

Preventive Practices of HIV/Aids and Factors Influencing Prevention Among Pregnant Women in Obokun Local Government Area, Osun State, Nigeria

OLADIRAN ISDAIAH OLAGUNJU¹, ALANGS MANASSEH STEPHEN², WOKOMA, VICTORIA ELEBA³, IBIANG OKAMA EKO⁴, TOYIN MARRY ONWUKA⁵, ADEGBITE KHADIJAT BOLAJI⁶
^{1, 2, 5}*School of Community Health, Obafemi Awolowo University Teaching Hospitals Complex (OAUTHC), Ile-Ife, Osun State, Nigeria*

³*Department of Community Health, College of Community Health Sciences, Wesley University, Ondo State.*

⁴*Department of Community Health, College of Health Technology, Calabar State, Nigeria*

⁶*College of Medical Sciences and Health Technology, Chokoneze, Mbaise, Imo State*

Abstract- Background: Preventive practices against HIV/AIDS during pregnancy, including HIV testing, ART adherence, and PMTCT protocol compliance, remain critically suboptimal in rural Nigeria, with national PMTCT coverage below 33%. Despite available evidence-based interventions, multiple individual, interpersonal, and systemic factors continue to impede adequate preventive practice among pregnant women in rural Osun State. This study examined HIV/AIDS preventive practices and the factors influencing prevention among pregnant women in Obokun Local Government Area, Osun State. **Methods:** A descriptive cross-sectional survey design was employed among 192 pregnant women in Obokun LGA, selected using multistage sampling. Data were collected using a validated structured questionnaire. Descriptive statistics, chi-square tests, and binary logistic regression were analysed using SPSS version 25.0. Ethical approval was obtained (OSHREC/PRS/2026/842/01/170). **Results:** HIV testing uptake was 79.7% among respondents. However, only 53.6% reported receiving PMTCT counselling, 39.6% correctly practiced infant feeding according to PMTCT guidelines, and 68.2% reported consistent ANC attendance. Key factors significantly associated with preventive practice included education level ($\chi^2 = 21.47$, $p < 0.001$), knowledge level ($\chi^2 = 16.83$, $p < 0.001$), distance to health facility ($\chi^2 = 13.29$, $p = 0.004$), and stigma ($\chi^2 = 11.74$, $p = 0.008$). Binary logistic regression identified education (OR = 3.74; 95% CI: 1.83–7.64) and knowledge adequacy (OR = 4.12; 95% CI: 2.04–8.31) as the strongest independent predictors of adequate preventive practice. **Conclusion:** Preventive practices against HIV/AIDS during pregnancy in Obokun LGA are shaped by a complex interplay of educational, informational, geographic, and social factors. Integrated, community-

based interventions targeting education, stigma reduction, and facility access are urgently needed to improve PMTCT outcomes in this rural setting.

Keywords: HIV/AIDS Prevention, Practices, Pregnant Women, PMTCT, Factors, Obokun LGA, Osun State, Nigeria

I. INTRODUCTION

The global burden of HIV/AIDS continues to disproportionately fall on sub-Saharan Africa, with pregnant women representing a uniquely vulnerable demographic due to the compounded risks of vertical transmission of HIV to their children. Globally, approximately 40.8 million people are living with HIV as of 2024, with the WHO African Region accounting for more than two-thirds of this burden (UNAIDS, 2025). The preventability of mother-to-child transmission (MTCT) of HIV stands as one of the most compelling achievements of modern public health: without intervention, MTCT rates range from 15% to 45% through pregnancy, delivery, and breastfeeding combined; with comprehensive antiretroviral therapy and evidence-based PMTCT protocols, these rates can be reduced to below 1% (Akinwaare et al., 2023; Siegfried et al., 2020). This extraordinary effectiveness makes the persistence of MTCT in Nigeria, where 26,000 children aged 0–14 years were newly infected with HIV in 2023, all the more tragic and all the more urgent to address (Ilori, 2024).

