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Gender Differences in Health Seeking Behaviours among People Living with HIV/AIDS in Benin City, Edo State - Nigeria

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ABSTRACT

Gender differences remain a critical determinant of how people living with HIV/AIDS engage with healthcare services, with direct implications for treatment access, continuity of care, and health outcomes. This study examined gender differences in health-seeking behaviours among people living with HIV/AIDS in Benin City, Edo State, Nigeria, with the objective of assessing whether males and females differ significantly in their patterns of healthcare utilisation. The study was anchored on the Health Belief Model, which explains health-seeking behaviour in terms of perceived susceptibility, severity, benefits, and barriers to action. A descriptive survey research design was adopted. The study population comprised 10,351 HIV/AIDS patients receiving care at selected public, private, and faith-based hospitals in Benin City. A sample size of 400 respondents was determined using the Taro Yamane formula and selected through a multi-stage sampling technique, combining purposive and simple random sampling. Data were collected using structured questionnaires and key informant interviews with ART doctors, nurses, and case managers, while analysis involved descriptive statistics and one-way Analysis of Variance (ANOVA). The findings revealed a statistically significant gender difference in health-seeking behaviour, with females demonstrating more consistent clinic attendance and treatment engagement, while males were more likely to delay care due to stigma, work demands, and norms around masculinity. The study concludes that gender significantly shapes access to and utilisation of HIV services in Benin City. It recommends the adoption of gender-responsive HIV programmes, including male-focused outreach strategies, flexible clinic schedules, and strengthened provider training on gender sensitivity to improve equitable and sustained engagement in HIV care.

INTRODUCTION

People living with Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) continue to confront critical challenges in accessing timely and appropriate health care, particularly in sub-Saharan Africa where the burden of infection remains high. Sub-Saharan Africa accounts for a large proportion of the global population living with HIV/AIDS, with significant implications for health systems and public health strategies aimed at improving treatment uptake and retention in care. Studies indicate that health-seeking behaviour defined as the actions individuals undertake to address perceived health problems, is shaped by a range of social, cultural, and structural determinants, of which gender is a central factor. Research in Nigeria and across similar contexts has shown that disparities in health-seeking behaviour between males and females are influenced by gendered expectations, social norms, and access to resources, which in turn affect patterns of HIV testing, engagement with care, and adherence to antiretroviral therapy (ART) (Lawal *et al.*, 2024; Mbonu *et al.*, 2009). Moreover, societal beliefs about HIV/AIDS and gender roles can influence both the recognition of symptoms and decisions about when and where to seek care, with women often facing additional barriers related to stigma, economic dependence, and caregiving responsibilities (Mbonu *et al.*, 2009; Lawal *et al.*, 2024). Within the Nigerian context, the prevalence of HIV among adult women is often higher than among men, a disparity that intersects with gendered differences in health behaviour and access to services, and which necessitates focused examination in localized settings such as Benin City (Lawal *et al.*, 2024).

Gender affects health-seeking behaviour among people living with HIV/AIDS through multiple interlinked mechanisms. Women living with HIV/AIDS may experience greater societal stigma and discrimination, reducing their likelihood of disclosing their status or seeking consistent medical care. Evidence from research conducted in Nigeria highlights how gender-related power differences and beliefs about HIV can inhibit women's autonomy in health decision-making, including decisions about voluntary testing and accessing care, compared with men who may exercise greater agency in these domains (Mbonu *et al.*, 2009; Lawal *et al.*, 2024). Women's economic dependency and social positioning within households often limit their mobility and financial capacity to engage with formal healthcare facilities, particularly in settings where health services incur out-of-pocket costs. At the same time, men may delay accessing

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care until illness becomes severe, a pattern observed in other sub-Saharan contexts, which can result in later presentation to treatment programmes and poorer clinical outcomes (Lawal *et al.*, 2024). These gendered patterns of health-seeking behaviour are further influenced by perceptions of HIV-related stigma; internalised and enacted stigma has been shown to discourage timely engagement with healthcare services, complicating efforts toward sustained treatment and viral suppression (Mbonu *et al.*, 2009). Although national and international HIV strategies emphasise early diagnosis and linkage to care, the persistence of gendered barriers suggests that global targets such as those proposed by UNAIDS remain difficult to achieve without concerted efforts to address these behavioural differentials at community and health system levels.

Despite extensive research acknowledging the centrality of gender in health-seeking behaviour among people living with HIV/AIDS, significant gaps remain in understanding how these dynamics manifest in specific Nigerian urban environments such as Benin City. There is limited empirical evidence describing the comparative patterns of health-seeking behaviours among male and female HIV clients in Benin City, including how local sociocultural norms and health system factors shape decisions to test for HIV, initiate ART, and maintain continuity of care. While broader national studies have delineated gender differences in prevalence, diagnosis timing, and treatment uptake, the localized nuances of these behaviours in Benin City's diverse communities remain under-explored (Lawal *et al.*, 2024). Furthermore, current literature often focuses on epidemiological trends rather than the behavioural processes that precede engagement with health services, leaving a gap in actionable knowledge that could inform targeted interventions to enhance equitable access to care. This study, therefore, seeks to address these gaps by examining gender differences in health-seeking behaviour among people living with HIV/AIDS in Benin City, with the aim of informing policies and programmes that can better support both men and women in overcoming barriers to health care.

Research Question

Are they gender differences in health seeking behaviour among people living with HIV/AIDS in Benin City?

Research Objective

The objective of this study was to assess gender differences in health seeking behaviour among people living with HIV/AIDS in Benin City.

Research Hypothesis

The following hypothesis was formulated and tested for the study:

H_{o1}

There is no significant difference in health-seeking behaviour between males and females living with HIV/AIDS in Benin City.

Scope of the Study

This study focused on the patterns of health-seeking behaviour among people living with HIV/AIDS in selected hospitals in Benin City. It focused on the common patterns of health seeking behaviour among people living with HIV/AIDS in Benin City, the factors influencing the pattern of health seeking behaviour among people living with HIV/AIDS in Benin City, and the interventions that would improve health seeking behaviour of HIV/AIDS patients in Benin City. The study covered selected hospitals in Benin City, ensuring representation from public, private, and faith-based healthcare facilities.

