



ACCEPTABILITY OF MANDATORY PREMARITAL HIV TESTING AMONG YOUTHS IN LAFIA LOCAL GOVERNMENT AREA, NASARAWA STATE, NIGERIA



Collins Okekabile Saliu

Department of Sociology,
Federal University Wukari, Taraba State, Nigeria
Correspondence: collinsosaliu@gmail.com

Daniel, Francis Omoche

Department of Microbiology
Federal University Wukari, Taraba State
francisd100@gmail.com

Abstract

Despite decades of HIV/AIDS sensitisation in Nigeria, the acceptability of Mandatory Premarital HIV Testing (MPHT) among youths remains low, raising concern that awareness campaigns alone are insufficient to drive preventive health behaviour. This study examined the acceptability of MPHT among youths in Lafia Local Government Area, Nasarawa State, with specific objectives to assess their level of HIV/AIDS awareness, determine the extent of MPHT acceptability, identify associated fears, and test the statistical relationships among these variables. The study was anchored on the Health Belief Model, which explains health behaviour through perceived susceptibility, severity, benefits, and barriers and Rational Choice Theory. A quantitative survey design was adopted, using a structured questionnaire administered to 382 youths selected, with data analysed through descriptive statistics, Pearson correlation, the Friedman test, and a one-sample t-test in SPSS. Findings revealed a moderate-to-high level of HIV/AIDS awareness but comparatively lower MPHT acceptability, driven primarily by religious beliefs, cultural background, and inadequate sensitisation. A significant positive relationship was found between awareness and acceptance ($r = .52, p < .001$), while awareness was also positively associated with fear of MPHT ($r = .38, p < .001$). The factors influencing acceptability differed significantly in strength ($\chi^2 = 152.47, p < .001$), and fear of stigmatisation and loss of marriage opportunity emerged as the most influential and interrelated barriers. The study concludes that low acceptability reflects perceived social barriers rather than ignorance, and recommends stigma-reduction programming, religious leader engagement, and integration of MPHT into premarital counselling structures.

Keywords: Acceptability, Mandatory Premarital HIV Testing, HIV/AIDS Awareness, Health Belief Model, Youths, Stigma, Lafia LGA

Introduction

Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) has remained one of the most devastating global public health crises of the modern era. Since its first clinical identification in the United States in 1981, the virus has spread to every country in the world (Sharp & Hahn, 2011). As of the end of 2021, approximately 38.4 million people were living with HIV globally, with 1.5 million newly infected in that year alone (UNAIDS, 2022). Sub-Saharan Africa continues to bear the greatest burden, accounting for more than two-thirds of all people living with HIV worldwide. In this region, nearly 1 in every 25 adults (3.4%) is infected, with women and girls constituting about 63% of all new infections (UNAIDS, 2022). In Nigeria, the 2019 National HIV/AIDS Indicator and Impact Survey (NAIIS) estimated 1.9 million people living with HIV, placing the country third globally in total HIV burden. Young people aged 15–24 years account for approximately 31% of new HIV

infections in Nigeria (UNAIDS, 2021), making youths a primary target demographic for preventive interventions. The National Agency for the Control of AIDS (NACA, 2016) further reported that 40% of all new HIV infections in Nigeria occur in the 15–24 age group, the highest across all demographic categories.

Nasarawa State, where Lafia serves as the state capital, recorded an HIV prevalence rate of 2.0% in 2018, the sixth highest nationally (NAIIS, 2018). Lafia Local Government Area (LGA) specifically reported an HIV prevalence as high as 7.0%, ranking third within the state (NASACA, 2021). As of 2021, 65,000 people in Nasarawa State were on HIV medication while an additional 22,000 infected persons remained outside the treatment programme (NASACA, 2021). These figures underscore the continued urgency of preventive interventions in the area. Despite government efforts, complemented by United Nations agencies and Non-Governmental Organisations (NGOs), HIV/AIDS prevalence in Nasarawa State remains a significant public health concern. Several factors, including inadequate knowledge, stigmatisation, high-risk sexual behaviour, and cultural and religious barriers, continue to impede effective HIV/AIDS interventions (WHO, 2013). The NASACA has actively promoted Voluntary Counselling and Testing (VCT) and MPHT as preventive strategies; however, only 45% of young people aged 15–24 had been tested for HIV in the year preceding the study (NASACA, 2023). This gap between policy intention and actual uptake signals a need for empirical investigation into the factors governing MPHT acceptability.

The acceptability of MPHT is influenced by a complex interplay of socio-cultural, religious, psychological, and institutional factors. A survey by Musa, Ibrahim and Suleiman (2022) among undergraduate students in Lafia found that 72% expressed support for mandatory premarital HIV testing, yet the same study revealed stark disparities between urban (85%) and rural (54%) youth, indicating that acceptance is contextually variable and inadequately understood. Moreover, the acceptability of MPHT has not been comprehensively assessed within the specific socio-demographic context of Lafia LGA, particularly among the broader youth population aged 15–35 years. This study is drawn from a wider empirical study examining the awareness of HIV/AIDS and acceptance of MPHT among youths in Lafia LGA, Nasarawa State. Specifically, this paper addresses Objective 2 of the original study: to assess the level of acceptability of Mandatory Premarital HIV Testing (MPHT) among youths in Lafia LGA, Nasarawa State. The findings are expected to inform evidence-based health communication strategies, institutional policies, and community-level HIV prevention efforts. The following hypothesis was tested:

- H₀₁: There is no significant relationship between awareness of HIV/AIDS and acceptance of MPHT in Lafia LGA
- H₀₂: There is no significant impact of knowledge of HIV/AIDS on fears associated with MPHT among youths in Lafia LGA.
- H₀₃: There is no significant difference in the extent to which religion, culture, education, knowledge adequacy, cynicism, and sensitisation influence MPHT acceptability among youths in Lafia LGA.
- H₀₄: Youths in Lafia LGA do not report significant fear associated with MPHT (i.e., the mean fear score does not differ from the scale midpoint).

Literature Review and Theoretical Framework

Mandatory Premarital HIV Testing (MPHT)

Mandatory Premarital HIV Testing (MPHT) refers to a policy requiring intending couples to undergo HIV testing as a prerequisite for entering into a marriage contract. The policy originated in the United States states of Louisiana and Illinois and has since been adopted by governments and religious bodies across the world (Turnock & Kelly, 2009). The Open Society

Institute (2013) documented those twenty-six countries globally had some form of premarital HIV testing policy, including nations in the Middle East, Asia, and Africa. Countries such as Saudi Arabia, Bahrain, China, Ethiopia, India, and several sub-Saharan African nations have all implemented versions of this policy (Alswaidi & O'Brien, 2009; Chattu, 2014).

Proponents of MPHT argue that the policy empowers intending couples to know their HIV status before marriage, enabling them to make informed decisions about sexual behaviour, family planning, and prevention of mother-to-child transmission (Chattu, 2004). From a public health utilitarian perspective, MPHT promotes communal well-being over individual preference, with the potential to reduce HIV transmission rates at the population level (Mekonnen, 2010). In Nigeria, Faith-Based Organisations (FBOs) such as the Anglican Church have integrated MPHT into premarital requirements, and by 2003, the number of people seeking HIV testing to fulfil marriage requirements rose from 2.4% to 3.0% of total testers nationally (Arulogun & Adefioye, 2010).

