GENDERED DISPARITIES IN HEALTH SEEKING BEHAVIOUR AMONG THE YOUTH AND INFLUENCE OF MASS MEDIA: A CASE OF GA WEST DISTRICT ASSEMBLY

BY

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DECLARATION BY STUDENT – DISSERTATION

I hereby declare that this research is a result of my/our own original research and that, no part of it has been presented for another degree in this university or any other higher education institute. I further declare that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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CERTIFICATION BY SUPERVISOR

This Dissertation/Thesis has been prepared and presented under my supervision according to the guidelines for supervision and formatting of Dissertation/Thesis laid down by the University of Media, Arts and Communication, UniMAC.

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ABSTRACT

Health-seeking behaviour among youths remains a significant public health concern, particularly in developing societies where delays in using formal healthcare services contribute to preventable illness and mortality. Despite increased access to health information through traditional and digital media platforms, many young people continue to postpone seeking professional medical care or rely on informal alternatives. This study examined the influence of media exposure and gender differences on health-seeking behaviour among youths, with emphasis on how media messages shape perceptions, attitudes, and decisions regarding formal healthcare utilisation.The study was guided by objectives that assessed youth exposure to health-related media messages, examined the influence of such messages on health knowledge and attitudes, identified gender-based differences in responses to media health information, and analysed how these factors affect health-seeking behaviour. A quantitative research design was adopted, using a structured questionnaire administered to youths within the study population. Data from 123 valid responses were analysed using descriptive and comparative statistical techniques. Findings showed that youths are regularly exposed to health messages, especially through social media, which emerged as the dominant information source. Media exposure generally improved understanding of health conditions and preventive practices; however, fear-inducing or judgmental messages discouraged timely healthcare utilisation. Gender differences were evident, with females showing stronger tendencies toward formal healthcare use and more positive responses to media messages, while males were more likely to delay seeking care. The study concludes that effective, gender-sensitive, and non-judgmental health communication, combined with improved access to affordable youth-friendly services, is essential for promoting timely health-seeking behaviour among youths.

DEDICATION

This dissertation is dedicated to my parents for their unwavering support, to my family and friends, and to all those who believed in me and supported me throughout this journey.

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WHO	–	World Health Organization
COVID-19	–	Coronavirus Disease 2019
HIV	–	Human Immunodeficiency Virus
AIDS	–	Acquired Immunodeficiency Syndrome
TB	–	Tuberculosis
HBM	–	Health Belief Model
TRA	–	Theory of Reasoned Action
HSB	–	Health Seeking Behaviour
UniMac	-	University of Media, Acts and Communication

CHAPTER ONE

INTRODUCTION

1.0 Introduction

This Chapter explores the background of the study, problem statement, research problem and gap, research objectives and questions **as** well as the significance of the study. The chapter concludes by looking at the organization of the study.

1.1 Background of the Study

Health-seeking behaviour is a critical determinant of individual and public health outcomes, particularly in contexts where communicable and non-communicable diseases intersect with socio-cultural barriers to care. Among youth populations, health-seeking practices are not only shaped by personal choices but also by gender norms, socio-economic status, and access to accurate health information (WHO, 2014; Courtenay, 2000; Andersen, 1995) .In Ghana, young people aged 15–35 constitute over a third of the population (Ghana Statistical Service, 2021), making their health practices central to the nation's development trajectory.

Gender disparities in health-seeking behaviour are well documented globally (Courtenay, 2000; Mahalik et al., 2007). In Sub-Saharan Africa, women are often more proactive in seeking healthcare, especially for reproductive and maternal needs, whereas men delay or avoid care due to socially constructed notions of masculinity that associate health-seeking with weakness (Beia et al., 2021). In Ghana, these disparities manifest in multiple ways: women are more likely to utilise maternal health services, while men are underrepresented in preventive and reproductive health programmes (Ahinkorah et al., 2021).

Mass media ranging from traditional platforms such as radio, television, and newspapers to

emerging digital and social media plays a pivotal role in shaping health-related knowledge and influencing behaviour. Campaigns like *GoodLife, Live it Well* and the COVID-19 information drive by the Ghana Health Service demonstrate how strategic communication can raise awareness and change attitudes. Research shows that well-designed media interventions can positively influence health outcomes (Wakefield et al., 2010; Noar et al., 2006). However, the framing, content, and gender sensitivity of media campaigns remain inconsistent, often privileging women's reproductive health while neglecting male-specific health needs (Amo-Adjei & Kumi-Kyereme, 2014).

Thus, understanding how young men and women in urban Ghana respond differently to health messages disseminated by mass media is critical. This intersection of gender, media, and health behaviour provides an important lens for analysing how communication strategies may either bridge or reinforce existing disparities.

1.2 Problem Statement

Despite the extensive use of mass media in national health campaigns in Ghana, gender disparities in health-seeking behaviour among youth persist (GSS, GHS & ICF, 2019; WHO, 2018). Young women, although facing stigma in accessing reproductive and sexual health services, tend to engage more proactively with healthcare systems, especially maternal and reproductive health initiatives (UNFPA, 2017; Amu & Dickson, 2016). Conversely, young men often disengage due to masculinity norms that discourage vulnerability, illness disclosure, or preventive care (Courtenay, 2000; Mahalik et al., 2007).

Although exposure to media has been shown to improve reproductive autonomy among young women (Ahinkorah et al., 2021), similar gains are less visible among young men, who remain

marginalised both in terms of campaign content and accessibility. This disparity suggests that media, while influential, may not be functioning as an equitable catalyst for health-seeking behaviour across genders. Instead, it risks reproducing and reinforcing existing inequalities if campaigns are not deliberately gender-sensitive.

Existing scholarship in Ghana has examined the relationship between media exposure and reproductive health behaviour among young women (Amo-Adjei & Kumi-Kyereme, 2014; Asampong et al., 2020). However, limited attention has been given to male youth health-seeking behaviour and the mediating role of gender norms in responses to health messages. Furthermore, there is limited empirical evidence on whether media campaigns act as catalysts for equitable health-seeking behaviour across genders or inadvertently perpetuate disparities. This study addresses the issues raised by focusing on the gendered reception, interpretation, and application of health messages disseminated by mass media among youth in Ga West.

1.4 Research Objectives

Broad Objective

To investigate the influence of mass media on gendered health-seeking behaviours among youth in the Greater Accra Region.

Specific Objectives

1. To identify gender-specific patterns in health-seeking behaviour among youth in Accra.
2. To evaluate the role of mass media in shaping health-seeking behaviour.
3. To examine how gender norms influence the reception and interpretation of media health messages.

1.5 Research Questions

1. What gender-specific patterns exist in health-seeking behaviour among youth in Accra?

2. How does mass media influence the health-seeking behaviour of male and female youth differently?

3. How do gender norms shape youth responses to media health messages?

4. Which media platforms are most trusted and frequently used by young men and women in Accra?

1.6 Significance of the Study

This research is significant for both academic and practical reasons. From an academic perspective, it contributes to scholarship on health communication, gender studies, and youth health behaviour in Sub-Saharan Africa. It provides empirical evidence on how media intersects with gender norms to influence health-seeking behaviour, thus filling a key knowledge gap in Ghana's urban context.

From a policy and practice perspective, the study aligns with the Sustainable Development Goals (SDG 3: Good Health and Well-being; SDG 5: Gender Equality) by addressing systemic communication barriers that perpetuate health inequities. Findings will inform the design of gender-responsive media campaigns by government agencies, NGOs, and health practitioners. They will also provide insights for policymakers and the Ghana Health Service in developing targeted interventions that address both young men's and young women's unique health-seeking challenges.

1.6 ORGANIZATION OF STUDY

This study is divided into five distinctive sections. Chapter one will outline the background of the study, followed by problem statement, objective of the studies, research questions, delimitation of the study and organization of the study. The chapter two will present a rigorous examination of the

literature; various concepts and relevant theories will be reviewed and synthesized to answer the research question. Chapter three will outline the various research methodological approaches through which data will be collected; and the data analysis instrument employed to achieve the objective of the study will also be discussed. Chapter four will discuss and present the major finding from raw data collected whiles chapter five outlines summary of findings, conclusions, and recommendation.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter reviews literature related to gendered health-seeking behaviour and the role of mass media in shaping youth health outcomes. It begins with theoretical insights on health-seeking behaviour, examines the influence of gender norms, assesses the role of media in health communication, and highlights existing gaps.

2.1.1 Health-Seeking Behaviour: Definitions and Determinants

Health seeking is a learned behavior, meaning that any effort to encourage people to seek medical care must be grounded in an understanding of what motivates them to do so (Oberoi et al., 2016). Health seeking behavior refers to the actions individuals take to find appropriate solutions for either existing or potential health problems. When these actions are taken in response to an actual health issue, it is referred to as illness behavior, whereas when they are undertaken to prevent future illness or maintain wellbeing, it is known as health behavior (WHO, 1999; WHO & UNAIDS, 2003).

Illness behavior involves any effort made to find relief or meet a health need, while health behavior refers to the visible actions individuals take to prevent disease and enhance their overall wellbeing (Oestergaard, Alkema, & Lawn, 2013). Kasl and Cobb (1966) describe health seeking behavior as any action carried out by individuals who believe they have a health problem, with the goal of finding an appropriate remedy or identifying the issue early, even before symptoms appear. Health-seeking behaviour also refers to the actions individuals take in response to perceived health needs, including preventive measures, consultation, and treatment (Mackian et al., 2004). Determinants of such behaviour include socio-economic status, cultural beliefs, health system accessibility, and

personal attitudes. Among youth populations, health-seeking is further mediated by peer influence, risk perception, and trust in information sources (Asibey, 2017).

Globally, evidence shows that timely health-seeking behaviour improves health outcomes, while delays are linked to adverse consequences, particularly for maternal and reproductive health (World Health Organization, 2018). However, disparities persist between genders, socio-economic groups, and geographic contexts. Health seeking behavior falls under the broader concept of health behavior, which includes actions taken to maintain health, prevent illness, and manage situations that move individuals away from good health (WHO, 1995). A key framework within this field is the health belief model, which explores how personal beliefs influence health decisions (Abraham & Sheeran, 2014). Developed by Hochbaum (1958), the model is built around four main concepts perceived seriousness, perceived susceptibility, perceived benefits, and perceived barriers (Taylor et al., 2006). Together, these help explain why people choose to engage or not engage in certain health behaviors.

According to the health belief model, a person's decision to take health related action depends on two main factors: how threatening they perceive a disease to be, and how effective they believe the preventive behavior is in reducing that threat. The sense of threat is shaped by how likely they think they are to get the disease and how severe they believe its consequences would be. The perceived effectiveness of a preventive action, on the other hand, depends not only on whether they think it works but also on how costly or demanding it is in terms of time, money, or effort. Health messages that clearly show the reality of a threat while convincing people that certain actions can protect them are more likely to result in positive behavior change.

