

Marriage Denial: A Phenomenological Study of Dual Stigmatization and Resistance among People Living with HIV under Bauchi State's Mandatory Premarital Testing Regime**Bitkon Vrimda Adamu Tubi¹ & Usman Hamza²**

1. Department of Social Standard Development, Sustainable Procurement, Environment and Social Standards Enhancement Centre of Excellence (SPESSCE), Abubakar Tafawa Balewa University, Bauchi, Nigeria

2. Department of Estate Management, Abubakar Tafawa Balewa University, Bauchi, Nigeria
bvadamu.pg@atbu.edu.ng; uhamza@atbu.edu.ng

Abstract

Marriage constitutes a fundamental social institution in Northern Nigeria, yet People Living with HIV (PLHIV) face systematic exclusion from it due to the implementation of mandatory premarital HIV testing laws. Anchored on Goffman's stigma theory and Farmer's concept of structural violence, this phenomenological study explored the lived experiences of 30 PLHIV navigating mandatory premarital HIV testing laws and marriage restrictions in Bauchi Metropolis, Northern Nigeria, where serodiscordant couples are effectively barred from legal marriage under the Bauchi State HIV/AIDS Prevention and Control Law of 2017. Semi-structured interviews were conducted using interpretive phenomenological analysis (IPA). Findings revealed three dominant themes: the bureaucracy of exclusion, in which testing processes acted as gatekeeping mechanisms that denied PLHIV access to legal marriage; the stigma spiral, in which disclosure triggered compounding institutional, familial, and religious rejections; and resistance architectures, encompassing proxy testing, document falsification, and underground matchmaking networks. Participants experienced internalized shame, marriage-related post-traumatic stress, and systematic exclusion from a core social institution. The study concludes that Bauchi's premarital HIV testing regime constitutes structural violence, violating PLHIV rights to family life and non-discrimination. Policy recommendations include repealing mandatory testing laws, implementing confidential voluntary testing protocols, and funding psychosocial support services for affected individuals.

Keywords: Bauchi State, HIV stigma, mandatory premarital testing, PLHIV, structural violence, phenomenology

INTRODUCTION

Marriage is a central social institution in Nigerian society, carrying deep cultural, religious, and legal significance (Nnaji *et al.*, 2014). However, for People Living with HIV (PLHIV), this institution has become a site of systematic exclusion, particularly in States where mandatory premarital HIV testing laws have been enacted. In Bauchi State, the HIV/AIDS Prevention and Control Law of 2017 requires all intending couples to present HIV test results before marriage, effectively prohibiting serodiscordant couples from contracting legal marriages (Bauchi State Law, 2017). This policy, while ostensibly aimed at curbing HIV transmission, intersects with deep-seated cultural and religious stigma to produce profound harm for PLHIV. HIV-related stigma and

discriminatory laws continue to pose significant barriers to marriage and social inclusion for PLHIV in Northern Nigeria (UNAIDS, 2022). Mandatory premarital HIV testing has been described as unethical because it increases stigmatization of those who test positive (Akoku *et al.*, 2018). In conservative regions like Bauchi, where marriage is a prerequisite for social adulthood and community belonging, these policies compound existing cultural and religious stigma, leaving PLHIV vulnerable to isolation and serious mental health crises.

The problem addressed by this study is the gap between the intended public health objectives of Bauchi's mandatory premarital HIV testing policy and its lived impact on PLHIV. Existing studies have examined HIV stigma in Nigeria at the population level (Verinumbe *et al.*, 2024; Tadesse *et al.*, 2024), and legal scholars have critiqued mandatory testing regimes on human rights grounds (Ifemeje, 2011). However, few studies have adopted a phenomenological lens to explore how PLHIV themselves experience and resist these oppressive structures in Northern Nigeria. This study fills that gap by centering the voices of PLHIV in Bauchi, providing empirical insights into their lived realities and the psychosocial consequences of policy-induced exclusion.

