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Attitude of the Community towards People Living with HIV/AIDS in Abukwaka Local Area Council of Suleja Local Government Area in Niger State

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Abstract **Original Research Article**

This study investigates the attitude of community towards people living with HIV/AIDS in Abukwaka area council of Suleja local government in Niger state. A total of 60 randomly selected HIV/AIDS patients from the general population participated in the study. The data for the study was collected using 25 structured items questionnaire with sections A, B, C and D, the data was analyzed using frequency and descriptive statistics. The work aimed at examining the level of discriminatory attitudes towards people living with HIV/AIDS and the factors in association with such attitudes. The study revealed that about 89 % of the respondents exhibited discriminatory attitudes in the entire eleven relevant items variable. Stigma among the community was significantly high ($P<0.05$) which was mostly due to fear of contracting the disease as a result of poor general knowledge about HIV/AIDS. In conclusion, community health education must be enforced in order to eradicate the challenge of misconception about the disease and necessity for a change of negative to positive attitudes towards people living with HIV/AIDS (PLWHA).

Keywords: HIV/AIDS, Community, Stigma, Discriminatory, PLWHA (People Living with HIV and AIDS) Attitudes.

STUDY BACKGROUND

The knowledge of HIV/AIDS and attitude of people in the community towards people living with HIV/AIDS has become a complex and current matter of daily discussion. Negative attitudes and behaviors related to HIV/AIDS are based on unfounded ideas and fears that constitute stigma and discrimination [1].

AIDS: The Acquired Immune Deficiency Syndrome(sometimes called 'slim' disease)is a fatal illness caused by a retro virus known as the human immune deficiency (HIV) which breaks down the body's immune system leaving the victim vulnerable to a hast of life threatening opportunistic infection, neurologic disorders or unusual malignancies [2].

Although the HIV/AIDS was rarely known in the 1980s in Nigeria while the world has comprehensive data on the epidemics of HIV/AIDS. The acquired immunodeficiency syndrome which was first recognized in 1989 in the United State of America, did not cause much concern, here in Nigeria until about 1984 among researchers, Yaba, Lagos State. The first confirmed AIDS case in Africa was reported in 1984 in Nairobi Kenya while the first evidence of AIDS in Nigeria was reported to health officers (whereby many people including some medical practitioners denied its existence. But today the World is under the fear of this plaque and it has attracted more attention than any known disease to mankind [3]. According to worldwide AIDS and HIV statistics including deaths, the number of people living with HIV rose from 8 million in 1990 to 38.6 million 2005and is still growing. 63% of people living with HIV/AIDS were in Sub-Sahara African [4]. According to UNAIDS (2009) report, worldwide some 60 million people orphaned children in South Africa alone, since the epidemic began. WHO, (2009). The high level of ignorance on the reproductive health issues especially HIV/AIDS among the general populace serves as a strong catalyst for the spread of the virus, consequently, the growth of HIV infection has reached the alarming rate. Since the first reported cases of HIV/AIDS in Nigeria, the Federal Government has continued to respond to the pandemic through the implementation of various programme aimed at

preventing, controlling and mitigating its impact (FMOH 2005).

Despite the effect of global, national and local in prevention and control of HIV/AIDS, the stigma and discrimination are one of the key barriers to combating AIDS epidemic whereby people living with HIV/AIDS face negative response toward them by the people in the social environment stigma and discrimination often have profound impact in the lives of people living with HIV/AIDS their responses may range from unconscious gesture to rejection and mistreatment tinged with harassment and hospitality. The stigma or discrimination of communities towards people living with HIV/AIDS brings some effect: for example, re-infection and the spread of the virus, increase suicidal tendencies, no accurate data, broken homes, loss of jobs, abuse of rights, etcetera. We discovered that many people exhibiting discriminatory attitudes about people living with HIV/AIDS, fear related to it and exposure to HIV related information were independent predictors of discriminate attitudes toward people living with HIV/AIDS. The general public has formed some negative perception of people living with HIV/AIDS, are common and cover different aspect of their lives. (Joseph 2004). As it was observed that awareness was more among literates, therefore government and health educators should provide tailor made education programme for these at lower education level. (Lakashmi V 2004). Stigma among the community member was mostly due to fear of contacting the illness and stigma does exist to significant degree among uncharged HIV test (Mithra 2010). Prejudice can often be linked to misconception about HIV itself and its impacts on people lives and some fact about HIV. If known more widely will do much to reduce stigma and discrimination, for example, that an HIV positive can have a healthy baby that people with HIV in work take no time off for sickness than anyone else that an HIV diagnosis no long means an early death [5]. Also knowledge is most crucial in the fight against the discriminatory and stigmatization towards people living with HIV/AIDS especially among community. It was pointed out that social aspects of infectious diseases are often less well known than epidemiological aspects of infection diseases [6]. Therefore people living immunodeficiency virus HIV/Acquire immune against by other which comprises the effectiveness of HIV prevention and care programme. In the past three decades, HIV infection is undoubtedly the disease that was captured more political and scientific mobilization than any other disease. The latest data from WHO reveals that 33.4 million people live with HIV virus worldwide with almost 90% of the infected living in developed countries (WHO 2009).

