

HIV/AIDS Voluntary Counselling and Testing (VCT): Perspectives of Rural Youths in Oyo State, Nigeria

Thomas, K. A., O. P. Fawole and Al-ameen, M. O.

Department of Agric. Extension and Rural Development, University of Ibadan, Ibadan

E-mail: kehindeadesina@yahoo.com

Abstract: The HIV/AIDS pandemic has become a source of concern all over the world with much impact in Sub-Saharan Africa. In Nigeria, the current national rate is over 4%, despite this challenge, the patronage of Voluntary Counselling and Testing is still very low. This study was designed to ascertain the perspectives of rural youths towards HIV/AIDS Voluntary Counselling and Testing in selected rural communities in Oyo state. Multistage sampling technique was used to select 121 respondents as sample size for the study. Data were collected using interview schedule. Parameters assessed were personal characteristics, awareness, knowledge level, constraints affecting VCT and perception towards VCT. The data were subjected to descriptive and regression analyses. The result showed that majority (52.8%) were female, single (64.2%), Muslims (53.5%), and mainly of Yoruba tribe (81.0%) with mean age of 25years. Major information sources on VCT identified include television (89.3 %,) and radio (83.5%), while major constraints identified were, fear of outcome of the VCT result, stigmatisation and beliefs and majority had unfavourable perception towards VCT. Regression analysis revealed that knowledge and constraints were the major determinants of rural youth perspective about the programme. It becomes imperative to increase the level of knowledge of the respondents through awareness campaigns and training using their preferred information sources.

Keywords: HIV/AIDS, Voluntary Counselling and Testing, Perspectives, Rural youth.

INTRODUCTION

Acquired Immune Deficiency Syndrome (AIDS) caused by Human Immunodeficiency Virus (HIV) is a pattern of devastating infections which attacks and destroys certain white blood cells that are essential to the body's immune system (Odu and Akanle, 2008). HIV/AIDS is a major source of concern all over the world as it constitutes a major source of death and a threat to national development. The virus has negative impact on economic, social, political and most especially agricultural development of the nation, since it is believed that over 70% of Nigeria population reside in rural areas while engaging in agriculture as their main sources of livelihood. Sub-Saharan Africa although home to only 10% of the world's population has approximately 70% of all the persons living with HIV/AIDS (UNAIDS 2007). Statistics indicated that as at the end of 2007, an estimated 22 million adults and children in sub-Saharan Africa were living with HIV. Also, an estimated 1.5 million Africans died from AIDS while 11.6 million African children became orphans as a result of HIV/AIDS. Specifically, as at the end of 2007, Nigeria had 2.6 million people living with HIV/AIDS, 170,000 died of AIDS and 1.2 million were orphaned as a result of HIV/AIDS (Yahaya et al., 2010).

Nigeria is one of the countries with a relatively high prevalence 4.4% of people living with HIV/AIDS in Africa (UNAIDS/WHO, 2007). The first case of AIDS in Nigeria was reported in 1986. The virus spread rapidly from 1.8% (of the population) in 1991 to 3.8% in 1994, 4.5% in 1996, 5.4% in 1999, 5.4% in 2001, 5% in 2003 and dropped

slightly to 4.4% in 2005 (National Action Committee on AIDS (NACA, 2006). The virus was said to be common among young and sexually active individuals between the ages of 18-48 years (Adeyipo, 2007). Similarly, (UNAIDS, 2008) estimated that in Nigeria about 3.1% of people between ages 15-49 are living with HIV/AIDS. According to (NBS, 2009), the prevalence rate of HIV/AIDS in Oyo State has increased from 1.8 in 2007 to 2.2 in 2008, most of which are youths. Due to the deadly effect of HIV/AIDS and other deadly diseases, Nigeria's life expectancy dropped from 53.8 years for women and 52.6 years for men in 1991 to 46 years for women and 47 years for men in 2007 (UNAIDS 2008). About 80% of HIV infections in Nigeria are transmitted through heterosexual activities, 10% of the new HIV infections are transmitted through blood transfusions while another 10% HIV infections are transmitted through mother to child transmission and other HIV risk behaviours, such as circumcisions and incision of tribal marks (Yahaya et al., 2010). The World Health Organisation estimated that youths comprised 50% of all new HIV infections and consequently must be targeted for education in decreasing transmission and reducing the stigmatization of HIV and increasing its diagnosis (WHO, 2004).

