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# The perception and belief about HIV/AIDS in Wudil local community, Kano, Nigeria

Adamu Mustapha

Department of Environmental Sciences, Faculty of Environmental Studies, Universiti Putra Malaysia.

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**ABSTRACT**

The study examines the various myths and misconception about HIV/AIDS in Wudil local community kano, Nigeria. Focus Group Discussion (FGD) and questionnaire administrations were undertaken to gather data for the study. It was discovered that the people of the area believed that sharing food and cloth, among other things, with an infected person as well as insect bite can lead to HIV/AIDS infections. The people required enlightenment on the mode of transmission of the disease, the need for knowing one's status and the means of protecting oneself from being infected with the disease. It was suggested, among other things, that constant counseling on HIV/AIDS should be accorded to the members of the community.



## Introduction

The Human Immunodeficiency Virus (HIV) is a virus found only in human beings that weakens the immune system of the body, which normally protects a person against disease. The virus is a very small germ/organism that multiplies rapidly and damages certain cells in the body called CD4 cells. These are cells that fight infections and when this virus weakens them it may lead to AIDS.

AIDS stand for Acquired Immune Deficiency Syndrome, it is a condition caused by HIV when the body protection is lost leading to the development of many serious opportunistic infections. A person who has reached the AIDS stage of HIV infections shows a number of major/minor signs of illness. If two major and one minor signs are present in an adult or two major and two minor signs are present in a child he/she may likely be diagnosed to have AIDS. However, without a proper HIV test from a registered medical institute, it may be impossible to know if someone has HIV, because the symptoms may also be as a result of another major illness.

There are some of myths underlying the misconceptions concerning HIV/AIDS in Wudil community. Myths are imaginary, fictitious or invented stories about a thing or event while a misconception is a wrong understanding of a thing or concept. Indeed a lack of adequate knowledge of a thing leads to misconception which in turn leads to the development of myths around the subject matter. Therefore, most of the myths and misconceptions about HIV/AIDS grew out of lack of adequate knowledge of the disease.

The main aim of the study is to identify the myths and misconception about HIV/AIDS among the people of Wudil. It is also to determine the strength and direction of such belief as well as the consequences of the belief on the people. Such a study at the grassroots is important because it will help those interested in reducing the menace of HIV/AIDS what to do to make local people understand and take necessary precautions to prevent the spread of the disease, the study also proffers some suggestions.

## Materials and Method

### Description of the study area

Wudil local government area has a surface area of about 4,058sq km and a population of about 150,602 (1991 census) and one of the 44 local goverment areas in Kano State. Wudil local government is located between latitudes $11^{0}55^{1}$ and $12^{0}00^{1}$ North and longitude $8^{0}45^{1}$ and $9^{0}00^{1}$ East. The study area is underlain by Basement complex rocks which have been subjected to deep chemical and physical weathering to produces regolith and laterites. The rocks are of Precambrian in origin and consist of metamorphic and igneous types which have been in existence for several million years (Olofin,1987).

The study area falls under the landform region of Nigeria known as the High Plains of Hausaland (Olofin, 1987). The plains constitute the largest of the landforms units occupying about 40% of the Kano region. The elevation ranges between 450m – 700m. There also is an additional wind-drift material on the plains especially around the old Utai road in southern part of the area.

The present climate of the region is the tropical wet and dry type. In a normal year the mean annual rainfall in and around the study area is about 800mm – 1000mm. Temperature is warm or hot throughout the year, even though there is a slight cool period between November to February. December is considered the coolest month with mean values ranging between $12^{0}C$ – $21^{0}C$ while April and May are the hottest months with mean average of $35^{0}C$. Temporal variation of temperature from one year to the other is very marginal. Actual evapotranspiration is estimated to be about 60% of the rainfall in the southern part of the region increasing to about 75% in the north. Relative humidity is higher in the south by 2% than the northern part (Olofin,1987).

Generally, land in the study area is extensively used for both agricultural and settlement purposes. The study area is extensively cropped; the crops commonly grown in the area include both cash and food crops. Example includes sorghum, millet, beans, sugarcane, tomatoes, pepper, rice, wheat, mango, guava, carrot and cabbage, among other things.

**Tele:**

**E-mail addresses: amustapha494@gmail.com**

Agriculture in the area employs more than 70% of the total population, and about 60% of the total local income is derived from agriculture. Consequent upon these, people in the area invest more labour and capital on the farms during the rainy season. It should also be noted that considerable number of people in the area around the river engage in fishing activities while a small number engage in trading, tailoring, pottery, animal rearing etc.

