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Traditional Patriarchal System and Sexually Transmitted Infections Among Women in Rural Abia State, Nigeria: Implications for Sustainable Development

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Abstract
This research investigated how traditional patriarchal system in Abia State, Nigeria, perpetuate gendered power dynamics that limit women's autonomy in sexual and reproductive health and affects sustainable development goal in the area. Traditional patriarchal systems (TPS) significantly influenced women's vulnerability to sexually transmitted infections (STIs) and pose barriers to their health and well-being. Using a qualitative approach, this exploratory, cross-sectional study interrogated the intersection of traditional patriarchal norms and STI prevalence among women, employing the Social Ecology Model (SEM) and EPIS (Exploration, Preparation, Implementation, Sustainment) framework of implementation science strategy, to develop context-specific interventions for the affected population. Data collection involved 6 Focus Group Discussions (FGD) among rural women and stakeholders, while 7 key-informant (KI) data were collected with community leaders, health care professionals, and state coordinators selected purposively from Abia North, Abia Central, and Abia South. The study provided nuanced insights into cultural norms, barriers to care, and societal perceptions. Findings revealed that patriarchal systems limit women's decision-making power, perpetuate stigma, and create inequitable healthcare access, emerging economic dependency, and judgmental fear as critical barriers to seeking medical care, and resource constraints limited effective management of STIs. Guided by the EPIS framework, this study proposes strategies to address patriarchal barriers and improve STI prevention and care by tailoring interventions through stakeholder engagement to integrate gender-sensitive training for the affected population, to promote equitable healthcare for women in rural areas, contributing to sustainable development in relevant context.

Keywords: Patriarchy norms, Women's autonomy in sexual health, Sustainable development in Rural Abia

Background

Globally, sexually transmitted infections (STIs) are a public health issue and mostly affect low and middle-income countries, especially sub-Saharan Africa, that account for up to 75–85% of new cases, with cultural, structural, and gendered factors interrelating to endanger female populations (Ouahid *et al.,* 2023; *The Origins of Patriarchy*, n.d.). In Nigeria, bleak masculine perspectives exist and increase unhealthy sexual behaviors that require interventions among women (Sheikh, 2025), whereas gender norms present social and cultural beliefs that are rooted in the fabric of sexual and reproductive behavior that restrict women's autonomy over their sexual and reproductive health (Ouahid *et al.,* 2023). Besides traditional patriarchal systems (TPS), male authority is always kept at the top, and this limits women's empowerment**,** autonomy**,** equality**,** liberation**,** independent decision-making, and freedom within families and communities. This continues to shape gender dynamics and reinforces harmful stereotypes that hinder gender equality (Ouahid *et al*., 2023; *The Origins of Patriarchy*, n.d.)

The Social Ecological Model (SEM), like a mirror, portrays the multiple influences of the social environment at various levels, interacts, and shapes people's perception, which impacts health (Ewald *et al.,* 2023). These social environmental levels include individual, interpersonal, community, organisational, and policy. Within the backdrop of SEM, the susceptibility of females to STIs may be impacted by their perspectives based on personal knowledge, belief system, interpersonal relationships (significant others), communal patterns (patriarchal traditions- stigma), organizational features (access to care,), and policy perspectives and implementation (gender inequality, financial dependency (Nankinga *et al.,* 2016; Otu *et al.,* 2021). The knowledge of these key factors bridges the gap between culturally relevant STI prevention and treatment programs (Chitneni *et al.,* 2024). The key aspect of this study is the ability to develop implementation strategies important for measuring community constructs (Aarons *et al*., 2014), likely to impact the implementation of safe cultural practices devoid of patriarchal marginalization.

