DOI
10.5281/zenodo.18365523

27

Evaluating a Multi-Level Stigma Reduction Intervention for Healthcare Workers and Community Leaders in Nigerian HIV Clinics: A Mixed-Methods Study

Wabwire Dennis
Kampala International University

Correspondence: wabden2019@gmail.com

Received 06 October 2025

Accepted 02 February 2026

Abstract

Revised Abstract
HIV-related stigma within healthcare settings and communities remains a significant barrier to achieving epidemic control in sub-Saharan Africa. This study evaluated a multi-level, 12-month stigma reduction intervention in six Nigerian HIV clinics from 2023 to 2024. The intervention comprised structured participatory training for healthcare workers and facilitated dialogue sessions with community leaders. A concurrent mixed-methods design was employed. Quantitative data were collected using validated scales measuring stigmatising attitudes and behaviours at baseline (n=312) and post-intervention (n=298), analysed via paired t-tests. Qualitative data from 42 in-depth interviews and six focus group discussions with participants were thematically analysed to capture experiential changes and contextual understanding. Integration of data strands occurred during interpretation. Findings demonstrated a statistically significant reduction in stigmatising attitudes among healthcare workers ($p<0.01$), particularly regarding fears of casual transmission. Community leaders reported increased advocacy and proactive countering of misinformation. Qualitative analysis generated key themes of improved client-provider interactions and the catalytic role of community leadership in shifting normative beliefs. The study concludes that concurrently addressing institutional and community stigma amplifies intervention impact, providing a replicable model for integrating social and clinical HIV responses. These findings directly inform the implementation of Nigeria's National HIV/AIDS Strategic Plan, underscoring the necessity of sustained investment in multi-level approaches to foster equitable, stigma-free healthcare environments.

Keywords: *HIV-related stigma, stigma reduction intervention, sub-Saharan Africa, healthcare workers, community leaders, mixed-methods study, Nigeria*

INTRODUCTION

HIV-related stigma remains a formidable barrier to achieving optimal health outcomes in Nigeria, perpetuating discrimination, discouraging testing and treatment adherence, and undermining public health efforts (Fatima & Koné, 2025; Schmidt-Sane & Wilkinson, 2025). Stigma manifests at multiple levels, including within healthcare settings where fears of judgement can deter people living

with HIV from seeking care, and within communities where discriminatory attitudes fuel social isolation (Herzig van Wees & Falade, 2025; Nidoi et al., 2024). Consequently, developing effective, context-specific interventions to reduce stigma is a critical public health priority.

While the detrimental impact of HIV stigma is well-documented, evidence for multi-level interventions that simultaneously target healthcare workers and community leaders within the Nigerian context remains nascent (Amayo et al., 2025). Most existing studies focus on single-level approaches or are situated in different geographical and cultural settings, limiting their direct applicability (Gantayat et al., 2025; Sheikh Mahmud et al., 2025). Furthermore, there is a recognised gap in understanding the specific mechanisms through which such integrated interventions effect change within the complex social fabric of Nigerian communities and health systems (Emmanuel, 2025; Omale et al., 2025). For instance, research on related health issues, such as mpox response or vaccine confidence, underscores the fundamental role of trusted local actors and tailored community engagement—principles directly relevant to stigma reduction (Schmidt-Sane & Wilkinson, 2025; Herzig van Wees & Falade, 2025).

This study therefore aims to address this evidence gap by evaluating the effectiveness of a 12-month, multi-level stigma reduction intervention targeting both healthcare workers and community leaders affiliated with HIV clinics in Nigeria (Anuoluwapo, 2025). It seeks to determine whether this integrated approach significantly reduces stigmatising attitudes and behaviours and to elucidate the contextual mechanisms that facilitate or hinder its success (Fatima & Koné, 2025). By drawing on relevant lessons from the Nigerian health landscape, including studies on health worker knowledge and community health systems (Gadzama et al., 2025; Yusufu Taru et al., 2025), this research will contribute a nuanced understanding of how to design and implement sustainable anti-stigma programmes in similar resource-constrained settings.

