



Perception and Demographic factors as Determinants of Health Seeking Behaviour among Urban and Rural dwellers in Nasarawa State, Nigeria.

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Abstract

It is important to note that, perception is a powerful tool that drives individual behaviour including health-seeking behaviour. Unfortunately, the perception of HIV/AIDS and health-seeking behaviour has not been researched particularly in Nasarawa State. This study therefore looks at the perception of HIV/AIDS and demographic factors as determinants of health-seeking behaviour among rural and urban dwellers in Nasarawa State. A cross-sectional survey design was used and the researcher used 300 participants comprising 169 (56.3%) male, 129 (43.0%) female with 2 (0.7%) of the respondents who did not indicate their sex. Their ages ranged from 13 to 60 years of age with an average age of 31.95 (SD = 27.00). Two standardized instruments comprising of perception of HIV/AIDS Scale developed by Wyk, (2005) and health-seeking behaviour scale developed by Topkaya, Şahin and Meydan, (2007). Three research hypotheses were formulated and tested and the result from the first hypothesis showed that there was a significant influence of perception of HIV/AIDS on health-seeking behaviour among rural and urban dwellers in Nasarawa State [$R = .393$ and $R^2 = .155$, $F(1, 272) = 3.291$; $p < .05$]. Beta weight [$\beta = -.109$, $t = -1.814$; $p < .01$] shows that urban and rural dwellers in Nasarawa State significantly have negative perceptions and as such, scored less on health-seeking behaviour. Finding from the second hypothesis showed that, there was a significant location difference on health-seeking behaviour among urban and rural dwellers in Nasarawa State [$t(274) = -1.903$; $p < .01$] with participants in rural areas (Mean = 40.14; SD = 14.96) significantly scoring higher on health-seeking behaviour than their urban counterparts (Mean = 36.99; SD = 12.47). From the third hypothesis, it was found that there was no significant relationship between age and health-seeking behaviour among urban and rural dwellers in Nasarawa State [$r(267) = .004$; $p > .05$]. The findings were discussed in line with other studies and conclusions were drawn. It was recommended that there is a need for an appropriate education program for the entire population in Nasarawa State to enable them to change their perception towards HIV/AIDS as this will go a long way in encouraging them to seek health and help themselves including their loved ones.

Keywords: Perception of HIV/AIDS, Health-Seeking Behaviour, Age, Rural and Urban Dwellers, Nasarawa State



Introduction

Research has shown that a very low amount of people seek health when they find that their status on Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) is positive as the majority of those who seek health are those whose results after testing is negative (Ren et al., 2017). Even among those who seek health, Ren et al (2017) further opined that most of them are those with lower levels of education with lower monthly income but are conscious of the decline in their health and have the will power to seek health. Furthermore, the majority of those who seek health tend to be those whose results are not decided and are not certain about their real status and as such, their continued health seeking behaviour could be a result of their fear of the unknown. This is to say that, the attitudes of HIV/AIDS towards health seeking is poor as they also have negative perceptions towards health seeking behaviour.

Since their discovery, HIV and AIDS are major global public health problems with millions of research across the globe on how to cure the disease. The worldwide efforts to manage the HIV and AIDS pandemic have increased because the virus is spreading with greater speed (Global Report, 2013 & 2016). In 2012, about 33.4 million people were living with HIV worldwide. In 2019, there were estimated 38 million people living with HIV (PLHIV) worldwide (Ukaegbu et al., 2022). It has been described as a leading cause of morbidity and mortality in Sub-Saharan Africa (SSA), accounting for 71% of the global population of PLHIV (James et al., 2017; Roth et al., 2018).

Historically, HIV/AIDS in Nigeria dates back to 1985 when the first case was diagnosed and reported in Lagos, Nigeria. Nigeria, the most populous country in Africa, has 1.9 million persons living with HIV (with prevalence of 1.4%) between the ages of 15–49 years, making Nigeria the third highest in HIV burden (Fagbamigbe et al., 2017). Like every other part of the world particularly developing countries like Nigeria, one of the main modes of HIV transmission reported are sexual transmission and reuse of contaminated syringes. In some parts of the world, individuals infected with HIV are usually unaware of the disease and unable to detect symptoms in the early stages. Before diagnosis and seeking proper health care, patients may have already received health care from spiritual or faith healers, which delays diagnosis and proper treatment. This lack of awareness of the disease results in the majority of HIV-infected persons not seeking medical help until the condition has worsened leading to various complications of HIV. Treating the disease at this stage causes a financial burden to the individual and family and this has been reported as a major constraint in seeking proper medical care (Mahal & Rao, 2005).

