

# The Behavior of Health Professionals in Dealing with People Living with HIV (Stigma and Discontinuation of Treatment) -A Case Study in Oran Town (Algeria)-

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## Abstract:

The stigmatization of people living with HIV AIDS has always been seen as a recurring issue. But coming from the health professionals of the care structures, this can be an obstacle for a good care. The stigmatization of PLHIV within health structures in Algeria raises several questions, namely: What care do people living with HIV / AIDS have? Are they treated like any other person in these departments? What are the consequences of this stigma on these people and on the continuity of care? To answer these questions, a qualitative survey was conducted by a multidisciplinary team at Oran University Hospital (CHU) between 2014 and 2015 through 25 semi-structured interviews and continuous observation with healthcare professionals, health and people living with HIV. The survey collected data on the behavior of health professionals towards PLWHIV and their effects on the care of these people. These data have shown the existence of behaviors of discrimination and stigmatization of certain health professionals. The care of these people is marked by a discontinuity of care following the behavior of professionals. We observed that women are most affected than men.

**Keywords:** Stigma; AIDS; PLWHIV; Algeria; Health professionals

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سلوك عمال الصحة اتجاه الأشخاص الذين يعيشون بفيروس الإيدز  
(الوصمة و عدم استمرارية العلاج) -مدينة وهران (الجزائر) نموذجاً -

الملخص:

لطالما اعتبر وصم الأشخاص المصابين بفيروس نقص المناعة البشرية المكتسب (الإيدز) مشكلة متكررة، ولكن عندما تكون من طرف عمال الصحة على مستوى مؤسسات العلاج، يمكن أن يكون عقبة أمام رعاية صحية جيدة. يطرح وصم

المصابين بفيروس نقص المناعة البشرية / الإيدز في المؤسسات الصحية في الجزائر عدة أسئلة، مثل: ما هي الرعاية الصحية التي يقدمونها للأشخاص المصابين بفيروس نقص المناعة البشرية / الإيدز؟ هل يعاملون مثل أي شخص آخر في هذه المصالح؟ ما هي عواقب هذه الوصمة على هؤلاء الأشخاص واستمرارية العلاج؟ للإجابة على هذه الأسئلة، أجري مسح نوعي من قبل فريق متعدد التخصصات على مستوى المستشفى الجامعي لوهران ما بين عامي 2014 و 2015، من خلال مقابلات شبه منظمة والمراقبة المستمرة مع المتخصصين في الرعاية الصحية و الأشخاص المصابين بفيروس نقص المناعة البشرية / الإيدز. سمحت الدراسة الميدانية من جمع بيانات عن سلوك المهنيين الصحيين فيما يتعلق بالمصابين بفيروس نقص المناعة البشرية / الإيدز وتأثيره على رعاية هؤلاء الأشخاص. أظهرت هذه البيانات وجود سلوكيات تمييزية ووصمة من قبل بعض المهنيين الصحيين، والنساء هن الأكثر تضررا من الرجال. كما أن الرعاية الصحية لهؤلاء الأشخاص تتحيز بعدم استمرارية العلاج نتيجة لسلوكيات المهنيين.

**الكلمات المفتاحية:** الوصمة - السيدا - فيروس نقص المناعة البشرية - الجزائر - عمال الصحة.

## **I- Introduction :**

Since the advent of HIV, discrimination and stigma in accessing health care for people living with HIV (PLWHIV) has become a reality. These people are regularly exposed to stigma and discrimination in different spheres of their lives. In health care, discrimination can manifest itself in different ways. It is located on a continuum between refusal of care, unfounded differential treatment and a simple lack of know-how on the part of the health professional.

The stigmatization of people living with HIV by different categories of the population has always been considered a recurring issue. But coming from health professionals in care structures, this can be an obstacle for good care. Stigma, discrimination and denial are said to take on significance comparable to that of the disease itself (Mann and WHO, 1987, p, 3).

