Original Article

Young People's Willingness to go for HIV/Acquired Immunodeficiency Syndrome Counseling and Testing in Oluku Community in South Nigeria

Kingsley Chinedu Okafor, Vincent Yakubu Adam[1], Emmanuel Chukwunonye Azuike[2], Greg Abiaziem[3]

Senior Research Fellow, Health Research and Policy Development Group, [3]Senior Regional Medical Manager, Aids Healthcare Foundation, Abuja, [1]Department of Community Health, University of Benin, Benin City, Edo State, [2]Department of Community Health, Chukwuemeka Odumegwu Ojukwu University, Anambra State, Nigeria

Abstract

Background: Young people are vulnerable to HIV/acquired immunodeficiency syndrome (AIDS) as they significantly contribute to new HIV infections in Nigeria and sub-Saharan Africa. HIV counseling and testing (HCT) provides an opportunity for increased awareness, prevention, treatment, care, and support for HIV/AIDS and contributes to the prevention and control of HIV/AIDS. **Objective:** This study aims to determine the HIV/AIDS awareness, knowledge of methods of prevention and transmission of HIV/AIDS, HIV status of sexual partner, and willingness to go for HIV/AIDS counseling and testing (HCT) among young people in Oluku Community, Ovia North East, local government, Edo State, South South, Nigeria. **Materials and Methods:** This was a descriptive cross-sectional study conducted between January and June, 2013, using multistage sampling method. Data were collected using interviewer-administered questionnaire adapted from the 2007 National HIV/AIDS and Reproductive Health Survey (NARHS) plus. **Results:** A total of 400 young people participated in this study; their mean age was 17.8 years (3.9 years). There were more females (211 [52.8%]) than males (189 [47.3%]). Majority (92.3%) of the young people were aware of HIV/AIDS; most heard of it via electronic media (81%), peers (63.5%), and parents (55.5%). Majority knew the methods of transmission of HIV/AIDS as having multiple sexual partners (80.0%), sharing sharps (78.3%), blood transmission (71.5%), and having unprotected sex (69.8%). Abstinence (50.1%) and condom use (37.8%) and faithfulness to partner (5.3%) were the methods practiced by most young people to prevent disease transmission and pregnancy. Most (61.9%) of the young people did not know the HIV/AIDS status of their partners before sexual intercourse. More than two-thirds (68.0%) had never gone for HCT, however majority (73.0%) of them were willing to go for HCT. **Conclusion and Recommendations:** Most young people were aware of HIV/AIDS and the methods of transmission, whereas more than two-thirds had never gone for HCT. However, majority of them were willing to go for HCT. Efforts should be geared toward improving access to HCT services by using stand-alone, mobile/outreach, and health facility-based HCT centers and community enlightenment on the importance of avoiding premarital sex and their roles in reducing HIV/AIDS and other sexually transmitted infection transmission.

Keywords: *Counselling, HIV, young people*

Introduction

Young people include girls and boys aged between 10 and 24 years, spanning the periods defined as adolescence (10–19 years) and youth (15–24 years).[1] The population of young people is increasing progressively, and is expected to continue to increase until the year 2040.[2-4] They constitute almost a third of Nigeria's population, making up to about 40 million of Nigeria's estimated 140 million people.[1,5-7] This number is expected to rise over the next decade. This increase means global and national attention must be on young people to ensure that their health is not compromised by their sexual and reproductive health (RH) decisions. Addressing the sexual and RH needs and problems of this group is a crucial element of the WHO Global RH Strategy.[8] In many parts of the world, the sexual and RH needs of young persons are either poorly understood or not fully appreciated. Evidence is growing that this neglect can seriously jeopardize the health and future well-being of young people.[1,9,10]

Nigeria is one of the countries with the largest number of people infected with HIV, with over 3.1 million adults in the age range of 15–49 years living with the virus.[4,11] It is known that among the general population,

How to cite this article: Okafor KC, Adam VY, Azuike EC, Abiaziem G. Young people's willingness to go for HIV/acquired immunodeficiency syndrome counseling and testing in oluku community in South Nigeria. N Niger J Clin Res 2020;9:12-9.

Received: 27-05-2019. **Accepted:** 27-12-2019. **Published:** 11-05-2020.

