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Gender Inequality in Women's Knowledge and Awareness of HIV/AIDS in Port Harcourt

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Abstract

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BS, University of Massachusetts, 2010

BA, Benue State University, 2000

Dissertation Submitted in Partial Fulfillment of

the Requirements for the Degree of

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Abstract

In Nigeria, gender inequality significantly impacts women's knowledge and awareness of the transmission of the human immunodeficiency virus (HIV) and the proliferation of acquired immunodeficiency syndrome (AIDS). Early marriage, traditional beliefs, religion, and polygamy all contribute to gender inequality. This study explored the role of these and other sociocultural practices in the gender inequalities that increase vulnerability of contracting HIV/AIDS among women in Port Harcourt, Rivers State, Nigeria. The study employed a phenomenological design, collected data through a semistructured interview approach, which was managed using NVivo software. The purposive sample comprised 20 female students from a college in Port Harcourt. This study's key findings correlated with other studies highlighting the interconnectedness of sociocultural practices responsible for increasing HIV/AIDS among Port Harcourt women. Other underlying findings included women's lack of economic power to achieve personal needs, such as access to HIV treatment, and the lack of skills to negotiate safe sex, which contributed to increased HIV/AIDS among women. Recommendations for further research include programs for reduction of gender inequality related to this HIV/AIDS outbreak. The implications for social change included adequate government funding to help provide available and accessible health services to women, promote safe sex conduct and education among the most vulnerable (women), and reduce HIV transmission from mother to child.

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Dedication

I dedicate this study to the Almighty God, my Creator, who has been there for me from inception; and to my beloved husband and three wonderful sons, for being my inspiration and backbone, and forgiving me their unending love, support, and prayers throughout this great journey.

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Chapter1: Introduction to the Study

Introduction

This research explored the impact of sociocultural practices of early marriage, traditional beliefs, religion, and polygamy on the gender inequalities that cause lack of knowledge and awareness of the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) among women in Port Harcourt, Rivers State, Nigeria, hence increasing their vulnerability to the virus. This has become a serious global public health issue as well. Vidanapathirana, Randeniya, and Operario (2009) demonstrated that researchers have recognized the affiliation of inequality and HIV/AIDS among women in the United States since the virus's first outbreak in the 1980s. Yahaya, Jimoh, and Balogun (2010) found HIV/AIDS to be "one of the main causes of worldwide and public health problems, mostly as it is the key factor that impacts the economic, national development of Sub-Saharan Africa, and women's health, as well as death" (p. 159). Achalu (2011) concluded that the HIV/AIDS epidemic continues to be the most overwhelming health disaster in the history of humanity.

Though 25 million people died of AIDS complications in 2005, nearly 40 million were still infected with the disease as of 2006, and approximately 95% of those cases were in Sub-Saharan Africa (Lamptey, Johnson, & Khan, 2006). Osauzo (2011) reported that AIDS was not just a health problem, but also a social problem threatening the wellbeing of women in Sub-Saharan African society. Researchers such as Lamptey et al. (2006) and Osauzo found that nearly 1,700,000 Nigerians had died of HIV/AIDS-related conditions since 2003, 57% of them women, and that the gender gap in HIV/AIDS in

Sub-Saharan Africa was related to sociocultural practices such as early marriage, polygamy, traditional beliefs, faith, and individual behaviors that exposed women to HIV. In this research study, I employed the terms *culture* and *tradition*; both denote culturally inherited practices and beliefs that significantly affect human lives (Gyekye, 1997, p. 220). Therefore, the use of these terms was appropriate for my research population (the participants in the study) and the study's geographical location.

Statistics and recent studies showed that approximately 22 million people had HIV in 2007, more than 1million died of the virus, and several hundred thousand children were orphaned as a result of it in Sub-Saharan Africa (Yahaya et al., 2010, p. 159). For example, in Nigeria, approximately 2.6 million individuals were infected, 170,000 died, and 1.2 million children became orphans in 2007. This contributed to Nigeria's reduction in longevity—47 years for men, 46 for women—in 2007 (Yahaya et al., 2010, p. 160). The Nigeria HIV Fact Sheet (2011) also reported that, in 2009, women comprised 52% of HIV prevalence; men, 37%; and children, 11%; and the death rate from HIV increased to 215,000 in 2010.

Background

HIV, an infection that develops into AIDS, has no vaccine and cannot be cured, but can be managed with different medications, though it ultimately becomes a terminal disease (Centers for Disease Control and Prevention [CDC], 2013). As of 2009, the largest HIV/AIDS-infected population resided in Nigeria, where the virus's impact on young adults aged 15 to 49 escalated from 1.8% in 1991 to 5.8% in 2000 and dropped to 3.9% in 2005; the disease still affected nearly 2.9 million Nigerians (Monjok, Smesny, &

Essien, 2009). Additionally, the World Bank (2012) reported that in India about 83% of all HIV/AIDS cases were among individuals aged 15 to 49,39% of them female.

Though it is now the third decade of the HIV/AIDS epidemic, the disease still has no active/preventive vaccine or cure. The main preventive measure from further spread of the virus remains behavioral risk prevention interventions. For example, current statistics demonstrated that HIV impacts mostly women, and the inequality that accompanies the infection remains prominent among women (Darbes, Kennedy, Peersman, Zohrabyan, & Rutherford, 2013).

Furthermore, in Kenya, the HIV/AIDS rate among women was 1.9%—nearly 2 times that of men, 1.0%—and the 2008-2009 Kenya Demographic Health Survey revealed that the HIV/AIDS rate among women was four times that of men in the same age group (Lee, 2012). Similarly, in Nigeria and Rwanda, gender determined the behaviors considered proper for men and women, the extent to which an individual was at risk for HIV/AIDS, and ability to access available health information and services (Mbonu, Van Den Borne,& De Vries, 2009; Nteziryayo, 2009). Recent studies also demonstrated that women have been ignored in global HIV/AIDS research, treatment, and prevention endeavors (American Foundation for AIDS Research Fact Sheet, 2008).

Statement of the Problem

Gender inequality implies that men and women do not live with equal social standing (Bah, 2005). In Nigeria, gender inequality significantly impacts women's knowledge and awareness of HIV/AIDS transmission; sociocultural practices such as early marriage, traditional belief, polygamy, and region have contributed to this gender

inequality (Mbonu et al., 2009). Every community or society has its special way of operation, and these cultural practices influence the people's attitudes, perception, and management of any disease, including other health-related issues they experience (Oleribe & Alasia, 2006). These sociocultural factors predispose women to HIV, especially in rural areas, and women are more vulnerable to the virus due to unequal access to educational resources on it (Iwara & Alonge, 2014). Additionally, sociocultural practices that spread HIV/AIDS cause high death rates in Nigeria, where sex is a secret topic considered unacceptable, unhealthy, and indecent to discuss with teenagers, specifically females. So youths flounder in lack of knowledge and awareness about sexual health information (Oleribe & Alasia, 2006).

Also, gender inequality reduces women's capacity to protect themselves from unhealthy sexual behaviors outside and inside marriage, further increasing their risk of contracting HIV (World Bank, 2012). For example, in Port Harcourt, Nigeria, cultural norms permit men to engage with multiple sex partners, which leads to polygamy. Women in Port Harcourt have experienced gender inequalities related to the HIV/AIDS disease (Mbonu et al., 2009). Nteziryayo (2009) found that Rwandan women lack access to health education and services (p. 4); in Rwanda, every woman is supposed to be discreet and reserved for her future or current husband. Women lack the privilege to express their opinions regarding their family life, which contributes to their inferior societal position and their HIV/AIDS vulnerability (Nteziryayo, 2009).

According to Ramjee and Daniels (2013), women are denied equality in decision making with their partners, thereby promoting marginalization in homes and public

places. Similarly, sociocultural practices such as polygamy, religion, traditional beliefs, and even individual behaviors, together with economic influences, promote unsafe sex conduct among women, leaving them with minimal to no power to say no (Ramjee & Daniels, 2013). This traditional gender role that promotes inequality has displaced women for generations and must be re-examined in the light of justice and compassion in present society (Ramjee & Daniels, 2013).

Purpose of the Study

In this study, I explored the sociocultural practices of early marriage, polygamy, traditional belief, and religion related to gender inequalities, which affect the lives of women in Port Harcourt, the largest city in the southern part of Nigeria and the capital of Rivers State, located in the Niger Delta region along Bonny River, 41 miles (66 km) from the Gulf of Guinea. Gender inequality has displaced women in this region for generations and must be re-examined in the light of justice and compassion in the present society.

Research Questions

1. How do early marriage, polygamy, traditional beliefs, and religion promote HIV/AIDS transmission among women in Port Harcourt?
2. How does unequal power relation promote women's lack of HIV/AIDS awareness?
3. How does sexuality hinder access to health services and knowledge of HIV/AIDS?

Theoretical Framework

My research proposal was based on a theoretical framework of social cognitive theory (SCT),which portrays events and issues associated with gender inequality related to HIV/AIDS and the sociocultural influences on the infection/disease transmission among women in Port Harcourt (Pajares, Prestin, Chen, &Nabi, 2009). This proposal was a segment of a wider survey to explore through SCT the sociocultural factors (early marriage, polygamy, religion, and traditional beliefs) that enhance HIV/AIDS risk among women. This study also aimed to create and improve awareness and knowledge of HIV/AIDS and to educate the public on issues of gender inequality related to HIV/AIDS and its effects on women's health.

Though gender inequality is the key obstacle to effectual response to the HIV/AIDS epidemic, a theoretical framework for this research was crucial, particularly for connecting various studies and their outcomes (Radhakrishna, Yoder, & Ewing, 2007). Similarly, according to SCT, HIV/AIDS reduction efforts have been effective, based on human beings' productive focus on their own advancement, as well as practice measures that control their perceptions, emotions, and actions (Pajares et al., 2009). SCT thus highlighted the different perceptions of individuals regarding gender inequality related to HIV/AIDS among women and its consequences for general society. This social cognitive framework impelled the conceptualization of gender inequality related to HIV/AIDS as a basis for exploring how women's beliefs on tradition, religion, early marriage, and polygamy influence their infection with HIV (Pajares et al., 2009).

Nature of the Study

The study involved a qualitative approach employing a phenomenological method to show how sociocultural practices (faith, traditional beliefs, personal behaviors, and polygamy) influence gender inequality related to lack of knowledge and awareness of HIV/AIDS among women, and how such inequality bars women from protecting themselves from the infection and seeking help/health intervention for it (American Psychological Association [APA], 2013). Study participants were female students from a college in Port Harcourt, aged 18 to 45. Semistructured one-on-one interviews with participants were chosen as the main data sources, to better understand participants' personal perceptions or shared experiences about gender inequality and sociocultural factors influencing HIV/AIDS among women. I employed a convenient sampling method to choose my participants for the interview. I also posted flyers on notice boards on the college campus where students met. These flyers included a short description of the study, including the assurance of participants' confidentiality. Walden University approved the interview instrument prior to data collection, as required. In addition, questionnaires created room for my interaction with the participants. The method also explained the research procedure and invited participants' questions. In conclusion, several research studies on HIV/AIDS have employed questionnaires, because they are advantageous in gathering data from participants.

Descriptive Epidemiology of HIV/AIDS

HIV is the cause of AIDS (United Nations Acquired Immunodeficiency Syndrome [UNAIDS], 2008), which is capable of decreasing the white blood cells known

as $CD4^+$ lymphocytes that comprise the human immune system. HIV is transmitted through the blood or bodily fluids of anyone infected with it. Also, infected pregnant women can transmit the virus to the fetus at birth or by breast-milk (UNAIDS, 2008).

Though any HIV-infected individual can be asymptomatic for years with no knowledge of the virus living in them, the body system weakens as the disease progresses (UNAIDS, 2008). Furthermore, an HIV-infected individual becomes most vulnerable to developing AIDS if unaware of it, reluctant to seek timely treatment for it, and/or succumbing to various illnesses. A fully AIDS-diagnosed individual is estimated to live 2 to 3 years post diagnosis (UNAIDS, 2008).

Definitions of Terms

Culture: Although culture comprises beliefs, knowledge, laws, morals, customs, and other social practices, it is fundamentally the set of basic ways people live and act in patterns common to themselves and their immediate social groups (Oleribe & Alasia, 2006).

Early marriage: This is the practice of marrying off female children at young ages, usually to guard them from the outside world. Nigeria, especially its northern region, has some of the highest global rates of early marriage (United Nations Population Fund, 2004). Early marriage occurs in both genders but affects female children more.

Polygamy: Delecce (2014) defined polygamy as a cohabiting structure in which a male or female is socially and sexually involved with more than one spouse concurrently.

Religion: This refers to the belief in a supreme-being or god, the conviction in supernatural realities significant to mankind's wellbeing, thus purportedly giving

meaning to one's life. Religion comprises issues in broadly different beliefs and ideas that are exhibited in social and private settings and are accessible to every individual in a society (Pecorino, 2000).

Sociocultural practices: These are customary actions that shape everyday lives of people in a community (United Nations Educational, Scientific and Cultural Organization, 2012). Every individual, despite racial differences from others, has personal practices and beliefs regarding disease and health (Oleribe & Alasia, 2006).

Traditional beliefs: These are the beliefs in a supreme being that "created the heavens and the earth" (Genesis 1:1) yet is unreachable and distant. However, more reachable lower deities allegedly act as mediators of that supreme-being (Madu, 2013).

Assumptions

I assumed that participants in this qualitative study truthfully responded to the interview questions. I also presumed that participants were comfortable sharing their lived experiences because they were initially notified of their individual rights and the study benefits toward gender inequality related to sociocultural practices that influence HIV/AIDS among women. In addition, despite the sensitivity of the topic and the secret nature of one's sexual behavior and relationships, participants were comfortable giving true answers to questions during the interview phase. Finally, I assumed that the open-ended structured questions made participants comfortable responding without bias.

Delimitations of the Study

The research focused on the effects of gender inequality on women's knowledge and awareness of HIV/AIDS in Port Harcourt, Nigeria. The study mainly involved

women aged 18 to 45, because most Nigerian women of these ages live with their husbands. The study also focused on the effects of sociocultural practices on women's health. The participants were 20 students from a college in Port Harcourt, Rivers State, because these women could read and write English with reasonable fluency. Data collection was based on the perceptions and views of these 20female participants after completion of the one-on-one interviews with them.

Limitations of the Study

This study had some limitations—as the small number of participants shows—which made it cumbersome to make sure the sample was well represented. This small sample also limited generalizability, as the recruitment method may not have attracted a socioeconomically diverse group. Also, because only female participants who had college education, belonged to a certain age group, and spoke and wrote English fluently participated in the study, it could not be generalized for all ethnic groups in Rivers State or the female gender in general.

Because the participants were from a certain age group, diverse backgrounds and ethnic groups, and because all were female English speakers, the study could not be generalized for all ethnic groups in Rivers State or the female gender in general. Also, due to the secret nature of one's sexual behavior and relationships, some participants hesitated to give true answers to interview questions, which could have altered some of the research findings, yet all participants responded to all questions, though they were allowed to skip any question that made them uncomfortable.