Using the EPIS (Exploration, Preparation, Implementation, Sustainment) framework of implementation science, the context of the rural women in Abia State was split into phases. In the Exploration phase, barriers and facilitators to STI were identified. During the Preparation phase, stakeholders were engaged, and implementation plans were made. At the Implementation stage, the intervention plan of training rural women on avoiding harmful patriarchal practices was made, and in the Sustainment stage, a long-term integration plan was designed, and the plan of scaling-up these interventions to other states and Africa for SDG sustainment and life improvement was targeted (Houghtaling *et al.,* 2023). The SEM and EPIS frameworks were used to explore how

Traditional Patriarchal Systems (TPS) affect women's Sexually Transmitted Infections (STIs) exposure through evidence-based practices (EBP) that require intervention for the sustainability of good health and well-being of the female gender.

There is scant knowledge and a lack of cultural sensitivity on the interplay of interactions existing at the multiple levels of socio-ecological space of traditional patriarchal norms, which exposes women to hazardous practices despite efforts to reduce the STI burden. Although many studies on the phenomenon have emerged, and mostly centered on how TPS strengthens femaleness disparities that heighten women's susceptibility to STIs and limited access to health information and services, assessing the gender inequality level of progress for achieving the Millennium Development Goals (Nwokocha, 2015; *Nssckbi*, n.d.; Otu *et al.,* 2021). Most Nigerian studies are cross-sectional, which limits causal inference and the temporal understanding of STI risk. There is minimal integration of the SEM and EPIS frameworks on how multilevel gender norms intersect with implementation processes. Also, gender-transformative interventions have not been systematically tested using the EPIS model in Nigeria's rural settings.

Therefore, this research highlights the underlying factor linking gendered hierarchical structures to preventive community health care. Hinged on the EPIS framework is significantly sacrosanct for tailoring interventions in this backdrop, enabling the standardized evaluation of contributing components, stakeholder engagement/participation, and the consolidation of gender-sensitive policies relevant to community implementation research, where culturally specific interventions remain scarce.

The specific objectives were designed to explore how traditional patriarchal systems influence women's autonomy, STI risk, health-seeking behaviours, and access to care in rural Abia State, Nigeria, to group the pinpointed influences to the SEM levels (individual, interpersonal, community, institutional, policy) and to utilize the EPIS framework to generate context-specific, stakeholder-driven strategies for STI prevention and care among women in the study area.

A Brief Literature Review

Patriarchal System in Nigeria

Patriarchy is predominant in many rural communities of Nigeria, vividly impacting various aspects of women's lives, particularly their health and reproductive wellbeing (Allanana, 2013). Patriarchy, a social structure that accentuates men's supremacy over women in decision-making, authority, and resource allocation, significantly influences how women access health care services, including sexual and reproductive health care (Oluwakemi, 2017; Omigie & Nwagbale, 2025). Nigerian women in rural areas are usually susceptible to many reproductive health challenges, like STIs, due to their limited access to health care and insufficient autonomy to negotiate safe sex (Imo, Odimegwu, & De Wet-Billing, 2022). In many cases, literature reveals

that women often lack decision-making power about their sexual interaction and choices and use of contraception and access to treatment when infection occurs (Anizoba & Davis, 2019; Imo *et al.,* 2022). This lack of independence is further strengthened by educational and financial deprivation and cultural taboos associated with women's sexuality (Hnin *et al.*, 2024). Accordingly, the burden of STIs among women echoes the dominant influence of patriarchal structures on women's health outcomes.

Patriarchal supremacy also influences knowledge and awareness about STIs. In many instances, men are seen as the custodians of sexual norms, while women are passive and oblivious about their sexual health matters. The culture of silence about sexual matters, the societal expectation of chastity, ignorance, fear, and stigma associated with the diagnosis of STIs usually discourage women from seeking medical attention (Awoleye, Solanke, Kupoluyi, & Adetutu, O. M. 2022; Oharume, 2020). Untreated infection may consequently lead to long-term complications like infertility and Pelvic inflammatory diseases.