The theory of reasoned action, proposed by Fishbein and Ajzen in 1975, explains that an individual's health behavior is guided by their intention to perform it, which in turn is influenced by their beliefs, attitudes, and the social norms around them. This means that people's actions are

shaped not only by what they believe but also by how they think others will view their choices (Glanz & Bishop, 2010). The "four A's" model adds that the availability, acceptability, affordability, and accessibility of health services all play a major role in whether people seek care. Maslow's hierarchy of needs suggests that individuals are continuously motivated to reach higher levels of satisfaction. In terms of health, this means people are always seeking ways to improve or maintain their wellbeing. Similarly, Herzberg's motivation hygiene theory highlights that human motivation is driven both by the desire to avoid discomfort, such as illness or pain, and by the need for personal growth and fulfillment (Abera et al., 2018).

McClelland's theory of needs further explains that people's motivations evolve over time and are shaped by experience. He identified three main needs achievement, affiliation, and power and argued that individuals strive for balance among them. Those with a strong need for achievement tend to take responsibility for solving problems, prefer feedback, and set challenging yet attainable goals, and value intangible rewards like knowledge or health over material gains (Loomis & Cook, 2012).

2.1.2 Concept of Health Seeking Behaviour

Health seeking behaviour (HSB) refers to the actions, decisions, and attitudes that individuals adopt to promote, maintain, or restore their health and wellbeing (Kasl & Cobb, 1966; WHO, 1995). It encompasses a spectrum of activities, ranging from preventive behaviours such as maintaining good hygiene and regular exercise to curative actions like consulting a doctor or using prescribed medication when ill. Fundamentally, health seeking is not a spontaneous act; rather, it is a conditioned and learned behaviour shaped by one's social environment, cultural values, level of health literacy, and access to available healthcare resources (Oberoi et al., 2016).

According to the World Health Organization (1999), health seeking behaviour manifests in two

primary forms illness behaviour and health behaviour. Illness behaviour refers to the observable actions taken by individuals who perceive themselves as sick or symptomatic and seek a cure or relief. This could include self-medication, consulting traditional healers, or visiting a hospital. In contrast, health behaviour involves preventive measures taken by healthy individuals to maintain wellness and prevent disease, such as participating in vaccination programmes, eating nutritious foods, and engaging in physical activity (Oestergaard, Alkema, & Lawn, 2013). Both behaviours exist on a continuum and are influenced by how individuals perceive risk, vulnerability, and the benefits of taking preventive or curative actions.

Health seeking is also a socially constructed process, meaning it is learned through interaction within families, peer groups, and communities. From childhood, people observe how others respond to illness and internalize norms around what is acceptable or appropriate health behaviour. For example, in many African societies, traditional and faith based healing practices coexist with modern medical systems, shaping pluralistic health seeking patterns (Agyemang et al., 2020). This pluralism implies that the decision to seek care is not purely biomedical but reflects deeper cultural and psychological influences such as beliefs in spiritual causation, family expectations, and societal taboos around illness disclosure.

Moreover, HSB is dynamic it changes with time, age, education, and exposure to information. Among young people, especially in urban areas like Accra, health seeking decisions are increasingly mediated by exposure to digital and social media platforms. The internet has become a primary source of health related information, providing opportunities for knowledge sharing but also posing risks of misinformation. Youths often rely on online platforms such as TikTok, Instagram, and YouTube to access health advice, self-diagnose, or experiment with alternative remedies (Eysenbach, 2020). While this democratization of information can empower youth to make informed choices, it can equally lead to confusion, delayed medical consultation, and the

spread of myths about illness and treatment.

Health seeking behaviour is thus influenced by trust trust in health systems, healthcare providers, and the accuracy of information. When young people perceive the healthcare system as inaccessible, judgmental, or unaffordable, they are more likely to avoid formal medical services, even when they are aware of their health needs. Gender also plays a central role in shaping this trust. For instance, social expectations of masculinity may discourage young men from admitting vulnerability or seeking medical advice, while young women might face stigma when seeking reproductive or sexual health services. Such factors illustrate that health seeking is not only a reflection of individual motivation but also a response to structural inequalities and power relations embedded within societies.

Furthermore, HSB is influenced by the interplay between perceived need and perceived control. Individuals who believe they have agency over their health outcomes tend to engage more in preventive actions. Conversely, those who attribute health conditions to external forces such as fate, divine will, or the inefficacy of the health system may delay seeking care. This psychological dimension aligns with constructs in the Health Belief Model and Theory of Planned Behaviour, which emphasize perception, motivation, and self-efficacy as determinants of health related decision making.

In the Ghanaian context, studies reveal that youth often navigate between modern healthcare systems and traditional healing practices, guided by both convenience and cultural relevance (Amoah, 2018). The affordability of services, availability of youth friendly facilities, and perceived respect from health workers also influence decisions. Media representations further amplify or suppress these behaviours. For example, when health campaigns portray clinic visits as empowering and beneficial, they encourage proactive behaviour. Conversely, sensational or moralistic portrayals of illness common in some radio and TV discussions can reinforce stigma

and discourage health seeking.

2.1.3 Gender and Health-Seeking Behaviour

Gender remains one of the most significant predictors of health seeking behaviour worldwide. Across diverse cultural settings, women are generally more likely than men to seek healthcare services, a pattern attributed to both biological and sociocultural influences (Galdas et al., 2005). Biologically, women experience reproductive health processes such as menstruation, pregnancy, and childbirth that require frequent interaction with health systems. Culturally, women are often more health conscious due to caregiving roles that heighten awareness of bodily and family well-being.

Men tend to exhibit lower rates of health service utilization, often delaying or avoiding medical consultation. This behaviour has been linked to masculinity norms that equate help seeking with weakness or vulnerability (Mahalik et al., 2007). In many African contexts, including Ghana, social expectations that men should appear strong, self-reliant, and unemotional contribute to underutilization of healthcare services, particularly for preventive or mental health issues.

A study by Osei (2020) found that Ghanaian men were less likely to attend routine checkups or seek early medical advice, opting instead for traditional remedies or over the counter treatments. This gendered difference in care seeking not only affects individual health outcomes but also shapes community level health dynamics, as women's greater interaction with healthcare systems often positions them as the primary health decision makers for families. Addressing these gender disparities requires culturally sensitive health communication that redefines masculinity to include proactive health behaviour.

Gender norms significantly influence how men and women seek healthcare. Courtenay (2000) argues that constructions of masculinity discourage men from expressing vulnerability,

contributing to lower rates of healthcare utilisation. Mahalik et al. (2007) similarly found that male perceptions of normative health behaviours are shaped by cultural expectations, resulting in delays in seeking care.

In contrast, women particularly in Sub-Saharan Africa tend to access health services more regularly, especially those tied to reproductive and maternal health (Beia et al., 2021). In Ghana, young women frequently engage in antenatal and reproductive health services, though stigma and fear of judgement remain barriers for services related to sexual health (Ahinkorah et al., 2021). Young men, on the other hand, are underrepresented in preventive health programmes, highlighting a structural gender imbalance in health-seeking.

2.2 Mass Media and Health Communication

Mass media has long been recognised as a powerful tool in health promotion (Noar et al., 2006; Wakefield et al., 2010). Media campaigns influence knowledge, attitudes, and behaviours through repeated exposure to tailored messages. In Ghana, initiatives such as *GoodLife, Live it well* and media campaigns on HIV/AIDS, malaria, and COVID-19 illustrate how health communication can be mainstreamed into national development strategies.

However, the effectiveness of media campaigns depends on content relevance, cultural sensitivity, and framing. Amo-Adjei and Kumi-Kyereme (2014) found that Ghanaian youth responded differently to reproductive health messages, with women benefiting more than men. Asampong et al. (2020) highlighted that media campaigns addressing abortion stigma improved women's decision-making autonomy but did little to shift male engagement. These findings suggest that while media influences health outcomes, it does not always do so equitably across genders.

2.2.1 Role of Mass Media in Health Seeking Behaviour

The mass media plays a critical and multifaceted role in shaping health seeking behaviour by serving as both an educator and a social influencer. Through its ability to reach large audiences and shape collective consciousness, the media has become a powerful tool for promoting public health awareness, influencing attitudes, and motivating behaviour change. In the Ghanaian context, where disparities in health literacy and access to formal education persist, the media acts as a bridge between public health institutions and citizens, translating complex health information into accessible narratives that influence everyday decision making.

Traditional media comprising radio, television, and print remains the cornerstone of health communication in Ghana. Radio, in particular, is one of the most influential platforms due to its wide geographic reach, affordability, and use of local dialects. It serves as a trusted source of information, especially in rural and peri urban areas where literacy levels are relatively low and internet penetration remains limited. Health programmes broadcast in local languages allow communities to understand preventive practices, recognize symptoms, and seek early treatment. Television and newspapers also play essential roles in reinforcing public health messages through visual storytelling, expert interviews, and community based discussions. Campaigns such as those addressing malaria prevention, maternal health, or vaccination uptake have successfully used traditional media to disseminate relatable, context specific content. For example, the Ghana Health Service has leveraged radio talk shows and TV documentaries to promote antenatal care, hygiene, and environmental sanitation. These platforms provide opportunities for interactive engagement, where listeners can ask questions, share experiences, and receive clarifications from professionals, thus enhancing trust and learning.

According to Wakefield, Loken, and Hornik (2010), mass media campaigns are most effective when they combine consistent, long term exposure with community mobilization and interpersonal

communication. This observation aligns with Ghana's experience, where sustained media efforts have contributed to improved awareness of diseases like malaria and HIV/AIDS. Traditional media thus functions not merely as a transmitter of information but as a cultural educator, embedding health messages within the social and moral fabric of the community.

2.2.3 Gender Norms and the Reception of Media Health Messages

Gender norms and roles profoundly shape how individuals, particularly youth, interpret, internalize, and act upon health related messages. These norms operate as invisible yet powerful social codes that define what is deemed "appropriate" behaviour for men and women, influencing both their perceptions of illness and their willingness to seek care. In the context of health communication, gender is not simply a biological distinction but a social construct that determines power, expectations, and opportunities all of which influence how health messages are received, understood, and acted upon.

In many African societies, including Ghana, gender norms are rooted in traditional and cultural values that assign distinct roles and responsibilities to men and women. Men are often socialized to display resilience, strength, and stoicism, while women are encouraged to express empathy, nurture, and attentiveness to family wellbeing. These social constructs shape how both genders approach healthcare. Men, for instance, may view illness as a threat to their masculinity and autonomy, thereby delaying medical consultations until symptoms become severe (Courtenay, 2000). In contrast, women whose roles are often tied to caregiving and family health management tend to be more proactive in seeking medical care both for themselves and their dependents (Mahalik et al., 2007).

