UNIVERSITY OF CAPE COAST

DETERMINANTS OF PSYCHOLOGICAL HEALTH-SEEKING BEHAVIOUR AMONG PUBLIC UNIVERSITY STUDENTS IN GHANA

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LOCUS OF CONTROL, STIGMA AND CULTURE AS DETERMINANTS OF PSYCHOLOGICAL HEALTH-SEEKING BEHAVIOUR AMONG PUBLIC UNIVERSITY STUDENTS IN GHANA

BY

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Thesis submitted to the Department of Guidance and Counselling of the Faculty of Educational Foundations, College of Education Studies, University of Cape Coast, in partial fulfilment of the requirements for the award of Doctor of Philosophy degree in Guidance and Counselling

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DECLARATION

Candidate's Declaration

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

Candidate's Signature …… Date:……..

Name: Patience Araba Mba

Supervisors' Declaration

We hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

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

Name: Prof. Eric Nyarko-Sampson

Co-Supervisor's Signature …… Date ……..

Name: Prof. Joshua A. Omotosho

ABSTRACT

This study examined determinants of psychological health-seeking behaviour among students of selected public universities in Ghana. Specifically, the study investigated whether locus of control, stigma and culture have effects on the health-seeking behaviour of the respondents. The target population comprised 5,369 regular undergraduate students in four public universities in Ghana: University of Professional Studies, Accra (UPSA), Kwame Nkrumah University of Science and Technology (KNUST), University for Development Studies (UDS) and University of Cape Coast (UCC). A sample of 588 respondents was selected from the four public universities for the study which adopted the mixed methods research design, employed questionnaire and interview for data collection. Locus of control, stigma, culture and attitudes towards seeking professional psychological help short form (ATSPPHS-SF) scales were employed to explore the relationship between health-seeking behaviour and locus of control, stigmatization and culture. The independent t-test, ANOVA and the Structural Equation Model were the statistical tools for the data analysis, whilst the software packages for data analysis, editing, coding and computation was the Statistical Product and Service Solution (SPSS version 20). Findings revealed that age and gender have no significant influence on the health-seeking behaviour of the students, but geographical location has a significant effect. Also, each of the three independent variables (locus of control, stigmatisation and culture) significantly predicted the health-seeking behaviour of the respondents. These findings call for counsellors to focus on anti-stigma campaigns, while paying critical attention to the cultural orientation and the personality profiles of their clients.

KEYWORDS

Culture

Health-seeking behaviour

Locus of control

Psychological health

Stigmatization

Structural equation model (SEM)

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DEDICATION

To my family whose encouragements and companionship I have always enjoyed.

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CHAPTER ONE

INTRODUCTION

The health of university students is very paramount for their educational endeavours because students need to be very healthy in order to meet up with the pressures from their academic activities. Their intention to seek for help, and their choice of health care in times of challenges, whether formal or informal, are also very important to consider, as these have a bearing on their overall well-being. The essence of this research, therefore, is to examine the health-seeking behaviour of students in Ghanaian public universities and also determine which factors (e.g., stigma and culture) affect their choice of health care.

Background to the Study

Any action undertaken by individuals perceived to have some health condition(s) to solve their health problem constitutes a health-seeking behaviour (Wade & Halligan, 2004). Health-seeking behaviour is a conscious attempt made by ailing individuals to seek medical assistance from other people (Rickwood, Deane, Wilson, & Ciarrochi, 2005). This conscious effort involves interpersonal communication with other people towards soliciting advice or important health information. Thus, health-seeking behaviour thrives on interpersonal skills (Rickwood et al., 2005).

People hardly seek psychological assistance and services. This is true even among people with psychological disorders (Rickwood & Braithwaite, 1994). Many factors have been identified for people's failure to solicit

psychological assistance. For example, it has been reported that people fear to disclose their emotions to others. Again, cultural factors have been reported as serving as barriers to people's attempt to seek psychological help (Barwick et al., 2009; Rickwood & Braithwaite, 1994; Tata & Leong, 1994; Vogel & Wester, 2003).

Sources of psychological help vary depending on a number of factors. Principal among such factors is the person's stage of lifespan (Rickwood et al., 2005). For example, one may solicit assistance from friends when the need arises (Bee, 1994). However, professionals provide the best assistance (McLennan, 1991). This is because some problems can best be handled by professionals rather than by family and friends (Setiawan, 2006).

