



## Determinants of Healthcare-Seeking Behaviour of People Living With HIV and AIDS (PLWHA) in South-East, Nigeria

Goodluck Ikechukwu Nshi

Department of Nursing Science, Ebonyi State University, Abakaliki, Nigeria  
[mekagoodluck@yahoo.com](mailto:mekagoodluck@yahoo.com)

### ABSTRACT

**Background:** HIV/AIDS remains one of the major public health challenges in sub-Saharan Africa, where over 70% of global burden of the disease occurs. Nigeria – particularly the South-East with prevalence rate of 5.48%, which is above the WHO's 4% red line has an alarming burden of the disease and is said to be at an explosive stage of the disease. Factors that moderate PLWHA healthcare-seeking which in turn fuel and sustain such a high and ugly burden of HIV/AIDS in South-East, Nigeria, has not been investigated by previous studies.

**Objective:** This study was conducted to assess the determinants of Healthcare-Seeking Behaviour (HCSB) among PLWHA in South-East, Nigeria. Five specific research questions and two hypotheses guided the study.

**Methodology:** Using a descriptive survey design, the study accessed a sample of 400 PLWHA who registered in HIV clinics from 5 government-owned, three missionary and two privately owned hospitals across the South-East zone between the month of June and August 2015. Multiple cluster sampling technique was used to draw this sample from an estimated 931600 People Living with HIV/AIDS (PLWHA) in South-East, Nigeria. A self-structured, validated and pretested questionnaire titled PLWHA Healthcare-Seeking Behaviour Questionnaire (PHCSBQ) was the instrument used for data collection. The instrument was subjected to a reliability test using Pearson product moment correlation ( $r=0.94$ ). Descriptive statistics of frequency counts, percentages, mean and standard deviation were used to analyze data. Inferential statistics of chi-square was used to test hypotheses at 0.05 level of significance.

**Results:** Results showed that HCSB of PLWHA in South-East, Nigeria, reflected in their preference for treatment facilities and varied based on location and educational levels. Results also showed that place of residence (location) ( $1.83 \pm 0.17$ ), educational level ( $1.86 \pm 0.23$ ) and religio-cultural belief ( $1.76 \pm 0.084$ ) were minor determinants whereas regularity of income ( $2.57 \pm 0.059$ ) and stigmatization ( $2.63 \pm 0.046$ ) were major determinants of PLWHA healthcare-seeking in South-East, Nigeria. The study also revealed that HCSB significantly differed between PLWHA in urban and rural areas. Furthermore, the study revealed that HCSB differed among PLWHA of different educational levels.

**Conclusion:** Stigma and irregular income were major determinants of PLWHA's HCSB in South-East, Nigeria. There is need for vigorous health education campaign to enlighten the people more on the disease and tackle the devastating effect of stigma. It is imperative that Governments at different levels, donor agencies, and spirited affluent individuals collaborate in synergic fashion to institute financial social welfare packages that would be accessible on regular basis to PLWHA at various treatment facilities to mitigate the adverse effect of lack of regular income on healthcare-seeking behaviour of PLWHA.

#### To cite this article

[Nshi, G. I. (2017). Determinants of Healthcare-Seeking Behaviour of People Living With HIV and AIDS (PLWHA) in South-East, Nigeria. *The Journal of Middle East and North Africa Sciences*, 3(10), 32-40]. (P-ISSN 2412- 9763) - (e-ISSN 2412-8937). [www.jomenas.org](http://www.jomenas.org). 3

**Keywords:** Determinants, Healthcare, seeking, behaviour, HIV/AIDS, South-East.

#### 1. Background:

HIV/AIDS is a serious health problem in Nigeria. This stems from the report that 9% of the 0.8% global burden of the disease occurs in Nigeria (UNAIDS, 2008;

WHO, 2014). The disease is responsible for more than 2 million deaths annually of which over 71% occurs in the Sub-Saharan Africa (WHO, 2014). South-East, Nigeria, being part of the Sub-Saharan Africa is also seriously



challenged by the burden of the disease and has been reported to have 5.48% prevalence of the disease, meaning that almost 55 out of every 1000 people living in the region are likely to have HIV/AIDS (National Agency for control of AIDS [NACA], 2013). Having a prevalence rate (5.48%) that is higher than the WHO threshold of 4% prevalence rate for classifying a region as having “high burden”, the South-East, Nigeria, can be said to be at a potentially explosive stage of the disease (NACA, 2013).

