International Journal of
Humanities, Education, and Social Sciences

e-ISSN : 3026-0892
p-ISSN : 3026-1422

Index: Harvard, Boston, Sydney, Dimensions, Lens, Scilit, Semantic, Google, etc

https://doi.org/10.58578/IJHESS.v4i2.9248

Cultural Perceptions Towards HIV/ AIDS in Southern Ijaw Local Government Area, Bayelsa State, Nigeria

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Article Info:

Submitted:	Revised:	Accepted:	Published:
Feb 18, 2026	May16, 2026	May 28, 2026	Jun 2, 2026

Abstract

Cultural beliefs remain a significant factor shaping public understanding, communication, and health-seeking behaviour related to HIV/AIDS in many communities. This study investigated cultural perceptions of HIV/AIDS in Southern Ijaw Local Government Area, Bayelsa State, Nigeria. A mixed-methods cross-sectional survey design was adopted, involving 400 respondents for the quantitative component and 30 participants for the qualitative interviews. Quantitative data were analysed using SPSS version 26, while qualitative data were analysed thematically. The findings revealed that cultural beliefs and norms strongly influenced respondents' perceptions, discussions, and health-seeking behaviours related to HIV/AIDS. The study also found that HIV/AIDS was sometimes interpreted through spiritual or moral lenses, which contributed to silence, stigma, and limited open dialogue about sexual health and HIV prevention. The study concludes that cultural perceptions play a critical role in shaping HIV/AIDS awareness and prevention practices in Southern Ijaw. It recommends that parents and caregivers, with support from family welfare units and social workers, should be engaged through community sensitisation and capacity-building programmes to strengthen effective communication about

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HIV/AIDS and sexuality. Traditional leaders should also be involved in challenging harmful traditional beliefs, reducing HIV-related stigma, and promoting open community dialogue on sexual health. This study contributes to public health and social work practice by highlighting the need for culturally responsive HIV/AIDS education and prevention strategies that engage families, community institutions, and traditional leadership structures.

Keywords: HIV/AIDS Awareness; Cultural Perceptions; Health-Seeking Behaviour; Stigma; Southern Ijaw.

Introduction

Beyond its biological transmission, HIV/AIDS is also a socially constructed phenomenon. Early narratives of HIV/AIDS in Nigeria and other parts of Africa often linked the disease to immorality, sexual promiscuity, and divine punishment. These cultural interpretations created an environment of stigma and fear, where individuals were reluctant to test for HIV or disclose their status. Even today, stigma persists, though improved education and advocacy have helped reduce discrimination in many areas (Ogunbanjo & Akinola, 2020).

Cultural practices such as polygyny, early marriage, and widow inheritance further increase vulnerability to HIV in certain communities. For example, in polygynous households, the risk of HIV transmission is higher if one partner becomes infected, given the interconnected sexual networks. Similarly, women's limited autonomy in negotiating safe sex practices reinforces their vulnerability, even when they possess adequate knowledge about HIV prevention (Mayanja *et al.* 2017). Therefore, culture both shapes the way HIV is transmitted and influences how individuals and communities respond to prevention and treatment efforts.

Cultural and religious beliefs play a significant role in shaping perceptions of HIV/AIDS. In many traditional African societies, discussions about sexuality are considered taboo, leading to secrecy and misinformation. Practices such as polygyny and widow inheritance further complicate community responses, as they heighten vulnerability while discouraging open conversations about prevention **(**Mayanja *et al*., 2017**).**

Religious interpretations of HIV/AIDS also influence perceptions. Some religious leaders frame HIV as a divine punishment for sinful behaviour, which strengthens stigma

against those infected. Conversely, faith-based organisations have also played positive roles in promoting care, compassion, and treatment access. In Southern Ijaw, where Christianity and traditional beliefs dominate, perceptions of HIV/AIDS are often filtered through these cultural and religious lenses, shaping how individuals respond to prevention and treatment efforts.

