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HIV/AIDS KNOWLEDGE, ATTITUDE AND PRACTICE [KAP] IN ANINRI LOCAL GOVERNMENT AREA OF ENUGU STATE

***Nwobodo H. A.**

Department of Medical Microbiology, College of Medicine, Enugu State University of Science & Technology, Enugu State, Nigeria.

***Corresponding Author: Nwobodo H. A.**

Department of Medical Microbiology, College of Medicine, Enugu State University of Science & Technology, Enugu State, Nigeria.

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ABSTRACT

The aim of this study was to evaluate HIV/AIDS knowledge, attitude and practice among the natives of Aninri Local Government Area of Enugu State in order to make recommendation to stakeholders on context specific intervention appropriate for HIV/AIDS prevention and control in the area. A total of 554 participants randomly selected from 11 communities in Aninri took part in the study. Face-to-face pretested structured questionnaires were used for data collection. Ethical clearance was obtained from Enugu State Ministry of Health (ESSMOH) ethical committee before the study was conducted. Data were collected (1st – 13 May, 2014) and analyzed using SPSS version 16.0 software package. Knowledge of HIV/AIDS was 61.0 percent, HIV testing rate was 45.7 percent, with 67.1 percent reporting willingness to test for HIV. Condom use was 49.1 percent. Widow inheritance was viewed as a safe practice by 44.0 percent and culturally acceptable (40.1 percent). Radio (44.2 percent) and NGO (30.5 percent) were the major sources of HIV/AIDS information in the area and the most preferred. Government (36.5 percent) and family (30.7 percent) are the major care providers for AIDS patients. There are no legal rights that protect orphans & widows (46.8 percent) though these rights are existence. Stigmatization and discrimination of people living with HIV/AIDS was reported by 72.4 percent and 70.9 percent participants respectively. Females (462) in reproductive age were dominant in the study because they are among the most at risk group, vibrant and sexually active for the purpose of procreation. Condom use for prevention of STIs/STDs and unplanned pregnancies was poor. Interestingly, the majority (61.0 percent) of participants know the various ways of transmitting HIV. This notwithstanding, significant number of individuals had inappropriate knowledge of how HIV is transmitted stating sexual intercourse with an infected person as the only mode of transmission and recommending outright killing of infected person as a way of preventing spread of the infection. Female Genital Mutilation (FGM), cutting of tonsil in tonsillitis, male circumcision, removal of tumors and other traditional practices like "Ichi mbu" and home delivery performed by traditionalists and the locals were not considered as potential sources of HIV infection, even though they involve exchange of sharps. This study suggests that inappropriate knowledge, negative attitude and unsafe practices towards HIV/AIDS remain a serious challenge to HIV/AIDS prevention and control in Aninri. For effective prevention and control of HIV/AIDS, massive awareness campaign should be instituted using various approaches including: one-one, group and mass education in order to correct and improve knowledge and change attitude and practice.

KEYWORDS: *HIV/AIDS, Knowledge, Attitude, Practice.*

INTRODUCTION

The World Health Organization (WHO) reported that approximately 33.3 million people were infected with HIV/AIDS globally in the year 2009 (Zafar *et al.*, 2014). In 2011, 1.7 million people died from AIDS-related causes worldwide with Sub-Saharan Africa accounting for 70 percent of all people dying (UNAIDS, 2012).

After South Africa, Nigeria with an estimated population of 160 million is second in the number of people (3.4 million) living with HIV/AIDS worldwide, representing 9 percent of the global burden of the disease (National Population Commission (NPC) 2014). Since 1991, the country has employed a sentinel surveillance system among pregnant women age 15-49 attending antenatal care to track HIV prevalence. Surveillance results show that HIV prevalence has declined over the years, from 5.8 percent in 2001 to 4.6 percent in 2008 and 4.1 percent in 2010. In 2010, across the country's states, HIV prevalence ranged from 1.0 percent in Kebbi to 12.6 percent in Benue (Federal Ministry of Health [FMoH], 2011 and NPC, 2008).

