International Journal of Science and Healthcare Research
[Indexed, Peer-Reviewed Journal]
Vol. 10; Issue: 3; July-Sept. 2025
Website: ijshr.com
Original Research Article *ISSN: 2455-7587*

Assessment of Community Perception and Myths About Dementia in Elderly: A Population-Based Study in Ilorin Metropolis

Arise Victor Oluwaseyifunmi[1], Sodunke Taiwo Ganiyat[2], Samuel Makinde-Ojo[3], Andorbe Bernard Andorbe[4], Ibrahim Rukayat Motunrayo[5]

[1]Department of Public Health, University of Ilorin, Nigeria.
[2]Department of Public Health, Sheffield Hallam University, UK.
[3,4]Department of Medicine, Rostov State Medical University, Russia.
[5]Department of Public Health, Ahmadu Bello University, Nigeria.

Corresponding Author: Arise Victor Oluwaseyifunmi

DOI: https://doi.org/10.52403/ijshr.20250317

ABSTRACT

Background: Dementia represents a critical global health challenge with significant implications for elderly individuals. The prevalence of dementia is on the rise as the elderly population grows. This study aims to assess the community perception and myths about dementia in Ilorin metropolis.

Methods: A cross-sectional design was used to assess community perceptions and myths about dementia among the elderly population. A total of 414 individuals comprising elderly persons and their care givers were selected within the Ilorin metropolis through multistage sampling technique and data was collected through interviews and structured questionnaires. Statistical software, STATA 11.0 was employed for data analysis, including descriptive and inferential statistics to examine associations. Level of statistical significance was set at $p < 0.05$ at confidence level of 95% for all inferential analysis.

Results: The study underscores that majority had low perceptions, various myths and misconceptions about dementia. The findings suggest a moderate level of awareness about dementia among the participants, with a focus on symptoms and some recognition of related activities. Attitudes towards dementia were predominantly positive, with more than 60% of respondents expressing a positive attitude. Individuals who are unaware of dementia have significantly higher odds of perceiving mythical prevalence with an odds ratio of 5.32 (95% CI: 2.39-11.85, $p<0.001$), which is statistically significant.

Conclusion: The study underscores the prevailing myths and perceptions of dementia among community members in the Ilorin metropolis. Also, the study critically assessed the attitudes of residents on the understanding and acceptance of dementia and revealed there is a significant level of lack of awareness and understanding about dementia. However, enhancing preventive strategies collectively by individuals, caregivers and policymakers is essential to alleviate the negative effects of the existing myths about dementia.

Keywords: *Dementia, Stigma, Community perception, Elderly myths.*

BACKGROUND

Population aging characterized by alterations in age distribution, such as an uptick in the percentage of elderly

individuals contributes to the surge of many diseases and healthcare conditions including dementia. In 2021, approximately 57 million people globally were living with dementia, with over 60% residing in low- and middle-income countries. Each year, nearly 10 million new cases of Dementia are recorded which arises from various diseases and brain injuries with Alzheimer's disease being the most prevalent and accounts for 60–70% of cases (WHO, 2023). Projections indicate that approximately 75 million people globally will be living with dementia by 2030, with the majority of cases concentrated in low and middle-income nations (Wimo *et al*., 2023). As the world's population ages, the number of individuals affected by dementia is expected to triple from 50 million in 2018 to 152 million by 2050 (Benyumiza et al., 2023). The documented prevalence of dementia in Sub-Saharan Africa (SSA) varies between 2% and 5%. Despite this, dementia research is generally lacking in most of these regions, leading to limited awareness and response to the condition (Akinyemi *et al*., 2022). In Nigeria, numerous communities still associate dementia with a natural aging process, resulting in stigmatization and abandonment of many patients who believe their condition is beyond medical intervention (Baba and Yarube, 2021). Consequently, those affected often delay seeking medical care which leads to unfavorable outcomes. This situation is further compounded by inadequate access to mental health services, contributing to high out-of-pocket expenses that few individuals can afford (Schwarz, 2021).

Dementia can lead to complications such as a loss of self-care abilities and communication difficulties. As the disease advances, PLWD may encounter challenges in problem-solving and experience memory lapses (Lam et al., 2021). Since there is no curative treatment for dementia, the World Health Organization's Global Action Dementia Plan emphasizes prevention and proactive management of modifiable risk factors to delay or slow the onset or progression of the disease (Livingston *et al*., 2020). Therefore, controlling these modifiable risk factors becomes essential, with primary care being an optimal setting for addressing these concerns. Studies on dementia risk prediction models, initially focused on high-income countries (HIC), are now being tested for applicability in low-income countries (LIC) (Wingren et al., 2022). Predictive modeling for LIC suggests that dementia shares common risk factors with cardiovascular disease, which is a known cause of stroke and subsequent sequelae of vascular dementia (Avan and Hachinski, 2023). Twelve potentially modifiable risk factors for dementia include lower education, hearing loss, traumatic brain injury, alcohol consumption, obesity (body mass index ≥30), hypertension, smoking, depression, social isolation, physical inactivity, air pollution and diabetes (McGrattan *et al*., 2021). Dementia rise poses a substantial challenge for LMICs, given their limited access to disease estimates and information about key risk and protective factors. Moreover, most residents of LMICs considered dementia as a natural aging condition and seldom seek medical attention. Also, national policies to address the social and economic burdens of dementia, along with risk reduction programs crucial for influencing future statistics are poor. This study aims to assess community perceptions and myths about dementia within Ilorin metropolis.

