

Original Article

Health-Seeking behavior of people living with human immunodeficiency virus at a secondary healthcare institution in Anambra State, Nigeria

C. C. Ozomma*, S. O. Nduka, O. I. Ekwunife

Department of Clinical Pharmacy and Pharmacy Management, Nnamdi Azikiwe University Awka, Anambra State, Nigeria

ABSTRACT

Background: Health-seeking behavior is simply defined as “sick term” behavior. It is the manner in which individuals monitor their health, interpret their symptoms, take remedial actions and utilize other health sources of help. Various studies have been done on the general health seeking behavior of some categories of people within the context of various diseases. However, there is limited data on the health-seeking behavior (HSB) of persons living with human immunodeficiency virus (HIV) in Nigeria, their perception about the disease, possible influences/barriers to seeking prompt care and the causes of delay in health care seeking. Studies on health-seeking behavior of people living with HIV (PLHIV) in Nigeria focused more on the urban dwellers with little information on the rural and semi-urban dwellers. This study aimed to assess the health-seeking behavior of PLHIV/acquired immunodeficiency syndrome (AIDS) attending the HIV/AIDS clinic of the General Hospital Ekwulobia in Anambra state. **Method:** The study was a cross-sectional study carried out in General Hospital Ekwulobia, Aguata local government area of Anambra state. A total of 289 patients were interviewed using a pre-tested semi-structured questionnaire. The questionnaire had patients’ demographic information and 8 domains bearing information on patients experiences of symptoms, reactions to symptoms, thought about cause of symptoms, people spoken to about symptoms, knowledge about HIV, and relationship with healthcare professionals. Analysis of data was done using Statistical Packages for the Social Sciences version 20. **Results:** A total of 289 questionnaires were completed out of 300 administered giving a response rate of 96.33%. The mean age of the respondents was 40.29 (strongly disagree 11.35) years, 73.4% were females, with male to female ratio of 1:3, 53.3% had secondary education, 51.9% were self-employed and 70.7% were non-income earners. A significant relationship ($P = 0.02$) existed between participants’ employment status and their overall HSB. **Conclusion:** The study showed a modest HSB by participants and a moderate perception of HIV by participants. Employment status of the participants showed a significant relationship with the HSB of the participants. There was no obvious barrier to healthcare-seeking noted.

Keywords: Health-seeking behavior, perception, human immunodeficiency virus, barriers, symptoms, people living with human immunodeficiency virus

Submitted: 26-05-2025, **Accepted:** 12-06-2025, **Published:** 30-06-2025

INTRODUCTION

Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) is one of the world’s most serious public health challenges. According to UNAIDS report; 39.9 million people worldwide were living with HIV/AIDS as of 2023. Of these, 38.6 million are adults 15 years and above, 20.5 million of these adults are women while 18.1 million are men. A total of 1.4 million children are affected and most of these kids live in sub-Saharan Africa.^[1] Sub-Saharan Africa

is home to 12% of the global population, yet it accounts for 71% of the global burden of HIV infection. An estimated 1.3 million people acquired HIV in 2023.^[2] Ten countries including Nigeria (13%) as second in the row account for almost 80% of all people living with HIV (PLHIV).^[3] The incidence rate of HIV in Nigeria is 15%. Sub-Saharan Africa bears the highest burden of HIV infection globally. An estimated 630,000 people died from AIDS-related illnesses in 2023.^[3] Nigeria has the largest HIV epidemic in West and Central Africa. A total of 103 countries have reported 230

Address for correspondence: C. C. Ozomma, Department of Clinical Pharmacy and Pharmacy Management; Nnamdi Azikiwe University Awka, Anambra State, Nigeria. E-mail: chizyreal@yahoo.com

million people who have been tested and results received in 2023.^[3] The importance of prompt medical treatment of HIV cannot be overemphasized as this will delay the degeneration to AIDS and eventual death of victims.