Significance of the Study

This study is important in its provision of information about gender inequality related to HIV/AIDS among women and the sociocultural influences on gender inequality among women in Port Harcourt, Rivers State of Nigeria. The findings could help public health professionals to develop effective prevention programs and intervention strategies proper for this specific group (Mbonu et al., 2009).

The findings could also assist HIV/AIDS program interventionists, HIV/AIDS prevention and control funding agencies, policy makers, and institutions in developing ways to help decrease or possibly eradicate gender inequality related to HIV/AIDS among women in Port Harcourt. In addition, this study encouraged Port Harcourt communities to engage and empower women and community leaders to develop strategies to minimize this problem. Therefore, ignoring the role of women regarding HIV/AIDS prevalence not only affects their reproductive health but also influences their mortality and morbidity rate (Mbonu et al., 2009).

Implication of Social Change

Following present efforts to lessen the gender inequality that relates to HIV/AIDS among women, the application of social change could strengthen public health policies in Port Harcourt. Social change could give women access to HIV/AIDS prevention and intervention programs and could enable communities, political/religious leaders, and women themselves to address issues of gender inequality as it affects women's health. This initiative could also improve awareness and knowledge about HIV/AIDS throughout Nigeria.

To enhance present endeavors to reduce gender inequality related to HIV/AIDS among women, social change through adequate government funding could improve women's access to appropriate health services, thereby enhancing women's adherence to prevention strategies and possibly decreasing mother-to-child transmissions of HIV (Brooks, McDougall, Patel, and Kes, 2010).Similarly, public health professionals and researchers must co-investigate current HIV/AIDS prevention strategies and educational/promotional materials on HIV/AIDS.

They must also disseminate facts about HIV/AIDS transmission that could ameliorate sexual conduct among the most vulnerable population (women) to prevent infection transmission and to promote effective prevention and intervention strategies. These must include campaigning against gender inequality, false perceptions about HIV transmission, and social/sexual exploitation of women by their partners (United Nations Department of Economic and Social Affairs, 2007).

Overall, furnishing HIV transmission information through social media, rallies, campaigns, and posters to local and traditional leaders, government bodies, and religious organizations will increase the HIV/AIDS awareness necessary to encourage safe sex conduct, which in turn will promote social change. Also, voluntary counseling and testing for individuals and couples will help to decrease attitudes and perceptions that encourage proliferation of the disease among women. These endeavors could be achieved by developing new policies and empowering legal efforts to reduce gender inequality related to HIV/AIDS among women (United Nations Department of Economic and Social Affairs, 2007).

Summary

HIV/AIDS still has no effectual cure, but researchers have actively sought remedies and hope to find a cure someday (CDC, 2013). However, a strong HIV/AIDS awareness program could help prevent future infections by providing data about the disease and its transmission process (AVERT, 2013). Such a program could also help to reduce the HIV/AIDS-related gender inequality that promotes misconceptions and false information about the disease, hence spur sits escalation by demoralizing individuals from seeking voluntary testing and counseling as well as medical care (AVERT, 2013). Therefore, effective awareness and prevention programs are essential in reducing HIV/AIDS transmission among women.

In Chapter 2, I provide an overview of the current literature and explore previous research related to the study's topic to determine what has been discovered about gender inequality as a factor in HIV/AIDS transition among females so far. This literature review is a starting point for this study's further investigation of HIV/AIDS as a dilemma for Port Harcourt women.

Chapter2:Literature Review

Literature Search Strategy

Databases searched for literature pertinent to this study included: ProQuest, CINAHL, UNAIDS, CDC, World Health Organization (WHO), United Nations Population Fund, United Nations Educational, Scientific and Cultural Organization site, Nigeria HIV Fact Sheet, American Foundation for AIDS Research Fact Sheet, APA site, World Bank site, Medline, Pub Med, Nursing and Allied Health Source, Community Vanguard, Journal of Preventive Medicine, UNICEF, and the Walden Library, which comprised the EBSCO, Cochrane, and Med-well journals.

Terms used to retrieve these resources included: *HIV/AIDS knowledge among woman in Sub-Saharan Africa; Gender inequality and HIV/AIDS among women in Nigeria; HIV/AIDS epidemic globally, in Africa, Sub-Saharan Africa, and Nigeria; HIV/AIDS worldwide; HIV/AIDS prevention and intervention among women in Nigeria; Gender issues in Sub-Saharan Africa, Gender Issues in Nigeria; Sociocultural factors and HIV/AIDS in Sub-Saharan Africa; Sociocultural factors and HIV/AIDS in Nigeria; Effects of culture on women's health; Lack of HIV/AIDS awareness among women in Nigeria, HIV/AIDS prevalence in Rivers State; HIV prevalence with Maps*.

Data from peer-reviewed journals, nonprofit organizations, research papers, established health organizations, university researches, dissertations, and government organizations revealed no studies on gender inequality or lack of HIV/AIDS awareness among women in Port Harcourt, Nigeria. The articles dated from 2000 to 2015, and most of the reviewed studies were culturally designed for women of childbearing age.

Nteziryayo (2009) reported that HIV/AIDS has affected more women in Sub-Saharan Africa, particularly in Kamony, Rwanda, where women from poor communities are at the region's highest risk for HIV. The gender norms that influence unequal power between men and women are rooted in the sociocultural concept of every community and carried out by workplaces, schools, health systems, families and other institutions there (Nteziryayo, 2009).

The United Nations Population Fund (2013) reported approximately 33 million people infected with HIV worldwide, and over 20 years about half of the infected were women. Similarly, in Sub-Saharan Africa, approximately 76% of all infected populations were female. In Nigeria, the HIV epidemic surveillance has indicated that women aged 15 to 49 make up 56% of the total 4.74 million infected with the disease (United Nations Population Fund, 2013). Despite this global rise in HIV/AIDS prevalence, women have continued to suffer gender inequality, thus a lack of knowledge and awareness of the disease transmission or how to protect themselves from it, compared to their male counterparts. Furthermore, women suffer shame and humiliation from their partners or spouses and are voiceless, unable to negotiate safe sex conduct or decline unwanted intercourse with their partners or spouses (United Nations Population Fund, 2013).

To modify these trends, researchers must focus on gender inequality's significant roles in women's health and how it impacts HIV/AIDS prevention among this population (United Nations Population Fund, 2013). For example, Monjok et al. (2009) found that gender inequality related to HIV/AIDS could be classified on three levels:

- *The individual level:* Gender inequality led to seclusion, low self-esteem, alienation, and personality catastrophe, all of which led to inability to practice prevention intervention. Similarly, fear of stigma and discrimination reduced the positive effects of HIV testing programs.
- *The community level:* Fear of stigma and discrimination impeded pregnant women from voluntary counseling and testing, the recognized method of decreasing HIV transmission from mother to child. Also, mothers exposed their children to HIV infection through ways other than breast-feeding, which raised suspicion about their health conditions (Monjok et al., 2009, p. 23).
- *The institutional level:* This represented HIV-impacted individuals who suffered denial of employment, job termination, hostility from bosses and/or coworkers, and even early retirement. Overall, gender inequality in healthcare systems was one of the most adverse forms of institutional stigma and abuse women suffered due to HIV/AIDS (Monjok et al., 2009, p. 24).

Theoretical Framework

The theoretical framework for this research was SCT. Based on individual presumption, SCT demonstrates that people are completely fixated on personal growth, and they exhibit behaviors that dominate their emotions, behaviors, conducts, and perceptions (Pajares et al., 2013). For this reason, the theoretical framework that included concepts, assumptions, beliefs, expectations, and theories supporting the research was the main part of this study design, as a good conceptual framework connects a study to a broader topic and a body of existing knowledge (Schneider, 2005, p. 10).

Loggerenberg et al. (2012) found that women's denial of equality and lack of awareness and knowledge of HIV/AIDS influenced its spread. The United Nations (2001) concluded that gender inequality related to HIV/AIDS contributed to a higher rate of the disease, thus placing women at high vulnerability to contract HIV, as they possessed less power to coordinate safe sex. Additionally, once they were infected with HIV, their partners and spouses isolated and physically abused them as their culture allowed (United Nations, 2001). This traditional inequality-promoting gender role has dehumanized women with HIV/AIDS for more than two decades and must be re-examined for justice in various communities such as Port Harcourt (United Nations, 2001).

Present studies demonstrated that young women were most at risk for HIV virus in Sub-Saharan Africa. Nonetheless, the empowerment of women to discuss safe sex conduct and condom use was one of the most advocated techniques for controlling the high rate of HIV/AIDS among women worldwide (Loggerenberg et al., 2012). Similarly, a traditional mode of prevention could help to modify sexual conducts among women by maximizing HIV/AIDS knowledge and awareness campaigns and programs. For example, many studies carried out in Western nations demonstrated favorable decrease in HIV rates with assistance from educational awareness campaigns, whereas Sub-Saharan Africa continued to experience HIV rate increases despite the increased public awareness of the virus there (Loggerenberg et al., 2012).

For Arrivillaga, Ross, Useche, Alzate, and Correal (2009), to improve female compliance to HIV/AIDS treatment in Colombia, one must first eliminate gender inequality, which is a barrier to healthcare services (p. 502). Similarly, Shisana, Rice,

Zungu, and Zuma (2010) and Zhihong and Ulla (2008) found that gender inequality is a key catalyst of HIV/AIDS prevalence among women, and segments of gender inequality could include age difference between spouses, traditional norms, and financial support from the spouse (Arrivillaga et al., 2009, pp. 506-509).

These studies demonstrated that gender inequality contributes to women's vulnerability to HIV/AIDS globally, but knowledge and awareness initiatives including prevention campaigns have inadequately met the needs of target populations. Employing SCT could help discover the various impressions of people about HIV infection/AIDS disease and the overall effects of gender inequality on women in Port Harcourt through Nigerian sociocultural practices.

Social Cognitive Theory

This theory of human behavior illustrates how people obtain categories of values and attitudes, as well as the practice that determines their daily level of societal functioning (Bandura, 2004, p. 76). This research study specifically involved a version of SCT that could help to identify and examine various views and attitudes about gender inequality and its effects on women's knowledge and awareness of HIV in Port Harcourt.

SCT has three interconnected components: personal, environmental, and behavioral factors (Pajares, 2002). A person's private experience can be connected to the environmental and behavioral factors:

- In person-behavior communication, the cognitive process of that individual affects the behavior, and the conduct of such behavior may change the individual's way of thinking.

- In person-environment communication, cognitive skills, ideas, and beliefs are changed by external components: a stressful environment, hot weather, a supportive parent, and so forth.
- In environment-behavior communication, external factors can change the way an individual displays any behavior.

Knowledge Gap Theory

Another theory reviewed was the knowledge gap theory, which proposed that not everyone in a society evenly obtained the allocation of facts, as people with higher socioeconomic status seemed to understand facts better than those with lower status, which created a division between these two groups (University of Twente, 2014). In light of this, the SCT could also be used to examine the sociocultural practices that influence gender inequality as it relates to HIV/AIDS and women's health, regarding women's lack of allocation of facts about the virus compared to men.

According to the Boston University School of Public Health (2013), SCT is broadly used in public health promotions and is thus a main focus today, especially at individual and environmental levels, in health promotion and awareness programs, as it shows that, for effectual learning to take place, an individual must show proper behavior, display positive personal features, and live in a supportive environment (Pajares, 2002).

According to Reif, Geonnotti, and Whetten (2006), social and environmental factors increase HIV risk among African American women in the United States, so women sometimes use sex (prostitution) for money, food, and shelter (p. 235). Also,

women in relationships are subjected to their partners' sexual pleasures and desires with the belief that they are safe (Reif et al., 2006).

Williams, Ekundayo, Udezulu, and Omishakin (2003) found that some women believe HIV/AIDS is a repercussion and punishment from God for alleged wrongdoings, which adversely affects their response to prevention strategies. Bowleg, Lucas, and Tschann (2004) stated that another detriment to women's health and knowledge of HIV/AIDS is submissiveness within relationships: the men always control what happens within the relationship. For example, men decide whether or not to use condoms. Therefore, women often feel uncomfortable discussing sex and condom use with their spouses (Bowleg et al., 2004).

Though my research focused on sociocultural practices that influence HIV/AIDS among women, Lyles et al. (2007) used SCT to analyze HIV programs that most effectively changed HIV-related behaviors. Similarly, Jarama, Belgrave, Bradford, Young, and Honnold (2007) researched contributions to high-risk behaviors among African American women and found that sociocultural factors affect adoption of HIV prevention efforts. Williams et al.(2003) also used SCT to study behaviors and HIV awareness/knowledge levels among women.

Theory of Gendered Power

Regarding women's vulnerability to HIV/AIDS, the theory of gendered power deals with three major factors of gender relationships: (a) sexual division of power, (b) sexual division of labor, and (c) the structure of attachment and social norms, also known as *cathexis* (Rosenthal& Levy, 2010). Together with the growing number of studies

examining the correlation between power and women's risk of HIV/AIDS, use of this theory has widened scholars' comprehension of the elements that contribute to the growing number of women being infected with HIV from their male spouses or partners (Rosenthal& Levy, 2010).

For Mbonu, Van Den Borne, and De Vries (2010), the theory of gendered power is structured around behavioral gender differences between women and men in relationships. Women are less likely to adhere to HIV prevention strategies as a result of power differences in the family, in which women accept any condition they are in to maintain their relationship while risking HIV infection from their spouses (Mbonu et al., 2010, p. 5). For example, a Nigerian woman may feel powerless in her relationship, hence lack the ability to freely discuss and practice safe sex.

Social Dominance Theory

Created by Sidanius and Pratto (1999), social dominance theory addresses four major bases of gendered power described by Pratto and Walker (2004). However, Rosenthal and Levy (2010) found that this theoretical framework could increase the organization and understanding of the accrued practical research outcomes on the relationship between power and women's vulnerability to HIV infection from their male spouses or partners (p. 22). They proposed that this theory could accompany present theories and inform theoretically driven interventions that address heterosexual communication of HIV infection (Rosenthal& Levy, 2010, p. 22).

For this study, I employed SCT because it provided a relevant theoretical framework to explain how individuals obtained and maintained some behavioral patterns.

For Meisslerm (2012), SCT used real-world behavioral examples, focused on significant theoretical issues such as stability of behaviors and the role of reward in learning, concerned crucial social behaviors, and described a better view of individuals' behaviors in society than the other theories. SCT also revealed people's behaviors through observation and clarified that: (a) society and individual behavior were intertwined, and (b) people's personalities were interactions among three elements: personal behaviors, psychological processes, and their entire environment (Meisslerm, 2012).

Contraction of HIV

The incidence of AIDS was first reported in the United States in 1981 regarding cases of *pneumocystis carinii* pneumonia among five Los Angeles men who were described as homosexuals (CDC, 2001).HIV is a virus that spreads through body fluids in a way that affects CD4 or T cells, which protect the body from infection by destroying cells the body cannot use to protect against infections and diseases. When this occurs, the body is vulnerable to AIDS. Overall, the human body cannot destroy HIV; if contracted, it remains terminal (CDC, 2014). HIV is not contracted from tears, saliva, kissing or any casual contact but is transmitted through any infected person's body fluids, childbirth, breastfeeding, blood, vaginal secretions and semen (CDC, 2007). Similarly, engaging in high-risk sexual behaviors such as multiple sex partners and the sharing of infected needles during drug injections increase vulnerability to the infection (CDC, 2007).