RESEARCH METHODS

Study Area Description

The study area encompasses the urban and peri-urban regions of the Ilorin metropolis, the capital city of Kwara State, Nigeria. Ilorin is a bustling urban center with a diverse demographic composition and serves as a hub for various economic, social and cultural activities in the state. Within the Ilorin metropolis, several neighborhoods and communities represent different socioeconomic backgrounds and cultural identities, providing a rich tapestry of perspectives on health-related issues such as

dementia. These communities encompass a range of residential areas, including urban, peri-urban, and rural settlements, each with its own unique characteristics and challenges. In terms of healthcare infrastructure, Ilorin boasts numerous health facilities, including hospitals, clinics, and primary health centers, catering to the healthcare needs of its residents.

Community Entry and Advocacy for Penetration

Prior to commencing the study, formal letters for community entry and advocacy were obtained and presented to relevant authorities including the Kwara State Ministry of Health and community leaders within the Ilorin metropolis. Efforts were made to prevent any form of obstruction or resistance within the community by garnering support from local stakeholders and influencers.

Study Population

The target population for this study comprises elderly individuals and their caregivers residing in the Ilorin metropolis.

Study Design

This study adopts a cross-sectional design to assess community perceptions and myths about dementia among the elderly population in the Ilorin metropolis. Data was collected through structured interviews and surveys conducted for elderly residents and caregivers selected through stratified sampling techniques.

Inclusion Criteria

- Elderly individuals aged 60 years and above residing in the Ilorin metropolis.
- Household members or caregivers of elderly persons

Exclusion Criteria

- Elderly individuals with severe cognitive impairments or communication difficulties hindering participation in the study.
- Individuals unwilling to provide informed consent for participation

Sample Size Determination

The sample size for this study was determined based on the estimated proportion of the elderly population in the Ilorin metropolis and the desired level of confidence and precision. A sample size calculation was performed using established statistical methods to ensure adequate representation of the target population.

The sample size was calculated using Fischer's formula: (Bolarinwa, 2020).

$n = z^2 pq/d^2$

Where,

n= the minimum sample size when the population is more than 10,000

z= the standard normal deviate was set at 1.96, which corresponds to 95% confidence level.

P= proportion of dementia among the elderly at prevalence of 20% (WHO, 2020)

P=0.2

q= 1- p

d= degree of accuracy, set at 0.05 for this study

$n= (1.96)^2 \times (0.2) \times 0.8/ (0.05)^2$

$n \approx 3.85 \times 0.2 \times 0.8(1,5)/0.0025$

$n \approx 414$

Sampling Techniques

The sampling technique employed was multi stage sampling technique.

Stage 1 involved Selection of Clusters, Ilorin Metropolis was divided into distinct clusters with geographical areas based on administrative divisions or neighborhoods. From this division, a total of 10 clusters were randomly selected to represent the entire metropolis.

Stage 2 involved selection of Primary Sampling Units (PSUs) such that within each selected cluster, primary sampling units (PSUs) were identified. These PSUs including smaller subdivisions such as streets, blocks, or housing estates.

Stage 3 as the final stage involved selection of Study Participants of which Within each selected PSU, households and individuals

eligible for the study were identified. The first respondent was selected through simple balloting and other individuals were randomly selected from each PSU until the desired sample size is met.

Research Instrument: Validity, Pretesting

The research instrument, survey questionnaires, was developed based on existing literature and validated measures of dementia awareness and perceptions. The instruments undergo rigorous validation processes, including expert review and pretesting conducted with 10% of the sample size (41 respondents) in Offa to ensure the instrument's reliability and validity in the context of the study population. Feedbacks from the pretest was used to refine the instrument for consolidated accuracy and reliability.

Methods of Data Collection

Data was collected through face-to-face interviews and structured questionnaires administered by the Researchers. The questionnaire was prepared in English language and audio-translated to fluent local languages spoken within the Ilorin metropolis during data collection. Participants were asked about their awareness, beliefs and attitudes regarding dementia, as well as any prevalent myths or misconceptions.

Measurement of Variables and Data Processing

Variables of interest include awareness of dementia, beliefs about its causes and risk factors, attitudes toward individuals with dementia, and prevalent myths or misconceptions within the community.

(a) Dependent variable: The primary outcome measure of the study is perceptions on dementia and will be assessed by 'Strongly Agree' 'Agree', 'Strongly Disagree' and 'Disagree' responses.

(b) Independent Variables: Socio-demographic characteristics: Age, marital status (single, married, divorced, widowed), religion (Christianity, Islam, others), tribe (Yoruba, Igbo, Hausa/Fulani, others), educational level (no formal education, primary, secondary, tertiary), occupation (unemployed, farming/trading, government employee, private employee) and monthly income. For processing, Data was coded and entered into a secure database for analysis using appropriate statistical methods.

