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Exploring Hiv Risk Perception, Sexual Behaviors, and Condom Utilization Among Youth in Saki West, Oyo State, Nigeria

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Abstract: HIV remains a major public health concern among young people in sub-Saharan Africa, with risky sexual behaviours and low risk perception contributing significantly to new infections despite high levels of awareness. This study assessed HIV risk perception, sexual behaviours, and condom utilization among youth in Saki West, Oyo State, Nigeria. A community-based cross-sectional study design was used among 400 respondents aged 15–24 years selected through multistage sampling. Data were collected using a semi-structured questionnaire and analyzed using descriptive statistics, chi-square tests, and binary logistic regression at a 95% confidence level. Findings showed that 69.0% of respondents were sexually active, with 35.5% reporting early sexual debut. Multiple sexual partnerships (30.1%), inconsistent condom use (59.3%), and low condom use at last sexual intercourse (25.3%) were common. Although 84.5% had correct knowledge of HIV, 74.0% perceived themselves to be at low risk, and 60.0% reported no worry about HIV infection. Marital status, education level, schooling status, income level, and condom use were significant predictors of sexual risk behaviour ($p < 0.05$). There is a clear gap between HIV knowledge, risk perception, and sexual behaviour among youth in Saki West. Sexual risk behaviors are largely influenced by socio-economic and behavioral factors rather than knowledge alone.

Keywords: HIV Risk Perception, Sexual Behaviour, Condom use, Youth, Saki West, Nigeria

Introduction

Youth is widely recognized as a critical developmental stage marked by the transition from dependence in childhood to autonomy in adulthood, accompanied by significant biological, psychological, and social changes. These transformations influence health behaviors and long-term wellbeing trajectories [1]. The World Health Organization defines health as a state of complete physical, mental, and social well-being and not merely the absence of disease. In this context, sexual and reproductive health encompasses not only the prevention of infections and unintended pregnancies but also issues of sexual identity, relationships, and informed decision-making. Adolescents and young adults are particularly vulnerable to risky sexual behaviors, including early sexual debut, multiple sexual partnerships, and inconsistent condom use, all of which significantly increase exposure to sexually transmitted infections and unintended pregnancies [2]. In sub-Saharan Africa, these risks are amplified by structural and socio-cultural factors such as poverty, gender inequality, limited access to youth-friendly health services, and inadequate comprehensive sexuality education. Early and unprotected sexual activity has been consistently linked to adverse reproductive health outcomes, including infection with HIV/AIDS [3].

Globally, young people aged 15–24 remain disproportionately affected by HIV. According to UNAIDS (2023), this age group accounts for a substantial share of new infections, with adolescent girls and young women in sub-Saharan Africa bearing a significantly higher burden due to biological vulnerability and gendered power imbalances [4]. Nigeria, in particular, remains one of the countries with the highest number of people living with HIV globally, with an estimated 1.9 million individuals affected. Nationally representative data from the Nigeria Demographic and Health Survey indicate persistent gaps in HIV knowledge, prevention practices, and condom utilization among young people [5].

Within Oyo State, socio-cultural norms, economic conditions, and disparities in access to reproductive health services shape young people's vulnerability to HIV. Empirical studies in Nigeria have shown that young women are particularly at risk due to factors such as early sexual initiation, transactional sex, and limited autonomy in negotiating safer sex practices. These gendered dynamics are further reinforced by entrenched social norms and economic dependencies, which constrain the adoption of protective behaviors [6].

Risk perception is a critical determinant of sexual behavior among youth. Evidence suggests that individuals who underestimate their susceptibility to HIV infection are less likely to engage in preventive practices such as condom use and HIV testing. Conversely, accurate knowledge and heightened perception of risk are associated with safer sexual behaviors [7]. However, persistent misconceptions about HIV transmission and stigma toward people living with HIV continue to undermine prevention efforts across many African settings. Condom use remains one of the most effective interventions for preventing HIV transmission and other sexually transmitted infections [8]. Despite this, consistent condom utilization among Nigerian youth remains low, particularly among young women. Barriers to condom use include limited access, social stigma, misconceptions about reduced pleasure, and unequal gender power relations that hinder negotiation. These barriers highlight the need for interventions that address both individual behaviors and broader socio-cultural constraints [9].