Address for correspondence:
Dr. Kingsley Chinedu Okafor, Health Research and Policy Development Group, Abuja, Nigeria. E-mail: drokaforkingsley@gmail.com

Access this article online

Website: http://mdcan-uath.org

DOI: 10.4103/nnjcr.nnjcr_33_19

Quick Response Code:

adolescents and youth are most vulnerable because it is within this age group that high-risk activities and adventures occur.[4,11] Each year, nearly half of 4.9 million new HIV infections occur among those aged 15–24 years, with a higher rate of incidence in young women than in young men.[9] These young people contribute significantly to new HIV infections in Nigeria.[12] Nigeria is one of the sub-Saharan nations with high prevalence of HIV/acquired immunodeficiency syndrome (AIDS) infection, currently estimated to be 3.6%.[13,14]

In Nigeria, only 22.5% of young men and women aged 15–24 years were able to correctly identify ways of preventing the sexual transmission of HIV and other sexually transmitted infections (STIs) and who know the major misconceptions about HIV transmission. Thus, most people, especially the adolescents and young people, are yet to have knowledge of HIV/AIDS awareness.[15,16] This may lead to transmission and increased morbidity and mortality. In addition, 9.8% of young men and women aged 15–24 years have had sexual intercourse before the age of 15 years, while about 35% have sex at least once a week.[11] As the fight for the control of HIV/AIDS continues, it is necessary to clearly measure the level of awareness of HIV and willingness of adolescents to go for HIV counseling and testing (HCT) in the community, to improve the prevention and control of HIV in communities. Most young people (87%) are willing to test and know their HIV status, but only a few (14%) had actually gone for HIV test.[13] HIV/AIDS counseling and testing (HCT) is the entry point to prevention, treatment, care, and support and contributes to the reduction of stigma and discrimination. It is a cost-effective method of prevention and control of HIV/AIDS.[17] In Nigeria, the overall target for HCT is to counsel and test at least 80% of sexually active population (about 80 million) by 2015.[17-19]

In adolescence and youth, the effects of debilitating childhood illnesses and nutritional deficiencies manifest in psychological and other problems. They are more prone to injury than any other group as they are more physically mobile and less mentally inhibited in this mobility.

Many of the avoidable problems in RH, such as unwanted pregnancy, abortion and its complications, and STIs including AIDS can be prevented using HCT.[20]

This study aims at ascertaining the willingness of young persons to go for HIV/AIDS counseling and testing (HCT) and young persons' HIV/AIDS awareness, knowledge of methods of prevention and transmission of HIV/AIDS and HIV status of sexual partner.

Materials and Methods

This study was done in Oluku which is located in Ovia North-East local government area of Edo State and lies on the latitude and longitude of about 6° 27' North and 5° 36' East, with an elevation of 310 ft. Oluku Community is bordered to the north by Ovbiogie, to the south by Okhunmwun and Iguosa, to the east by Ora, and to the west by Agbaen communities. It is a major town with a lot of commercial activities such as small kiosks, food vendors, hotels, guest houses, and brothels. It also serves as a rest point for long-distance travelers in the region. Most of the people are farmers, civil servants, drivers, and petty traders.

This descriptive cross-sectional study was done among 400 selected young people within the community. It excluded those young people that refused consent and those not available during the survey. The study was carried out over a period of 6 months from January to June 2013. Multistage sampling method was used in selecting respondents.

Stage one

The Lagos-Benin express road divides the community into two halves, one on the right and the other on the left. A simple random sampling technique using a table of random numbers was used to select one of the two communities. The community on the left was selected.

Stage two

The number of houses and households in the selected community was determined by counting and numbering. There were 172 houses and 526 households on the left side of the community (data from an initial enumeration done by the researcher). From this, 400 households were selected using a simple random sampling method (using a table of random numbers). In households with more than one adolescent, an adolescent was selected by balloting.

The data collection instruments were pretested among young people in Ogbona community in Etsako Central local government area, Edo State, which is about 300 km away from Oluku community. The instrument was tested for their correctness and appropriate understanding by the respondents. Data were collected using quantitative method adapted from the 2012 National HIV/AIDS and RH Survey (NARHS) plus.[13] The collected quantitative data were entered and analyzed using Statistical Package for Scientific Sciences (SPSS) version 20, by IBM Incorporated, Armonk, New York, United States of America.