Symptoms of HIV

The National Institute of Allergy and Infectious Diseases (2004) reported that people infected with HIV are usually without obvious symptoms but experience some

mild signs such as fever, weight loss, night sweats, fatigue, and diarrhea in their first two to four weeks of exposure. Most HIV-positive people are not aware of this, thus they can spread it to others unknowingly. However, the best way to know whether one is HIV-positive is to be tested (NIAID, 2004).

Gender Inequality and HIV/AIDS

Current analysis and studies identified gender inequality as a major public health problem in Nigeria and Sub-Saharan Africa in general. Kelly (2003) found that gender discrimination, lack of awareness and knowledge of HIV/AIDS, little access to healthcare services and education, and sociocultural practices all influence gender inequality related to HIV/AIDS among women around the world. Additionally, several studies conducted in Ukraine, Zambia, Burkina Faso, India, and Zambia found that HIV-infected pregnant women were humiliated and devalued, and they suffered rejection by their spouses and sometimes their own families (Panos Institute, 2001).

Breastfeeding and HIV

In Tanzania, Ethiopia, Zambia, and Nigeria, where breastfeeding is common, an HIV-infected mother who refuses to breast feed risks isolation, excommunication, and even physical, emotional, or verbal abuse (International Center for Research on Women, 2002). Collymore (2003) found that mother-to-child transmission of HIV attracts suspicion, especially when the child is male.

Acronym Definitions

The acronyms *HIV* and *AIDS* can be confused with each other because they describe the same disease, but many HIV-positive individuals do not have AIDS.

Similarly, an HIV-positive individual whose status has advanced to AIDS may not be able to fight certain infections and diseases such as cancers, pneumonia, and tuberculosis due to a weakened immune system (U.S. Department of Veterans Affairs, 2014).

HIV/AIDS Globally

The WHO (2015) reported that, from its inception, HIV has affected about 78 million individuals; nearly 39 million of them have died. Between 35 million and 37.2 million people lived with HIV through the end of 2013; 3.2 million of them were children under age 15. Additionally, an estimated 0.8% adults aged 15 to 49 were infected with HIV. However, Sub-Saharan Africa remained the most HIV-affected, and almost 1 of every 20 adults accounted for about 71% of those living with HIV globally (WHO, 2015). UNAIDS (2014) found that, out of the 35 million individuals infected with HIV, 19 million did not know they had the virus.

HIV/AIDS in Sub-Saharan Africa

According to Okodu and Ross (2015), HIV and AIDS were one of the world's largest health challenges for decades, and Sub-Saharan Africa carries the largest incidence of the disease, though it contained only 10% of the world's population. For example, Nigeria had the second largest number of individuals infected with HIV/AIDS after South Africa, and approximately 60% of every new case of HIV infections in Sub-Saharan Africa occurred among young women aged 10 to 24 (Okodu & Ross, 2015).

Mboup, Musonda, Mhalu, and Essex (2006) estimated 22.5 million HIV cases among adults in Sub-Saharan Africa, with 1.3 million deaths, compared to North America's 1.5 million cases and 26,000 deaths and Western and Central Europe's

820,000 cases and 8,500 deaths, in 2005.Furthermore, Africans made up about 70% of the world population infected with HIV and those who died of AIDS complications, even though Africa comprised about15% of the global population (Mboup et al., 2006).

According to UNAIDS (2012), Sub-Saharan Africa remained the highest impacted geographic region in the worldwide HIV epidemic. For example, about 23.5 million people infected with HIV lived in Sub-Saharan Africa in 2011, representing 69% of the worldwide HIV burden. Also in 2011, nearly 92% of pregnant women in Sub-Saharan Africa had HIV, and over 90% of these cases were children. WHO (2015) reported, "The prevalence of HIV virus among urban women was 1.6 times higher on average than that among rural women and urban men for 26 countries in sub-Saharan Africa." For example, in Swaziland, HIV prevalence among urban women was as high as 37%, compared to 31% in Lesotho (WHO, 2015).

In addition, more than 58% of Zambia's HIV patients reported suffering stigma and discrimination between 2008 and 2011. In Rwanda, 53%, and in Kenya, 56% of HIV-positive individuals reported verbal and emotional abuse against them (UNAIDS, 2012). In Cameroon, 13% of all HIV-positive individuals reported that they were denied access to healthcare services, including dental care. Similarly, in Nigeria and Ethiopia, 1 out of 5 (20%) infected people with HIV reported suicidal thoughts due to mistreatment by community members (UNAIDS, 2012).

HIV/AIDS in Nigeria

The HIV epidemic in West Africa was acknowledged in 1985 with recorded cases in Mali, Benin, and Côte d'Ivoire. Ghana, Senegal, Liberia, Nigeria, Cameroon, and

Burkina Faso followed in 1986; Niger, Togo, and Sierra Leone, in 1987; Guinea, Gambia, and Guinea-Bissau, in 1989. Cape Verde, in 1990. Niger, Mali, and Chad have the lowest HIV prevalence in West Africa; Côte d'Ivoire, Burkina Faso, and Nigeria have the highest. However, Nigeria was second in HIV prevalence in the Western region of Africa, while South Africa was first (Medwiser, 2013). Kenechi (2010) reported that Nigeria's first two cases of HIV/AIDS were confirmed in Lagos in 1985, though the Nigerian government was reluctant and slow to intervene in the virus's growing rate initially. Approximately 1.8% of Nigerians were already infected in 1991, and frequent survey reports indicated that the epidemic increased from 3.8% in 1993 to 4.5% in 1998 (Kenechi, 2010).

In Nigeria, nearly 6 million people (5.4% of the population) had HIV/AIDS in 2003, 5.3 million (4.4% of the population) in 2005 (HIV/AIDS Policy Fact Sheets, 2005). However, studies on other countries' HIV rates showed that Nigeria had a greater occurrence than several other world nations. For example, the incident rate of HIV/AIDS in the US and the UK from 2003-2005 was 0.6% and 0.2%, respectively (The Global HIV/AIDS Epidemic, 2005). Similarly, in Haiti, beginning in 2003-2004, the incident rate was 3.8%, and Brazil—the second most populous nation in the Americas after the United States—was 0.5% from 2004-2005 (The Global HIV/AIDS Epidemic and The Global HIV/AIDS Pandemic, 2006).

In African nations, HIV/AIDS rates differed greatly: Madagascar recorded 1.7%, Ghana, 3.1%, Angola 3.9%, Democratic Republic of Uganda, 4.1%, and Swaziland,

38.8% (HIV/AIDS Policy Fact Sheets, 2005). So Nigeria had the highest HIV prevalence rate in 2005.

Nigeria's HIV prevalence could influence the death rate in all age groups. The crude death rate in Nigeria was 14 per 1,000; approximately 1.65 million deaths occurred yearly (Nasidi & Harry, 2006). However, the number of deaths among individuals aged 15 to 64implied that the HIV/AIDS death rate increased every ten years, but it differed in years such as 1990 (51.3), 2000 (53.6), and 2010 (53.8) (Trading Economics, 2015).

In 2000, more than 150,000 Nigerians died of HIV/AIDS complications, which posed serious consequences for the nation's socioeconomic development. Given this high prevalence rate, Nasidi and Harry (2006) predicted that the cumulative number of HIV/AIDS deaths could reach a staggering 9.4 million by 2015 (p. 33). Compared to the destructive global impacts of HIV/AIDS, especially in Sub-Saharan Africa, the acknowledgement of these effects in Nigeria was relatively recent, though it was Africa's most populated nation (Nasidi & Harry, 2006). In fact, for decades several Nigerians perceived HIV/AIDS as signs of hatred from far away countries and as products of scientists' imaginations.

Since then, Nigeria has become one of the world's most HIV-affected nations, and the second most affected region in Sub-Saharan Africa (Nasidi & Harry, 2006, p. 18). Moreover, Kanabus and Fredriksson-Bass (2007) and Soyinka, Ogundare, Olowookere, and Akinsola (2004) found that the high rate of HIV/AIDS in Nigeria and Sub-Saharan Africa generated severe social, economic, and health problems.

HIV/AIDS in Rivers State

Rivers State, located in the southern region of Nigeria known as South-South Zone, comprises 23local government areas. Port Harcourt is its capital. Rivers State has a general population of 5,198,716 (2006 population census): 2,525,690 females, 2,673,026 males, and a yearly population growth ratio of approximately 3.41%. In 2012, the population increased to 6,429,596, with an estimated 1,414,511 women of childbearing age and 321,480 pregnant women living there by the end of 2012 (Rivers State Ministry of Health, 2015). The HIV/AIDS prevalence stands at 6% and has been fluctuating since 1999. However, since 2001, it has exceeded the federal prevalence level of 4.1% as of 2013 (RSMH, 2013).

Rivers is one of 13 Nigerian states that comprise 70% of Nigeria's HIV mother-to-child transmission burden (RSMH, 2013). For example, the state's 2010 Antenatal Sero-Prevalence Survey data on the HIV/AIDS epidemic revealed that an estimated 10,680 pregnant women were HIV-positive, and about one third (3,560) of them infected their infants with the virus in the same year (RSMH, 2013). Similarly, nearly 19,289 of 321,480 pregnant women in Rivers State in 2012were HIV-infected, and about one third (6,833) of this population infected their infants (RSMH, 2015).

Gender Issues and HIV/AIDS Globally

According to the United Nations Development Program (2004), the HIV/AIDS epidemic has become highly feminized worldwide as girls and women become more at risk and carry the stress of care for impacted family members. Young adult women comprise 60% of all 15-to24-year-olds infected with HIV/AIDS globally. Additionally,

the United Nations Development Program found a solid connection between vulnerability to HIV/AIDS and population age. For example, the 2003 sentinel seroprevalence analysis indicated a predominance ratio of 5.2% for young people showing a greater national average of 5.0% (United Nations Development Program, 2004).

Otive-Igbuzor (2003) referred to *gender* as an array of community values, beliefs, attitudes and norms that shape and describe what is agreeable as feminine and masculine behavior. Though feminine and masculine mores differ among cultures, they usually favor men. However, sociocultural factors and practices reflect several roles, norms, society expectations, and beliefs that guide these people's way of life in society. For example, cultural values are described as inviolable and sacred, specifically where these values influence superiority over the other group or gender, as the African autocratic system exemplifies (Otive-Igbuzor, 2003). Siyanda (2012) defined the patriarchal system as a gendered network of political, economic, and social relationships in which men dominated women's sexuality, reproduction and labor and defined women's privileges, rights, and social status.

According to Wingood and Diclemente (2000), patriarchy thrived on women's economic dependence on men, men's access to women's bodies for sex, and unequal power relations between men and women. Society promoted these norms in families, healthcare institutions, schools, and workplaces. Overall, these norms promoted gender division of labor, as well as the stereotypic structure of femininity and masculinity (Wingood & Diclemente, 2000).

In Sub-Saharan Africa

Africa's portion of the worldwide HIV/AIDS epidemic has escalated dramatically. Of the 23.0 million adults infected with HIV/AIDS, 13.2 million are women, which comprise 77%of all women with HIV/AIDS across the globe as of 2003 (World Bank, 2005). Africa is the only continent in which the HIV rate is greater for women than for men: women account for 57% of HIV/AIDS-impacted adults there. For example, for every 15-to19-year-old boy with HIV, five to six girls in the same age group are HIV-positive (World Bank, 2005).

In Sub-Saharan Africa, about 40% of all illnesses that affected women of childbearing age occurred as a result of reproduction and sex, and for several women sex was accompanied by fear of HIV infection or pregnancy (Otive-Igbuzor, 2003).

From 2001 to 2003, the number of women aged 15 to 49 with HIV/AIDS increased from 5.3% to 13.2 million, while the number of men increased from 5.0% to more than 9.8 million (World Bank, 2005). The ratio of females to males with HIV/AIDS rose from 12:10 in 2001 to 13:10 in 2003. Youths aged 15 to 24 comprised nearly one half of all new infections, both globally and in that age group. In southern Africa, gender disparity is most significant, ranging from 24:10 to 45:10 (females to males) in Mali and Kenya, respectively (World Bank, 2005). Three crucial interconnected elements place gender inequality at the center of Africa's HIV/AIDS epidemic:

- Vulnerability to the virus/disease greatly differed for women and for men, as most evident in prevalence difference in age and sex.

- The effect of HIV/AIDS varied along gender lines, following women's and men's diverse duties and roles in their families. Similarly, gender inequality in access and ability to control resources has implications for support, care, and treatment programs, and mostly for addressing the demands of 12 million AIDS orphans in Sub-Saharan Africa.
- Gender relations related to sociocultural practices in Sub-Saharan Africa must be changed for Nigeria, as part of Sub-Saharan Africa, to abolish or reduce its HIV/AIDS epidemic and its long-term effects on women's health (World Bank, 2005).

In Nigeria

Nigeria is a male-dominated society in which woman's main role is to bear and care for children and manage the home. This low status, coupled with no access to education, and the following of sociocultural practices such as early marriage, polygamy, religion, traditional belief, and culture increase women's vulnerability to HIV (Nasidi & Harry, 2006, p. 30). In addition, Nigerian marriage practices violate women's human rights and influence the high rate of HIV among females.

Unfortunately, Nigeria as a nation has no record for appropriate age of women for marriage, and early marriage is still practiced as a culture. Parents consider this practice a way to safeguard their young daughters from the outside world and maintain their chastity. Female children are allowed to marry at 12 and 13, and the age difference between husbands and wives is very large: husbands can be as much as 20 to 25 years older (Nasidi & Harry, 2006, p. 31). Furthermore, girls who marry so young are more

vulnerable to HIV infection from their husbands, because it is culturally acceptable for husbands to have multiple sexual partners outside marriage, and even marry more than one wife. These practices intimidate young married girls such that they cannot negotiate safe sex or condom use (Nasidi & Harry, 2006, p. 31).

In Nigeria, heterosexual communication played a key role in the spread of HIV, accounting for nearly 80% of all infections. For females at childbearing age, most ill-health stress was related to reproduction and sex.

In Nigeria, women are culturally connected to reproductive roles not valued in the society. Though they comprise about 70% of the farmers, their contribution to their nation's socioeconomic growth is seldom remunerated or acknowledged, and they are put in a dependent, passive, subordinate social position with chastity, moral, virginity, motherhood, obedience, and superiority as key virtues (WHO, 2002).

Additionally, men in Nigeria are identified as independent, knowledgeable, and income-earning. Men see no wrong in smoking, reckless driving, alcohol abuse, aggression, and such risk-taking behaviors as having multiple sex partners, because these traits are perceived as masculine and give men a false sense of immunity and power (WHO, 2002). The Nigeria HIV Fact Sheet (2011) reported that women age 15 and up have an HIV prevalence of 52%, men of that age bracket have a 37% prevalence, and children under 15 have an 11% prevalence.