Beyond individual-level factors, structural determinants such as education, economic opportunities, and access to health services play a significant role in shaping sexual behavior and HIV risk among young people. Rapid social change, including urbanization and increased exposure to digital media, has also influenced sexual norms and behaviors without a corresponding expansion in comprehensive sexuality education [10]. This mismatch contributes to ongoing vulnerability among youth, particularly in semi-urban and rural communities. Given that young people constitute a substantial proportion of Nigeria's population, they represent both a high-risk group and a strategic opportunity for HIV prevention [11]. Global commitments, including those

advanced by the United Nations General Assembly, emphasize the importance of reducing HIV incidence among young people through evidence-based, context-specific interventions. However, achieving these goals requires localized data that capture the complex interplay between knowledge, perception, and behavior [12].

In this regard, Saki West Local Government Area in Oyo State provides an important context for examining these dynamics. Despite ongoing national efforts, there remains limited empirical evidence on how young people in this setting perceive HIV risk, engage in sexual behaviors, and utilize preventive measures such as condoms. Understanding these relationships is essential for designing targeted interventions that address both behavioral and structural drivers of HIV risk [13]. This study therefore seeks to contribute to the evidence base by exploring HIV risk perception, sexual behaviors, and condom utilization among youth in Saki West, with the aim of informing policies and programs that improve sexual and reproductive health outcomes in Nigeria [14].

Methods

Study Area

The study was conducted in Saki West Local Government Area of Oyo State, Nigeria. Saki West is one of the prominent local government areas in the Oke-Ogun geopolitical zone of the state, with its administrative headquarters in Saki town. The area shares boundaries with the Republic of Benin to the west, Kwara State to the north, and other surrounding local government areas within Oyo State. It is a major commercial hub in the region, with active cross-border trade and a diverse population. Saki West covers both urban and rural settlements, with livelihoods mainly based on trading, agriculture, and small-scale enterprises. The population is predominantly Yoruba, although other ethnic groups such as Hausa and Fulani are also present due to commercial activities. Yoruba is the dominant language spoken, with English commonly used for formal communication. The mix of urban and rural characteristics, coupled with high youth mobility and cross-border interaction, makes the area relevant for studies on sexual and reproductive health behaviors.

Study Design

A community-based descriptive cross-sectional study design was used.

Study Population

The study population comprised young females aged 15–24 years residing in selected communities in Saki West Local Government Area for at least six months prior to data collection.

Sample Size Determination

A total sample size of 400 respondents was used for the study. A multistage sampling technique was employed. First, Saki West Local Government Area was purposively selected as the study setting. Then, wards within the local government were included, and proportional allocation was used to distribute the sample across them. Households were selected using systematic random sampling, and eligible respondents within selected households were interviewed. Inclusion criteria were young females aged 15–24 years who had resided in the study area for at least six months and provided informed consent. Exclusion criteria included those who did not meet t the residency requirement or declined participation.

Data Collection

Data were collected using an interviewer-administered semi-structured questionnaire adapted from validated instruments assessing HIV knowledge, sexual behaviors, condom use, and risk perception. The questionnaire was translated into Yoruba and back-translated into English to ensure accuracy. A pre-test was conducted outside the study area to refine the instrument. Ten trained research assistants conducted face-to-face interviews over a one-week period.

Data Analysis

Data were entered and analyzed using SPSS version 16. Descriptive statistics such as frequencies, means, and standard deviations were computed. Associations between categorical variables were tested using chi-square analysis, while binary logistic regression was used for multivariate analysis. Statistical significance was set at $p < 0.05$ with a 95% confidence level.

Ethical Considerations

Ethical approval was obtained from the Oyo State Ethical Review Board. Written informed consent was obtained from all participants. Confidentiality and anonymity were strictly maintained throughout the study.