However, critics argue that MPHT violates fundamental human rights, including the right to privacy, informed consent, and non-discrimination. The Centre for the Right to Health (2003) contended that HIV testing without specific informed consent is unconstitutional under Nigerian law. Additionally, Turnock and Kelly (1989) and Fonner et al. (2012) showed that public education, counselling, and voluntary testing reduced HIV spread more effectively than mandatory premarital screening. The 'window period', up to 90 days during which HIV antibodies remain undetectable, also poses a technical challenge to MPHT's reliability, potentially producing false negatives (Chattu, 2014).

Acceptability of MPHT

Studies on MPHT acceptability across Africa reveal mixed findings. A cross-sectional study among 571 unmarried youths in Ibadan, Nigeria found that 82.8% believed MPHT could reduce HIV spread, yet 43.8% feared the policy would increase stigmatisation for those testing HIV positive (Arulogun & Adefioye, 2010). A qualitative study from Malaysia found that fear of social stigma, discrimination, and lack of understanding were major concerns militating against mandatory HIV screening (Noronha, George & Sreedevi, 2021). A population-based study in Cameroon found that the majority of respondents who tested HIV negative would refuse to marry their HIV positive partner, revealing the social dynamics of sero-sorting and its implication for MPHT acceptability (Akoku, Tihnje, Tarh & Tarkang, 2018).

A survey by Adebayo et al. (2020) in a neighbouring Nigerian state found that 87.5% of young adults supported MPHT in principle; however, actual uptake remained below expected levels due to structural barriers including stigma, fear of discrimination, and limited access to testing facilities. These findings align with a broader observation by Levesque, Harris and Russel (2013) that even when outreach services are available, acceptance cannot be assumed, as individual autonomy and community norms significantly moderate health-seeking behaviour. In Uganda, 79% of participants intending to marry stated that a partner's HIV status would determine their marriage decision, with 50% preferring sero-negative partners, a finding underscoring how MPHT can reshape marital choices and, paradoxically, deter testing (Akoku et al., 2018).

Socio-Demographic Determinants of MPHT Acceptability

Religion

Religious affiliation is one of the most potent determinants of MPHT acceptability in Nigeria and across Africa. Arulogun and Adefioye (2010) found that Christians were almost three times more likely to be aware of and accept MPHT than Muslims. Umar and Oche (2012) reported low levels of HIV/AIDS knowledge among Muslim scholars in Sokoto and found that this

influenced their discordant attitudes towards MPHT. Alswaidi and O'Brien (2009) similarly found that in Islamic countries such as Saudi Arabia and Bahrain, religious beliefs served as significant obstacles to premarital HIV testing. The Islamic world was historically perceived as being shielded from HIV/AIDS by Islamic moral prescriptions, male circumcision, and ritual hygiene practices, a perception that may produce nonchalant attitudes towards MPHT (Gray, 2004). In this study's context, with 69.4% of respondents being Muslim, religion's role in shaping MPHT acceptability is particularly salient.

Education

Educational attainment positively predicts MPHT acceptability by improving health literacy and enabling informed decision-making. Peters et al. (2010) found that individuals with higher education practised more protective health behaviours against HIV/AIDS in Ghana. Vandemoortele and Delamonica (2002) showed that HIV/AIDS spread twice as fast among uneducated girls in Zambia, and that women who remained in school after primary level were five times more likely to know basic facts about HIV/AIDS than illiterate women. De Neve et al. (2015) demonstrated that additional years of secondary schooling had a significant protective effect against HIV risk in Botswana, particularly among women. In the current study context, 37.4% of respondents had only secondary education, while 4.5% had no formal education, suggesting that educational deficits could meaningfully constrain MPHT uptake.

Socioeconomic Status and Cultural Background

Socioeconomic status (SES) influences HIV-related health behaviours. A lack of socioeconomic resources has been linked to riskier sexual behaviour, reduced health-seeking motivation, and delayed testing (Pellowski, Kalichman, Matthews & Adler, 2013). In poverty-ridden communities, out-of-pocket healthcare expenditure further constrains access to testing services. Additionally, cultural norms around gender, marriage, and sexuality shape MPHT attitudes. In many African cultures, marriage negotiations involve entire families, making confidentiality of individual HIV test results difficult to maintain and deterring prospective couples from testing (Open Society Institute, 2013). Cultural expectations around marital obligations also place pressure on individuals, particularly women, to accept partners without objective health assessment.

Fears Associated with MPHT

Fear of Stigmatisation and Discrimination

HIV-related stigma, defined by UNAIDS (2014) as negative beliefs, feelings, and attitudes towards people living with HIV, is the most frequently cited barrier to HIV testing globally. Stigma prevents individuals from accessing HIV information, testing services, treatment, and support (UNAIDS, 2014). In the specific context of MPHT, youths fear that testing positive will lead to public exposure of their HIV status, social ostracism, and rejection by partners, families, and communities. Alubo et al. (2002) documented that in high HIV prevalence areas of Nigeria, stigmatisation of persons living with AIDS (PLWA) was pervasive, with infected individuals reporting social exclusion, poverty, and lack of community empathy. The association of HIV/AIDS with sexual promiscuity further compounds stigma, making disclosure particularly distressing (Giddens et al., 2005).

Fear of Loss of Marriage Opportunity

A positive premarital HIV test result can effectively terminate a prospective marriage, particularly in sero-discordant scenarios. The cancellation of marriage plans following testing creates visible community suspicion about the positive partner's HIV status, irreparably compromising confidentiality (Open Society Institute, 2013). Akoku et al. (2018) found that fear of marriage denial in the event of a discordant result led peers and community members to conclude that one or both partners was HIV positive, a consequence that many youths seek to

avoid by not testing. Scott (2007) observed that denial was psychologically more comforting than awareness of one's HIV status, providing a rationale for avoidance behaviour.

Fear of Lack of Confidentiality

Maintaining the confidentiality of MPHT results is structurally challenging. In many settings, healthcare workers disclose test results directly to religious marriage committees or traditional leaders (Open Society Institute, 2013). In Malaysia, Muslim couples are required to submit HIV status certificates to state religious departments when applying for marriage licences, rendering confidentiality practically impossible. In Nigeria, faith-based premarital testing programmes involve disclosures to church or mosque officials, inadvertently exposing HIV-positive individuals to community-level discrimination (Arulogun & Adefioye, 2010). This structural lack of confidentiality is a significant deterrent, especially in communities where social identity and marital prospects are closely linked.

Theoretical Framework

This study is anchored on two complementary theoretical frameworks: the Health Belief Model (HBM) and the Rational Choice Theory.

Health Belief Model

The Health Belief Model was developed in the 1950s by social psychologists Godfrey Hochbaum, Irwin Rosenstock, Stephen Kegeles, and Howard Leventhal, who were working with the U.S. Public Health Service to understand why individuals failed to participate in disease-prevention and screening programmes, particularly tuberculosis screening. Rosenstock (1974) later formalised and popularised the model in its most widely cited form, positioning it as one of the earliest systematic frameworks for explaining preventive health behaviour.

