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Original Research Article

Healthcare seeking practices of People Living with HIV and AIDS (PLHIV) in Bangladesh

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ABSTRACT

Aim: To explore the dynamics of healthcare seeking practices of people living with HIV and AIDS and examine the major socio-demographic factors determining their healthcare choices in Dhaka, Bangladesh.
Background: This study is about exploring the healthcare seeking practices of People Living with HIV and AIDS (PLHIV) in Bangladesh.
Materials and methods: The study employed both quantitative and qualitative methods of data collection. Samples were selected purposively using snowball sampling procedure for the survey. A total of 100 PLHIV were interviewed for the survey and 20 case studies were conducted for exploring the meaning, context and reasons for healthcare choices.
Results: Results of the study reveal that the socio-demographic and socio-economic status of PLHIV has a relation with healthcare seeking choices. In the study 'perceived barriers' emerged as determining factors in seeking health services by the PLHIV. Knowledge of the PLHIV on HIV/AIDS and STDs was found moderately high.
Conclusion: The state should play an active role in providing HIV/AIDS health services for the PLHIV with the help of monitoring and assessing the integrative performances of health practitioners directed by health ministry and local administration.
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1. Introduction

Acquired Immune Deficiency Syndrome (AIDS), caused by the Human Immune Deficiency Virus (HIV), is the most devastating epidemic of today and has spread relentlessly around the globe smashing all the development initiatives organized by the states. Globally, 34.0 million [31.4–35.9 million] people were living with HIV at the end of 2011 [1]. Worldwide, the number of people newly infected continues to fall: the number of people (adults and children) acquiring HIV infection in 2011 was 20% lower than in 2001. In 2011, 1.7 million people died from AIDS-related causes worldwide. This represents a 24% decline in AIDS-related mortality compared with 2005 when 2.3 million deaths occurred [1]. The number of people already newly infected is continuing to decline across the globe, but national epidemics continue to expand in many parts of the world. Bangladesh, being one of the world's most densely populated countries and being surrounded by the HIV infected countries, is highly susceptible to HIV transmission. In Bangladesh, the estimated number of HIV/AIDS remains at 7500 [2]. In 2011 the National HIV/AIDS and STDs Program (NASP) informed that there were 445 newly reported cases of HIV and 251 new AIDS cases, while 84 people had died. Thus the cumulative number of reported HIV cases till date in Bangladesh stands at 2533, AIDS cases at 1101 and deaths at 325 [2].

Bangladesh is dramatically located in a conflux of geographical proximity and geo-political disadvantaged position promoting risk practices and health hazards. The needs and desires of PLHIV are not addressed in an integrated and comprehensive manner, not even assessed on the basis of positive portrayal of the victim. Healthcare seeking practices of PLHIV are determined by the availability and accessibility to treatment and testing facilities. Prior to perceive the fact of being infected with HIV positive the infected people take medicine and counseling from the nearest drug store and very often go to traditional healers and unqualified practitioners [3]. Many studies have concentrated that PLHIV are satisfied with treatment and care from NGO clinics and to some extent from government hospitals. Organizational guidelines of organizations providing services to PLHIV may differ greatly between the different organizations, which are supported by the

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government and other donor agencies. In Bangladesh PLHIV may encounter social discrimination which creates serious problem in obtaining the requisite service and support [4]. Lots of sources of illegal entrance and exit tantalize the current status of export-import trade keeping a severe threat to national economy and risk practices. With the direct supervision of society and state, sex trade has ushered in Bangladesh from the nineteenth century and still keeps the country more vulnerable to health risks. In order to conceptualize and measure the nature and status of HIV related services the researcher has kept in mind the contradictory patterns of services promoted by a variety of factors. So the importance of this systematic study is more rational in this geographically vulnerable situation. The major objective of this study is to explore the dynamics of healthcare seeking practices of People Living with HIV and AIDS (PLHIV) and examining the major socio-demographic factors determining their healthcare choices in Dhaka, Bangladesh.

2. Materials and methods

The study utilized both quantitative and qualitative techniques of data collection. In order to supplement the quantitative data, qualitative data were incorporated. Case studies were conducted for collecting qualitative data from PLHIV. Collecting data through survey was accomplished for exploring the healthcare seeking practices and the existing perceived barriers to HIV treatment and care. To carry out the survey a semi-structured and self-employed interview schedule was used for collecting data keeping in view the objectives of the study. The PLHIV were the population of this research work. The researcher managed to interview 100 respondents who are HIV positive. As part of collecting qualitative information the study adopted twenty cases of PLHIV. The data were collected purposively from the PLHIV who were available during the special treatment and counseling day. Dhaka, the capital city of Bangladesh was chosen as the research area for collecting data. The researcher identified some selective NGO clinics and govt. clinics working on the treatment and care of PLHIV in Dhaka city to get an overall scenario of the healthcare seeking practices of the victims. Univariate data analysis was done for presenting the findings of the study. The field work for the present study was conducted for a period of six months, from July, 2012 to December, 2012.

