

Factors contributing to voluntary counselling and testing uptake among youth in colleges of Harar, Ethiopia

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Abstract: Background: Voluntary counseling and testing (VCT) is an integral component of HIV prevention and care strategies worldwide. Methods: A cross sectional study design was used to collect data. The collected data were entered in Epi Info version 3.5.3. Data analyses were done using SPSS for windows version 16.0. Descriptive analysis was used to describe the data. Binary logistic regression analysis was used to measure the association between the dependent variable and independent variables calculating odds ratio and its 95% confidence interval (CI). Statistical significance was set at $\alpha \leq 0.05$. Multivariable analyses were applied to identify the relative effect of explanatory variables on the dependent variable. Result: The prevalence of HIV testing was 52.8%. The finding also showed that students who are sexually active (AOR=1.261, CI=1.134, 1.822), youth having a boy/girl friend (AOR=1.233, CI=1.211, 2.923), youth having sex with their partner (AOR=3.823, CI=1.891, 7.730), who are willing to pay for VCT (AOR=2.233, CI=1.633, 3.052), those who discuss HIV/AIDS with their family (AOR=1.504, CI=1.029, 2.199), colleague utilized VCT (AOR=1.775, CI= 1.269, 2.482), were more likely to be tested. Conclusions and Recommendations: The results indicated that there is still less number of students utilized VCT service: therefore there is a need of further information, education and communication program with regard to increase VCT service uptake, expanding youth targeted VCT service.

Keywords: VCT Uptake, HIV Testing, HIV Counseling, Youth, Ethiopia

1. Introduction

HIV/AIDS remains a global health problem of unprecedented dimensions. Young people (15-24) account for more than 50 percent of all new HIV infections worldwide. Youth have the highest prevalence rate about 5.6% [1]. Young people are especially vulnerable to HIV infection due to early sexual debut, emotional and developmental factors, low condom use, biological and social vulnerabilities, sexually transmitted infections, poor health-seeking behavior, and alcohol and substance abuse [2].

Sub-Saharan Africa remains the most affected region in the world with an estimate of 22.5 million people living with HIV. Approximately 1.7 million new infections occurred in sub-Saharan Africa in the year 2007 [1]. Ten million young people aged 15–24 years and almost 3 million children under 15 years are living with HIV [1].

Studies among African youth have shown that even when

youth are aware of HIV/AIDS and of the existing VCT sites, and even when a majority of the youth have a strong interest in knowing their HIV status, only a few go for the actual HIV testing. The reasons established for not going for testing are mostly age, education, sex, inaccurate risk perception [3-6]; fear, stigma and discrimination [7-11].

VCT uptake among youth in Ethiopia is also low [12, 13]. Examining and understanding factors contributing to VCT uptake is a vital and timely activity to facilitate HIV prevention and control effort, these factors are expected to differ among youth. There are few studies conducted on this issue among college students and youth [14, 19, 20, 21, 22]. Not only are the studies conducted inadequate, but also they are not wide-ranging. In Harar town youth there is lack of information regarding the most important contributing factors to VCT uptake. It is, therefore, crucial to have data on the most important contributing factors to VCT uptake among youth.

2. Materials and Methods

Study Area and Period: The study was conducted in Harar town. Based on the data from the Regional Education and Health Bureau, currently in Harar town there are three government and five private colleges providing education on a regular basis and during the study period, January to February, 2010.

Study Design: A descriptive cross-sectional study was used in this study.

Source Population: All college youth students of Harar town enrolled in the academic year of 2009/10.

Study Population: All day time youth students in the colleges of Harar town enrolled in the academic year of 2009/2010 in the selected departments.

Sample size: The sample size was determined by using single population proportion formula with the following assumptions: 39.7% prevalence (p) of VCT uptake, a study conducted in AAU undergraduate students in 2008 [21] 5% marginal error (d) and 95% confidence interval of certainty ($\alpha=0.05$) By adding 10% non response rate the sample was 405 and by considering the design effect 2 the total sample size will be 810.

