

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY, KUMASI

COLLEGE OF HEALTH SCIENCES

SCHOOL OF PUBLIC HEALTH

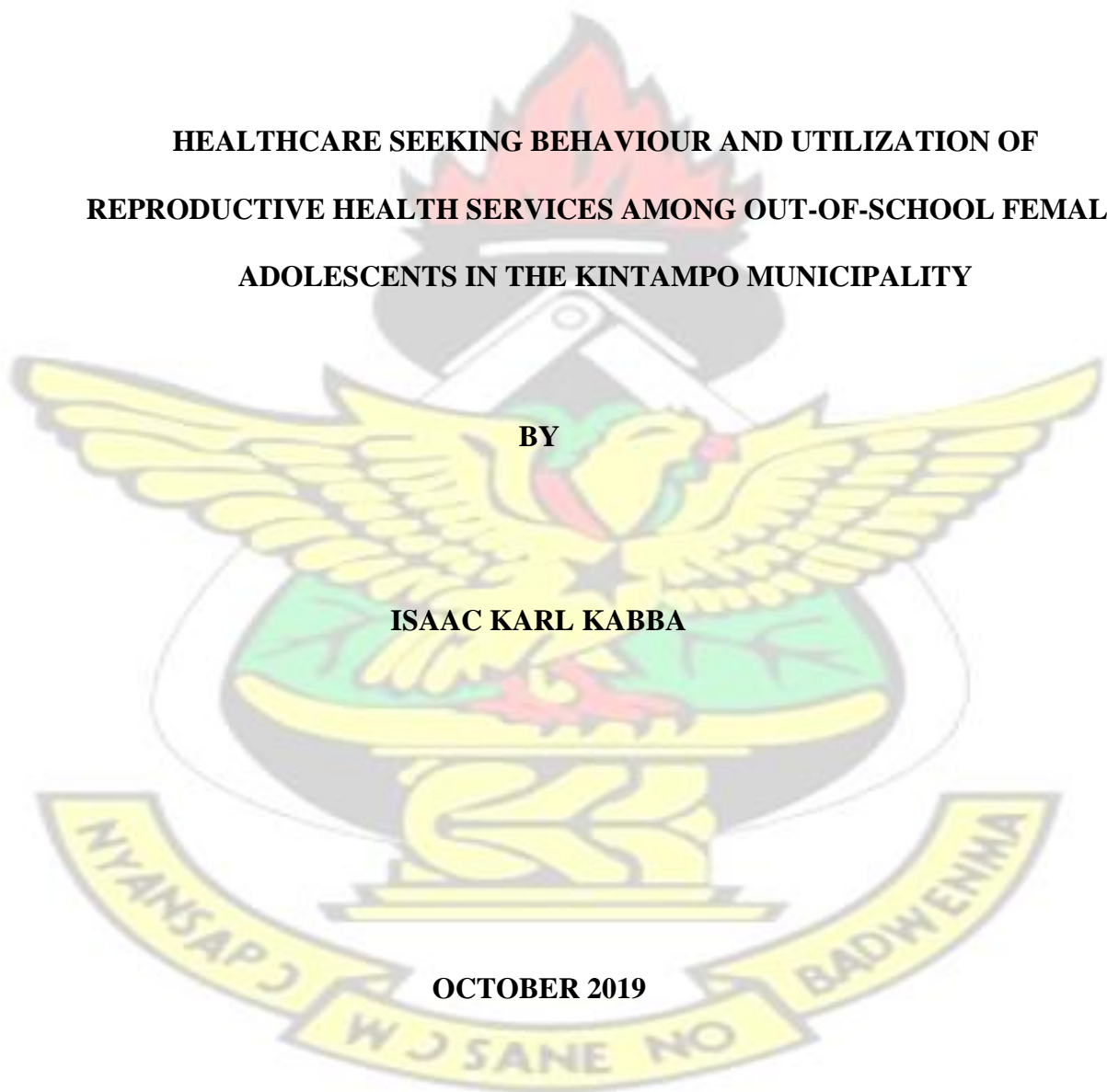
DEPARTMENT OF POPULATION, FAMILY AND REPRODUCTIVE HEALTH

**HEALTHCARE SEEKING BEHAVIOUR AND UTILIZATION OF
REPRODUCTIVE HEALTH SERVICES AMONG OUT-OF-SCHOOL FEMALE
ADOLESCENTS IN THE KINTAMPO MUNICIPALITY**

BY

ISAAC KARL KABBA

OCTOBER 2019



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ISAAC KARL KABBA

**A Dissertation Submitted to the College of Health Sciences, School of Public Health,
Kwame Nkrumah University of Science and Technology in Partial Fulfilment of the
Requirements for the Degree of
MASTER OF PUBLIC HEALTH.**

OCTOBER, 2019

DECLARATION

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the award of any other degree or diploma at Kwame Nkrumah University of Science and Technology, Kumasi or any other educational institution, except where due acknowledgment is made in the thesis.

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DEDICATION

I dedicate this work first and foremost to my beloved, wonderful and God gifted Children; Palmer Agyepoh Kabba, Thelma Perra Kabba and Diwedam S. Kabba, you are me and every good thing I do is about you.

KNUST



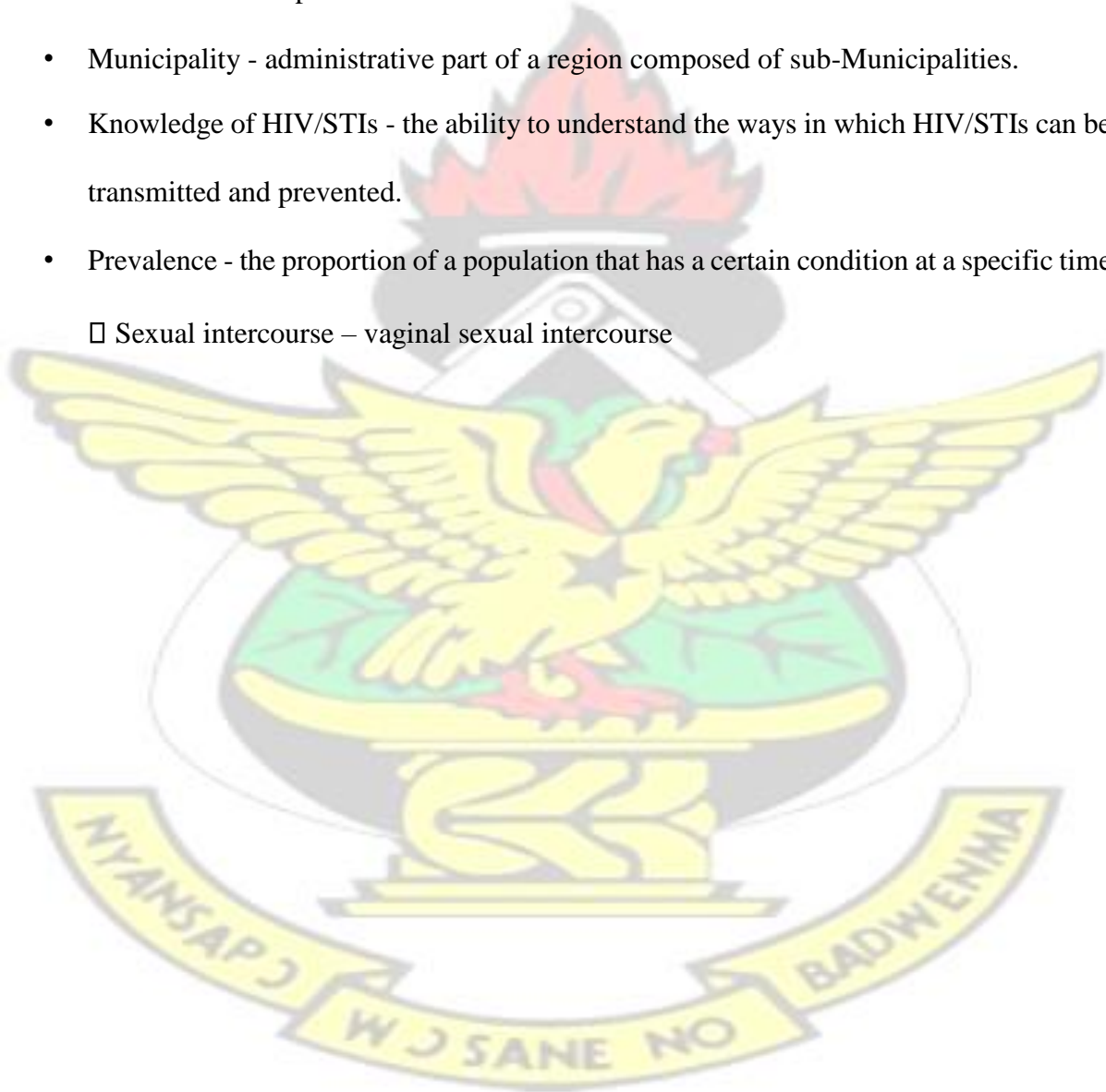
ACKNOWLEDGEMENT

All praises and gratitude are exclusive to the Almighty God for guiding and guarding me with strength to complete this piece. Without His support, my effort for a successful completion of this study would have been futile. Despite my personal effort in coming out with this piece, I believe I still owe allegiance to some well cherished personalities for the perpetual support and inspiration as well coaching in the course of my write-up. First of all, I am very grateful to my supervisor and advisor at the University (Prof. A.K Edusei) for his guidance in helping me to keep on track with this thesis. This research would have lagging behind without his ideas and comments, indeed, by going through every single line of this pack, Prof. I am most grateful.

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DEFINITION OF TERMS

- Adolescent - an adolescent is defined by WHO as a person between ages 10 and 19 years
 - Attitude – subjective judgments held by individuals and/or groups, good or bad, about particular objects, issues, persons or any other identifiable aspect of an environment.
 - Belief – People reported knowledge of HIV/AIDS/ STIs which deviates from biomedical concepts about these infections and diseases.
 - Municipality - administrative part of a region composed of sub-Municipalities.
 - Knowledge of HIV/STIs - the ability to understand the ways in which HIV/STIs can be transmitted and prevented.
 - Prevalence - the proportion of a population that has a certain condition at a specific time
- Sexual intercourse – vaginal sexual intercourse



LIST OF ABBREVIATION

ANC - Ante-natal Care

ARHD - Adolescent Reproductive Health and Development

ASRH - Adolescent Sexual and Reproductive Health

FP - Family Planning

GSS – Ghana Statistical Service

HIV - Human Immunodeficiency Virus

HSB – Health Seeking Behaviour

IUCD - Intra-Uterine Contraceptive Devices

MOH - Ministry of Health

PNC - Post Natal Care

RH - Reproductive Health

SPSS - Statistical Package for Social Sciences

SRH - Sexual and Reproductive Health

STIs - Sexually Transmitted Infections

UNAIDS - United Nations Program on HIV/AIDS

UNFPA - United Nations Population Fund

WHO - World Health Organization

YFRHS - Youth Friendly Reproductive Health Services IE&C-
Information Education and Communication.

ABSTRACT

Female adolescents between the ages of 12 and 19 represent an important sub-group of the population of Ghana. With the resurgence of STIs and unwanted pregnancy among adolescents, interest in reproductive health problems is gradually gaining attention. Adolescents have insufficient knowledge on how to protect themselves from pregnancies and STIs. Although both male and female adolescents have many reproductive health challenges, the female adolescents have additional burdens that are gender and sex specific. It was therefore the main aim of the study is to assess the health seeking behavior (HSB) and utilization of reproductive health services (RHS) among female adolescents who are out-of-school in the Kintampo Municipality, with specific objectives being to assess the HSB among out-of-school female adolescents in Kintampo; to assess the influence of culture, values and belief systems on HSB among out-of-school female adolescents; to determine the health provider related factors influencing HSB and to assess the factors influencing the use of RHS among out-of-school female adolescents in Kintampo. The research design used was a cross-sectional survey design. The main target of the research group were out-of-school female adolescents. Questionnaires which were administered to obtain information from the respondents for the purpose of the study. The results showed that approximately 72% of the female adolescents in the municipality do not know about family planning services and so do not make maximum use of them. According to them, their religion and age does not permit them to access family planning services. The ability to ensure confidentiality and privacy were found to facilitate the ability of adolescents to seek and utilize RHS in the current study from the health facilities. During an assessment of their reproductive health seeking behavior within the last six to twelve months, it was identified that those who have not accessed family planning during their pregnancy is 69.9%. The study concluded that, the actions of health practitioners does not encourage female adolescents to seek reproductive health services. It was therefore recommended that, health professionals should embark on active sensitization of the youth in order to provide relevant information, education and communication (IE&C) on reproductive services that are underutilized.

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CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

An adolescent is an individual who is between the ages of 10 and 19 (Solar and Irwin, 2010). There is a global public health in relation to Adolescent Sexual and Reproductive Health (ASRH). ASRH has increased in many nations across the globe. Adolescents make up a fifth of the world's population (Solar and Irwin, 2010). Ssewanyana (2017) further described Adolescence as a time when young people engage in increasing risk-taking behaviour that exposes them to many health risks. According to WHO (2003), many adolescents below 20 years are already sexually active, but many encounter difficulties in obtaining reproductive health care.

Similarly, adolescents have insufficient knowledge on how to protect themselves from pregnancies and STIs (WHO, 2012). Globally, there are 1.7 billion young people aged 10 to 24 years, representing one quarter of the world's population, with over 85% living in developing countries (Ashford, 2007). However, in recent times, Yesus and Fantahun (2010) puts the global population of adolescents over a quarter of the population and they form a part of what the medical practitioner will term as the sexually- active age group.

According to Best *et al.* (2014) it is estimated that 90% of the 1.2 billion individuals aged 10–19 in the world today live in low and middle income countries (LMIC) with India and China having a combined adolescent population of 443 million (Nyblade *et al.*, 2017). In Sub-Saharan Africa, however, adolescents make up the greatest proportion of the population, with 23% of the region's population aged 10–19 years (Nyblade *et al.*, 2017). In West Africa, Nigeria has the highest adolescent population otherwise known as young people where it makes up over a third (31.6%) of Nigeria's large and growing population (National Population Commission, 2013).

In Ghana, about 25% of the population are within the adolescents aged thus 12 -19 years (Kandasamy *et al.*, 2010). This is about 12% and 11% respectively of the 10-14 and 15-19 year olds and is a further confirmation of how young the Ghanaian population is. The records show that the proportion of the male population classified as adolescents is higher than that for females. The urban-rural variation shows that in the rural areas, adolescents aged 10-19 years compared to 21.4% of the females represented 24.4% of the male population. This compares with almost 22% of the urban population classified as adolescents among either the males or females (Kandasamy *et al.*, 2010).

Although both male and female adolescents have many reproductive health challenges, the female adolescents have additional burdens that are gender and sex specific. For instance, UNFPA (2004) reported that female adolescents are more vulnerable to rape, harassment and sexual exploitation, and physical and verbal abuse because they are less able to prevent or stop such manifestations of power. However, evidence from the Mabry *et al.* (2010) suggests Ghanaian adolescents still avoid reproductive health services, particularly due to the stigma around premarital sex, while over 750,000 adolescents become pregnant annually.

Further, Awusabo-Asare and Anim (2008) found that 2 in 3 young women and 4 in 5 young men with STI symptoms did not seek treatment, while approximately half of unmarried sexually-active female adolescents and over one-third of sexually-active male adolescents did not use contraceptives. With these challenges faced by female adolescents, few studies have looked at the factors determining the extent to which adolescents access and utilize existing health care services. Still, whereas 'adolescent-friendly services' and 'youth-friendly clinics' are seemingly global concepts, and the norm in developed countries and certain urban areas of developing countries, adolescent-friendly services are largely lacking in developing countries including Ghana. Several factors have been associated with poor access and low use of health services among adolescents in developing countries.

These include a general lack of access to family planning services (including contraceptives), lack of access to prevention and treatment services for sexually transmitted diseases, and to pregnancy care. For many adolescents, the opening times, location and cost of services make the services inaccessible. It is unusual for health providers to request for parental or spousal consent before providing services to adolescents under 18 years (Dehne and Reidner, 2005). This study therefore assess the health seeking behavior and utilization of reproductive health service among out- of- school female adolescents in the Kintampo Municipality.

1.2 Problem Statement

Globally, 60 out of every 1,000 adolescent girls give birth each year, and many of the pregnancies are unwanted (Ssewanyana, 2017). Further, up to 4.4 million girls aged 15 to 19 undergo unsafe abortions (WHO, 2010). While more than 10 million young people between the ages of 15 and 24 are already infected with HIV, nearly half of all new infections and about 60 % of all newly sexually transmitted infections (STIs) occurred to people under age 25 years (Dehne and Riedner, 2005). In Ghana, 2003 estimates revealed that the HIV/AIDS prevalence rate among 15-19 year-olds were 1.9 %, while the median prevalence rate for the adult population increased from 2.3 % in 2000 to 3.6 % in 2003 (Agyepong *et al.*, 2004).

