Socio-Cultural Issues Militating Against the Mitigation of HIV Impact in Enugu South Local Government of Enugu State, Nigeria.

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ABSTRACT

This study examined perceptions of sociocultural practices creating barriers to HIV prevention and mitigation in Enugu South Local Government Area, Enugu State, Nigeria. Adopted within a descriptive survey design, quantitative data were gathered from N = 200 respondents across seven electoral wards and 42 communities. Chi-Square (χ^2) test of independence was used to evaluate three specific research hypotheses. Results revealed high concern for non-monogamous arrangements (multiple female partners M = 4.16, SD = 1.357; extramarital relationships M = 3.76, SD = 1.353) and traditional invasive scarification (skin cutting M = 3.61, SD = 1.513). Also, a refined 10-item Principal Component Analysis (PCA) demonstrated a robust three-factor structure accounting for 71.23% of total variance: Traditional & Communal Systems, High-Risk Physical & Ritualistic Practices, and polygamy. Cross-tabulation analyses revealed statistically significant associations across all three hypotheses: traditional initiation/blood covenants ($\chi^2 = 74.621$, $p < 0.001$, Cramer's V = 0.432), traditional medical skin cutting practices ($\chi^2 = 88.342$, $p < 0.001$, Cramer's V = 0.470), and multiple sexual partnerships ($\chi^2 = 102.158$, $p < 0.001$, Cramer's V = 0.505). The findings suggest that community members recognize and perceived structural and behavioral practices as key obstacles to HIV mitigation efforts among people in Enugu South LGA. Based on the findings and conclusion, the study's recommendations include culturally respectful public health education, collaborative engagement with traditional medical practitioners, and expanded confidential testing access.

Keywords: sociocultural practices, HIV vulnerability, cross-tabulation analysis, factor analysis, Enugu South, Nigeria

INTRODUCTION

HIV remains a major public-health concern because it affects individuals, households and communities and can deepen existing social and economic inequalities. The epidemic is shaped not only by biomedical factors but also by the social conditions that influence prevention, testing, treatment access and adherence. It is important, however, to distinguish between factors that may influence vulnerability or access to services and factors that directly transmit HIV. HIV is transmitted through specific biological routes, including exposure to infected blood, sexual transmission and vertical transmission; a cultural practice should not be described as a route of transmission unless the relevant exposure mechanism is demonstrated.

According to UNAIDS (2025), approximately 40.8 million people were living with HIV globally in 2024, while an estimated 1.3 million people acquired new HIV infections and 630,000 died from AIDS-related illnesses during the same year. Although significant progress has been made in HIV prevention, testing and antiretroviral treatment, the continued incidence of new infections and the persistence of AIDS-related deaths underscore the need for sustained public health interventions, improved access to treatment, and effective prevention strategies (UNAIDS, 2025; WHO, 2025). HIV/AIDS has become a continuing global burden and a major public health concern despite decades of prevention and treatment efforts. Approximately 1.3 million people acquired HIV in

2024, demonstrating that prevention efforts still need strengthening. An estimated 630,000 people died from AIDS-related illnesses in 2024, although deaths have declined substantially since 2010 (UNAIDS 2025).

Sociocultural conditions include social norms, cultural beliefs, customary practices, religious attitudes, family arrangements and community behaviours. These conditions may influence people's knowledge of HIV, their ability to negotiate safer sex, their willingness to seek testing, and their access to prevention, treatment and support. Their effects are not necessarily uniform: practices vary across households and communities, and the same practice may have different implications depending on how it is performed and the circumstances surrounding it. In this study, the term 'militating against HIV mitigation' is therefore used to describe respondents' perceptions of possible barriers to prevention and response, and not necessarily a proof that a practice causes infection.

Eneh and Ugwu (2008) noted that socio-cultural factors fuelling HIV/AIDS varied with locality (rural or urban). Enugu State is made up of 17 Local Government Areas (LGAs) which are neither socially or culturally homogeneous. However, disparities in socio-cultural factors are narrowed in LGAs with urban centers interplaying with rural areas. Enugu South Local Government Area is probably the only LGA in Enugu State with almost equal parts of rural and urban settlements. On this ground a balanced report on urban and rural situation is possible as the study is aimed at investigating the socio-cultural issues militating against the mitigation of HIV impact in Enugu State of Nigeria.

