

The Influence of Cultural Practices on the Spread of HIV/AIDS and the Challenges to Its Effective Control in Akwa Ibom State, Nigeria

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Abstract

Despite sustained efforts by national and international health organisations to reduce the high prevalence of HIV, Akwa Ibom State continues to record one of the highest rates in Nigeria. Cultural practices remain a highly significant yet often underestimated contributor to the persistence of the epidemic, alongside well-recognised biological and socio-economic drivers. This study critically examines how specific societal norms, rituals, and cultural beliefs inadvertently facilitate the transmission of HIV and undermine effective prevention and control measures in Akwa Ibom State. Employing a qualitative research approach, the study draws on in-depth interviews and focus group discussions with healthcare professionals, community members, and traditional leaders. It identifies practices such as polygyny, ritualised non-marital sex, multiple concurrent sexual partnerships, poverty, levirate marriage and sexual cleansing, female genital mutilation, widow inheritance, traditional scarification and tattooing, as well as the pervasive male dominance in sexual decision-making. The findings underscore the urgent need for cultural sensitisation and context-specific interventions that respectfully engage with local traditions while promoting evidence-based public health practices.

Keywords: Sexual health, gender dynamics, prevention, public health, HIV/AIDS.

Introduction

Sustainable health is a key target of the United Nations Sustainable Development Goals (SDGs). Goal 3 specifically seeks to “ensure healthy lives and promote well-being for all at all ages” through improvements in reproductive, maternal and child health; the eradication of major communicable diseases; reductions in non-communicable and environmentally induced illnesses; and the prevention of sexually transmitted infections, including HIV/AIDS (United Nations, 2017). In line with this vision, governments worldwide have adopted the 2016 Political Declaration on Ending AIDS, a commitment that extends beyond the public sector to include private industry, labour unions, faith-based groups, non-governmental organisations (NGOs), and civil society organisations representing people living with HIV (World Bank, 2014). The 2019 Global AIDS Monitoring marked the third year of transition from the Millennium Development Goals to the SDGs and the third year of reporting on the 2016–2020 HIV monitoring framework. The World Health Organisation (WHO), UNAIDS, and their partners have since developed consolidated strategic information guidelines and promoted “Fast-Track” commitments to end AIDS by 2030 (WHO, 2017; USAIDS, 2015).

Despite these global efforts, HIV/AIDS remains a formidable epidemic and public health challenge, with Sub-Saharan Africa disproportionately affected. Nigeria, home to Africa's largest population, bears a particularly heavy burden of the disease. According to the National Agency for the Control of AIDS (NACA), Akwa Ibom State consistently ranks among the top three states with the highest prevalence, with 161,597 cases reported in the 2024 Spectrum Estimates (Punch Newspaper, 2025; Premium Times, 2025). The persistence of such high prevalence rates, despite widespread awareness campaigns, indicates that several underlying factors, particularly cultural and behavioural, continue to sustain transmission.

Culture plays a significant role in the spread of HIV/AIDS. Practices such as female genital mutilation, polygamy, ritualised sexual activity, and unprotected sex have hindered prevention efforts in Africa. Female genital mutilation, which takes forms such as *gishiri* cuts (incisions on the vaginal wall performed with unsterilised instruments) poses severe risks. These tools are often used repeatedly on multiple individuals, thereby facilitating the transmission of blood-borne diseases, including HIV/AIDS (Madiba & Mokgatle, 2016; UNSDA, 2017). The presence of scar tissue and altered anatomy following mutilation may also increase susceptibility to vaginal tears during intercourse, further heightening transmission risk (WHO, 2017; Soares, Garbin, Rovida & Garbin, 2015).

Similarly, other practices involving the sharing of unsterilised instruments, such as ritual scarification, circumcision, tattooing, and shaving with communal blades,

contribute to transmission (Shoko, 2016). Extramarital sexual relationships, often culturally normalised, also play a major role. Men, in particular, are reported to engage in sexual relations with sex workers or multiple partners, placing their spouses and wider networks at risk (Marindany, 2017). Age and lifestyle factors, such as migration and marital estrangement, have been found to increase the likelihood of extramarital sex across Nigeria, Ghana, Zambia, and other African countries (Chanda et al., 2017). Such behaviours, deeply rooted in sociocultural contexts, reinforce unsafe sexual practices, which remain the primary mode of HIV transmission in Nigeria (NACA, 2018; Ugoji et al., 2024).