According to Barnet *et al.* (2004), the utilization of Health care services, including sexual and reproductive health, is essential in addressing numerous health problems affecting the adolescents. However, the literature suggests that adolescents fail to consume existing reproductive health services due to a number of factors. For instance, adolescents may or may not know about the services and do not want to seek them due to some concerns that they need to be addressed (Chen and Farruggia, 2002).

Factors influencing their decision to access and utilize health service vary from behavioral factors to socio-cultural factors. For instance, research has found the links between educational level, employment status, wealth quintile and culture and health-seeking behaviour of adolescents to play a roll (Motlagh *et al.*, 2015; Vawda and Maqutu, 2011). In addition, several other researchers have found mainstream medical care costs and lack of access to health care facilities, which are important determinants of health-seeking behaviour (O'Donnell, 2007; Akeju *et al.*, 2016). The seeking of support and utilization of help system by adolescent have a safeguarding effect on responses to stress, resulting in healthier adjustment and less emotional and behaviour challenges (Nielsen,2016)

Mostly, adolescents prefer to seek support from informal source since the format for help usually required is of a causal nature and thus they do not consider this kind of support as a performance of seeking help. Despite the wealth of available literature looking at factors affecting health-seeking behaviours among female adolescent school dropouts, little or no study has been conducted in Ghana, particularly Kintampo, especially among adolescent who are out of school. Therefore, this study sought to fill in the gap by identifying the factors influencing the health-seeking behaviour of female adolescents who are out of school and its effect on the utilization of health service in Kintampo municipality.

1.3 Rationale of the Study

With reference to the assertion of Shaikh and Hatcher (2004) health-seeking behaviour of an individual is highly correlated with the social class of a person; the study was to identify the factors influencing health-seeking behaviour of female adolescent's dropouts. However, the subject of adolescent out of school health-seeking behaviour have actually not been well explored in Ghana especially where the study is conducted. This study is necessitated to assess the factors that are influencing health-seeking behavior among female adolescents out of school. The study outcome would help health providing

services such as the Ministry of Health, Ghana Medical Association, and Traditional Healers Association of Ghana in the provision and formulating of policies to enhance quality of health service in the country. The study outcome will influence Information, Education and Communication (IEC) in adolescent units within the various health facilities to re-structure their policy towards the youth. The document would assist adolescents, in particular, to improve upon their health-seeking behavior, making use of the health resources available to them. Finally, the study would serve as a source of reference for academia and researchers in the field of public health and add knowledge to literature for people who need information on health seeking behaviour of female adolescents out of school in the Kintampo municipality.

1.4 Conceptual Framework

Health-seeking behaviour can be explained using many theories. The theory used in this study to explain the predictors of health-seeking behaviour for individuals is the Theory of Planned Behaviour (TPB) by (Povey *et al.*, 2000). The TPB is usually used to shape behavior and therefore provides determinants for behavioral change (Armitage and Conner, 2001). The TPB assumes that people usually make rational choices that determine their behaviour (Armitage and Conner, 2001). The focus of the TPB is on the intention to act in a certain way of whether or not to seek health care or not. This intention is the determinant of the behavior (Norman and Conner, 2006). The intention is predicted by three other determinants namely: the attitude towards the behavior, subjective norm regarding the behavior, and perceived control over the behavior.

Attitude is defined as a general evaluation of an object that is based on cognitive, emotional and behavioural information (Maio *et al.*, 2018). It, therefore, relies on beliefs and the personal opinion

about the consequences of certain behaviour. The attitude is shape by previous experiences and environmental factors of the individual involved (Armitage and Christian, 2003).

The subjective norm is a social component in the TPB which is defined as a perceived social pressure of group conformity from people that have a considerably high influence on the individual or the belief in whether significant others will approve of one 's behaviour, coupled with the personal motivation to fulfil the expectations of others Armitage and Conner, (2001). One's behaviour and by extension, health-seeking behaviour can be influenced significantly by people popularly referred to as significant others such as the family and friends of the individual (Maio *et al.*, 2018). Perceived behaviour control is the third determinant and describes how people estimate the extent to which they are free to make their own decisions (Armitage and Conner, 2001).

In order to be able to perform a certain action, people have to feel self-efficient to undertake that action. They also need to think that they are capable of behaving autonomously and intentionally. In seeking healthcare, this could be understood as the feeling to be able to control the decisions regarding one's own health-seeking behaviour, as to when, where and how to seek this healthcare; as well as the belief about access to the resources needed in order to act successfully, and the success of these resources. (Information, abilities, skills, dependence or otherwise from others, barriers, and opportunities) then, the socio-demographic variables and personality traits which condition attitudes, subjective norms and perceived behavioral control.

Independent Variables

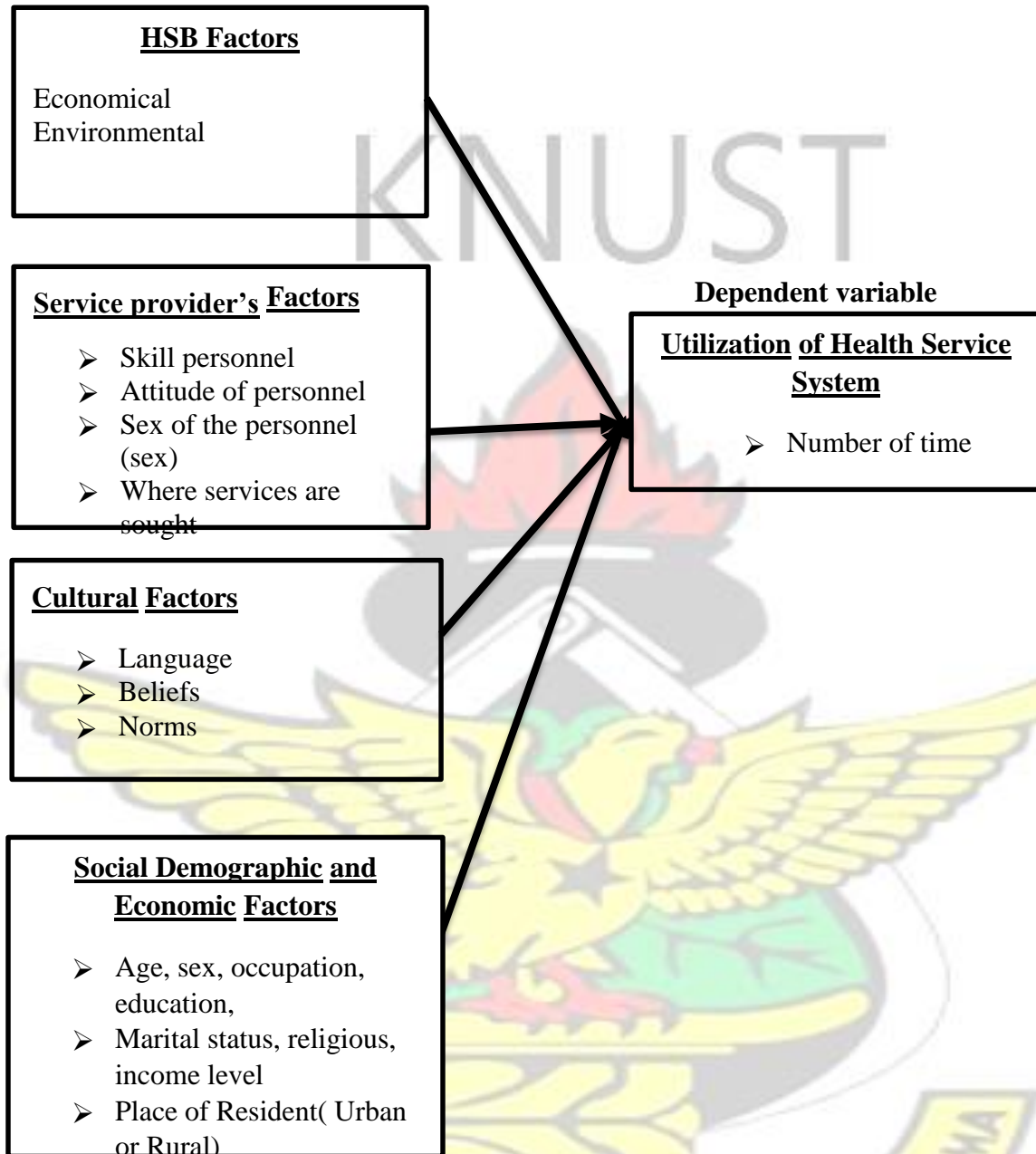


Figure 1: Conceptual Framework

The conceptual framework shows the various factors that affect female adolescent out of school in utilization of health services. These factors include social, cultural, and health provider-related factors.

The schematic representation also illustrates the variable that determines the factors that affect the utilization of health service by the adolescents, which include socio-cultural factors such as peer influence, family values, religion, education and availability of finances to health personnel to access the adolescents in various parts of the study locale.

Socio-cultural factors have an effect on the utilization of health seeking behaviour, thereby influencing the utilization of health services. In addition, the attitude of health providers towards female adolescents also influences the health seeking behaviour of adolescents.

Family values had both positive and negative influence to access to health services though, only to a smaller percentage did the family member discuss about health services.

1.5 Research Questions

1. What is the health seeking behaviour among out-of-school female adolescents in Kintampo Municipality?
2. Do culture, values and belief systems influence health-seeking behaviour among out-of-school female adolescents in Kintampo Municipality?
3. What are the health-provider related factors that influence health seeking behaviour among out-of-school female adolescents in Kintampo Municipality?
4. What are the factors that influence the utilisation of reproductive health services among out-of-school female adolescents in Kintampo Municipality?

1.6 Objectives of the Study

1.6.1 General Objective of the Study

The main objective of this study was to assess health care seeking behaviour and utilization of reproductive health services among out-of-school female adolescents in the Kintampo Municipality.

1.6.2 Specific Objectives

Specifically, the study sought to achieve the following objectives;

1. To assess the health-seeking behavior among out-of-school female adolescents in Kintampo Municipality, Ghana.
2. To assess the influence of culture, values and belief systems on health-seeking behaviour among out-of-school female adolescents in Kintampo Municipality, Ghana.
3. To determine the health-provider related factors influencing health-seeking behaviour among out-of-school female adolescents in Kintampo Municipality, Ghana.
4. To assess the factors that influence the utilisation of reproductive health services among out-of-school female adolescents in Kintampo.

1.7 Profile of the Study

1.7.1 Study Area

This section provides more information on the area in which the research work was conducted. This also comprises the education of the people in the area, their health and their demographic characteristics as well as their religion and ethnicity.

1.7.2 Location

The Kintampo municipal is one of the twenty-two (22) municipal in the Brong Ahafo region of Ghana. The municipality was created from the Kintampo District which included the Kintampo South District in 2004. It is located between latitude 8 45N and 7 45N and longitude 120 E and shares boundaries with five districts in the country, namely central Gonja district to the North, Bole district to the West, East Gonja district to the North-East (all in the Northern region), Kintampo south district to the south and Pru district to the South-East (all in the Brong Ahafo region). In terms of size and location, the Municipal is strategically located at the center of Ghana and serves as a transit point between the Northern and Southern sectors of the country. With regard to the topography, the Municipal falls within Volta basin southern plateau. The physiographic region is plain with a rolling and undulating land surface with a general elevation between 50-150 meters above sea level.

1.7.3 Demography

Kintampo Municipal has an estimated population of 111,263 (2012 Estimate) comprising 53,940 males and 57,323 females, representing 51.5% and 48.8% respectively with a growth rate of 2.6%. The age composition of the population indicates that 29.5% of the population is aged between 0 – 14 years, 64% is aged between 15-64 years and 6.5% is aged 65 years and above. The Municipality has a population density of 21.75 persons per square kilometer. This implies that there is little pressure on the land with large tracts of land available for agricultural purposes, and this has attracted a large number of migrants.

1.7.4 Education

Educational level in the Municipality is not encouraging. About 42 percent of the population had never attended school while 47 percent had had formal education from primary to junior secondary or

middle school. 10.6 percent of the population had attained secondary education with only 0.4 percent has had tertiary education. The overall literacy rate of the Municipality stands at about 58.4 percent as against the national figure of 67 percent. The district has a low standard of education, a the majority of the school-age population are primary and junior secondary/middle school leavers (47% and 45% respectively), who cannot read and write properly. In all, the district has 45 public and private basic schools, 5 private and public secondary schools and a tertiary (College of Health and Wellbeing).

1.7.5 Health

Kintampo - North Municipality is blessed with health facilities; a government hospital, which serves a dual purpose for the main inhabitants and referrals from its six (6) other sub-districts and their catchment areas. As the only government hospital and located along a major transit, linking the northern and southern sectors of the country together, the hospital's human and material resources become overburdened during sudden periods of mass casualty (Road Traffic Accidents, RTA,). Other facilities include; One (1) private health insurance accredited hospital, two (2) accredited private clinics, a private maternity clinic, sixteen (16) CHPS compounds, four (4) health centers and a new operating Non-Governmental Organizations (NGOs) hospital. Interestingly, the Municipality also has the following health-related facilities worth reporting on; the Municipal Health Insurance Scheme, Kintampo Health Research Centre, and the College of Health and Well-Being where middle -level health professionals of all categories are trained.

1.7.6 Ethnicity and Religion

The ethnic composition of the municipality is heterogeneous with the Mos and Nkoranzas being the indigenous custodians of the land. There are, however, a large proportion of northern tribes which forms the third force in the Municipality not forgetting of other Akan tribes, Ewes, Gas, and others. In terms of religion, Christians dominate, comprising 62.2% of the total population and the Muslim

Community 29.6%. This may be due to the immigration of settler farmers from the north who are mostly Muslims. Traditional religion still has a place in the Municipality and is practiced by 8.2% of the population.

1.7.7 Climate

The Municipality experiences the Tropical Continental or Interior Savannah type of climate, which is a modified form of the Tropical Continental or the Wet-Semi Equatorial type of climate. This is due largely to the fact that the Municipality is in the transitional Zone between the two major climatic regions in Ghana. The mean annual rainfall is between 1,400mm, 1,800mm and occurs in two seasons; from May to July and from September to October with the minor season (May - July) sometimes being obscured. However, because of the transitional nature of the area, the distinction between the two peaks is often not so marked (Meteorological Service Department).

1.8 Scope of the Study

The focus of the study was aimed at assessing the factors that influence health-seeking behavior among out of school female adolescents in the Kintampo Municipality. The research was limited to out of school female adolescents in the municipality. The study concentrated on health-seeking behavior factors such as socio economic, health provider related, socio-cultural and impact on utilization of health services among female adolescents who are out of school. The researcher targeted female adolescents in the Kintampo Municipality of Ghana because there is a high rate of pregnancy among females who are within the age range of 15 and 19. Similarly, no research has been conducted in this part of the country to result in formulation of measures to solve this problem. This study therefore sought to determine the factors influence health seeking behaviour of out-of-school females in the Kintampo Municipality of the country.

1.9 Organization of Report

The research work was grouped into six chapters. The first chapter centered on the introduction. It entailed the background of the study, the statement of problem, objectives of the study, the research questions, significance of the study, the scope of the study and the conceptual framework of the study. The second chapter focused on the review of literature that is relevant to the research work conducted. Various theories and models that underpin the study was discussed. The third chapter focused on the research methodology employed in the study. It consisted of the research design, target population, sampling size and the sampling method, the research instruments used for gathering relevant data, source of the data collection and data analysis procedures. Chapter four presented the results obtained from the field through structured questionnaires. Chapter five dealt with discussion of findings gathered from the previous chapter. Finally, chapter six presented conclusions and recommendations for further studies and policy makers.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter reviews some of the related literature, which deals with the variables selected for the related factors, which influence health-seeking behaviors. The chapter outlines the concept of healthseeking behavior, the factors influencing health-seeking behaviour and the relationship between health seeking behaviour and the utilization of health services.

2.1 Adolescent Reproductive Health

Adolescence is a time of increased risk-taking. Adolescents are children between the ages of 13 and 19. They are vulnerable to behavioural challenges during (Cudjoe, 2018) Adolescents make efforts to create their own identity to be autonomous. They are also conscious making their own decisions and actions (Häggström-Nordin, 2005). Adolescents see themselves to be free from diseases and infirmities. Adolescents therefore tend to think that they are not vulnerable to illness because of their possession of few colleagues who battle with major illnesses. This however makes children between the ages of 13 and 19 involve themselves in risk-taking behaviours that make render them exposed to health challenges that negatively affects their current and future health (Armitage and Conner, 2001).

