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AWARENESS AND UTILIZATION OF VOLUNTARY COUNSELLING AND TESTING FOR HIV/AIDS AMONG SENIOR SECONDARY STUDENTS IN ONITSHA NORTH LOCAL GOVERNMENT AREA OF ANAMBRA STATE

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ABSTRACT

The purpose of the study was to assess the level of awareness and utilization of voluntary counseling and testing for HIV/AIDS among senior secondary school students in Onitsha North L.G.A. of Anambra State. Three objectives and two hypotheses guided the study. The study adopted a descriptive design. A sample of 384 students determined using Taro Yamane were used for the study. A multistage sampling technique was also employed. A pre-tested researcher developed questionnaire consisting of 16 items was used for data collection. The questionnaire was divided into four sections (A, B, C and D). Section A elicited information on the personal data of the respondents and has four items, section B has seven items and elicited information on level of awareness towards voluntary counseling and testing, section C with three items elicited information on utilization of VCT while section D has two questions to determine the barriers to utilization of VCT. Data were analyzed using frequencies and percentages and were presented in tables and T-test was used to test the hypotheses. The result showed that Almost half (49,47%) of the respondents have heard about voluntary HIV counseling and testing with more females (68.09%) having heard of VCT for HIV/AIDS than males (31.91%). There was poor utilization of VCT as only 93(24.47%) of the respondents have ever tested for HIV before. A good number 59(20.56%) of the respondents identified fear of positive result as a barrier to their utilization of VCT. There was a significant difference in the mean ratings of male and that of the females towards awareness of VHCT with that of the

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females higher (79.50+28.47) and that of the males (39.17+10.93). There was a significant difference in the ratings of male and female senior secondary students as regards their utilization of VCT for HIV/AIDS and findings showed that females (25.00 ± 2.56) utilized VCT for HIV/AIDS more than the males (19.33 ± 20.20). Based on the findings, it was recommended that an appropriate model of VCT services that is client-initiated and youth-friendly be put in place and educational institutions should adopt testing for HIV as part of admission requirement.

Keywords: Awareness; Utilization; Voluntary Counselling; Testing; HIV/AIDS; Secondary Schools

Introduction

Globally, the number of adolescents and young people is at an all time high (United Nations, 2012). In 2012, the world had 1.6 billion persons aged 12-24, of which 721 million were adolescents aged 12-17 and 850 million were youths aged 18-24 (United Nations, 2012). More than 90 percent of this adolescent population lives in developing countries (Global Health Initiative, 2012). It is estimated that by the year 2025, adolescent population in the world would have doubled (United Nations, 2012). This unprecedented increase in adolescent population poses an enormous social and economic challenge. These boys and girls face multiple sexual and reproductive health risks such as unintended pregnancy, unsafe abortion and sexually transmitted infections (STIs) including human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS). HIV/AIDS is a dangerous virus which destroys the body immunity. It leads to a progressive loss of a specific type of immune cell called T-helper or CD4 cells. As the virus grows in the body, it damages or kills the cells and weakens the immune system leaving the infected person vulnerable to various opportunistic infections and other illnesses (Yahaya, Jimoh & Balogun,2010).

According to the Joint United Nations Programme on HIV and AIDS (UNAIDS) (2011), nearly 12 million young people in the world (15-24 years of age) are living with HIV and AIDS; and more than 7000 young people become infected with HIV every day. Approximately, 35 million people are currently living with HIV globally with

sub-Saharan Africa accounting for about 70% of all new HIV cases reported in 2012 (Joint United Nations Programme on HIV and AIDS, 2013). Similarly, there is an increasing trend of HIV/AIDS prevalence in Nigeria with about 3.4 million people living with HIV/AIDS. The prevalence among young people aged 20-40 years is 3.2% with about 80% of HIV/AIDS cases in Nigeria contracted through sexual intercourse (Joint United Nations Programme on HIV and AIDS (USAID), 2013). Acquired immunodeficiency syndrome (AIDS) caused by the human immunodeficiency virus (HIV) is a major health problem in many parts of the world, and is considered as a pandemic disease (Kallings, 2008). World Health Organisation (WHO) (2011) estimated 34 million people living with HIV and an estimated 1.8 million deaths around the world. Sub-Saharan Africa remains the region most heavily affected by HIV. In 2010, about 68% of all people living with HIV resided in Sub-Saharan Africa. Sub-Saharan Africa also accounted for 70% of new HIV infections and almost half of the deaths from AIDS related illness in 2010 (WHO, 2013). Almost a quarter of people living with HIV are under the age of 25. Young people ages 15-24 represent 45% of all new HIV infections. In Sub-Saharan Africa, nearly 3.3 million youths are living with HIV. Lack of information, skills, and access to services for youths is expected to fuel the epidemic (Joint United Nations Programme on HIV and AIDS, 2013).

