Health Seeking Behaviour of Young Adults in Accra, Ghana

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Abstract

Background: Health-seeking behavior encompasses individuals' actions when facing health issues and can be influenced by various factors, such as socioeconomic status, cultural beliefs, and healthcare accessibility. Understanding these behaviors is crucial for improving health outcomes and ensuring effective healthcare utilization.

Methods: A cross-sectional study design was used to collect data on healthcare-seeking behaviors of young adults in Accra. A semi-structured questionnaire was administered to 330 participants using both convenience and simple random sampling.

Results: Majority of respondents reported their health status as good. However, despite generally positive self-assessments, 48.5% of respondents reported being ill in the past three months, with about 50% diagnosing themselves. Using binary logistic regression, the study found that higher social status increased the likelihood of reported illness (OR = 2.47, p = 0.001), whereas self-employment significantly reduced illness risk (OR = 0.27, p = 0.008).

Conclusion: Barriers identified with regard to seeking healthcare included lack of education, time constraints, and distance. Raising awareness of the importance of timely healthcare seeking and improving access to healthcare services across communities in Accra may help address these challenges.

Keywords: Healthcare-seeking behavior, healthcare access, barriers to healthcare, young adults

Introduction

The young adult population is a fast-growing segment of the population, especially in low-income and middle-income nations (Meagley et al., 2016). Healthcare access among young adults continues to be a vital public health concern with lifelong consequences for both health and socioeconomic stability (Omotoso et al., 2022). The utilization of healthcare services is intricately connected to the structure of a country's healthcare system as well as the resources available in terms of medicines. In addition, healthcare utilization patterns are affected by individuals' healthcare-seeking behaviors (Abuduxike et al., 2020).

Health-seeking behavior (HSB) is defined as actions taken by people when they become sick to receive proper treatment. Behavior is a key indicator of healthcare utilization among communities. It is influenced by a broad

set of factors, including the level of education, economic situation, cultural beliefs, socio-demographic factors, exposure to healthcare services, gender relations, and the general structure of the healthcare system (Ng'ambi et al., 2020). The HSB is within the broad framework of healthcare consumption, which includes preventive care, curative care, health maintenance, and seeking information concerning one's health and medical prognosis (Latunji & Akinyemi, 2018). It reflects the extent to which individuals take proactive steps, delay seeking care, or stay inactive upon discovering a health issue, thereby determining their recovery process and overall health status (Saah et al., 2021).

Health-seeking behavior is a key determinant of a nation's overall health system. It is also used to indicate future trends in public health, economic growth, and social development. It offers a glimpse of how individuals engage in healthcare systems and utilize existing services (Mboweni & Sumbane, 2019).

Accra, the capital city of Ghana, is situated in the south-eastern part of the country. It is one of Ghana's most densely populated regions, with around 1,235.8 people per square kilometer. Notably, the region is highly urbanized, with approximately 90.5% of the population living in urban areas, and it continues to experience significant urban growth at an annual rate of 3.1% (Odonkor et al., 2019). Migration trends show that more people move into the region from other parts of the country than leave, contributing to its urban expansion and population pressure. Despite efforts by the government to enhance healthcare infrastructure, access to medical services in Accra remains a challenge. Public hospitals often struggle with overcrowding and inadequate funding, highlighting the persistent gaps in healthcare delivery (Odonkor et al., 2019).

Improving the health of citizens is of utmost importance to all nations because of its position as a key asset for the enablement of daily life. Healthy citizens are vital in promoting economic growth, as citizens can work and contribute to national development (Egbunu & Yunusa, 2022). However, in sub-Saharan African (SSA) countries and some low- and middle-income countries, prospects for receiving medical care are largely absent (Saah et al., 2021). It is essential to understand the factors that shape the timing and manner in which young individuals consult medical care, ranging from informal discussions with their social networks to interactions with formal providers to optimize health promotion initiatives and service provision (Meagley et al., 2016). This research aimed to examine the healthcare-seeking behaviors exhibited by young adults in Accra, Ghana.

Method

Research Design

This study was conducted in Accra, Ghana's capital city. A quantitative research approach was employed using a cross-sectional study design to collect the data (Boakye & Mavhandu-Mudzusi,

2019). The study focused on young adults residing in Accra, Ghana.

Study Population and Sampling

A population is a group of individuals or objects with shared characteristics (Polit & Beck, 2008). This research was conducted in Accra, where convenience sampling was used to select specific towns and simple random sampling was applied to select participants in the towns.