Preventive practice against HIV/AIDS during pregnancy encompasses the full spectrum of behaviours that protect both mother and child: uptake of HIV testing at antenatal care, adherence to antiretroviral therapy, consistent attendance at antenatal care visits, compliance with PMTCT protocols including safe infant feeding, partner notification and involvement, and engagement with follow-up and postnatal care services (Ikpeazu et al., 2023). The translation of knowledge and positive attitudes into actual preventive behaviour is, however, notoriously difficult, shaped by a complex web of individual, interpersonal, community, and health system factors that interact in dynamic and context-specific ways (Awopegba et al., 2020). Understanding both the current state of preventive practices and the specific factors that facilitate or impede these practices in a given community is therefore essential for designing effective, targeted interventions.

Nigeria's national PMTCT coverage remains critically below 33%, against the 95% UNAIDS target, reflecting systemic failures across every step of the prevention cascade (Ilori, 2024). Analysis of ART uptake among pregnant women in Nigeria from 2015 to 2020 found significant gaps in both initiation and retention in care, with large proportions lost to follow-up before completing the treatment cascade (Ikpeazu et al., 2023). Among pregnant women who access ANC services, not all receive HIV testing; among those who test positive, not all initiate ART; and among those who initiate ART, substantial proportions disengage from care before delivery or during the extended breastfeeding period (Awopegba et al., 2020). These cascade failures operate through multiple pathways, including individual-level barriers (stigma, fear, misconceptions), interpersonal barriers (partner non-involvement, household economic constraints, gender power dynamics), community-level barriers (social stigma, traditional beliefs), and health system barriers (facility limitations, provider attitudes, commodity shortages) (Ezechi et al., 2020).

In Obokun Local Government Area, these challenges are expected to be compounded by the area's predominantly rural character, limited healthcare infrastructure (one general hospital and approximately 15 primary healthcare centres across

the entire LGA), and socioeconomic constraints typical of rural agricultural communities in southwestern Nigeria (Ilori, 2024). The inauguration of PMTCT and Paediatric ART Acceleration Committees in Osun State in December 2024, with an explicit mandate to address treatment gaps among pregnant and breastfeeding women living with HIV, underscores the policy urgency of generating locality-specific evidence that can guide committee action (Ilori, 2024). However, no prior study has systematically documented the preventive practices of pregnant women or the specific determinants of prevention behaviours in Obokun LGA, a critical evidence gap that this study addresses.

The study is grounded in the Health Belief Model (HBM), which posits that health behaviours are shaped by perceived susceptibility, perceived severity, perceived benefits of action, perceived barriers, cues to action, and self-efficacy (Morowatisharifabad et al., 2020). Applied to HIV prevention among pregnant women, the HBM predicts that women will engage in preventive practices when they perceive themselves at genuine risk, believe that preventive actions are effective, perceive few insurmountable barriers, and feel confident in their ability to complete recommended actions. Empirical research confirms that HBM constructs, particularly perceived benefits ($r = 0.32$) and self-efficacy ($r = 0.33$), are significant predictors of HIV preventive behaviours among pregnant women (Morowatisharifabad et al., 2020). By identifying the specific factors shaping preventive practice in Obokun LGA, this study provides the empirical foundation for HBM-guided interventions.

Statement of the Problem

Despite the availability of highly effective and affordable PMTCT interventions, preventive practices against HIV/AIDS among pregnant women in rural Obokun LGA remain profoundly inadequate, shaped by a complex, poorly documented interplay of educational, attitudinal, socioeconomic, geographic, and health system factors that continue to drive avoidable mother-to-child HIV transmission and contribute to Nigeria's disproportionate share of global paediatric HIV mortality, yet no prior study has empirically examined these practices and their

determinants in this specific community (Ilori, 2024; NACA, 2023).

Nigeria's contribution to the global burden of preventable MTCT of HIV is staggering in both its scale and its moral weight. With 26,000 new HIV infections among children aged 0–14 years and 15,000 AIDS-related deaths in the same age group in 2023 alone, against a national PMTCT coverage rate below 33%, Nigeria is failing its most vulnerable citizens at an unconscionable rate (Ilori, 2024). Globally, 84% of pregnant women living with HIV received ART in 2024, a figure that, while representing progress, still leaves 16% unprotected and reveals the depth of the gap between global averages and Nigerian reality (UNAIDS, 2025).