Evidence from Southern Africa further supports the link between cultural norms and HIV vulnerability. Price (2009), cited in Parsitau (2017), observed that culturally defined gender inequalities limit women's ability to negotiate safer sex, thereby increasing infection risks. Advocacy against multiple concurrent partnerships is particularly important, as traditional norms in parts of Southern Africa often sanction such relationships. Notably, abstinence is sometimes rejected outright as incompatible with cultural identity. For instance, in Japan's Kawasaki region, annual fertility festivals (e.g., *Kanamarimatsuri*) promote sexual encounters, including with sex workers, thereby facilitating potential HIV spread (UMECSSST, 2019).

In Akwa Ibom State, the epidemic is further driven by promiscuity among married men, widow inheritance practices, poverty-induced sex work, rape, and drug use, all of which heighten exposure risks (AKSACA, 2016, 2018, 2019). Reports indicate that married men often transmit HIV to widows or younger women, perpetuating a cycle of infection (AKSACA, 2019). While polygamy is waning under religious influence, the tendency towards multiple sexual partnerships outside marriage remains prevalent. Poverty, unemployment, and hunger exacerbate the problem by compelling individuals, particularly the youth, into risky behaviours.

In light of these challenges, mitigating HIV/AIDS in Akwa Ibom State requires interventions that are not only evidence-based but also culturally sensitive. A deeper understanding of how traditional practices influence vulnerability is essential for designing strategies that resonate with local realities. This study therefore seeks to examine how cultural norms and practices in Akwa Ibom State contribute to the persistence of HIV/AIDS, with the ultimate goal of informing more effective and context-specific interventions.

Elements of HIV/AIDS Transmission

Polygyny

Polygyny is practised among many groups across Africa. In Kenya, polygyny is legal if a man's first marriage is contracted according to customary law but illegal if contracted after a civil or Christian marriage. In Cameroon, polygyny is legal if, during the first marriage, the first among the Luhya people of Kenya, the final funeral ritual takes place

40 days after the burial of the deceased man. Relatives assemble in the house of the deceased. The widow prepares food and places it between the legs of the brother whom she has chosen (if there is more than one brother) to be her new husband. The ceremony takes place at night and ends with the consummation of the marriage the same night (Rotich, Rono and Mutisya 2014).

As a cultural practice, polygyny appears to be under pressure in Africa. In the 1970s, 33% of households in the Kisi region of western Kenya were polygynous. By the late 1990s, less than 10% of households in the same region were polygynous. Between 1990 and 2003 in Nigeria, the percentage of married women in polygynous unions fell from 41 to 36%. Increasing poverty on the continent means that the cost of maintaining a polygynous household has become prohibitive for many men, and, as women enter the workforce, the latter no longer need to be part of polygynous households to secure their old age. Young men and women in Africa increasingly find polygyny unnecessary and undesirable, and the practice will likely erode over time, though later among some groups than others. As of 2015, the risk of HIV in Uganda was higher in polygynous households than in monogamous ones (Ministry of Health and ORC Macro 2016).

Ritualised Non-Marital Sex

Across Africa, some ethnic groups ritualise premarital and extramarital sex. A practice that has received particular attention is the ritualised sexual initiation of pubescent and prepubescent girls. Among the Chewa and Yao ethnic groups of Malawi, the practice, known as *fisi* (hyena, in the local language), involves sexual intercourse between an adult man and adolescent girls at the end of an initiation ceremony (Kamwendo and Kamowa, 1999, Malawi Ministry of Tourism and Culture, 2019). Data from the Accelerated Stunting Reduction Program (ASRP) study show that the ritual takes three forms. In the first, girls who have reached puberty are secluded for several weeks and given instruction on sex and reproduction and on the role that men and women play in the process. Three to four male instructors will have sexual intercourse with the girls at the close of the period of seclusion. According to local belief, the process enhances and guarantees the fertility of the girls. When a man marries a woman, he expects her to have undergone the ritual. As the local saying goes, "No fisi, no husband."