The policy also intersects with Nigeria's broader HIV legal framework, which includes provisions that may penalize non-disclosure to partners. In the Nigerian context, studies have shown that a majority of prospective couples would call off marriage plans if a partner tested positive for HIV (Nnaji *et al.*, 2014), while churches have been known to deny weddings based on screening results (Ezugwu *et al.*, 2019). PLHIV in Bauchi face intersecting forms of stigma: institutional stigma, in which legal restrictions label them as "unmarriageable" or as public health risks, and social stigma, characterised by rejection from partners, families, and communities upon disclosure.

Objectives of the Study

The following research objectives guided the study:

- i. To examine how PLHIV in Bauchi experience and interpret mandatory premarital testing laws and marriage bans;
- ii. To assess the effects of mandatory premarital HIV testing policies on the mental health and social well-being of PLHIV in Bauchi;
- iii. To identify the coping strategies employed by PLHIV to navigate institutional and social barriers to marriage

LITERATURE REVIEW

HIV-related stigma refers to negative attitudes, beliefs, and behaviours directed at people perceived to have HIV, and it operates across multiple levels, including individual, interpersonal, community, and structural domains (Ogunbajo *et al.*, 2025). In the context of mandatory premarital HIV testing, stigma becomes institutionalized through legal frameworks that categorize PLHIV as threats to public health and restrict their access to social institutions such as marriage.

Recent research confirms that HIV-related stigma remains a significant barrier in Nigeria. A large study of 1,244 PLHIV across Nigeria found that over half (55.5%) demonstrated low to moderate levels of internalized stigma, while more than one-quarter (27.3%) showed high levels of internalized stigma (Verinumbe *et al.*, 2024). Furthermore, HIV-related stigma has been associated with psychological distress, with higher stigma levels observed among unmarried patients and those who had not disclosed their HIV status (Akoko *et al.*, 2023). Studies also indicate that limited support from family, friends, and significant others increases stigma and discrimination among PLHIV, while those who enjoy social support are less likely to be adversely affected (Babalola *et al.*, 2023).

Research on mandatory premarital screening has documented concerns regarding coercion and interference with individual decision-making (Al-Aama, 2010), as well as fears about confidentiality, counselling, and discrimination among PLHIV (Barmania & Aljunid, 2017). A population-based study in Cameroon found that fear of stigma, discrimination, and lack of confidentiality were primary reasons individuals would refuse such testing, suggesting these policies may paradoxically drive testing avoidance (Akoku *et al.*, 2018). Maigoro *et al.* (2023) reported high compliance (64.4%) with mandatory premarital HIV testing in rural Bauchi, attributing this to community health education; however, their study did not account for the lived experiences of those who tested positive.

A recent meta-analysis of 28,355 PLHIV across Africa found that Nigeria has the highest prevalence of HIV-related perceived stigma (50.04%) on the continent (Tadesse *et al.*, 2024). Ogunbajo *et al.* (2025) documented how intersectional stigma exacerbates health disparities among PLHIV in Nigeria. Consistent with Ifemeje's (2011) legal critique, mandatory premarital HIV testing that bars HIV-positive individuals from marrying constitutes a gross violation of the rights of people living with HIV, including the right to family life, privacy, confidentiality, and freedom from discrimination. These studies collectively point to the need for qualitative, person-

centred research that captures the subjective experience of PLHIV navigating marriage-related stigma in Northern Nigeria.

THEORETICAL FRAMEWORK

This study integrates two complementary theoretical perspectives: Goffman's (1963) stigma theory and Farmer's (2004) concept of structural violence. Goffman's theory posits that stigma produces what he termed a "spoiled identity," reducing a person "from a whole and usual person to a tainted, discounted one" (Goffman, 1963, p. 3). Recent scholarship continues to affirm the relevance of Goffman's framework for understanding HIV-related stigma, distinguishing between public stigma (stereotypes and prejudice of the general public) and self-stigma (internalization of negative attitudes) (Chenneville *et al.*, 2024). Furthermore, scholars have extended Goffman's concept to include "courtesy stigma," referring to stigma that affects family members and associates of stigmatized individuals (Aluah *et al.*, 2024; Giordana & Caci, 2025). Aluah *et al.* (2024) found that professionals working with PLHIV experience courtesy stigma regardless of their personal HIV status, which compromises their personal and professional well-being.