This study targeted young adults aged 18–26 years living in Accra. Bonnie et al., (2015) stated that young adulthood typically ranges from 18 to 26 years. Individuals outside this age bracket, those unwilling to participate, or those who declined participation were excluded from the study. According to Polit and Beck (2008), simple random sampling ensures that every individual in a population has an equal chance of being selected.

Sample Size

The sample size for this study was determined using Yamane's (1967) formula, which provides a simplified method for calculating population-based sample sizes. The formula for selecting the sample size was used to reduce selection bias.

According to the 2021 population census by the Ghana Statistical Services, the total number of young adults in Accra aged 18-26 is 950,499. Using Yamane's formula, the sample size was 400. However, only 330 questionnaires were fully completed and used in this study. The remaining responses (70) were excluded due to incomplete or inconsistent answers.

Data Collection

A semi-structured questionnaire was meticulously designed to align with the objectives of the study. This format incorporated both structured and open-ended questions, allowing for a balance between collecting specific data and enabling participants to provide detailed responses, where necessary. Pretesting was conducted with a small group of 15 young adults to ensure clarity and relevance. Modifications were made based on the participant feedback.

Data Analysis

The survey responses were analyzed using SPSS version 26. Descriptive and inferential statistical methods were used to present the findings of the study. Descriptive statistics help to effectively summarize and interpret large datasets (Blankson & Ashie-Nikoi, 2025). Chi-square tests, correlation analysis, and logistic regression were used to explore the relationships between the variables. A significance level of 0.05 was used to test whether there was a statistically significant relationship between respondents' social status and their likelihood of experiencing illness. Similarly, it was used to test if the mode of transportation was significantly associated with the distance to the nearest health facility. The results were presented using percentages and frequency distributions, with tables and graphs clearly representing the findings.

Ethical Consideration

Participants were fully informed about the purpose of the research and assured that the collected data would be used strictly for academic purposes. Their voluntary participation was emphasized, and they had the right to withdraw without consequences. Participants' responses were kept strictly within the study to protect confidentiality and were not shared with third parties. The participants signed an informed consent form before the study. Their identities remained undisclosed to prevent any association with their responses. Throughout the study, the participants' privacy rights were upheld and safeguarded.

Results

This section outlines the empirical results of an in-depth analysis of the collected data. The findings highlight notable patterns, relationships, and statistically significant outcomes pertinent to this study.

Demographic Characteristics of Respondents

Table 1 presents the respondents' demographic characteristics. The sample was fairly balanced, with 52.7% female and 47.3% male. Most respondents (76.4%) were within the 18-23 age range. Most respondents (60.3%) had completed Senior High School (SHS), whereas only 3.3% had no formal education. The population is predominantly urban (84.2%), with only 15.8% living in rural areas. Most respondents (94.5 %) were single, 82.4% were identified as Christians, and 17.6% were Muslims. Approximately 75.2% of the respondents were unemployed, only 9.6% were formally employed, and 15.2% were self-employed. In relation to social status, the majority (78.2%) were identified as middle class, 4.8% considered themselves as lower class, and 17.0% as upper class, which is relatively high compared to the lower-class percentage. A high percentage (90.9%) of the respondents had health insurance.

Table 1

Socio-Demographic Characteristics of Respondents

Variable	Frequency(n=330)	Percentage (%)
Gender		
Female	174	52.7
Male	156	47.3
Total	330	100.0
Age group		
18-20	130	39.4
21-23	122	37.0
24-26	78	23.6
Total	330	100.0
Level of education		
No formal education	11	3.3
Primary/JHS	40	12.1
SHS	199	60.3
Tertiary	80	24.3
Total	330	100.0
Residence		
Urban	278	84.2
Rural	52	15.8
Total	330	100.0
Marital status		
Single	312	94.5
Married	18	5.5
Total	330	100.0
Religion		
Christian	272	82.4
Muslim	58	17.6
Total	330	100.0
Employment status		
Employed	32	9.6
Self-employed	50	15.2
Unemployed	248	75.2
Total	330	100.0
Social status		
Lower class	16	4.8
Middle class	258	78.2
Upper class	56	17.0
Total	330	100.0
Health insurance		
Yes	300	90.9
No	30	9.1
Total	330	100.0