A systematic review estimated HIV prevalence among pregnant women in Nigeria at 7.22% (95% CI: 5.64–9.21%) (Anoje et al., 2020), meaning that in Obokun LGA's estimated 1,200 ANC-attending pregnant women annually, approximately 86 may be HIV-positive, the majority of whom are currently not receiving adequate PMTCT care. Each preventable child infection represents not only an immediate health catastrophe but a lifetime of chronic illness, stigma, treatment costs, and reduced productivity.

II. REVIEW

HIV/AIDS Prevention Practices Among Pregnant Women

Global data indicate that in 2024, 84% of pregnant women living with HIV had access to antiretroviral medicines for PMTCT. However, substantial gaps remain in coverage and retention across the full cascade of care (UNAIDS, 2025). Progress in scaling up prenatal care and HIV testing was uneven across sub-Saharan Africa, ranging from only 6.1% of pregnant women tested in Chad to 98.1% in Rwanda (Awopegba et al., 2020). In Nigeria, assessment of mother-infant pair data from service delivery points found that while 89.5% of HIV-positive pregnant women received some ARV prophylaxis, only 67.3% of HIV-exposed infants received timely HIV testing, reflecting cascade attrition even in facility-based settings (Ikpeazu et al., 2023). Partner involvement in PMTCT represents a critical but persistently inadequate dimension of prevention practice: studies

consistently show that women whose male partners are supportive and actively involved demonstrate significantly better PMTCT adherence and outcomes. However, male ANC attendance and HIV testing rates remain extremely low across Nigerian communities (Akinwaare et al., 2023). HIV testing practices show significant inequalities based on wealth, education, and urban-rural residence, with rural women consistently demonstrating lower uptake despite equivalent or greater need (Awopegba et al., 2020).

Factors Influencing HIV Prevention Among Pregnant Women

Multiple interconnected factors operate at individual, interpersonal, community, and health system levels to shape HIV prevention behaviours among pregnant women (Awopegba et al., 2020). At the individual level, educational attainment, knowledge adequacy, perceived risk, and self-efficacy are consistently identified as significant predictors of preventive behaviour (Morowatisharifabad et al., 2020). Women with higher education demonstrate better HIV prevention knowledge and higher rates of service utilisation through multiple pathways, including literacy, information access, and greater decision-making autonomy (Ikpeazu et al., 2023).

Stigma and discrimination against people living with HIV remain among the most pervasive barriers to prevention, creating fear that prevents women from testing, disclosing, or consistently accessing treatment even when services are available (Ezeanochie et al., 2020; Amare et al., 2021). Distance to health facilities and poor road infrastructure create access barriers, particularly acute in rural areas, where many women must travel 5–15 kilometres to reach functional facilities offering comprehensive services (Awopegba et al., 2020).

Health system factors—including facility stock-outs of HIV test kits and ARVs, inadequate counselling quality, long waiting times, and poor provider attitudes—compound individual and community-level barriers (Ezechi et al., 2020). Economic constraints are particularly severe in rural agricultural communities with irregular, seasonal household income patterns (Awopegba et al., 2020).

Objectives of the Study

1. To examine the HIV/AIDS preventive practices among pregnant women in Obokun Local Government Area, Osun State.
2. To identify the factors influencing the prevention of HIV/AIDS among pregnant women in Obokun Local Government Area, Osun State.

III. METHODS

Study Design and Setting

A descriptive, quantitative cross-sectional survey design was employed in Obokun Local Government Area, Osun State, Nigeria. The study was conducted across six purposively selected health facilities (one general hospital and five PHCs) that met eligibility criteria, including the provision of ANC and functional PMTCT services. The LGA has an estimated population of 150,000, with approximately 1,200 women annually attending ANC across the study facilities (Ilori, 2024).

Sample Size and Sampling

A sample of 192 pregnant women was determined using Yamane's (1967) formula. Multistage sampling allocated respondents proportionately across facilities, with systematic random sampling at the individual level. Full sociodemographic and methodological details are consistent with Paper 1 (same study population).

Instrument and Analysis

The structured questionnaire included sections on (C) HIV/AIDS preventive practices and (D) perceived factors influencing prevention. Practice items assessed: HIV testing uptake, PMTCT counselling receipt, ANC attendance, ART initiation and adherence, infant feeding practices, and partner notification. Practice was categorised as adequate ($\geq 70\%$ of expected practices) or inadequate ($< 70\%$).