A second form of *fisi* be referred to as consensual adultery (UNICEF, 2016). If a woman does not become pregnant, despite having undergone the *fisi* ritual, the husband can hire another man to have sex with his wife to impregnate her. Finally, in a third form of *fisi* known as *kulongosolamwana* (taking the baby back), another man has sex with the nursing mother before the husband resumes sexual relations with his wife. The HIV/AIDS status of the men who play the *fisi* role is not known, thereby exposing girls and married women to an unmeasured risk of infection (Nyabero, Omwenga and Okari 2016). In Kenya, some funeral rituals are said to involve sexual licence. Among the Luhya people of Wang'a, for example, the commemoration of the dead (*lung'anyo*, or revisiting the shadow of the dead) is based on the idea that the spirit of the deceased

person needs to be provided with a peaceful entry into the spirit world. The ritual facilitates that process by cleansing the living from any evils and stigma associated with the dead and also commemorates and appeases the dead. The ceremony takes place a month after a person's death and involves all married members of the community.

The Levirate and Sexual Cleansing

The levirate, or widow inheritance, is well known in Western society from the Old Testament and is practised, in one form or another, in patrilineal cultures across the world. Among the Bassa of Cameroon, for example, a married woman is considered as having entered into a permanent contract with the kin group of the husband. The death of the husband does not nullify the husband's contractual right to lineage continuity. This is achieved by transferring procreative duties to another male member of the lineage.

Among the Luhya people of Kenya, the final funeral ritual takes place 40 days after the burial of the deceased man. Relatives assemble in the house of the deceased. The widow prepares food and places it between the legs of the brother whom she has chosen (if there is more than one brother) to be her new husband. The ceremony takes place at night and ends with the consummation of the marriage the same night. The following morning, the woman shaves her pubic area, signalling a new beginning and the cutting of ties with the deceased (Parsitau, 2017). From a public health perspective, the levirate and sexual cleansing rituals for widows and widowers introduce at least one new sexual partner into each person's life, almost always without knowledge of the HIV status of either partner. Although this increases the risk of infection, it also prevents the impoverishment of widows, some of whom might otherwise be driven into prostitution.

Unsterilised Instruments in Surgical Procedures

Across Africa, various groups practise scarification, piercing and tattooing, male circumcision and FGC. Scarification, piercing and tattooing are widely practised for aesthetic purposes and as means of ethnic identification. Among the Guiziga and Mafa peoples in Cameroon, for example, the perforations of lips and nose (for hanging rings) have been traditional symbols of ethnic identity and forms of beautification for women. Among the Samburu of Kenya, women traditionally underwent scarification of the forehead and chest to enhance their beauty (Chanda et al., 2017). Male circumcision is a common practice in many societies across Africa, though certainly not all. Among societies in the ASRP study, the Luo, a major ethnic group in Kenya, do not practise circumcision and traditionally initiated young men through the ritual removal of six lower teeth (Chanda et al., 2017). Even where circumcision is the norm, the ideology that underlies this practice differs from culture to culture.

In some cultures of Cameroon, for example, circumcision is performed without great ceremony, usually when a boy is between eight and ten years old or even younger. The operation is simply an exercise to remove the foreskin and enhance the sensitivity of the glans penis.

Among the Samburu and Luhya in Kenya, by contrast, circumcision is part of an elaborate rite of passage from childhood to adulthood. It allows men to own and control property and prepares them for marriage. Among the Samburu, the circumcision ritual appears to take place every fifteen years (Kenya Demographic and Health Survey, 2016). FGMC (also called female genital mutilation and female circumcision) primarily involves excision of the clitoris and excision of the labia minora but, in some groups, involves infibulation and excision of the labia majora. A common reason given for these practices by informants in the ASRP study was to prevent premarital and extramarital sex by removing the most sensitive part of the sex organ and thus prepare girls for marriage. All of these practices involve risk of disease transmission when performed collectively or when the instruments are not sterilised between users. The extent to which such local surgeries attract vectors for HIV, however, remains to be determined (Chanda et al., 2017).