For PLHIV, HIV status becomes a spoiled identity that invites shunning, avoidance, and outright discrimination. Recent scholarship distinguishes between the "discreditable" (those with concealable attributes such as living with HIV) and the "discredited" (those with overt traits), while noting that concealment of HIV occurs at high physiological and social cost (Kimera *et al.*, 2025). Researchers have further developed the concept of "intersectional stigma" to examine the experiences of discrimination resulting from inhabiting multiple stigmatized identities across individual, interpersonal, community, and structural domains (Ogunbajo *et al.*, 2025).

However, Goffman's micro-social focus requires supplementation with a macro-structural perspective. Farmer's (2004) structural violence framework reveals how laws, policies, and social norms systematically harm individuals by preventing them from meeting their basic needs. Applied to PLHIV, structural violence is evident in legal frameworks that, in criminalizing HIV transmission, inadvertently stigmatize PLHIV and discourage testing and disclosure (Kimera *et al.*, 2025). By synthesizing these frameworks, this study gains a comprehensive understanding of the intersectional oppression that PLHIV face in Bauchi's premarital testing regime.

METHODOLOGY

This research utilized an interpretive phenomenological analysis (IPA) framework (Smith *et al.*, 2009) to explore how PLHIV perceive their experiences with marriage restrictions, identify coping strategies, and assess the psychological and social ramifications of these policies. This methodology is particularly effective in highlighting marginalised perspectives and examining the structural barriers that influence lived experiences (Abdellatif & Haynes, 2024). IPA has gained traction in HIV research, focusing on the experiences of PLHIV dealing with stigma, discrimination, and social exclusion, especially in African settings (Philip, 2024; Mpofu *et al.*, 2024). Goitsemanang *et al.* (2025) illustrated that phenomenological methods effectively capture the effects of institutional segregation and stigma on health-seeking behaviours and psychological well-being.

The study was conducted in Bauchi Metropolis, the capital of Bauchi State, North-Eastern Nigeria. Bauchi State operates a mandatory premarital HIV screening policy requiring all couples to present test results before marriage, with serodiscordant couples effectively banned from legal marriage under the Bauchi State HIV/AIDS Prevention and Control Law of 2017.

Purposive sampling was used to select information-rich cases (Palinkas *et al.*, 2015). Inclusion criteria were HIV-positive adults aged 18 years and above, with experience of Bauchi's premarital testing system, and currently or previously seeking marriage. The sample size was 30 participants, determined by thematic saturation (Hennink *et al.*, 2017). Recent methodological research confirms that thematic saturation in qualitative studies is typically achieved between 9 and 17 interviews for moderately homogeneous populations, with 25 interviews providing sufficient depth for meaning saturation (Guest *et al.*, 2020; Hennink & Kaiser, 2022). Recruitment was conducted through referral from people living with HIV and subsequent snowball sampling for hard-to-reach populations (Browne, 2005; Parker *et al.*, 2019; Valerio *et al.*, 2016). The final sample comprised 19 women and 11 men, aged 20 to 49 years, with diverse socioeconomic backgrounds and marital histories. Most participants preferred telephone interviews, while some accepted physical interviews. Most participants also consented to being recorded, provided their names were not recorded.

Semi-structured interviews were conducted in Hausa or English based on participant preference, lasting 30 to 60 minutes. Interviews took place in private rooms at participants' preferred locations and were audio-recorded with informed consent. The interview guide covered four domains: policy

experiences (walking through the premarital testing process), stigma manifestations (experiences of discrimination and family/community reactions), coping strategies (daily management techniques and system navigation methods), and psychosocial impacts (emotional consequences and future aspirations). Field notes on non-verbal cues were also recorded for the physical interviews.