Historical Briefs of Abukwaka Area Council

Abukwaka is a town in Suleja local government, Niger State of Nigeria. The original inhabitants were Gwari people. The paramount ruler is Sariki-Gwari. However, with the emergence of Suleja in Niger State so many changes occurred in Kwamba-Maje, one of such changes were the imposition of an Emir in Suleja and re- naming of the original name from the indigenous Abukwaka to Kwamba just for the ease of pronunciation by settlers. History had it that the Gwari people do not operate the emirate system of government traditionally. Thus questions have been asked as to the reasons behind the emergence of the Emirate system in Suleja.Maje. Research has however revealed that the emirs who are Hausa by tribe were from Zaria, Kaduna state and his ethnic group could not be found in Suleja.

METHODS

This was a simple randomized, blinded, non-experimental, and descriptive and community based cross- sectional study. Well-structured research questionnaire instruments were used for data collection between two populations of those who were blindly grouped into unisex knowledgeable and those unknowledgeable. The knowledge tested was simply based on the method for the transmission of HIV/AIDS, the General knowledge about HIV/AIDS, Demographic data, and Attitudes of the community towards people living with HIV/AIDS. The unpaired t test was the statistics technique adopted to appraise the level of significance of ignorance between these two populations unisex.

HYPOTHESES

1 Null Hypothesis

Ho: There is no significant difference between those that are knowledgeable (unisex) and those not knowledgeable (unisex) on all the possible routes of HIV/AIDS transmission in Kwamba community Suleja

Alternative Hypothesis

Ha: Significant difference exists between those that are knowledgeable (unisex) and those not knowledgeable (unisex) on all the possible routes of HIV/AIDS transmission in Kwamba community Suleja.

HYPOTHESES TWO

2 Null Hypothesis

Ho: There is no significant difference between those that are knowledgeable, 'attitudinal wise' (unisex) and those not knowledgeable in Kwamba community attitudinal wise towards people living with HIV/AIDS "PLWHA".

Alternative Hypothesis

Ha: There is significant difference between those that are knowledgeable, 'attitudinal wise' (unisex) and those not knowledgeable in Kwamba community attitudinal wise towards people living with HIV/AIDS "PLWHA"

RESULTS

Table-1: Appraisal of hiv/aids knowledge of transmission

MODE OF HIV TRANSMISSION	UN-KNOWLEDGIBLE (WRONG RESPONSE) (%) (UNISEX) (X_1)	(d_1) (X_1-X)	(d_1^2) $(X_1-X)^2$	KNOWLEDGIBLE (RIGHT RESPONSE (%) (UNISEX) (X_2)	(d_2) (X_2-X)	(d_2^2) $(X_2-X)^2$
Mosquito bite	89	10.9	118.81	11	-12.7	161.29
Blood transfusion	89	10.9	118.81	21	-2.7	7.29
Sharing sharp object	79	0.9	0.81	25	1.3	1.69
Unprotected sex	75	-3.1	9.61	20	-3.7	13.69
Multiple abortion	80	1.9	3.61	35	11.3	127.69
Breast feeding	70	-8.1	65.61	30	6.3	39.69
Sleeping together	65	-13.1	171.61			
∑			488.87			351.34

N_1= 7, χ_1= 78.4, N_2= 6, χ_2= 23.7, $\sum d_1^2$=488.87, $\sum d_2^2$= 351.34, $S.D_1^2$= 69.83, $S.D_2^2$= 58.6, $t_{calculated}$= 12.14, $t_{tabulated}$ =2.20

$t_{calculated} > t_{tabulated}$

Since the calculated value is greater than the tabulated value, we don't have sufficient evidence to retain the null hypothesis; hence it is rejected for the alternative hypothesis which is hence retained. In other words there was significant difference between those that are knowledgeable, 'HIV/AIDS Transmission wise' (unisex) and those not knowledgeable about all possible routes of HIV/AIDS transmission in Kwamba community Suleja. This significant difference in knowledge of issues pertaining.

