

CONTEMPORARY SOCIAL SCIENCES

PEER REVIEWED, INDEXED & REFEREED QUARTERLY INTERNATIONAL JOURNAL

ISSN 0302-9298

<https://www.jndmeerut.org>

[Vol. 35, No. 1 (January-March), 2026]

<https://doi.org/10.62047/CSS.2026.03.31.131>

Healthcare Access and Challenges Faced by People Living with HIV: Evidence from Chaukune Rural Municipality, Surkhet

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Abstract

This study examines healthcare access and related challenges faced by HIV-infected individuals (PLHIV) in Chaukune Rural Municipality. It assesses the availability, affordability, and utilization of health services while identifying the structural, economic, and social barriers that hinder effective access. A descriptive research design was adopted using purposive sampling. Primary data were collected through interview schedules from 55 respondents selected through snowball sampling. The findings indicate that although free healthcare services and government support programs are available, access remains constrained by poverty, stigma, limited transportation, and inadequate local health facilities. Many respondents experience irregular treatment adherence due to financial hardship and social discrimination. Food insecurity and unstable income further weaken their ability to seek timely medical care. The study highlights the persistent gaps between service provision and actual accessibility, emphasizing the need for more inclusive and community-sensitive healthcare interventions in rural areas.

Keywords

HIV, Health care, Accessibility, Discrimination.

**Research Foundation International, New Delhi
(Affiliated to UNO)**

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1. Background of the Study

Human Immunodeficiency Virus (HIV) is a chronic viral infection that attacks the immune system, particularly CD4 or T-cells, weakening the body's ability to fight infections and diseases. If untreated, HIV progresses to Acquired Immunodeficiency Syndrome (AIDS), the most advanced stage of the disease, characterized by severe immune damage and vulnerability to opportunistic infections and certain cancers. Although there is no complete cure for HIV/AIDS, significant advances in medical science have made the infection manageable through Antiretroviral Therapy (ART). Regular and sustained use of ART suppresses viral replication, improves immune function, and enables people living with HIV (PLHIV) to lead longer and healthier lives (Mobaderi *et al.*, 2025). Early diagnosis, continuous treatment adherence, and uninterrupted access to healthcare services are therefore essential to prevent disease progression and improve overall well-being.

Access to healthcare is a critical determinant of health outcomes and quality of life for PLHIV. Effective HIV management requires lifelong ART, regular clinical monitoring, counseling services, and adequate nutritional support. Consistent access to these services not only improves individual health outcomes but also reduces the risk of further HIV transmission. However, access to healthcare is influenced by multiple socio-economic and structural factors. Poverty, stigma, discrimination, transportation challenges, and weak healthcare infrastructure frequently limit individuals' ability to obtain timely and consistent treatment. Such barriers may lead to irregular medication adherence, deteriorating health conditions, and increased morbidity and mortality (Obeagu *et al.*, 2024). Thus, understanding healthcare access within broader socio-economic contexts is essential for improving treatment outcomes.

Globally, economic conditions significantly shape the healthcare experiences of PLHIV. In many low- and middle-income countries, HIV disproportionately affects economically disadvantaged populations who already face limited employment opportunities, unstable income

sources, and inadequate living conditions. Although international initiatives have expanded access to ART and related services, economic inequality continues to create disparities in healthcare utilization. Organizations such as UNAIDS, WHO, and The Global Fund have played a central role in increasing treatment coverage worldwide. Nevertheless, access gaps remain pronounced, particularly in resource-constrained settings. In sub-Saharan Africa, where HIV prevalence remains high, many individuals must travel long distances to reach treatment centers and bear indirect expenses such as transportation and supplementary medicines. Similar challenges are observed in parts of Asia and Latin America, where poverty, gender inequality, and social stigma continue to hinder equitable access to care (Payagala & Pozniak, 2024). While global interventions have improved survival rates, economic vulnerability remains a persistent obstacle to sustained treatment adherence and comprehensive healthcare access.