The majority of adolescents may be at risk of HIV infection due to their engagement in unsafe sex. Young people are also at risk for human immunodeficiency virus syndrome infection from unsafe injection, drug use, exposure to contaminated blood product or unsterilized skin-piercing procedures. In Africa alone, an estimated 1.7 million young people are infected annually. Adolescents are particularly vulnerable to HIV because of the strong influence of peer pressure and the development of their sexual and social identities, which often lead to experimentation. As they are initiating sexual behaviour, counselling for safe practice is vital. Adolescents should be counselled to delay their sexual debut and practice abstinence (Gatta & Tshweneagae, 2012).



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Voluntary HIV/AIDS counselling and testing (VHCT) provides an avenue for education and promotion of behaviour change, resulting in a reduction in risk behaviours (Musheke, 2013). Novel approaches to VHCT such as routine VHCT, home-based VHCT, provider-initiated VHCT, client-initiated VHCT, use of community-based lay counselling, and couples counselling and testing have been added to the traditional facility-based VHCT delivery systems (Chimoyi, Tshuma, Muloongo, Setswe, Sarfo & Nyasulu, 2015). HIV counselling and testing consists of a minimum of pre- and post-test HIV counselling and testing and is a key strategic entry point to prevention, treatment, care and support services. Most studies in Africa show that knowledge of HIV test results promotes behaviour change and reduces transmission. According to Akodu (2014), the benefits of early detection of the virus have also increased because the most effective treatment results occur in the earliest stage of HIV infection. It is evident that sexual activity and engagement in high-risk behaviours, which favour the spread of HIV infection, are on the increase among youths. A concern is that not all individuals who may be at risk for HIV infection chose to be tested. (Akodu, 2014) reports that only 36% of individuals who were classified as having high-risk behaviour had been tested for HIV.

Research conducted in both developing and developed countries has identified social and economic barriers as well as health system factors as impediments to accessing voluntary counselling and testing services (Mall, Middelkoop, Mark, Wood & Bekker, 2013). Several possible contributing factors known to influence uptake of voluntary counselling and testing are socio-demographic characteristics, nearness to a health facility, HIV-related awareness and' knowledge, perception of being at risk of HIV infection, perceived benefits of VHCT, and psychosocial factors such as HIV/AIDS-related stigma and discrimination and anxieties about confidentiality, fear that result might be positive (Nwachimereze, 2013). AIDS-related stigma and discrimination, factors that influence decisions surrounding the uptake of voluntary counselling and testing and HIV treatment services have profound effects on an individual by reducing his or her willingness to engage in not only HIV testing but also treatment and prevention

that would improve such an individual's quality of life (Florom-Smith & DeSantis, 2012).

VCT is the process by which an individual undergoes counselling enabling him or her to make an informed choice about being tested for HIV. This decision must be entirely the choice of the individual and he or she must be assured that the process will be confidential. VCT is an effective strategy for facilitating behavioral change around both preventing HIV as well as getting early access to care and support. It is also instrumental in bringing about behavioral change, reducing unprotected sex and helping reduce the incidence of HIV and other STIs. However, the availability of VCT services in Ethiopia has been uneven, and even when available, uptake has been relatively low. Studies in different areas indicated that knowledge, attitude and practice of tertiary school students towards VCT is low and its uptake is minimal. The low uptake was found to be associated with ignorance, fear of being positive, cost of VCT, inadequate number of VCT centers and stigmatization constituted major hindrances to acceptances of VCT for HIV (Uzochukwu, Uguru, Ezeoke, Onwujekwe & Sibeudu, 2011).

Sex and gender are both important determinants of health. Sex and gender interact to produce differential risks and vulnerability to ill health and differences in health seeking behaviour and health outcomes for women and men. Gender refers to the socially constructed characteristics of women and men such as norms, roles and relationships of and between groups of women and men. While most people are born either male or female, they are taught appropriate norms and behaviours - including how they should interact with others of the same or opposite sex within households, communities and work places. When individuals or groups do not "fit" established gender norms they often face stigma, discriminatory practices or social exclusion all of which adversely affect health. Gender norms, roles and relations influence people's susceptibility to different health conditions and diseases and affect their enjoyment of good mental, physical health and wellbeing. They also have a bearing on people's access to and uptake of health services and on the health outcomes they experience throughout the life-course (WHO, 2019).