Sociocultural practices in Nigeria. Iwara and Alonge (2014) found that sociocultural practices increased women's vulnerabilities and risks of communicable infections and diseases, and these sociocultural factors blocked their access to support

and treatment for them. For example, many harmful traditional beliefs and practices such as wife inheritance, tattooing, child marriage, scarification, and female genital mutilation/circumcision put women at more risk to HIV infection. In a typical traditional African society such as Nigeria, a woman functions as a child bearer and caregiver and, as such, carries the burden of the effect of HIV and AIDS. Furthermore, Nigerian women are often forced to take responsibility for their sick spouses, parents or children, and to care for orphans. This is a cumbersome role, as women in various regions of Nigeria lack access to health awareness, good healthcare, property or inheritance. Female children are usually taken out of school to help the family with more income, often through the sex trade (Iwara & Alonge, 2014).

Cultural practices both impact women's health in a given geographic location and influence their daily affairs, including their overall health and disease. Augustine (2007) stated that each society has a particular *modus operandi,* and these cultural practices influence the people's attitudes toward perception and management of any disease, including other health problems they experience. Similarly, Iwara and Alonge (2014) found that these sociocultural factors make women more vulnerable to HIV, especially in rural areas (2014).Also, certain sociocultural practices that spur the spread of HIV heavily influence Nigeria's high HIV/AIDS epidemic and death rate (Augustine, 2007).

Medwiser (2013) reported that a major impediment to HIV/AIDS tests and therapy was the sociocultural influence and stigma associated with the disease. The following sociocultural practices promoted HIV/AIDS among women in Nigeria:

- *Polygamy*. Men often saw this cultural norm as compulsory in a community. It was legally acceptable wherever men were allowed to marry more than one wife. This created a concurrent sexual network inside the marriage with multiple wives and one husband, as well as any extramarital sexual contacts in which the husband may have been involved, which put the women at greater risk for HIV (Nteziryayo, 2008).
- *Early marriage.* This put young girls at serious risk for HIV, because they are most likely to be forced into sexual activity with their spouses, who are usually much older, as a consequence of gender inequality. For example, Nteziryayo (2008) found that in Ethiopia an 11-year-old girl from Amhara Village was forced to marry at age 5, and she first had sex at 9.
- *Traditional beliefs and practices.* Cutting of female genitals, widowhood, and sexual cleansing not only put women at risk for HIV, but also caused them irreversible health damage and permanent suffering. For example, female genital cutting put girls at greater HIV risk through the use of unclean instruments, such as knives and razors (Nteziryayo, 2008, p. 3).
- *Religious belief systems and practices.* They reject sex before marriage, condom use, homosexuality, and contraception. Certain religions promote gender inequality in marital relations and foster women's ignorance in sexual issues all in the name of purity, but others condemn HIV as sinful and a punishment from God. Gender and sexuality stereotypes as a result of these religious beliefs and practices could hinder HIV prevention endeavors

(Nteziryayo, 2008, p. 4). Additionally, this religious judgment played a major role in creating HIV/AIDS-related fear and stigma, which further increased women's vulnerability to the disease. Religious belief systems and practices also precluded both male and female exposure to perception and knowledge of risks, HIV/AIDS prevention messages, and adherence to prevention strategies (Nteziryayo, 2008, p. 4). In Kenya, for example, safe-sex commercials were banned, as Pope Benedict, during his 2009 trip through Africa, banned condom use in general. In addition, the Catholic religious denomination renewed the condom ban in 2013 in Catholic schools (Medwiser, 2013). The Muslim leaders took a similar stance in 2008. Condemnation from both Muslim and Christian religious leaders regarding HIV/AIDS and preventative measures significantly impeded safe sex campaigns as well (Medwiser, 2013).

Methodology in the Literature

Several studies of women's health and HIV prevention strategies in Nigeria used a qualitative research methodology through questionnaires. For Patton and Cochran (2002), qualitative methodology explored attitudes and experiences of people or a community and answered questions about the *how*, *why* or *what* of an event instead of the *how much* or *how many* that are answered in a quantitative method (p. 3). Questionnaires are a quick way to collect adequate data from a large sample of participants, and the researcher need not always be present when the questionnaires are completed (McLeod, 2014). Questionnaires also allowed me more interaction with the participants, in terms of explaining the research procedure and answering any questions the participants asked.

Summary

Recent studies indicated that women have been ignored in HIV/AIDS research, treatment, and global prevention endeavors (American Foundation for AIDS Research Fact Sheet, 2008). The literature review demonstrated that gap and justified the need for this study. In addition, this study needs to be conducted in Nigeria to better understand the effects of gender inequality on women contracting HIV/AIDS at different stages, particularly the influence of gender inequality on prevention, intervention, support, and care among women from different Nigerian cultures (Monjok et al., 2009).

HIV/AIDS prevention/intervention improvement requires consideration of the fundamental public notions and structure of activities that influenced risks and enhanced the disease transmission and growth (Auerbach, Parkhurst, Cáceres, & Keller, 2013). Though significant progress has been made in HIV/AIDS prevention and intervention since the 1980s, the virus has continued to spread worldwide (Auerbach et al., 2013).

Chapter 3 describes the strategy employed in gathering and interpreting data for this study. Chapter 4 focuses on the research findings, along with participants' responses during the one-to-one interviews. Chapter 5 presents the analysis of the study results, the research questions, the implications for social change, and a call for future research for taking further action against the HIV/AIDS epidemic.

Chapter3:Research Method

Introduction

The purpose of this study was to explore the impact of sociocultural practices of early marriage, traditional beliefs, religion, and polygamy on the gender inequalities that cause lack of knowledge and awareness of HIV/AIDS among women in Port Harcourt, Rivers State, Nigeria. In this chapter I discuss my use of the qualitative approach and a phenomenological design I employed to hear participants' life stories and experiences in their own words, which were very helpful in data collection. I also explain the research design, the researcher's role, and the rationale for choosing a phenomenological design. In addition, this chapter presents the study sample and the process through which they were selected to participate in the study. Overall, this chapter outlines the instrument and method for data collection and data analysis, including ethical considerations.

Research Design and Rationale

Phenomenological design was employed to elicit participants' life stories and experiences in their own words, which aided data collection. Phenomenology "describes the meaning for several individuals of their lived experiences of a concept or a phenomenon" (Creswell, 2007, p. 58) when used as a study technique of investigation in which the researcher establishes the essence of people's experiences as the participants describe them (Creswell, 2007). This technique involved a semistructured questionnaire. Mack, Woodsong, Macqueen, Guest, and Namey (2011) defined a qualitative research method as a type of scientific study comprising a survey that methodically employed a predefined set of procedures to answer research questions, collect proof, furnish results

that were not predetermined, and produce results applicable to the research study. Through this research study, I intended to answer the following questions:

1. How do early marriage, polygamy, traditional belief, and religion promote HIV/AIDS transmission among women in Port Harcourt?
2. How does unequal power relation promote women's lack of HIV/AIDS awareness?
3. How does sexuality hinder access to health services and knowledge of HIV/AIDS?

The use of probing and open-ended questions in qualitative research lets the participants answer questions in their own words rather than force them to choose from established answers, as a quantitative study method would do. In a qualitative research method an open-ended question can also induce a response that is rich and explanatory in nature, therefore useful and culturally pertinent to the participant (Mack et al., 2011).

Phenomenological Design and Background

A phenomenological method was used in this study to show the effects of sociocultural influences on gender inequality related to HIV/AIDS among women in Port Harcourt. This design focused on gaining participants' knowledge and understanding of sociocultural contexts and their interpretations of lived experience and sociocultural factors. The different types of phenomenology include realistic, existential, constitutive, and hermeneutic (Linsenmayer, 2011).

However, the one that applied to my study was realistic phenomenology, which could address issues of gender (Linsenmayer, 2011). This method gave me more insight

into gender inequality and women's thoughts, feelings, and perceptions of HIV/AIDS, as well as how their lack of knowledge and awareness of the virus increases their risk of contracting it. Thus, the subjective aspect of the sociocultural practices made the phenomenological design more fitting than a quantitative method. Phenomenological researchers try to find the basis of an experience, recognize shared experiences, and discern the global nature of the experience (Ballad & Bawalan, 2012, p. 3).

Similarly, a phenomenological study enabled me to employ perceptions, stories, cultural experiences, and descriptions from the participants. A phenomenological qualitative approach also secured against bias by letting me set aside my prior knowledge of the event, my personal beliefs, and my professional familiarity with all literature studied on the event (Ballad & Bawalan, 2012). According to Myers (2007), a qualitative study employs individual documentaries, interviews, and experiences of the participants' information to comprehend and describe behavioral and sociocultural events that influence gender inequality related to lack of awareness and knowledge of HIV/AIDS among women.

Phenomenological research minimized prejudice by disregarding people's misconceptions about culture, beliefs, and customs while handling problems with a new, unbiased openness of mind (Kelle, 2005, p.3). This helped me to draw specific questions for the interviews and the questionnaire and to focus more on the study's main topic.

A phenomenological qualitative study design also captures participants' feelings and impressions based on their past and present experiences associated with their culture, which were applicable to the study's purpose (Creswell, 2005). Also, phenomenological

design is ideal for emerging studies, minimally studied topics, and exploratory research, as it deals with problems associated with population, gender, behavior, culture, religion, ethics, and ethnicity.

Therefore, the study design collected information to explore gender inequality related to such sociocultural elements as polygamy, religion, early marriage, and traditional beliefs and practices that promoted and increased HIV/AIDS risks among women in Port Harcourt. The phenomenological method featured an in-depth interview session with each female participant in a one-on-one semistructured format with audio recording. These open-ended qualitative interviews let the participants express their ideas more freely without restraint or any subjective opinions from the interviewer (Creswell, 2005). The interviews also captured each participant's perception and experience of HIV/AIDS. Ballou (2011) demonstrated that the features of open-ended questions were reduced when the researcher failed to listen closely to participants' responses. Open-ended questions in the questionnaire for the face-to-face interviews also reduced any inclusion of preconceived bias (Ballou, 2011).

Researcher's Role and Background

Growing up as a female child in a polygamous family, I was always driven to advocate against polygamy, gender inequality, and early marriage, as women have been mistreated and denied their rights as humans in their individual homes and the community in the name of culture and tradition. My passion for this research study was not to cause further harm or bias to women, but to impart knowledge and insights from my research participants regarding gender inequality related to HIV/AIDS.

As a health practitioner, my private encounters working with young adult female clients facilitated a culturally appropriate communication strategy regarding gender inequality and HIV/AIDS among women in this setting. However, my geographic background and shared culture with my participants created a private bond to these female participants' lived experiences of gender inequality related to HIV/AIDS without creating bias. I also developed a foundational understanding by which to examine the topic from a local point of view, which would need the use of appropriate competence to carry out the study and demonstrate my relationship as a researcher with the participants. In addition, I made sure all data collected were reliable, valid, and free of bias.

I conducted research using a semistructured questionnaire for one-to-one interviews with participants as a means of exploring and identifying each participant's beliefs, insights, and perceptions. Their responses were based on their individual experiences of sociocultural values and practices, whether or not they participated or were intimate with those who carried out those sociocultural practices and values in Port Harcourt. According to the United Nations Educational, Scientific and Cultural Organization (2009), the significance of institutional study in creating cultural techniques for diverse populations was a way to formulate educational awareness of HIV/AIDS. My travels to Port Harcourt enabled me to visualize the environment, meet with the participants, and request permission to use the institution and students for this research.

My major role during the study was to ensure the confidentiality and privacy of the participants and their answers per Walden University research policy. To maintain this, codes replaced participants' full names, and a tape recorder was used during the one-

on-one interviews. Before starting the interviews, I introduced myself, my mission and my research purpose and supplied an informed consent and confidentiality form, which each participant signed. I made sure to vividly explain all necessary information to participants for better comprehension of the study before each interview began.

Methodology

The study was done analytically through one-on-one interviews to explore participants' perceptions and experiences of gender inequality related to HIV/AIDS among women, so that I could draw more accurate, current data directly from the participants' perceptions, stories, cultural experiences, and descriptions, without bias.

Study Population

A population is defined as a group of individuals with similar features that separate them from different groups (Creswell, 2005). This study population comprised female students from different ethnic groups in Rivers State. Previous research studies included both men and women, especially women who were more submissive in a culture that defined men as superior (Ezumah, 2003; Smith, 2003). However, this study involved educated women only: 20 female students from a college in Port Harcourt. In a phenomenological study, the sample size can range from six to 20 (Creswell, 1998; Morse & Chung, 2003). A qualitative research study's sample size "should not be too big, in order to avoid the difficulty of extracting rich data" (Onwuegbuzie & Leech, 2007, p. 242). Nor should the sample size be too small, as it could be cumbersome to accomplish saturation of data (Onwuegbuzie & Leech, 2007). In addition, qualitative researchers should use a minimum sample of 12, as this number allows enough time to

plan, structure, conduct, and partly translate these interviews (Baker & Edwards, 2012, p. 10).

The participants were women aged 18 to 45, and their selection was done through a purposive sampling, which is employed to make sure the participants are appropriate for the study (Neuman, 2014).A study sample must also involve participants who furnish proper data comprising formation of cultural elements (Saunders, 2012). This sample selection fit, because the study was not carried out to compare findings with other populations, but to explore the sociocultural practices that put women at high risk of HIV/AIDS in Port Harcourt.

I chose women who spoke, read, and wrote English with reasonable fluency, as English was the primary language used to transmit all lectures and information in the institution. The participants had to be female, because the topic revolved around women. Each interview section lasted from 45 minutes to an hour, and every participant was allowed ample time to answer the interview questions. The study was conducted in a private room inside the school auditorium, the college's most convenient environment for conducting a study and gathering sufficient data for analysis.

Criteria for Study Sample Selection

To cull participants, I posted notices of the study on the school board, and flyers were shared among the students. The participants were allowed to review the consent form before signing it and were reassured that participation was voluntary and withdrawal from the study at any time was permitted. Participants were also assured of strict confidentiality of all information they furnished in the research process. To protect

their identity, their full names were not reflected in the study questionnaire; all data gathered in a research study must be kept strictly confidential to assure the study's integrity (Cone & Foster, 2003). As such, I used codes in lieu of names to keep all participant feedback anonymous. At the start of the study, a 2-to-3-member focus group was arranged to assure reliability and validity of the interview questions.

Data Collection Procedures

Data were gathered from the narrative descriptions of participants' responses on the questionnaire, which provided information on individual perceptions of women regarding the effects of gender inequality on women's knowledge and awareness of HIV/AIDS transmission. The narratives also revealed sociocultural forces that increased women's vulnerability to HIV, which included, but were not limited to, polygamy, faith, traditional beliefs, individual conduct, and cultural practices. These participants either participated in or had close relationships with people who followed those sociocultural practices and lifestyles. Data were collected from participants' responses from the questionnaire during one-to-one interviews, feedback from open-ended questions, and telling of stories related to past experiences and their current perceptions about HIV/AIDS. I geared my questions toward participants' perceptions of the effects of unequal power relationships between men and women.

The one-to-one interview with open-ended format questions enabled the participants to furnish more information significant to the research and enhanced their capability to express their stories freely, because the forum and environment were conducive to collecting data for the study. Similarly, employing one-to-one open-ended

qualitative interviews allowed participants to speak freely without restriction or biases toward me (Creswell, 2005).