In Nigeria, HIV/AIDS is promoted by inadequate sexual health education, inadequate voluntary HIV testing and counselling, unhealthy cultural practices and poor health care system (Jimoh, 2003; Alao, 2004). A healthy condition is an essential condition to meaningful contribution to national and agricultural development. HIV/AIDS is a source of

threat to life, thus individuals need to be aware of HIV/AIDS infection and know their HIV status in order to help control its spread as well as effectively manage the ailment in case of people already infected. Various preventive strategies have been employed to curb the spread of HIV infection, as there is presently no cure. The strategies among others include: Abstinence, avoidance of multiple sexual partners, condom use and voluntary counselling and testing (VCT).

Notable among these strategies is Voluntary Counselling and Testing (VCT). VCT is necessary as it helps to reduce transmission and involvement in risky sexual behaviours. It also promotes early treatment and adjustment (Jimoh, 2003; Oshi *et al.*, 2007). HIV/AIDS counseling involves educating a client or a group of clients on the control management and prevention of HIV/AIDS. Counseling assists people to make informed decisions, cope better with life challenges and prevent further transmission of HIV/AIDS. According to Tenibiaje, (2010), attitude of individual is a contributory factor for behavioural change towards VCT. It is against this background that this study was designed to investigate the perspectives held by youths towards HIV/AIDS voluntary counselling and testing in selected rural communities of Oyo State, Nigeria.

METHODOLOGY

Study area: Oyo state is located in the South-West geopolitical zone of Nigeria, Oyo State was one of the three States carved out of the former Western State of Nigeria in 1976. Oyo State consists of 33 Local Government Areas. The State covers a total of 27,249 square kilometres of land mass and it is bounded in the south by Ogun State, in the north by Kwara State, in the west it is partly bounded by Ogun State and partly by the Republic of Benin, while in the East by Osun State. The 2006 population census figure indicated that, youths constitute about 40 percent of the state population of 5,591,589 people (National Population Census, 2006). Apart from its administrative functions, Oyo also served as a centre of trade in agriculture and crafts manufacturing.

Study Population: The target population of the study comprise all the rural youth in Oyo state within the ages 18 to 30 years old (National Youth Development Policy of Nigeria, 2001)

Sampling procedure and sample size

Rural LGA	10% of the rural LGA	Sampled rural communities	No in the list of youth association	20% of sampled respondents
28	Ido	Ido	170	34
	Ibarapa east	Eruwa	210	42
	Iseyin	Iseyin	180	36
Total			560	122

Multistage sampling procedure was used for the study. Twenty eight rural local government (LGAs) out of the 33 local government areas in Oyo state were purposively selected. Three local government areas were randomly selected namely: Ido, Ibarapa east and Iseyin. Proportionately, 122 respondents were randomly sampled from the list of most prominent youth association in the selected rural communities used for the study but only 121 were analysable.

Measurement of variables

Perception towards HIV/AIDS voluntary counselling and testing- The information on perception was obtained using a five-point-likert scale of strongly agree, agree, undecided, disagree and strongly disagree with scores of 1, 2,3,4,5 assigned respectively for positively worded perception statement and the reverse for negatively statements. Perception categories were obtained using the mean score to categorise into favourable (\geq mean) and unfavourable ($<$ mean) perception.

Knowledge of VCT for HIV/AIDS - Knowledge of the respondents was measured by obtaining their responses on a 10-point knowledge statements using dichotomous response of Yes or No. The correct statement attracted a score of 1 while incorrect response attracted a score of 0. The highest score was obtained as 10 while the lowest score was 0. The mean score was obtained and used to categorise the respondents' knowledge level (High or Low) based on the deviation from the mean. Respondents with scores below the mean were categorised as having low knowledge while those with mean's score and above were categorised as having high knowledge of VCT.