Method of Data Management and Analysis

Data management involved organizing, cleaning, and storing collected data in a secure and confidential manner. Statistical software (STATA 11.0) was used for data analysis, including descriptive statistics, inferential tests, and regression modeling to examine relationships between variables and identify predictors of dementia awareness and perceptions.

Consent and Methods of Protection of Human Subjects

Written informed consent was obtained from all participants prior to their inclusion in the study. Measures were taken to protect the confidentiality and privacy of participants, including anonymization of data and secure storage protocols.

Ethical Considerations

Ethical approval for the study was obtained from the relevant institutional review boards and ethical committees in accordance with established guidelines and regulations. Respect for participant autonomy, beneficence, and justice guided all aspects of the research process.

Limitations of the Study

Limitations of the study may include sampling biases, recall biases, and social desirability biases inherent in self-reported data. Additionally, the study may be limited by the availability of resources and the willingness of participants to disclose sensitive information about dementia. Efforts were made to minimize these limitations through careful study design and data collection procedures.

RESULTS

Section A: Demographic and Socio-economic characteristics of respondents

Table 4.1a: Demographic of respondents

Variable	Frequency	Percent
Age in years	**Freq.**	**Percent**
<60	1	0.24
61-70	253	61.11
71-80	109	26.33
81-90	46	11.11
≥91	5	1.21
Mean age ± SD	**71 ± 9**	
Gender		
Male	155	37.44
Female	259	62.56
Educational level		
No formal education	333	80.43
Primary	61	14.73
Secondary	19	4.59
Tertiary	1	0.24
Ethnicity		
Yoruba	414	100

Table 4.1b: Demographic of respondents

Variable	Frequency	Percent
Religion		
Christianity	19	4.59
Islam	395	95.41
Marital status		
Single	2	0.48
Married	227	54.83
Divorced	20	4.83
Widowed	165	39.86
Occupation		
Civil servant	15	3.62
Artisan	37	8.94
Trader	226	54.59
Farmer	2	0.48
Others	134	32.37
Average monthly income (₦)		
<20,000	153	36.96
20,000-50,000	222	53.62
50,001-100,000	35	8.45
>100,000	4	0.97
Mean average monthly income ± SD	**29208 ± 28611**	

The respondents' mean age is 71 ± 9, with majority aged 61-70 years (61.11%) and a small number under 55 or over 85. About two third (62.56%) of respondents were female, most respondents have no formal education (80.43%), and all are of Yoruba ethnicity. A significant majority are Muslims (95.41%) and more half (54.83%) are married with a few single or divorced. Occupations of respondents were predominantly trading (54.59%) with average monthly income of 20,000-50,000 Naira for more than half (53.62%) of respondents and a mean income of 29,208 ± 28,611 Naira.

Section B: Prevailing perceptions of dementia among community members

Table 4.2a: Respondents level of perception about Dementia

Perceptions and myths about dementia	SA	A	N	D	SA
Dementia is a normal part of aging	125(30.19)	187(45.17)	57(13.77)	41(9.9)	4(0.97)
Dementia is considered hereditary	16(3.86)	60(14.49)	139(33.57)	181(43.72)	18(4.35)
Dementia is inevitable among the aged	54(13.04)	118(28.5)	100(24.15)	131(31.64)	11(2.66)
Dementia is caused by loneliness	44(10.63)	126(30.43)	98(23.67)	135(32.61)	11(2.66)

Table 4.2b Respondents level of perception about Dementia

Perceptions and myths about dementia	SA	A	N	D	SA
Dementia has no treatment plan	19(4.59)	155(37.44)	134(32.37)	99(23.91)	7(1.69)
Dementia has no treatment plan	19(4.59)	155(37.44)	134(32.37)	99(23.91)	7(1.69)
Dementia only affects the elderly	71(17.15)	146(35.27)	88(21.26)	100(24.15)	9(2.17)
Dementia cannot be prevented	21(5.07)	134(32.37)	127(30.68)	122(29.47)	10(2.42)
Mythical perception					
High	191(46.14)				
Low	223(53.86)				

SA = Strongly agree, A = Agree, N = Neutral, D = Disagree, SD = Strongly disagree

Respondents hold varied perceptions and myths about dementia. Many view dementia as a normal part of aging (75.36%) and believe it is inevitable among the elderly (41.54%). There are misconceptions that dementia is caused by loneliness (41.06%) and has no treatment plan (42.03%). About half (46.14%) of respondents were classified by scoring of responses to have high mythical perceptions of dementia.

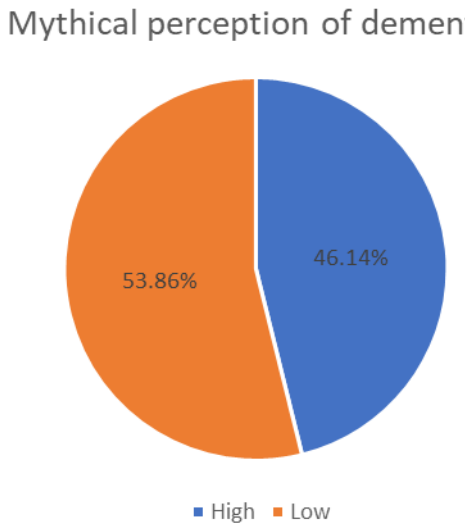

Figure 4.3: A pie chart showing the Level of mythical perception among respondents on dementia.