In Algeria, as elsewhere, it is illegal to treat a person differently because of their HIV status. "The code of ethics"<sup>1</sup> indicates that a health professional cannot refuse to provide professional services to a patient for reasons related to the nature of his/her illness. So much so that the national strategic plan for the fight against HIV and sexually transmitted infections (STIs) 2010-2014 makes the fight against discrimination for equal rights, prevention and care one of these principles and the one of its priorities (MSPRH, 2015).

In the Algerian society, anything related to sexuality is a taboo issue (Bouhdiba, 1975, p. 130). This is why the PLWHIV is labeled as a person who has broken societal rules when it comes to sexuality. It is heavier when it comes to women. This fact is considered most often as a "disease of shame" "hchouma"<sup>2</sup> or "ayb"<sup>3</sup>. This helps to explain why the person living with HIV

<sup>1</sup> It is a set of rights and duties that govern a profession.

<sup>2</sup> It is an Arabic word of North African origin, with an axile meaning between shame and modesty.

<sup>3</sup> It means the must.

Our study is to understand precisely the types of relationships that health professionals make with people living with HIV. This is to show the place and status of the HIV-positive person in the social representations produced by the health staff. We have indeed observed a high mobility of HIV-positive patients who wander from one service to another, often in isolation and in the absence of any explanation provided by health professionals. The study attempts to shed light on the different social logics deployed by health professionals who are confronted daily with patients living with HIV. By social logics, we mean the way of doing and saying of the staff during interactions with people living with HIV. The heuristic value of our research lies in highlighting the notions of cooperation, distancing, conflict, stigma or empathy, which can be at the heart of the relationships forged between professionals and patients with HIV. By focusing on the socio professional discourses and practices of health personnel, it is important to describe and analyse the socio-health context which allows a better understanding of the challenges of care for people living with HIV who have come for medical consultation in hospitals. In other words, we try to highlight the daily issues at the heart of the interactions established by health professionals with people living with HIV / AIDS.

## **II-Literature Review:**

Therefore, it seems important to us to refer to the way in which the health staff builds their relationship with these patients who are often stigmatized in the strongest terms in society. Our research perspective is based on the work of sociologists of health. Indeed, Goffman (1975) clearly shows the discredit and social distance that operates with regard to the so-called mental patients hospitalized in an "asylum". It is also essential to draw on the pioneering research of Herzlich C. (1984) which shows that the meaning of evil is embedded in a biological and social order. In the Algerian society, the person living with HIV / AIDS is in fact the object of labelling and often negative interpretations which reinforce their guilt. According to Freidson (1970: 1984), doctors gradually gain a monopoly in the management of the disease, thereby excluding the social representations of patients, who are forced to comply with "the medical order" (Freidson, 1986).

In this research, we also refer to the studies carried out on the discrimination of AIDS by health professionals. The "Crips"<sup>5</sup> survey (France, 2007) showed that nearly one in two people said they had been discriminated because of their HIV status. One in four has given up on a consultation, medical examination or treatment, and about one in three denied their HIV status.

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<sup>4</sup> As it was expressed in the speech of our interviewees of our survey.

<sup>5</sup>. Regional Centers for Information and Prevention of AIDS and for Youth Health

Several types of discrimination were observed, such as refusal of treatment, derogatory remarks or attitudes, and even failure to respect medical confidentiality. Another survey revealed that 44% of people living with HIV have already been discriminated by a health professional (AIDS-Info-Service, 2009). The study "Index conducted in Great Britain in 2009" on Stigma showed that 47% of HIV-positive people surveyed suffered a violation of their rights during the year, and 17% were at hospitals were refused because of their HIV status and 31% did not have a constructive relationship with their caregivers (Mellouk, 2011, p.2).