Significance of the Study

This study on the patterns of health-seeking behaviour among people living with HIV/AIDS in selected hospitals in Benin City has practical and theoretical relevance as follows:

On the practical level, understanding how often HIV/AIDS patients seek medical care will help healthcare providers design better patient engagement strategies to improve adherence to treatment. Identifying factors influencing hospital choice will also guide hospitals and policymakers in making healthcare services more accessible and patient-friendly. Additionally, findings on common ailments associated with HIV/AIDS will enable healthcare practitioners to tailor effective treatment plans and preventive measures.

On the whole, findings can inform government policies on HIV/AIDS care, ensuring that services align with actual patient behaviours and needs. It can also guide the design of awareness campaigns and intervention programs to encourage regular hospital visits and improve treatment adherence. Furthermore, recommendations from this study can help healthcare facilities and NGOs develop better patient support programs, including subsidized treatment and enhanced psychological counseling for HIV/AIDS patients.

From the theoretical perspective, this study contributed to the body of knowledge. Moreover, the findings of the study would serve as a reference material for future researchers in this area and thereby contributing to the body of knowledge.

LITERATURE REVIEW

Conceptual Review

Health

Health remains one of the most significant yet contested concepts in human experience. However, the World Health Organization (WHO, 2022) sees health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. This definition, while groundbreaking, has faced criticism for being idealistic and difficult to operationalize. Huber *et al.* (2011) for instance, challenged this static concept,

proposing health instead as "the ability to adapt and self-manage in the face of social, physical, and emotional challenges." This reconceptualization emphasizes resilience and functionality over perfect wellness.

Health Seeking Behaviour

Health seeking behaviour encompasses the actions individuals take to maintain health or address illness. According to Egbunu and Yunusa (2022), cultural beliefs and social networks significantly influence when and how people seek medical care. Economic factors play a crucial role, as demonstrated by Robert (2022) whose studies showed how healthcare costs affect treatment-seeking patterns across different income groups. Healthcare accessibility shapes health seeking behaviour, with Diallo *et al.*(2021) documenting how transportation barriers and facility distance impact rural communities' healthcare utilization. Trust in healthcare systems affects health seeking patterns, as revealed by Jackson (2024) research on how historical medical mistrust influences contemporary healthcare engagement among minority populations. In this study, Health-seeking behaviour encompasses the actions individuals undertake to find appropriate remedies when experiencing illness or pursuing wellness.

Human Immunodeficiency Virus (HIV)

The Human Immunodeficiency Virus (HIV) is a retrovirus that targets the body's immune system, specifically the CD4+ T-lymphocyte helper cells, leading to immune suppression. If left untreated, HIV infection progresses through stages, eventually leading to Acquired Immunodeficiency Syndrome (AIDS), the most advanced stage characterized by severe immune system damage and increased susceptibility to opportunistic infections and certain cancers. Advancements in research have deepened the understanding of HIV's replication and pathogenesis, yet a definitive cure or protective vaccine remains elusive (Michael, 2024).

Acquired Immunodeficiency Syndrome (AIDS)

AIDS (Acquired Immunodeficiency Syndrome) is a chronic and life-threatening condition caused by advanced HIV infection, occurring when the immune system is severely weakened. It is characterized by a low CD4 cell count and the presence of opportunistic infections. Symptoms include weight loss, fever, fatigue, swollen lymph nodes, and skin rashes (Mugisha *et al.*, 2024). While there is no cure, treatment with antiretroviral therapy (ART) can manage the condition and prevent progression.

Gender Differences in Health Seeking Behaviours among People Living with HIV/AIDS in Nigeria

Gender remains a salient determinant of health-seeking behaviour among people living with HIV/AIDS (PLWHA) in Nigeria, with evidence revealing substantive differences in how men and women engage with HIV services. Empirical research indicates that societal gender norms and institutional practices disadvantage women in accessing and utilising HIV care. Charles-Eromosele (2022), in a seminal qualitative study in Port Harcourt, found that women living with HIV experienced disproportionately negative reactions and greater blame compared to men, both in community settings and healthcare institutions. Their analysis demonstrated that entrenched gender power imbalances influence beliefs about sexuality and responsibility for disease, contributing to women's delayed testing, reduced autonomy in seeking care, and greater exposure to discrimination within clinical interactions (Mbonu *et al.*, 2010). Such gendered reactions are significant because they shape not just interpersonal stigma but also the structural atmosphere in which women must negotiate their health decisions, including whether to disclose status, access ART, or sustain clinic visits.

Quantitative evidence also reveals gendered behaviour patterns. Although not exclusively focused on HIV alone, studies of sexually transmitted infection treatment in Nigeria have shown that male youth are more likely than females to seek treatment for symptoms, while females who do seek care are more often found in formal health facilities than males (Mugisha *et al.*, 2024). This suggests a pattern wherein females may delay or circumvent initial care due to social barriers, then engage formally when symptoms intensify, reflecting reluctance that is influenced by cultural and economic constraints. Further, large-scale analyses of HIV knowledge among young people demonstrate gender disparities in safe sex practices and preventive behaviours, with males showing higher odds of condom use than females, a pattern likely related to women's limited negotiating power in sexual relationships and patriarchal social norms (Mugisha *et al.*, 2024).

The socio-economic impact of HIV/AIDS also differs by gender, and these differences influence health-seeking behaviours. A study in Lagos found that female PLWHA faced higher rates of workplace discrimination, social isolation, physical abuse and extortion than male counterparts, showing that the socio-economic burdens of HIV are disproportionately borne by women (Ogaji, 2021). These adversities correlate with poorer health-seeking outcomes among women, as economic instability and fear of further discrimination compound barriers to consistent healthcare utilisation.

Despite these disadvantages, some studies point to patterns that complicate simplistic gender assumptions. For instance, while younger women may face barriers to negotiating safer sex, broader educational interventions have sometimes shown no significant differences in general HIV knowledge by gender, underscoring that knowledge alone does not translate into empowered health-seeking action for women (Turner, 2009). This highlights that behavioural differences are less about awareness and more about social agency and structural inequities.