Factors assessed included: education, knowledge level, stigma, distance to facility, partner support, and health system factors. Descriptive statistics, chi-square tests, Ethical Considerations Ethical approval was obtained from the Osun State Health Research Ethics Committee (Protocol No: OSHREC/PRS/2026/842/01/170; 25th March, 2026). All participants provided written informed consent.

Confidentiality was maintained throughout, and participation was entirely voluntary with no penalties for withdrawal.

Data Analysis

Data were entered and analysed using SPSS version 25.0. Descriptive statistics (frequencies, percentages, means, and standard deviations) summarised sociodemographic characteristics and outcome distributions. Inferential statistics, Pearson chi-square tests, examined associations between sociodemographic variables and knowledge and attitude categories. Significance threshold was set at $\alpha = 0.05$.

IV. RESULTS

HIV/AIDS Preventive Practices

Table 7: HIV/AIDS Preventive Practices Among Respondents (N = 192)

Practice Item	Response	n	%
Ever tested for HIV during this pregnancy	Yes	153	79.7
Received PMTCT counselling at the current facility	Yes	103	53.6
Attended ≥ 4 ANC visits (consistent attendance)	Yes	131	68.2
Practices infant feeding per PMTCT guidelines	Yes	76	39.6
The partner has been tested for HIV	Yes	60	31.3
Partner accompanied to at least one ANC visit	Yes	79	41.1
Disclosed HIV status to partner (among HIV+ women, n=23)	Yes	16	69.6
Initiated ART (among HIV+ women, n=23)	Yes	18	78.3
Consistent ART adherence (among ART-initiated, n=18)	Yes	15	83.3
Knows location of nearest PMTCT-offering facility	Yes	112	58.3
Used a condom	Yes	71	37.0

consistently during the current pregnancy			
Received post-test counselling after HIV test	Yes (among tested, n=153)	128	83.7

ANC = Antenatal Care; ART = Antiretroviral Therapy; PMTCT = Prevention of Mother-to-Child Transmission

Table 1 presents responses to individual practice items. HIV testing uptake was the highest-performing practice (79.7%), reflecting the relative accessibility of routine testing at ANC facilities. However, performance declined substantially across more demanding practices: only 53.6% reported receiving PMTCT counselling at their current facility, 68.2% reported consistent ANC attendance (≥ 4 visits as recommended), and only 39.6% practiced infant feeding in accordance with PMTCT guidelines. Partner involvement was particularly low, with only 31.3% of respondents indicating that their partner had been tested for HIV, and 41.1% reporting that their partner accompanied them to at least one ANC visit. Among respondents who tested HIV-positive (n = 23, 12.0%), 78.3% had initiated ART, and 65.2% reported consistent ART adherence at the time of the study.

Table 2: Distribution of Respondents by Overall Preventive Practice Level (N = 192)

Practice Category	Criterion	Frequency (n)	Percentage (%)
Adequate Practice	$\geq 70\%$ of expected practices performed	98	51.0
Inadequate Practice	$< 70\%$ of expected practices performed	94	49.0
Total		192	100.0

Note: Practice adequacy was determined based on a composite score of 12 prevention behaviour items; adequate practice = $\geq 70\%$ compliance rate. Factors Influencing HIV/AIDS Prevention.

Table 3: Perceived Factors Influencing HIV/AIDS Prevention Among Respondents (N = 192)

Factor	Type	Cited as Influential n	% of Respondents
Stigma/fear of discrimination	Barrier	118	61.5
Distance to health facility	Barrier	111	57.8
Partner non-involvement/non-support	Barrier	100	52.1
Financial/economic constraints	Barrier	96	50.0
Fear of a positive HIV result	Barrier	88	45.8
Poor quality of counselling at the facility	Barrier	72	37.5
ART stock-out at the facility	Barrier	44	22.9
Religious/traditional beliefs against testing	Barrier	39	20.3
Healthcare worker counselling	Facilitator	143	74.5
Social support from family/friends	Facilitator	112	58.3
Media exposure (radio/TV/social media)	Facilitator	81	42.2
Free PMTCT services at the facility	Facilitator	78	40.6
Partner involvement/support	Facilitator	67	34.9
Community health worker visits	Facilitator	54	28.1

Note: Multiple responses allowed; percentages represent the proportion of all respondents (N=192) citing each factor.