Section C: Common myths and misconceptions surrounding dementia among the elderly population

Table 4.3: Assessment of level of Awareness about dementia

Variable	Yes (%)	No (%)
Have you lived with people older than 65 years of age?	285(68.84)	129(31.16)
Have you heard of dementia before?	224(54.11)	190(45.89)
What do you think are the causes of dementia?		
Aging	338(81.64)	76(18.36)
Genetics	31(7.49)	383(92.51)
Head injury	112(27.05)	302(72.95)
Infections	66(15.94)	348(84.06)

Lifestyle factors (e.g. smoking, diet)	77(18.6)	337(81.4)
What are the common symptoms of dementia?		
Memory loss	285(68.84)	129(31.16)
Difficulty in reasoning or problem solving	189(45.65)	225(54.35)
Language problems	67(16.18)	347(83.82)
Change in mood or behavior		414(100)
What activities do you consider related to dementia among the elderly populations?		
Hallucinations	125(30.19)	289(69.81)
Frequent need for advice	47(11.35)	367(88.65)
Confusion or disorientation	273(65.94)	141(34.06)
Arguments about known facts	90(21.74)	324(78.26)
Level of knowledge		
Good	65(15.7)	
Poor	349(84.3)	

A majority of respondents have lived with individuals over 65 years old (68.84%) and about a half of respondents (54.11%) are familiar with dementia. The most commonly recognized cause of dementia by more than three quarters (81.64%) of respondents is aging, while genetics (7.49%) and infections (15.94%) are less acknowledged. Common symptoms identified include memory loss by more than two third (68.84%) of respondents and confusion or disorientation (65.94%). About a third (30.19%) of respondents associated dementia with hallucinations, while more than a third (45.65%) identify difficulty in reasoning as a symptom. Most respondents (84.3%) were classified by scoring of responses to have low knowledge about dementia.

Section D: Attitudes on the understanding and acceptance of dementia and associated factors

Table 4.4: Assessment of perceived stigma, cultural beliefs and help-seeking behavior on dementia

Variable	Frequency	Percent
If someone in your family show signs of dementia, would you provide support for such person?		
Yes	383	92.51
No	31	7.49
Health seeking advice		
Yes	206	53.79
No	177	46.21
Moral support		
Yes	221	57.7
No	162	42.3
Financial support		
Yes	101	26.37
No	282	73.63
If you or someone in your family show signs of dementia, where would you seek help		
Family and friends	124	29.95
Health care practitioner (doctor, nurse	247	59.66
None	2	0.48
Religious leader	26	6.28
Traditional Healer	15	3.62
Are there any cultural or traditional practices in your community associated with		
Yes	48	11.59
No	366	88.41
How comfortable do you feel discussing dementia openly in your community		
Not comfortable at all	36	8.7

Not very comfortable	67	16.18
Somewhat comfortable	97	23.43
Very comfortable	214	51.69
Attitude		
Negative	155	37.44
Positive	259	62.56

Most respondents (92.51%) would support a family member showing signs of dementia, though only about a quarter (26.37%) would provide financial support. For health-related advice, more than half (53.79%) of respondents seek help, and more than half (57.7%) offer moral support. If facing signs of dementia, more than half (59.66%) of respondents would consult a healthcare practitioner, while more than a quarter (29.95%) would turn to family and friends. Although most respondents (88.41%) do not believe in cultural practices related to dementia, more than half (51.69%) of respondents are very comfortable discussing it. The general attitude of respondents towards dementia was classified by scoring of responses to be positive for about two third (62.56%) of respondents.

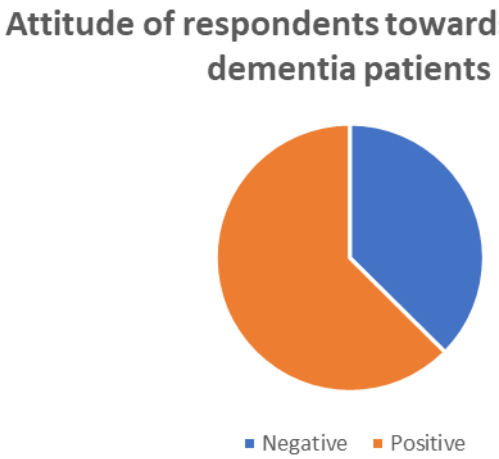

Figure 4.4: A pie chart showing the attitude of respondents towards support for dementia patients

Section E: level of awareness and knowledge about dementia risk factors, symptoms, and available treatments among community members

Table 4.5: Level of awareness and knowledge about dementia

Variable	Frequency	Percent
Are you aware of dementia?		
Yes	170	41.06
No	244	58.94
If yes, what is your source of information		
Family/friends	75	44.12
Health worker	50	29.41
Lecturer	2	1.18
Internet	3	1.76
Radio/Television	23	13.53
Others	17	10
Have you experience it before?		
Yes	53	12.8
No	361	87.2
If yes, do you have adequate support?		
Yes	36	67.92