(vi) traditional healing systems where people prefer traditional medicine for various ailments from traditional healers and traditional birth attendants.

New information has emerged recently regarding neighbouring Eritrea's epidemic, where the 2003 HIV surveillance survey pointed to an epidemic that was stabilising at relatively low levels (2.4% adult HIV prevalence overall). However, infection levels varied considerably across the country and ranged from under 2% to an AIDS epidemic. The disease is causing economic crises and continues to wreak havoc and undermine development in the region.

The Scope of Its Impact

The impact of HIV/AIDS is wide-ranging, extending across social, economic, and individual dimensions. Its effects can be summarised as follows:

Destruction of social capital: The outbreak of HIV/AIDS undermines the knowledge base of society, weakens productive sectors such as agriculture and industry, and erodes institutions and essential services including governance, the civil service, the judiciary, the armed forces, education, and healthcare. It can also inhibit private sector growth, deepen poverty, reduce savings and profits, and compromise food security. Furthermore, it contributes to increased migration, stigma and discrimination, the breakdown of social support systems, rising numbers of orphans, the risk of a “lost generation,” and poor socialisation. The epidemic disproportionately affects the most productive members of society, thereby undermining long-term development (Chanda et al., 2017).

Reduced life expectancy: HIV/AIDS significantly shortens life expectancy and increases the prevalence of widows, orphans, and other vulnerable groups.

Threats to economic development: The epidemic places immense pressure on national economies, as governments are compelled to allocate substantial resources to

research, treatment, and the provision of antiretroviral drugs. These expenditures divert funds from other crucial sectors of development.

Emotional and psychological instability: Individuals living with HIV/AIDS often experience emotional distress, depression, and low self-esteem due to societal stigma, discrimination, and the burden of living with a chronic illness.

Unfulfilled potential: Many people living with HIV/AIDS are unable to achieve their life goals and aspirations, as the disease frequently leads to premature death and the truncation of personal and professional ambitions.

Study Area

Akwa Ibom State is predominantly inhabited by the Ibibio, Annang, and Oron ethnic groups, reflecting its cultural diversity. These groups share many norms, customs, and traditions, including strong communal ties, respect for elders, and a patriarchal social structure. While traditional belief systems remain influential, Christianity also plays a major role in shaping people's perceptions of health, illness, and socially acceptable conduct.

Research Methodology

The study employed a mixed-methods approach, combining quantitative household sampling with qualitative exploration of cultural practices. The sample size was calculated to estimate the prevalence of HIV/AIDS among adults aged 18 years and above, as well as children aged 0–17 years. A total of 5,814 households across 290 clusters were selected, with each cluster consisting of approximately 20 individuals. This yielded a representative sample of 19,222 adults aged 18 years and above, alongside children within the 0–17 years age bracket.

A two-stage probability sampling method was used. In the first stage, 290 clusters were selected with probability proportional to population size, based on demographic data provided by the National Population Commission (NPC, 2006). In the second stage, households were systematically sampled within each cluster. To explore the interrelationship between cultural practices and the spread of HIV, a qualitative research design was adopted. The study was purposively conducted in three local government areas—Uyo, Ikot Ekpene, and Itu—to capture varying levels of cultural adherence and exposure to modern influences. Participants included individuals from diverse educational and occupational backgrounds, such as traditional healers, traditional birth attendants, healthcare professionals from both primary and secondary health facilities, and people living with HIV (both positive and negative cases, with identities kept anonymous).

Data collection methods included in-depth interviews and focus group discussions within the selected communities. Data were systematically coded and

analysed using SPSS software, with the chi-square test employed as the primary statistical technique.