**Methodology**

The study was designed as a survey of changes in the perception and belief of Wudil local community that is myths and misconceptions of HIV/AIDS. The survey was carried out through Group Focused discussion (GFD) and administration of questionnaire.

The sample framework adopted involved the selection of ten wards within wudil local community using random techniques. The wards were picked from north, south, west and east of Wudil town. The wards are Darki, Dan-Kaza, Indabo, Achika, Cikin-Gari, Sabon-Gari, Kausani, Lajawa, Utai and Dagumawa.To do this, the names of all the wards in Wudil were written on pieces of paper and folded up, then a neutral person was asked to pick ten out of the total at random, that way each ward had an equal chance of being picked with others.

The questionnaire was designed in two parts, the first part contained question and information relating to the respondents: that is their Bio-Data, while the second part was designed for other aspects of the survey. Five copies of the questionnaire were administered in each of the ten wards of wudil making the total number of copies of questionnaire to be fifty (50). The questionnaire was randomly administered in each of the ward.

Group Focus Discussion (GFD) was undertaken on both structured and unstructured basis. In some cases, other members of the family from within the household were picked to verify and correlate the accuracy of the information given by the respondents by providing additional information.

**Results**

The results are presented and illustrated with tables.

Profile of Respondents

The Profile of the respondents relating to age, sex, occupation, marital status and education is illustrated in Tables 1 to 5 below.

Table 1 indicates that no respondent is younger than 15 years and the majority 56% are older than 45 years. This group are mostly parents who moves from one place to another especially farmers after harvesting period. Most of them move to cities in search of second employment and risks themselves to commercial sex workers.

Table 4 show that the population consists mainly of married people. This can be linked to the fact that people in this area marry at an early age. Divorced people constituted the lowest percentage with 12%, this could be probably be because it is a taboo and sign of irresponsibility to be a single parents.

Table 5 shows the educational status of the respondents. Majority of the respondents have Arabic education while about 26% have no formal education and only 8% go beyond secondary schools. It could be deduced from this that majority of the people use their time in farming rather than going to school which they believed is time consuming. This also shows the level of ignorance among the community.

Table 6 shows that only 20% of the respondent agreed that HIV/AIDS is real. After counseling and GFD the level of those that agree HIV/AIDS is real increases to certain level. Some respondents initially have the belief that HIV/AIDS is not a disease of black people.

Table 7 shows that only 2% of the respondents have been to clinic to know their status. To some the reason given is that, if you know you are positive, the life of the infected person get shorter, because of the trauma. Some have the belief that if they go to clinic during testing they can be contracted by health workers there. Some of the respondents are worried about confidentiality and fear that the result would be shared without consent. At the treatment level, discussion forum was opened; counseling and teaching on the importance of HIV/AIDS testing was strengthened. At the posttest stage it was discovered that all the respondents agreed to go to clinic for HIV/AIDS testing.

Table 8 shows that the level of understanding the HIV/AIDS is very low among the respondent. Only 2% of the respondents ever know anybody in the community that have HIV/AIDS, this is due to ignorance and failure of the people in the community to go to clinic for testing. An infected person will die without knowing what kill him. During treatment stage, it emphases that it's not only HIV/AIDS that kills; there are other dangerous diseases that kill.

Table 9 shows that only 8% of the respondents have the knowledge of an infected person dying as a result of HIV/AIDS. This also shows the level of ignorance among the community.

Table 10 shows that about 60% of the respondents have the misconception of AIDS that it is an American invention to discourage sex. During treatment stage the researcher told the respondents that America did not invent any diseases, people from every race and nationality have been affected by HIV/AIDS. At posttest all the respondents agreed.

Table 11 shows that the entire respondent s100% does not agree with the statement that HIV/AIDS can be cured by having a sex with a young virgin girl. This is a belief of the South African people.

Table 12 shows that 80% of the respondents agreed that religious people do not get HIV/AIDS. During the treatment stage the researcher told them that it does not matter who a person is, HIV is transmitted by what a person does. At the posttest, all the respondents agreed that HIV can be contracted by the virus irrespecting of your status in the community.

Table 13 shows that 84% believed that AIDS is a disease of immoral people. Many references and cases were given by the respondents. They have the belief that HIV can only be transmitted through sexual activities. At the treatment level, other modes of transmission were discussed. At the posttest all the respondents agreed that apart from transmission through sexual activities, there are other modes of transmission.

Table 14 shows that 80% of the respondents agreed that when an infected person breathes or cough on someone, the person can be infected with the virus. While 20% of the respondents agreed that sharing cloth or eating with an infected person can lead to HIV/AIDS infection.