Perceptions of HIV/AIDS are also influenced by gender dynamics. Women, for instance, are often perceived as being more responsible for HIV transmission due to stereotypes linking female sexuality to promiscuity. Such perceptions increase the burden of stigma on women, who may be blamed for introducing the virus into families even when evidence suggests otherwise (Dworkin & Ehrhardt, 2007). Moreover, women's limited autonomy in sexual and reproductive decision-making means that their perceptions of HIV/AIDS are shaped by societal expectations and male-dominated power structures. As a result, even when women perceive themselves to be at risk, cultural norms may prevent them from negotiating condom use or seeking testing.

Cultural factors play a pivotal role in shaping the perceptions, engagement, and responses of adults of reproductive age toward HIV/AIDS, particularly in sub-Saharan Africa, where deeply rooted traditional values, religious beliefs, and social norms influence health behaviours. In Southern Nigeria, these cultural dynamics often perpetuate misinformation and hinder access to effective prevention and care services, ultimately affecting attitudes and behaviours toward HIV/AIDS.

Practices such as early marriage, polygamy, and widow inheritance significantly heighten HIV vulnerability among adults of reproductive age. In many Nigerian communities, young women are married to older men, often in polygamous relationships, where power imbalances severely limit their ability to negotiate condom use or access sexual health education. These cultural arrangements foster environments of sexual coercion, limited autonomy, and low health literacy, all of which are associated with higher HIV prevalence (Obeagu *et al.,* 2023). Widow inheritance, still practised in some regions, further exacerbates the risk. In this tradition, a widow is married to a male relative of her deceased husband without HIV testing or protective measures, exposing both parties to potential infection and reinforcing gender inequalities that restrict access to prevention and treatment services (Widow Inheritance, 2025).

Stigma, superstition, and religious beliefs also strongly shape the HIV-related attitudes and behaviours of people. In Nigeria, HIV is frequently perceived as the result of immoral conduct, curses, or divine punishment. Such beliefs foster secrecy, denial, and an unwillingness to discuss HIV openly, even among educated populations. For example, research among secondary school teachers in Ibadan revealed that religious and cultural beliefs continued to influence negative attitudes toward HIV testing and counselling, undermining prevention efforts (Adebayo *et al.,* 2021; Obeagu *et al.,* 2023). Superstitions and reliance on traditional or spiritual healing further delay engagement with biomedical care. In communities where herbal remedies and spiritual interventions are prioritised, individuals may forego HIV testing or antiretroviral therapy (ART), resulting in late diagnoses, continued transmission, and poorer health outcomes (Obeagu *et al.,* 2023).

Gender norms and power imbalances represent another significant cultural barrier. In many Nigerian communities, cultural expectations allow men to have multiple sexual partners while prescribing submissiveness for women, severely limiting women's ability to negotiate condom use or refuse risky sexual encounters. Such norms discourage preventive behaviours and perpetuate a lack of autonomy and knowledge among women of reproductive age. Transactional sex, fueled by economic disparities and cultural silence around female sexuality, further amplifies HIV vulnerability. Without cultural structures that empower women to seek sexual health services or advocate for safe sexual practices, women remain disproportionately at risk (Obeagu *et al.,* 2023).

Theoretical Framework

The Information-Motivation-Behavioural Skills (IMB) Model, developed by Fisher and Fisher (1992), provides a comprehensive framework for understanding and promoting health behaviour change, particularly in the context of HIV/AIDS prevention. This model is well-suited for the current study, which aims to assess knowledge and perceptions of HIV/AIDS among adults of reproductive age in the Southern Ijaw Local Government Area (LGA) of Bayelsa State, Nigeria. The IMB model integrates three key components: accurate information, motivational readiness, and behavioural skills that are critical for adopting and sustaining preventive health behaviours.