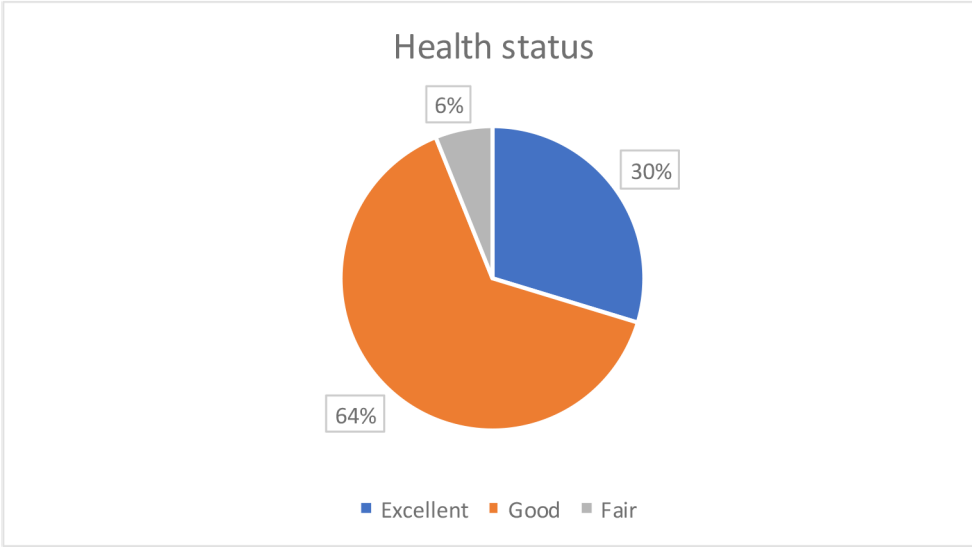
Source: Field work

Health Status and Health-Seeking Behavior

From Figure 1, 64.2% of the respondents rated their health as "Good." About 29.7% consider their health "Excellent," while 6.1% rate their health as "Fair."

Figure 1

Health Status of Respondents

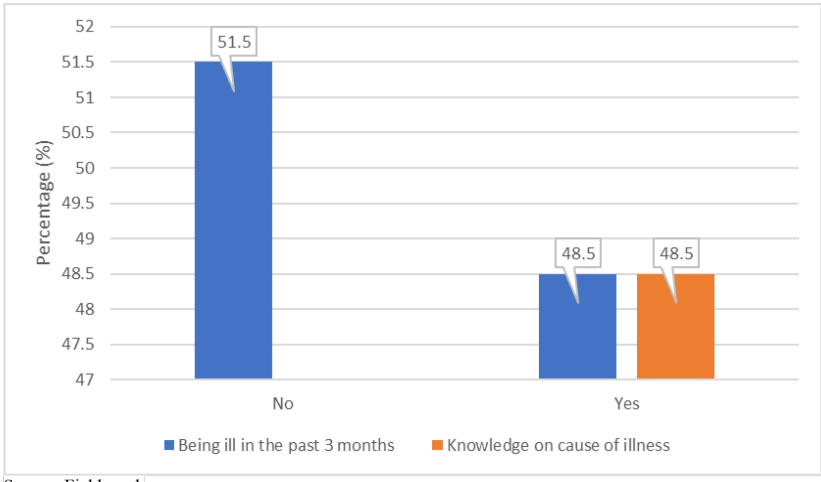


Source: Field work

As shown in Figure 2, almost half (48.5%) of the respondents reported being ill in the past three months. Among those who were ill, 48.5% reported that they knew the cause of their illness.

