PRESBYTERIAN UNIVERSITY COLLEGE, GHANA

FACULTY OF DEVELOPMENT STUDIES

DEPARTMENT OF ENVIRONMENTAL AND NATURAL RESOURCES MANAGEMENT

HEALTH SEEKING BEHAVIOURS OF YOUTH IN RELATION TO SEXUALLY TRANSMITTED DISEASES

BY

ASANTE KWAPONG LOVINA

SEPTEMBER 2019

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A Dissertation Submitted in Partial Fulfillment of the Award of Master of Science Degree in Environmental Health and Sanitation

BY

ASANTE KWAPONG LOVINA

SEPTEMBER, 2019

DECLARATION

Candidate's Declaration

I hereby declare that this project work is the result of my original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature: …….. Date: ……...

Name: LOVINA KWAPONG ASANTE

Supervisor's Declaration

I hereby declare that the preparation and presentation of the project work were supervised in accordance with the guidelines

Supervisor's Signature: ……... Date: ……...

Name: DR. EDWARD DEBRAH WIAFE

ABSTRACT

Health Seeking Behavior refers to those actions' individuals undertake to find appropriate solutions for health problems. This study examined the rationale behind delay in seeking treatment for STI. Data was collected using structured questionnaires administered to participants. The study indicates education has influence on STI information. School teacher and social media were recorded to be the main source of information on STI across the various educational levels. JHS, SHS and Tertiary recorded 43.8%, 26% and 26.8% for school teacher while social media recorded 9.5%, 37.5%, and 24.4% respectively. Peer group and TV were however indicated by primary school level and no education respectfully as a source of STI information. It was revealed that family members and health workers play lesser role in educating youth on STI. Delay in seeking care for STI - related illness were common among the youth. More than half 54.9% of the respondents indicated first treatment option for STI management as going to a health facility with just a handful self-medicating 19.2%, or seeking help and self- medicating at the same time. The use of both western and traditional medication or either of the two was common on the grounds of medication has worked before. The most preferred health facility was government hospital (42.3%) with a greater perception of treatment being more effective there, 40% of respondents who preferred pharmacy indicated privacy as a reason. The study found more than half of the respondents reporting main barrier to seeking care as acceptability of the service and affordability. To encourage young people to access formal health care, specific health services should be provided for youth where they are assured of confidentiality.

DEDICATION

This piece of work is dedicated to my daughter Christabel Appiah – Hagan

ACKNOWLEDGEMENTS

I wish to acknowledge the immense guidance, encouragement and contribution of my supervisor Dr. Edward Debrah Wiafe.

Thanks to my entire family, and to my best friend Samuel Amoaning Boahen have remained steadfast in prayer and support throughout the course of this program.

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LIST OF ABBREVIATIONS

AIDS – Acquired Immune Deficiency Syndrome

GDHS - Ghana Demography and Housing Survey

JHS – Junior High School

HIV – Human Immunodeficiency Virus

MOH - Ministry of Health

NHIS – National Health Insurance Scheme

SHS – Senior Secondary school

STD – Sexually Transmitted Disease

STI – Sexually Transmitted Infection

WHO – World Health Organization

CHAPTER ONE

INTRODUCTION

The Study investigates the determinants of health seeking behavior related to Sexually Transmitted Infections (STI) among the youth in Abuakwa South Municipal Assembly of Ghana. The preliminary chapter presents the background to the study which illuminates the subject matter in a way which easily leads to defining the problem to be investigated in this thesis. It is then followed by the statement of the problem, research question, significance of the study, delimitations of the study and objectives. The chapter ends with the organization of the study which gives an overview of the thesis.

1.1 Background to the study

Over one million people globally get infected with sexually transmitted infections (STIs) every day. About 357 million people are estimated to be newly infected with one of four sexually transmitted diseases annually: chlamydia, gonorrhea, syphilis, and trichomoniasis (World Health organization, 2015). In relation to reproductive health of women other STDs cause considerable morbidity in particular, and are also associated with increased transmission of HIV (Langeni, 2007; Raviglione & Maher, 2017; World Health Organization, 1995). It is difficult to quantify the proportion of these infections which go undiagnosed and untreated, which is part of the problem of understanding and managing untreated infections (Mapp, Wellings, Hickson, & Mercer, 2017).

The World Health Organization defines sexual health as a state of physical, emotional, mental and social wellbeing in relation to sexuality. Sexual health

needs vary according to factors such as age, gender, sexuality and ethnicity. However, there are needs common to everyone such as the provision of high quality information and education to enable people to make informed responsible decisions, and access to high quality services, treatment and interventions (Standards & Committee, 2015). Many sexually transmitted diseases, such as syphilis, gonorrhea and urethritis, are easy to diagnose and treat, and yet millions of cases in the world are left untreated leading to continued transmission and serious chain reactions. Empirical studies suggest that less than 50% of untreated chlamydia spontaneously resolves without treatment (Raviglione & Maher, 2017). A research conducted by The Alan Guttmacher Institute in 2004 indicated that four in 10 Ghanaian women and two in 10 men aged 15–19 have ever had sex. By age 20, 83% of women and 56% of men have had sex; the median age at first inter-course is 17.4 for women and 19.5 for men. Among those who have had sex, four in 10 women and six in 10 men aged 12–24 have had more than one sexual partner. STIs disproportionately affect young people. Adolescents in Ghana generally begin sexual activity in their teens (Glover et al., 2003). The 2003 GDHS reported that more women than men have had first sex by age 15 and 18 respectively.

1.2 Statement of the problem

The greatest impact of STI remains in young heterosexuals' 15-24 years. The national survey of sexual attitude and lifestyle shows that most people become sexually active and start forming relationships between ages of 16 and 24 years. Young people in this group have significant poor sexual health including STI and abortion. In 2002 the estimated HIV prevalence rate among the youth between

ages 15-24 years in Ghana was 34%. The early recognition of symptoms, presentation to health facility and compliance with effective treatment can reduce the spread of treatable STI. Youth are mostly unable and or unwilling to obtain the health care service they need. Understanding what current barriers to seeking health care are could provide understanding of what challenges still exist. Delayed seeking of health care may partially explain high rates of sexually transmitted diseases among adolescents and young adults. Health care seeking is a central issue in control of sexually transmitted diseases, since the duration of infection increases the probability of harmful sequelae and of transmission to others.

Factors including concerns about confidentiality, embarrassment in disclosing health issues, absence of medical insurance or limited financial accessibility, low knowledge of existing services and lack of trust in health professionals have been identified to influence the decisions of youth to assessing care for STI. Understanding the different barrier based on the context, provides a very significant insight into their health seeking challenges and gives a direction on appropriate interventions. It is only when an underlying problem is understood that an appropriate intervention can be proposed to address it. Understanding the influencing factors to not seeking health care early when STI is suspected should be done with them and not without them if meaningful progress is to be achieved. This thesis sought to explore the different influencing factors to adolescent sexual behavior, their attitude towards seeking health care for STI problems and reasons for their choice of treatment options for STI related issues. The findings from the

study will bring to limelight important factors in addressing the sexual and reproductive health problems of adolescents in the Abuakwa North Municipality.

1.4 Objectives of the study

The main objective of the study is to establish reasons for delay in seeking treatment or STI related illness.

Specific objectives

To investigate factors influencing delay in seeking care for STI treatment

1. To determine where youth obtain information on STI from.
2. To determine the first point of call for STI treatment by the youth.
3. To determine the most preferred facility in seeking treatment for STI and reasons for preference.
4. To determine barriers youth experience or perceive in relation to seeking. health care for STI relate issues.

1.5 Research Questions

The following research questions were asked:

1. What is the main source of information on STI for the youth?
2. What is the first point of call in finding treatment for STI by the youth?
3. Which barriers do the youth experience or perceive in relation to seeking health care for STI related issues?
4. Which facility is mostly preferred by the youth in seeking treatment for STI related issues and why?

1.6 Significance of the study

The study is to find out the factors which influence health seeking behaviors among the youth with STI. It is hoped that the study would help health providing services such as the Ministry of Health, Ghana Medical Association, and Traditional Healers Association of Ghana in the provision and distribution of health resources in Ghana. The results of the research would immensely benefits policy makers, and health practitioners as well as NGOs to pursue health literacy and design appropriate programs for the youth in this case. It is also hoped that it would assist youth in particular to improve upon their health seeking behavior, making informed decision about their health and seeking for treatment in time at appropriate health facility. It will also inform health care providers on better approaches in handling youth with STI who reports to their facility. Finally, the study would serve as a source of literature for people who need information on health seeking behavior of youth with some sort of STI, particularly in Abuakwa North Municipality.

1.7 Organization of the study

The thesis is divided into six chapters. Chapter One deals with the background of the Study, statement of the problem, objectives, research questions, significance of the study, delimitations, limitations and organization of the Chapters.

Chapter two reviews literature on the determinants of health seeking behavior related to sexually transmitted infections among the youth. Chapter Three discusses the research methodology which includes the type of data used in the analysis, the source of the data, the method of analysis and tools or instruments

used in the analysis. It has been structured in such a way as to make replication very easy for future researchers. Chapter Four discusses the results from the data analysis, describing the descriptive Statistics and use of central tendency measures and inferential statistics. Chapter Five gives discussions and findings, and Chapter Six gives the summary, conclusion and recommendations resulting from the findings of the study.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.0 Health Seeking Behavior Theoretical Approach

Health seeking' is a conditioned behavior, so any attempt to encourage people to seek care requires an understanding of their motivation for such behavior (Oberoi, *et al.*,2016). Health seeking behavior refers to actions that people resort to undertake for the purpose of finding an appropriate remedy that can occur for both actual and potential problems. When it occurs for actual problems, it is called illness behavior and when it occurs for potential problems, it is called health behavior (Who, 1999; World Health Organization and Joint United Nations Programme on HIV/ AIDS, 2003).