In the Maghreb, a study carried out by the Association for the Fight against AIDS (ALCS) in Morocco between 2008 and 2009 revealed that discrimination in the healthcare sector remains the most important. 40% of HIV-positive people questioned were confronted with it at least once in their life (Mellouk, 2011, p. 4). Stigma leads to self-stigma (Ken Morrison, 2006, p. 147). This prevents the person from telling their HIV status and generally, it promotes denial. These are the main consequences for people living with HIV which include isolation, abandonment, loss of self-esteem and depression. Today, people living with HIV and receiving treatment are much less 'dangerous' to society than those who ignore their HIV status. They believe that they are HIV negative and stigmatize and discriminate HIV positive (Mellouk, 2011, p. 4).

### **III– Methods and Materials:**

In order to reach our objective, a survey was carried out by a multidisciplinary group<sup>6</sup>, at Oran University Hospital (CHU), specifically in three departments: Department of infectious diseases, obstetrics and gynecology between 2014-2015 . The study focused on different dimensions, such as the relationship between the staff and the patients, the representation of the disease, reception, and the way in which patients are placed in relation to other patients in the structure.

We favored the qualitative approach based on two techniques: the first is the semi-structured interview. 25 in-depth and repeated semi-structured interviews were carried out with health professionals of diverse status working in these three services (infectologist specialist, gynecologists, surgeons, pediatricians, resuscitators, midwife, nurse and 20 interviews with PLWHIV of both sexes aged 19 to 70 years. The second technique is the fine and detailed long-term observation of hospital services and interactions between health professionals and PLWHIV. These two techniques have enabled us to understand the discourse of professionals, health and the constraints experienced within the hospital structure by the health staff. It should be noted that the names of our interviewees are fictitious.

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<sup>6</sup> The multidisciplinary group is made up of three researchers: A demographer, a doctor in infectious diseases and a retired midwife trained in anthropological perspectives.

#### **IV- Results and discussion :**

The analysis of the 45 interviews carried out with PLWHIV and health professionals, allowed us to bring out several forms of stigma experienced by PLWHIV which can constitute a barrier to prevention, continuity of care and management of HIV.

##### **IV.1- Stigma in Health Services by Health Professionals:**

###### **IV.1.1- Discriminatory acts observed:**

Various discriminatory acts were observed in the three services investigated and particularly the non-specialized services (intensive care and gynecology). These acts consisted of the use of multiple gloves and single-use equipment specific to PLWHIV, the wearing of an operating mask in a non-surgical context, particularly by new staffs, and sometimes the isolation of the patient. These different acts can be explained by the lack of information on the modes of transmission of HIV and the fear of being infected. The taboo ideas surrounding this disease that gravitated among caregivers may also be at the origin of the following behaviors.

###### **IV.1.2- Refusal of treatment in healthcare structures:**

People living with HIV have been denied access to treatment in public or private health care facilities because of their HIV status. Healthcare professionals believe that it is better for these people to refer to another more experienced professional. Their department lacked the appropriate bed and equipment to support them. Denial of access to treatment is illegal according to health international since people living with HIV are not treated in the same way as other patients. These professionals continue to refuse to treat them and therefore stigmatize them despite of carrying universal precautionary measures and the state of scientific knowledge on HIV and its modes of transmission which are not lacking. However, a number of PLHIV express fear, and even discomfort regarding disclosure and their HIV status, confidentiality and the reactions of the health staff.

*"I have seen the dental surgeon several times despite the intervention of my attending physician; he does not want to treat me. So I saw another dentist, I told him like my GP advised me, that I had hepatitis B. He ended up treating me, so now every time I have a problem with health; I inform the doctors that I have hepatitis B. It is less humiliating and it is accepted"* (Malika, female, 38 years old).

People with HIV remember caregivers' refusal of treatment even when seen by other health care practitioners. They speak of it as violence, unexpected towards them. This deeply felt pain is difficult to ignore. The literature clearly shows that HIV contamination during healthcare is much lower compared to that of the hepatitis C virus and hepatitis B virus (0.3% against 3% and 30% respectively) (Bégué et al., 1997, p. 31). We realize that the hepatitis B virus is 100 times

more transmissible than HIV. But what has been observed is that practitioners find it difficult to accept patients with hepatitis viruses and categorically refuse PLWHIV.