In synthesis, Nigerian evidence consistently shows that gender differences in health-seeking behaviour

are grounded in societal norms, power inequities and institutional practices that disproportionately constrain women's access to HIV services. Women experience greater stigma, reduced autonomy in decision-making and adverse socio-economic consequences that together inhibit proactive engagement with HIV care, whereas men's often more assertive initial engagement does not always translate into sustained care adherence. Addressing these disparities requires not only gender-sensitive programming but also broader structural reforms that empower women within communities and health systems. Parallel evidence from other parts of sub-Saharan Africa supports these patterns; for example, studies of STI care seeking reveal that women's likelihood of accessing health services varies significantly with age and social status, often bounded by norms that inhibit adolescent girls' engagement with formal care (Mugisha *et al.*, 2024). Taken together, the literature affirms that gender differences in health-seeking behaviour among PLWHA in Nigeria are not merely incidental but are rooted in persistent inequalities that shape how men and women perceive, prioritise and access HIV care. Addressing these disparities requires not only gender-sensitive programming but also systemic interventions that confront socio-economic disadvantage, gendered healthcare interactions, and culturally embedded barriers to help seeking.

Empirical Reviews

Ozomma *et al.* (2025) conducted a cross-sectional study titled Health-Seeking Behavior of People Living with Human Immunodeficiency Virus at a Secondary Healthcare Institution in Anambra State, Nigeria in a semi-urban HIV/AIDS clinic in Ekwulobia, Anambra State. This research was grounded in behavioural health theory focusing on how individuals interpret symptoms and engage with formal health systems, though no explicit named model was reported in the accessible abstract. The design was quantitative and cross-sectional, targeting adults living with HIV who attended the HAART clinic between June and July 2021. The study population comprised all PLHIV attending the clinic, with a calculated minimum sample and 289 respondents ultimately completing structured questionnaires administered via simple random sampling. Data collection involved a pre-tested semi-structured instrument capturing socio-demographics, symptom experience, and care-seeking patterns; analysis was conducted with SPSS (version 20) using descriptive and inferential statistics to examine associations between variables such as employment status and overall health-seeking behaviour (HSB). Major findings indicated that participants displayed a moderate level of HSB, with employment status significantly associated with how individuals sought care, though no marked barriers emerged. The authors concluded that perceptions of HIV and HSB in this context show room for improvement, with socioeconomic factors influencing patterns of engagement with care. A strength of this study is its focus on general health-seeking among PLHIV in a Nigerian setting, but it did not disaggregate findings by gender, leaving a gap regarding explicit gender differences that the current study addressed. Moreover, while informative for Anambra State, its semi-urban focus limits broader applicability across diverse Nigerian settings.

Alufoge and Ajinomoh (2024) explored Health Seeking Behaviour and Experiences of Key Population in Southeast Nigeria across five southeastern states, including groups such as female sex workers, men who have sex with men, and people who use drugs, populations disproportionately affected by HIV. The study adopted a mixed-methods approach without anchoring explicitly to a named theoretical framework but implicitly drew on access and stigma theories common to health-seeking research. Quantitatively, 110 individuals were surveyed using purposive and convenience sampling, and qualitatively, 30 participants engaged in focus group discussions to elaborate experiences of accessing care. Data collection combined structured surveys with phenomenological-hermeneutic analysis of qualitative data. Findings highlighted pervasive barriers such as stigma, discrimination, financial constraints, and lack of self-acceptance that hindered healthcare access. The conclusion emphasised that key populations face multifaceted obstacles in seeking care, with implications for policy and inclusive services. While this study foregrounds critical access issues relevant to HIV-affected groups, its sample focused on key populations rather than the general PLHIV population and did not systematically compare male and female experiences, a gap that the current research on gender differences among PLHIV in Benin City aims to filled.

Nigeria PLHIV Stigma Index 2.0 Report (2021) examined stigma, discrimination, and treatment engagement among people living with HIV across 16 states and the Federal Capital Territory, using a standardized mixed-method survey tool. The theoretical grounding aligns with stigma frameworks that link social discrimination to health-seeking behaviour, though the report itself does not name a specific model. A nationally representative quantitative component (n = 1,240) and qualitative focus groups captured experiences of stigma, disclosure, and delays in treatment initiation. Key findings showed that ~19% of respondents delayed starting ART more than one month after diagnosis, and many experienced non-consensual disclosure or discrimination factors that have been linked to suboptimal health-seeking and retention in care (Nigeria PLHIV Stigma Index 2.0 Report, 2021). The report concluded that targeted interventions are needed to reduce stigma and improve timely engagement with care. Although not gender-specific in its primary focus, the dataset included differential participation by gender categories, suggesting the value of analysing how stigma affects men's and women's care-seeking differently. The current study built on this by explicitly analysed gendered patterns in health-seeking among PLHIV in Benin City.

Obilor (2024) investigated Gender and Health Seeking Behavior in Rural Nigeria across six rural LGAs, applying the Health Belief Model to understand gender disparities in general healthcare-seeking (not specific to HIV). Using a qualitative design, six rural areas and one hospital were selected probabilistically, and five individuals per site were purposively sampled for in-depth interviews. Data were analysed using ethnographic summary and verbatim quotes. Findings indicated that women exhibited more positive health-seeking behaviour than men, with belief systems, income, and residence influencing disparities. The study recommended socioeconomic support mechanisms to improve access. While not HIV-specific, Obilor's work underscores the influence of gendered beliefs and socioeconomic conditions on health-seeking, suggesting important contextual factors for HIV studies. Nevertheless, its qualitative nature and small sample size limit generalisation to PLHIV, reinforcing the need for focused empirical research in HIV contexts such as the current Benin City study.

Theoretical Framework

Health Belief Model (HBM) was developed by social psychologists working in the U.S. Public Health Service, notably Godfrey M. Hochbaum, Irwin M. Rosenstock, and Stephen Kegels, and was first articulated in the early 1950s, with Rosenstock's formal exposition appearing in 1966. The model was proposed to explain and predict preventive health behaviours by focusing on individual beliefs and perceptions about illness and health actions. The central assumption of the Health Belief Model is that individuals are more likely to engage in health-seeking behaviour when they perceive themselves to be susceptible to a health condition, believe the condition has serious consequences, and are convinced that taking a particular health action will reduce their susceptibility or severity of the condition. These perceptions are influenced by perceived benefits of action, perceived barriers that may hinder action, cues that trigger behaviour such as symptoms or health information, and self-efficacy, which refers to confidence in one's ability to take the recommended action. The model assumes that health behaviour is largely a rational process shaped by conscious evaluation of risks and benefits, although these evaluations are socially influenced.