Thematic analysis followed Braun and Clarke's (2006) six-phase framework (Byrne, 2022; Khraban, 2024). The phases were: (1) familiarization through repeated reading of transcripts and initial note-taking; (2) generating initial codes; (3) developing themes via axial coding to connect related codes into broader patterns; (4) reviewing themes through member checking with five participants and peer debriefing; and (5) interpreting and contextualizing the findings within structural violence theory. Verbatim transcription with pseudonyms, and back-translation for Hausa interviews, was completed during the familiarization phase (Braun & Clarke, 2006).

Ethical Considerations

Ethical clearance for this study was granted by the Bauchi State Health Research Ethics Committee (BSMOH/REC/00207/2026) under the Bauchi State Ministry of Health and Social Welfare (Ref. No. MOH/GEN/S/1419/II), with Protocol Approval No. NHREC/TR/BAU-HREC/28/8/2023, dated 24th April 2026, valid through March 2027. The research was classified under the Low Risk Category. Informed consent was obtained from all participants. Counselling referrals were made available to participants who experienced distress. Data were stored on password-protected files, and identifiable data were destroyed after analysis.

Quality Assurance

Trustworthiness was established following Lincoln and Guba's (1985) criteria. Credibility was ensured through prolonged engagement (one month of fieldwork) and peer debriefing with HIV researchers. Transferability was addressed through thick description of the Bauchi sociocultural context and clear inclusion criteria. Dependability was maintained via an audit trail and a code-recode procedure. Confirmability was established through reflexive journaling and triangulation with policy document analysis.

RESULTS

Table 1 presents the distribution of participants by gender, age group, marital status, years since HIV diagnosis, and antiretroviral therapy status. A total of 30 PLHIV participated in this study,

comprising 19 women (63%) and 11 men (37%). The largest age group was 30 to 39 years (43%, n = 13), followed by 20 to 29 years (37%, n = 11) and 40 to 49 years (20%, n = 6). Regarding marital history, more than half had never married (57%, n = 17), 33% (n = 10) were previously married (divorced or widowed), and 10% (n = 3) were currently in informal serodiscordant unions. Half of the participants had been diagnosed for 2 to 5 years (50%, n = 15), 27% (n = 8) for more than five years, and 23% (n = 7) for less than two years. The vast majority (90%, n = 27) were on antiretroviral therapy (ART).

Table 1: Distribution of Participants by Gender, Age Group, Marital Status, Years Since HIV Diagnosis, and ART Status (N = 30)

Characteristic	Category	Frequency (n)	Percentage (%)
Gender	Female	19	63
	Male	11	37
Age (years)	20-29	11	37
	30-39	13	43
Marital status	40-49	6	20
	Never married	17	57
	Previously married (divorced/widowed)	10	33
	Currently married (serodiscordant, informal)	3	10
Years since HIV diagnosis	< 2 years	7	23
	2-5 years	15	50
	> 5 years	8	27
On antiretroviral therapy	Yes	27	90
	No	3	10

Source: Field Survey, 2026

Thematic analysis revealed three dominant themes characterizing PLHIV's experiences with Bauchi's premarital testing regime. Representative verbatim quotes (translated from Hausa where applicable) illustrate each theme.

Theme 1: The Bureaucracy of Exclusion

Participants described the testing process as a “gatekeeping ritual” (Male, 32) designed to exclude rather than inform. One female participant recounted:

“At the marriage counselling, they demanded my test like a criminal’s warrant. When the pastor saw ‘reactive’, he slid the result back saying ‘you can’t wed’.”
(Female, 28)

Systemic barriers included document falsification. A male participant explained:

“I tried to pay ₦10,000 to change ‘reactive’ to ‘non-reactive’.” (Male, 35)

Differential enforcement by socioeconomic status was also reported:

“Rich men bribe their way through. We women get trapped.” (Female, 24)

Theme 2: The Stigma Spiral

Disclosure triggered compounding rejections across institutional, familial, and religious domains.