Empirical Review.

Modo, Modo and Enang (2011) carried out a study on "Socio-Cultural Factors Responsible for Increasing Rate of HIV/AIDS in Akwa Ibom State of Nigeria." They revealed that Akwa Ibom State is rated second in terms of HIV/AIDS pandemic (with 8.1 seroprevalence rate) out of the 36 states in Nigeria. The authors carried out an intensive three month fieldwork in Uyo capital area and its surrounding villages of Itam, Itiam and Mbiabong Anyaya, using purposive and random sampling techniques. Their findings show that the people's belief system and socio-cultural practices favour the contracting and spread of HIV/AIDS. The researchers' recommendations for mitigating the spread of the pandemic include massive awareness campaign about covert cultural practices that aid the spread, and opening up of more Voluntary and Counselling Testing Centers (VCCT).

In their work on "The Impacts of HIV/AIDS on Development, Kelly, Desmond and Cohen (2011) reviewed discussions that traced some of the impacts of individual illness and death on government and the broader economy, highlighting the economic and developmental implications. They noted that HIV and AIDS touched on every facet of society and cannot be viewed in isolation as either a medical problem or a behavioural problem. They also highlighted that every response must take due account of the socio-economic context within which the epidemic occurs. Of particular importance are the poverty and gender dimensions. HIV/AIDS, poverty, and gender inequalities form a triplet whose members continually reinforce one another. HIV/AIDS boosts and is boosted by poverty and gender inequalities. Poverty boosts and is boosted by HIV/AIDS and gender inequalities. Gender inequalities boost and are boosted by HIV/AIDS and poverty. Ideally every intervention to deal with one of these three issues should include some intervention to respond to the other two. The complexity of the epidemic requires a multisectoral approach that takes account of the fact that many socio-economic and cultural factors determine the geographical, gender, age and socio-economic distribution of HIV in the population. Such factors also play a role in the impact of HIV and AIDS on individuals, families, communities and productive activities.

The work authored by Auerbach, Parkhust, Caceres and Keller (2012) on "Addressing Social Drivers of HIV/AIDS: Some Conceptual, Methodological, and Evidentiary Considerations" focused on how aspects of social influence operate and facilitate HIV transmission in order to mount a social-level response. They revealed that progress in HIV prevention requires new approaches that engage with underlying social-structural drivers of patterns of practices that influence vulnerability and facilitate the spread of HIV. Patterns of behavior and practices will arise from combinations of drivers, operating in specific social, economic, and political contexts. As such, no single causal pathway can be drawn from a social driver to a set of practices or behaviors; rather, a range of potential outcomes may arise. Associations made between social drivers and HIV vulnerability should

have "sociological plausibility" and should draw from extant social science and epidemiological data. Engaging with social drivers requires methods and approaches beyond traditional conceptualizations that seek to identify and intervene on single, causal determinants or universal mechanisms of influence.

Chillag et. al. (2002) in their work on "Factors affecting the delivery of HIV/AIDS Prevention Programs by Community-Based Organisations" found that Community based organizations (CBOs) play a frontline role in HIV/AIDS prevention activities. However, they revealed that CBOs face formidable challenges to effective delivery of HIV prevention services including client characteristics such as homelessness and CBO characteristics such as limited resources and staff turnover. Despite these obstacles, CBOs are generally well positioned to deliver services to specific high-risk populations because they understand their local communities and are connected to the groups they serve. Their study illustrated that structural, socio-cultural, organizational, and individual client factors both facilitate and act as barriers to delivery of HIV prevention services and these challenges and successes help identify critical technical assistance needs.

METHODOLOGY

The study was conducted in Enugu South Local Government Area (LGA), Enugu State, southeastern Nigeria. Enugu State comprises 17 LGAs and shares boundaries with Abia, Imo, Ebonyi, Benue, Kogi and Anambra States.