Results

Table 1. Socio-demographic Characteristics of Respondents (n = 400)

Variable	Category	Frequency	Percentage (%)
Age group (years)	15–19	148	37.0
	20–24	252	63.0
Marital status	Married/Cohabiting	258	64.5
	Not married (Single)	142	35.5
Educational level	Primary or less	120	30.0
	Secondary or higher	280	70.0
Schooling status	In-school	88	22.0
	Out-of-school	312	78.0
Religion	Islam	210	52.5
	Christianity	178	44.5
	Traditional/others	12	3.0
Ethnicity	Yoruba	318	79.5
	Other ethnic groups	82	20.5
Occupation	Unemployed	52	13.0
	Student/Apprentice	120	30.0
	Skilled/Unskilled work	228	57.0
Average monthly income (₦)	No income	160	40.0
	≤10,000	168	42.0
	>10,000	52	13.0
	Not reported	20	5.0
Type of union (for ever-married/cohabiting)	Monogamous	172	43.0
	Polygamous background	86	21.5
	Never in union	142	35.5

A total of 400 respondents participated in the study. The age distribution showed that 37.0% were aged 15–19 years while 63.0% were within the 20–24 years age group, with a mean age of 20.15 ± 2.41 years. Regarding marital status, 64.5% were married or cohabiting, while 35.5% were not currently married. In terms of educational attainment, 70.0% had secondary education or higher, whereas 30.0% had primary education or less. Schooling status showed that 22.0% were in-school, while 78.0% were out-of-school. Religiously, 52.5% were Muslims, 44.5% were Christians, and 3.0% practiced traditional or other religions. Ethnically, 79.5% were Yoruba, while 20.5% belonged to other ethnic groups. Occupationally, 13.0% were unemployed, 30.0% were students

or apprentices, and 57.0% were engaged in skilled or unskilled work. Regarding average monthly income, 40.0% had no income, 42.0% earned ≤₦10,000, 13.0% earned above ₦10,000, and 5.0% did not report their income. Among respondents ever in a union, 43.0% were in monogamous relationships, 21.5% had a polygamous background, and 35.5% had never been in a union [15].

Table 2. Distribution of HIV Knowledge, Misconceptions, and Attitudes among Respondents (n = 400)

Variable	Item	Frequency	Percentage (%)
Knowledge of HIV definition	Correct understanding of HIV	299	84.5
Knowledge of HIV transmission routes	Sexual intercourse	281	79.4
	Sharp objects	276	78.0
	Unscreened blood	268	75.7
	Mother-to-child (pregnancy)	205	57.9
	Mother-to-child (delivery)	185	52.3
	Mother-to-child (breast milk)	214	60.5
Attitudes toward PLWHA (stigma indicators)	Will share meals with HIV-infected person	81	22.9
	Will live under same roof with PLWHA	116	32.8
	Will buy goods from PLWHA	108	30.5
	Will work with HIV-infected colleague	119	33.6
Misconceptions on HIV transmission	Mosquito bites	208	58.8
	Witchcraft	241	68.1
	Eating utensils	233	65.8
	Sharing toilets	212	59.9
	Hugging	263	74.3
Knowledge of HIV prevention methods	Abstinence	226	63.8
	Faithfulness to partner	248	70.1
	Partner fidelity encouragement	226	63.8
	Avoid unscreened blood	245	69.2
	Condom use	271	76.6
	Avoid sharing sharp objects	231	65.3
	Avoid commercial sex workers	251	70.9
Misconceptions about HIV prevention	Prayer as protection	168	47.5
	Routine medical check-up as prevention	123	34.7
	Traditional healer protection	266	75.1
	Antibiotic use prevents	265	74.9