Additionally, Systemic factors exacerbate this cycle of vulnerability. The inadequate reproductive health infrastructure, low prioritization of women's health, and dominance of males in decision-making regarding women's health often reflect patriarchal biases. In many cases, cultural approval is required from husbands or male relatives before women can access healthcare services, leading to delays in treatment and worsening of infections (Sinai, I., Azogu, O., Dabai, S. S., & Waseem, S., 2024). These systemic inequities highlight the need to interrogate how traditional patriarchal norms continue to determine women's exposure, perception, and response to sexually transmitted infections in rural communities.

Understanding the relationship between patriarchal systems and the prevalence of STIs among women is critical in the broader context of sustainable development in Africa. The African Sustainable Development Goals (SDGs), particularly Goals 3 and 5, emphasize ensuring good health and promoting gender equality. However, achieving these goals requires confronting the cultural and structural barriers that undermine women's sexual and reproductive health rights. Addressing patriarchal constraints is therefore important for gender fairness and impartial development.

This study, therefore, seeks to examine the influence of traditional patriarchal systems on the prevalence and management of sexually transmitted infections among women in rural Abia State, Nigeria. In exploring how gender norms, decision-making patterns, and cultural expectations shape women's vulnerability to STIs, the study aims to generate insights that will inform culturally sensitive health policies and community-based interventions. Ultimately, the findings will contribute to understanding how dismantling patriarchal barriers can advance women's health and support the attainment of sustainable development.

The female susceptibility to STIs may be impacted by their perspectives based on personal knowledge, belief system, interpersonal relationships

(significant others), communal patterns (patriarchal traditions- stigma), organizational features (access to care), and policy perspectives and implementation (gender inequality, financial dependency).

Theoretical Framework

The Socio-Ecological Model (SEM), as propounded by Urie Bronfenbrenner (1979), is a theory that explained human development as a multifaceted system of intricate interaction affected by multidimensional aspects of the surrounding environment, which he conceived as a series of multilevel structures. This theory established that human behaviour and wellness are shaped by the network of social interaction in the environment, which are interconnected, ranging from interpersonal to societal and policy frameworks.

In the application of this framework to the design of Abia State, the patriarchal system functions at the various levels, as explained by Bronfenbrenner. The individual perception shapes close interrelationships and reinforces rural norms and values in policies that do not protect or project women's autonomy. This affects or impacts women's limitations in health care rights. Therefore, women's vulnerability to STIs is a result of an ecological system that constrains their choices and limits their opportunities.

Within the field of implementation science, the EPIS framework was developed (Gregory Aarons, Michael Hurlburt, & Sarah Horwitz, 2011) to bridge the gap between factors that connect both inner context, which is organizational-level structures like culture or leadership, and outer context like policies, community norms, or funding at the system level, through different stages. This framework explains how evidence-based interventions can be recommended, used and sustained adequately in real-world settings by bridging the characteristics of the communities and service programs (interventions).

Empirical Review

Traditional Patriarchal Practices and Cultural Norms

Empirical studies across Nigeria demonstrate that patriarchal ideologies are entrenched in traditional and cultural structures that define men as authority figures and women as subordinates, directly influencing women's sexual autonomy and reproductive decision-making power. For instance, a descriptive analytical study in Zaria, Kaduna State, employing documentary and content analysis of legal, cultural, and sociological texts to explore how patriarchy sustains gender inequality, revealed that men dominate decision-making and resource control, leading to the economic and sexual subordination of women (Makama, 2013). The findings revealed that men dominate decision-making and resource control, leading to the economic and sexual subordination of women. Similarly, a cross-sectional quantitative study in Enugu and Anambra States, South-East Nigeria, analyzed data from 420 married women through structured questionnaires and logistic regression models. Results indicated that patriarchal family structures significantly limit women's capacity to negotiate

safe sexual practices, increasing their vulnerability to sexually transmitted infections (STIs) (Imo, 2022).

