

## **30. The attitude of nurses to HIV/AIDS patients in a Nigerian University Teaching Hospital**

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### **Introduction**

“The revelation that perhaps up to four million Nigerians might have contracted (the) AIDS virus should spur the country into some form of coordinated action. Despite the havoc which HIV/AIDS has caused throughout the world, particularly Africa, Nigerians have, regrettably, continued to carry on as if nothing is happening. Many people still maintain multiple sex partners and engage in casual and unprotected sex. Our AIDS control strategy remains, at best, unstructured, without direction. If the report that some people have received blood infected with the virus is true, then there is danger on the horizon. It only goes to show that AIDS screening is not properly carried out in the country. Sadly, the problem has been compounded by the fact that the disease is still being treated with a less than honest approach by many Nigerians” (*Daily Times* 1997).

This editorial by the leading government-owned newspaper conveys the lack of a proper response to one of the main threats to public health in Nigeria. The data is in line with earlier figures which calculated that 1,050,000 Nigerians were HIV positive by the end of 1994 and an extrapolation of over two million using the double-blind method (Orubuloye 1995; Sowunmi and Ikhemueh 1996). Three-quarters of commercial sex workers are HIV positive, so are 5 percent of blood donors and 4 percent of pregnant women (Sowunmi and Ikhemueh 1996). By implication, this means that babies from HIV/AIDS infected women are potential victims. The social width of the disease knows no bounds: the media reported the infection of schoolgirls in Akwa Ibom State and the AIDS-death of a community leader in Plateau State in the month of January 1997 alone (*Post Express* 1997; *Punch* 1997). The probability is that more Nigerians infected by HIV/AIDS is even higher than these startling figures suggest.

Compared to other African countries, Nigeria has been inordinately slow to wake up to the reality of HIV/AIDS. It has been even slower to embark on caring for HIV/AIDS patients. University College Hospital (UCH), Ibadan, is a Federal Teaching Hospital with a leading reputation for health care in the country. UCH operates an AIDS Screening Centre, the only one in Ibadan, a city of over 3 million inhabitants. In 1993, “the Oyo State Minister of Health declared wanted 43 blood donors whose blood showed traits of HIV” (AIDS

Information Exchange Resource Centre 1993). Wanted for receiving the appropriate care, or wanted like criminals? In whatever case, the infrastructure is simply not in place, being not a priority among hospital managers and government ministries.

For Nigerians with HIV/AIDS, health care is a misnomer. There is only health care neglect. On hearing a HIV/AIDS diagnosis of a patient, hospital authorities abandon all notions of caring. A notice of 23 March 1995 issued by the Chairman of the Medical Advisory Committee of UCH stated that:

- “(1) established cases of clinical HIV/AIDS should not be admitted.
- (2) using their own discretion, doctors could admit in rare cases HIV/AIDS patients for IV and blood transfusion, after which the patient must be discharged.
- (3) known HIV/AIDS cases should be referred to the medical social services department for advice”.

Many carriers of the causative virus are known to lead active lives. Allowing these people to remain in society without caution exposes the populace to avoidable danger. In the present setting, nothing bars HIV/AIDS carriers from donating blood or doing many other things which can impair the lives of other citizens. When asked in a recent magazine interview about the Federal Government’s policy towards HIV/AIDS under the title ‘Playing the ostrich’, Dr Lolade Olusola Ojo of the National AIDS and STD Control Programme in Nigeria responded:

“We have a policy that is still undergoing the normal scrutiny of the government. This delay on the policy is because when AIDS was first discovered the government did not believe we had AIDS in the country”.

The Nigerian Federal Ministry of Health has been very slow in waking up to the realities of HIV/AIDS and making combative plans to control its spread. Nothing has been done about equipping hospitals for proper management of HIV/AIDS cases. Another aspect of Dr Olusola’s revelations concerned the screening of blood:

“There are 818 blood screening centres in Nigeria. A law is coming up to compel screening of all donated blood before transfusion. This is because for now, most of the medical laboratories write ‘screened blood’ on blood bags that are not screened. Sixteen percent of these so-called ‘screened blood’ [bags] are found to be contaminated”.

