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Health-seeking behaviors and associated factors in individuals with substance use disorders at Chainama Hills College Hospital, Lusaka, Zambia

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Abstract

Introduction: Studies in mental health care for low-resource settings indicate that providing services at the primary care level would significantly improve the provision utilization of mental health services. Challenges related to inadequate funding were noted as significant barriers to service provision, with the contribution of low knowledge of mental health conditions and stigma in the community.

Objective: This study aimed to assess and explore health-seeking behaviors and their associated factor at Chainama Hills College Hospital (CHCH), Lusaka, Zambia. The study was conducted at CHCH on clients and/or their caregivers receiving and accessing in- and outpatient (OPD) alcohol and drug detoxification and rehabilitation services at CHCH. 79 participants took part in the study taking into consideration all ethical issues.

Methodology: Data was collected using the structured questionnaire administered to 79 participants and primary caregivers. Qualitative data was collected using in-depth interviews captured using the digital recorder. The quantitative data were analyzed using SPSS software and the digitally recorded responses for qualitative data were transcribed and analyzed using thematic analysis.

Results: Factors influencing health-seeking behavior were related to health systems, socio-cultural, socioeconomic, and individual factors. The main system issues were related to the availability and attitudes of staff and the shortage of supplies and medicines.

Conclusion: The engagement of community health workers and increasing efforts to sensitize the community about mental health would prove beneficial. Strengthening the community health systems for mental health could improve access and increase the utilization of services.

Keywords: Health-seeking behavior; Substance abuse; SUD; Addiction medicine: Addiction psychology; Community psychiatry

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1. Introduction

Substance abuse is a known and significant public health concern worldwide and is prevalent in all sectors of societies in all countries [1]. Further, substance abuse is noted to be more prevalent among young people [1]-[2]. According to Institute for Health Metrics and Evaluation (IHME), substance abuse has raised concern all over the world, and the gravity and its characteristics vary from region to region, country to country; people of all ages get affected and a significant morbidity and mortality rate has been noted [3]. According to World Health Organization (WHO) defines substance abuse as a set of related conditions associated with the consumption of mind and behavior-altering substances that have negative behavioral and health outcomes [4]. This includes the harmful or hazardous use of psychoactive substances including alcohol and illicit drugs.

The harmful use of substances particularly alcohol results in 3.3 million deaths each year and at least 15.3 million persons have drug use disorders. Injecting drug use is reported in 148 countries, of which 120 report Human immunodeficiency virus (HIV) infection among this population [5].

Globally, it is estimated that 18.5% and 6.4% of males and females respectively are affected by substance abuse and its identified as a significant contributor to new global rates of HIV/AIDS and deaths due to road injuries [3]. Global statistics further indicate that about 190 million drug users are reported each year and of them, 40 million are identified with serious drug-related illnesses or injuries. Alcohol alone is reported to contribute to 7.6% and 4% of males' and females' deaths respectively. Whereas more than 20 million are diagnosed with alcohol-related diseases such as alcohol-related injuries, alcohol dependence, liver cirrhosis, and cancers [6]. Substance abuse has also been ranked as the 4th leading cause of death with mortality rates of 33.0 percent and 6.9 percent of alcohol and illicit drugs respectively per 100,000 people [7]. Substance abuse is also associated with many social problems such as poverty, crime situations, risky behaviors, and stigmatization which are important components of mental health [2], [4].

The issue of great concern, however, is the effects of substances on developing young people, especially in their childhood and adolescent years. Childhood and adolescent years are important formative years of life during which, the child acquires academic, cognitive, social, and life skills [8]-[12]. Any substance abuse at this age is likely to interfere with normal development and may have a grave impact on the future life not only of the child but also on the family and society as a whole [13].

It is evident that substance abusers need health care services, however; the utilization of the available substance use treatment services remains unsatisfactory. Global studies on substance use services utilization rates identify a gap of 83.9 and 15.9 percent between the number of people needing treatment for substance abuse, and the number of people seeking professional and formal help [14].

In sub-Saharan Africa, the trend seems not to be different from the global trends. According to a study conducted in Rwanda to assess the help-seeking behaviors and barriers to care and self-efficacy for mental health care, the self-efficacy scale for seeking mental health care shows low confidence and poor efforts in accessing mental health care in young adults [15]. This resulted in persistent abuse of substances accompanied by several problems including academic difficulties, health-related problems, poor peer relationships, involvement with the juvenile justice system, and disputes with family members, the community, and the entire society [16].

In Zambia, Substance abuse has continued to increase causing more problems, particularly among the youths with a minority of them seeking the available health services [17]. This has led to disturbed self-esteem, poor social interaction, physical and psychological harm including chances of personal injury and self-harm, and others. Further, substance abuse has led to poor quality of life and criminal penalties.

The most abused substances include alcohol, cannabis, heroin, cocaine, and combinations of different substances [18]. Among the abused substances, alcohol, in particular, has strongly been associated with unsafe sex; spread of HIV/AIDS; loss of health due to accidents and violence; onset of chronic disease and alcoholism; gender-based violence (GBV); breakdown of family harmony; violation of rights of children and instigation of acts of crime [19]. Substance abuse has also been identified as a risk factor for premature death, liver diseases, and Non-Communicable Diseases (NCD) such as cardiovascular diseases, cancers, and mental illnesses [20].

Alcohol use disorders including alcohol dependence and harmful use of alcohol are highly prevalent among Zambians above 15 years of age WHO African Region [21]. However, despite the evident presence and experiences of substance use health and social related problems, a poor health-seeking attitude was noted. Health-seeking behavior (HSB) is defined as an activity or attempt undertaken by individuals who perceive themselves to have a health problem or to be

ill for finding an appropriate remedy. The desired HSB is responding to an illness by seeking help from a trained allopathic doctor in a recognized health care center. It is well established that HSB is influenced by the manifestation of symptoms. The HSB of a community determines how health services are used and in turn, the health outcomes of populations, and participation in treatment has generally been associated with positive outcomes among substance abusers [22]-[23]. To achieve these benefits, however, substance abusers must enter treatment in the first place which is a significant problem in many settings. However, most of the people with evident problematic drinking and abuse of substances do not realize the problem and lack the motivation to seek medical help. This is because some substances such as alcohol are socially acceptable in society and loosely regulated. It is therefore imperative for health professionals to be aware of these trends, reach out, and approach each case holistically and courteously.