In Enugu State, the prevalence of HIV/AIDS was 5.1 in 2013 (FMoH, 2011). The high prevalence of the disease was despite interventions at global, national and local levels aimed at reducing transmission of new HIV infection and preventing development of HIV to AIDS among infected individuals. For instance, the minimum prevention package intervention (MPPI) which simultaneously use different classes of prevention activities (behaviour, biomedical and structural) that operate on multiple levels, to respond to the specific needs of the target audience (WHO) and massive awareness campaign were some interventions aimed at reducing HIV/AIDS burden in Nigeria. Another important intervention strategy was the scaling up of antiretroviral therapy in low- and middle-income countries including Nigeria (UNAIDS, 2012).

The federal government of Nigeria transformed the National Action Committee on AIDS into an agency, the National Agency for the Control of AIDS, in July 2007 to strengthen AIDS multisectoral response coordination. For the purpose of sustaining and improving the effectiveness and coordination of the national HIV response, states have taken the same step of transforming smaller committees and bodies into agencies.

Nationally, HIV and AIDS programmes have received a boost through the efforts of the government and the support of development partners, which has led to a scale up of prevention, care, and treatment programmes aimed at combating the disease. Also, the monitoring and evaluation system has been strengthened, and there have been increases in the amount of HIV research conducted (FMoH, 2014).

These efforts focus on HIV/AIDS prevention and control and have generated broad-based health gains like the saving of 14 million life-years in low- and middle-income countries, with sub-Saharan Africa accounting for 64.3% of such gain (UNAIDS, 2012). As programmatic scale-up has continued, health gains have accelerated, with the number of life-years saved by antiretroviral therapy in sub-Saharan Africa quadrupling in the last four years (UNAIDS, 2012).

However, these efforts and gains notwithstanding, knowledge, attitude and practice of natives in some local communities regarding HIV/AIDS leave much to be desired in HIV/AIDS prevention and control. It is a well known fact that new HIV infections in Nigeria are fuelled by low perceptions of personal risk, multiple and concurrent sexual partnerships, intense transactional and intra-generational sex, Female Genital Mutilation (FGM), cutting of tonsil in tonsillitis, male circumcision, local removal of tumors and other traditional practices like “Ichi mbu” (local incision or markings on inflamed parts of the body) and home delivery performed by traditionalists and the locals (FMoH, 2014). Others factors that encourage new HIV infection and development of HIV infection to AIDS are; ineffective and inefficient treatment services for sexually transmitted infections (STIs), entrenched gender inequalities and inequities, chronic and debilitating poverty and the persistence of HIV/AIDS-related stigma and discrimination as well as inadequate access to and poor quality of HIV/AIDS services (National Agency for the Control of AIDS (NACA), 2010). HIV/AIDS-related knowledge, attitude, and practice among individuals or group of individuals together with the prevailing tradition determine the extent to which people may be exposed and/or engaged in behaviours that may place them at risk of contracting HIV (NPC, 2014).

According to Hurt (2012) women in reproductive age are women between the age of 15 – 49 years. This age group falls between the period of initiation of sexual activity, marriage and child bearing. It is often a time of sexual experimentation and active sexual activities involving risky behaviors that increase the likelihood of HIV/AIDS (NPC, 2014).

The fight against HIV will depend on well-articulated prevention programmes addressing issues such as HIV/AIDS-related knowledge among the general population especially women in reproductive age, social stigmatization, risk behaviour modification, access to quality STI treatment services, provision and uptake of HIV counselling and testing, and access to care and antiretroviral therapy (ART), including prevention and treatment of opportunistic infections. The objective of this study is to present detailed information on these issues in Aninri local Government Area of Enugu State among women in reproductive age.

Socio-cultural and economic vulnerabilities are among the main drivers of the epidemic which result in high risk behaviors such as multiple partnerships, forced/coerced sex, early initiation of sexual activity, crack/cocaine usage and infrequent condom use. Nigerian government in collaboration with development partners have made strident moves in creating an enabling environment to reduce vulnerability to HIV and other diseases. Focal points of this multisectoral strategy include strengthening the legal/policy political, social and cultural agenda and frameworks to provide sustained and effective services in the population (Hope Caribbean co ltd, 2012).

What is HIV/AIDS knowledge, attitude and practice (KAP) pattern in Aninri? Continuous monitoring of trends in knowledge, attitude and practice (KAP) patterns is a key component of the evaluation of programmatic interventions which have been implemented over the past years. This remains important to the development of appropriate strategies to manage HIV/AIDS epidemic. Hence the objective of this study is to assess KAP of natives of Aninri LGA of Enugu State in order to make evidence-based recommendation to stakeholders that will inform development of appropriate strategies for prevention and control of HIV/AIDS in the area.