Previous studies on health-seeking behaviour reveal some patterns. In the first place, there is evidence from studies in Australia that compared to the elderly, young people hesitate from seeking professional assistance when they face psychological and educational problems (Sawyer, Kosky, Graetz, Arney, Zubrick & Baghurst, 2000; Zubrick, Silburn, Garton, Burton, Dalby et al, 1995). On the converse, majority of young people first solicit assistance from informal sources before turning to professional ones (Boldero & Fallon, 1995), with the minority seeking professional assistance (Alonso et al., 2004).

Also, young people consider their friends, rather than their parents, as the first source of emotional help (Boldero & Fallon, 1995; Schonert-Reichl & Muller, 1996). Also, it has been revealed that the likelihood of help-seeking is higher among females than among males who suffer mental health issues, though this varies according to the nature of help (Boldero & Fallon, 1995; Rickwood & Braithwaite, 1994). Generally, males would like to keep their

problems to themselves or deny the existence of psychological problems (Offer, Howard, Schonert & Ostrov, 1991).

Finally, whether or not an individual will seek help depends on the nature of the health problem, and the sources consulted for assistance also depend on the kind of problem faced. For example, people prefer talking about their relationship issues with friends (Boldero & Fallon, 1995). It has also been revealed that while young people frequently contact their friends and family on their psychological issues, they hardly get the assistance they require (Offer, Howard, Schonert & Ostrov, 1991). Even when they get assistance from their unprofessional sources (family and friends), it is uncertain whether such assistance is helpful in dealing with the psychological problems. On the contrary, professional assistance has been proven useful in offsetting psychological health problems including suicidal tendencies among people (Greenberg, Domitrovich & Bumbarger, 2001; Rudd, Rajab, Orman, Stulman, Joiner, & Dixon, 1996).

Stigma (public stigma and self-stigma) has been reported as the most common barrier to help-seeking (Corrigan, 2004; Vogel, Gentile, & Kaplan, 2009). Public stigma involves discriminatory societal attitudes towards some illnesses, while the internalization of stigma that results in low self-esteem is termed as self-stigma (Corrigan, 2004). Because of stigma, people who have mental health problems often suffer discrimination in society (Corrigan, 2004; Corrigan & Penn, 1999; Masuda & Latzman, 2011), which results in negative help-seeking attitudes (Leong & Zachar, 1999) especially among people with suicidal thoughts (Batterham, Calear & Christensen, 2013).

Certain aspects of culture also determine whether or not people will seek health services. Culture, in itself, involves a wide range of elements pertaining to the language, religion, music, etc. of a group of people (Alvesson & Sveningsson, 2008; Randall, 2004; Zimmermann, 2017). All of these elements can influence people's willingness to seek health assistance. In terms of religion, people's religious beliefs influence not only the decision to seek help but also the types of healers (whether faith healers of modern healers) they consult when they are ill (Kasl, 1996; Subedi, 2009; Twumasi, 2005). For example, when people believe that their illnesses are caused by spiritual forces, they are likely to seek spiritual solutions to such illnesses. This implies that people conceptualize and explain various illnesses within the context of their specific religious beliefs (Arnault, 2009). In Africa, religion constitutes an indispensable aspect of culture such that religion permeates all facets of life (Abotchie, 1997). Traditional Africans hold strong religious beliefs that influence their help-seeking behaviours. For example, they believe that some illnesses can be caused by malevolent spiritual forces such as witches and sorcerers (Odejide & Oyewumi, 1989).

The perception and beliefs people have about what determines the state of their health constitutes Health Locus of Control (HLC) (Bane, Hughes, & McElnay, 2006). It is often considered from the perspective of social learning theory (Rotter, 1954). Locus of control (LOC) has been generally conceptualised as either external or internal. However, recent studies have categorized it into three: Internal LOC, Powerful Others LOC, and Chance LOC (Wallston, Wallston, Kaplan & Maides, 1976). Extant literature shows that internal locus of control is associated with health information seeking

behaviour and whether or not people will adhere to medical recommendations, especially in cases of hypertension (Norman, Bennett, Smith & Murphy, 2008) and weight reduction (Colditz et al., 1990). On the other hand, smoking has also been reported as a correlate of internal locus of control by other previous studies (Schnoll et al., 2004), though this finding disagrees with the postulations of some theories on health and risk behaviours (Hashimoto & Fukuhara, 2004).