Figure 2

Reported Illness and Knowledge on Cause of Illness

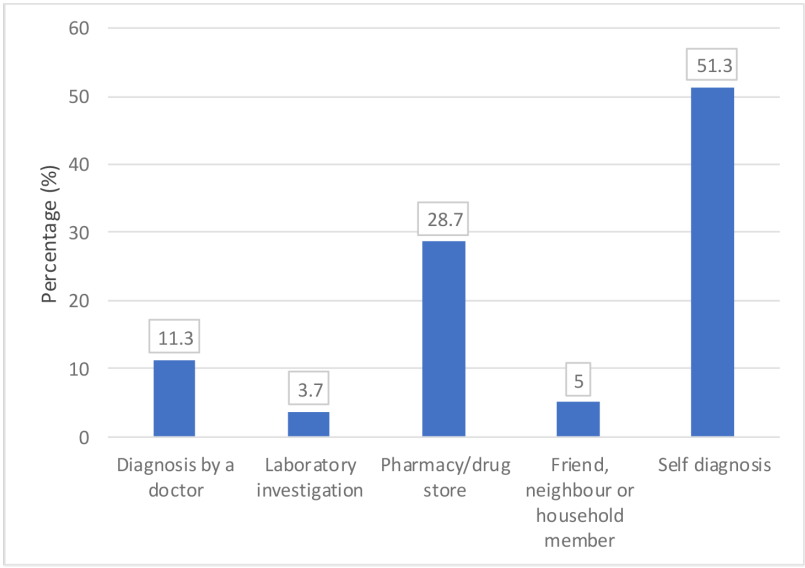


Source: Field work

Figure 3 shows how respondents determined the cause of their illness. The majority (51.3%) of respondents diagnosed their illness themselves, 11.3% were diagnosed by a doctor, and 3.7% underwent laboratory investigations. 28.7% consulted a pharmacy or drug store, while 5% relied on friends, neighbors, or household members to determine illness causes.

Figure 3

Determination of Cause of Illness

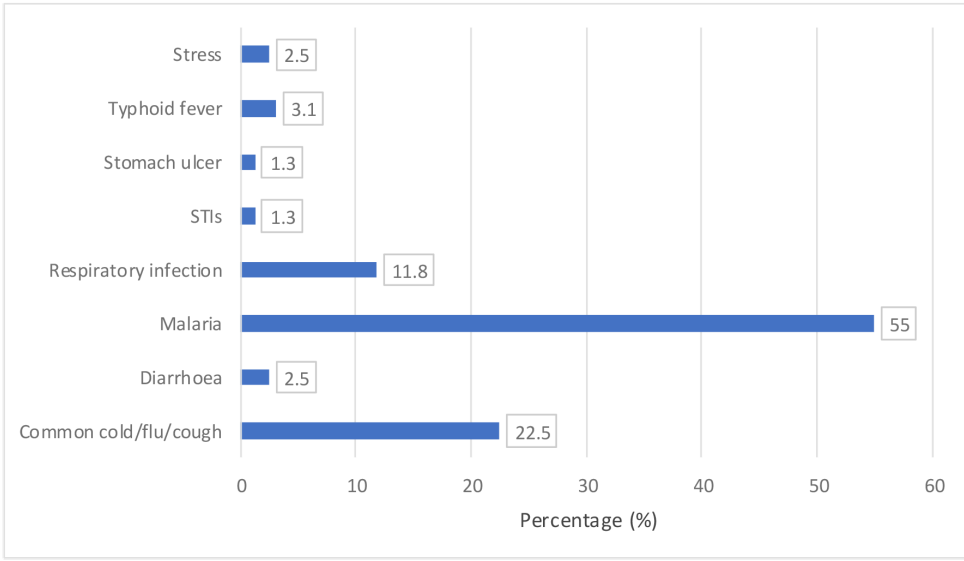


Source: Field work

Regarding reported diagnoses, most (55%) of respondents who fell ill were diagnosed with malaria, 22.5% reported cold/flu/cough, and 11.8% had respiratory infections. The incidence of typhoid fever (3.1%), diarrhea (2.5%), and stomach ulcers (1.3%) was relatively low. Approximately 1.3% reported sexually transmitted infections (STIs), while 2.5% of respondents attributed their illness to stress (Figure 4).

Figure 4

Diagnosis of Illness



Source: Field work

The results on respondents' behavior towards seeking treatment showed that the majority (96.2%) of the respondents sought treatment for their illness, while 3.8% did not seek treatment due to financial constraints. Of the 96.2% who sought treatment, 40.4% sought treatment at government hospitals, 22% sought treatment from pharmacies/drugstores, 22% went to private hospitals, and 15.6% relied on self-treatment.

At a 5% significance level, the study tested two hypotheses. The first examined whether an individual's social status was significantly linked to their likelihood of reporting illness. The chi-square test results in Table 2 indicated a statistically significant relationship between social status and reporting illness in the last three months ($\chi^2 = 14.477$, df = 2, $p = 0.001$). The middle class had the highest number of respondents, with 112 reporting illness. The upper class had a relatively high percentage of people reporting illness (40 out of 56, approximately 71.4%). The lower class had the smallest total sample but showed an equal split between those who were ill and those who were not ill.