The application of the IMB model is justified by its proven effectiveness in explaining how knowledge and personal/social motivation influence the development of behavioural

competencies necessary for HIV prevention, such as safe sex practices, HIV testing, and stigma reduction. This is particularly relevant in Southern Ijaw, where cultural beliefs, limited access to health information, and prevailing social norms shape attitudes and behaviours related to HIV/AIDS among people in this region.

Recent empirical studies support the IMB model's applicability in similar contexts. For example, Peng *et al.* (2023) applied the IMB model to assess antiretroviral therapy (ART) adherence among people living with HIV in Shanghai, finding that information and behavioural skills strongly predicted adherence, with motivation playing an indirect role. Similarly, Jamil et al. (2024) used the IMB framework to develop an HIV education toolkit for adolescents in Malaysia, demonstrating its effectiveness in adult-focused interventions. Walsh *et al.* (2021) employed the situated IMB (sIMB) model in a community-based intervention in Uganda, targeting HIV service uptake in a hyperendemic fishing community, highlighting the model's ability to address cultural and environmental factors. Additionally, Jalilian *et al.* (2025) utilised the IMB model to promote dietary adherence among HIV-positive individuals in Iran, reinforcing its versatility across diverse populations and behavioural domains.

These studies underscore the IMB model's empirical validity and flexibility, making it an appropriate framework for guiding this study's exploration of knowledge, perceptions, information sources, and cultural influences on HIV/AIDS attitudes among people in Southern Ijaw L.G.A. The model provides a theoretically sound structure for data collection, analysis, and interpretation, enabling the identification of knowledge gaps, motivational barriers, and practical skills needed for HIV prevention.

The Information-Motivation-Behavioural Skills (IMB) Model provides a comprehensive framework for understanding health behaviour change related to HIV/AIDS prevention among adults of reproductive age in the Southern Ijaw Local Government Area (LGA) of Bayelsa State, Nigeria. The model's information component aligns with the study's first objective, which assesses knowledge of HIV/AIDS transmission, prevention, treatment, and symptoms, positing that accurate and relevant health information is foundational for health-promoting behaviors, such as understanding transmission modes (e.g., unprotected sex, sharing needles, mother-to-child transmission) and prevention methods (e.g., condom use, abstinence, PrEP), as gaps or inaccuracies in this knowledge among adults in Southern Ijaw may contribute to the persistence of the epidemic by hindering risk-reducing behaviors

or engagement with testing and treatment. The second objective, exploring perceptions towards individuals living with HIV/AIDS, corresponds to the motivation dimension of the IMB model, which includes personal attitudes, perceived social support, and emotional responses, recognizing that adults who harbor stigma or fear may be less likely to seek testing or discuss HIV prevention openly, even if well-informed, while positive attitudes and empathy can foster health-seeking behaviors, influenced by social and cultural norms in Southern Ijaw that may either support or reinforce discriminatory attitudes. The third objective, investigating sources of HIV/AIDS information (e.g., healthcare providers, media, peers, religious institutions), connects to both the information and motivation components, as access to reliable, culturally relevant information sources increases the likelihood of acquiring accurate knowledge, while the framing and tone of this information can either motivate or deter health-seeking behaviors, such as when community leaders or religious groups present HIV in a moralistic or fear-inducing manner, potentially reducing motivation for testing or treatment despite accurate information, and this study will explore how these sources shape knowledge and motivation in Southern Ijaw. The fourth objective, examining the influence of cultural factors on attitudes towards HIV/AIDS, primarily aligns with the motivation component but also relates to behavioral skills, as cultural beliefs in Southern Ijaw, such as taboos around discussing sex, myths about HIV causation, or gender norms, can significantly affect motivation to engage in preventive behaviors, for instance, by discouraging women from negotiating condom use or seeking testing, or by reducing the perceived need for prevention among men due to cultural acceptance of practices like multiple sexual partnerships, while behavioral skills, such as negotiating condom use, accessing healthcare, or applying knowledge in real-life situations, are also shaped by the cultural environment, where adults may possess knowledge and motivation but lack confidence or practical ability to act due to societal constraints, and this study will assess how these cultural factors influence both motivation and the development of behavioral skills critic

Theoretical Framework

The theoretical framework for this study is the Information-Motivation-Behavioural Skills (IMB) Model, propounded by Fisher and Fisher (1992). The model integrates three key components: accurate information, motivational readiness, and behavioural skills that are critical for adopting and sustaining preventive health behaviours.