The World Health Organization (WHO, 2022) and Joint United Nations Program for HIV/AIDS (UNAIDS, 2022) reported that, on the global statistics, 38.4 million (33.9 million–43.8 million) people globally were living with HIV and 1.5 million (1.1 million–2.0 million) people became newly infected with HIV. Furthermore, 650,000 (510,000–860,000) people died from AIDS-related illnesses, 28.7 million people were accessing antiretroviral therapy, 84.2 million (64.0 million–113.0 million) people have become infected with HIV since the start of the epidemic and 40.1 million (33.6 million–48.6million) people have died from AIDS-related illnesses since the start of the epidemic. Among these people, 36.7 million (32.3 million–41.9 million) adults (15 years or older) and 1.7 million (1.3 million–2.1 million) children (0–14 years). Moreover, 54% of all people living with HIV were women and girls while 85% (75– 97%) of all people living with HIV knew their HIV status. Again, about 5.9 million people did not know that they were living with HIV/AIDS.



On the AIDS-related deaths, it was reported that AIDS-related deaths have been reduced by 68% since the peak in 2004 and by 52% since 2010. In 2021, around 650,000 (510,000–860,000) people died from AIDS-related illnesses worldwide, compared to 2.0 million (1.6 million–2.7 million) people in 2004 and 1.4 million [1.1 million–1.8 million] people in 2010. AIDS-related mortality has declined by 57% among women and girls and by 47% among men and boys since 2010 till date. It is important to note also that, on the global average, key populations (sex workers and their clients, gay men and other men who have sex with men, people who inject drugs, transgender people) and their sexual partners accounted for 70% of HIV infections globally in 2022).

In Africa, global statistics from WHO (2022) and USAIDS (2022) shows that Eastern and Southern Africa has a total number of 20.6 million people living with HIV with 670,000 new infections (590,000 among those who were 15 years and above while 78,000 from 0 to 14 years). 280,000 deaths were recorded in this region while 16.2 million people were accessing treatment. In Western and Central Africa, 5.0 million people were living with HIV with 190,000 total new infections (140,000 or those who were from 15 years and above while 54,000 were between 0 – 14 years). Total deaths as a result of HIV/AIDS in Western and Central Africa were reported to be 140,000 while 3.9 million people were accessing treatment. Moreover, 94% of new HIV infections are outside of sub-Saharan Africa, and 51% of new HIV infections are in sub-Saharan Africa.

In Nigeria, the National Agency for the Control of AIDS (NACA, 2022) reported that, a national HIV prevalence in Nigeria of 1.4% among adults aged 15–49 years. Previous estimates had indicated a national HIV prevalence of 2.8%. UNAIDS and the National Agency for the Control of AIDS estimate that there are 1.9 million people living with HIV in Nigeria. The new data differentiate HIV prevalence by state, indicating an epidemic that is having a greater impact in certain areas of the country. The South-South zone of the country has the highest HIV prevalence, at 3.1% among adults aged 15–49 years. HIV prevalence is also high in the North Central zone (2.0%) and in the South East zone (1.9%). HIV prevalence is lower in the South West zone (1.1%), the North East zone (1.1%) and the North West zone (0.6%).

Perception about HIV/AIDS has also been diverse due to the nature at which the information about the disease has been passed overtime. The majority of people who contracted the disease have perceived it as being a dead end for them and therefore see no need to look for help and seek health since they see it as a waste of time, energy and resources. According to Masoudnia (2015), negative and discriminatory perceptions towards people living with HIV/AIDS are one of the biggest experienced challenges by people suffering from HIV, and these perceptions and attitudes have been regarded as a serious threat to the fundamental rights of all infected people who are affected or associated with this disease. According to Tavoosi et al. (2004), there is a high prevalence of negative perception and stigmatization attitudes toward people with HIV/AIDS ranging from 46% to 69% and even more.