According to the fact sheet of the United Nations Special Session on Gender and HIV, gender roles play into the course of HIV/AIDS epidemic and drive the pattern of vulnerability among men, women, boys and girls, as well as the kinds of responses observed in different communities and societies. In sub-Saharan Africa, the burden of HIV is disproportionately tilted towards women, and this has been attributed to societal and biological vulnerabilities (Onu, Towolawi, Oluwasina, Obioma, Nwakanma & Ogbang, 2016). A survey conducted in Nigeria, which assessed the HIV-related stigma among two main ethnic groups, revealed that female participants were less likely to utilize voluntary HIV/AIDS counselling and testing for fear of stigmatization from partners (Odimegwu, Adedini & Ononokpono, 2013). A cluster randomized controlled trial conducted in urban and rural South Africa suggested a link between HIV testing and stigma in which low levels of stigma increased the uptake of HIVtesting (Mitchell. Cockcroft, Lamothe & Andersson, 2010). Since these studies have shown a strong association between stigma and testing for HIV, HIV infections can be reduced by identifying and controlling factors which play critical roles in this association.

Preventing HIV amongst adolescents is particularly critical in Sub Saharan Africa (SSA), where in many countries adolescents comprise more than 30% of the population and general HIV prevalence rates often exceed 10% (Gatta & Tshweneagae, 2012). Studies done both in developed (Hall, Ruiguang, Rhodes *el al.* 2008) and developing countries (Thupayagale - Tshweneagae 2010; Nwachimereze, 2014) recognize adolescent friendly services such as voluntary HIV counselling and testing (VHCT) as the best modem of educating adolescents about HIV and AIDS related risks. Many studies have been conducted in Nigeria on HIV/AIDS and voluntary counselling and testing though mostly on adults and university students (Akodu, 2014; Eze, 2014; Nwachimereze, 2014) but not much have been done among senior secondary school students and it is the intention of the researcher to fill this gap. It is based on the foregoing that this study on awareness and utilization of voluntary HIV counselling and testing among senior secondary students in Onitsha

North Local Government Area was carried out.

Statement of the Problem

Adolescents face early sexual debut, unprotected sex, sex with multiple sexual partners, high frequency of sex, age differences in relationship, peer pressure and need to belong, which often predisposes them to the risk of HIV infection. In parts of the world most severely affected by HIV/AIDS especially in Nigeria, fewer than 1 in 10 people with HIV/AIDS know they are infected. Furthermore, many HIV infected adolescents remain unaware of their status and do not seek health care. This, by implication, signifies an under utilization of VCT services. It is therefore imperative that efforts be made to step up VCT so as to maximize opportunities to reach those with HIV infection or at high risk. One way of achieving this is by finding out peoples' knowledge, utilization and barriers to utilization of VCT.

Many studies have been conducted in Nigeria on HIV/AIDS and voluntary counselling and testing though mostly on adults and university students (Akodu, 2014; Eze, 2014; Nwachimereze, 2014; Onu et al 2016) but not much have been done among senior secondary school students and it is the intention of the researcher to investigate the situation among secondary school students. It is based on the forgoing that this study was done to assess the awareness and utilization of voluntary counselling and testing for HIV/AIDS among senior secondary students in Onitsha North Local Government Area of Anambra State with the view to improving the delivery and utilization of VCT services among this group and the larger society.

Research Questions

- To what extent are senior secondary school students in Onitsha North L.G.A. aware of voluntary counselling and testing for HIV/AIDS (VHCT)?
- To what extent do secondary school students in Onitsha North L.G.A. utilize voluntary counselling and testing for HIV/AIDS (VHCT) services?
- What barriers prevent/hinder utilization of voluntary counselling and testing for HIV/AIDS (VHCT) services among secondary school students in Onitsha North L.G.A.?

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Hypotheses

The following null hypotheses were formulated for the study.

- **H_{O1}**: There is no significant difference between the mean ratings of male and female senior secondary students towards the awareness of voluntary counselling and testing for HIV/AIDS among senior secondary school students in Onitsha North L.G.A.
- **H_{O2}**:There is no significant difference between the ratings of male and female senior secondary students in Onitsha North L.G.A. as regards their utilization of voluntary counseling and testing for HIV/AIDS.