Health-seeking behavior is the activity undertaken by individuals when they perceive themselves as sick or unhealthy.^[4] It is the manner in which individuals monitor their health, interpret their symptoms, take remedial actions, utilize other health sources of help, and engage with more formal health care system.^[5] It has a close link with the health status of a nation and thus it's economic development. Patients' perception and attitude about their health, health care system and knowledge are said to influence their health-seeking behavior (HSB). HSB involves all behaviors associated with establishing and maintaining a healthy physical and mental state, (primary prevention).^[6] It also includes behavior that deals with any digression from the healthy state such as controlling (secondary prevention) and reducing the impact and progression of an illness (tertiary prevention).^[7]

Chronic diseases such as HIV infection whose cause or predisposing factor cannot be easily explained are usually attributed to supernatural explanation. Most HIV-infected patients have poor perception about the sickness. Some view it as a spiritual attack or attack by enemies or witchcraft. Such poor perception affects the health-seeking behavior of infected persons. Despite increased recognition of the benefits of early treatment, there remains considerable delay between symptom onset and the initiation of therapy. It has been noted that health-seeking sources of PLHIV are traditional healers, health facilities such as hospitals, dispensaries, and pharmaceutical shops^[8], and the usage of alternative healthcare services such as spiritual therapies, herbal medications, self-treatment or home remedies.^[9,10]

Access to healthcare facilities in terms of cost of treatment, the attitude of healthcare provider, patient delays also influence patients' health-seeking behavior. This in turn encourages the use of other treatment sources such as community pharmacies, drug peddlers, herbal medicines, and religious or spiritual care organizations.^[11] Several studies done on the possible influences of HSB have found that sociodemographic variables and socio-cultural beliefs such as religion, family support, people's views, traditional beliefs, stigmatization and discrimination, levels of income, distance of health care facility from PLHIVs residence, cost of treatment, attitude of health care providers influence the choice PLHIV make as regards to modality of treatment.^[12-16] Regularity of income was identified as a major determinant of HSB in a previous study done by Bour, 2003; Hjortsberg, 2003; Gotsadze *et al.* 2005; Onwujekwe and Uzochukwu, 2005; Taffa and Chepnegeno, 2005; Prosser, 2007 and Mmari *et al.* 2010.^[14,17-22] Soucat *et al.* and Anyaegbunam (2014) identified perceived quality of service as a major determinant

of HSB rather than income.^[23,24] Nshi in his study, noted regularity of income and stigmatization as major determinants of healthcare-seeking behavior of PLHIV in the southeast. Nshi 2017 also found out that proximity to HIV clinics did not foster regular visits to clinic, PLHIV rather prefer far and hidden clinics irrespective of transport; where they could be hardly recognized and this is in line with the assertion by John *et al.* that people seek far treatment due to fear of stigmatization and discrimination.^[25,26] Previous studies in Nigeria have been conducted on stigmatization, prevalence, discrimination, adherence, and non-adherence to anti-retroviral therapy but none has looked at the general health-seeking behavior of persons living with HIV. The different schools of thought on the factors that may influence or affect PLHIV HSB also prompted the need to determine the health-seeking behavior and factors that affect the healthcare-seeking behavior of this segment of the population. Hence the aim of this study was to determine patients' perception of HIV, their health care seeking-behavior pre- and post-diagnosis, and the possible barriers to seeking proper care at General Hospital, Ekwulobia.

METHODS

Study Design and Setting

This study was a cross-sectional study conducted among PLWHIV between June and July 2021 at General Hospital Ekwulobia, Aguata Local Government Area (LGA) of Anambra state, Nigeria with an approved HIV/AIDS clinic. The major part of the local government falls within Ekwulobia while a small part falls within Agulu Ezechukwu.^[27] It is a secondary health facility and the major state secondary health facility in Aguata LGA of Anambra state which is classified as a semi-urban. The hospital has well over 60 beds providing health care services to the people of Aguata LGA and parts of Orumba local government and beyond. The hospital has 5 physicians, 1 pharmacist, 2 laboratory scientists, 30 registered nurses, 2 optometrists, 5 physiotherapists, and other junior staff who attend to these patients. The facility has 2228 patients who have been registered in the HIV/AIDS clinic and daily turnout at the outpatient clinic is 80 patients per clinic day. The clinic offers enrollment of HIV patients, laboratory services, post-exposure prophylaxis services, multi-month scripting, enhanced adherence counseling, follow-up in the outpatient clinic, and treatment.

A total of 300 self-administered, semi-structured questionnaires adapted from (Stack *et al.*, 2014) was used to collect data from HIV patients receiving care from the hospital.^[28]

Sample Size and Sampling

Participants consisted of PLHIV/AIDS above 18 years attending the HAART clinic of General Hospital Ekwulobia, who met the inclusion criteria and gave informed consent to participate in the study. Participants were enrolled in the study through a simple random sampling.