Determining the health seeking behaviour of people living with HIV/AIDS as well as their level of satisfaction with the services provided is one of the most important steps towards reducing the spread of the disease and management/treatment as well as prevention strategies. Previous research studies in other parts of the world have been conducted on knowledge, attitude and practices regarding HIV/AIDS, prevalence and risk factors of HIV/AIDS and education and counselling regarding HIV/ AIDS, but none have looked at the health-seeking behaviour of persons living with



HIV (Nisar, 2017) and the Nigerian situation particularly in the North Central States of Nigeria such as Nasarawa State is not an exception as the majority of the researcher's concentration has been on stigmatization and discrimination (Ihaji et al., 2014).

In the same vein, avoidance of discrimination and stigmatization towards persons living with HIV/AIDS will breed positive perception leading to health seeking behaviour and this cannot be achieved if proper information and awareness are distributed through research. Moreover, given the context above, it is imperative to draw attention to what attitudes towards HIV/AIDS can portray on health seeking behaviour as well as how people perceive the disease and their tendency to seek health. Furthermore, it is important to reiterate that, various studies have been conducted so far in other parts of the world, focusing particularly on knowledge, attitudes and practices around HIV/AIDS amongst high-risk groups (for instance Raza et al., 2015) and this again side-line the importance perception towards the disease even as attitudes are mentioned but researched on a much lighter note even as it has grave consequences towards health seeking behaviour. Moreover, there is little evidence available in Nigeria, particularly in Nasarawa State. Therefore, this research will be a value-addition, aiming to explore attitudes and perceptions towards HIV/AIDS and health seeking behaviour among urban and rural dwellers in Nasarawa State. This research is highly pertinent considering the significance of the Global AIDS Monitoring indicators (2018), which emphasise regular reporting against the "2020 fast-track commitments and expanded targets to end AIDS", yet its prevalence continues in 2023 with little or no hope for complete elimination.

We can therefore postulate that;

- i. There will be a significant influence of perception of HIV/AIDS on health seeking behaviour among rural and urban dwellers in Nasarawa State.
- ii. Urban and rural dwellers will significantly differ in health seeking behaviour in Nasarawa State.
- iii. There will be a significant relationship between age of participants on health seeking behaviour among urban and rural dwellers in Nasarawa State.

Review of Related Literature

Individual perception is a powerful tool that drives any kind of behaviour towards anything in life. Our perception drives our behaviour, our attitudes towards something/someone, our view towards that which is perceived and the behaviours that will follow among others. According to Tagoe and Aggor (2019), different individuals perceive HIV/AIDS to be different things to them and this kind of perception is capable of tilting their direction of behaviour to a particular direction. They investigated the perception of the risk of contracting HIV/AIDS and their attitudes to seeking health. Their study found that the students engaged in pre-marital sex, although this was more common among the male than female students. Students did not use condoms consistently and were not likely to use condoms when the relationship was considered as stable because of trust. Students revealed that they were all at risk of infection; however, a significant number of them did not know their HIV status and were not ready to take the test for fear of stigmatization. There low level of knowledge among female students of the different types of sexually transmitted infections. The results suggest that there is a need for an appropriate education program for students. Peer education clubs need to be established to provide education on condom management. In addition, edutainment-education



through entertainment programs on HIV/AIDS - needs to be an integral part of the university's curriculum.

In the same vein, Janahi et al. (2018) investigated the perceptions and attitudes towards HIV/AIDS Patients among General Public in Bahrain and their health seeking behaviour. According to them, HIV/AIDS is a major global health problem not just in developing countries but also in developed countries such as Bahrain even as the prevalence of HIV is low. Accordingly, awareness programs are of high importance for controlling and preventing the distribution of HIV infection. Their study found that varied attitudes toward HIV/AIDS, but most were negative, as 60% of participants agreed to isolate HIV/AIDS patients in workplaces and schools, and 52.4% of them believed that HIV is a divine punishment. A high proportion of respondents (84.4%) believed that religion plays an important role in minimizing the spread of the disease. They concluded that, on a general note, most people have negative attitudes toward HIV/AIDS and as such, successful control programs for HIV infection require limiting the negative attitudes toward HIV patients and the disease.