Illness behavior is any act of searching for relief to fulfil a health need. Health behavior is the observable actions of individuals aimed at preventing disease and improving of wellbeing (Oestergaard, Alkema, & Lawn, 2013). Kasl & Cobb, 1966 defined health seeking behavior as any activity performed by individuals who perceive themselves to have a health problem with the aim of finding an appropriate remedy or detecting it in an asymptomatic stage. HSB is found within the broader concept of health behavior, which is made up of activities undertaken to maintain good health, to prevent ill health, as well as dealing with parting from a state of good health (WHO, 1995). Health behavior also includes the sub-discipline of health belief modelling, which seeks to specify certain beliefs that can justifies individual motivations that contribute towards health behavior (Abraham & Sheeran, 2014). The health belief model, developed by Hochbaum

(1958), has four constructs namely perceived seriousness of the disease, perceived susceptibility, perceived benefits, and perceived barriers (Taylor et al., 2006), which in combination can be used to explain health seeking behavior. The health belief model (HBM) proposes that whether a person performs a particular health behavior is influenced by two major factors: The degree to which the disease (negative outcome) is perceived by the person as threatening and the degree to which the health behavior is believed to be effective in reducing the risk of a negative health outcome. The first factor, i.e., perceived threat, is determined by whether someone believes he or she is susceptible to (that is, likely to get) the disease, and how severe that person believes it would be if it developed. The second factor, perceived effectiveness of the preventive behavior, takes into account not only whether the person thinks the behavior's useful, but how costly (in terms of money, time and effort) it is to carry out the preventive behavior. When health messages demonstrate to people that there is a real threat to their health and also convince them that a particular behavior can reduce their risk, the likelihood of behavior change is greatly increased.

Theory of reasoned action developed in 1975 by Fishbein and Ajzen proposes that a person's health behavior is determined by his intention to perform the health behavior. This intention is itself determined by the person's beliefs, attitudes, norms, intentions and his perception of how significant others approve of or otherwise of the behavior. The theory of "four A's" addresses the availability, acceptability, affordability and accessibility of health services (Glanz & Bishop, 2010). Abraham Maslow hierarchy of needs theory intimates that individuals

always aim to attain a higher level of satisfaction other than their currency. In the continuum of health, people are always seeking to attain a higher level of wellbeing by engaging in behavior that does not threaten the comfort of good health. The motivation Hygiene theory by Frederick Herzberg identifies two factors that influence satisfaction. He observes that humans have needs that emphasize on avoidance of loss of life, hunger, pain, fears and those that compel the individual to realize his potential. It is in this quest to avoid life fears that people look for motivators for good health (Abera et al., 2018).

McClelland's theory of needs asserts that an individual's specific needs are a function of time and experience. He views needs as a function of achievement, affiliation and power. Individuals tend to avoid low and high-risk situations that may destabilize them. McClelland did not look at hierarchy as a concept but saw the needs as occurring simultaneously. He placed emphasis on achieving needs submitting that individuals with high need of achievement have five distinguishable characteristics; responsibility for finding solutions to difficulties, a preference for immediate feedback on performance, avoidance of easy attainable and highly difficult goals, enjoyment of challenging yet achievable tasks and preference for intangible e.g. knowledge or health as opposed to tangible e.g. money rewards (Loomis & Cook, 2012).

The purpose of presenting the above theory review is to highlight the amount of research that has gone into theorizing health seeking behavior. The Andersen's Health Care Utilization model suggests that predisposing factors,

enabling or impeding to use factors and their need for care determine health care use.

2.1 Predisposing factors influencing health seeking behavior.

Age, Gender and Religion influence health, its perception and its pursuit either alone or in combination with other factors. With the greater importance to adolescence girls, there is believed to be intensification in the sexual pressures boys and men put on young women, reduced control over young people by the older generation, and a concomitant rise in teenage childbearing occurring outside of an approved relationship (Dynamics et al., 1993). Opportunities for secondary schooling that now exist provide young men with considerable autonomy, removing them from the family compound or home and the watchful eyes of elders.

Secular institutions have largely replaced social and religious institutions, which once governed values, rites of passage, marriage and the extended family (GSS, 2009). The effect of social change among young people is of great concern, especially because they form a large chunk of the country's population. In 1998, 44 percent of the Ghanaian population was below 15 years (GSS, 2009). This is probably because evidence suggests that adolescents in Ghana are increasingly becoming sexually active at early ages prior to marriage. Nabila and Fayorse (1996) stated that age at first sex was found to be as early as age 10. Adolescents are at higher risk of exposure to STIs than adults because of their immature reproductive systems, misconceptions and lack of knowledge about STIs (Kumi-Kyereme, Awusabo-Asare, & Biddlecom, 2007).

Adolescents and young adults are more likely to have multiple partners (sequential or concurrent partnerships) rather than long-term relationships. Higher partner numbers and concurrent partnerships increase the chance of exposure to an STI. Adolescents are more likely to choose sex partners who are also adolescents and who may already have an STI (Glover et al., 2003).

Differences in gender roles significantly influence the trends of health-seeking behaviors between men and women. According to study by (Mbatha & Bhana, 2007) a survey of Ghanaian youth revealed that 11% of sexually experienced males and 4% of females reported having had more than one sexual partner. Goparaju, 2003 conducted a search in 2003and reported that in Dodowa two times more adolescent males than females reported having more sexual partners over the past years. This ranges from 0-12 years or males and 0-22 years for females. Males were more than twice likely to have multiple sexual partners as females (55% vs 26%). Males might simply experience STIs differently than females. Many women who experience such STI symptoms as vaginal discharge and genital itching do not regard them as serious or as the result of sexual intercourse and, therefore, do not believe that they need to be treated (Mmari, Oseni, & Fatusi, 2010a).

In Ghana, most frequent sexually transmitted infections have the tendency to be higher among young women than among men (Genna, Feske, Angiolieri, & Gold, 2011; Onokerhoraye & Maticka-Tyndale, 2012). Considering the impact of sexually transmitted infections on HIV infections, the youth, especially young women are at increasing risk of contracting an STI including HIV (Rietmeijer et

al., 2013; Pollack, Boyer, & Weinstein, 2013) Girls tend to have older partners who may have already contracted non-curable (often silent) STIs such as HIV. In many cultures, the median age of first marriage for women is well under 20 years. Young women may have more difficulty negotiating around sex, especially with older, more experienced partners.

Christianity is the most dominant religion in Ghana with 71.2% of the population identifying as Christian, followed by Islam at 17.6% and Traditional African Religion at 5.2%. An additional 5.2% of the population do not identify with any religion, while all other minority religions make up 0.8% of the population. (Gyimah, Adjei, & Takyi, 2012)

2.3 Enabling and hindering factors influencing health seeking behavior.

2.3.1 Cost and health insurance

The aim of universal coverage of health is to ensure that individuals use health services they need without being constrained by cost (WHO, 2010). People with higher incomes have better health because they can afford the cost of care. Most youth may not be able to afford the cost of treatment for STI because they are mostly unemployed or have to depend on parents or other family relations for support. Adolescents have less access to healthcare and fewer resources for health services or effective treatment.

2.3.2 Embarrassment

A study in the Gambia showed that shame was a key reason young people did not access health services, even if they had STI symptoms (K. Miles *et al*., 2001). Other studies from Kenya, Senegal, South Africa, Uganda, and Zimbabwe

reported adolescents had a fear of encountering acquaintances and general embarrassment when navigating large community clinics and hospitals to obtain services, as well as concerns that health workers were too busy in these environments to sufficiently respond to their questions.

2.3.3 Fear of confidentiality.

Most young people have culture of discomfort in seeking help (Starr & Wallace, 2009) Evidence shows existence of consultations that do not follow laid down protocols are rampant within the medical profession (Mchidi, 2016). This unfortunate scenario has been attributed to perceived trust one has in the physician they consult with the fear of their condition being disclosed to close relation, friends of their family or other staff who might also reveal their condition.

Fear of confidentiality breach has increase delay in seeking treatment or not seeking treatment at all for STI (Fox et al., 2010). Late or lack of treatment for curable STIs increases the likelihood of adverse consequences. Avoiding treatment also increases the likelihood that partners will not be treated, and further STI spread.

2.4 Sexually Transmitted Infections (STI)

The terms ‘Sexually transmitted diseases’ and ‘Sexually transmitted infections’ are frequently used interchangeably; however, there exists conceptual differences between these two terms. Sexually transmitted infections (STIs) refer to ‘Infections caused by microorganisms that can be transmitted from one person to another through sexual contact’. When associated with genital symptoms and

complications, these STIs are called as sexually transmitted diseases (STDs) (Center for Disease Control, 2007).

This implies that a person with STI may be infected and may potentially infect others, without showing signs of 'disease. The World Health Organization (WHO) defines Sexually Transmitted Infections as infections that are spread primarily through person-to-person by means of sexual intercourse (UNAIDS/WHO, 2004; Workowski, Bolan, & Centers for Disease Control and Prevention, 2015). The non-absolute nature of the definition suggests that, there are other means of transmission. The National Health Service (NHS) referring to the four publicly funded healthcare systems in the United Kingdom specifies that the transmission is through unprotected sex (sex without a condom) and also through genital contact (Mercer et al., 2013).

Nonetheless, several STIs, in particular HIV and Syphilis, can also be transmitted from mother to child during pregnancy and childbirth, and through blood products and tissue transfer (Rogstad & Rogers, 2008). Transmission takes place through person-to person direct sexual contact with infected individuals (with acute, chronic or asymptomatic clinical forms).

The probability of infection from infected individuals to their partners may differ broadly between STIs (Díez & Díaz, 2011). The apparent disparate transmission modes of STIs as indicated earlier, its name (STI) only seem to take recognition of the dominant mode of transmission. In fact, the causative element of STIs is not the sexual activity, but viral or through a bacteria or parasite. Venereal disease was the term used to describe STDs before the 1990s however

the nomenclature has changed to STIs in contemporary times (Gruber, Lipozenčić, & Kehler, 2015). STIs cause major acute illness, infertility, long-term disability and death with serious medical and psychological consequences on humanity.

There are over 30 bacterial, viral and parasitic pathogens that have been identified to date, that can be transmitted sexually (Smith, 2013; World Health Organization and Joint United Nations Programme on HIV/ AIDS, 2003).