It is a serious issue that HIV/AIDS has numerous negative outcomes (Prosser, 2007), which include huge human and economic cost associated with poor quality of life, rampant hospital consultation, hospitalization, and treatment, as well as low productivity and lost incomes (MAAS-CHRD, 2006; NACA, 2010; Ukpere and Okoroji, 2011). It has been observed that healthcare-seeking of people living with HIV/AIDS (PLWHA) includes visits to traditional healers, health facilities such as hospitals, dispensaries, and pharmaceutical shops (Plummer et al., 2006), and the usage of alternative healthcare services such as spiritual therapies, herbal medication, self-treatment or home remedies (Mills, Cooper, Seely, and Kanfer, 2005; Mohaleni, 2013).

Studies have found that sociocultural and socio-demographic variables – such as traditional belief, family support, religion, people’s opinion, discrimination and stigmatization, income levels, distance of healthcare facility from PLWHA homes, cost of treatment and transportation, attitudes of care providers and so on – determine and moderate the choice PLWHA make with regard to place for treatment or treatment modality (MAAS-CHRD, 2006; Adeyemo, and Oyinloye, 2007; Prosser, 2007; Bourne, 2009; and Mbonu, Bourne and de Vries, 2011).

Because the South-East, Nigeria is at a potentially explosive stage of HIV/AIDS the factors that fuel or contribute to sustain such a high burden of the disease need to be known. This became necessary as a google search on determinants of PLWHA’s healthcare-seeking behaviour (HCSB) in South-East, Nigeria, produced no result. The present study, therefore, investigated concurrently the sociocultural and socio-demographic determinants of healthcare-seeking behaviour (HCSB) of PLWHA vis-a-vis place of residence (location), educational levels, regularity of income, religio-cultural belief and stigmatization. It equally furthered to investigate the extent to which these determinants moderate the HCSB of PLWHA. The study examined HCSB of PLWHA with respect to their preference for the following treatment facilities: government-owned hospitals, private hospitals, patent medicine shops/pharmacies, traditional healers/herbal homes and spiritual churches/prayer houses. The study, therefore, investigated the determinants of HCSB among PLWHA in South-East, Nigeria, to provide empirical basis for helping health policy makers to make informed policy choices in addressing the challenges

occasioned by these factors, which inadvertently put the South-East at an “explosive stage” of HIV/AIDS epidemic.

## 2. Methodology:

### 2.1. Study Site

The study was conducted in the South-East, Nigeria. The South-East is a geopolitical zone that comprises five States out of the 36 States of Nigeria, namely, Anambra, Abia, Ebonyi, Enugu and Imo. It is the inherited abode of the Igbo ethnic group of Nigeria. Other ethnic nationalities of Nigeria such as Hausas, Yoruba’s, Ijaws, Ibibio etc and foreigners from other countries live among the Igbos in the South-East but their population forms less than 15% of the total population (Widjaja, 2011).

South-East states are representative of the vast Nigeria people especially the Igbos that are diverse in sociocultural orientation. In the year 2014, South-East has a population of about 21 million people based on the National Population Commission [NPC] (2006) projection. Among this number an estimated 931600 persons were living with HIV/AIDS based on the sentinel survey report of 5.48% prevalent rate across the zone (National Agency for control of AIDS [NACA] 2011, 2013).

Table 1: A breakdown of the Population of the South- East Zone according to State and Gender, (United Nations Population Fund [UNFPA], 2014 Population Projection from NPC (2006) Population Census).

