

INFLUENCE OF HEALTH BELIEFS ON QUALITY OF LIFE AMONG KEY POPULATIONS ACCESSING CARE AT ONE STOP SHOP, KADUNA STATE

Akatu Adikwu, David Markus Shekwolo PhD, Denis O. Atafo & Rebecca Temetope
Newton

Department of Psychology, Nigerian Defence Academy Kaduna

Email Address: akatuadikwu@gmail..com Phone NO:07074875092

ABSTRACT

The study investigated influence of health belief on quality of life among key populations accessing care at one stop shop, Kaduna State. The study adopted a cross-sectional survey design using stratified and purposive to 262 participants for the study. The participants comprised 225 were males and 37 were females. Their age ranged from 18 to 50 years with mean age of 28.65 and a standard deviation of 5.78. The instruments used for data collection were: AIDS Health Belief Scale and World Health Organization Quality of Life Brief. Multiple Regression Statistics were used to test the study hypotheses. The results showed that perceived susceptibility at ($F_{4, 257}$) $\beta = .07$, $t = 1.23$ had no influence on quality of life at $p < .05$. Perceived severity at ($F_{4, 257}$) $\beta = -.23^*$, $t = -3.63$, and perceived susceptibility at ($F_{4, 257}$) $\beta = -.27^*$, $t = -4.13$ had negative influence on quality of life at $p < .05$. Perceived benefit at ($F_{4, 257}$) $\beta = .21^*$, $t = 3.16$ had positive influence on quality of life at $p < .05$. It was concluded that health beliefs significantly influence the quality of life among key populations. Therefore, it was recommended that there should be programs that focus on enhancing health belief information and self-image among individuals.

Keywords: Health beliefs, quality of life and key population.

Introduction

The quality of life among Human Immunodeficiency Virus key populations accessing healthcare in Nigeria is a critical area of study, reflecting broader issues of healthcare equity, and access to services. Ironically, HIV epidemic in the country is heavily concentrated among these populations, who are often marginalized and underserved by the healthcare system (Emmanuel et al., 2025). Moreover, the prevalence of HIV among key populations in Nigeria is significantly higher than in the general population, with Female Sex Workers (FSWs) and Men who have Sex with Men (MSM) being particularly affected. This

heightened vulnerability is exacerbated by factors such as poverty, social exclusion, and the criminalization of certain behaviours, which further hinder access to essential HIV treatment services which in turn impact their quality of life (Ochonye et al., 2019).

Unfortunately, key population under this mainstream, MSM often feel guilty, have low self-esteem, and fear discrimination, which may eventually lead to depression and suicidal thought (Hidru et al., 2016). Consequently, scholars noted that the HIV infection, which is believed to be life-threatening, could lead to distressing psychological and emotional states of mind and may further lead to low quality of life (Owusu, 2022). Due to some HIV-infected key population believe that their lives are not worth living anymore due to multiple reasons and pressures (Kutnick et al., 2017). For example, key population who believe that HIV is out of control, chronic, and has serious consequences for which there is no treatment, which will decrease their quality of life (Mo et al. 2018).

According to World Health Organization (2023) health beliefs is “the convictions that individuals hold regarding their health and the health of others, which guide their health-related decisions and actions.” This encapsulates the social dimension of health beliefs, recognizing that individual convictions are often influenced by societal norms and collective health behaviours. Similarly, Glanz et al. (2008) perceived health beliefs as “the individual’s perceptions of health threats and the efficacy of health-promoting behaviours.” The authors integrate the notion of self-efficacy, which refers to an individual’s confidence in their ability to execute behaviors necessary to produce specific performance attainments. This addition underscores the importance of empowering individuals through education and skill-building, thereby enhancing their capacity to engage in health-promoting behaviours. This could be reason Zareiyan et al. (2015) stated that health belief is known as one of the health promotion and disease prevention in which decisions and motivations in an individual in terms of adopting a health behaviour depend on three separate components of individual perception, behavioural adjustment, and a possibility to act or to show a behaviour. According to Parsa (2017) personal beliefs and perceptions in fear from the health problems and assessment of benefits and barriers to the preventive behaviours can lead to the adoption of health behaviour. Since, the person is expected to see the risk of the problem, and then understand the depth of the physical and psychological complications, and in case of the positive evaluation of the benefits and the lack of serious barriers, the preventive behaviour adopted (Shojaeezadeh et al., 2011).