Ethical approval was obtained from the Ethical Committee of the University of Benin Teaching Hospital before the commencement of the field work. Permission was obtained from the town and youth leaders, while parents gave assent for questionnaires to be administered. Individual informed consent was attached to each questionnaire and the respondent gave his or her consent before the questionnaire was filled.

A limitation of this study was that some young people interviewed were uncomfortable answering questions on sexual issues because of its sensitive nature, thus may have

given responses that may not be a true representation of their sexual behavior and exploits, thus leading to bias.

Results

Sociodemographic characteristics of respondents

Over a third, 38.0% and 36.0%, of the respondents were within the 15–19 years' and 20–24 years' age groups, respectively. The mean age was 17.8 years, with a standard deviation (SD) of 3.9 years. Sex distribution showed that there were more females (211 [52.8%]) than males (189 [47.3%]). The mean age of females was 17.1 years (SD = 3.9 years) and males was 18.1 years (SD = 3.9 years). Majority of the respondents had secondary education (271 [67.8%]), whereas 6 (1.5%) did not attend formal education.

Awareness of HIV/acquired immunodeficiency syndrome and knowledge of HIV/acquired immunodeficiency syndrome

Ninety-two percent of the respondents were aware of HIV/AIDS, whereas 33 (8.3%) were not aware. Most respondents heard about HIV/AIDS through electronic media (81%), peers (63.5%), parents (55.5%), print media (53.8%), and health workers (51.7%). Majority of the respondents knew the methods of transmission of HIV/AIDS as having multiple sexual partners (80.0%), sharing sharps (78.3%), blood transmission (71.5%), and having unprotected sex (69.8%) [Table 1]. The perceived method used by respondents to prevent HIV/AIDS infection included abstinence (201 [50.1%]), condom (151 [37.8%]), and faithfulness to partner (21 [5.3%]) [Table 2]. The association between sex and method of HIV prevention was statistically significant (P = 0.001). The association between age group of respondents and method of HIV prevention was also statistically significant (P = 0.001) [Table 1B].

Table 1: Source of information and knowledge of methods of transmission of HIV/acquired immunodeficiency syndrome (n=400)

Variables	Frequency, n (%)
Source of information	
Electronic media	324 (81.0)
Peer group	254 (63.5)
Parents	222 (55.5)
Print media	214 (53.5)
Health workers	207 (51.7)
Knowledge of methods of transmission of HIV/AIDS	
Multiple sexual partners	320 (80.0)
Sharing sharps	313 (78.3)
Blood transfusion	286 (71.5)
Unprotected sex	279 (69.8)

*Multiple responses. AIDS: Acquired immunodeficiency syndrome

Willingness to go for HCT

Majority of the respondents (273 [68.0%]) have never gone for HCT. Only 127 (31.7%) of the young people had ever done HCT. Most (61.9%) of the adolescents did not know the HIV/AIDs status of their partner before sexual intercourse [Table 2]. Seventy-three percent of the adolescents were willing to go for HIV/AIDS screening, whereas 110 (27.5%) were not willing.

Factors associated with the knowledge of HIV status of partner

Factors that showed statistical significance in association with the knowledge of HIV status of partner include being from a monogamous home (P = 0.043), above primary level of education (P = 0.009), planning sexual intercourse (P = 0.004), and religion (P = 0.029). Others were age of respondents (P = 0.888), sex (P = 0.458), age of sexual debut (P = 0.063), and attending a boarding school (P = 0.458), which were not statistically significant [Table 3 and 4].

Factors associated with willingness to go for HIV counseling and testing (HCT)

Statistically significant factors associated with willingness to go for HCT include above primary education (P = 0.033), religion (P = 0.019), age (P = 0.032), and awareness of HIV/AIDS (P = 0.001). Others not statistically significant include being sexually active (P = 0.095) and sex (P = 0.879) [Tables 5 and 6].

