

# Determinants of a Disjointed Health Seeking Behaviour amongst HIV Positive People: A Case Study of Chirundu Border Town in Zimbabwe.

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## ABSTRACT

This research aimed at assessing the determinants associated with disjointed health seeking behaviour on HIV case management in Chirundu border town. The specific objectives were to evaluate the socio-economic factors and characteristics of the community contributing to disjointed health seeking behaviour, to assess the rate of treatment compliance among patients from different health facilities, to establish differences on how HIV case management between Chirundu Zimbabwe and Zambian side is conducted and to investigate how health systems can be integrated to manage disjointed health seeking behaviour of HIV patients in Chirundu border town. A mixed-methods approach was used to collect data from 188 respondents. Data collected was analysed on SPSS. Quantitative results were presented in bar graphs, pie charts, frequency tables. The results show that 79.6% had negative health seeking behaviour while 87.8% preferred receiving health care support from the Zambian government hospital. The rate of treatment compliance among patients from different health facilities in Chirundu border town was 84%. The score for HIV case management was 26% which indicated that there is inadequate HIV case management conduction between Chirundu Zimbabwe and Zambia. In conclusion, health facilities in Chirundu Zimbabwe and the Zambia should be linked to reduce disjointed health seeking behaviour of HIV patients. There is also need to train and educate community members on ART adherence and the side effects of changing the regimen. There is a need to capacitate health institutions concerning the management of HIV cases between Chirundu Zimbabwe and Chirundu Zambia. There is a need to develop a robust joint action plan on both sides of the borders. There is need for both sides of the border to exchange materials on HIV health education, provide uniform ART regimen and a system of referral for follow-up of patient already put on treatment who may move from one side of the border to the other.

**Key Words:** determinants, disjointed, health, seeking, behaviour

## INTRODUCTION

Currently 40 million people are living with HIV and 95% of this population live in developing countries. Zimbabwe has the third largest HIV burden in Southern Africa. Chirundu Border Post is considered as one of the hot spots for prevalent HIV/AIDS cases as it is characterized by constant STI infections. Despite the move by the government, to decentralize the HIV prevention, care and treatment, patients in Chirundu prefer crossing the border to get treatment on the Zambian side.

## Background of the Study

Health seeking behaviour is a theme that threads itself in the success of HIV prevention, care and treatment. The study intends to examine the Determinants of disjointed health seeking behaviour in Chirundu border town on HIV case management. HIV has reached devastating proportions, especially in sub-Saharan African countries and adults have been infected with HIV/AIDS worldwide. Currently 40 million people are living with HIV/AIDS, of which about 95 % live in developing countries. According to Sibanda (2012), 23.6 % of population in world shows positive health seeking behaviour and 57.7 % depicted a negative health seeking behaviour due to different reasons based on the health care sought Zimbabwe National Statistics Agency and ICF International, (2012). Zimbabwe has not been spared from the virus epidemic. With nearly 10% of the estimated population of 12.7 million people infected with HIV, Zimbabwe has the third largest HIV burden in Southern Africa.

Dube (2013) exclaimed that Chirundu Border Post is considered one of the hot spots for HIV/AIDS, and is characterised by the constant STI outbreaks in the community. Toomer and Grietens, (2012) elaborated that health seeking has been described as an evolving process rather than an even, with many influencing factors at play, such that many models have been proposed to explain the decision, type and volume of care sought at various stages of ill health. Gregson et al (2010) highlighted that Human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) are major global public health problems. The worldwide efforts to manage the HIV and AIDs pandemic have been increased because the virus is spreading rapidly. Bircher and Kuruvilla (2014) connoted that the wide variations in health outcomes based of type, timing, and quality of health intervention sought or received can be hard to ignore. Individuals with health problems desire to be better regardless of the choice of intervention. Fineberg (2012) further emphasized that, not all avenues for health intervention may improve the health seekers conditions, as some of these avenues may worsen the health status of an individual or even lead to fatal outcomes, especially in situations where time health sensitive health conditions are concerned.

According to Powel (2006) health seeking behaviour is a social process and involves the individual's interaction with the social network, it is paramount to examine the decision-making process from this perspective. The health seeking behaviour of a community determines how they utilise the health services. Utilisation of health facilities can be influenced by the cost of services, distance to health facilities, cultural beliefs, level of education and health facility inadequacies such as stock-out of drugs Musoke et al (2014). The health seeking behaviour of a community determines how health services are used and in turn the health outcomes of populations. Health seeking behaviour is preceded by a decision-making process that is further governed by individuals or household behaviour, community norms, and expectations as well as provider related characteristics and behaviour Kasse, et al (2006).

The outcomes of every desired health seeking behaviour is responding to an illness by seeking help from a trained allopathic doctor in a recognized health care centre. Jurcev-Savicevic and Kardum, (2012) connoted that health seeking behaviour has become a tool for understanding how people engage with the health care systems in their respective socio-cultural, economic and demographic circumstances and these behaviours can be classified as various institutional levels that include the family and community. Massey et al (2017) connoted that a main driver for the health seeking behaviour is the organization of the health care system. It is well established that health seeking behaviour is influenced by manifestation of symptoms.

Aday et al (2004) noted that health seeking behaviour has been defined as a sequence of remedial actions that individuals undertake to rectify perceived ill health, thus in particular, health seeking behaviour can be highlighted as with data collected from information such as the time difference between the onset of an illness and getting in contact with a healthcare professional, type of health care provider patients sought help from, how compliant patient is with the recommended professional and reasons for not seeking help from exceptional health professionals. Latunji and Akinyemi (2018) further jotted that health seeking behaviour

also include behaviours that deal with any digression from the healthy state, such as controlling and reducing impact and progression of illness.

HIV prevalence rates in Chirundu Border Post is estimated to be 12.6 % in 2014. A number of educational campaigns have been aimed at improving HIV transition and prevention knowledge among community members in an effort to reduce infection rates. Munjoma (2010) postulates that the district hospitals have implemented activities which are aimed at improving knowledge about the important health issues for instance, how to prevent illness, identify symptoms and where to seek assistance, increase the number of people willing to be tested for HIV and reduce stigma associated with testing and treatment. In an effort to generate data regarding the impacts of disjointed health seeking behaviour on HIV staging, the research will assess how the HIV treatment service is conducted in Zimbabwe and also investigate why most patients choose to seek health attention in the neighbour ring country. The study reviews the impact of disjointed health seeking behaviour on HIV staging in relation to Chirundu Border Post.

### **Statement of the Problem**

The government and health based Non-Governmental Organizations working with clinics and hospitals in Zimbabwe have implemented various programs to reduce the spread of HIV virus, for instance, offering free medication for all HIV patients in Zimbabwe. The goals of the national policy and strategic framework are to prevent the spread of HIV and to reduce the personal, social and economic impact of the epidemic. All these moves by the government are meant to create a viable process by which HIV patients can access treatment at designated places within communities and townships.

Despite the move by the government, to decentralize the HIV prevention, care and treatment, patients in Chirundu would prefer crossing the border to get treatment in Zambia. Chirundu is a one stop border post, this set up entails the merging of the two communities respectively Chirundu Zambian side and Chirundu Zimbabwean side. Locals have access to services either side of the border hence this being one of the reasons patients can access health services from the Zambian Side. Chirundu Town (Zimbabwean Side) has 2 satellite NGO Health facilities and 1 Ministry of health clinic while Chirundu Zambian side has 1 major mission hospital and 2 Private surgeries and 1 satellite NGO clinic. This as a result has negatively impacted the Zimbabwean health care system hence leading to the disjointed health seeking behaviour on HIV staging. Thus, this study sought to bridge the existing gap and give more insight on the impacts of disjointed health seeking behaviour on HIV case management.