The HBM assumes that an individual's likelihood of engaging in a health-protective behaviour, such as HIV testing, is determined by six interacting beliefs: (1) perceived susceptibility: the individual's belief about their risk of contracting the condition; (2) perceived severity: beliefs about how serious the condition and its consequences are; (3) perceived benefits: beliefs about the effectiveness of the recommended action in reducing risk; (4) perceived barriers: beliefs about the psychological, social, financial, or practical costs of taking the action; (5) cues to action: internal or external triggers (e.g., symptoms, media campaigns, a partner's request) that prompt the behaviour; and (6) self-efficacy: the individual's confidence in their ability to successfully carry out the behaviour.

The HBM directly frames how this study interprets its central paradox: that youths in Lafia LGA are broadly aware of HIV/AIDS (high perceived susceptibility and severity) yet exhibit comparatively low MPHT acceptability. The model explains this through perceived barriers the stigma, fear of lost marriage prospects, and confidentiality concerns function precisely as the barriers the model predicts will suppress uptake even where awareness is high. Similarly, the finding that inadequate sensitisation was the most strongly endorsed obstacle to acceptability reflects a deficiency in cues to action youths are not being sufficiently prompted or supported toward testing.

The HBM offers a parsimonious, empirically well-tested structure that isolates specific, individually measurable belief dimensions, making it highly suited to survey-based quantitative research such as this study. It has been extensively validated across decades of health behaviour research, including HIV-prevention studies in African contexts (Manakandan & Sutan, 2017), lending it strong external credibility.

The model has been criticised for its individualistic orientation, treating health decisions as the product of personal cost-benefit calculation while giving limited explicit weight to social,

relational, and structural forces such as family pressure, religious authority, or peer influence. It also does not adequately explain why certain barriers, such as stigma or fear of marital rejection, carry the specific social weight they do within a given community. This limitation is precisely what necessitates a second, complementary theory.

The Health Belief Model (Rosenstock, 1974) posits that an individual's health-related behaviour is determined by their perceived susceptibility to a health threat, the perceived severity of the threat, the perceived benefits of taking preventive action, and the perceived barriers to action. In this study's context, youths who perceive themselves as susceptible to HIV infection and understand the severity of AIDS are more likely to accept MPHT; conversely, those who perceive the social and psychological costs of testing (stigma, confidentiality loss, and marriage cancellation) as outweighing the benefits are less likely to accept the programme. The HBM also incorporates cues to action, such as health campaigns and peer influence, and self-efficacy, which determine whether awareness translates into action (Amzat & Razum, 2014).

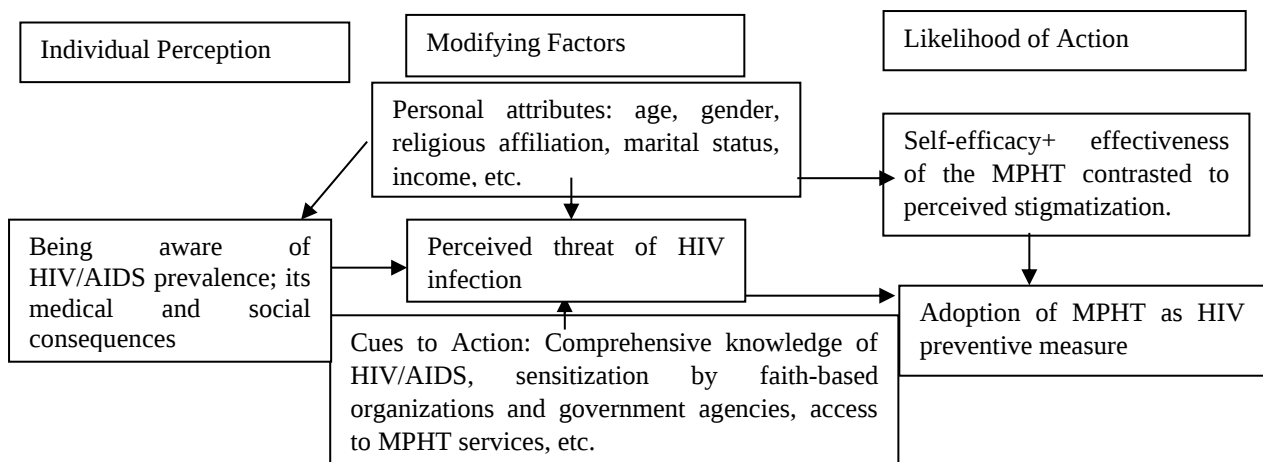


Figure 1: The Health Belief Model showing awareness towards the MPHT

The model above shows some potential strategies that may be applied to change an individual's perception of a disease and encourage appropriate behaviour. Basically, Glanz et al. (2005) presented how HBM can be used in the execution and promotion of health programmes. The model presents a form of the causal analysis of health-related behaviour, which is an important model for health care and planning.

Social Exchange Theory

Social Exchange Theory emerged from the work of sociologists George Homans (1958), Peter Blau (1964), and John Thibaut and Harold Kelley (1959), who conceptualised human social behaviour as an exchange process governed by the pursuit of rewards and the avoidance of costs, drawing on principles from behavioural psychology and elementary economics.

SET assumes that individuals evaluate their social interactions and decisions much as they would an economic transaction: weighing the rewards (social approval, marriageability, acceptance within one's community) against the costs (stigma, social exclusion, loss of status) that a given course of action is likely to produce. Behaviour is sustained when perceived rewards exceed perceived costs, and avoided when costs are judged to exceed rewards. The theory further holds that individuals compare available alternatives and act to maximise net social benefit within their relationships and community standing.

SET supplies the social-relational logic that the HBM's more individualistic framing leaves underspecified. Within Lafia LGA's marriage-oriented cultural context, MPHT is not

experienced by youths merely as a private health decision but as a socially consequential exchange: submitting to testing carries the potential cost of stigmatisation and diminished marriageability (Table 4), while declining testing preserves social standing and marital prospects in the short term, even at the expense of long-term health security. This directly explains why fear of stigmatisation and fear of loss of marriage opportunity were found to be the most strongly correlated fears in the study both represent the same underlying social cost calculation within the exchange framework. SET also illuminates why religion and culture emerged as the most influential barriers to acceptability.

The theory brings an explicitly social and relational dimension to the analysis, capturing how community norms, marriageability, and religious/cultural expectations function as tangible social currencies that shape individual decisions. It is particularly well-suited to studies of behaviour embedded in courtship and marriage contexts, as is the case with MPHT.

The theory has been criticised for its assumption of rational, calculated decision-making, which may understate the role of emotion, habit, or unconscious social conditioning in shaping behaviour. It can also be difficult to operationalise precisely, since "rewards" and "costs" are subjectively defined and not always directly measurable, a limitation partially addressed in this study through the use of Likert-scale fear and acceptability items as proxy indicators of perceived social cost.

