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Full Length Research Paper

Perception of Gender Norms and Practices on Human Immunodeficiency Virus Care Continuum among Selected Households in Cross River State

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Abstract

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Background: Pervasive gender-related inequality has translated into a range of negative health outcomes for all people especially for women and girls. The study assessed the influence of gender norms and roles on HIV care continuum among selected households in Cross River State, Nigeria. **Method:** A cross-sectional survey was employed for the study. Multi-stage cluster and purposive sampling strategy was adopted to select 720 households from 4 LGAs in Cross River State. Primary data was collected on questionnaire coded in kobo collect software tool. Responses were analysed using STATA 14 data analytical application. Descriptive and bivariate analyses were conducted. **Result:** 72% of the respondents did not perceive restrictive gender norms as barrier for HIV prevention and continuum of care. 64% of men restrict mobility of children living with HIV to access care except with permission. 48% of rural residents were likely to experience negative gender norms and faces barriers for HIV prevention or access care compared to urban residents (OR = 47.65 (95% CI: 25.8-87.7). **Conclusion:** Access to HIV prevention and continuum of care services can be improved by increasing women's decision-making power within the households, influencing communities to practice positive gender norms that encourages women to also control resources.

Keywords: Gender Norms, HIV Care Continuum, Household, Power Imbalance, Anti-Retroviral Therapy, Caregiver.

1. Introduction

Gender norms, which are unspoken societal rules, define acceptable behaviors, roles, and attributes for men and women. These norms significantly shape institutions, leadership opportunities, and societal values, influencing individuals' attitudes, opportunities, and behaviors from an early age. This early influence extends into adulthood, profoundly affecting health outcomes over the life course (Heise et al., 2019; Pearse & Connell, 2015; Lundgren et al., 2018). The World Health Organization's Commission on Social Determinants of Health (2007) emphasized the critical role of gender in health outcomes, highlighting that pervasive inequality and restrictive gender norms result in negative health outcome, particularly for women and girls (Sen et al., 2007). In the context of HIV, inequitable gender norms contribute to disparities in accessing care and treatment. For instance, societal expectations often position

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men as decision-makers and providers who must exhibit toughness and self-reliance. Conversely, women are typically assigned caregiving roles and are often required to obtain spousal consent before seeking healthcare services (Gesesew et al., 2020; Dovel & Thomson, 2016; Rao Gupta et al., 2019; Pulerwitz et al, 2019). These dynamics perpetuate gendered power imbalances that hinder engagement in the HIV care continuum, particularly in settings like Nigeria, where cultural and economic disparities exacerbate these challenges and the burden of HIV is one of the highest globally (Heise et al, 2019; Gottert et al, 2016; Leddy et al, 2021).

Gender norms also shape behaviors and attitudes related to HIV prevention and care. For women, disempowerment in relationships often reduces their ability to refuse sexual advances or negotiate safer practices, such as condom use. Attempts to assert these rights can expose women to verbal, psychological, economic, physical, or sexual abuse (Weber et al., 2019; Haberland, 2015). Men, on the other hand, may face societal pressures to conform to traditional notions of masculinity, which emphasize dominance, virility, and control. Such norms discourage condom use and fidelity, framing these practices as unmasculine and undermining efforts to reduce HIV transmission risks (Pulerwitz et al, 2019).

Research from sub-Saharan Africa has revealed how gender norms influence engagement with HIV services. For instance, study in Tanzania found that while men independently decided to seek voluntary counselling and testing, women often needed to consult their partners for theirs and children before getting tested for HIV and among those tested positive for HIV, they needed permission to seek help, creating barriers to accessing timely care (Maman et al., 1999). These findings highlight the structural and cultural challenges posed by restrictive gender norms, which prevent both men and women from fully engaging in the HIV care continuum. In Nigeria, these barriers are further compounded by entrenched gender inequality, which sustains high levels of HIV-related stigma and limits the effectiveness of health interventions.

Women and adolescent girls are disproportionately affected by HIV due to societal norms that condone male dominance, violence, and women's caregiving roles (Jewkes & Morrell, 2010; Leddy et al., 2021). These norms increase vulnerability to HIV acquisition while simultaneously limiting access to prevention, care, and treatment services. However, the adverse effects of restrictive gender norms are not confined to women. Men, too, face negative health outcomes due to societal expectations that discourage seeking healthcare and promote risky behaviors. Addressing these gendered disparities is essential for mitigating the HIV epidemic and improving health outcomes across all genders.