In response to the increasing problem of substance abuse and its contribution to the emergence of non-communicable diseases, several strategies have been put in place to address the problem. The Government of the Republic of Zambia developed the NCD strategic plan based on the WHO Global Action Plan for NCDs 2013–2030 driven through the Ministry of Health. This is to maximize the accessibility of substance-use health services [21]. Despite considerable efforts directed towards prevention, the problem of drug and alcohol abuse has continued to rise especially among the learners in Zambia's schools who are unable to willingly seek treatment when they begin experiencing substance-related problems [19].

Other interventions include Drug and alcohol abuse awareness and prevention activities conducted by the Republic of Zambia Government Ministries/Agencies, Non-Governmental Organizations (NGOs), and religious organizations through the media and community activities. Mental health technical support is given to community-based primary health care settings to make mental health services accessible as close to their homes and family as possible as per the Ministry of Health statement. The Ministry of Health has also intensified its efforts to educate Zambians on the negative challenges through community-based psychiatric services, radio and television programs, and other print and electronic media. Treatment options are available for substance abuse, which includes psychotherapy, rehabilitation, and detoxification services.

Despite the preventive and treatment measures put in place, the number of affected individuals continued to rise and there is a perceived delay in seeking treatment by clients. This has significantly contributed to chronicity and the development of substance-induced medical conditions such as hypertension, diabetes, and liver conditions with increased mortality rates recorded. Minority individuals with substance abuse the treatment or utilize the few available services. There is a perceived delay in seeking treatment or if sought, it is aided and the reasons for not seeking treatment among individuals with substance abuse remain unclear. It is also possible that other alternative treatments are sought before formal presentation the health institutions, a reality that health professionals concerned with substance use health cannot ignore.

Health seeking behavior (HSB) is closely linked with the health status of a nation and thus its economic development. Several studies have described HSB within the context of various diseases. However, knowledge of HSB among individuals with substance abuse remains scanty. Studies have shown that receiving professional help early has been shown to reduce long-term harm associated with substance use [13]. Additionally, studies have shown delays in seeking of treatment in substance-based treatment services compromise the effectiveness of the treatment leading to poor prognosis and the development of medical and chronic psychiatric disorders [24].

According to Chainama Hills Hospital, 38.5 % on average of all admissions with substance use disorders have resulted due to delayed treatment seeking. The hospital statistics have further shown a steady increase in the number of clients presenting late for treatment to the institution resulting in the development of substance-related medical conditions and chronic psychiatric conditions [18].

Alcohol and substance use contributes significantly to most psychiatric, neurological, and medical conditions presenting in the mental, surgical, and medical emergency and critical care units and potentially can impair its outcome [25]-[31]. Taking part in treatment generally results in positive outcomes. To have treatment benefits, substance abusers seek treatment options for a better outcome. However, a majority do not seek treatment. The felt need and barriers in the treatment of substance abuse and their HSBs for treatment among individuals with substance abuse in Zambia are unexplored. Studies conducted on general medical conditions have identified good HSBs for example on tuberculosis [32]. Little is known about substance abuse hence limited references to substantiate treatment-seeking behavior for substance abuse and substance use disorders in the Zambian context. However, statistical information obtained from the clinical settings shows a steady increase in mental and behavioral disorders due to alcohol and psychoactive substance use [18].

It is against this background that this study seeks to assess the levels of health-seeking and its factors associated with individuals who suffer from problematic substance use. The findings will aid in providing a better understanding of the substance abuse situation in Zambia and put in appropriate measures. It was against this background that this study was undertaken aimed at assessing the HSB, exploring and identifying the factors influencing the seeking behaviors among individuals with substance and alcohol use disorder at CHCH in Lusaka Zambia. Understanding the HSB of substance abusers is an important link in providing effective health care for the treatment and prevention of complications of substance abuse. Therefore, this study aimed at exploring HSB among individuals with substance use disorders and associated factors. This would foster early seeking of treatment and prevent the development of chronic problems. Health workers and other stakeholders to deliver health education on alcohol will use the findings from this study and substance abuse and assist individuals in the risk category of alcohol and substance use to promptly seek treatment. The findings will also help healthcare planners and policymakers to design appropriate alcohol and substance use control programs and create behavioral change-focused programs in communities. Further, the findings will help determine appropriate health education strategies to deliver to communities to enhance the effectiveness of substance use, consumption, and distribution control efforts.

2. Methodology

The study adopted a mixed method study design. Quantitatively, an exploratory cross-sectional study design was used to explore the factors associated with HSB among individuals with substance use disorder. This was because the study was to investigate the effects of one or more independent valuables upon a dependent value of interest. This aided in establishing the relationship between the HSB, and the factors influencing it.

Qualitatively, a generic qualitative inquiry design was used. Generic qualitative inquiry investigates people's reports of their subjective opinions, attitudes, beliefs, or reflections on their experiences, of things in the outer world. The topic under study was unsuitable for or could not be adapted to the traditional qualitative designs such as case study, ethnography, grounded theory, or phenomenology. This study design was appropriate as it endeavored to understand the HSBs and their associated factors by exploring the participants' views and perceptions of the phenomena. No assumptions, philosophical or scientific theory, no deductive logic procedures, and other empirical science or psychological speculations informed the inquiry. Instead, the focus was on what was given directly to an individual's intuition. Bracketing of the work was also observed so that the researcher's individual subjectivity did not bias the data analysis and interpretations.