Moreover, one of the primary health beliefs of the key populations is the perception of vulnerability to health issues, particularly infectious diseases such as HIV/AIDS and hepatitis. According to Anuar et al., (2020) showing preventive belief and behaviours depends on key populations perceived risk of the disease, the effect of the disease on their life and the effect of healthy behaviours on less susceptibility to and severity of the disease. Hence, Stangl et al. (2019a) highlight that this belief is often rooted in personal experiences and peer

relations, which reinforces the importance of this belief. For instance, when individuals see their peers engaging in safe practices, such as using clean needles, they are more likely to adopt similar health beliefs and behaviours. This communal reinforcement often fosters a sense of collective responsibility for health, encouraging individuals to prioritize their well-being and that of their peers.

Health Belief Model (HBM) by Rosenstock (1952), which provides a framework for understanding how perceptions influence health behaviours and, consequently, quality of life. Within this model, perceived severity and perceived barriers tend to significantly impact an individual's quality of life negatively. When individuals perceive a health condition as severe, they may experience heightened anxiety and stress, which can detract from their overall well-being. This heightened awareness of severity may lead to a sense of helplessness, making individuals feel overwhelmed and less likely to engage in proactive health behaviors. Consequently, this can result in a diminished quality of life as they struggle to cope with the psychological and emotional burdens associated with their perceptions. Furthermore, when individuals perceive high barriers—such as cost, accessibility, or lack of support—they may refrain from seeking necessary medical care or adopting healthier lifestyles. This avoidance can lead to untreated health issues and a decline in physical and mental health, further exacerbating the negative impact on quality of life. Conversely, when individuals recognize the advantages of engaging in healthy behaviors or seeking medical treatment, they are more likely to take action. This recognition fosters a sense of agency and empowerment, encouraging individuals to adopt healthier lifestyles that can lead to improved physical health, emotional well-being, and overall life satisfaction. The positive influence of perceived benefits can thus create a reinforcing cycle, where improved health outcomes lead to a better quality of life, further motivating individuals to maintain their health-promoting behaviours.

Park et al. (2025) identified that perceived susceptibility positively correlates with healthful eating, glucose monitoring, and foot care practices. Additionally, perceived severity was positively associated with diet adherence and glucose monitoring. However, Park et al. (2025) found that perceived barriers negatively impacted self-care practices, particularly glucose monitoring. Interestingly, perceived benefits did not have a significant effect on overall self-care behaviors. The authors concluded that self-efficacy, perceived susceptibility, and perceived severity are significant predictors of self-care behaviors among Black/African American men with type 2 diabetes (T2D). Rajapakshe et al. (2024), which demonstrated that self-efficacy, perceived susceptibility, and perceived severity significantly influenced the perceived benefits of quality sexual and reproductive health (SRH) education. Agyemang-Duah and Rosenberg (2023) found a positive and statistically significant relationship between perceived susceptibility to health problems, cues to action, and healthcare utilization among informal caregivers of older adults. Their study also revealed a negative and statistically

significant association between the perceived severity of health problems and healthcare utilization in this population.

Statement of the Problem

The quality of life among key populations in Nigeria seems to present a significant public health challenge. This situation might be deeply intertwined with systemic discrimination, social stigma, and a lack of access to essential services. These challenges faced by key populations in Nigeria are not only health-related but also encompass broader social determinants that affect their overall quality of life. Perhaps due to discrimination and criminalization from the general populace, which creates an environment in which key populations may experience violence, both physical and emotional, possibly leading to severe mental health issues. In addition, the fear of stigma often prevents key populations from accessing health services, resulting in untreated conditions that further exacerbate feelings of isolation and despair.