Data Analysis

I used NVivo10 (qualitative) software to analyze the data. Creswell (2005) recommended new software for research analysis because it aided data sorting, securing, and analysis, specifically in times of pressure (p. 234). All data were transcribed and put into the software, which revealed developing trends, themes, and features. NVivo 10 also minimized bias and strengthened the validity of the data. In classifying the participants' answers, NVivo10 contrasted participants' responses based on their perceptions and understanding of the effects of gender inequality related to lack of knowledge and awareness of HIV/AIDS prevalence among women living in Port Harcourt.

NVivo is "a code and theory building tool" that lets the user duplicate all capabilities of the pen-and-paper system into the software (Jones, 2007, p. 13), which permits unified emphasis of content by font, feature styles, and color. Furthermore, NVivo 10's file linkage capacity let me link data together instantly without affecting documents in the system and code and manipulate the data by permitting unlimited control on it without changing the initial dataset. NVivo also expanded the ratio at which the data could be accessed, retrieved, and viewed, thus allowing for limitless sample sizes and data searches (Jones, 2007).

Creswell (2005) demonstrated that researchers had to be able to code, segment, and distribute data into ideas. So, in this research, data were organized according to subject matters or ideas and arranged in segments for interpretation.

Overall, NVivo 10 helped me to analyze the qualitative data through precise coding of it between classifications and ideas. The research questions, data collection, and data analysis were coded following the qualitative research procedure. I maintained the categories and principles of the study software to decide the main ideas significant to the data's concluding interpretation.

Location of the Study

The research was conducted at a college in Port Harcourt, Rivers State, Nigeria. The city, located in the southern part of the country known as South-South Zone, comprised 23 local government areas and had a general population of 5,198,716 (2006 population census), including 2,525,690 females and 2,673,026 males, with a yearly population growth rate of approximately 3.41%.By 2012, Port Harcourt's total population had grown from 6,162,000 in 2011 to 6,429,596, with about 1,414,511 women of childbearing age and 321,480 pregnant women (City Population Index, 2015; Rivers State Ministry of Health, 2015). Also, the college enrolled more women into different programs—nursing, midwifery, public health, and so-on—to honor and encourage female education. Women were thus educated at higher levels to fulfill the geographic region's need for a larger number of well-educated, well-informed women.

Threats to Validity

In every research study, the researcher must acknowledge the possibility of bias during data collection. This study's major threat to validity was participants' mood changes. For instance, participants' behavior was liable to change from good to bad moods, or they could exhibit boredom, tiredness, inattention, hunger, and so forth.

Similarly, participants may not have slept well the night before the interview, or may have been thinking about upcoming tests or their course load, which may have caused them fatigue or inattention.

To prevent compromise in findings and data interpretation, I was welcoming and open-minded, and I accepted participants' refusal to continue. One-to-one interviews and the fear of insecurity among participants could threaten validity due to the nature of the research topic and the shame that accompanied it, so I had to possess professionalism, reliability, genuineness, and personal integrity to win participant trust.

Ethical Procedures

The current study involved human subjects who shared their ideals, perceptions, and experiences of gender inequalities related to HIV/AIDS among women. I first asked Walden IRB for permission to protect my human subjects' confidentiality and had the participants voluntarily agree to informed consent. This did not pose any challenge, even though people in Nigeria were sensitive to the subject of HIV/AIDS. However, I used codes to label participants' information instead of full names to document the data. I also asked for permission from the college to use the students and the school environment for my research, which enabled me to gain IRB approval to do so.

I also informed participants of the intended technique for safeguarding their anonymity. This way I knew all information was secured and confidential for research only; knowing how sensitive the HIV/AIDS topic was in my research location, a protected environment such as an office inside a school auditorium was more ideal for concealing the participants' physical identities. They were informed that the study was

voluntary and they could skip any question that gave them discomfort, but they were encouraged to respond to all questions and were free to withdraw at any time.

Treatment of Data

All collected data were kept confidential and safe from modification, loss, distortion and adjustment to protect participants' rights. To maintain this confidentiality, I prepared to decline anyone asking to obtain the research data.

Summary

This chapter began by describing the research design, which involved a semistructured questionnaire that was based on the study's three core research questions but encompassed open-ended questions that enabled the participants to answer in their own words so more authentic information on their ideals, perceptions, and experiences of gender inequalities related to HIV/AIDS among women could be solicited.

Then I explained my choice of a phenomenological design to give me deeper insight into gender inequality, women's thoughts, feelings, and perceptions of HIV/AIDS, and how lack of knowledge and awareness of the virus increase women's risk of contracting it. This qualitative approach enabled me to experience the participants' perceptions, stories, cultural experiences, and feelings about their experiences more directly. Possible threats to validity included participants' mood changes or thought/feeling distractions during the interview process.

I then related how my background as a female child in a polygamous family motivated me to advocate against polygamy, gender inequality, and early marriage, hence conduct a study on how these and other sociocultural values and practices influence the

spread of HIV/AIDS among women. This study involved one-on-one interviews with 20 female students at a college in Port Harcourt, Nigeria, aged 18 to 45. Because such a study would probe into sensitive personal issues for them, I explained the care I had taken to assure each study participant's privacy and confidentiality by replacing participants' names with codes and tape-recording their interviews.

My methodology also included culling data directly from responses to the questionnaire during one-to-one interviews, feedback from open-ended questions, and narratives of past experiences and current perceptions of HIV/AIDS. Data were managed through NVivo 10 software, which revealed developing trends, themes, and features helpful to the study's goals and linked coded and manipulated data appropriately without altering the initial data set or breaching the confidentiality agreement.

In summary, this chapter covered the entire research blueprint and process. Chapter 4 presented a fuller description of the research data and analysis and reported the results of this process.

Chapter4:Results

Introduction

The purpose of this study was to explore the impact of sociocultural practices of early marriage, traditional beliefs, religion, and polygamy on the gender inequalities that cause lack of knowledge and awareness of HIV/AIDS among women in Port Harcourt, Rivers State, Nigeria. The participants were female students from a college in Port Harcourt, aged 18 to 45. The main research questions that aided this study were:

1. How do early marriage, polygamy, traditional beliefs, and religion promote HIV/AIDS transmission among women in Port Harcourt?
2. How does unequal power relation promote women's lack of HIV/AIDS awareness?
3. How does sexuality hinder access to health services and knowledge of HIV/AIDS?

Data Collection and Definitions of Terms

Before interviewing, I defined the terms below. All participants accepted all of my term definitions.

Polygamy: This is the sociocultural practice of marrying more than one wife, which is legal in most world regions. Delecce (2014) defines polygamy as a cohabiting structure in which a male or female gets involved with more than one spouse concurrently.

Early marriage: This is the act of marrying before age 18. For example, Nteziryayo (2009) found that in Ethiopia an 11-year-old girl from Amhara Village was forced to marry at 5, and she engaged in sexual activity when she turned 9.

Religious beliefs: Nigerian religious beliefs dictate that premarital sex, condom use, homosexuality, and contraception are "evil" acts, thus condemn HIV as punishment from God and promote gender and sexuality stereotypes as HIV preventers in women.

Traditional beliefs: These declare that such acts as female genital cutting, widowhood, and sexual cleansing put women at high risk for HIV. For example, use of unclean knives, razors, and so forth to cut genitalia renders girls more susceptible to the virus (Nteziryayo, 2009).

The participants, 20 female students from a college in Port Harcourt, expressed willingness to discuss sociocultural practices of early marriage, traditional beliefs, religion, and polygamy and the gender inequality related to HIV/AIDS in one-on-one interviews in a safe location. Participants were married women aged 18 to 25, selected through a purposive sampling. They shared the same race, ethnic or cultural background, and geography. All met the study demographics requirements proposed in Chapter 3. I assigned each participant a fictitious name to hide her identity throughout the interview process and data analysis.

The 45-to 60-minute interviews were conducted in English, as the participants could speak, read and write English with reasonable fluency. Before the interviews and the signing of the informed consent form, participants were allowed to read the form and ask questions about it and were assured of their right to opt out of the study at any time.

Table 1 presents the participants' demographic information, along with their pseudonyms.

Table 1

Demographic Information for Study Participants

Name of Participant (not real name)	Age	Local Government	Years of Post-Secondary Education	Years Married
Joy	26	Ogba/Egbema	2	9
Beatrice	24	Ndoni	2	6
Margaret	30	Ikwerre	2	10
Ada	23	Okrika	2	5
Ichechi	25	Ahoada	3	8
Ogechi	22	Ogba/Egbema	1	4
Gladys	21	Gokana	2	4
Peace	27	Omumma	3	10
Judith	26	Emohua	2	9
Blessings	24	Degema	2	6
Ornu	25	Obio-Akpor	1	7
Chima	26	Ikwerre	1	6
Winifred	24	Ahoada	1	4
Doris	27	Okrika	3	8
Ruth	27	Etche	3	8
Juliana	29	Bonny	2	11
Jennifer	25	Bori	2	8
Oyiyechi	28	Ikwerre	2	9
Comfort	21	Opobo/Nkoro	3	3
Juliet	23	Obio-Akpor	2	3

Findings

I imported the interview transcripts into NVivo10 for data analysis and management. Then I assigned data analysis nodes related to the three research questions. I carefully reviewed the transcripts to familiarize myself with their contents and to ensure that their content aligned with the purpose of the study.

I then reread the transcripts to separate the information into units of meaning, or codes. These codes were then assigned to each data analysis node and grouped into

categories, and then themes. The themes were organized according to the research questions.

I used inductive design to analyze the themes I had discovered, to allow important analysis dimensions to emerge from the research questions and to establish a clear link between the participants' experiences and the general phenomena of gender inequality as a hindrance to women's knowledge and awareness of HIV/AIDS.

The themes that emerged from the participants' narratives during the interviews are detailed in Figure 1.

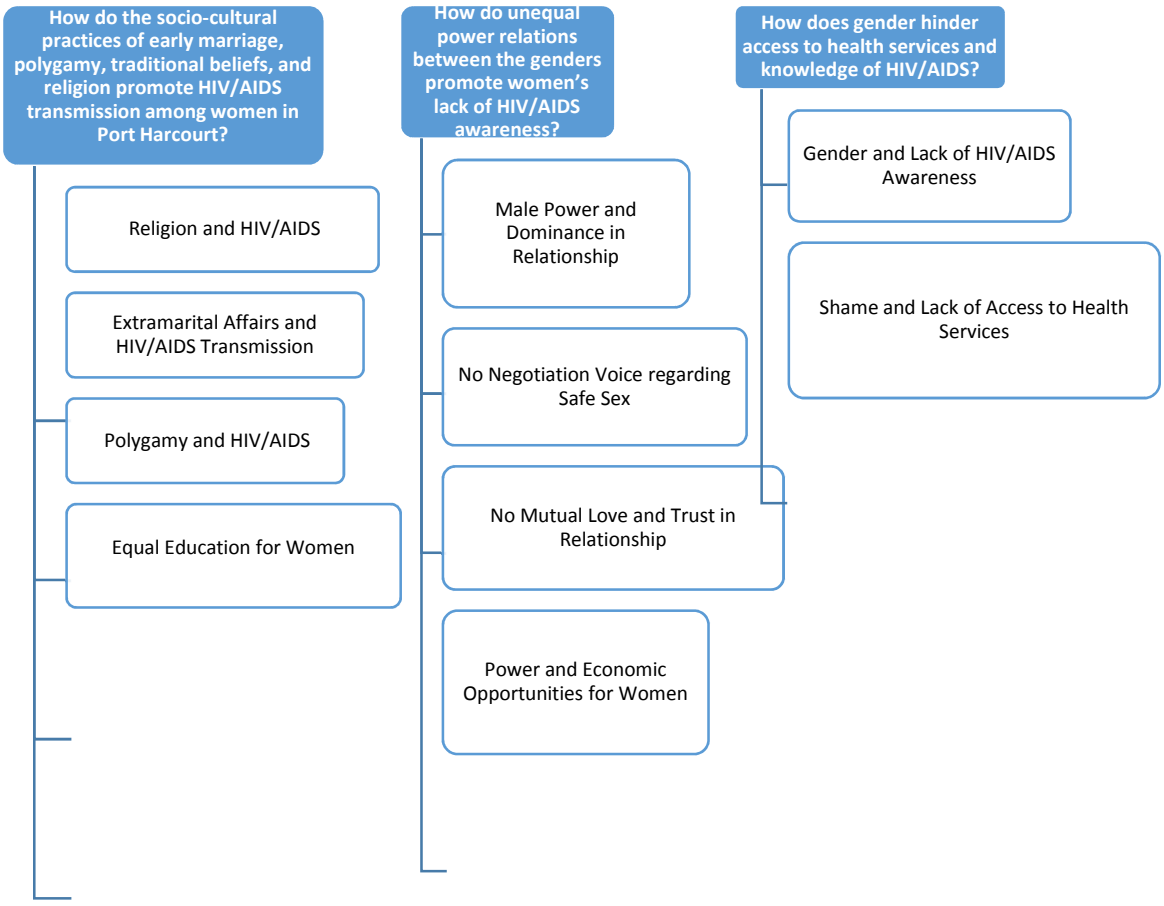

Figure 1. Themes.

Research Question 1

How do early marriage, polygamy, traditional beliefs, and religion promote HIV/AIDS transmission among women in Port Harcourt?

The themes that emerged from participants' responses are described below.

Religion and HIV/AIDS. All agreed that religion encouraged inequality in marriage, and that the religious belief that women must always submit to men, even to the detriment of women's safety, put them at risk of contracting HIV/AIDS. On this subject, Doris said:

> I don't want to sound like I hate church, but, you know, all these abuses come from the church. How can a man, beat up his wife, and the church counseled the woman to stay in an abusive and controlling marriage? This was what happened to me, and I had to leave the church, and the pastor said I was the bad one. The truth is, I have peace today. No woman should endure abuse of any type… I think many people will give you different answers depending on what they think.

Winifred said:

> In talking about religion or culture, they both promote gender inequality. Also, based on what I said earlier, these practices contribute to the increasing HIV/AIDS among women. When churches support society on this idea of men controlling women from the pulpit, it becomes a part of the women's daily living in their families and the society at large.

Jennifer said:

> Madam, I believe you go to church. Don't you hear every Sunday, "Women, submit to your husbands,""Women should not deny their husband sex,""Men are the head of the family,""Men make the final decisions in the house," and so on? Does this sound like equality, or inequality?

Based on religious and cultural practices in Port Harcourt, women could not resist men's sexual advances. Questioning a husband's extramarital affair, though known to contribute to HIV/AIDS transmission among women, translated to disobedience of the man, who was in control of the relationship. Because this increased women's vulnerability to HIV/AIDS, religion did play a big role in its transmission, which became a byproduct of the gender inequality and male dominion that Nigerian religious tradition preached. With this value, women had no say in the marriage, thus could not ask their husbands to use condoms for protection against HIV.

Extramarital affairs and HIV/AIDS transmission. The role of religion in marriage perpetuated the norm of extramarital affairs. This theme emerged from the responses to the ninth interview question: In what ways do religious beliefs and practices promote gender inequality and transmission of HIV/AIDS among women? On this subject, Blessing said:

> Religious values here put the women down, and then preach love. They will tell you that God treats everyone equal, but they don't treat women with the same respect and equality. Putting the women down is not getting better, despite changes in today's world. How would men feel if women controlled them?

