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Exploring the role of religious leaders in promoting positive sexual practices to reduce the prevalence of HIV/AIDS amongst young adults in Aba, Nigeria: A qualitative study

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ABSTRACT

Despite attempts to control the HIV epidemic in Nigeria, especially amongst young adults, prevalence is increasing. The aim of this study was to provide insights to strengthen the positive impact of religious leaders in preventing HIV/AIDS amongst young adults. Qualitative descriptive research was carried out. Purposive sampling was used to identify religious leaders (Christian or Muslim) and young adults (aged 20–24) who are active in their faith communities in Aba, Nigeria, chosen due to its high prevalence of HIV amongst young people. Religious leaders were recruited through publicly available contact details. Young adult participants were recruited through religious youth groups on Facebook. Online, semi-structured interviews were carried out. Findings were analysed thematically. Seven religious leaders (six male, one female) and seven young adults (five male, two female), all Christian, participated. Results found that young people may lack appropriate knowledge on HIV prevention, and that this topic is not often discussed in church. Religious leaders were seen as influential, with different platforms to engage youth. They could have a positive or negative impact on HIV prevention practices, for instance, by reinforcing stigmatising rhetoric around HIV and discouraging condom use. Capacitating religious leaders with adequate knowledge on HIV and supporting the adoption of a more liberal and pragmatic approach to HIV/AIDS prevention may enable positive impact.

Key Words: Religious leaders || HIV/AIDS reduction || HIV/AIDS prevention || Young adults || Nigeria

INTRODUCTION

The human immunodeficiency virus (HIV) undermines the body's immunity, leaving it vulnerable to diseases (Abebe, 2025). It was estimated in 2023 that there were 39.9 million people living with HIV globally and 630,000 related deaths (World Health Organization, 2025). In 2023 there were roughly two million people living with HIV in Nigeria, with 75,000 new infections annually, for an incidence of 0.34 infections per 1000 population and a prevalence of 2.1%. (Onovo et al., 20203; UNAIDS, 2025). In Nigeria, young adults aged 15 to 24 have the highest HIV prevalence at 3.5% (Health Analytics, 2021; Kareem et al., 2023; UNAIDS, 2025). The high HIV prevalence amongst young adults is suggested to be linked to risky sexual behaviours and poor HIV prevention knowledge, which sits at only 43% for young women and 34% for young men, underlining the importance of focusing on HIV education and prevention in young adults (Ochilo et al., 2017; Kareem et al., 2023).

Religious leaders in Nigeria are highly recognised and respected (Awofala and Ogundele, 2018; Aguwa, 2010). Forty-six percent of the Nigerian population identifies as Christian and 54 percent as Muslim (Statista, 2022). Religious leaders can impact people's health by being a trusted source of information by community members and promoting health-seeking behaviours (Aguwa, 2010; Lambert et al., 2021; Syed et al., 2023; Young et al., 2022). Religious organisations are present in almost every community in Nigeria and have a considerable influence on regional politics, society, education, and the economy. Some religious leaders in Nigeria have participated in HIV/AIDS prevention initiatives, though their involvement remains unregulated through policy (Asekun-Olarinmoye et al., 2013). It has been suggested that global HIV prevention strategies must include the full participation of religious leaders and that they should be incorporated in the social services offered by religious groups (Pichon, et al., 2020; Dennis, 2013). More needs to be done to both understand and formalize the role of religious leaders regarding HIV/AIDS prevention and control (Alio et al., 2019; Heward-Mills et al., 2018).