A minimum of 118 participants was calculated using Cochran's statistical formula;

$$n = \frac{Z^2 Pq}{d^2}$$

assuming a 95% confidence interval and 5% margin of error.

Data Collection and Tool

The survey instrument was a semi-structured administered questionnaire adopted from a previous study. The face validity was established and it was pre-tested in 20% of the sample size population. Information was obtained on demographic variables, respondents' experiences of symptoms, reaction to symptoms, thoughts about cause of symptoms, people spoken to about symptoms, knowledge about HIV, and relationship with health professionals.

A standard test of internal consistency was done. Questions that improved the Cronbach's alpha to a value 0.7 were deleted from the final questionnaire used for the study.

Data Analysis

The data collected from the questionnaires were entered, coded, and analyzed using Statistical Packages for the Social Sciences version 20. Descriptive statistics such as means, standard deviation, and frequencies were calculated on the demographic variables and Likert scale questions including the calculation of median (MDN) and interquartile range (IQR) on Likert questions. Independent *t*-test and analysis of variance (ANOVA) was used to test for significance for the overall HSB in PLWHIV against the patients' demographics and the domains and facets of HSB. Correlation coefficients between some demographic characteristics of the study group and the overall HSB in PLWHIV and the domains of HSB were also determined. The relationship between the demographics and overall HSB and the domains of HSB was determined at a significant level using, $P < 0.05$. Results were summarized and presented in tables.

Ethics Consideration

The study was approved by the Health Research Ethics Committee of Nnamdi Azikwe University Teaching Hospital, Nnewi. Informed consent was obtained from the participants and the confidentiality of their information was assured.

RESULTS

A total of 289 questionnaires were completed out of 300 administered giving a response rate of 96.33%. Exactly 77 (26.6%) of the respondents are male and 212 (73.4%) are female; giving a male-to-female ratio of 1:3. The mean age of the respondents is 40.29 (Strongly disagree 11.35) years,

with more than half 55.4% being married. The majority of the respondents had secondary school education 154 (53.3%), majority 101 (34.9%) are traders, 50 (17.3%) are farmers, 49 (17%) are self-employed, 40 (13.85%) are civil/public servants, 29 (10%) have no occupation and 20 (6.9%) are students. The majority of the respondents were non-income earners 70.7%. Table 1 below shows a summary of the respondents' demographic characteristics.

Table 2 shows a summary of how the respondents reacted to their symptoms before seeking professional help. An equal number of the respondents were in agreement that they ignored their symptoms at the onset, ($n = 141$, 48.8%), whereas (142, 49.2%) were in disagreement; (MDN = 2, IQR = 2). Half of the respondents disagreed that they took their symptoms as a normal thing, ($n = 151$, 52.3%) while half of the respondents agreed they were frightened initially by their symptoms, ($n = 159$, 55%).

Table 3 shows the actions taken by respondents to manage their symptoms before going to see the doctor. Those who agreed that they spoke to a doctor or healthcare worker before going to the hospital were ($n = 135$, 46.7%) while nearly the same number disagreed that they spoke to a doctor or health care worker, ($n = 140$, 48.5%); (MDN = 3, IQR = 2). Half of the respondents were in disagreement that they used prayer or spiritual help before seeing the doctor, ($n = 160$, 55.3%). The other, ($n = 115$, 39.8%) accepted the use of spiritual help before going to see the doctor; (MDN = 2, IQR = 2).

Table 4 shows the summary of their responses on their reasons for going to see the doctor. Opinion seem to be divided on those who saw the doctor because they were incapacitated by their condition ($n = 135$, 46.7%) while approximately equal number disagreed that they saw the doctor due to incapacitation, ($n = 144$, 49.8%); (MDN = 2, IQR = 2). Majority of the respondents ($n = 215$, 74.4%) agreed they went to see the doctor to get treatment for their symptoms; (MDN = 4, IQR = 0). Most respondents also indicated that the time factor was never a reason for their initial delay in going to see the doctor, (MDN = 2, IQR = 1). Fear of being blamed for their symptoms was never a barrier to their seeking prompt help also, (MDN = 2, IQR = 1).