Seven broad aspects including: socio-demographic information; HIV & AIDS knowledge, attitudes & practice; condom use; sexual relations & socio-cultural practices; sources of HIV & AIDS information; community support and local structures; HIV & AIDS related legal rights issues will be studied.

METHODS

Study area

Aninri, meaning the land of edibles, has an area of 364 km^2 and a population of 133,723 according to 2006 census, with women in reproductive age (15 – 49 years) estimated to be about 30,000 (NPC, 2008) predominantly farmers cultivating rice, plantain, banana, cassava and trading on them.

Study design and period

This cross-sectional study was conducted among the natives of Aninri local government area from 1st - 13th May, 2014.

Sample size and sampling technique

Multistage sampling technique was employed. In the first stage, 11 communities that participated in the study was selected by a simple random sampling, using the list of all the communities in Aninri local government area collected from the Ministry of Rural Development and Chieftaincy, Enugu State. In the second stage, a total of 554 participants representing the various villages in each of the eleven communities were presented by the traditional rulers of the eleven communities selected in stage 1.

Data collection

Face-to-face pretested structured questionnaires were used for data collection. Information were collected on-demographic characteristics; STDs/STIs in the past or currently, issues bothering on sexual intercourse; source of HIV/AIDS education/awareness; HIV testing and counseling; condom knowledge, use and access. Interviewers were recruited and trained on the design of the study and the tools for data collection. The questionnaires were translated into Igbo language- the local language of the area, pretested among twenty respondents before final amendments were made based on observations recorded during pretesting.

Data analysis

Data were analyzed using SPSS version 16.0 software package. Descriptive statistics were used to describe socio-demographic characteristics.

Study limitations

Long distance, bad road, fear and reluctance to respond were constraints to the survey. These constraints were resolved by leaving very early each day, using nose mask and assuring them of confidentiality.

Ethical issues

The study was ethically approved by the Ethical Review Committee of Enugu State Ministry of Health. The details of the study were made known to the participants in writing and explained using local language. Consented participants were included in the study. Truthfulness, autonomy, and confidentiality were maintained. Data storage complied with Nigerian Data Act and Enugu State Data Protection Code. Participants were not given over optimistic assurance concerning benefits of the study as it does not guarantee cure for people already infected or protecting those not infected from future HIV infection if exposed to risky behaviour. Rather they were counselled after interview during which basic information, positive attitudes and safe practices which can prevent the spread of the infection were provided. Vulnerable people and those living with disability that could allow them participate were handled on grounds of human dignity, while participation was non-discriminatory and based on equity.

Scoring

Measurable and verifiable indicators that determine appropriateness of knowledge, positive attitude and safe practice include the number of respondents who know at least three modes of transmission/prevention of HIV/AIDS and two of the benefits of HCT as well as number that have voluntarily requested for HIV test and took the test, used PMTCT services, condom with non regular partners in the last act of sexual intercourse, and reporting no discrimination against PLWH.

Outcome variables are: knowledge which could be Appropriate or Inappropriate; Attitude which could Positive or Negative and Practice which could be Safe or Unsafe depending on the score. According to Zafar *et al.*, 2014, Eckstein and Likert scales are widely used in population based studies assessing the HIV/AIDS knowledge/Attitude and Practice respectively.

RESULTS

Out of 554 individuals that took part in the survey, 92 (16.6%) were males while 462 (83.4%) were females. Females between 18-23 years of age constituted 20.4% while males >50 years accounted for 1.4% of the participants as presented in table 1.

Table 1: Age distribution of participants

S/N	Age group (years)	Male (%)	Female (%)	Total (%)
1	< 18	11 (2.0)	109 (19.7)	120 (21.7)
2	18-23	31 (5.6)	90 (16.2)	121 (21.8)
3	24-39	17 (3.1)	113(20.4)	130 (23.5)
4	40-49	25 (4.5)	99 (17.9)	124 (22.4)
5	>50	8 (1.4)	51 (9.2)	59 (10.6)
Total		**92 (16.6)**	**462 (83.4)**	**554 (100)**

The major religious groups in the area were Christians-Roman Catholic and Protestant/Anglican and Traditionalists accounting for 53.4%, 35.4% and 1.8% of the participants respectively.