Within urban settings like Accra, such patterns continue to manifest, albeit in evolving forms. Owusu and Asante (2021) found that male youth are less likely to engage with health messages

that emphasize vulnerability or emotional wellbeing, perceiving such topics as inconsistent with societal expectations of masculine toughness. On the other hand, female youth demonstrate higher responsiveness to campaigns that highlight family health, reproductive care, or self-empowerment. These findings illustrate that gendered socialization affects not only how messages are perceived but also which types of media content are trusted and acted upon.

The media, as both a mirror and a molder of society, plays a dual role in reinforcing or challenging gender norms. Health messages that rely on stereotypical portrayals such as women depicted solely as caregivers or men as the primary decision makers can unintentionally perpetuate inequities in health seeking behaviour. For instance, advertisements and public health campaigns that address mothers exclusively in child health initiatives may exclude fathers from active participation, reinforcing the notion that caregiving is a feminine responsibility. Similarly, the underrepresentation of men in health promotion messages related to emotional wellbeing, nutrition, or preventive screenings contributes to the invisibility of male health vulnerabilities.

This imbalance is often visible in public service announcements and radio discussions where women's reproductive health receives substantial attention, whereas men's preventive health practices (such as prostate screening or mental health care) are rarely foregrounded. Consequently, men may not perceive themselves as target audiences for preventive health communication. This selective framing creates an implicit hierarchy of health priorities and reinforces the notion that men are naturally resilient while women require medical support.

To counter these tendencies, gender sensitive communication frameworks emphasize the importance of designing health messages that recognize the unique needs, roles, and challenges of both genders. Such communication not only ensures inclusivity but also promotes equitable access to information and health services. Gender sensitive approaches avoid prescriptive stereotypes and instead highlight diversity, agency, and shared responsibility in health maintenance.

According to Dworkin, Fleming, and Colvin (2015), gender transformative health communication moves beyond awareness to challenge underlying social norms that sustain inequality. For example, campaigns that depict men supporting their partners during antenatal visits or women participating in sports and wellness programs contribute to redefining gender roles in ways that promote health equity. Similarly, peer to peer media campaigns that feature both male and female youth discussing common health concerns such as stress, diet, or reproductive health encourage dialogue and normalize mutual participation.

Gender sensitive media content should reflect intersectionality, acknowledging that gender intersects with age, class, education, and socio economic status to produce varied health experiences. Urban youth with internet access may respond differently to digital campaigns compared to rural populations who rely on radio or community engagement. Recognizing these layers enables more nuanced message targeting and improved behavioural outcomes.

Gender norms also influence decision making autonomy, particularly regarding when and where to seek care. In patriarchal societies, men often control household resources and decisions, including those related to healthcare access. This dynamic can delay women's health seeking, particularly in contexts where financial dependency limits their ability to visit clinics independently. Conversely, men's socialization into self-reliance may discourage them from discussing symptoms or accepting medical help, contributing to late diagnosis of preventable conditions.

While education and urbanization have improved women's autonomy in health related decisions, deep rooted patriarchal attitudes persist, especially in low income and rural settings. Campaigns that engage both men and women in joint decision making such as family planning or maternal health initiatives have proven more effective than those targeting only one gender. Encouraging shared responsibility in healthcare strengthens collective agency and dismantles restrictive gender

norms.

Modern health communication recognizes the media's potential to act as a catalyst for social change, particularly through narrative framing and representation. By featuring stories that challenge traditional gender roles, the media can reshape perceptions of what constitutes acceptable health behaviour for men and women alike. For instance, portraying male characters seeking counselling or women advocating for preventive screenings signals that such actions are socially acceptable and even desirable.

Digital media platforms especially social media provide new opportunities for grassroots advocacy and gender inclusivity in health messaging. Young influencers, vloggers, and content creators in Ghana are increasingly using these platforms to address taboo topics such as mental health, menstrual hygiene, and sexual wellness, creating safe spaces for open dialogue. These online communities often transcend traditional hierarchies, empowering youth to redefine gender norms through peer led communication.

However, digital spaces also reproduce inequalities when gender based harassment or cyberbullying silences women's voices or stigmatizes men who engage in health discourse. Therefore, policies promoting safe and equitable online engagement are essential to harnessing social media's transformative potential for public health.

2.2.4 Media Campaigns as Catalysts or Barriers to Equitable Health Seeking

Mass media campaigns play a pivotal role in shaping public health outcomes by influencing knowledge, attitudes, and behavioural intentions. Through television, radio, print, digital platforms, and community based communication, the media functions as a key determinant of health literacy and a mediator between public health institutions and the general population. However, the impact of these campaigns on health seeking behaviour is not uniformly positive.

Depending on their framing, tone, and inclusivity, mass media messages can serve either as catalysts that promote equitable access to healthcare or as barriers that inadvertently reinforce stigma, exclusion, or misinformation (Wakefield, Loken, & Hornik, 2010).

When designed with audience diversity and cultural context in mind, media campaigns can transform public perceptions, challenge misinformation, and empower individuals to take proactive steps towards better health. Successful campaigns often combine informational, motivational, and behavioural elements, using relatable narratives and emotional appeals to inspire change.

For example, Ghana's "Stop TB" and "Know Your HIV Status" campaigns used community radio and television talk shows to encourage voluntary testing and treatment seeking. By featuring testimonies from real people, health workers, and community leaders, these initiatives created a sense of identification and trust key factors in persuading audiences to act on health advice. Similarly, mass media has proven instrumental in maternal and child health interventions, promoting antenatal care visits, facility based deliveries, and immunization adherence (Amo Adjei, 2012).

The Social Cognitive Theory (Bandura, 1986) provides a theoretical foundation for understanding this process. According to the theory, individuals learn not only from direct experience but also by observing others, particularly those perceived as similar or aspirational. Media campaigns that showcase role models such as peers, celebrities, or respected community figures engaging in positive health behaviour can increase the likelihood of audience imitation. When young Ghanaians see figures they admire discussing mental health, safe sexual practices, or healthy lifestyles, it normalizes these actions and reduces stigma.

Moreover, multimedia integration enhances reach and effectiveness. Coordinated campaigns that combine radio jingles, social media challenges, street theatre, and short video documentaries create

message reinforcement across multiple touchpoints. In Ghana, radio remains a dominant source of information, particularly in rural and peri urban areas, while digital media has become increasingly influential among urban youth. Blending these platforms ensures both inclusivity and continuity of message exposure, which is essential for sustained behaviour change (Noar et al., 2009).While the potential of media for public health promotion is undeniable, its capacity to act as a barrier arises when messages are poorly conceptualized, culturally insensitive, or disseminated without verification. Fear based or moralistic campaigns, for instance, may generate short term attention but can simultaneously induce anxiety, shame, or resistance, especially among young audiences. Messages that rely heavily on fear appeals such as emphasizing death or punishment without offering practical solutions can discourage open discussion and deter individuals from seeking professional help (Witte & Allen, 2000).

An example is found in early HIV/AIDS campaigns that used imagery of death or isolation to deter risky sexual behaviour. While they succeeded in raising awareness, they also amplified stigma, making it difficult for infected individuals to seek testing or treatment due to fear of social ostracism. In Ghana, similar issues have been observed in reproductive health messaging where adolescents, particularly young girls, have been framed as moral deviants rather than individuals in need of information and support (Adih & Alexander, 1999). Such framing alienates rather than engages the audience, deepening inequalities in access to care.

The digital media environment compounds this challenge. Social media platforms such as Facebook, X (formerly Twitter), TikTok, and WhatsApp have democratized health information dissemination, allowing rapid spread of both verified facts and misinformation. During the COVID 19 pandemic, for example, the World Health Organization (2023) highlighted the “infodemic” phenomenon an overabundance of information, including false or misleading content, which complicated public understanding and reduced confidence in health institutions. In Ghana,

misinformation around vaccines, herbal remedies, and conspiracy theories circulated widely online, shaping risk perceptions and delaying uptake of preventive services.

This underscores that access to information alone does not guarantee effective health communication. The credibility of sources, clarity of messages, and alignment with cultural values are critical determinants of behavioural outcomes. If audiences perceive messages as foreign, judgmental, or inconsistent with their lived realities, they are less likely to trust or adopt them.

Equitable health communication requires recognizing and addressing socioeconomic, linguistic, and digital divides that affect access to information. In Ghana, for instance, urban youth may benefit from digital health campaigns through social media, while rural populations rely more on community radio and interpersonal communication. Campaigns that overlook these distinctions risk widening existing inequalities.

Language is another critical factor. Health messages communicated in English may exclude large segments of the population who primarily speak local languages such as Twi, Ga, Ewe, or Dagbani. Effective campaigns therefore employ local language translations, culturally relevant idioms, and community participation to ensure comprehension and resonance. Radio dramas such as “Abiba” and “Makola Stories” have demonstrated success by embedding health messages into relatable storylines using local dialects, humor, and everyday experiences. This participatory communication approach fosters ownership and trust among audiences, transforming health campaigns into dialogues rather than top down directives.

Health communication must also navigate cultural norms and gender expectations. Campaigns that neglect gender dynamics may unintentionally reinforce inequitable power relations. For instance, messages that address only mothers in child health programs overlook fathers’ roles, while those that focus solely on male decision making reinforce female dependency. A gender responsive approach ensures both men and women are portrayed as active participants in health decisions and

as equal beneficiaries of care.

Youth friendly campaigns must recognize generational differences in media consumption and risk perception. Adolescents often seek privacy, peer validation, and interactivity; thus, traditional lecture style messaging is less effective. Interactive media formats such as short social videos, influencer led discussions, or mobile chatbots can encourage youth engagement while preserving anonymity and dignity.

To ensure that media campaigns act as catalysts rather than barriers, communication strategies must prioritize transparency, credibility, and dialogue. Collaborating with health professionals, local leaders, influencers, and journalists enhances message legitimacy. Fact checking organizations, such as GhanaFact and Africa Check, play a critical role in maintaining informational integrity. Additionally, media literacy education should be promoted among the public to help audiences evaluate sources, verify facts, and resist misinformation.

Creating interactive platforms such as call in radio shows, health focused podcasts, and community discussion forums fosters two way communication, allowing individuals to ask questions and clarify doubts. This participatory model aligns with Paulo Freire's theory of critical consciousness (1970), which emphasizes empowering individuals to become active agents in their own health improvement rather than passive recipients of information.

2.2.5 Media Framing and Gendered Interpretations

The way media messages are framed plays a crucial role in how audiences interpret them. Framing Theory (Entman, 1993) posits that the inclusion or exclusion of certain aspects of an issue shapes perception. In the Ghanaian context, many health campaigns are framed around women's reproductive needs, inadvertently reinforcing the notion that health-seeking is a feminine responsibility. This framing marginalises men and contributes to their disengagement.

Digital media adds another dimension, as youth increasingly rely on social media for health information. Yet misinformation and gendered stereotypes can exacerbate inequalities, especially when platforms amplify dominant narratives rather than challenge them.