A female participant described institutional betrayal:

“The test centre laboratory personnel announced my result just by the way he was looking at me; I could read positive all over his face.” (Female, 29)

Familial rejection was severe:

“My uncle said I’d cursed the family. This is my reward for the loose life they kept warning me about.” (Male, 27)

Psychological impacts manifested as internalized shame and trauma:

“I feel like walking sin.” (Female, 33)

“Now when I see wedding gowns, my chest tightens.” (Female, 26)

Theme 3: Resistance Architectures

Participants developed sophisticated coping systems. Camouflage strategies included proxy testing and informal unions:

“My sister did the test using my name.” (Female, 30)

“We did traditional marriage — more of a live-in couple where no one asks.”
(Male, 38)

Counter-networks included underground matchmaking:

“Our support group connects positive singles, and we too connect ourselves by ourselves.” (Female, 40)

“We change facility and even location for receiving services, just scout out young females receiving treatment there.” (Male, 34)

DISCUSSION OF FINDINGS

This study’s findings demonstrate how Bauchi’s mandatory premarital HIV testing policies operationalize structural violence (Farmer, 2004) through medicalised exclusion and moral punishment. The bureaucracy of exclusion theme reveals how ostensibly health-promoting policies function as border-policing mechanisms that systematically deny PLHIV access to marriage. Recent scholarship confirms that structural violence manifests in health policies that inadvertently stigmatize PLHIV and discourage testing and disclosure (Kimera *et al.*, 2025; Tadesse *et al.*, 2024).

The stigma spiral theme extends Goffman’s (1963) concept of spoiled identity by demonstrating how institutional stigma (legal restrictions) triggers and amplifies social stigma (community rejection), creating a mutually reinforcing cycle. This dual stigmatization produced severe psychological consequences, including what participants described as marriage-related post-traumatic stress. HIV-related stigma consistently increases the risk of psychological problems among PLHIV and creates barriers to social support (Aluah *et al.*, 2024; Chenneville *et al.*, 2024). Participants’ resistance architectures align with Scott’s (1985) concept of “weapons of the weak,” encompassing everyday resistance (document falsification, proxy testing) and collective re-appropriation (underground matchmaking networks). These findings mirror those of Kumar *et al.* (2015) in South India, who identified affiliation with support groups and financial independence as positive coping strategies among PLHIV. However, Bauchi participants faced additional structural barriers, including legal marriage bans and religious stigma, which constrained these adaptive strategies. Giordana and Caci (2025) extended this understanding by documenting courtesy stigma affecting family members of stigmatized individuals, which helps explain the familial rejection documented in our findings.

Consistent with Verinumbe *et al.* (2024), who found that PLHIV engaged in peer support groups were significantly less likely to report high levels of internalized stigma (aOR = 0.30, $p < .001$), our participants developed underground matchmaking networks as a form of collective resistance and social support. This finding aligns with Kimera *et al.* (2025), who noted that concealment of

HIV carries high physiological and social costs, making peer support networks essential for mitigating stigma.

While Maigoro *et al.* (2023) reported high compliance (64.4%) with mandatory premarital HIV testing in rural Bauchi, attributing this to community health education, our findings reveal that such participation rates mask systemic coercion. Our participants described being “forced to test” (Male, 29) or facing marriage bans upon disclosure, complicating the authors’ recommendation for maintaining the policy. This disparity underscores the need for mixed-methods research to reconcile policy efficacy with human rights impacts.