2.5 Types of STI

STIs are categorized based on class of causative microorganism. There is no basic classification except for common groupings such as bacteria, protozoa, fungus, virus and parasite. Examples of STIs caused by bacteria are Syphilis, Gonorrhoea, Chancroid, Chlamydia, Mycoplsma Genitalium (which is associated with bacterial vaginosis (BV) and Pelvic Inflammatory diseases (PID); causes non-gonococcal urethritis in men) and Lymphogranuloma Venereum (LGV).

Trichomoniasis is a protozoal disease and Candidiasis (yeast infection) is a fungal infection. Some viral infections are HIV infection, Hepatitis A, B, and C, Genital Herpes, Cytomegalovirus, Genital Warts. There is also the Human Papillomavirus (HPV) which is viral and has about 70 variants. Parasitic diseases are pubic lice and scabies. STIs common to women are Gonorrhoea, Chancroid, Genital Warts and Trichomoniasis. Syphilis, gonorrhoea and Chlamydia are however very common to males with Urethritis (both gonococcal and non-gonococcal) also very common among sexually active teenage males (Ross,

2007). HIV/ AIDS which is quite prevalent remains the most dangerous of all STDs common to both sexes and does not have any cure yet

2.6 Mode of Transmission

Human beings are the only known host for 90% of STIs. STIs may be passed on from one person to another through blood and blood products, semen, vaginal fluid and other body fluids such as saliva, sweat and lymph fluids. The major transmission routes are sexual intercourse which could be peno-vagina, peno-anal or peno-buccal (Workowski & Berman, 2011). Other transmission routes include blood transfusion, contaminated sharp objects, mother to child transmission, body contacts and kissing (Newman et al., 2015). Mode of infection for the various STIs differs.

Certain bacteria or viruses are present in vaginal secretions or semen; example is HIV and Gonorrhea while others are shed from the genitals that is, Herpes Simplex Virus and Human Papilloma Virus. Infections typically occur during sexual activities or when the genitals come into close contact. It can occur during oral sex as well, from an oral lesion to the genitals or vice versa (Golden & Wasserheit, 2009).

2.7 Behavioral Factors Affecting STI Transmission

Not every encounter with an infected partner will automatically result in an STI. Certain pathogens appear to be highly infectious: For example, exposure to the gonorrhea causing bacteria results in transmission to a sex partner in up to 50% of sexual exposures (i.e., 1 in 2 exposures). Other pathogens, such as HIV, are much less infectious. In prospectively observed discordant couples (one

partner HIV infected and the other uninfected), only 0.002 to 0.0001% of sexual exposures led to a new HIV infection (i.e., between 1 in 500 to 1 in 10,000 exposures) (Varghese et al., 2002).

This observation has supported the notion that HIV transmission or acquisition may require additional "help" through means of an underlying co-infection (for example an STI causing an ulcer or inflammation), a break in the skin, a partner with a particularly high HIV viral load or some other factor. In fact, laboratory and clinical research supports that new HIV infections are strongly associated with STIs causing genital ulcers, and to a lesser extent those causing inflammatory urethral and cervical responses.

2.7.1 Risky Sexual behaviors

Risky sexual behavior is the various behaviors that increase an individual's risk of contracting a sexually transmitted infection (Center for Disease Control, 2007). Adolescents and youth are sometimes used in this study interchangeably and this qualified since they fall within the age category. In this study, risky sexual behavior is explained as behaviors that can predispose an individual into acquiring an STI. Such behaviors are further explained using four characteristics; having sexual intercourse without using a condom, having sex under the influence of alcohol/drugs, multiple sexual partners and early sexual initiation.

Kenyon and colleagues (2014), emphasized that, the prevalence of STIs is subjected to a wider range of factors, which include treatment effectiveness, biological interactions with other STIs, socio-economic and other upstream factors

as well as sexual behavior. Different factors such as non-condom use, multiple sexual partners, having sex under the influence of alcohol and early sexual initiation, may cartel the effects on the increase rate of STI incidence; the difficulty, rate and extent of the variations in STI incidence poses a huge problem to any effort to classify world populations based on STI prevalence (Kenyon, Buyze, & Colebunders, 2014).

Literature have shown that multiple sexual partners, non-condom use and drug use have been classified as behavioral factors that are thought of as risky for the transmission of STIs (Abera et al., 2018). Risky behaviors such as excessive alcohol consumption, non-condom uses and the increasing number of sexual significant other's place majority of the youth especially collegial population at a higher danger of an STI infection compared to their counterparts who do not indulge in such activities (Adefuye, Abiona, Balogun, & Lukobo-Durrell, 2009). Findings from Ghanaian adolescents in urban poor areas in two towns in the Brong Ahafo region revealed that 29% of the adolescents were involved in multiple sexual relations. More males (57.6%) than females (14.9%) stated having multiple sexual partners. It further presented that adolescents in the two communities' sexual activity was high. In spite of their personal and social life, condom use is lacking thereby increasing their likelihood of having an STI (Darteh & Nnorom, 2012).

2.8 Sexually Transmitted Disease control

Sexually transmitted disease control is a public health outcome, it is however measured as reduced incidence and prevalence and achieved by implementing strategies composed of multiple synergistic interventions.

STI control is frequently used interchangeably with "STI treatment", yet these are quite different things. Control of any communicable disease is a public health outcome, measured as reduced prevalence (total infections) or incidence (new infections) in a population. Treatment is a biomedical intervention that, unless part of a broader control strategy, usually does not result in lower transmission rates or disease burden (Otwombe et al., 2015).

The determinants of STD epidemiology are as multifaceted as the approaches to prevention and care should be. The interventions for preventing the spread of STDs and HIV should take into consideration the role of human physiology, human behavioral patterns and sociocultural influences. STD and HIV prevention cannot be addressed by behavior and barrier methods alone. Other factors such as family units and values, provision of housing to minimize disruption of family life, employment, education, religion, culture, age, gender and so on need to be kept in mind at all times (World Health Organization & Joint United Nations Programme on HIV/ AIDS, 2003).

2.8.1 Primary Prevention

The objectives of STD prevention and care are to reduce the prevalence of STDs by interrupting their transmission, reducing the duration of infection and preventing the development of complications in those infected. Primary

prevention, which is concerned with the entire community, curbs the acquisition of infection and resulting illness. It can be promoted through health education, and involves practices such as safer sex behavior, including the use of condoms, and abstinence from sex (UNAIDS, 1998)

2.8.2 Secondary Prevention

Secondary prevention entails the provision of treatment and care for infected and affected persons. The activities should include: promotion of health care seeking behavior directed not only at those with symptoms of STDs, but also at those at increased risk of acquiring STDs, including HIV infection; the provision of clinical services that are accessible, acceptable and effective, and which offer diagnosis and effective treatment for both symptomatic and asymptomatic patients with STDs, and their partners and support and counselling services for both STD and HIV patients (Newton-Levinson, Leichliter, & Chandra-Mouli, 2017; Steen, Wi, & Ndowa, 2009).

CHAPTER THREE

METHODOLOGY

This chapter describes the methodology of the study. It presents the research methodology and design, population, sample and sampling design, the data collection protocol and techniques of analysis of data is also presented.

3.1 Study Area

The East Akim municipal known to cover land area of 508.3 square kilometers gained municipal status in 2008. Its total population of 167,896 in 2010 is 6.4 percent of Eastern regional population. More than half (51.3%) of the population are females giving rise to a sex ratio of 94.9, indicating that in the East Akim municipal, there are 95 males to every 100 females.

The population of children (14 years or younger) representing more than a third (56.0%) of the entire population, contributes to a high child dependency ratio; about 62 dependents (child and old age) for every 100 people working. In East Akim municipality, a total of 2,092 households with an average of 4.0 persons per household have about 51.3 percent of the households with females as head. Children to household head form more than a third (38.9%) of the household population, followed by grandchildren (12.1%) and then spouse (10.3%). Modern societies endorse nuclear family system as the most convenient system of building a family. The coverage for literate population includes those who may not have had any formal education but can read and write. The East Akim municipality has 87.7 percent of 122,816 persons who are 11 years and older to be literate. Almost

three-quarters (71.1%) are literate in, English and Ghanaian language only, English only (17.1%) and Ghanaian language only

3.2 Research Design

The study is a descriptive cross-sectional design that utilized quantitative method which looks into how age, sex, behavior, knowledge, availability and accessibility of health care, and other factors influence health seeking behavior. Several studies on health seeking behavior have found the design robust. A descriptive survey studies social conditions, relationships and behavior, and is simply to provide information, and what questions can be clarified.

3.3 Population

The target population for the study is the youth in Kyebi in the Abuakwa South municipality in the eastern Region of Ghana.

The Abuakwa South Municipal is located in the central portion of Eastern Region with the administrative capital as Kibi**.** It was elevated to a municipal status with LI 1878 in the year 2008 and has a total land area of approximately 725km2. The Municipality is bounded by six districts namely Atiwa District to the north, West Akim District to north west, Fanteakwa District to the East, New Juaben to the south, Yilo Krobo District to the south east and Suhum-Kraboa-Coaltar District to the west.

The district capital, Kibi, is 55km from Koforidua, 105km from Accra and 179km from Kumasi. The Municipality has a total projected population of One Hundred and Eight-One Thousand One Hundred and Fifty-Three (181,153) with 48% male and 52% female. Nearly forty percent of the population is rural.

The district has a sex ratio of 94.9. The population of the district is youthful (35.9%) depicting a broad base population pyramid which tapers off with a small number of elderly persons (6.7%). The total age dependency ratio for the District is 74.3, the age dependency ratio for males is higher (77.1) than that of females (71.7).

The main occupation in the municipality is farming, with about 65% of the working population engaged in active farming. The most important cash crops cultivated are Cocoa and Coffee followed by staples, like cassava, maize, plantain, oil palm and banana. Of the population 11 years and above, 71.0 percent are literate and 29.0 percent are nonliterate. The proportion of literate males is higher (50.4 %) than that of females (449.6%). Eight out of ten people (71.1%) indicated they could speak and write both English and Ghanaian languages.