No	17	32.08
Are you currently experiencing or being managed for dementia?		
Yes	44	10.63
No	370	89.37
If yes, any adequate support?		
Yes	44	100
If yes, from who?		
Friends and family	40	90.91
Neighbours/colleague	3	6.82
Religious body	1	2.27
Any family member with dementia?		
Yes	78	18.84
No	336	81.16

Among the respondents, more than a third (41.06%) are aware of dementia, from which more than a third (44.12%) are aware primarily through family/friends and more than a quarter (29.41%) through health workers. Only a fraction (12.8%) has personal experience with dementia, with more than a third (67.92%) of those receiving adequate support. Currently, a small fraction (10.63%) of respondents is being managed for dementia, all of whom report adequate support from friends and family (90.91%). Additionally, less than a quarter (18.84%) of respondents have a family member with dementia.

Table 4.7b: Factors affecting dementia patients' help-seeking behaviors among the elderly population in Ilorin.

Variable	**Would you provide support for a family member with dementia?**			**χ2**	**P value**
	No	**Yes**	**Total**		
Myth					
High	20(64.52)	171(44.65)	191(46.14)	4.5557	0.033
Low	11(35.48)	212(55.35)	223(53.86)		
Knowledge					
Good	1(3.23)	64(16.71)	65(15.7)	3.9399	0.047
Poor	30(96.77)	319(83.29)	349(84.3)		
Attitude					
Positive	7(22.58)	252(65.8)	259(62.56)	22.8672	<0.001
Negative	24(77.42)	131(34.2)	155(37.44)		

Mythical Perception of dementia significantly affects the likelihood of providing support, with individuals holding high myths about dementia being less supportive ($\chi^2 = 4.556$, $p = 0.033$). Knowledge of dementia also plays a crucial role; those who have good knowledge of dementia are more likely to provide support ($\chi^2 = 3.940$, $p = 0.047$). Additionally, having a positive attitude towards dementia increases the likelihood of offering support ($\chi^2 = 22.867$, $p < 0.001$).

Table 4.8a: Association between demographic characteristics and Mythical perception of respondents.

Variable	**Mythical perception**			**chi2**	**p value**
	High	**Low**	**Total**		
Age in years					
<60	0(0)	1(0.45)	1(0.24)		
61-70	119(62.3)	134(60.09)	253(61.11)	1.0803	0.897
71-80	49(25.65)	60(26.91)	109(26.33)		
81-90	21(10.99)	25(11.21)	46(11.11)		
≥90	2(1.05)	3(1.35)	5(1.21)		
Gender					
Male	68(35.6)	87(39.01)	155(37.44)	0.5112	0.475

Female	123(64.4)	136(60.99)	259(62.56)		
Educational level					
No formal education	149(78.01)	184(82.51)	333(80.43)		
Primary	29(15.18)	32(14.35)	61(14.73)	4.9614	0.175
Secondary	13(6.81)	6(2.69)	19(4.59)		
Tertiary	0(0.00)	1(0.45)	1(0.24)		

Table 4.8b: Association between demographic characteristics and Mythical perception of respondents.

Variable	**Mythical perception**			**chi2**	**p value**
	High	**Low**	**Total**		
Marital status					
Single	1(0.52)	1(0.45)	2(0.48)		
Married	112(58.64)	115(51.57)	227(54.83)	2.167	0.538
Divorced	8(4.19)	12(5.38)	20(4.83)		
Widowed	70(36.65)	95(42.6)	165(39.86)		
Occupation					
Civil servant	10(5.24)	5(2.24)	15(3.62)		
Artisan	25(13.09)	12(5.38)	37(8.94)		
Trader	112(58.64)	114(51.12)	226(54.59)	21.6992	<0.001
Farmer	0(0.00)	2(0.9)	2(0.48)		
Others	44(23.04)	90(40.36)	134(32.37)		
Average monthly income					
<20,000	78(40.84)	75(33.63)	153(36.96)		
20,000-50,000	95(49.74)	127(56.95)	222(53.62)		
50,001-100,000	18(9.42)	17(7.62)	35(8.45)	6.264	0.099
>100,000	0(0.00)	4(1.79)	4(0.97)		
Religion					
Christianity	11(5.76)	8(3.59)	19(4.59)		
Islam	180(94.24)	215(96.41)	395(95.41)	1.1081	0.292
Are you aware of dementia?					
Yes	88(46.07)	82(36.77)	170(41.06)	3.6783	0.055
No	103(53.93)	141(63.23)	244(58.94)		
Knowledge					
Good	10(5.24)	55(24.66)	65(15.7)	29.3399	<0.001
Poor	181(94.76)	168(75.34)	349(84.3)		
Attitude					
Negative	85(44.5)	70(31.39)	155(37.44)	7.5523	0.006
Positive	106(55.5)	153(68.61)	259(62.56)		

Table 4.8 shows the association between various demographic and socioeconomic variables and mythical perceptions of dementia. Age ($\chi2 = 2.0687$, $p = 0.723$) and gender ($\chi2 = 0.5112$, $p = 0.475$) did not show significant differences in mythical perception. Education level ($\chi2 = 4.9614$, $p = 0.175$) and marital status ($\chi2 = 2.167$, $p = 0.538$) were also not significantly associated. However, occupation showed a significant difference ($\chi2 = 21.6992$, $p < 0.001$). Awareness of dementia ($\chi2 = 3.6783$, $p = 0.055$) approached significance, while knowledge ($\chi2 = 29.3399$, $p < 0.001$) and attitude ($\chi2 = 7.5523$, $p = 0.006$) were significantly associated with mythical perceptions.