A number of socio-demographic features have also been reported as having associations with health information seeking. These include educational level (Carlsson, Waters, Waters & Carlsson, 2000; Gollop, 1997; Wilkinson, Dyke, Jatlow, Barash & Bych, 1980) and place of residence (Njoku, 2004). For example, studies have shown that people with a high level of education are more likely to access health information (Carlsson et al., 1997; Wilkinson et al., 1980), while rural residents are also more likely to rely on family and friends for health information (Njoku, 2004). In America, Lachman and Weaver (1998) used socio-economic status to assess the health of Americans. The study confirmed that residents of poorer households are more likely to suffer from depressive symptoms.

In the context of Uganda, Ikoja-Odongo and Ocholla (2004) have recommended the need for health communication channels to be grounded in oral tradition and indigenous knowledge so as to meet the information needs of poor, rural residents. Similar recommendations have been made in other studies (e.g., Alemna & Sam, 2006). The population of developing countries including Ghana is made up of rural and urban dwellers that have difference in attitudes and behaviour towards psychological health-seeking.

In Ghana, a study conducted by Russell (2008) has revealed cost as a significant determinant of health-seeking behaviour. In the study, the cost involved the amount spent on medical care, as well as indirect costs such as those related to transportation and time spent at the health facility. Russel specifically revealed that a journey to a health facility drains a significant part of the monthly income of people in rural areas (Van den Boom, Middleton, Calder & Miller, 2004). This shows that cost is an important factor affecting health-seeking behaviour of rural Ghanaians.

Statement of the Problem

Globally, mental health cases among young adults in contemporary times are on the ascendency. For example, Zivin, Eisenberg, Gollust and Golberstein (2009) found one-third of university students to be experiencing mental health problems. Besides, a survey across 26,000 undergraduate students in the USA revealed that 18% of them were undergoing serious mental illness and suicidal ideation (Drum, Brownson, Denmark & Smith, 2009).

Studies point to the fact that Ghanaian university students also suffer from a lot of psychological issues such as suicidal ideation, stress, depression, and anxiety. With respect to suicide, for instance, the Kintampo Health Research Centre (2019) revealed reports of suicide cases among two young female university students in Ghana in 2019. In addition, the study of Atindanbila and Banyem (2011) showed that all students who participated in the study encountered equal numbers of stressors irrespective of their gender, level of education, and residential status.

Studies on depression and anxiety have shown varying results. For instance, the study of Asante and Andoh (2015), which focused on depressive symptoms among university students in Ghana, revealed varying levels of depression among the studied population. Again, anxiety and depression were seen to be prevalent among Ghanaian university students in a study conducted by Kugbey, Osei-Boadi and Atefoe (2015). Bettmann, Prince, Hardy and Dwumah's (2019) study showed that compared with the U.S. counterparts, Ghanaian students reported less general distress related to anxiety and depression. From the foregoing, it has been established that students in the university go through a lot of psychological challenges and this may warrant them to find appropriate remedy to these problems.

Even though university students go through a lot of psychological distresses, their attitude towards psychological health-seeking such as counselling is very poor despite the fact that they have counselling facilities at their disposal on their campuses. A study conducted by Joseph and Edward (2020) portrayed that despite the availability of guidance and counselling services at the various Colleges of Education in Ghana, the students still exhibit a lukewarm attitude towards assessing those services. As a professional counsellor, the researcher sought to explore on some of the barriers hindering students from seeking help in times of psychological difficulties.

Consequently, students have started seeking for help in the various health facilities in Ghana (Ministry of Health, 2013). Students receive a wide range of psychological services, including counselling and social support (Ministry of Health, 2013). This report strongly suggests a high prevalence of

psychological issues among young adults. Risk factors associated with young adults' psychological woes include poverty, drug abuse, etc. (Eisenberg, Golberstein & Hunt, 2009).