The study was conducted at CHCH, which is the country's mental referral hospital, and the respondents were accessed from the de-addiction units and outpatient departments. The target population comprised clients and/or their caregivers receiving and accessing in- and outpatient alcohol and drug detoxification and rehabilitation services at CHCH, Lusaka, Zambia.

All clients and/or their caregivers accessing the alcohol and drug detoxification services at CHCH de-addiction units, are available at the time of data collection and in sound mind. Caregivers included were those who would have lived with clients for a period of more than six (6) months at the time of data collection.

A purposeful sampling strategy was used to facilitate the identification and selection of participants that could provide rich data on the phenomenon of interest. This was due to the unpredictability of participants' mental states and the aspect of information reliability.

All the clients accessing the substance use health services were eligible to participate in the study. Included in particular were clients deemed stable upon passing an initial in-person mental state screening test using a standardized tool, available at the time of data collection, willing to participate, and signing the consent form. The study also included caregivers who would have lived with the client for more than six (6) months.

All the clients who were in a confusional state and who were still manifesting active psychopathological symptoms that could distort reality testing at the time of data collection were excluded.

The qualitative sample size was determined on the principle of saturation and/or until data achieve saturation. However, attention was paid to ensuring that the sample size is large enough to sufficiently describe the phenomenon of interest and address the research question at hand at the same time taking into consideration the risks of having repetitive data.

A convergent mixed method of data collection approach was applied. In this design, both forms of data (quantitative and qualitative) were collected at the same time and then integrate the information in the interpretation of the overall results.

Two standardized tools were used namely the Treatment-Seeking Motivation Tool (TSMT) and the Motivation for Treatment Tool (MTT) adapted from the institute of behavioral sciences tools. A questionnaire was developed from the selected tools, which contained both open and closed-ended.

During data collection, data on the questionnaire were reviewed for completeness and consistency on daily basis to assess its quality. The hard copies of the data collection tools were kept in a safe and secure place and disposed of by burning them after entering them into the software analysis databases. The entered information was kept on the password-secured computer. The digitally collected data was transcribed and the audio data were deleted after transcription.

The questionnaire was coded using numbers. This was done manually using physical counting and a calculator. Data was entered and analyzed using SPSS version 21. The Chi-Square test was used with a p-value of 0.05 and confidence of 95%. This was to establish the relationship between variables. Multiple regressions were used to determine the relationship between the dependent and independent variables.

To analyze the qualitative data, hyper TRANSCRBE software was used to aid in the manual transcription of audio data. QSR NVivo computer software package was used to aid in organizing and sorting the data set. The data was analyzed by thematic analysis. It consisted of five steps namely data familiarization, code generation, theme search, themes revision, and theme definition.

Integration of the quantitative and qualitative data involved the merging of results from both the qualitative and the quantitative databases. Quantitative statistical results were reported first and then discuss the qualitative findings (e.g., themes) that either confirm or disconfirm the statistical results. The integration also included a side-by-side comparison involving joining some parts of the discussion sections to supplement the findings in the quantitative data.

To ensure validity and reliability, the questionnaire relevantly covered major aspects of HSB and associated factors such as demographic, socio-cultural, and socio-economic factors. The questions were clearly stated in simple and easy-to-understand language to elicit relevant information from the respondents. In addition, the research supervisors and statistician were involved in the development of the research instrument. The pilot study was undertaken to ensure the consistency and stability of the tool. The questions were regularly reviewed for consistency on daily basis. The participants were critically assessed to ascertain their mental stability to ensure the reliability of the information. Collateral information was also collected to supplement the data through one-on-one discussions.

A pilot study was done two weeks before the actual study to ascertain the validity and reliability to help make necessary changes to the set questions and get rid of unnecessary questions in the questionnaire so that the precise scope was grasped by the respondents. It consisted of 10% of the actual study sample population.

3. Results

The demographic characteristics of the respondents are shown in table 1.

The age group 20-29 years old had the highest number of people with substance use disorders at 48.1% (38/79), the less than 19years old were 25.3% (20/79), 30-39 years were 13.9% (11/79), the 40-49years were at 8.9% (7/79) and the lowest number was among the less than 50 years old with 3.8% (3/79). On the gender aspect, the males represented the greater proportion at 82.3% (65/79) while the females were at 17.7% (14/79). The data showed that the ones who were single had the highest percentage at 70.9% (56/79), the married had 13.9% (11/79) and the separated had 10.1% (8/79), the divorced and the widowed had the lowest at 2.5% (2/80) each respectively. On the participants' level of education, 52.5% (42/79) had attained secondary school education, 31.3% (25/79) had attained tertiary education, and 15% (12/79) only attended primary school level. In addition, only1.3percentage (1/79) had never been to school. On the employment status, the highest percentage was 31.6% (25/79) for the ones who have never been employed and the lowest was 10% (7/79 for the ones that had been dismissed from work. On the duration of substance use, 78.5% (62/79) have used substances for the duration of more than two (2) years and 21.5 percent have used the substances for a duration of less than two (2) years. The statistics further showed that most of the participants had sought treatment for other medical reasons with 65.8% (52/79) who had sought treatment for stomach aches before substance use treatment and 7.6% (6/79) were the first attendants.