Conclusively, it is very clear that lack of formal education, ignorance and poverty are the causes of the unfortunate myths and misconception about HIV/AIDS in Wudil Local community. The following are some recommendations arising from these findings:

The community should have access to factual and accurate information about HIV/AIDS. This can be done through public enlightenment campaign by Governmental and non-Governmental, local and International organizations.

The enlightenment can be through the showing of films and slides followed by discussion to the community. There should also be the encouragement of formal education among the community. This will reduce the level of ignorance. Similarly, debates/panel discussions are also recommended for enlightenment. This will change the quality of thought and cognitive development/analysis of the community of the people in the local community.

**References**

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**TABLE 1: Age distribution of Respondents**

| AGE GROUP | FREQUENCY | % OF TOTAL |
|---|---|---|
| 15-25 YEARS | 6 | 12 |
| 26-35 YEARS | 7 | 14 |
| 36-45 YEARS | 9 | 18 |
| 46-55 YEARS | 13 | 26 |
| 55 –ABOVE | 15 | 30 |
| TOTAL | 50 | 100 |

**TABLE 2: Sex status of the Respondents**

| SEX | FREQUENCY | % OF TOTAL |
|---|---|---|
| Male | 40 | 80 |
| Female | 10 | 20 |
| TOTAL | 50 | 100 |

Table 2 shows that 80% of the respondents are male and only 20% are female. This is because women in the area are indoors always.

**TABLE 3: Occupational characteristic of Respondents**

| OCCUPATION | FREQUENCY | % OF TOTAL |
|---|---|---|
| Farmers | 38 | 76 |
| Traders | 4 | 8 |
| Civil servant | 1 | 2 |
| Others | 7 | 14 |
| TOTAL | 50 | 100 |

Table 3 shows that 76% of the respondents are farmers. This shows that the area is a rural settlement.

**TABLE 4: Marital status of the Respondents**

| MARITAL S. | FREQUENCY | % OF TOTAL |
|---|---|---|
| Single | 9 | 18 |
| Married | 25 | 50 |
| Divorced | 6 | 12 |
| Widowed | 10 | 20 |
| TOTAL | 50 | 100 |

**TABLE 5: Educational status of Respondent**

| EDUC S. | FREQUENCY | % OF TOTAL |
|---|---|---|
| Arabic | 16 | 32 |
| No Formal Educ. | 13 | 26 |
| Primary | 10 | 20 |
| Secondary | 7 | 14 |
| Higher Educ. | 4 | 8 |
| TOTAL | 50 | 100 |

**TABLE 6: Agreement that HIV/AIDS is real**

| | FREQUENCY | % OF TOTAL |
|---|---|---|
| YES | 10 | 20 |
| NO | 40 | 80 |
| TOTAL | 50 | 100 |

**Table 7: Verification Of Personnel Status**

| | FREQUENCY | % OF TOTAL |
|---|---|---|
| YES | 2 | 4 |
| NO | 48 | 96 |
| TOTAL | 50 | 100 |

**Table 8: Knowledge Of Hiv/Aids Patients In The Locality**

| | FREQUENCY | % OF TOTAL |
|---|---|---|
| YES | 1 | 2 |
| NO | 49 | 98 |
| TOTAL | 50 | 100 |

**Table 9: Knowledge Of Hiv/Aids Casualities**

| | FREQUENCY | % OF TOTAL |
|---|---|---|
| YES | 4 | 8 |
| NO | 46 | 92 |
| TOTAL | 50 | 100 |

**Table 10: Belief In Hiv/Aids As An American Invention**

| | FREQUENCY | % OF TOTAL |
|---|---|---|
| YES | 30 | 60 |
| NO | 20 | 40 |
| TOTAL | 50 | 100 |

**Table 11: sex with a yoyng girl as a cure of Hiv/Aids**

| | FREQUENCY | % OF TOTAL |
|---|---|---|
| YES | 0 | 0 |
| NO | 50 | 100 |
| TOTAL | 50 | 100 |

**Table 12 Beliefs That Religious People Do Not Get Hiv/Aids**

| | FREQUENCY | % OF TOTAL |
|---|---|---|
| YES | 40 | 80 |
| NO | 10 | 20 |
| TOTAL | 50 | 100 |

**Table 13: Perception That Hiv/Aids Is A Disease Of Immoral People**

| | FREQUENCY | % OF TOTAL |
|---|---|---|
| YES | 42 | 84 |
| NO | 8 | 16 |
| TOTAL | 50 | 100 |

**Table 14: Percieved Causes Of Hiv/Aids In Wudil Community**

| | FREQUENCY | % OF TOTAL |
|---|---|---|
| Breathing And Coughing With Aids Patient | 40 | 80 |
| Eating and sharing clothes with patient | 10 | 20 |
| Total | 50 | 100 |