These studies confirm that patriarchal ideologies persist through the intergenerational transmission of cultural values that define men as custodians of sexual morality and women as passive subjects, creating barriers to women's sexual rights and health autonomy.

Cultural Norms and Community Enforcement Mechanisms

At the community level, empirical studies reveal that informal social control mechanisms sustain gender norms that restrict women's sexual expression. A mixed-method study in Delta and Edo States involving 620 participants using questionnaires and eight focus group discussions (FGDs) revealed that social sanctions such as ridicule, gossip, and ostracism are used to discipline women who defy sexual norms or challenge male authority (Oharume, 2020). The study concluded that patriarchal structures embedded in rural community systems reinforce women's silence on sexual matters, thereby undermining sexual health education and STI prevention.

In rural communities of Abia State, similar enforcement practices exist, as noted in the Umungasi Area Study (2010), which adopted a community-based survey design with 210 respondents. Findings revealed that 78% of female participants avoided discussing sexual health for fear of stigma, thus relying on informal and often inaccurate information sources.

Social Ecological Model and Women's Sexual and Reproductive Health

The Social Ecological Model (SEM) provides a useful empirical mirror for understanding the multiple layers influencing women's sexual health outcomes. At the individual level, there is limited STI knowledge, myths about infection transmission, and misconceptions about condom use (Oharume, 2020). At the interpersonal level, a cross-sectional study in tertiary institutions in Abia State using multistage sampling, recruited 520 female undergraduates, and the study demonstrated that intimate partner violence (IPV), economic dependence, and fear of male retaliation significantly reduced women's negotiation power in sexual decision-making, resulting in greater STI vulnerability (Odini, Amuzie, Kalu, Nwamoh, & Ukaegbu, 2024).

At the community level, social norms and religious beliefs further shape sexual behaviour, while at the institutional level, the lack of gender-responsive health services constrains access to STI prevention and treatment.

Traditional Patriarchal Systems and Women's Vulnerability to STIs

A clear empirical pattern emerges across Nigerian studies: patriarchal systems amplify women's exposure to STIs through structural, economic, and cultural restrictions found that women with limited decision-making autonomy were 45% less likely to use condoms consistently and 38% less likely to discuss STI testing with their partners (Imo, 2022). Similarly, an analysis of hospital-based data from a tertiary health facility in Owerri, Imo State, between 2012 and

2014, employing retrospective chart reviews and descriptive statistics, indicated that women aged 20–35 years accounted for 63% of STI cases, with a strong correlation between low socio-economic status and infection prevalence (Nwadike, Olusanya, & Adeoye, 2015).

The Umungasi Area Study (2010) also observed that traditional gendered power relations expose rural women to unprotected sex and discourage health-seeking behaviour. Qualitative data from key informant interviews revealed that male partners' extramarital affairs are culturally normalized, while women who question fidelity face social and emotional violence. (Umungasi Area Study, 2010).

Implementation Science, EPIS Framework, and Empirical Gaps

Implementation science provides an analytical structure for translating evidence into sustainable interventions. A systematic review of 89 peer-reviewed studies applying the Exploration, Preparation, Implementation, and Sustainment (EPIS) framework across global health contexts using qualitative meta-synthesis identified weak incorporation of gender dimensions and patriarchal influences in intervention phases. (Moullin, Dickson, Stadnick, Rabin, & Aarons, 2019). In the African context, a narrative review of implementation science applications in Nigeria, Kenya, and South Africa concluded that cultural and gendered determinants remain underrepresented in program design and evaluation (Ojo, 2021). Further demonstration of implementation research in Nairobi, Kenya, failed to address patriarchal attitudes that hindered adolescent girls' participation in HIV prevention programs (Beima-Sofie, Inwani, Wools-Kaloustian, and John-Stewart, 2023).