Theoretical Synthesis

Used jointly, the HBM and SET offer a fuller account of MPHT acceptability than either theory alone: the HBM explains the individual, cognitive weighing of health risk and benefit, while SET explains why the "barriers" identified by the HBM carry the specific social weight they do within Lafia LGA's marriage-centred cultural context. This dual-theory approach is consistent with the study's core finding that MPHT acceptability is shaped less by health knowledge itself than by the perceived social cost of testing within a community where marriage prospects and religious standing are highly valued.

The Rational Choice Theory (Coleman, 1990) complements the HBM by emphasising that individuals make calculated cost-benefit assessments before engaging in health behaviours. In the context of MPHT, Giddens et al. (2005) noted that stigmatisation of HIV-positive individuals is one of the major obstacles to successful HIV/AIDS interventions. A rational actor weighs the anticipated social, psychological, and economic consequences of testing positive against the health benefits of knowing their status. The interplay of social stigma and perceived susceptibility, filtered through rational calculation, largely determines whether youths accept MPHT.

Theory to Instrument Mapping

Theory	Construct	Operational definition	Example survey item	Response scale
Health Belief Model	Perceived susceptibility	Belief about personal risk of acquiring HIV	I believe I am at risk of getting HIV	5-point Likert
Health Belief Model	Perceived severity	Belief about seriousness of HIV consequences	HIV/AIDS would seriously affect my future	5-point Likert
Health Belief Model	Perceived benefits	Belief that MPHT yields protective outcomes	Premarital testing protects partners and marriage	5-point Likert

Theory	Construct	Operational definition	Example survey item	Response scale
Health Belief Model	Perceived barriers	Perceived social, psychological, logistical costs of testing	I fear stigma or loss of confidentiality if tested	5-point Likert
Health Belief Model	Cues to action	External prompts that trigger testing behaviour	I have seen campaigns encouraging premarital testing	Frequency or 5-point Likert
Health Belief Model	Self-efficacy	Confidence in ability to get tested and cope with results	I can get tested and handle a positive result	5-point Likert
Rational Choice Theory	Perceived costs	Expected social/psychological/economic losses from testing positive	A positive result would harm my marriage prospects	5-point Likert
Rational Choice Theory	Perceived benefits (rational)	Expected material/non-material gains from knowing status	Knowing my status helps me access treatment and plan	5-point Likert
Rational Choice Theory	Subjective probability	Individual estimate of likelihood of being HIV positive	I think there is a high chance I am HIV positive	0–100% or 5-point Likert
Rational Choice Theory	Expected utility	Composite net payoff from testing (benefits×probability – costs×probability)	Composite score computed from cost, benefit, probability items	Continuous composite
Rational Choice Theory	Stigma as social cost	Anticipated stigma weight in decision calculus	People will avoid me if I test positive	5-point Likert
Rational Choice Theory	Rational intention	Deliberative intention to accept MPHT after weighing outcomes	Given what I know, I intend to accept premarital HIV testing	5-point Likert

Figure 2: Theory-to-instrument mapping for the Health Belief Model and Rational Choice Theory constructs

The table succinctly links Health Belief Model and Rational Choice Theory constructs to measurable survey items and response formats: HBM constructs (perceived susceptibility, severity, benefits, barriers, cues to action, self-efficacy) are operationalized with clear belief-statements and mostly five-point Likert responses to form scale scores for predicting or moderating acceptance of MPHT, while Rational Choice constructs (perceived costs, perceived benefits, subjective probability, expected utility, stigma, and rational intention) are captured as Likert items or a computed continuous expected-utility index to model net payoff and intention; together the mapping enables testing complementary cognitive and cost–benefit pathways from awareness to acceptance, provided items are validated and scales checked for reliability.

Methodology

The study was conducted in Lafia Local Government Area (LGA), the state capital of Nasarawa State, Nigeria. Lafia was selected for its strategic location, serving as a transit point

between Abuja (Federal Capital Territory), Benue State (which has the highest HIV burden in Nigeria), and Plateau State. The town's heterogeneous population, diverse occupational groups, and relatively high HIV prevalence rate of 7.0% (NASACA, 2021) make it an appropriate site for this study.

The study adopted descriptive survey design. The entire population of the youths between the ages of 15-35 years in Lafia LGA was conceived as the population of the study. Youths constitutes 65% (718,328) of the total population of 1,105,119 in Lafia Local Government Area of Nasarawa State (NAGIS, 2021). Although the population of the study was “718,328” for the thirteen wards in Lafia LGA, the target population of seven randomly selected wards for the study was “470,398”. Hence, a sample of 382 respondents was selected to represent the target population in accordance with Krejcie and Morgan’s (1970) table for determining the sample size for research purpose. Using Krejcie & Morgan (1970), the required sample size for a population of $N = 470,398$ is 384 respondents. This follows the Krejcie & Morgan table and the standard formula (confidence level 95%, $d=0.05$, $P=0.5$). Krejcie & Morgan’s table and formula assume 95% confidence, margin of error $d=0.05$, and population proportion $P=0.5$ (maximizes required sample).

$N=470,398$, $P=0.5$, $d=0.05$:

$$S = 3.8416 \times 470,398 \times 0.250.0025 \times (470,398 - 1) + 3.8416 \times 0.25 = 383.85$$

Rounded up to the nearest whole respondent gives 384 respondents

Sample Sizes (tabular)

Population (N)	Sample size (S) per Krejcie & Morgan	Notes
470,398	384	Value from formula and table rounding; matches Krejcie & Morgan’s plateau near 380–384 for very large N.

Source: Author’s computation

Multi-stage sampling technique (including cluster sampling, stratified sampling, simple random sampling and proportionate sampling) was adopted. Data were collected using a structured questionnaire designed in line with the study objectives. The instrument was divided into sections addressing: socio-demographic characteristics; awareness of HIV/AIDS and MPHT; factors influencing MPHT acceptability; and fears associated with MPHT. Response items were structured on a five-point Likert scale: Strongly Agree (5), Agree (4), Neutral (3), Disagree (2), Strongly Disagree (1). For ease of analysis, Strongly Agree and Agree responses were merged, as were Disagree and Strongly Disagree responses. The questionnaire was translated into Hausa, the dominant local language, to enhance comprehension among respondents with limited English proficiency. The services of a certified language expert were employed for the translation and back-translation process.

Descriptive and inferential statistics were used to analyze the data with the assistance of Statistical Packages for Social Sciences (SPSS). Face and content validity was used to validate the data and the reliability of the instrument was assured through test-retest method, which was administered on the same hypothetical sample different from the actual sample for the study on two separate occasions; an interval of one week to forestall the effects of intervening variables.

Results

384 copies of questionnaire were sent out and out of the 384, 382 representing 99.5% were successfully retrieved, while 2 representing 1.5% were discarded because they were incorrectly filled and thus considered invalid. The 382 representing 99.5% was used in the study.

Socio-Demographic Characteristics of Respondents

Table 1 presents the socio-demographic profile of the 382 respondents who participated in the study.