Consultant haematologist Sumailman Akanmu also found a similar percentage of blood bags labelled screened and HIV negative, especially from private laboratories had, in fact been tainted with the HIV positive virus (Sowunmi and Ikhemuemhe 1996).

It is in this negative sort of working environment that nurses’ attitudes to HIV/AIDS patients is examined with particular reference to UCH, Ibadan (Effa-Heap 1997). Specific sub-problems to investigate include the level of knowledge of nurses on HIV/AIDS; their sources of information on HIV/AIDS; their attitude towards caring for HIV/AIDS patients; the relationships between the nurses’ age, exposure to infected patients, years of nursing experience, and the nurses’

attitude towards HIV/AIDS patients; and whether UCH is well equipped for the management of HIV/AIDS cases.

### Literature Review

Sexually Transmitted Diseases (STDs) have been around for a long time and, in West Africa, STDs are next to malaria in spread. But man has tackled STDs because the causes, course, treatment and preventive measures are known. With the entrance of AIDS, all other STDs have been relegated to the background. AIDS is a devastating disease which progresses at an alarming rate. Death usually occurs within twelve months of diagnosis. AIDS dementia complex (ADC) is the most common central nervous system complication in people infected with HIV. Typically, HIV attacks white matter, the frontal, occipital, parietal lobe and the basal ganglia (Lasher 1989). At the end stage, infected persons become 'vegetative', with only rudimentary intellectual and social functionings. The treatment of HIV/AIDS patients is only palliative, composing mainly the management of opportunistic infections that take advantage of the body's impaired immune system.

In Nigeria, HIV/AIDS has been treated as a moral rather than a medical issue. The way in which the disease has been described and classified reflects the same social and cultural prejudices that made the disease shameful in the first place (Barnett and Blaikie 1992). Known cases of HIV/AIDS are stigmatised by the society in which they live. Features common to stigma include identifying the person concerned in terms of the stigmatizing attributes which in turn override other characteristics and social roles. It spreads to the whole person and 'spoils' the person's identity, devalues the person and leads to discrimination and outright rejection, all of which result in reduced opportunities (Goffman 1963).

Attitude derives from the Latin 'aptitudo', meaning 'fitness'; that is fitness to engage in the execution of the task (Reber 1988). The modern usage of the term is a predisposition to act in a certain way towards some aspect of one's environment, including other people. Attitude can be positive or negative and can affect the behaviour of an individual. They serve a primary function of bringing together the diverse experiences to which an individual is exposed and forming them into a cohesive, organised whole. It is through the attitude and belief systems of an individual that environmental perception acquires meaning. The danger is that attitudes may become so rigidly adhered to that instead of assisting an individual in understanding his environment and the events taking place within it, they become the perception. The process of changing attitudes requires that the individual objectively examine the critical elements of the attitude and identify those components that are valid and those that are prejudgements (Gross 1987).

Social psychologists describe attitude as a complex tendency of persons to behave in positive or negative ways or to respond in a

favourable or unfavourable manner to social objects in his or her environment. They all agree that attitudes are learnt, but differ on how. Attitudes are enduring systems but there are times when it is necessary to effect change. On the other hand, the functionalists believe that attitudes serve a particular motivational function, that is, serve ego needs and are therefore protective of self. They also form support for one's values and therefore are intrinsically rewarding. The view makes it difficult to change attitude since it would need to change what is motivating the individual, which is further compounded by the fact that what is underlying the motivation is usually unknown even to the individual. The cognitive theorists feel that the individual is always striving for consistency; therefore the way to institute change is through the components of attitude. They argue that there are three structural components of attitude and these are the affective components which refer to positive or negative emotions about something; the behavioural component involves intentions to act in certain ways, to engage in behaviours that are somehow relevant to one's attitude and lastly the cognitive component, which refers to the thinking and interpreting that goes into forming or using an attitude (Baron and Byrne 1991).