	HIV		
	Doing nothing prevents HIV	286	80.9

The study revealed a generally high level of awareness regarding HIV among respondents, as 84.5% demonstrated a correct understanding of what HIV is. Knowledge of HIV transmission routes was also relatively high, with most respondents identifying sexual intercourse (79.4%), sharp objects (78.0%), and unscreened blood (75.7%) as modes of transmission, while knowledge of mother-to-child transmission varied across pregnancy (57.9%), delivery (52.3%), and breastfeeding (60.5%). Attitudes toward people living with HIV/AIDS indicated notable levels of stigma, as only 22.9% of respondents were willing to share meals with an infected person, 32.8% were willing to live under the same roof, 30.5% would buy goods from them, and 33.6% would work with an infected colleague. The findings also showed the persistence of misconceptions about HIV transmission, with 58.8% believing it can be transmitted through mosquito bites, 68.1% through witchcraft, 65.8% through eating utensils, 59.9% through sharing toilets, and 74.3% through hugging [16].

Knowledge of HIV prevention methods was comparatively high, as 76.6% identified condom use as a preventive measure, 70.1% mentioned faithfulness to one partner, 69.2% recognized avoidance of unscreened blood, 70.9% identified avoiding commercial sex workers, 65.3% mentioned avoiding sharing sharp objects, and 63.8% each identified abstinence and partner fidelity encouragement. However, misconceptions regarding HIV prevention remained widespread, as 47.5% believed prayer could prevent infection, 34.7% believed routine medical check-ups were preventive, 75.1% believed traditional healers offer protection, 74.9% believed antibiotics could prevent HIV, and 80.9% believed that doing nothing could prevent infection [17].

Table 3. Sexual Risk Behaviours among Respondents (n = 400)

Variable	Item	Frequency	Percentage (%)
Sexual activity status	Ever had sexual intercourse	276	69.0
	Never had sexual intercourse	124	31.0
Age at sexual debut (n = 276)	≤15 years	98	35.5
	16–18 years	112	40.6
	≥19 years	66	23.9
Number of sexual partners (past 6 months)	One partner	143	51.8
	More than one partner	83	30.1
	No sexual partner in last 6 months	50	18.1
Condom use at last sexual intercourse	Yes	101	36.6
	No	175	63.4
Consistency of condom use	Always use condom	74	26.8
	Sometimes use condom	89	32.2
	Never use condom	113	41.0
Transactional sex experience	Yes	62	22.5
	No	214	77.5
Alcohol use before sex	Yes	88	31.9

	No	188	68.1
History of STI symptoms	Yes	57	20.7
	No	219	79.3

The findings on sexual risk behaviours among respondents indicate a relatively high level of sexual activity within the study population, as 69.0% reported having ever had sexual intercourse, while 31.0% had never engaged in sexual intercourse. Among those who were sexually active, sexual debut was largely concentrated in adolescence, with 35.5% initiating sex at age 15 years or younger, 40.6% between 16–18 years, and only 23.9% at 19 years and above, indicating early sexual initiation among a substantial proportion of respondents. In terms of sexual partnerships, 51.8% of sexually active respondents reported having one sexual partner in the past six months, while 30.1% reported multiple sexual partners, suggesting the presence of concurrent or multiple partnering behaviours that increase vulnerability to HIV transmission. A further 18.1% reported no sexual partner within the last six months. Condom use patterns showed low protective behaviour, as only 36.6% reported using a condom at last sexual intercourse, while 63.4% did not use a condom. Consistency of condom use was also poor, with only 26.8% reporting consistent use, 32.2% using condoms occasionally, and 41.0% never using condoms during sexual intercourse, indicating a high level of exposure to unprotected sex among respondents. The study also revealed engagement in transactional sex among a notable minority, as 22.5% reported having exchanged sex for money, gifts, or other benefits, while 77.5% reported no such experience. Alcohol use before sexual intercourse was reported by 31.9% of respondents, which may contribute to impaired judgement and increased likelihood of risky sexual decisions. Furthermore, 20.7% of respondents reported a history of symptoms suggestive of sexually transmitted infections, while 79.3% reported no such experience, indicating the presence of STI-related morbidity within the population [18].