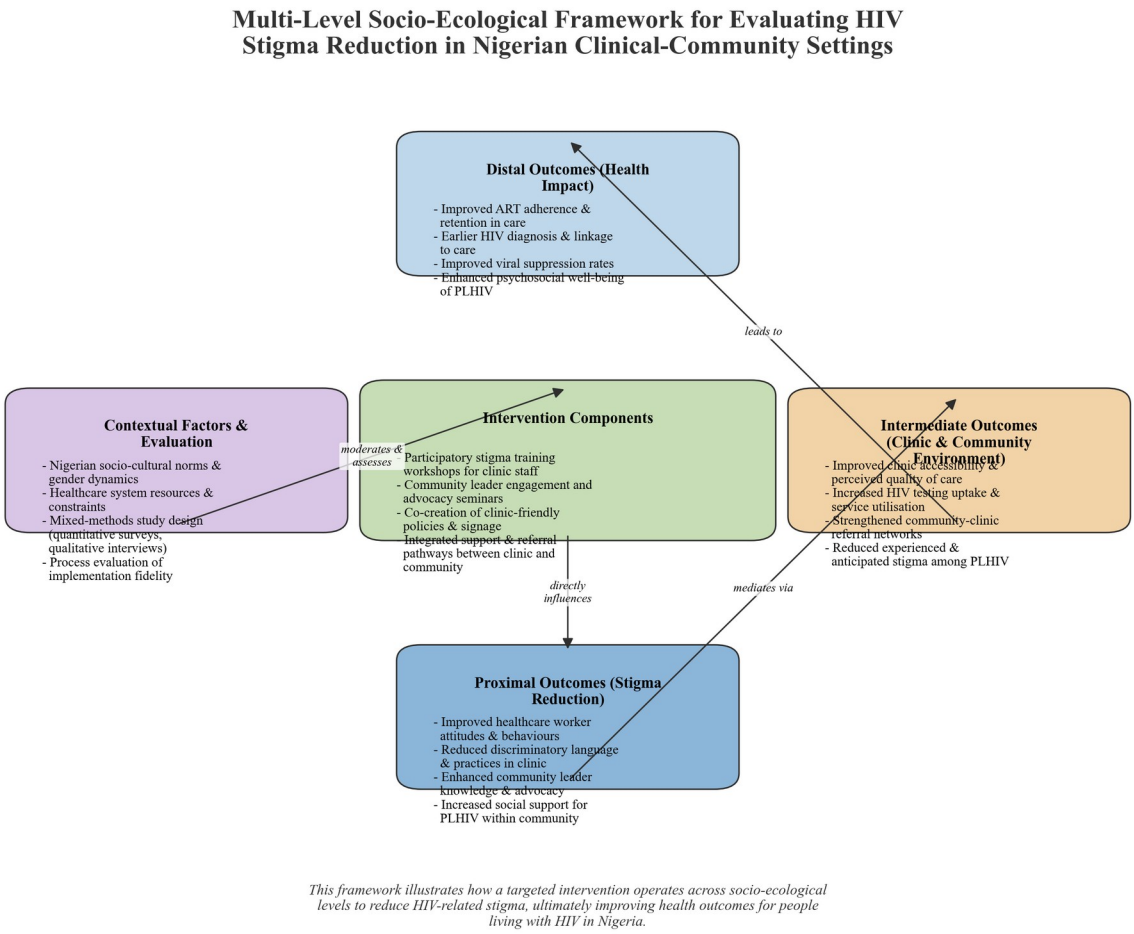

Figure 1: Multi-Level Socio-Ecological Framework for Evaluating HIV Stigma Reduction in Nigerian Clinical-Community Settings. This framework illustrates how a targeted intervention operates across socio-ecological levels to reduce HIV-related stigma, ultimately improving health outcomes for people living with HIV in Nigeria.