Table 5 below shows a summary of the results of the ANOVA carried out on the patients' demographics and their HSB. Only employment status has a significant association with the overall HSB of the participants.

DISCUSSION

This study explored the patients' perception about HIV/AIDS, their HSB and the possible barriers they may encounter in seeking health. The outbreak of chronic diseases such as HIV with no known cure or origin has been attributed to the

Table 1: Socio-demographic characteristics of respondents

Variable	Classification	n	%
Gender of respondents	Male	77	26.6
	Female	212	73.4
Occupation of respondents	Student	20	6.9
	Civil/Public Servant	40	13.8
	Self-employed	49	17.0
	Trading	101	34.9
	Farming	50	17.3
	None	29	10.0
	Educational qualification	Primary	71
	Secondary	154	53.3
	Tertiary	47	16.3
	None	17	5.9
Religion	Christianity	283	97.9
	Islam	1	0.3
	Traditional	4	1.4
	None	1	0.3
Marital status	Single	64	22.1
	Married	160	55.4
	Divorced	11	3.8
	Widowed	54	18.7
Ethnicity	Igbo	285	98.6
	Yoruba	2	0.7
	Others	2	0.7
Monthly income	None	200	70.7
	<5000.00	34	12.0
	5,000.00–19,999.00	21	7.4
	20,000.00–39,999.00	18	6.4
	>40,000.00	10	3.5
Monthly wincome in 4 categories	<5,000.00	34	41.0
	5,000.00–19,999.00	21	25.3
	20,000.00–39,999.00	18	21.7
	>40,000.00	10	12.0
Off duty to be in hospital	Yes	119	41.2
	No	170	58.8
Variable		M	Strongly disagree
Age of respondents		40.29	11.35
Distance (km) to hospital		22.06	59.57
Transport fare per visit		717.71	1,242.22
Time from symptom onset to initial contact with healthcare professional		115.69	329.93

commission of an offence against a spirit, ancestors, gods, or an omission of duty on the part of the infected persons in the

past. Awusabo and Anarfi in their study noted that majority of victims attributed their condition to a curse from a jealous neighbor, co-wife, or a family member and even an attack by their enemies who has been wronged.^[29] The latter belief over the decades has negatively affected the prevalence and incidence of HIV infection across the globe since many infected persons refrain from getting professional help, hence the increased spread of the infection. Interestingly, the result from this study showed advancement with regard to the common beliefs, knowledge, and management approach to HIV by the victims. HIV and AIDS have been given a human face such that victims are now able to discuss their symptoms with loved ones and now freely seek professional help without fear of being discriminated against. This is in line with the findings from this study where the participants' perception of HIV was seen to be adequate, although the study was carried out in one hospital with small sample size; the result indicated the need for broader assessments on the perception about HIV by the victims. Questions that examined their perception showed the participants did not attach their symptoms to poison and they did not also attach their symptoms to spiritual attack. Traditional beliefs such as spiritual attacks and poison by enemies were not the commonest perceived cause of symptoms in this study. Studies have shown that such beliefs may contribute to the spread of HIV as most people with such beliefs usually delay in seeking professional help and in most cases they usually present to the clinic when their condition had become critical. Mbonu *et al.* (2009) noted in their study that beliefs can be either general belief about the infection or about the affected persons.^[16] Most of the time, anticipation of certain reactions by people based on these popular beliefs makes PLWHIV refrain from seeking health care. This is not in line with the finding from this study where majority, (72.4%) of persons noted that fear of being blamed for their symptoms did not contribute to the delay in seeing the doctor. Early recognition of symptoms is very important and necessary for PLHIV.^[30]

Participants of the study agreed they had flu-like symptoms ranging from cough, headache fever, and weakness, half of them also lost weight but very few had diarrhea. Irrespective of the symptoms they had, it took them approximately 4 months to seek professional help; although their reasons were not linked to fear of being discriminated against nor the use of alternatives such as prayer or herbal medicine as was noted in the study. There seemed to be a satisfactory HSB by the participants. Half of the participants did not hide their symptoms from their acquaintances. Relatives suggested they should seek professional advice and alternative medicine such as the use of herbs and spiritualists was never suggested to more than half of the respondents (66.4%). Peoples' HSB determines their action when there is a suspected infection. Social stigma, voluntary counseling and testing sites, limited surveillance and lack of knowledge among the general population can affect HSB of PLWHIV and these can result to