Table 1 Description of the participants' characteristics (N=79)

Variable	Frequency	Percentage	Cumulative Percentage
Age (n=79)			
<19 years	20	25.3	25.3
20-29 years	38	48.1	73.4
30-39 years	11	13.9	87.3
40-49years	7	8.9	96.2
>50years	3	3.8	100
Gender (n=79)			
Female	14	17.7	17.7
Male	65	82.3	100
Marital status (n=79)			
Single	56	70.9	70.9
Married	11	13.9	84.8
Divorced	2	2.5	87.3
Widowed	2	2.5	89.9
Separated	8	10.1	100
Level of education (n=79)			
Primary	12	15	15
Secondary	42	52.5	67.5
Tertiary	25	31.3	98.8
Never been to school	1	1.3	100
Duration of Substance use (n=79)			
<2 years	17	2178.5	21.5
>2 years	62		100
Treatment for medical reasons (n=79)			
None	6	7.6	7.6
Headache	8	10.1	17.7
Stomach aches	52	65.8	83.5
Cough	4	5.1	88.6
Obesity	1	1.3	89.9
Diabetes	3	3.8	93.7
Pancreatitis	2	2.5	96.2
Hepatitis	3	3.8	100
Treatment for psychological issues (N=79)			
None	33	41.8	41.8
Anxiety	7	8.9	50.6

Stress	7	8.9	59.5
Low mood	11	13.9	73.4
Depression	7	8.9	82.3
2 of the above	7	8.9	91.1
3 of the above	5	6.3	97.5
All of the above	2	2.5	100
Social and Relational Issues (n=79)			
None Conflicts with parents	4 13	5.1 16.5	5.1 21.5
Difficulties making friends	6	7.6	29.1
Difficulties in studies	2	2.5	31.6
Drug alcohol and smoking issues	52	65.8	97.5
All	2	2.5	100
Realization of problem (n=79)			
Never realized	31	39.2	39.2
Told by people	30	38.0	77.2
When started experiencing problems	18	22.8	100
Duration to seek treatment (n=79)			
Immediately problems started	14	17.7	17.7
<6 months	19	24.1	41.8
6-1 year	14	17.7	59.5
>year	18	22.8	82.3
Never	14	17.7	100
Causes of delayed for seeking of treatment (n=79)			
Distance	6	7.6	7.6
Fear of stigma	40	50.6	58.2
Lack of information	23	29.1	87.3
Lack of finances	3	3.8	91.1
Others	7	8.9	100
Source of motivation (n=79)			
My health status	14	17.7	17.7
Family and friends	48	60.8	78.5
My realization	12	15.2	93.7
A health care provider	2	2.5	96.2
Others	3	3.8	100
First treatment sought (n=79)			
Spiritual	23	29.1	29.1

Traditional	5	6.3	35.4
Professional	51	64.6	100
Source of Treatment (n=79)			
Public health facility	69	87.3	87.3
Private health facility	6	7.6	94.9
Traditional Clinics	4	5.1	100
Source of substance use information (n=79)			
Newspapers/magazines Radio/Television	6 4	7.6 5.1	7.6 12.7
Internet	19	24.1	36.7
Educational class	5	6.3	43.0
Friends and Family	45	57.0	100
Impact of Knowledge (n=79)			
Very Much	31	39.2	39.2
Much	20	25.3	64.6
Average	10	12.7	77.2
Little	8	10.1	87.3
Very little	10	12.7	100

The data also that 41.8% (33/79) of the participants had never been treated for some psychological issues while 59.2% (46/79) experienced at least one or two of the psychological issues which include anxiety, stress, low mood, and depression with the low mood being the most experiences psychological issue at 13.9%. The statistics further showed that most of the participants had drug, alcohol, and smoking issues at 65.8% (52/79) seconded by conflicts with parents.

On the realization of substance use problems, 39.2% (31/79) never realized, people made 38.0% (30/79) of the participants were aware of their problem. While 22.8% (18/79) realized that, they had the problem when they started experiencing the after-effects of substance use. Out of this population, 40.5% took more than six (6) months to seek treatment, 17.7% (14/79) sought treatment immediately after they realized the problems while the other 17.7% never sought any treatment. For those that sought treatment, 64.6% (51/79) were professional, 29.1% (23/79) were spiritual and 6.3% (5/79) were traditional. The treatment was st from the public health facilities (87.3%), private health facilities (7.6%), and traditional clinics (5.1%).

On the knowledge, participants had some knowledge obtained through friends and family members and 57% (45/79) seconded by the internet at 24.1% (19/79) with the least source being educational class and radio/television at 6.3% (5/79) and 5.1% (4/79) respectively. Data further show that the information obtained had very much impact at 39.2% (31/79), much at 25.3% (20/79), average at 12.7% (10/79) with little and very little at 10.1% and 12.7%.

The socio-cultural characteristics of the participants are presented in table 2.

The socio-cultural and socio-economic factors of the given population showed that those that belonged to extended families were 50.6% (40/79) while those from nuclear families were at 49.4% (39/79). The people that had good family support were 87.5% (70/79) while those that had poor family support were 12.5% (10/79). From the population, the ones that earned less than K3000 accounted for 66.3% (53/79) while those that earned between K3000-K5000 were 12.5% (10/79) and 21.3% (17/79) of the population were those that earned more than K5000. The Bemba tribe and others accounted for 23.8% of the population (19/80) each respectively while the Kaonde tribe had the least percentage at 1.3 (1/79). From the population, the majority of the participants were Christians 86.3 % (69/80), and 5.0% (4/80) were Islam, while 8.8% (7/80) were those that belonged to other religions.

Table 2 Socio-cultural characteristics of the participants (N=79)

Variable	Frequency	Percentage	Cumulative percentage
Family Type (n=79)			
Nuclear	39	49.4	49.4
Extended	40	50.6	100
Family support (n=79)			
Good	69	87.5	87.5
Poor	10	12.5	100
Employment status (n=79)			
Student	13	16.5	16.5
Never been employed	25	31.6	48.1
Presently employed	19	24.1	72.2
Self employed	15	19.0	91.1
Dismissed	7	8.9	100
Monthly income (n=79)			
<K3000	52	66.3	66.3
K3000-K5000	10	12.5	78.8
>K5000	17	21.3	100
Tribe (n=79			
Luvale	11	13.9	13.9
Bemba	19	24.1	38.0
Nyanja	17	21.5	59.5
Tonga	10	12.7	72.2
Lozi	3	3.8	75.9
Kaonde	1	1.3	77.2
Others	18	22.8	100
Religion (n=79)			
Christian	69	87.3	87.3
Islam	4	5.1	92.4
Others	7	7.6	100

The findings of HSBs among individuals with substance use disorders are shown in figure 1.