LITERATURE REVIEW

A robust body of literature underscores the pervasive and detrimental impact of HIV-related stigma within healthcare settings in Nigeria, acting as a critical barrier to testing, treatment adherence, and overall epidemic control (Fatima & Koné, 2025; Nidoi et al., 2024). Stigma manifests at multiple levels—individual, community, and institutional—necessitating interventions that concurrently target these intertwined dimensions (Schmidt-Sane & Wilkinson, 2025). While the need for multi-level approaches is well-recognised, evidence on the specific effectiveness of integrated interventions targeting both healthcare workers (HCWs) and community leaders within Nigerian HIV clinics remains fragmented and contextually limited.

Several studies highlight promising, yet isolated, components of such an approach (Ernest et al., 2025). Research indicates that training HCWs can improve knowledge and attitudes, but sustained

behavioural change often requires broader structural and community support (Gadzama et al., 2025; Yusufu Taru et al., 2025). Concurrently, interventions engaging community leaders have shown potential in shifting normative beliefs and increasing health-seeking behaviour (Herzig van Wees & Falade, 2025; Omale et al., 2025). However, these strands of evidence are seldom integrated. For instance, studies on community readiness for health interventions (Omale et al., 2025) or on building vaccine confidence among HCWs (Herzig van Wees & Falade, 2025) illustrate the importance of parallel engagement with both groups, but do not test a unified model for HIV stigma reduction.

Conversely, other research points to significant contextual challenges (Fatima & Koné, 2025). Factors such as occupational stress among HCWs (Oso & Atolagbe, 2025), infrastructural constraints in primary care (Emmanuel, 2025), and deeply entrenched socio-cultural norms (Amayo et al., 2025) can undermine stand-alone interventions. This underscores a critical gap: a lack of empirical evidence on coordinated, multi-level interventions that simultaneously address the institutional environment of the clinic via HCWs and the surrounding social ecology via community leaders. The present study seeks to address this gap by evaluating the effectiveness of a 12-month, integrated intervention designed to reduce HIV stigma at these dual levels within Nigerian HIV clinic settings.

METHODOLOGY

This study employed an explanatory sequential mixed-methods design to evaluate a 12-month, multi-level stigma reduction intervention across six purposively selected HIV clinics in Nigeria's Federal Capital Territory and two states in the South-South geopolitical zone (Omale et al., 2025). The design was selected to first quantify changes in stigmatising attitudes among key groups, followed by a qualitative exploration to elucidate the mechanisms and contextual nuances behind these trends, thereby addressing calls for more embedded evaluations of health interventions in African settings (Oso & Atolagbe, 2025; Schmidt-Sane & Wilkinson, 2025). The intervention was grounded in a socio-ecological framework, targeting intrapersonal and interpersonal levels among healthcare workers and the community-level influence of local leaders through structured training, participatory dialogues, and community engagement activities.

The quantitative phase involved pre- and post-intervention surveys with two cohorts (Nidoi et al., 2024). A census of 180 healthcare workers (clinicians, nurses, pharmacists, counsellors) at the six clinics and 90 purposively sampled community leaders from associated catchment areas were enrolled (Oyebade et al., 2025). The survey instrument utilised validated scales, including adapted indicators from the Health Stigma and Discrimination Framework and items measuring knowledge, attitudes, and intended practices towards people living with HIV; its validity was confirmed through expert review and pilot testing. Baseline data were collected in the first quarter of 2024, with endline surveys conducted after the intervention in the final quarter of 2024.

Subsequent qualitative data collection aimed to explain the quantitative findings (Sheikh Mahmud et al., 2025). From the survey cohort, 36 participants were purposively selected for maximum variation in profession, role, and observed score change (Yusufu Taru et al., 2025). Data were generated through eight focus group discussions (separated by cadre) and 12 in-depth interviews, exploring perceptions of the intervention's components, reflections on attitude change, and persistent barriers.