2.2.6 Education and Health Literacy

Education significantly enhances one's ability to understand, interpret, and respond to health information. Individuals with higher educational attainment are better equipped to identify symptoms, comprehend medical advice, and navigate complex health systems (Rahman et al., 2021). They are also more likely to trust biomedical interventions and to engage with preventive health measures such as vaccination, regular screening, and balanced diets.

Health literacy the ability to access, understand, and use health information acts as a bridge between education and health seeking. Educated individuals tend to process health messages more critically and are more receptive to behaviour change campaigns. In Ghana, youth with tertiary education are increasingly relying on digital platforms such as social media, health websites, and mobile apps to obtain medical information and locate services (Asare et al., 2020). However, disparities in literacy levels continue to create information gaps, especially in peri urban and rural communities, where misinformation, myths, and mistrust of modern medicine can prevail.

Low educational attainment often correlates with limited awareness of disease prevention, poor recognition of symptoms, and reliance on traditional or home based remedies. Hence, education functions not only as a determinant of individual behaviour but also as a social determinant of health equity, influencing community level outcomes and overall public health engagement.

2.2.7 Enabling and Hindering Factors

Even when individuals are predisposed to seek healthcare through awareness, education, or motivation their ability to actually access and utilize services is heavily influenced by enabling and hindering factors. These factors determine whether a person who recognizes a health need can translate intention into action. Andersen's Behavioral Model of Health Services Use (1995) identifies enabling factors as those that facilitate or support access to care, while hindering factors are structural or contextual barriers that limit utilization. Collectively, they include the availability, affordability, accessibility, and acceptability of healthcare services, as well as personal and community level resources such as income, transportation, social support, and health insurance coverage.

In many developing contexts like Ghana, the interplay of these factors has profound implications for young people. Even when adolescents and youth acknowledge the importance of seeking professional help, they may still face economic, social, or institutional barriers that hinder timely and effective healthcare utilization. Understanding these dynamics is essential for addressing inequities in health outcomes and promoting inclusive health systems.

One of the most significant determinants of healthcare utilization is cost. Financial barriers often determine whether individuals seek care promptly or delay treatment until symptoms worsen. The World Health Organization (2010) emphasizes that universal health coverage aims to ensure that people obtain the health services they need without suffering financial hardship. However, in low and middle income countries, many individuals particularly young people and those in informal employment remain excluded from financial protection mechanisms.

In Ghana, although the National Health Insurance Scheme (NHIS) was introduced to reduce out of pocket expenditures and improve equity in access, several limitations persist. Youth often face difficulties enrolling due to bureaucratic processes, lack of awareness, or inability to pay

registration fees. Additionally, perceived inefficiencies such as delays in service provision or unavailability of drugs at accredited facilities undermine trust in the system (Aboagye & Yawson, 2021).

Adolescents and young adults especially those who are unemployed or financially dependent on parents are particularly vulnerable. The cost of consultation, laboratory tests, and medication often deters them from visiting formal health facilities. Many resort instead to self medication, over the counter drugs, or traditional healers, which may offer cheaper and more flexible payment options. Consequently, financial constraints not only delay care but can also lead to misdiagnosis, complications, and higher long term healthcare costs.

Accessibility extends beyond financial affordability to include the geographical and logistical ease of reaching health services. In Ghana, while major cities such as Accra and Kumasi have relatively dense health infrastructure, many peri urban and rural communities still experience geographic inequities in service distribution. Distance to the nearest facility, poor road conditions, lack of reliable transportation, and long waiting times all serve as deterrents, particularly for young people who may not have independent means of mobility.

The World Bank (2018) reports that physical access remains one of the most persistent challenges for youth in sub Saharan Africa. For instance, an adolescent experiencing mild illness may prefer to “wait it out” rather than incur transportation and consultation costs, especially if health facilities are several kilometers away. This delay often exacerbates the severity of conditions that could otherwise be treated early.

Accessibility is not solely about location it also encompasses operational hours, staff availability, and service efficiency. Many health facilities in Ghana operate during traditional working hours, which may conflict with school or work schedules. For students or young employees, this

mismatch reduces the feasibility of attending clinics without missing classes or risking disciplinary action at work. Thus, the accessibility challenge is both spatial and temporal, and addressing it requires flexible, youth friendly service delivery models.

Even when services are available and affordable, individuals may choose not to utilize them if they perceive them as unfriendly, judgmental, or culturally insensitive. Acceptability refers to the degree to which health services align with the values, expectations, and sociocultural norms of the community. In many African settings, this dimension is particularly significant for young people, who may feel embarrassed, judged, or misunderstood when discussing sensitive health issues.

Studies have shown that adolescents often avoid seeking care for reproductive, sexual, or mental health concerns due to fear of stigma or breaches of confidentiality (WHO, 2018). Young women, for example, may refrain from visiting clinics to seek contraceptives or treatment for menstrual problems out of fear that community members or healthcare workers will label them as promiscuous. Likewise, young men may perceive healthcare facilities as spaces for women and children, thus reinforcing gendered avoidance of care.

Acceptability is further shaped by perceived quality of care. Negative past experiences such as rude staff, long queues, or lack of privacy can discourage repeat visits. In Ghana, complaints about disrespectful attitudes of healthcare providers toward youth, especially unmarried young women, have been widely documented (Adomako et al., 2022). To enhance acceptability, health systems must cultivate youth friendly environments that prioritize confidentiality, empathy, and inclusivity.

Health literacy represents the cognitive and social skills that determine individuals' capacity to obtain, process, and understand basic health information necessary to make appropriate health decisions (Nutbeam, 2008). In modern societies, where health systems are increasingly complex,

literacy plays a decisive role in enabling individuals to interpret symptoms, navigate bureaucratic systems, and adhere to medical advice.

Disparities in health literacy persist, particularly among youth in low income or rural settings. Misconceptions about disease causation, overreliance on traditional remedies, and limited knowledge about preventive services reduce timely engagement with formal healthcare systems. Conversely, the rise of digital platforms and social media has created new opportunities for youth health education, but it has also exposed them to misinformation and unverified medical advice. A study by Boateng and Mensah (2020) revealed that while Ghanaian youth increasingly use online platforms to obtain health information, only a fraction verify the credibility of sources before acting on them. This underscores the need for targeted health communication strategies that not only disseminate accurate information but also build critical thinking and digital literacy among young people.

Social networks comprising family, peers, and community members serve as crucial enablers or barriers to health seeking behaviour. Supportive family environments that encourage open discussion about health often facilitate timely care, whereas restrictive or judgmental settings can have the opposite effect. Among adolescents, peer influence plays a particularly strong role. When peers normalize healthy practices such as clinic attendance or vaccination, individuals are more likely to follow suit. Conversely, when peers stigmatize illness or view formal healthcare as unnecessary, individuals may avoid care to maintain social acceptance (Atinga et al., 2021).

The role of elders and religious leaders also carries significant weight. Their endorsement of formal healthcare especially in communities with strong traditional ties can substantially improve utilization rates. Therefore, interventions that leverage community networks and peer led education can effectively address social barriers to health seeking.

Trust in the healthcare system is a decisive factor that can either enable or hinder utilization. Perceived corruption, inadequate supplies, and inconsistent service delivery erode public confidence in formal health systems. When individuals feel that health workers prioritize profit over care, or that facilities lack essential medicines, they are less likely to seek professional treatment.

Institutional trust is especially critical for youth, who are forming lifelong attitudes toward healthcare. Early negative experiences can foster cynicism and promote long term disengagement from formal systems. Conversely, responsive and transparent institutions that communicate clearly and treat young clients with respect can build lasting trust and promote consistent engagement.

2.3 Theoretical Frameworks Underpinning Health Seeking Behaviour

Health-seeking behaviour is underpinned by theoretical frameworks such as the Health Belief Model, among others which explain how perceptions of risk, access to services, social norms, and gender roles influence individuals' decisions to seek healthcare.

2.3.1 The Health Belief Model (HBM)

The Health Belief Model (HBM), originally developed by Hochbaum (1958) and further refined by Rosenstock (1974) and Becker (1975), remains one of the most widely used theoretical frameworks for understanding individual health decision making. It provides a psychological explanation for why individuals choose to engage or not engage in health related behaviours. The model was initially applied to predict the uptake of preventive health measures such as tuberculosis screening, but has since evolved to explain a wide array of behaviours including vaccination, adherence to medication, safe sex practices, and help seeking for mental or physical health concerns (Janz & Becker, 1984; Abraham & Sheeran, 2014).

At its core, the HBM posits that health behaviour is determined by an individual's perception of four key constructs: perceived susceptibility, perceived severity, perceived benefits, and perceived barriers. These factors interact to shape the likelihood that a person will take a recommended health related action. The model also incorporates cues to action and self-efficacy two constructs later added to account for environmental prompts and confidence in one's ability to perform the desired behaviour.

Perceived Susceptibility refers to an individual's belief about the likelihood of contracting an illness or experiencing a health condition. For instance, a young person who believes that poor sanitation or unprotected sexual activity exposes them to disease is more likely to adopt preventive measures. Conversely, when the perception of risk is low often due to misinformation or a sense of invincibility common among youth the likelihood of engaging in preventive behaviour diminishes. In Ghana, studies show that some adolescents perceive conditions such as malaria or respiratory infections as "common" and thus not serious enough to warrant medical attention, delaying treatment or resorting to home remedies (Amo Adjei, 2014).

Perceived Severity reflects the individual's evaluation of how serious the consequences of an illness might be. This can include both medical implications (pain, disability, death) and social implications (stigma, loss of income, or social rejection). Among Ghanaian youth, cultural interpretations of illness often intertwine with moral and spiritual dimensions illness may be perceived as a punishment, curse, or spiritual attack rather than a medical condition (Asante & Meyer Weitz, 2017). These beliefs shape whether young people perceive health threats as severe enough to seek biomedical care. For instance, mental health problems or reproductive issues may be downplayed or hidden due to fear of stigma and moral judgment.

Perceived Benefits concern the individual's belief in the effectiveness of a recommended action to reduce risk or severity. A youth who believes that visiting a clinic, adhering to medication, or

exercising regularly will improve health is more likely to engage in such actions. In the era of digital media, exposure to success stories or health education campaigns on platforms like Facebook, YouTube, and television can strengthen these perceptions of benefit. However, if the information environment is saturated with misinformation such as unfounded claims about herbal cures or vaccine dangers it may weaken belief in scientifically recommended interventions (Eysenbach, 2020).

Perceived Barriers, perhaps the most critical component, refer to the individual's evaluation of the obstacles that impede health action. These may include tangible barriers such as cost, distance to healthcare facilities, waiting time, and lack of privacy, or intangible ones like fear, embarrassment, stigma, and distrust of healthcare providers. Among young people, particularly those from low income backgrounds, affordability and confidentiality remain major barriers to accessing care (WHO, 2018). Young women may avoid seeking reproductive or sexual health services for fear of being judged by healthcare workers, while young men may perceive seeking care as a sign of weakness that contradicts masculine ideals (Courtenay, 2000). Such barriers often outweigh perceived benefits, delaying timely care.