#### IV.1.3- Disclosure of status and lack of confidentiality:

Confidentiality in the context of HIV remains a delicate character more than anywhere else as the disclosure of the secret of the serological status of the PLWHIV can be at the origin of agitation in the entourage and disruption of the medical and psychosocial care. This confidentiality is at the heart of the relationship of trust which is fundamental between the caregiver and the patient. It is not specific to HIV. It is a requirement of medical ethics. Sometimes some doctors reveal the diagnosis to the family while the patient is still careless.

Disclosure and confidentiality of HIV status are recurring themes in our survey of PLWHIV. The reasons given by people living with HIV are to explain the desire not to disclose their status of fear of the refusal of treatment, judgment and breach of confidentiality generally stemming from negative experiences in the past. This does not mean that PLWHIV are satisfied with their behavior. Conversely, the survey shows that this decision does not come without some discomfort and has an impact on access to care for an HIV-positive person. It can discourage them from going to the doctor and prevent them from accessing health care appropriate to their condition.

*"My whole family knew about what I had during my hospitalization except me. I found out when I left. The family took care of me but now I'm being avoided "(Nora, female, 27).*

Some PLWHIV evoke the weight of the indiscretion of the nursing staff. They retain traces of a trauma that continues to mark their relationships and the choice of their caregivers.

*"I needed dental treatment one day and I was seeing a dentist, I informed him of my illness, the latter informed his nurse who told my contacts about my HIV status. I had to quit my job, but this story still marks me and I drag it behind me whenever I go to see a healthcare professional. This trauma has never left me: I can't get past it. However, I have spoken about it to those around me" (Fatima, female, 27 years old).*

#### IV.1.4- Distinguished looks, attitudes and behavior

People living with HIV complain about their doctor's behavior. They observe the distance and the distance of the caregivers. This could disturb trust between patients and caregivers.

*"The gynecologist told me: I can't do anything for you, you have AIDS. You will be transferred to a colleague who is used to 'this'" (Fatiha, female, 37).*

*"When you say you are HIV positive, the behavior changes, for example my doctor never examined me. He takes my blood pressure, gives me a prescription, but no more"* (Mohammed, male, 42 years old).

Apart from specialized services for infectious diseases, the entry of HIV into the health care setting leaves more rooms for distant reactions and fear, often through ignorance or failure to include HIV on a file. This information therefore disrupts the relationship between the caregiver treated and acts on the latter as a permanent reminder of his or her difference. This arouses a feeling of rejection, even self-exclusion behaviors that are harmful to the therapeutic relationship.

*"I learned about my HIV status from the midwife who was to follow my pregnancy. Her reaction was not very favorable. She opened her eyes wide and asked me "is this contagious?" And then gently pushed me out the door "* (Hakima, female, 35).

Another case:

*"The hospital staff sometimes do more harm than good. when I prepare my coming here every month, my heart is heavy as if I am going to undergo a punishment, luckily my doctor is sensitive to my problem, I call him beforehand to find out if he will be present for a consultation and if the drugs are available given the repeated shortages, so as not to disturb me for nothing. I am well received by my doctor. Sometimes my doctor is on leave, it's a hassle, the wait is long, the consultation begins at 10 am and I feel touched in my dignity because there are doctors who do not consider you"* (Kamel, Male, 49).