Farming was their major occupation (75%). Up to 67.7% of the participants were married, 15.9% reported ever used condom. Table 2 shows educational level of participants. Approximately 5.8% had no formal education, 16.8% had only primary education, 39.4% post secondary level of education, 34.5% had secondary level and 3.6% with university education.

Table 2: Educational level of participants

Educational level	Number (%)
None	20 (3.6)
Primary	93 (16.8)
Secondary	191 (34.5)
Post secondary	218 (39.4)
University	32 (5.8)
Total	**554 (100%)**

Half of the participants (50.0%) reported knowing someone who had HIV/AIDS. Participants unable to state at least a mode of transmission of HIV were described as having no knowledge (4.0%), while those stating just one or more than one were described as having poor knowledge (35.0%) and good knowledge (61.0%) of HIV transmission respectively. Majority (31.8%) of participants did not know how long it takes before someone with HIV gets sick as shown in table 3.

Table 3: Knowledge/care of someone living with HIV/AIDS

Knowledge/care of someone living with HIV/AIDS	Number (%)	
	Yes	No
Ever known any person who has/had HIV/AIDS in the community	277 (50)	277 (50)
Ever lived with someone with HIV/AIDS	96 (17.3)	458 (82.7)
Ever taken care of someone who had HIV/AIDS	89 (16.1)	465 (83.9)

In the study, married participants make up 67.7 percent participants- 53.1 percent of female and 14.6 percent of males, followed by 26.0 percent never married, 3.2 percent Widowed, 2.3 percent divorced/separated and 0.7 percent widower. Only 0.7 percent of married participants and 10.6 percent of those never married reported no sexual intercourse. None of the divorced/separated widowed and widowers reported condom use, while 5.8 percent of never married and 15.9 percent of those married reported having used condom. Other details on marital status, sexual activity and condom use were presented in table 4.

Table 4: Marital status cum ever had sexual intercourse, ever used condom

Marital status	Number (%)	Sex (%)		Sexual intercourse (%)		Condom use (%)	
		Male	Female	Yes	No	Yes	No
Never married	144 (26.0)	7 (1.3)	137 (24.7)	85 (15.3)	59 (10.6)	32 (5.8)	112 (20.2)
Married	375 (67.7)	81 (14.6)	294 (53.1)	371 (67.0)	4 (0.7)	88 (15.9)	287 (51.8)
Divorced/Separated	13 (2.3)	0	13 (2.3)	13 (2.3)	0	0	13 (2.3)
Widowed	18 (3.2)	0	18 (3.2)	18 (3.2)	0	0	18 (3.2)
Widower	4 (0.7)	4 (0.7)	0	4 (0.7)	0	0	4 (0.7)
Total	**554**	**92 (16.6)**	**462 (83.4)**	**491 (88.6)**	**63(11.4)**	**120 (21.7)**	**434 (78.3)**

Knowledge, belief and attitude of participants to HIV/AIDS in table 5 showed that 8.8 percent disagreed that someone who looks healthy but has HIV can pass it to other people. Minority (13.4%, 25%, 29.4% and 41.6%) of the participants agreed that one can get HIV/AIDS by touching, sharing foods/cups, wearing cloth with a person who has HIV/AIDS and by being bitten by a blood sucking insects like mosquito respectively. On whether one can get HIV by being bewitched, 12.6 percent agreed while 71.1 percent didn't know. About 37.9 percent and 29.1 percent disagreed that a pregnant woman who has HIV & AIDS can pass it to her unborn baby and woman with HIV & AIDS can produce a negative HIV baby HIV baby respectively.

Table 5: HIV/AIDS knowledge, beliefs & Attitudes

HIV/AIDS knowledge, Beliefs & Attitudes	Agree (%)	Disagree (%)	Don't Know (%)
Someone who looks healthy but who has the HIV can pass it to other people	498 (89.9)	49 (8.8)	7 (1.3)
One can get HIV & AIDS by touching a person who has HIV/AIDS?	18 (3.2)	480 (86.6)	56 (10.1)
One can get HIV & AIDS by sharing food or cups with a person who has HIV & AIDS?	22 (4.0)	417 (75.3)	115 (20.8)
One can get HIV & AIDS by being bitten by a mosquito or other blood-sucking insects?	150 (27.1)	329 (59.4)	75 (13.5)
One can get HIV & AIDS by wearing clothes used by a person who has HIV & AIDS?	102 (18.4)	391 (70.6)	61 (11.0)
One can get HIV & AIDS by being bewitched?	70 (12.6)	90 (16.2)	394 (71.1)
A pregnant woman who has HIV & AIDS can pass it to her unborn baby?	266 (48.0)	240 (37.9)	48 (6.7)
A woman with HIV & AIDS can produce a negative HIV baby HIV baby?	340 (61.4)	161 (29.1)	53 (9.6)