Attitude is gained through experience and contact with the world around us (Davis and Houghton 1995). As individuals develop, they acquire a set of beliefs and attitudes that in part influence how they interact. They may be altered by new experiences and information. Essentially, attitudes are formed through a learning process, which can occur in a number of ways: classical conditioning, operant conditioning, observational learning and imitation.

The nursing of HIV/AIDS patients requires special skills. They include the identification and management of specific clinical problems, counselling techniques, the administration of patient care and the ability to communicate effectively with individuals, families and community groups. Staff caring for HIV/AIDS patients need to acquire new attitudes, knowledge and skill as they become immersed in the multi-disciplinary problems of AIDS care and prevention. They should be ready to learn from personal experience and from their colleagues. When talking about attitudes, feelings and values, it is essential to remain objective, to empathise without becoming emotionally involved, to listen with respect and to challenge received wisdom where necessary.

Nigerian nurses are human beings living within the society. They do not exist in some rarefied atmosphere. Outside work they still interact with acquaintances, friends, family members and colleagues. They are therefore exposed to the same influences as the general public. If AIDS has been stigmatised, and its victims apportioned blame for being infected by our society, one should expect not only lay social groups but health professionals to respond differently to sick people for whom they hold responsible for the illness and those seen as blameless (Miles 1991). Ghodse's (1978) study of the attitude of British casualty staff towards caring for drug overdose patients showed that patients deemed to be responsible for their 'condition' received

less sympathy and medical effort than was the case with those whom staff deemed to be blameless for their condition. An important part of the sick's role is society's acceptance that sick people are not responsible for their condition, did not bring it about and could not have avoided it. If professionals or lay social groups input responsibility to sick persons for their sickness much less sympathy and assistance is accorded them; rather, they meet with social disapproval. Here again, HIV/AIDS infection, especially in adults, is illustrative of the sorts of condition for which the social group charges responsibility to the sufferer. The view widely held is that HIV/AIDS is the disease of 'the impure', affecting some culturally defined outgroups (Miles 1991).

Other factors shown by the literature which could bear influence on nurses' attitude includes the highly bureaucratic system in Nigeria's health care institutions, which ignores and fails to utilize the informal organisation. This demand to conform to bureaucratic regulation leads to ritualism, defensiveness and difficulties. But nurses do not believe that nursing care operates in a vacuum. They are apt to hold some strong opinions and be highly vocal. They view neither the supervisor nor the director of nurses as infallible. All this is not to say that today's nurses are unfeeling, lack dedication or are any less concerned with patient care than were their predecessors, nor have they lost respect for physicians and their awesome responsibilities. On the contrary, they want, and demand, participation and respect. In the rapidly changing health care patterns of today, however, the nurse finds herself in a precarious, threatened and frustrating position.

Fear is another factor which can blur judgement and compromise the quality of nursing care. It is brought about by feelings of impending danger and could manifest itself in the form of anxiety (Baird and Bearslee 1990). Some nurse experience nightmares and increased anxiety levels while nursing HIV/AIDS patients, while others have been known to request for transfer or even leave the profession. Armstrong-Esther and Hewitt (1990) found the level of fear among nurses was surprisingly high, and the desire to identify and isolate HIV/AIDS patients in clinical and social settings disturbingly high. In a related work by Akinsanya and Rouse (1992), 33 percent of hospital staff thought that nurses and doctors caring for HIV/AIDS patients would run the risk of infection. In their sample of hospital and community nurses, Melby *et al.* (1992) found the former group more fearful of nursing HIV/AIDS patients and thus more liable to refuse to care despite the availability of appropriate equipment.