### **Research Objectives**

1. To assess the determinants of disjointed health seeking behaviour on HIV case management
2. To assess the socio-economic factors and characteristics of the community contributing to disjointed health seeking behaviour
3. To determine the degree of compliance to HIV treatment among patients
4. To assess differences in HIV case management between Chirundu Zimbabwe and Zambian side.
5. To determine the barriers that hinder HIV patients from fully taking up the available HIV care and management services
6. To establish possible intervention strategies to curb disjointed health seeking behaviour

### **Justification**

The study might serve as a management policy guide for the stakeholders in the health sector especially for sectors that are closely involved in the HIV treatment processes, since the study will unveil the loopholes in the HIV treatment processes conducted in Chirundu Zimbabwe and also level the performance based on the response by patients. The Government can therefore use the results to determine how best to curb the

disjointed health seeking behaviour on HIV case management. Zimbabwe intends to modify some of its borders to also become One Stop Borders in the near future this research may proffer mitigation measures to manage challenges brought by health seeking behaviours.

Moreover, the research will serve as a foundation for future works on similar studies, in the area of health seeking behaviours on HIV case management. HIV patients will be equipped with knowledge on better health care response, better choices and improved service delivery.

## RESEARCH METHODOLOGY

Mixed research method approach was used. Creswell et al (2016) noted that mixed methods research is a procedure which incorporates mixing Quantitative and Qualitative research and methods in a one study. Wisdom and Creswell (2013) concur by noting that the term “mixed methods” refers to an emergent methodology synergistic utilization. This type of a study enables a researchers to understand complex phenomena qualitatively as well as to explain the phenomena through numbers, charts, and basic statistical analyses. The Data analysis plan used involved Qualitative data analysis plan and Quantitative data analysis plan. The Quantitative data analysis plan was employed to analyse data from interviews and questionnaires. A Thematic approach was also used to analyse data since most of the data collected will be qualitative by nature. The researchers identified patterns presented by the in-depth interviews, focus group discussions and questionnaires. The data collected from all tools was scored and categorised to derive quantitative data which was easier to analyse. The data analysis software used was the SPSS. SPSS was used to score the responses, come up with rankings and percentages. Statistical tools such as frequency, descriptive statistics were employed. The Quantitative method enabled the research to compare the deference in diagnosis and HIV treatment between Zimbabwe and Zambian hence highlight the shortfalls of the Zimbabwean health care system in relation to HIV staging. On this note, this enabled the research to unearth the motive on the reasons why HIV patients prefer seeking health care services.

## LITERATURE REVIEW

### **Socio-Economic Factors and Characteristics of the Community Contributing to Disjointed Health Seeking Behaviour.**

According to Deeks et al., (2013), the initiation of anti-retroviral therapy has sustained the lives of people living with HIV. However, socio-economic factors and characteristics of the community makes it difficult for patients to access the necessary HIV care and management services. In a study conducted by ACE, it was reported that almost 30% of 905 adult people living with HIV (PLWH) had issues with being in HIV care (HIV Epidemiology and Field Services Program, 2019). Various authors such as (Dasgupta et al., 2016; Freeman et al., 2017) have suggested that socioeconomic factors and individual factors among HIV patients are linked with numerous care outcomes such as ART uptake, care commitment, and viral suppression. The studies by (Dasgupta et al., 2016; Freeman et al., 2017) further indicated that African-American HIV patients experience lower care commitment and poor adherence to ART than White counterparts, resulting in hostile clinical outcomes.

Poor economic status is another factor that affects health seeking behavior. Sumbi (2004), highlights that financial constraints like poverty, shortage of food, lack of transport, costs of drugs, unemployment are important barriers to positive health seeking behaviour. In their study they also observed that mobility due to employment is one of the major reasons for defaulting treatment. Females’ participants are more willing to test for HIV better than their male counter parts. Furthermore, according to (Cargill, 2013), black men and women living with HIV have significantly higher mortality rates. At the same time, the findings of (Kenyan et al., 2003), have shown that men and women experience diverse barriers to care.

According to Mwale (2016), who highlights that lack of formal education and poor health literacy about ART and HIV/AIDS can make patients not to understand about the effectiveness of medications. This may lead to challenges in adhering to treatment and poor retention in care. This is supported by Stonebraker (2015) and Charles and Sheeran (2000), who highlights that in many cases, HIV positive patients living in rural or low-income areas that lack educational and/or healthcare infrastructures may exhibit negative health seeking behaviour and are at higher risk for not learning about prevention methods, not knowing their status, not receiving the information they need to manage a positive diagnosis and not being able to obtain or maintain the optimal treatment adherence.

Marital status influences health seeking behaviour especially in women have little or no control over their sexual encounters as well as decisions regarding health seeking behaviours like HIV-testing. Mwale (2016), also highlights those interpersonal relationships with marital partners, family members have an effect on an individual's health seeking behaviour and actions. This is because when a patient's emotions, opinions, or behaviours are affected by others, adherence to medication and long-term retention is affected. Mwale (2016), further states that married people may not disclose their HIV status to their marital partners or other social network members for fear of domestic violence, partner abandonment or rejection by the community; which then affects their health seeking behaviour.

### **Outline of the Health Sector in Zimbabwe**

The health delivery system in Zimbabwe broadly falls under the Ministries of Health and Child Welfare (MoHCW), and the Ministry of Local Government Public Works and Urban Development. According to the Zimbabwe Health Survey Authority (2010) the MoHCW has the sole mandate of the entire health delivery system and it is particularly responsible for policy planning, administration, allocation of funds and coordination response to national health issues among other responsibilities. The public health system is categorized into four distinct levels comprising of primary, secondary, tertiary and quaternary care (Tafara, 2013). Thus, all the health care programs provided by the public health systems are implemented through the Primary Health Care system and are mandated to provide health care services for both preventive and curative needs.

Although the public sector has the largest health care facilities which offer a wide range of health care services, the quality of both the health care facilities and services is continuously deteriorated owing to bureaucratic management, inadequate funding and to a larger extent, corruption. Tafara (2013) asserted that in Africa and Zimbabwe in particular the public health sector has been seen to be very slow keeping pace with the modern technologic development owing to budgetary constraints. As such, the quality of service delivery has been deteriorating at an increasing rate partly due to uneconomic user fees and also partly due to lack of funding and bureaucratic management systems. Manaf and Nooi (2004) observed that patients generally expect to access low diminished quality of services from public health facilities since they are paying very low user fees as treatment fees. IBID asserted that the major problem affecting public hospitals in emerging economies is rampant corruption. Tafara (2013) who propounded that in most public health care centres in Zimbabwe, the hospital staff have devised sophisticated methods of extorting desperate patients for the mere facilitation of due services. The above has resulted in Zimbabweans seeking health services outside the country.

### **Factors Affecting Patient's Healthcare Satisfaction**

Chifamba (2013) cautioned that satisfaction is a very vital variable that determines the survival and profitability of a healthcare provider. This was also echoed by O'Brien (2013) who argued that in the healthcare services sector, satisfaction has a catalytic effect in determining whether patients will comply with the treatment and also whether they will continue their relationship with the health provider. In essence, this could be implying that satisfied patients are likely to refer their relatives and friends to a



healthcare facility. This is akin to O'Brien (2013) who pointed out that recommendation by friends and relatives is amongst some of the factors affecting patient's choice of a health care provider. Chifamba (2013) further connoted that patient satisfaction is increasingly becoming more and more important in health care delivery systems. According to Jannati et al (2013), this has been sparked by the competitive environment characterizing the health care services sector.

Leister and Stausberg (2007) pointed out that the 21st century has seen patients becoming more and more concerned about their health and the manner they select health care services than ever before. This means that health care service providers also need to be more and more sensitive to the needs and expectations of their patients if they want to remain competitive. Under such circumstances, service quality and patient satisfaction becomes the panacea for competitive advantage. This observation is in line with the asserting of O'Brien (2013) who expounded that whilst the quality of doctors is critical in influencing hospital choice decisions, patients also consider other factors. Basing on this connotation, the researcher therefore seeks the quality of service provided by the health care facilities in Chirundu Boarder post compared to that being favoured by many HIV patients crossing to Zambia.