Sampling Technique: To get a representative sample population for the survey, a multi-stage sampling technique was employed in order to select the study units and probability proportionate to sample size (PPS) were used to determine the sample proportion. Since the colleges have more than one department, two departments were selected randomly from each of the colleges. After identifying the specific departments, list of students' names in the respective departments were taken from the registrar and assigned accordingly.

2.1. Study Variables

The dependant variable of the study was VCT service uptake. *Independent variables* included Socio-demographic variables, (age, sex, religion, ethnicity, place of previous residence, pocket money, marital status, department, performance of religious activity, and year of study). Sexual behaviors, HIV risk perception, Knowledge and attitude towards HIV/AIDS and VCT.

Data Collection: A total of 810 students were included in the study. The students were selected proportionally considering all departments and both sexes in a random way. A structured self administered questionnaire adopted from a standard questionnaire of BSS [12] and from existing survey was developed to be filled by the students. The questionnaire prepared in English translated in Amharic and Afan Oromo. The Amharic and Afan Oromo version translated to English again to see its consistency with the original. The questionnaire was pre-tested among Dire Dawa TVET College.

Data Quality Assurance: Properly designed and pre-tested questionnaire was used. Interviewers/ facilitators and

data clerks were trained and closely supervised during data collection and entry; and double data entry was used to ensure data quality.

Data Analysis: The data were entered into a pre-drafted coding sheet on Epi info software, version 3.5.3 by two different data clerks. Binary logistic analysis with conditional method calculating odds ratios (OR) and 95% confidence intervals (CI) was used to estimate the association between the dependent variable and independent variables. Statistical significance was set at $\alpha \leq 0.05$. In an attempt to identify the relative effects of explanatory variables on the outcome variable, multivariable analyses was applied. Explanatory variables with P-value < 0.2 were entered into the final regression model based on the likelihood ratio for further analyses to identify factors that predict the service uptake.

2.2. Ethical Approval

The ethical approval and clearance for this research study was obtained from Haramaya University College of Health Sciences Institutional Research Ethics Review Committee. At all levels, officials were contacted and permission from administrators was secured. All the necessary explanation about the purpose of the study and its procedures was explained with the assurance of confidentiality. Both written and verbal consent from the

Table 1. Demographic and socio-economic characteristics of youth in colleges of Harar town, 2010

Demographic and Socio-Economic Characteristics	Number	Percent
Sex		
Male	455	57.7
Female	333	42.3
Age		
15-19	388	49.2
20-24	400	50.8
Ethnicity		
Oromo	480	60.9
Amhara	210	26.6
Harari	39	4.9
Gurage	25	3.2
Somali	18	2.3
Others	16	2.1
Marital status		
Single	742	94.2
Married	46	5.8
Religion		
Muslim	469	59.5
Orthodox	255	32.4
Protestant	49	6.2
Others	15	1.9
Performance of Religious activities		
Every day	538	68.9
Every week	164	20.9
Sometimes as I find it convenient	31	3.9
Not at all	55	6.3
Place of previous residence		
Rural	277	35.2
Urban	511	64.8

study participants was also secured.

3. Results

3.1. Socio-Demographic Characteristics

A total of 788(97.3%) college students were included in the study of whom 455(57.7%) were males and the remaining 333(42.3%) were females giving a sex ratio of 1.36:1. Among the students 292(37%) of them were learning in health science departments. There were 335(42.5%) first year, 251(31.9%) second year and 202(25.6%) third year students.

About 80% (628) of the students were in the age group 15-19., with the mean age of 19.5 and SD ± 1.51 . Oromo ethnic group comprised of 479(60.8%). Most of the study participants were single 739(93.8%). There were 469(59.5%) Muslims. About 543(68.9%) of them attend religious services every day. Regarding income (pocket money) about 280(35.5%) got less than 200 birr. Most of the respondents 510(64.7%) were in urban and about

345(43.8%) were living with their parents (Table 1).