The United States Centers for Diseases Control (1987) reported twelve health care workers to be HIV positive after work-related exposure to infected blood. Also, in a disturbing report in the *Nursing Times*, a nurse infected with HIV was indirectly forced to resign by constantly being given sick leave when he felt he was fit enough to work. When allowed to work, he was effectively reduced to washing bedpans and changing bedsheets. The hospital authority made sure the news about his diagnosis spread around the hospital, even circulating at a student party he attended (Carlisle 1993). Should

HIV/AIDS health workers be forced to keep a deadly secret for fear of their appointment being terminated? In this respect HIV/AIDS is dissimilar to many other serious diseases and its occurrence in the workplace raises questions which go beyond those posed by other illnesses.

Nurses may be knowledgeable about HIV/AIDS, but they still exhibit inappropriate behaviour and reluctance to undertake essential nursing duties. Nigerian nurses are yet to be trained on how to handle HIV/AIDS patients. Unlike in other nursing fields, there are no HIV/AIDS specialist nurses. The practicing nurses are not willing to take the risk, more so when the basic materials they need are not provided by the hospitals despite the grim reality that HIV/AIDS patients are growing at a perplexing rate (Sowunmi and Ikhemuembe 1996). Nurses should have the right to protection during the course of their professional duties, together with the right to a working environment minimizing work-related infection. Facilities, equipment and supplies must be made available (Abiteboul *et al.* 1992). Nurses should have the right to express their concerns and fears regarding AIDS (Melby *et al.* 1992). There is also the need to have the legal right to complain about potentially unsafe working conditions (Kazanowski 1992).

Nursing is a dynamic process of action, coordination and interaction between the nurse and patients such that the basic needs of daily living and the ability to cope with health and illness at a particular point in life is enhanced (Laoye 1988). Nurses' friendliness, demonstrable empathy and understanding of the patient as a unique individual have been found to be conducive in the therapeutic relationship. Positive encouragement and reassurance is of great value to the patient since many HIV/AIDS patients see their diagnosis as a death sentence (Beedham and Wilson-Barnett 1995). It gives them some kind of hope, which is a factor in maintaining and regaining health and accepting illness limitations and even death. Hope is present in all stages of life including dying (Stephenson 1991). Nurses should therefore accept HIV/AIDS patients for what they are and not attribute characteristics to them based on their illness or its source because the majority of HIV/AIDS patients are usually abandoned by family and friends, with the patient often left to rely on the nurse for care and support.

### **Methodology**

The theoretical framework used in this study is based on the theory of interpersonal relationships by Peplau and Festinger's theories of cognitive dissonance. Peplau (1988) described nursing as a therapeutic interpersonal relationship which facilitates the growth and development of both patient and nurse. The nurse-patient relationship is the essential tool with which to heal, as vital as applying mechanical techniques or other procedure. Nurse-patient interactions are geared towards "helping a patient gain intellectual and interpersonal

competences beyond that which they have at the point they became ill and to nurture the evolving competencies" (Peplau 1988). Long-term involvement with HIV/AIDS patients affords the nurse an opportunity to elaborate this therapeutic relationship in a unique way and to recognise that it is a partnership in which both learn and grow.

Festinger (1957), on the other hand, assumed that attitude exists in an organised psychological structure and that in maintaining this structure individuals avoid dissonance and seek consonance among attitudes relevant to each other. A dissonant relationship exists between two attitudes or cognitive elements which one implies the opposite of the other. Festinger said that one way for attitude change to occur is through cognitive dissonance. This means that the individual has feelings of discomfort because he or she has two opposing views about the same thing. This is "generated by conflicts among a person's beliefs or by inconsistencies between a person's action (behaviour) and attitude" (Baron and Bryne 1991). The individual can reduce or resolve this tension to match the behaviour or discount the importance of the dissonance. The latter is usually done by rationalising either the belief, the behaviour or the feeling.