Table 1: Socio-Demographic Characteristics of Respondents (N = 382)

Characteristic / Category	Frequency	Percentage (%)
Age Group		
15–19 years	168	44.0
20–24 years	61	16.0
25–29 years	67	17.5
30–35 years	86	22.5
Total	382	100
Sex		
Male	236	61.8
Female	146	38.2
Total	382	100
Marital Status		
Single	140	36.6
Married	97	25.4
Separated	55	14.4
Divorced	41	10.7
Widowed	49	12.8
Total	382	100
Religion		
Christianity	96	25.1
Islam	265	69.4
Traditional Religion	21	5.5
Total	382	100
Occupation		
Student	93	24.3
Self-employed	125	32.7
Civil Servant	79	20.7
Unemployed	85	22.3
Total	382	100
Level of Education		
No Formal Education	17	4.5
Primary	110	28.8
Secondary	143	37.4
Tertiary	74	19.4
Others	38	9.9
Total	382	100

Source: Author's Fieldwork, 2025.

The sample comprised predominantly male respondents (61.8%), with females constituting 38.2%, indicating reasonable gender representation. The largest age cohort was 15–19 years (44%), reflecting a young study population consistent with the HIV/AIDS risk profile in Lafia

LGA. A majority (69.4%) of respondents were Muslim and 25.1% were Christian, reflecting the predominantly Muslim population of north-central Nigeria. Regarding education, 37.4% had secondary education, 28.8% primary, 19.4% tertiary, and 4.5% had no formal education, a distribution that has implications for health literacy and MPHT awareness. In terms of occupation, 32.7% were self-employed, 24.3% students, 22.3% unemployed, and 20.7% civil servants.

Level of Awareness of HIV/AIDS and MPHT among Respondents

Table 2 presents findings on respondents' level of awareness of HIV/AIDS and MPHT, which provides the contextual basis for assessing acceptability.

Table 2: Respondents' Awareness of HIV/AIDS and MPHT (N = 382)

Statement	SA (%)	A (%)	N (%)	D (%)	SD (%)	Mean	SD
Youths in Lafia have insignificant knowledge of HIV/AIDS and MPHT	200 (52.4)	100 (26.2)	20 (5.2)	32 (8.4)	30 (7.9)	4.07	1.27
Youths in Lafia are totally ignorant of HIV/AIDS and MPHT	10 (2.6)	15 (3.9)	8 (2.1)	150 (39.3)	199 (52.1)	1.66	0.90
Authorities fail to sensitise youths about HIV/AIDS dangers and MPHT importance	20 (5.2)	40 (10.5)	12 (3.1)	95 (24.9)	215 (56.3)	1.84	1.21
Youths do not believe in the existence of HIV/AIDS and efficacy of MPHT	15 (3.9)	10 (2.6)	5 (1.3)	145 (38.0)	207 (54.2)	1.64	0.94
Youths believe one can contract HIV/AIDS through indiscriminate sex	350 (91.6)	25 (6.5)	4 (1.0)	2 (0.5)	1 (0.3)	4.89	0.43
Youths possess superior knowledge to avoid HIV/AIDS regardless of their excesses	12 (3.1)	28 (7.3)	45 (11.8)	180 (47.1)	117 (30.6)	2.05	1.00

SA = Strongly Agree; A = Agree; N = Neutral; D = Disagree; SD = Strongly Disagree. Source: Author's Fieldwork, 2025.

The findings in Table 2 present a mixed but broadly encouraging picture of HIV/AIDS awareness among youths in Lafia LGA, though with clear gaps in depth and quality of knowledge. A majority of respondents (78.6%) agreed that youths in the LGA possess insignificant knowledge of HIV/AIDS and MPHT (Mean = 4.07; SD = 1.27), suggesting that while some awareness exists, it is widely perceived as shallow or incomplete. This is corroborated by the very low endorsement of the statement that youths are “totally ignorant” of HIV/AIDS and MPHT (Mean = 1.66; SD = 0.90), with 91.4% of respondents disagreeing indicating that a baseline level of awareness is present, even if it falls short of comprehensive understanding. Together, these two findings point to a population that has been exposed to HIV/AIDS messaging but has not fully internalised the nuances of prevention and treatment programmes such as MPHT.

Respondents were similarly disinclined to hold local authorities solely responsible for sensitisation failures, with the statement scoring a low mean (1.84; SD = 1.21) and 81.2% disagreement. This suggests that awareness gaps in the community may stem from a

combination of factors including cultural transmission of information, personal engagement with health messaging, and structural access to services rather than a single point of institutional failure.

The most decisive finding was near-universal agreement (98.1%) that youths understand indiscriminate sexual activity as a mode of HIV/AIDS transmission (Mean = 4.89; SD = 0.43), reflecting strong awareness of the primary transmission pathway. This is an important finding because it demonstrates that basic epidemiological knowledge is well established, even where deeper understanding of prevention technologies like MPHT lags behind.

Notably, the belief that youths possess “superior knowledge” sufficient to protect themselves regardless of risky behaviour was firmly rejected (Mean = 2.05; SD = 1.00), with 77.7% disagreement. This finding is consistent with the broader pattern: respondents acknowledge a working awareness of HIV/AIDS transmission but do not believe this awareness is deep enough to be relied upon as a substitute for structured prevention interventions such as MPHT. Taken together, Table 2 suggests that the awareness gap in Lafia LGA is one of depth rather than existence a distinction with direct implications for how sensitisation campaigns should be designed, moving beyond basic transmission facts toward more comprehensive engagement with prevention technologies.

Level of Acceptability of MPHT among Youths

Table 3 presents respondents' opinions on specific dimensions of MPHT acceptability.

Table 3: Respondents' Opinions on Acceptability of MPHT in Lafia LGA (N = 382)

Statement	SA (%)	A (%)	N (%)	D (%)	SD (%)	Mean	SD
Inadequate knowledge of HIV/AIDS affects youths' acceptance of MPHT	195 (51.0)	150 (39.3)	10 (2.6)	17 (4.5)	10 (2.6)	4.32	0.92
Religious beliefs of youths affect their acceptance of MPHT	250 (65.4)	115 (30.1)	5 (1.3)	8 (2.1)	4 (1.0)	4.57	0.72
Cultural background of youths influences acceptance of MPHT	270 (70.7)	100 (26.2)	6 (1.6)	4 (1.0)	2 (0.5)	4.66	0.62
Cynical attitudes of youths affect their acceptance of MPHT	25 (6.5)	55 (14.4)	15 (3.9)	140 (36.6)	147 (38.5)	2.14	1.25
Educational background of youths affects their acceptance of MPHT	200 (52.4)	125 (32.7)	10 (2.6)	32 (8.4)	15 (3.9)	4.21	1.09
Lack of adequate sensitisation campaign affects acceptance of MPHT	340 (89.0)	38 (9.9)	2 (0.5)	1 (0.3)	1 (0.3)	4.87	0.41

SA = Strongly Agree; A = Agree; N = Neutral; D = Disagree; SD = Strongly Disagree. Source: Author's Fieldwork, 2025.

Table 3 reveals that MPHT acceptability among youths in Lafia LGA is shaped by an interaction of knowledge, cultural, and institutional factors, with socio-cultural variables emerging as the most powerful barriers. Inadequate knowledge of HIV/AIDS was strongly linked to reduced MPHT acceptance, with 90.3% of respondents agreeing (Mean = 4.32; SD =

0.92), reinforcing the link between the awareness gaps identified in Table 2 and actual behavioural acceptance of prevention programmes. This suggests that acceptability is not a standalone attitudinal variable but is directly downstream of the depth of HIV/AIDS knowledge within the community.