The consequences of such avoidance are severe, as untreated health conditions such as HIV/AIDS can lead to a decline in both physical and mental health, further entrenching the cycle of poverty and marginalization. In Kaduna State Nigeria for instance, these key populations tend to face heightened vulnerability not only to HIV infection but also to the social and psychological burdens associated with living with the condition. This makes many affected persons still experience reduced quality of life due to persistent stigma, discrimination, and negative health beliefs (Saeed & Ayuwat, 2020). Perhaps due to experience of denial of care and discrimination from healthcare providers often creates an environment where health risks, including sexually transmitted infections (STIs) and mental health disorders, remain unaddressed, ultimately diminishing quality of life (Bosire, 2023; Coleman et al., 2025; Isano et al., 2023).

More so, gaining a comprehensive understanding of quality of life among key populations is challenging. This challenge can be addressed by an integrated approach that considers the complex interplay between health beliefs, stigma and quality of life. Since, extant literatures (Adewuyi, & Adewuyi, 2023; Oladejo et al., 2024) has often focused exclusively on individuals of the general populace entering clinical care, with less attention given to the influence of health beliefs on quality of life among key populations living with HIV/AIDS in Kaduna State, Nigeria. Therefore, this study becomes imperative to address the above gaps in knowledge and literature empirically.

Research Question

The following research question guided the study:

- i. What is the influence of health beliefs on quality of life among key populations at one stop shop, Kaduna State?

Objective of the Study

The objective of the study investigated the relationship among health beliefs and quality of life among key populations at one stop shop, Kaduna State. Specifically:

- i. To examine the significant influence of health beliefs on quality of life among key populations at one stop shop, Kaduna State.

Hypothesis

The following hypothesis was tested in the study:

- i. There will be a significant influence of health beliefs on quality of life among key populations at one stop shop, Kaduna State.

METHODS

Design

The research adopted a cross-sectional survey design to collect numerical data through the use of standardized instruments that measured the key variables of the study. The design was considered appropriate due to its merit in describing people of different ages, genders, educational backgrounds, and social statuses, among others. The survey method helped collect data to measure the influence of health beliefs and stigma, and quality of life among the key population accessing care.

Setting

The study setting focuses on the One Stop Shop (OSS) in Barnawa, Kaduna South Local Government Area (LGA). Barnawa is a district within Kaduna South Local Government Area (LGA) in Kaduna, Nigeria. Located south of the Kaduna River, it's about 6 kilometers from the Kaduna city center. The OSS was established in 2018 by the Society for Family Health (SFH) which is a Pan-African Nongovernmental Organisation (NGO), founded in 1983 and incorporated in 1985. Currently, the OSS is managed by the Centre for Integrated Health Programs (CIHP) and its programme focus includes prevention and treatment of HIV (including prevention of mother-to-child transmission) and tuberculosis (TB) prevention and treatment. Barnawa OSS consist of Antiretroviral Therapy (ART) Clinician (Medical Doctor), ART Nurse, Laboratory Scientist, ART Pharmacist, Clinical Psychologist, Adherence Counsellor, Monitoring and Evaluation Officer, Data Entry Officer, and Client Case Managers (In-charge of Clients). The OSS serves as a centralized location where key populations, such as men who have sex with men, female sex workers, and people who inject drugs, can access essential health services in a supportive and non-judgmental environment. This accessibility is crucial because individuals from these groups often face significant barriers to healthcare due to stigma and discrimination.

Participants

The population for this study comprised of 758 clients from the key population who accessed care at the One-Stop Shop facility, Barnawa in Kaduna State from

July to December. Key population in the context of this research includes men who have sex with men (MSM), Female sex workers (FSW) and people who inject drugs (PWID).