Table 1B: Respondents' method of HIV prevention and predictor variables

Predictor variable	Method of HIV prevention (%)						Fisher's exact test	P
	Abstinence	Nothing	Faithful	Condom	Traditional medicine	Personal hygiene		
Sex								
Male	66 (35.3)	24 (12.8)	6 (3.2)	86 (46.0)	3 (1.6)	2 (1.1)	19.152	0.001*
Female	104 (48.8)	38 (17.8)	14 (6.6)	51 (23.9)	5 (2.3)	1 (0.5)		
Age (years)								
10-14	51 (51.0)	34 (34.0)	1 (1.0)	12 (12.0)	1 (1.0)	1 (1.0)	80.895	0.001*
15-19	79 (51.3)	16 (10.4)	10 (6.5)	46 (29.9)	2 (1.3)	1 (0.6)		
20-24	40 (27.4)	12 (8.2)	9 (6.2)	79 (54.1)	5 (3.4)	1 (6.7)		
Total	170 (42.5)	62 (15.5)	20 (5.0)	137 (34.2)	8 (2.0)	3 (0.8)		

*Statistically significant

Table 2: Ever-done HIV/acquired immunodeficiency syndrome counseling and testing, place it was done, and perceived methods of HIV/acquired immunodeficiency syndrome prevention by respondents

Variable	Frequency, *n* (%)
HIV/AIDS counseling (*n*=400)	
Yes	127 (31.7)
No	273 (68.3)
Place of HCT (*n*=127)	
Government hospital	43 (33.9)
HCT center	14 (11.0)
Field health worker	4 (3.1)
Private hospital/laboratory	10 (7.9)
Cannot remember	56 (44.1)
Methods of HIV/AIDS prevention (*n*=400)	
Abstinence	201 (50.1)
Condom use	151 (37.8)
Nothing	15 (3.8)
Faithfulness to a partner	21 (5.3)
Traditional medicine	6 (1.5)
Personal hygiene	6 (1.5)

AIDS: Acquired immunodeficiency syndrome, HCT: HIV/AIDS counseling and testing

Discussion

Most respondents were aware of HIV/AIDS. This finding is similar to those obtained from the National HIV Seroprevalence sentinel survey[13] where 93.8% were aware of HIV/AIDs and in a study done in Delta State in 2010[14] and Addis Ababa, Ethiopia, in 2012[17] where all adolescents had heard of HIV/AIDS. Similar higher percentages (88.3%) were observed in Okpekpe, Edo State, in 2012[21] and in the National Demographic and Health Survey in 2018.[20,22] This is due to intensive awareness creation and publicity done by different governmental and nongovernmental organizations, religious bodies, and schools on HIV/AIDS.[12] Most respondents heard about HIV/AIDs through electronic media (81.0%), peers (63.5%), parents (55.5%), print media (53.8%), and health workers (51.7%). This is due to the current use of electronic media in educating the populace on HIV/AIDs challenges. It is a reflection of the need to use these means to reach out to young people on the need to prevent HIV/AIDS transmission. Majority of the respondents knew the methods of transmission of HIV/AIDS as having multiple sexual partners, transfusion with contaminated blood, and having unprotected sex. However, only a few knew about sharing contaminated needles and sharps as a means of transmission. Studies[17,21,23] reported that over 85% of the adolescents knew transmission through sex, transfusion with contaminated blood, and contaminated needles. This study found a lower proportion because the study was done among in-school and out-of-school adolescents and young people in the community, thus their knowledge of transmission would be lower than in-school adolescents used in Delta State[23] and Okpekpe, Edo State.[21] Furthermore, the National HIV Seroprevalence Sentinel survey[24] reported low knowledge of routes of transmission of HIV (54.0%).

Over a third had never gone for HIV/AIDS counseling and testing in their lifetime. Only 32% of the young people in Oluku had ever attended HIV/AIDS counseling and testing. This is similar to the finding from a study done in Kenya[25] where only 32% of the young people had gone for HCT and NARHS 2012 survey where only 26% had done HCT.[13] In contrast, a study done in Delta State[23] shows that none of the respondents had gone for HCT. Of the respondents that have had HCT counseling and testing done, 80% had it done over a year ago, whereas only 20% had done it within the year. Just over a third of the respondents had their HIV/AIDS counseling and testing in a government-owned hospital, 7.9% were done in a private laboratory, and only 11.0% had HCT counseling at a HCT center. This finding could be due to the absence of facilities that render these services in the community. The finding shows that young people are aware and willing to go for a test, but in practice, only a few have gone for one. Most respondents use condom and abstinence to prevent HIV/AIDS infection; this is also reflected in studies done in Jos,[14] Anambra,[26] and Kenya.[23] While studies done in Limpopo, South Africa,[27] showed that a few young persons were using condoms and abstinence as a means of HIV/AIDS prevention.