### **Compliance to HIV Treatment among Patients**

Adherence to antiretroviral therapy is a crucial determinant of treatment success. Adherence is defined as the extent to which a person's behaviour in terms of taking medications follows agreed recommendations from a health care provider (WHO, 2003). Non-compliance to antiretroviral treatment is a major challenge to successful management of patients with HIV/AIDS. Non-adherence to antiretroviral treatment has been a critical issue in addressing the threat of HIV/AIDS globally. According to (Paterson et al., 2000), it is estimated that adherence rates of 90% or more generally need to be obtained to achieve virology success. Various authors such as (Monjok et al., 2010; Mills et al., 2006) have reported that non-adherence to antiretroviral therapy in the adult population has been shown to range from 33% to 88% depending on how adherence is defined and assessed.

In a study by Mwale (2016), it is reported that the overall retention rate of the ART sites at three primary health facilities in the Kabwe district in Zambia was 65%. Fox & Rosen (2010), allude to this and further state that ART programs in African countries have retained about 60% of their patients at the end of two years on ART treatment. The high percentages accounting for defaulting patients presents challenges in the drive to achieve positive health seeking behaviours. Retention in care is still a challenge facing ART programs in Zimbabwe which needs the attention of health care providers and the Ministry of Health and Child Care (MoHCC). Mwale (2016), highlights that patients on ART are poorly retained in ART programs and this loss to follow up is a major challenge in HIV care.

According to Mills et al., (2006), regardless of the increasing access to treatment, non-compliance to HIV treatment and drop-out of care is the chief obstacle in the fight against HIV/AIDS. Therefore, after obtainability of HIV medication, the upholding of adherence and retention in care in order to obtain optimal treatment outcomes for the patient is a major challenge (Cohen et al., 2011). Furthermore, various studies such as those of John Bartlett, has established that there is a relationship between adherence and plasma HIV ribonucleic acid (RNA) levels, CD4 cell counts, and mortality among HIV patients. Research studies further reveal that adherence levels above 95% are mandatory to preserve viral suppression. However, current adherence rates among HIV patients are lower than the required rates (Chesney, 2000). (Chesney, 2000) further highlights that at least 40% to 60% of HIV patients are less than 90% adherent to the HIV regimen especially among patients who have been taking medication for a long time.

Various reasons for non-compliance to HIV treatment vary widely with the main reason being simply forgetting to take medication. Additional reasons comprise undergoing a change in daily routine, being away from home, being busy with work. The findings have also shown that psychiatric disorders which

entail depression, substance abuse; doubting the efficacy of treatment concerns about side effects and complexity of the treatment are also reasons for non-adherence. Studies in Ghana have indicated that HIV patients do not adhere to treatment due to lack of provision of inclusive support services such as HIV/AIDS case management, peer support groups and nutritional enrichment due to inadequate resources in public health care facilities.

However, other studies have shown when support services are offered to HIV patients, the patients are retained in care. Hence, Mannheimer, (2006) states that Directly Observed Therapy (DOT), cued-dose timing, electronic reminders, cash incentives, timelines and pillboxes set up by nurses are used as adherence tools. Takaza, (2012) also adds that HIV patients articulated that even if the quality of care is commonly decent, they are running short of food, proper medication, and transport to carry them to the hospital, a balanced diet and emotional support. Concerning side effects being a reason for non-adherence, (Sendagala, 2010) states that the side effects of ART are associated with diminished adherence and HIV patients who encounter more than two severe reactions to the regimen are highly likely to default. Various researcher such as (D'Armino et al, 2000; Mocroft et al, 2001; Stone, 2001) reported that above 25% of newly initiated HIV patients stopped their treatment within the first year due to side effects of the regimen.

### **HIV Case Management**

Despite being the epicenter of most HIV infections, Sub-Saharan Africa receives only a fraction of the attention in terms of care, support, and antiretroviral treatment (ART) programs. Case management support service is a type of service model that is typically offered to HIV patients. It entails providing clients with support services as well as establishing a special relationship and communication between HIV service providers and their clients. This ensures effective coordination of medical care and social support services for patients. The ultimate goal of case management support services is to effectively engage and retain clients and ensure good adherence to medication and treatment as a whole. Adequate support services result in an efficient continuum of care from HIV diagnosis to successful treatment, which is essential for tracking HIV treatment outcomes. According to reports, providing social, physical, and spiritual care is an important part of HIV/AIDS clinical management.

In recent decades, there has been a significant increase in care engagement and adherence to ART. According to a 2013 study, individual, relationship, community, health care system, and policy factors can all influence care engagement (M. J. Mugavero et al., 2013). A person's ability to take public transportation to seek medical care may be hampered if they are in poor physical health. Poor mental health may be linked to decreased trust in health care providers' ability to provide adequate care and in the competency of the health care system, particularly when mental illness is combined with a physical illness such as HIV (Cunningham et al., 2007; Loeb et al., 2012). Furthermore, people who have recently been diagnosed with HIV are more likely to have a poor link to care (Bhatia et al., 2011). It can thus be hypothesized that the longer someone has been diagnosed with HIV, the better they are linked to and retained in care, resulting in fewer barriers to care.

According to Becker (2007), patient monitoring is critical for ensuring the quality and continuity of HIV care and treatment. HIV case management generates data that allows programs to track patients' treatment and health status over time, as well as measure program performance across health facilities and geographical settings. According to WHO (2002), an effective HIV patient monitoring system allows for the measurement of standardized indicators at the sub-national and national levels for in-country and global reporting. Because patient monitoring systems provide information for program monitoring, they are an essential component of many health information systems and the overall health system.

WHO (2010) recommends that HIV patient monitoring be integrated as closely as possible with patient-related conditions, particularly HIV and tuberculosis, and in all settings where patients are initiated or

monitored on ART. Rahman and Rahman (2007) went on to say that, in the long run, countries should strive to integrate and link HIV patient monitoring with monitoring of patients receiving care for other chronic conditions. According to Global AIDS Response Progress Reporting (2016), the approach to HIV case surveillance informs and supplements patient monitoring by promoting the routine collection of patient data for defined sentinel events from all diagnosed HIV cases, drawing on a database of HIV cases.

Diminished barriers to care, early linkage to care, and a supportive and flexible treatment environment have all been linked to increased retention in care (Mugavero et al., 2013). Continued participation in HIV primary care increases ART adherence, improves health, and lowers morbidity and mortality in PLWH (Giordano et al., 2007). According to a 2013 study, 81.9 percent of the 1,148,200 people living with HIV in the United States in 2009 had been diagnosed, 65.8 percent were linked to care, 36.7 percent were kept in care, 32.7 percent were prescribed antiretroviral treatment, and 25.3 percent had a repressed viral load (200 copies/mL) (Hall et al., 2013). Surveillance statistics indicates that of the approximately 90,800 people living with HIV in New York City in 2018, 93 percent were diagnosed, 87 percent received care, 83 percent received ART, and 77 percent were virally suppressed, a significant improvement over previous years (HIV Epidemiology and Field Services Program, 2019).

The public health approach to HIV case management reported by COMOH, (2017) is characterised by commencing ART early, monitoring viral load to prevent transmission, collaborating with health and community stakeholders and post counselling services. COMOH, (2017), further states that health care providers should collaborate for effective long term clinical management of HIV cases to be possible to ensure that there is repeated screening and provision of behavioural counselling of HIV patients. WHO, (2001) points out that HIV/AIDS is closely linked with the brutal circle of poverty and disease. The findings of (WHO, 2001) further show that migrating populations are at a greater risk of contracting infectious diseases, and this crisis is distinct along the international borders. The finding of Dyk (2011) approve that drugs used to manage HIV have side effects ranging from mild to serious. Roural et al. (2009) accentuates that these side effects result in poor health seeking behaviour and actions that may result in refraining from taking medicine.

According to Takaza, (2012), the burden of providing care in the middle of high levels of poverty provides exhaustion among health workers, which causes them to get stressed which in turn influence the quality of care they provide to people living with HIV. Moreover, Takaza, (2012), emphasises that Zimbabwe health institutions provide poor quality of services, which are not appreciated by patients, which results in patients going across the border for HIV treatment. In a study by Takaza, (2012), health workers accentuated that they need assistance with regard to regular follow up visits in order to manage HIV cases. According to (Assefa et al., 2011) counselling with regard to adherence is the obligation of health care providers participating in the delivery of ART in health facilities. Hence, clinicians, nurses, pharmacy personnel and adherence counsellors should all provide counselling services for adherence and retention.