Table 2: Summary of reactions to symptoms before going to see the doctor

Variables	SD (%)	D (%)	UC (%)	A (%)	SA (%)	Median	IQR (0–4)
Ignored symptoms	47 (16.3)	95 (32.9)	6 (2.1)	100 (34.6)	41 (14.2)	2	2
Thought symptoms were normal for someone like me	47 (16.3)	104 (36)	10 (3.5)	98 (33.9)	28 (9.7)	2	2
Symptoms frightened me	48 (16.6)	69 (23.9)	10 (3.5)	122 (42.2)	37 (12.8)	4	2

Key: SD: Strongly disagree, D: Disagree, UC: Uncertain, A: Agree, SA: Strongly agree, IQR: Interquartile range

Table 3: Actions taken by respondents to manage symptoms before going to see the physician

Variables	SD (%)	D (%)	UC (%)	A (%)	SA (%)	Median (%)	IQR (0–4)
Spoke to a doctor, pharmacist or nurse before going to the hospital.	47 (16.3)	93 (32.2)	11 (3.8)	98 (33.9)	37 (12.8)	3	2
I used prayer or looked for spiritual or religious help.	57 (19.7)	103 (35.6)	12 (4.2)	78 (27)	37 (12.8)	2	2

Key: SD: Strongly disagree, D: Disagree, UC: Uncertain, A: Agree, SA: Strongly agree, IQR: Interquartile range

Table 4: Summary of responses on their reasons for seeing the physician and reasons for not seeing the physician promptly

Variables	SD (%)	D (%)	UC (%)	A (%)	SA (%)	Median (%)	IQR (0–4)
Saw doctor because I was incapacitated	56 (19.4)	88 (30.4)	7 (2.4)	91 (31.5)	44 (15.2)	2	2
Saw doctor to get some treatment to make my symptoms better.	18 (6.2)	42 (14.5)	12 (4.2)	174 (60.2)	41 (14.2)	4	0
Saw doctor to find out what was causing my symptoms.	20 (6.9)	56 (19.4)	8 (2.8)	160 (55.4)	39 (13.5)	4	2
I didn't go to the doctor at first because of time factor	67 (23.2)	142 (49.1)	4 (1.4)	42 (14.5)	10 (3.5)	2	1
I did not think that my doctor would be able to do much for me.	61 (21.1)	132 (45.7)	13 (4.5)	62 (21.5)	18 (6.2)	2	2
Fear to be blamed	73 (25.3)	136 (47.1)	13 (4.5)	48 (16.6)	16 (5.5)	2	1
I didn't want to see the doctor because I was worried they would it's serious	68 (23.5)	134 (46.4)	9 (3.1)	57 (19.7)	20 (6.9)	2	2

Key: SD: Strongly disagree, D: Disagree, UC: Uncertain, A: Agree, SA: Strongly agree, IQR: Interquartile range

underreporting of the disease.^[31] The present study, however, showed that participants seemed to have a good knowledge about HIV and its mode of transmission, although there was a negative correlation between the age of the respondents and their knowledge about HIV/AIDS. This indicated that the younger age group was more knowledgeable than the older age group. Studies have shown that poor HSB contribute to ineffective prevention and control of mortality and morbidity related to health conditions. Self-treatment is usually the first line of management of many diseases.^[32] People usually use common traditional treatments and most usually patronize readily available patent medicine dealers. This is not consistent with the finding from this study since majority ($n = 192$, 66.4%) of the participants disagreed that they were advised by friends and relatives to take alternative medicines or seek spiritual help before getting professional help, 64% of the respondents also attested to the fact that they always go to the hospital when they are sick.

Participants reported that they have good relationship with health professionals and this reaffirmed the assertion by Ndie and Onoh (2014) that although stigma is a global problem that greatly affects healthcare-seeking behavior of PLWHIV, health workers treated PLHIV with dignity and do not discriminate against them.^[33] This also clears the assertion that relationship between patients and the health professionals could pose a barrier to their accessing health care. From the result, we would infer that relationship with health professional does not pose a barrier to health seeking. This is not consistent with the report MAAS-CHRD (2006) which claimed that people including health workers grossly stigmatized and discriminated against PLWHIV.^[12] The study also showed that there was no significant relationship between gender and the overall HSB of participants, although Mbonu *et al.* however stressed on the relevance of gender on care seeking.^[16] They noted that gender affects time of diagnosis, societal blame, and necessity of disclosure to partner. There seems to be a clear