Adolescent reproductive health is a problem encountered by people across the globe. Many adolescents engage themselves in a lot of health risk behaviours that pose threats to their wellbeing and health (Pardee *et al.*, 2017). These behaviours of adolescents presents unwanted pregnancy and sexually transmitted diseases such as HIV/AIDS and syphilis. These diseases and unwanted pregnancy pose serious economic, physical and social challenges to affected adolescents (Kamau *et al*, 2006). There are about three million adolescents that are annually infected with STDs globally. According to WHO estimates, rates of STDs are more in Sub-Saharan Africa with 69 million cases every year.

Females are known to encounter greater reproductive health problems than males in puberty. Current condition of sexual and reproductive health service is not the best. There is insufficient accessibility and utilization of service. This however calls for attention of the authority of societies and the government (Joshi *et al.*, 2006). Challenges to use and access preventive RHS by people within the age range of 10 and 19 consist of lack of confidentiality and privacy, inability to afford services and insensitive staff (Martin *et al.*, 2004).

2.2 Health Seeking Behaviour

Health Seeking Behaviour (HSB) refers to a decision or an action taken by an individual to maintain, attain, or regain good health and to prevent illness. The action taken to redeem health challenges may encompass all available health care options like visiting a public or private and modern or traditional health facility, self-medication and use of home remedies or not to utilize the available health services etc.

Although HSB includes seeking health remedy from traditional health facilities, the desired HSB has been related to visiting official channels in a formally recognized health-care.

As for health care system, in almost all the developing countries, the public and the private health sector coexist but private care provider is usually preferred all around due to easy accessibility even in the night, quick relief and individual attention (Sudharsanam, 2007). Health seeking behavior is common believed as the ways in which people behave in relation to their health. It can also thought of as the utilization of health-care services, which is an endpoint of the process of seeking care.

According to Chauhan *et al.* (2015), the health-seeking behavior is a result of a complex interaction of provider, patient, illness and household characteristics. Further, Prosser (2007) posits that healthseeking behavior is a complex and multi-dimensional topic, which driven by several determinants. These complex interactions of HSB encompass a variety of socio-economic variables, including sex, age, the social status of women, the type of illness, access to services and perceived quality of the service.

For the purpose of this study, the health-seeking behavior is, defined as the attitude of an individual to attain and seek quality health in other to avoid sickness. The concept of health-seeking behaviors has evolved over the course of time and has ultimately become a tool for understanding how people employ the health care systems in their respective socio-cultural, economic and demographic circumstances.

All these behaviors actually define social position of health and provide a better understanding of the disease process of people. However, for the purpose of this study, the scope of health-seeking behaviour will be widened to cover health behaviours generally for female adolescents out of school and their health challenges.

2.2.1 Adolescent Health Seeking Behaviour

Adolescence is a transitional fraught with confusion and searches for identity. In this developmental stage, adolescents experience increased sensitivity, making them an especially vulnerable group to health (Cudjoe, 2018). Adolescents undergo many physical, emotional and behavioural changes because adolescence is a period of transition from childhood to adulthood. Some of the challenges faced by adolescents include peer pressure, dating anxiety, emerging sexuality, independence, separation anxiety, responsibility, as well as more serious like violent behaviour and other reproductive health challenges.

Further, the causes of ill health in female adolescents are mostly psychosocial rather than biological (Martin *et al.*, 2004). Female adolescents often engage in health risk behaviours that reflect the processes of adolescent development: experimentation and exploration, including using drugs and alcohol, sexual (Cudjoe, 2018). However, seeking health help when sick by these adolescents can be a problem. Therefore, understanding adolescents' health seeking behaviour is critical for quality service improvement.

Adolescents or parents to seek assistance from other people to cope with problems (Cauce and Srebnik, 2003) conceptualize adolescent health seeking as a multi-step process that involves efforts made. On the health seeking behavior of adolescents on mental health, literature has found that the overall prevalence of help-seeking for adolescents with symptoms of mental health problems was 8.3 percent (Sareen, *et al.*, 2005). Moreover, research has shown that health-seeking behaviour consistently shows

that adolescents underutilize mental health services (Cudjoe, 2018). Similarly, Blanco *et al.* (2008) found low treatment rates across all psychiatric disorders, with fewer than half of those with mood disorders and less than 20% of those with anxiety disorders receiving treatment. In a gender-related research, females were identified to be more likely to self-disclose (Peter and Valkenburg, 2011) and seek help for their mental health problems than males.

Research has shown that adolescents also seek health care services less frequently than any other age group and are less likely to have health insurance than any other age group. The challenges of accessing PRHS are greater for adolescents living in developing countries where adolescent health care services are few or lacking, and there are no mandatory health insurance systems (Ahmed *et al.*, 2016). The health of adolescents has largely been ignored in comparison to that of children under 5 years and adults (Kamau *et al.*, 2006).

Kabir *et al.* (2014) explored the treatment-seeking behaviour of 800 unmarried female adolescents for selected reproductive health (RH) concerns in two low-performing areas of Bangladesh and found that only 40% of the female adolescents with menstrual problems sought treatment from qualified physicians.

Regarding oral health seeking behaviour among adolescents, Abebe and Awoke, (2014). found that 85.9% of 460 female adolescents with diabetes reported having appropriate health-seeking behaviour at the time of the house-to-house community survey in Tanjong Karang District. In summary, Cudjoe (2018) posits that appropriate health-seeking behaviour among adolescents could solve emergency problems and save lives.

2.3 Female Adolescent Utilization of Health Service

According to WHO, to be able to reduce the above health challenges during adolescence, they need to have access to timely and safe information and service to make decisions that will enhance and protect their health (Ahmed *et al.*, 2016). Besides, because most adolescents are not fully aware of the risks in their environment, they need a safe and supportive environment to live and achieve their potentials through play, work, and studies (Kabir *et al.*, 2014). Access to health care can be defined in a variety of ways. In its most narrow sense, it refers to geographic availability. A far wider definition recognizes four areas of access: availability, accessibility, affordability, and acceptability. O'Donnell (2007) also defines access as the opportunity to use health care; others draw no distinction between access and use. One very crucial intervention necessary to tackle most of the health problems during adolescence is access to confidential health and counseling services. This prevents health problems and mitigates them when they do occur (Ahmed *et al.*, 2016).

Utilization of health services is a complex behavioral phenomenon. Empirical studies of preventive and curative service have often found that the use of health services is related to availability, quality, and cost of services as well as to social structure, health beliefs and personal characteristics of the users (Kamau *et al.*, 2006).

Sedgh *et al.* (2015), in a study of the utilization of maternal healthcare among adolescent mothers in urban India: evidence from DLHS-3 revealed that 22.9% of mothers received full antenatal care. In addition, Mohammed, (2017) in his study on access to and utilization of antenatal care services in Uganda also revealed that less than 46.9% of the women less than 20 years in Uganda made a minimum of four antenatal visits almost relatively proportionate to those who made between 1-3 visits (47.3%). In addition, Singh (2014), in the study Utilization of Maternal Health Care Services among Married Adolescent Women: Insights from the Nigeria Demographic and Health Survey, 2008 shows that out

of 2,434 eligible women who gave birth in the 15 to 19-year-old age group, 35.1% had at least four ANC visits. Apart from female adolescents' utilization of maternal health services, some related studies have also looked at their utilization of the services of other related diseases. For instance, in Ethiopia, utilization of family planning services in the existing health care delivery system by young people was very low and a high rate of unintended pregnancy and abortion complications occur (Ahmed *et al.*, 2016).

2.4 Socio-economic Factors Influencing Health Seeking Behaviour among Female Adolescents

A number of factors including social-economic determinants of health influences the health seeking behaviour of female adolescents. According to Ahmed *et al.* (2016), social and economic determinants of health are the conditions in which people are born, grow, live and work. Therefore, socio-economic status is considered as a central factor in determining health outcomes of adolescents and holds a greater importance (Rutstein and Johnson, 2004) than the demographic factors, as suggested by few studies (Habibullah and Afsar, 2013). Furthermore, the health-seeking behaviour is being acknowledged progressively in the literature as an interconnecting mechanism through which this phenomenon occurs (Stringhini *et al.*, 2010) and is, therefore, the major focus of this study.

The American Psychological Association defines socio-economic status as the social positioning of individuals or population group within a milieu that is determined by the socioeconomic factors of education level, occupation, and income. By examining socioeconomic status, inequities are revealed in terms of resource accessibility, as well as the distribution of power, prestige, and domination within a society (Albert and Davia, 2010).

Base on the definition by the APA, this study modified the definition of socioeconomic status to suit the WHO CSDH framework with reference to indicators such as education, employment status and income, which are the most common method of measuring the construct in the public health field

(Matthews and Gallo, 2011). Because using income as a socioeconomic indicator has its own limitations, this study decided to use multiple correspondence analyses to construct an asset index as a proxy for socioeconomic status, as it is assumed that income is the amount required to buy an asset. There are various empirical studies on the influence of socioeconomic factors on the utilization of health services by female adolescents. For instance, empirical evidence suggests that education is an important determinant of health (Albert and Davia, 2010) with higher levels of educational attainment associated with improved maternal and infant health outcomes (Chou *et al.*, 2010), adolescent health (Viner *et al.*, 2012), and reduced morbidity and mortality (Baker *et al.*, 2011). For example, the widely cited Marmot Review in health inequality research reported that obtaining a tertiary qualification is associated with increased health and longevity. Their study conducted in England found that an estimated 202,000 premature deaths could be averted if all of the population achieved a degree (Jakab and Marmot, 2012).

A pronounced education gradient in health is cited in the literature, suggesting that as the level of education increases, so does the likelihood of positive health outcomes (Zimmerman *et al.*, 2015). Therefore, education can be proposed to be an important component in improving the life trajectories of population groups whilst reducing health inequalities that stem from disparities in health-seeking behaviour.

The dominant findings in the literature from countries in sub-Saharan Africa is that education is an important determinant of health-seeking behaviour with lower levels of education associated with a decreased likelihood of seeking care (Anselmi *et al.*, 2015; Njuki *et al.*, 2014; Zyaambo *et al.*, 2012). In contrast to this view, a study by (Anselmi *et al.*, 2015) examined the health-seeking behavior of populations in 24 developed European countries and found the opposite effect. In other words, that lower levels of education were indicative of increased health-related activity.

A study conducted in Zambia linked education to increased knowledge about ill health, how to recognize symptoms, and increased awareness about where to go when sick. Furthermore, education is a proxy of socio-economic status as educational attainment generally results in better employment and income, which allows the individual a broader spectrum of choices when it comes to health care Zyaambo *et al.*, (2012). The above reasoning could offer as explanations for why this was the dominant finding in the literature.

A study conducted in Burkina Faso, a low-income country in West Africa found that increased educational attainment improved the likelihood of visiting a formal healthcare service provider Beogo *et al.*, (2014). A possible explanation for this was provided by Tarafder *et al.*, (2014) who found that misconceptions and myths deterred seeking treatment from the formal healthcare sector as uneducated groups tend to perceive western medicine to be too severe for treating their infants, and believed that government health clinics only catered for the reproductive needs of females resulting in distrust and avoidance.

Although this study was situated in the urban slums in Bangladesh, it is plausible to believe this to be a barrier in South Africa given its history and general distrust towards western practices by many historically disadvantaged population groups.

Employment status is recognized in the literature as one of the most important determinants of health outcomes, particularly in the African context, as shown in a decomposition analysis by Hosseinpoor *et al.* (2012). The researcher found that employment status contributed significantly to health disparities among the various populations who resided in sub-Saharan Africa. Broadly, the literature on the relationship between employment status and health has focused on the effects of either unemployment or employment. Being employed has been associated with increased physical and mental health, as well as improved quality of life (Hosseinpoor *et al.*, 2012), whilst being unemployed has been linked to reduced fertility (Del Bono *et al.*, 2012),

In relation to the association between employment status and health-seeking behaviour, international literature examining data from both developed and underdeveloped countries including those in subSaharan Africa suggest that being employed is a deterrent to seeking healthcare services, particularly among lower socio-economic groups who are fearful of losing employment by taking time off work to go to a clinic or hospital. In some circumstances, this has resulted in people choosing informal healthcare providers such as pharmacies who are open until late (Tarafder *et al.*, 2014). Moreover, as mentioned above, being unemployed can lead to poorer mental and physical health, which would increase the need of seeing a health practitioner (Del Bono *et al.*, 2012; Henkel, 2011; Tarafder *et al.*, 2014) when compared to the employed who have been shown in the literature to experience lower incidences of morbidity (Hosseinpour *et al.*, 2012).

The empirical evidence that the unemployed utilize the healthcare system more than the employed is not conclusive. A cross-sectional study in Sweden found that being unemployed was associated with a decreased likelihood of going to a healthcare facility regardless of the need (Del Bono *et al.*, 2012). Sweden is categorized as a high-income country according to Johnson *et al.* (2005) and therefore is not comparable to low- and middle-income countries, which suggests the effect of socio-economic status on health-seeking behaviour occurs at both a household level and a macroeconomic scale (Beogo *et al.*, 2014).

Since income is required in order to acquire assets, this section will consider the effects of wealth-related quintiles on health and health-seeking behaviour by exploring studies that have used either income, or assets as a measure of socio-economic status, as the outcome is assumed the same. The literature appears to indicate that the effects of wealth on health cannot be examined without adopting an inequality lens. The consensus in the literature is that the populations from wealthier quintiles exhibit better health outcomes whilst those from the poorest quintiles experience the worst

health outcomes. Therefore, a gradient in health emerges where progressing up a quintile equally improves health outcomes (Braveman *et al.*, 2010). Moreover, financial capital, which is a prerequisite for acquiring assets, has been linked to life expectancy, diabetes and coronary heart diseases (Braveman *et al.*, 2010; Gray and Vawda, 2011).

Another study designed to assess the factors associated with health-seeking behaviour and to explore feasible solutions to the obstacles migrant workers in China faced with when accessing health-care with a sample size of 2478 found that the high cost of health service was a significant obstacle to health-care access for 40.5% of the migrant workers who became sick (Habibullah and Afsar, 2013). However, 94.0% of the migrant workers did not have any insurance coverage in Beijing. The multilevel model analysis indicates that health-seeking behaviour among migrants is significantly associated with their insurance coverage (Zyaambo *et al.*, 2012). Meanwhile, such factors as household monthly income per capita and working hours per day also affect the medical visitation rate of the migrant workers in Beijing (Peng *et al.*, 2010). Operationally, these migrant workers may include female adolescents and so the findings of the study reflected the entire health seeking behaviour of larger demography.

In considering the literature pertaining to health-seeking behaviour from LAMI countries, the general consensus is that the population groups from wealthier quintiles have an increased likelihood of utilizing the healthcare system and subsequently have improved health outcomes to those in the poorer quintiles (Hosseinoor *et al.*, 2012). Empirical evidence from less developed countries in Asia and sub-Saharan Africa concur that population groups which experience poverty have poorer health due to the decreased access to healthcare facilities caused by financial barriers (Njuki *et al.*, 2014).

Focusing specifically on South Africa, Del Bono *et al.* (2012) investigated the prevalence of depression among a sample of 977 persons in the Eastern Cape Province and found that persons in lower income quintiles were less likely to seek help for their depression of which a major determinant was a lack

of finances. A finding confirmed by both a nationally representative study and a study in the North West Province of South Africa (Hosseinpoor *et al.*, 2012; Van der Hoeven *et al.*, (2012). Therefore, it can be tentatively proposed that financial resources have an influential role on the accessibility of healthcare and the type of healthcare facility accessed.

Having a higher income and subsequent wealth enables individuals with the freedom of choice in terms of healthcare provider and due to many government healthcare facilities in sub-Saharan Africa being described as congested with long waiting periods and with discourteous staff, given the option, people who can afford to choose go to private healthcare facilities regardless of the increased cost (Beogo *et al.*, 2014). Contradictory evidence from Karachi in Pakistan found that the public sector was the dominant choice when seeking healthcare service, which is highly subsidized as is the case in South Africa (Habibullah and Afsar, 2013). The arguments suggest that by improving the quality of service delivery and care in the public health sector of South Africa, citizens may choose this option over the other types of healthcare. In considering the above literature, wealth is an important determinant of health-seeking behavior.

2.5 Health Provider Related Factors' Influence on Health Seeking Behaviour among Female Adolescents

Studies have reported that health workers lack the skills and knowledge to provide adolescent friendly services (Beogo *et al.*, 2014). Most health workers are unable to provide age appropriate information and education to the adolescent. Besides, adolescents have also been reported having discomfort discussing health problems with health worker especially those related to reproductive and sexual health issues. Also, they are disappointed with how healthcare workers answer their questions or interact with them. According to Habibullah and Afsar (2013), both female adolescents and parent wish health care professionals discuss a broad range of health issues with them.