According to Okonkwoh, (2011), a judgemental community dampens people from adherence to medication. Moreover, the criticisms of family and friends affect the decision to seek and adhere to treatment. Dickens et al, (2013) and Tuller et al., (2010) emphasize that risk factors in low-income countries include transportation costs, restricted access to antiretroviral medication and cost of medication and fear of side effects. The findings of (Yu et al., 2007), also state that economic limitations contribute to non-adherence. Even if, ART is available free to HIV positive patients in sub-Saharan Africa, the cost of transportation to obtain the medication continue as a cause for non-adherence.

### **Barriers Hindering HIV Patients from Fully Taking HIV Care and Management Services**

Barriers including delays associated with receiving care from treatment centers, long distance to treatment centers, high financial costs associated with accessing and receiving ART, job insecurity ascending from



regular leave of absence to receive ART, shortage of drugs and other commodities, fear of side effects of taking ARVs and stigma have been reported in various research studies. In a study by (Lewis et al., 2012), the barriers related to language barriers and those related to fears and suspicions of being recognised while receiving care were categorised as quality of care barriers. Other categories identified were financial and structural barriers.

Structural barriers were demarcated as logistical issues that came about in the process of attempting to receive medical care such as lack of transportation and matters associated with working hours. Berman (2014) defined accessibility as the geographical relationship between health care provider and clients. It is determined by travel time to the next public and or private health facility, distance and transportation costs. Hence, not only distance in kilometres matters, but also types of transportation available and costs to reach the health facility. Leister and Jurgen (2007) connoted that living far away from health facility impacts access to medicines, because transportation costs increase, thus transportation costs can be added to the costs of the final products if total costs are too high, demand for the product will be zero even when the final product is for free.

Regarding barriers that prevent HIV patients from fully utilizing available HIV care and management services, Liu (2011), states that these barriers are linked to the patients' characteristics, such as age, income, and ethnicity, as well as the attitudes and abilities of health care providers and health care systems, which include organizational policies and quality of care. In a study conducted in Laos by Phrasisombath et al., (2012) the main barriers to obtaining health care among patients with STI symptoms were both structural (cost of travel, health institution operating hours, and social stigma) and individual (fear of societal discrimination and the negative attitudes of nurses).

Liu's (2011) further states that despite the fact that some health services are free, patients who use them frequently express annoyance, dissatisfaction, and a lack of trust in the health-care system. Patients viewed the health system as a staff-oriented system rather than a patient-oriented one, according to Liu (2011). (Howse et al. 2005) states that a patient who perceives that a health institution or medical practitioner offers poor service is deterred from using that service. Judgmental perceptions and attitudes with regard to health services can hinder patient utilization (Jirojwong and Manderson 2002). Prior substandard acquaintances with health care providers are regarded as a barrier that prevents people from using health services, according to (Scheppers et al. 2006). Howse et al. (2005), adds that patients' beliefs that nothing and/or no one can help them functions as a perceived barrier to getting treatment. Chen (2001) adds that sick people often avoid seeking medical aid because they fear no one will be able to help them or that nothing will be done which is the case with chronic illnesses.

According to (Watt et al. 1993; Jirojwong and Manderson, 2002), a lack of indigenous language abilities hinders efficient communication between patients and health-care professionals of various ethnic backgrounds. Patients have linguistic challenges, according to King et al. (2007), while communicating sentiments and reading communications and medical instructions. Liu, (2011), states that almost all of the participants faced language barriers as they could not understand and speak English with health professionals. Furthermore they had barriers in reading the printed materials from health care services such as prescriptions, letters and posters in the hospital.

Various researchers such as (Ma, 1999; Aroian et al. 2005), further revealed that absence of health insurance and the high cost of health services stalled patients from seeking help. Furthermore, a study by Hsu-Hage et al. 2001) revealed that financial barriers hindered the public's utilisation of health services in Austria. According to Blazer et al. (1995), transportation and physical access to health centers are significant hurdles, particularly for the sick and old. Distance, ease of physical access, transportation availability, time away from work, and travel time all influence the type of health treatment that a patient seeks. Other authors such as (Garrett et al. 1998; Scheppers et al. 2006) state that chaotic public transport was reported as a

barrier to health care for patients seeking medical assistance.

According to Muthulingam et al., 2013, poverty is another barrier to fully taking up medical services among people diagnosed with HIV. Furthermore, Messeri, et al., (2019), adds that the physical location based on the area of residence provided by the HIV patient during initiation is perceived barriers to medical care as most HIV patients seek health care services outside of their area of residence. Hence according to Dombrowski et al., (2015) and Yehia et al., (2015), the obvious effects of barriers to care comprise of low commitment to treatment and retention in care, which in turn results in poor HIV health and higher rates of HIV transmission.

Concerning the availability of health care services, Thorson (2006) defined availability as the link between volume and type of health service provision and the need of the population. In the context of access to medicine it refers to the availability of medicine in the private and public sector. Hart (2005) propounded that the availability of good medical care tends to vary with the need of the population served. Since access to healthcare, including medicines, might not be satisfied by the private sector, providing public healthcare is supposed to enhance access to healthcare. However, there are several reasons why availability of medicines in the public sector might be a potential barrier to care.

The affordability of care is another barrier hindering HIV patients from fully taking up services. According to Dercon (2002), affordability is the ability of the population to receive care from the health system. Client’s income, the presence of insurance schemes, and prices in the private sector affect affordability. IBID, connoted that asymmetric information, as a consequence of high transportation costs, results in moral hazard and adverse selection issues that complicate the development of private insurance companies. Due to high risk aversion at low-income levels, the demand for insurance is high. Okwero et al (2010) highlighted that accommodation and acceptability are related to the organization of supply resources and the client’s attitude about the provider. In terms of medicines, it mainly refers to the quality of medicine treatment which is categorized as the quality of the medicine itself, skilled health workers and the equipment quality.

## RESEARCH FINDINGS AND DISCUSSION

### Socio-Economic Factors and Characteristics of the Community Contributing to Disjointed Health-Seeking Behaviour

#### A. Categorisation of health care seeking factors

Chirundu health facility has days set aside for HIV support programs. These support groups are held once in 3 to 4 weeks. The focus group discussion was administered on the day of the support program for HIV clients. Figure 1 shows the push factors when HIV patients seek medical care.

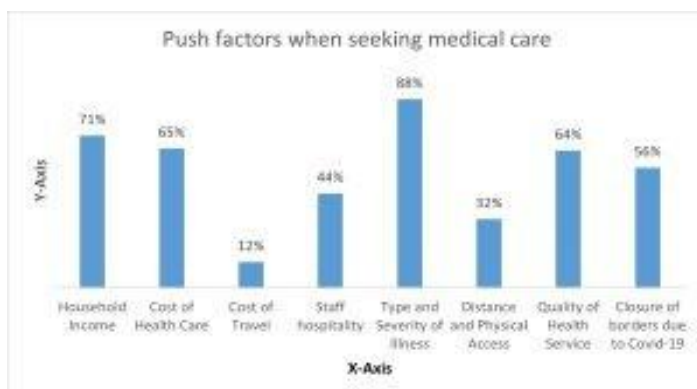


Figure 1 Push factors when seeking medical care at Chirundu hospices.

When asked when they decide to go for HIV health care services, the respondents highlighted that the following factors push them to seek services. Most respondents (88%) asserted that the nature and severity of illness is a push factor when respondents seek medical care. 65% stated that the cost of care in terms of the required treatment and quality of health service were push factors.

In the study, the socio-economic factors such as educational level, occupation, marital status and economic status contributing to disjointed health-seeking behaviour were assessed. Table 1 shows the determinant of socioeconomic factors and its key sphere of influence.