Constraints Associated with HIV/AIDS VCT - Thirteen factors were highlighted and marked as possible constraint to VCT. These factors were measured as Most severe =4, Severe =3, Not severe =2 and Not a constraints =1. The scores were computed

to obtain the mean and the mean was used to rank the constraints.

Method of data collection and analysis:

Primary data were collected from the respondents by means of a pre-tested questionnaire. Data obtained include personal characteristic indices, information sources, awareness of VCT (Voluntary counseling and testing), and knowledge of HIV test among respondent, the constraints to VCT and perception of respondents towards VCT.

The data collected were subjected to descriptive and regression analysis to ascertain youths perspectives towards VCT of HIV/AIDS programme. The regression equation is as follows. $Y = \beta_0 + \beta_1X_1 + \beta_2X_2 + \beta_3X_3 + \beta_4X_4 + \beta_5X_5 + \varepsilon$

Where Y is the dependent variable (Perception scores) β_0 is the intercept and $\beta_1, \beta_2, \beta_3, \beta_4$ and β_5 are the slope parameters of the model

X_1 = Awareness of VCT of HIV/AIDS (scores)

X_2 , = Sources of information on VCT of HIV/AIDS (score)

X_3 , = Knowledge of VCT of HIV/AIDS (score)

X_4 , = Constraints to VCT of HIV/AIDS

X_5 , = Age of respondents (years)

ε = error term.

RESULTS AND DISCUSSION

Personal characteristics of respondents

Table 1 revealed that majority (74.8%) of the respondents fall between the age brackets of 14-30 years. This implies that the respondents are in their sexual active stage of life and could be vulnerable to HIV/AIDS infection. Majority (52.8%) of the respondents were female and mostly single (64.2%). This makes the incidence of pre-marital sex possible and consequently predisposes them to HIV/AIDS infections. This finding is consistent with Mishra (2005) who opined that young people are highly vulnerable to HIV/AIDS. He asserted that in many countries, 60% of the new infections are among the age group of 15-24years and stressed that the highest rate of STD's are usually found among the youth of ages 20-24 who are predominantly single.

Table 1: Frequency distribution of respondents by personal characteristics n = 121

Variables	Frequency	Percentage
Age range in years		
14-20	34	27.6
21-30	58	47.2
31-40	29	25.2
Sex		
Male	58	47.2
Female	63	52.8
Marital status		
Single	79	64.2
Married	42	35.8

Variables	Frequency	Percentage
Occupation		
Student	55	44.7
Farming	4	3.3
Artisan	7	7.3
Technician	5	4.1
Apprentice	7	5.7
Teaching	9	7.3
Civil servant	3	2.4
Private business	29	23.6
Engineer	2	1.6
Religion		
Christianity	57	46.5
Islam	61	53.5
Traditional	2	1.6
Ethnic group		
Yoruba	98	81.0
Igbo	6	5.0
Hausa	8	6.6
Efik	9	7.4

Sources of Information

The results in Table 2 revealed that television (89.3%) and radio (83.5%) were the major sources of information on HIV/AIDS voluntary counselling and testing programme. Other prominent sources include friends (79.9%), print media (69.8%) and health workers (78.8%). The implication of this is that information on VCT promoted through television, radio, peers and health workers could facilitate behavioural change faster among youths in rural community. This corroborated the research findings conducted in Kenya where media and peers have been found to be an effective means of reaching young people on reproductive health issues (McCauley, 2004; Aarons & Jenkins, 2002 and Dennison et al., 2006).