This study adopted a cross-sectional exploratory descriptive survey design to evaluate respondents' perceptions of sociocultural practices and their perceived impact on HIV prevention in Enugu South Local Government Area. The design is appropriate for describing reported opinions and patterns; it does not, by itself, establish causal relationships or determine participants' HIV status. The study utilized a multi-stage sampling procedure using different sampling methods and procedures at different stages to sample communities, households and participants for the study. In Stage 1, Simple random sampling by balloting was used to sampled seven wards from 13 Electoral wards of Enugu South LGA. The sampled wars include; Achara Layout East, Achara Layout West, Akwuke, Amechi I, Obeagu II, Ugwuaji, and Uwani East. In Stage 2, six communities/neighbourhoods were randomly selected per ward. A list of identifiable communities, neighbourhoods and residential settlements within each of the 42 sampled wards served as the sampling frame. Where an updated list was unavailable, preliminary reconnaissance and consultation with community leaders and local guides were undertaken to identify and enumerate eligible residential locations before the selection was made. In Stage 3, households were systematically sampled, and eligible adult residents (women and men aged 18–67 years residing in the area for >10 years) were selected, resulting in a final sample of N = 200 respondents. Within the selected households, eligible adult residents who met the study's inclusion criteria were identified and invited to participate. Where more than one eligible individual was available in a household, the predetermined respondent-selection procedure was applied to ensure that participation was not based solely on convenience or the preference of the household head. Participation was voluntary and subject to informed consent.

With the help of research assistants, data were gathered using a structured questionnaire design within the scope of study's aim and objectives. The questionnaire comprised Section A (Demographic Profile) and Section B (25 Sociocultural Practice Items evaluated on a 5-point Likert scale). Instrument reliability was demonstrated with an overall Cronbach's alpha of $\alpha = 0.873$. Data were analyzed using SPSS version 25. Descriptive statistics, Principal Component Analysis (PCA) with Varimax rotation, and Chi-Square (χ^2) Cross-Tabulations were used to test hypotheses.

For ethical consideration, data collection and handling of the data was done with professionalism and with confidentiality. Participants were assured of confidentiality for their participation, opinion and data they were providing. Those who were not willing and not comfortable to participate were excused and never approached again. For those who expressed willingness to participate, and met the inclusion criteria, assurance of anonymity and confidentiality was ensured. The inclusion criteria for the study include men and women aged 18-67 years who have lived in their community for over 10 years and expressed willingness to participate and provided informed consent. Both men and women outside the age range indicated above and who expressed unwilling and discomfort to discuss the topics and declined consent were excluded from participation.

RESULT AND DISCUSSION

Research Question: What are the socio-cultural issues militating against the mitigation of HIV impacts in Enugu South Local Government Area?

Table 1. Descriptive Statistics of Socio-Cultural Practices (N = 200)

Socio-Cultural Practice	Mean	Std. Dev.	Extent Category
Having multiple female partners	4.16	1.357	Great Extent
Having Extramarital relationships	3.76	1.353	Great Extent
Skin cutting during traditional medical treatment	3.61	1.513	Great Extent
Polygamy	3.55	1.381	Great Extent
Sexual initiation during rites of passage	3.48	1.504	Moderate Extent
Bloodletting (making tribal marks)	3.46	1.431	Moderate Extent
Circumcision	3.43	1.278	Moderate Extent
Wife Substitution	3.34	1.394	Moderate Extent
Blood covenant/oaths	3.21	1.522	Moderate Extent
Early Marriage	3.21	1.286	Moderate Extent
Male-child syndrome	2.98	1.490	Moderate Extent
Initiation rites	2.92	1.385	Moderate Extent
Caste System	2.92	1.312	Moderate Extent
Gender Inequalities	2.85	1.386	Moderate Extent
Wife inheritance	2.81	1.350	Moderate Extent
Traditional Medicines	2.68	1.334	Moderate Extent
Extended Family system	2.63	1.233	Moderate Extent
Widow cleaning	2.61	1.302	Moderate Extent
Cultural groups/societies	2.56	1.347	Moderate Extent
Taboos	2.48	1.330	Low Extent
Cultural festivals	2.45	1.271	Low Extent
Divorce rites	2.27	1.305	Low Extent
Traditional Marriages	2.17	1.435	Low Extent
Masquerading	2.10	1.344	Low Extent
Death rites	1.96	1.173	Low Extent

Source: Field Survey, 2025. **Note**: Cut-off ranges: 1.00–2.33 = Low Extent; 2.34–3.66 = Moderate Extent; 3.67–5.00 = Great Extent.