For the population aged 3 years and above (63,357) in the district, 11.2 percent has never attended school, 40.8 percent are currently attending and 47.9 percent have attended in the past. The major development problems of the Municipality are low internal revenue generation; increasing prevalence rate of HIV/AIDS pandemic; inadequate institutional capacity of local government structures to effectively perform their role in governance; declining performance of school children; increasing rate of waste generation in the municipality and inadequate capacity to manage solid and liquid waste; haphazard spatial development; inadequate logistic support to decentralized departments to enhance performance; high unemployment rate especially among the youth population;

poor condition of market infrastructures; incidence of criminal activities including rape; defilement, armed robbery and drug addiction.

The target population is youth in Abuakwa south municipality which consists of adolescent and young adults between ages 15-24 years which reflects the target group as defined by the topic of study. These include youth in junior high schools, senior schools, churches, on the street, and in houses.

3.4 Sample and Sampling Procedure

Kibi or Kyebi is a town and the capital of the East Akim Municipal District, a district in the Eastern Region of south Ghana, on the eastern slopes of the Atewa Range Kibi lies at an altitude of 318 m, and, Kibi has a 2013 settlement population of 11,677 people. The multistage cluster sampling technique was chosen for the study.

This sampling technique, according to Moser and Kalton (1990) is a process of sampling complete groups and tends to lower field costs in investigation. Youth from various institutions in the three settlements chosen that is churches, schools, houses and on the street (clusters) will be randomly selected to represent respondents for the study. The multistage cluster will be used because it randomly samples within the selected cluster and its used in situations where no list of the entire population exist but list of clusters and where respondents must be geographically close together to survey in a cost-effective way. Sample was calculated using the formula below

$$n = Z^2 P \frac{(1-p)}{e^2} \quad \text{.....equation 1}$$

Where: n = required sample size,

z = confidence level at 95% (standard value of 1.96),

p= estimated prevalence of not seeking health care at all in Ghana was 40%(Gaddah & Munro, 2011)

1-p = estimated prevalence of seeking health care in Ghana, estimated at 60% and;

e = the margin of error at 5% (standard value of 0.05). This gave a sample size of 376 respondents. This figure will be adjusted to 380 to compensate for errors in answering the questionnaire

3.5 Instruments

A structured questionnaire was used to collect data from respondents. Questionnaires were self-administered to respondents in Abuakwa south in the eastern region. Youth were educated on how to answer the questionnaire appropriately. The questionnaires were filled by ticking and writing where necessary. The variables to be studied included, gender, religion, age and relationship status, attitude to sex and knowledge of protection methods. To help understand the factors influencing delay to seeking health for STIs among the youth.

3.6 Data analysis

Data was captured using Microsoft Excel 2007 to generate frequencies and percentages. Data analysis was done using Statistical Package for Social Science (SPSS) version 11.0.0 for windows.

3.7 Data Collection

Data were collected from 190 respondents personally by the researcher over a period of two weeks. Structured questionnaires with close and open-end questions were used to get information from the respondents

CHAPTER FOUR

RESULT AND DISCUSSION

This chapter presents the results for the study on selected demographic characteristics of survey respondents' that is age, education, religion, relationship status source of information on STI). The chapter also considered the relationships status of those who are single but dating, variables relating to respondents' attitudes about STIs; as well as treatment seeking for STI.

4.1 Demographic characteristics of respondents

Respondents of the study where youth between ages 15 – 24 years. Mean age of respondent was 17years. Out of 190 study participants approximately 56% were females and 44% males. A substantial proportion of the respondents were educated or have had formal education making up about 98.4% however, a very small proportion about 1.6 % of the respondent had no formal education. Most of the respondents were Christians constituting about 86.3% of the total respondent and 12.6% were Muslims, 0.5% respondent indicated being affiliated to the traditional religion.

A small portion of respondents however refused to indicate their religious affiliation. On respondent's marital status 54% reported being single, 40% represented those dating, 3.7% indicated being married and 1.6% were cohabiting. Those who indicated being single were asked if they have ever had a boyfriend 30% responded Yes and 23.7% responded No.

Table 1: Demographic characteristics of respondents

Age of Participant		
	Frequency	Percent
15	12	6.5
16	23	12.4
17	49	26.5
18	30	16.2
19	15	8.1
20	11	5.9
21	7	3.8
22	6	3.2
23	21	11.4
24	11	5.9
Total	185	100.0
Gender of Participants		
Male	83	43.7
Female	107	56.3
Total	190	100.0
Relationship status		
Single	104	54.7
Dating	76	40.0
Married	7	3.7
Co-habitation	3	1.6
Total	190	100.0
If currently single have you had a partner before		
Yes	58	56.3
No	45	43.7
Total	103	54.2

Source: Field Survey (2019)

4.2 participants source of information on STI

Out of 183 participants 28.4% said school teacher was their main source of information. About 27.4 indicated social media as their main source of information, TV recorded 12.6% out of the total, radio recorded 7.9% while family members and health worker recorded 6.8% each, article recorded the least 0.5%.

A cross tabulation was performed to ascertain if there is any association between source of information and educational background. there was a significant relationship between STI information source and educational background p (0.04) < 0.05 at a 95% confident level as shown in table 2.

There exist an association between information source and educational background, respondent with a primary educational status indicated peer group as a main source of information on STI, out of 32 respondents within the JHS category 42.8% indicated school teacher as a source, 11% indicated health worker and 8.3% indicated family members. TV and social media recorded 11.4% and 9,3% respectively. Trends recorded within the SHS group saw an increase in social media being the main source of information. out of 104 respondents in this category, 39 (38%) indicated social media as main source of information and 26% indicating school teacher as their source of information on STI.

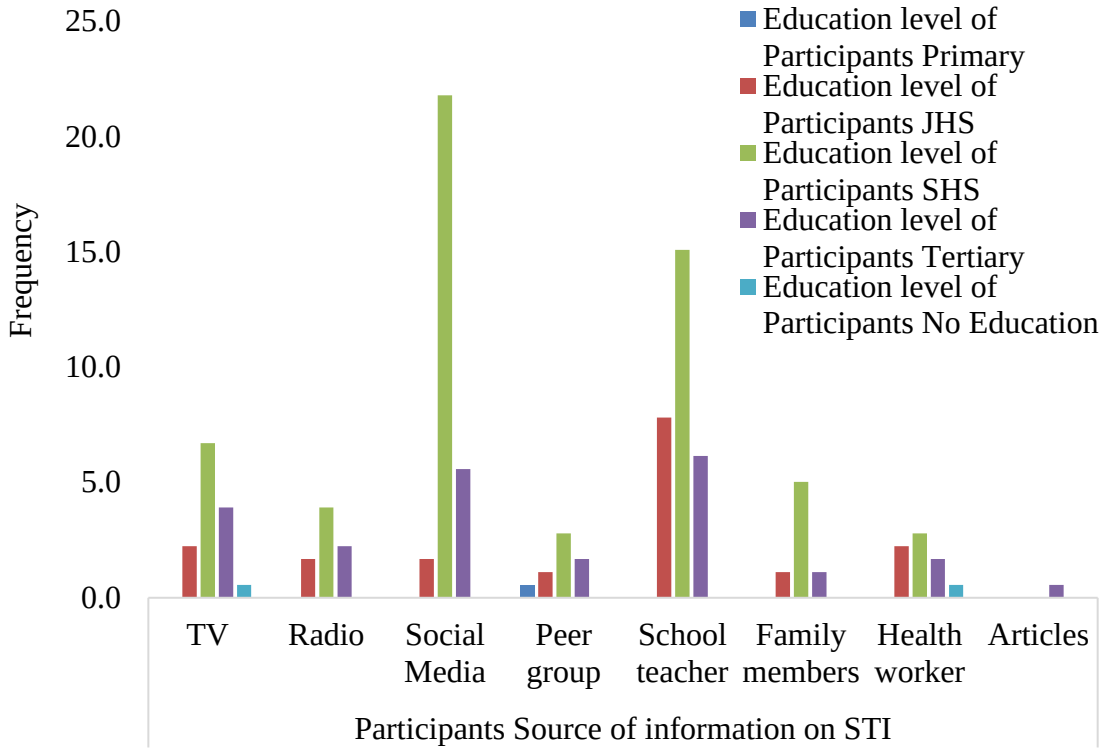
Here again health worker and family members recorded very low percentage 8.6% and 4.8% respectively. Respondents with tertiary educational status recorded 26.8% and 24.4% for school teacher and social media respectively.

The only respondents with no education indicated TV as a source of information on STI as represented in figure 1. It can be deduced from the findings

that family members fail in communicating on sexuality with their children therefore adolescents do not have the courage to discuss anything relating to sex with their relations unless a close confider is identified by that adolescent.

Findings from Denison, 2017 indicates there was a general opinion among the interviewees that sexuality education received at school and elsewhere had not adequately prepared them for the dangers associated with engaging in sexual activity. This reflects the findings of Mercer et al., 2013, where the majority of men and women across all age groups felt that they ought to have known more about sexual health (including STIs) when they first felt ready to have some sexual experience. The United Nations Educational, Scientific and Cultural Organization (UNESCO) has also recognized this gap, stating in their 2018 International

Technical Guidance on Sexuality Education that "far too few young people are receiving adequate preparation which leaves them vulnerable to coercion, abuse, exploitation, unintended pregnancy and sexually transmitted infections, including HIV" (UNESCO, 2018). The findings of this thesis support that judgement, and call for an improvement of sexuality education of the youth, including more information about STIs, a move away from scare tactics, and continuation of education into older ages.