#### IV.1.5- The exclusion of PLWHIV:

Among the results of discrimination in health care settings is the exclusion of PLWHIV and indiscretion, according to a 57-year-old PLWHIV:

*"I felt that everyone was afraid of me because of possible contamination. The people were "jafiaines"<sup>7</sup>. The nurse who was afraid of me and who lives near my mother. One day I met her mother, I want to say hello to her as usual. But when she saw me, she walked away not to say hello".*

Another 48-year-old PLWHIV:

*"I recovered from my illness with difficulty, now I accept it and live with it. One day I was at a wedding party, I was happy, very elegant. As I was dancing in my pretty outfit and jewelry, women*

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<sup>7</sup> Jafiaines: It is an Arabic word which means a hard, cold person without any feeling

*were looking at me and pointing fingers at me. I felt threatened, and suddenly I stopped. I realized afterwards that a girl at the party informed these women that I had AIDS. This girl was a medical student and was doing an internship in the department where I was treating myself”.*

If some patients experience their disease on antiretroviral treatment, they are discreet. Women hide behind clothing so as not to identify them. They link disease and sexuality.

*"I find the care offered to me acceptable but being afraid of the reaction of others I come in 'jilbab'<sup>8</sup> to hide. I go unnoticed, no one recognizes me". (Amira, female, 28 years old).*

These testimonies, which are lessons, show that discrimination can manifest itself in unjustified unequal treatment, but also in attitudes or indiscretions, the consequences of which, but also in giving rise to attitudes of indiscretion and self-exclusion behaviors.

#### **IV.1.6- A diverse perception of HIV AIDS:**

The perception of caregivers towards PLWHIV differs from one caregiver to another. It is from their perception that they build their relationship with these sick people. Some professionals think of AIDS as any other disease. Their perception is linked to the daily and permanent confrontation of PLWHIV in the exercise of their work. The distance separated these professionals from this disease. This is due to the image conveyed by the media. But with the increase in the proportion of HIV-positive patients, their proximity to the disease is accentuated. However, other professionals see it as a serious illness. Their perception is based on the critical vision of the first approaches deployed by the international community. According to them, the way the disease came to light, influenced people a lot. The way we look at this disease is strongly linked to the social values that condemn these people. The fact that it has been linked to people with homosexual behavior contributes to linking its mode of contamination to the sexual route (Diarra and Moumoune, 2008, p. 7). Indeed, sexuality in our society is a taboo issue and anyone with a sexual illness is someone who has transgressed the social and Muslim norms that govern society.

*"In our country, speak of AIDS has spoken of sexual relations prohibited by religion and society. It is linked to a haram act"<sup>9</sup> (Doctor, intensive care unit, 60 years old).*

This category of professionals distinguishes HIV / AIDS from other diseases. This could accentuate its spread, particularly with the low proportion of voluntary screening and the self-

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<sup>8</sup> Jilbab: This is an outfit that some Muslim women wear to hide all their bodies even their faces and the hands, nothing appears of the woman's body.

<sup>9</sup> Forbidden by religion.

The Behavior of Health Professionals in Dealing with People Living with HIV (Stigma and Discontinuation of Treatment) -A Case Study in Oran Town (Algeria)-  
righteousness of the nature of the disease by infected people (Diarra and Moumouni, 2008, p. 8).  
The fear of health professionals of being infected takes a back seat.

*"A health professional should not be afraid of AIDS. There are more serious diseases with a higher rate of contamination, I am quoting Hepatitis B" (Doctor, infectious department, 34 years old).*

#### **IV.1.7- Difficult behavior of PLWHA:**

Some healthcare professionals are often coerced into the behaviors of people living with HIV. They see that they are difficult and malicious. Let's listen to this nurse:

*"We had the case of a difficult; I can say even a naughty, patient who came to give birth. She threw those intimate Dirty towels on the floor. When the cleaning lady pointed out to her, she started screaming and screaming to the point where the head doctor came and penalized the cleaning lady in an attempt to calm the situation "* (Nurse, Gynecology Department, 43 years).

Some people living with HIV have sex with their partners but they hide their HIV status, which can put them at risk of infection.

In some situations, they show defensive reactions. Therefore, the health professionals are forced to use means to control them. They think that they do not accept their HIV status. They do everything to get their attention because they lack psychological support. Among other things, they complain about the workload, the lack of qualified staff, especially psychologists and social workers.