3.2. VCT Uptake

Among students participated 416(52.8%) of them have been tested for HIV. The main reasons given by the respondents for being tested for HIV were, the majority 374(89.9%) of them utilized the service to know self, 16(3.8%) to engage in marriage. Frequency of religious service use was significantly associated with VCT utilization. Those students who use the religious service everyday were 0.627 times less likely to utilize VCT compared with others (AOR=0.627, CI=0.377, 0.865). About 53% of students in health science departments utilized VCT compared to 44% of students in other departments. With regard to year of study 56% of first year, 46.6% of second year and 54.9% of third year students utilized VCT. Rural residents were 0.695 times less likely to utilize VCT service as compared to urban residents (AOR=0.695, CI=0.489, 0.989) (Table 2).

Table 2. VCT utilization versus socio-demographic variables of youth in colleges of Harar town, 2010

Demographic and socio-economic characteristic	VCT uptake		OR(95%CI) Crude	Adjusted
	Yes	No		
Sex: Male	225(49.5)	230(50.5)	0.727(0.547,0.967)*	0.904(0.651,1.256)
Female	191(57.4)	142(42.6)	1	1
Age: 15-19	196(50.5)	192(49.5)	0.835(0.631,1.105)	0.759(0.563,1.024)
20-24	220(55.0)	180(45.0)	1	1
Performance of Religious activities				
Every day	265(49.3)	273(50.7)	0.512(0.287,0.916)**	0.627(0.377,0.865)*
Every week	98(59.8)	66(40.2)	0.784(0.414,1.482)	1.175(0.539,2.562)
Sometimes as I find it convenient	17(54.8)	14(45.2)	0.641(0.261,1.576)	0.583(0.290,1.170)
Not at all	36(65.5)	19(34.5)	1	1
Presently live				
Alone	59(56.2)	46(43.8)	1.557(0.923,2.628)	1.416(0.898,2.234)
With father and mother	172(49.9)	173(50.1)	1.207(0.800,1.823)	0.361(0.096,1.363)
With father alone	14(82.4)	3(17.6)	4.712 (1.550,5.667)**	1.150(0.522,2.061)
With mother alone	57(58.2)	41(41.8)	1.688(0.989,2.882)	1.045(0.547,1.996)
With brother and sister	38(58.5)	27(41.5)	1.709(0.931,3.136)	0.958(0.330,2.787)
With husband or wife	27(60.6)	19(39.4)	1.868(0.854,4.086)	1.387(0.806,2.387)
Others	56(45.2)	68(54.8)	1	1
Place of previous residence				
Rural	120(43.3)	157(56.7)	0.555(0.413,0.746)***	0.695(0.489,0.989)*
Urban	296(57.9)	215(42.1)	1	1

Table 3. Sexual Practice and risk perception of HIV/AIDS versus utilization of VCT among youth in colleges of Harar town, 2010.

Variables	VCT uptake		OR(95%CI) Crude	Adjusted
	Yes	No		
Ever had sexual intercourse				
Yes	186(62.2)	113(37.8)	1.854(1.382,2.486)***	1.261(1.134,1.822)*
No	230(47.0)	259(53.0)	1	1
Have Boy/Girl friend				
Yes	247(59.4)	169(40.6)	1.756(1.323,2.329)***	1.233(1.211,2.923)*
No	169(45.4)	203(54.6)	1	1
Have had sex with Boy/Girl friend				
Yes	129(70.9)	53(29.1)	2.393(1.588,3.605)***	3.823(1.891,7.730)***
No	118(50.4)	116(49.6)	1	1

About 772(98%) of the students responded as if having low risk perception of contracting HIV/AIDS. Youth who ever had sexual intercourse were more likely to be tested

than those who had not had sexual intercourse (AOR=1.261, CI=1.134, 1.822). Regarding having a boy/girl friend, those youth who had a boy/girl friend were more likely to have

utilized VCT service than those who do not have (AOR=1.233, CI=1.211, 2.923). Having sex with a boy/girl friend showed statistically a significant association with VCT utilization. The likelihood of VCT utilization among those who had sex with a boy/girl friend was about 3 times higher than those who did not have (AOR=3.823, CI=1.891, 7.730) (Table 3).