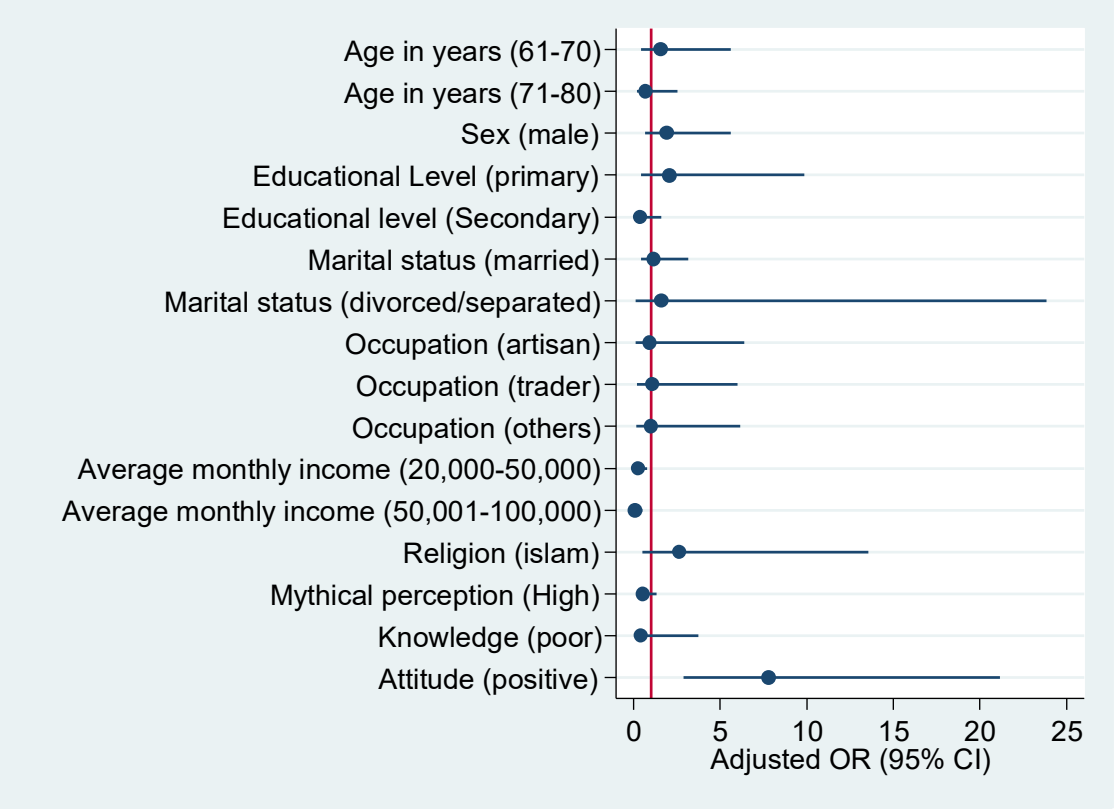

Figure 4.6: A forest plot showing the association between willingness to seek for help and respondents sociodemographic

DISCUSSION

The study provides an in-depth exploration of dementia in the elderly, assessing its community perception and myths. According to the WHO (2025), presently, there are 57.6 million individuals worldwide affected by dementia and approximately 10 million new cases are identified annually indicating the prevalence of dementia is on the rise and represents a critical global health challenge with significant implications for both individuals and societies. Previous findings underscored dementia has risen over 400% in Nigeria (63,512 in 1995, to 318,011 in 2015) among persons aged 60 years and over (Avan and Hachinski, 2023). Relatively as revealed in this study, age distribution of participants shows that the majority were in the 55-70 age group, followed by 70-85 and in relation to dementia perception, people of this age range expects dementia classifying it as part of aging and suggests a common perception that dementia is exclusively an elderly condition. The study further presents the perceptions and myths about dementia among the surveyed population focusing on common beliefs and misconceptions. A significant portion of the population views dementia as an expected consequence of aging. Furthermore, major risk factors are attributed to age and genetics or family history as emphasized by Lee et al., in 2023 stating advancing age is the most significant risk factor for dementia. Previous study identifies the prevalence of dementia increases with age, and it is more common in older adults and family history and genetics play a role in some types of dementia. However, in this study, only a small percentage attributed dementia to genetics, highlighting a potential gap in understanding the role of genetics in dementia coupled with the significant level of unfamiliarity with the condition among the study participants.