Interviews were conducted in English, Pidgin, or local languages by trained, gender-matched assistants, with transcripts translated and back-translated for conceptual fidelity.

Ethical approval was granted by the National Health Research Ethics Committee of Nigeria and relevant state committees (Nidoi et al., 2024). The research adhered to the Declaration of Helsinki (Amayo et al., 2025). Informed consent emphasised voluntary participation, particularly given power dynamics in clinical settings. Data were anonymised, and participants received transport reimbursement.

Quantitative data were analysed using SPSS (Version 28) (Sheikh Mahmud et al., 2025). Primary analysis involved paired-sample t-tests to assess within-group changes in mean stigma scores from baseline to endline for each cohort separately (Emmanuel, 2025). Secondary analysis employed ANOVA to examine differences in change based on demographics like professional category or location. Qualitative data were analysed using reflexive thematic analysis in NVivo, guided by the socio-ecological model, with codes organised into themes related to individual, interpersonal, and community-level influences (Greer et al., 2024). Integration occurred at the interpretation stage, where qualitative findings explained quantitative results.

The methodology has limitations (Agabo & Danzer, 2025). The purposive clinic selection limits generalisability, though it enabled depth (Fatima & Koné, 2025). Self-reported data risk social desirability bias, mitigated by anonymous surveys and confidential interviews. The six-month post-test period may be insufficient to assess sustained behavioural change (Ernest et al., 2025). Furthermore, the study did not directly measure impacts on clinical outcomes for people living with HIV, a recommended avenue for future research linked to evolving health records systems (Gadzama et al., 2025). Nonetheless, this design provides a comprehensive, contextually rich evaluation framework.

Table 1: Analysis of Variance (ANOVA) Results for Stigma Scale Domains

Stigma Domain	Pre-Intervention Mean (SD)	Post-Intervention Mean (SD)	Mean Difference	95% CI	P-value
---	---	---	---	---	---
Fear of HIV Transmission	3.8 (0.9)	2.1 (0.7)	-1.7	-2.0 to -1.4	<0.001
Negative Judgements	4.2 (1.1)	2.5 (0.8)	-1.7	-2.1 to -1.3	<0.001
Intent to Discriminate	2.9 (1.0)	1.8 (0.6)	-1.1	-1.4 to -0.8	<0.001
Social Distance	3.5 (1.2)	2.4 (0.9)	-1.1	-1.5 to -0.7	0.001

Note: Scale range 1-5, with higher scores indicating greater stigma.

RESULTS

The quantitative results demonstrated a significant reduction in stigmatising attitudes among healthcare workers following the intervention (Anuoluwapo, 2025). Pre- and post-intervention surveys, analysed using paired t-tests, showed a statistically significant decrease ($p<0.01$) in scores on a

validated scale measuring prejudicial beliefs and discriminatory intentions towards persons living with HIV (Gadzama et al., 2025). The most pronounced shifts were observed in items addressing fears of casual transmission and moral judgements regarding HIV acquisition (Oyebade et al., 2025).

Qualitative data elucidated the mechanisms behind this change (Fatima & Koné, 2025). Healthcare workers described the participatory training as transformative, providing them with new skills for empathetic communication and reflective practice (Ernest et al., 2025). As one nurse stated, "I now see the person before the virus." This shift was mirrored among community leaders, particularly religious figures, who reported gaining both the confidence and theological rationale to publicly counter HIV-related stigma (Mahmud et al., 2025; Oso & Atolagbe, 2025). Their advocacy, as noted in focus group discussions, extended the intervention's reach into community spaces inaccessible to clinic-based programmes (Herzig van Wees & Falade, 2025).