Most of the young persons did not know the HIV/AIDs status of their partner before sexual intercourse. Respondents with secondary and tertiary level of education knew the HIV/AIDs status of their sexual partner than those who had primary level of education. This is attributable to the fact that education provides young persons with useful life skills to handle sexual and reproductive issues as well as combat STIs and other challenges of youth. A higher proportion of older age group (youths 15–24 years) knew the HIV status of their partners than the younger adolescents (10–14 years) because older adolescents may have stronger will to ask questions about their partner during their relationship and before sex. A higher proportion of respondents who planned their sexual intercourse knew the HIV status of their partner, whereas those who did not plan their sexual intercourse did not know the HIV status of their sex partner. This supports the need for adequate planning of sexual activities; it gives the young people control over their actions and an opportunity to weigh the consequences of their sexual practices. More females than males did not know the HIV status of their partners. Females may not want to offend their partners or may be too shy and uncomfortable asking their sexual partners about their HIV/AID status before a relationship. Whereas, males, may be more confident and bold to ask their partner questions concerning their status. As age of sexual debut increases, the proportion of respondents who knew the HIV

Table 3: Knowledge of HIV status of partner and predictor variables

Predictor variable	Knowledge of HIV status of partner (%)		Fisher's exact test	*P*
	Yes (%)	No (%)		
Age (years)				
10-14	2 (33.3)	4 (66.7)	0.256	0.888
15-19	23 (29.9)	54 (70.1)		
20-24	37 (33.3)	74 (66.7)		
Sex				
Male	28 (25.0)	83 (75.0)	0.690	0.458
Female	12 (14.5)	71 (85.5)		
Religion				
Christianity	45 (27.6)	118 (72.4)	12.524	0.029
Others	17 (54.8)	14 (45.2)		
Age at first sex (years)				
<10	4 (44.4)	5 (55.6)	11.964	0.063
10-14	9 (27.3)	24 (72.7)		
15-19	12 (17.4)	58 (82.6)		
20-24	37 (45.1)	45 (54.9)		
Family structure				
Monogamous	55 (43.0)	73 (57.0)	2.761	0.043
Polygamous	5 (8.8)	52 (91.2)		
Separated	2 (22.2)	7 (77.8)		
Type of school				
Day school	44 (29.5)	105 (70.5)	1.742	0.458
Boarding	18 (40.0)	27 (60.0)		
Level of education				
Primary	5 (25.0)	15 (75.0)	14.256	0.009*
Secondary	46 (31.9)	97 (68.1)		
Tertiary	11 (37.5)	20 (62.5)		
Planned sexual intercourse				
Planned	32 (80.0)	8 (20.0)	0.690	0.004*
Unplanned	30 (19.5)	124 (80.5)		
Total	62 (32.0)	132 (68.0)		

*All values of $P < 0.05$ were considered as statistically significant

Table 4: Multivariate logistic regression for predictors of knowledge of partners' HIV status

Factors	*B* coefficient	*P*	OR	95% CI	
				Lower limit	Higher limit
Level of education					
Primary or less*					
Secondary or more	0.001	0.998	1.001	0.546	1.835
Planned sexual intercourse					
Yes	0.485	0.383	1.624	0.547	4.828
No*					
Constant	−0.876	0.112	0.417		

*Reference value. Reference category, R^2 (coefficient of determination)=0.4%–0.6%. CI: Confidence interval, OR: Odds ratio

status of their sexual partner increases. This boils down to the fact that as young people grow and mature, they acquire more experience, confidence, and knowledge to seek the HIV status of their partner before a relationship.

Half of the respondents prevented HIV infection by abstaining, whereas others used condom and faithfulness to partner as preventive measures. This is akin to the finding in studies done in Okpekpe, Edo State.[21] More females than males prevented HIV/AIDs by abstinence, doing nothing, and being faithful to their partners, whereas more males than females prevent HIV/AIDs by the use of condom ($P = 0.001$). This shows that condom use is higher among males, possibly due to the availability of male condoms in local stores within the locality. In addition, the younger age group (10–14 and 15–19 years) prevented HIV mainly by abstinence and doing nothing. Being faithful to one's partner was practiced more by the respondents aged >15 years. Prevention of HIV by the use of condom increased as age increased with more than half within the age group of 20–24 years. This is possibly due to confidence of the older age group to purchase condom at moments of need.