Results and Discussion Of Findings

Table 1: Cultural Practices Influencing the Spread of HIV/AIDS in Akwa Ibom State Compared with Literature

Cultural Practice / Finding	Evidence From This Study	Supporting Literature
FEMALE GENITAL MUTILATION (FGM)	Still practised in rural areas; seen as cultural identity, purity, and premarital chastity despite government ban. Increases risk of HIV through unsterilised blades.	FGM persists despite prohibition, especially in rural areas (Olaniran, 2013). Prevalence fluctuated but persisted between 2011–2021 in Nigeria (Olamijuwon & Adebayo, 2023). COVID -19 pandemic slowed reduction; prevalence increased in some states (Okorie et al., 2023).
SCARIFICATION, TATTOOING, TRIBAL MARKS	High risk due to reuse of blades across multiple individuals.	Similar findings show cultural body modification practices increase exposure to HIV if unsterilised tools are used (Olaniran, 2013).
MULTIPLE CONCURRENT SEXUAL PARTNERS	Most prevalent practice (50%); linked to poverty, youth survival strategies, and commercial sex with “sugar daddies/mummies.”	Cultural approval of polygyny and poverty-linked survival sex increase HIV vulnerability among Nigerian women (Adamu & Joseph, 2015). High prevalence of multiple sexual partners before HIV diagnosis, especially among men (Ojieabu et al., 2020).
WIDOW INHERITANCE	Persists as part of cultural tradition; increases risk of HIV transmission through forced/ritual remarriage.	Widow inheritance continues in Igboland and Benin City, driven by economic and social obligations, increasing HIV exposure (Eze, 2022; Okoh, 2024).

VIRGIN CLEANSING / SEXUAL CLEANSING	Least reported practice (2%); still present in rural traditions.	Documented as a high -risk but declining practice across sub-Saharan Africa (Morris, 1997; Kretzschmar, 2000, as cited in your study).
POLYGYNY AND MALE DOMINANCE	Encourages multiple sexual relationships and female subordination.	Polygyny and gender inequality identified as key drivers of HIV transmission (Adamu & Joseph, 2015).
HIV-RELATED STIGMA AND DISCRIMINATION	Stigma leads to poor utilisation of traditional communication channels and low testing uptake.	Cultural stigma, fear, and mistrust of Western medicine limit HIV testing and counselling in Nigeria (Omeje et al., 2017).

The Chi-square test yielded a value of 509.394 with a two-sided p-value of 0.000, indicating a statistically significant influence of cultural practices on the spread of HIV/AIDS in Akwa Ibom State. This suggests that deeply rooted cultural beliefs and norms continue to play a substantial role in driving the epidemic, presenting major obstacles for control and prevention efforts.

Among the cultural practices implicated by this study are female genital mutilation (FGM), traditional scarification, tribal tattooing or incision, virgin cleansing, widow inheritance, polygyny, male dominance, and concurrent sexual partnerships. Use of unsterilised instruments exacerbates the risk of HIV transmission. For example, even though efforts are made to outlaw FGM (particularly its more extreme forms), the practice persists, especially in rural areas, where it is seen as a symbol of cultural identity, purity, and premarital chastity (Olaniran, 2013; ResearchGate, 2019).

Recent evidence from Nigeria reinforces these findings. A retrospective analysis of FGM prevalence between 2011 and 2021 revealed that, although awareness fluctuated, prevalence in some Nigerian states increased, demonstrating the resilience of cultural practices despite interventions (Olamijuwon & Adebayo, 2023). Similarly, a cross-sectional study conducted after the COVID-19 pandemic observed that while national FGM prevalence among girls aged 0–14 decreased between 2018 and 2021, prevalence either increased or remained unchanged in some states, with cultural norms identified as key drivers (Okorie et al., 2023).

The present study also found that 50% of respondents identified multiple concurrent sexual partnerships as a major contributor to HIV transmission. This aligns with previous findings in Lafia, Nigeria, where polygyny, male dominance, and poverty were strongly associated with women's heightened vulnerability to HIV infection (Adamu & Joseph, 2015). Cultural values that normalise male dominance and multiple sexual partnerships therefore continue to play an enabling role in HIV spread.

High-risk sexual behaviour among persons living with HIV/AIDS (PLWH) further illustrates this cultural dimension. A study in Nigeria revealed that many participants had multiple sexual partners before diagnosis, but the number decreased significantly post-diagnosis. Importantly, gender differences were observed, with men more likely than women to have multiple partners before diagnosis (Ojieabu et al., 2020). These findings confirm that gendered cultural expectations shape behaviour both before and after individuals are aware of their HIV status.