State	Male-Population (2006)	Female-Population (2006)	Total Population (2006 Census)	Growth Rate (%)	Population Projection for year 2014
Abia	1,430,298	1,451,082	2,845,380	2.7	3,555,326
Anambra	2,117,984	2,059,844	4,177,828	2.8	5,263,475
Ebonyi	1,064,156	1,112,791	2,176,947	2.8	2,742,647
Enugu	1,596,042	1,671,795	3,267,837	3.0	4,185,509
Imo	1,976,471	1,951,092	3,927,563	3.2	5,114,191
<b>Total</b>	<b>8,184,951</b>	<b>8,246,604</b>	<b>16,395,555</b>	<b>14.5</b>	<b>20,861,148</b>

During the 2006 Population Census, the National Population Commission estimated the population of the South-East zone to be 16, 395,555. This population forms about 11.7% of the total estimated Nigeria population then which is about 140 million people. However, UNFPA (2014) projects that by 2014 at an average growth rate of 2.9% across the zone (NPC, 2006 and NPC, 2014), the population would be about 20,861,148 people. NPC equally projects Nigeria’s population to be about 160 million people by 2014. Out of this, NACA (2011) disclosed that about 3.4 million Nigerians live with HIV/AIDS and that the average national prevalence rate is 4%. NACA (2013) also disclosed that South-East has a total of 27.4% of Nigeria’s HIV/AIDS burden with an average of 5.48% across its five states.



Table 2: Population of PLWHA in South-East Zone per State (NACA, 2013).

State	Prevalence Rate (%)	Population of PHWHA
Abia	7.3	248200
Anambra	8.7	295800
Ebonyi	3.3	112200
Enugu	5.1%	173400
Imo	3.0%	102000
<b>Total</b>	<b>27.4%</b>	<b>931600</b>

Each of the States has at least one Federal Teaching Hospital and numerous State owned hospitals that among other services provide comprehensive HIV/AIDS care.

The zone has a land mass of about 16,000 square miles and lies approximately between latitude 5–7 degrees north and longitude 6–8 degrees east. It is boarded in the east, west and south by South-South zone, and in the north by the North-Central zone. Among all the HIV/AIDS thematic centers in the Zone, ten Hospitals – two from each State comprising five government owned hospitals, three missionary hospitals, and two privately owned hospitals – were selected for prime representation of the geographical and cultural diversity of the zone as well as individual preferences for care-seeking.



Figure 1. The location of the South- East zone in Nigeria.

2.2. Study Design:

The descriptive survey design was used for the study. The respondents were PLWHA who received care from the selected HIV/AIDS thematic centers. 400 PLWHA were selected for the study out of the 931600 PLWHA in the zone.

2.3. Sample Size Determination:

Sample size was determined statistically using Yaro Yamane formulae for finite population as cited in Okoli (2014). The formula is

$$n = \frac{N}{1 + N(e)^2}$$

Where

n = sample size =?

N = finite population = 931600 PLWHA

e = level of significance or limit of error tolerance = 5 % = 0.05

1 = unity (a constant)

Deriving the sample size using the formula, the following was gotten

$$n = \frac{931600}{1 + 931600(0.05)^2}$$

$$= \frac{931600}{1 + 931600(0.0025)} = \frac{931600}{1 + 2329}$$

$$= \frac{931600}{2330} = 399.8$$

Therefore, 400 participants across the ten selected hospitals in the zone was the study sample. Across hospitals between 25 to 50, PLWHA participated in the study per Hospital.

2.4. Instrument for Data Collection:

Data collection was done by means of a self-constructed questionnaire titled: People Living with HIV/AIDS (PLWHA) Healthcare-Seeking Questionnaire (PHCSBQ).

The instrument was arranged in two sections, namely: A and B. Section A elicited questions on socio-demographic variables in relation to location, educational qualifications, regularity of income, stigma and religio-cultural beliefs of the participants. Section B, on the other hand, was grouped into three clusters, namely: facilities ever visited by PLWHA after diagnosis, what determined their choice of utilized facility (determinants of healthcare-seeking behaviour) and treatment modalities (facilities) preferred if they had choice (HCSB based on choice of facilities). In constructing cluster two (2), the 3-point scale was adopted. The response options included: true = 3, false = 2 and don't know = 1.