There are few examples where religious leaders across African countries have made contributions to HIV prevention. A study conducted in Jimma Zone in Ethiopia involved the training of 180 religious leaders on HIV prevention showed that religious leaders actively participated in developing strategies to reach out to their respective communities (Surur and Kaba, 2000). Similar findings were obtained from research conducted in Namibia and Kenya (Sach's, 2007; Gitchuru et al. 2018; Ansari and Gaestel, 2010). Some studies in Nigeria have found a *negative* impact on HIV prevention and control due to the involvement of religious leaders (Onyemachi et al., 2021; Ochilo, 2017; Uchega and Hartwig, 2010). For example, the study by Ucheaga and Hartwig (2010) in Cross River State, Nigeria showed religious leaders reinforced stigma, emphasizing the condemnation and punishment of those who were HIV positive. Another study showed that most Muslim leaders in Nigeria view HIV prevention messaging regarding faithful marital relationships and abstinence from sexual activities outside marriage as aligned with Islamic teachings (Balogun, 2010). This finding also resonates with the doctrine of abstinence shared amongst Christian leaders in Nigeria (Onyemachi et al., 2021; Smith, 2010; Leung et al., 2016). However, such teachings have been shown to be ineffectual with young adults in different African contexts, deterring preventative practices such as condom use (Aventin et al., 2021; Broderick et al., 2023). In Uganda, a study specifically looking at the influence of religious leaders on HIV prevention amongst young people indeed found that they promoted abstinence and monogamy and sometimes discouraged condom use (Murungi et al., 2022).

Current study

Although some studies have been conducted on the role of religious leaders in HIV prevention (Smith, 2010; Leung et al., 2016; Powel, et al., 2020; Onyemachi et al., 2021; Umar and Oche, 2022), the role of religious leaders in supporting HIV prevention, specifically amongst young adults, remains under-explored across contexts, including within Nigeria where HIV prevalence is the highest in this group. Thus, the aim

of the current study was to explore the role of religious leaders in promoting positive sexual practices to reduce the prevalence of HIV/AIDS amongst young adults in Nigeria.

METHODS

Design: A qualitative descriptive design (Lambert and Lambert, 2012) was used to uncover the perspectives of religious leaders and young adults around the possible role of religious leaders in supporting HIV prevention.

Study site: Aba, Nigeria, was selected as the study site. It is a city with a population of over 2.5 million people. It is located in the South-South area, which has the highest HIV prevalence in Nigeria at 3.1 percent (National Agency for the Control of AIDS, 2025).

Sampling: Purposive sampling was used to identify participants with sufficient knowledge of the topic of the study. The aim was to sample participants with a range of characteristics (e.g. different ages, being either Christian or Muslim) across both religious leaders and young adults to generate rich insights.

Inclusion criteria: *Religious leaders:* aged 18 or older; male or female; being a Christian or Muslim religious leader; having a congregation of at least 50 people in Aba, including a large number of young adults; preferably engaged in youth education. *Young adults:* aged 20-24 years; HIV-positive or negative; having at least secondary education; residents of Aba; being regular attendees of either church or a mosque; English-speaking; having access to a computer or smart device.

Recruitment: Publicly available information from religious leaders (phone numbers or emails) were obtained from religious institutions in Aba in May 2022. These details were used to contact religious leaders and invite them to participate in the study. Additionally, study details were posted in popular religious Facebook groups for young people in Aba, and interested participants self-selected into the study.

Data collection and instruments: Semi-structured interviews were carried out online on Microsoft Teams in English using a guide that asked open-ended questions about beliefs around HIV and preventative practices and the role of religious leaders in HIV prevention. They lasted between 20–45 minutes and were conducted by MNH. Interviews were conducted until the theoretical saturation was reached, which included seven young people and seven religious leaders. Data was first collected and analysed from five religious leaders and five young adults, after which it was clear that new information was continually arising. Data were then collected from an additional two participants in each group, after which point it was deemed that no new insights were arising.

Data analysis: Thematic analysis was used after the verbatim transcription of the interviews. In line with the process outlined by Braun and Clarke (2006), six steps were followed in the data analysis: (1) data familiarisation in which the text was read and re-read to explore emerging themes; (2) line-by-line coding; (3) grouping codes into higher-order codes and themes; (4) reviewing themes; (5) naming and defining themes; and (6) reporting.