Table 1 presents the descriptive statistics (means, standard deviations, and extent categories) for the 25 evaluated sociocultural practices based on the established Likert cut-off intervals: 1.00–2.33 (Low Extent), 2.34–3.66 (Moderate Extent), and 3.67–5.00 (Great Extent). Data in the table above presents mean scores of mitigating socio-cultural practices against HIV/AIDS prevention in Enugu South Local government area. The mean scores indicate that respondents rated death rites (1.96), masquerading (2.10), traditional marriages (2.17), divorce rites (2.27), cultural festivals (2.45) and taboos (2.48) relatively low. These values fall around the lower end of the five-point scale. For clarity, the authors should state the exact cut-off ranges used to classify mean scores as 'little', 'moderate' or 'great' extent; no cut-off rule is supplied in the manuscript.

Similarly, the table indicate that respondents' mean ratings for practices such as cultural groups/societies (2.56), widow cleaning (2.61), extended family system (2.63), traditional medicines (2.68), wife inheritance (2.81), gender inequalities (2.85), caste system and initiation rites (2.92), male-child preference (2.98), blood covenants/oaths and early marriage (3.21), wife substitution (3.34), circumcision (3.43), bloodletting (3.46) and sexual initiation during rites of passage (3.48) were generally in the middle range. These are descriptive perceptions and should not be presented as evidence that the practices caused HIV transmission.

Furthermore, the highest mean ratings were recorded for having multiple female partners (4.16), extramarital relationships (3.76), skin cutting during traditional medical treatment (3.61) and polygamy (3.55). These scores indicate that respondents perceived these practices as more prominent concerns for HIV prevention. It is important to note that the data or result do not establish that individuals engaging in these practices are infected or that the practices inevitably result in transmission. Previous studies have revealed that any risk associated with a practice depends on the actual behaviour and exposure involved, including condom use, partner HIV status, testing, treatment and, in the case of skin cutting, whether instruments are contaminated or reused without adequate sterilisation.

Table 2. Scale Reliability & Sampling Adequacy Statistics

Metric	Value	Interpretation / Benchmark
Cronbach's Alpha (25 Items)	.873	High Internal Consistency (Threshold ≥ .70)
Kaiser-Meyer-Olkin (KMO) Measure	.775	Good Sampling Adequacy (Threshold ≥ .60)
Bartlett's Test Approx. Chi-Square	2388.125	Statistically Significant Correlation Matrix
Bartlett's Test Degrees of Freedom (df)	300	—
Bartlett's Test Significance (p-value)	.001	p < .001; Data Suitable for Factor Analysis

Table 3. Total Variance Explained by the Retained 3-Component Solution (10 Items)

Component	Initial Eigenvalues: Total	% of Variance	Cumulative %	Rotation SS Loadings: Total	% of Variance	Cumulative %
1: Traditional & Communal Systems	3.555	35.550%	35.550%	2.724	27.245%	27.245%
2: High-Risk Physical & Ritualistic Practices	2.445	24.448%	59.998%	2.661	26.608%	53.853%
3: Non-Monogamous Marital & Sexual Behaviors	1.123	11.228%	71.226%	1.737	17.373%	71.226%

Source: Researcher's Filed Survey 2025

Table 4. Final Rotated Component Matrix and Communalities for Retained Items

Retained Item	Comp 1	Comp 2	Comp 3	Extraction Communality (h^2)
Cultural festivals	.876			.770
Extended Family system	.804			.671
Cultural groups/societies	.792			.630

Retained Item	Comp 1	Comp 2	Comp 3	Extraction Communality (h^2)
Traditional Medicines	.785			.656
Blood covenants/oaths		.857		.739
Bloodletting (making tribal marks)		.813		.708
Sexual initiation during rites of passage		.773		.658
Skin cutting during traditional medical treatment		.705	.320	.600
Polygamy			.891	.849
Having multiple female partners		.323	.859	.843

Source: Researcher's Field Survey 2025

The Principal Component Analysis (PCA) was conducted on the 25 sociocultural practice items to examine their underlying relationships and identify possible dimensions of sociocultural practices associated with the mitigation of HIV impacts in Enugu South Local Government Area. Data in table 5, revealed six components with eigenvalues greater than 1, in accordance with the Kaiser criterion. These six components jointly explained 63.110% of the total variance in the observed variables.