Widow inheritance practices also contribute to vulnerability, as documented in Igboland and Benin City. Studies indicate that widow inheritance persists despite modernisation and is linked to economic dependency, social pressure, and emotional needs, which indirectly increase HIV risk (Eze, 2022; Okoh, 2024). These findings underscore how socio-cultural obligations continue to expose women to both economic exploitation and health risks.

Additionally, cultural and religious beliefs strongly influence HIV testing and counselling. A study in Enugu State, using the PEN-3 cultural model, revealed that barriers such as fear of testing, stigma, and conspiratorial beliefs reduce uptake of HIV services. However, positive influences such as church support, family involvement, and health worker encouragement improved acceptance (Omeje et al., 2017). This highlights the dual role of culture—both as a barrier and as a potential facilitator of HIV prevention and treatment.

Taken together, these findings confirm that cultural practices are deeply intertwined with behavioural risk factors, gender imbalances, and stigma in Akwa Ibom and across Nigeria. While interventions have made progress, particularly in raising awareness, cultural transformation remains slow and uneven. Addressing these challenges requires context-sensitive strategies that not only legislate against harmful practices but also engage cultural institutions, traditional leaders, and communities in reshaping the norms that perpetuate HIV vulnerability.

Conclusion

Cultural practices remain a major impediment to the eradication of HIV/AIDS in Akwa Ibom State. Among these, the prevalence of multiple sexual partnerships stands out as the most critical factor driving the epidemic, contributing significantly to its alarming spread. Despite sustained interventions by non-governmental organisations (NGOs), government agencies, and community-based initiatives, cultural norms continue to reinforce risky behaviours and undermine prevention efforts. Extramarital relationships, particularly among married men, alongside prostitution among youths, further exacerbate the situation. Consequently, cultural traditions serve as a formidable barrier against the effective elimination of HIV/AIDS in the state. Addressing these challenges requires urgent, multi-dimensional, and culturally sensitive strategies that align with the broader goals of sustainable development.

Recommendations**i. Community Sensitisation and Anti-Stigma Campaigns**

Awareness should be deepened through mass media such as television programmes, radio jingles, magazines, and locally adapted campaigns that directly address the cultural roots of HIV-related stigma. Positive narratives about people living with HIV should be promoted. Government should provide adequate resources, including drugs, equipment, and trained personnel, to strengthen the health sector and enhance grassroots sensitisation efforts towards achieving an HIV/AIDS-free society.

ii. Comprehensive Sexuality and Peer Education

Sexuality and peer education should be integrated into the national curriculum at all educational levels. The emphasis should be on empowering individuals, especially women, to negotiate safe sex, make informed decisions about their sexual health, and foster shared responsibility among men. Gender-transformative programmes that promote equality and challenge restrictive norms should be prioritised. This approach ensures that learners at the primary, secondary, and tertiary levels become carriers of accurate information regarding HIV/AIDS.

iii. Culturally Responsive HIV/AIDS Programmes

Government programmes should be tailored to reflect the cultural realities of local communities. For instance, traditional norms that once discouraged premarital sex should be re-examined and leveraged as positive behavioural frameworks. Public education on HIV/AIDS should be consistent and accessible, particularly in rural areas. Furthermore, policies should mandate the initiation of antiretroviral therapy (ART) immediately upon diagnosis, ensuring early intervention and reducing the risk of further transmission.

iv. Regulation of Traditional Birth Attendants (TBAs) and Informal Healthcare Providers

The government should enact and enforce legislation to regulate unskilled healthcare practices. Traditional birth attendants should be trained, licensed, and closely monitored, with clear limitations on their scope of practice. Sanitation standards must be established, and defaulters held accountable under the law to safeguard community health and minimise the risk of HIV transmission.

- v. Finally, the legal body should make legislations against the operation of unskilled health care homes. Traditional Birth Attendants should be monitored, licensed, controlled, trained and made to know, their limitations. Standards of sanitation should be set and defaulters should be made to face the law.

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