In Nepal, the situation reflects many of these global trends. PLHIV often belong to economically marginalized groups, including daily wage labourers, migrant workers, and individuals engaged in informal employment. Irregular and low income makes it difficult for them to meet essential needs such as nutritious food, transportation to ART centers, and other healthcare-related expenses. Although the Government of Nepal, in collaboration with national and international partners, has established ART centers that provide free medication and counseling, geographical and financial barriers continue to restrict consistent access, particularly in rural and mountainous regions. Long travel distances, high transportation costs, and limited healthcare infrastructure pose substantial challenges. Moreover, stigma and discrimination remain significant social barriers, discouraging individuals from seeking timely testing and treatment. As Budhathoki (2025) notes, economic hardship, limited awareness, and entrenched social stigma collectively reinforce a cycle of deprivation that constrains both livelihood opportunities and healthcare access.

Beyond medical challenges, HIV/AIDS also has profound economic implications. The infection can reduce productivity due to recurrent illness, fatigue, and frequent medical visits. Employment instability and income loss are common among PLHIV, particularly in contexts where workplace discrimination persists. Many individuals experience reduced working hours or job termination, resulting in financial insecurity and household vulnerability (Hadingham, 2018). Loss of income not only affects immediate living conditions but also limits the capacity to invest in long-term economic activities, savings,

and education. Consequently, households affected by HIV may become increasingly dependent on external assistance.

The financial burden of managing HIV is further compounded by ongoing healthcare needs. Despite the availability of free ART in many contexts, individuals may incur indirect expenses related to laboratory tests, transportation, nutritional supplements, and treatment of opportunistic infections. Berg (2017) highlights that continuous healthcare expenditures can contribute to debt accumulation and reduced household consumption, thereby deteriorating living standards. Social stigma intensifies these challenges by limiting employment opportunities and reducing social support networks. Fear of discrimination may prevent individuals from disclosing their status or accessing services openly, resulting in delayed treatment and worsening health outcomes.

Addressing these interconnected issues requires an integrated and inclusive approach that acknowledges both health and socio-economic dimensions. Combating stigma, improving awareness, and strengthening community support mechanisms are essential for fostering a supportive environment where PLHIV can access healthcare without fear. Expanding affordable and decentralized medical services, including testing, treatment, counseling, and nutritional support, is equally critical. Furthermore, social protection measures such as skill development programs, livelihood training, and conditional cash transfers can enhance economic resilience among affected individuals (Kallollikar, 2011). Coordinated efforts between government agencies, healthcare providers, and community organizations are necessary to reduce the economic and social vulnerabilities associated with HIV.

Despite national and international initiatives aimed at improving HIV-related healthcare and social support systems, localized challenges remain under-explored, particularly in rural municipalities of Nepal. In Chaukune Rural Municipality of Surkhet District, PLHIV face multiple and interrelated barriers that affect both their healthcare access and livelihood stability. Economic hardship, limited employment opportunities, food insecurity, and unstable income sources are common concerns. These challenges are compounded by inadequate healthcare infrastructure, limited availability of specialized services, and persistent social stigma. Dependence on government or non-governmental support remains high, yet existing services may not sufficiently address the complex socio-economic and healthcare needs of this population.

Although several studies have examined HIV-related health outcomes at the national level, there is limited research focusing specifically on the intersection of economic conditions and healthcare access among PLHIV in rural settings such as Chaukune. Understanding how income, employment status, social support, and health-related productivity influence access to medical services is essential for designing context-specific interventions. Identifying localized barriers can help policymakers and development organizations formulate targeted strategies that strengthen both healthcare delivery and socio-economic support systems.

Therefore, this study seeks to examine the economic conditions and healthcare access of PLHIV in Chaukune Rural Municipality, Surkhet. By analyzing the barriers and challenges they face, the research aims to generate evidence-based insights that can inform more inclusive and sustainable healthcare and social protection strategies tailored to rural contexts in Nepal.

2. Objectives/Research Questions

The main objective of the study is to examine the nature and extent of healthcare access and the challenges encountered by People Living with HIV (PLHIV) in Chaukune Rural Municipality, Surkhet.

An attempt has been made in this study to find out the answer of following research questions based on empirical evidence:

1. What is the status of healthcare access in healthcare services for PLHIV in Chaukune Rural Municipality?
2. What are the challenges faced by PLHIV in the study area?

3. Review of Previous Studies

3.1 Theoretical Review

Mostly studies on PLHIV are mostly guided by the **Biological Determinism Theory** (Costello, 2001; Degroote *et al.*, 2014; Setswe, 2022) as the biological consequences of HIV not only influence the health of the individual but also create long-term economic vulnerabilities that perpetuate a cycle of poor health and financial hardship. Furthermore, the intersection of biological need and social barriers severely restricts healthcare access and worsens the overall condition of HIV-infected people. Therefore, to fully address the challenges faced by PLHIV, it is crucial to integrate biological, economic, and social perspectives when designing healthcare interventions and development policies.