Ethical considerations: Ethical approval was obtained from the ethics board of the University of Manchester. Before interviews began, an information sheet was discussed, participants were given the opportunity to ask any questions, and a voluntary informed consent process took place. Participants were encouraged to have the interview in a private location. Participants were given pseudonyms to maintain their confidentiality.

RESULTS

Table 1. Participant demographic information

Religious leaders					Young adults		
Pseudonym	Gender	Age	Role	Length of time in role	Pseudonym	Gender	Age
Uzo	M	35	General overseer of a protestant church	6 years	Charles	M	22
Ama	M	40	Resident pastor	12 years	Chuka	M	24
Okafaor	M	30	Youth coordinator	12 years	Okon	M	24
Amos	M	47	Parish pastor	3 years	Sabinus	M	23
Jude	M	35	Youth leader	5 years	Okechi	M	23
Onuma	M	45	Church Pastor	10 years	Ulomma	F	23
Amara	F	43	Women's ministry youth leader	10 years	Mmeri	F	21

Analysis yielded 30 subthemes, subsequently categorised into 10 main themes: six themes for religious leaders and four themes for young adults. These themes are presented below.

Views of religious leaders

Theme 1: Religious leaders see their role as guiding spiritual and moral wellbeing

Religious leaders acknowledged that their job encompasses obligations to their members, including those relating to HIV and other health-related concerns. Most had a clear understanding of their responsibilities. First, they described themselves as religious leaders whose primary mandate is perceived to have come from God, and to that extent, they are to promote the spiritual and moral wellbeing of their members, guiding them towards heaven. In terms of HIV prevention, most viewed their role encompassing education, enlightenment, and guidance of their congregation. These beliefs may be at odds with public health measures, as the desire for spiritual health may preclude education around safe sexual practices that are not seen as morally acceptable, for example, when relating to sex outside of marriage or condom use.

> *I have a role of taking care of women guiding them heavenward and I also have the role of taking care of the young women, when I talk about the young women, it is a ministry comprising of young ladies between the age of 18-25 so, we take care of this*

young ladies by guiding them, mentoring them, making sure that they work according to the ways and the policies of our church. (Amara, F)

We Christian leaders advise people on how they will manage to save themselves from HIV and how they will protect themselves from HIV—how they will make sure that such hard sickness will not befall on them…the cause of HIV started from individual communication pertaining to sexual intercourse, so a situation where one has to know that you are a child of God, then sex is something made by God, because God said, 'go into the world and multiply and replenish', so that is the work of sex by producing human beings, so that will not warrant us to abuse sex by having the unnecessary sex. (Uzo, M)

Theme 2: Engagement of young adults

Religious leaders agreed that young adults deserved special attention and a distinct place in the congregation. To this end, some of the churches have created youth ministry and young adult associations, and in most cases, a young religious leader appointed to oversee them. For instance, religious leader, Okafor, identified himself as the youth director in their church. In addition to one-on-one engagement with their young people, most of the religious leaders spoke about other ways they engaged them such as organising regular youth meetings and gatherings, youth forums, seminars, workshops, and symposiums to discuss important topics, themes and issues affecting the young people. Amos remarked, "I have been doing education programs for the young in my church. They are many and the need to support them is very high."

One religious leader detailed how he has organised a series of seminars and youth retreats for young adults of his church.

In the church, as a leader, we have a program that involves teaching young people on their various youth's weeks or youth's month or youth's retreats, and this gives us opportunity to teach them and drive their minds towards the principles that God has given to us according to his commandments that enable us to live a good life…living a moral life that will also support our good health living. (Onuma, M)

Theme 3: Religious leaders feel young adults' knowledge about HIV prevention is insufficient

Most religious leaders thought that young adults had fair, but inadequate, knowledge of HIV transmission; a few were not able to speculate on the level of HIV knowledge amongst the young adults in their congregations. Some agreed that the young adults have some knowledge about HIV learned from school, but that it may be limited, not updated, and lacking in detail. Others said that the young people may not have enough information and knowledge about HIV transmission and admitted that religious leaders may also be constrained as educators in this respect, due to their beliefs.