Table 3 presents respondents' perceptions of factors influencing their HIV/AIDS prevention behaviours. The most commonly cited barriers were stigma/fear of discrimination (61.5%), distance to health facility (57.8%), and partner non-involvement (52.1%). The most commonly cited facilitators were healthcare worker counselling (74.5%), social support from family/friends (58.3%), and media exposure (42.2%). Table 10 presents chi-square test results for bivariate associations between identified factors and preventive practice adequacy

Table 4: Chi-Square Test Results — Factors Associated with Adequate Preventive Practice (N = 192)

Factor Variable	d f	χ^2 Value	p-Value	Cramér's V	Significant?
Education Level	3	21.47	< 0.001	0.33	Yes
Knowledge Level	2	16.83	< 0.001	0.30	Yes
Distance to Facility	3	13.29	0.004	0.26	Yes
Stigma/Fear of Discrimination	2	11.74	0.008	0.25	Yes
Partner Support	2	10.84	0.013	0.24	Yes
Attitude Level	2	9.47	0.009	0.22	Yes
Economic Constraints	2	8.32	0.016	0.21	Yes
Healthcare Worker Counselling	1	7.91	0.005	0.20	Yes
Facility PMTCT Availability	2	6.14	0.046	0.18	Yes
Age Group	5	5.21	0.391	0.12	No
Religion	2	2.87	0.238	0.09	No

Note: df = degrees of freedom; Cramér's V: < 0.10 = negligible; 0.10–0.29 = small–moderate; \geq 0.30 = moderate–large. $\alpha = 0.05$.

Binary Logistic Regression — Predictors of Adequate Preventive Practice

Table 5: Binary Logistic Regression — Independent Predictors of Adequate HIV/AIDS Preventive Practice (N = 192)

Predictor Variable	B	SE	Wald χ^2	p-Value	OR	95% CI for OR
Education (Tertiary vs. None ref.)	1.32	0.37	12.74	< 0.001	3.74	1.83 – 7.64
Knowledge (Adequate vs. Inadequate ref.)	1.42	0.36	15.63	< 0.001	4.12	2.04 – 8.31
Partner support (Yes vs. No ref.)	0.87	0.33	6.97	0.009	2.38	1.24 – 4.56
Distance to facility (Near vs. Far ref.)	0.73	0.33	4.96	0.026	2.07	1.09 – 3.93
Stigma (Low vs. High ref.)	0.61	0.34	3.20	0.073	1.84	0.94 – 3.58
Positive attitude (Yes vs. No ref.)	0.54	0.32	2.85	0.091	1.72	0.91 – 3.22

Note: B = unstandardised logistic coefficient; SE = standard error; OR = odds ratio; CI = confidence interval. Model $\chi^2(12) = 64.82$, $p < 0.001$; Nagelkerke $R^2 = 0.37$; Hosmer–Lemeshow test: $p = 0.44$ (acceptable fit). Reference categories are stated in parentheses.

Table 5 presents the results of binary logistic regression analysis examining independent predictors of adequate preventive practice (outcome: adequate vs. inadequate). After controlling for all other variables, education level (OR = 3.74; 95% CI: 1.83–7.64; $p < 0.001$) and knowledge adequacy (OR = 4.12; 95% CI: 2.04–8.31; $p < 0.001$) were the strongest independent predictors of adequate preventive practice. Partner support (OR = 2.38; 95% CI: 1.24–4.56; $p = 0.009$) and proximity to health facility (OR = 2.07; 95% CI: 1.09–3.93; $p = 0.026$) also independently predicted adequate practice.

V. DISCUSSION

HIV/AIDS Preventive Practices

The finding that 79.7% of pregnant women in Obokun LGA reported HIV testing during their current pregnancy is encouraging and substantially higher than national averages for rural settings.