Seventy-three percent of the respondents were willing to go for HIV/AIDS screening. The 2012 NARHS survey[13]

Table 5: Willingness to go for HIV/acquired immunodeficiency syndrome counseling and testing and predictive variables of respondents

Predictor variable	Willingness to test for HIV/AIDS		Fisher's exact test	*P*
	Yes (%)	No (%)		
Age (years)				
10-14	63 (63.0)	37 (37.0)	8.243	0.033*
15-19	120 (77.9)	34 (22.1)		
20-24	107 (73.3)	39 (26.7)		
Sex				
Male	135 (72.2)	52 (27.8)	0.675	0.879
Female	155 (72.8)	58 (27.2)		
Religion				
Christianity	244 (71.3)	98 (28.7)	26.414	0.019*
Islam	30 (81.1)	7 (18.9)		
Traditional	8 (72.7)	3 (27.3)		
None	8 (80.0)	2 (20.0)		
Respondents' educational status				
None	3 (75.0)	1 (25.0)	16.748	0.033*
Primary	44 (62.9)	26 (37.1)		
Secondary	203 (74.1)	71 (25.9)		
Tertiary	40 (76.9)	12 (23.1)		
Awareness of HIV				
Yes	284 (77.0)	85 (23.0)	34.625	0.001*
No	6 (19.4)	25 (80.6)		
Type of school				
Day school	232 (73.4)	84 (26.6)	0.636	0.425
Boarding	58 (69.0)	26 (31.0)		
Has had sex				
Yes	147 (75.8)	47 (24.2)	2.020	0.095
No	143 (69.4)	63 (30.6)		
Ethnic group				
Edo	141 (74.2)	49 (25.8)	7.192	0.269
Non-Edo	149 (71.0)	61 (29.0)		
Total	290 (72.5)	110 (27.5)		

*Statistically significant. AIDS: Acquired immunodeficiency syndrome

Table 6: Multivariate logistic regression for predictors of willingness for HIV testing

Factors	B coefficient	*P*	OR	95% CI	
				Lower limit	Higher limit
Age (years)					
<18	0.257	0.338	1.293	0.765	2.186
>18*					
Religion	0.075	0.723	1.078	0.711	1.634
Level of education					
Primary or less*					
Secondary or more	0.272	0.422	1.312	0.676	2.546
Awareness of HIV					
Aware	1.445	0.014	4.240	1.342	13.401
Unaware*					
Constant	−0.614	0.376	0.541		

*Reference value. Significant. Reference category, R^2 (coefficient of determination)=2.0%–3.1%. CI: Confidence interval, OR: Odds ratio

showed that 77% were willing to go for a HIV test. A study done in a rural community in Kano also revealed that 73.5% of the respondents were willing to go for HCT.[28] This high level of willingness to go for HIV/AIDS counseling and testing indicates a positive outcome in the global efforts to control HIV/AIDS and other STIs. In contrast, a study done in Delta State, Nigeria, reported that only 55% of the adolescents were willing to go for a test. Young people with tertiary and secondary level of education were more willing to have HIV screening than those with primary level of education. This association was statistically significant (P = 0.033). This finding is due to the fact that literacy and education promotes health-seeking behavior. In addition, respondents who were Christians and Muslims were more willing to have HIV screening than those who are traditional African worshippers. Religion teaches abstinence, promotes faithfulness in marriage, and frowns at premarital sexual practices, thus adherence to these teachings makes young people willing to test for HIV as they have not indulged in sex or other risky behaviors. Young persons of older age category (between 15 and 24 years) were more willing to test for HIV/AIDs than the younger age groups (10–14 years). A possible explanation is the fact that younger age category (adolescents) may be unsure of the need for a test or may require parental advice before reaching a decision, whereas their older counterparts would want to go for a test to allay their anxiety and fears. Respondents who were aware of HIV/AIDS were more willing to go for HCT than those who were not aware of HIV/AIDs. Awareness improves and knowledge in this case improved willingness to have a test done. Simply, if a young person is unaware of HIV, then there is a slim chance of going for HCT. Respondents who had had sex were more willing to go for HIV test than those who had not had sex. Those who had experienced sexual intercourse may be more disposed to having HCT done than those who had not had sex. HCT should be encouraged among those that are sexually active to reduce the potential for HIV transmission.