CONCLUSION

This study has demonstrated that Bauchi’s mandatory premarital HIV testing regime constitutes a form of structural violence that systematically excludes PLHIV from the institution of marriage. The three dominant themes — the bureaucracy of exclusion, the stigma spiral, and resistance architectures — collectively reveal how legally sanctioned testing policies intersect with institutional, familial, and religious stigma to produce profound psychosocial harm. PLHIV in Bauchi experience internalized shame, marriage-related post-traumatic stress, and systematic exclusion from a core social institution. Their coping responses, while creative and resilient, underscore the extent to which oppressive policy environments compel marginalised individuals to develop underground survival strategies. These findings advance empirical evidence of policy-induced trauma among PLHIV in Northern Nigeria and provide a framework for analyzing health policy as structural violence. By centring the voices of PLHIV, this study fills a critical gap in the literature on how mandatory testing policies are experienced from below.

RECOMMENDATIONS

Based on these findings, the following policy recommendations are made:

- i. Legal reforms: Repeal mandatory premarital HIV testing laws in Bauchi State, aligning with UNAIDS (2022) guidelines indicating that such laws do not reduce transmission and violate human rights.
- ii. Healthcare protocols: Implement confidential voluntary testing with pre- and post-test counselling, eliminating mandatory requirements and third-party disclosure.
- iii. Support systems: Fund PLHIV-specific marriage counselling and peer support networks to address the psychosocial consequences of exclusion.

- iv. Community engagement: Train religious leaders and family elders as allies to reduce institutionalized stigma and foster more inclusive community responses to HIV.

Limitations of the Study

This study is subject to several limitations. First, social desirability bias may have caused some participants to underreport illegal coping mechanisms, such as bribery. Second, the findings are closely tied to the sociocultural context of Bauchi, which may limit their applicability to other regions in Nigeria or across Africa. Additionally, male viewpoints might be underrepresented due to stigma that discourages participation. Furthermore, while snowball sampling was effective in reaching hard-to-access individuals, many potential participants declined interviews out of fear of disclosure and HIV-related stigma. Finally, recruiting through people living with HIV may have resulted in a homogenous group of participants, potentially constraining the range of perspectives gathered.

Acknowledgements

The authors express gratitude to the individuals living with HIV in Bauchi Metropolis who played a crucial role in participant recruitment, and extend heartfelt thanks to the 30 participants who, with remarkable courage and openness, shared their personal experiences. We also sincerely acknowledge those who accepted to be interviewed and, due to personal reasons, later had to decline. Thank you for your willingness and the time you gave us. We are equally grateful to those who were unable to participate but still helped by referring others for the survey. Your support made this work possible. Your efforts, in every form, are seen, valued, and truly appreciated.

References

- Abdellatif, A., & Haynes, K. (2024). Be-ing seen: Towards a feminist interpretative phenomenological analysis to researching the marginalised. *Culture and Organisation*, 31(3), 64–85. <https://doi.org/10.1080/14759551.2022.2085311>
- Akoko, B., Regan, S., Idigbe, I., Ezechi, O., Pierce, L. J., Musa, Z., Okonkwo, P., Freedberg, K. A., & Ahonkhai, A. A. (2023). HIV-related stigma and psychological distress in a cohort of patients receiving antiretroviral therapy in Nigeria. *AIDS Care*, 36(2), 204–211. <https://doi.org/10.1080/09540121.2023.2183555>
- Akoku, D. A., Tihnje, M. A., Tarh, E. O., Tarkang, E. E., & Mbu, R. E. (2018). Disclosure of HIV status and pre-marital HIV testing: A population-based study in Cameroon. *International Journal of MCH and AIDS*, 7(2), 250–263. <https://doi.org/10.21106/ijma.244>