However, this study does not focus on biological determinants of HIV and as such Biological Determinism Theory is not an appropriate primary theoretical framework for an analysis of healthcare access. Biological determinism emphasizes genetic and physiological causes of behaviour or outcomes, besides its focus on biological predisposition. It has often been criticized in social sciences for downplaying structural and social determinants.

As our study is concerned with socio-demographic and economic determinants of healthcare of PLHIV, it is guided by **Ronald M. Andersen's Behavioural Model of Health Services Use**, a widely recognized framework for analyzing factors influencing access to healthcare services (Andersen, 1968, 1995). Originally developed in 1968 and subsequently revised, the model explains healthcare utilization through three major components: predisposing factors, enabling factors, and need factors. The framework is particularly relevant for examining healthcare access among People Living with HIV (PLHIV) in Chaukune Rural Municipality, where multiple socio-economic and structural barriers intersect.

According to Andersen's model, **predisposing factors** include demographic characteristics such as age, gender, and education, which influence an individual's tendency to seek healthcare services. In the present study, variations in educational background and gender roles may shape awareness levels, health-seeking behaviour, and attitudes toward HIV-related treatment. Social stigma associated with HIV also functions as a predisposing social factor that may discourage individuals from accessing care.

The second component, **enabling factors**, refers to the practical resources that facilitate or hinder healthcare utilization. These include income level, employment status, transportation availability, and proximity to health facilities. The study findings indicate that financial constraints, transportation costs, and loss of daily wages significantly limit consistent access to HIV treatment services. Although antiretroviral therapy (ART) is officially provided free of cost, indirect expenses act as structural barriers, demonstrating the importance of enabling resources in determining actual accessibility.

The third dimension, **need factors**, relates to the individual's perceived and evaluated health status. For PLHIV, the chronic nature of HIV infection and the requirement for lifelong ART create an ongoing medical need. When respondents reported frequent illness, reduced productivity, and irregular treatment adherence, these reflected both perceived and clinically evaluated health needs influencing healthcare utilization.

Andersen's Behavioural Model thus provides a comprehensive analytical lens for understanding how demographic characteristics, socio-economic conditions, and health status collectively shape healthcare access among PLHIV. The model emphasizes that access is not determined solely by the availability of services but by the interaction between individual characteristics and structural conditions. Applying this framework enables the study to systematically examine how poverty, stigma, transportation barriers, and perceived health needs influence the utilization of HIV-related healthcare services in a rural context.

3.2 Review of Empirical Studies

Several studies have been conducted globally and nationally to understand the economic status and healthcare access of PLHIV, highlighting the multifaceted impact of the disease on health, economy, and society. For example, Simkhada (2015) conducted a study entitled "Economic Burden of HIV/AIDS upon Households in Nepal: A Critical Review." The study identified HIV/AIDS as a significant economic burden in Nepal, particularly because most infected individuals are of working age. It aimed to explore the existing knowledge gap regarding the household-level economic impact of the disease and to provide policy recommendations. The findings revealed that the economic burden exerted by HIV/AIDS was severe enough to push affected households into poverty. Simkhada concluded that limited research existed on the economic implications of HIV/AIDS in Nepal, recommending further studies to better understand the financial challenges faced by affected families and to design appropriate economic support interventions.

Karki (2019) conducted a retrospective study reviewing the "HIV/AIDS Status and Trend in Nepal" by analyzing published and unpublished documents from 1988 to 2004. The study revealed that the majority of HIV/AIDS cases in Nepal were among clients of sex workers (57.8%), followed by injecting drug users (15.6%), sex workers (13.9%), and housewives (10.6%). The HIV prevalence was highest among injecting drug users (38.4%), followed by female sex workers (4.1%) and migrants (3.0%). The study found that the number of HIV/AIDS cases had been sharply increasing since the mid-1990s, emphasizing the need for targeted intervention programs focusing on high-risk groups to reduce transmission rates and improve healthcare access.