Research Method

Descriptive survey research design was adopted for the study. The study was carried out in Onitsha North Local Government Area of Anambra State. The population of the study comprised 9718 (Nine thousand, seven hundred and eighteen) senior secondary school students in Onitsha North Local Government Area. The sample size for the study comprised 384 (Three hundred and eighty-four) senior secondary school students drawn from the population of the study. The multi-stage sampling technique was used to draw the sample size. A 16-item self-structured questionnaire titled "Questionnaire on Awareness and utilization of voluntary counselling and testing (QAUVOCT) was used to collect data. The questionnaire was divided into four sections. Section "A" sought information on bio-data with four items, section "B" had seven items that elicited information on awareness to voluntary counselling and testing (VCT) for HIV/AIDS, section "C" contained three question to determine the utilization of VCT for HIV/AIDS, while section "D" with two items obtained information on barriers to utilization of VCT for HIV/AIDS.

The instrument was validated by two experts from the Department of Educational Foundations, Chukwuemeka Odumegwu Ojukwu University, Igbariam.

Cronbach Alpha statistics was used to determine the reliability of the instrument by administering copies to 38 students from Oyi Local Government Area of Anambra State. After analyzing the responses, a co-efficient of 0.85 was

obtained and considered adequate for the study. Instrument was administered to the respondents through the help of two research assistants, out of the 384 copies distributed 280 were retrieved and used for the study. Descriptive statistics was done to show the response frequency and percentages and same was presented in tables. T-test was to test the magnitude and significance of relationship of gender to awareness and compliance to VCT for HIV/AIDS at 0.05 level of significance.

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Data Analysis

Table 1: ***Gender distribution***

Gender	Frequency	Percentage
Male	154	40.53%
Female	226	59.47%
Total	**380**	**100%**

The above table shows that 40.53% are males and 59.47% are females.

Table 2: ***Class distribution***

Class level	Male	Female	Frequency	Percentage
SS 1	40	60	100	26.32%
SS 2	50	80	130	34.21%
SS3	64	86	150	39.47%
Total	**154**	**226**	**380**	**100%**

Table 2 shows that 26.32% of the respondents are in SS 1, while 34.21% and 39.47% are in SS 2 and SS 3 respectively.

Table ***3: Age distribution***

Age range	Male	Female	Frequency	Percentage
12-14 years	49	76	125	32.89%
15-17 years	63	92	155	40.79%
18 years and above	42	58	100	26.32%
Total	**154**	**226**	**380**	**100%**

Table 3 shows that 32.89% are within the ages of 12-14 years, while 40.79% are within 15-17 years and 26.32% are 18 years and above.

Table 4: Religion

Religion	Male	Female	Frequency	Percentage
Christianity	135	213	348	91.58%
Islam	17	13	30	7.89%
Traditionalist	2	0	2	0.53%
Total	**154**	**226**	**380**	**100%**

From the above, 91.58% of the respondents are Christians while 7. 89% and 0.53% are Islam and traditionalists respectively.

Research Question 1: To what extent are senior secondary school students in Onitsha North* L.GA *aware of voluntary counselling and testing for HIV/AIDS (VHCT) ?

Item 5-11 answered the research question.

Item 5: Have you heard about voluntary HIV counseling and testing (VCT) before today?

Tab***le 5; showing response to having heard of voluntary HIV counselling and testing before***

Option	Response		Frequency	Percentage
		Male	**Female**	
Yes	60	128	188	49.47%
No	94	98	192	50.53%
Total	**154**	**226**	**380**	**100%**

The above table shows that 49.47% has heard of VCT for HIV **while** 50.53% has not.

Item 6: if yes, through which medium?

Table 6: Showing medium through which** they **heard of VCT for HIV

Option	**Response**		**Frequency**	**Percentage**
	Male		**Female**	
Electronic mass media	4	20	24	12.77%
Friends	10	17	27	14.36%
School	7	15	22	11. 70%-
Health worker	5	26	31	16.49%
Church/Mosque	5	8	13	6.91%
Internet	29	42	71	37.77%
Total	**60**	**128**	**188**	**100%**

Table 6 above shows that 12.77% of the respondents heard about VCT for HIV from electronic 36% from friends, 11.70% from the school, 16.49% from health workers, with 6.91% from the church /mosque and internet respectively.