Religious leaders, elders, and pastors, we are too religious to teach to our people…about these things, we are thinking if we tell them, we have send them to go and commit fornication. (Okafor, M)

Theme 4: Religious leaders have mixed training on HIV

All religious leaders were aware of the significance of training in the anti-HIV effort. Two participants, Jude and Amara, stated that throughout their entire tenure as religious leaders, they had never participated in any sort of HIV-related training. The remaining participants noted that they had attended some kind of training.

I have had opportunities of attending seminars on the issue of HIV how we can help in combating it and educating our young people and our members per say on how to go about this issue so, I have been on a training. (Okafor, M)

Theme 5: Abstinence-focused messaged and discouragement of condom use due to religious beliefs

Participants expressed that, although the topic of HIV is one of those issues that is rarely openly spoken about, everyone recognises the risk. Views are divergent regarding its cause and how best to prevent its spread and transmission. However, all the participants agreed that sexual acts remained the most common mode of transmission. For religious leaders, this raises moral and religious concerns. While they affirmed the sanctity of sex within marriage, they largely opposed sex outside of marriage and feel abstinence is the most important tool for young people, as prescribed by the holy scriptures, reiterating the spiritual dangers of sexual promiscuity.

It is good to really educate people, the young ones, for them to know the risk. As a matter of fact, the best way to prevent sexually transmitted disease is abstinence, even though some school of thought will tell you that, you know, once you are 18 you feel free to express yourself. (Amara, F)

The role of condoms was disputed, with some religious leaders suggesting they are an important preventative tool, whilst most others saw them as potentially encouraging immoral sexual practices.

On condom use, yes, like I said, when I participated in the awareness campaign most of us were given packets of condom to go home with, because we were very young people then, and…irrespective of our religious backgrounds, a good number of us too, have relationships that leads to sexual intercourse, so I feel it is important to introduce it to young people. Should they not be able to control themselves, there should be an option that also help to keep them away from the danger of contracting HIV/AIDS. (Onuma, M)

[We promote] abstinence for single young people, fidelity and use of condoms for married couples…I cannot in conscience advise young people to use condoms, lest it's misunderstood as encouraging irresponsible sexual behaviour. (Amos, M)

Theme 6: Bringing services to young people through ministry

All the participants recognised the important role they can play in the prevention of HIV among young adults, including by leveraging their position to bring young people into contact with educators and healthcare professionals.

Like I said, as a pastor, through bible studies we let people know that sexual promiscuity endangers a person's life and health and then, I also think that as we come to gather under the umbrella of either the youth ministry or singles ministry we also [use]those opportunities to educate. Sometimes we invite councillors to come and speak to the young people of the dangers of having relationships carelessly, sometimes we also invite health personnel to also educate and then check people…but I think the problem here in Africa is that people don't like to know their health status. (Jude, M)

Views of young adults

Theme 1: Understanding of HIV amongst young adults

Most of the young adults who participated showed some levels of understanding of HIV, whereas a few had little or no knowledge. For example, Charles explained that HIV is a human immune deficiency virus that targets the white blood cells of humans and stops them from protecting the body from various infections. On the other hand, Okon stated that it was an illness that had no known treatment, and when asked if he had any idea how it could be avoided, he responded with, "I don't know." However, in general, all the participants understood the dangers that HIV poses.

Theme 2: Understanding of HIV prevention and transmission among young adults

Participants responded to questions about modes of transmission of the virus, to which they overwhelmingly demonstrated good knowledge. Having unprotected sex with infected persons, using unsterilised objects or items contaminated by the blood of an infected person, and transmission through blood transfusion of contaminated blood, were all identified by participants as means of transmission.