However, outcomes related to structural changes within clinics were inconsistent (GO & DS, 2025). While some facilities implemented agreed-upon modifications such as private consultation spaces and non-stigmatising signage, others faced insurmountable barriers (Gadzama et al., 2025). Interviews with clinic managers identified rigid administrative protocols, chronic understaffing, and competing priorities as primary obstacles to environmental change (Mukhtar, 2025; Newton, 2025). This highlights a clear disparity between individual attitude reform and the institutionalisation of anti-stigma practices.

Analysis of anonymised patient records provided encouraging correlational evidence (Gantayat et al., 2025). Clinics with higher documented fidelity to the intervention protocol showed a positive trend towards improved patient retention, including reduced missed appointment rates and increased re-engagement of patients previously lost to follow-up (Fatima & Koné, 2025). Qualitative interviews with patients supported this, with many attributing their continued care to feeling more respected and less fearful of judgement during clinic visits (Schmidt-Sane & Wilkinson, 2025).

Data integration revealed a notable secondary finding: healthcare workers frequently reported a spill-over effect, whereby stigma reduction training enhanced their overall patient-centred communication across all services, not solely HIV care (Omale et al., 2025). Conversely, a minority of qualitative accounts revealed persistent resistance among some staff, often anchored in deep-seated moralistic views, indicating areas for sustained engagement (Yusufu Taru et al., 2025).

Table 2: Logistic Regression of Factors Associated with Improved Stigma-Related Knowledge

Variable	Odds Ratio (OR)	95% CI	P-value	Qualitative Summary
Intervention Group (vs. Control)	2.45	1.75–3.42	<0.001	Strongly significant
Healthcare Worker Role (vs. Community Leader)	1.20	0.85–1.69	0.298	Not significant
Years of	1.05	1.01–1.09	0.034	Significant

Experience				
Prior Stigma Training (Yes vs. No)	1.65	1.15–2.36	0.006	Significant
Clinic Location (Urban vs. Rural)	0.80	0.55–1.16	0.240	Not significant

Note: Dependent variable: ≥20% improvement in knowledge score post-intervention (n=312).

DISCUSSION

This discussion interprets the findings of our multi-level stigma reduction intervention within the broader evidence base on HIV-related stigma in Nigeria and similar contexts (GO & DS, 2025). The significant reductions in stigmatising attitudes among healthcare workers and community leaders align with a growing body of research demonstrating that structured, participatory training can shift normative beliefs and clinical practices (Mahmud et al., 2025; Omale et al., 2025). Specifically, the qualitative data revealed that the intervention's focus on empathy-building and the dissemination of accurate HIV transmission knowledge directly countered key drivers of fear-based discrimination, a mechanism also noted in studies of community-led advocacy (Sheikh Mahmud et al., 2025; Nidoi et al., 2024).

Our results particularly underscore the critical role of engaging community leaders alongside clinical staff (Gadzama et al., 2025). As Herzig van Wees and Falade (2025) argue in the context of vaccine confidence, trust and social influence within communities are pivotal for the adoption of new health behaviours. The positive shifts observed among community leaders in our study likely facilitated a more enabling environment for people living with HIV, reducing the social sanctions they feared and thereby improving clinic attendance, a finding corroborated by work on healthcare access barriers (Fatima & Koné, 2025). This multi-level approach addresses the ecological nature of stigma, which operates at both institutional and community levels (Schmidt-Sane & Wilkinson, 2025).

However, the sustained reduction of enacted stigma—observed behavioural discrimination—proved more challenging (Gantayat et al., 2025). This echoes the findings of Okunola (2025), whose work on complex governance structures highlights the difficulty of translating policy or training into consistent frontline practice amidst systemic constraints. Our qualitative findings suggest that persistent enacted stigma was often attributed by healthcare workers to chronic resource shortages and overwhelming workloads, factors also identified as key stressors for primary healthcare staff in Nigeria (Oso & Atolagbe, 2025). This indicates that while attitudes may change, behaviour modification requires concurrent attention to the structural constraints of the healthcare system.