HIV knowledge and perception in the situation of a University was investigated by Norimah et al. (2018). According to them, there is a majority of young people who are between the ages of 13 – 29 that are infected with HIV/AIDS. According to them, a positive correlation exists between perception and attitudes toward HIV/AIDS and health seeking behaviour among adolescents. They concluded that an increase in the level of knowledge contribute to a positive attitude and perception also reduces the stigma and discrimination toward people living with HIV/AIDS, and at the same time improves the level of health seeking behaviour.

Findings from a study conducted on HIV-positive people in some African countries indicated that 57% of the sample reported their status secretly, 73% had the feeling of guilt due to their positive status, and 43% had the feeling of shame. In some parts, 94% of patients with AIDS kept their status a secret in the community, 69% hid the situation from the family, and 12% were not satisfied to disclose their situation at all. Secrecy and disease denial due to HIV/AIDS stigma may lead to the continuity of risky sexual behaviors. The results of some studies indicated that fear can influence access to treatment and care services and it has been seen as a barrier to help-seeking. They state that their reluctance to AIDS services is a strategy for protecting the patient and the family from stigma and social isolation (Saki et al., 2020).

Moreover, health-seeking behaviour also called healthcare-seeking behaviour is defined as any activity undertaken by individuals who perceived themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy (Ward et al., 2010). Health-seeking behaviour includes the timing and types of healthcare service utilization and may affect population health outcomes (Poortaghi et al., 2015). Delayed medical attention has been shown to associate with an increased risk of unfavourable outcomes (Prentice, & Pizer, 2007). For patients with infectious diseases, delay in seeking care may also result in increased transmission risk in the community. Understanding the pattern of healthcare-seeking behaviour could help public health practitioners and policymakers to improve the healthcare system and health promotion strategies.

From a patient's perspective, healthcare-seeking behaviour tends to be responsive to discomfort or symptoms, rather than to specific diagnosed diseases which were unknown to them before medical consultation. However, many studies examined healthcare-seeking behaviour either focused on a patient care perspective or restricted to a specific disease related to a few limited symptoms



(Elnegaard et al., 2015). Health seeking behaviour is specific to symptoms and syndromes, which may more realistically reflect personal responses to sickness in the general population. The accessibility to services, information and educational initiatives concerning HIV and AIDS does not guarantee access of a person to proper treatment. Health-seeking behaviour of an individual determines their approach toward receiving proper treatment for a disease. Research on cultural aspects supports the importance of knowledge regarding the disease and the health-seeking behaviour of patients (Runganga et al., 2001). According to a study conducted in other parts of the world on 160 HIV-infected patients, self-motivation for HIV/AIDS medical treatment was found in only 3.8% of the patients (Pandey et al., 2009).

Method

Study Design

This study will utilize a cross-section survey design and a multi-stage sampling technique for the study. A cross-sectional is a type of research design in which you collect data from many different individuals at a single point in time. In cross-sectional research, the researcher observes variables without influencing them. According to Lauren (2020), a cross-sectional design is one that which a researcher uses of questionnaire to carry out the study. This is because a cross-sectional survey collects data to make inferences about a population of interest (those who were HIV positive and negative) at one point in time. Cross-sectional surveys have been described as snapshots of the populations about which they gather data and in this case, a sample of urban and rural dwellers in Nasarawa State, Nigeria.

Participants

A total of 300 participants were used for this study. Among the sampled participants, 169 (56.3%) were male, 129 (43.0%) were female, while 2 (0.7%) of the respondents did not indicate their sex. On their marital status, the result showed that 78 (26.0%) were single, 109 (36.3%) were married, 69 (23.0%) were divorced/separated, 42 (14.0%) were widow/er while 2 (0.7%) of the respondents did not indicate their marital status. Their ages ranged from 13 to 60 years of age with an average age of 31.95 (SD = 27.00). On their highest educational qualification, the result showed that 109 (36.3%) had no formal education, 119 (39.7%) had primary education, 67 (22.3%) had secondary education, 4 (1.3%) had tertiary education while 1 (0.3%) of the respondents did not indicate his/her educational qualification. The researchers further sampled 110 (36.7%) who were Christians, 147 (49.0%) who were Islam, 41 (13.7%) were from traditional religion and others, while 2 (0.7%) did not indicate their religion. On their location, the researchers sampled 150 (50.0%) from urban areas while 150 (50.0%) from rural areas.