SN	DESCRIPTION OF POPULATION	NUMBER	PERCENTAGE
1	Men who have sex with men (MSM)	194	25.6
2	Female sex workers (FSW)	385	50.8
3	People who inject drugs (PWID).	179	23.6
	Total	758	100

The descriptive statistics indicated that participants age ranged from 18 to 50 years with mean age of 28.65 and a standard deviation of 5.78. Their gender data showed that 225(85.9%) were males, and 37(14.1%) were females with mean of 1.14 and a standard deviation of .34. Marital status indicted that 33(12.6%) were married, 227(86.6%) were single, and 2(.8%) were divorced with mean of 1.18 and a standard deviation of .35. Educational data showed that 147(56.1%) had tertiary education, 103(39.3%) had secondary education and 12(4.6%) had Primary education with mean of 1.48 and a standard deviation of .59. Religion data indicated that 149(56.9%) were Christians, 93(35.5%) were Islam, and 48(11.1%) were African Traditionists with mean of 1.51 and a standard deviation of .64.

Sample Size and Sampling Technique

The sampling technique that was adopted for the study was the stratified sampling technique. This was appropriate when the nature or characteristics of the population consisted of distinct sub-groups (MSM, FSW, and PWID) that needed to be represented in the sample. The reason for the stratification was to ensure that a more inclusive representative sample that accommodated all characteristics within the One-Stop Shop was drawn for the study. This sampling procedure allowed the population for the study to be divided into strata based on their unique characteristics to ensure that participants making up the sample were drawn through an unbiased method. The researcher adopted the Yamane (1986) for sample size calculation for appropriate sample size determination.

The formula is given as:
$$n = \frac{N}{1 + N(e)^2}$$

Thus, applying the formula, the sample determined size was:

Where

n = sample size

N = Estimated population

E = error margin (which for this study is 5%)

1 = constant

n = 758

$$\begin{aligned}n &= \frac{1 + 758 (0.05)^2}{758} \\n &= \frac{1 + 758 (0.0025)^2}{758} \\n &= \frac{1 + 758 (0.0025)}{758} \\n &= \frac{2.895}{758} \\n &= n \approx 261.83\end{aligned}$$

The sample size was approximately 262 patients. This sample size ensures a representative subset of the population with a 95% confidence level and a 5% margin of error which were used in this study.

Inclusion Criteria

- i. Individuals had a confirmed HIV-positive status documented in their medical records.
- ii. Participants who belonged to one of the specified key populations: Men who had sex with men (MSM), Female sex workers (FSW), or People who injected drugs (PWID).
- iii. Participants who were receiving antiretroviral treatment (ART) at the One-Stop Shop in Kaduna State.

Exclusion Criteria

- i. Individuals with incomplete medical or demographic records that did not provide sufficient information for the study were excluded.
- i. Individuals below the age of 18 were not allowed to be part of the study.
- ii. Individuals who were not confirmed HIV-positive, even if they belonged to a key population group, were excluded.

Instruments

The instruments that were used for data collection were detailed: AIDS Health Belief Scale, World Health Organization and Quality of Life Brief. The instruments of data collection were segmented into three.

Section A: This section contains items that measure the demographic details of the respondents, which include age, gender, marital status, level of education and religious affiliation.

Section B: The AIDS Health Belief Scale (AHBS): This instrument was created by Zagumny and Brady (1998). It was designed measures cognitive and emotional factors influencing individuals' health-related behaviours, including engagement in safe practices or barriers to such behaviours. The four primary components of the health belief model (HBM) concerning HIV: perceived susceptibility (4 items: e.g. I think it is worth the effort to have condoms readily available), perceived severity of the disease (4 items: e.g. I would rather have any other terminal illness than HIV), perceived