A survey of adolescents showed more than 50% said their physicians never addressed any of the health risks that adolescent wanted to discuss (Alemayehu *et al*, 2012). Studies have it that due to lack of skill and knowledge by some health care providers, adolescents have been denied some crucial services or treated in a disrespectful manner (Awusabo- Asare and Anim, 2008). It has been recognized that adolescent-friendly services are very necessary for adolescents to receive health services especially reproductive and sexual health services.

Adolescent friendly services are health services prepared to be convenient and utilized by adolescents. They include counseling, contraceptive services, post-abortion care, VCT, and STI information and management, including referrals. Unfortunately, such services are limited, and when even available most adolescent do not access them because of incompetent staffs and lack of confidentiality (Neema *et al*, 2004). Other studies also suggest that healthcare workers have a high interest in developing these special skills required to work effectively with the adolescent but their educational needs are unmet (Kruk *et al.*, 2010). WHO suggests that these deficiencies of health care providers in the adolescent field are associated with undefined work processes and lack of resource. Different authors describe factors that influence oral health seeking in different ways but broadly, these are associated with psychological and economic experiences of communities and individuals. Mndzebele and Kalambay (2014) in a study conducted in three areas in Kentucky, America, found that access to care, affordability, attitudes towards dental care and fear influenced utilization of oral health services. As reported in Atuyambe *et al.* (2005), among adolescents on the experiences that often medical staffs have poor receptions with such intimidating mentality that would deter one from returning for health care service at a health facility or receive assistance from skilled attendants but would rather prefer TBAs.

For female adolescents to continue to make use of healthcare services, health workers must commit themselves to behave positively towards them. Analogous to service industry clients, female adolescents will hesitantly seek care in health facilities where their earlier experience with health professionals is negative (Magoma *et al.*, 2010). Bad word of mouth – feeling of being abandoned and feeling of not being gladly accepted largely explain why female adolescents are not utilizing maternal health care service (Petit *et al.*, 2013).

The quality of healthcare is also reliant on a number of supply-side factors, which include supplies and logistics (drugs and non-drugs), medical equipment, appropriate technology and ability to handle maternity cases (O'Donnell, 2007). The perception of the quality of service drives female adolescents towards the health facility regardless of the ownership of the facility. For instance, Chauhan *et al.* (2015) found that adolescents preferred private practitioners due to their better availability and quality of health care services compared to the public health system, which has governmental support. However, Andersson *et al.* (2012) also raised an interesting point that adolescents with weaker beliefs in health care professionals may be more likely to engage in risky behaviours in relation to their diabetic status. Thus, this doctor-patient dynamic is yet again raised as an important issue.

Using data on medical care quality collected through both vignettes and direct observations in India, Indonesia, Tanzania, and Paraguay, (Mohanani *et al.*, 2015) show not only that the competence of doctors in low-income countries is low, but also that the quality of care patients receive is even lower than would be expected given their doctor's competence, especially among the poor. For example, they found that in Delhi, a doctor spends on average of only 3.8 min with a patient and performs less than one examination procedure. In Tanzania, doctors complete only 24% of the essential checklist when faced with a patient with malaria and only 38% when the patient is a child with diarrhea (Mohanani *et al.*, 2015).

2.6 Cultural Factors Influence the Health-Seeking Behaviour of Female Adolescents

Understand the better understanding of why adolescent female out of school have some health-seeking behaviour better if there is a proper appreciation of their socio-cultural values and belief systems.

Bourn and Rhule (2009) posit that where cultural practices are more pervasive, an individual's status in terms of the level of education, marital status, income and social standing have no effect on the health-seeking behaviour of the people. Literature studying different cultures clearly demonstrates that beliefs often influence health care seeking behaviour including oral health care seeking behaviour among female adolescents. Makubalo (2012) found different patterns of health care seeking behaviour in the United States, which are attributable to religiosity and spirituality in the choice of complementary alternative medicines.

These authors found that female adolescents who rated themselves as religious (those whose beliefs are validated by institutional communities) tended to use minimum complementary and alternative medical techniques while the self-rated spiritual individuals (those with a personal inclination not associated with an institution or collective activity) tended to use more of these techniques.

According to Dutta-Bergman (2005), culture shapes health-seeking behaviours and serves as the lenses for perceiving and interpreting experiences. Further, Ikamba and Ouedraogo (2003) posits that sociocultural structures and processes influence adolescent health-seeking behaviour. These factors contribute to understanding societal and population processes such as current and changing rates of morbidity, survival, and mortality. For instance, Pramukh and Palkumar (2006) in their study among the Bogatha found that adolescents attribute diseases to nature and divine rules without logical explaining to these events.

This means when adolescents perceive they have an illness they seek a spiritual cure in a traditional way instead of seeking it from a health facility. They believe in the power of prayers and rituals that enable some herbs to act as medicines to heal diseases among them. The researchers in their quest to

understand these cultural influences on health-seeking behaviour did not indicate the other sources of health seeking, in case of failure of the first line of treatment (Pramukh and Palkumar, 2006). Despite the fact that there are multiple sources of treatment, the emphasis was laid only on the conventional healthcare delivery system.

Another study by Johnson *et al.* (2005) that aimed to predict patient treatment seeking behaviour in Guatemala found that there was very little influence of culture on their health-seeking behaviour. Their treatment choice was based on the efficacy of treatment but not on cultural beliefs. Johnson *et al.* (2005) in a study that reviewed the literature on the influence of spiritual beliefs on treatment decisions of Africans.

They found spiritual beliefs and practices as sources of comfort, coping, and support. God held to be responsible for physical and spiritual health and the doctor seen as God's instrument of healing (Johnson *et al.*, 2005).

One of the studies that were conducted in Zimbabwe on what was mainly affecting the reproductive health of many Africans found out that the majority of the adolescents were not visiting existing reproductive health facilities due to long distance, a young person's being too busy with others generally feeling shy to go for the services (Erulkar *et al.*, 2005).

According to Allen *et al.* (2005), peer group influence or pressure which is a determinate of health seeking behaviour among adolescents. They argue that pressure from peer groups encourages individuals to change his or her attitude, values or behavior in order to conform to group norms (Allen *et al.*, 2005).

Adolescent peer pressure is one of the most frequently referred to forms of negative peer pressure. It is particularly common because most young people spend a large amount of time in fixed groups regardless of their opinion of those groups and they lack the maturity to handle pressure from their friends. Ikamba (2003) says that female adolescents are forced into having sexual intercourse by peer

pressure. Peers play a role in initiating sexual activities, which frequently ends in unwanted and or early pregnancies.

However, according to Steinberg and Monahan (2007), adolescents in a group are willing to behave positively towards those who are not members of their own peer groups. These include but not limited to their mentors, religious leaders, and parents among others.

The level of illness and the type of illness also determines the health seeking behaviour of adolescents. For example, Meyer-Weitz *et al.* (2000) investigated the determinants of delay behaviour in health care seeking in a sample of 292 adolescent patients (20 years and younger) with STD symptoms. Fifty-six percent (56%) of the adolescents sought health care within the first 6 days of noticing symptoms, 23% waited between 7 to 10 days and 21% waited longer than 10 days before seeking health care. Early health care seeking was determined by the perceived seriousness of STDs, an absence of self-treatment prior to seeking care and positive attitudes regarding personal autonomy in condom use behaviour. This means the danger of the type of disease to the adolescent decides their health-seeking behaviour.

The environment under which female adolescents grow determines their health-seeking behaviour. When female adolescents are surrounded by good reasons to protect their health, it is much easier for them to adopt and sustain positive behaviours. Therefore, it is important to foster an environment where female adolescents find it rewarding to make positive decisions about their reproductive health (Allen *et al.*, 2005). However, Johnson *et al.* (2005) observes that lack of adequate privacy, confidentiality and judgmental attitudes of service providers, who often lack counseling skills, are determinants of health-seeking behaviour and recommends that a package of training modules for youth in reproductive health service information.

Edwards (2016) evaluated the impact of socio-economic and demographic determinants on the health-seeking behaviour of the South African population in an attempt to add to the limited literature

on the topic. A quantitative secondary analysis was conducted using the data from the National Income Dynamics Study Wave 4.

Multivariate binomial logistic regressions were used to examine the socio-economic and demographic determinants of health-seeking behaviour. Some of the main findings were that women, the elderly and adults who were affiliated with quintile 5 had the highest odds of ever having visited a healthcare facility in the past year; whilst adults who had completed secondary education or resided on farms had the lowest odds. In relation to the type of healthcare facility last visited, adults who had a post-matric qualification belonged to wealth quintile 5 or who were married had the highest odds of going to a private healthcare facility. In contrast, adults who were unemployed who resided in traditional areas and women had the lowest odds of going to a private healthcare facility.

A study conducted in Burkina Faso, a low-income country in West Africa found that increased educational attainment improved the likelihood of visiting a formal healthcare service provider (Beogo *et al.*, 2004). A possible explanation for this was provided by Caldwell *et al* (2014) who found that misconceptions and myths deterred seeking treatment from the formal health care sector as uneducated groups tend to perceive western medicine to be too severe for treating their infants, and believed that government health clinics only catered for the reproductive needs of females resulting in distrust and avoidance.

Although this study was situated in the urban slums in Bangladesh, it is plausible to believe this to be a barrier in South Africa given its history and general distrust towards western practices by many historically disadvantaged population groups (Neema *et al*, 2004).

In relation to the association between employment status and health-seeking behaviour, international literature examining data from both developed and underdeveloped countries including those in subSaharan Africa suggest that being employed is a deterrent to seeking health care services,

particularly among lower socio-economic groups who are fearful of losing employment by taking time off work to go to a clinic or hospital.

In some circumstances, this has resulted in people choosing informal healthcare providers such as pharmacies who are open until late (Caldwell *et al.*, 2004). Moreover, as mentioned above, being unemployed can lead to poorer mental and physical health, which would increase the need of seeing a health practitioner (Del Bono *et al.*, 2012). When compared to the employed who have been shown in the literature to experience lower incidences of morbidity (Hosseinpoor *et al.*, 2012).

The empirical evidence that the unemployed utilize the health care system more than the employed is not conclusive. A cross-sectional study in Sweden found that being unemployed was associated with a decreased likelihood of going to a healthcare facility regardless of the need (Caldwell *et al.*, 2004). Sweden is categorized as a high-income country according to Bernard *et al.* (2015) and therefore is not comparable to low and middle-income countries, which suggests the effect of socio-economic status on health-seeking behaviour occurs at both a household level and a macroeconomic scale. A study by Zyaambo *et al* (2012) concluded that Zambian urban citizens who were between the ages of 30 and 39 years were two times more likely to utilize the health care system than those in the age group of 15 to 19 years old. From the health belief model angle, this trend could be attributed to adults being more aware of the importance of maintaining a healthy state than the youth, whilst if an economic perspective is adopted it could be explained as adults being more financially independent. This was substantiated in a South African study by Henkel (2011) whose sample only included adolescents. The study found that only 27% sought out medical care in the past six months of which the majority of the sample went to clinics, with the smallest proportion seeking help from homeopaths or traditional healers.

In contrast to these views, two studies in developing countries outside of sub-Saharan Africa found no association between age and health-seeking behaviour which could be explained due to the poor

methodological design of the study (Habibullah and Afsar, 2013), and sampling a very different target population of migrant workers in urban China who have a tendency to return home when ill thereby distorting the study's findings (Peng *et al.*, 2010).

From the literature reviewed, no studies were found which investigated age as a determinant of the type of healthcare facility accessed. Consequently, this study attempts to provide insight into this relationship and contribute to the limited literature.

2.7 Health Seeking Behaviour and the Utilization of Health Services

Many adolescents in developing countries, upon their exposure to formal health and social services still prefer to confide in family and friends when faced with sexual and reproductive health problems. A study in Vanuatu reported that about 12.6% of adolescent girls do not seek formal treatment for reproductive health problems as a result of fear and shame (Joshi *et al.*, 2006). Most adolescents associate modern contraceptives with heavy menstrual flows, excessive weight gain and future infertility (Mitchell *et al.*, 2014).

Access to oral health care is critical to prevent oral disease as well as to identify oral health problems early and prevent disease progression where it already exists. Health features among children and adolescents are more closely related to the mother than to the father. When oral health services are not obtained, adolescent girls may be omitting vital preventive oral health screening and education. In this regard, Habibullah and Afsar (2013) evaluated the utilization of oral health services among adolescent girls through a cross-sectional study of adolescent girls attending secondary schools in the immediate vicinity of a tertiary health facility that provides dental services. The results show that the majority (97.3%) knew who a dentist is. Of all the respondents, 113 (25.5%) had visited a dentist.

There was no statistically significant association between parents' educational status and utilization of oral health services among the respondents. More than three quarters (79.6%) of the respondents that had visited the dentist were satisfied with the treatment they received. The respondents who had never

visited a dentist gave several reasons why they had not, with having no dental problem (77.0%) as the most frequent reason.

Despite the growing health needs of adolescents due to intrinsic and extrinsic factors, health services in developing countries are not prepared to provide appropriate care due to inadequate awareness of adolescent health needs, and inadequate training and capacity of the service providers. The inability of health service providers to ensure that qualified personnel is employed to give adequate care to adolescents influence their utilization of health services. Cross-sectional survey, to assess adolescents' health service utilization pattern, their attitudes towards the existing health services and their preferences in selected schools in Addis Ababa using an anonymous self-administered questionnaire found that Considerable proportion of the adolescents reported that existing health services are inaccessible (30.5%), unaffordable (20.2%) and unacceptable (24.2%) (Berhane, *et al.*, 2005).

Adolescent's preference regarding the service place and person serving vary widely, but the majority prefers special service hours designated for adolescents (70.1%), and a discounted price or free service (80.0%). Pricing influences the utilization of health services by adolescents.

Antenatal care provides an opportunity to empower pregnant adolescents to recognize and respond to the signs and symptoms of obstetric complications. Adolescent pregnancy is a high-risk situation because of these mothers' physical and psychological immaturity for reproduction (Henkel, 2011). Mohammed (2017) examined the various determinants that may result in their inability to attend antenatal care at the various health facilities among 126 pregnant adolescents in the Yendi Municipality using a cross-sectional, non-experimental descriptive study design with both quantitative and qualitative data collected and analyzed. The study revealed among others that majority of adolescent mothers in the Yendi municipality attributed long-distance travel to health facilities, mother's and partner's level of education, unfriendly attitude of health workers, cultural beliefs and income as the main determinants for the utilization of antenatal care services. The chi-square analysis

performed, also identified a number of factors that have a significant association with the utilization of antenatal care services, these include place of residence, ethnicity, religion, marital status, partner's education level and distance to a health facility.

Studies have also shown that adolescents' utilization of RHS may be restricted because of fear, stigma, and shame (Nmadu, 2017). A study in Tanzania reported that adolescents do not seek formal treatment for reproductive health problems because of shame and fear of disclosure (Nyblade *et al.*, 2017).

Another study conducted in Australia revealed that young people were discouraged from visiting clinics because of fear of the possible stigma attached to ARHS (Mohammed, 2017). Young people fear stigma and repercussions or judgment from providers, family, and communities, which hinder them from accessing RHS, particularly unmarried adolescents and especially girls (Nmadu, 2017). Nyblade *et al.* (2017) examined whether personal religiosity was in any way associated with adolescents' propensity to seek out formal mental health care. Using the National Longitudinal Study of Adolescent Health (NLSAH), this study uses logistic regression models to test for an association between personal religiosity and mental health services use a net of depressive symptomology and demographic controls. The results showed a negative, statistically significant relationship between personal religiosity and mental health services use. Highly religious adolescents had lower odds of having seen a mental health professional compared to their less religious counterparts even after controlling for depressive symptomology.

Some factors that operate at the social level that deter adolescents from the utilization of RHS include gender inequity and economic dependence (Morris and Rushwan, 2015). Girls and women often suffer disproportionately from reproductive ill health, which affects their wellbeing in a negative manner, because of peculiar gendered barriers to accessing health care (Nmadu, 2017). With regard to gender inequity, in many countries around the world, women and girls have still been found to have lower

status, fewer opportunities and lower income, less control over resources and less power than men and boys.

These gender roles may weaken the young women's ability to protect themselves and gain access to the services they need (Nmadu, 2017). When young women are, submissive they lack autonomy and ability to make decisions on SRH issues and this increases vulnerability, which has been found to limit their access to reproductive health information, services and contraceptives (Mbeba *et al*, 2012).