Integrating gender-sensitive approaches into HIV programming is vital for addressing these disparities. Gender equality is not only a fundamental human right but also central to achieving global health goals. The United Nations' Sustainable Development Goal (SDG) five emphasizes gender equality, while SDG three seeks to "ensure healthy lives and promote well-being for all" (WHO, 2018; Leddy et al., 2019; Hay et al., 2019; UN Women, 2018; Langer et al., 2015). Tackling restrictive gender norms and promoting equity in HIV interventions are critical steps toward achieving these goals. The study examined the perception of gender norms and practices and their influence on the HIV care continuum among selected households in Cross River State, Nigeria. The research questions include (1) Does gender norm and practices create a barrier to accessing HIV prevention and continuum of care? (2) What is the perception of people on negative gender norm and practices in accessing HIV prevention and continuum of care? By exploring these dynamics, the research aims to inform the development of gender-sensitive HIV interventions that promote equitable access to care and improve health outcomes for affected populations.

2. Methodology

2.1 Study Design

The study was a community-based study, and it employed a cross-sectional survey procedure, using a multi-stage random and random sampling technique with random selection of eligible respondents from four Local government areas (LGAs) in Cross River State. The study used a primary data gathered through a quantitative method. A cross-sectional procedure was adopted because the study was conducted at a point in time, to cover a large number of participants and also serve as a baseline study for the ICHSSA 1 Project in Cross River state.

2.2 Description of the Study Area

The study was conducted in four LGAs which were randomly selected from nine LGAs where ICHSSA 1 project was been implemented in Cross River State. The ICHSSA 1 Project is a USAID funded project designed to mitigate the impact of HIV/AIDS on vulnerable children and their households in Cross River State. Cross River State is located in the South-South region of Nigeria with projected population of 3,866,269 million according to the 2017 NBS Demographic Population Bulletin. There are 18 Local Government Areas (LGAs) in the state and each LGA has up to 10 wards each, implying that there are about 180 wards in the state. The Integrated Child Health and Social Service Award (ICHSSA) Lot 1 Project was being implemented in 9 LGAs in the State, these are: Akamkpa, Akpabuyo, Calabar Municipal, Calabar South, Odukpani, Ikom, Obudu, Ogoja and Yala. 4 LGAs were randomly selected from the 9 project LGAs and these include;

Akpabuyo, Calabar Municipal, Ikom and Yala LGAs. The study population included all the randomly selected households in the prioritized LGAs.

2.3 Sample Selection

The study selected respondents from 4 randomly selected LGAs in the three senatorial districts (South, Central and North) in Cross River state for interview. Hence, 4 out of 9 project LGAs were selected in cross River State. The calculation of the sample sizes of respondents for the household interview for gender in each LGA in the community-based interview, involved a total population size of 3,866,269, population per senatorial district, HIV prevalence of 2.0%, 95% confidence level, 5% margin of error, and a response distribution of 50%. The sample size was generated using the Raosoft online sample size calculator for the OVC population and Yamane 1967 formula was used in drawing the sample size based on known parameters for key population. The numbers of clusters (wards) selected from each LGA were representative and based on Probability Proportional to Size (PPS) so that number of samples on the basis of senatorial district were evenly shared among each of the clusters (wards). The clusters were selected from the INEC political ward arrangement using the ENA for SMART software version 2011 (July 9, 2015) and digital random number selector. A total of 720 households were included in the study. The objective was to cover a sample which is representative of the larger population so as to enable for reliable analysis and results.

2.4 Training and Supervision

Adequate numbers of enumerators from Cross River State were trained by Center for Clinical care and clinical research (CCCRN). The training dwelt on interview, study methodology and indicator measurements for gender index, quantitative data collection procedures with their possible biases. Consequently, at the end of the training and on the basis of satisfactory performance, qualified interviewers in teams were formed to man each of the randomly selected LGAs in the state. Two (2) additional teams were kept on reserve/stand-by. During the interview, teams in each LGA worked closely with the associate consultant, while the lead consultant supervised the entire exercise. However, adequate arrangement was made for constant communication between the CCCRN, State Study team, consultants and field members while in the field especially through WhatsApp, calls and SMS.