A study was carried out at the University College Hospital, Ibadan, Nigeria. 200 male and female nurses were selected, within all the nursing ranks, and between the ages of 20 to 60 years. 200 questionnaires were distributed, which consisted of two parts: the first sought demographic data, while the second sought the nurses' attitude towards caring for HIV/AIDS patients. 193 were completed (96.5 percent response rate). Each nurse administered a copy of the questionnaire was asked to fill it in private. To ensure their anonymity, respondents were instructed not to write their names, wards and addresses. Analysis of the data was done using percentages, means, analysis of variance and standard deviation.

## Findings

The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities which contribute to health, to recovery, or to peaceful death, that would be performed by the patient if the patient had the necessary strength, will or knowledge, and to do this in such a way as to help him gain independence as rapidly as possible.

This study therefore finds out what the attitude of nurses in a leading Nigerian hospital will be towards caring for an increasing tide of HIV/AIDS patients, even though these patients are normally thrown out of hospital on diagnosis. 193 responses of nurses were analysed, comprising of 150 females and 43 males. 68 fell within the age range 20-30, 92 within the 31-40 age range and 33 within 41-50. 67 nurses were single, 123 were married and 3 widowed or divorced. As regards years of nursing experience, 58 nurses had up to 5 years, 57 had 6 to 10 years worth and 78 had been health professionals for over 11 years.

All of the nurses had heard of HIV/AIDS. Information on this topic comes to nurses mostly in the form of medical journals and personnel (47.7 and 70.5 percent respectively [more than one answer allowed]), as well as through the media (53.9 percent) and conferences (25.4 percent). The nurses were also found to be highly knowledgeable about HIV/AIDS-related issues, picking out sexual intercourse, shared needles and transfusion from casual contact, toilet seats and towels as modes of spread. As regards the correct measures when dealing with HIV/AIDS patients, nurses cited gloves (92.2 percent), washing hands (83.9 percent), isolation (78.8 percent), decontamination (73.1 percent), barrier nursing (71.5 percent) and masks (35.2 percent). This is in contrast with a number of admittedly earlier investigations on AIDS-related knowledge, such as that found among Canadian nurses who were ill-informed and had over-cautious attitudes to AIDS patients (Armstrong-Esther and Hewitt 1990). Bond *et al.* (1990) then associated this lack of knowledge to the anxiety, uncertainty and fear experienced by nurses on the topic generally.

One interesting aspect of this study is that even with the high level of knowledge, virtually everyone sampled still believed nurses should be given more information on AIDS. To support this finding, Bond *et al.* (1990) also found that 70 percent of their nurses sampled felt that nurses should receive specialist training in order to safely carry out the nursing care of HIV/AIDS patients. Steele and Melby (1995) state that most nurses, regardless of where they work, gain knowledge of AIDS by reading nursing journals, watching television, listening to radio and reading newspapers and magazines. More than 60 percent of their sample also indicated that they felt insufficiently trained to care for HIV/AIDS patients. This creates an element of mistrust and fear prevails amongst nurse.

In relation to exposure to infected cases, 61.1 percent of nurses sampled claimed that they had been exposed to HIV/AIDS cases in the hospital, 8.8 percent in the clinic and 1 percent in the community at large. The majority (73.1 percent) of those exposed in the hospital claimed that it was without their knowledge. This they blame on University College Hospital's doctors and administrators who somehow felt entitled to the right to admit HIV/AIDS patients without informing the nurses who provide the care. This practice was stopped in 1995 after the nurses threatened to go on strike if the practice was not discontinued. In this respect, one then wonders why UCH was made an AIDS Screening Centre with the aim of identifying and checking the spread of the disease when in actual fact it is negligent in spreading the disease to its staff who are occupationally in contact with these and other patients.

A further finding of the study showed that 70.5 percent of nurses sampled believed that University College Hospital was not equipped to manage HIV/AIDS cases in terms of materials (even water shortages), resources and skills. This is similar to Plant and Foster's (1993) study in which the overall pattern of response indicated that the highest level of concern was related to the perceived lack of in-service training, the availability of resources to treat infected patients, the issue of keeping

up with current trends and developments, and the lack of experience in dealing with HIV/AIDS patients.