While these studies validate the utility of the EPIS framework, few apply it to rural Nigerian contexts where patriarchal norms distinctly influence health outcomes. Synthesis of Empirical Gaps reviewed the empirical evidence and demonstrates that patriarchal and cultural systems substantially heighten women's vulnerability to STIs by constraining their autonomy, silencing discourse on sexual health, and normalizing male sexual privilege. The goal of applying implementation science using SEM theory, is to enhance the appropriateness of the intervention program for rural women by identifying and overcoming barriers to implementing research-based strategies to ensure that evidence-based interventions are utilized in these settings.

Conceptual Framework

Applying the SEM and EPIS frameworks to patriarchal impacts in the rural communities of Abia, the Exploration phase involved identifying how ingrained norms and system disparities influenced STI susceptibility. At the second stage of Preparation, a bridge was built between communities, health systems, and intervention, with overarching aims to ascertain cultural relativity and stakeholder involvement. Whereas Implementation centered on rendering the transformative strategies of the sex, identity, and category that respond to the community norms while identifying institutional barriers and facilitators,

sustainment portrays the EPIS focus on entrenched extant routines and practices in systems to encourage progress in women's sexual health after the initial intervention program.

These theories exposed the fundamentals and relational components at all level through which patriarchy increases STI risk, while EPIS framework portrays a systematic strategy for designing and maintaining interventions that can disrupt these components. The synthesis of both model forms a mutually compatible, theoretical approach for enhancing female's health outcomes in the rural communities of Abia State, advancing African Sustainable Developmental Goals of gender equality, health, and social justice.

Materials and Methods

This cross-sectional study employed a qualitative, explorative approach that utilized 6 focus group discussions (2- ranging from 5-8 participants in a group, in each senatorial district) and 7 key informant interviews (2 in each district and one from the state). The instruments were designed using the SEM frameworks to explore the research questions, while the EPIS framework guided the process based on the literature review and the SEM, which informed the interview guides conceptually. The study design allowed exploration of the lived experiences of women and stakeholders regarding patriarchal norms, STI risk, and access to care. Focused Group interview guides were developed for women and stakeholders (comprising community members, both male and female). The key informant interview guides (KII) were designed for policymakers and healthcare professionals. The interview guides used for the study were validated by experts in gender, public health and medical sociology.

The study utilized a multi-stage sampling technique, with systematic random sampling. Purposive sampling was used to select 6 groups of participants, comprising of women and stakeholders (community members, both women and men), and key informants (community leaders, healthcare providers, NGO/ Gender experts, and government representatives) were interviewed to get individual, community, organizational, and policy-level data. Participants in Abia North, Abia Central, and Abia South were selected using:

- Multi-stage sampling to select LGAs and communities.
- Systematic sampling to select households using a fixed interval (every *k-th* household).
- One respondent per selected household participated. The instruments used centred on patriarchal norms perceptions; decision-making in sexual and reproductive health; experiences of or barriers to STI prevention and treatment; and suggestions for interventions and how interventions can be a useful strategy in combating the traditional harmful practices.

Data Analysis

Qualitative data from FGD and KII were audio recorded, transcribed verbatim, and content-analyzed using a method that identifies patterns and themes within behavioral scientific research (Nowell *et al*., 2017).

Codes were generated inductively and then mapped onto the SEM levels (individual, interpersonal, community, institutional, policy) through audio-recorded interviews, which were subsequently aligned with the EPIS framework to develop intervention strategies. Qualitative data from the KIIs were analyzed using thematic content analysis, a method suitable for identifying patterns and themes within sociological research (Nowell *et al*., 2017).

Measurement of Variables

The variables were designed to explore how traditional patriarchal systems influence women's autonomy, STI risk, health-seeking behaviours, and access to care in rural Abia State, Nigeria. To understand the intricacies of the social realities of this study, variables were grouped to the SEM levels (individual, interpersonal, community, institutional, policy) and to utilize the EPIS framework to generate context-specific, stakeholder-driven strategies for STI prevention and care among women in the study area.