From an empirical perspective, a number of authors have examined health-seeking behaviours of students in Ghana. Some of these studies considered samples suffering from a particular health condition such as cardiovascular disorders (Sarfo, 2015) and schistosomiasis-related symptoms (Danso-Appiah et al., 2010). These conditions used in the two studies were purely medical but the current study tends to focus specifically on psychological health-seeking behaviour. With respect to samples, the two studies utilized samples which were not students but rather patients and indigenes in some villages. However, this current study made use of students in order to obtain data on the psychological health-seeking behaviour of educated individuals. Another related study by Boafo (2013) focused on respondents from Accra College of Education only, but this current study has been expanded to cover the northern, middle and southern belts of Ghana. Again, while Mba (2015) focused on locus of control and psychological health-seeking behaviour among Ghanaian youth, this current study has broadened the scope to include stigma and culture as possible determinants.

Stigma affects the health-seeking behaviour of university students, as evidenced in the work done by Andoh, Asante and Osafo (2015). However, Andoh, Asante and Osafo's (2015) study focused on a single university, which presents a limitation. This study widened the scope of the previous study by using a population from four different universities in Ghana, and has expanded

on stigma to include other health-seeking determinants such as locus of control and culture.

Sarfo (2015) established from his studies that cultural belief systems significantly influenced the health-seeking behaviour of his respondents, but the current study explored the degree of cultural influence on the psychological health-seeking behaviour of university students in four different regions in Ghana. From the foregoing, it can be established that the current study filled gaps that exist in literature on health-seeking behaviour of university students considering the variables used, methodology and the geographical location of the study sites, hence the study.

Purpose of the Study

The purpose of the study was to find out the extent to which stigmatization, locus of control and culture determine the health-seeking behaviour of university students in Ghana. Given the above-mentioned context on which the present study was predicated, the objectives of the study were to:

1. examine the extent to which a demographic variable such as age impacts on the health-seeking behaviour of public university students in Ghana.
2. examine the extent to which a gender impacts on the health-seeking behaviour of public university students in Ghana
3. examine the extent to which geographical location impacts on the health-seeking behaviour of public university students in Ghana
4. examine the extent to which locus of control, stigma and culture are determinants of psychological health-seeking behaviour of public university students in Ghana.

5. investigate how locus of control affects the psychological health-seeking behaviour of the public university students in Ghana
6. explore the extent to which stigmatization affects the psychological health-seeking behaviour of public university students in Ghana
7. examine how culture affects the psychological health-seeking behaviour of public university students in Ghana

Research Questions

1. How does culture affect your psychological health-seeking behaviour?
2. How does stigmatization affect your psychological health-seeking behaviour?
3. How does the ability to control your destiny affect your psychological health-seeking behaviour?

Hypotheses

The following hypotheses were generated to guide the conduct of the study:

$H_0 1$: There is no statistically significant gender difference in the psychological health-seeking behaviour of public university students.

$H_A 1$: There is statistically significant gender difference in the psychological health-seeking behaviour of public university students.

$H_0 2$: There is no statistically significant geographical difference in the psychological health-seeking behaviour of public university students.

$H_A 2$: There is a statistically significant geographical difference in the psychological health-seeking behaviour of public university students.

$H_0 3$: There is no statistically significant age difference in the psychological health-seeking behaviour of public university students.

H_A3: There is a statistically significant age difference in the psychological health-seeking behaviour of public university students.

H_04: Locus of control, stigmatization and culture will not statistically significantly predict public university students' psychological health-seeking behaviour.

H_A4: Locus of control, stigmatization and culture will statistically significantly predict public university students' psychological health-seeking behaviour.

Significance of the Study

The study sought to address the research gap in psychological health-seeking behaviour. It therefore provided critical information about how innate personality preference such as locus of control is related to psychological health-seeking behaviours. Stigma and culture have effects on the psychological health outcome of university students. Such a study will help in advocating for more anti-stigma campaigns in order to encourage students to access the psychological services available to them on their campuses. Mental health professionals and general health care providers would also appreciate the essence of delving into the cultural background of their clients and patients before designing an appropriate psychological intervention that best addresses their health care needs. Results from the research could be used to advance psychological health programmes and initiatives which have a more profound impact on the long-term health pattern of university students.