Item 7: VCT involves individuals being tested on their own will?

Table 7: showing response to if VCT involves testing individuals at

Option	Response		Frequency	Percentage
	Male		**Female**	**-**
Yes	31	48	79	42.02%
No	15	57	72	38.30%
Don't know	14	23	37	19.68%
	60	128	188	100%

Table 7 above shows that 42.02% of the respondents affirmed that VCT involves testing at will, 38.30% answered no while 19.68% had no idea.

Table 8: VCT is important to prevent HIV?

Table 8: sho*wing response to if VCT is important to prevent HIV*

Response			Frequency	Percentage
Option	**Male**	**Female**		
Yes	39	67	106	56.38%
No	15	42	57	30.32%
Don't know	6	19	25	13.30%
	60	**128**	**188**	**100%**

From the above table, 56.38% viewed VCT as important in preventing HIV, 30.32% did not and had no idea.

Item 9: VCT process involves pre-testing counseling, testing and post-test counseling?

Table 9: showing response to the processes involved in VCT

Option	Response		Frequency	Percentage
	Male	**Female**		
Yes	31	62	93	49.47%
No	20	24	44	23.40%
Don't know	9	42	51	27.13%
Total	**60**	**128**	**188**	**100%**

From the above table, 49.47% of the respondents viewed VCT as involving pre-test counselling, testing and post-test counselling, 23.40% did not while 27.13% did not know the process involved.

Item 10: VCT involves confidentiality?

*Table **10: showing response to if VCT involves confidentiality.***

Option	Response		Frequency	Percentage
	Male	**Female**		
Yes	42	95	137	72.87%
No	12	10	22	11.70%
Don't know	6	23	29	15.43%
Total	**60**	**128**	**188**	**100%**

The above table shows that 72.87% of the respondents viewed VCT as involving confidentiality, 11.70% did not and 15.43% had no idea.

Item 11: Do you know where VCT services are offered?

*Table **11: showing knowledge of where VCT services are offered.***

Option	Response		Frequency	Percentage
	Male	Female		
Yes	32	77	109	57.98%
No	28	51	79	42.02%
Total	**60**	**128**	**188**	**100%**

From table 11 above 57.98% claim they know where VCT services are offered while 42.02% do not.

Research Question 2: To what extent do secondary school students in Onitsha North L.G.A. utilize VHCT services?

Items 17 to 19 were used to answer this research question.

Item 17: have you ever tested for HIV before?

Table 12: showing response to having ever tested for HIV before.

Option	Response		Frequency	Percentage
	Male	Female		
Yes	41	52	93	24.47%
No	113	174	287	75.53%
Total	**154**	**226**	**380**	**100%**

From the above table, only 24.47% of the respondents have ever tested for HIV before.

Item 18: if yes, how many times have you done HIV test voluntarily?

Table ***13: showing response to number of times they have tested for HIV voluntarily.***

Option	Response		Frequency	Percentage
	Male	**Female**		
Never	25	33	58	62.37%
Once	5	5	10	10.75%
Twice	3	3	6	6.45%
Thrice	6	6	12	12.90%
More than thrice	2	5	7	7.53%
Total	**41**	**52**	**93**	**100%**

In table 13, a greater percentage 62.37% has never done an HIV test by their own volition, while the smallest percentage 7.53% has done a voluntary HIV test more than thrice.

Item 19: when was the last time you did a voluntary HIV test?

Table 14: showing the last time they did a voluntary HlV test

Option	Response		Frequency	Percentage
	Male	Female		
Less than one month ago	1	3	4	11.43%
One to six months ago	5	5	10	28.57%
Six months to one year ago	2	4	6	17.14%
More than one year ago	8	7	15	42.86%
Total	**16**	**19**	**35**	**100%**

Table 14 above revealed that 42.86% of those that have ever done a VCT did so more than one year ago, 28.57% one to six months ago, 11.43% and 17.14% less than one month ago and six months to one year ago respectively.

ResearchQuestion 3: What barriers prevent/hinder utilization of VHCT services by secondary schoolstudents in Onitsha North L, G.A.?