The p-value (0.001) was less than 0.05, suggesting a significant association. Cramer's V (0.209) indicated a small-to-moderate association between social status and illness occurrence (Table 2).

Table 2

Social Status of Respondents Influences the Likelihood of Getting Ill

		Experienced illness in last 3 months			Chi-Square value	Sig.	Cramer's V
		No	Yes	Total			
Social status	Lower class	8	8	16			
	Middle class	146	112	258	14.477	0.001	0.209
	Upper class	16	40	56			
	Total	170	160	330			

Source: Field work

Binary logistic regression was conducted to examine the effect of social status, age, and employment status on the likelihood of reporting illness in the last three months. The overall model was statistically significant (χ^2 (4) = 20.908, p <.001), indicating that the predictors collectively contributed to explaining illness status. Nagelkerke R^2 = 0.082, indicating that approximately 8.2% of the variance in illness reporting was explained by the model.

Social status was a significant predictor of illness (B = 0.902, Wald (1) = 11.243, p = .001. The odds ratio (Exp(B) = 2.465) suggests that individuals with higher social status were 2.47 times more likely to report illness than the reference group. Age was also a significant predictor (B = 0.317, Wald (1) = 4.123, p = .042, with an odds ratio of Exp(B) = 1.373. This suggests that the odds of reporting an illness increase by 37.3% as age increases.

Employment status was a significant predictor (χ^2 (2) = 7.038, p = .030. Compared to employed individuals, self-employed individuals had significantly lower odds of reporting illness (B =-1.301, p =.008, Exp (B) = 0.272), indicating that they were 72.8% less likely to report illness. Unemployed individuals also had lower odds of reporting illness (B =-0.802, p =.052, Exp (B) = 0.448), although this effect was not significant (p > .05) (Table 3).

Table 3

Effect of Each Predictor on Illness

Variable	B	S.E.	Wald	p-value	Exp(B) (Odds Ratio)	B
Social Status	0.902	0.269	11.243	**0.001**	**2.47**	0.902
Age Group	0.317	0.156	4.123	**0.042**	**1.37**	0.317
Employment (Ref: Employed)			7.038	**0.030**		
Unemployed	-0.802	0.413	3.781	0.052	0.45	-0.802
Self-Employed	-1.301	0.490	7.037	**0.008**	**0.27**	-1.301
Constant	-1.757	0.801	4.814	**0.028**	0.17	-1.757

Source: Field work

Accessibility to Health Services

Regarding proximity to health facilities, 63% of the respondents reported that a hospital was their nearest health facility. Of the respondents, 23% lived closer to clinics, 6.7% had a health center nearby, 6.1% were closest to a dispensary, and 1.2% reported that an herbal center was their closest facility. Concerning the respondents' mode of transportation and travel time, 62.4% of respondents travel to health facilities by vehicle, 34.6% reach healthcare facilities on foot, and 3% use motorbikes to access healthcare. In relation to the travel time from residence to health facility, 54.5% of respondents reached a health facility in less than 15 minutes, 32.2% of respondents travelled between 15 and 30 minutes to reach a facility, 9.7% travelled between 30 minutes and 1 h, and 3.6% travelled for one to two hours to reach a healthcare facility.

The second hypothesis explored the association between the mode of transportation used by respondents and the distance to the nearest health facility. Spearman's rank-order correlation was conducted to examine the relationship between the mode of transportation and distance to health facilities. The results showed a weak, but statistically significant, positive correlation ($r = 0.130$, $p = 0.018$), indicating that the choice of transportation was slightly associated with the distance to reach a health facility (Table 4).

Table 4

Distance to Facility Influences Mode of Transport

			Mode of transport	Distance to facility
Spearman's rho	Mode of transport	Correlation Coefficient	1.000	0.130*
		Sig. (2-tailed)	.	0.018
		N	330	330
	Distance to facility	Correlation Coefficient	0.130*	1.000
		Sig. (2-tailed)	0.018	.
		N	330	330