Table 1: Breaking down determinants that may influence health care seeking behavior

<i>Category</i>	<i>Determinant</i>	<i>Details</i>	<i>Sphere</i>
<i>Socio-economic</i>	Household Resources	Educational Level	Cultural
		Occupation	Propriety
		Marital Status	Informal
		Economic Status	

Respondents with secondary education contributed the bulk of the respondents (75%), diploma (16.2%), degree (5%) and primary education (2%) as shown in Figure 1. The majority of the respondents were employed 80%. The marital status of the respondents indicated that the majority were married (78%). Figure 2 shows the place of residence of respondents.

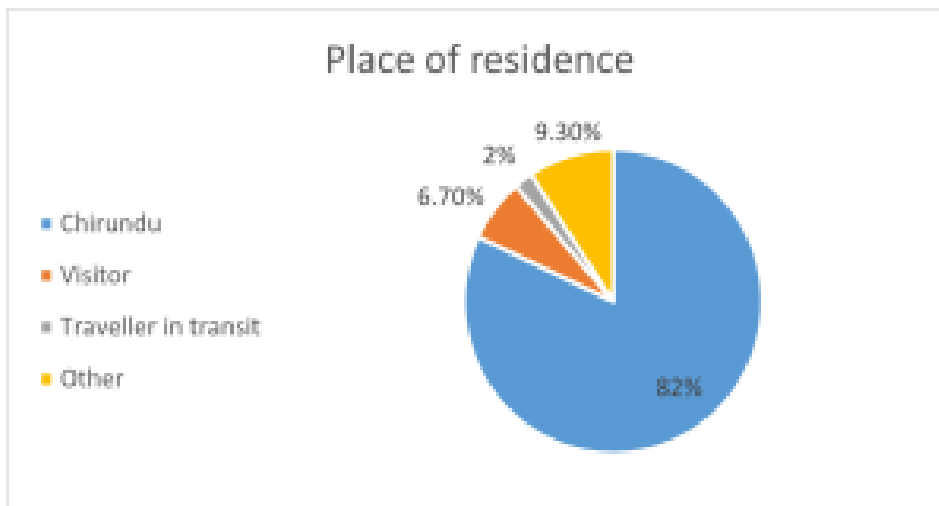


Figure 2: Place of residence of respondents

The results revealed that most respondents (82%) reside in Chirundu. 66% of respondents were from extended families while 12% live alone. The average monthly household income is ZWL 16500.

### B. Health-Seeking Behaviour of the Participants

The key informants highlighted that the Chirundu health facilities offers these services to HIV patients: HIV testing and counselling, treatment commencement (Initiation), uteral cancer screening, viral load monitoring, peer to peer counselling, youth friendly programs and treatment reviews.

With regard to the factors that contribute to choice of where to get HIV care services (Zambian side or Chirundu Zimside), the respondents highlighted that no two individuals are similar when it comes to choice of health care. Different individuals perceive the same services in a different way, hence the experiences at Chirundu or at the Zambian side determine where the HIV patient will go to access care services.

When asked where they prefer to access HIV health services (Chirundu or Zambian side), the results from the focus group discussion revealed that they consider the following: distance to the health facility, the probability of meeting someone they know, the type of treatment they will get at the place of treatment without being judged and the personality of the nurse who will assist them. Figure 3 presents the preferred place of treatment for respondents.

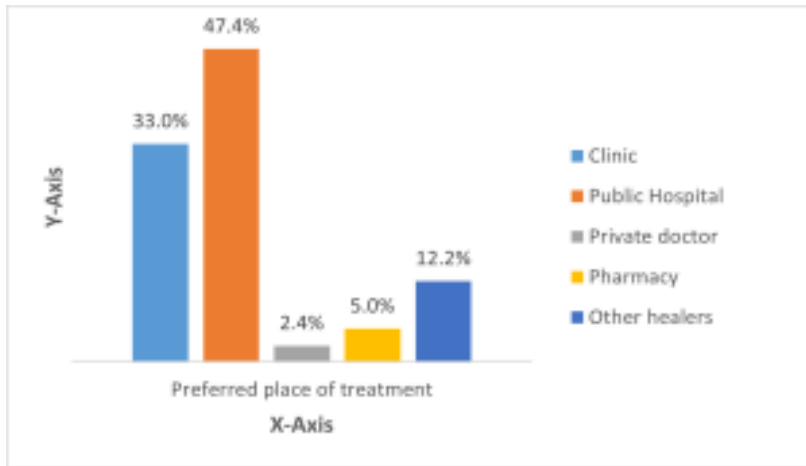


Figure 3: Preferred place of treatment for respondents

Most respondents (47.4%) prefer being treated in a public hospital. Women willing to be tested allegedly to prefer to receive care at government healthcare centres, men preferred seeking alternative health care. The results further revealed that female participants (59%) cited willingness to test for HIV better than their male (23%) counter parts. Furthermore, the health records for HIV patients and membership in support groups indicated that there are more women than men presently accessing HIV case management services in Chirundu. Figure 4 represents the testing acceptance and formal medical support seeking behaviour of respondents.

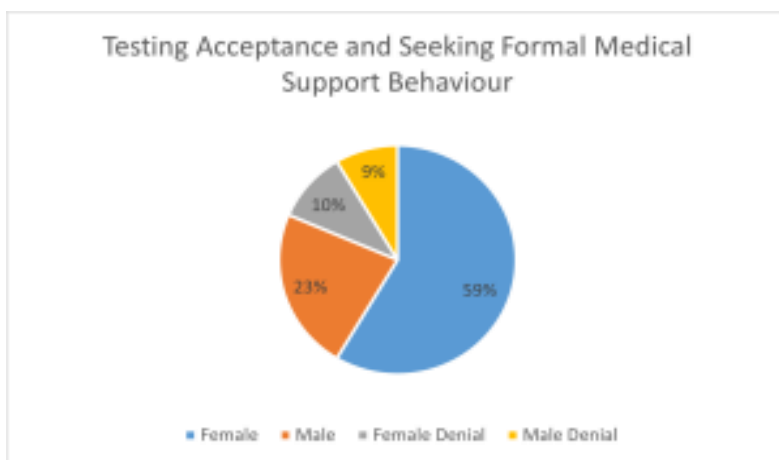


Figure 4: Testing acceptance and formal medical support seeking behaviour of respondents

59% of women were willing to be tested or to seek formal health care support systems while 23% of males felt the same. This trend was observed in the results because women are more vulnerable to HIV than men



hence they seek HIV health care services habitually. In addition, social and economic vulnerability of women at Chirundu stimulates patterns of unsafe sexual practices as the results revealed that some HIV patients are sex workers. Figure 5 shows the health seeking behaviour of the participants.

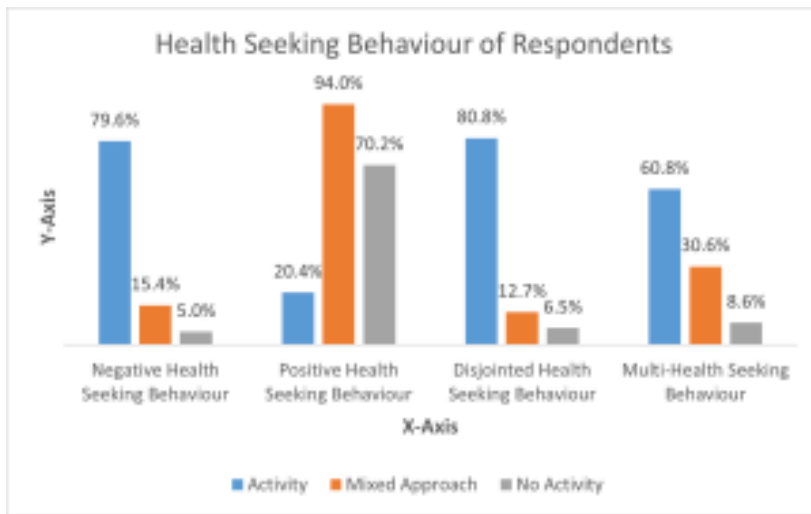


Figure 5: Health seeking behavior of the participants

The findings indicated 79.6% negative health seeking behaviour of the participants. Only 20.4% of the participants contacted health care professionals on noticing first symptoms of the disease. The 80.8% of the participants reported that they were getting treatment on a regular basis in a disjointed manner, thus making effort to access health support services between Zimbabwe and Zambia.