Adolescent health seeking behavior is a cyclic process, depended on social and individual factors, as well as last treatment. Nyblade *et al*. (2017) analyzed the reproductive health seeking behavior of China, and provide support for policy improvement on youth sexual reproductive health services among 22288 unmarried young people aged 15-24 years old from 40 counties. The survey revealed that during the latest one year, out of 27.35% of youth who needed the service, only 46.11% literally was served. Some of the concerns like “problem is not serious”, “fear of being ridiculed” and “don't know where to see doctors” were most common factors that kept them from accessing medical services. Public hospital is youth's most commonly accessed institution (56.99%), and quality of the services, privacy protection, service prize and other factors accounted for their choices.

Research on the utilization of health services provides an opportunity to identify and determine the quantity and quality of factors, which can facilitate or debilitate access to services. Nmadu (2017). Investigated factors affecting the utilization of outpatient services and to determine the effect of health insurance on financial support for individuals and the results show that basic and full insurance coverage was the main factor, influencing the utilization of outpatient health services. On the contrary, educational level and household size had negative effects on demand for outpatient health services. The behaviour of parents especially mothers towards their female adolescents can be a predicting factor in the utilization of health services. Asafu-Adjaye (2004) investigated predictors of mental

health service utilization from age 5 through age 16 with 399 children, including 338 European Americans and 61 African Americans and the results show that the combination of elevated internalizing and externalizing behaviors predicted a higher likelihood of first-time service use in adolescence, mainly among European American children. It explains that mother-reported internalizing behaviours are less likely to forecast mental health service utilization among African American children compared with European American children. In terms of education and care seeking, there seem to be more mixed findings. Although education is widely accepted as a very important determinant, Nmadu (2017), found no significant effect on the decision to choose a professional health care among more educated respondents in Nicaragua. However, the positive association of education and care seeking has been supported and confirmed by many other studies including Sreeramareddy *et al.* (2006) in Ghana.

Finally, individuals' perception of the severity of illness is associated with increased utilization of health care. A study by Halvorsen *et al.* (2011) on febrile illness in Kenya and another study on malaria provider choice in Ghana by Dzator and Asafu-Adjaye (2004) both confirmed that perception of the severity of illness is associated with higher levels of health care utilization. Further, the severity of illness itself also matters. It has been established that individuals who are seriously ill are more likely to travel further to seek care than those who are less ill (Dzator and Asafu-Adjaye, 2004).

The satisfaction derived from health services encourages the utilization of health services. This means that health providers or health facilities that treat adolescents well could coerce adolescents to patronize health services whenever there is a health risk. For instance, Dagnew *et al.* (2015) assessed health service utilization, reported satisfaction and predictors of satisfaction among adolescents of 15–19 years in Dejen District in a community based cross-sectional study done from February 05 to 17, 2012. Interview method was used to collect data from 690 adolescents. The following stratification into urban and rural, six kebeles were selected by lottery method. Study participants allocated

proportionally to households' size of kebele. Households were selected randomly, and one from each household was used. Among 690 adolescents, 313(45%) used health service. Of these, 190 (60.7%) were satisfied. Physical proximity (AOR=3.6, 95% CI: 1.8, 7.3), drug availability (AOR=2.7, 95% CI: 1.3, 5.8), health services availability (AOR=2.5, 95% CI: 1.1, 6.0), treatment in separate room (AOR=2.9, 95% CI: 1.4, 5.6), checked all adolescents' problem (AOR=4.0, 95% CI: 2.0, 8.5), treated with respect (AOR=3.0, 95% CI: 1.4, 5.7) an opportunity to explain feeling (AOR=3.3, 95% CI: 1.7, 6.6) were predictors of satisfaction.

Joshi *et al.* (2006) assessed their reproductive health problems and help-seeking behaviour among 300 urban schools going adolescents between 11-14 years chosen at random and assessed using four tools namely self-administered questionnaire: provision of adolescent-friendly services; medical screening and focus group discussions. Seventy-two percent of girls and 56% boys reported health problems during the survey with an average of 1.93 complaints per girl and 0.5 complaints per boy.

However, only 43% girls and 35% boys reported to the clinic voluntarily to seek help and only one fifth the amount of problems were reported at the clinic in comparison to the quantum of problems reported in the survey, which probably reflects a poor health-seeking behaviour. A medical check-up with emphasis on assessment of reproductive health and nutritional status helped in detecting almost the same number of reproductive health problems as reported by them in the survey. This intervention helped to increase the client attendance in the subsequent period of next one year from 43% to 60% among girls and from 35% to 42% among boys.

A study to evaluate the factors that discouraged the youth from using the youth-friendly services in South Africa revealed that inconvenient hours of locations, unfriendly staffs and lack of privacy were among the reason adolescents and young people not using the services (Dagnew *et al.* (2015). Majority of the participants in a study conducted in Nepal believed that service providers at health post do not

keep information confidential and do not behave nicely if sexual health problems are shared with them (Regmi *et al.*, 2010).

Adolescents often lack basic reproductive health knowledge and access to affordable and confidential health services. Helamo *et al.* (2017) assessed factors affecting adolescents and youth friendly reproductive health service utilization among high school students in Hadiya zone, Ethiopia. The institution-based cross-sectional study design was employed to collect data from eight secondary schools in Hadiya zone by using self-administered questionnaire from a sample of 702 students.

The utilization level of adolescents and youth-friendly reproductive health service was only 38.5%. Youths with a good knowledge of the type of adolescents and youth friendly reproductive health services were more likely to utilize the service than their counterparts [AOR=1.68 (95% C.I:1.06-2.65)] and those respondents who believed that youth friendly services can improve youth's health were more likely to utilize the service than their counterparts [AOR=2.02 (95% C.I:1.16-3.52)].

CHAPTER THREE

METHODOLOGY

3.0 Overview

This chapter entails the various techniques that were employed by the researcher to collect the needed data for the study. It highlighted the procedure for selecting the sample, data collection and data analysis

3.1 Research Methods and Design

Every research work needs a design to facilitate collection of important information for the purpose of the study (Halcomb and Hickman, 2015). A research design can be in the nature of descriptive, exploratory, explanatory, research survey or case study (Carter and Little, 2007). The research design adopted here was descriptive. Descriptive research designs are adopted when the researcher needs to provide more evidence and explanation to the results obtained.

It is normally used in social science research works but generally accepted in other fields of study. Descriptive research design has been used in studies that make it a priority to describe features, opinions and perceptions that people have about adolescence and reproductive health services (Orodho, 2004).

Quantitative technique was employed in this research work because of the ease and flexibility with which information is obtained from respondents. This technique makes it possible for the respondents to choose from various options provided. It also facilitates and speeds up the data collection process as all questions are simplified to make the lay man understand every detail (Denzin and Lincoln, 2011).

3.2 Data Collection Techniques and Tools

The study made use of questionnaires as the research instrument. As opined by Saunders and Lewis (2012), data collected using questionnaires can be stable, constant and has uniform measure without variation. It also reduces bias caused by the researcher's presentation of issues. Questionnaires were designed for the adolescents between the ages of 12-19 in the Kintampo municipality. The questionnaire had five sections. Section A addressed respondents' demographics. Section B addressed the factors that hinder adolescents from health seeking services in the municipality. Section C addressed why adolescent seek Healthcare at Kintampo Municipality. Section D addressed the various

Health-Seeking behaviors among the adolescents. Section E addressed the effect of Health-Seeking behavior factors on Utilization of the system in the municipality.

3.3 Study Population

The population is generally defined as a group of people with similar characteristics (Polit and Beck, 2010). In the context of this study, population refers to adolescent out-of-school in the Kintampo municipality. The study population also included community-based health officers (CHOs) who offered health services to the Kintampo municipality. The researcher considered them suitable for the study because they either benefited from or provided school health services, and as such were able to provide detailed information which enriched the discussions.

3.3.1 Target Population

The entire number of individuals that the researcher aims at conducting the study on is referred to as the target population (Sekaran *et al.*, 2010). A target population is also referred to as a number of individuals with similar characteristics in which a researcher is interested in (Mugenda and Mugenda, 2003). The targeted population from which significant information was obtained included all female adolescents who are out-of-school in the Kintampo Municipality. The main reason behind their selection was to ascertain those factors that influence their ability to access reproductive health services in health facilities in the Municipality.

3.4 Study Variables

3.4.1 Independent Variable

The independent variables of interest are, Health Seeking Behavior Factors. These were measure using structured questionnaires to solicit information from respondents.

3.4.2 Dependent Variable

The dependent variable of interest is Utilization of the Service (Outcomes)

3.5 Sampling Technique

Conversances sampling techniques was used to select the adolescents for the study (Flockhart *et al.*, 2016). Convenience sampling techniques is where the sample is taken from an existing basis, such as an organization or community. The researcher utilized the convenience sampling techniques to select various respondents from the Kintampo Metropolis. The respondents were selected based on the willingness to participate in the study

3.5.1 Sample Size and sample frame determination

A sample is defines as the sunset of population from which much attention given in a conducted of research (Sekaran *et al.*, 2010). Sampling is the method of selecting a portion of the population as items for the study based on critierial adapted by the researcher. The sample frame for the study comprises all out of school female adolescents in the Municipality. The study adopted Yamane, (1976) Sample size determination formula to select respondents from the population. The mathematical breakdown of the sample is shown below.

$$n = \frac{N}{1 + N(e)^2}$$

Where n= sample size, N= target

population and α = confidence level

(95%) e = Significant level of error

(0.05) or 5%

$$n = \frac{N}{1 + N(e)^2}$$

$$n = 465$$

Therefore, the sample size is = 465 Respondents.

3.6 Pre-testing

Pretesting in research is generally done to assess the feasibility of the study, test the data capturing tools and techniques, and make adjustments as and when necessary for the actual study (Polit and Beck 2010). Based on these, the researcher conducted pretested study in the Kintampo municipality using respondents who met the inclusion criteria. This pre-testing was made of two structure questionnaires. The pre-test however enabled the researcher identify challenges with data collection tools and processes, and the necessary changes effected before the actual study (Polit and Beck 2010). Suggestions that were made helped the investigator to modify and restructure the questionnaire appropriately.

3.7 Data Handling

The research assistants were well informed on confidentiality and secrecy of all information. No names were used in order to preserve confidentiality for all records. All answered questionnaires were collected at the end of every day. They were put in a cabinet under lock and key by the investigator. All persons handling the data were keenly supervised especially during the stage of analysis. The computers for the data analysis had passwords, which were known by only the principal investigator.

3.8 Data Analysis

According to Bernard *et al* (2015), data analysis consists of systematically looking for patterns in recorded observations and formulating ideas that account for those patterns. The quantitative data that

were gathered through the administration of the questionnaires were edited, corded, summaries sorted in other to avoid omission of variables. The Data were analyzed with the Statistical Package for Social Science (SPSS) Version 24. The outcomes of the study were presented using tables, figures, charts and graphics for easily interpretations.

3.9 Ethical Consideration

An introduction letter was sought from the District Director of Ghana Health Services for ethical clearance and support and a copy shown to respondents to gain their consent. Permission was also sought from the various assemblymen in the municipality by giving a copy of the introduction letter which explained the purpose of the study and the benefits to the adolescents. The questionnaire was confidential and anonymous and were processed and held safely. Confidentiality was ensured by respecting clients' right to privacy and information given. No information was passed on to anyone that could allow for the possibility of identifying persons completing the forms. As much as possible data and information were kept electronically.

3.10 Limitations of the Study

The challenges met during the study were time constraint and accessibility to the remote villages. Therefore, not all the communities within the municipality were captured.

CHAPTER FOUR

RESULTS

4.0 Introduction

This part of the study presents the findings of the research. Analyzed results were put into tables to facilitate the interpretation of results. The first part of the findings describes the demographic characteristics of respondents and their family background. This includes the age, educational background, knowledge on reproductive health service and their utilization. The subsequent sections and interpretations are based on the specific objectives of the research work. The total number of questionnaires administered to respondents were 465 however 460 were filled and returned given a sample size of 460 for the analysis.

4.1 Demographic Characteristics of Respondents.

The researcher asked basic questions, which are viewed to be personal information, before delving into the aims of the research work. This was mainly to establish some rapport with the respondents.

Table 4.1: Distribution of Age of respondent.

Variables	Category	Frequency	Percent (%)
Age	12-14	9	2
	15-17	206	45.8
	18-19	235	52.2
	Total	450	100
Marital status	Married	15	3.3
	Single	424	94.3
	Co-habitation	11	2.4
Educational background	JSS/JHS	204	45.3
	SSS/Technical/commercial	79	17.6
	Primary school	167	37.1

Source: Field Work, 2019

From the findings on the table 4.1, it was identified that 2% of the respondents questioned were between the ages of 12 and 14 years, while 206 (45.8%) of them fell within the age range of 15 and 17 years. The largest number of respondents were of the age range of 18 to 19 years. They however formed the greatest percentage compared to the other age ranges.

Marital status of the respondents. From their responses, 15 of them representing 3.3% are married. The findings showed that 11 of the respondents who form 2.4% of the entire respondent number co-habit with other people. Majority (94.2 %) of the respondents are single and not married. Even though the 94.2% are single, a number of them are Pregnant and others have given birth while the rest have not. The 94.2% are people who depend on their parents and caretakers.

In identifying the level of education reached by the respondents, it was seen that 204 of them representing 45.3% of the entire respondent number reached or attained JHS. Even though 45.3% attained or reached JHS, not all of them were able to complete. Some of them dropped at JHS1, JHS2 and others completed but did not further. Seventy-nine (79) respondents, representing 17.6% attained secondary education while 167 representing 37.1% attained only primary school.

4.1.1 Source of income

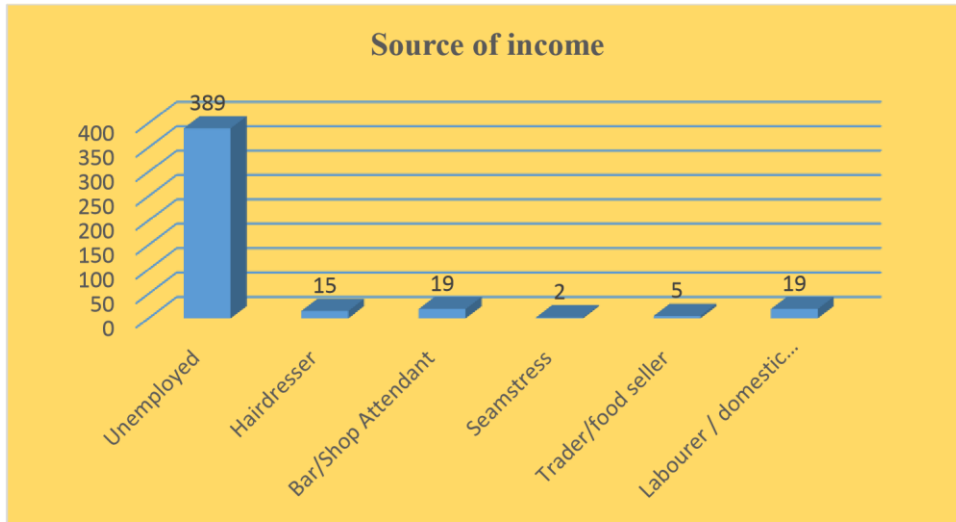


Figure 4.1: Respondents Source of income

From the figure above, out of the 450 respondents questioned, 61 of them representing 13.6% are adolescents who have regular source of income. However, out of the 61 adolescents, 15 representing 3.3% are hairdressers, 19 representing 4.2% are those who take care of peoples shops. Few of them are those who own shops by themselves. 2 of them representing 0.6% are seamstresses while 1.1% of them are traders and food sellers, and 4.2 % are labourers, domestic workers and farmers. Comparing the working group and the non-working group, it can be seen that the working group is less than the non-working group. This implies that, there is high dependency ratio where all the 86.4% depends solely on their parents and other family members. While 61 respondents representing 13.6% had a regular income source, 389 people representing 86.4% did not have any regular income source. They depend solely on the income of their parents and the head of their household. This is because; most of them stay with their parents or guardians. It was also revealed that, even though most of the respondents do not have a regular source of income, majority of them are into apprenticeship.

Table 4. 2: Household Head

Household Head	Frequency	Percent
Husband	15	3.3
Father	185	41.1
Mother	167	37.1
Self	22	4.9
Missing system	9	86.4
Total	450	100

Source: Field Work, 2019

Table 4.4 depicts the respondents who are heads of the household. From the table, 15 people representing 3.3% acknowledged the fact that, their husbands are the heads of their household.

However, from our observation, it was realized that, among those who have given birth, not all of them are married but they consider any person who impregnated them as their husbands since they were staying together. Most of the respondents (41.1%) are taken care of by their fathers while mothers take care of 37.1% of the respondents. 22 people representing 4.9% are those who take care of themselves. This emphasized on the fact that, there is high dependency ratio in the communities.