The application of the IMB model is justified by its proven effectiveness in explaining how knowledge and personal/social motivation influence the development of behavioural competencies necessary for HIV prevention, such as safe sex practices, HIV testing, and stigma reduction. This is particularly relevant in Southern Ijaw, where cultural beliefs, limited access to health information, and prevailing social norms shape attitudes and behaviours related to HIV/AIDS among people in this region.

Recent empirical studies support the IMB model's applicability in similar contexts. For example, Peng et al. (2023) applied the IMB model to assess antiretroviral therapy (ART) adherence among people living with HIV in Shanghai, finding that information and behavioural skills strongly predicted adherence, with motivation playing an indirect role. Similarly, Jamil et al. (2024) used the IMB framework to develop an HIV education toolkit for adolescents in Malaysia, demonstrating its effectiveness in adult-focused interventions. Walsh et al. (2021) employed the situated IMB (sIMB) model in a community-based intervention in Uganda, targeting HIV service uptake in a hyperendemic fishing community, highlighting the model's ability to address cultural and environmental factors. Additionally, Jalilian et al. (2025) utilised the IMB model to promote dietary adherence among HIV-positive individuals in Iran, reinforcing its versatility across diverse populations and behavioural domains.

These studies underscore the IMB model's empirical validity and flexibility, making it an appropriate framework for guiding this study's exploration of knowledge, perceptions, information sources, and cultural influences on HIV/AIDS attitudes among people in Southern Ijaw L.G.A. The model provides a theoretically sound structure for data collection, analysis, and interpretation, enabling the identification of knowledge gaps, motivational barriers, and practical skills needed for HIV prevention.

This study, while examining the influence of cultural factors on attitudes towards HIV/AIDS, primarily aligns with the motivation component but also relates to behavioral skills, as cultural beliefs in Southern Ijaw, such as taboos around discussing sex, myths about HIV causation, or gender norms, can significantly affect motivation to engage in preventive behaviors, for instance, by discouraging women from negotiating condom use or seeking testing, or by reducing the perceived need for prevention among men due to cultural acceptance of practices like multiple sexual partnerships, while behavioral skills, such as negotiating condom use, accessing healthcare, or applying knowledge in real-life situations,

are also shaped by the cultural environment, where adults may possess knowledge and motivation but lack confidence or practical ability to act due to societal constraints, and this study will assess how these cultural factors influence both motivation and the development of behavioral skills critical for HIV prevention.

Results

Table 1: Responses on whether cultural beliefs discourage open discussions about sex and HIV

	Frequency	Percentage
Strongly Agree	124	31.0
Agree	146	36.5
Neutral	68	17.0
Disagree	42	10.5
Strongly Disagree	20	5.0
Total	400	100%

Source: Field Survey, 2025

Table 1 shows respondents' perceptions of how cultural beliefs influence discussions about sex and HIV. Out of 400 respondents, 124 (31.0%) strongly agreed, and 146 (36.5%) agreed, making a total of 270 respondents (67.5%) who acknowledged that their cultural beliefs discourage open conversations about these topics. Meanwhile, 68 respondents (17.0%) were neutral, possibly indicating uncertainty or mixed experiences with cultural norms. On the other hand, 42 respondents (10.5%) disagreed, and 20 (5.0%) strongly disagreed, totalling 62 respondents (15.5%) who believed that cultural beliefs do not hinder such discussions.