3.3. Knowledge and Attitude towards VCT among Youth

All students have heard about VCT service. Students had multiple responses with regard to source of information about VCT. About 450(57.1%) heard it from mass media. The most common benefit of VCT mentioned was to know HIV sero-status 713(90.1%). About 53.5% of the respondents have favorable attitude towards VCT. The majority 763(96.8%) of the students were willing to take HIV test whether they have or not in the past. About 91.1% of youth have information that the service given by the institutions was good. Among those who had no desire for VCT, 60% mentioned uncomfortable time of service delivery. Regarding the preference of VCT service delivery institutions, 282(35.8%) of them choose FGAE centers. Of

these 399(50.6%) of them preferred health personnel, 164(20.8) preferred peer counselors for getting counseling service. The majority of the students 465(59%) prefer to receive HIV test result face to face. About 643(81.6%) wanted to receive their test result on the same day. Students were asked the convenient time for VCT service delivery. A total of 388(51%) students responded at weekends.

Students who are willing to pay for the VCT service were two times more likely to utilize VCT than those not willing (AOR=2.233, CI=1.633, 3.052). Youth who knew a person living with HIV/AIDS were more likely to be tested than those who do not know (AOR=1.758, CI=1.226, 2.520). Students who have colleagues who utilized VCT service were more likely to be tested than those who did not have (AOR=1.775, CI= 1.269, 2.482). Youth who had promoted VCT services for others were two times more likely to utilize VCT service (AOR=2.636, CI=1.723, 4.034). The likelihood of VCT utilization among those who have discussed about HIV/AIDS with their family were more likely than those who did not discuss (AOR=1.504, CI=1.029, 2.199) (Table 4).

Table 4. VCT utilization versus selected variables among youth in colleges of Harar town, 2010

Variables	VCT uptake		OR(95%CI)	Adjusted
	Yes	No	Crude	
Willing to pay for VCT service				
Yes	281(65.0)	151(35.0)	3.046(2.276,4.077)***	2.233(1.633,3.052)***
No	135(37.9)	221(62.1)	1	1
Know person living with HIV/AIDS				
Yes	331(60.8)	213(39.2)	2.907(2.122,3.982)***	1.758(1.226,2.520)**
No	85(34.8)	159(65.2)	1	1
Have colleagues utilized VCT				
Yes	279(65.2)	149(34.8)	3.048(2.278,4.087)***	1.775(1.269,2.482)**
No	137(38.1)	223(61.9)	1	1
Have promoted VCT for others				
Yes	374(59.7)	252(40.3)	4.240(2.882,6.238)***	2.636(1.723,4.034)***
No	42(25.9)	120(74.1)	1	1
Discussed with family on HIV				
Yes	344(58.3)	246(41.7)	2.447(1.755,3.413)***	1.504(1.029,2.199)*
No	72(36.4)	126(63.6)	1	1

In this study the barriers of VCT uptake, which includes: worries about confidentiality 654(82.9%) and fears that results would be shared with parents or partners without their consent 534(67.8%), inaccurate risk perception 772 (98.0%), fear of being labeled and stigmatized 708(89.8%) by their families and communities expressed as the major reason

4. Discussions

This study tried to look into some of the important factors that contribute for VCT uptake among youth in colleges. In this study four hundred sixteen (52.8%) youth had utilized VCT service before and this figure is considerably higher when compared with DHS 2005, the

report in Ethiopia which was only 14% of youth had utilized the service [13]. However, this may also be under estimation of the true effect since the study participants have higher education status and may also not reflect or representative of youth in Ethiopia. The figure is also considerably higher when we compare with Nigerian youth in which only around 7.1% have utilized the service [14], despite the fact that it has been found to be an effective means of reducing the HIV/AIDS burden. This might be due to educational status of study participants, improvement in VCT service currently compared to past in terms of number, accessibility and awareness creation and also VCT campaign.