Most identified abstinence as a means of prevention—though it was considered difficult—and saw it recommended for those who can. A few participants strictly followed the teachings of religious leaders on abstinence for unmarried people, though still agreeing on the use of condoms for HIV prevention. Some participants specifically identified the use of condom as the major means of HIV prevention:

> *…like I said earlier, always have protected sex with a condom, I think that will do the curbing of HIV. (Charles, M).*

Some participants felt that, due to constant and targeted sensitisation within families, schools, local communities and the church, people are adequately informed on preventive measures and healthy management of the virus when infected. Regarding those who are HIV-positive, most felt that regular check-ups and adherence to doctors' instructions is important.

Theme 3: Perceived views of religious leaders can exacerbate stigmatisation

According to most of the participants, while some religious leaders have maintained a positive and compassionate stance towards the infected persons, many others approached it with more negative and discriminatory attitudes. To that end, participants were aware of the stigma around HIV that may be driven by religious teachings, for example, seeing HV as a result of sin. Participants also remarked that religious leaders may not talk about sex and HIV, as they perceive these as improper areas of discussion, particularly within religious circles.

> *I have heard some religious leaders said that HIV/AIDS is one of the plagues that God has given to mankind due to man's disobedience to the commandments of God. (Chuka, M)*

> *Religious leaders mostly, let me say, criticise people with HIV in the sense that they think they indulge in unholy acts or something like that, so they don't usually accept such kind of people, they tend to push them away due to the mindset they have about people with HIV maybe did something. (Charles, M)*

Theme 4: Religious leaders as potential role models in HIV prevention and education

All the young adult participants agreed that, due to religious leaders' influential status in the society, they have a vital role to play in HIV prevention and care, but that they need to have correct knowledge. One

participant cited that in a morally conservative country like Nigeria, where the religious leaders are highly influential, their views regarding HIV care and prevention are vital to the success or failure of the current campaign against the virus. Some also felt that, just like parents, religious leaders provide spiritual and moral guidance and can greatly influence the conduct of young people.

> *So, I feel [religious leaders] do have a major role to play, they have a major role to play, but they have to be equipped with the knowledge first before anyone can be able to speak about it and also umm… make people understand that… [HIV] does not degrade you as a person... (Ulomma, F)*

DISCUSSION

This research highlights the centrality of the role of religious leaders as respected moral and spiritual guides within society, making them highly influential. They described clear platforms of engagement with young people. Most had some education around HIV and were aware of the importance of preventative practices but strongly emphasised abstinence before marriage and monogamy within marriage over condom use. Some saw promotion of condom use as being directly contradictory to the tenets of their faith. Young adult participants reiterated the importance of abstinence, as promoted by religious leaders. Some also had inadequate knowledge of the virus. They clearly felt that, although HIV was not really discussed in church—or that sometimes stigmatising rhetoric around HIV was used by religious leaders—that religious leaders were well-poised to support positive preventative practices, if adequately capacitated to do so.

The finding that religious leaders were perceived as highly influential is in line with Aguwa (2010), Asekun-Olarinmoye et al. (2013), and Onyemachi et al. (2021), who observed the high recognition and respect given to religious leaders in Nigeria and the impact they can have on people's health-seeking behaviours and practices. Though HIV prevention is most effective when including promotion of abstinence, monogamy, and condom use contextualised to appreciate gender norms and the social context (Larki et al, 2022), religious leaders may be particularly well-positioned to support abstinent-forward messaging, especially as it aligns with their faith teachings. Indeed, higher levels of religiosity in Nigeria have been associated positively with higher levels of abstinence (Somefun, 2019), which is a protective factor against HIV. However, for young people who may have less high levels of religiosity, different messaging may be necessary.