The research gathered that at given extent the majority cited challenges in accessing antiretroviral drugs on the Zimbabwean end. In that regard with the unitary system at the Zimbabwe and Zambia border they considered accessing drugs on a regular basis from the Zambian end. The other cultural determinants could not be ruled off as 60.8% of the participants reported that they simultaneously sought the assistance of faith healers and other alternatives.

**Test for differences in health seeking behaviours**

H<sub>0</sub>: The proportions of people of in each health-seeking behaviour category are evenly distributed.

H<sub>1</sub>: The proportions of people in each health-seeking behaviour category are not evenly distributed.

Table 2: summarising all the statistical tests conducted

Test	Type of Test	Test Statistic	P-value	Decision
<b>Differences in health seeking behaviors.</b>	Chi-Square Goodness of fit test.	4.766	0.1898	Fail to reject the null hypothesis.
<b>Dependence of healthcare facility on the country.</b>	Chi-Square test for independence.	115.841	<0.0001	Reject the null hypothesis.
<b>Case management comparison of means.</b>	Independent samples t-test.	-2.2929	0.051034	Fail to reject the null hypothesis.
<b>Proportion of patients that default treatment.</b>	Z-test	-1.514	0.0655	Fail to reject the null hypothesis.

Using the sample data, we fail to reject the null hypothesis and conclude there is no statistically significant difference in each health-seeking behaviour. This means that the differences in proportions of people in each category are not statistically significant.

### Health care facility satisfaction

The research findings further indicate that about 87.8% of our participants preferred to receive health care support from the Zambian end, government hospital. Respondents stated that the causes attributed to not seeking of health care support services on the Zimbabwean end government clinic was attributed unavailability of essential drugs and negative attitude of health care support staff. Figure 6 shows the health care facility satisfaction results.

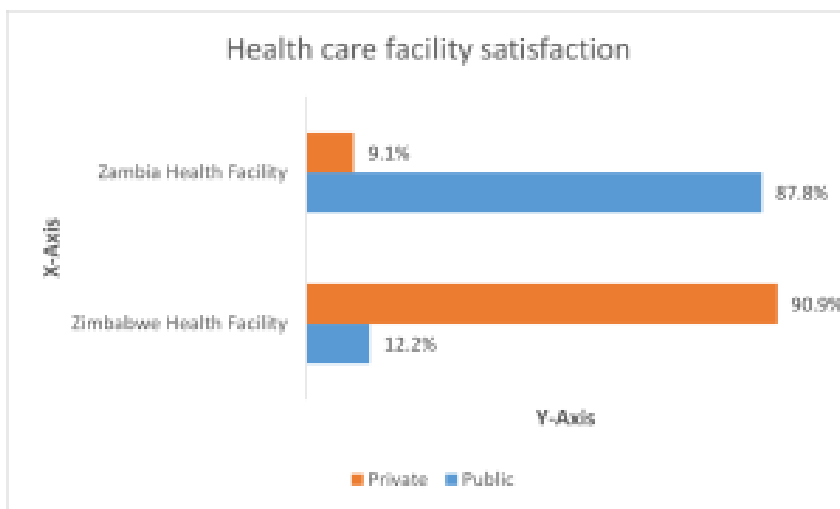


Figure 6: Health care facility satisfaction

However, the Zimbabwean private sector health facility received high ranking of 90.9% in terms of service and patient support compared to the Zambian end, as they were satisfied with the health care services provided to them. Almost all of the participants (94.5%) reported that they would continue to seek healthcare support services from the Zambian government hospital and only switch when service is considered better at Zimbabwean public institutions.

$H_0$ : The type of health care facility preferred is independent of the country.

$H_1$ : The type of health care facility preferred is dependent on the country.

The statistical calculations are shown in Table 3. Using the sample data, we reject the null hypothesis and conclude that there is sufficient evidence to support the claim that the type of health care facility is dependent on the country. The majority of those that prefer Zimbabwean health facilities, use the private ones whilst those that prefer Zambian health facilities use the public ones.

### Degree of compliance to HIV treatment among patients at Chirundu border town.

The members of the focus group discussion highlighted that they are already knowledgeable about ART. The following reasons for desire to be on ART which prompt HIV patients to go to Zambia side if they are not able to access the services at Chirundu were cited: the need to sustain good health and lengthen life, the assurance that ART will suppress the HIV virus and the desire not to communicate HIV to unborn children. Figure 7 shows the reasons for adhering to ART.

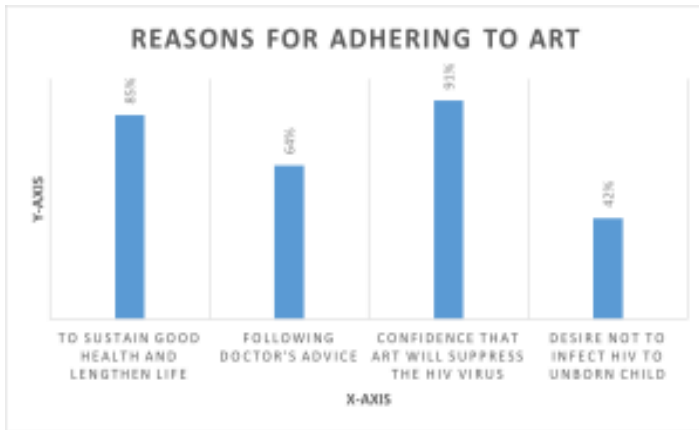


Figure 7: Reasons for adhering to ART

Most respondents (91%) adhere to ART because they have the confidence that it will suppress HIV. The results (Table 3) revealed that during that 32% of patients refrained from taking medication at least 4 times a week. 77% of respondents collect ARVs from the health facility that initiated them while 16% have been recorded as a defaulter or loss to follow-up client by the health facility attended. 21% of respondents agreed that they have been forced by a situation to get medical attention or their HIV treatment package from a health facility they did not want to go to within Chirundu.

Table 3: Treatment compliance among patients from different health facilities

Treatment compliance	Frequency
Number of defaulting patients	32%
Number of times per week	4
Number of patients collecting medication from initial institution	77%
Number of patients recorded as defaulters	16%

**Testing if the proportion of patients that default treatment is significant.**

Assuming that the proportion of patients that default treatment is considered to be significant if it is at least 20%, the hypotheses to be tested are as follows:

H0: The proportion of patients that default treatment is 20%.

H1: The proportion of patients that default treatment is less than 20%.

The sample proportion =  $30/188 = 0.16$

Z-Statistic = -1.514

P-value = 0.0655

Based on the sample data, there is no statistically significant difference in the proportion of patients who default treatment.

Concerning the experience in accessing HIV health services in Chirundu, one participant had this to say:

*When I went to a hospital in Chirundu, the staff was very positive. I got counselling and felt that I was in a safe space. Participant 8*

Another participant had this to say:

*Getting the HIV care services at Chirundu is not a problem. The challenge is being seen by somebody who knows you. These community members will start sharing the news with others.* Participant 1

*One time I saw somebody I know and avoided getting services.* Participant 3

With regard to experiences in accessing health services after having their HIV status known by health care workers, the participants highlighted that the health care workers were extra careful when treating them to avoid being infected.

Most respondents reported that they did not meet anyone familiar in a foreign hospital as compared to when they visited Chirundu health facilities. 53% of participants said that they were treated better in Chirundu health facilities than when they were in a foreign hospital.

When asked if they have ever obtained treatment or collected your ARV treatment package from Mutenderi rather than from Chirundu health facilities most participants (51%) have not collected their treatment packages from other health institutions besides Chirundu health facilities.

Most respondents (72.3%) reported that although the ARV regimen acquired from a different facility was different there were no side effects while 18.7% experienced side effects after changing an ARV schedule.

When asked if they found the need to go back to a previous Health facility after changing place of treatment or collection of ARV treatment package, 66% of respondents felt the need to go back to their initial health institution while 28% continued receiving treatment at the new facility.

Regarding the improvement of health facilities in Chirundu to ensure consistency in health seeking behaviour, the respondents highlighted that there is need to improve monitoring and support of patients to enhance compliance to treatment. The results also revealed that patients need supportive and non-judgmental health care providers.