This behavior is said to be disingenuous on the part of the patient and is probably a defensive reaction to say I am there; do not forget me!

Sometimes healthcare professionals are forced to use restrictive methods to deal with difficult patients. According to them, this is due to the psychological non-preparation of the PLWHIV to accept their seropositivity which is in the majority of cases due to the workload and the absence or lack of support staff such as qualified psychologists and especially social workers whose role is crucial.

*"The care of patients is very difficult and demanding for caregivers because it is accompanied by a heavy emotional load, often due to the severity of the disease in young patients in general. The social worker, or the psychologist, can provide caregivers with support to overcome the psychological difficulties of care and support. The assistant puts herself at the service of PLWHIV / AIDS, their*

*parents and society. So with insufficient staff, you can imagine what inconvenience this can cause.*"(Doctor, Infectious Department, 56 years old).

#### **IV.1.8- Labeling of PLWHIV and specialized professionals:**

The answers of our interviewees show that the care of PLWHIV has become the main activity of the infectious department. This represents an institution that does not escape social judgment which classifies the individual outside the social norm, all of all labeling and stigma. Moreover, anyone regardless of their status comes to this service and is seen as a person with HIV / AIDS in the eyes of the public. So, PLWHIV and specialist professionals are subject to labeling and stigma.

*"You have AIDS. That's why you're here because here there are only AIDS patients"* (Relative of a PLWHIV).

While this labeling has negative effects on the therapeutic monitoring of patients, it also disrupts the mental state of health staff in the infectious department. This infectious disease doctor says:

*"I received a midwifery colleague who gave me a young woman with HIV to take care of her. The patient was hardly convinced to consult in our department. At the end of the consultation, I prescribed her a check-up and made an appointment for two days later. When she left my office, she came to whisper to me, can't you come see me at home Because I can't come to this place?. I tried to reassure her so that she would come and I even offered to give her my phone number so that she could avoid waiting in the service. In vain, after that day she is lost to follow-up."*(Doctor in infectious disease, infectious department, 56 years old).

Another case:

*"A PLWHIV told me that she disguises herself to enter our service. She comes with her elegant outfit from her wilaya, arriving at the station, she goes to the changing rooms where she changes with an ordinary outfit with a dark scarf and hides her face with a "laajar"<sup>10</sup>. She checks the service, returns to the station, puts on her elegant outfit again and goes home. She does not want anyone to know that she comes to this service"* (Nurse, infectious department, 28).

However, health professionals in the gynecology and intensive care units receive people living with HIV on an occasional basis. The interactions are almost distant. People living with HIV are therefore frequently exposed to professional refusal and lack of confidence.

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<sup>10</sup> A piece of cloth that a woman wraps around her head to cover her face.

Unlike the other services surveyed that are not specialized in HIV (resuscitation and gynecology-obstetrics), patients are seen occasionally. The staffs are not used to welcoming PLWHIV and therefore the refusal is frequent and the clumsiness towards the PLWHIV is numerous.

*"When we ask a surgeon, at the beginning he asks us for Para clinical examinations, then the opinion of the anesthesiologist, after other examinations, at the end tells us that he does not have the means of protection. . I got angry and carried away and I said what means, I am ready to provide them to you, he answers me that he does not have special gloves, there are no special gloves. It was only a pretext to avoid the patient"* (Chief physician, infectious department, 58 years old).

#### **IV.2- Self-stigmatization behaviors:**

Self-stigma is a major form of stigma (Ky-Zerbo et al., 2014, p.4). Almost all of the PLWHIV surveyed declared having experienced self-stigmatization that differs according to age, sex and social and professional category.