Neupane *et al.* (2022) conducted a qualitative descriptive cross-sectional study titled "Perceived Discrimination Among People Living with HIV in Nepal." The study explored the discrimination

experienced by PLHIV within their families, communities, and healthcare settings. Eighteen HIV-positive participants (10 men and 8 women) from four districts were interviewed through in-depth semi-structured discussions. The findings revealed that women experienced higher levels of household violence and financial restriction compared to men. Participants also reported social exclusion, such as being barred from social participation, denied services from shops, and subjected to harassment. Discrimination in healthcare facilities was especially concerning, with some individuals being refused treatment due to their HIV status. The study concluded that discrimination remains a major barrier to healthcare access and social inclusion for PLHIV in Nepal.

Payagala and Pozniak (2024) conducted a global study titled “The Global Burden of HIV.” The objective was to assess the global impact of HIV/AIDS on health, treatment disparities, and social implications. Reviewing worldwide epidemiological data, the study revealed that around 38 million people live with HIV globally, with many unaware of their status. Despite advances in treatment, social stigma and economic inequality continue to hinder progress. The study found that access to ART (antiretroviral therapy) has improved but remains uneven, especially in marginalized and low-income communities. It concluded that eliminating HIV/AIDS by 2030 requires addressing healthcare inequities, reducing stigma, and tackling broader social determinants of health.

Baughner (2024) conducted a study entitled “Prevalence of Discrimination and the Association Between Employment Discrimination and Health Care Access and Use: National HIV Behavioural Surveillance Among Transgender Women, Seven Urban Areas, United States, 2019–2020.” The research analyzed data from 1,608 transgender women and found that approximately 70% experienced at least one form of discrimination within the past year. About 9.9% were fired, and 32.4% faced job application rejections due to gender identity. Employment discrimination was strongly associated with lower socioeconomic status, lack of health insurance, and reduced access to healthcare, including gender-affirming care. The study concluded that employment discrimination contributes to economic marginalization and health disparities, underscoring the need for inclusive employment and healthcare policies for marginalized groups living with HIV.

Mahmoud *et al.* (2024) conducted a study titled “Late Presentations and Missed Opportunities Among Newly Diagnosed

HIV Patients Presenting to a Specialty Clinic in Lebanon.” The retrospective study analyzed 150 newly diagnosed adult HIV patients between 2012 and 2022 to identify patterns of late diagnosis. The study found that 51.3% were late presenters, with 35.3% having advanced HIV infection upon diagnosis. Notably, 76.5% of these individuals had previously visited healthcare providers but were not tested for HIV despite showing symptoms such as weight loss, chronic diarrhea, and lymphadenopathy. The study highlighted missed opportunities for early detection and called for improved HIV screening protocols within healthcare systems to enhance early diagnosis and treatment outcomes.

These studies collectively emphasize that HIV/AIDS not only poses severe health challenges but also carries deep economic, social, and psychological implications. In Nepal, economic hardship and discrimination are major obstacles to healthcare access, while globally, disparities in healthcare systems, stigma, and socio-economic inequalities continue to perpetuate the burden of HIV. Addressing these issues requires integrated policies that link economic empowerment, healthcare accessibility, and anti-discrimination measures, ensuring that PLHIV can live with dignity and stability.

Despite considerable research on the socio-economic challenges faced by PLHIV, there is a notable gap in understanding the specific condition in healthcare access issues in rural contexts like Chaukune Rural Municipality, Surkhet. Most existing studies focus on urban areas, where healthcare facilities and economic opportunities are more readily available, leaving rural populations under-represented in the literature. This research aims to fill this gap by providing a focused analysis of the unique challenges faced by PLHIV in Chaukune, considering factors like income, employment, social support, and government assistance, to offer a more nuanced understanding of their livelihood strategies and healthcare access in rural settings.

4. Methodology

Since the primary objective of the study was to examine healthcare access among PLHIV in Chaukune Rural Municipality, a descriptive research design was adopted. The study aimed to describe the status of healthcare access and the challenges experienced by PLHIV in the study area. Snowball sampling technique was employed to select 55 respondents. Primary data were collected through structured interview schedules to obtain detailed information regarding their access to healthcare services and related difficulties.

5. Data Presentation and Analysis

5.1 Socio-demographic Profile

This sub-section of the study concerns with the analysis and interpretation of socio-demographic information of the respondents as follows:

5.1.1 Age Structure

Age is an important factor as well as a moderating variable in this study. The respondents were asked about their present age to understand the age composition of HIV-infected people in the study area. The distribution of respondents by their age group has been presented in the table below:

Table-1: Distribution of Respondents by Age Group

Age group (in years)	No. of Respondents	Percent (%)
Below 20	6	10.91
21-30	18	32.73
31-40	20	36.36
41-50	8	14.55
Above 50	3	5.45
Total	55	100.00

Source: Field Survey, 2025.