Religious beliefs emerged as one of the most powerful factors shaping acceptance, endorsed by 95.5% of respondents (Mean = 4.57; SD = 0.72). Cultural background was rated even more strongly, with 96.9% agreement (Mean = 4.66; SD = 0.62) the highest mean recorded among the substantive barriers in this table. Together, these findings indicate that acceptability of MPHT in Lafia LGA is governed less by rational engagement with health information and more by deeply embedded religious and cultural frameworks that mediate how youths interpret and respond to prevention technologies. This has significant implications for programme design: sensitisation strategies that do not engage directly with religious leaders and cultural gatekeepers are unlikely to shift acceptability meaningfully.

By contrast, cynical attitudes that is, scepticism about MPHT's efficacy or necessity were the least endorsed barrier, with 75.1% of respondents disagreeing (Mean = 2.14; SD = 1.25). This is an important nuance: the low acceptability of MPHT does not appear to stem from active distrust of the programme itself, but rather from external constraints religion, culture, and knowledge gaps that operate independently of youths' opinions about MPHT's actual usefulness.

Educational background was also identified as a significant factor, with 85.1% of respondents agreeing that it shapes acceptance (Mean = 4.21; SD = 1.09), suggesting that the depth and quality of schooling affects how receptive youths are to health interventions. Finally, the near-unanimous endorsement (98.9%) that inadequate sensitisation campaigns undermine MPHT acceptance (Mean = 4.87; SD = 0.41) underscores a clear, actionable policy gap: irrespective of religious or cultural constraints, more consistent and better-targeted awareness campaigns appear to be a necessary if not sufficient condition for improving MPHT uptake among youths in the LGA.

Fears Associated with MPHT among Youths

Table 4 details the specific fears that inhibit MPHT acceptance among youths in Lafia LGA.

Table 4: Fears Associated with MPHT among Youths in Lafia LGA (N = 382)

Statement	SA (%)	A (%)	N (%)	D (%)	SD (%)	Mean	SD
Fear of stigmatisation influences MPHT among youths	180 (47.1)	160 (41.9)	15 (3.9)	17 (4.5)	10 (2.6)	4.27	0.92
Fear of loss of marriage opportunity influences MPHT among youths	230 (60.2)	130 (34.0)	8 (2.1)	9 (2.4)	5 (1.3)	4.50	0.77
Fear of lack of confidentiality influences MPHT among youths	90 (23.6)	185 (48.4)	20 (5.2)	62 (16.2)	25 (6.5)	3.66	1.19
Fear of loss of support influences MPHT among youths	195 (51.0)	130 (34.0)	15 (3.9)	32 (8.4)	10 (2.6)	4.23	1.03

SA = Strongly Agree; A = Agree; N = Neutral; D = Disagree; SD = Strongly Disagree. Source: Author's Fieldwork, 2025.

Table 4 demonstrates that psychosocial fears play a substantial and multidimensional role in shaping youths' engagement with MPHT in Lafia LGA, with fears tied to social identity and

relational consequences proving more influential than concerns about the testing process itself. Fear of stigmatisation was strongly endorsed, with 89.0% of respondents agreeing that it influences their MPHT decisions (Mean = 4.27; SD = 0.92). This aligns with wider literature on HIV-related stigma in Nigeria, where a positive test result is frequently associated with social exclusion rather than treated purely as a clinical outcome.

The most strongly endorsed fear in the table was loss of marriage opportunity, with 94.2% agreement (Mean = 4.50; SD = 0.77). This finding is particularly significant given Lafia LGA's context, where marital status carries substantial social and economic weight; it suggests that MPHT is perceived by many youths not merely as a health decision but as one with direct consequences for their marriageability and social standing. Fear of loss of social support followed a similar pattern, with 85.0% agreement (Mean = 4.23; SD = 1.03), reinforcing the finding that MPHT decisions are experienced as deeply relational rather than purely individual.

By comparison, fear of lack of confidentiality, while still a meaningful concern, was less dominant, with 72.0% agreement and a comparatively lower mean (3.66; SD = 1.19). This suggests that while youths harbour some distrust of health system confidentiality protocols, this concern is secondary to the broader social consequences of a positive result becoming known within their community.

Collectively, Table 4 indicates that fear-based barriers to MPHT acceptance in Lafia LGA are primarily social and relational rather than procedural. Interventions that focus narrowly on improving confidentiality protocols, while valuable, are unlikely to substantially shift MPHT uptake unless they are paired with community-level strategies that address stigma and the perceived marital and social costs of testing.

Test of Hypothesis

The test of hypothesis was achieved with the aid of Statistical Package for Social Sciences (SPSS) 20.0 version at 0.05 level of significance.

Level of significance: $\alpha = 0.05$

Test statistic

$$X^2 = \sum \frac{(O-E)^2}{E}$$

Decision rule: Reject H_0 if P-value is less than α -value

Hypothesis 1: Relationship between Awareness of HIV/AIDS and Acceptance of MPHT

H_{01} : There is no significant relationship between awareness of HIV/AIDS and acceptance of MPHT in Lafia LGA.

Table 5: Pearson Correlation- Awareness of HIV/AIDS and Acceptance of MPHT (N =382)

Variable	N	Mean	SD	R	df	p-value
Awareness of HIV/AIDS	382	16.15	3.71	.52*	380	<.001
Acceptance of MPHT	382	24.77	3.24			

*Significant at $p < .05$. Source: SPSS Output, Author's Fieldwork, 2025.

A moderate, positive, statistically significant correlation was found between awareness of HIV/AIDS and acceptance of MPHT ($r = .52, p < .001$). Since the p-value is below the .05 significance threshold, the null hypothesis is rejected. This confirms that as HIV/AIDS awareness among youths increases, their level of MPHT acceptance correspondingly improves, though the moderate strength of the relationship indicates that awareness alone does not fully determine acceptance other factors, such as religion and culture, continue to play a substantial role.

Hypothesis 2: Impact of HIV/AIDS Awareness on Fears Associated with MPHT

H_{02} : There is no significant impact of knowledge of HIV/AIDS on fears associated with MPHT among youths in Lafia LGA.

Table 6: Pearson Correlation- Awareness of HIV/AIDS and Fear of MPHT (N = 382)

Variable	N	Mean	SD	r	df	p-value
Awareness of HIV/AIDS	382	16.15	3.71	.38*	380	<.001
Fear associated with MPHT	382	16.66	2.98			

*Significant at $p < .05$. Source: SPSS Output, Author's Fieldwork, 2025.

A weak-to-moderate, positive, statistically significant correlation was found between HIV/AIDS awareness and fear of MPHT ($r = .38, p < .001$). The null hypothesis is rejected. This finding suggests that greater awareness of HIV/AIDS and its consequences is associated with somewhat elevated fear regarding MPHT, plausibly because deeper knowledge of the disease intensifies the perceived stakes of a positive result. This underscores the need for awareness programmes to be paired with psychosocial support and stigma-desensitisation components, rather than assuming that increased knowledge alone will reduce anxiety around testing.