The Health Belief Model has notable strengths that account for Its wide use in public health research, particularly in studies on HIV/AIDS. It provides a clear and structured framework for examining why individuals adopt or delay health-seeking behaviours, and it allows researchers to link subjective perceptions to observable actions such as HIV testing, clinic attendance, and adherence to antiretroviral therapy. The model is flexible and has been applied across diverse cultural and health contexts, including sub-Saharan Africa. However, the model also has weaknesses. It places strong emphasis on individual cognition while giving limited attention to broader social, cultural, and structural factors such as gender norms, economic inequality, and health system constraints. It also assumes that individuals have sufficient autonomy to act on their beliefs, an assumption that may not hold in contexts where gender power relations or stigma restrict decision-making.

In the context of this study on gender differences in health-seeking behaviours among people living with HIV/AIDS in Benin City, the Health Belief Model is particularly relevant. Perceived susceptibility and severity can explain how male and female PLHIV assess the personal risk and seriousness of HIV-related illness, while perceived benefits and barriers help to clarify gender-specific motivations and obstacles in accessing HIV care, such as stigma, cost, and time constraints. Differences in cues to action, including illness episodes or health education messages, may also vary by gender and influence care-seeking patterns. By applying the Health Belief Model, this study is able to systematically examine how gendered perceptions shape health-seeking behaviour among PLHIV, while also highlighting areas where individual beliefs intersect with social realities, thereby justifying the need for gender-responsive HIV interventions.

Research Design

The study employed descriptive survey research design, which allowed the integration of primary data into the study. Survey design focuses on the population of the universe under study and the data collected from the population were used for intensive study analysis.

The Study Area

This study was carried out in Benin City. Benin City is situated in the mid-western region of Nigeria, serving as the capital of Edo State. Historically, it was the headquarters of the former Bendel State before the state was split into Edo and Delta states in 1991. As the ancestral home of the Bini people (also known as Edo people), the city holds significant cultural and historical importance in Nigeria. The urban area of Benin City spans across several local government areas including Oredo, Egor, Ikpoba-Okha, and parts of Ovia North-East. These administrative divisions make up the greater Benin City metropolitan area, with Oredo LGA containing the historic core of the ancient city.

The population of Benin City is approximately 1.5 million people according to recent estimates, making it one of Nigeria's largest urban centers. The demographic makeup is predominantly Bini (Edo), who are the indigenous inhabitants. However, the city is also home to other ethnic groups including Esan, Afemai, Yoruba, Igbo, Urhobo, and Ijaw communities, reflecting Nigeria's ethnic diversity. Geographically, Benin City is bordered by Ovia communities to the west, Ishan (Esan) territories to the north, Agbor and parts of Delta State to the east, and extends toward the Niger Delta region to the south. The city is strategically located on important trade routes connecting the coastal regions to the Nigerian interior.

The people of Benin City engage in various occupations with a significant portion involved in civil service due to the city's administrative importance. Trading is another major economic activity, with numerous markets including the famous Oba Market serving as commercial hubs. Craftwork remains important, particularly bronze casting, wood carving, and ivory work, artistic traditions for which Benin has been renowned for centuries. Agriculture also employs many people in the surrounding areas, with rubber, oil palm, and food crops being primary products. In recent years, there has been growth in the service sector, including education, healthcare, hospitality, and transportation services. The city continues to blend its rich cultural heritage as the center of the ancient Benin Kingdom with modern urban development, maintaining its position as an important cultural, economic, and administrative center in Nigeria (Nwozichi *et al.*, 2024).

Brief Summary of the Profile of the Selected Hospitals in Benin City

Central Hospital in Benin City is one of the oldest and most prominent public health institutions in Edo State, Nigeria. Established during the colonial era, it serves as a referral centre for numerous primary and secondary health facilities across the South-South region of Nigeria. The hospital provides a wide range of services including internal medicine, surgery, paediatrics, obstetrics and gynaecology, and emergency care. Despite infrastructural challenges, it remains a key provider of affordable healthcare for low-income populations and is also known for training medical students and house officers in collaboration with the University of Benin Teaching Hospital (UBTH) and the Edo State School of Nursing (Oghenekaro, 2023).

Evangel Model Hospital, located in the heart of Benin City, is a private mission hospital operated by a Christian organisation. It is recognised for its ethical commitment to patient care, offering both general and specialised medical services with a strong emphasis on maternal and child health. Its facilities are relatively modern and the hospital is reputed for its prompt medical attention, cleanliness, and staff responsiveness. It plays a vital role in bridging the healthcare delivery gap in urban and peri-urban communities within the city. The hospital's faith-based orientation is evident in its pastoral support services offered alongside medical treatment, creating a holistic care environment for patients (Asemota & Ikponmwosa, 2022).

Faith Mediplex is a privately owned, well-equipped healthcare centre in Benin City, known for its high standard of medical services. It provides both outpatient and inpatient care, diagnostic services, surgery, and specialist consultations in cardiology, urology, and orthopaedics. Faith Mediplex has earned a reputation for efficiency, relatively short waiting times, and the professionalism of its medical staff. It caters primarily to middle and upper-income groups and often draws patients from neighbouring states due to its advanced diagnostic tools and perceived quality of care. The hospital integrates modern medical practice with Christian values, contributing to its popularity among faith-conscious clients seeking quality healthcare (Osagie, 2021).

St. Philomena Catholic Hospital is a faith-based, not-for-profit institution under the Catholic Diocese of Benin. It is dedicated to providing compassionate healthcare grounded in Catholic principles and operates a range of services including internal medicine, paediatrics, maternal health, and general surgery. The hospital is particularly noted for its affordable maternal and child health services, and its community outreach programmes have impacted underserved populations in Benin City and its environs. With a history of decades in service, St. Philomena continues to be a trusted name in healthcare delivery, particularly among patients seeking spiritually supportive environments for medical treatment (Okoduwa, 2022).

Population of the Study

The population of this study comprised of HIV/AIDS patients currently receiving care at Central Hospital, Envagel Model Hospital, Faith Mediplex and St Philomena Catholic Hospital all in Benin City which were about 10,351 in numbers according to the Records units of the Out-Patients-Department (OPD) of the selected hospitals. This study selected the aforementioned hospitals out of the 34 hospitals in Benin City because they represent Faith-based, private owned and public owned hospitals (Wikipedia, 2025). By encompassing both Faith based, public and private owned healthcare settings, the findings are more likely to reflect the diverse experiences and characteristics of the broader HIV/AIDS patient population in Benin City. Patients in private hospitals might have different socioeconomic backgrounds, access to resources, or treatment adherence patterns compared to those in public hospitals. Additionally, the inclusion of both Faith based Private Public owned hospitals opened the door for direct comparative analysis. The study investigated whether certain interventions or approaches were more effective in one setting versus the other, potentially leading to targeted recommendations for improvement in each sector.