Table-2: Attitudes of the community towards people living with HIV/AIDS

Attitudinal variables of the community towards PLWHA	UN-KNOWLEDGIBLE (WRONG RESPONSE) (%)(UNISEX) (X_1)	(d_1) (X_1-X)	(d_1^2) $(X_1-X)^2$	KNOWLEDGIBLE (RIGHT RESPONSE (%)(UNISEX) (X_2)	(d_2) (X_2-X)	(d_2^2) $(X_2-X)^2$
Hugging	89	-2.4	5.76	11	-3.3	10.89
Eating from the same plate	89	-2.4	5.76	11	-3.3	10.89
Sitting together	79	-1.4	1.96	21	6.7	44.89
Hand-shake	100	8.6	73.96			
Sleeping together in the same room	100	8.6	73.96			
∑(summation)	457		160.6	43		66.67

N_1= 5, N_2= 3, X_1= 91.4, X_2= 14.3, $S.D_1^2$= 32.12, $S.D_2^2$= 22.22,

$t_{calculated}$ = 19.67, $t_{tabulated}$= 2.45

$t_{alculated} > t_{abulated}$ (H_0 is rejected)

Since the calculated value is greater than the tabulated value, we don't have sufficient evidence to retain the null hypothesis, hence it is rejected for the alternative hypothesis which is hence retained. In other words there is significant difference between those that are knowledgeable, 'attitudinal wise' (unisex) and those not knowledgeable towards people living with HIV/AIDS "PLWHA" in Kwamba community

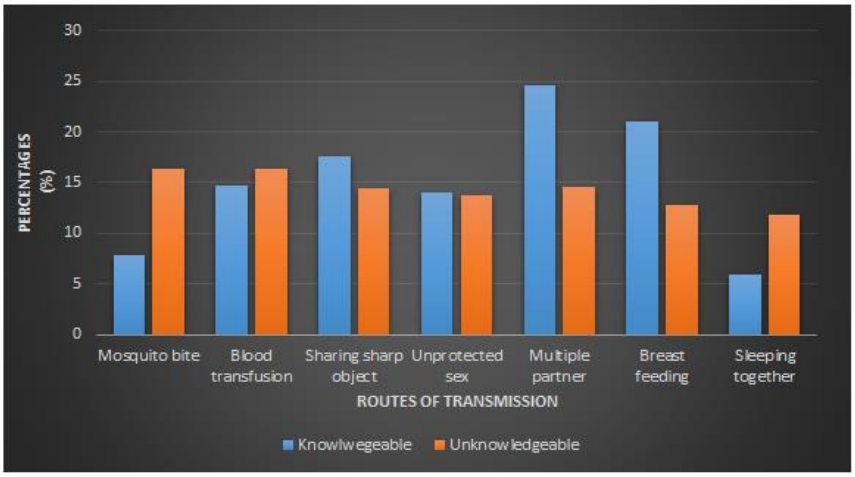

Fig-1a: Bar chart Representing People Living with HIV/AIDS in Different Route of Transmission among Knowledgeable and Unknowledgeable Individuals in Their Respective Communities