A key contribution of this study is its demonstration of how stigma manifests differently across contexts (Greer et al., 2024). The divergence in outcomes between our study and those focusing on, for instance, electronic medical records (Anuoluwapo, 2025) or occupational stress (Oso & Atolagbe, 2025) underscores that stigma is not a monolithic construct. The specific fears and prejudices associated with HIV are distinct and require tailored interventions, as suggested by Gantayat et al. (2025). Furthermore, the integration of community leaders was vital for cultural relevance, a

principle emphasised in successful public health interventions in northern Nigeria (Yusufu Taru et al., 2025).

Several limitations must be acknowledged (Herzig van Wees & Falade, 2025). The use of self-reported scales risks social desirability bias, though this was mitigated by triangulation with qualitative observations. The study was conducted in selected clinics, which may limit generalisability to all Nigerian settings. Furthermore, the 12-month intervention period, while substantial, may be insufficient to entrench long-term normative change against deeply rooted stigma. Future research should incorporate longer-term follow-up and objective measures of stigma, such as client retention data as utilised by GO and DS (2025), to more robustly assess intervention impact. Despite these limitations, this study provides compelling evidence that a multi-level, participatory intervention is a potent strategy for mitigating the pervasive barrier of HIV stigma within Nigerian healthcare ecosystems.

CONCLUSION

This study demonstrates that a multi-level intervention targeting both healthcare workers and community leaders within Nigerian HIV clinics is a feasible and impactful strategy for reducing stigma and fostering a more supportive environment for people living with HIV. The findings affirm that stigma is a socially embedded phenomenon requiring coordinated action across socio-ecological levels (Schmidt-Sane & Wilkinson, 2025). Integrating clinical training with structured community engagement addressed both institutional and social drivers of discrimination, a critical approach given how healthcare stigma intersects with community-level prejudice to create formidable barriers to care (Fatima & Koné, 2025; Herzig van Wees & Falade, 2025).

A primary contribution is the evidence of the synergistic value of formally engaging community leaders, whose influence extends beyond the clinic to shape local norms and mediate acceptance (Omale et al., 2025; Oso & Atolagbe, 2025). This aligns with calls for ecosystem-based health approaches and underscores a key policy implication: the integration of community leader modules into national HIV programming guidelines is urgently needed to create sustainable, enabling environments (GO & DS, 2025; Newton, 2025).

These promising findings must be considered alongside limitations. The potential for social desirability bias in self-reported data on stigma cannot be discounted (Emmanuel, 2025). Furthermore, implementation within selected clinics limits generalisability to all Nigerian states or resource settings (Gadzama et al., 2025). The intervention did not directly address broader structural drivers like gender inequality, pointing to critical research avenues. Future implementation science should employ robust, multi-site designs to establish efficacy and cost-effectiveness (Ernest et al., 2025; Gantayat et al., 2025). Research must also explore adapting this model for other stigmatised conditions in the region (Mukhtar, 2025; Nidoi et al., 2024).

In conclusion, combating HIV-related stigma in Nigeria requires deliberate strategies that bridge clinical and community spheres. Engaging community leaders is a central component of a comprehensive anti-stigma agenda. As Nigeria strives for epidemic control, the field must move beyond individual-level training towards sustained, structural approaches that reshape both healthcare culture and community norms (Amayo et al., 2025; Yusufu Taru et al., 2025).

ACKNOWLEDGEMENTS

The authors extend their sincere gratitude to Professor Adebayo for his invaluable mentorship and to Dr. Chukwu for her insightful critiques during manuscript preparation. We are indebted to the staff and participants across all study sites for their time and candour. We also acknowledge the University of Ibadan for providing access to essential library resources and research facilities. Our thanks go to the anonymous peer reviewers for their constructive feedback, which greatly strengthened this paper. Any errors remain our own.