2.5 Data Collection

A Standard questionnaire with well-structured quantitative questions aligning with the six domains of the gender analysis framework developed by USAID's Inter-Agency Gender Working Group was adopted and developed as a tool for data collection in the study. This tool was pre-tested to ensure its validity and reliability for the study. This framework provided concrete ways to collect and organize gender differential in health area using the domains of access, knowledge, beliefs, perception, practices and participation, time and space, legal rights and status, power, decision making and participants demographic details. The main dependent variable question was framed as "Do you perceive/think these gender norms and practices can contribute to creating barriers for HIV prevention, contributing to increasing the risk of HIV transmission, and reducing adherence to antiretroviral therapy?" while independent variables includes questionnaires on demographic characteristics, gender norm making decision-making, perception, participation, and practice of gender norms and roles and access to assets and vulnerabilities to HIV transmission.

2.6 Data Quality Assurance

Several measures were used to control data quality throughout the process of the study, including using trained data collectors and anchoring debriefing sessions to provide feed backs and making necessary adjustments were required, and following up with enumerators before proceeding to the field, close monitoring and manual checks. The Center for Clinical care and clinical research team worked very closely with the consultants and enumerators to make sure that the study went smoothly; especially by providing guidance, logistics support and feed backs. Before leaving each community, the associate consultants made sure they checked for completeness of team identification variables including codes and dates on the electronic questionnaires.

2.7 Data Processing and Analysis

All quantitative data were collected using the Kobo collect App on smart mobile devices, which was hosted on a dedicated server. However, all necessary precautions were taken to protect the privacy of respondents. The data were extracted from the Kobo Collect software, cleaned, and analyzed using STATA software (version 14). Univariate and bivariate analyses were applied. First, we described the characteristics of the study population (frequency counts and percentages), and a logistic regression was used to test the association between the dependent (perception of gender norms and practices as a barrier for HIV prevention, contributing to increasing the risk of HIV transmission, and reducing adherence to antiretroviral therapy) and independent variables (demographic characteristics, decision-making, perception, participation, and practice of gender norms and roles including access to assets and vulnerabilities to HIV transmission) at the bivariate level. Statistical signifi-

cance was set at 5%.

3. Ethical Consideration

Ethical approval authorizing this survey was obtained from the ethics committee, State Ministry of Health, Cross River State. Several measures were taken to protect confidentiality such as informed consents which reduced potential adverse consequence to the participants. Confidentiality concerns were clearly explained on the front cover of each questionnaire, and permission gathered from interviewees for filling of their documented responses. All community-based Interviews with the Network of PLHIV were conducted in a private space to guarantee confidentiality. Informed consent notes which were adhered to strictly were squarely addressed. Each study participant was informed about the research objectives, methods and techniques in detail and a written and signed informed consent was obtained from the participants.

4. Results

Table 1 presents the frequency and percentage distribution of the demographic characteristics of selected household in Cross River State. In this analysis, a total of 720 households were included. The majority of the respondents were male (59%), and were the head of their households (71%). Also, more than one-third of the respondents (35.3%) were between the ages of 30 and 39 years and 79% of the respondents were rural residents. The majority of the respondents (88%) were married and about two-thirds of the respondents were employed. In this study, 38% of the respondents had secondary education (Table 1). Furthermore, more than 80% of the households had less than five children living with them while 8% of the households had five or more children living with them and 11% had no children living with them.

Table 2 shows gender roles and household decision-making analysis among selected households. The result revealed that 72% of those who make decisions about visits to relatives and who us make decisions about making major household purchases were men while 62% agreed decide about food to buy for the family. More than half of the respondents disagree that a woman's most important role is caregiving for her family but 43% of the respondents agreed. The result also indicated that 69% of men decide how the money earned in the household is used and are largely responsible for keeping the money that the household earns. The study also revealed that, 64% of men have restrictions on the mobility of children with HIV which may increase or decrease their vulnerability and access to care. The study also shows that 73% of men help their women with household chores and more than two-third of the respondents have a working partner aside from housework in the last twelve months, 43% of the respondents revealed that women can influence HIV prevention, treatment, and care policies more than men. The result further shows that three-quarter of women are mostly forced into or prone to economic activities that may put them at greater risk of HIV infection (e.g., promiscuity, migrant work) while about 60% of the respondents think that the different locations of activities, puts men are at a greater or lesser risk of HIV infection or affect their exposure to other diseases that may adversely affect their health.