Chances of getting HIV/AIDS was not likely among 35.7 percent and 19.8 percent didn't know. Genital discharge ever was reported in 32.5 percent, lasting for 0-6 months (32.8 percent), 7-12 months (25.6 percent), > A year (41.7 percent), with 47.2 percent untreated medically. There is poor (69.8 percent) and no knowledge (4.2 percent) of STD preventive measures respectively.

HIV testing rate was 45.7 percent, with 67.1 percent reporting willingness to test for HIV. Lack of money for transport to HCT centre (46.4 percent) was mostly reported as reason for having not tested for HIV. Other reasons for not going to take a blood test were; "HIV cannot come to my home", "I don't have multiple sex partner", etc. Most of the participants preferred no charge for HIV test among the 83.8 percent that suggested 0-300 naira. Almost half (48.0 percent) of the participants reported not knowing any HIV testing centre. On what should be done to ensure that people infected with HIV do not pass it to other people, 19.5 percent had good knowledge, 64.3 percent had poor knowledge while 10.1 percent had no knowledge. Killing those infected as a way of protecting the uninfected was reported by 6.1 percent of the participants.

On condom use presented in table 6, 50.9 percent never used condom. Those that reported condom use in the last 12 months, 15.2 percent reported use with spouse/regular partner and 5.4 percent with casual partner. None use of condom was majorly (33.9 percent) due to no need. Condom use was difficult according to 44.6 percent of the participants. Health centre was the major source of condom.

Participants that reported condom as making sex less enjoyable/interesting were 48.9 percent, while those agreeing that condoms are most appropriate for use with casual partner sex partner, can stuck into the inside of a woman, can prevent HIV/AIDS and STDs if properly used and can allow HIV pass through were 46.0 percent, 48.7 percent, 69.7 percent and 33.2 percent respectively.

Table 6: Condom knowledge, beliefs & Attitudes

Condom knowledge, beliefs & Attitudes	Number (%)		
	Agree	Disagree	Don't know
Condoms make sex less enjoyable/interesting	271 (48.9)	17 (3.1)	19 (3.4)
Condoms are most appropriate for use with casual sex partner	255 (46.0)	143 (25.8)	156 (28.2)
Condoms can get stuck into the inside of a woman	270 (48.7)	159 (28.2)	125 (22.6)
Condoms can prevent HIV & AIDS & STDs if used properly	386 (69.7)	111 (20.0)	57 (10.3)
HIV can pass through a condom	184 (33.2)	226 (40.8)	144 (26.0)

On how to get spouse, normal courtship then marriage without HIV test was 31.9 percent and courtship with HIV test before marriage (38.8 percent), while cases of girls moving in man's house & regularizing marriage later (2.5 percent) and come & go type of marriage (0.7 percent) still existed.

Widow inheritance was viewed as a very good practice by 44.0% and culturally acceptable (40.1 percent), 59.9 percent participants stating that it provides for widows to be cared for.

Radio (44.2 percent) and NGO (30.5 percent) were the major source of HIV/AIDS information in the area and the most preferred. Majority (73.5 percent) of the participants own a radio and 61.2 percent reported yes HIV/AIDS information in the last 3 months.

Government (36.5 percent) and family (30.7 percent) are the major care providers for AIDS patients in the community and should keep providing care for AIDS patient. Report on maltreatment of orphans/widows was high (45.2 percent). There are no legal rights that protect orphans & widows (46.8 percent) though in existence according majority (53.2 percent) of the participants. About 65.2 percent claimed that there is legal education in the area.

About 31.9 percent of the participants had never discussed HIV. Among those that ever discussed the disease, only about 24.4 percent discussed HIV at the interval of 1-2 weeks, 14.8 percent at 3-4 weeks, 28.9 percent at several times.