- Al-Aama, J. Y. (2010). Attitudes toward mandatory national premarital screening for hereditary hemolytic disorders. *Health Policy*, 97(1), 32–37. <https://doi.org/10.1016/j.healthpol.2010.03.007>
- Aluah, C. P., Robillard, A., Billings, D., & Smallwood, S. (2024). Courtesy stigma and HIV professionals: A brief review of implications for psychosocial and professional well-being. *Social Work in Public Health*, 39(4), 368–378. <https://doi.org/10.1080/19371918.2024.2316027>
- Babalola, O. E., Badru, O. A., Bain, L. E., & Adeagbo, O. (2023). Determinants of social support among people living with HIV in Nigeria: A multicenter cross-sectional study. *Frontiers in Public Health*, 11, Article 1120192. <https://doi.org/10.3389/fpubh.2023.1120192>
- Barmania, S., & Aljunid, S. M. (2017). Premarital HIV screening in Malaysia: A qualitative exploratory study on the views of major stakeholders involved in HIV prevention. *BMC International Health and Human Rights*, 17(1), Article 12. <https://doi.org/10.1186/s12914-017-0120-5>
- Bauchi State Law. (2017). Bauchi State HIV/AIDS prevention and control law. Government of Bauchi State.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>
- Browne, K. (2005). Snowball sampling: Using social networks to research non-heterosexual women. *International Journal of Social Research Methodology*, 8(1), 47–60. <https://doi.org/10.1080/1364557032000081663>
- Byrne, D. (2022). A worked example of Braun and Clarke’s approach to reflexive thematic analysis. *Quality & Quantity*, 56, 1391–1412. <https://doi.org/10.1007/s11135-021-01182-y>
- Chenneville, T., Kosyluk, K., Gabbidon, K., Franke, M., Serpas, D., & Galea, J. T. (2024). Positive, open, proud: An adapted disclosure-based intervention to reduce HIV stigma. *Frontiers in Global Women’s Health*, 5, Article 1469465. <https://doi.org/10.3389/fgwh.2024.1469465>
- Ezugwu, E. C., Osamor, P. E., & Wendler, D. (2019). Ethical issues in denial of church wedding based on couple’s hemoglobin genotype in Enugu, south eastern Nigeria. *BMC Medical Ethics*, 20(1), Article 37. <https://doi.org/10.1186/s12910-019-0375-z>
- Farmer, P. (2004). *Pathologies of power: Health, human rights, and the new war on the poor*. University of California Press.
- Giordana, J.-Y., & Caci, H. (2025). Stigma by association revealed in a survey conducted among UNAFAM members. *L’Encéphale*, 51(4), 429–436. <https://doi.org/10.1016/j.encep.2024.06.007>
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Prentice-Hall.