Table 4.3: Other responses on household head

Other Household Head	Frequency	Percent
Aunt	8	1.8
Brother	8	1.8
Grandfather	1	0.2
Grandmother	13	2.9
Sister	6	1.3
Uncle	24	5.3
Total	61	100

Source: Field Work, 2019

Table 4.3 showed that household heads of respondents were aunts, brothers, grandfathers, grandmothers, sisters and uncles with percentages of 1.8, 1.8, 0.2, 0.2, 2.9, 1.3 and 5.3 respectively. Some of the respondents attributed the reason to the fact that, these people have become their household head because they lost their parents and therefore needed to stay with them to survive.

While others say the need to stay with these relatives is to learn a trade.

Table 4.4: Household head's highest educational level reached

HH Level of Education	Frequency	Percent
None	146	32.4
Primary school	110	24.4
Middle continuation school, JHS	51	11.3
Technical, commercial, SHS	20	4.4
Post-middle college, teacher training, secretarial	7	1.6
Post-secondary, nursing, teacher, polytechnic	22	4.9
University	8	1.8
Not known	86	19.1
Total	450	100

Source: Field Work, 2019

Table 4.4 depicts the educational level of the household head. Their educational level directly influenced their knowledge on reproductive health. From the table, 146 household heads representing 32.4% did not attend school and therefore do not have any level of education. One hundred and ten (110) representing 24.4% reached primary school but could not further anymore. 51 people representing 11.3% had access to middle continuation school or JHS. It was further identified that, 20 people representing 4.4% attained Technical, Commercial, SHS, 7 people representing 1.6% attained Post-middle college, teacher training, secretarial. Out of the whole number of respondents, 22 people representing 4.9% reached post-secondary school, nursing training school, teacher training school or the polytechnic while 8 of the household heads representing 1.8% of the total number of respondents attained university education. Eighty- six (86) respondents representing 19.1% do not know the educational level of their household heads. From the table, it can be seen that household heads who did not attend school and who attained primary school education form the majority of the population.

Table 4.5: Source of income of Household Head

Source of income of Household Head	Frequency	Percent
Professional – teacher, nurse, accounts, administrator etc.	46	10.2
Clerical /secretarial	2	0.4
Trader/ businessman / driver with own car	44	9.8
Employed tradesman, driver without own car, builder.	7	1.6
Farmer / labourer / domestic worker	272	60.4
No	62	13.8
Other source	17	3.8
Total	450	100

Source: Field Work, 2019

Table 4.5 shows the sources of income of household heads in the study area. The rationale for this information is to inform the researcher on the financial status of household head while taking care of their adolescent children. It is very difficult for adolescents who meet *all* their needs from their parents to involve themselves in unaccepted social behaviors. From the respondents, 46 household heads representing 10.2% are professionals. They include teachers, nurses, accountants, administrators and others. 2 people representing 0.4% are clerical or secretarial workers, 44 people representing 9.8% are traders, businessmen or drivers with own cars, 7 people representing employed tradesmen, drivers without own car or mason while 272 household heads representing 60.4% were farmers, laborers or domestic workers. Sixty-two (62) household heads representing 13.8% are people who do not have any source of income. They depend on family relatives who are outside the town. However, 17 household heads are people who do not fall under the above source. They involve hairdressers, mechanics, seamstress and storekeeper.

4.2 Health-care Seeking Behaviour

Table 4.6: Reproductive Health service

Reproductive Health service	Yes (%)	No (%)
Family planning	125 (27.8)	325 (72.2%)
Antenatal care	75 (16.7%)	375 (83.3%)
Postnatal care	22 (4.9%)	428 (95.1%)
STI treatment	202 (44.9)	246 (54.7%)

Health Education	395 (87.8%)	55 (12.2%)
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Source: Field Work, 2019

Table 4.6 shows the reproductive health service that has been used by adolescents within the last 6 to 12 months. From the table, it was seen that most of the respondents (72.2%) within the last 6 to 12 months did not access family planning service while only 27.8% accessed the service. Seventy-five (75) people representing 16.7% were respondents who went for antenatal care within the said period, which implies that, the said number, are people who have given birth. 375 of the respondents did not access such service. Majority of the respondents (95.1%) did not go for postnatal service. While 202 representing 44.9% are people, who went to seek treatment on sexual transmitted disease, while 395 respondents had health education. From the respondents most of them had the education from their association meetings where health workers are mostly invited to speak on reproductive health and other health issues.

Table 4.7: Distribution of facilities from which respondent's access health care services.

Response	Frequency	Percent
CHPS/Outreach service	113	25.1
clinic/hospital	259	57.6
Adolescent clinic	6	1.3
Drugstore	55	12.2
drug peddlers	11	2.4
market side	6	1.3
Total	450	100

Source: Field Work, 2019

Table 4.7 shows the facilities where the respondents go and access the above listed services. From the respondents, 113 representing 25.1% do go to CHPS or outreach services that has been organized by health professional, 259 respondents representing 57.6% go to clinics or hospitals. This contains the majority because most of the service can only be obtained at the hospitals or clinic. In addition, most of the people do not want to access some service at the facility within their community. Example of such service is the family planning. Few (12.2%) get their access to such

service from drugstores while those who go to drug peddlers and market side are 2.4% and 1.3% respectively.

Table 4.8: Distance covered to access the service

Response	Frequency	Percent
1km to 4km	409	90.9
5km to 10km	36	8
More than 10km	5	1.1
Total	450	100

Source: Field Work, 2019

The table above shows the distance an adolescent will cover before she can access reproductive health service at a facility. From the respondents, 409 people representing 90.9% are those who cover less than 4km before they reach the facility, 36 people cover from 5 to 10 km while 5 people representing 1.1% are those who travel more than 10km.

Table 4.9: Age at which respondents had their first menstruation

Response	Frequency	Percent
11 Years	14	3.1
12 Years	46	10.2
13 Years	154	34.2
14 Years	153	34
15 Years	47	10.4
16 Years	33	7.3
17 Years	3	0.7
Total	450	100

Source: Field Work, 2019

Table 4.9 shows the various ages at which the female adolescents had their first menstruation. From the analysis, it was revealed that most of the adolescents (respondents) had their first menstruation at the age of 13 and 14 years (48.2%) while few of them started menstruating at a later age. From the respondents' view, the normal age for menstruation should have been 13 and 14 years. However, due to other factors such as the food they eat, others do get theirs earlier.

Table 4.10: Period that menstruation has stopped

Months	Frequency	Percentage %
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1-3 Months	35	7.7
4-6 Months	41	9.0
7-9 Months	7	1.7
Total	83	18.4

Source: Field Work, 2019

The table above shows the number of months' respondents have stopped menstruating. Out of the 83 respondents who are not menstruating, 35 of them representing 7.7% of the total respondents experienced a stop in menstruation for the past 1 to 3 months prior to the date for the research. From the results, 41 people had theirs occurring from 4 to 6 months with 7 respondents falling within the period of 7 to 9 months. It should be noted that, the current situation of some of these respondents is the result of pregnancy while that of others is the result of their involvement in family planning. As stated earlier in the analysis, family planning can occur in two ways.

Menstruation do not occur while they involve themselves in one part, which is common with the injectable.

Table 4.11: Knowledge on Means of delaying or avoiding pregnancy

Avoiding pregnancy	Frequency	Percent
YES	411	91.3
NO	39	8.7
Total	450	100

Source: Field Work, 2019

Table 4.11 shows the knowledge level of adolescents in relation to means of delaying or avoiding pregnancy. Their knowledge influences their action as to whether to get pregnant or not. Extensive knowledge on the subject matter helps to reduce teenage pregnancy. From their responses, 411 respondents representing 91.3% do have knowledge on how to avoid pregnancy or delay it while 39 respondents representing 8.7% do not have any knowledge on how to delay or prevent pregnancy. However, it should be well noted that, even though most of the people have the knowledge, not all of them practice it resulting in premature pregnancy.

Table 4.12: Knowledge on Means of avoiding or delaying pregnancy

Response	Yes (%)	No (%)
Male condom	285 (63.3%)	165 (36.7%)
Copper T	0 (-)	450 (100%)
Oral contraceptive	344 (76.4%)	106 (23.6%)
Permanent method	0 (-)	450 (100%)
Natural method	197 (43.8%)	253 (56.2%)
Urinate immediately after sex	57 (12.7%)	393 (87.3%)
Withdrawal	11 (2.4%)	439 (97.6%)
Abstinence	89 (19.8%)	235 (52.2%)
Injectable	215 (47.8%)	235 (52.2%)
Female condom	62 (13.8%)	388 (86.2%)
N.A	39 (6.4%)	0(-)

Source: Field Work, 2019

Table 4.12 explains in details some methods commonly known by respondents as a means of avoiding or delaying pregnancy. From the respondents, 285 are aware of male condoms while no body know of copper T, 344 of the respondents know of oral contraceptives, 197 of them know of the natural method and 57 of them made mention of urinating immediately after sex. 11 people spoke of the withdrawal method while 89 respondents agreed that, the best method to delay or prevent pregnancy is to abstain from sex with 215 respondents having knowledge on family planning (injections). Six-two (62) respondents are aware of the female condoms. However, 39 of the respondents do not have any knowledge on any of the above options and for that matter; they are considered as illiterates in terms of knowledge on pregnancy prevention methods.

Table 4.13: Contraceptive usage

Response	Frequency	Percent
YES	208	46.2
NO	242	53.8

Source: Field Work, 2019

Table 4.13 shows the usage of these contraceptives among adolescents in the study area. From their responses, 208 respondents representing 46.2% are those who use contraceptives to delay or

prevent themselves from getting pregnant. Majority (53.8%) respondents do not use these contraceptives. Some of these adolescents rely on their natural menstruation cycle while others do not use any. This has accounted for many unwanted pregnancies among adolescents in the study area.

Table 4.14: Contraceptive often used

Response	Frequency	Percent
Female condom	3.0	0.7
Oral contraceptive	152	33.8
Withdrawal	4.0	0.9
None of the above	242	53.8
Injection	49	10.8

Source: Field Work, 2019

Table 4.14 depicts the different contraceptives often used by the respondent. Out of the 208 respondents that use contraceptives, 3 of them use female condoms while 152 representing 33% use oral contraceptives which is commonly known as pills. After probing further, it was revealed that, the common pills used by female adolescents include the Postino 2, the N tablet and Levon 2. Four respondents rely on the withdrawal method where they do not allow the sperms to penetrate, during their sexual intercourse, 49 of the respondents are those who go for injection (family planning). Most of the respondents go in for the oral contraceptive because they are of the view that, other family planning methods have high negative effects than that of the oral contraceptive.

Table 4.15: Source of the supply

Source of the supply	Frequency	Percent
CHPS/Outreach service	12	2.7
clinic/hospital	40	8.9
Drugstore	155	34.4
Not Known	243	54
Total	450	100

Source: Field Work, 2019

Table 4.15 depicts the various sources that respondents gets their supply from. Twelve (12) respondents representing 2.7% gets their supply from CHPS/Outreach service. Forty (40)

respondents representing 8.9% are people who go to clinics or hospitals while 155 respondents representing 34.4% do get their supply from drugstores. The rationale behind this increment is associated to the fact that, drugstores are the common facility within the communities where they can access most of these services. For instance, pills and condoms are commonly accessible at drugstore with minimal time consumption and easily accessible. However, 243 respondents representing 54% are people who do not use these services. Most of them rely on their natural period and others will always not see the need of going to any facility or the application of any method, but to urinate immediately after sex hoping that she would have brought out all the sperms deposited in her during such a sexual intercourse.

4.3 Culture, Values and Belief systems that Influence Health Seeking Behaviour

Table 4.16: Distribution of Ethnic Group of respondents.

Ethnic Group	Frequency	Percent
Akan	233	51.8
Bimoda, Chokosi	12	2.7
Dagarti, Frafra, Kusasi	77	17.1
Gonja, Dagomba, Mamprusi	41	9.1
Konkomba, Basare	37	8.2
Mo	16	3.6
Sissala, Wala	30	6.7
Zambraba	2	0.4
Banda/Pantra	2	0.4
Total	450	100

Source: Field Work, 2019

Table 4.16 shows the ethnic composition of the respondents in the study area. Out of the 450 respondents, 233 representing 51.8% were Akans, which include the Ashanti's, Fanti's, Bono's and others. 12 people representing 2.7% were Bimoda or Chokosi while 77 people representing 17.1% were Dagarti, Frafra or Kusasi. 9.1% were Gonja, Dagomba and Mamprusi, 8.2% were Konkomba or Basare with 3.6% been Mo, 6.7% are of the Sissala and Wala tribes while Zambraba and Bandaor Pantra comprise of 0.2% each.

Religion

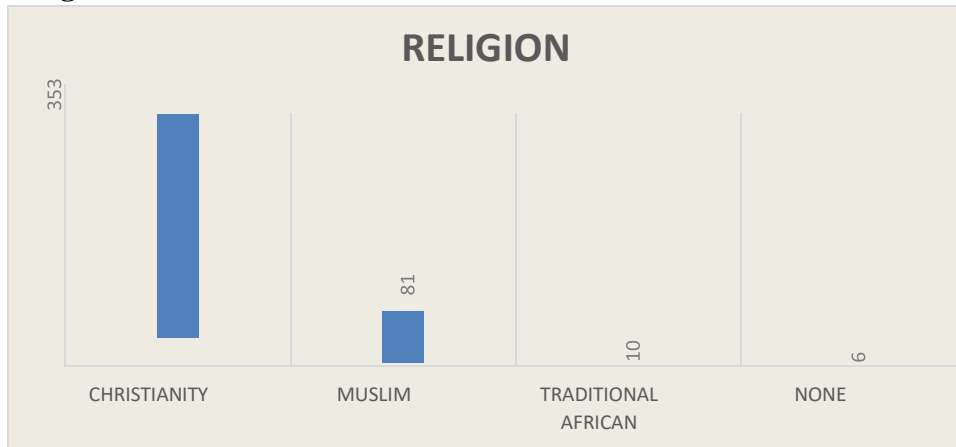


Figure 4.1: Distribution of Religion of respondents.

Source: Field Work, 2019

The chart shows the religious background of the respondents in the study area. From the 450 respondents, 353 people representing 78.4% are Christian, 81 respondents representing 18% are Muslims while 10 respondents representing 2.2% are traditionalists. However, 6 respondents representing 1.3% were adolescents who did not belong to any of the mentioned religions. From the analysis, it implies that, almost all the study communities are Christian dominated communities and for that matter, religious teaching must be well induced in the adolescents while health workers can also use the religious meeting days to teach and motivate adolescents when they go for their religious meetings.

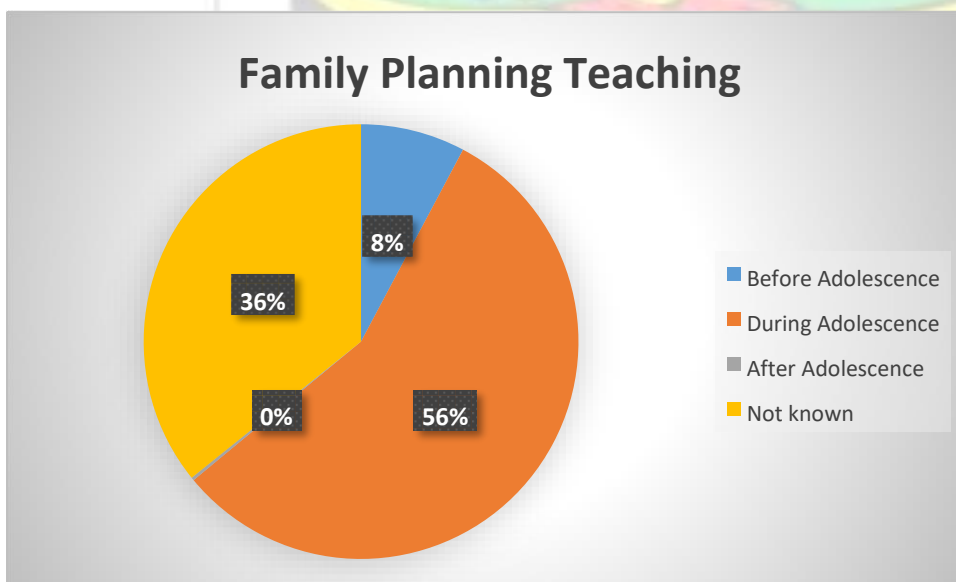


Figure 4.2: Stage in the life of a female child that your ethnic group encourage teaching on family planning services

The chart above shows the stages in the life of an adolescent female child that their ethnic group encourages teachings on family planning service. From the respondents, 35 of them representing 7.8% of the respondents viewed that, teachings on family planning should be done before they get to their adolescent age while 253 are of the view that such teaching should be done when the person gets to her adolescent stage. Their reason was that, this is the stage that female adolescents want to know more, and can easily become pregnant too if care is not taken, if such teachings are given to them at that stage, it helps them prevent and protect themselves from the risk of life and its consequences. Only 1 respondents said such teaching should be done after adolescence.