Ethical Considerations

All ethical protocols were dully observed during the research process. Participants received an adequate understanding of the purpose of the research, their involvement prior to the start of the interview and how the data will be shared and used. Their consent was adequately sort. They were informed that participation was totally voluntary and that they were free to withdraw from the study at any point, without facing any consequence. However, their identity was anonymized and data was securely stored to maintain adequate confidentiality. A safe environment was created for participants and they felt respected. The researcher made sure that participants were comfortable and this reinforced their autonomy and ensured that their rights and well-being were prioritized during the study period.

Results

Socio-Demographic Profile of Participants

The demographic characteristics of participants from the senatorial districts in Abia State, Nigeria, offered insights into the makeup and its association with gender health disparities. An average of eight participants (P1–P8) in each FGD took part in the study, comprising five males and three females for the stakeholder group in each of the senatorial districts, indicating a slight male dominance (62.5%) in the sample.

The average age of the participants ranged from 30 to 50 years, suggesting that the study primarily engaged adults in their productive and reproductive years.

In terms of marital status**,** five participants were married**,** while three were single across the FGD groups, and almost all participants in the KII groups were married. This reflects a mixture of marital experiences and perspectives relevant to the study's focus on gender and health behaviour. The number of children reported ranged from zero to four, showing variability in family size and reproductive history.

Regarding educational attainment, the participants were generally well educated. Most held tertiary qualifications**,** including BA, BSc, OND, and MA degrees, while a few participants had completed secondary education. This suggests that the group possesses a relatively high level of educational awareness that could influence their understanding and attitudes toward gender and health-related issues.

All participants were identified as Christians**,** indicating a religiously homogeneous sample, which impacted on cultural and moral undertone related to sexuality, gender roles, and health-seeking behaviour within the community space. In terms of experience in years of service, 51.3% had 1-5 years of experience, and 15.4% had over 16 years, showing a mix of new and determined workers. Data on monthly earnings indicated that most participants earned between N51,000 and N100,000 per month, indicating a mid-level income, which has an undertone with the financial and health-related challenges. Finally, the workforce is young, educated, gender-balanced, and predominantly married with children.

Theme 1: Deep-rooted shame, disgrace, and misconceptions about STIs

Across the participants, there is strong ostracism and moral judgment associated with Sexually transmitted infections. Many people associate STIs with sexual immorality, promiscuity, and divine punishment. As stated by one of the participants, 'Women in this community believe that a woman with STIs is simply wayward and unfaithful in marriage. This could be as a result of jumping from one man to another,' *(FGD).* In buttressing this fact, another participant in an FGD stated that STIs are usually contracted by prostitutes. Similarly, there is a perceived understanding in the area that STI is seen as a punishment for immoral behaviour. This assertion was echoed by an FGD participant and expanded by a stakeholder in a KII.

This demoralizing perception about STIs will create deep shame and a culture of silence surrounding STIs. Consequently, it may delay or impede treatment-seeking. While interrogating the perception regarding STIs, an FGD Participant disclosed that women feel shy to discuss STIs, so they live with it and suffer with it alone. The reason for this silence is explained in the view of another participant that the community views them as people who should be avoided. In other words, those with *STIs* are ostracized, secluded, and avoided.

Theme 2: Gender Inequality and Male Control in Health Decisions

Participants emphasized how patriarchal norms limit women's independence in making health decisions. Husbands are commonly seen as the ultimate authority in deciding when and where a woman seeks care. This is emphasized in one of the Participants' (FGD) comments, **"**The husband has the right to make that decision even if the wife is making more money in the family, "and maintained by another participant's view that the woman can only seek health care if the husband approves. In extreme cases, a KII participant noted that the woman may experience humiliation and violence if she asks for money from her husband for STI treatment. This view is confirmed further by another KII Participant, who raised a striking point that:

> Definitely, the woman will be affected, especially when she depends on the man for financial support. The worst scenario is when the woman is being suspected, the man even beats her for asking for money to seek healthcare for an STI treatment. The fear of the man may make the woman withdraw for fear of being judged, and she may suffer in silence, and this may lead to death.

