adopting social support system from friends, family members, colleagues, and members of the society will enhance positive self-confidence and self-esteem, which reduces anxiety, depression, and psychological distress, thereby increasing a positive attitude towards health and psychological well-being. Further research should intensively explore gender discrimination and HIV stigma with implications to social policies on HIV/AIDS and stigma in Nigeria.

**Public Interest Statement**

Given the increase in gender-based discrimination and HIV stigma among women in North Central Nigeria. It is pertinent to employ advanced qualitative methodologies to explore the impact of psychosocial determinants on gender-based discrimination and HIV stigma and its implications to health and well-being. Through the application of thematic analysis using ATLAS.ti8 software, the paper suggests that the greatest contribution is how the patriarchal and polygamous system influence gender discrimination and HIV stigma, and the socio-cultural practice of forced marriage that is predominantly among the uneducated and low socioeconomic families. A community-based behavioural intervention may be considered a sure way to gender equality and anti-discrimination policies that advocate for gender-based practice, public awareness, social support, and skills acquisition in improving health and well-being.

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