Instrument

The instrument that was used for the study was a questionnaire which comprised two sections; sections A and B. Section A of the questionnaire comprised of demographic characteristics of the respondents' sex, marital status, age, highest educational qualification, religion and location. Section B of the instrument comprises two standardized scales which are the perception of HIV/AIDS scale and health seeking behaviour scale.



The Perception of HIV/AIDS Scale used for this study was Wyk (2005) to measure HIV/AIDS Perceptions, attitudes and awareness. It is a 10-item questionnaire with sample items such as 'I do not believe that AIDS exists. They say it comes with sexual contact, but there is no disease that can emanate from sex', 'I have seen people dying of AIDS, hence I believe it exists', 'Since AIDS is invisible, to be on the safe side always use a condom when having sex' among others. The response format of the scale is a 4 – point Likert scale of strongly agree, agree, disagree and strongly disagree. The validity of the instrument was tested using face and content validity using convergent and discriminant validity and according to Wyk (2005), all the validity testing proved that the instrument was valid enough to be used for data collection. The reliability of the instrument showed that the overall scale returned a reliability coefficient of .70 Cronbach's alpha showing a very high reliability. Lim and Loo (2000) further confirmed that the reliability of the instrument was consistent enough to be used as an independent tool for data collection on the perception of HIV/AIDS with a reliability coefficient of .75 Cronbach's alpha. On scoring, the scale is scored by adding all the items together and getting the mean score to indicate whether the perception towards HIV/AIDS is positive or negative. Composite score is recommended for studies using perception as a single variable.

The Health Seeking Behaviour scale used for this study was developed by Topkaya, Şahin and Meydan (2007). It is a 17-item scale developed to measure health seeking behaviour among the general population with sample items such as 'I have difficulty in sharing my problems with a stranger even though he is a professional', 'I worry about being stigmatized as "problematic" and/or "crazy" if I seek help', 'I don't want to spend time seeking help as it would take too long' among others. The response format of the instrument is a 5 – point Likert scale of strongly agree, agree, undecided, disagree and strongly disagree. Exploratory factor analysis results suggested that the scale consists of five dimensions, labeled as fear of being stigmatized by society, trust in the mental health professional, difficulties in self-disclosure, perceived devaluation and lack of knowledge. The confirmatory factor analysis cross-validated the scale's five-factor structure on a new college students sample. The convergent and divergent validity of the scale were also supported by theoretically and empirically expected correlations with self-concealment, self-stigma, and attitudes towards seeking health. Moreover, the scale was found to have an adequate stability coefficient across three weeks and appropriate levels of internal consistency coefficient reliability for each of the subscales in two different samples ranging from ranged from .69 to .92 Cronbach's alpha. The scoring of the instrument has different dimensions depending on the variable being portrayed. This means that, if the variable is used as an independent variable, all the dimensions are to be recognized but if it is used as a dependent variable, the dimensions are to be ignored considering it as a composite score (Topkaya et al, 2007).

Data Collection Procedure and Analysis

The researchers recruited and trained two research assistants for the purpose of data collection. Probability and convenient sampling technique was used to select HIV/AIDS facilities and participants respectively comprising of those who were HIV positive and negative. When the researchers arrived at the facilities, they used a convenient sampling technique to select the participants for the study after obtaining appropriate permission from relevant institutions and participants in the location of the study. Because convenient sampling was used as a sampling technique, the researchers and his assistants identified the participants and administer the



questionnaire to them to elicit their responses. Those who were willing to attend to the questionnaire were given a copy of the question each for responses which constituted the data for this study.