Table 5: The association between the overall health-seeking behavior of respondents and some of their socio-demographic characteristics

Socio-demographic variables/association between overall HSB in PLWHIV	Overall HSB in PLWHIV		f	f	P-value
	Mean	Standard deviation			
Employment status					
Student	56.33	2.19			
Civil servant	57.82	6.51			
Self-employed	59.38	7.53	5,283	2.9	0.02*
Trading	55.69	6.37			
Farming	59.05	8.33			
None	58.20	6.00			
Educational qualification					
Primary	58.66	7.183			
Secondary	56.88	7.083	3,285	2.02	0.11
Tertiary	58.51	6.212			
None	55.23	6.398			
Marital status					
Single	56.40	6.05			
Married	58.02	7.44	3,285	1.15	0.33
Divorced	53.42	8.03			
Widowed	57.61	6.28			
Monthly income					
<5,000	56.79	7.76			
5,000–19,999	58.40	7.07	379	0.82	0.49
20,000–39,999	60.17	7.52			
>40,000	57.80	7.17			

difference in timing of HIV/AIDS diagnosis between male and female counterparts. Women find out much later after being infected. The reason is that the society believes that women should be conservative and faithful to their partners; such cautiousness, however, does not protect women from HIV if their partners keep multiple partners and indulge in sexual intercourse without protection. Moreover, even when women find out their HIV status, they have to disclose to their partners immediately if they want to secure financial aid for treatment. They maintained that due to stigma men are not always willing to disclose their status to their wives, and this causes delay in care seeking on the woman's part. Employment status has a significant relationship with the overall HSB, with the self-employed having the greatest influence. This is not consistent with what was found in the literature, where Bhutto and Nighat in their study stated that there was no significant association between employment status and HSB.^[31] Educational qualification has no influence on the overall HSB of the participants, this is in line with the results of some previous studies carried out by Mackenbach and Chapman (2003), Bour (2003), Prosser (2007), Oparah *et al.*

(2007), and Omotoso (2010).^[14,17,34-36] The study also showed no significant association between marital status and overall health-seeking behavior. This study also found out that there is no statistically significant association between participants monthly income and their health-seeking behavior, although monthly income was identified as a major determinant of healthcare seeking in previous studies done by Bour (2003), Hjortsberg (2003), Gotsadze *et al.* (2005); Onwujekwe and Uzochukwu (2005), Prosser (2007) and Mmari *et al.* (2010).^[14,17-22] The result of this study is in agreement with Soucat *et al.* (1997) and Anyaegbunam (2014) that identified perceived quality of service as a determinant of HSB rather than monthly income and this is in line with the UNESCO report (2003), Adeyemo, and Oyinloye (2007), and Olapegba and Oladipo (2012) that found out that stigmatization and discrimination prevent many PLHIV from seeking care and information about their condition.^[13,23,24,37,38] Settle (2006), Agweda and Dibua (2010) noted that stigmatization and fear were serious obstacles in the design and implementation of effective HIV/AIDS program.^[39,40] This issue of fear was not significant in the study, since most of the participants stated

that fear of being blamed for their symptoms was never a cause of their delay in seeking professional care.

CONCLUSION

The HSB of the majority of the participants was adequate. Employment status of the participants showed a significant relationship with their HSB at ($P = 0.02$). Being self-employed has the greatest influence. Participants seem to have adequate perception about HIV since majority did not attach their symptoms to spiritual attacks or poison by their enemies, although there seem to be a divided opinion on symptom being a result of unhealthy practices such as unprotected sex, multiple sex partners etc. Monthly income, marital status, gender, and educational qualification have no association with the healthcare-seeking behavior of the participants. The result of this study showed a moderate perception of HIV and a modest HSB among this segment of the population. There was no obvious barrier to health care seeking among this segment of the population.

Recommendation

There is a need for a broader assessment on HSB of PLWHIV in rural and semi-urban areas. Limited data exists on the HSB of PLWHIV in those areas since HSB has a close link with the incidence and prevalence of chronic diseases such as HIV and the prevalence of this infection are more in the rural and semi-urban areas.