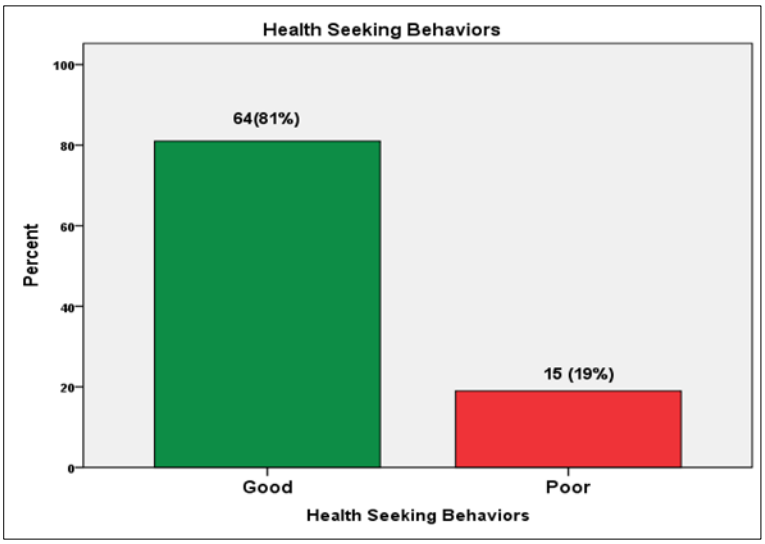

Figure 1 Health Seeking Behaviour (HSB)

The figure above shows that most participants (81.01%) had good HSB and few (18.99%) had poor HSB.

The statistics of social support for the participants are as shown in figure 2 below.

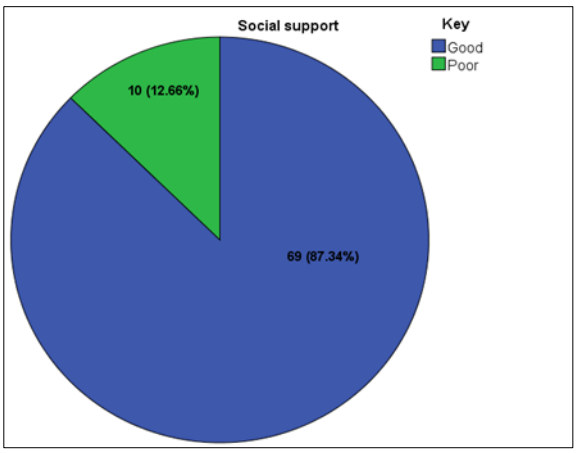

Figure 2 Social support

The figure above shows that majority 87.34% (69/79) of the participants had good social support

The findings of participants' income status are as shown in figure 3 below.

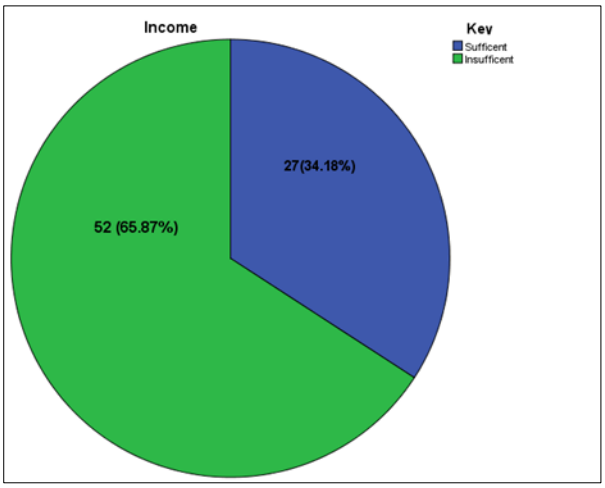

Figure 3 Income status of the participants

In figure 3 above, the statistics show that 65.87% (52/79) had insufficient income. This indicates that the earning below 5,000. While 34.18% (27/79) had sufficient income, which implies that, they earned a monthly income of less than 5,000.

Figure 4 below shows the results of the health care services accessibility for substance abuse. 88.61% (70/79) had easy access to the services and 11.39% (9) found it difficult to access substance use health services.

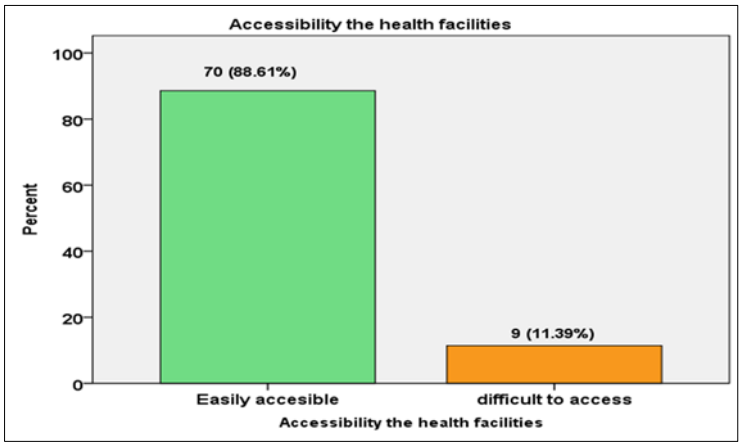

Figure 4 Accessibility of substance use health care services

The findings on the cultural beliefs influence of participants towards HSB-seeking substance abuse are presented in figure 5 below. Cultural beliefs of 82.28% (65/79) participants had weak influence on the participant HSBs while 17.72% (14/79) played a role in the use of the substances and eventually the seeking of treatment.