The construct of Cues to Action represents triggers that motivate individuals to take health related action. These cues may be internal (such as experiencing pain or symptoms) or external (such as health campaigns, peer influence, or social media posts). In contemporary Ghana, where youth are heavily engaged on digital platforms, cues to action increasingly emerge from media sources. A viral post on mental health awareness or a radio program discussing the dangers of self-medication can prompt individuals to seek care or change behaviour. The effectiveness of such cues, however, depends on their credibility, cultural sensitivity, and emotional resonance.

Self-Efficacy, introduced later by Bandura (1977), captures the individual's confidence in their ability to successfully perform a recommended health behaviour. For example, a young woman

who believes she can confidently ask a health provider questions, or a young man who feels capable of changing his diet, is more likely to adopt healthy practices. Media interventions that model positive behaviour through relatable storytelling, role models, and peer narratives can enhance self-efficacy by demonstrating that others like the audience have successfully overcome similar challenges.

The Health Belief Model provides a valuable lens for understanding how cognitive perceptions interact with cultural, social, and media influences to shape health seeking behaviour among youth. In Ghana, where health systems are pluralistic and media exposure is rising, the model underscores the importance of addressing both psychological and structural determinants of care. Health promotion interventions that combine accurate risk communication with supportive environments such as youth friendly health services and non-judgmental media messaging are more likely to translate awareness into action.

2.3.2 Theory of Reasoned Action (TRA)

The Theory of Reasoned Action (TRA), developed by Fishbein and Ajzen (1975), provides one of the most influential frameworks for understanding how individuals make decisions regarding their health. The theory posits that human behaviour is primarily determined by behavioural intention, which itself is influenced by two key factors: attitudes toward the behaviour and subjective norms. Attitudes toward the behaviour refer to an individual's overall evaluation of performing that behaviour, whether favourable or unfavourable. In health seeking contexts, this attitude may be shaped by a person's belief about the outcomes of seeking medical care such as early detection of illness, recovery, or stigma associated with visiting certain health facilities. For instance, if a young person believes that visiting a hospital is an indication of weakness or moral failure, this negative attitude may reduce their intention to seek care even when experiencing symptoms. Conversely, if

healthcare is perceived as empowering or responsible behaviour, it enhances positive intention and likelihood of action.

Subjective norms, the second determinant, encompass social pressures or expectations from significant others including family, friends, peers, community leaders, and increasingly, media personalities. These norms influence whether an individual perceives that people important to them approve or disapprove of the behaviour. Among the youth in Accra, for example, peer influence and online social networks play a critical role in shaping health related decisions. When peers openly discuss wellness checks or mental health care, it normalizes help seeking. In contrast, when cultural narratives or peer groups ridicule vulnerability or illness, individuals may refrain from seeking care to maintain social acceptance.

In the context of modern Ghanaian youth culture, mass media and digital communication platforms serve as powerful transmitters of subjective norms. Social media influencers, celebrities, and even health content creators can model and reinforce particular health seeking patterns. For instance, campaigns that feature relatable young influencers advocating for preventive health practices such as vaccination, blood donation, or mental health counselling can significantly enhance the perceived social approval of such actions. These mediated behaviours often have a spillover effect, shaping offline norms within peer groups.

However, the TRA also highlights the potential for media to discourage positive health seeking through misinformation, stigmatizing portrayals, or reinforcing harmful stereotypes. For example, sensationalized reporting about illnesses can instil fear or fatalism, leading youth to avoid testing or treatment. Similarly, the overemphasis on physical appearance and “body perfection” in media narratives can distort perceptions of what constitutes healthy living, prompting unhealthy self-care behaviours.

The Theory of Reasoned Action underscores the need for culturally and socially sensitive media

communication that not only provides accurate information but also fosters supportive social norms. Effective health communication must consider how attitudes and perceived social expectations interact to shape youth intentions toward health seeking. When applied strategically, this model helps explain variations in health behaviour across gender lines since societal expectations often differ for men and women and provides a framework for designing media interventions that can shift both individual attitudes and collective norms toward healthier behaviour.

2.4 Andersen's Health Care Utilization Model

The Andersen Health Care Utilization Model, first proposed in 1968 and later revised by Ronald Andersen (1995), is one of the most comprehensive frameworks used to understand and predict patterns of healthcare seeking behaviour. The model was developed to identify and classify the multiple determinants that influence why individuals choose to use or not use healthcare services. It posits that healthcare utilization is a function of three major categories of factors: predisposing factors, enabling factors, and need factors. These determinants interact dynamically, shaping both the propensity and capacity of individuals to access healthcare.

2.4.1 Predisposing Factors

Predisposing factors refer to the sociodemographic and cultural characteristics of individuals that influence their likelihood of seeking care even before an illness occurs. These include age, gender, education level, marital status, ethnicity, occupation, and cultural beliefs (Andersen, 1995). In the Ghanaian context, these factors are particularly salient given the diversity in social norms and health perceptions across ethnic and socioeconomic groups. For instance, younger individuals in

Accra may have greater exposure to modern health information through mass and digital media, but their attitudes toward healthcare may still be shaped by family traditions or cultural expectations about masculinity and femininity.

Gender, in particular, remains a powerful predisposing factor. In many African societies, health seeking is often viewed through gendered lenses where men are socialized to perceive seeking medical care as a sign of weakness, while women may experience restrictions due to household or caregiving responsibilities (Addai, 2018). Educational attainment also strongly predicts health seeking behaviour. Youth with higher levels of education are more likely to recognize symptoms, understand medical advice, and value preventive care. Conversely, low literacy levels may limit health knowledge and reduce confidence in interacting with health professionals, leading to delays in seeking formal healthcare.

Cultural values and health beliefs further underpin predisposing factors. In Ghana, traditional beliefs about illness causation such as attributing disease to spiritual forces or witchcraft can lead individuals to prefer traditional healers or religious interventions over biomedical treatment (Amo Adjei & Darteh, 2016). These beliefs coexist with modern health practices, creating a pluralistic health seeking environment where individuals may alternate between traditional and formal healthcare systems depending on perceived cause, severity, or social acceptability of the illness.

2.4.2 Enabling Factors

While predisposing factors explain an individual's inclination toward health seeking, enabling factors determine the practical ability to access healthcare services. These include financial resources, health insurance coverage, and accessibility of health facilities, availability of transportation, and the quality of the healthcare infrastructure (Andersen, 1995). Enabling factors

often represent the structural and systemic conditions that facilitate or impede access to care.

In Ghana, especially in urban areas such as Accra, enabling factors vary across socioeconomic strata. For example, although private clinics and hospitals are abundant, their cost can be prohibitive for low income youth, pushing them toward over the counter self-medication or reliance on informal care providers. The National Health Insurance Scheme (NHIS) was introduced to mitigate such disparities, yet coverage remains uneven, particularly among informal workers and unemployed youth.

Proximity to healthcare facilities remains a critical enabling variable. While urban centres enjoy relatively high service concentration, peri urban and marginalized communities face geographic and infrastructural barriers. Inadequate transportation or long waiting times often discourage individuals from seeking timely care. In the digital era, however, the rise of telemedicine and online health platforms offers new enabling avenues for youth to consult healthcare professionals remotely, although digital literacy and data costs still limit widespread use.

2.4.3 Need Factors

The need component of Andersen's model captures both perceived and evaluated health needs. Perceived need refers to an individual's subjective assessment of their health status how sick they feel or how urgent they believe their symptoms to be. Evaluated need, on the other hand, reflects a clinical or professional judgment about the person's actual health condition (Andersen, 1995). Together, these factors are critical in triggering the decision to seek care.

Among young people, perceived need is often shaped by self-assessment, peer comparison, and media exposure. For example, exposure to public health campaigns emphasizing mental health awareness may heighten youth sensitivity to stress or depression, thereby increasing their perceived need to seek counselling. Conversely, when health problems are asymptomatic or

normalized such as fatigue, minor infections, or anxiety perceived need may be low, delaying or deterring formal care seeking.

Gender again plays a mediating role in how need is perceived and acted upon. Women, due to reproductive health experiences and caregiving roles, may be more attuned to bodily changes and thus exhibit higher perceived need for healthcare. Men, however, often underreport symptoms or postpone medical consultation until conditions become severe, reflecting societal expectations of endurance and self-reliance (Osei, 2020).

2.5 Motivational and Behavioral Theories of Health Seeking Behaviour

Understanding health seeking behaviour through the lens of motivational and behavioural theories provides a broader psychological context for why individuals pursue or avoid healthcare. These theories highlight that human actions related to health are not only responses to illness but are deeply tied to fundamental needs, drives, and aspirations for wellbeing. Among the most influential theories that illuminate these motivations are Maslow's Hierarchy of Needs (1943), Herzberg's Motivation Hygiene Theory (1959), and McClelland's Theory of Needs (1961). Each offers unique insights into how human motivation shapes decisions about maintaining, protecting, or restoring health.

Abraham Maslow's Hierarchy of Needs remains one of the most enduring frameworks for understanding human motivation. Maslow posited that individuals are driven by a series of hierarchical needs, beginning with basic physiological requirements and progressing toward self-actualization. The five levels of the hierarchy physiological, safety, love/belonging, esteem, and self-actualization are arranged in an ascending order of importance, where higher order needs emerge only after lower level ones have been substantially satisfied (Maslow, 1943).

In this context of health seeking behaviour, Maslow's model implies that individuals pursue health

as both a basic necessity and an aspirational goal. At the most fundamental level, physiological needs include access to food, water, rest, and medical attention. A person suffering from illness or malnutrition cannot pursue higher goals without addressing these immediate physical concerns. The next level safety needs encompasses the desire for security, stability, and freedom from harm. Seeking medical care to prevent disease, accessing vaccinations, or adopting health insurance are all manifestations of this need for safety.

At the social level, the need for love and belonging influences how individuals engage with family, peers, and community in health related decisions. For example, in Ghanaian society, communal structures and family networks play a crucial role in encouraging or discouraging healthcare utilization. Adolescents and young adults, especially, are often influenced by peer norms when deciding whether to seek formal healthcare or rely on informal remedies.

Maslow's higher order needs esteem and self-actualization are particularly relevant to health promotion and wellness behaviours. Health seeking may serve as a means of achieving self-respect, confidence, and a sense of control over one's body. In modern urban contexts such as Accra, educated youth may pursue preventive healthcare, fitness, and mental wellbeing not merely to avoid illness but to achieve a state of optimal functioning and self fulfilment. This highlights the growing shift from illness centred to wellness oriented models of care, where individuals view health as an enabler of personal growth and achievement.