Items 20 and 21 answered this research question.
Item 20: if yes to question 17, why did you decide to lest?
*Table **15: showing response to why they decided to test.***

Option	Response		Frequency	Percentage
	Male	Female		
Was sick	32	26	58	62.37%
Had unprotected sex	]	3	4	4.30%
Raped	0	2	2	2.15%
Had blood transfusion	2	3	5	5.38%
Cut with sharp object	1	0	1	1.07%
Just want to know my status	3	10	13	13.98%
Accompanied someone	2	0	2	2.15%
Planning to marry	0	8	8	8.60%
Total	**41**	**52**	**93**	**100%**

From the table above, a good number, 62.37% did a VCT because they were sick, 8.60% because they were planning to marry. *5.38%* because they had a bloodtransfusion, 4.30% because they had unprotected sex and *2.15%* because they were raped. Onlya few 13.98% did a test because they wanted to know their status.

Item 21; if no to question 17, why have you not tested?

Table 16: showing response to why they have not tested .

Option	Response Male		Frequency	Percentage
Scared of positive result	24	35	59	20.56%
The test is expensive	6	2	8	2.79%
Afraid of stigmatization	9	26	35	12.19%
I don't know where to test	7	8	15	5.23%
Afraid other people will know	10	16	26	9.06%
I am sure I don't have HIV	21	16	37	12.89%
I am a virgin	25	42	67	23.34%
I only have one partner	11	29	40	13.94%
Total	**113**	**174**	**287**	**100%**

From the table above, 20.56% are scared of positive result, 2.79% did not test because they believe the test is expensive, 12.19% are afraid of stigmatization, 5.23% did not know where to go test, 9.06% were afraid people would know, 12.89% were sure they did not have HIV, *23.34%* believe as virgins they don't need to be tested and 13.94% have only one partner as such should not test.

Hypotheses Testing

Table 17: Hypothesis test of Awareness and Utilization of VCT for HIV/AIDS among senior secondary students in Onitsha North L.G.A.

Hypothesis	Male (Mean±SD)	Female (Mean±SD)	Mean Difference	P-Value
H_{o1} (Awareness of VCT for HIV/AIDS)	39.17±10.93*	79.50±28.47*	-40.33	0.000
H_{o2} (Utilization of VCT For HIV/AIDS)	19.33±20.20*	25.00±24.56*	-5.67	0.025

*Level of Significance (a)

Among senior secondary school students in Onitsha North L.G.A., ANOVA showed there were significant differences (*P < 0.05) between the mean scores of male and mean scores of female towards awareness and utilization of VCT for HIV/AIDS as shown in Table 23 above. Hence we reject the Null Hypotheses (Ho1 & Ho2) since their P-values are less than 0.05.

Summary of Findings

- Almost half (49.47%) of the respondents have heard about voluntary HIV counselling and testing with more females (68.09%) having heard of VCT for HIV/AIDS than males (31.91%).
- There is poor utilization of VCT as only 93 (24.47%) of the respondents have ever tested for HIV before.
- A good number 59 (20.56%) of the respondents identified fear of positive^ result as a barrier to their utilization of VCT.
- Two null hypotheses were tested and all were rejected.

✓ **H_{o1}**which stated that there is no significant difference between the mean ratings of males and females towards the awareness of VHCT among senior secondary school students in Onitsha North L.G.A. was rejected (p=0.000). From the findings, there was a significant difference in the mean ratings of male and that of the females towards awareness of VHCT with that of the females higher (79.50+28.47) and that of the males (39.17+10.93).

✓ **H_{02}**stating that there is no significant difference in the ratings of male and female senior secondary students as regards their utilization of VCT for HIV/AIDS in Onitsha North L.G.A. was rejected (p=0.025).. Findings from the study showed that females (25.00 ± 2.56) utilized VCT for HIV/AIDS more than the males (19.33 ±20.20)

DISCUSSION OF RESULTS

Considering the result of hypothesis one, result reviewed that there were significant differences between the mean ratings of males and females towards the awareness of voluntary counselling and testing for HIV/AIDS among senior secondary school students in Onitsha North L.G.A, with that of the females higher (79.50+28.47) than that of the males (39.17+10.93).

The finding of the present study is in line with Eremie & Kennedy (2016) in their descriptive study of university students' perception of VCT for HIV/AIDS in Rivers State where a sample of 200 students was used. It was revealed that about 96% of the female population sample of 100 indicated that they have heard of VCT through media, friends, and university health centre. While 4% indicated that they were uninterested about VCT, but have heard of HIV/AIDS. In the male category, 65% claimed to have heard of VCT through media, friends, and university health Centre, but the remaining 35% indicated that they have heard of HIV/AIDS, but have no knowledge about VCT. It was also noted that female students had better positive attitude towards when respondents were asked, if they *will* access VCT services in the near future if validly available about 80% (female) indicated "strongly agree" while, about 65% (male) "Agree". But most of the respondents indicated that VCT utilization is necessary for spread of HIV/AIDS. Mean scores of males is 24.45; female is 36.20, female score was an that of male. Therefore, there was significant difference between male and female students' perception utilization of Voluntary Counselling and Testing (VCT) on S in Rivers State, Nigeria.