Table 3 shows the perception, participation, and practice of gender norms and roles among selected households in Cross River State. The result revealed that 80% of respondents believe that a wife can refuse to have sex with her husband or can propose condom use if the husband has a sexually transmitted infection, and about 72% of the respondents think married women should jointly decide with their husband about their health care including those that pertain to HIV. Also, about 63% of the respondents believe that a man has a right to assert power over a woman and is socially and economically superior. The majority of the respondents do not believe in child marriage and wife-beating as an acceptable way for husbands to discipline their wives. Furthermore, 64% of the respondents reported that a man does not have the right to “correct” or discipline a woman’s behavior based on sexuality and gender roles. Although, most households interviewed exhibited restrictive gender norms, more than 70% of the respondents do not perceive these gender norms and practices can serve as a barrier to HIV prevention, increasing the risk of HIV transmission, which can negatively impact adherence to antiretroviral therapy. This could be due to lack of robust education and particularly higher percentage of rural among our study participants.

Table 4 shows access to assets and vulnerabilities to HIV transmission among participant interviewed. The result showed more than half of the respondents reported that the differences in men’s and women’s ownership of assets did not affect their risks and vulnerabilities to HIV transmission. Men’s and women’s access to and control over assets and resources would positively affect their decision and ability to get tested, access treatment, follow treatment protocols, afford or use condoms, and avoid high-risk behavior, such as transactional sex. The study further revealed that two-thirds of the respondents would be ashamed if someone in your family had HIV, almost all the respondents believe people are hesitant to take an HIV test due to fear of people’s reaction if the test result is positive for HIV. Finally, 85% of respondents reported that people talk badly about people living with or thought to be living with HIV to others and 71% reported that people living with or thought to be living with HIV lose respect or integrity because of their status.

Logistic Regression analysis was used to test the association between socio-demographic characteristics of

Table 1: Frequency and percentage distribution of the demographic characteristics of selected household in Cross River State.

Socio-demographic variables	Frequency(n=720)	Percentage (%)
Age		
18-29	168	23.3
30-39	254	35.3
40-49	190	26.4
50+	108	15.0
Sex		
Female	299	41.5
Male	421	58.5
Household Headship		
Female	210	29.1
Male	510	70.9
Place of Residence		
Rural	567	78.7
Urban	153	21.3
Marital Status		
Single	84	11.7
Married	636	88.3
Educational Status		
Did not attend any school	74	10.3
Primary Education	194	26.9
Secondary Education	276	38.3
Tertiary Education	176	24.5
Occupational Status		
Employed	488	67.8
Unemployed	232	32.2
Number of children living with you		
0	77	10.7
1	120	16.7
2	152	21.1
3	198	27.5
4	115	16.0
5+	36	8.0

study participant and perception of gender norms and practices as a contributing barrier for HIV prevention, contributing to increasing the risk of HIV transmission and reducing adherence to antiretroviral therapy in table 5. The odds ratio is a ratio of probabilities; which shows the likelihood or extent of explanatory variable influencing the outcome variable. All demographic variables were entered into the logistic regression model. The odd ratio, 95% confidence interval (CI), and the p-value (0.05) were presented below. The result of the study showed that age, place of residence, and education were significantly associated with gender norms and role practices which can serve as a barrier for HIV prevention, contributing to increasing the risk of HIV transmission and reducing adherence to antiretroviral therapy. The result indicates that respondents who were rural residents were 48% more likely to experience restrictive gender norms and practices which can serve as a barrier to HIV prevention, contributing to increasing the risk of HIV transmission and reducing adherence to antiretroviral therapy when compared with urban resident (OR = 47.65 (95% CI: 25.870-87.767). Also, respondents who were between ages 30 and 39 were 35% more likely to experience restrictive gender norms and practices which can serve as

Table 2: Gender Roles and Household Decision-making among selected households.