- Goitseman, W., Ogundipe, R. M., & Masupe, T. (2025). Segregated healthcare impact on patients living with HIV in a clinic in Botswana. *Southern African Journal of HIV Medicine*, 26(1), Article a1729. <https://doi.org/10.4102/sajhivmed.v26i1.1729>
- Guest, G., Namey, E., & Chen, M. (2020). A simple method to assess and report thematic saturation in qualitative research. *PLOS ONE*, 15(5), Article e0232076. <https://doi.org/10.1371/journal.pone.0232076>
- Hennink, M. M., Kaiser, B. N., & Marconi, V. C. (2017). Code saturation versus meaning saturation: How many interviews are enough? *Qualitative Health Research*, 27(4), 591–608. <https://doi.org/10.1177/1049732316665344>
- Hennink, M., & Kaiser, B. N. (2022). Sample sizes for saturation in qualitative research: A systematic review of empirical tests. *Social Science & Medicine*, 292, Article 114523. <https://doi.org/10.1016/j.socscimed.2021.114523>
- Ifemeje, S. (2011). Mandatory premarital HIV testing policy in Nigeria: A gross violation of the rights of people living with HIV/AIDS. *The International Journal of Human Rights*, 16(3), 401–410. <https://doi.org/10.1080/13642987.2011.569327>
- Khraban, T. (2024). Thematic analysis in the study of social and psychological phenomena. *Bulletin of National Defense University of Ukraine*, 82(6), 188–195
- Kimera, E., Alanyo, L. G., Pauline, I., Andinda, M., & Mirembe, E. M. (2025). Community-based interventions against HIV-related stigma: A systematic review of evidence in Sub-Saharan Africa. *Systematic Reviews*, 14, Article 8. <https://doi.org/10.1186/s13643-024-02737-0>
- Kumar, S., Mohanraj, R., Rao, D., Murray, K. R., & Manhart, L. E. (2015). Positive coping strategies among people living with HIV in South India. *AIDS Patient Care and STDs*, 29(3), 157–163. <https://doi.org/10.1089/apc.2014.0182>
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage.
- Maigoro, A. M., Usman, U. S., Abdullahi, A. I., Salisu, R. B., Maje, S. S., Mohammed, S., & Mele, U. A. (2023). Knowledge, attitude and practice of premarital screening for HIV/AIDS among residence of rural areas in north-eastern Nigeria. *West African Journal of Medicine*, 40(11, Suppl. 1), S12.
- Mpofu, L., Moyo, I., & Mavhandu-Mudzusi, A. H. (2024). Exploring sociocultural factors and ubuntuism for women living with HIV in rural Zimbabwe. *Curationis*, 47(2), Article a2627. <https://doi.org/10.4102/curationis.v47i2.2627>
- Nnaji, G. A., Ezeagwuna, D. A., Osakwe, O. J., Nwigwe, A. C., Ofiaeli, N. G., & Nnaji, I. J. (2014). Premarital HIV testing on prospective couples in a teaching hospital in sub Saharan Africa. *Nigerian Journal of Medicine*, 23(1), 13–19.
- Ogunbajo, A., Sotubo, O., Okanlawon, K., Shoyemi, E., Oginni, O., & Mayer, K. H. (2025). Intersectional stigma and adherence to antiretroviral (ART) among sexual minority men living with HIV in Nigeria: A qualitative inquiry. *PLOS ONE*, 20(12), Article e0338933. <https://doi.org/10.1371/journal.pone.0338933>

- Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health and Mental Health Services Research*, 42(5), 533–544. <https://doi.org/10.1007/s10488-013-0528-y>
- Parker, C., Scott, S., & Geddes, A. (2019). Snowball sampling. In P. Atkinson, S. Delamont, A. Cernat, J. W. Sakshaug, & R. A. Williams (Eds.), *SAGE research methods foundations*. Sage. <https://doi.org/10.4135/9781526421036831710>
- Philip, A. A. (2024). “Double wahala for dead body”: Adherence to antiretroviral therapy among persons with disabilities living with human immunodeficiency virus in Nigeria [Doctoral dissertation, Queensland University of Technology]. QUT ePrints.
- Scott, J. C. (1985). *Weapons of the weak: Everyday forms of peasant resistance*. Yale University Press.
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. Sage.
- Tadesse, G., Rtbey, G., Andualem, F., Takelle, G. M., Melkam, M., Abate, A. T., Wassie, Y. A., Alemayehu, T. T., & Ge, G. W. (2024). HIV-related perceived stigma and internalized stigma among people living with HIV/AIDS in Africa: A systematic review and meta-analysis. *PLOS ONE*, 19(10), Article e0309231. <https://doi.org/10.1371/journal.pone.0309231>
- UNAIDS. (2022). *In danger: UNAIDS global AIDS update 2022*. Joint United Nations Programme on HIV/AIDS.
- Valerio, M. A., Rodriguez, N., Winkler, P., Lopez, J., Dennison, M., Liang, Y., & Turner, B. J. (2016). Comparing two sampling methods to engage hard-to-reach communities in research priority setting. *BMC Medical Research Methodology*, 16(1), Article 146. <https://doi.org/10.1186/s12874-016-0242-z>
- Verinumbe, T., Katonski, A. S., Turpin, G., Syarif, O., & Looze, P. (2024). Characterizing the relationship between HIV peer support groups and internalized stigma among people living with HIV in Nigeria. *AIDS and Behaviour*, 28, 1068–1076. <https://doi.org/10.1007/s10461-023-04218-8>