Source: Field Survey (2019)

Figure 1: Participants source of information on STI

Table 2: Cross tabulation of source of information by educational background

N= 181		Participants Source of information on STI								
		TV	Radio	Social Media	Peer group	School teacher	Family members	Health worker	Articles	chi², p- value
Education level of Participants	Primary	0 (0%)	0 (0%)	0 (0%)	1 (0.6%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	42.63, 0.04
	JHS	4 (2.2%)	3 (1.7%)	3 (1.7%)	2 (1.1%)	14 (7.8%)	2 (1.1%)	4 (2.2%)	0 (0%)	
	SHS	12 (6.7%)	7 (3.9%)	39 (21.8%)	5 (2.8%)	27 (15.1%)	9 (5.0%)	5 (2.8%)	0 (0%)	
	Tertiary	7(3.6%)	4 (2.2%)	10 (5.6%)	3 (1.7%)	11 (6.1%)	2 (1.1%)	3 (1.7%)	1 (0.6%)	
	No Education	1 (0.6%)	0 (0%)	0 (0 %)	0 (0%)	0 (0%)	0 (0%)	1 (0.6%)	0 (0%)	

Source: Field Survey (2019)

4.3 Attitude of respondents towards STI

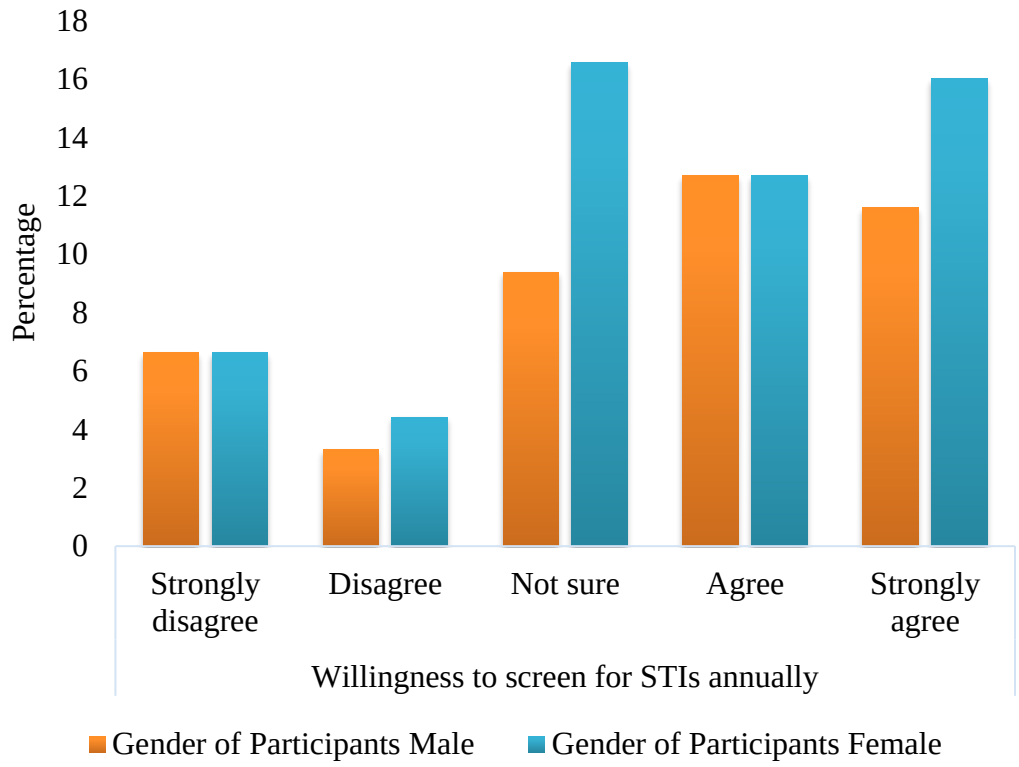
4.3.1 Willingness to test for STI

The intensity of youth's feelings towards STI screening was captured on a five-point Likert scale. The tendencies of males and female's willingness to screen for STI annually were tested for normality using the Kolmogorov-Smirnov normality t-tests, data assumed a normal distribution (r = 0.0 14, p = 0.00). It was deduced that there is weak positive and statistically significant difference in males and female's willingness to screen for STI. It can be said that some variations in testing for STI can slightly be attributed to gender differences. Testing and treating infected individuals limit the harm that STIs may cause to the individual and also

reduces the potential for transmission to new partners. Regular STI testing is recommended for sexually active

young people in many developed countries (UNICEF Malaysia, 2011).

Source: Field Survey September 2019



Source: Field Survey September 2019

Figure 2.Males and female's willingness to screen for STI

A paired sample t- test was performed to ascertain the association between educational level and knowledge of STI transmission when infected persons are asymptomatic. ($r = -0.187$, $p = 0.00$) indicates a weak negative correlation and statistically significant relationship between participants level of education and

knowledge of STI transmission by asymptomatic individuals as represented in table 3.

Some variations in knowledge can be somehow attributed to difference in educational status. The only respondent with a primary education background had no knowledge in STI transmission in asymptomatic persons. Out of 32 respondents in JHS, 15 (46.9%) believed STI can only be transmitted when symptoms are present. This represent a poor knowledge in STI transmission in asymptomatic persons and can increase transmission of infections. 10 (31.3%) disagreed to the statement indicating good knowledge and 21.9% did not know. Within SHS category more than half (50.5%) of the respondents made a strong disagreement or disagreed with the statement of STI can be transmitted only when symptoms are present this was marked as good knowledge. 31.1% made a strong agreement or agreed to the statement which was marked as poor knowledge and 18.4% did not have any knowledge. Again, within the tertiary category a greater percentage (61.5%) disagreed or strongly disagreed to the statement representing good knowledge, 20.5% made a strong agreement or agreed with the statement and 17.9% did not know. The no education category recorded 33.3% for disagreement or strong disagreement to the statement however more than half of the respondents here (66.7%) responded in strong agreement or agreed to the statement as indicated in figure 3.

A person can have an STI without having obvious symptoms of disease (World Health Organization, 2018). Good knowledge on STI transmission in asymptomatic individuals can help shape behavior of the youth in putting

measures to reduce being infected. Among women, STIs may present as asymptomatic infections for a while before showing mild to moderate symptoms (Jayapalan, 2015).

Table 3: STI infection in asymptomatic individuals by level of education

		STIs can only be transmitted when symptoms are present N = 178, (%)					
		Strongly disagree	Disagree	Not sure	Agree	Strongly agree	r, p- value
Education level of Participants	Primary (1)	0 (0.0)	0 (0.0)	1 (1.8)	0 (0.0)	0 (0.0)	-0.187, 0.01
	JHS (32)	5 (8.8)	5 (8.8)	7 (12.3)	9 (15.8)	6 (10.5)	
	SHS (103)	34 (59.6)	18 (31.6)	19 (33.3)	16 (28.1)	16 (28.1)	
	Tertiary (39)	17 (29.8)	7 (12.3)	7 (12.3)	6 (10.5)	2 (3.5)	
	No Educ (3)	1 (1.8)	0 (0.00	0 (0.0)	2 (3.5)	0 (0.0)	

Source: Field Survey September 2019

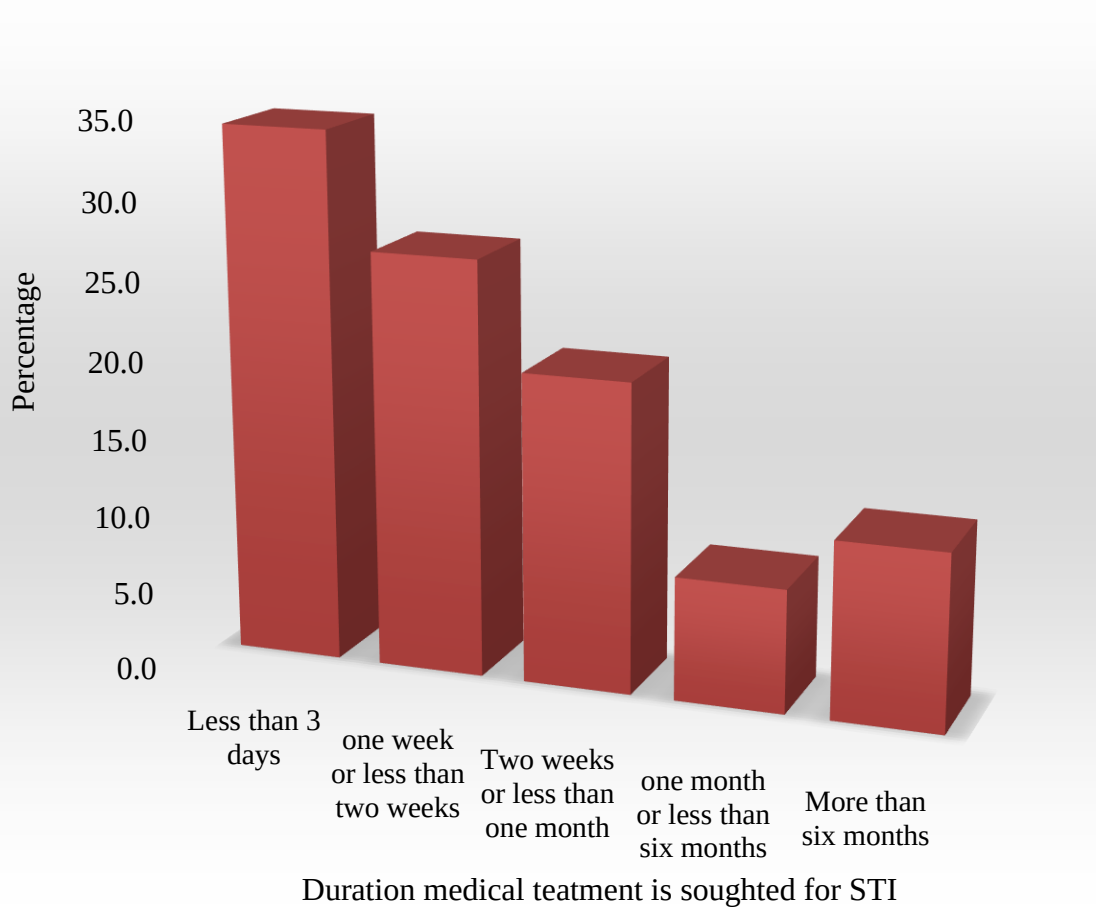
4.4 Health seeking behavior

4.4.1 Period of treatment seeking for STI

Respondents were asked how long it will take them to seek treatment for STI. About 34.1% of the respondent indicated that they will sort care in less than 3days when STI symptoms are realized with another 26.7% indicating seeking medical treatment in less than one week or two weeks, 19.9% indicated that they will seek

medical care in one month or less than six months and 11.4% indicated that they will seek for treatment after six months. More than half of the respondents delay in seeking help for STI as shown in figure 3. Countless studies have proven the fact that many people delay in seeking care for their illnesses in general (Getahun, Deribe, & Deribew, 2010).