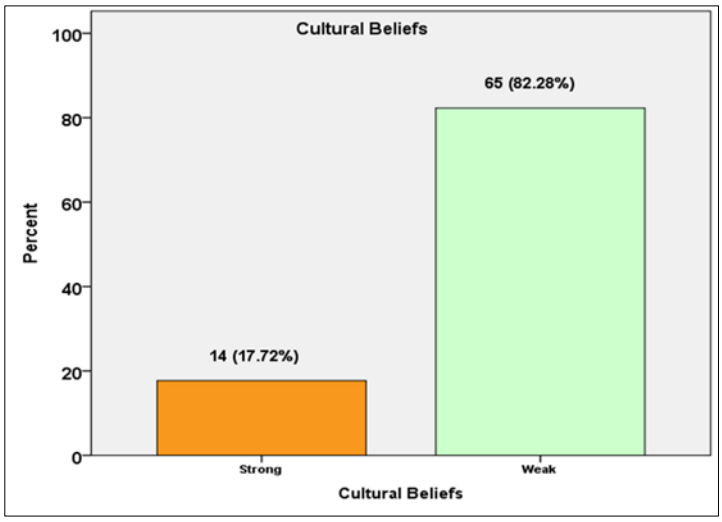

Figure 5 Cultural beliefs' influence

Figure 6 below shows the results for the knowledge of the participants on substance abuse and its consequences. The majority of the participants, 70.89 (56/79), had adequate knowledge of substance abuse including its consequences while 29.11% (23/79) had inadequate knowledge.

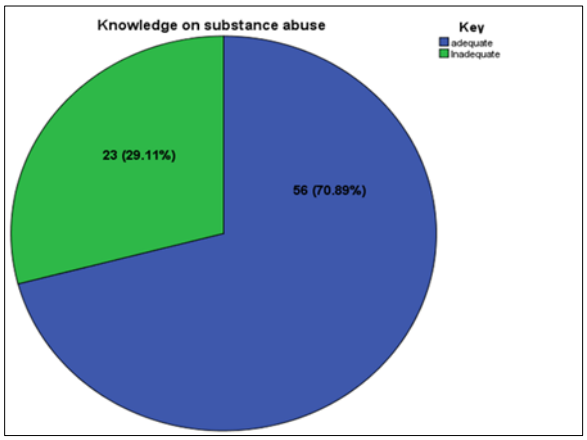

Figure 6 Knowledge on Substance abuse

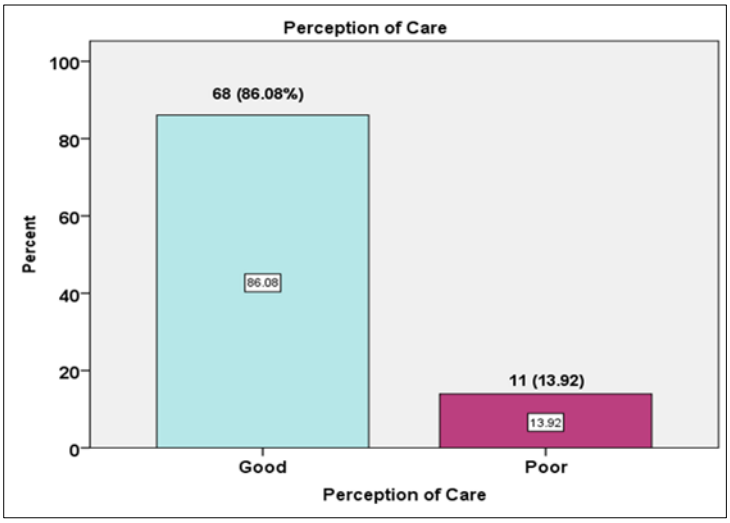

Figure 7 Perception of care

The findings on the perception of care are shown in figure 7 above. 86.08% (68/79) rated care provides as good while 13.92% (11/79) rated it as poor.

The findings of stigma experienced by the participants are shown in figure 8 below. 62.03% (49/79) expressed low stigma towards substance abuse and 37.97% (30/79) expressed high stigma towards substance use treatment.

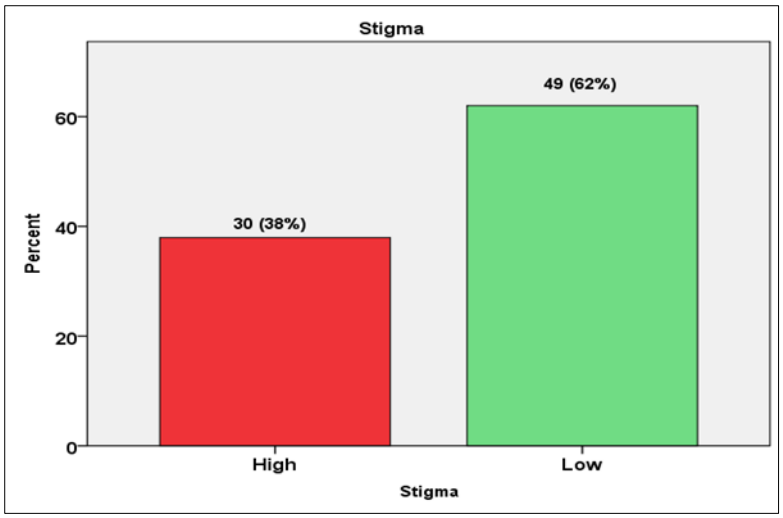

Figure 8 Stigma

The findings for the attitude of health care providers as rated by the participants are shown in the figure 9 below. 94.9% (75/79) was good while only 5.1% (4/79) was poor.