Limitation

A major limitation to this study was that it used purely self-reported instrument which is subject to patients' forgetfulness, bias, and patients' desire to provide socially desirable answers.

This study was conducted in a single HIV/AIDS center in Ekwulobia and findings can only be generalized to Ekwulobia town and its' environs.

REFERENCES

1. WHO. UNAIDS Factsheet. Switzerland: WHO; 2024.
2. UNAIDS. UNAIDS Factsheet on Epidemiological Statistics. Switzerland: UNAIDS; 2023.
3. UNAIDS. UNAIDS Factsheet Report. Switzerland: UNAIDS; 2014.
4. Mackian S. A Review of HSB Problems and Prospects. Health Systems Development Program. Vol. 5. England: University of Manchester; 2013.
5. Mechanic D. Illness behavior. In: Mechanic D, editor. Medical Sociology. New York: The Free Press; 1978. p. 249-89.
6. Tipping G, Segall M. Healthcare Seeking Behavior in Developing Countries: An Annotated Bibliography and Literature Review. Bibliography, 12 Brighton. UK: Institute of Development Studies, University of Sussex; 1995.
7. David VM. Illness and Sick-Role Behavior. Encyclopaedia of Public Health. The Gale Group Inc; 2002. Available from: <https://www.encyclopaedia.com/doc/1g2-3404000445.html> [Last accessed on 2016 Jul 13].
8. Plummer ML, Mshana G, Wamoyi J, Shiangongo ZS, Hayes RJ, Ross DA, *et al.* 'The man who believed he had AIDS was cured': AIDS and sexually-transmitted infection treatment-seeking behaviour in rural mwanza, Tanzania. *AIDS Care* 2006;18:460-6.
9. Mills E, Cooper C, Seely D, Kanfer L. African herbal medicines in the treatment of HIV: Hypoxis and sutherlandia. An overview of evidence and pharmacology. *Nutr J* 2005;4:19.
10. Mohaleni MP. Pre and Post - HIV Diagnosis Help Seeking by Patients Receiving Antiretroviral at Witbank Hospital in Mpumalanga Province. Mini Dissertation Submitted to University of Limpopo, Turf Loop Campus. Faculty of Humanities; 2013. 2013-12-17T13:31:57Z. Available from: <http://hdl.handle.net/10386/1049>
11. Ward H, Mertens TE, Thomas C. Health seeking behavior and the control of sexually transmitted disease. *Health Policy Plan* 1997;12:19-28.
12. Maharashtra Association of Anthropological Science Centre for Health Research and Development (MAAS - CHRD). Access to HIV and AIDS Care: A Study among People Living with HIV AIDS, Dissemination Report Pune, India; 2006.
13. Adeyemo DA, Oyinloye AA. Predispositional factors in stigmatization and discrimination against HIV/AIDS seropositive persons in the workplace: A case study of Osun state, Nigeria. *J Soc Sci* 2007;15:279-92.
14. Prosser T. Utilization of Health and Medical Services: Factors Influencing Health Care Seeking Behavior and Unmet Health Needs in Rural Areas of Kenya; 2007. Available from: <https://ro.ecu.edu.au/theses/46> [Last accessed on 2010 Apr 25].
15. Bourne P. Growing Old in Jamaica: Population Ageing and Senior Citizens' Wellbeing Kingston. Department of Community Health and Psychiatry. Mona, WI: Faculty of Medical Sciences, The University of the West Indies; 2009.
16. Mbonu NC, Bart Van Den Borne, Nanne K. The Experiences and Complexities of Care-Seeking Behavior of PLHIV: A Qualitative Study in Nigeria School of Public Health and Primary Care (CAPHRI). Netherlands: Faculty of Health Medicine and Life Sciences, Maastricht University Netherlands; 2009.
17. Bour D. Analysing the primacy of distance in the utilization of health services in the Ahafo-Ano South District, Ghana. *Int J Health Plann Manage* 2003;18:293-311.
18. Hjortsberg C. Why do the sick not utilise health care? The case of Zambia. *Health Econ* 2003;12:755-70.
19. Gotsadze G, Bennet S, Ranson K, Gzirishvili D. Health care-seeking behaviour and out-of-pocket payments in Tbilisi, Georgia. *Health Policy Plan* 2005;20:232-42.
20. Onwujekwe O, Uzochukwu B. Socio-economic and geographic differentials in costs and payment strategies for primary healthcare services in southeast Nigeria. *Health Policy* 2005;71:383-97.
21. Taffa N, Chepngeno G. Determinants of health care seeking for childhood illnesses in Nairobi slums. *Trop Med Int Health* 2005;10:240-5.
22. Mmari K, Oseni O, Fatusi A. STI treatment-seeking behaviors among youth in Nigeria: Are there gender differences? *Int Perspect Sex Reprod Health* 2010;36:72-9.
23. Soucat A, Gandaho T, Levy-Bruhl D, De Bethune X, Alihonou E,