All students reported that they have heard of VCT. The major source of information mentioned in this study is

mass media (57.3%) which is consistent with other studies in which it was mentioned that mass media is the major source of information [15, 16,17,18].This shows a need to reconsider the use of the mass media (TV, Radio, news papers, magazines) as a means of reaching youth with information that is related to VCT. This study showed the age group of 20-24 to utilize services more than the 15-19 age groups. These might be older youth have more sexual experience and risk exposure than younger ones. This finding is consistent with the findings in other studies [4, 5, 19]. However study done in Gondar and Harar showed that highest VCT acceptance was observed among those study subjects aged 15 to 19 years [3, 15].

There was difference in VCT uptake between female and male youth in this study, where less number of males utilized VCT when compared with female. This result was consistent with similar other studies, [3, 7, 20, 21] in which females were more frequently tested than males. But it is in contradiction with one previous study [11]. Youth who were from urban areas before they join the colleges have utilized VCT service more than rural [7, 10]. This might be youth in urban have had better access to utilize VCT since the centers are available in urban areas. But this finding is not consistent with an unpublished study done among Addis Ababa undergraduate students in which the odds of HIV testing among rural is more compared urban [20].

Sexually active youth were more likely to be tested than not sexually active ones in this study. This may be due to self perceived risk of HIV infection. This may be linked with that the commonest route for transmitting HIV in this environment is through sexual intercourse thus respondents who had never had sex perceived themselves as being at low risk of infection hence may not bother to take HIV test than sexually active youth. The finding is also supported by other studies, [4, 7, 16,22]. A significant association has also existed between having a boy/girlfriend and HIV testing. A relatively higher proportion of respondents who have a boy/girlfriend had tested for HIV than those respondents who do not have. This might be boy/girl friend youths who begin long lasting relationship first could take an HIV test at VCT center, this was a practice that encourage in decreasing the HIV/AIDS spread. There is statistical difference between tested and untested youth regarding recommending of VCT service for others, tested youth recommend VCT more than untested youth. In addition those youth who have colleagues utilized the service were tested than those who do not have.

In this study the following factors were recognized as barriers of VCT uptake, which includes: worries about confidentiality and fears that results would be shared with parents or partners without their consent, inaccurate risk perception, fear of being labeled and stigmatized by their families and communities expressed as the major reason. This is also supported by other previous studies [7, 8, and 9].

In conclusion, the study revealed that all respondents

have heard about HIV and VCT. The major sources of information were mass media and health workers. Most of the youth have desire to be tested in the future. It can be said that the level of knowledge about HIV/AIDS seems to be high among study subjects. A considerable amount of respondents had favorable attitude towards VCT. The total prevalence of uptake of VCT by youth students in different colleges is at 52.8%. According to this study the following factors were associated with increased uptake of VCT: those ever had sex, had boy/girl friend, had sex with partner, willing to pay for VCT service, know person living with HIV/AIDS, have colleague utilized VCT, have promoted VCT for others, discussed with family on HIV/AIDS. According to this study the following factors were recognized as barriers of VCT uptake, which includes: worries about confidentiality and fears that results would be shared with parents or partners without their consent, inaccurate risk perception, fear of being labeled and stigmatized by their families and communities expressed as the major reason.

We recommend that there is a need of promotion of VCT through sound and viable information and counseling interventions by involving mass media, colleges, mass organizations and parents. Health institutions found in Harar town should have to provide voluntary HIV counseling and testing services during extra working days and hours. Youth friendly VCT services have to be expanded and the existing facilities need to be strengthened to address the need of youth in the town.

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Authors' Contributions

AD conceived of and designed the study, supervised data collection, analyzed the data, drafted the paper and approved the final version. BM and HK contributed to the conception, designing, data analysis, drafting and approval of the manuscript. WG participated in interpretation of findings, contributed to the drafting of the paper, revising the manuscript critically for intellectual content and updated the manuscript. All authors read and approved the manuscript.

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