Table 2: Sources of Information on VCT of HIV/AIDS n= 121

Source of Information	Yes Freq (%)	No Freq (%)
Television	92 (89.3)	11 (10.7)
Radio	76 (83.5)	15 (16.5)
Newspaper	44 (69.8)	19 (30.2)
Conference	24 (54.5)	20 (45.5)
Adults	30 (60.0)	20 (40.0)
Friends	51 (79.7)	13 (20.3)
Health workers	52 (78.8)	14 (21.2)

Awareness of VCT for HIV/AIDS

Result in Table 3 showed that majority (96.7%) of the respondents were aware of HIV/AIDS, 57.5% never had any HIV/AIDS test before, 58.7% were aware of VCT package while, 63.1% believed VCT was an option in HIV/AIDS programme. Majority

(71.3%) were willing to have VCT and 71.2% of the respondents submitted that there was no VCT centre around them.

Although, respondents were aware of VCT, the awareness was not adequate as indicated by majority (71.0%) of the respondents. Inadequate awareness may have negative influence on perspectives of the respondents towards the programme which may in turn affect their participation. Specific information packaging that will meet the need of the rural populace will enhance behavioural change among the youth.

Table 3: Awareness of VCT of HIV/AIDS n =121

Awareness	Freq	Percent
Aware about HIV	118	96.7
Had any form of HIV/AIDS test	51	42.5
Do you know that VCT is an option in HIV/AIDS program	71	58.7
Willing to have VCT	70	63.1
Do you know any VCT centre around	82	71.3
Is the process friendly	32	28.8
Is it very expensive	39	52.7
Do you think the present information on VCT is adequate	25	66.2

Table 4a: Knowledge of HIV/AIDS VCT

Knowledge	Correct %	incorrect %	Mean
1 It is one of the several packages in HIV/AIDS program	85.3	14.7	0.85
2 There is no difference between VCT and other forms	34.3	65.7	0.34
3 VCT is not confidential	46.8	53.2	0.47
4 There are more than 3 phases in VCT	52.5	47.5	0.53
5 There exist a pre and post counselling stage in VCT	81.4	18.6	0.81
6 VCT has other test follow up	49.3	50.7	0.49
7 VCT for HIV/AIDS is not free	44.9	51.0	0.45
8 VCT has plans for ongoing support after test	60.0	40.0	0.60

Table 4b: Knowledge of HIV/AIDS VCT

Knowledge Category	Knowledge score	Frequency	Percentage
Low	0-4	85	74.6
High	5-9	36	25.5

Constraints associated with HIV/AIDS VCT

The result in Table 5 revealed that fear of outcome of the VCT result, stigmatisation and beliefs were the most prominent constraints associated with HIV/AIDS voluntary counselling and testing. This implies that going for the test could expose their secret sexual behaviour and consequently HIV/AIDS

Is VCT a better option	31	29.0
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Knowledge of HIV/AIDS voluntary counselling and testing

The results in Tables 4a and 4b of the survey revealed that majority (74.6%) of the respondents have low knowledge about VCT. This low knowledge may negatively influence their perspectives about HIV/AIDS voluntary counselling and testing programme. Consequently, rural youth knowledge of HIV/AIDS voluntary counselling and testing will help to reduce the risk of acquiring or transmitting HIV, access HIV-specific treatment, care and support, manage one's health and plan for the future (WHO,2002). VCT is also vital for providing access to emotional support, improving skills to cope with HIV-related anxiety, and increasing motivation to avoid risky behaviours (UNAIDS, 2000). Furthermore, counselling and testing provide awareness of safer options in preventing vertical HIV transmission if pregnant women and their families use such services and learn about their sera status. For society, widespread knowledge of one's HIV status can lead to better community mobilization against the epidemic, and may reduce HIV-related stigma and discrimination (WHO, 2002) and support human rights (Baggaley, 2001).

status. This finding is consistent with Yahaya, Jimoh and Balogun (2010) in a study conducted among youth in Kwara state and found that factors affecting the rate of acceptance of HIV/AIDS messages are ignorance, fear of being positive, poverty, inadequate VCT centre and stigmatization.