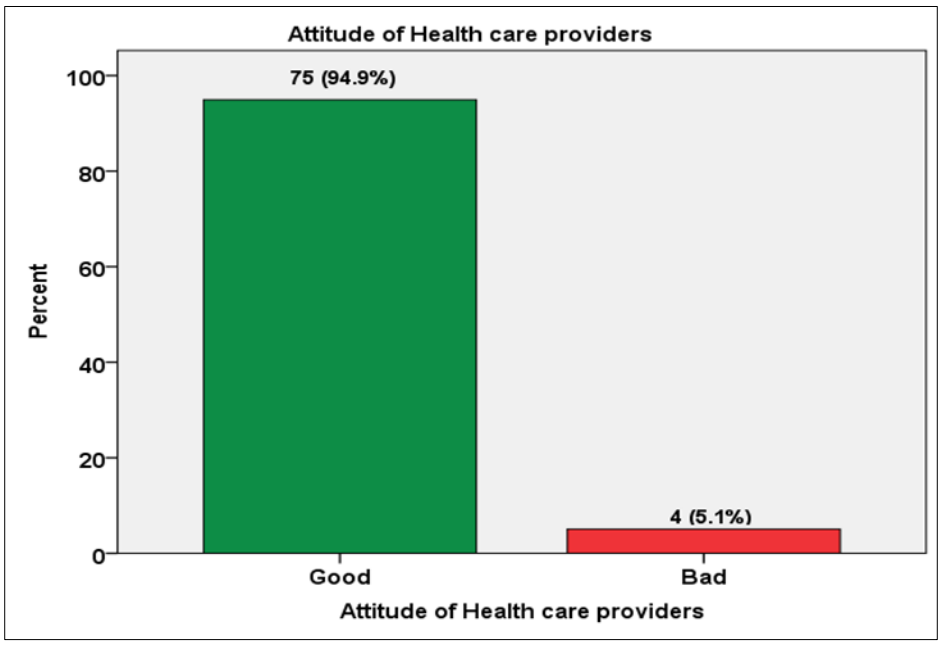

Figure 9 Attitude of the health care providers

The relationship between the HSBs and the demographic characteristics of the participants was measured using Pearson's chi-squared test and is shown in table 3. None of the socio-demographic characteristic had statistically significant relationship to the HSBs of the individuals with substance use disorders.

Table 3 Health Seeking Behaviours by socio-demographic characteristics (N=79)

		Health Seeking Behaviours			
		Good	**Poor**		**P-Value**
Age	<19yrs	14	6	20	0.293
	20-29	33	5	38	
	30-39	8	3	11	
	40-49	7	0	7	
	>50	2	1	3	
		64	15	79	
Gender	Female	10	4	14	0.313
	Male	54	11	65	
	Total	64	15	79	
Tribe	Luvale	9	2	11	0.834
	Bemba	17	2	19	
	Nyanja	12	5	17	
	Tonga	8	2	10	
	Lozi	2	1	3	
	Kaonde	1	0	1	
	Others	15	3	18	
		64	15	79	
Marital Status	Single	43	13	56	0.293
	Married	10	1	11	
	Divorced	2	0	2	
	Widowed	1	1	2	
	separated	8	0	8	
		64	15	79	
Religion	Christian	56	13	69	0.419
	Islam	4	0	4	
	Others	4	2	6	
		64	15	79	
Education levels	Primary	10	2	12	0.840
	Secondary	33	9	42	
	Tertiary	21	4	25	
		64	15	79	
Employment status	Students	7	6	13	0.069
	Never employed	20	5	25	
	Employed	17	2	19	

	Self Employed	14	1	15	
	Dismissed	6	1	7	
		64	15	79	
Family type	Nuclear	32	7	39	0.816
	extended	32	8	40	
		64	15	79	
Family support	Good	57	12	69	0.342
	Poor	7	3	10	
		64	15	79	

The relationship between HSBs and associated factors is shown in table 4. Stigma and health care providers' attitudes had a statistically significant relationship to HSB of individuals with substance use disorder while social support, income, accessibility of health care, cultural beliefs, knowledge about substance abuse, and perception of care had no significant relationship with their HSBs.

Table 4 Health-seeking behaviors by associated factors (N=79)

	Health Seeking Behaviours			
		Good	**Poor**	**P-Value**
Social support	Good	57	12	0.342
	Poor	7	3	
Income status	Sufficient	21	6	0.597
	Insufficient	43	6	
Accessibility of healthcare	Accessible	57	14	0.106
	Inaccessible	7	2	
Cultural beliefs	Strong influence	12	2	0.621
	Weak influence	52	12	
Knowledge on substance abuse	Adequate	43	13	0.135
	Inadequate	21	2	
Perception of care	Good	55	14	0.438
	Poor	9	1	
Stigma	High	28	2	0.015
	Low	36	12	
Healthcare provider's attitude	Good	64	12	0.003
	Bad	1	3	

Generally, the study revealed that most participants had positive HSB for the substance-related illness however, the primary source of treatment included the spiritual, traditional, or continuous intake of the substance to relieve the symptoms before professional treatments.

The common themes that emerged to be associated with HSBs among the participants were: fear of perceived stigma in the public health institutions, perceived quality of care and attitude of the health care personnel, treatment cost and

availability of funds, perceived quality of care and attitude of the health care personnel, and non-availability of treatment services.

The findings further revealed that people who initially had resistance to accessing the services from CHCH particularly due to institutional stigma changed their perceptions towards the health care providers and the hospital as they described the care as beneficial, and health care staff as understanding, caring, welcoming and non-judgement unlike the ones at primary health care level.

4. Discussion

The HSB was good at 64% though the professional help seeking was lower as most participants sought other remedial therapies. Patients sought various channels of care for their substance use problems such as traditional and spiritual means before conventional intervention [33]. The findings are higher compared to previous studies in Ethiopia (22.9%) which was done on individuals with depression, which is a major, driver to substance abuse as the coping strategy or self-medication [34]. Professional HSB is mostly affected by common cultural beliefs in traditional practice and this is common in lower and middle-income countries including Zambia. Factors influencing HSB were related to health systems and the patient socioeconomic and structural environment. The main system issues were related to availability and attitudes of staff and shortage of supplies and medicines in the health facilities particularly at primary health care level.

Most people perceived the treatment to substance use as mere reducing the amount of alcohol or substance of abuse as a common practice, which apparently was the failing practice. The patient factors were related to awareness, perceived severity, perceived effectiveness of therapy, and adverse effects of the substance use treatment. The patient socioeconomic status played a role.