The questionnaire was completed during a person-to-person interaction with the Researcher or trained Research Assistants in the suitable language, that is, English, Broken English, Central Igbo language, Native Language or a mix. This is a better option for normal population sampling since every member of the sample may not be literate enough to understand the words of the questionnaire in English Language and may need interpretation assistance for proper understanding (Prosser, 2007).



### 2.5. Data Collection:

Following proposal and review by the faculty of education, a letter of introduction was issued to the researcher by the Department of Human Kinetics and Health Education of Ebonyi State University, Abakaliki. This letter helped the researcher to obtain permission from the hospital authorities and thus gain access to PLWHA attending HIV/AIDS clinics. To ensure that the PLWHA responded willingly, a brief note of appeal for their acceptance and compliance accompanied the questionnaire. Data was collected with administered questionnaire during a person-to-person interaction between researcher or research assistants (Nurses at the HIV Clinics) and a person living with HIV/AIDS. Only those currently seeking treatment from any of the designated hospitals were included in the study. The fieldwork lasted for a period of 8 weeks with 2 to 3 days spent at each unit per week.

### 2.6. Data Management and Analysis:

Copies of the PHCSBQ were examined for completeness of copies. Data collected from the questionnaires were tallied and put into frequencies using Statistical Package for Social Sciences (SPSS), version 16.0. Consequently, frequency counts and simple percentages were used in computing and describing the research questions. Research items on determinants of HCSB (cluster 2) were analyzed using mean and standard deviation. While mean was used to describe the determinants of healthcare-seeking behaviour, standard deviation was used to show the variation of scores from the central mean. Items on treatment modalities (facilities) preferred by PLWHA which depicted their HCSB (cluster 3) were subjected to test of hypothesis using chi-square. Results were considered significant at not more than 5% level of significance i.e.  $P \leq 0.05$ .

### 3. Results:

These results identified determinants of HCSB of PLWHA in South-East, Nigeria, with respect to the place of residence (location), educational levels, regularity of income, religio-cultural belief and stigmatization. It also identified HCSB with respect to PLWHA preferences for care facilities/modalities.

The results indicated that place of residence (location) ( $1.83 \pm 0.17$ ), educational level ( $1.86 \pm 0.23$ ) and religio-cultural belief ( $1.76 \pm 0.084$ ) were minor determinants whereas regularity of income ( $2.57 \pm 0.059$ ) and stigmatization ( $2.63 \pm 0.046$ ) were major determinants of PLWHA healthcare-seeking in South-East, Nigeria.

Results showed that HCSB of PLWHA in South-East, Nigeria, reflected in their preference for treatment facilities and varied based on location and educational levels.

HCSB significantly differed between PLWHA in urban and rural areas with regard to their preference for treatment facilities (Table 3).

Table 3: *Chi-Square Summary of HCSB of PLWHA residing in urban and rural area in South-East, Nigeria, based on preferences for treatment facilities*

S/N	Treatment modalities (facilities) preferred by PLWHA	Urban 136 (34%)	Rural 264 (66%)	$\chi^2$	P-value	Dec
1	Government owned Hospital(s)	78 (19.50)	198 (49.50)	4.05	0.030	S
2	Private Hospital(s)	42 (30.88)	19 (7.20)	33.02	0.023	S
3	Patent medicine Shop(s)/Pharmacy(ies)	3 (0.75)	13 (3.25)	1.65	0.071	NS
4	Traditional healer(s)/Herbal home(s)	5 (1.25)	16 (4.00)	0.97	0.651	NS
5	Spiritual church(es)/Prayer house(s)	8 (2.00)	18 (4.50)	0.12	0.672	NS
Chi-Square				39.8	0.026	S

Key: Dec=Decision, S=Significant Difference, NS=No Significant Difference, P=Probability Level (Significant level).