On the issue of providing care, over half (52.3 percent) of nurses claimed that they have actually nursed HIV/AIDS patients. Of these, 26.4 percent said their reaction was one of fear, followed by anxiety (52.4 percent) and skepticism (6.7 percent), while 7 percent managed to stay neutral and 6.7 percent remained calm. Reasons for this skewed response reaction include lack of proper equipment (60.1 percent), fear (15.5 percent), ethical considerations (13 percent), and the fact that they were trying to care for patients with an incurable disease (11.4 percent). Only tuberculosis epidemics in the past has ever resulted in such an equivalent public hysteria as HIV/AIDS has today (Breault and Polifroni 1992). As regards Nigerian nurses' attitude to HIV/AIDS, the sample divided into 62.7 percent neutral, 20.7 percent positive and 16.6 percent negative. This finding is in marked contrast to most other studies that have tended to show health care workers in a rather poor light, discriminating in their treatment of HIV/AIDS patients.

The study also found that a majority (54.9 percent) of nurses would willingly care for HIV/AIDS patients if their work could be carried out in a well-equipped hospital setting. An overwhelming majority, 82.4 percent, agreed that such patients should not be left to die alone just because there is no cure. Over two-thirds (68.4 percent) of nurses in this study felt that HIV/AIDS patients should not be apportioned blame for being infected and a similar total, 64.8 percent, showed willingness to make cash donations to AIDS funds. These findings contradict the findings of Wellings and Wadsworth (1990) who reported that 53 percent of their sample agreed with the statement that "AIDS sufferers have only themselves to blame". Kelly *et al.* (1987) used a simulation measurement technique to conduct an experimental study of the relationship between patients' medical diagnosis, sexual orientation and nurses' attitude towards patients. They found that an HIV/AIDS medical diagnosis and a homosexual orientation in a patient elicited negative judgemental attitudes. In the nurses' majority view, they considered HIV/AIDS patients to be responsible for their illness and so deserving of their dire health condition.

Finally, using the analysis of variance test, no significant relationship was found between the age of the nurse and the attitude portrayed. The data on the relationship between the knowledge of HIV/AIDS and the nurses' attitude to HIV/AIDS was not significant. No significant difference was also found in the attitude of the nurses exposed to HIV/AIDS and the nurses not exposed.

AIDS is spreading rapidly in Nigeria. Yet nurses are providing care for HIV/AIDS patients with inadequate protection in terms of education and physical hospital equipment. The health workers are scared of this condition; they can only feel comfortable when they are assured of their own protection. Nurses are not scared of caring for HIV/AIDS patients, but for their own safety and the implications of being infected. Such fears can only be countered with an adequately resourced nursing staff, with adequate support staff to help clean the

wards, fully equipped with gloves and anti-bacterial handwash, free access to running water, laundries, autoclaves, incinerators and other safe methods of cleaning or disposing of infected material. In relation to the attitudes displayed by Nigerian nurses, they differ little from contemporaries in others parts of the world. What has to be appreciated, however, is that the nursing of HIV/AIDS patients is a developing field of standards and procedures; this continuum of universal improvement means that some groups of nurses are further down the line towards appropriate measures in terms of practice, equipment and attitude than others. In this regard, Nigerian nurses, while lagging behind in material considerations, do possess qualities which lend themselves to caring for HIV/AIDS patients.

### **Recommendations**

1. A law should be enacted and properly enforced for the proper screening of donated blood before transfusion.

2. Hospital management must reconsider the implications of dismissing or forcing HIV/AIDS health workers to resign from their jobs, especially when infection is work-related.

3. The recognition and full utilization of professional nursing skills by administrative and governmental bodies is required. Nurses should participate in planning and policy-making at all levels in the health service by establishing interdisciplinary teams to coordinate the educational and supportive responsibilities for providing high-quality care to HIV/AIDS patients. These teams will formulate, plan and implement inservice training for all ranks of nurses, as suggested MacNeil (1992).