Stigmatization and discrimination of people living with HIV/AIDS was reported by 72.4 percent and 70.9 percent participants respectively.

DISCUSSION

Females (462) were dominant in the study with those between 24-39 years of age making up 23.5 percent of the participants and representing the group most vibrant and socially active, ready to participate in activities in their area when compared with those greater than 39 years of age. More than 75 percent of the participants in the study were farmers, supporting the name- Aninri (meaning - Land of foods/edibles).

Age at first sex is an important indicator of both exposure to risk of pregnancy and exposure to STIs. Young people who initiate sex at an early age are considered to be at a higher risk of becoming pregnant or contracting an STI than young people who delay initiation of sexual activity. Young women in rural areas are more likely than their urban counterparts to have initiated sex before age 15 (24 percent versus 7 percent) and before age 18 (64 percent versus 34 percent). NDHS 2013 reported that 16 and 53 percent women as against 3 and 21 percent men had sex before the age of 15 and 18 years respectively (NPC, 2014). It was not surprising to observe that 67.7 percent of participants were married. This could be attributed to early marriage especially in rural areas of the south eastern Nigeria among the less educated individuals. Exposure to sexual intercourse is one of the ways through which HIV is transmitted and early exposure increases the risk.

None of the divorced/separated widowed and widowers reported condom use, while 5.8 percent of never married and 15.9 percent of those married reported having used condom. Condom use (49.1 percent) for prevention of STIs/STDs and unplanned pregnancies was poor. Genital discharge ever was reported in 32.5 percent, lasting for 0-6 months (32.8 percent), 7-12 months (25.6 percent), > A year (41.7 percent), with 52.8 percent treated medically. This result did not agree with 14.5 percent and 4.7 percent STI prevalence among women and men in Nigeria (NPC, 2014).

This finding agrees with similar studies in Karachi among Fishermen and in Cambodia Sexual Behaviour study as well as a study in South Africa among nurses (Zafar *et. al*., 2014., USAID. 2000, and Smith, 2005). To a very large extent, condom use in this study is contrary to 60 percent of female and 78 percent recorded among students of the University of Botswana in 1999 (Seloilwe, 2005).

Participants with university, post secondary and secondary level of education (5.8 percent, 39.4 percent and 34.5 percent respectively) were low, while significant percentage (3.6 percent) had no formal education. Education is a determinant of health. The likelihood of having HIV increases if one does not have knowledge of modes of transmission and prevention of the disease. This assertion concurs with the findings of Stephen *et. al.*, 2012 in HIV-Related knowledge, attitudes, and practice among educated young adults in Botswana and Seloilwe *et. al.*, 2001 in a study titled; 'HIV/AIDS at the University of Botswana: behavioural and prevention issues', suggesting that education has a way of influencing knowledge and correcting negative attitude. The prevalence of HIV testing and receipt of test results increased with increasing education and wealth (NPC, 2014). Opposing this claim, Ibekwe *et. al*., (2010) argued that knowledge does not in all cases translate into action.

Half of the participants (50.0 percent) reported knowing someone with HIV/AIDS in the area, 17.3 percent of which had lived with and 16.1 percent taken care of someone who had HIV/AIDS. According to Nigeria Demographic and Health Survey 2013, willingness to care for HIV patient was 92.4 percent, a value far above 16.1 percent recorded in this study.

Interestingly, 61.0 percent of participants in the study know the various ways of transmitting HIV and were able to state the following; sexual intercourse, unprotected sexual intercourse with an infected person, sharing of unsterilized instrument/equipment, blood transfusion, sharing of tooth brush with an infected person, mother to child transmission, etc. This notwithstanding, significant number of individuals that took part in the study had inappropriate knowledge of how HIV is transmitted stating sexual intercourse with an infected person as the only mode of transmission and recommending outright killing of infected person as a way of preventing the disease. Inappropriate knowledge was reported as one of the factors that influence the spread of HIV/AIDS (Seloilwe, 2005). Among the 4.0 percent without idea of how HIV is transmitted, some of them believed that HIV infection is as a result of witchcraft. This finding agrees with 2013 NDHS in which 70.5 percent, 68.4 percent and 85.3 percent of the respondents reported that HIV cannot be transmitted by mosquito bites, supernatural means and sharing food with infected person respectively, while others had contrary view. Dispelling misconception about

HIV/AIDS was reported as the key to addressing inappropriate knowledge, negative attitude and unsafe practice towards HIV/AIDS (Jennings, 2012).