2.5.1 Predisposing Factors Influencing Health Seeking Behaviour

Predisposing factors refer to the demographic, social, and cultural characteristics that shape an individual's inclination to engage in health seeking behaviour even before an illness occurs. These are the fundamental determinants that predispose individuals to perceive, interpret, and respond to health needs in specific ways (Andersen, 1995). They encompass variables such as age, gender,

education, marital status, cultural orientation, and belief systems. These factors do not directly determine healthcare utilization, but they influence the probability that individuals will recognize symptoms, value medical advice, or seek professional intervention when health challenges arise. In the Ghanaian and broader African context, predisposing factors operate within sociocultural systems where communal values, gender roles, and belief patterns deeply influence how health is perceived and acted upon. Young people, particularly, are influenced not only by individual level factors such as knowledge and education but also by social norms and family expectations that determine when and how one should seek healthcare.

2.5.2 Age as a Determinant of Health Seeking Behaviour

Age is a crucial demographic variable influencing health seeking patterns. Different age groups perceive illness, vulnerability, and health priorities differently. Younger individuals, especially adolescents and young adults, often exhibit lower health service utilization rates despite increased exposure to health risks (Wang et al., 2018). This paradox arises because youth tend to perceive themselves as resilient, underestimate health threats, and prioritize social or economic activities over preventive health.

In Ghana, for instance, young people are more likely to engage in self-medication, rely on peers for advice, or postpone care until symptoms worsen (Aikins, 2017). In contrast, older adults may demonstrate more frequent health facility use due to accumulated chronic conditions and heightened health awareness. However, youth often have greater exposure to digital health information, which, if properly leveraged, could enhance early diagnosis and preventive action. Therefore, age intersects with other factors such as education and media exposure to shape unique patterns of healthcare engagement.

2.6 Conceptual Framework

The conceptual framework guiding this study is built on the interaction between three domains: gender norms, media exposure, and health-seeking behaviour.

1. **Gender Norms:** Influence perceptions of health, with masculinity often discouraging health-seeking and femininity linked to reproductive health utilisation.
2. **Media Exposure and Framing:** Shapes knowledge and attitudes but often frames health as a women's issue, reinforcing gender disparities.
3. **Health-Seeking Behaviour Outcomes:** Vary across genders, with women showing higher utilisation but facing stigma, and men showing lower utilisation due to social norms.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter presents the methodological framework for the study. It outlines the research design, study population, sampling strategy, data collection instruments, analytical techniques, and ethical considerations. The design is guided by the study's objectives, which seek to explore gendered differences in health-seeking behaviour among youth in Ga West and the role of mass media in shaping these behaviours.

3.2 Research Design

The study adopts a quantitative method design, combining quantitative and qualitative approaches. This design is appropriate because it allows for both statistical analysis of health-seeking patterns and an in-depth exploration of how gender norms and media framing influence behaviour. The quantitative component involves a structured survey.

3.3 Study Area

The research will be conducted in Accra, Ghana's capital, which is a diverse urban hub with extensive media penetration and a large youth population. The city provides a useful case study because it reflects both traditional health communication channels (radio and television) and newer platforms (social media), offering an ideal setting for studying media influence on health-seeking behaviour.

3.4 Population of the Study

The study population comprises youth in Accra aged 18–35 years. This group is chosen because it represents the most active users of both traditional and digital media and is at a critical stage in establishing long-term health behaviours.

3.5 Sampling Technique and Sample Size

A stratified random sampling technique will be employed. The strata will be based on gender (male and female) to ensure balanced representation. Within each stratum, participants will be randomly selected from the Ga West District Assembly.

3.6 Quantitative survey: A quantitative survey approach will be employed, targeting a sample size of approximately 120 respondents. This sample size is considered appropriate for an MA-level research project, as it allows for meaningful statistical analysis while ensuring adequate reliability and representativeness of the study population.

3.7 Data Collection Methods

3.7.1 Survey

A structured questionnaire will be administered to collect quantitative data on:

- Demographics (age, gender, education, income).
- Health-seeking behaviour indicators (frequency of hospital visits, preventive care, delays in seeking treatment).
- Media exposure (type, frequency, and trust in media sources).
- Perceptions of gender norms in relation to health-seeking.

3.7.2 Data Analysis

- **Quantitative data** will be analysed using SPSS. Descriptive statistics (frequencies, percentages, cross-tabulations) will summarise demographic and behavioural patterns. Inferential statistics (chi-square tests, logistic regression) will test associations between gender, media exposure, and health-seeking behaviour.

3.8 Ethical Considerations

Ethical clearance will be sought from the University of Media, Arts and Communication, UniMAC's Institutional Review Board. Informed consent will be obtained from all participants, and they will be assured of anonymity and confidentiality. Sensitive issues especially relating to sexual and reproductive health will be handled with care to minimise discomfort. Participation will be voluntary, with the option to withdraw at any stage.

3.9 Limitations of the Study

- The study is limited to urban youth in Accra, which may not capture rural dynamics.
- Self-reported survey data may be subject to recall or social desirability bias.
- The sample size, while sufficient for an MA thesis, may not capture the full diversity of youth experiences in Ghana.

CHAPTER FOUR

DATA ANALYSIS AND RESULTS

4.1 Introduction

This chapter presents a detailed analysis of the findings of the study titled "Media Influence, Gender Differences and Health-Seeking Behaviour Among Youths**."** The analysis is based on data obtained from one hundred and twenty-three (123) valid responses collected through the administration of a structured questionnaire. The questionnaire was designed to capture information on respondents' demographic characteristics, exposure to health-related media messages, perceptions of media influence, gender-related attitudes, and patterns of health-seeking behaviour.

The chapter employs descriptive statistical techniques to summarise and interpret the data. Frequencies, percentages, means, and comparative measures are used to describe respondents' characteristics and to identify emerging trends in media exposure and health-seeking behaviour. Particular attention is given to examining gender differences in responses and how these differences influence attitudes towards formal healthcare utilisation. The analysis further explores the extent to which media messages encourage or discourage timely health-seeking among youths.

Findings are presented in a clear and systematic manner using tables, graphs, and narrative explanations to enhance understanding and interpretation. The visual representations support the statistical results and highlight key patterns and relationships identified in the data. Overall, this chapter provides empirical evidence that addresses the study's research objectives and forms the basis for the discussion, conclusion and recommendation

4.2 Demographic Characteristics of Respondents

4.2.1 Age Distribution

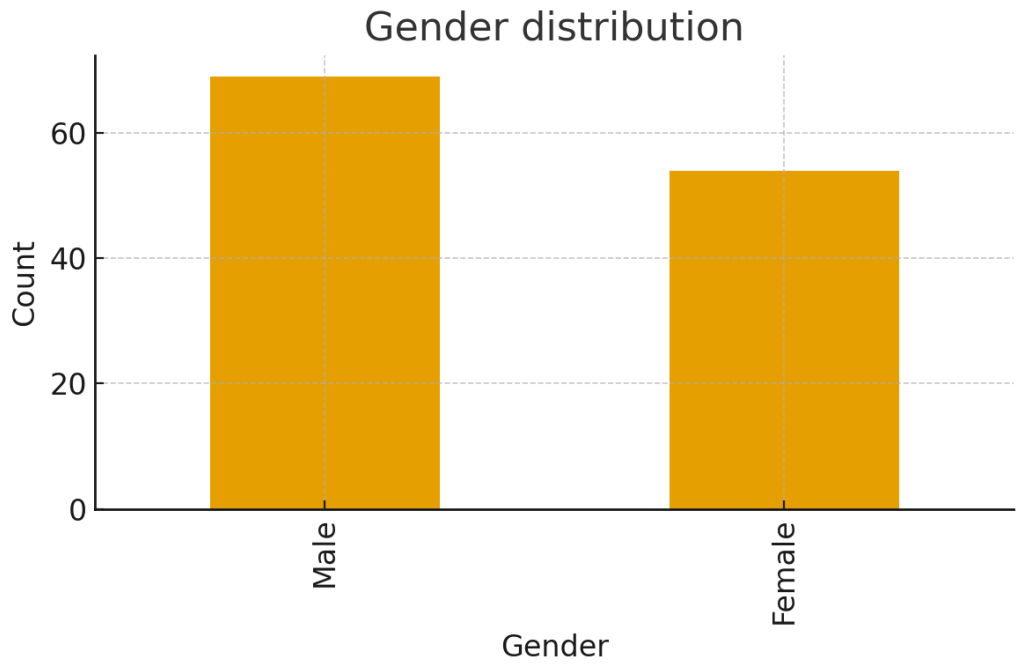
Respondents were categorised into four age groups to examine the age composition of the study population and its possible influence on health-seeking behaviour. The findings show that the majority of respondents fell within the 18–22 years age category, accounting for 42 respondents. This was followed by those aged 23–27 years, who constituted 34 respondents, and respondents aged 28–32 years, numbering 31 respondents**.** A relatively smaller proportion of respondents, 8 individuals, fell within the 33–35 years age category.

The age distribution indicates that the study sample was largely composed of younger youths, particularly those in late adolescence and early adulthood. This is significant, as individuals within these age groups are often more exposed to media content and may exhibit distinct health-seeking behaviours compared to older adults. Their perceptions and responses to health messages are therefore critical in understanding how media influence shapes healthcare utilisation among youths. The dominance of younger respondents suggests that the findings largely reflect the experiences, attitudes, and behavioural patterns of this active and media-engaged segment of the population.

4.2.2 Gender Distribution

The gender distribution of respondents is presented in Figure 4.1. The results indicate a nearly balanced representation of male and female respondents, which provides a strong basis for comparative analysis. This balanced distribution enhances the reliability of examining gender differences in media influence and health-seeking behaviour, which is a central focus of the study.

Figure 4.1: Gender Distribution of Respondents



4.2.3 Educational Level

The educational background of respondents was examined to understand how literacy and formal education may influence exposure to media messages and health-seeking behaviour. The findings revealed that respondents possessed varying levels of education, with a clear dominance of tertiary-level qualifications. A smaller proportion of respondents had completed secondary education, while only a negligible number reported lower levels of formal education. This distribution indicates that the study population was largely educated and therefore likely capable of understanding and interpreting health-related information disseminated through both traditional and digital media platforms.

The high level of educational attainment among respondents is particularly significant in the context of this study, as education has been consistently identified in the literature as a key determinant of health knowledge and healthcare utilisation. Individuals with higher levels of education are generally

more exposed to diverse sources of information and are better equipped to critically evaluate media messages. As such, the dominance of tertiary-educated respondents suggests that limited literacy is unlikely to be a major constraint in the interpretation of health messages within this sample. Instead, variations in health-seeking behaviour observed in the study are more likely to be influenced by factors such as message framing, gender norms, perceived severity of illness, and structural barriers rather than a lack of understanding.

Furthermore, educated youths are more likely to be active users of social media and digital platforms, which enhances their exposure to online health campaigns. However, higher education does not automatically translate into positive health-seeking behaviour, as attitudes, beliefs, and social expectations may still discourage timely healthcare utilisation. The findings therefore highlight the need for health communication strategies that go beyond information provision to address behavioural and psychosocial factors influencing youths.