Margaret agreed:

> When churches teach young girls not to question the authority of these men, what do you expect? Go to this corner of the street: now you can see young girls out there hassling to survive even with people older than them, and you questioned what the increased rate of HIV among women here is. Also, we are talking about inequality, so, as you can see, there are always men putting down women because they engage in extramarital affairs with these women. This inequality was rooted so many decades ago and will take a lot of work to root it out, despite what you see as civilization today in our society.

Polygamy and HIV/AIDS. Participants agreed that, in a polygamous relationship, women were more vulnerable to HIV/AIDS than men. This theme emerged from the responses to the fifth interview question: What do you understand by polygamy? Its third sub question was: How is marrying more than one wife (polygamy) a factor that influences HIV/AIDS among women? In response, Gladys said:

> I think so, because most men sleep around and will not do screening for HIV before they get married. More so, they may marry the young girls who are HIV-positive, and they keep transferring it to other women who may not be aware that the new wife is positive of HIV. But how can you stop the men from not looking for the young girls for marriage? One of my co-workers, who has two wives, mentioned to me before that he got married to the second wife because he realized he wasn't going to get a male child after four girls from his first marriage. Unfortunately, the young or new wife happened to be HIV-positive. You see how marrying more than one wife contributes to the increasing HIV?

Doris said:

> The way the society allows men to treat women is not right. Just last week, my neighbor died and was buried, and the husband's elder brother wanted to take his brother's widow as the second wife. The woman's family refused to have their daughter taken as the second wife. Could you believe that this matter generated to a big violence between the two families? So the elders held that the man has the right to take the woman as the second wife based on the tradition. Up till now I still can't comprehend it. For me, I feel like the woman is forced to the man—the man who is known to sleep around with other young girls in the community because he's a politician. And this kind of man can spread HIV without him knowing.

Cultural traditions. The sixth interview question was: It is believed that cultural traditions promote subservience and submissiveness that lead to women's dependence on men in sexual relationship. Its third sub question was: What are the subservient behaviors and treatments that make women vulnerable to HIV/AIDS? In response, Comfort said:

> The subservience and submissiveness that you are talking about is bad for women. Both culture and religion support women's submissiveness like I talked about in Question 5 or 6. This behavior promotes power and authority on men over women in the sense that women can't question men's sex behaviors. So, yes, this behavior certainly will expose the women to HIV.

Men who practice polygamy value male children over female children. For example, if a first wife is unable to have a male child, the man seeks a second wife for that purpose. In

most cases, if the second wife does not produce a male, the man will continue to seek one by marrying more wives. This practice not only puts women at further risk for contracting HIV, but also underscores the importance of reproductive health education for people clinging to the unfounded belief that women, not men, determine the baby's sex. Thus, the lack of reproductive health education in Port Harcourt causes women to believe and accept the blame for not bearing a male child for their husbands. Nigerian culture's insistence that every woman must bear a male child for her husband gives more credence to the practice of polygamy.

Equal education for women. This theme emerged from the responses to the sixth interview question's fourth sub question: Share with me what you think can be done to alleviate this problem of sociocultural practices that promote HIV/AIDS among women. Participants agreed on how culture should be transformed so the oppression of women could be alleviated with equal educational and economic opportunities. Ada said:

> As I mentioned before, a young girl like my sister got into this situation because of her economy situation. Sometimes I don't blame her, because today people are defined by money, their way of lives, where they live—and I can keep up mentioning other things. Now you can see there needs to be economy opportunities, to empower them to know that they are valuable citizens, not individuals created to serve men, but to play vital roles in our society. Some of these girls sponsored themselves in college and need help from the government. Like subsidize school fees. We have to stop these young girls from being out there selling their bodies for economy reasons. I am sure you see what I mean. By

> supporting the girls through education and services, we can reduce the rate of HIV/AIDS among women.

Judith offered a similar perspective:

> What I don't understand is why more and more women are being infected with HIV than men. May be more men are not going for screening, compared with the women. So, there should be a program specifically directed toward the women in an effort to create awareness among these young women. There should also be a program targeting young men to go for the screening, too. Colleges should require students to do screening yearly. They should also have a free support system in place for students who may have been tested HIV-positive.

All participants agreed on the need for laws against female abuse, jobs for young women and their older children, and access to education about women's reproductive health and free college education for young women.

Early marriage. The eighth interview question was: What do you understand by early marriage? Its second sub question was: Tell me what happens when the woman decides to leave the marriage. In response, seven participants reported that children were their reason for not leaving their polygamous marriages, and when they tried to leave they realized they could not care for either themselves or their children as single mothers.

Research Question 2

How does unequal power relation promote women's lack of HIV/AIDS awareness?

The following themes emerged:

Male power and dominance in relationships. Participants affirmed that male dominance in relationships influences the spread of HIV in the community. The seventh interview question was: According to tradition, men control sexual relationships while women submit to them as tradition permits. In response, Juliet said, "This is not something that just happened now. Men have controlled women since when they were created."Winifred agreed:

> I think no one has the right to control another human being. They should work together and make decisions together to better the relationship. That is what I think, but I know it's not the fact, as more men control relationships.

Joy, however, related a trend of female willingness to risk reproductive health and safety by submitting to these sociocultural practices:

> As I am talking to you now, there is a competition of how many wives a man marries. I went through it getting married through this arranged marriage. The man approached my parents to marry me. The man promised my parent he would take care of me, and my parents agreed that I marry him. Being young, in my late seventeens, I couldn't say no to my parents, as that will mean disrespecting them against the culture or tradition. I know so many young girls, too, who got married earlier, and I was not concerned about my situation, so I accepted it and moved on. I have two children from my husband plus seven children from the other two women: this is an example of a polygamous marriage. As you can see, this sociocultural practice continues to influence everyone here in Port Harcourt.

In agreement with Joy, Beatrice said:

> How can this be a relevant practice in today's civilization, where HIV is prevalent? In my experience, young women suffer from this kind of relationship. It is sad to be under this control, but you really can't do anything because of the influence of the man. When a man goes from one woman to another and the culture encourages him to keep going after the young girls in the name of marriage using his influence, what do you expect? A rise in HIV/AIDS here in Port Harcourt! Remember, you can't even ask the man to use condom protection, as this can mean being disrespectful.

Margaret affirmed that these practices enable men to wield authority over women, which puts women at greater risk of contracting HIV/AIDS:

> Our culture still allows young girls to get married to older men because of power and money, and they don't care if they have two or three wives. All they need is a man to care for them.

This question's first sub question was: Explain to me how this behavior promotes HIV/AIDS among women in our present day. In response, all participants expressed unanimous agreement that men controlled sexual relationships while women submitted to men. Doris said:

> When men look at their wives as properties, they have sex with them whenever they want against their will. I mean, the women have no right to their bodies. Don't you think this behavior can promote HIV, since the women are always at the receiving end? That is, unequal power promotes men's masculinity, thus placing women in a position of unconditional obedience to their husbands.

Jennifer said:

> The women carry their bodies, but they don't control their bodies. Just like a woman cannot stop the man from sleeping outside, she cannot stop herself from carrying HIV because the man controls her. This is a big problem.

Juliana agreed:

> Don't you think women who are controlled do not have a sense of purpose? They tend to have low self-esteem that allows them to be vulnerable to HIV. They don't have the skill to negotiate decisions in a relationship, like asking the man to use condoms. Don't you think these women are vulnerable to HIV? Yes, they are.

Most participants described the contribution of male dominance in relationships to the spread of HIV among women, which Ogechi confirmed:

> I don't know where to start. There is a lot of what I considered sociocultural practices here in Port Harcourt. I don't know if you know that men control this city. They control the women, they control money, they control even relationships, they control churches, and they control traditional values. They can twist it around with money and influence. To me, it looks like women were just meant to serve man. I don't know, and sometimes I struggle to understand why, but I got no answers.

No negotiation voice regarding safe sex. Sharing their gender inequality experiences, participants discussed multiple facets of sexuality. Some suggested that sex motivates gender inequality; others tied it to economy and power. Regardless of causes, all agreed that gender inequality contributes to the increase in HIV/AIDS among women.

Expressing her views about men controlling women in a relationship, Oyiyechi agreed with other participants: “I think everyone knows that men control women in relationships, but what can be done to stop men from controlling women as their bed-right?”

Comfort added, “Like I said, when men are in control of the relationship, they can continue to bring women to the house or keep women outside of the marriage. The result is that the women will be exposed to the HIV.”

The above theme emerged from the responses to the sixth interview question: It is believed that cultural traditions promote subservience and submissiveness that lead to women’s dependence on men in sexual relationship. Its third sub question was: What are the subservient behaviors and treatments that make women vulnerable to HIV/AIDS? In response, Juliet said:

> The problem today is, women, in the name of marriage, are treated as properties by most men who feel they must control the women. By marrying another woman, men tend to feel they have control over the women, thus making the women vulnerable to HIV. Women need to be loved, not to be controlled or forced to submit to the man’s authority.

Religious beliefs and practices. The ninth interview question was: In what ways do religious beliefs and practices promote gender inequality and transmission of HIV/AIDS among women? In response, Margaret said:

> This is what I think: inequality starts from the church, where women are subjected to obey man’s authority. It’s a common faith—or, as you may call it, religious

> beliefs. These practices make it difficult for women to negotiate sex, like the use of condoms to protect sexual diseases like HIV/AIDS. Why? Because men are taught to be in control, and the women cannot even question where they [men] have been to, or question their outside activities.

Most participants agreed that the systematic controlling of women in relationships not only enforces their low self-esteem but also takes their negotiating voice away regarding safer sex that could have resulted in reducing HIV/AIDS prevalence among women.

No mutual love and trust in the relationship. All participants agreed that lack of mutual love and trust in marriage promotes HIV/AIDS. This theme emerged from the responses to the seventh interview question: According to tradition, men control sexual relationships while women submit to them as tradition permits. Its first sub question was: Explain to me how these behaviors promote HIV/AIDS among women in our present day. In response, Comfort said:

> The need to be loved is crucial and not to be controlled or forced to submit to the man's authority. More importantly, the right to reproductive health, including HIV/AIDS education, is essential to safeguard women's health.

That question's third sub question was: What do you believe should be done to create the mutual love and trust necessary to honor a women's right to reproductive education? In response, Ruth said:

> Go to the traditional rulers, politicians, lawmakers, and religious leaders. Tell them their practice of looking up to women as properties should be abolished. By treating women this way, it is a shame, and they should know that this controlling

> behavior make the women vulnerable to HIV/AIDS. Men make decisions about the woman's body. Some believe the culture forbids them to use protection like condoms to protect themselves. HIV doesn't care who you are—if it knocks at your door, you have to open. You can see I am frustrated with this stupid culture that doesn't help women, rather destroys them.

Power and economic opportunities for women. Participants agreed that these sociocultural practices are rooted in power and economic opportunities. This theme emerged from the responses to the third interview question: What do you understand by culture and tradition of your people? Its sub question was: How does the cultural tradition influence the community's way of life today? In response, Margaret highlighted an environment in which older men plied young women with money, which gave the men sexual power over the women. The men would exert this power to avoid using condoms during sex and would dominate this relationship. In agreement with Margaret, Ichechi said:

> You mean something like the girls and boys walking around with their pants down, showing their bodies? And they think HIV cannot touch them. Let me tell you, some of them are walking around with HIV, and the big men that are running after them may not know. I can tell you, if you enter that restaurant, you can see young girls waiting for these men who have wives at home. By the way, the society or the culture approves these practices. Some of them have more than one wife, and they control those women. This has been like this, and there is nothing you can do to change it.

Corroborating with Ichechi's experience, Judith further described this situation:

> This is a culture of money and power—no moral. Community fights the other community because of power: who controls the community land. Think of politics for a second—it's becoming violence every single day. Another thing I noticed today is how young girls don't respect themselves because of the same money and power. When you see a young girl between 16 and 21 going out with a 40-year-old man, what do you call this, opportunity? They control them because of money and power. Sometimes, I don't judge them because of the economic situation in the state. Most of them are dying, and people put it on malaria or yellow fever. I am very sure some died from HIV/AIDS. Because young women relied on older men in the community for economic opportunities and education, these older men were able to exert their control over the women through established sociocultural practices.

Participants agreed that these sociocultural practices have negative impacts on women's reproductive health and safety. Ada said, "These sociocultural practices are not great values, and I think they are destroying women's health in our community."

All participants agreed that the decades-old sociocultural practices promoting HIV/AIDS transmission among Port Harcourt women encouraged male dominance, creating unequal power relations between the genders. They also agreed that such cultural tenets as traditional beliefs and polygamous practices in Port Harcourt greatly determined women's societal positions in relation to social power and economic opportunities, which not only put women at risk of contracting HIV/AIDS, but also prevented them from

receiving information about reproductive health education and resources, including access to HIV/AIDS diagnoses and treatments. Yet the participants' concern for shared ownership of reproductive health among community stakeholders went beyond HIV/AIDS education. They all called for treating women with respect and integrity in general, to assure them overall safe reproductive health.

Research Question 3

How does sexuality hinder access to health services and knowledge of HIV/AIDS?

The following themes emerged:

Gender and lack of HIV/AIDS awareness. The first interview question was: How do female children differ from male children [physically and behaviorally] in the society? In response, participants agreed that gender bias was a key reason for increased HIV/AIDS among Port Harcourt women. Peace said:

> This society is structured in a way that women submit to men in all walks of life. Women can't attend to their reproductive health because their husbands do not want them to have this knowledge. Men can still be in authority, yet allow women to learn about their reproductive health. I have also seen a few women who stand up for themselves. To these women, the society condemned them for being possessed with demons. This is a way of manipulating women to submit to men's authority in a relationship.

The society's acceptance of the authoritative male role in the relationship exacerbates this gender-based epidemic, in part by denying women access to preventative health services and information. Comfort noted:

> A lot of women will like to know their HIV status, but may not know how to access this important information about their health, because their husband dictates or controls them, including the information that they need.

Shame and lack of access to health services. Participants agreed that economic and power structures favored men placing women at risk of contracting HIV/AIDS infection, in part by limiting reproductive health information, inflicting shame and stigmatization upon women, and not enacting policies that would protect this vulnerable population. This theme emerged from the responses to the tenth interview question: What do you think will happen if a woman tested positive for HIV?" and its sub question, "In what ways can a woman pay for diagnoses and treatment? In response, Ornu said:

> You know most women depend on the men to provide for them and the children. Most families are in poverty. Some struggle to eat once a day. So where is the money for HIV testing? No woman wants to tell another person that she's tested positive? So what this means is, women deny being positive, and continue to infect others. Some women don't even have the money to go for testing unless the husband or relative provides them the money. Another thing is, if a woman is tested positive and the news goes around the community, both the woman and man may be stigmatized in the community. This means that the man may not be able to talk to other women because of shame. Think about this: if the man was a

> leader in the church or a tribal leader, don't you think this is the reason most men stop their wives from going for HIV testing, to save the family from shame?