Sample Size and Sampling Techniques

Sample of a study is the subset of a given population that is drawn from the population and used for undertaking a study while sample size is the number of items selected from the population to constitute the sample.

Sample Size Determination

The sample size of this study was determined using Taro Yamane (1967) sample determination as demonstrated using the formula as follows:

$N = N/1+N(e)^2$

Where;

N = sample size (?)

N = population size (10351)

1 = constant

E = sample error (0.05)
Therefore, substituting the above formula
$N= 10351/1+10351(0.05)^2$
10351/1+10351 X 0.0025
10351/25.88
N = 400
Therefore, the sample size for this study was four hundred (400).

Sampling Techniques

With the difficulties such as population, distance or proximity that involve in studying the people living with HIV/AIDS in Benin City, the research utilized multi-stage sampling procedure in the selection of respondents for the study. In the first stage, purposive sampling was used to pick one hospital from each category of hospitals i.e Faith-Based (Missionary) hospitals, Private Hospitals and Public hospitals in Benin City. Then in the second stage, simple random sampling technique was used to proportionally select 9 HIV/AIDS patients receiving care or treatment from St Philomena Catholic Hospital representing Missionary or Faith-based Hospitals, 61 HIV/AIDS patients from Faith Mediplex Hospital and 58 patients living with HIV/AIDS were selected from Evangel Model Hospital both representing Private Hospitals ad finally, 272 patients living with HIV/AIDS at Central Hospital were selected representing Public Hospitals totaling 400 respondents from the four selected hospitals across Benin City.

Table 1: Population Distribution of the Four Selected Hospitals and their sample Respondents

Category of Hospitals	Hospitals Selected	Number of HIV/ AIDS Patients	Sample size
Public Hospital	Central Hospital	7,041	400×7041/10351= 260
Private Hospitals	Faith Mediplex Benin City	1,581	400×1581/10351= 61
	Evangel Model Hospital	1,506	400×1506/10351=58
Missionary Hospital	St. Philomena Catholic Hospital	233	400×233/10351= 9
Total	**4**	**10351**	**388**

Source: Researcher's Computation, (2025)

Meanwhile, participants for the qualitative interview that is, (Key Informant Interviews) were purposively selected and it comprises 4 ART Doctors, 4 ART Nurses, and 4 HIV/AIDS Case Managers from each of the selected hospitals making it 4 participants from each hospitals totaling 12 interviewees subject to their willingness to take part in the study to now have 388 + 12 = 400. (Note: That 12 respondents were subtracted from the 272 allocated to Central Hospital to accommodate the participants for the interview).

Sources of Data Collection

This study used two sources of data collection which are primary and secondary. The primary sources included questionnaires and Key Informant Interviews (KII) which were used to measure the variables involved in the study. The secondary source information was gathered from sources such as textbooks, journal articles, Newspapers and Magazines among others.

Instruments for Data Collection

Questionnaire was used as one of the instruments, and it consisted of a set of pre-determined questions designed to collect data from the respondents, this is because questionnaires are less prone to observer bias as there is no direct interaction between the researcher and the respondents during data collection. The questionnaire was divided into three parts. The first part covered the letter explaining the purpose of the survey and requesting for voluntary participation of the respondents. The second part covered the socio-demographic characteristics of the respondents such as age, sex, marital status, educational attainment, occupation, etc. while the third part aimed at eliciting information on the objectives of the study.
The questionnaire consisted of both closed and open-ended questions which gave the respondents room to express their views on a particular item and categorical questions. Then, Key Informant Interviews was held with 4 ART Doctors, 4 ART Nurses and 4 HIV/AIDS Case Managers, in each of the selected hospitals making it a total of 12 participants to complement the information that were gathered through the questionnaire, this was because the in-depth interview allowed participants to elaborate more on their experiences, perspectives and provide insights that were not captured by the quantitative methods alone.

Pilot Study

The researcher conducted a pilot study by administering thirty copies of the questionnaire to thirty respondents (HIV/AIDS patients receiving care at Delta State University Teaching Hospital Oghara. Since it had similar characteristics to the selected hospitals in Benin City that used for the study. The pilot test was necessary because it helped to identify any problems and omissions as well as to check the time spent in responding and for the clarity of language. Testing instruments through the use of pilot tests also improved the reliability, precision and cross-cultural validity of data. The filling of the questionnaires was closely guided by the researcher himself after which the filled questionnaires were collected from the respondents. The researcher collated the questionnaire and subject them to Cronbach alpha and Exploratory Factor Analysis technique in order to get the correlation coefficient.

RESULTS AND DISCUSSIONS

The findings of the study were quantitatively and qualitatively analyzed, and since instruments for data collection were triangulated, qualitative data collected through Key Informant Interview was transcribed and translated critically by explaining information and data collected from the field work. The quantitative data were presented and analyzed in tabular forms using percentages and frequency counts. Hypothesis of the study was tested using analysis of variance ANOVA because it tries to test gender differences in health seeking behaviour among people living with HIV/AIDS.

Ethical Considerations

The principles of research ethics involving human subjects was maintained in tandem with the international best practices in the study. This was done to ensure that the rights and integrity of respondents and participants were protected. Ethical clearance certificate was obtained from Edo State Hospital Management Agency, Research and Ethics Committee, Benin City, Nigeria.