### **To assess differences in HIV case management between Chirundu Zimbabwe and Zambian side.**

With regard to HIV case management between Chirundu Zimbabwe and Zambia side, the key informants highlighted that there is sharing of notification cards between care givers. Patient information is not shared from care giver to care giver. As a result, HIV patients who were initiated in Chirundu end up being given a different regimen when they access services at a different health facility.

The results further revealed that patient follow-up is limited between the clinic and health care institutions in the two countries, which has resulted in lack of capacity to trace and support patients back on ARV treatment programs if they are on the other side of the border.

Concerning seeking professional help in remembering medicines times 14% of the respondents highlighted that they get the service at Chirundu while 26% highlighted that they seek professional help at the Zambian side. Most respondents (66%) access HIV case management services in Chirundu while only 12% access the services in the Zambian side.

Regarding access to an HIV peer support group most participants have access in Chirundu (78%) in contrast



with the 3% who have access to an HIV peer group support on the Zambian side. Most respondents (68%) get their HIV regimen through the healthy facilities in Chirundu while 42% get the medication in through the healthy facilities in Zambia.

76% of respondents agreed to have attended a counselling session at health facilities in either Zimbabwe or Zambia. 32% of participants acquired counselling services in Zambia while 43% were counselled concerning HIV in Chirundu. Figure 8 shows the HIV case management between Chirundu, Zimbabwe and Zambia side.

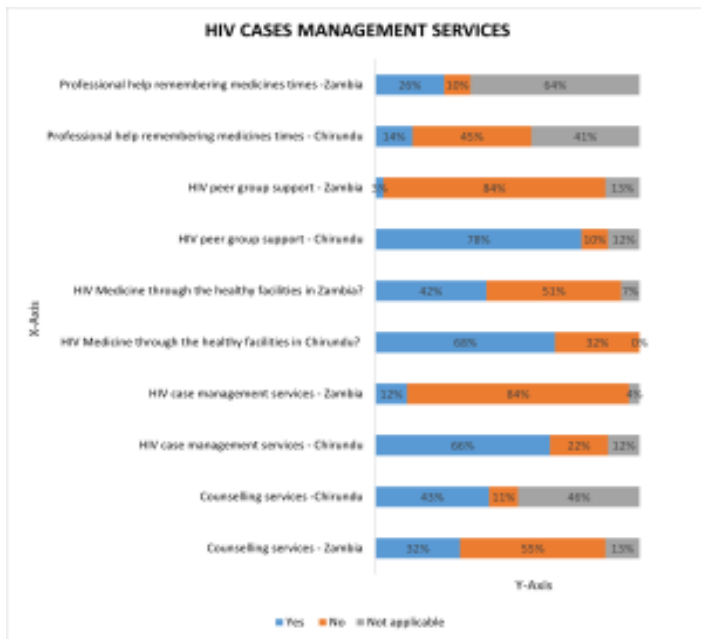


Figure 8: HIV case management between Chirundu, Zimbabwe and Zambia side.

The results show that the 38% of the respondents' agreed that there is HIV case management between Zimbabwe and Zambia while 40% disagreed. The score for HIV case management has a mean of 29% with a SD of 0.2598. This therefore indicates that there is inadequate HIV case management conduction between Chirundu Zimbabwe and Zambia.

### Case Management comparison of means

Using the percentages of case management questions answered yes we can test if there is a significant difference in mean percentages of Zambia and Chirundu. The table below shows these percentages.

Table 4: Case management Percentages

Zambia	Chirundu
26	14
3	78
42	68
12	66
32	43

$H_0$ : There is no significant difference in the mean percentages between Zambia and Chirundu.

$H_1$ : There is a significant difference in the mean percentages between Zambia and Chirundu.

Using the 2-Samples t-test we obtain the following results:

Table 5: T-test Results

	<i>Zambia</i>	<i>Chirundu</i>
Mean	23	53.8
Variance	243	659.2
Observations	5	5
Pooled Variance	451.1	
Hypothesized Mean Difference	0	
df	8	
t Stat	-2.2929	
P(T<=t) one-tail	0.025517	
t Critical one-tail	1.859548	
P(T<=t) two-tail	0.051034	
t Critical two-tail	2.306004	

At the 5% level of significance, there is no significant difference in the mean percentages between Zambia and Chirundu. The difference in case management between the two locations is not statistically significant.

When asked what should happen to make HIV case management more efficient in Chirundu, the participants highlighted that there is a need to reach out to HIV positive men with available treatments to ensure adherence to ART as there were more males who were not following the HIV regimen.

The fear of side effects which reduces adherence to medication can be mitigated by teaching HIV patients about the appropriate taking of medicines and the expected side effects of different treatment regimens and how to minimise potential side effects. This will encourage those who were initiated at Chirundu to continue getting their regimen there to avoid being given a different regimen at the Zambia side which could be detrimental to their health.

The respondents highlighted that HIV case management can be improved in Chirundu by launching more ART centres, training more nurses and instituting an individualised booking system so ART clients can choose different days to receive care to solve the challenge of traveling long distances and waiting too long in the queue to get assistance.

The results further revealed that sporadic outreach programmes to care for ART clients, donor programs which cater for nutrition of HIV patients can solve the financial challenges. Creating family, community and peer support groups where the community members of Chirundu can be educated on HIV and learn about the effects of stigmatisation to people living with HIV was also mentioned as a solution.

The respondents further highlighted that the shortage of drugs and medical equipment can be mitigated by allocating more financial resources to ART in border towns, prevent wastage in the use of drugs and reduce inadequacies in HIV case management.

## **To Determine the Barriers that Hinder HIV Patients in Chirundu from Fully Taking Up the Available HIV Care and Management Services.**

Concerning the barriers hindering HIV patients in Chirundu from fully taking up the available HIV care and management services, the key informants highlighted that comparing the resources available at Chirundu and on the Zambia side health facilities could be the reason for poor use of facilities in Chirundu. The key informants highlighted that Mutenderi hospital in Zambia is a larger hospital with state of the art laboratories and medical equipment. Furthermore, the services are available at an affordable price in contrast with the health facilities at Chirundu.

The key informants highlighted that although HIV management or treatment services are for free on the Zimbabwe side, individuals prefer getting services at the Zambia side where diagnosis is better and resources are available at a cheaper price.

Additionally, the key informants highlighted that HIV patients are more comfortable being treated on the Zambian side since no one knows them or their social circle. HIV patients consider that their secret is safe as compared to getting treatment at the Zimbabwe side health care centres.

The results from the key informant interviews further revealed that a significant population in Chirundu are commercial sex workers hence they take being treated at a local clinic as being bad for their business. Hence this triggers disjointed health seeking behaviour.

With regard to the challenges faced by HIV patients that act as barriers in beginning and frequently attending HIV clinical care services in Chirundu, the members of the focus group discussion highlighted the following:

1. Delay in receiving care due to staff shortage and long queues.
2. Fear of ARVs side effects
3. High costs of accessing and receiving ART
4. Job insecurity due to absence to receive ART
5. Shortage of drugs and medical equipment
6. Stigma from community members
7. Traveling long distance to get treatment.

The challenges highlighted were categorised as follows: quality of care, discrimination, financial and structural related barriers.

### **Barrier 1: Quality of care**

About 14% said the service at Chirundu health facilities is poor, 40% said the service was fair while 7% gave the service an excellent rating. The key informants also attested HIV patients perceive the health services offered to be poor. Figure 9 presents the ratings of the quality of care offered by health workers at Chirundu health facilities.



Figure 9: Ratings of the quality of care offered by health workers

About 14% said the service at Chirundu health facilities is poor, 40% said the service was fair while 7% gave the service an excellent rating. The key informants also attested HIV patients perceive the health services offered to be poor.

14.9% of the respondents highlighted that they do not trust the health workers at the clinic especially with regard to confidentiality about their HIV status. Most respondents asserted that they are sometimes given time to seek clarity while 12% felt that the health workers were not competent to deal with my problem. Figure 10 shows the attitudes of HIV patients towards the quality of care they get from health workers.