These responses illustrate the inequality and patriarchal cultures that suppress women's autonomy in decision-making, even when it relates to their health. While in this study, health care decisions are dependent upon spousal permissions.

Theme 3: Socioeconomic and Structural Barriers to Healthcare

Apart from the patriarchal control of women's health care decisions, structural and economic barriers also limit women's ability and access to quality STI treatment. primary health centers in most communities are poorly furnished.

One of the participants in the FGD group explained thus: *"*Sometimes you go to hospitals, some apparatuses are not available, and you will be referred to another place, and because of lack of money and distance, you will not go."

Participants also described negative provider attitudes and breaches of confidentiality, particularly in teaching hospitals where student doctors gossip about patients. Such experiences discourage women from seeking care and drive them toward unregulated pathways of care.

Theme 4: Cultural and Religious Influences on Sexual Health Behavior

Cultural norms reinforce gendered double standards in STI perception and response. One of the participants in an FGD captured this vividly. She stated, *"*Men are polygamous in nature, hence when they contract STIs, they are pitied…but when a woman contracts such, she is treated as being promiscuous."

Religious doctrines sometimes discourage biomedical treatment, as Participant, in an FGD, noted: *"Some religious practices forbid their members to take medications so they depend only on faith and prayer."* At the same

time, both religious and traditional leaders can be agents of change. Another FGD participant echoed that *"Pastors encourage women to open up,"* while another in the same interview group added *"traditional leaders organize programs to sensitize and educate men and women on harmful norms."*. Thus, religion and culture function as double-edged swords, sources of stigma but also potential platforms for community transformation when engaged constructively.

Theme 5: Role of NGOs and Community Support Structures

Several participants acknowledged the positive role of NGOs, churches, and community organizations in promoting STI awareness and linking women to care. A KII participant described the efforts of Delifespring Women Organization, an NGO that goes from community to community sensitizing women and linking them to reproductive-health services. One of the KII participants also noted that Churches also serve as important avenues for premarital testing and counseling, while traditional August meetings provide opportunities for women's education. These examples show that community-based organizations are crucial allies in addressing STI stigma and improving access to information and healthcare.

Theme 6: Empowerment and Pathways to Sustainable Change

Participants consistently emphasized the need to empower women through education, leadership, and inclusion in decision-making. A KII participant urged that *"*Women should be trained to occupy leadership positions,*"* while another KII participant advocated for "intentional girl-child education from childhood through adulthood."

Empowerment was viewed not only as participation in projects but as long-term community ownership. Another KII participant stated, *"*The program managers should train the stakeholders…to own it and continue after the intervention."

These responses suggest that intervention is necessary to alleviate women's vulnerability. Also, sustainability depends on integrating STI initiatives into existing community structures and ensuring local women leadership beyond donor-funded timelines.

Discussion

The demographic features of the study population showed variation in marital, educational and sexual orientation. The predominance of Christians and educated participants in the study area is significant because having a degree and being a Christian have a significant influence on shaping moral values and health attitudes. The addition of married and single participants exemplifies a better understanding of the various family responsibilities and social expectations that are essential to explaining the gender norms, women's autonomy, and health-seeking behaviour.

These responses illustrate that inequality and patriarchal cultural norms suppress women's autonomy in decision-making even when it relates to their health. while our study showed that health care decisions are dependent upon spousal permissions, as it is found in other studies that women's independence and decision-making ability are dependent on spousal approval (Agyemang *et al*, 2017; Mutombo, *et al* 2015; Osamor & Grady, 2018). Women's autonomy in health decisions is very important. These affect their preventive and curative care. For example, the study by Seidu *et al* 2020 indicated that women's autonomy influences their uptake of HIV testing. Another study, Yaya *et al* (2018), shows that women's empowerment is associated with contraceptive use.