benefits of engaging in preventive behaviours (4 items: e.g. I am afraid that I contracted AIDS), and perceived barriers to those behaviours (4 items: e.g. Using a condom is an insult to my partner). This 16-item scale provides a structured way to evaluate attitudes and beliefs that may influence individual decision-making regarding HIV prevention and risk management. The scale has 5 points likert scale rating format: 1=Strongly Disagree, 2=Disagree, 3=Neither Disagree or Agree, 4=Agree and 5=Strongly Agree. Higher scores in specific subdomains (e.g., perceived barriers) indicate areas requiring targeted interventions, while lower scores in perceived susceptibility or severity highlight a lack of awareness. The psychometric properties of the original and modified AHBS demonstrate reliability and construct validity, with the scale effectively measuring its intended components of the HBM. The overall AHBSs demonstrated a high degree of internal consistency ranging from 0.82 to 0.93, while the subscales have internal consistencies of: Perceived susceptibility 0.83 (M: 3.65), perceived severity 0.83 (M: 3.90), perceived benefits 0.93 (4.13), and perceived barriers 0.93 (2.93). For this study, the researcher conducted pilot test and reported Cronbach alpha of 0.70 (M: 14.21, SD: 2.95) for Perceived susceptibility, 0.73(M: 14.66, SD: 3.18) for perceived severity, 0.77(M: 14.66, SD: 3.00) for perceived benefits and 0.74(M: 14.25, SD: 3.25) for perceived barriers. The overall scale demonstrated a high degree of internal consistency ranging from 0.88(M: 57.78, SD: 9.87).

Section C: WHO Quality of Life Scale-Bref (WHOQOL-Bref). The World Health

Organization Quality of Life Brief was developed by World Health Organization (1998).

The scale assesses individuals' perceptions of their quality of life, incorporating their physical health, psychological state, social relationships, and environmental factors. The WHOQOL-Bref evaluates overall quality of life with an emphasis on four core domains: Physical Health (7 items: e.g. How satisfied are you with your ability to perform your daily living activities?). Psychological Health (6 items: e.g. How much do you enjoy life?). Social Relationships (3 items: e.g. How satisfied are you with the support you get from your friends?). Environment health domain (8 items: e.g. How safe do you feel in your daily life?). Global items (2 items: e.g. How satisfied are you with your health?).

The test demonstrated high internal consistency across domains. Reliability coefficients (Cronbach's alpha) are robust, indicating consistency in responses. The scale uses a five-point Likert scale, where higher scores reflect a better quality of life. The raw scores are summed for each domain and then transformed into a 0–100 scale. Missing data are addressed by substituting domain-specific averages when no more than one item is missing from the domain. Higher Scores indicate a better perception of quality of life in the respective domain. While lower Scores suggest poor perception of quality of life in the respective domain. In Nigeria, Maduekwe et al. (2025) reported Cronbach alpha of 0.70 for the overall scale. Nkporbu et al. (2023) reported high Cronbach's Alpha of 0.83 for the

overall scale in Nigeria. For this study, the researcher conducted pilot test and reported Cronbach alpha of 0.78(M: 23.06, SD: 4.14) for physical health, 0.63(M:21.11; SD: 3.58) for psychological health, 0.76(M: 10.57, SD: 2.21) for social relationship and .77(M: 26.91, SD: 5.12) for environmental health. The overall scale Cronbach alpha of 0.85(M: 88.52, SD: 12.52) was reported.

Procedure

A pilot study was also conducted before the main data collection to test the suitability of the research instruments and procedures. The pilot study was carried out 85 participants who had similar characteristics to the target population but were not included in the main study. This helped to assess the clarity of the items, the time required to complete the questionnaire, and the overall reliability of the instruments. Feedback from the pilot study was used to make necessary adjustments to the instruments and improve the administration procedure before the actual study commenced.

Before the data collection, the researcher obtained a from the selected organization where the research was conducted. The researcher, along with the letter of introduction, sought approval to conduct the research from the clinical lead of the OSS (a medical doctor). This letter outlined the purpose of the study, ensuring that the clinical lead understood the research's objectives and significance. Once approval was secured, the doctor assigned three staff members to serve as research assistants.