The above distribution indicates that the majority of HIV-infected respondents were in their active and productive age group (21–40 years). It suggests that individuals in this age range are more exposed to risk behaviours or socio-economic vulnerabilities that may lead to HIV infection. The lower percentage of respondents in the above 50 age group shows that older individuals are comparatively less affected or less reported. This finding implies the need for focused awareness and health interventions targeting the young and middle-aged population to reduce the risk and ensure better access to healthcare services among PLHIV.

5.1.2 Gender Structure

Gender is a significant demographic variable in this study, as it helps to understand the distribution of HIV-infected people by sex and its potential influence on economic status and healthcare access. Gender differences may shape patterns of health-seeking behaviour, exposure to stigma, employment opportunities, and control over household resources, all of which can affect access to treatment and support services. In many rural settings, social norms and cultural

expectations further influence the vulnerability and coping mechanisms of men and women living with HIV. Respondents were asked about their gender, and the distribution is presented in the table below:

Table 2: Distribution of Respondents by Gender

Gender	No. of Respondents	Percent (%)
Male	32	58.18
Female	23	41.82
Total	55	100.00

Source: Field Survey, 2025.

The above table indicates that more than half (58.18 percent) were male and remaining (41.82 percent) were female. This shows that HIV infection was slightly more prevalent among males in the study area. This higher proportion of male respondents could be attributed to differences in exposure to risk behaviours, social mobility, or patterns in healthcare-seeking behaviour. Understanding the gender distribution is crucial for designing gender-sensitive interventions and improving healthcare access for both male and female HIV-infected individuals.

5.1.3 Educational Status

Education is a key socio-economic factor that influences both awareness and access to healthcare among PLHIV. Respondents were asked about their highest level of education, and the distribution is presented in the table below:

Table-3: Distribution of Respondents by Highest Level of Education

Education Level	No. of Respondents	Percent (%)
No Formal Education	8	14.55
Primary Education	15	27.27
Secondary Education	20	36.36
Higher Education	10	18.18
Vocational Training	2	3.64
Total	55	100.00

Source: Field Survey, 2025.

The above distribution in the table indicates that the majority of respondents, i.e. a little more than one-third, had at least a secondary level of education, which may facilitate better understanding of HIV, adherence to treatment, and utilization of healthcare services. However, a significant proportion with low or no formal education may face challenges in accessing health information and services, highlighting the need for targeted educational and awareness programs for PLHIV with limited literacy.

5.2 Socio-economic Conditions and Support Systems

This sub-section deals with the analysis and presentation of data regarding health care access of HIV infected people in the study area. It contains: support from social or community organizations, satisfaction with social support, days unable to work due to health-related issues, household food security, monthly household savings, participation in community or social activities, dependence on government assistance programs and effectiveness of government assistance programs as follows:

5.2.1 Support from Social or Community Organizations

Support from social or community organizations is a key factor influencing the well-being and healthcare access of PLHIV. Respondents were asked whether they receive any assistance from such organizations, and the distribution is presented in the table below:

Table-4: Distribution of Respondents by Support from Social or Community Organizations

Response	No. of Respondents	Percent (%)
Yes	30	54.55
No	25	45.45
Total	55	100.00

Source: Field Survey, 2025.

The distribution of respondents in the table shows that slightly more than half (54.55 percent) of the PLHIV in the study area benefit from assistance programs, which may include medical aid, counseling, or financial support. Access to such support can improve healthcare utilization, adherence to treatment, and overall quality of life. However, the significant proportion (45.45 percent) not receiving support indicates gaps in outreach and highlights the need to strengthen community-based interventions to ensure all PLHIV have adequate access to necessary services.