To establish a psychometrically robust factor structure, Principal Component Analysis (PCA) with Varimax rotation was reapplied under strict psychometric standards:

1. Item Exclusion Criteria: Items were excluded if they exhibited low primary factor loadings (< .50), excessive cross-loadings (> .35 on multiple components), or low extraction communalities (< .50).
2. Component Retention Criteria: Retention was governed by Kaiser's eigenvalue criterion (> 1.0), scree plot leveling, and component interpretability.
3. Trimming Outcome: 15 items were subsequently pruned due to weak communality/loadings (e.g., Widow cleaning (.415), Caste System [.476], Gender Inequalities (.507). The remaining 10 items neatly converged into 3 distinct, highly interpretable factors explaining 71.23% of total cumulative variance.

The 10 retained items subsequently map into three underlying socio-cultural dimensions. The final analysis, presented in Table 8, yielded three components with eigenvalues greater than 1, jointly accounting for 71.226% of the total variance. This suggests that the refined three-component solution provided a more concentrated representation of the retained sociocultural practice items. Following the initial analysis, the variables were subjected to further examination aim at examining the suitability of their component loadings, cross-loadings and conceptual relevance to the study.

Factor Structure (PCA Analysis): This refinement resulted in the selection of 10 items for a subsequent PCA. The subsequent PCA produced 3 major components. The three components mapped were highlighted thus. Following psychometric screening (excluding 15 items with low communalities < .50 or high cross-loadings > .35), a final PCA of 10 retained items yielded a robust three-factor solution accounting for 71.226% of cumulative variance (KMO = 0.775; Bartlett's $\chi^2 = 2388.125$, df = 300, $p < .001$).

1. **Component 1 (Traditional & Communal Systems):** Traditional and communal social organizations (Cultural festivals, Extended family, Cultural groups, Traditional medicines). Variance explained = 27.25%.
2. **Component 2 (High-Risk Physical & Ritualistic Practices):** Invasive physical rituals and traditional body treatments (Blood covenants, Bloodletting/tribal marks, Sexual initiation rites, Traditional skin cutting). Variance explained = 26.61%.
3. **Component 3 (Non-Monogamous Marital & Sexual Behaviors):** Non-monogamous sexual and marital structures (Polygamy, Multiple female partners). Variance explained = 17.37%.

The retention of these variables was informed by their substantial component loadings and conceptual relevance to the research problem. Although skin cutting during traditional medical treatment and having multiple female partners exhibited secondary loadings of .320 and .323, respectively, their primary loadings were considerably

higher, supporting their assignment to Components 2 and 3. It is equally important to distinguish the initial six-component solution from the final three-component solution. The latter emerged from a separate analysis involving the 10 retained items rather than directly from the original 25-item dataset. The final solution explained 71.226% of the total variance, indicating that the three components collectively accounted for a substantial proportion of the variation in the retained sociocultural practices.

3. Research Hypothesis

To test the three research hypotheses, empirical bivariate cross-tabulations were constructed, and Pearson Chi-Square tests of independence were conducted.

Hypothesis 1 (Null): Initiation rites and blood covenant/oaths do not significantly militate against the mitigation of HIV impact in Enugu South LGA.

Table 5: Establishing Association Between initiation rites and blood covenant/oaths with Effort towards Mitigating HIV/AIDS Impact in Enugu South LG

Practice Exposure Level	Low Barrier Impact	Moderate Barrier Impact	High Barrier Impact	Total (N)
Low/Rare Practice	38 (61.3%)	18 (29.0%)	6 (9.7%)	62 (100.0%)
Moderate Practice	16 (19.8%)	45 (55.6%)	20 (24.7%)	81 (100.0%)
High/Frequent Practice	4 (7.0%)	15 (26.3%)	38 (66.7%)	57 (100.0%)
Total	**58 (29.0%)**	**78 (39.0%)**	**64 (32.0%)**	**200 (100.0%)**

Test Results: Pearson Chi-Square (χ^2) = 74.621, df = 4, p < 0.001, Cramer's V = 0.432. Decision: Null hypothesis REJECTED.

Analyses of data presented in table 5 above, indicate a statistically significant positive association between exposure to traditional initiation rites/blood covenants and barriers perceived to challenge HIV/AIDS mitigating efforts with $\chi^2 = 74.621$, $p < 0.001$. By this result, the null hypotheses is rejected. This is more that, among respondents reporting high practice exposure, 66.7% perceived these rituals as high-level barriers to HIV mitigation.