The selected research assistants (three) were trained by the researcher on how to approach and administer the copies of the instruments to the clients/participants. The researcher emphasized the importance of relating ethically with these clients/participants. Participants were selected from the OSS using a stratified sampling technique. Specifically, the population was divided into relevant subgroups based on characteristics pertinent to the study, and participants were selected from each stratum to ensure representation of the different groups. Only individuals who met the inclusion criteria and provided informed consent were recruited.

Prior to the administration of the questionnaire, the purpose of the study was explained to the selected participants. They were informed that there were no right or wrong answers and were encouraged to respond honestly. To minimize social desirability bias, participants' identities were kept confidential to ensure anonymity, particularly given the sensitive nature of the study topics, which included HIV and sexual orientation. The questionnaires were administered by the researcher and the trained research assistants at the OSS premises in a quiet and private setting to promote comfort and confidentiality. The administration of the questionnaires took approximately 15 to 45 minutes per participant.

Data Analysis

The results of the study were analyzed using descriptive and inferential statistics. Descriptive statistics, including mean, standard deviation, and

percentage, were used to analyze the demographic variables. The study hypothesis was tested using Multiple Regression.

Ethical Considerations

Informed Consent: The researcher provided participants with a comprehensive explanation of the study's objectives, methodology, and potential impacts. This information was presented in clear, jargon-free language. Participants were informed that their involvement was entirely voluntary, and they had the right to refuse participation or withdraw at any time without any negative consequences. Participants were asked to sign an informed consent form that outlined all relevant details about the study, ensuring they acknowledged their understanding and agreement to participate.

Confidentiality: All data collected were stored securely, with access limited to authorized personnel only. Identifiable information was separated from responses to maintain anonymity. Participants were assigned unique identifiers instead of using their names. This approach ensured that individual responses could not be traced back to specific participants. If the results of the study were published, they would be presented in aggregate form, ensuring that no individual participant could be identified.

Protection of Participant Rights: The researcher treated all participants with respect and dignity, recognizing their autonomy and individuality. This included being sensitive to cultural and personal values. Participants were not deceived about the nature of the research. If any deception was necessary for the study design, it was minimized and fully justified, with debriefing provided afterward. Participants were informed of their right to withdraw from the study at any point without facing any penalties or loss of benefits. This right emphasized the voluntary nature of participation. Participants were provided with information about support services or resources related to the study topic, particularly if the research involved sensitive issues that might evoke emotional responses.

RESULTS

This chapter presents the result of the statistical analysis of the study. Brief interpretation was given below each table. The collected data were analysed using the version 27 of the Statistical Package for Social Sciences (SPSS).

Test of Hypothesis

Hypothesis One: There will be a significant influence of health beliefs on quality of life among key populations at one stop shop, Kaduna State.

Table 1: Descriptive and Zero-Order Matrix Correlational Coefficient Statistics of Health Belief and Quality of Life

Variables	Mean	StD.D	QOL	PS	PSe	PBe.	PBa.
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	v.						
Quality of Life	88.48	12.33	1.00				
Perceived Susceptibility	14.22	3.00	.38	1.00			
Perceived Severity	14.53	3.25	.51*	.50*	1.00		
Perceived Benefit	14.61	3.06	.53*	.40*	.52*	1.00	
Perceived Barrier	14.18	3.32	.55*	.43*	.53*	.63*	1.00

The significant level: *P<.05.