3. Results

3.1. Socio-demographic profile of the People Living with HIV and AIDS (PLHIV)

In the study 100 PLHIV ranging from age 17 to 58 were interviewed. Of them 67 respondents were male and 33 respondents were female. The number of male respondents seems to be higher because of their direct participation in risk practices more than the female ones. The highest number of PLHIV belongs to the intervals 30–35 and 35–40, claiming 19 and 21 respectively. On the contrary 33.33 percent female PLHIV belongs to less than 25 year which indicates a vulnerable stage of women (Table 1).

The average age of the respondents was 35.9 years with a standard deviation of 7.30. A large number of the PLHIV (62 percent) remains married in the study which is another important socio-demographic factor. The outstanding character of marital status was separated life (16 percent) of the PLHIV, the concern goes 09 percent of the respondents who are widowed having lost their husband in an immature age. Around 59 percent of the PLHIV hails from village area who are compromisingly concerned with working facilities in foreign countries and urban areas of the respective living place. Of the PLHIV 26 percent of the respondents assert them as city dwellers who are at most risk in terms of health related hazard. Only 15 percent of the PLHIV lived in Upazilla sadar of the country. An astounding majority of the PLHIV (92.0 percent) was Muslim and the rest of them was Hindu. This figure is also congruent with the national statistics of Bangladesh. The majority of the population of Bangladesh (about 88 percent) is Muslim [5].

Table 1
Distribution of the PLHIV by socio-demographic characteristics.

Characteristics	Male (%)	Female (%)	Total (%)
Age (in years)			
<25	02 (2.99%)	11 (33.33%)	13 (13.0%)
25–30	09 (13.43%)	08 (24.24%)	17 (17.0%)
30–35	15 (22.39%)	04 (12.12%)	19 (19.0%)
35–40	15 (22.39%)	06 (18.18%)	21 (21.0%)
40–45	11 (16.42%)	04 (12.12%)	15 (15.0%)
45+	15 (22.39%)	00 (0.0%)	15 (15.0%)
Marital status			
Single	11 (16.41%)	01 (3.03%)	12 (12.0%)
Married	45 (67.16%)	17 (51.51%)	62 (62.0%)
Separated	10 (14.93%)	06 (18.18%)	16 (16.0%)
Widowed	01 (1.49%)	08 (24.24%)	09 (9.0%)
Deserted	00 (0.0%)	01 (3.03%)	01 (1.0%)
Place of living			
City	15 (22.39%)	11 (33.33%)	26 (26.0%)
Upazilla	12 (17.91%)	03 (9.09%)	15 (15.0%)
Village	40 (69.70%)	19 (57.57%)	59 (59.0%)
Religion			
Islam	61 (91.04%)	31 (93.93%)	92 (92.0%)
Hindu	06 (8.96%)	02 (6.06%)	08 (8.0%)
$N = 100$	67 (100.0%)	33 (100.0%)	100 (100.0%)

3.2. Knowledge and awareness

The study explores the level of knowledge of the respondents as to HIV/AIDS using a scale of knowledge-measurement. A set of fourteen questions about knowledge and awareness of HIV/AIDS and STDs was asked to each of the victims in order to measure their knowledge level. The PLHIV who answered ten to fourteen questions correctly were placed in the high level of knowledge, whereas PLHIV who could answer one to six questions correctly were placed in low category of knowledge. The PLHIV who were supposed to answer seven to nine questions correctly were counted as the medium level knowledge holders in this scale. The level of moderate knowledge has been dominated by fifty seven percent of the PLHIV while thirty seven percent of respondents had high knowledge of HIV/AIDS. Only six percent of the respondents demonstrated a poor level of knowledge (Table 2).

Ninety-eight PLHIV asserted that practicing safe sex (condom use) was one of the major criteria of combating HIV/AIDS. Eighty-five respondents out of 100 PLHIV confirmed that pure blood transfusion was a major determinant of preventing HIV. Anti-drug, a remedy of combating HIV and AIDS was supported by 64 respondents. The practice of keeping single sexual partner

Table 2
Awareness of combating HIV and AIDS by sex.[a]

Combating HIV/AIDS	Male	Female	Total
Practicing safe sex (condom use)	66	32	98
Keeping single sexual partner	22	09	31
Taking pure blood	58	29	87
Anti-drug	42	22	64
Self-medication	23	12	35
Homeopathic treatment	16	10	26
Herbal practice	15	06	21

[a] Multiple responses.

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