**. Correlation is significant at the 0.05 level (2-tailed)

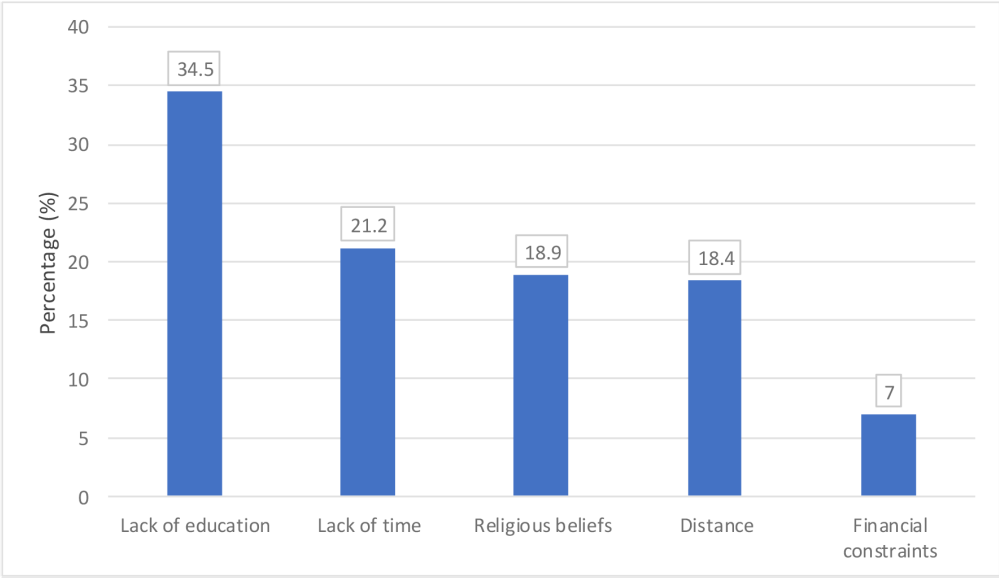
Preferences Mode for Information and Barriers to Healthcare

Concerning the preferred mode of receiving healthcare information, 40.4% of the respondents preferred to receive healthcare information via mobile phones (WhatsApp/SMS). A total of 22.4% mentioned email, 18.2% said lectures and seminars, 3.6% said pamphlets, and 4.2% said mail. Approximately 11.2% preferred to receive healthcare information from social media.

In relation to barriers to seeking healthcare services, over one-third of respondents (34.5%) cited a lack of education as a barrier to seeking healthcare. A majority (21.2%) mentioned a lack of time as a barrier. Almost 19% of respondents hesitated to seek medical care because of their religious beliefs. Approximately 18.4% of respondents attributed their reluctance to distance, and 7% cited financial constraints as a reason for not seeking healthcare, as shown in Figure 5.

Figure 5

Barriers to Seeking Healthcare Services



Source: Field work

Discussion

Health-seeking behavior is influenced by individual and household behavior, community norms, and provider-related characteristics. Cultural attitudes and socioeconomic factors significantly shape perceptions of health and illness, affecting the decision to seek formal medical assistance or informal support (Haileamlak, 2018).

This study aimed to examine health-seeking behaviors among young adults in Accra, focusing on their self-reported health status, methods of diagnosis, types of illnesses experienced, and barriers to accessing healthcare services. The findings revealed a complex interplay between individual perceptions, cultural beliefs, and socioeconomic factors that shape health-related decisions in this urban context.

The findings from the study reveal that over 90% of respondents rated their health positively, either as "good" or "excellent," with nearly half reporting experiencing illness within the past three months. This apparent disconnect between perceived health and actual morbidity suggests that young adults in Accra may have underestimated the significance of their health challenges. Similar patterns have been observed elsewhere. For instance, Uzochukwu and Onwujekwe (2004) found high self-diagnosis rates despite widespread illness reporting in Nigeria, highlighting the broader issue of self-assessed health literacy and its implications for timely care.

Malaria emerged as the most commonly reported illness, followed by cold/flu and respiratory infections. This finding is consistent with the disease burden observed in Accra, where malaria remains the leading cause of morbidity despite ongoing control efforts. Unlike Awuah et al. (2018), who reported that about 60% of urban poor in Accra relied on self-medication for malaria symptoms, this study revealed that a strong majority (96.2%) of affected respondents sought some form of care albeit often outside formal health facilities. This suggests that while self-diagnosis is widespread, a substantial proportion of young adults are motivated to seek treatment, even informally, underscoring a nuanced shift in health-seeking behavior in urban areas. The study also found that government hospitals were the most frequently used healthcare facilities; however, private clinics, pharmacies, and self-treatment remained important alternatives. This diverse pattern of care-seeking highlights the role of accessibility, affordability, and trust in shaping provider choices. Orish et al. (2021) documented similar preferences in the Volta Region, where many participants opted for patent medicine stores or pharmacies rather than formal health facilities, indicating that convenience and perceived effectiveness are key drivers of health-seeking decisions.