Taboos on reproductive health service

The total number of respondents questioned acknowledged that there are no taboos associated with reproductive health.

Table 4.17: Parents talk about sex with their adolescent female children

Response	Frequency	Percent
YES	146	32.4
NO	304	67.6
Total	450	100

Source: Field Work, 2019

The table above shows the relationship between parents and their adolescent females in relation to sexual issues within their community. From the respondents, within their community, 32.4% of them agree that parents within the community talk to the children about sex while 304 people representing 67.6% are of the view that, parents within their community do not talk about sex with their adolescent children. This has pushed their children to confide in their friends, and definitely will get poor or bad information, which can influence their lives negatively.

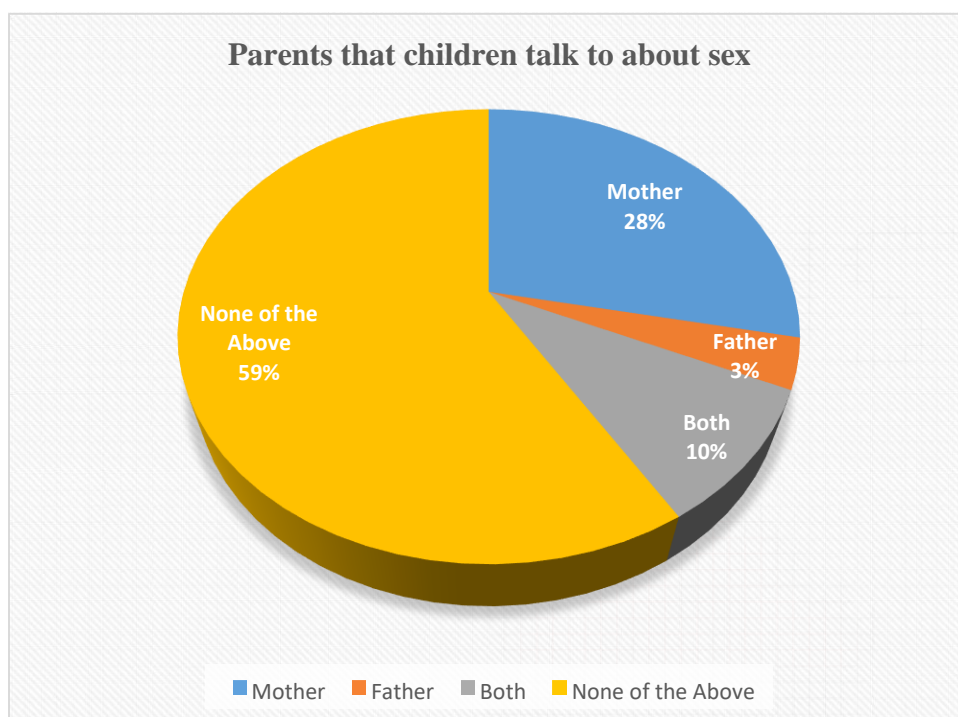


Figure 4.3: Parents that children talk to about sex

Parents under normal circumstance should have been the main source of information to their children while they are with them in their home. The table above depicts parents that are able to discuss sexual issues with their adolescent children. From the respondents, 127 respondents representing 28.2% are those who are able to talk to their children, 16 fathers representing 3.6% are fathers who are able to discuss sexual issues with their children. Forty-three (43) respondents discuss such issues with both parents while 264 respondents said their parents do not talk to them about sexual matters, neither do they also do. This means Children's under study discuss issues relating to sex with their peers more than family's' members.

4.4 Health-Provider Related Factors influencing health seeking behavior among out-of-school female adolescents.

Table 4.18: The experience discovered at the health facility

Response	Frequency	Percent
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Excellent	217	48.2
Very Good	119	26.4
Good	61	13.6
Satisfactory	18	4.0
Poor	8.0	1.8
Indifferent	27	6.0
Total	450	100

Source: Field Work, 2019

Table 4.18 shows the experience of the adolescents questioned in the facility. This provided more information as to whether to go back to the facility or not to when the need arises. Most (48.2%) are those who had excellent experience at the facility and for them, they are ready to go back anytime the need arises, 26.4% had very good experience at the facility, 13.6% had good experience while 4% were satisfied, and 8 respondents representing 1.8% are those who had poor experience while 27 respondents representing 6% could not determine their stand at the facility.

From the respondents, the main factors they were looking up to be time factor, and privacy.

Table 4.19: Time spent at the facility before receiving attention.

Response	Frequency	Percent
Less than 1hour	437	97.1
1hour to 3hours	12	2.7
4hours to 5hours	1.0	0.2
Total	450	100

Source: Field Work, 2019

Table 4.19 shows the time adolescents spend at the facility in a bit to access the facility. From the findings on the field, it was identified that 437 respondents representing 97.1% spend less than 1 hour at the facility. According to them, this motivates them to go to the facility any time they need such service. 12 respondents representing 2.7% are those who spend 1 to 3 hours while 1 person spends 4 to 5 hours. From the one person, she delayed because there was a little complication in her situation. From the respondents, services such as family planning do not take much time unless

you meet many people who want to access the same service, according to her she had multiple health service needs at the time.

Table 4.20: Facility to access family planning service when the need arises

Variables	CHPS/Outreach Service	clinic/hospital	Adolescent clinic
	Frequency (%)	Frequency (%)	Frequency (%)
Family planning	106(23.6)	341(75.8)	3(0.6)
Pre-natal services	101(22.4)	347(77.1)	2(0.4)
Post-natal care	100(22.2)	348(77.4)	2(0.4)

Source: Field Work, 2019

Table 4.20 shows facilities where adolescents can go and access family planning service, prenatal service and postnatal care when the need arises. From the respondents, in terms of family planning, 23.6% of the respondents know they can go to the CHPS compounds for that service. 341 people representing 75.8% know they can go to the clinic or hospital for such service. With prenatal service, 23.6% of the respondent know they can go to CHPS compounds for such service while 75.8% made mention of clinic or hospital with 2 people talking about adolescent clinic which were located in the Municipal or Districts hospitals. 22.2% adolescents will go to CHPS compounds when they need post-natal care, 348 of the respondents representing 77.4% have the knowledge to go to clinics or hospitals when they need post-natal care.

4.5 Factors that influence the utilization of reproductive health service seeking behavior among out of school female adolescent

Table 4.21: Perceived factors that influence the utilization of family planning services

Variables	Yes	%	No	%
Religious factor	55	12.2	395	87.8
Cultural factor	23	5.1	427	94.1
Age factor	49	10.9	401	89.1
Locational factor	18	4.0	432	96.0
Peers factor	342	76.0	108	24.0

Source: Field Work, 2019

The table above shows the factors that influences the utilization of family planning service among adolescence within the study area. Out of the 450 respondents, 55 of them stated that their religion does not support the utilization of family planning while 395 of them representing 87.8% made mention that, their religion does not speak against family planning. 5.1% said their culture prevents their utilization of family planning service while 94.1% agreed that there are no cultural factors that prevents their utilization of family planning. However, peers are the only factor than mostly influence the utilization of family planning service.

From the table and the analysis, it implies that there are no serious and actual factors that can prevent the utilization of family planning service and for that matter, if health professionals are to put much into sensitization on family planning services, it will and can have positive impact in the life of the female adolescent which will help reduce teenage pregnancy and its associated problems.

Table 4.22: Perceived factors that prevent the utilization of family planning methods.

Variables	Yes	%	No	%
Family planning	7	1.6	0	0
Antenatal care	443	98.4	0	0.

Source: Field Work, 2019

The table above depicts or show whether there are factors that prevents the utilization of family planning, Antenatal care and postnatal care. From their responses, there are no factors that prevents the utilization of Antenatal care and postnatal care. However, 7 people representing 1.6% agreed that there are certain factors that prevent their utilization of family planning service. From them. Even though it is not a taboo, but past instance or situations that has occurred in their families prevent them from going to access such service. For example, some of them said, their family members who engaged themselves in such acts found it difficult to give birth and that has put the

fear in them. The indication is that there are less health education programs going on in the said communities.

Table 4.23: Perceived factors that influence the utilization of health care outside home

Response	Frequency	Percent
Newspaper	1.0	0.2
Television	121	26.9
Radio	188	41.8
Total	310	68.9
None	140	31.1
Total	450	100

Source: Field Work, 2019

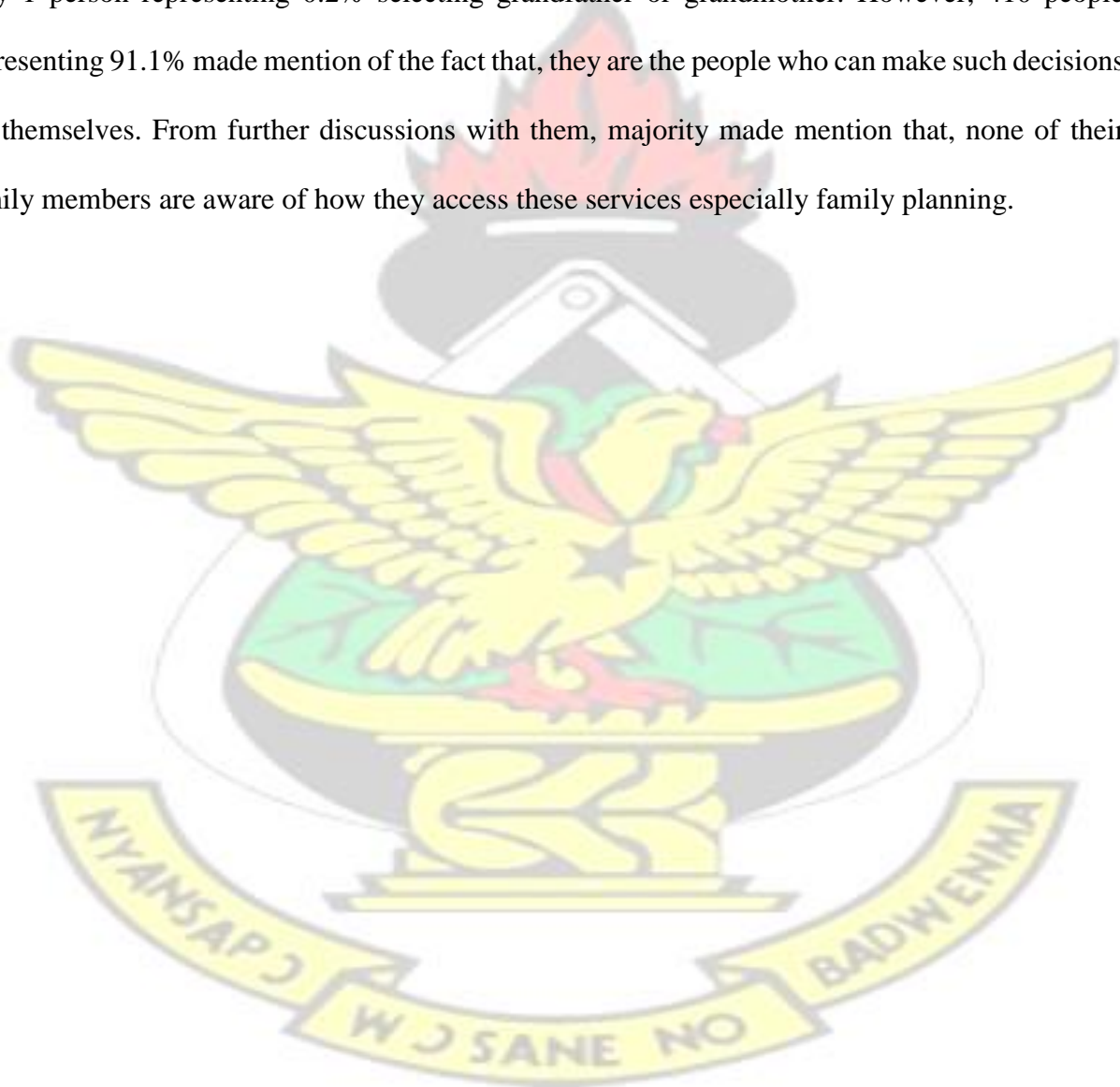
Table 4.23 shows the factors that influence the utilization of health care outside home. These factors in recent times do have higher impact on the adolescent more than other factors, which are within their home. Only 1 person representing 0.2 was influenced by newspapers. It can be seen that most of these adolescents do not utilize the newspapers and for that matter, loses vital information that may concern their health and life and is communicated through the newspapers. 121 people representing 26.9% are influenced by the television while 188 respondents representing 41.8% are influenced by the radio. However, 140 respondents representing 31.1% are people who are not influenced by any of these factors. From the analysis, it can be seen that most of these adolescents get most of their health information from mostly TV and radio programs. Most of the respondents associated the source of their information to a popular TV and radio program known as “ODO AHOMASO” on ADOM TV and ADOM FM on weekends.

Table 4.24: who makes decision to seek health care.

Response	Frequency	Percent
Head of household	4	0.9
Mother	33	7.3
Father	2	0.4
Grandfather or Grandmother	1	0.2
Myself	410	91.1
Total	450	100

Source: Field Work, 2019

Table 4.24 shows who makes decisions to seek health care or advice to family planning issues. From the respondents, 0.9% of the respondents agreed to the fact that, their household heads are the only people who can make such decisions. 33 respondents representing 7.3% said, their mothers are people who take such decisions whiles two people made mention of their fathers with only 1 person representing 0.2% selecting grandfather or grandmother. However, 410 people representing 91.1% made mention of the fact that, they are the people who can make such decisions for themselves. From further discussions with them, majority made mention that, none of their family members are aware of how they access these services especially family planning.



CHAPTER FIVE

DISCUSSION

5.0 Introduction

This part of the study present a discussion based on the relevant information obtained from respondents according to the specific objectives utilized in the study. In light of this, findings obtained were linked to literature that has been documented by other researchers in the same field.

5.1 Demographic Characteristics

Results of the research work showed that of the 450 respondents who participated in the study, 204 of them have attained only Junior High School education. Of this, 31 were able to complete and attain their basic education certificate. Those who acquired Senior High School education were only 79 in number while those who only attended primary school and could not go further were 167. Even though some of the adolescents attained some form of education, 120 of them were viewed to have dropped out in the third year of Junior High School. A total number of 204 were identified to have dropped out in Junior High School. Seventy-nine of the entire number of respondents acknowledged that they dropped out of Senior High School. The level of education among these participants is very low as majority of them did not complete an educational level.

From the findings, it was identified that female adolescents who were given teachings on family planning services before adolescence were less than those who were given similar teachings on the same subject matter after adolescence. Since majority of them dropped out of school at an early stage, they could not distinguish between obtaining information on planning services before or after reaching adolescence. However, the results showed that most of the respondents selected clinics or hospitals, depending on their location. CHPS compounds are common in communities

that mostly do not have Hospitals. Because of this, most of the respondents even classify CHPS compounds as hospitals, since they are the first highest health facility available. This implies that, most of the adolescents within the study area have high knowledge on facilities to go when the need for the discussed services arise. This will help avoid unwanted situations in relation to adolescent health.

5.2 Health-seeking behavior among out- of- school female adolescents

Some of the causes of female adolescents dropping out-of-school is related to lack of financial support from the family, lack of interest in education, poor parental care mainly due to divorce, teenage pregnancy among others (Barnet *et al.*, 2004). In Ghana, most children in their adolescent stage are left to fend for themselves, as this were mostly the result of unwanted pregnancy. In some cases, they are children from poor homes. In view of this, parents do not discuss matters of relevance to their children. This was in line with the findings of Berhane *et al.* (2005).

Low level of education among heads of households in the various communities, has led to their low level of knowledge with respect to adolescent reproductive health (Abebe and Awoke, 2014). Female adolescents do not get the chance to get more explanation about the events of adolescence, which mostly serve as the stage that ushers the girl-child into adulthood. This make their female children find it difficult to discuss their reproductive issues with them (Albert and Davia, 2010). Majority of the respondents confirmed by replying no when asked whether their parents talk about sex with them. As a result, female children end up repeating the mistakes of their parents (Beogo *et al.*, 2014).