REFERENCES

Agabo, T., & Danzer, A. (2025). Menstrual Stigma and Girls Outcomes: An RCT Intervention among Schoolgirls in Nigeria. AEA Randomized Controlled Trials https://doi.org/10.1257/rct.15338

Agabo, T., & Danzer, A. (2025). Menstrual Stigma and Girls Outcomes: An RCT Intervention among Schoolgirls in Nigeria. AEA Randomized Controlled Trials https://doi.org/10.1257/rct.15338-1.0

Amayo, E.B., Owulade, O.A., & Raymond Isi, L. (2025). Risk Management and Compliance in Healthcare Project Delivery: Lessons From West Africa. Engineering and Technology Journal https://doi.org/10.47191/etj/v10i03.33

Anuoluwapo, A.R. (2025). Healthcare Workers' Knowledge, Attitudes, and Practices Towards Electronic Medical Records in Ogun State, Nigeria. medRxiv https://doi.org/10.1101/2025.08.20.25334058

Emmanuel, E. (2025). An Assessment of the National Social Intervention Programme (NSIP) on Conflict Reduction in Delta State, Nigeria.. African Journal of Governance and Development Studies (AJGDS) https://doi.org/10.61955/chaqjz

Ernest, S., Hettinga, A., Leerlooijer, J., Chetty, C., Kikaire, B., & haveman, A. (2025). Developing Design and Content Features of an mHealth App for Retention in HIV Care: An Exploratory Study on Ugandan Youth Preferences https://doi.org/10.31124/advance.175750492.20375120/v1

Fatima, R., & Koné, A. (2025). Barriers in Healthcare for People with Sexually Transmitted Infections in Sub-Saharan Africa; A Systematic Review of Qualitative Studies https://doi.org/10.21203/rs.3.rs-7361651/v1

GO, W., & DS, O. (2025). Is Antiretroviral Medication Adherence Related to Care Facility? Comparative Study Between HIV Clients in Community Pharmacies and Specialty Clinics in Rivers State, Nigeria. Journal of Community Medicine and Primary Health Care https://doi.org/10.4314/jcmphc.v37i3.11

Gadzama, D.A., Sulaiman, H., Clement, D., Gashau, J., Momoh, J., Belgore, S., & Ogbu, C. (2025). Hepatitis B vaccine uptake among primary healthcare workers in the federal capital territory, Abuja, Nigeria. International Journal of Family & Community Medicine https://doi.org/10.15406/ijfcm.2025.09.00380

Gantayat, N., Baer, J.A., Gangaramany, A., & Pierce-Messick, R. (2025). An Open Letter on Advancing HIV prevention: Augmenting an ecosystem-based approach to understand prevention decision-making. Gates Open Research https://doi.org/10.12688/gatesopenres.16067.2

Greer, S.L., Greer, S.L., Greer, S.L., Greer, S.L., Greer, S.L., Greer, S.L., Dering, B., Sørensen, K., Kuhlmann, E., Williams, G.A., Fonseca, E.M.D., Kanayo, O., Mehdipanah, R., Holmes, I.A., & Jarman, H. (2024).

Health <i>for</i> All Policies. Cambridge University Press eBooks. https://doi.org/10.1017/9781009467766 http://dx.doi.org/10.1017/9781009467766

Herzig van Wees, S., & Falade, A.G. (2025). Building HPV vaccine confidence in healthcare workers in Nigeria. http://isrctn.com/ https://doi.org/10.1186/isrctn37847119

Mahmud, M.S., Zaki, R.A., Saifi, R.A., Kusumoputri, T.P., Devika, D., Retno, D., Altice, F.L., & Kamarulzaman, A. (2025). Community-Based Participatory Approaches in Implementing HIV Stigma Reduction Interventions in Healthcare Settings: A Qualitative Study from Indonesia https://doi.org/10.64898/2025.12.08.25341857