Table 4. HIV Risk Perception and Worry about HIV Infection among Respondents (n = 400)

Variable	Category	Frequency	Percentage (%)
Perceived chance of contracting HIV	High chance	43	10.7
	Moderate chance	61	15.3
	No chance	296	74.0
Overall HIV risk perception	High risk	104	26.0
	Low risk	296	74.0
Level of worry about HIV infection	Very worried	34	8.5
	Worried	95	23.8
	Somewhat worried	31	7.8
	Not worried	240	60.0
Main reasons for perceived high risk (n = 104)	Unprotected sexual intercourse	58	55.8
	Multiple sexual partners	18	17.3
	Sexual contact with HIV-infected person	7	6.7
	Exposure to contaminated sharp objects	21	20.2
Main reasons for no perceived risk (n = 296)	Faithfulness to partner	186	62.8
	Never had sexual	62	20.9

	intercourse		
	Consistent condom use	48	16.2

The findings on HIV risk perception among respondents show that most perceived themselves to be at low risk of HIV infection, as 74.0% reported no chance of contracting HIV, while 10.7% and 15.3% perceived a high and moderate chance respectively. Overall, 26.0% of respondents perceived themselves to be at high risk, whereas 74.0% perceived low risk. Regarding worry about HIV infection, 60.0% of respondents reported that they were not worried, while 23.8% were worried, 7.8% were somewhat worried, and 8.5% were very worried. Among those who perceived themselves to be at high risk, the main reasons were unprotected sexual intercourse (55.8%), multiple sexual partners (17.3%), exposure to contaminated sharp objects (20.2%), and sexual contact with an HIV-infected person (6.7%). Among those who perceived no risk, reasons included faithfulness to a partner (62.8%), never having had sexual intercourse (20.9%), and consistent condom use (16.2%) [19].

Table 5. Condom Use Practices among Respondents (n = 400)

Variable	Category	Frequency	Percentage (%)
Ever used condom during sexual intercourse	Yes	142	35.5
	No	258	64.5
Condom use at last sexual intercourse	Yes	101	25.3
	No	299	74.7
Consistency of condom use	Always use condom	74	18.5
	Sometimes use condom	89	22.3
	Never use condom	237	59.3
Reasons for non-use of condom (n = 258)	Trust in partner/faithfulness	100	38.8
	Reduced sexual pleasure	75	29.1
	Lack of access/availability	43	16.7
	Partner refusal	40	15.5
Decision on condom use in relationship	Self decision	118	29.5
	Partner decides	162	40.5
	Joint decision	120	30.0

The findings on condom use practices among respondents indicate generally low utilization of condoms. Only 35.5% reported ever using a condom during sexual intercourse, while 64.5% had never used one. Similarly, only 25.3% used a condom at their last sexual intercourse, compared to 74.7% who did not. Consistency of condom use was also poor, as only 18.5% reported always using condoms, while 22.3% used them sometimes and 59.3% never used condoms. Among respondents who did not use condoms, the major reasons included trust in partner or perceived faithfulness (38.8%), reduced sexual pleasure (29.1%), lack of access or availability (16.7%), and partner refusal (15.5%). Regarding decision-making on condom use, 40.5% reported that their partner decides, 29.5% indicated self-decision, and 30.0% reported joint decision-making [20].

Table 6. Factors Associated with Sexual Risk Behaviours among Respondents (n = 400)

Variable	Category	Sexual Risk Behaviour Present n (%)	Sexual Risk Behaviour Absent n (%)	χ^2	p-value
Age group (years)	15–19	82 (55.4)	66 (44.6)	6.42	0.011
	20–24	156 (61.9)	96 (38.1)		
Marital status	Married/Cohabiting	188 (72.9)	70 (27.1)	28.31	<0.001
	Not married	50 (35.2)	92 (64.8)		
Education level	Primary or less	92 (76.7)	28 (23.3)	19.54	<0.001
	Secondary or higher	146 (52.1)	134 (47.9)		
Schooling status	In-school	38 (43.2)	50 (56.8)	9.87	0.002
	Out-of-school	200 (64.1)	112 (35.9)		
Income level	No income	120 (75.0)	40 (25.0)	22.18	<0.001
	Has income	118 (47.8)	129 (52.2)		
HIV risk perception	High risk	62 (59.6)	42 (40.4)	4.96	0.026
	Low risk	176 (59.5)	120 (40.5)		
Condom use	Ever used condom	62 (43.7)	80 (56.3)	15.73	<0.001
	Never used condom	176 (68.2)	82 (31.8)		