Contrast with the findings of the present study is a cross-sectional descriptive survey on knowledge and utilization of HIV counseling and testing services among students of a tertiary situation in Abia State, South East Nigeria by Onyeonoro et al., (2014) where a total of 312 were selected by multi-staged sampling technique and their responses were elicited from a pretested, self-administered questionnaire on bio-data, knowledge of HCT, desire HIV testing, risk perception, access and utilization of HCT services. They reported that out of respondents, one hundred and eighty four students, (59%) were aware of HCT, out of which and 57.1% of males and females respectively have heard of HCT.

The result of hypothesis two indicates that there were significant differences between the mean ratings of males and mean ratings of females towards utilization of voluntary counselling and testing for HIV/AIDS. Findings from the study showed that females (25.00 ± utilized VCT for HIV/AIDS more than the males (19.33 ± 20.20).

Contrast with the findings of this study is a study by Onu et al. (2016) on "Gender and HIV Service Uptake: Trend in Northern Nigeria" a review of data from 423 community and based HTC program of AIDS Healthcare Foundation (AHF) conducted in Abuja, Nasarawa, Benue and Kogi States, North-central Nigeria between August 2012 to July 2015. 1Information on socio-demographic characteristics, HIV counseling and testing and time to accessing care was obtained and means and proportions were used to document the result.. A total of 459,223 clients were tested for HIV during the period under study. Majority were tested through community based testing approaches 92.2% *(n* = 423,551) compared to those tested through facility-based testing approach 7.8% *(n* = 35,672). Among those that accessed HTC in the facilities (n=35,672), women made up of 55.3% of the clients, while the male dominated (70.9%) among those that came for testing in the community-based testing (n=423, 551). A pattern observed was that though more males were tested in the overall, 76.2% of the positive cases were recorded among the female population, while uptake of treatment and care (linkage to care) was higher among the female.

Conclusion

Almost half (49.47%) of the respondents have heard about voluntary HIV counselling and testing with more females (68.09%) having heard of VCT for HIV/AIDS than males (31.91%).There is poor utilization of VCT as only 93(24.47%) of the respondents have ever tested for HIV before.A good number 59(20.56%) of the respondents identified fear of positive result as a barrier to their utilization of VCT. There was a significant difference in the mean ratings of males and that of the females towards awareness of VHCT with that of the females higher (79.50+28.47) and that of the males (39.17+10.93).There was a significant difference in the ratings of male and female senior secondary students as regards their utilization of VCT for HIV/AIDS and findings showed that females (25.00 ± 2.56) utilized VCT for HIV/AIDS more than the males (19.33 ± 20.20).

Recommendations

Based on the findings of this study the following recommendations were made

to improve Knowledge, and practices of VCT among adolescent.

1. Schools should contribute largely to disseminating information encouraging HIV testing, they should not shy away from educating people on this topic because most adolescents absorb and follow what they are thought at school. This can be done by establishing healthy clubs in these institutions.
2. Collaboration between school authorities and relevant partners in establishing a sustainable youth-friendly, school-based HCT services with efforts made to incorporate sexual reproductive health/HIV education into the training curriculum of secondary schools.
3. More electronic mass media campaign on the importance of VCT in the prevention of HIV and its process needs to be put in place. The benefits of VCT as a means of behaviour modification, early treatment and care for HIV/AIDS need to be more emphasized.
4. An appropriate model of VCT services that is client-initiated and youth-friendly need to be put in place and accessible to young people. VCT services should not be limited to health institutions, establishment of HIV testing centres where rapid test can be done should be introduced in educational institutions.
5. Educational institutions should adopt testing for HIV as part of admission requirement.
6. School health programme should be strengthened as appropriate health messages can be passed to students in school.
7. Schools should inculcate health education as a compulsory course in the curriculum of the students.
8. There is need to engage health workers to maintain confidentiality as this cultural factor is a barrier to utilization of VCT services by the youth.

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