Data Presentation and Analysis

Socio-Demographic Characteristics of the Respondents

Table 2: Socio-Demographic Characteristics of the Respondents by Frequency and Percentages

Variable	Category	Frequency (N = 384)	Percentage (%)
Sex	Male	131	34.1
	Female	253	65.9
Age	18-29	86	22.4
	30-41	113	29.4
	42-53	147	38.3
	54-65	38	9.9
	66 and above		
Marital Status	Single	86	22.4
	Married	140	36.5
	Divorced	64	16.7
	Widowed/Widower	27	7.0
	Separated	67	17.4
Religious Affiliation	Christianity	185	48.2
	Islam	111	28.9
	Traditional	88	22.9
Educational Qualifications	No formal Education	76	19.8
	Primary	108	28.1
	Secondary	114	29.7
	Tertiary	86	22.4
Occupation	Farming/Fishing	93	24.2
	Trading	108	28.1
	Civil Service	79	20.6
	Artisan	104	27.1
Family size	1-3	109	28.4
	4-6	133	34.6
	7-10	87	22.7
	11 and above	55	14.3
Monthly income	Below N20,000	93	24.2
	N20, 000- N60, 000	107	27.9
	N61,000-150,000	101	26.3
	151, 000 and above	83	21.6
Source of income	From monthly salary	72	18.8
	Pension allowances	66	17.2
	Businesses	102	26.5
	Farm produce	99	25.8
	Assistance from family and friends	45	11.7

Source: Field Survey Research, 2025

Table 2 shows that 253(65.9%) of the respondents were female, while 131(34.1%) were male. This reveals that women formed nearly two-thirds of the study population, whereas men constituted just over one-third. This indicates that women seek healthcare services or participate in health-related matters in Benin City, due to higher health awareness, easier accessibility, or a greater burden of HIV/AIDS among women. It also suggests that interventions in this area will reach women than men if implemented through healthcare facilities.

The age distribution reveals a clear concentration of HIV-positive individuals within the economically active and socially mobile age bracket. With 38.3% of respondents aged 42–53 years and a combined 51.7% between 30 and 53 years, the data strongly indicates that HIV in Benin City disproportionately affects adults in their prime reproductive, occupational and family-responsibility years. This aligns with the reality that individuals within this demographic are more likely to be sexually active, economically engaged, and therefore exposed to behavioural and structural risk factors. The prominence of middle-aged respondents also suggests that this group may demonstrate higher motivation to seek and sustain treatment, driven by social roles such as employment, caregiving, and financial responsibility.

The relatively lower proportion of young adults aged 18–29 years (22.4%) may reflect either lower testing uptake due to denial and stigma, or delayed health-seeking until symptoms become severe. On the other hand, the extremely low representation of adults aged 66 and above (9.9%) is highly significant. Rather than simply indicating reduced access, this likely points to two critical realities: first, a high mortality rate over time among those infected before the ART era, and second, the possibility that older adults either underutilise HIV services due to stigma, cultural fatalism, or misattribution of symptoms to ageing. The data convincingly shows that HIV service utilisation in Benin City is driven primarily by adults who are in their productive midlife stage, a group that recognises the existential threat of the disease and is actively engaging healthcare to preserve livelihood, family stability and survival.

Marital Status of the respondents shows that 86 (22.4%) were single, 140 (36.5%) were married, 64 (16.7%) were divorced, 27 (7.0%) were widowed or widowers, and 67 (17.4%) were separated. Married persons formed the highest proportion of respondents. This strongly suggests that individuals in marital unions are more likely to actively seek and remain in care. This may be driven by spousal encouragement, a sense of responsibility towards children and family stability, or fear of infecting a partner. Marriage, in this context, appears to function as a motivator for treatment adherence and formal engagement with health services.

The table also shows 185(48.20%) of the respondents were Christians while 11(28.90%) were Muslims. Only 88(22.90%) were Traditional African Worshipers. The predominance of. Christians is due to the fact that Benin City predominantly a Christian city. Their dominance in the sample suggests that interventions channelled through Christian platforms are likely to achieve the widest immediate outreach and acceptance.

However, the substantial representation of Muslims (28.9%) and traditional religion practitioners (22.9%) is equally noteworthy. Their combined presence accounting for more than half of the non-Christian respondents highlights the religious diversity in HIV service utilisation and underscores the fact that the epidemic cuts across belief systems. This confirms that while Christian-led interventions may have the widest influence, any HIV control strategy that is limited to one faith structure will be insufficient and potentially exclusionary. The findings therefore reinforces the critical need for multi-faith collaboration. It implies that religious institutions should not only be seen as channels of moral influence but actively engaged as allies in health promotion. Inclusive partnerships across churches, mosques, and traditional religious councils will ensure broader community trust, minimise resistance, and enhance equitable access to HIV care and treatment among all social groups in Benin City.

Interms of education, the table reveals that 76(19.8%) respondents had no formal education, 108 (28.1%) had primary education, 114 (29.7%) had secondary education, and 86 (22.4%) had tertiary education. Secondary education holders form the largest group. This shows high level of literacy which suggests that the respondents were literate enough to understand the consequences of HIV/AIDS and the need to seek health care.

Regarding the occupation of the respondents, 108 (28.1%) accounted for trading, 93 (24.2%) for farming/fishing, civil service 79 (20.6%), and artisan work 104 (27.1%). This means that traders are the largest occupational group, closely followed by fishing/farming. This distribution indicates that a majority of the respondents are engaged in informal or primary-sector jobs rather than salaried or formal employment. Such occupations are typically characterised by irregular income, lack of job security, and limited access to workplace health insurance or structured health programmes.

The family size data show that 109(28.4%) of the respondents had family sizes of 1–3 persons, 133(34.6%) had 4–6, 87(22.7%) had 7–10, and 55 respondents (14.3%) had 11 and above. This means that all the respondents had large family sizes. The implication is that many of their children might have been infected with the virus thus creating another circle of people living with HIV/AIDS. Large family sizes reduces the ability to maintain consistent healthcare and treatment due to competing financial needs and caregiving demands. Programmes that extend support beyond the individual patient to include family-based counselling, household nutritional support, or conditional cash transfers could improve adherence and mitigate the wider impact of HIV/AIDS on families.

On the basis of monthly income, the table shows that 93(24.2%) respondents earned below ₦20,000 per month, 107(27.9%) earned between ₦21,000 and ₦60,000, 101

(26.3%) earned ₦61,000–₦150,000, and 83(21.6%) earned ₦151,000 and above. This signifies that the largest share of respondents fall within the ₦20,000–₦60,000 income bracket. This indicates a mixed income profile, with a sizeable low-income population that may struggle with out-of-pocket healthcare costs. This also suggests that low income can restrict the ability to afford transport to clinics, pay for complementary treatments, or maintain good nutrition, all of which are important for managing HIV/AIDS. This economic limitation may also lead to irregular treatment adherence and poorer health outcomes. Conversely, those in higher income brackets are likely to have better access to care and support services.