Psychological health care providers understanding of psychological health behaviour of university students could also open important avenues for modern psychological interventions. For example, psychological health behaviour of students that is linked to "powerful others" health beliefs might

be of interest for health campaigns. A study of this kind will be very beneficial for counsellors and psychologists. This is because the need to research into variables that influence psychological health, specifically locus of control, stigma and culture will help determine their influence on mental health and guide treatment planning, thus improving on its effectiveness. Also, counselling centres in some universities routinely organize programmes that focus on health-promotion and risk-taking behaviours such as stress and anger management, time management, addiction and alcohol use in an effort to educate the students on mental health issues. It is, therefore, very important to discover the relationship between these variables and the health-seeking behaviour of university students in order to develop a more effective intervention for this population. University students access information on their psychological healthcare online, therefore findings from such a study will be very useful in designing software programmes and packages that would be more appropriate and useful to the students. Lastly, the study would serve as a source of literature and open the door for more research in this area.

Delimitations

The study focused on locus of control, stigma and culture as independent variables, and health-seeking behaviour as dependent variables. It also focused on some demographic characteristics such as age, gender and geographical location as factors that affect the health-seeking behaviour of university students.

The study also focused only on undergraduate students who were in the age range of 18 to 30 years and above. Consequently, postgraduate

students who fell within the age brackets ranging from 18 years to 30 years and above were exempted.

Four of the universities namely: university of Professional Studies, University of Cape Coast, Kwame Nkrumah University of Science and Technology and University for Development Studies were selected for the study. The chosen universities cover the entire areas of origins of the country; the coastal belt, forest zone and savannah area. These universities were chosen because they have accommodation facilities and as a result attract students with various demographic characteristics across the country.

Limitation of the Study

One of the limitations of this study was that the instruments for data collection were questionnaires and response biases could not be ruled out completely. Questionnaires do not provide the opportunity to collect additional information through probing, prompting and clarification of questions while they are being completed. This is to say the issues may not be well explained as expected. To minimise this, the questions were carefully worded and explained to the respondents. The descriptive survey design which was employed in the work, might also limit the findings of the study. This was because the phenomenon under study could change over a period of time and this could affect the internal validity of the research. To minimise this phenomenon, the study was carried out within the stipulated time so the findings reflected what pertained on the grounds.

This work did not consider the socioeconomic status of the parents of the university students which is a crucial variable that can help in determining the health-seeking behaviour of the respondents. Due to the COVID 19, the

questionnaires were administered online, and it was possible that not all the students were from the Accounting Departments of the various universities. Also, the study did not include students from private universities who also form part of the university students' population in Ghana, and this could limit the generalizability of the results.

By collecting data online, response rates could mostly be very poor and this can affect the validity of the study. To cater for this, 5 Ghana cedis worth of talk time was provided for all participants to encourage their full participation. It was also known that repeated requests by researchers to complete online survey could be perceived by participants as annoying and therefore backfire against the research. To check this, research assistants did not frequently contact participants to fill their questionnaires but rather stressed on the deadlines and the need to complete the survey.

Operational Definition of Terms

Psychological Health-Seeking: This concerns the extent of public university students' inclination to engage the expertise or facilities of a counsellor or a psychotherapist whenever they encounter academic, occupational, health, etc. issues.

Stigma: This concerns the display of some attitudes, behaviour or action intended to show that someone else is worthy of shame or condemnation.

Culture: Culture involves the common ways of doing things among a group of individuals such as students, which results from their common customs, knowledge, beliefs, etc.

Locus of Control: The psychological concept of locus of control refers to the extent to which individuals like students attribute the power or ability to

control their situations or experiences either to themselves or to an external force.

Geographical Location: For the purpose of this study, geographical location refers to the place of residence of the respondents during vacation, be it rural or urban.

Age Range

18-24 years: This age range represents students who are young adults

25-29 years: This age range represents students who are adults

30 and above: This age range represents students considered to be matured

Organisation of the Study

This thesis is organized into five chapters. The first chapter covered the background to the study, the statement of the problem, purpose of the study, research questions, hypotheses, significance of the study, delimitations and limitations of the study and operational definitions of important terms. Chapter two focused on the review of related literature on the concept of health-seeking behaviour, locus of control, stigma culture, the theoretical and conceptual frameworks of the study and some factors that affect the health-seeking behaviour of students. Chapter Three described the methodology for the study which covered the research paradigm, research design, study area, population, sampling procedures, data collection instruments, validity and reliability, ethical considerations, data collection procedures and data processing and analysis. The fourth chapter of the study concentrated on the results and discussions from the findings. Chapter five presented the summary, conclusions and recommendations made to the study. The chapter

concluded with the contributions of the study to knowledge and suggestions for further research.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter is in three sections namely theoretical, empirical and conceptual reviews. The first part examines some of the existing theories on health-seeking behaviour to form the theoretical framework for the study. The next section of this chapter reviews available studies related to health-seeking behaviour taking into account issues of stigmatization, locus of control, cultural beliefs and demographic variables with health-seeking behaviour. The final section examines some concepts in relation the study, whilst the chapter concludes with the summary of the literature.