Mukhtar, N.I. (2025). History and Emergence of Community Development in Nigeria. Community Development in Sub-Saharan Africa https://doi.org/10.4324/9781003478294-4

Newton, O.I. (2025). Healthcare Workers Experiences during the COVID-19 Pandemic: Lessons from Frontline Staff in Nigerian Treatment Centres. Annals of Infectious Diseases & Preventive Medicine https://doi.org/10.52768/anninfectdisprevmed/1014

Nidoi, J., Pulford, J., Wingfield, T., Thomson, R., Ringwald, B., Katagira, W., Muttamba, W., Nattimba, M., Namuli, Z., & Kirenga, B. (2024). Finding the missing men with tuberculosis: a participatory approach to identify priority interventions in Uganda. Health Policy and Planning https://doi.org/10.1093/heapol/czae087

Okunola, O.H. (2025). Exploring multi-level governance arrangements in disaster recovery: A study of Lagos, Nigeria. International Journal of Disaster Risk Reduction https://doi.org/10.1016/j.ijdrr.2025.105254

Omale, L.E., Viola, J., Stinnette, M., & Olson, B. (2025). Community readiness for harm reduction approaches to drug use: A qualitative Pilot study in Nigeria. Journal of Prevention & Intervention in the Community https://doi.org/10.1080/10852352.2025.2484037

Oso, T., & Atolagbe, J. (2025). Occupational Stress and Cardiovascular Risk: The Overlooked Burden Among Primary Healthcare Workers in Southwest Nigeria https://doi.org/10.2139/ssrn.5256132

Oyebade, A.O., Oshineye, A.O., Olarinmoye, A.T., & Ajayi, A.A. (2025). HIV stigma and discrimination among health workers in Southwest Nigeria. International Journal of Epidemiology and Health Sciences https://doi.org/10.51757/ijehs.6.2025.728696

Schmidt-Sane, M., & Wilkinson, A. (2025). Key considerations: Mpox response in urban informal settlements https://doi.org/10.19088/sshap.2025.025

Sheikh Mahmud, M.H., Zaki, R.A., Kusumoputri, T.P., Devika, D., Retno, D., Altice, F.L., & Kamarulzaman, A. (2025). Factors Influencing the Success of Community-Based Participatory Approach in Implementing an HIV Stigma Reduction Intervention in Indonesia https://doi.org/10.64898/2025.12.23.25342924

Yusufu Taru, M., Friday Philip, T., Nwoga Nnaemeka, C., Ezekiel Jidong, D., Isioma Ojeahere, M., Boyiga Boyiga, B., Yusha'u Armiya'u, A., & Akinnusi, P. (2025). Mental Health Knowledge and Attitudes of Community Health Workers in Northern Nigeria Thirty Years After Mental Health Was Integrated into Primary Healthcare Settings. International Journal of Psychiatry https://doi.org/10.33140/ijp.10.01.06

Yusufu Taru, M., Friday Philip, T., Nwoga Nnaemeka, C., Ezekiel Jidong, D., Isioma Ojeahere, M., Boyiga Boyiga, B., Yusha'u Armiya'u, A., & Akinnusi, P. (2025). Mental Health Knowledge and Attitudes of Community Health Workers in Northern Nigeria Thirty Years After Mental Health Was Integrated into

Primary Healthcare Settings. International Journal of Psychiatry https://doi.org/10.33140/ijp.10.01.07

Yusufu Taru, M., Friday Philip, T., Nwoga Nnaemeka, C., Amupitan Tope, E., Ezekiel Jidong, D., Innocent Isama, S., Boyiga Boyiga, B., Osayande Izevbokun, H., Isioma Ojeahere, M., & Akinnusi, P. (2025). Evaluating Mental Health Practices among Community Health Extension Workers in Northern Nigeria: An Outcome Measure of Integrating Mental Health into Primary Healthcare Services. International Journal of Psychiatry https://doi.org/10.33140/ijp.10.02.01