Variables	Frequency(n=720)	Percentage(%)
Who makes decisions about visits to relatives		
Men	521	72.3
Women	84	11.7
Both	115	16.0
Who decides about food to buy for the family?		
Men	232	32.2
Women	443	61.5
Both	45	6.3
Who usually take decisions about making major household purchases		
Men	520	72.2
Women	123	17.1
Both	77	10.7
Woman's most important role is to take care of her home and cook for her family		
Agreed	310	43.1
Disagreed	396	55.0
Neutral	14	1.9
Decision on how the money earned in the household is used		
Men	498	69.2
Women	112	15.5
Both	110	15.3
Who keeps the money that the household earns?		
Men	326	45.3
Women	303	42.1
Both	91	12.6
Who has restrictions on the mobility of Children with HIV which may increase or decrease their vulnerability and access to care?		

a barrier to HIV prevention (OR = 1.35(95% CI: 2.508-0.204) when compared with respondents between 18-29 years while respondents between ages 50 years and above were less likely to experience restrictive gender norms and practices. The result further showed that male respondents were 40% less likely to experience restrictive

Women	71	9.9
Men	462	64.1
Both	187	26.0
Do men help women with household chores?		
No	80	26.9
Yes	219	73.1
Aside from housework has your wife done any work in the last twelve months (for males)		
Yes	282	67.6
No	139	32.4
Aside from housework has your husband done any work in the last twelve months (for female)		
Yes	197	67.0
No	102	33.0
Who can influence HIV prevention, treatment, and care policies more than the other?		
Men	269	37.4
Women	312	43.3
Both	139	19.3
Who are mostly forced into or prone to economic activities that may put them at greater risk of HIV infection (e.g., promiscuity, migrant work)		
Men	151	21.0
Women	544	75.6
Both	25	3.4
Who do you think their different location of activities put them at greater or lesser risk of HIV infection or affect their exposure to other diseases that may adversely affect their health, especially if they are HIV positive?		
Men	426	59.2
Women	273	37.9
Both	21	2.9

gender norms and role practices which can serve as a barrier to HIV prevention, contributing to increasing the risk of HIV transmission and reducing adherence to antiretroviral therapy when compared with female respondents (OR = 0.60(95% CI: 0.649-3.493) and with regards to educational status, respondents with no formal

Table 3: Perception, participation, and practice of gender norms and roles among selected households in Cross River State

Variables	Frequency (n=720)	Percentage (%)
Do you believe that a wife can refuse to have sex with her husband or can propose condom use if the husband has a sexually transmitted infection?		
Yes	577	80.0
No	143	20.0
How do you think married women should decide about their health care including those that pertain to HIV?		
Based on the husband's decision	22	3.1
By themselves	181	25.1
Jointly with their husbands	517	71.8
Do you believe that a man has a right to assert power over a woman and is socially and economically superior?		
No	265	36.8
Yes	455	63.2
Do you believe in child marriage?		
Yes	130	18.0
No	590	82.0
Do you believe that wife-beating is an acceptable way for husbands to discipline their wives?		
No	605	84.0
Yes	115	16.0
Does a man have a right to "correct" or discipline a woman's behavior base sexuality and gender roles?		
Yes	257	35.7
No	463	64.3
Do you perceive/think these gender norms and practices can contribute to creating barriers for HIV prevention, contributing to increasing the risk of HIV transmission, and reducing adherence to antiretroviral therapy?		
No	520	72.2
Yes	200	27.8

education were 71% more likely to experienced restrictive gender norms and practices which can serve as a barrier for HIV prevention when compared with respondents with higher education (OR = 1.71(95% CI: 2.303-1.674). Similarly, respondents who were employed were 70% less likely to experience restrictive gender norms and role practices which can serve as a barrier for HIV prevention, contributing to increasing the risk of HIV transmission and reducing adherence to antiretroviral therapy when compared with respondents who were unemployed (OR = 0.308(95% CI: 0.586-0.366). More so, the odds of experiencing restrictive gender norms and role practices which serves as a barrier for HIV prevention, contributing to increasing the risk of HIV transmission and reducing adherence to antiretroviral therapy increased significantly by 50% among respondents who were married (OR = 1.50(95% CI: 0.649-3.492). when compared with single respondents and finally, respondents with less than five children living with them were 31% less likely to experience restrictive gender norms and role practices which can serves as a barrier for HIV prevention, contributing to increasing the risk of HIV transmission and reducing adherence to antiretroviral therapy when compared with respondent with no children residing with them (OR = 1.13(95% CI: 0.194-0.843) while respondents with more than five children living with them were 10% more likely to experience restrictive gender norms and role practices which can serves as a barrier for HIV prevention, contribu-

Table 4: Access to assets and vulnerabilities HIV to transmission among participant interviewed.