The symptoms of dementia can manifest differently in each individual which affects various aspects such as memory, attention span, communication, reasoning, judgment,

problem-solving and visual perception. Indications that may suggest dementia include becoming disoriented in familiar surroundings, using unconventional language to describe familiar objects, forgetting the names of close relatives or friends, experiencing memory lapses and struggling to complete tasks independently. Relatively, study participants affirm common symptoms of dementia as memory loss, difficulty in reasoning or problem solving and language problems. Regarding activities related to dementia among the elderly, confusion or disorientation was recognized by larger percentage of the participants, while hallucinations was also identified as an activity attributed to dementia. However, a significant portion of participants did not associate other activities like frequent need for advice or arguments about known facts with dementia. Disprow (2021) highlighted behavioral symptoms of dementia may manifest as agitation, restlessness, inappropriate conduct, sexual disinhibition, and aggression, which can be either verbal or physical. Ensuring access to appropriate medical care is crucial for managing dementia symptoms and addressing underlying health issues. This includes regular check-ups, medication management, and treatments to alleviate specific symptoms such as memory loss, agitation, or sleep disturbances. Collaboration with healthcare professionals, including neurologists, psychiatrists, and geriatricians, can help optimize the management of dementia (Wingren et al., 2022). However, in evaluating the understanding and acceptance of dementia and associated factors within the study area, a significant majority indicated to provide support if a family member showed signs of dementia, with only 7.49% stating they would not.

As inferred from this study, in terms of cultural or traditional practices associated with dementia, only few acknowledged their presence in their community and comfort levels in discussing dementia openly varied, with majority feeling very comfortable. Overall attitudes towards dementia were predominantly positive which highlighted the general willingness to support family members with dementia. Furthermore, the exploration of medical challenges confronted by dementia patients provides valuable insights into the multifaceted nature of their needs, encompassing cognitive decline, behavioral symptoms, mobility issues and susceptibility to infections. The outlined preventive measures underscore the significance of holistic healthcare practices, encompassing a healthful lifestyle, cognitive engagement and proactive management of cardiovascular risk factors. All factors of support inferred from the study are however relevant as purported by Lam (2020) that the impact of dementia extends beyond the medical realm to encompass intricate social dynamics within communities.

CONCLUSION

This research investigates the societal beliefs and misconceptions about dementia held by older adults and those who care for them in Ilorin, Nigeria. The study identifies a major public health problem. Although a large percentage of people living in Ilorin (62.56%) show positive attitudes towards the elderly with dementia, their good intentions are counteracted by a general lack of understanding about the illness. This analysis shows that misinformation is prevalent. Significantly, more than half of the population in Ilorin (75.36%) incorrectly view dementia as a normal part of aging and about 46.14% hold myths about it. Statistically, these factors are linked to behavior, where poor knowledge ($p<0.001$) and negative attitudes ($p=0.006$) correlate with mythical beliefs, eventually leading to a reduction in the willingness to offer support for these patients. This research shows that there's a crucial gap between the people's compassion and its capacity for dementia care. To close this gap, it's essential to launch health sensitization programs that replace the myths the

population holds about dementia among elderly patients.

RECOMMENDATIONS

Based on the analysis of the study, the following strategic recommendations are proposed for key stakeholders.

For Public Health Authorities and Policymakers (Federal and State Ministries of Health)

- ✓ Prioritize the immediate development of a comprehensive Nigerian National Dementia Plan. This plan should be aligned with the seven action areas of the WHO Global Action Plan on Dementia and informed by local data, such as this Ilorin study.
- ✓ Integrate Dementia Screening into Primary Care and mandate the use of cognitive screening tools (e.g., Mini-Cog, AD8) into routine health assessments for older adults.
- ✓ Establish caregiver support systems, design and implement policies that provide tangible support for the informal caregivers of people with dementia.

To Healthcare providers and the Community

- ✓ Facilitate in-depth community education to raise awareness about dementia, dispel myths, and reduce stigma.
- ✓ Enhance cultural awareness and utilize various communication channels, including community gatherings, local media, and healthcare facilities to avail support for dementia patients.
- ✓ Power early diagnosis, appropriate management, and effective communication with dementia patients and their caregivers.

For Future Researchers

- ✓ **Conduct Longitudinal and Intervention Studies:** Move beyond cross-sectional designs to conduct longitudinal studies that track the progression of dementia in Nigerian communities. Furthermore, robust implementation science research is needed to rigorously evaluate the clinical and economic impact of interventions like the proposed task-shifting model.
- ✓ **Develop and Validate Appropriate Tools:** Invest in the development and validation of diagnostic and screening tools that are culturally, linguistically, and educationally appropriate for Nigeria's diverse populations to improve the accuracy of diagnosis and prevalence estimates.
- ✓ **Investigate Social Determinants of Health Beliefs:** Conduct further qualitative and quantitative research to explore the specific social and environmental drivers behind the strong correlation between occupation and mythical beliefs identified in the Ilorin study. Understanding these pathways is key to refining future public health messaging.

Author Contributions

Arise V.O.: Study conceptualization, methodology design, data collection, manuscript drafting.