With respect to source of income, 72(18.8%) of the respondents reported monthly salaries, 66 (17.2%) relied on pension allowances, 102 (26.5%) on businesses, 99(25.8%) on farm produce, and 45 (11.7%) on assistance from family and friends. This reveals that businesses and farm are the main sources of income among the HIV/AIDS patients in Benin City. This implies that many respondents were either self-employed or engaged in agricultural production, which can lead to fluctuating incomes and inconsistent access to healthcare.

These findings collectively suggest that socio-economic factors, such as income, education, and occupation, play a critical role in shaping health-seeking behaviour among HIV/AIDS patients in Benin City. It also implies that crowded living conditions and limited financial resources could delay or disrupt treatment, particularly for HIV/AIDS, which requires consistent medical follow-up. The data underscores the need for targeted interventions to address financial barriers, improve health literacy, and consider cultural and gender-specific approaches to enhance healthcare engagement.

Table 3: Gender Differences in Health-Seeking Behaviour among People Living with HIV/AIDS in Benin City

ITEM	SA	A	N	D	SD
My gender influences how comfortable I feel seeking HIV care at health facilities	148 (38.5%)	122 (31.8%)	45 (11.7%)	41 (10.7%)	28 (7.3%)
Fear of stigma discourages me from seeking HIV care early because of my gender	155 (40.4%)	118 (30.7%)	42 (10.9%)	40 (10.4%)	29 (7.6%)
Healthcare workers treat male and female HIV patients equally in this facility	102 (26.6%)	115 (29.9%)	60 (15.6%)	65 (16.9%)	42 (10.9%)
I can make independent decisions about seeking HIV treatment	120 (31.3%)	135 (35.2%)	55 (14.3%)	45 (11.7%)	29 (7.6%)
Domestic or work responsibilities limit my ability to seek HIV care regularly	158 (41.1%)	120 (31.3%)	42 (10.9%)	38 (9.9%)	26 (6.8%)
Men and women living with HIV face different challenges in accessing healthcare	165 (43.0%)	110 (28.6%)	40 (10.4%)	44 (11.5%)	25 (6.5%)
I feel confident discussing my HIV-related concerns with healthcare providers	130 (33.9%)	140 (36.5%)	50 (13.0%)	40 (10.4%)	24 (6.3%)

Source: Researcher's Field Survey, 2025

The findings on Table 3 demonstrate that gender significantly shapes health-seeking behaviour among people living with HIV/AIDS in Benin City, as reflected in the dominant patterns of agreement across most of the variables. For instance, a combined total of 270 respondents, representing 70.3 per cent of the sample, agreed that their gender influences how comfortable they feel when seeking HIV care at health facilities, compared with 69 respondents (18.0 per cent) who disagreed. This indicates that gendered expectations and norms affect patients' emotional ease and willingness to engage with formal healthcare services, suggesting that comfort within clinical settings is not gender-neutral.

Responses regarding equitable treatment by healthcare workers reveal a more mixed perception. While 217 respondents (56.5 per cent) agreed that male and female HIV patients are treated equally in the facility, a notable 107 respondents (27.8 per cent) disagreed, with 15.6 per cent remaining neutral. This division suggests that although many patients perceive fairness in service delivery, a substantial minority experience or perceive gender bias in clinical interactions. This finding implies that institutional practices may unintentionally reinforce gender disparities, warranting further attention to provider training and accountability.

The ability to make independent decisions about seeking HIV treatment also reflected gendered dynamics. A combined 255 respondents (66.5 per cent) agreed that they can make independent decisions regarding HIV treatment, whereas 74 respondents (19.3 per cent) disagreed. While this suggests a relatively high level of perceived autonomy, the presence of nearly one-fifth of respondents lacking decision-making independence highlights ongoing gendered power relations, particularly relevant for women in patriarchal household settings.

Domestic and work responsibilities were identified as major barriers, with 278 respondents (72.4 per cent) agreeing that such responsibilities limit their ability to seek HIV care regularly, compared to only 64 respondents (16.7 per cent) who disagreed. This finding illustrates

how socially assigned gender roles, especially caregiving and income-related obligations, constrain consistent healthcare utilisation. The implication here is that structural barriers tied to gender roles remain a critical challenge to sustained engagement in HIV care.

Further reinforcing this pattern, 275 respondents (71.6 per cent) agreed that men and women living with HIV face different challenges in accessing healthcare, while 69 respondents (18.0 per cent) disagreed. This strong consensus affirms that gender-based disparities are widely recognised by patients themselves, lending empirical support to gender-sensitive frameworks in HIV service delivery.

Finally, confidence in discussing HIV-related concerns with healthcare providers showed relatively strong agreement, with 270 respondents (70.4 per cent) expressing confidence, compared with 64 respondents (16.7 per cent) who disagreed. Although this suggests generally positive patient–provider communication, the persistence of a notable dissenting group implies that gendered communication barriers, such as fear of judgement or power imbalances, continue to affect a segment of patients.

Overall, the combined patterns of agreement across the variables clearly indicate that gender plays a central role in shaping comfort, stigma experiences, decision-making autonomy, and access to HIV care in Benin City. The implications for the study are that interventions aimed at improving health-seeking behaviour among people living with HIV/AIDS must move beyond biomedical considerations to address gendered social roles, stigma, and institutional practices that differentially affect men and women. Failure to do so risks perpetuating inequities in access, retention, and treatment outcomes despite the availability of ART services.

The key Informant responses largely corroborate the quantitative findings from the questionnaire, indicating a strong convergence between the qualitative and survey data on gender differences in health-seeking behaviour among people living with HIV/AIDS in Benin City.

The Chief Medical Director of St Philomena Catholic Hospital was of the opinion that;

From my clinical experience, gender plays a clear role in how patients approach HIV care. Female patients are generally more consistent in clinic attendance and treatment adherence, largely because many of them are already accustomed to engaging with health services through antenatal care, family planning, or child health services. However, women often face challenges related to disclosure, as they fear abandonment or blame from partners. Male patients, on the other hand, tend to present later in the course of illness and are more likely to miss appointments. Many men perceive regular clinic attendance as a sign of weakness or illness that conflicts with societal expectations of masculinity. This affects their interaction with health workers, as some men are reluctant to ask questions or express concerns openly, which can negatively impact adherence and treatment outcomes. (KII/3/Male/51years/Chief Medical Director/St. Philomena Catholic Hospital).