Hypothesis 3: Uniformity of Factors Influencing MPHT Acceptability

H_{03} : There is no significant difference in the extent to which religion, culture, education, knowledge adequacy, cynicism, and sensitisation influence MPHT acceptability among youths in Lafia LGA.

Table 7: Friedman Test- Factors Influencing MPHT Acceptability (N = 382)

Factor	Mean Rank
Lack of adequate sensitization	5.62
Cultural background	4.94
Religious beliefs	4.71
Inadequate knowledge	3.85
Educational background	3.40
Cynical attitudes	1.48

$\chi^2(5, N = 382) = 152.47, p < .001$. Source: SPSS Output, Author's Fieldwork, 2025.

The Friedman test reveals a statistically significant difference in the extent to which the six factors influence MPHT acceptability, $\chi^2(5, N = 382) = 152.47, p < .001$. The null hypothesis is rejected: the factors are not equally influential. Lack of adequate sensitisation and cultural background emerge as the strongest drivers of low MPHT acceptability, while cynical attitudes rank as the weakest, consistent with the descriptive findings reported in Table 3. This indicates that the various factors inhibiting MPHT acceptance do not operate with equal force and that

interventions should be prioritised toward sensitisation and culturally-embedded strategies rather than applying uniform emphasis across all factors.

Hypothesis 4: Existence of Fears Associated with MPHT

H₀₄: Youths in Lafia LGA do not report significant fear associated with MPHT (i.e., the mean fear score does not differ from the scale midpoint).

Table 8a: One-Sample t-Test- Fear Associated with MPHT (Test Value = 12, Scale Midpoint)

Variable	N	Mean	SD	T	df	p-value
Fear associated with MPHT	382	16.66	2.98	28.94	381	<.001

Source: SPSS Output, Author's Fieldwork, 2025.

The sample mean fear score (16.66) is significantly above the neutral midpoint (12) of the four-item fear scale, $t(381) = 28.94$, $p < .001$. The null hypothesis is rejected: youths in Lafia LGA do report significant fear associated with MPHT, rather than approaching the subject with indifference.

Table 8b: Pearson Correlation Matrix- Fears Associated with MPHT among Youths (N=382)

Fear Variable	1	2	3	4
1. Fear of stigmatization	1			
2. Fear of loss of marriage opportunity	.57*	1		
3. Fear of lack of confidentiality	.254*	.031	1	
4. Fear of loss of support	.288*	.207*	.218*	1

*Correlation significant at the 0.05 level (2-tailed); critical $r \approx .100$ at $N = 382$. Source: SPSS Output, Author's Fieldwork, 2025.

Table 8b shows that all correlations among the four fear dimensions are statistically significant at $p < .05$, with the exception of fear of loss of marriage opportunity and fear of lack of confidentiality ($r = .031$, not significant). The strongest association is between fear of stigmatisation and fear of loss of marriage opportunity ($r = .57$), reflecting that both arise from the social consequences of a positive HIV result within the marriage context. Taken together with the one-sample t-test result above, these findings affirm that multiple, interrelated fears co-exist and interact to suppress MPHT acceptance among youths in Lafia LGA, with stigma and marriage-related concerns forming the most tightly linked cluster.

Discussion of Findings

The findings of this study reveal a theoretically coherent, if practically concerning, pattern: youths in Lafia LGA demonstrate a moderate-to-high level of HIV/AIDS awareness (Table 2) alongside a comparatively lower level of MPHT acceptability (Table 3), with substantial fear-based resistance (Table 4) mediating the relationship between the two. This section situates these findings within the Health Belief Model and the wider empirical literature on premarital HIV testing in Nigeria and comparable contexts.

Awareness without acceptance: the perceived-barriers gap; The apparent paradox, that awareness does not automatically translate into acceptance, is well accounted for by the Health Belief Model (Rosenstock, 1974). The HBM holds that health-protective behaviour is not a simple function of knowledge; it also depends on perceived susceptibility, perceived severity,

perceived benefits, and, critically, perceived barriers. An individual may be fully aware that HIV/AIDS is transmissible and that MPHT exists as a protective measure, yet still decline to participate if the anticipated social and psychological costs stigma, loss of marriage prospects, breach of confidentiality appear to outweigh the health benefit. The present findings map cleanly onto this framework: respondents overwhelmingly acknowledged the transmission risk of HIV/AIDS (Table 2) and even recognised inadequate sensitisation as a driver of low acceptance (Table 3), but simultaneously reported strong fears of stigmatisation and loss of marriage opportunity (Table 4) that plausibly function as the “perceived barriers” the HBM identifies as the final gatekeeper of behaviour. This pattern is consistent with Manakandan and Sutan's (2017) observation that premarital HIV screening is often broadly endorsed as a concept while remaining constrained in practice by structural and attitudinal barriers the same disjunction between principle and uptake evident in the Lafia data.

Corroboration from comparable Nigerian settings; The finding also aligns with Arulogun and Adefioye's (2010) study of unmarried youths in Ibadan Northwest LGA, where 82.8% believed MPHT could reduce the spread of HIV, yet 43.8% simultaneously feared it would increase HIV-related stigma the same coexistence of conceptual support and practical apprehension observed in Lafia LGA. Umar and Oche's (2012) study of religious leaders in Sokoto similarly found that greater HIV/AIDS knowledge was associated with more favourable views of MPHT, but that religious and cultural considerations continued to shape whether leaders required it of couples in practice reinforcing the present study's finding that religion and culture, not knowledge deficits alone, are the dominant forces suppressing acceptability (Table 3). Taken together, these studies suggest that low MPHT acceptability is not a localised anomaly in Lafia LGA but a recurring feature of Nigerian premarital HIV testing contexts more broadly, rooted in shared socio-cultural dynamics around marriage, stigma, and religious authority.

The awareness–acceptance relationship; The Pearson correlation analysis found a moderate, statistically significant positive relationship between awareness of HIV/AIDS and acceptance of MPHT ($r = .52$, $p < .001$; Table 5). This is consistent with the HBM's proposition that “cues to action,” including health education and sensitisation campaigns, increase the likelihood of preventive health behaviour by raising perceived susceptibility and benefits. It also aligns with Peters et al.'s (2010) findings in rural Ghana, where the cognitive and decision-making skills fostered by formal education, more so than HIV knowledge in isolation, were associated with a greater likelihood of adopting protective health behaviours. This nuance matters for the present study: it suggests that the relationship between awareness and MPHT acceptance in Lafia LGA may be strengthened not simply by disseminating more HIV/AIDS facts, but by building the broader health literacy and reasoning skills that allow youths to translate awareness into action. This is further supported by Vandemoortele and Delamonica's account of education as an “education vaccine” against HIV, drawing on evidence including Zambian data, which frames education as a durable structural lever for HIV-protective behaviour change across African contexts, not merely a one-off information transfer.