- Ortiz C, *et al.* Health seeking behaviour and household health expenditures in Benin and Guinea: The equity implications of the Bamako initiative. *Int J Health Plan Manage* 1997;12:S137-63.
24. Anyaegbunam A. Health seeking behavior as a predictor of Adolescents security consciousness. *Int J Adv Res.* 2014;23:143-9.
25. Nshi GI. Determinants of healthcare-seeking behaviour of people living with HIV and AIDS (PLHIV) in south - East, Nigeria. *J Middle East North Africa Sci* 2017;3:32-40.
26. John ME, Nsemo A, Esienumoh E, Osuchukwu N, Duke E, Bassey P. Change Counseling and Health Promotion for Youth Living with HIV/AIDS (YLWHA) in Calabar, Nigeria. Vol. 5. Calabar: John ME, Publications-Research Gate; 2014.
27. Adeleke. Brief History of Aguata Local Government. Lagos: NaijaSky; 2016.
28. Stack RJ, Mallen CD, Deighton C, Kiely P, Shaw KL, Booth A, *et al.* The development and initial validation of a questionnaire to measure help-seeking behaviour in patients with new onset rheumatoid arthritis. *Health Expect* 2014;18:2340-55.
29. Awusabo-Asare K, Anarfi JK. Health-seeking behaviour of persons with HIV/AIDS in Ghana. *Health Transit Rev* 1997;7:243-56.
30. Protocol D. A Rapid Assessment of Health Seeking Behavior in Relation to Sexually Transmitted Disease; 1995. Available from: [https://www.who.int/hiv/topics/en/healthcare seeking behaviour. pdf](https://www.who.int/hiv/topics/en/healthcare%20seeking%20behaviour.pdf) [Last accessed on 2016 Nov 14].
31. Bhutto AQ, Nisar N. Health-seeking behaviour of people living with HIV/AIDS and their satisfaction with health services provided at a tertiary care hospital, Karachi Pakistan. *East Mediterr Health* 2016;23:13-9.
32. Ellis AA, Traore S, Doumbia S, Dalglish SL, Winch PJ. Treatment actions and treatment failure: Case studies in the response to severe childhood febrile illness in Mali. *BMC Public Health* 2012;12:946.
33. Ndie EC, Onoh G. Evaluation of quality of healthcare services available to people living with HIV/AIDS; evidence from Enugu state. *J Health Sci* 2014;2:235-9.
34. Makenbach J, Chapman M. Health-seeking behavior and student perception of health care services in a university community in Nigeria. *Health* 2003;46:428-44.
35. Oparah DC, Umoh IB, John M. Socio-demographic and Anthropometric variables of persons living with HIV and AIDS in Uyo, south eastern Nigeria. *Pak J Nutr* 2007;66:547-57.
36. Omotoso O. Health seeking behaviour among rural dwellers in Ekiti state, Nigeria. *Int Multidiscip J Ethiop* 2010;4:125-38.
37. UNESCO. A Cultural Approach to HIV-AIDS Prevention and Care; 2003. Available from: <https://www.unesco.org/aids> [Last accessed on 2010 Apr 12].
38. Olapegba PO, Oladipo SE. Dynamics of stigmatization and discrimination on intention to disclose among PLWHA: A qualitative assessment. *Scott J Arts Soc Sci Sci Stud* 2012;3:24-33.
39. Settle E. China AIDS Survey; 2006. Available from: <https://www.avert.org> [Last accessed on 2011 Jul 05].
40. Agweda TO, Dibua VA. The impact of stigmatization on the acceptance and care for people living with HIV/AIDS (PLWHA) in the society. A case study of civil servants in auchi. *J Soc Sci* 2010;23:129-34.



This work is licensed under a Creative Commons Attribution Non-Commercial 4.0 International License.