5.2.2 Days Unable to Work due to Health-Related Issues

The number of days respondents were unable to work due to health-related issues reflects the impact of HIV infection on their productivity and daily life. Respondents were asked about the number of days in the past month they could not work because of health problems, and the distribution is presented in the table on next page:

Table-5 : Days Unable to Work Due to Health Issues by Respondents

Days Unable to Work	No. of Respondents	Percent (%)
None	20	36.36
1-5 days	15	27.27
6-10 days	12	21.82
More than 10 days	8	14.55
Total	55	100.00

Source: Field Survey, 2025

The distribution in the above table indicates that while a significant portion of respondents could maintain their work (36.36 percent) all the days, the remaining a little less than two-third (63.64) experienced health-related work absenteeism to varying degrees. These findings highlight the impact of HIV on the economic productivity and daily functioning of infected individuals, emphasizing the need for effective medical care, regular monitoring, and supportive work environments to reduce health-related disruptions.

5.2.3 Household Food Security

The availability of sufficient food in the household is a key indicator of economic status and overall well-being. Respondents were asked to rate how often they had enough food for their household on a scale of 1 to 5, and the distribution is shown in the table below:

Table-6: Distribution of Respondents by Perceived Household Food Security

Rating	No. of Respondents	Percent (%)
Never	4	7.27
Rarely	8	14.55
Sometimes	15	27.27
Often	18	32.73
Always	10	18.18
Total	55	100.00

Source: Field Survey, 2025.

The data contained in the above table suggest that while a majority of households frequently have sufficient food, a significant proportion (29.82 percent) experience food insufficiency at least sometimes. This highlights the economic vulnerability of HIV-infected households and underscores the importance of programmes that support food security alongside healthcare and income-generating interventions.

5.3 Healthcare Access and Service-related Challenges among People Living with HIV

5.3.1 Healthcare Access

Access to healthcare services is a critical factor influencing the health outcomes of PLHIV. Respondents were asked how often they accessed healthcare services for their HIV condition, and the distribution is presented in the table below:

Table-7: Distribution of Respondents by Frequency of Accessing Healthcare Services

Frequency	No. of Respondents	Percent (%)
Never	3	5.45
Rarely	7	12.73
Sometimes	12	21.82
Often	20	36.36
Always	13	23.64
Total	55	100.00

Source: Field Survey, 2025

The data contained in the above table indicate that the majority of respondents (60 percent) frequently access healthcare services (often or always), which reflects relatively good utilization of available healthcare facilities. However, a smaller proportion (18.18 percent) access healthcare services infrequently (never or rarely), suggesting barriers such as financial constraints, distance, or social stigma. This emphasizes the need to improve healthcare accessibility, awareness, and support for PLHIV to ensure consistent treatment and care.

5.3.2 Perceived Quality of Healthcare Services

The perceived quality of healthcare services reflects how HIV-infected individuals evaluate the effectiveness, accessibility, and overall standard of the medical care they receive. Respondents were asked to rate the quality of healthcare services on a scale of 1 to 5, and the distribution is presented in the table below:

Table-8: Distribution of Respondents by Perceived Quality of Healthcare Services

Quality Rating	No. of Respondents	Percent (%)
1 - Very Poor	3	5.45
2 - Poor	7	12.73
3 - Average	15	27.27

4 - Good	20	36.36
5 - Excellent	10	18.18
Total	55	100.00

Source: Field Survey, 2025.

The above table indicates that a majority of respondents perceive the quality of healthcare services as good or above average (81-82), indicating a generally positive assessment of available medical care. However, the proportion of respondents rating services as poor or very poor (18.18 percent) highlights areas needing improvement, such as reducing waiting times, improving service delivery, ensuring availability of medications, and enhancing patient-provider interactions to better meet the needs of PLHIV.

5-3-3 Major Barriers to Accessing Healthcare Services

Identifying barriers to healthcare access is crucial for understanding the challenges faced by PLHIV in obtaining timely and adequate medical care. Respondents were asked to indicate the major barriers they experience, and the distribution is presented in the table below:

Table-9: Distribution of Respondents by Major Barriers to Healthcare Access

Barrier	No. of Respondents	Percent (%)
Financial Constraints	28	50.91
Lack of Transportation	20	36.36
Lack of Information about Services	15	27.27
Social Stigma	18	32.73
Total	55	100.0

Source: Field Survey, 2025.

The above table indicates that financial limitations are the most significant obstacle to accessing healthcare services among HIV-infected individuals, followed by transportation issues and social stigma. Lack of awareness about available services further compounds the problem. These results highlight the need for comprehensive interventions, including financial support, improved transportation facilities, community awareness programs, and stigma reduction initiatives, to ensure better healthcare access for HIV-infected populations.