Sodunke T.G.: Data and statistical analysis, manuscript revision.

Makinde-Ojo S.: Literature review, theoretical framework, manuscript writing and revision.

Andorbe B.A.: Subject expertise, methodology development, manuscript revision.

Ibrahim R.M.: Project administration, data analysis support, editorial assistance.

Declaration by Authors

Acknowledgement: None

Source of Funding: None

Conflict of Interest: The authors declare no conflict of interest.

REFERENCES

1. Akinyemi, R. O., Yaria, J., Ojagbemi, A., Guerchet, M., Okubadejo, N., Njamnshi, A. K., Sarfo, F. S., Akpalu, A., Ogbole, G., Ayantayo, T., Adokonou, T., Paddick, S. M., Ndetei, D., Bosche, J., Ayele, B., Damas, A., Coker, M., Mbakile-Mahlanza, L., Ranchod, K., Bobrow, K. African Dementia Consortium (AfDC) (2022). Dementia in Africa: Current evidence,

knowledge gaps, and future directions. *Alzheimer's & dementia: The Journal of the Alzheimer's Association*, *18*(4), 790–809. https://doi.org/10.1002/alz.12432

2. Avan, A. and Hachinski, V. (2023). Global, regional, and national trends of dementia incidence and risk factors, 1990–2019: a Global Burden of Disease study. *Alzheimer's & Dementia*, *19*(4):1281-1291.
3. Baba, S. S. and Yarube, I. U. (2021). Raised high-sensitivity C-reactive protein and cognitive impairment among African stroke survivors within the first three months following stroke. *Journal of Clinical Neuroscience*, *88*:191-196.
4. Benyumiza, D., Kumakech, E., Gutu, J., Banihani, J., Mandap, J., Talib, Z. M., Wakida, E. K., Maling, S., & Obua, C. (2023). Prevalence of dementia and its association with central nervous system infections among older persons in northern Uganda: cross-sectional community-based study. *BMC geriatrics*, *23*(1), 551. https://doi.org/10.1186/s12877-023-04174-9
5. Disbrow, E. A., Arnold, C. L., Glassy, N., Tilly, C. M., Langdon, K. M., Gungor, D. and Davis, T. C. (2021). Alzheimer disease and related dementia resources: Perspectives of African American and Caucasian family caregivers in northwest Louisiana. *Journal of Applied Gerontology*, *40*(2), 209-219.
6. Lam, J. O., Hou, C. E., Hojilla, J. C., Anderson, A. N., Gilsanz, P., Alexeeff, S. E and Silverberg, M. J. (2021). Comparison of dementia risk after age 50 between individuals with and without HIV infection. *Aids*, *35*(5):821-828.
7. Livingston, G., Huntley, J., Sommerlad, A., Ames, D., Ballard, C., Banerjee, S., Brayne, C., Burns, A., Cohen-Mansfield, J., Cooper, C., Costafreda, S. G., Dias, A., Fox, N., Gitlin, L. N., Howard, R., Kales, H. C., Kivimäki, M., Larson, E. B., Ogunniyi, A., Orgeta, V., … Mukadam, N. (2020). Dementia prevention, intervention, and care: 2020 report of the Lancet Commission. *Lancet (London, England)*, *396*(10248), 413–446. https://doi.org/10.1016/S0140-6736(20)30367-6
8. McGrattan, A. M., Zhu, Y., Richardson, C. D., Mohan, D., Soh, Y. C., Sajjad, A. and Stephan, B. (2021). Prevalence and risk of mild cognitive impairment in low and middle-income countries: a systematic review. *Journal of Alzheimer's Disease*, *79*(2):743-762.
9. Schwarz, T., Schmidt, A. E., Bobek, J., & Ladurner, J. (2022). Barriers to accessing health care for people with chronic conditions: a qualitative interview study. *BMC health services research*, *22*(1), 1037. https://doi.org/10.1186/s12913-022-08426-z
10. Wimo, A., Seeher, K., Cataldi, R., Cyhlarova, E., Dielemann, J. L., Frisell, O. and Dua, T. (2023). The worldwide costs of dementia in 2019. *Alzheimer's & Dementia*, *19*(7): 2865-2873.
11. Wingren, M., Lidström-Holmqvist, K., Roshanai, A. H., Arvidsson, P., Janeslätt, G., White, S. and Holmefur, M. (2022). One-year follow-up after the time management group intervention Let's Get Organized. *Scandinavian Journal of Occupational Therapy*, *29*(4), 305-314.
12. World Health Organization. (2025). *Dementia fact sheet*. WHO. Retrieved from https://www.who.int/news-room/fact-sheets/detail/dementia (communitymedicine4asses.wordpress.com, who.int)

How to cite this article: Arise Victor Oluwaseyifunmi, Sodunke Taiwo Ganiyat, Samuel Makinde-Ojo, Andorbe Bernard Andorbe, Ibrahim Rukayat Motunrayo. Assessment of community perception and myths about dementia in elderly: a population-based study in Ilorin metropolis. *International Journal of Science & Healthcare Research.* 2025; 10(3): 146-159. DOI: *10.52403/ijshr.20250317*

******