Table 2: Responses on whether people with HIV are considered cursed or unclean

	Frequency	Percentage
Strongly Agree	86	21.5
Agree	118	29.5
Neutral	98	23.5
Disagree	72	18.0
Strongly Disagree	30	7.5
Total	400	100%

Source: Field Survey, 2025

Table 2 presents respondents' views on cultural perceptions toward people living with HIV. Out of 400 respondents, 86 (21.5%) strongly agreed, and 118 (29.5%) agreed,

totalling 204 respondents (51.0%) who believed that, within their culture, individuals with HIV are considered cursed or unclean. Meanwhile, 98 respondents (23.5%) were neutral, suggesting uncertainty or unwillingness to express strong opinions on the issue. Conversely, 72 respondents (18.0%) disagreed, and 30 (7.5%) strongly disagreed, summing up to 102 respondents (25.5%) who rejected this cultural belief.

Table 3 Responses on whether cultural norms influence young people's access to HIV-related health services.

	Frequency	Percentage
Strongly Agree	96	24.0
Agree	124	31.0
Neutral	86	21.5
Disagree	64	16.0
Strongly Disagree	30	7.5
Total	400	100%

Source: Field Survey, 2025

Table 3 reveals respondents' opinions on the influence of cultural norms on young people's access to HIV-related health services. Out of 400 respondents, 96 (24.0%) strongly agreed and 124 (31.0%) agreed, making a total of 220 respondents (55.0%) who believed that cultural norms indeed hinder young people from accessing such services. In contrast, 64 respondents (16.0%) disagreed, and 30 (7.5%) strongly disagreed, totalling 94 respondents (23.5%) who felt that cultural norms do not restrict access. Additionally, 86 respondents (21.5%) remained neutral, possibly indicating uncertainty or mixed experiences.

Table 4: Responses on whether it is a taboo to talk about HIV/AIDS

	Frequency	Percentage
Strongly Agree	108	27.0
Agree	132	33.0
Neutral	78	19.5
Disagree	58	14.5
Strongly Disagree	24	6.0
Total	400	100%

Source: Field Survey, 2025

Table 4. presents the respondents' views on whether discussing HIV/AIDS is considered taboo within their families or communities. Out of 400 respondents, 108 (27.0%) strongly agreed, and 132 (33.0%) agreed, giving a combined 240 respondents (60.0%) who affirmed that talking about HIV/AIDS is culturally or socially prohibited in their environment. Conversely, 58 respondents (14.5%) disagreed, and 24 (6.0%) strongly

disagreed, making 82 respondents (20.5%) who believed that HIV/AIDS discussions are not taboo. Additionally, 78 respondents (19.5%) were neutral, possibly reflecting mixed experiences or uncertainty about their community's stance.

Table 5: Responses on whether Traditional healers are preferred over hospitals in treating HIV/AIDS

	Frequency	Percentage
Strongly Agree	68	17.0
Agree	96	24.0
Neutral	102	25.5
Disagree	86	21.5
Strongly Disagree	48	12.0
Total	400	100%

Source: Field Survey, 2025

Table 6 presents respondents' opinions on whether traditional healers are preferred to hospitals for the treatment of HIV/AIDS. Out of 400 respondents, 68 (17.0%) strongly agreed, and 96 (24.0%) agreed, giving a total of 164 respondents (41.0%) who believed that traditional healers are favoured over hospital-based treatment. On the other hand, 86 respondents (21.5%) disagreed, and 48 (12.0%) strongly disagreed, making a combined 134 respondents (33.5%) who rejected this view. Additionally, 102 respondents (25.5%) remained neutral, which may indicate a level of uncertainty or limited exposure to both traditional and medical treatment options.

Additionally, the qualitative analysis reveals that Traditional healers are preferred over hospitals in treating HIV/AIDS.

Stated below:

"Right from the time of our forefathers, there is nothing like HIV, and people often take herbal treatments when they are sick and get healed; so, we still prefer our traditional healers more than the white man's medicine that is introduced to us. Therefore, anyone with HIV can be treated by a traditional healer". (49-year-old farmer).