In order to assess health-seeking behavior among female adolescents, it was imperative to identify the cause of their being in that situation. According to the researcher, the main reason for them not being able to seek health care even in fatal conditions is that they do not know much about family planning services and so do not make maximum use of them. Religion and age are factors that do not permit adolescents to access family planning services (Boamah *et al.*, 2014).

Another factor that affects health-seeking behavior is that of funds. From the research work, it was identified that 83.7% of the respondents from which information was used to draw conclusion for the research were jobless. Very few of them (3.2%) were hairdressers, while 4% of them were shop or bar attendants. Only 0.4% were seamstresses while 1% were traders or food sellers. Those who were laborers were 19. Not all these jobs pay much, hence; serve as a restriction for female adolescents to access health care services (Caldwell *et al.*, 2014).

Most of the people do not want to access the facility, which is within their community so they travel to different communities and mostly to the district or municipal hospitals. The reason for their travel is associated to the fact that, they have the fear of been seen by the parents or the community (Chen and Farruggia, 2002).

5.3 The influence of culture, values and belief systems on health-seeking behaviour among out-of-school female adolescents

Female adolescents were viewed to show negative attitude to pre-marital sex and contraceptive use. The female adolescents questioned for the purpose of this study did not consider sexual relations to be accepted at their age. This was confirmed by Chen and Farruggia (2002) in their study on culture and adolescent development. They went further to distinguish between the attitude of female adolescents and contraceptives. According to them, it was a reflection of their beliefs and socio-cultural norms.

Majority of the female adolescents expressed complete mistrust in health professionals and negatively influenced their utilization of reproductive health care (Santhya and Jejeebhoy, 2015). The ability of female adolescents mistrusting health professionals is that their identity and their sexual health should be kept confidential. Thomas *et al* (2006) stated that when the identity of adolescents is not kept confidential, they are less likely to utilize services of health care. It has been documented in the literature that when confidentiality is compromised, adolescents will be less likely to use the services in the future and will be less open about their sexual health conditions (Thomas *et al.*, 2006).

The female adolescents recruited in the research work made it clear that, they do not feel comfortable when talking to a health practitioner who is not the same age as they are. Biddlecom *et al* (2007) established in his study that, female adolescents do not feel comfortable when they talk with health care professionals who are not of the same sex as them. Gender norms are responsible for adolescents feeling reluctant and embarrassed to share sexual health problems with health workers of the opposite sex (Upadhyay, 2016).

Female adolescents feel uncomfortable when they voice out their health condition to health practitioners of the opposite sex. This highlights the need for taking into consideration the cultural and religious beliefs of adolescents and the community at large in designing and implementing adolescent RH programs (Biddlecome *et al.*, 2007).

5.4 Health-provider related factors influencing health-seeking behavior among out-of-school female adolescents

In determining those things that health-providers do to prevent female adolescents from accessing and utilizing health services, it was identified that, female adolescents do not visit health care facilities because they do not keep their identity confidential. This was found to be consistent with

a study conducted by Regimi *et al* (2010). Female adolescents also acknowledged the fact that health professionals do not act in a professional way when young adolescents share their sexual problems and health conditions associated with sex to them (Helamo *et al.*, 2017).

Female adolescents do not receive better treatment when they visited the health facility. Some of the despicable actions include shouting at patients, not providing the opportunity for them to express themselves and voice out how they feel, and health professionals exhibiting a negative and judgmental thought about them (Makubalo, 2012). Santhya and Jejeebhoy (2015) established that, the mistreatment of female adolescents has direct impact on their ability to frequently access health care services related to reproductive health. This was however stated otherwise by Akeju *et al.* (2016) that most adolescents have trust in the public health facilities than in individuals.

Another factor that influenced the ability of female adolescents to access reproductive health services easily is time (Marmot, 2011). This was evident in the results obtained from this study as 93.9% of the entire number of respondents made it clear that, they spend less than an hour in a health facility. However, 2.6% were identified to have spent about 1 to 3 hours in the hospital while only one person said that she spends about 4 to 5 hours in a health facility because of multiple needs.

A study by Atuyambe *et al* (2015) acknowledged this in their research work where on accessibility and utilization of RHS among adolescents in Uganda. Their research considered extending operating hours of health centers to meet the requirements of female adolescents who live very far from the health facility.

Ensured confidentiality and privacy were found to be facilitators to adolescents seeking and utilizing RHS in the current study. The adolescents preferred obtaining contraceptives from sources such as the local shops or supermarkets, patent medical stores and pharmacies, for the

above reasons adolescents felt that their privacy and confidentiality were respected by these sources, which was the reason they rather went to these sources to obtain contraceptives than visit public health care centers. They did not trust that health workers would maintain their privacy and confidentiality. This finding is consistent with a study conducted in Ghana on adolescents' use of contraceptives where adolescents preferred to purchase contraceptives from pharmacies instead of going to the health facility because of lack of confidentiality (Boamah *et al*, 2014).

5.5 Factors that influence the utilization of reproductive health services among out-of-school female adolescent

The percentage of adolescents who do not have any knowledge on contraceptives and so do not attend health facilities for adolescent health reproductive services like STIs is an indicator of a long term need of reproductive health (Peng *et al.*, 2010). The study revealed that, 95.3% of the females do not know that family planning services are rendered at health facilities. This finding was however more than that of (Kamau, 2006 and Chauhan *et al.*, 2015) who recorded only 79% of their respondents not having any knowledge on the family planning services rendered in hospitals in their community. The reason for the difference could be because the educational level of the latter is higher compared to that of the former. Similarly, 52% of the adolescents used for the study had not tested for STIs before in their lives. This was found to be intriguing by Upadhyay (2016). Berhane and Cherie (2005) stated that female adolescents who do not have much knowledge about sex and its consequences, engage in the act due to pressure from friends. They however, turn to health care facilities after contracting gonorrhea and syphilis. This accounts for the large number of female adolescents who access STI treatment in health facilities (Zyaambo *et al.*, 2012).

Other factors which have been proven by (11) to affect utilization of reproductive health services among out-of-school adolescents include ignorance and inadequate information obtained from health professionals. Peng *et al.* (2010) also stated that, the reason for this can be due to their inability to read fluently and write, as some of such health services are written in newspapers and other books.



CHAPTER SIX

CONCLUSION AND RECOMMENDATION

6.0 Introduction

This chapter provides the conclusion and recommendations drawn from the study. The final part of the chapter highlights suggested project works in the same field of study to be carried out in order to add more works to literature that already exists.

6.1 Conclusion

In conclusion, majority of the female adolescents who are out-of-school in the Kintampo Municipality do not access reproductive health services like counseling, family planning and antenatal care because they are unaware of the existence of such services at the hospitals. Those who are aware of such services fail to access them because of proximity to health facilities and the fear of being stigmatized when seen by their friends or people in their communities at such centres.

The income level of parents and guardians were also identified as a restricting factor to female adolescents accessing reproductive health services rendered at clinics and hospitals. To conclude, it is clear that confidentiality and attitude of nurses are major concerns of female adolescents. Nurses should therefore be sensitized about their actions to adolescents in order to make them have clear and sound minds to access reproductive health services whenever the need information and education as well as when they encounter any abnormalities in their health

6.3 Recommendation

In order to maximize the health-care seeking behavior and use of reproductive health services among female adolescents in the Kinatmpo Municipality who are out-of-school, recommendations were set. These were also to check unwanted pregnancies among female adolescents.

The research acknowledges that it is important to embark on active sensitization of the youth in order to provide relevant information on reproductive health services that are under-utilized, because it is evidently clear that there exist many health professionals in Ghana, the issue is to match them with service patronage. This would level the knowledge of the youth on reproductive health services that exists, thus increasing their accessibility.

It is important to provide training to more health care professionals in order to deal with adolescents so that they would exhibit friendly character to them. It is also important to train more health workers who are at the family and community level in order to complement other health care professionals to impart knowledge of reproductive health to the adolescents.

Many efforts should be directed to provide exclusive adolescent friendly reproductive health services in community health facilities. This would improve the confidence of the girl-child and bring the services to their doorstep for easy accessibility and utilization.

Government and other NGOs should increase funds given to health professionals to provide RHS to adolescents. Similarly, all female adolescents should be encouraged on the governments free SHS education for them to successfully complete with certificates so that they can secure high paying jobs if the need be to take care of themselves no matter the situation at their homes.

6.4 Suggestions for further research

The researcher studied a significant aspect of accessibility to reproductive health services among female adolescents in the Kintampo Municipality. Nevertheless, more research works need to be conducted in order to identify the knowledge level of adolescents about their reproductive health rights. Research should also be conducted to assess the level to which the national policy, which guides reproductive health services, are being implemented.

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APPENDICES

Questionnaires

INFORMED CONSENT

PLEASE READ TO RESPONDENT WHO HAVE STAYED HERE FROM 1-12 MONTHS OR MORE;

My name is Isaac Karl Kabba and I am an MPH student of KNUST and also a staff of the Ministry of Health. I am conducting a local survey that asks female adolescents about various reproductive health issues and I will be asking you questions on your demographic characteristics as well. I will be using this information as a partial fulfilment of my thesis on ‘Health care seeking behavior and utilization of reproductive health service among female adolescent in the Kintampo Municipality’. I would appreciate your participation in this survey. This information will help us inform the government to plan better on health services. The survey usually takes 10 and 15 minutes to complete. Whatever information you provide will be kept strictly confidential and will not be shown to anyone other than members on our survey team. Participation in this survey is voluntary and if we should come to any question you do not want to answer, just let me know and I will go on to the next question, you can also stop the interview at any time when the need be. However, we hope that you will participate in this survey since your views are important?

IDENTIFICATION INFORMATION

1.0 Community Name COMNAME

1.1 Compound Number CPDNUM

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1.2 Interview Date

--	--	--	--	--	--	--	--

DOVISIT

1.3 Interviewer code

--	--

CODE

1.4 Consent of study participant obtained?.....

1. Yes	2. No
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CONSENT

BACKGROUND INFORMATION OF THE RESPONDENT

2.0 What is your age?

2.1 What is your marital status?

1. Married	2. Living together	3. Widowed
4. Divorced	5. Separated	6. Single, unmarried

2.2 Did you complete Junior High School?

1. YES	2. NO
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2.3 If yes to question 2.2 what was your highest educational level reached?

1. JSS/JHS	2. Primary school	3. SSS /Technical/commercial
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2.4 At which class/ form did you have to drop out of school?

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2.5 Do you have a regular cash income/are you a salaried worker?

1. YES	2. NO
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2.6 What is your source of income?

1. Hairdresser	2. Bar/Shop Attendant	3. Seamstress,	
4. Trader/food seller	5. Labourer / domestic worker / farmer	6. Other: -----	7. Not Applicable

2.7 Who is your household head? (define HH)

1. Husband	2. Father	3. Mother	4. self	5. Not Known	6. other.....
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2.8 What is the household head's highest educational level reached?

1. None	2. Primary school	3. Middle, continuation school, JHS	4. Technical, commercial, SHS, Secondary school
5. Post-middle college, teacher training, secretarial	6. Post-secondary, nursing, teacher, polytechnic	7. University	8. Not known

2.9 Does the household head have a regular cash income or salaried job?

1. Professional – teacher, nurse, accounts, administrator etc.	2. Clerical /secretarial	3. Trader/ businessman / driver with own car etc.	4. Employed tradesman, driver without own car, builder, etc.
5. Farmer / labourer / domestic worker	6. Other:	7. No	8. NK

Health-Seeking Behaviour

3.0 Have you used any of the following reproductive health services in the last six to twelve months?

1. Family Planning	1. Yes	2. No	3. Not Applicable
2. Antenatal care	1. Yes	2. No	3. Not Applicable
3. Postnatal care	1. Yes	2. No	3. Not Applicable
4. STI treatment	1. Yes	2. No	3. Not Applicable
5. Health Education	1. Yes	2. No	3. Not Applicable

3.1 If yes to question 3.0 above, then where did you go to access the services?

1. CHPS/Outreach service	2. clinic/ hospital	3. Adolescent clinic	4. drugstore
5. drug peddlers	6. market side	7. Traditional healer	8. Not Applicable

3.2 How far did you have to travel to access this/these service(s)

1. Less than 1km	2. 1km to 4km	3. 5km to 10km	4. More than 10km	5. Not Applicable
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3.3 At what age did you have your first menstruation?

..... Years

3.4 Are you still menstruating? Yes No

3.5 If no, how long have you stopped menstruation?
(Still menstruation, code 00)

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3.6 Have you ever heard of any means of delaying or avoiding pregnancy?

1. Yes	2. No
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3.7 If Yes to Q3.6 what are some of the means of avoiding pregnancy that you know of? (Circle as many as possible)

1 Male condom	2. Copper T	3. Oral Contraceptive Pill	4. Permanent Method	5. Natural Method	6. Others
7. Withdrawal	8. Abstinence	9. Injectable	11. Female condom	12. Urinate immediately after sex	13. NA

3.8 Have you ever used any contraceptive?

1. Yes	2. No
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3.9 If yes in question Q3.8 which contraceptive (s) have you use?

1. Female condom	2. Oral contraceptive	3. Rhythm method	4. Withdrawal
5. Intrauterine device	6. No plant	7. Other: specify.....	8. Not Applicable

3.10 If yes in question 3.8 where do you get your supply from?

1. CHPS compound//Outreach services	2. Clinic//Hospital	3. Adolescent clinic	4. Drug store
5. Drug peddler	6. Market place	7. Traditional healer	8. Not Applicable

Cultural, Values and Belief Systems Influence Health Seeking Behaviour and Utilization 4.0

What Ethnic group do you belong to?

1. Akan e.g. Bono, Ashanti, Fanti. etc.	2. Bimoda, Chokosi	3. Dagarti, Frafra, Kusasi	4. Fulani
5. Ga, Adangbe, Ewe	6. Gonja, Dagomba, Mamprusi	7. Konkomba, Basare	8. Mo
9. Sissala, Wala	10. Zambraba	11. Banda/Pantra	12. Other:

4.1 What is your religion?

1.Christianity	2. Muslim	3. Traditional African	4. Other/None(specify).....
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4.2 At what stage in the life of a female child does your ethnic group encourage teaching on family planning services?

1. Before Adolescence	2. During Adolescence	3. After Adolescence	4. N.K
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4.3 Do you have taboos on reproductive health services e.g. Family planning, pre-natal and post-natal care in your community?

1.Yes	2. No
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4.4 If Yes to question 4.3.... above, name the taboos (If NO = NA)

.....

4.5 In this community do adolescents talk about sex at home with their parent?

1.Yes	2. No
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4.6 Which of your parents do you talk to about sex?

1, Mother	2. Father	3. Both	4. NA
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Health-Provider Related Factors

5.0 What was your experience during the visit to the service provider?

1.Excellent	2.Very Good	3.Good	4.Satisfactory	5. Poor
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5.1 How long did you have to wait before you were attended to for reproductive health services?

1. Less than 1hour	2. 1hour to 3hours	3. 4hours to 5hours	4. More than 5hours	4. NA
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5.2 If you have to seek reproductive health care such as Family planning which facility will you go?

1.CHPS/Outreach service	2. clinic/hospital	3. Adolescent clinic	4. drugstore
5. drug peddlers	6. Traditional healer	7. Not Applicable	

5.3 If you have to seek reproductive health care such as pre-natal which facility will you go?

1.CHPS/Outreach service	2. clinic/hospital	3. Adolescent clinic	4. Drugstore
5. Drug peddlers	6.Traditional healer	7. Not Applicable	

5.4 If you have to seek reproductive health care such as post-natal care, which facility will you go?

1. CHPS/Outreach service	2. clinic/hospital	3. Adolescent clinic	4. Drugstore
5. Drug peddlers	6. Traditional healer	7. Not Applicable	

Factors that Influence Utilization of RHS

6.0 Which factors influence your utilization of family planning services? (circle all responses)

1. Religion	2. Culture	3. Age	4. Location of facility
5. Peers	6. Other:		

6.1 Is there anything in your household that prevents you from using any of the following services?

1. Family Planning

1. Yes	2. No	3. Not Applicable
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2. Antenatal care

1. Yes	2. No	3. Not Applicable
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3. Postnatal care

1. Yes	2. No	3. Not Applicable
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6.2 Does any of the following influence you to seek health care outside home?

1. Newspaper	2. TV	3. Radio	4. Others planning services?: specify.....
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6.3 In your household, who makes the decision to seek health care or advises on family planning issues? For example, the use of contraceptives to prevent pregnancy or determine when to get pregnant, prenatal care etc.?

1. Head of household	2. Mother	3. Father	4. Grandfather or Grandmother	5. Myself
6. Other (specify).....				

END OF INTERVIEW

FIGURE BELOW SHOWS THE MAP OF THE STUDY AREA (KINTAMPO MUNICIPALITY)