Table 5: Constraints associated with HIV/AIDS VCT

Constraints	Most severe		Severe		Not severe		Not a constraint		Mean	Rank
	F	%	F	%	F	%	F	%		
Fear of outcome	42	36.8	28	24.6	18	15.8	26	22.8	2.75	12 th
Location and access to VCT centre has no privacy	44	39.6	25	22.5	23	20.7	19	17.1	2.85	10 th
Cost of VCT is expensive	53	58.7	18	20.0	8	8.9	11	12.2	3.26	1 st
Personnel problem/attitude of VCT staff is not friendly	45	50	14	15.6	20	22.1	11	12.2	3.03	6 th
Lack of personal confidence	46	41.4	31	27.9	11	9.9	23	18.7	2.90	8 th
Risk of losing popularity among peer groups	65	56.5	14	12.2	12	10.4	24	20.9	3.04	5 th
Stigmatization associated with HIV/AIDS	62	55.9	19	17.1	14	12.6	16	14.4	3.14	2 nd
Beliefs(Religious, cultural and personal)	66	60.6	8	7.3	15	13.8	20	18.3	3.10	3 rd
Awareness problem	48	43.2	17	15.3	24	21.6	22	19.8	2.82	11 th
Stigmatization and discrimination	51	47.7	15	14.0	20	18.7	21	19.6	2.90	8 th
Time involve in taking VCT	56	51.9	21	19.4	16	14.8	15	13.9	3.09	4 th
Complex process	51	53.1	12	12.5	12	17.7	16	16.7	3.02	7 th
Inadequate VCT facilities	39	41.5	15	16.0	16	17.0	24	25.5	2.73	13 th

Perception of HIV/AIDS VCT PROGRAMME

Result in Tables 6a and 6b perception categories showed that majority (56.7%) of the respondents had unfavourable perception towards HIV/AIDS voluntary counselling and testing programme. This might be as a result of inadequate awareness, low knowledge and severity of constraints associated with HIV/AIDS voluntary counselling and testing

programme. The implication is that, respondents may not be willing to participate in HIV/AIDS voluntary counselling and testing programme. The result agree with the findings of a study in Nigeria by Oshi *et al.* (2007) which established that those young people who profess low self-perception of risk, least went for HIV screening.

Table 6a: Distribution of respondents based on perception of HIV/AIDS voluntary counselling and testing programme

Perception statements	SD Freq (%)	D Freq (%)	U Freq (%)	A Freq (%)	SA Freq (%)	MEAN
1. It is just another option in the HIV/AIDS program to prevent infection.	57 (49.1)	38(32.8)	5(14.3)	2(1.7)	14(12.1)	1.85
2. VCT process could be an effort of wasting time and resources	11(9.6)	13(1.3)	18(15.7)	35(30.4)	38(33.0)	3.66
3. On the surface, VCT appears to be the best package for youth on HIV/AIDS.	54(48.2)	35(28.5)	16(14.3)	4(3.6)	3(2.7)	1.81
4. I am worried that many people are not using VCT even when it is the way out to prevent the HIV/AIDS scourge.	23(20.7)	48(43.2)	24(21.6)	10(9.0)	6(5.4)	2.35
5. VCT is a strong tool/mechanism for behavioural change process	22(28.2)	25(32.1)	18(23.1)	6(7.7)	7(9.0)	2.04
6. VCT does not have any presumed negative effect on the patient	43(39.1)	38(34.5)	17(15.5)	5(4.1)	7(16.4)	2.37
7. I would always want to have it but for the poor access within our neighbourhood	44(43.1)	23(22.5)	17(16.7)	11(10.8)	7(6.9)	2.16
8. I can recommend it to another person base on my experience.	37(37.8)	38(38.8)	13(13.3)	5(5.1)	5(5.1)	2.01
9. The current process of VCT requires a lot	31(37.3)	31(37.3)	11(13.3)	7(18.4)	3(3.6)	2.04