4. All nurses caring for HIV/AIDS patients should be given incentives to motivate them. A large number of nurses in Nigeria are leaving nursing for jobs with higher salaries, less stress and more respect in other fields.

5. Both public and private agencies should be encouraged to establish support groups for HIV/AIDS patients. Evidence suggests that social support can act as a buffer against stress, cushioning its impact. It also has a direct, positive effect on psychological well-being (House *et al.* 1982).

6. Since the fear of HIV/AIDS is associated with occupational hazards, it is important for health staff to make use of universally accepted precautionary measures (Centers for Disease Control 1987). Care of HIV/AIDS patients can be properly provided in hospitals. The practice of hospitals forcibly discharging HIV/AIDS patients is an affront to basic human rights and must cease. The Federal Government of Nigeria must provide the resources to treat all HIV/AIDS cases.

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Gladys EFFA-HEAP, *The attitude of nurses to HIV/AIDS patients in a Nigerian University Teaching Hospital*

*Summary* — There may be up to four million Nigerians with HIV/AIDS, but Nigeria has been slow to embark on caring for HIV/AIDS patients. The Nigerian Government has not sufficiently resourced this area of the Federal Health Service; this has implications for nurses caring for HIV/AIDS cases. Using the specific example of University College Hospital (UCH), Ibadan, the leading Teaching Hospital in the country, the paper examines the attitude of nurse caring for HIV/AIDS patients. 193 nurses were sampled with a questionnaire, and their answers analysed using percentages, means and analysis of variance. Results showed that the nurses were knowledgeable about HIV/AIDS. Nurses' attitude to HIV/AIDS patients divided into 62.7 percent neutral, 20.7 percent positive and 16.6 percent negative. Over 70 percent of nurses believed UCH was not equipped to manage HIV/AIDS patients. No significant relationships were found between attitude and either the nurses' age, the nurses' knowledge of HIV/AIDS, or the level of exposure to HIV/AIDS patients. With realistic remedies to produce more dignified treatment urgently required, recommendations for future government policies and health care practices are suggested.

*Keywords:* nurses • attitude • care • HIV/AIDS • patients • Nigeria.

Gladys EFFA-HEAP, *L'attitude des infirmières envers les patients malades du sida dans un Hôpital Universitaire du Nigeria*

*Résumé* — Il se peut qu'il y ait quelque quatre millions de Nigeriens porteurs du VIH/sida, mais le pays a été lent à s'engager dans la prise en charge des patients du VIH/sida. Le gouvernement nigerien n'a pas alloué de ressources suffisantes à ce champ d'intervention du Service Fédéral de la Santé. Cette situation a des implications pour les infirmières apportant les soins aux malades du sida. A partir de l'exemple spécifique du Centre Hospitalier Universitaire d'Ibadan, le principal Hôpital de Formation du pays, cette étude examine l'attitude des infirmières soignant les patients malades du VIH/sida. Un échantillon de 193 agents de santé a été retenu pour une enquête par questionnaire ; les réponses ont été analysées, en termes statistiques (pourcentages, variance). Les résultats ont montré que les infirmières étaient informées sur le VIH/sida. Leur attitude envers les malades du sida était divisée : 62,7% étaient neutres, 20,7% positives et 16,6% négatives. Plus de 70% parmi elles pensaient que le Centre Hospitalier Universitaire n'était pas équipé pour prendre en charge les malades du sida. Il n'y a pas eu de relations significatives entre leur attitude, leur âge, leur connaissance sur le VIH/sida ou le niveau d'exposition aux malades du VIH/sida. Avec des propositions réalistes pour promouvoir un traitement plus digne, qui est urgemment requis, des recommandations sont faites pour mettre en œuvre les politiques sanitaires futures et améliorer les pratiques de soins.

*Mots-clés :* infirmières • attitude • prise en charge • VIH/sida • malades • Nigeria.