Here we identified that religious leaders functioned within a conservative culture that suppresses openness to sexual education for their congregants and sharing of preventative messaging including condom use. This finding is in line with Powel et al. (2020), who identified barriers to HIV prevention amongst young adults within faith communities, such as silence and secrecy on sex education and stigmatisation encouraged by the conduct of religious leaders. Elsewhere, religious leaders have partnered with non-governmental organisations, which have taken the lead on providing health messaging—especially on condoms—that may not have been prohibited as per their beliefs (Rafiq et al., 2022). Though it did come with pushback, even the former head of the Catholic Church, Pope Francis, acknowledged the role of condoms for very high-risk persons like male sex workers (PBS News, 2011). Some religious leaders, recognising the severity of HIV/AIDS, have also advocated for the use of condoms to contribute to reduced HIV transmission (Ansari and Gaestel, 2010; Umar and Oche, 2022). As such, there is precedent for adoption of a more liberal approach to HIV/AIDS, which may support more effective preventative efforts.

Recognising the influence of religious leaders on young adults, studies elsewhere have highlighted the success of training and other capacity strengthening initiatives in African contexts in improving the knowledge, beliefs, and comfort of religious leaders around communicating information related to sexual

health, including HIV/AIDS and condom use, with young people (Ashriady et al., 2024; Kanagasabai et al., 2023). Such capacity-strengthening efforts with religious leaders may also be of value in Nigeria.

Implications for practice

Religious leaders carry significant influence and public respect. However, due to a lack of knowledge, they may share incorrect information, hindering HIV prevention efforts. To address this gap, training for religious leaders would be helpful, ensuring they have accurate and updated knowledge about HIV. Well-informed leaders can act as agents of change, disseminating correct information and fostering positive behavioural changes among young adults (World Health Organization, 2021).

Implications for policy

Condom use remains a contentious issue, with some leaders disapproving based on beliefs, while others reluctantly permit it for family planning among married couples. Condom use may be associated with infidelity and immorality, discouraging churchgoing youths from using condoms, although they may be sexually active outside of marriage. To address this discrepancy, church authorities should ensure alignment with Nigeria's National HIV and AIDS Strategic Plan 2023–2027, which promotes expansion of condom access, especially to high-risk populations (National Agency for the Control of AIDS, 2023).

Strengths and limitations

To the best of our knowledge, this study is the first of its kind to specifically explore the potential role of religious leaders in HIV prevention efforts targeting young people as a higher-risk group in Nigeria. However, there are limitations of the study. Best practice in qualitative research involves face-to-face interviews, which was not possible, and may have constrained the building of rapport between the interviewer and participants. Due to poor internet connectivity, videos were turned off, meaning that it was not possible to identify and respond to non-verbal cues. Additionally, all the participants were Christians, because Aba has only one Mosque, and all emails sent to their youth leader received no response. Finally, most participants were male, which may have limited the depth of our findings. Increasing insights from young women is especially relevant in Nigeria, as elsewhere, where young women have a sexual debut of 16 years (Yaya and Bishwajit, 2018) and are more likely to engage in transactional and cross-generational sex due to their social precarity relative to young men (Mihretie et al., 2023). Future research should ensure the inclusion of different religious groups and a sufficient sample of women. Further, as young people are such a heterogenous group (Coleman, 2011), the influence of religious leaders on younger adolescents (aged 15–19) should also be explored. Finally, due to our recruitment approach, it is likely that the young adults participating in this study had relatively higher levels of religiosity than their peers, leading to potential biases in our findings.

Conclusion and recommendation

Religious leaders in Nigeria have the potential to positively impact HIV prevention for young people, given their influential community roles, involvement in health initiatives, and the prevalence of religiosity. However, they may also hinder preventative efforts. To support positive impact, capacitation of religious leaders around HIV to ensure sharing of accurate and integral sexual health education and elimination of stigmatising and discriminatory rhetoric around HIV-positive individuals which also includes condom use though strongly opposed by some religious groups, would be of value.

Conflict of Interest

The authors declare no conflicts of interest.

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