Table 6: Responses on whether disclosing HIV status is considered shameful

	Frequency	Percentage
Strongly Agree	142	35.5
Agree	134	33.5
Neutral	72	18.0
Disagree	38	9.5

	Frequency	Percentage
Strongly Disagree	14	3.5
Total	400	100%

Source: Field Survey, 2025

Table 7 shows respondents' perceptions of whether disclosing one's HIV status is viewed as shameful within their community. Out of 400 respondents, 142 (35.5%) strongly agreed, and 134 (33.5%) agreed, giving a combined 276 respondents (69.0%) who believe that revealing one's HIV status is socially stigmatised and shameful. In contrast, 38 respondents (9.5%) disagreed, and 14 (3.5%) strongly disagreed, totalling 52 respondents (13.0%) who did not share this view. Meanwhile, 72 respondents (18.0%) were neutral, possibly reflecting uncertainty or varied experiences with stigma in their communities.

Discussion

The findings on cultural influences towards HIV/AIDS in Southern Ijaw Local Government reveal that cultural beliefs and norms strongly influence perceptions, discussions, and health-seeking behaviours related to HIV/AIDS among respondents in Southern Ijaw Local Government Area. The data show that most respondents believe their cultural beliefs discourage open discussions about sex and HIV. These finding underscores how traditional values and taboos surrounding sexuality remain major barriers to open dialogue about sexual health and HIV prevention. According to Adebayo and Olorunfemi (2021), cultural restrictions on sexual discussions in many Nigerian communities hinder the dissemination of accurate HIV information, especially among young people. Similarly, Nnadi (2020) found that in conservative rural societies, conversations about sexual behaviour are viewed as immoral or inappropriate, limiting opportunities for education and awareness. This suggests that entrenched cultural norms perpetuate silence, stigma, and misinformation surrounding HIV/AIDS.

The study also found that many respondents believe that people living with HIV are often perceived as cursed or unclean within their cultural context. This perception reflects the persistent stigma associated with HIV in traditional societies, where illness is sometimes interpreted through spiritual or moral lenses. The findings align with Chinweuba et al. (2022), who observed that in many African communities, HIV infection is still viewed as divine punishment or witchcraft, leading to social exclusion and discrimination against infected persons. Similarly, Oni and Ajayi (2020) noted that stigmatising cultural beliefs discourage

individuals from seeking testing or disclosing their status, thereby undermining public health efforts aimed at controlling the spread of HIV. Such deep-rooted stigmatisation remains a significant obstacle to both prevention and treatment initiatives.

Furthermore, the study revealed that respondents perceive cultural norms as major barriers preventing young people from accessing HIV-related health services. This is consistent with findings by Eze and Uche (2021), who reported that cultural taboos, gender roles, and parental expectations often prevent adolescents from accessing reproductive health services or discussing sexual matters with health professionals. Okoro and Nwankwo (2023) also emphasised that restrictive cultural expectations—especially those promoting chastity and silence on sexual issues—make it difficult for youths to seek HIV testing or counselling. This suggests that cultural beliefs indirectly contribute to vulnerability by limiting young people's access to information and care.

The study also indicates that in many communities, discussing HIV/AIDS remains a taboo subject within families and social gatherings. Respondents affirmed that cultural prohibitions discourage open discussions about HIV, reflecting the influence of social conservatism in their communities. This finding corresponds with Ogunyemi and Adeola (2020), who stated that in many Nigerian homes, sexual and reproductive health issues are seldom discussed due to cultural discomfort and fear of moral corruption. Mugisha et al. (2020) similarly found that such silence perpetuates ignorance and misinformation, especially among adolescents who rely on informal sources of information. Hence, the cultural taboo surrounding HIV discussion continues to reinforce stigma and limit effective community engagement.