Participants agreed that denying the existence of HIV, or even attributing it to witchcraft, was a way to mask the shame and stigma associated with HIV diagnoses. Chima said:

> What I think is that most women will be too scared to talk about it. Here, people blame witchcraft for everything. I can imagine these women blaming people in their family for doing the juju—I mean the black power. Some prefer not to talk about it and die with it because of shame and being scorned by friends and family members.

Participants agreed that sociocultural practices of gender inequality subjected women to economic pressures, making them more HIV-vulnerable than men. They also agreed that women were often less able to seek reproductive health education due to economic dependence on their male partners and fear of shame or stigmatization, which translated gender inequality practices into a cultural repression autonomy that denied women their right to safe reproductive health.

Summary

Throughout this qualitative phenomenological study, I explored the perceptions and beliefs of women about gender inequality and HIV/AIDS among women, as well as factors that influence HIV/AIDS prevalence among this population in Rivers State, Nigeria. Participants furnished insights into their perceptions about the effects of early marriage, polygamy, and religious and traditional beliefs on HIV/AIDS proliferation among women in Port Harcourt. My analysis of participant responses to the three

research questions and their corresponding interview questions and sub questions revealed several dominant themes relating to the interviews' major lines of inquiry into the role of these sociocultural practices in HIV/AIDS.

Responses to Research Question 1 and its corresponding interview questions and sub questions revealed that religion encouraged women's submission to men in marriage and even permitted the norms of extramarital affairs and polygamous relationships to continue unchecked, both of which increased women's risk of contracting HIV/AIDS. The respondents also agreed on the importance of transforming Nigerian culture to eliminate men's oppression of women so equal educational and vocational opportunities could be opened up to women.

Answers to Research Question 2 and its corresponding interview questions and sub questions confirmed that male dominance in relationships does influence the proliferation of HIV among women in the community. This is exacerbated by systematic controlling of women, which deprives them of their ability to negotiate safer sex and use of condoms as HIV/AIDS prevention measures. These male dominance norms are rooted in decades-old sociocultural practices, beliefs, and polygamy patterns, as well as the absence of mutual love and trust in marriage, another byproduct of gender inequality. Such norms also impeded the availability to women of reproductive health education and information resources, including access to HIV/AIDS diagnoses and treatments.

Replies to Research Question 3 and its corresponding interview questions and sub questions confirmed gender bias and sociocultural practices of gender inequality as contributors to the increase of HIV/AIDS infection among Port Harcourt women. These

norms subjected women to economic pressures and power structures favoring men, which limited reproductive health information availability to women, inflicted shame and stigmatization upon them, and hampered the enactment of laws and policies that would protect them from these vices.

When asked about how the sociocultural practices of early marriage, polygamy, and Nigerian religious and social beliefs promote HIV/AIDS transmission among Port Harcourt women, participants responded that those practices are continuing in the community despite growing efforts to confront their adverse effects on women's reproductive health. Therefore, Port Harcourt culture should incorporate initiatives to alleviate the suffering and oppression of women, such as improved educational and economic opportunities for them.

Regarding unequal power relations between the genders as a hindrance to female HIV/AIDS awareness, participants responded that, in a polygamous relationship, women play little or no part in decision making, as sociocultural tradition and Nigerian religion promotes male authority over women. The ensuing systematic controlling of women in relationships leaves them with little or no negotiation power on safe sex. Women are prohibited from resisting men's sexual advances, thus cannot question their husbands' extramarital affairs, a main cause of HIV/AIDS transmission. Instead, relationships must be based on mutual love and trust.

When asked how gender hinders access to health services and knowledge of HIV/AIDS, participants responded that female children are expected to be submissive to male authority in a relationship, which limits their access to health services for, and

knowledge of, HIV/AIDS, as does the limited economic power women receive as a result of this submissiveness.

Chapter 5 presents a discussion of the above findings and their implications on future research and practice.

Chapter 5 Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to explore the impact of sociocultural practices of early marriage, traditional beliefs, religion, and polygamy on the gender inequalities that cause lack of knowledge and awareness of HIV/AIDS among women in Port Harcourt, RiversState, Nigeria. Despite the need for more public health programs on HIV/AIDS, the demand for intervention and prevention programs based on a cultural approach is higher. To explore the effects of these sociocultural practices on gender inequality related to HIV/AIDS among women, the following research questions were addressed:

1. How do early marriage, polygamy, traditional beliefs, and religion promote HIV/AIDS transmission among women in Port Harcourt?
2. How does unequal power relation promote women's lack of HIV/AIDS awareness?
3. How does sexuality hinder access to health services and knowledge of HIV/AIDS?

Interpretation of the Findings

The findings from the data collected from the interviewsvalidated this study'stheoretical framework. For example, Radhakrishna et al. (2007) stated that despite gender inequality is the key obstacle to effectual response to HIV/AIDS epidemic, developing a theoretical framework for this research is very crucial, as it is equally essential in creating connections between types of studies, theoretical frameworks, and outcomes of the study.

Similarly, Loggerenberg et al. (2012) found that women's denial of equality and lack of awareness and knowledge influences the spread of HIV/AIDS in the society. The study demonstrated howSCTcorrelates with knowledge of the influence of the sociocultural practices of early marriage, religion, traditional beliefs, and polygamy upongender inequality related to HIV/AIDS proliferation among women.

Research Question 1

How do early marriage, polygamy, traditional beliefs, and religion promote HIV/AIDS transmission among women in Port Harcourt?

In answering this question, participants shared experiences through the interview process, whichI organized into the following themes: (a) religion and HIV/AIDS, (b) extramarital affairs and HIV/AIDS transmission, (c) polygamy and HIV/AIDS, and (d) equal education for women.

Religion and HIV/AIDS. In the one-on-one interviews, all participants shared beliefs about what makes women voiceless in a relationship, including specific male-dominated culture-related religious practices. Within the boundaries of tradition and religious beliefs, women lacked autonomy and control overtheir sense of purpose in a relationship.

Also highlighted was the inequality in male-dominated relationships, which religious practices promoted, even by calling divorce an abomination, despite the disproportionately high levels of physical violence and sexual abuse women often faced. One participant said, "When I reported my husband to the church elders that I was physically abused, and my husband was asked, he denied that I was beaten. The church

sided with him." Evidently, women believed they had no voice in a relationship supported by bothcultural practicesand the entire society. The reviewed literature correlated this study finding. Augustine (2007) said that women wereoften put in a passive subordinate position to men regarding morals, virginity, motherhood, and obedience, and that religious beliefs supported thisfemale subordination. As the women lacked the resources to provide for their families, theirdecision-making skills became subjugated as well.

Extramarital affairs and HIV/AIDS transmission. African studies on sexuality confirmed maleextramarital affairs and a total neglect of sexual negotiation between husband and wife (Monjok et al., 2009). The findings indicated that women tended to marry much older men, who thus dominated the relationship, preventing a woman from making decisions, negotiating for safe sex, or even questioning the man's extramarital affairs, hence increasing her risk for HIV/AIDS. The cultural practices of older men marrying younger women have been well researched and documented in Nigeria (Iwara & Alonge, 2014).

Polygamy and HIV/AIDS. In discussing polygamous relationships and women's roles in decisionmaking, participants individually reported being voiceless in a male-dominated relationship. Physiological studies and reports on women affirmed women's higher vulnerability to HIV infection compared to men (Okerentugba et al., 2015), because women hada greater mucosal surface that made their tissue more susceptible to such infections when exposed to infectious fluid during sexual activity. In addition, polygamy contributed to increasing HIV/AIDS transmission among women in Africa,

specifically in Nigeria (Augustine, 2007; Nasidi & Harry, 2006), in part because an adolescent female as a second or third bride likely received less reproductive health education and was powerless to negotiate safer sex (Siyanda, 2012).

Previous studies in Nigeria demonstrated that women aged 15 or younger were more likely to become HIV-positive than those aged 21 or older (Nteziryayo, 2008), in part because young women in early and polygamous marriage wereless likely to receive formal health education than older women (Iwara & Alonge, 2014; Okerentugba et al., 2015). All study participants shared their personal experiences of this sociocultural practice, in whicha woman wastreated as "a subject," as one participant put it. Few believed that men in polygamous marriages viewed women as concurrent sexual partners rather than spouses.

On the other hand, few other study participants saw themselves as women expected to be faithful and unquestioning of their husbands' behavior. Literature on female subordination in various African communities emphasized that such maltreatment elevated reproductive health risks, including sexually transmitted diseases and HIV/AIDS (Nteziryayo, 2008). Participants also said thatwomen refusing sex might be portrayed as unfaithfuland subjected to shame, including beating and public humiliation.

Equal education for women. All participants agreed on what should be done to alleviate the suffering and oppression of women. According to one, "Cultural practices were created by man and can be uttered by man" to address the suppression, disempowerment, and maltreatment of women by the adamant sociocultural practices. Suppression, disempowerment, exploitation, belittlement, and other forms of

maltreatment of African women had been highlighted in various literature and research for decades (Iwara & Alonge, 2014; Siyanda, 2012). Sociocultural practices are mainly responsible for the oppression of women, specifically in Port Harcourt (Augustine, 2007).

The analysis of theinterconnection of cultural practices such as polygamy and male dominance with women's suppression and economic oppression (Iwara & Alonge, 2014) suggested a need to integrate women into the sociocultural practices in Port Harcourt. Participants mentioned: (a) access to education, (b) reproductive health education, (c) job training and opportunities, and (d) empowerment of women's rights and privileges, and 65% of the study participants reported not having formal secondary school education because their parents had given them into early marriage for economic reasons. Similarly, 100% of the study participants reported dependency on their husbands for all means of living assistance, as well as lack of protection against abuse and exploitation. Acknowledging the importance of informing women of sexual reproductive health and safety resources hinged on collaborating with the community stakeholders to develop a sustaining preventive strategy that recognizes the role of women in integrated sociocultural practices relating to improving their sexual health and safety.

Social cognitive theory. This multifaceted issue justifies the use of SCT in this study to learn the level of awareness of HIV among Port Harcourt women. Three factors aligned with SCT influence the increases in HIV infection among women: environment, people, and behavior. The environment supports the sociocultural models for behavior (Kanekar & Sharma, 2009), and these practices continue for decades as other people in the community observe the actions of others and continue to reinforce these behaviors

(Meisslerm, 2012), until they become normative over time (Kanekar & Sharma, 2009). In a study Okudo and Ross (2015) conducted about the knowledge and attitudes of young people in Nigeria about HIV/AIDS, the authors used SCT to conclude that the three aforementioned factors influence the increase of HIV/AIDS cases. A similar study by Okerentugba et al. (2015) of the prevalence of HIV among pregnant women in Rumubiakani, Port Harcourt, reached the same conclusion. SCT thus underscores the implications of sociocultural practices of early marriage, polygamy, traditional beliefs, and religion that promote HIV/AIDS transmission among women in Port Harcourt.

Research Question 2

How does unequal power relation promote women's lack of HIV/AIDS awareness?

In analyzing this research question, the following themes emerged:

Male power and dominance in relationships. Male dominance, which both the participants and the literature cited as a major obstacle to gender equality, increasingly contributed to HIV/AIDS transmission among women in Nigeria. While sharing their personal stories, participants overwhelmingly reported that the sociocultural practices permit maltreatment of women at men's hands. For example, churches taught women to obey the church elders and the male authority. Subsequently, women are subjected to male dominance (Okerentugba et al., 2015). Individually, study participants described how male dominance created and supported by sociocultural practices alienated them from contributing to important family decisions, including the right to reproductive health and safety.

During the one-on-one interview process, more than half of the study participants had difficulty talking about their reproductive health, citing fear of intimidation from their respective "husbands," a sign of low self-esteem cited as a direct consequence of male dominance over women (Augustine, 2007; Okerentugba et al., 2015). According to the participants, men "totally" dominated women's lives, including relationships permitted and supported by the society that instilled prestige and status to the male gender, while devaluing women's worth and capabilities.

No negotiation voice regarding safe sex. Study participants individually narrated their lack of negotiation ability in their relationships, which rendered them powerless to question their husbands' extramarital activities. In response to the interview question "According to tradition, men control sexual relationships while women submit to them as tradition permits; explain to me how these behaviors promote HIV/AIDS among women in our present day," most participants said men solely initiated and demandedsex in marriages at will. This reinforced the cultural values that preconditioned women to always wait for men to make sexual advances and not to question them, even if the men are infected with HIV. Most participants said they rarely made direct or indirect sexual advances themselves for fear of being labeled as promiscuous.

Decades of African studies reported patriarchal norms in whichwomen weredenied an equal part in family decisions (Ramjee & Daniels, 2013), which severely impacts their sexual health. One participant said:

> I know my husband sleeps with other women outside without using condom because he does like to use it and when he comes home, we sleep together too, I

cannot say no because our culture forbids a woman to deny husband sex regardless of the circumstances except the woman is on her menstrual circle.

This typifies male behavior in a male-dominant relationship aligning with gender norms.

No mutual love and trust in the relationship. Participants overwhelmingly stressed the lack of mutual love and trust in theirpolygamous relationships and believed this endangered their right to HIV education, which increased their riskof contracting HIV. As this tradition-supported imbalance in relationships poses significant obstacles to the reduction of HIV among Port Harcourt women, these obstacles need urgent intervention,whichmay include education and empowerment of women to stand up for their rights to reproductive health. Monjok et al. (2009) concluded that the Nigerian government had done little to address the increasing HIV infection among women. However, Auerbach et al. (2013) argued that, even when women's rights to reproductive health, including HIV education, are affirmedthrough various laws and statutes, society as a whole ignores such rights. These rights are also suppressed by existing levels of poverty and cultural biases that impede women from reporting abuses in marriage.

For example, when asked why women cannot report abuse in a polygamous marriage, participants said doing so would seem not only unnatural, but also disrespectful toward the men who controlled the relationships. One reported, "You cannot do that, since you depend on the man for food allowances and other needs." Thus, not only does the local culture forbid the reporting of spousal abuses, but also women lack the courage to report them. In addition, all participants believed the Nigerian government supported female suppression.

The SCT is relevant to unequal power relations between the genders and the promotion of the lack of HIV/AIDS education for women, in that this power inequality, in which women are taught to succumb to men's authority, immensely influences women's behavioral patterns. These patterns typify fear and dependence, resulting in an inability to negotiate safer sex with spouses or insufficient resources to meet the women's financial needs. The passing of these cultural practices from one generation to another has further increased women's risk for HIV.

Power and economic opportunities for women. Women's exclusion from economic opportunities, powersharing, HIV/AIDS knowledge access, and decision making in the relationship due to sociocultural practices promoting male dominance (Auerbach et al., 2013) has been cited in many studies as a key barrier to gender inequality and thus HIV/AIDS prevention in developing countries, specifically Nigeria (Augustine, 2007). All participants shared how their behavior and approach to life regarding sexual and reproductive health was shaped around the bias disadvantage placed in the community via its sociocultural practices. These practices, which they described as "oppressive," "sexual slave," "powerless," "housemaid," and "sex toy," limited their power and economic advancement, as their inability to contribute to key family decisions left them powerless to negotiate safe sex and access HIV/AIDS prevention resources.

Research Question 3

How does sexuality hinder access to health services and knowledge of HIV/AIDS?