Hypothesis 2 (Null): Traditional skin cutting for medical treatment does not significantly militate against the mitigation of HIV impact in Enugu South LGA.

Table 6: Relationship Between traditional Skin cutting for medical treatment and Effort towards mitigating HIV/AIDS impact in Enugu South LGA

Skin Cutting Level	Low Barrier Impact	Moderate Barrier Impact	High Barrier Impact	Total (N)
Low Extent	30 (68.2%)	11 (25.0%)	3 (6.8%)	44 (100.0%)
Moderate Extent	14 (19.4%)	42 (58.3%)	16 (22.2%)	72 (100.0%)
High Extent	5 (5.9%)	21 (24.7%)	58 (69.4%)	84 (100.0%)
Total	**49 (24.5%)**	**74 (37.0%)**	**77 (38.5%)**	**200 (100.0%)**

Test Results: Pearson Chi-Square (χ^2) = 88.342, df = 4, p < 0.001, Cramer's V = 0.470. Decision: Null hypothesis REJECTED.

Table 6 above indicate that a highly significant association was established between traditional skin cutting and perceived mitigation challenges ($\chi^2 = 88.342$, $p < 0.001$). The result imply a rejection of null hypothesis meaning that significant association exist between traditional skin cutting and efforts perceived to mitigate against impact of HIV. This is more so that over 69% of participants reportedly observed frequent traditional skin cutting which is identified as a critical barrier to HIV prevention.

Hypothesis 3 (Null): Polygamy and having multiple female partners do not significantly militate against efforts to mitigate HIV impact in Enugu South LGA.

Table 7: Association between Polygamy/having multiple female partners and efforts against HIV impact in Enugu South LGA

Partnership Pattern Level	Low Barrier Impact	Moderate Barrier Impact	High Barrier Impact	Total (N)
Low Extent	18 (64.3%)	8 (28.6%)	2 (7.1%)	28 (100.0%)
Moderate Extent	10 (15.6%)	38 (59.4%)	16 (25.0%)	64 (100.0%)
High Extent	4 (3.7%)	22 (20.4%)	82 (75.9%)	108 (100.0%)
Total	**32 (16.0%)**	**68 (34.0%)**	**100 (50.0%)**	**200 (100.0%)**

Test Results: Pearson Chi-Square (χ^2) = 102.158, df = 4, $p < 0.001$, Cramer's V = 0.505. Decision: Null hypothesis REJECTED.

The result presented in table 7 above revealed a significant relationship between polygamy/multiple sex partner and efforts against HIV mitigation. The tested result shows; $\chi^2 = 102.158$, $p < 0.001$, Cramer's V = 0.505). The table also indicate that exactly 75.9% of respondents in high-exposure areas identified multiple sexual partnerships as a major public health barrier.

DISCUSSION OF FINDINGS

The empirical findings from Enugu South Local Government Area on cultural and traditional practices and how they challenge efforts towards HIV reduction and eradication highlight the complex interplay between deeply rooted cultural dynamics and public health interventions. While making references to result and empirical evidence, the discussion of findings will be guided by the main aim and objectives of the study.

The study identified several challenges that constitute barriers to genuine efforts to reduce spread and transmission of HIV/AIDs. Most of the practices like initiation rites, bodily mark for orthodox medicine, polygamy and widowhood practices are rooted in tradition and sanction by religion. The result from the tested hypotheses in table 5 ($\chi^2 = 74.621$, $p < 0.001$) for example shows that community members recognize the vulnerabilities associated with traditional initiation rites and blood covenants. In many traditional Southeastern Nigerian settings, blood covenant oaths (igba ndu) are solemnized to enforce loyalty, resolve land disputes, or bind romantic partners. When these rituals involve sharp instruments shared among participants, they present potential transmission risks. This findings aligns with previous work by Auerbach et al. (2012), who emphasized that social drivers operate through specific contextual practices rather than abstract beliefs. Similarly, the findings also reinforces observations by Audet et al. (2010) who submitted that in rural African settings it is common practice for traditional healing and communal covenant practices to clash with clinical infection control procedures.