The findings on the Socioeconomic and Structural Barriers to Healthcare resonate with evidence that health-system barriers, particularly inadequate infrastructure, high costs, and lack of privacy, staff attitude, and long waiting times, prevent women from using formal sexual-health services (Olajubu, Olowokere , and Naanyu 2025; Desmennu, Titiloye, & Owoaje, 2018).

On cultural and religious influences of sexual health behavior, religion and culture function as double-edged swords, first as sources of stigma and also potential platforms for community transformation when engaged constructively. The examples on the role of NGOs and community support structures show that community-based organizations are crucial allies in addressing STI stigma and improving access to information. Empowerment was viewed not only as participation in projects but as long-term community ownership. Participant (KII) stated thus, "The program managers should train the stakeholders…to own it and continue after the intervention**."**

In addressing responses on sustainability, there is a need to integrate STI initiatives into existing community structures and ensure local leadership, particularly by women, beyond donor-funded timelines. The need for intervention to reduce gender disparities and enhance women's autonomy is key and requires an adequate sustainability plan in the rural areas of Abia State.

Summary

The thematic analysis reveals a complex web of social stigma, gender inequality, economic hardship, and weak health systems that restrict women's access to STI care. Yet, within these constraints lie opportunities for transformation through community-based sensitization, engagement of religious and traditional leaders, and deliberate efforts to empower women.

Addressing STI prevention and treatment, therefore, requires a holistic, gender-transformative approach that combines health-system strengthening, economic empowerment, and social norm change. Sustainable progress depends on partnerships between women's groups, men, local leaders, NGOs, researchers (implementation scientists), and government agencies, working together to dismantle stigma and promote sexual-health rights for all women.

Conclusion

This study highlights that sexually transmitted infections (STIs) in the community are shaped by complex social, cultural, and structural factors beyond biomedical considerations. Persistent stigma, shame, and misconceptions, compounded by gender inequality and male-dominated health decision-making, limit women's autonomy and delay access to screening and treatment. Socioeconomic challenges and weak health infrastructure further hinder effective care, while cultural and religious norms reinforce silence and reliance on faith-based remedies. Despite these barriers, NGOs and community-based organizations play a critical role in education, counseling, and outreach, reflecting a community desire for intervention, empowerment, knowledge, and policy redesign. Addressing STIs, therefore, requires integrated interventions that combine medical care with sustained social and structural change.

Significance of Sustainable Development Goals (SDGs)

This research promotes sexual health and access to health services, hence supports SDG 3 (Good Health and Well-being). Enhancing women's autonomy and challenging patriarchal norms contribute to SDG 5 (Gender Equality). Efforts to expand education and reduce inequalities also reinforce SDG 4 (Quality Education) and SDG 10 (Reduced Inequalities), ensuring that interventions get to those who need them, especially in Abia State and African communities.

Recommendations

1. Community-Based Education and Awareness: Implement ongoing, culturally sensitive STI education to dispel myths, reduce stigma, and promote dialogue, especially among youth and women.
2. Gender-Responsive Health Policies**:** Strengthen initiatives that enhance women's autonomy and address patriarchal influences in sexual and reproductive health decision-making.
3. Accessible and Quality Health Services**:** Subsidize STI testing and treatment, ensure confidentiality, and train providers in empathetic, non-discriminatory care.
4. Engagement of Cultural and Religious Leaders**:** Collaborate with traditional and faith leaders to reshape narratives around sexual health, stigma, and gender norms.
5. Support for NGOs and Community Networks**:** Expand NGO partnerships to reach marginalized populations and establish community-led monitoring systems.
6. Empowerment Pathways**:** Integrate sexual health education, economic empowerment, and gender equity programs to foster lasting behavioral and attitudinal change.

7. Co-create a context-specific intervention package on STI prevention for rural communities: Involve stakeholders in the creation of strategies to ameliorate gender disparities in the communities.

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