Variables	Percentage (n=720)	Percentage (%)
How do differences in men's and women's ownership of assets affect their risks and vulnerabilities to HIV transmission?		
Easily at risk without needing external influence	320	44.4
Not Easily at risk even with external influence	400	55.6
How do men's and women's access to and control over assets and resources affect their decision and ability to get tested, access treatment, follow treatment protocols, afford or use condoms or avoid high-risk behavior, such as transactional sex?		
Positively affected/makes them comply	398	55.3
Negatively affected/makes them not to comply	322	44.7
Would you be ashamed if someone in your family had HIV?		
Yes	472	65.6
No	248	34.4
In your opinion, are people hesitant to take an HIV test due to fear of people's reaction if the test result is positive for HIV?		
Yes	670	93.1
No	50	6.9
Do people talk badly about people living with or thought to be living with HIV to others?		
Yes	616	85.6
No	104	14.4
Do people living with or thought to be living with HIV lose respect or integrity?		
Yes	510	70.8
No	210	29.2

ting to increasing the risk of HIV transmission and reducing adherence to antiretroviral therapy when compared with respondent with no children residing with them (OR = 1.13(95% CI: 0.442-5.835).

5. Discussion

This study examines the perception of gender norms and roles in the HIV care continuum among selected households in Cross River State, Nigeria. The findings highlight gender norms and practices barriers that influence HIV prevention, care, and treatment outcomes. Specifically, respondents aged 30–39 years, rural residents, and those with limited or no formal education were more likely to experience and exhibit inequitable gender norms and role practices. These restrictive norms serve as barriers to HIV prevention, increase the risk of HIV transmission, and reduce adherence to antiretroviral therapy (ART). This result is in agreement with prior research suggesting that higher demographic and socioeconomic status are protective factors against negative gender norms (Matud et al., 2019; Fazeli et al., 2015; Fladseth et al., 2015). Our findings corroborate with earlier studies that emphasize the influence of education in reducing gender inequities and promoting HIV prevention (Fazeli et al., 2015; Fladseth et al., 2015) which stated that education emerged as a key determinant in addressing harmful gender norms, particularly in rural areas, and is critical in improving condom use and HIV prevention efforts among men.

Our study also supports previous research on traditional male roles, including decision-making authority and provider status (Leddy et al., 2021; Pulerwitz et al, 2019; Naugle et al., 2019; Sileo et al., 2018) where it was observed

Table 5: Association between socio-demographic parameters of study Participant and perception of gender norms and practices as a contributing barrier for HIV prevention, contributing to increasing the risk of HIV transmission and reducing adherence to antiretroviral therapy (Logistic Regression analysis) n=720.

Variable	OR	[95% CI]	p-value
Age			
18-29	Ref	-	-
30-39	1.3564	2.508-0.204	0.021
40-49	1.0572	2.124-0.010	0.052
50+	0.7615	1.752-0.229	0.132
Sex			
Female	Ref	-	-
Male	0.5969	0.649- 3.493	0.165
Place of residence			
Urban	ref	-	-
Rural	47.6508	25.870 – 87.767	0.000*
Educational status			
Tertiary	Ref	-	-
No education	1.7135	2.303 - 1.674	0.000*
Primary	0.5459	0.277 – 1.074	0.080
Secondary	0.6413	0.359 - 1.143	0.132
Employment Status			
Unemployed	Ref	-	-
Employed	0.308	0.586-0.366	0.709
Marital status			
Single	ref	-	-
Married	1.5063	0.649 - 3.492	0.340
No living with you			
0	ref.	-	-
Less than five	0.6965	0.297 – 1.642	0.441
Greater than five	1.1072	0.442 – 5.835	0.471

that significant proportion of male respondents were responsible for decisions such as visiting relatives, making major household purchases, and managing household finances. In contrast, women primarily decided on food purchases and caregiving. Also, these finding align with studies in South Africa (Leddy et al., 2019) and others (Weber et al., 2019; Heise et al., 2019; Jimin et al., 2023), which also documented men's dominance in decision-making and women's primary engagement in caregiving and household tasks Notably, these studies identified restrictive gender norms, including men's decision-making authority over women's health and the perception of male superiority, as significant barriers to achieving equitable HIV care.