4.2.4 Employment Status

Respondents' employment status was analysed to assess their socioeconomic positioning and its potential influence on health-seeking behaviour. The distribution revealed that 64 respondents were employed**,** 32 were students**,** 15 were unemployed**,** and 12 were self-employed**.** This composition reflects a diverse socioeconomic background within the study population.

The dominance of employed respondents suggests that a significant proportion of participants had a regular source of income, which may positively influence their ability to afford healthcare services. However, employment does not necessarily eliminate financial barriers, as healthcare costs may still compete with other living expenses. Students and unemployed respondents, on the other hand, may

face greater financial constraints, making them more susceptible to delaying healthcare or relying on self-medication and informal care.

Self-employed respondents occupy a unique position, as their income levels may fluctuate, and taking time off work to seek healthcare may be perceived as a loss of income. This can further contribute to delayed health-seeking behaviour. The diversity in employment status underscores the relevance of socioeconomic factors in understanding patterns of healthcare utilisation, particularly in relation to cost and convenience. These findings are important for interpreting respondents' perceptions of healthcare affordability and accessibility, especially when analysed alongside media influence and gender-related attitudes.

4.2.5 Media Exposure and Influence

This section examines the extent to which respondents are exposed to health-related media messages and how such exposure influences their understanding, attitudes, and health-seeking behaviour. Media exposure is a central variable in this study, as the media serves as a primary channel for disseminating public health information to youths.

4.2.6 Exposure to Health Messages

The findings indicate that respondents experienced moderate exposure to health information across various media platforms, including television, radio, posters, and social media. Among these channels, social media emerged as the most frequently cited source of health messages. This aligns with contemporary communication trends, as youths increasingly rely on digital platforms such as Facebook, WhatsApp, Instagram, and other online spaces for information.

Television and radio also played a role in disseminating health information, particularly in the form of public service announcements and health-related programmes. Posters and printed materials were less frequently cited, suggesting a shift away from traditional static forms of health communication. The widespread exposure to health messages suggests that access to information is not a major challenge for the study population. Rather, the critical issue lies in how these messages are perceived and acted upon.

The prominence of social media as a source of health information highlights both opportunities and challenges. While digital platforms allow for rapid and wide dissemination of health messages, they also expose youths to misinformation and unregulated content. This underscores the importance of ensuring that health messages disseminated through social media are accurate, engaging, and tailored to the needs and preferences of youths.

4.2.7 Media Influence on Understanding

Respondents' perceptions of the influence of media messages on their understanding of health issues were assessed using Likert-scale items. The findings show that media messages moderately enhanced respondents' understanding of health conditions, symptoms, and preventive measures. Many respondents acknowledged that exposure to health information through the media had increased their awareness of when and how to seek medical help.

However, the findings also revealed concerns regarding the nature and tone of some media messages. A number of respondents indicated that certain health messages made them feel anxious, fearful, or judged, particularly when messages emphasised severe consequences or adopted a moralistic tone. Such perceptions may discourage youths from seeking care, especially for sensitive health issues.

These findings suggest that while media plays an important educational role, its effectiveness is influenced by message framing. Messages that are overly alarmist or judgmental may undermine their intended purpose by reinforcing fear and stigma. Therefore, health communication strategies should prioritise clarity, empathy, and encouragement rather than fear-based approaches.

4.2.8 Gender Differences in Media Influence and Health-Seeking Behaviour

To examine gender differences in health-seeking behaviour, Likert mean scores were calculated for items related to perceived barriers, formal health-seeking tendencies, and delay in seeking care. The analysis revealed meaningful differences in how male and female respondents responded to media health messages and healthcare decisions.

The mean score for perceived barriers was 2.65, indicating a moderate level of agreement that media messages sometimes discourage care-seeking. The mean score for tendency to seek formal healthcare was 3.21**,** suggesting a generally positive, though not strong, inclination towards formal healthcare utilisation. The mean score for delay in seeking care was 2.54**,** reflecting a moderate tendency to postpone healthcare until symptoms worsen.

4.2.9 Perceived Barriers

The mean score of 2.65 for perceived barriers suggests that media-induced fear or feelings of judgment constitute a moderate barrier to health-seeking behaviour among youths. While not overwhelmingly negative, these perceptions are significant enough to influence decision-making, particularly among male respondents. Some youths reported feeling that health campaigns did not adequately reflect their realities or were targeted in a way that felt accusatory.

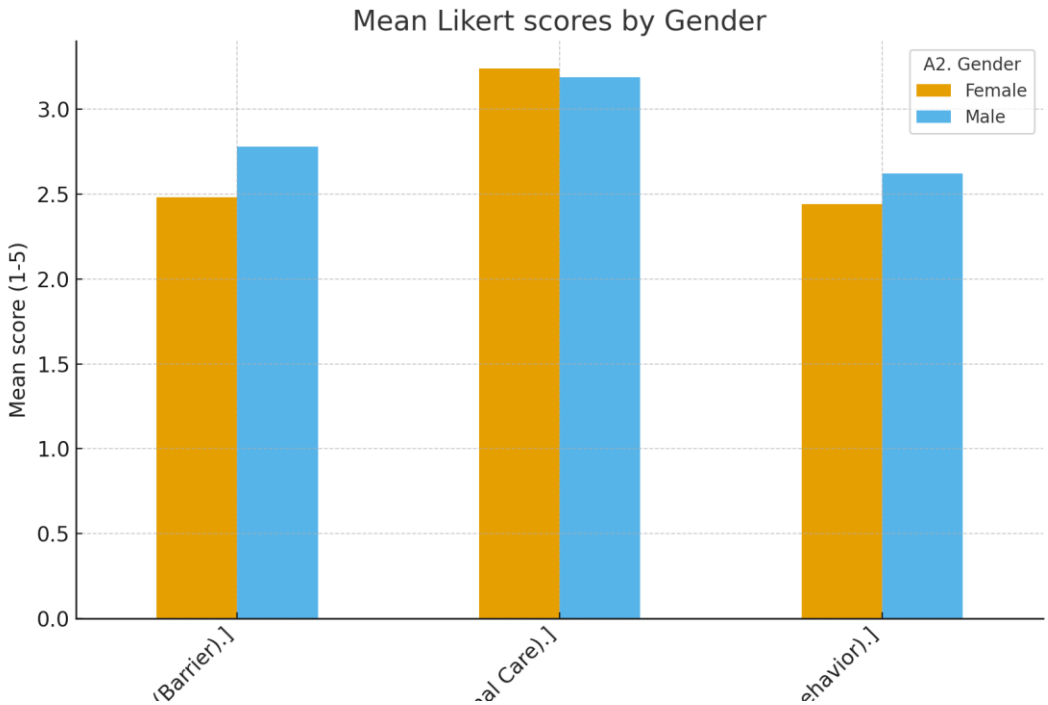
This finding highlights the importance of understanding how gender norms shape the interpretation of health messages. Males, in particular, may be less receptive to messages that challenge notions of strength or self-reliance, thereby increasing resistance to seeking care.

4.3 Formal Health-Seeking Behaviour

The mean score of 3.21 for formal health-seeking behaviour indicates a generally positive attitude towards seeking care from clinics and hospitals. However, the moderate nature of this score suggests that willingness does not always translate into action. Gender-based analysis revealed that female respondents recorded slightly higher mean scores for formal healthcare utilisation compared to males, as illustrated in Figure 4.2.

This finding supports existing literature that suggests females are more proactive in seeking healthcare and more responsive to health information. Males, conversely, may delay seeking care due to social expectations and perceived invulnerability. These gender differences underscore the need for targeted health communication strategies that address the unique concerns and motivations of both males and females.

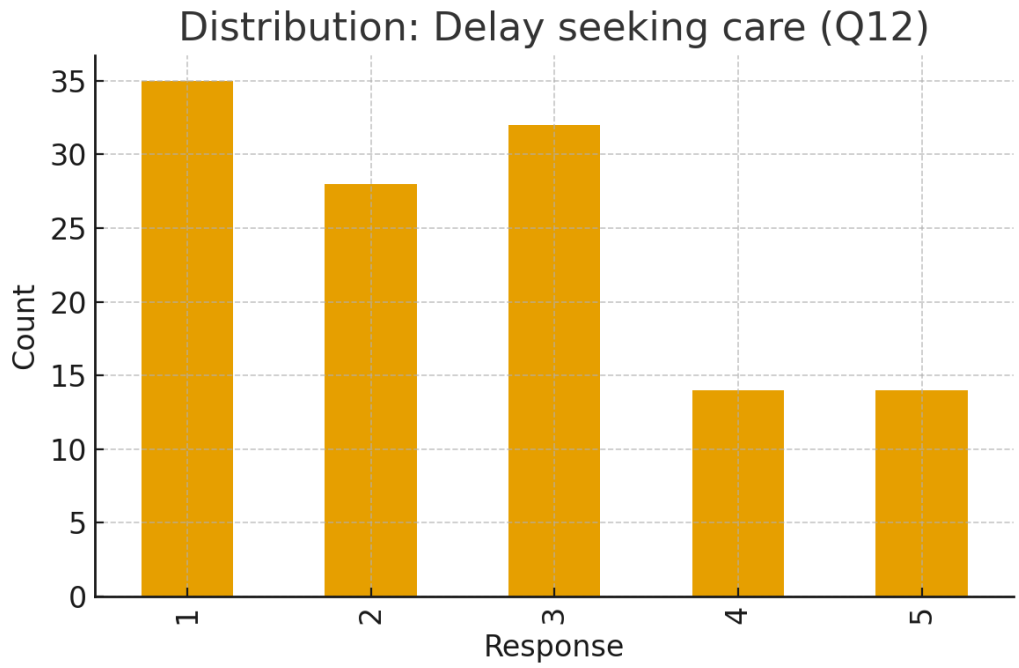
Figure 4.3: Mean Scores by Gender



4.3.1 Delay in Seeking Healthcare

The mean score of 2.54 indicates that delays in seeking healthcare are fairly common among respondents, a pattern that is further illustrated by the distribution of responses presented in **Figure 4.3**

Figure 4.3.1: Delay in Seeking Health Care (Q12)



Males were more likely than females to agree that they delay seeking healthcare, a finding that strongly supports existing literature on gendered patterns of health behaviour. This tendency among male respondents reflects broader social and cultural expectations that often associate masculinity with strength, self-reliance, and emotional restraint. Such norms can discourage men from acknowledging illness or seeking professional medical help promptly, leading to delayed healthcare utilisation. In contrast, female respondents demonstrated a greater willingness to seek healthcare services and appeared more responsive to health-related information. These differences underscore the importance of considering gender as a critical variable in understanding health-seeking behaviour and designing effective health communication strategies.

4.3.2 Relationship Between Media Exposure and Health-Seeking Behaviour

This section examines the relationship between media exposure and health-seeking behaviour among youths, with particular attention to how message content, tone, and framing influence decisions to seek formal healthcare. The analysis revealed several important patterns that highlight the complex role of media in shaping health behaviour.