In this study, 26.7% of participants delayed for a week or less than two weeks, 19.9% delayed for a month or less than six weeks and 11.4% indicated seeking help after six months. A similar study in Kenya involving 471 people attending an STI Clinic revealed that 41% of patients waited for more than a week and 23% delayed for more than two weeks (Agambire, 2013)



Source: Field Survey September 2019

Figure 3. Duration for seeking medical treatment for STI

4.4.2 Measure of dispersion on how long it takes to seek treatment and what is done when STI symptoms are realized

A pairwise sample t-test was used to analyze data and inferences made on relationship between duration of sorting for medical treatment and what is done when symptoms are realized for STI. Also, mean and standard deviation was used to explain the dispersion from the mean. Table 3 and 4 represents descriptive statistics and crosstabulation of the test variables respectively. As indicate in table

3, participants response on what they will do upon realization of STI symptoms was more distributed than the duration they will sort medical treatment for STI (mean score was 3.27 and 2.40 respectively). Responses to how long it will take to sought medical treatment for STI was however more spread than that of what they will do upon realization of STI symptoms (std dev 1.326 and 1.079 respectively). Responses on what will be done on STI symptom realization is closer to the mean as shown in appendix II. Duration treatment is sort for STI and what is done when symptom is realized are weekly and negatively correlated, further analysis showed $t(153) = -5.747$, $p = 0.00$, $r = 0.19$ this indicates that differences is statistically significant at 95% confident level. It can be suggested that decision taken on what to do upon STI symptom realization affects duration to sort for treatment however weekly, its significant and can have a slight impact table 5.

How serious an individual perceives symptoms may influence his or her decision to delay health care seeking. If the symptoms do not interfere with one's sexual activity, and if it is not considered as severe, the patient may delay seeking of care (Ward, Mertens, & Thomas, 1997). Most of the respondent however delayed but indicated going to a health facility after symptom realization, the time taken for this decision to be taken may be influenced by some factors.

A study in Singapore showed that 73% waited for 4 week and 27% delayed for over 2 weeks before seeking care. Reasons for delay include: social stigmatization against sexual promiscuity, fear of public exposure, embarrassment, and lack of privacy (Jayapalan, 2015).

Table 4: Cross tabulation of how long it takes to seek treatment and what is done

		What will you do when you realize symptom of STI?					
N = 154		Self-medicate	seek help	both self-medicate and seek help	Go to a health facility	Don't know	r, p 0.149, 0.00
How long does it take you to seek medical treatment	Less than 3 days	1 (0.7%)	9 (5.8)	10 (6.5)	30 (19.5)	0 (0.0%)	
	one week or less than two weeks	4 (2.6%)	3 (2.0%)	7(4.6%)	24 (15.6%)	2 (1.3%)	
	Two weeks or less than one month	4 (2.6%)	3 (2.0%)	7 (4.6%)	17 (11.0%)	3 (2.0%)	
	one month or less than six months	3 (2.0%)	2 (1.3%)	1 (0.7%)	6 (3.9%)	0 (0.0%)	
	More than six months	4 (2.6%)	4 (2.6%)	3 (2.0%)	7 (4.6%)	0 (0.0%)	

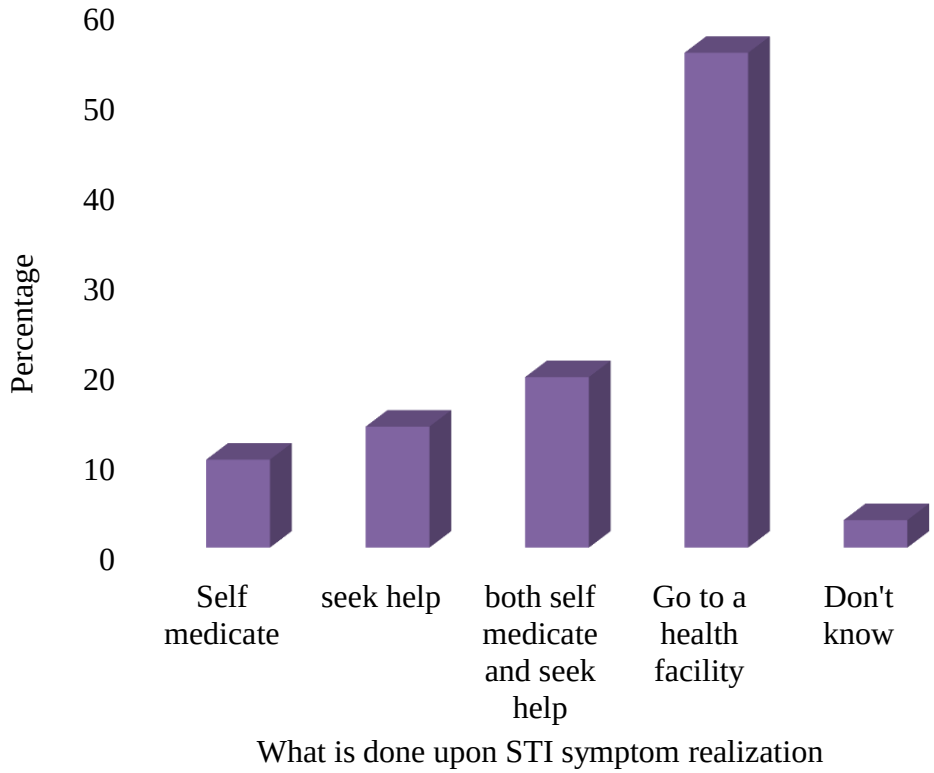
Source: Field Survey (2019)

4.5 Treatment seeking for STI

4.5.1 Measures taken in finding treatment for STI

Out of 164 respondents, 90 (54.9%) representing more than half of the total respondents indicated going to a health facility to seek treatment upon first realizing STI symptoms. 19% indicated they will self-medicate and seek help at

the same time. 13% said they will seek help and 9.8% indicated self-medication. 3% however said they don't know what they will do.

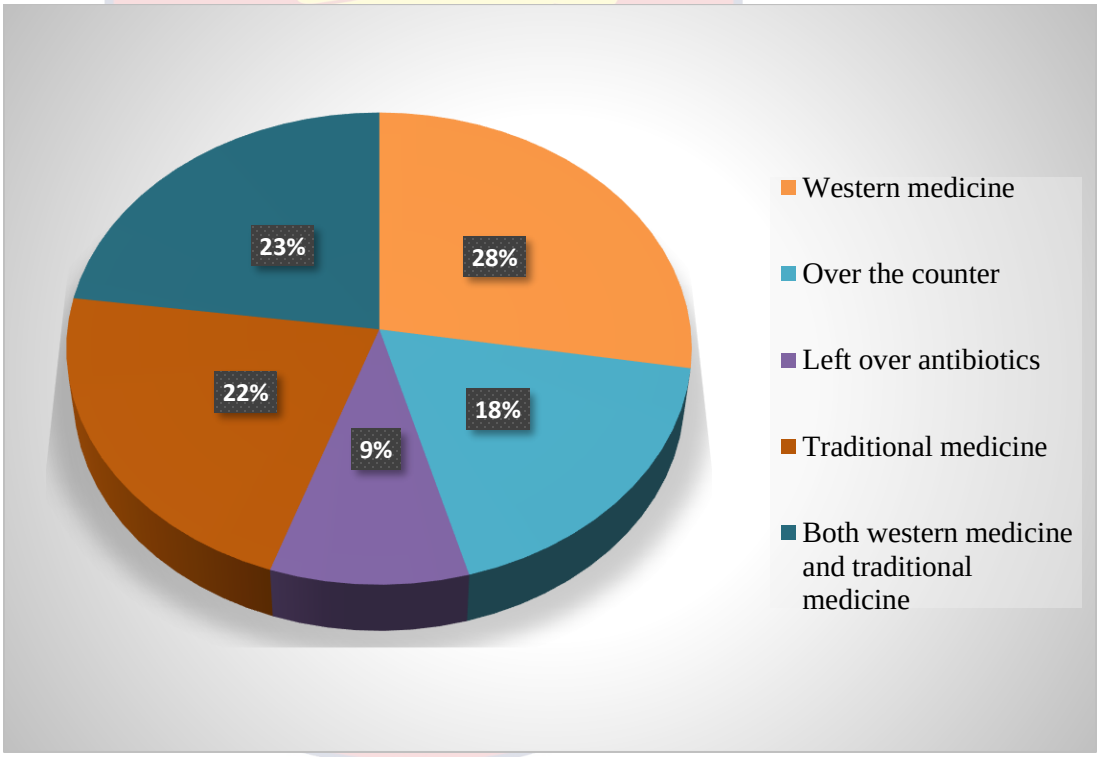


Source: Field Survey September 2019

Figure 4. First point of call in STI symptom realization

4.5.2 Medication used in terms of self-medication

In terms of self-medication, 28% of respondents use western medicine, 23% use both western and traditional medicine, 22% use traditional medicine, 18 % use over the counter drug and 9% use leftover antibiotics. This was in accordance with works from Sarfo & Sarfo, 2016 the use of Traditional Health System's treatment efficacy and Orthodox Health System's treatment efficacy were significant predictors of Health Seeking Behaviors among respondents.