Interestingly, the study shows that most respondents believe their cultural values promote abstinence before marriage, reflecting the persistence of moral and traditional teachings on sexual purity. This positive cultural aspect aligns with Oche and Umar (2021), who found that abstinence-centred cultural teachings can serve as protective factors against early sexual initiation and risky behaviours. However, Nnorom (2022) cautioned that while abstinence is valuable, overemphasis without comprehensive sex education may lead to misinformation or neglect of safer sex practices among sexually active individuals. Thus, while cultural values promoting abstinence have moral benefits, they should be complemented with evidence-based health education to enhance HIV prevention outcomes.

The findings on the preference for traditional healers over hospitals reveal a persistent reliance on indigenous medical practices for HIV treatment. Respondents, including a 49-year-old farmer, expressed that traditional healing has long been trusted and is often perceived as more effective than "white man's medicine." This aligns with Oluwole and Adebisi (2021), who reported that in rural Nigeria, traditional healers remain influential due to cultural familiarity, affordability, and deep-rooted beliefs in herbal efficacy. However, Okafor *et al* (2023) cautioned that dependence on unverified traditional remedies poses serious health risks, as it delays access to proper HIV testing and antiretroviral therapy. Despite their prominence, traditional healers' practices need to be harmonised with biomedical approaches through community engagement and education.

Lastly, the study found that disclosing one's HIV status is widely viewed as shameful within the community. This finding highlights the pervasive stigma associated with HIV/AIDS and the fear of social ostracism. Similar findings were reported by Amoran and Oloruntoba (2020), who noted that fear of discrimination and labelling discourages individuals from voluntary testing or seeking treatment. UNAIDS (2023) also emphasised that stigma and shame surrounding HIV disclosure remain major obstacles to achieving global prevention and treatment goals. These social perceptions not only isolate those living with HIV but also discourage collective community action toward ending the epidemic.

Conclusion

Cultural factors, including stigma and taboos, remain significant barriers in handling HIV/AIDS in several communities in the study area. These cultural norms isolate those living with HIV and discourage collective community action toward ameliorating or ending the epidemic. HIV/AIDS remains a taboo subject within families and social gatherings. Cultural prohibitions discourage open discussions about HIV, reflecting the influence of socially conservative communities.

Recommendations

Parents and caregivers, with the support of family welfare units and social workers, should be engaged through community sensitisation and capacity-building programmes that equip them with the skills and knowledge to communicate effectively with their children about HIV/AIDS and sexuality. This will help break the cultural silence surrounding these topics and strengthen the family's role in promoting awareness and healthy behaviour among

adults. Also, traditional leaders within the community should help challenge harmful traditional beliefs, reduce stigma associated with HIV, and encourage open dialogue around sexual health and HIV prevention. The health ministry and local primary healthcare managers should strengthen the availability and accessibility of adult-friendly health services. This includes training healthcare providers to offer non-judgmental, confidential, and respectful services to adolescents and young adults. Such services should include HIV counselling, testing, follow-up care, and education tailored specifically to the needs of adults.

Author Contributions

Egberipou, A., and Odubo, T. (the authors) made substantial contributions to conception and design. Egberikpo, A., worked on the survey, analysis and interpretation of data. Both authors contributed to writing, editing and reviewing the final manuscript.

Conflict of Interest Statement

The authors declare that the research was conducted in the absence of any conflict of interest. There are no financial/personal interests or beliefs that could influence the authors' objectivity.

Funding

None. No funding was received during the study, research, or assembly of the paper.

Ethical Consideration

The study adhered to ethical guidelines for research involving human subjects. Ethical approval was obtained, along with additional permission from local authorities and community development chairmen. Written informed consent was secured from all participants after full disclosure of the study's purpose, procedures, risks, and benefits.

Informed Consent

The research is a cross-sectional study. Respondents were duly informed of the study's subject and purpose. They were assured that while it was a voluntary exercise, all information would be used strictly for academic purposes. Key details of the study were made known to ensure they fully understand what they are agreeing to. Respondents were assured that they were at liberty to abstain or withdraw from participating in the research at their discretion.

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