The study revealed that most of the participants were in the age range of 20-29 years (48%). This is attributed to the large proportion of youths composing the Zambia population and substance has been found to more prevalent among the youths particularly among the youths with minority of them seeking the available health services [17]. Being male was associated with good HSB compared to female gender. Low trust in health care systems and professionals is another common barrier to care, especially among female gender and youths [35]. It less participation the female gender may be due to that fact that alcohol and substance abuse are culturally not known to be the female dominated habit. Even if some women have the similar problem, they hesitate to seek treatment in fear of being known or exposed.

HSB was largely also influenced by the socioeconomic status of patients and structural and cultural factors. Patients with better socioeconomic standing had better HSB. The study revealed that social support acted as a facilitator to early help seeking. Facilitation was determined at the level of social relationships where confrontation with substance use disorder (SUD) is exercised with good social support and health services with good supportive approach, good accessibility, and positive image of services.

Our findings agree with the finding in the study by Geuijen and their colleagues (2022) in Netherland on the barriers and facilitators of help seeking among the physicians with substance use disorders (SUD). Further, the study revealed that factors that were associated with the help seeking were based on physicians' self-negative perception and awareness of the problem as were the health accessibility. In a similar study conducted by Matsuzaki and their colleagues (2018), social support was associated with better-perceived access to care and fewer barriers to care in the HIV-negative participants which is also a marginalized condition similar to alcohol and Substance abuse [35].

HSB was also largely influenced by the socioeconomic status of patients and structural and cultural factors. Patients with better socioeconomic standing had better compliance and better HSB. The study revealed that majority of the participants had good family support and developed good HSB more especially the support coming from the extended family. This further reduced the levels of stigma, anxiety and maximized self-esteem and confidence to enter treatment and further increased the knowledge of the services offered at the institution, heightened the participants' participation in the treatment process. As it has been reported in other settings, socioeconomic status has a great influence on HSB. In South Africa, authors reported that patients with greater economic resources were more likely to seek treatment from private doctors and spend considerably more for all types of health services compared to their counterparts in the low socioeconomic index [35]. Likewise, in Nigeria, poor socioeconomic status, low level of education, unemployment, lack of effective social support networks, unstable living conditions, long distance from treatment center, and high cost of transport negatively influenced treatment HSB [37].

Our findings are similar to the findings from the United Kingdom; it was found that perceived stigma was associated with lower self-esteem, higher depression and anxiety, and poorer sleep and with good support system, client developed higher self-esteem, lower depression and anxiety, and their sleeping pattern improved [38]. This study also found that financial burdens of care, logistical difficulties in accessing care, and low social support were common challenges among individuals using illicit drugs and/or drinking hazardously.

The study found that individual participants with negative feelings and lack awareness of disease or lack of insight into the problem delayed in seeking health compared to those who realized the problem early. Perceived self-stigma and social support was associated with lower self-esteem characterized by internalized stigma and shame which hugely influenced the help seeking outcome.

Similarly to the finding of Gutierrez and their colleagues (2020) in which self-stigma contributed to alcohol and other drug use as coping strategy. Stigma is a problem with health conditions ranging from cancer and HIV to many mental illnesses including alcohol and substance abuse and has prevented individuals seek and utilize the available health care services. The findings of this study are similar to those in the study of NIDA (2020) in their attempt to evaluate stigma-surrounding addiction, which reported that public stigma prevented individual with addiction problem to alcohol and other substance from utilizing the available health care service set up for such kind of ailment [40].

5. Conclusion

The study assessed the levels of HSB among individuals with substance use disorders. The HSB was generally good however they mainly influenced the health systemic, socio-cultural, socio-economic, and individual factors. Under health systemic, it revealed the availability of substance use services at the primary health care level, the attitude of the health care providers at primary health care levels, non-availability of medicines and other counseling services. Socio-economic factors included: social support and adequate income, and socio-cultural factors included good social support and health services with a good supportive approach, good accessibility, and a positive image of services. While individual factors were self-stigma, lack of insight into the problem, and lack of self-awareness.

Study limitations

The study was limited to patients in CHCH. Additionally, the sample size was small. However, the results obtained were generalizable to the target population.

Recommendations

These findings have significant policy and practical implications on the delivery of services for individuals with alcohol and substance abuse. These revolve around the need for educating the patients, families, communities, and the general population on alcohol and substance use. Also conducting routine screening, ensuring continuity of care, adherence to treatment, patient-provider relations particularly in the health facilities, and organization of services to minimize movements for clients to access services from distant facilities, availing the alcohol and substance use services, and enhancing competencies of staff.

It is important to maximize the raising of awareness and sensitization campaigns, strengthening the integration of mental health services at the primary health care level and making the alcohol and substance use health services available and easily accessible in all health care facilities and attitude change for health care providers at primary health care facilities. Strategies to address the multifactorial dimensions that affect HSB are needed to improve substance use control in this population. Working on mental health literacy in the community is important to increase HSB. People should be educated on the effects of substance abuse. Programs on television and radio stations teach about the effects of alcohol and substance abuse, how to recognize the problem or its effects, and seek treatment early.

Compliance with ethical standards

Acknowledgments

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Disclosure of conflict of interest

The authors declare that there is no conflict of interest.

Statement of ethical approval

Ethical approval and clearance were sought from the University of Zambia Biomedical Research Ethics Committee (UNZABREC) and the National Health Research Authority (NHRA) and Permission was obtained from the Hospital's Senior Medical Superintendent.

During interviews and administration of a questionnaire, participants were assured of their voluntary participation in the study, the confidentiality of the information provided to the researcher, and that it was not going to be used against them in any way. Participants were also assured that they were at liberty to withhold information should they feel uncomfortable.

Statement of informed consent

Only the participants who met eligibility criteria, expressed willingness to participate, and provide written informed consent were enrolled in the study. The consent processes were done in English since the researcher only chose participants whose parents were able to read and write. The potential participants were given a chance to answer all questions. A copy of the information sheet and consent form was offered to the study participants' parents or legal guardians who were required to read and sign which the researcher countersigned. Appropriate informed consent was obtained from all individual participants included in the study.

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