Socioeconomic status has emerged as a significant predictor of reporting of illness. Chi-square analysis showed that individuals in higher social classes reported higher illness rates, possibly due to better health awareness or greater access to healthcare services (Table 2). Individuals with lower socioeconomic status often face significant barriers, including financial constraints, that hinder their ability to seek timely medical care (Ahinkorah et al., 2022). Logistic regression analysis confirmed that social status, age, and employment status were significant predictors of illness reporting. Self-employed individuals reported fewer illnesses, which may reflect flexible work schedules or different risk exposure (Table 3). These findings align with Ahinkorah et al. (2022), who emphasized the influence of financial constraints on healthcare-seeking, particularly in low- and middle-income countries. According to Malki (2020), access to healthcare is influenced by social status, which can affect the timeliness and effectiveness of the medical attention received by individuals. Moreover, Walsh and Doorley (2022) state that employed individuals tend to report better health and experience lower levels of illness. These results highlight the persistent role of socioeconomic inequality in shaping health outcomes, even in rapidly urbanizing settings, such as Accra.

Barriers to healthcare seeking were multifaceted and deeply embedded in socioeconomic and cultural contexts (figure 5). Over one-third (34.5%) of the respondents cited a lack of education as a key barrier, echoing Mboweni and Sumbane's (2019) study on adolescents, which found that limited health knowledge often led to reliance on peers rather than formal care.

Time constraints were also significant (21.2%), suggesting that work and other responsibilities frequently clashed with healthcare access. Abuosi and Anaba (2019) similarly highlighted prolonged waiting times as facility-related barriers, particularly for vulnerable groups, such as pregnant adolescents. While Peprah et al. (2020) suggested that mHealth could reduce time burdens, the findings from this study indicate that structural issues such as employment demands still pose major challenges.

Religious beliefs influenced health-seeking behavior for nearly 19% of the respondents, underscoring the importance of cultural factors in decision-making. Wasti et al. (2011) emphasized the profound role of spirituality and tradition in shaping treatment adherence in Nepal. Acquah (2024) noted that faith healing provides psychological comfort in Ghana, but can conflict with essential medical interventions. This dynamic highlights the need for culturally sensitive health education that respects beliefs, while promoting effective medical care. Other barriers included long distances to healthcare facilities (18.4%) and financial constraints (7%), both of which align with Musoke et al. (2014), who identified service costs and travel distance as major obstacles in Uganda.

These findings demonstrate that a combination of individual perceptions, socioeconomic status, cultural beliefs, and systemic barriers shape health-seeking behavior among young adults in Accra. This study contributes to the literature by highlighting the specific experiences of young urban adults in Accra, which is often overlooked in health research. This underscores the importance of targeted interventions that address financial and geographical obstacles, educational gaps, and cultural factors. Strengthening health literacy, expanding affordable healthcare services, and fostering culturally sensitive approaches are essential for improving health outcomes in this population.

Conclusion

This study provides valuable insights into health status, healthcare-seeking behaviors, and the challenges respondents face accessing healthcare services. A greater proportion of the respondents rated their health as good. Despite the generally positive health self-assessment, nearly half of the respondents (48.5%) reported being ill in the past three months, with about half diagnosing themselves. The analysis revealed a statistically significant relationship between social status and illness occurrence, with individuals from higher social classes being more likely to report an illness. Age and employment status also emerged as significant predictors of illness reporting, with older and employed individuals being more likely to report illness. Proximity to health facilities and transportation modes significantly influenced healthcare access.

The study also highlighted various barriers to seeking healthcare, including a lack of education, time constraints, religious beliefs, and distance to health facilities. The preferred mode of receiving healthcare information was primarily mobile phone-based, emphasizing the

importance of leveraging digital platforms to improve health communication. These findings suggest that while many respondents enjoy relatively good health, barriers such as self-diagnosis, limited access to healthcare, and socioeconomic factors significantly affect health-seeking behavior. Addressing these challenges through improved healthcare accessibility, education, and communication strategies could enhance community health outcomes.

Limitations of the Study

The study employed a cross-sectional design and used convenience sampling to select specific towns in Accra, followed by simple random sampling of participants within those towns. While random sampling within towns adds rigor, the initial non-random town selection introduces selection bias, limiting the generalizability of the findings.

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Conflicts of interest: None

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