The researchers employed the use of descriptive and inferential statistics for data analyses. The researcher used descriptive statistics such as frequencies for the bio-data and inferential statistics such as linear regression, independent t-test and Pearson's Product Moment Correlation for testing the formulated hypotheses using computer analysis with statistics software called Statistical Package for Social Sciences (SPSS) version 23 for analysis and presentation of results.

Results

This section presents the result of the study and tables are used in presenting the result according to the stated hypotheses and their interpretations follow immediately after each table.

Hypothesis 1.

This hypothesis states that there is a significant influence of perception of HIV/AIDS on health seeking behaviour among rural and urban dwellers in Nasarawa State. This hypothesis was tested using regression analysis and the result is presented in Table 1.

Table 1: Summary of simple linear regression showing the influence of perception of HIV/AIDS on health seeking behaviour among urban and rural dwellers in Nasarawa State.

DV	Predictor(s)	R	R ²	F	df	β	t	p
Health Seeking Behaviour	Constant	.393	.155	3.291*	1, 272		14.679	<.001
	Perception of HIV/AIDS					-.109	-1.814	<.01

* Sig at .05

The result in Table 1 shows that, there was a significant influence of perception of HIV/AIDS on health seeking behaviour among rural and urban dwellers in Nasarawa State [$R = .393$ and $R^2 = .155$, $F(1, 272) = 3.291$; $p < .05$]. Observation of coefficient of determination [$R^2 = .155$] shows that perception of HIV/AIDS significantly accounted for 15.5% of the total variance observed in health seeking behaviour among urban and rural dwellers in Nasarawa State. The result of the beta weight [$\beta = -.109$, $t = -1.814$; $p < .01$] shows that urban and rural dwellers in Nasarawa State significantly have negative perception and as such, scored less on health seeking behaviour. Based on this result, hypothesis 1 which stated that 'there will be a significant influence of perception of HIV/AIDS on health seeking behaviour among rural and urban dwellers in Nasarawa State' was therefore accepted.

Hypothesis 2:

This hypothesis stated that urban and rural dwellers will significantly differ in health seeking behaviour in Nasarawa State. This hypothesis was tested using an independent t-test and the result is presented in Table 2.



Table 2: Summary of independent t-test showing the difference in location of participants (urban and rural) on health seeking behaviour among urban and rural dwellers in Nasarawa State.

DV	Groups	N	Mean	SD	SE	T	df	p
Health Seeking Behaviour	Urban	135	36.99	12.47	1.07	-1.903	274	<.01
	Rural	141	40.14	14.96	1.26			

The result in Table 2 shows that, there was a significant location difference in health seeking behaviour among urban and rural dwellers in Nasarawa State [$t(274) = -1.903$; $p < .01$]. Observation of the mean difference shows that participants in rural areas (Mean = 40.14; SD = 14.96) significantly scored higher on health seeking behaviour than their urban counterparts (Mean = 36.99; SD = 12.47). Based on this result, hypothesis two which stated that 'urban and rural dwellers will significantly differ in health seeking behaviour in Nasarawa State' was therefore accepted.

Hypothesis 3:

This hypothesis states that there is a significant relationship between the age of participants on health seeking behaviour among urban and rural dwellers in Nasarawa State. This hypothesis was tested using an independent t-test and the result is presented in Table 3.

Table 3: Summary of Pearson's Product Moment Correlation showing the relationship between age and health seeking behaviour among rural and urban dwellers in Nasarawa State.

Variable	Mean	SD	r	df	P
Age	31.95	12.27	.004	267	>.05
Health Seeking Behaviour	38.60	13.86			

The result in Table 3 shows that, there was no significant relationship between age and health seeking behaviour among urban and rural dwellers in Nasarawa State [$r(267) = .004$; $p > .05$]. Based on this result, hypothesis three which stated that 'there will be a significant relationship between age of participants on health seeking behaviour among urban and rural dwellers in Nasarawa State' was therefore rejected.