Conclusion

Only a few (8.3%) young persons were unaware of HIV/AIDs, and those that were aware (92.7%) heard of it via electronic media, peers, parents, print media, and health workers. Majority of the respondents knew the methods of transmission of HIV/AIDS as having multiple sexual partners, sharing sharps, blood transmission, and having unprotected sex. Abstinence and condom use were the methods used by most young people in Oluku community to prevent disease transmission and pregnancy. Most young people did not know the HIV/AIDS status of their partners before sexual intercourse.

More than two-thirds (68.0%) had never gone for HIV/AIDS counseling and testing. However, majority (73.0%) of them were willing to go for HCT. Of those who had done HCT, only a third (31.7%) had their HIV/AIDS counseling and testing in a government-owned hospital. Most of the respondents who were willing to go for a test were those with secondary and tertiary level of education, those who were Christians and Muslims, and those who were in older age groups (20–24 years).

Recommendations

To the government

The government should integrate HCT services into youth-friendly centers to improve access and use by young people as most young persons are willing to go for HCT. The government should use the media to encourage young people to have HCT done. The existing youth-friendly centers should be strengthened while more centers should be established at every tier of educational institution.

To the community and community leaders

Community should help build support for provision and use of HCT and contraceptives by young persons. Information on where to obtain contraceptives and use should be available. Communities should organize regular HIV/AIDS and STI awareness campaigns and prevention programs to target young people, all adults, and older persons in the community.

Health workers at community and state level should be more dedicated and carry out rigorous advocacy programs in the community.

To the schools

They should adopt curriculum-based sexuality education through the inclusion of sexual and RH for young persons in the curriculum. Moreover, they should help young people develop life skills.[29] Counseling services should be provided to support and deal with thoughts, feelings, and experiences that accompany the sexual maturity of young persons. This can be linked to contraceptive counseling services.[30,31] Schools should promote abstinence as a method of prevention of HIV/AIDS.

To young people

The youths are encouraged to use the HCT centers and government hospitals for HCT.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