Perception statements	SD Freq (%)	D Freq (%)	U Freq (%)	A Freq (%)	SA Freq (%)	MEAN
of improvement in order to encourage more patronage.						
10. I would be willing to be an ambassador of VCT on campus if given the opportunity.	31(37.3)	20(24.1)	20(24.1)	6(7.2)	6(7.2)	2.23
11. To me, VCT is a very good program.	69(62.7)	23(20.9)	7(6.4)	5(4.5)	6(5.5)	1.69
12. Even with the numerous problem been faced by VCT, it is recommendable.	37(35.9)	47(45.6)	9(18.7)	7(6.8)	3(2.9)	1.95
13. VCT's advantage still outweighs its flaws in every respect.	16(14.3)	17(15.2)	12(10.7)	32(28.6)	35(31.3)	3.47
14. VCT could lead to sexual freedom, growth and improper sexual behaviour if promoted and not controlled among the youth.	23(21.1)	21(19.3)	12(11.0)	25(22.9)	28(25.7)	3.12
15. VCT is only meant for adult and married couple, while the young ones are to understudy their parents.	12(10.6)	22(19.3)	20(17.7)	30(26.5)	29(25.7)	3.37
16. Getting tested and for HIV/AIDS is what matters but not necessarily through VCT.	12(11.7)	35(34.0)	21(17.1)	25(24.3)	10(9.7)	2.86
17. HIV/AIDS and VCT still remain western culture.	11(9.9)	23(20.7)	15(13.5)	28(25.2)	34(30.6)	3.46
18. The disposition of VCT staff is the reason for success and failure of the programme.	31(28.7)	29(26.9)	14(13.0)	22(20.4)	12(11.1)	2.58
19. There is no need for counselling as it has no effect on youth sexual behaviour.	16(9.9)	23(6.7)	15(13.5)	34(30.8)	28(30.6)	3.15
20. Reason why people don't want to use VCT is because of the stigma associated with anyone who eventually found tested positive.	31(28.7)	29(26.9)	14(13.0)	22(20.4)	12(11.1)	2.58

Table 6b: Categorisation of respondents based on their perception

Perception	Frequency	Percent
Unfavourable	69	56.7
Favourable	52	43.3
Total	121	100

Min = 20.0; Max = 100.0; Total mean score = 47.65

Determinants of youth perspectives towards HIV/AIDS Voluntary Counselling and Testing

Result of regression analysis from Table 7 shows that knowledge (Beta = 0.26, p = 0.01) and constraints associated with HIV/AIDS voluntary counselling and testing programme (Beta = 0.30, p = 0.00) contributed significantly to rural youth perspective about the programme. The implication is that constraints and knowledge of HIV/AIDS voluntary counselling and testing were the major variables that determine rural youth perspective about the programme.

Table 7: Regression analysis showing determinants of youth's perception towards HIV/AIDS VCT Programme

Model	B	t-value	p-value
Constant		4.504	0.000
Awareness	0.004	0.039	0.969
Information sources	0.073	0.755	0.452
Knowledge	0.256	2.626	0.010*
Constraints	0.300	3.335	0.001*
Age	0.078	0.924	0.357

Dependent Variable: perception

Predictors: (Constant), awareness, information sources, knowledge, constraints and age

* Significant at 5% level of significance, F = 7.41, R² = 0.24, Multiple R = 0.49, Standard Error = 11.81

CONCLUSION AND RECOMMENDATIONS

This study has shown that respondents were aware of HIV/AIDS voluntary counselling and testing programme, radio and television were the prominent information sources, knowledge level of the respondents about HIV/AIDS voluntary counselling and testing programme was low, major constraints identified were fear of outcome of the VCT result, stigmatisation and beliefs and majority had unfavourable perception towards VCT. Regression analysis revealed that knowledge and constraints were the major determinant of rural youth perspective about the programme.

Knowledge based information on HIV/AIDS voluntary counselling and testing targeted toward youth should be promoted on radio and television. Health extension workers should be adequately trained in order to handle issues related to the psychological effect of fear of VCT result outcome, stigmatisation and beliefs among others.

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