Results from table 1, showed that perceived susceptibility at r(262), .38 (M: 14.22, SD: 3.00), at p<.05 had no significant relationship with quality of life. Perceived severity at r(262), .51* (M: 14.53, SD: 3.25) at p<.05 had positive significant relationship with quality of life. Perceived severity at r(262), .50* at p<.05 had positive significant relationship with perceived susceptibility. Perceived benefit at r(262), .53* (M: 14.61, SD: 3.06) at p<.05 had positive significant relationship with quality of life. Perceived benefit at r(262), .40* at p<.05 had positive significant relationship with perceived susceptibility. Perceived benefit at r(262), .52* at p<.05 had positive significant relationship with perceived severity. Perceived barrier at r(262), .55* (M: 14.18, SD: 3.32), at p<.05 had positive significant relationship with quality of life. Perceived barrier at r(262), .43* at p<.05 had positive significant relationship with perceived susceptibility. Perceived barrier at r(262), .53* at p<.05 had positive significant relationship with perceived severity. Perceived barrier at r(262), .63* at p<.05 had positive significant relationship with perceived benefit.

This finding implies that as health belief dimensions perceived severity, perceived barriers and perceived benefit increase quality of life among key populations increase. In contrast, perceived susceptibility indicated no relationship with quality of life among key populations, meaning that it does not make any contribution to quality of life among key populations.

Table 2: Multiple Regressions Statistics of Health Belief and Quality of Life

Variables	B	StD.E	Df	F	t	β	R ²	Adj. R ²
							.401	.392
(Constant)	45.50	3.53	4, 257	42.99	12.88			
Perceived Susceptibility	.29	.24			1.23	.07		
Perceived Severity	-.86	.23			-3.63	-.23*		
Perceived Benefit	.83	.26			3.16	.21*		
Perceived Barrier	-1.01	.24			-4.13	-.27*		

The significant level: *P<.05.

Results from table 2, showed that health belief dimensions (perceived susceptibility, perceived severity, perceived benefit and perceived barrier) accounted for 40.1% of the quality of life, with $R^2 = .401$, adjusted $R^2 = .392$, $(F_{4, 257}) = 42.99$, $p < .05$ shows that the overall model made significant contribution to quality of life at 40.1%. Perceived susceptibility at $(F_{4, 257}) \beta = .07$, $t = 1.23$ had no influence on quality of life at $p < .05$. This means that perceived susceptibility had no influence on quality of life. Perceived severity at $(F_{4, 257}) \beta = -.23^*$, $t = -3.63$, and perceived susceptibility at $(F_{4, 257}) \beta = -.27^*$, $t = -4.13$ had negative influence on quality of life at $p < .05$. This implies that increase in health belief dimensions such as perceived severity and perceived barrier means decrease in quality of life among key populations. Perceived benefit at $(F_{4, 257}) \beta = .21^*$, $t = 3.16$ had positive influence on quality of life at $p < .05$. This implies that increase in health belief dimensions such as perceived benefit means increase in quality of life among key populations.

Discussion

The study examined the influence of health beliefs on quality of life among key populations at one stop shop, Kaduna State.

Hypothesis started that there will be a significant influence of health beliefs on quality of life among key populations at one stop shop, Kaduna State was confirmed partly. Due to perceived susceptibility, health beliefs did not influence quality of life. However, perceived severity and perceived barrier health beliefs had a negative influence on quality of life. The perceived benefit of health beliefs had a positive influence on the quality of life. This denotes that as perceived severity and perceived barrier increase, quality of life decreases, while as perceived benefit health belief increases, quality of life among key populations. This can be understood through the lens of psychological and behavioural responses to health perceptions. For instance, as perceived severity rises, individuals tend to experience heightened anxiety and fear regarding their health conditions. This distress at times leads to avoidance behaviours, where individuals become reluctant to seek medical help or engage in health-promoting activities. The overwhelming sense of severity often creates a paralyzing effect, diminishing motivation and resulting in a decline in overall well-being. Consequently, as individuals focus on the negative aspects of their health, their quality of life diminishes.

Similarly, perceived barriers, which include factors such as financial constraints, lack of access to healthcare, or social stigma, often significantly hinder individuals from taking necessary actions to improve their health. When these barriers are perceived as insurmountable, individuals may feel helpless and resigned, further exacerbating feelings of inadequacy and despair. This sense of helplessness not only reduces engagement in health-seeking behaviors but also negatively impacts mental and emotional health, leading to a lower quality of life.