Importantly, however, the moderate strength of the correlation ($r = .52$), rather than a very strong or near-perfect one, is itself a meaningful finding: it indicates that awareness is a necessary but not sufficient condition for MPHT acceptance. This is consistent with the broader thrust of the HBM and reinforces the study's central argument that religious, cultural, and fear-based barriers operate as independent forces that can suppress acceptance even where awareness is high. Fear as a mediating mechanism. The moderate positive correlation between HIV/AIDS awareness and fear of MPHT ($r = .38$, $p < .001$; Table 6) offers a further, somewhat counterintuitive, refinement of the HBM account: greater awareness of HIV/AIDS's consequences does not straightforwardly reduce anxiety about testing, and may in some

respects heighten it, by making the stakes of a positive result more vivid and concrete. This finding underscores a critical implication for programme design: HIV/AIDS sensitisation campaigns that focus solely on transmission facts and consequences, without a parallel psychosocial support and stigma-reduction component, may inadvertently increase resistance to testing even as they succeed in raising awareness.

Interlinked structural barriers; The Friedman test results (Table 7) demonstrate that the various factors inhibiting MPHT acceptability sensitisation adequacy, culture, religion, knowledge, education, and cynicism are not uniformly influential but form a hierarchy, with structural and socio-cultural factors (sensitisation, culture, religion) considerably outweighing individual cynicism. This finding refines the HBM's individual-level focus by pointing to the importance of the social-ecological context in which perceived barriers are formed: barriers to MPHT acceptance in Lafia LGA appear to be substantially inherited from community and institutional structures rather than generated by individual scepticism about the intervention itself.

The multidimensionality of fear; Finally, the one-sample t-test (Table 8a) confirms that fear associated with MPHT is significantly present among youths in Lafia LGA, rather than being a marginal or negligible concern, while the correlation matrix (Table 8b) shows that these fears are substantially interrelated, particularly fear of stigmatisation and fear of loss of marriage opportunity ($r = .57$). This clustering suggests that, in the Lafia LGA context, MPHT-related fear operates less as a set of discrete, independent worries and more as a single underlying anxiety about social and marital consequences, with confidentiality concerns forming a comparatively separate and secondary dimension. This has direct implications for intervention design: addressing stigma and marital-consequence fears together, rather than treating each fear dimension as a separate target, is likely to yield more efficient gains in MPHT acceptability than piecemeal interventions.

Summary; Collectively, the discussion affirms that MPHT acceptability among youths in Lafia LGA is shaped by a layered set of dynamics well captured by the Health Belief Model: awareness raises the theoretical plausibility of MPHT uptake, but perceived barriers stigma, marital consequences, cultural and religious constraints, and, paradoxically, heightened fear from greater awareness itself act as countervailing forces. This is consistent with, and extends, prior Nigerian findings (Arulogun & Adefioye, 2010; Umar & Oche, 2012) as well as the broader African literature connecting education, awareness, and HIV-protective behaviour (Peters et al., 2010; Vandemoortele & Delamonica, 2000). The findings suggest that MPHT sensitisation strategies in Lafia LGA will be most effective when they move beyond simple knowledge transfer to directly address stigma, marital-consequence fears, and the cultural and religious frameworks through which youths interpret HIV testing.

Conclusion and Recommendations

This study concludes that low MPHT acceptability among youths in Lafia LGA is not attributable to ignorance of HIV/AIDS, nor to outright rejection of MPHT as a concept. Rather, it is the product of a gap between knowing and accepting a gap that the Health Belief Model explains through the construct of perceived barriers, and that this study's findings substantiate empirically. Awareness of HIV/AIDS transmission is high and nearly universal, and youths broadly recognise the value of premarital testing in principle. What suppresses uptake is the anticipated social cost of testing: stigma, threatened marriage prospects, and the weight of religious and cultural expectation, reinforced by a sensitisation environment that respondents themselves judge to be inadequate.

The finding that awareness is positively associated with *both* acceptance and fear is the study's most theoretically significant contribution. It indicates that HIV/AIDS education, on its own, is

a double-edged intervention: it can move youths toward MPHT acceptance, but it can just as easily deepen anxiety about the social consequences of a positive result if it is not paired with parallel efforts to reduce stigma and strengthen community support structures. Simply put, more knowledge does not automatically produce more willing test-takers; it produces more *informed* youths who are weighing real social risks against a health benefit, and for many, the social risks currently outweigh that benefit.

The study further concludes that interventions aimed at improving MPHT acceptability in Lafia LGA cannot rely on a single-factor strategy. Because sensitisation, culture, and religion operate as the dominant and interlinked barriers, and because fear of stigma and fear of lost marriage prospects are tightly bound together rather than independent concerns, a fragmented approach that addresses only one barrier at a time is unlikely to move acceptability meaningfully. A coordinated, multi-pronged strategy is required.

Based on the findings and conclusions of this study, the following recommendations are offered:

1. Redesign sensitisation campaigns to go beyond transmission facts. Since inadequate sensitisation was the single most strongly endorsed barrier to MPHT acceptability, health authorities and NGOs operating in Lafia LGA should expand HIV/AIDS education programmes beyond basic transmission facts (which youths already largely know) to explicitly address the *purpose, confidentiality safeguards, and personal benefits* of MPHT specifically.

2. Pair every awareness campaign with a stigma-reduction and psychosocial support component. Given that awareness was positively associated with fear as well as acceptance (Hypothesis 2), health education programmes should not be delivered as standalone knowledge-transfer sessions. Each campaign should be paired with counselling access, peer-support structures, and visible messaging that normalises testing and living with a positive result, so that rising awareness translates into confidence rather than anxiety.

3. Engage religious and cultural leaders directly as MPHT advocates. Because religion and culture were identified as the strongest attitudinal barriers, interventions should prioritise structured engagement with imams, pastors, and traditional/community leaders in Lafia LGA, equipping them to publicly frame MPHT as compatible with, rather than opposed to, religious and cultural values around marriage.

4. Address stigma and marriage-related fears as a single, combined target. Since fear of stigmatisation and fear of loss of marriage opportunity were the most strongly correlated fears ($r = .57$), interventions should not treat these as separate problems. Community dialogues, media campaigns, and marriage-counselling integration should explicitly reframe a positive HIV status as compatible with marriage (e.g., through discordant-couple testimonies, serodiscordant marriage counselling, and partner-support programming), rather than addressing "stigma" and "marriage fears" through separate, uncoordinated messaging.

5. Strengthen confidentiality protocols and communicate them clearly. Although fear of lack of confidentiality was the least dominant of the four fear dimensions, it remains a meaningful concern for a majority of respondents. Health facilities offering MPHT should reinforce and visibly publicise confidentiality safeguards (e.g., private counselling rooms, coded result systems) to reduce this residual barrier.

6. Target youth-specific messaging given the age profile of the sample. With a substantial share of respondents in the 15–24 age bracket, sensitisation content, delivery channels (e.g., school-based programmes, social media, youth religious groups), and messaging tone should be tailored to a young audience rather than adapted from general-population HIV campaigns.

7. Institutionalise MPHT within pre-marital counselling structures. Local government health departments should work with religious and traditional marriage-registration bodies to embed MPHT information sessions within existing pre-marital counselling and courtship processes, rather than relying solely on standalone public health campaigns to reach youths.

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