##### **IV.2.1- Isolation and the feeling of being useless:**

Our survey results show that people living with HIV isolate themselves because they do not accept the disease. Some flee their homes as soon as the disease is discovered by their family or friends. They feel like they are useless. Fear of death and the gaze of others are feelings that often accompany their minds, having negative effects on the continuity of care and therefore their state of health. Several suicide attempts have been observed among PLWHIV (one third of the respondents). The presence of a psychologist and social assistance when the diagnosis is announced is essential.

##### **IV.2.2- Rejection by family and friends:**

The rejection of PLWHIV by family and friends is a real and frequent occurrence in our society. It contributes to the worsening of the physical and psychological health of the person living with HIV. It develops in her feelings of self-underestimation, isolation and suicide. Rarely do PLWHIV escape the feeling of guilt. According to our study, men blame themselves more than women. This difference is linked to the fact that in Algeria a large number of women are infected by their husbands unlike men.

*"One day a patient was transferred from another wilaya, her condition was very serious, she received no visits. She sometimes pulled out her infusions as if she wanted to die. When she died, people contacted her parents, and her father replied I will not do anything, it is the hospital that must take care of her burial"* (Nurse, infectious department, 36 years old).

### **V- Conclusion:**

Despite the development of medical research on HIV over the past decades, PLWHIV still face stigma and discrimination in different spheres of their lives and particularly in healthcare settings. However, this situation is added to the care context where access to resources is moderately sufficient. Respect for the person, the right to care and confidentiality are often ignored. The majority of health professionals adhere to the sexual theory of AIDS. That is, they see sex as the main route of infection with HIV. This discriminatory situation constitutes a major obstacle to the care of PLWHIV.

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## Appendix :

### 1-Interviews with PLHIV:

Fictitious name	Sex	Age	Level of education	Marital status
MALIKA	Women	38	Secondary	Single
NORA	Women	27	University	Single
FATIMA	Women	27	Average	Single
FATIHA	Women	37	Secondary	Single
MOHAMED	Man	38	University	Married
HAKIMA	Women	35	University	Single
KAMEL	Man	49	Average	Divorced
JAMILA	Women	57	Secondary	Married
Nacera	Women	48	Secondary	Divorced
AMIRA	Women	28	University	Single
Saliha	Women	36	University	Single
Mohammed	Man	29	University	Single
Hocine	Man	37	Secondary	Single
Cherifa	Women	29	University	Single
Fatima zohra	Women	23	University	Single
Houaria	Women	45	Average	Divorced
Djoher	Women	49	Secondary	Divorced
Salim	Man	39	Secondary	Married
Sadek	Man	57	Average	Married

Baghdad	Man	52	Average	Married

## 2- Interviews with health professionals:

Illustration N°	Sex	Age	Service	Professional status
01	Women	28	Infectiology	Nurse
02	Man	58	Infectiology	Infectious disease doctor
03	Man	36	Infectiology	Male nurse
04	Man	34	Infectiology	Infectious disease doctor
05	Women	43	Gynecology	Nurse
06	Women	56	Infectiology	Infectious disease doctor
07	Women	60	intensive care	Resuscitator doctor
08	Women	29	intensive care	Resident doctor
09	Man	33	intensive care	Resuscitator doctor
10	Women	36	intensive care	Nurse
11	Women	37	intensive care	Resuscitator doctor
12	Women	42	Gynecology	midwife
13	Women	38	Gynecology	Nurse
14	Women	31	Gynecology	midwife
15	Man	29	Gynecology	Resident doctor
16	Women	28	Gynecology	Resident doctor
17	Man	34	Gynecology	Gynecologist Doctor
18	Women	45	Gynecology	Gynecologist Doctor

19	Man	44	Infectiology	Infectious disease doctor
20	Man	37	Gynecology	Gynecologist Doctor
21	Women	41	Gynecology	Gynecologist Doctor
22	Man	44	Infectiology	Male nurse
23	Man	31	Infectiology	Resident doctor
24	Man	39	Infectiology	Doctor
25	Women	35	Gynecology	Nurse