Source: Field Survey September 2019

Figure 5. Medication used in terms of self-medication

The relationship between male and female's reasons not to see a doctor first upon STI symptom realization was tested using a paired sample t- test. There was a very weak negative correlation which is statistically significant between male and

female's reasons not to see a doctor first (p= 0.00, r = -0.01) significant at 95% confident level as indicated in table 6. Out of 104 respondents, 45 were males and 62 females. Those whose indicated medication had worked as a reason were 43% and 43.5% for males and females respectively. 26.7% males and 24.2% females indicated mild symptoms as a reason for not seeing a doctor first. 19.4% of female and 17.8% of males do self-medicate due to advise from friends. Those who self-medicated due to not knowing where to go were 13.5% males and 9.7% females. Only a few respondents reported cost as a reason

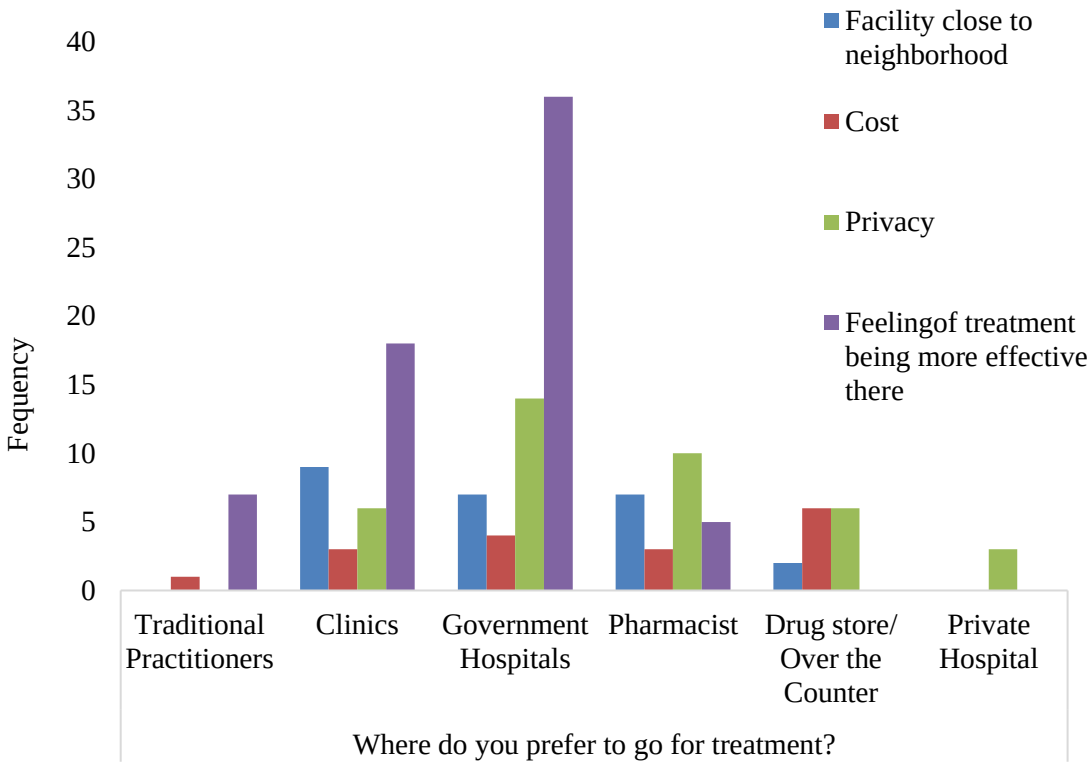
Table 5: Cross tabulation of gender by reasons for not seeing a doctor first

		(Those who self-medicate) Why didn't you see a doctor first?				
N =107		Mild symptom	Medication had worked for some symptoms before	Advice from friends	Didn't know where to go	Cost
Gender of Participants	Male (45)	12 (11.2%)	18 (16.8%)	8 (7.5%)	6 (5.6%)	1 (0.9%)
	Female (62)	15 (14%)	27 (25.2%)	12 (11.2%)	6 (5.6%)	2 (1.6%)

Source: Field Survey (2019)

4.5.4 Health care preference in seeking for STI treatment and reasons for preference

Results from the findings indicated government hospital as the preferred choice for the youth in seeking treatment for STI with the reason of feeling treatment being most effective there. The means were almost same (3.06, 3.03) respectively meaning distributions in both health care preference in seeking STI treatment and reasons for preference do not vary. A standard deviation of approximately 1.1 and 1.1 was recorded or both variables, coefficient of variation (CV) was calculated to find the level of dispersions in the test variables. CV was recorded to be 0.3 for both variables, CV<1 indicates a large amount of variations in both preferred choice for treat seeking and reasons for preference.



Source: Field Survey (2019)

Figure 6. Preference in health facility for STI treatment seeking and reasons for preference

As represented in table 6, (p = 0.74) indicates no statistically significant relationship between choice of treatment facility and reasons for preference. Out of 149 respondents, 63 (42.3%) indicated government hospital as a preferred choice of seeking STI treatment. 36 (24%) indicated preference for clinics, 25 (16.8%) indicated pharmacy. The respondents who indicated government hospital as a preferred choice also made an assertion of treatment being more effective there making up 57%, clinic as a choice for STI treatment also recorded 50% with

a reason of feeling treatment will be more effective there. Those whose indicated pharmacy as a preferred choice also mentioned privacy as a reason, out of 25 respondents in this category 10 (40.0%) made this assertion. Despite government hospital being a first point of call as indicated earlier in this study, pharmacy as first point of call cannot be overemphasize, studies have shown that between 50,000 to 90,000 cases of STIs are managed in Pharmacies within Accra only (Ministry of Health, 2003). According to the GSS, 2009, 7% of women and 14% of men seek care and counseling for STIs in Pharmacies or Licensed Chemical Shops (GSS, 2009).

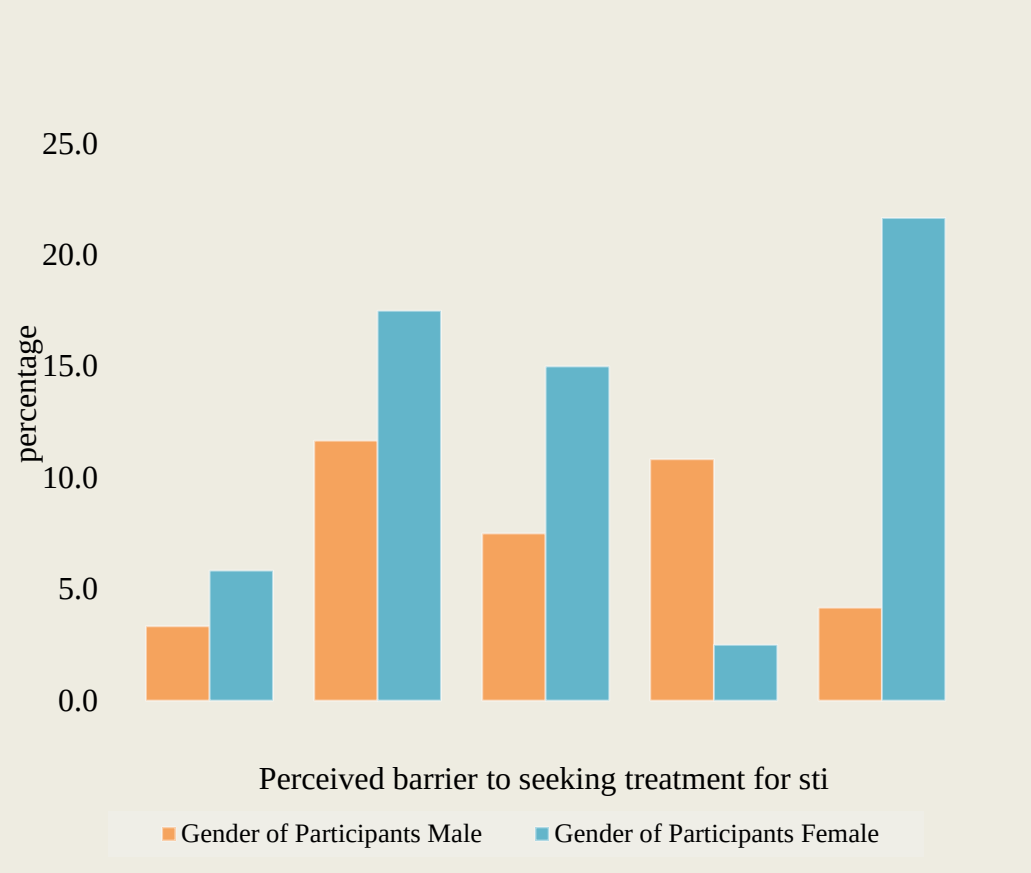
Table 6: Cross tabulation of reasons for treatment preference by choice of health facility

N = 149		Where do you prefer to go for treatment?					
		Traditional Practitioners	Clinics	Government Hospitals	Pharmacist	Drug store/ Over the Counter	Private Hospital
What will be your reason to your preference of treatment	Facility close to neighborhood	0 (0.0%)	9 (6.5%)	7 (5%)	7 (5%)	2 (1.4%)	0 (0.0%)
	Cost	1 (0.7%)	3 (2.2%)	4 (2.9%)	3 (2.2%)	6 (4.3%)	0 (0.0%)
	Privacy	0 (0.0)	6(4.3%)	14 (10.1%)	10 (7.2%)	6 (4.3%	3 (2.2%)
	Feeling of treatment being more effective there	7 (4.8%)	18(12.9%)	36 (25.9%)	5 (3.6%)	0 (0.0%)	0 (0.0%)

Source: Field Survey (2019)

4.6 Barriers to seeking treatment for STI

Out of 120 respondents making 63.2% of the total 190 delayed in seeking help for STI. It can be deduced that 36% out of the total respondents seek early treatment. The findings of the study indicated 29.2% reporting confidentiality as a barrier to seeking treatment for STI, 25.8% taught symptoms where normal and did not seek early treatment. Uncertainty of where to sort for STI treatment recorded 23.2%. 13.3% however indicated cost of STI treatment also delay or even prevent them from seeking medical treatment for STI. Knowledge of where to seek for treatment being a barrier recorded the least percentage of 9.1 as shown in figure 7.