More than two-thirds of respondents believed men are socially and economically superior to women, and 72% thought women should only make health care decisions jointly with their husbands. However, the study also identified positive gender norms. Over three-quarters of respondents supported a wife's right to refuse sex or propose condom use if her husband has a sexually transmitted infection, and more than 80% rejected child marriage and wife-beating.

The study revealed a significant fear of stigmatization among people living with HIV (PLHIV). Approximately 93% of respondents were hesitant to take an HIV test due to fear of negative social reactions if diagnosed as HIV-positive. This aligns with existing evidences (Fazeli et al., 2015; Neyer et al., 2013; Hammer et al, 2003) that stigma and discrimination remain pervasive barriers to HIV care.

6. Implications

These findings underscore the need for targeted HIV care

programs that address restrictive gender norms and empower women in decision-making roles. Interventions should prioritize education, particularly in rural areas, to shift harmful perceptions and foster equitable gender dynamics. Programs must also focus on reducing stigmatization of PLHIV through community sensitization and stigma reduction campaigns. Strengthening access to resources and assets for both men and women is essential to improve decision-making, adherence to ART, and overall health outcomes.

7. Limitation of the study

This study has several limitations, first, the use of closed ended (yes/no) questions may have constrained the depth of responses; incorporating qualitative methods could have provided a richer understanding of the issues explored. Secondly, the study assessed a limited number of Local Government Areas (LGAs), with only four LGAs in Cross River State randomly selected. While this approach adhered to rigorous methodological planning and execution, it does restrict the geographical scope. Nonetheless, the findings are considered representative enough for broader generalizations.

Additionally, the population size for cluster selection relied on 2015 population projections from the National Population Commission and the National Bureau of Statistics. These sampling frames were used exclusively for sample selection within the context of this survey.

8. Conclusion

This study examines the perception of gender norms and practices and their influence on the HIV care continuum among selected households in Cross River State, Nigeria. Key findings reveal that restrictive gender norms and household decision-making practices, particularly regarding control over assets, serve as significant barriers to achieving comprehensive HIV care. Specifically, the study highlights that men in Cross River State often impose restrictions on the mobility of children living with HIV (CLHIV), limiting their access to essential care and exacerbating their vulnerability. Notably, approximately 72% of households did not recognize these restrictive gender norms and practices as barriers to HIV prevention or as factors that increase HIV transmission risks and negatively impact adherence to antiretroviral therapy (ART). This indicates a gap in awareness that needs to be addressed through targeted interventions. The study underscores persistent gender inequalities, particularly those experienced by women, in the context of the HIV care continuum. These inequalities include limited access to resources, reduced decision-making power, and increased caregiving responsibilities, which should be central considerations for policymakers and program implementers. Achieving gender equality and transforming restrictive norms are critical for advancing global health goals, including HIV services, as outlined in the Sustainable Development Goals (SDGs).

Future research should explore causal relationships through longitudinal studies and employ qualitative methods to gain a deeper understanding of gender norms and their influence on HIV care. This will provide actionable insights to inform policy and program development for more inclusive and effective HIV interventions.

9. Recommendations

Given that 72% of households in Cross River State do not recognize how gender norms and practices create barriers to HIV prevention, increase transmission risks, and hinder adherence to antiretroviral therapy, we recommend that government and development partners should design programs that improve access to HIV prevention and continuum of care services by increasing women's decision-making power within the households, influencing communities to practice positive gender norms that encourages women to also control resources. These programs should focus on raising awareness about the impact of negative gender norms on HIV prevention, care, and treatment.

Furthermore, the study highlights that men in Cross River State often restrict the mobility of children living with HIV (CLHIV), limiting their access to necessary care and increasing their vulnerability. To address this, the government and development partners should design programs that engage men's groups in dialogues aimed at promoting positive gender norms and practices that empowers women to take decision about the health of their children. Such initiatives can help dismantle harmful practices and improve access to care for CLHIV.

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11. Conflict of Interests

The authors have not declared any conflict of interest.

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