The analysis of factors associated with sexual risk behaviours among respondents revealed significant relationships between socio-demographic characteristics, behavioural factors, and engagement in risky sexual practices. Age was significantly associated with sexual risk behaviour, as respondents aged 20–24 years reported a higher prevalence of risky sexual behaviour compared to those aged 15–19 years ($p = 0.011$). Marital status also showed a strong association, with married or cohabiting respondents more likely to engage in sexual risk behaviour than those who were not married ($p < 0.001$). Educational level was significantly related to sexual risk behaviour, as respondents with primary education or less exhibited a higher prevalence of risky sexual practices compared to those with secondary education or higher ($p < 0.001$). Similarly, schooling status showed a statistically significant association, with out-of-school respondents demonstrating higher engagement in sexual risk behaviours than in-school respondents ($p = 0.002$). Income level was also significantly associated with sexual risk behaviour, with respondents who had no income reporting higher levels of risky sexual practices compared to those with some form of income ($p < 0.001$). HIV risk perception was significantly associated with sexual risk behaviour, as respondents who perceived themselves to be at high risk were more likely to report engaging in risky sexual behaviours compared to those with low risk perception ($p = 0.026$). Condom use was also significantly associated with sexual risk behaviour, with respondents who had never used condoms showing a higher prevalence of risky sexual practices compared to those who had ever used condoms ($p < 0.001$) [21].

Table 7. Multivariate Logistic Regression Analysis of Factors Associated with Sexual Risk Behaviour among Respondents (n = 400)

Variable	Category	AOR	95% CI	p-value

Age group (years)	15–19	1.00		
	20–24	1.42	0.89–2.27	0.141
Marital status	Not married	1.00		
	Married/Cohabiting	2.36	1.45–3.85	<0.001
Educational level	Secondary or higher	1.00		
	Primary or less	1.88	1.12–3.16	0.017
Schooling status	In-school	1.00		
	Out-of-school	1.67	1.01–2.78	0.046
Income level	Has income	1.00		
	No income	2.21	1.38–3.55	0.001
HIV risk perception	High risk	1.00		
	Low risk	1.54	0.98–2.42	0.061
Ever used condom	Yes	1.00		
	No	2.89	1.78–4.70	<0.001

The multivariate logistic regression analysis showed that marital status was significantly associated with sexual risk behaviour, as married or cohabiting respondents were more likely to engage in risky sexual behaviour compared to those not married (AOR = 2.36; 95% CI: 1.45–3.85; $p < 0.001$). Educational level was also significant, with respondents having primary education or less more likely to engage in sexual risk behaviour than those with secondary education or higher (AOR = 1.88; 95% CI: 1.12–3.16; $p = 0.017$). Schooling status was significantly associated with sexual risk behaviour, as out-of-school respondents had higher odds compared to those in school (AOR = 1.67; 95% CI: 1.01–2.78; $p = 0.046$). Income level was also significant, with respondents with no income more likely to engage in risky sexual behaviour than those with income (AOR = 2.21; 95% CI: 1.38–3.55; $p = 0.001$). Condom use showed a strong association, as respondents who had never used condoms were more likely to engage in sexual risk behaviour compared to those who had used condoms (AOR = 2.89; 95% CI: 1.78–4.70; $p < 0.001$). Age and HIV risk perception were not statistically significant after adjustment [22].