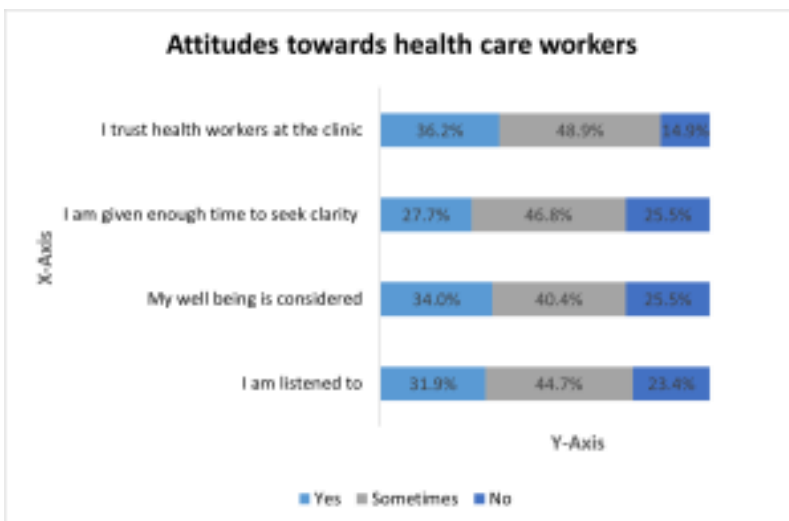


Figure 10: Attitudes towards the quality of care

The results further indicate that 34% of respondents were nervous about what the service provider might say since they are from the same community. 16% reported that the health care staff at the Chirundu facility do not speak their language which was a barrier to accessing quality care.

### Barrier 2: Discrimination

26% of the respondents highlighted that the healthcare workers at Chirundu are either impolite, disrespectful, or insensitive to the patients' needs. 3% highlighted that they were treated differently by health care providers due to their sexual orientation and status.



The key informants highlighted that the challenges faced by HIV patients in accessing ART services at Chirundu Border Town include fear of stigmatization. This is because Chirundu is a small community so most people find it difficult to come for treatment at the local clinics or even having status known by health care giver. The lack of trust between the patient and the service provider was identified as a cause for disjointed health seeking behavior for HIV patients in the process of seeking health services in Chirundu.

### Barrier 3: Financial

More than half (58%) of the respondents highlighted that Health care services are too expensive at Chirundu compared to Zambia which is a barrier hindering them from fully taking up the available HIV care and management services at Chirundu.

The results further revealed that the lack of resources to monitor time hinders them from fully taking up the available HIV care and management services. Figure 11 shows the reminders used by HIV patients to master pill taking times.

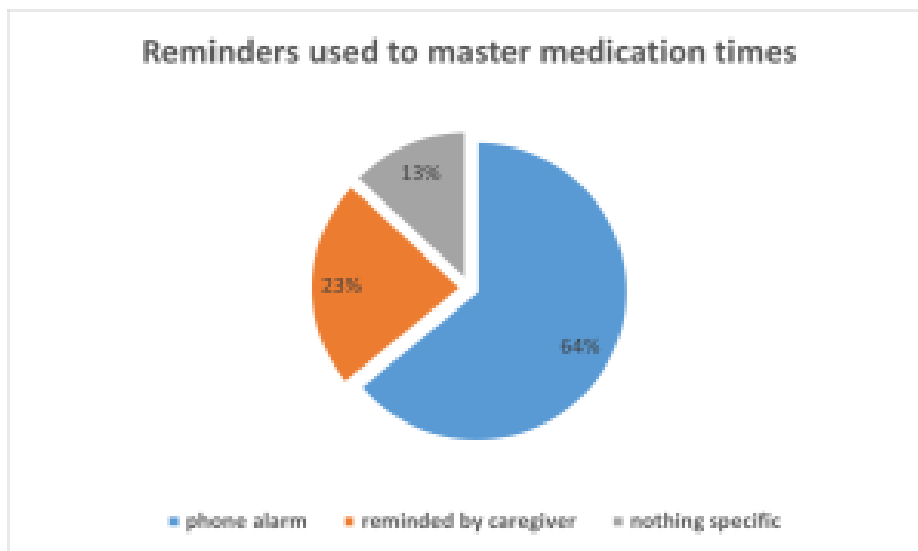


Figure 11: Reminders used to master pill taking times

Most respondents (64%) use the alarms on their phones. 13% pointed out that they had nothing specific to remind them

### Barrier 4: Structural

Concerning structural barriers, 23% mentioned that it was difficult to get transportation to a hospital in Chirundu especially during the lockdown. 8% highlighted that the hospital at Chirundu is not open at times convenient to them as they do not want to be seen by their neighbors.

41% stated that it takes long to get an appointment to see a medical provider at Chirundu which makes them seek health services on the Zambian side. Concerning the time spent waiting to get services at the health institution in Chirundu, HIV patients pointed out that the waiting times are too long. Figure 12 shows time taken waiting for services.

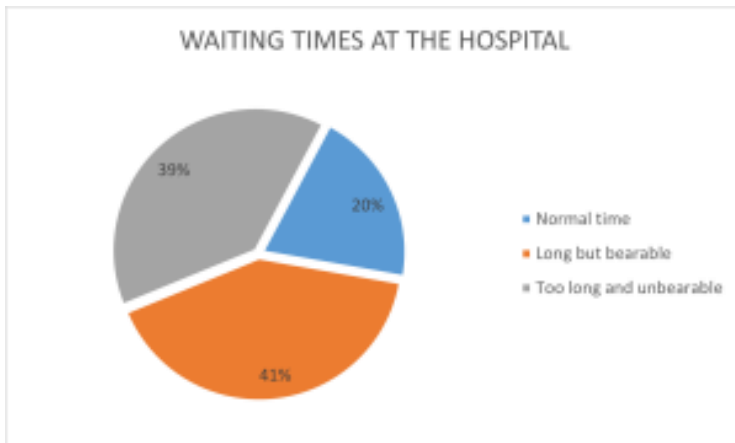


Figure 12: Time taken by HIV patients waiting for services at Chirundu.

20% of the respondents do not have a problem with the time they waited. Most respondents (41%) felt that the time was long yet bearable while 39% complained about long waiting time.

The key informants highlighted that for service delivery and compliance to treatment to be at its optimum in Chirundu health facilities, there is need for further patient support with regard to offering home visits, frequent adherence checks, the use of reminders and adherence tools. For those who come from low-income households, there is need to address food security.

The key informants highlighted that the following should be improved by health facilities in Chirundu to ensure consistency in health seeking behaviour: hospice infrastructure, accessibility of services and drugs and sensitising the general public on the impacts of disjointed health seeking behaviour

## CONCLUSION AND RECOMMENDATIONS

### Conclusion

1. The results indicate that socio-economic factors such as educational level, occupation, marital status and economic status of family and the characteristics of the community such as family size and place of residence contribute to disjointed health-seeking behaviour.
2. The findings indicated 79.6% of respondents had negative health seeking behavior of the participants. 87.8% preferred receiving health care support from the Zambian government hospital. The rate of treatment compliance among patients from different health facilities in Chirundu border town is 84%.
3. The score for HIV case management was 26% with a SD of 0.287, which therefore indicates that there is inadequate HIV case management conduction between Chirundu Zimbabwe and Zambia.
4. The barriers that hinder HIV patients in Chirundu from taking up the available HIV care and management services were financial, structural and individual factors which include quality of care, discrimination and stigmatisation, long waiting times and cost of transportation.

### Recommendations

1. There is a need to mobilise more resources and allocate budgets towards food security for people living with AIDS to reduce the impacts of socioeconomic factors influencing the health care seeking behaviour of HIV patients.
2. There is a need to train and educate community members on ART adherence and the side effects of changing the regimen in order to increase the degree of compliance to treatment.
3. There is a need to capacitate health institutions concerning the management of HIV cases between Chirundu and Zambia.

4. There is need to constantly enlighten health care workers on the provision of HIV care services to reduce the barriers hindering HIV patients in Chirundu from fully taking up the available HIV care and management services.

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