PLWHA residing in urban and rural areas in the zone differed significantly in their healthcare-seeking behaviour based on preference for government-owned hospital(s) ( $p = 0.03$ ) with rural PLWHA preferring government owned hospital(s) (49.50%) than their urban counterparts (19.50%). Urban and rural PLWHA in the zone equally differed significantly in their healthcare-seeking behaviour based on preference for private hospital(s) ( $p = 0.023$ ) with urban PLWHA (30.88%) preferring private hospital(s) than the rural PLWHA (7.20%). No significant difference was however observed for PLWHA preference for Patent Medicine Shop(s)/Pharmacy(ies) ( $p = 0.071$ ), Traditional Healer(s)/Herbal home(s) ( $p = 0.651$ ) and Spiritual Church(es)/Prayer House(s) ( $p = 0.672$ ). Generally, HCSB differed significantly between PLWHA residing in urban and rural areas in South-East, Nigeria, based on preference for treatment facilities ( $p = 0.026$ ).

The study further revealed that HCSB differed significantly among PLWHA of different educational levels, based on their preference for treatment facilities (Table 4).

PLWHA with NFE (9.25%) preferred government hospital(s) less than their counterparts with PE (19.75%), SE (21.50%), and PSE (18.50%). PLWHA with SE (9.00%) preferred private hospital(s) more than those with NFE (2.00%), PE (3.50%) and PSE (0.75%).

Table 4: Chi-square summary of HCSB of PLWHA of different educational levels in South-East, Nigeria, based on preference for treatment facilities

S/N	Facility preferred if by PLWHA	NFE (%)	PE (%)	SE (%)	PSE (%)	x <sup>2</sup>	p-value	Dec
1	Government owned Hospital(s)	37 (9.25)	79 (19.75)	86 (21.5)	74 (18.5)	8.67	0.021	S
2	Private Hospital(s)	8 (2.00)	14 (3.50)	36 (9)	3 (0.75)	16.03	0.014	S
3	Patent medicine Shop(s)/Pharmacy(ies)	3 (0.75)	8 (2.00)	4 (1)	1 (0.25)	4.95	0.418	NS
4	Traditional healer(s)/Herbal home(s)	7 (1.75)	8 (2.00)	5 (1.25)	1 (0.25)	8.24	0.011	S
5	Spiritual church(es)/Prayer house(s)	8 (2.00)	3 (0.75)	13 (3.25)	2 (0.50)	9.68	0.010	S
Chi-square						47.57	0.026	S

Key: Dec=Decision, S=Significant Difference, NS=No Significant Difference, NFE = Non-Formal Education, PE = Primary Education, SE = Secondary Education, PSE = Post-Secondary Education.

PLWHA with NFE (1.75%) and PE (2.00%) preferred traditional healer(s)/herbal home(s) than their counterparts with SE (1.25%) and PSE (0.25%). PLWHA with NFE (2.00%) and SE (3.25%) preferred spiritual church(es)/prayer house(s) than PLWHA with PE (0.75%) and PSE (0.50%). However, no significant difference was observed among the PLWHA of different educational levels in their preference for patent medicine shop(s)/pharmacy(ies) ( $p = 0.418$ ). Generally, healthcare-seeking behaviour differed significantly among PLWHA of different educational levels in South-East, Nigeria, based on their preference for treatment facilities ( $p = 0.026$ ).

#### 4. Discussion:

The findings that regularity of income and stigmatization were major determinants of PLWHA healthcare-seeking behaviour in South-East, Nigeria, indicated that premium should be placed on tackling the pressures from the duo if a meaningful progress must be made in the fight against HIV/AIDS in the region.

Regularity of income was identified as major determinants of healthcare-seeking in previous studies such as Bour, 2003; Hjortsberg, 2003; Gotsadze, Bennet, Ranson and Gzirishvili, 2005; Onwujekwe and Uzochukwu, 2005; Taffa and Chepngeno, 2005; Prosser, 2007 and Mmari, Oseni; Fatusi, 2010.

Despite that the results of the study showed that income problems did not limit PLWHA's clinic visits to only when they have serious symptoms, it portends great consideration for self-employed peasants or petty traders whose income can be unpredictable, and therefore cannot be relied upon, in terms of amount and regularity as it can

pose serious challenge to keeping and maintenance of regular check-ups since they reported that cost of treatment takes a substantial amount of their income. Cost of treatment here transcends beyond that incurred for hospital services to include transport fares and income lost as a result of close down of day's business to visit clinics for treatment sake.