Female Genital Mutilation (FGM), cutting of tonsil in tonsillitis, male circumcision, removal of tumors and other traditional practices like "Ichi mbu" i.e. sharp cuts on lumps, and home delivery performed by traditionalists and the locals were not considered as potential sources of HIV infection, even though they involve exchange of unsterilized or poorly sterilized sharps. In Enugu State, male circumcision at home was 30.2 percent with traditionalist contributing 58.1 percent, Catholic- 32.1 percent and other Christians -33.7 percent (NDHS, 2013) and in consonance with that reported by World Health Organization and Joint United Nations Programme on HIV/AIDS in New data on male circumcision and HIV prevalence (World Health Organization and Joint United Nations Programme on HIV/AIDS 2007).

The result of the study also showed that 76.7 percent of the participants do not have appropriate knowledge of the incubation period of HIV infection, mode of transmission and prevention, the implication of genital discharge without medical treatment, HIV testing, condom, and widow inheritance. This finding agrees with that reported in South Africa among nurses with appropriate knowledge regarding HIV/AIDS (Smith, 2005). For instance, some of the respondents in this study were of the opinion that killing those infected by HIV is a way of preventing others from getting infected, others were of the view that widow inheritance was good as it is an opportunity for widows to be taken care of. Without correcting the inappropriate HIV/AIDS knowledge, negative attitude and unsafe practices, spread of the infection is eminent.

HIV testing rate was 45.7 percent, with 67.1% percent reporting willingness to test for HIV. This was far above 20 percent in South Eastern Nigeria where Enugu State and Aninri situate (NDHS, 2013). Among reported barriers to taking HIV test were; lack of money to pay for the test (17.8 percent), lack of money for transport to HCT centre (46.4 percent), fear of knowing the result (13.2 percent), don't know where to take the test (1.8 percent), fear of getting infected by syringe and needle at the centre (5.6 percent), already infected (0 percent), no reason (14.1 percent). Other reasons for not going to take a blood test were; "HIV cannot come to my home", "I don't have multiple sex partner". Similar result showing inappropriate HIV/AIDS knowledge and attitude was reported by Zafar *et. al.*, 2014 among fishermen in Karachi.

Radio was the major source of HIV/AIDS information. This agreed with the result obtained in HIV-Related knowledge, attitudes and practice among educated young adults in Botswana in which the study was to re-evaluate the impact of nationwide media education campaigns and the opening of voluntary counselling and testing centers (Stephen *et. al.*, 2012). However, majority of the respondents preferred getting HIV/AIDS information from NGO because it gives an opportunity for two-way communication. Care for AIDS patients is not streamlined. The government (36.5 percent) and family members (30.7 percent) are the major care-givers to those living with HIV/AIDS. Where there is discrimination and stigmatization from family and community members including the health workers, use of available HIV/AIDS services by those living with the disease will be poor. Maltreatment of orphans/widows is still high and unacceptable. Reported unfair treatment to orphans/widows include force marriage, force labour, rape, battering, etc which increases the vulnerability of this group especially to HIV/AIDS. These findings were in agreement with report of National Agency for the Control of AIDS (NACA), 2010 in HIV mode of transmission in Nigeria. To prevent transmission of new HIV and the development of HIV to AIDS, unfair treatment against the orphans/widows should be addressed.

Although 53.2 percent of the respondents reported existence of legal rights protecting orphans/widows, 46.8 percent were unaware of such rights due to inadequate community education on legal rights. Hence implementation of legal rights protecting orphans/widows still leaves much to be desired.

CONCLUSION

The impacts of HIV/AIDS are enormous and pose a significant challenge to health and development across the world, especially in rural and hard to reach areas like Aninri local Government Area of Enugu State. Inappropriate knowledge, negative attitude, and unsafe practices regarding HIV/AIDS were identified among the natives of Aninri local government area. Improving knowledge and changing attitude and practice using Minimum Prevention Package Intervention (MPPI) which simultaneously uses different classes of prevention activities (behaviour, biomedical and structural) that operate on multiple levels, to respond to the specific needs of target individuals will be effective in preventing transmission of new HIV infection. Of MPPI addressing behavior is massive education campaigns through one-on-one, group and mass education.

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