Firstly, youths who reported exposure to clear, relatable, and practical health messages demonstrated a higher likelihood of seeking formal healthcare services such as clinics and hospitals. These messages were perceived as informative, supportive, and empowering, helping respondents to recognise symptoms, understand potential health risks, and appreciate the benefits of early medical intervention. When health messages were framed in a manner that acknowledged youths' realities and avoided technical jargon, respondents were more inclined to trust the information and act upon it.

Secondly, the study found that youths exposed to media messages perceived as fear-inducing, judgmental, or overly alarmist were more likely to report avoidance or delay in seeking healthcare. Messages that emphasised severe consequences without offering reassurance or practical guidance often triggered anxiety and fear, which discouraged proactive health-seeking. In some cases, respondents indicated that such messages made them feel blamed or stigmatised, particularly when addressing sensitive health issues. This reaction highlights the unintended negative effects that poorly framed health campaigns can have on their target audience.

Thirdly, the analysis revealed clear gender differences in responses to media health messages. Female respondents tended to respond more positively to health information disseminated through the media and were more likely to perceive such messages as encouraging. Males, on the other hand, reported slightly higher resistance to media health messages and were more likely to interpret them as intrusive

or judgmental. These differences reflect underlying gender norms and social expectations that shape how health information is interpreted and acted upon.

Overall, these findings align closely with the study's conceptual framework, which posits that media exposure does not operate in isolation but interacts with individual characteristics particularly gender norms to shape health-seeking behaviour. Media messages can therefore function either as facilitators or barriers to healthcare utilisation, depending on how they are framed and how they resonate with the target audience.

4.3.3 Summary of Findings

This study produced several key findings that address the research objectives and provide insight into the influence of media and gender on health-seeking behaviour among youths.

Firstly, the sample was dominated by younger respondents aged 18–22 years**,** indicating that the findings largely reflect the perceptions and behaviours of younger youths who are typically more engaged with digital media. Secondly, the gender distribution of respondents was relatively balanced, allowing for meaningful comparative analysis between male and female participants. This balance strengthened the reliability of conclusions drawn regarding gender differences in health behaviour.

Thirdly, exposure to health information through the media was found to be common among respondents, with social media emerging as the most prominent source of health messages. This highlights the growing importance of digital platforms in public health communication. Fourthly, media messages were found to moderately support respondents' understanding of health issues, suggesting that the media plays a useful educational role.

Fifthly, the study identified the presence of perceived barriers induced by media messages, particularly fear and feelings of judgment. While these barriers were not overwhelmingly strong, they were significant enough to influence healthcare decisions. Sixthly, female respondents demonstrated stronger tendencies toward formal healthcare utilisation compared to males, reinforcing existing evidence of gendered differences in health-seeking behaviour. Finally, delay in seeking healthcare emerged as a moderate but notable issue, indicating that many youths postpone seeking care until their condition worsens.

CHAPTER FIVE

5.0 DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter discusses the findings presented in Chapter Four in relation to the study's objectives and relevant literature reviewed in Chapter Two. It interprets the results within the broader context of media influence, gender norms, and youth health behaviour. The chapter further draws conclusions from the study and provides recommendations for health communication practice, policy formulation, and future research.

5.2 Discussion of Findings

5.3 Media Exposure and Understanding of Health Issues

The study revealed moderate but consistent exposure to health messages among youths, particularly through social media platforms. This finding aligns with existing studies that identify digital media as the primary source of health information for young people in contemporary societies. The widespread use of smartphones and social networking platforms has significantly increased youths' access to health-related information.

Media messages were found to contribute positively to respondents' understanding of health conditions, symptoms, and preventive practices. This supports assertions in the literature that the media serves as an important channel for disseminating public health information. However, the findings also indicate that exposure alone is insufficient to guarantee positive health behaviour. Some respondents perceived certain media messages as judgmental or fear-inducing, which reduced their effectiveness and discouraged engagement. This underscores the importance of message tone, language, and delivery in health communication.

5.4 Gender Differences in Media Influence

A central focus of the study was the role of gender in shaping responsiveness to media health messages. The findings indicate that females were more likely to feel encouraged and supported by media messages related to health, while males were more likely to feel judged or less motivated**.** These results are consistent with gender theories that suggest men often internalise norms of toughness and independence, which discourage vulnerability and help-seeking behaviour.

The findings reinforce existing evidence that gender norms strongly mediate health-seeking behaviour. Media messages that do not adequately consider these norms may unintentionally alienate male audiences. This highlights the need for gender-sensitive health communication strategies that recognise and address the distinct ways in which men and women interpret and respond to health information.

5.5 Health-Seeking Behaviour Among Youth

The study revealed a moderate tendency among youths to seek formal healthcare services. While many respondents expressed willingness to visit a clinic or hospital when ill, actual behaviour was often influenced by several barriers. Cost, self-assessment of illness severity, and fear of being judged emerged as key factors contributing to delayed healthcare utilisation.

The observed level of delay, reflected by a mean score of approximately 2.54, is concerning, as it suggests that a substantial proportion of youths postpone seeking medical attention until their condition becomes severe. This finding aligns with existing literature indicating that young adults often underestimate health risks and prioritize convenience, time, or financial considerations over early intervention.

5.6 Influence of Media on Health-Seeking Behaviour

The findings demonstrate a clear association between media influence and health-seeking behaviour. Media messages that were clear, relatable, and supportive increased the likelihood of formal healthcare utilization. In contrast, messages perceived as judgmental or fear-based discouraged care-seeking. This dual effect supports the study's conceptual framework, which recognizes media influence as both potentially promotive and deterrent.

The gendered differences observed further illustrate how social identity and expectations influence message interpretation. These findings emphasize the importance of designing health communication strategies that are not only informative but also empathetic and inclusive.

6.0 Conclusion

This study examined the influence of media exposure and gender differences on health-seeking behaviour among youths. The findings indicate that media plays a significant but complex role in shaping youth health behaviour. While exposure to health information can enhance understanding and encourage positive behaviour, poorly framed messages may reinforce fear and avoidance. Gender emerged as a critical determinant, with females showing more positive responses to health messages and males exhibiting greater resistance and delay in seeking care. Although youths generally value formal healthcare, delays in utilisation remain common.

7.0 Recommendations

7.1 For Health Communicators and Media Agencies

Health communicators should adopt positive, non-judgmental messaging that encourages help-seeking without inducing fear. Social media platforms should be deliberately leveraged, given their popularity

among youths. Gender-sensitive framing should be incorporated to ensure that messages resonate with both males and females without reinforcing stigma.

7.2 For Health Institutions and Policy Makers

Health institutions should increase access to youth-friendly services and reduce cost-related barriers through subsidies or insurance schemes. Policymakers should foster partnerships between health agencies and media organisations to deliver coordinated and consistent public health campaigns.

7.3 For Academic and Future Researchers

Future studies should use larger and more diverse samples and adopt mixed-method approaches to gain deeper insights into youth health behaviour. Further research may also compare the influence of specific media platforms such as TikTok, Facebook, and radio.

7.4 Limitations of the Study

The study relied on self-reported data, which may be subject to bias. The sample was geographically limited and may not fully represent all youths. Additionally, the number of validated Likert items was fewer than originally intended, which limited some comparative analyses.

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APPENDIX 1.0

QUESTIONNAIRE

SECTION A: Demography and Profile

A1. What is your age?
☐ 18–22 years
☐ 23–27 years
☐ 28–32 years
☐ 33–35 years

A2. Gender
☐Male
☐Female
☐Other (Please specify):

A3. Area of Residence

A4. Highest Education
☐SHS
☐Tertiary
☐Postgraduate
☐Other

A5. Employment Status
☐Student
☐Employed
☐Self-employed
☐Unemployed

A6. Self-Perceived Health Status
☐Excellent
☐Very Good
☐Good
☐Fair
☐Poor

A7. Average Monthly Income
Less than GHS 2000
GHS 2000 - 5000
More than GHS 5000

SECTION B: Media Access, Frequency, and Trust
B1: Access and Frequency (Check all that apply, then rate frequency)

Media Platform	**Do you have access? (Yes/No)**	**How often do you use it for any purpose? (1 = Never to 5 = Very Often)**
Traditional Radio	☐ Yes ☐ No	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Television	☐ Yes ☐ No	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Social Media (e.g., Facebook, TikTok, Instagram)	☐ Yes ☐ No	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
News Websites/Apps	☐ Yes ☐ No	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Informal Channels (e.g., Friends, Family, Peer Chat Groups)	☐ Yes ☐ No	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

B2: Media Trust (Likert Scale: 1 = Strongly Distrust to 5 = Strongly Trust)

I trust health information from Government media campaigns.
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

I trust health information shared by **social media influencers/celebrities**.
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

I trust health information from a **doctor or health expert interviewed on TV/Radio**.
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

I believe the health information I see in the media is **accurate and truthful**.
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

SECTION C: Health-Seeking Behavior and Gender Disparities
C1: Health-Seeking Behavior (Likert Scale: 1 = Strongly Disagree to 5 = Strongly Agree)

When I feel sick, I **always** seek care from a clinic or hospital (Formal Care).
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

I sometimes use **traditional remedies or herbal medicine** first before going to a clinic (Informal

Care).
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
I delay seeking healthcare until my illness becomes **severe** (Delaying behavior).
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

I am **less likely** to seek help for **mental health issues** than physical health issues.
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

C2: Gender Norms and Stigma (Likert Scale: 1 = Strongly Disagree to 5 = Strongly Agree)

Men in my community are discouraged from talking about their health problems.
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

My decision to seek health care is often influenced by my **partner or family**.
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

The need for me to manage household or work duties causes me to **delay seeking care**.
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

SECTION D: Media as Catalyst or Barrier
D1: Influence and Interpretation (Likert Scale: 1 = Strongly Disagree to 5 = Strongly Agree)
Media health campaigns are mainly targeted at the opposite gender.
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

I have sought health advice or visited a facility because of a specific message I saw in the media (Catalyst).
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Some health messages in the media make me feel anxious or judged, making me avoid seeking care (Barrier).
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Media messages about health services often make them seem too expensive or complex (Barrier)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Media helps me understand where and how to access health services in Accra.
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

SECTION E

- Can you describe a specific time you, or someone close to you (a male/female friend), chose not to seek formal medical help for a sickness? What were the main reasons for this decision?" (Probes for gendered barriers/stigma and the decision-making process).

- Think about the most recent health campaign you saw (e.g., COVID, HIV, Malaria). Did this message make you more or less likely to seek care? Please explain how it made you feel and what you did as a result." (Probes for the mechanism of influence/process of change).

- Describe the characteristics of a health message that would make you immediately distrust it. Conversely, what makes a health message on social media feel trustworthy to you?" (Probes for interpretation and specific factors influencing trust).

- In your opinion, do mass media health messages in Accra tend to speak more effectively to young men or young women? Please give an example and explain why." (Probes for perceived targeting and differential impact).