6. Discussion

The findings reveal a clear gap between the availability of healthcare services and their actual accessibility and perceived quality

among People Living with HIV (PLHIV) in Chaukune Rural Municipality. Although 60% of respondents reported accessing healthcare services “always” or “often,” substantial financial and structural barriers continue to hinder consistent engagement. Nearly 50.91% identified financial constraints as a primary obstacle, despite the nominal availability of free HIV services, while 36.36% reported transportation difficulties. These findings align with existing research in Nepal, which demonstrates that indirect costs—such as travel expenses, treatment of opportunistic infections, and productivity loss—create significant economic burdens for low-income households (Muddu *et al.*, 2023).

The study further highlights the interconnection between health status and economic productivity. With 72.73% of respondents reporting productivity loss, the results support earlier arguments that illness-related work interruptions reduce income stability and may disrupt treatment adherence. Social stigma, reported by 32.73% of participants, continues to influence healthcare-seeking behaviour, reinforcing findings from previous studies that stigma operates as both a social and clinical barrier. Additionally, 27.27% of respondents indicated inadequate information, suggesting that health literacy remains critical for sustained treatment adherence.

Perceptions of service quality reflect moderate satisfaction levels, yet limited confidence in government assistance indicates systemic gaps in support mechanisms. Overall, the findings underscore that HIV care cannot be addressed in isolation; rather, integrated approaches linking healthcare access with economic and social support systems are essential for improving long-term livelihood sustainability.

These findings are consistent with previous research in Nepal and other low-income settings, which highlights the burden of indirect treatment costs (Poudel *et al.*, 2025), stigma (Sasset *et al.*, 2026), and health literacy barriers (Young *et al.*, 2024) in shaping healthcare access among PLHIV

7. Conclusion

The study demonstrates that healthcare access for People Living with HIV (PLHIV) in Chaukune Rural Municipality remains inconsistent, as the availability of clinical services does not necessarily translate into effective accessibility. Although HIV treatment and medications are formally provided free of cost, structural barriers—particularly transportation expenses and loss of daily wages—create

significant financial constraints for economically vulnerable individuals. Social stigma and inadequate health information further limit sustained engagement with healthcare services, often resulting in delayed or irregular care-seeking behaviour.

Viewed through Ronald M. Andersen's Behavioural Model of Health Services Use, these findings illustrate how healthcare utilization is shaped by the interaction of predisposing, enabling, and need factors. While the medical necessity of lifelong ART represents a clear need factor, enabling resources such as income, transportation, and service availability significantly determine whether care is actually utilized. Similarly, stigma and limited awareness function as predisposing social factors that influence health-seeking behaviour. The findings suggest that existing health interventions remain largely focused on clinical treatment without adequately addressing the broader socio-economic realities of patients.

Improving accessibility therefore requires a more integrated and patient-centered approach that combines decentralized service delivery with strengthened social protection mechanisms. Addressing poverty, food insecurity, and stigma is essential for enhancing enabling conditions and ensuring sustainable treatment adherence and long-term health stability among PLHIV.

8. Social Work Intervention

The findings underscore the need for integrated social work interventions that combine healthcare support with livelihood assistance and social protection measures for People Living with HIV (PLHIV) in Chaukune Rural Municipality. Sustainable improvement in healthcare access requires addressing financial constraints, transportation barriers, stigma, and limited awareness simultaneously.

Participants emphasized affordability and continuity of care as central concerns. Many reported that although antiretroviral therapy is officially free, indirect expenses such as transportation and supplementary treatment costs create financial stress and disrupt adherence. Respondents also highlighted the need for decentralized service delivery, including mobile clinics, outreach programs, and periodic health camps to reduce geographic barriers.

Awareness and information dissemination emerged as additional priorities. Participants indicated that improved counseling services and community-based awareness campaigns could enhance health literacy and encourage timely care-seeking. Furthermore, psychosocial support mechanisms—such as peer-support groups and

stigma-sensitive training for healthcare providers – were identified as critical to improving patient confidence and sustained engagement with medical services.

From a healthcare access framework, these recommendations correspond to key dimensions of access, including affordability, physical accessibility, availability, and acceptability. Therefore, social work interventions must adopt a multidimensional approach that integrates economic support, decentralized healthcare delivery, community education, and stigma reduction strategies. Such an approach is essential to promote equitable access, treatment adherence, and long-term well-being among PLHIV.

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