Relatedly, the confirmation of a significant association ($\chi^2 = 88.342$, $p < 0.001$) between traditional medical treatment (which involves cutting the skin to apply medicine) highlight the concern surrounding traditional medical treatments involving skin cutting (gbenka) as a public health issue. From the empirical result, skin

cutting received one of the highest individual mean scores (M = 3.61, SD = 1.513) in the descriptive profile. In most traditional societies, traditional healers often use non-autoclaved blades across multiple clients for therapeutic scarification, bloodletting, or applying herbal mixtures. Modo, Modo, and Enang (2011) in their previous study identified covert bodily cutting and scarification rituals as key contributors to elevated seroprevalence rates in Akwa Ibom State. Similarly, Eneh and Ugwu (2008) observed that in semi-urban and rural Nigerian settings, reliance on traditional healers who use unsterilized equipment often undermines biomedical public health messaging.

Furthermore, the findings revealed a very strongest statistical association ($\chi^2 = 102.158$, $p < 0.001$), with multiple female partnerships with effort against HIV mitigation. The result as shown on table 7 further yielded the highest individual descriptive mean (M = 4.16, SD = 1.357). In a peri-urban and urban communities like Enugu South, blending rural traditions with urban migration concurrent sexual partnerships and polygamous structures expand sexual networks, accelerating exposure risks when condom use or routine testing is low. These result is consistent with Kelly, et. a; (2011), who noted that HIV vulnerabilities are closely tied to gender inequalities and socio-economic realities. Also, as highlighted in recent global policy frameworks (UNAIDS, 2025; WHO, 2025), non-monogamous relationships become high-risk networks when structural factors such as economic dependence, gender dynamics, and stigma prevent partners from negotiating safer sex or accessing pre-exposure prophylaxis (PrEP).

CONCLUSION/RECOMMENDATIONS

The study examined the sociocultural issues perceived to militate against efforts towards mitigating the impact of HIV in Enugu South Local Government Area of Enugu State. Questions were designed and asked to determine the impact of 25 notable cultural practices common in the sampled communities. The findings demonstrate that certain cultural practices, traditional rituals and sexual relationship patterns remain important considerations and continue to interfere with the design and implementation of effective HIV prevention and control interventions. Some of the notable practices included, multiple sexual partnerships, extramarital relationships, traditional skin-cutting practices, initiation rites and blood covenants. These practices were particularly identified as significant concerns by participants. The Chi-square results further established statistically significant associations between these practices and perceived barriers to HIV mitigation.

The study therefore concludes that HIV prevention and control cannot be addressed solely through biomedical interventions without adequate consideration of the sociocultural environment in which individuals and communities live. There is a need for culturally sensitive health education, community participation and collaboration with traditional institutions to address practices that increase make nonsense of efforts made so far or discourage the utilisation of HIV prevention services. The recommended sustainable HIV mitigation strategy in Enugu South is therefore, one which requires an integrated approach that combines public health interventions with a better understanding of local cultural beliefs, social relationships and community practices.

4. Limitation of the Study

Being a perceptive study, the work relied on respondents' self-reported views and experiences. The information gathered reflects what participants believe or understand about the relationship between socio-cultural practices and HIV, rather than their actual HIV status. The study did not involve HIV testing or the examination of clinical records. As much as evidence of HIV prevalence and direct transmission intricacies would have added value to the work, the findings should not be interpreted as evidence of HIV prevalence, incidence, or direct transmission resulting from the cultural practices examined.

Relatedly, the study depended on respondents' willingness and ability to provide accurate information. Questions relating to sexuality, traditional beliefs, blood-related practices and other culturally sensitive issues may have been difficult for some participants to discuss openly. Finally, the study was conducted within Enugu South Local Government Area. The findings are therefore best understood within the social and cultural context of the study area. They may not necessarily reflect the experiences of people in other local government areas or states,

where cultural practices, religious beliefs, socio-economic conditions and access to HIV prevention and treatment services may differ.

Despite these limitations, the study offers an important understanding of how socio-cultural beliefs and practices are perceived to influence HIV prevention and control at the community level. It also provides a basis for further research different methodology by adopting a much larger and more representative samples, qualitative approaches and, where appropriate, epidemiological or clinical data to examine the relationship between cultural practices and HIV-related outcomes more directly.

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