Source: Field Survey (2019)

Figure 7. A representation of perceived barriers to health seeking for STI against

gender

4.6.1 Delay in seeking care

A Chi square analysis was performed to test for relationship between gender and reasons for delay in seeking help. A p value of 0.01 was recorded at 95% confident level meaning there exist a significant relationship between gender and reasons for delay in seeking help for STI treatment. The null hypothesis that there is no significant relationship is rejected. Delay in seeking care has been attributed to many factors such as socio-demographic characteristics as well as support and behavioral factors (Jayapalan, 2015). A study in Kenya revealed that individuals delayed in seeking healthcare for reasons such as poor staff attitude, little confidentiality as well as age of clients (Adler & Newman, 2002). In this study, the main reason for patients delaying was confidentiality. Out of 45 males and 75 females making up 37.5% and 62.5% respectively. Percentage of males and females reporting confidentiality and subsequent delay in seeking care are 31.1% and 28% respectively. Males in this category recorded the highest percentage. In a study by Cherie & Berhane, 2012 respondents reported that because of perception of lack of privacy, meeting adults at health facility and meeting someone whom you know there is the fear that information being provided may not be kept confidential. Same study reported unfriendliness as well as believe that honest and open discussion of their health complaints with a physician is "more likely to elicit scorn than sympathy" they learn to say what they think the physician wants to believe. Newton-Levinson, Leichliter, & Chandra-Mouli, 2016's study also investigated youth's preference in seeking STI care, it was reported that

government hospital was the most preferred indicating accessibility and cost effectiveness as a reason for preference but problems in relation to confidentiality and poor attitude of providers act as a barrier and facilitate delays in seeking care. In relation to perceived seriousness of symptoms females 34% rather delay seeking care as compared to their male counterparts 11%. This was in agreement with work on gender differences in seeking health care by Mmari, Oseni, and Fatusi, 2010b where a greater proportion of young men than of women had sought treatment for genital ulcers (30% vs. 20%), although the finding was only marginally significant ($p<0.06$) females are likely to sought care late due to the fact that females tend to bear the bulk of the stigma attached to STIs, with infections often being perceived as a sign of promiscuity. As a result, women may choose not to confide in anyone, even if they have an unusual discharge or a sore also, males might simply experience STIs differently than females as mentioned previously, many women who experience such STI symptoms as vaginal discharge and genital itching do not regard them as serious or as the result of sexual intercourse and, therefore, do not believe that they need to be treated. 20% males as against 24% females delayed treatment due to uncertainty of the right facility to visit. Even though most of the respondents agree to visiting a government hospital with the feeling of treatment being more effective there, other factors can influence delay such as where to settle on in getting STI related care. With gender differences in relation to cost as a barrier, more males than females reported not having money as a factor for delay in seeking care 31% and 6.7% respectively as represented in table 7.

Table 7: Cross tabulation of gender by reasons treatment seeking was delayed

		Why will you delay before seeking help					
N=120 (63%)		Didn't know where to go	My confidentiality was not assured	Search for the right Doctor or Clinic	Didn't have enough money	Did not think symptoms were serious	chi, p value
Gender of Participants	Male (45)	4 (3.3%)	14 (11.7%)	9 (7.7%)	13 (10.8%)	5 (4.2%)	19.41, 0.01
	Female (75)	7 (5.8%)	21 (17.5%)	18 (15.5%)	3 (2.5%)	26 (21.7%)	

Source: Field Survey (2019)

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

This chapter, based on the objectives of the study summarizes all the findings, provides a conclusion to the study and finally provides recommendations on health seeking behavior of youth in Abuakwa North.

5.1 Conclusions

This study sought to find out the health seeking behaviors for STIs among youth in Kyebi in the Abuakwa North Municipality. It was a descriptive cross-sectional analysis which employed quantitative data collection tools and techniques. Multistage cluster sampling was used to employ 190 respondents into the study. A structured questionnaire was used in data collection and this data was analyzed using the latest version of SPSS for analysis. The study found that generally youth obtain STI information from school teacher and social media, however the information source was influenced by educational status. Health workers and family member contributed less in giving out information about STI to young adults. It was revealed that a greater section of the youth delay in seeking care for STI related illness. The decision taken on what to do affects duration to sought treatment for STI.

The first treatment option for STI management was by large going to a health facility with just a handful self-medicating, or seeking help and self- medicating at the same time. The use of both western and traditional medication or either of the two was common on the grounds of medication has worked before, due to mild symptoms or advice from friends.

The most preferred health facility was government hospital with a greater perception of treatment being more effective there. Preference for clinics was also listed with same reason and pharmacy was also preferred with the reason of privacy and over the counter drugs were used due to cost.

The study found out more than half of the respondents reporting main barrier to seeking care as acceptability of the service and affordability. Comparatively a greater percentage of males than females indicated confidentiality as a barrier and a larger section of males reported cost as a barrier.

5.2 Recommendations

Information source for STI among the youth is influenced by educational status, teachers are the main source and there is a need to lay down proper structures to help disseminate STI information appropriately in the different educational levels Inclusion of basic facts about STIs in sexuality education and the school curriculum to boost up their knowledge of STIs and thereby reduce the transmission and increase the prevention of STIs.

The roles of both traditional medication and western medication by the youth in attempt to finding care for STI treatment are indispensable. The healthcare professionals and others healthcare authorities should work together to increase the awareness of the public about the negative effects of self-medication if used inappropriately and help them to make the right decision related to health problems. In addition, educational intervention programs are needed to educate people on the proper use of non-prescription medicines that are usually taken for treating STI symptoms.

By improving the quality of care, proper maintenance of facilities and also by inculcating a caring and sympathetic attitude in health professionals while dealing with patients especially youth reporting with STI symptoms, unnecessary delays in seeking treatment for STI will be reduced since there is a strong believe by the youth that STI treatment will be more effective at a government hospital.

This study relied on self-reported answers, and these may be subject to recall and reporting bias. Unidentified predictors or confounders are still possible regarding attitude and perceptions of people about STI and health seeking behavior. Further research combining both quantitative and qualitative survey is needed to improve upon these limitations.

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APPENDIX I

QUESTIONNAIR ON HEALTH SEEKING BEHAVIOR OF THE YOUTH IN RELATION TO SEXUALLY TRANSMITTED DISEASES

The purpose of this quantitative study is to determine the factors and predictors of health-seeking behaviors among youth as a basis for developing an intervention program subsequently. This is an anonymous survey, and the privacy of every participant will be protected such that the results cannot be traced back to any participant at any point in time. All your responses will be kept confidential within reasonable limits. To be eligible to participate, you must be at least 15-24years of age at the time of completing the survey.

Please tick where applicable [√]

Demographic information

1. Age (in years) …….
2. Sex; a. Male [ ] b. Female [ ]
3. Religion; a. Christian [ ] b. Muslim [ ] c. Traditionalist [ ] d. Other Specify …….
4. Relationship status: a. Single [ ] b. Dating [ ] c. Married [ ] d. Separated/ divorce [ ] e. Co- habiting [ ], others please specify……
5. If you are currently single have you ever had a partner or boyfriend before? Yes [ ] No [ ]
6. Educational Level: a. Primary [ ] b. JHS [ ] c. SHS [ ] Tertiary [ ] e. No education [ ]
7. Your source of information on STIs? T.V [ ], Radio [ ], Social Media [ ], Peer group [ ], School teachers [ ], Family members [ ], Health worker [ ], other (specify)…….

HEALTH SEEKING BEHAVIOR

1. How long will it take you to seek medical treatment for STI? a. Less than 3 days [ ], b. one week or less than two weeks [ ], c. Two weeks or less than one month [ ], d. one month or less than six months [ ], e. more than six months [ ]

   a. For those who chose option c, d and e

2. Why the decision chosen above? a. due to embarrassment [ ], b. fear of being stigmatized [ ], c. thought symptoms will subside on its own [ ], d. not sure of where to go [ ], others please specify…….....
3. What will you do when you realize symptoms of STI? a. self-medicate [ ], b. seek help [ ], c. both self-medicate and seek help [ ], d. go to a health facility [ ], e. don't know [ ], others please specify……

   b. For those who chose options a and c

4. What medication do you use in terms of self- medication? a. western medicine [ ], b. over the counter [ ], c. left over antibiotics [ ], d. traditional medicine [ ], e. both western medicine and traditional medicine [ ], others please specify……

   ……

5. Why didn't you see a doctor first? a. mild symptoms [ ], b. medication had worked for some symptoms before [ ], advice from friends [ ], didn't know where to go [ ], others please specify…….

For those who seek help for symptoms

6. How long did you wait before seeking help? Less than 3 days [ ], one week or less than two weeks [ ], Two weeks or less than one month [ ], one month or less than six months [ ], others please specify …….
   ……
7. Why did you delay before seeking help? a. Didn't know where to go [ ], b. my confidentiality was not assured [ ], c. search for the right doctor or clinic [ ], d. didn't have enough money [ ], e. did not think symptoms where serious [ ], others please specify……
8. Where do you prefer to go for treatment (first place you will visit)? a. Traditional practitioners [ ], b. clinics [ ], c. government hospitals [ ], d. pharmacist [ ], d. drug store/ over the counter [ ], Others please specify……...
9. What will be your reason for the choice above? a. Facility close to neighborhood [ ], b. cost [ ], c. privacy [ ], e. feeling of treatment being more effective there [ ], others please specify……

ATTITUDE AMONG THE YOUTH ON SEXUALLY TRANSMITTED INFECTIONS

Please state your opinion on using a scale of 1 to 5 where 1 signify strongly disagree and 5 strong agreements to the following statements.

Rating scale: strongly disagree- [1], disagree- [2], not sure- [3], agree - [4], strongly agree -[5]

QUESTIONS / RESPONSE	1	2	3	4	5
I feel condom protects people from STIs					

I feel it is not necessary to use condom during anal sex					
There is no need to use condom if both partners are infected with STIs					
Numerous sexual partners play an important role in STI transmission					
Condom play an important role in STIs prevention					
I will willingly screen for STIs annually					
I feel being infected with STI is not dangerous because it can be cured					
I am concerned about getting infected with STI					
I have not given serious thoughts to STI problems					
If I have unprotected sexual intercourse, I am mostly concerned about;					
Getting HIV					
Unwanted pregnancy					
Getting STI other than HIV					
STIs can only be transmitted when symptoms are present					

APPENDIX II

Measure of spread and distributions on duration treatment will be sorted for STI and what will be done on realization of STI symptoms

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	How long does it take you to seek treatment	2.40	154	1.326	0.107
	What will you do when you realize symptom of STI?	3.27	154	1.079	0.087