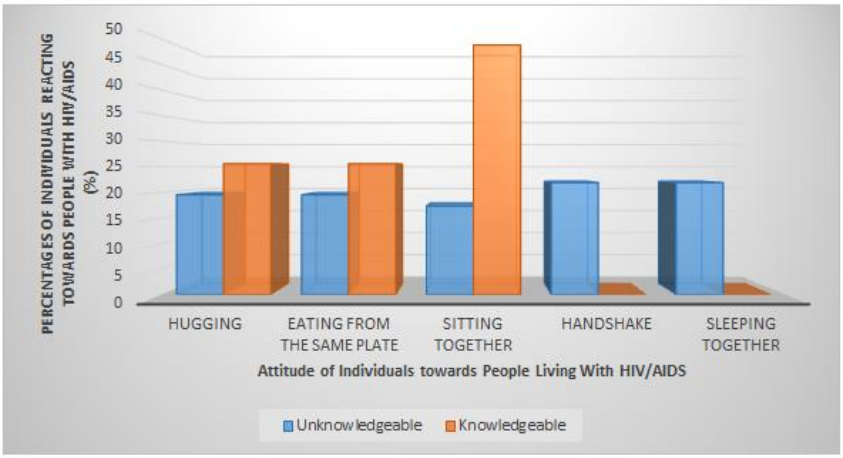

Fig-1b: shows the percentages of individuals reacting towards people with HIV/AIDS

DISCUSSION

Since the calculated value is greater than the tabulated value, we don't have sufficient evidence to retain the null hypothesis; hence it is rejected for the alternative hypothesis which is hence retained. In other words there is significant difference between those that are knowledgeable, 'attitudinal wise' (unisex) and those not knowledgeable towards people living with HIV/AIDS "PLWHA" in Kwamba community. This significant difference in knowledge of issues pertaining to HIV/AIDS transmission in community constituted the basis and origin of discrimination against those living with the disease, i.e. PLWHA. As explained in Tables 1 and 2 and also figures 1a and 1b.

This research was conducted among community members of Abukwaka Area Council of Suleja on their attitudes towards PLWHA. The need to carry out this study was born out of observations of the inclement environment, stigmatization, and the unpleasant situations their own relatives subjected them (PLWHA) to attitudinal wise due to HIV infection. Most of the results analysed above supported these observations as well as the charts.

Relevant literatures were reviewed and scheduled of instrument was used to collect the information from selected sample and the respondents were promised of confidentially for every information supplied.

The descriptive research design of survey type was used, among (100) participants as study population. The study demonstrated that discriminatory attitude towards PLWHA were common in Abbukwakwa Area council, and they have been strongly stigmatized. For instance, a noticeable proportion of the community population perceived PLWHA to be promiscuous. Many respondents thought that PLWHA were merely receiving punishment that they deserved.

On comparing the awareness of the respondents on the mode of spread of HIV and education levels, more respondents with less than secondary education felt that HIV could be spread through mosquito bite. This proved that knowledge regarding how HIV/AIDS was not spread was less than the knowledge about how it was spread. As a result of this, the above mentioned negative perception about PLWHA far related to AIDS and exposure to HIV related information were independent predictors of discriminatory attitude towards PLWHA.

CONCLUSIONS

From the findings, it was discovered that the general public has formed negative perceptions of PLWHA and discriminatory altitudes towards PLWHA are common and cover different aspects of their life interventions. The awareness of HIV/AIDS were confirmed by 98% of the "respondents but 54% do not know the cause of HIV/AIDS while those that believe in other cause were not many.

Also 68% have the option that one can get infected by physical contact with infected person meanwhile the stigma within the community was mostly due to fear of contacting the illness.

Stigma does not exist to significant degrees among the illiterate people which were suggested by about 89% of the participants agreed and said PLWHA should be made to live separately.

There is need for greater attempt towards making information regarding HIV/AIDS available to every individual of the society.

IMPLICATION

The implication of the study on the community and PLWHA are:

1. Stigmatizing individual may suffer discrimination that can lead to:
- Loss of employment and housing
- Estrangement from family and society
- Increase risk of violence.

2. HIV/AIDS related stigma also fuel new HIV infections because it can deter people from getting tested for the disease, make them less likely to acknowledge the risk of infection, and discourage those who are HIV positive from discussing their HIV status with their sexual partner and needle sharing partners
3. HIV related stigma and discriminatory can lead to depression, shame or even suicide thought among this population.

RECOMMENDATIONS

The following recommendations are based on the findings from the researchers:

1. There is a need for aggressive awareness educational and advocacy programs to inform and educate members of society about HIV/AIDS
2. PLWHA should be involved in the design and delivery of these programs.
3. Awareness programs should be provided at various levels of society and specifically targeted to the families of PLWHA.
4. Opinion leaders and religious leaders should engage in behaviour change interventions of the society.
5. The spiritual leaders should use their powers to encourage the church/mosque members to be more tolerant towards HIV infected individuals.
6. Community mobilization, political involvement and policy development and health education are essential to challenge misconception about the disease and change negative attitudes towards PLWHA.

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