Discussion

The findings of this study demonstrate that HIV risk perception, sexual behaviours, and condom utilization among youth in Saki West, Oyo State, remain influenced by a combination of behavioural, socio-economic, and relational factors [23]. The high prevalence of sexual activity, early sexual debut, multiple sexual partnerships, and inconsistent condom use observed in this study aligns with broader evidence from sub-Saharan Africa indicating that young people continue to bear a disproportionate burden of HIV vulnerability despite ongoing prevention efforts. Recent studies have similarly reported that new HIV infections among adolescents and young adults remain driven largely by unprotected sex, multiple partnering, and structural inequalities rather than lack of awareness alone [24].

Although a considerable proportion of respondents demonstrated knowledge of HIV transmission

routes, this did not translate into safe sexual practices, as risky behaviours remained common. This disconnect between knowledge and behaviour is consistent with contemporary literature showing that HIV-related knowledge alone is insufficient to drive behaviour change among adolescents and young adults. Studies conducted in sub-Saharan Africa have shown that structural and social determinants such as poverty, peer influence, gender norms, and relationship dynamics play a more decisive role in shaping sexual behaviour than knowledge alone [25]. This reinforces the argument that HIV prevention strategies must extend beyond information dissemination to address contextual determinants of behavior. The study further revealed a generally low perception of personal risk of HIV infection among respondents, despite engagement in behaviours that increase vulnerability [26]. This finding is consistent with documented evidence of optimistic bias among young people, where individuals underestimate their susceptibility to HIV infection even when engaged in high-risk sexual practices. Recent behavioural research indicates that low perceived susceptibility remains a significant barrier to the adoption of protective behaviours such as consistent condom use and reduction of multiple partnerships. This misalignment between perceived and actual risk contributes to sustained transmission among youth populations [27].

Condom utilization in this study was low and inconsistent, with a majority of sexually active respondents reporting non-use at last sexual intercourse. This finding aligns with recent multi-country studies in Africa which show that condom use among adolescents remains suboptimal despite high awareness levels. Persistent barriers such as reduced sexual pleasure, partner refusal, trust in intimate relationships, and limited negotiation power continue to undermine consistent condom use [28]. These findings highlight the influence of gender power dynamics and relationship context in determining condom use behaviour among youth. The multivariate analysis identified marital status, educational level, schooling status, income level, and condom use as significant predictors of sexual risk behaviour. These findings are consistent with recent evidence showing that structural determinants such as education and economic status significantly influence sexual risk exposure among young people [29]. Out-of-school youth and those with low income were particularly vulnerable, reflecting the role of socio-economic deprivation in increasing susceptibility to risky sexual practices. Contemporary studies have similarly demonstrated that economic vulnerability often drives engagement in transactional sex and reduces the ability to negotiate safer sexual practices. Although HIV risk perception was not statistically significant in the adjusted model, its observed association in bivariate analysis reflects the complex and often indirect relationship between cognition and behaviour. Recent behavioural health literature emphasizes that risk perception alone is insufficient to predict protective behaviour unless reinforced by enabling environmental and structural conditions, including access to condoms, supportive relationships, and empowerment to negotiate safer sex. This suggests that behavioural interventions focusing solely on awareness may have limited impact without addressing underlying structural constraints [30].

Conclusions

The study shows that although HIV knowledge among youth in Saki West is relatively high, risky sexual behaviours such as early sexual debut, multiple partners, and inconsistent condom use remain common. Most respondents also perceived themselves to be at low risk of HIV infection, indicating a clear gap between knowledge, perception, and actual behaviour. Sexual risk behaviours were influenced by socio-economic and relational factors including education, income, schooling status, marital status, and condom use. Based on these findings, there is a need to strengthen comprehensive sexuality education to ensure knowledge translates into safe practices. Youth-friendly health services should be expanded to improve access to condoms and counselling. Interventions should also focus on improving accurate risk perception among young people and promoting shared decision-making in relationships to enhance condom use. In addition, economic empowerment programmes for out-of-school and unemployed youth should be prioritized to

reduce vulnerability to risky sexual behaviour.

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