The results of this study, however, disagreed with that of Soucat et al., (1997) and Anyaegbulam (2014) that identified perceived quality of service rather than income as a determinant of healthcare-seeking behaviour. In their report they inferred that despite expenses being an obstruction to seeking of preventive and treatment care, even the lowest income groups would prefer to use curative services more and may even pay more, if a product was otherwise not available, if access became less easy or if there was improvement in perceived quality of services. This was not in tune with the findings of the present study which identified income as a major determinant of healthcare-seeking behaviour.

The findings on stigma, on the other hand, were consistent with Fredriksson and Kanabus (2005) who posited that ever since scientists first identified HIV and AIDS, the social responses of stigma have accompanied the epidemic with unmatched devastation. This was buttressed by submissions by most PLWHA that they either sneak into HIV thematic centres to avoid being seen by familiar persons or altogether utilize far centres where the probability of meeting persons that know them was very low. It also agreed with UNESCO (2003), Adeyemo, and Oyinloye, 2007 and Olapegba and Oladipo (2012) that HIV/AIDS-related stigma and discrimination prevent many PLWHA from seeking treatment and information about their condition, an indication that some were not likely to disclose their status and therefore constitute grave consequences for the transmission of the Virus.

PLWHA's report that health workers were friendly to them re-affirmed the assertion of Ndie and Onoh (2014) that although stigma is a global phenomenon that greatly affects healthcare-seeking behaviour of PLWHA, health workers treated PLWHA with dignity and did not discriminate against them. Nevertheless, the result affirmed the submission of settle (2006) and Agweda and Dibua (2010), that stigmatization and fear were serious obstacles to the design and implementation of effective HIV/AIDS programmes. The finding was also in agreement with MAAS-CHRD, 2006; Prosser, 2007; Fay et al., 2010; Bourne, 2009; Mbonu, Bourne and de Vries, 2011 and Churcher (2013), who all identified stigma as a major determinant of healthcare-seeking behaviour. However, it disagreed with MAAS-CHRD (2006) on its generalized report that people, including health workers, grossly stigmatized and discriminated against PLWHA.

The overall finding that place of residence (location) was a minor determinant of healthcare-seeking behaviour was striking owing to several literatures that pin



pointed it a major determinant of healthcare-seeking behaviour of PLWHA. For example, MAAS-CHRD, 2006; Prosser, 2007; Opara, Umoh and John, 2007; Tsion, Tefera, Ayalew and Amare, 2008; Pandey, Singh, Shankar and Sunder, 2009; Mbonu, Bourne and de Vries, 2011, all identified distance as a major determinant of healthcare-seeking behaviour. While they posited that farther distances of place of residence from treatment centers and higher cost of transport hinder access to care, the results of this study disagreed with them. This study revealed that closer location of HIV clinics to PLWHA residences did not foster regular visit and rather PLWHA preferred far and hidden HIV clinics irrespective of cost of transport. This findings was consistent with that of John, Nsemo, Osuchukwu, Esienu, and Duke (2014) that asserted that PLWHA due to fear of stigmatization and discrimination do opt for treatment in far clinics where they have vague identity than clinics within their surroundings where they are well known.

The revelation that education was a minor determinant of healthcare-seeking behaviour among PLWHA was also in line with the results of some previous studies such as those carried out by the following researchers: Mackenbach and Howden-Chapman, 2003; Buor, 2003; Nyamwaya, 2003; Prosser, 2007; Opara, Umoh and John, 2007; Afolabi, Ijadunola, fatusi and Olasode, (2010); and Omotoso, (2010). Notwithstanding that levels of education affected PLWHA understanding of therapeutic instructions coupled with the fact that instructions which were clearer to them when expressed in local dialect were hardly given in local dialect by health workers, PLWHA levels of education did not affect their ability to narrate and explain experienced symptoms clearly to health workers. This may stem from the approach of the health workers who took time to ensure that every PLWHA understood intended instructions well by assigning to those that manifest gross lack of understanding of English, Broken English or Central Igbo Language, which were main language medium used for instructions and counseling in South-East, Nigeria, to health workers that were conversant with local dialect they can communicate well with. Where this was not achievable, services of interpreters were usually sought by health workers, mostly, from other PLWHA. The results of this study agreed with the findings of Ndie and Onoh (2014) which identified education as a minor determinant of healthcare-seeking behaviour among PLWHA in Enugu State, a part of the South-East Nigeria, where the present study was carried out.