In contrast, when individuals recognize the perceived benefits of engaging in healthy behaviors or seeking medical care, they are more likely to take proactive steps toward improving their health. This recognition fosters a sense of empowerment and agency, encouraging individuals to adopt healthier lifestyles that can lead to better health outcomes. As perceived benefits increase, individuals often experience a boost in optimism and motivation, enhancing their overall quality of life. This positive reinforcement creates a cycle where improved health leads to greater satisfaction and engagement in life. In essence, the interplay between perceived severity, perceived barriers, and perceived benefits illustrates how health beliefs shape behaviors and emotional responses.

Theoretically, this finding supports Health Belief Model (HBM) by Rosenstock (1952), which provides a framework for understanding how perceptions influence health behaviours and, consequently, quality of life. Within this model, perceived severity and perceived barriers tend to significantly impact an individual's quality of life negatively. When individuals perceive a health condition as severe, they may experience heightened anxiety and stress, which can detract from their overall well-being. This heightened awareness of severity may lead to a sense of helplessness, making individuals feel overwhelmed and less likely to engage in proactive health behaviors. Consequently, this can result in a diminished quality of life as they struggle to cope with the psychological and emotional burdens associated with their perceptions. Furthermore, when individuals perceive high barriers—such as cost, accessibility, or lack of support—they may refrain from seeking necessary medical care or adopting healthier lifestyles. This avoidance can lead to untreated health issues and a decline in physical and mental health, further exacerbating the negative impact on quality of life. Conversely, when individuals recognize the advantages of engaging in healthy behaviors or seeking medical treatment, they are more likely to take action. This recognition fosters a sense of agency and empowerment, encouraging individuals to adopt healthier lifestyles that can lead to improved physical health, emotional well-being, and overall life satisfaction. The positive influence of perceived benefits can thus create a reinforcing cycle, where improved health outcomes lead to a better quality of life, further motivating individuals to maintain their health-promoting behaviours.

Empirically, the finding of this study aligns partially with the research conducted by Park et al. (2025), which identified that perceived susceptibility positively correlates with healthful eating, glucose monitoring, and foot care practices. Additionally, perceived severity was positively associated with diet adherence and glucose monitoring. However, Park et al. (2025) found that perceived barriers negatively impacted self-care practices, particularly glucose monitoring. Interestingly, perceived benefits did not have a significant effect on overall self-care behaviors. The authors concluded that self-efficacy, perceived susceptibility, and perceived severity are significant predictors of self-care behaviors among Black/African American men with type 2 diabetes (T2D). Furthermore, this finding is consistent with Rajapakshe et al. (2024), which demonstrated that self-

efficacy, perceived susceptibility, and perceived severity significantly influenced the perceived benefits of quality sexual and reproductive health (SRH) education. Similarly, Agyemang-Duah and Rosenberg (2023) found a positive and statistically significant relationship between perceived susceptibility to health problems, cues to action, and healthcare utilization among informal caregivers of older adults. Their study also revealed a negative and statistically significant association between the perceived severity of health problems and healthcare utilization in this population.

Conclusion

This study examined the influence of health beliefs and stigma on the quality of life of key populations accessing healthcare at the One-Stop Shop in Kaduna State, Nigeria. The study was grounded in a comprehensive review of existing literature, a clearly defined problem statement, testable hypotheses, and systematic data collection and analysis. The findings were interpreted with careful attention to the research objectives and the study context. Health belief dimensions such as perceived susceptibility did not influence quality of life. However, health belief dimensions such as severity and perceived barrier had a negative influence on quality of life. The health belief dimension, perceived benefit, had a positive influence on quality of life.

Recommendations

Based on the findings, several important recommendations are made:

1. There is need to develop educational programs that focus on increasing awareness of the severity of health issues and the barriers to accessing care. These programs should aim to enhance understanding of health implications, promote the positive aspects of health management, and encourage key populations to seek care.

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