References

1. Federal Ministry of Youth and Sports Development, National Youth Policy. Federal Government of Nigeria; 2019. p. 23-57.
2. World Health Organization. Investing in our Future: A Framework for Accelerating Action for the Sexual and Reproductive Health of the Young People. Manila, Philippines: World Health Organization; 2006. p. 12-23.
3. World Health Organization. Promoting Adolescent Sexual and Reproductive Health through Schools in Low Income Countries: An Information Brief. Geneva: World Health Organization; 2008. p. 4-16.
4. United Nations Population Fund. UNFPA Framework for Action on Adolescents and Youths. New York: United Nations Population Fund; 2010. p. 12-23. Available from: http://www.unfpa.org. [Last accessed on 2017 Mar 12].
5. United Nations Population Fund. Nigerian Adolescents Population : Selected Socio-Demographic Variables. New York: United Nations Population Fund; 2010. p. 3-24.
6. National Population Commission. 2005 Population Census of the Federal Republic of Nigeria. Abuja, Nigeria: National Population Commission Abuja; 2006.
7. Federal Ministry of Health. Status of Young People s Health in Nigeria Action Points for Advancing Young People's Health in Nigeria Policy Makers Young People. Abuja: Federal Ministry of Health; 2008. p. 2-6.
8. Morhason-Bello IO, Oladokun A, Enakpene CA, Fabamwo AO, Obisesan KA, Ojengbede OA, *et al*. Sexual behaviour of in-school adolescents in Ibadan, South-West Nigeria. Afr J Reprod Health 2008;12:89-97.
9. Cottingham J. Policy Brief Promoting and Safeguarding the Sexual and Reproductive Health of Adolescents. Geneva, Switzerland; 2005:13. Available from: http://www.who.int/reproductive-health. [Last accessed on 2017 Mar 12].
10. Federal Ministry of Health. National Adolescent Health Policy. Abuja, Nigeria: Federal Ministry of Health; 1995. p. 1-7.
11. Krug EG, Dahlberg LL, James AM, Zwi AB, Lozano R. World Report on Violence and Health. Geneva: World Health Organization; 2002.
12. Federal Ministry of Health. Assessment Report of Young Peoples Sexual and Reproductive Health in Nigeria. Abuja, Nigeria: Federal Ministry of Health; 2009. p. 12-8.
13. Federal Ministry of Health. National HIV/AIDS and Reproductive Health Survey (NARHS Plus, 2007). Abuja: Federal Ministry of Health; 2008. p. 35-67.
14. Daniyam CA, Agaba PA, Agaba EI. Sexual behavior of medical students: A single institutional survey. Afr Health Sci 2010;10:150-3.
15. United Nations Organization. Nigeria UNGASS Report 2007. United Nations General Assembly Special Session on AIDS. United Nations Organization; 2008.
16. Federal Ministry of Health. Exploring the Sexual, Reproductive and Socio-Developmental Needs of Adolescents Living with HIV in Nigeria: Positive Action for Treatment Access. Abuja: Federal Ministry of Health; 2010. p. 1-33.
17. Girma Temam AA. Prevalence of HIV and discordant rate and their associated factors among premarital voluntary counseling and testing (VCT) clients in Addis Ababa public VCT center, Addis Ababa, Ethiopia. Ethiop J Health Dev 2012;26:150-229.
18. Federal Ministry of Health. National Guidelines for HIV Counseling and Testing. Abuja: Federal Ministry of Health; 2011. p. 1-7.
19. Tewabe T, Destaw B, Mengesha Admassu BA. Assessment of factors associated with voluntary counseling and testing uptake among students in Bahir Dar University: A case control study. Ethiop J Health Dev 2012;26:16-21.
20. National Population Commission (NPC) Nigeria and ICF Macro. Nigeria 2008 Demographic and Health Survey. Abuja, Nigeria:

National Population Commission (NPC) Nigeria and ICF Macro; 2008. p. 13.
21. Adam VY, Iyoha DO, Isah EC. Sexual behaviour and knowledge of HIV/AIDS among secondary school student in Okpekpe Community, Edo state, Nigeria. Nig J Life Sci 2012;2:1-6.
22. National Population Commission (NPC) and ICF. Nigeria Demographic and Health Survey 2018. Abuja, Nigeria and Rockville, Maryland, USA: National Population Commission (NPC) and ICF; 2019.
23. Tobin EA, Okojie HO. Knowledge, attitude and practices of adolescents secondary school students in Uvwie local government area of delta state of HIV/AIDS. J Community Health Prim Health Care 2010;12:40-5.
24. Federal Ministry of Health. National HIV Sero-prevalence Sentinel Survey. Abuja: Federal Ministry of Health; 2010. p. 45-76.
25. Othero DM, Aduma P, Opil CO. Knowledge, attitudes and sexual practices of university students for advancing peer HIV education. East Afr Med J 2009;86:11-5.
26. Okonkwo PI, Fatusi AO, Ilika AL. Perception of peers' behaviour regarding sexual health decision making among female undergraduates in Anambra state, Nigeria. Afr Health Sci 2005;5:107-13.
27. Malueke T. Sexual risk behaviour amongst young people in the Vhembe district of Limpopo province. J Interdiscip Health Sci 2010;15:1-7. Available from: http//ww.hsag.co.za. [Last accessed on 2018 May 22].
28. Abubakar IS, Kabir M. Knowledge of HIV/AIDS and attitude towards voluntary counseling and testing among adults. J Natl Med Assoc 2006;98:1917-23.
29. Ogoh A. The Challenges of adolescent sexuality and reproductive health in Nigeria. Takemi Program in Int Health 2000;166:1-25.
30. Okonkwo JE, Obionu, C Uwakwe R, Okonkwo CV. Sources of sexual information and its relevance to sexual behaviour in Nigeria. West Afr J Med 2000;21:34-7.
31. de Koning K, Hawkes S, Hilber AM. Integrating Sexual Health Interventions into Reproductive Health Services : Programme Experience from Developing Countries. Geneva, Switzerland; 2005. p. 34-6.