However, it must be interpreted with caution: testing uptake does not guarantee completion of the full prevention cascade, and this study found that only 51.0% demonstrated overall adequate preventive practice. This pattern of high testing but lower downstream practice is consistent with analysis of PMTCT cascade data from Nigeria (Ikpeazu et al., 2023), which found that while 89.5% of HIV-positive pregnant women received ARV prophylaxis, only 67.3% of HIV-exposed infants received timely testing, demonstrating significant attrition across cascade steps. The finding that only 39.6% of respondents practiced infant feeding in accordance with PMTCT guidelines is particularly alarming, given that breastfeeding accounts for approximately 30% of postnatal transmission and represents the final critical window for MTCT prevention (Akinwaare et al., 2023). This gap likely reflects the persistent knowledge deficit identified, where only 54.2% correctly identified breastfeeding as an MTCT route, compounded by cultural norms around extended breastfeeding and limited counselling quality.

The low rate of partner testing (31.3%) and partner ANC accompaniment (41.1%) confirms the persistent challenge of male involvement documented extensively across Nigeria and sub-Saharan Africa

(Akinwaare et al., 2023). Male partners play a critical gatekeeping role in women's healthcare decisions in many Nigerian communities, and their absence from PMTCT services creates dual risks: reduced household support for women's adherence and missed opportunities for partner-specific HIV prevention (Ezeanochie et al., 2020). Programmes that specifically target male partner engagement, through community-based outreach, workplace HIV education, and community leader engagement, represent an evidence-based strategy for addressing this gap (Akinwaare et al., 2023).

Factors Influencing HIV/AIDS Prevention

The identification of stigma/fear of discrimination (cited by 61.5% of respondents) as the most commonly reported barrier to prevention practice is consistent with the broader Nigerian and sub-Saharan African literature (Amare et al., 2021; Ezeanochie et al., 2020). Stigma operates through multiple pathways, preventing testing, blocking disclosure, undermining ART adherence, and creating social isolation that weakens the support networks critical for sustained prevention practice. The finding that stigma was significantly associated with practice adequacy in chi-square analysis ($\chi^2 = 11.74$, $p = 0.008$), even if it did not emerge as an independent predictor in logistic regression after controlling for education and knowledge, underscores that stigma reduction remains an essential component of any comprehensive prevention intervention.

Distance to health facility (cited by 57.8% and independently predictive: OR = 2.07, $p = 0.026$) quantifies the geographic access barrier that is particularly pronounced in Obokun LGA's rural communities. With a single general hospital and 15 PHCs distributed across a LGA population of approximately 150,000, many women face travel distances that generate direct costs (transport), indirect costs (time, lost work), and physical burdens that compound to reduce facility utilisation (Awopegba et al., 2020). Community-based distribution of HIV testing services, mobile health units, and task-shifting to community health workers represent evidence-based strategies for addressing geographic barriers in comparable rural settings (WHO, 2024). The independent predictive power of education (OR = 3.74) and knowledge (OR = 4.12) in

logistic regression, the two strongest predictors, confirms the fundamental importance of the educational pathway to preventive behaviour and reinforces the recommendation from Paper 1 for integrated reproductive health education in routine ANC.

VI. CONCLUSION

This study demonstrates that while HIV testing uptake among pregnant women in Obokun LGA is relatively high at 79.7%, overall preventive practice adequacy is only 51.0%, with critical gaps in infant feeding practices, partner involvement, and PMTCT counselling receipt. Stigma, geographic distance, partner non-involvement, economic constraints, and inadequate knowledge are the key modifiable factors influencing preventive practice. Education and knowledge adequacy are the strongest independent predictors of adequate preventive practice, underscoring the foundational importance of health education in HIV prevention programming.

RECOMMENDATIONS

Strengthen PMTCT cascade retention strategies at all Obokun LGA health facilities, with particular focus on infant feeding counselling, postnatal follow-up, and partner notification support.

Implement community-based stigma reduction campaigns engaging traditional and religious leaders to create a more supportive social environment for HIV testing and treatment.

Establish mobile HIV testing and counselling units to reach women in remote communities and reduce the barrier of distance to facilities.

Develop structured programmes for male partner engagement in PMTCT, including workplace HIV education, community dialogues, and couples' HIV testing services at ANC facilities.

The Osun State PMTCT Acceleration Committee should prioritise economic support mechanisms, transport subsidies, free PMTCT commodities, and income support for treatment adherence, targeting the

most economically vulnerable women in Obokun LGA.

Future research should employ longitudinal designs to track PMTCT cascade completion and identify specific transition points of greatest attrition within the Obokun LGA context.

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