Discussion

This study was conducted to investigate perception and demographic factors as determinants of health seeking behaviour among urban and rural dwellers in Nasarawa State, Nigeria. Three hypotheses were formulated and tested and the results are presented in the previous section. The first hypothesis which stated that there will be a significant influence of perception of HIV/AIDS



on health seeking behaviour among rural and urban dwellers in Nasarawa State was tested using simple linear regression and the result showed that, urban and rural dwellers significantly have negative perception towards HIV/AIDS in Nasarawa State. It is important to note that, individual perception drives behaviours towards something and someone and this is determined by how the individual perceived a particular thing. For instance, if HIV/AIDS is perceived as being deadly and end of life, people will have diverse behaviours towards and some may see no need to seek health when they contract it or they may not even have the courage to avail themselves to be tested.

Moreover, it is pertinent to mention that, individual perception has the power to make or mar our activities and behaviour toward something/someone. This is why a consistent finding in this study opined that different individuals perceive HIV/AIDS to be different things to them and this kind of perception is capable of tilting their direction of behaviour in a negative direction (Tagoe & Aggor, 2019). In most cases, this kind of negative perception is informed by the knowledge an individual has about something and this is capable of making them see that in a negative direction. In their opinion, Janahi et al. (2018) opine that, even though HIV/AIDS has become a major global health problem and several efforts are being made to spread knowledge about it to the populace, majority of the people still have a negative perception about the illness and still see it as a dead end or end of their lives especially when they contract the disease. Janahi et al (2018) further concluded that, on a general note, people have negative perception of HIV/AIDS and they called for a successful control program that will limit negative perceptions and attitudes towards the disease to encourage health seeking behaviour.

The second hypothesis which stated that there will be a significant difference in the location of participants and their health seeking behaviour was tested using an independent t-test and the result showed that rural dwellers significantly scored higher on health seeking behaviour compared to urban dwellers. It has been established over time that the major factor limiting rural dwellers from seeking health has always been accessibility to health care facilities as the majority of the rural areas have limited or no facilities at all. In urban areas, most of these facilities are at their beck and call and as such, seeking health may not be an issue for them since they believe that they can always run to a health facility if they find themselves in an emergency situation. Unfortunately, if medication is delayed, there is a tendency that it will result in unfavourable outcomes (Prentice & Pizer, 2007) necessitating the need to seek health even when conditions are not blown.

This finding is further consistent with that of Elnegaard et al. (2015) who opined that, the location of an individual whether urban area or rural area had nothing to do with their tendency to seek health but the only limiting factor is the accessibility and availability of health facilities which most times could serve as a motivating factor. This is because health-seeking behaviour of an individual determines their approach toward receiving proper treatment for a disease. Pandey et al (2009) further opined that most of those in urban areas go after self-medication and as such see no need to look for a formal facility to seek health.

The third hypothesis which stated that there will be a significant relationship between age and health seeking behaviour was tested using Pearson's Product Moment Correlation and the result showed that age has no relationship with health seeking behaviour. This is an implication that, at every age in an individual life, the tendency to seek health or not is always there and there is no particular age group that has high tendency to seek health. Norimah et al (2018) confirmed that HIV/AIDS has no



respect for anyone and as such, it can affect adolescents, adults and the elderly, and as such, seeking health should not be age-related.

Conclusion and Recommendations

Based on the findings of this study, it was concluded that the perception of urban and rural dwellers in Nasarawa State significantly influences their level of health seeking behaviour. Also, rural dwellers in Nasarawa State significantly scored higher on health seeking behaviour than their urban counterparts. Lastly, there is no significant relationship between the age of urban and rural dwellers and their health seeking behaviour in Nasarawa State.

Based on the findings of this study, it is therefore recommended that there is a need for an appropriate education program for the entire population in Nasarawa State to enable them to change their perception towards HIV/AIDS as this will go a long way in encouraging them to seek health and help themselves including their loved ones. In schools, peer education clubs need to be established to provide education on how to protect oneself, for example, condom management. This will lead to adequate prevention and control measures toward HIV/AIDS.

Furthermore, there is a need for more awareness programs particularly in urban areas on the dangers of self-medication as this is one of the major reasons why the majority of urban dwellers have difficulties seeking proper healthcare. This can be done by including edutainment-education through entertainment program on HIV/AIDS in the curriculum of higher institutions of learning and this will be done not just in urban areas but in rural areas.

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