The finding of this study that religio-cultural belief was a minor determinant of healthcare-seeking behaviour of PLWHA was in contrast with the position of Awusabo-Asare and Anarfi (1997) that most PLWHA attributed the disease to a supernatural cause and sought supernatural solutions based on tribal (cultural) and religious leaning. It also disagreed with Babb, Pemba, Seatlanyane,

Charalambus, Churchyard, and Grant (2007) that cultural ties and religious beliefs mostly propel the use of healthcare services among PLWHA. It also contradicted the position of Omotoso (2010) that religious belief was a major determinant of healthcare-seeking behaviour among the rural communities. The assertion of Tofa (2014) that the explosion of churches and Trado-herbal homes highly convince seropositive persons to discontinue antiretroviral (ARV) drugs was equally contradicted by the findings of this study. It was evident from the study that although PLWHA were inclined to seek religiosity as a complementary therapy, it was never taken as an alternative to or substitute for ART (Denis, 2013). Therefore, the religion and culture of PLWHA in South-East, Nigeria, did not portray informal communication that weakens their capacity to negotiate the struggle with the disease. This tallied with the position of Agadjanian and Menjivar (2008); Kalofonos (2008) and Prince, Denis, and Dijk (2009) who all opined that most religions and cultures stand as a supportive link rather than weakening link in the fight against HIV/AIDS.

On HCSB, the higher preference of informal care such as patent medicine shops/pharmacies, traditional healers/herbal homes and spiritual churches/prayer houses by the rural PLWHA, as seen in Table 3, was in agreement with MAAS-CHRD (2006); Mohaleni (2013) and Tsion et al. (2008), who earlier reported that rural PLWHA are unlikely to seek formal healthcare than their urban counterparts for several reasons, including, lack of money, far distances from location of formal care centers, cultural belief, and myths about HIV/AIDS perception (more prevalent in rural areas) and severity of symptoms.

Equally on HCSB, the higher utilization of allopathic health facilities in the form of government owned and private hospitals by all PLWHA irrespective of educational levels, as seen in Table 4, contradicted some earlier studies such as Giang and Allebeck (2003); Bour (2003) and Pavlov et al. (2003), who reported that higher education manifested in higher utilization of allopathic health facilities and vice versa. It, however, agreed with Akin and Hutchinson (1999) that the perception that service would be better in allopathic facilities motivates all PLWHA irrespective of educational background to embrace allopathic services.

## 5. Conclusion:

Stigmatization and regularity of income are major determinants of HCSB among PLWHA in South-East, Nigeria. Consequently, stigmatization against PLWHA in South-East, Nigeria needs a well packaged and aggressive HIV/AIDS health education intervention to address the misconceptions that orchestrate and fuel stigmatization against PLWHA. Social welfare schemes should also be put in place to assist poor and irregular income earning PLWHA with financial help to enhance their coping and survival. More Primary Healthcare Centers should be



designated HIV/AIDS thematic clinics and made functional on sustainable basis, by deploying HIV/AIDS fighting resources including expert health workers, drugs, and materials, in order to enhance universal accessibility and strengthen the warfare at rural areas where misconceptions about the disease hold greater sway.

#### Corresponding Author:

Goodluck Ikechukwu Nshi, Ph.D(c).  
Department of Nursing Science, Ebonyi State University, Abakaliki, Nigeria.  
E-mail: [mekagoodluck@yahoo.com](mailto:mekagoodluck@yahoo.com)

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Received August 24, 2017; revised August 31, 2017; accepted September 06, 2017; published online October 01, 2017.