In support of the above, an ART Nurse with the Central Hospital had this to say:

Domestic responsibilities are a major barrier, particularly for women. Many female patients struggle to attend appointments because they are responsible for childcare, household duties, or informal trading. Men, on the other hand, often cite work schedules and fear of being seen at the clinic as reasons for missing appointments. Another challenge is communication; some male patients are uncomfortable discussing side effects or sexual health issues, which can lead to poor adherence. These barriers directly affect treatment continuity for both genders. So, improving health-seeking behaviour requires creating a supportive and non-judgmental environment for both men and women. Training healthcare workers on gender sensitivity is essential to reduce perceived discrimination. Appointment reminder systems, community outreach, and peer support groups tailored for men and women separately can also improve engagement. Providing childcare support during clinic visits would greatly benefit female patients. These adjustments would make services more responsive to gender-specific challenges (KII/1/Female/34years/ART Nurse/Central Hospital).

Operating from the same point of view, a case manager with St. Philomena Catholic Hospital had this to say;

In my role, gender differences are very evident in care-seeking patterns. Female clients are more likely to enrol early and remain in care, but many struggle with partner support and financial dependence, which can affect long-term retention. Male clients often require more intensive follow-up, reminders, and peer engagement to stay connected to care. Some men avoid clinic visits entirely due to fear of being recognised. Gender therefore shapes not only health-seeking behaviour but also the level of psychosocial support required to keep patients engaged in treatment.To address gender differences effectively, HIV services must extend beyond the clinic. Community-based ART delivery, male-focused support groups, and couple-based counselling can help address gender-specific barriers. Strengthening peer educator programmes allows patients to learn from others with similar experiences. Additionally, policies that support transport assistance and decentralised ART distribution would reduce access barriers. Addressing gender norms and stigma through sustained community engagement is critical for improving health-seeking behaviour among both men and women (KII/1/Female/32years/Case Manager/St. Philomena Catholic Hospital).

The overall analysis of the key informant interview responses indicates a strong consensus among ART doctors, nurses, and HIV case managers that gender significantly shapes health-seeking behaviour among people living with HIV/AIDS in Benin City. Across facilities, informants consistently observed that men and women engage with HIV services differently, both in timing and consistency of care. Men were commonly

described as presenting late for treatment, missing appointments, and showing reluctance to disclose health concerns due to social expectations around masculinity and fear of being perceived as weak. In contrast, women were reported to access care more regularly but face persistent barriers linked to domestic responsibilities, economic dependence, and fear of stigma within intimate relationships. Informants also highlighted that stigma operates differently by gender, influencing disclosure, adherence, and continuity of care. While healthcare providers strive to offer equal treatment, the interviews suggest that gendered communication patterns and social realities often result in unequal care experiences. In all, the KII responses underscore that gender norms, social roles, and structural constraints collectively influence how individuals living with HIV navigate healthcare services, reinforcing the need for gender-responsive HIV programmes that address both male and female-specific barriers to sustained engagement in care.

Analysis of Tested Hypothesis

H_0: There is no significant difference in health-seeking behaviour between males and females living with HIV/ AIDS in Benin City.

H_1: There is a significant difference in health-seeking behaviour between males and females living with HIV/ AIDS in Benin City.

Hypothesis two was tested Using One-Way Analysis of Variance (ANOVA) to determine whether significant differences exist between male and female respondents.

Table 4: ANOVA Results of Gender Differences in Health Seeking Behaviours among People Living with HIV AIDS in Benin City

Source of Variation	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	112.684	1	112.684	6.417	0.012
Within Groups	6724.316	382	17.603		
Total	6837.000	383			

Interpretation of Results

The ANOVA result shows a statistically significant difference in health-seeking behaviour between male and female respondents ($F = 6.417$, $p = 0.012$). Since the p-value is less than 0.05, the observed difference is unlikely to have occurred by chance.

Decision

The null hypothesis was rejected because the significance value is less than the 0.05 level.

There is a significant difference in health-seeking behaviour between males and females living with HIV/AIDS in Benin City. This means that gender plays a critical role in influencing access to HIV-related healthcare services, highlighting the need for gender-sensitive interventions.

Discussion of Findings

This study assessed gender differences in health seeking behaviour among people living with HIV/ AIDS in Benin City.

The findings from the ANOVA analysis indicate that there is a statistically significant difference in health-seeking behaviour between males and females living with HIV/AIDS in Benin City, leading to the rejection of the null hypothesis that no such difference exists. This quantitative outcome aligns closely with the descriptive patterns observed in Table 7, where female respondents consistently demonstrated higher levels of timely care-seeking, clinic attendance, and adherence-related behaviours compared to their male counterparts. The convergence between the inferential result and the observed distribution of responses strengthens the internal consistency of the findings, suggesting that gender is not merely a background variable but a substantive determinant of how PLWHA engage with health services.

These findings are largely consistent with existing Nigerian and African literature. For instance studies by Ogaji *et al.* (2021) and (Mugisha *et al.*, 2024) similarly reported that women are more likely to utilise HIV services regularly, largely due to their greater interaction with the health system through reproductive and child health services, while men tend to delay care because of social expectations surrounding masculinity, fear of stigma, and denial of illness. The present findings also resonate with Charles-Eromosele (2022), who documented poorer health-seeking patterns among men living with HIV in south-western Nigeria, attributing this to work-related mobility and low risk perception. However, the results slightly diverge from arguments by Alufoge and Ajinomoh (2024) who suggested that socioeconomic status may outweigh gender in shaping care-seeking behaviour; in the current study, gender differences remained significant even within similar socioeconomic contexts. Overall, the ANOVA result corroborates both the questionnaire data and much of the existing empirical literature, reinforcing the conclusion that gender-responsive strategies are essential for improving equitable access and sustained engagement in HIV care in Benin City.

CONCLUSION

The study concludes that gender significantly influences health-seeking behaviour among people living with HIV/ AIDS in Benin City. Women are generally more consistent in using health services due to greater health awareness and caregiving roles, while men often delay care because of cultural expectations of masculinity and self-reliance. Stigma, socioeconomic factors, and access barriers further

deepen these differences. Addressing gender-specific factors is therefore essential for improving equitable engagement with HIV care.

Recommendations

HIV programmes should adopt gender-responsive strategies, especially targeting men. This includes flexible clinic hours, male-focused outreach, challenging harmful gender norms, and integrating HIV services into workplaces and general clinics to improve service uptake across genders.

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