The study findings in response to this questionrevealed these themes:

Gender and lack of HIV/AIDS awareness. Port Harcourt's sociocultural placement of male authority over women represents the citizenry's mixed perception of a definition of a healthy relationship. Participants reported complete adherence to the region's gender norms which meant women had less knowledge about their sexuality, often did not recognize their health symptoms, failed to seek medical treatment, and were not treated humanly. They further noted that, in a patriarchal relationship, men controlled all of the domestic resources, which made decision making in the relationship or family unequal. This limited women's ability to pay for their healthcare expenses.

Shame and lack of access to health services. Participants shared a daunting experience from their maltreatment, abuse, and stigmatization: most believed they could notaccess health services because of fewer economic opportunities. They shared how their poverty not only affected their daily lives but also hindered their access to health services, including HIV testing and treatment. This assessment confirmed findings in reviewed literatures on the roles of women in polygamous relationships. For example, Nteziryayo (2008) confirmed that women were hopeless without economic power, and Arrivillaga et al. (2009) found that lack of economic power forced women to rely on their male partners to meet their economic needs.

This study's participants also revealed that most women relied on extended family support for their economic needs, which suggests that action on this issue should involve the entire community, including leaders and community healthcare providers, not women alone. Sustainable action must be initiated with all stakeholders involved, aimed at

addressing specific cultural barriers and building holistic approaches toward the achievement of gender equality, including universal access to health services.

Understanding the links among sociocultural practices regarding reproductive health and safety for women is critical to providing sustainable intervention programs for women vulnerable to HIV/AIDS in Port Harcourt. The reviewed literature pointed to a strong link between the indigenous cultures and the emerging attitude toward HIV/AIDS transmission (Monjok et al., 2009), which concurred with study participants' reports that sociocultural practices, including gender inequality,remain prominent in Port Harcourt and continue to spawn preventable diseases such as HIV/AIDS (Iwara & Alonge, 2014).

Most study participants reported that emerging reproductive health awareness failed to confront the negative sociocultural practices that impact women's reproductive health and safety. This parallels findings in the literature: Okoduand Ross (2015) reported that 60% of all new cases of HIV infection in Sub-Saharan Africa occurred among women aged 10 to 24, the age range the sociocultural practices affect the most, due to early marriage norms (Nteziryayo, 2008).

Furthermore, women's inability to access health services because of gender limitation supported by sociocultural values meant they had less behavioral capability to seek their wellbeing. Most study participants lacked the self-efficacy they needed to confront negative reinforcement behaviors. They described their emotional coping responses to the authoritative roles men subjected them to as "fear," "withdrawal," "denying," "shame," and "insignificant," which created paths to multiple behavioral changes, including withdrawal from most sensitive places in the community because of

the intimidation and stigmatization associated with HIV/AIDS victims. Women also failed to access health services because of limited safer sex negotiation skills.

By examining this assessment, SCT provided a framework for designing sustainable preventive strategies that included understanding the sociocultural practices that directly hindered women's access to health services and knowledge of HIV/AIDS.

Reliability of the Study

Overall, I have deemed this study's results and conclusion to be reliable. Adding credence to it were the use of qualitative method, phenomenological design, and a data collection method involving one-on-one interviews aiming to report participants' experiences directly from their narratives. The study population and demographics were carefully chosen to provide reliable data. Also, participant selection was carefully done to make sure common experiences of living with HIV/AIDS were consistent with the study's criteria for reliability.

The data collection process and management, including coding and thematic categorization with NVivo software, affirmed the study's reliability. Similarly, I followed a phenomenological research interview process, ensuring that all study participants answered the same questions, to share meaningful experiences of HIV/AIDS transmission. Their thorough description of their actual lived experiences further bolstered the study's reliability.

Limitations of the Study

That the participants were of certain age groups and from diverse backgrounds and ethnic groups made the study liable to bias. Additionally, the research study was

limited to only 20 female students (participants) aged 18 to 45 who spoke, read and wrote English fluently. Therefore, the research study could not be generalized to all ethnic groups in Rivers State and was less representative of the female gender in general.

In the qualitative result, I found that the fear of contracting HIV/AIDS as well as living with HIV/AIDS created a negative effect from the public behavioral conduct on women infected with the disease. Also, this qualitative result showed that sociocultural factors of gender inequality related to HIV/AIDS among women in Rivers State contributed to the psychological effects, such as feeling of guilt, shame, low self-esteem, and lowself-worth.

Recommendations for Further Research

The study's key findings revealed gaps that called for further study, such as implementation and evaluation of sustainable preventive programs that could reduce the prevalence of HIV/AIDS among this most vulnerable population in Port Harcourt and Nigeria. The themes gathered from this research study could inform a sociocultural-centered model aimed at understanding the gender values that were responsible for the increased proliferation of HIV among vulnerable women and assisting in creating, implementing, and evaluating results-oriented outcomes. The findings could guide community health best practices, specifically in developing countries such as Nigeria with increasingly high rates of HIV/AIDS among women.

Reviewed Nigerian journals presented some knowledge and perception of HIV/AIDS in Nigeria but lacked a comprehensive approach to unearthing the root causes of the increasing HIV transmission. Further research would address such areas as gender

empowerment, women's self-efficacy, and association of controlled and stigmatization. Understanding these areas under the lens of SCT could further inform intervention and prevention strategies targeting sociocultural barriers and vulnerable populations in Nigeria. Follow-up research using SCT to examine HIV-vulnerable women aged 26 and older could offer a different dataset useful in reducing HIV among an older population.

Also recommended is research on how stakeholders—community/religious leaders, community health experts, HIV/AIDS specialists, and so forth—could be brought in to help devise strategic solutions to the HIV/AIDS epidemic. Understanding this problem from the SCT perspective could better assist the community in finding a lasting solution, as the intricate promotion of the solution to sociocultural barriers could create awareness of HIV among both women and the entire community. Government and community health agencies could promulgate HIV and gender discrimination information through community education around sociocultural values, including male dominance and polygamy. The Nigerian government could also provide free access to health services, including confidential treatment to women tested HIV-positive.

Implications for Social Change

This study's lesson highlights the importance of positive social change in the community. Women who gain education on the effects of sociocultural practices in male-female relationships on HIV proliferation among women can in turn educate other women on these issues. This empowerment would supportwomen in speaking out against male dominance in the family, developing self-advocacy, and accessing treatment without stigmatization. As such, mortality and morbidity associated with increasing

HIV/AIDS rates also decrease with increased education on HIV/AIDS and its health risks (Iwara & Alonge, 2014). The involvement of community stakeholders—community/religious leaders, community health clinics, reproductive health experts, and so forth—could implement a comprehensive attainable solution for positive social change.

Moreover, research based on the socioeconomic and sociocultural factors with a clear conceptual framework such as SCT could intricately promote HIV/AIDS reduction. The alignment of health determinants and the best practice design model could address community health issues by providing understanding, strategies, implementation, and evaluation of programs aimed at reducing the prevalence of HIV/AIDS among vulnerable women in Port Harcourt. Any HIV intervention and prevention design must consider the environment, people, and behavioral change. Similarly, the analysis of shared common experiences from qualitative phenomenological design could reveal potential behavioral barriers that impede the decision making, family support and self-efficacy needed to counter the HIV epidemic, thus could assist indesigning sociocultural-centered intervention that recognizes the mutual roles of men and women in a relationship.

Also, focusing on economic and other causal agents for HIV proliferation could give women the economic power and skills necessary to negotiate safer sex to reduce HIV risks. Community health experts and policymakers could work together in this way to develop a comprehensive solution to women's vulnerability to HIV/AIDS in Nigeria.

Conceptualization of SCT provides implications for the findings of this study (Bandura, 1986). SCT considers the complex interrelationship among many influences,

such as environment, people and behavioral change correlated with early marriage, traditional beliefs, religion, polygamy, gender inequality, and lack of sustaining government policy. Therefore, because SCT was used to address the factors that left women with little or no reproductive health education and access to treatment for HIV/AIDS, the SCT perspective provided a multilevel strategy to address the increasing HIV transmission among Port Harcourt women. Four implications emerged from this strategy:

1. Governments should work with traditional institutions to promote positive sociocultural values that increase women's awareness of reproductive health rights and HIV/AIDS prevention resources.
2. Women should be empowered to say no and make decisions to safeguard their sexual and reproductive health.
3. The government should begin dialogue with the community aimed at examining the sociocultural values advancing the maltreatment of women, including gender inequality.
4. By working with sociocultural institutions, the entire community could gain information about HIV/AIDS risks and collectively devise ways to address gender inequalities and prevalence of HIV transmission among women.

Implementation of this positive social change could effectively promote an environment that advances the integrity of women and behavioral change toward the gender equality necessary to thwart HIV/AIDS transmission among women in Port Harcourt.

This study serves to empower not only women affected by HIV/AIDS, but also their environment and its sociocultural institutions, to prevent this epidemic through dissemination of information on female vulnerability to HIV/AIDS to the community stakeholders, including community health workers and reproductive health experts. Working directly with the sociocultural institutions could help them build the plausible communication and negotiation skills necessary to encourage better decision making to ensure safer sex. Hence, by adopting SCT approach in this study, I intended to assess gender inequality and increasing HIV/AIDS among women from a standpoint of collective social change implications.

Conclusion

This study concerned the role of sociocultural practices of early marriage, traditional beliefs, religion, and polygamy in the gender inequality related to HIV/AIDS among women in Port Harcourt, Rivers State, Nigeria. The use of SCT in this study offered relevant information for understanding sociocultural practices and the increasing HIV/AIDS transmission from a holistic approach that considers multiple influences from the environment, people and behavioral change, including sociocultural and government institutions and the accepted norms of the population at large. The findings correlated with other studies highlighting the interconnection of sociocultural practices responsible for increasing HIV/AIDS among Port Harcourt women.

Other findings included women lacking the economic power to meet their personal needs, including access to HIV treatment, and lacking the negotiation skills to coordinate safer sex with their spouses, both of which contribute to the increasing spread

of HIV/AIDS among women. The tolerated stigmatization of HIV/AIDS impedes women's access to treatment as well.

To attain positive social change in these areas, HIV/AIDS intervention must be approached from a sociocultural perspective involving all stakeholders. Dialoguing with traditional rulers, faith leaders, community health experts, and reproductive health experts could conduce to shared solutions to issues of the gender inequality that increases HIV/AIDS among women. The success of a comprehensive reproductive health education system involving the entire community would not only empower women with self-efficacy but also provide them with the skills they need to attain the behavioral change necessary to reduce both the risk of contracting HIV and the stigmatization HIV-positive women have suffered.

Finally, the methodological perspective adopted for this study could inform the design of sociocultural intervention and implementation of sustainable HIV/AIDS program specifically targeting women. The program should incorporate common shared experiences of women affected by gender inequality and increasing HIV/AIDS, as well as other stakeholders' inputs, to enhance positive social change to the fullest extent.

My goal in the future as a result of this research, is to collaborate with other health professionals and communities in the planning, implementation, and evaluation of health education programs to promote gender equality and women empowerment. I also plan to serve as health education resource personnel for women to ensure women empowerment by focusing on enduring sociocultural practices of early marriage, traditional beliefs, religion, and polygamy that influence gender inequality and

HIV/AIDS among women in general. Overall, I will develop and maintain a personal commitment to professional growth through self directed learning and scholarly research.

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Appendix A: Introduction Letter

RANDOM INDIVIDUAL ID: _____

QUESTIONNAIRE FOR INDIVIDUAL INTERVIEW

ISSUES OF GENDER INEQUALITY ON WOMEN'S KNOWLEDGE AND AWARENESS OF HIV/AIDS IN PORT HARCOURT

Dear Respondent,

I am a PhD student at Walden University of United States of America currently working on a research study about issues of gender inequality on women's knowledge and awareness of HIV/AIDS in Port Harcourt, Nigeria. In order to accomplish this, I am carrying out a survey here at the college in Port Harcourt to learn about knowledge, attitudes, perceptions, and behaviors regarding HIV/AIDS among women and the role of sociocultural practice to this effect. I hope to be able to use your responses to achieve this goal and to proffer recommendations that will help improve HIV/AIDS knowledge and awareness among women in Port Harcourt city.

Benefits and Risks

You may find some of the questions about HIV/AIDS sensitive, but the study poses no risks, and I do not anticipate any risks for participating in this survey, other than the daily life encounter in our present society.

Confidentiality is Guaranteed

All documents will be secured and any information to my institution will not include your personal identity. All study records will be kept confidential and only the researcher will be in possession of the records.

Participating is Voluntary

Your participation in the survey is totally voluntary. You may wish to skip any question that you do not feel comfortable with but I encourage you respond to all questions. However, if you decide to participate, you should feel free to withdraw at any time. Therefore, if you agree to participate, I will appreciate you read and sign the following consent form.

Appendix B: Consent Statement

I have read the above information, and have received answers to my questions. I thereby consent to participate in the survey.

Your Name in print: _____

Your Signature: _____ Date: _____

In addition to consenting to participate, I will be interviewed on one-to-one basis with tape recording.

Your Signature _____ Date: _____

Name of researcher (in print) _____ Date: _____

Signature of researcher _____ Date: _____

This consent form will be secured by the researcher for at least three years beyond the end of the study.

Appendix C: Participants' Profile

1. Age:
2. Sex:Female () Transgender ()
3. Religion:
4. Marital status:

Appendix D: Interview Questions

1. How do female children differ from male children in the society?
    a. Physically b. raised c. dressing d. behaviorally
2. Please explain to me what you understand by culture.
    a. How will you differentiate culture from tradition?
    b. Explain to me how cultural tradition influences your daily life style.
3. What do you understand by culture and tradition of your people?
    a. How does the cultural tradition influence the community's way of life today?
4. Marrying more than one wife is a cultural tradition passed on to the tribes and communities. Explain to me the relevance of this tradition in today's culture.
    a. How does this tradition increase women's risk of contracting HIV/AIDs?
5. What do you understand by polygamy?
    a. Tell me about the relationship between the wives.
    b. How are the children treated, knowing they are from different mothers?
    c. How is marrying more than one wife (polygamy) a factor that influences HIV/AIDS among women?
6. It is believed that cultural traditions promote subservience and submissiveness that lead to women's dependence on men in sexual relationship.
    a. Explain to me what these behaviors mean to your sexuality as a woman.
    b. Tell me who makes domestic decisions in the family.
    c. What are the subservient behaviors and treatments that make women vulnerable to HIV/AIDS?

d. Share with me what you think can be done to alleviate this problem of sociocultural practices that promote HIV/AIDS among women.

7. According to tradition, men control sexual relationships while women submit to them as tradition permits.
    a. Explain to me how these behaviors promote HIV/AIDS among women in our present day.
    b. Tell me how the daily needs of the family are met.
    c. What do you believe should be done to create the mutual love and trust necessary to honor a women's right to reproductive education?
8. What do you understand by early marriage?
    a. As part of tradition, explain to me the ways early marriage make women vulnerable to HIV/AIDS.
    b. Tell me what happens when the woman decides to leave the marriage.
9. In what ways do religious beliefs and practices promote gender inequality and transmission of HIV/AIDS among women?
10. What do you think will happen if a woman tested positive for HIV?
    a. In what ways can a woman pay for diagnoses and treatment?