Theoretical Framework

This study is predicated on four main theories to explain health-seeking behaviour. These theories are the Health Belief Model (Hochbaum, 1958), Theory of Planned Behaviour (Ajzen, 1991), Social Interactionist Theory of Stigma (Goffman, 1963) and Attribution Theory (Heilder, 1958).

Health Belief Model (HMB)

The Health Belief Model (HBM) was originally developed in the 1950s by Hochbaum. The model was originally developed to offer explanations to people's failure to get themselves involved in public health programs (Janz, Champion & Strecher, 2002). However, subsequent years have seen the utilisation of the model in designing public health interventions to boost adherence to preventive measures (Janz et al., 2002). In this model,

health decisions are presented in stages and variables that affect health action are also presented. However, the model fails to provide exact description of the operation of these variables. The model assumes that people's preventive behaviours are contingent on the cost and benefits of such behaviours. In the model, perception is categorised into types, which are discussed in the next sub-sections.

Perceived Susceptibility: This is an individual's way of judging his/her risks of being easily influenced by a condition. It deliberates more on one's chances of contracting the disease, and one begins to ask questions that depicts their chances of getting affected by the condition. This condition makes the individual to take precautionary measures and avoid the risk of getting trapped by the disease. A client who suspects he has the tendency of being affected by a health condition such as drug addiction will now begin to project into the future consequences of the influence of the addiction on him.

Perceived Seriousness of the Condition: This explains the individual's perception about the severe nature of the condition such as the health consequences, impairment, pain or even death in extreme cases. It must be noted that these consequences can have an effect on the person's way of living, such as education, relationships and all other social lives of the person. A combination of perceived susceptibility and perceived seriousness gives rise to perceived threat, which is a cognitive entity mostly influenced by information. Perceived threat always takes actions based on pressure, and it does not necessarily determine the reaction of the person.

Perceived Benefits of an Action: This stage explains an action that a person will take when he finds himself in a difficult health situation. In such

circumstances, the person now begins to ponder over behaviours that will be effective in reducing the health risk, as well as other alternative solutions which also have health benefits. It is interesting to note that a person's belief system, and social and cultural perception affect his or her health care choices. The perceived benefits and the value that a person relates with the consequences is likely to impact on the psychological health-seeking behaviour. To cite an example, a university student who finds herself entangled with relationship issues will begin to assess the situation and find out possible options she will resort to, with their associated benefits in order to come out from that entanglement.

Perceived Barriers to Action: After the person has identified some possible solutions and the benefits that he or she will derive from those solutions, he or she may be associated with some challenges. These challenges may include the cost, barriers, expense, pain or embarrassments (Maguen, Armistead & Kalichman, 2000). The balance between benefits and cost may inform the possibility of the person making choices on a more preferred course of action. In the long run, if the benefits are closely balanced against the costs, the person may sway unsteadily from one side to the other probably due to anxiety.

A Stimulus or Cue to Action: The final input in the HBM is the stimulus to elicit an action. Once a person senses a more rewarding action to take, some changes occur when external influences such as a change in health, doctor's advice or death of a loved one trigger an action. According to Rosenstock (1974), the range of signals needed to initiate an action is influenced by the motivation for the change and the cost-benefit ratio of the action. While the

relevance of clues has been noted by Hochbaum (1958), there is still a dearth of literature on clues.

The health belief model has been chosen as a theoretical component of this present study because it is closely linked with health-seeking behaviour. University students experience a lot of psychological problems, and they are more likely to seek professional psychological help when they realize that the health condition is becoming more serious and threatening. They have access to both medical and psychological healthcare free of charge. This notwithstanding, the individual's perception of the benefit he or she will derive from going to the hospital or visiting the counselling unit depends on each student. The physical symptoms of the illness may attract the attention of their close friends or significant others such as lecturers, who will now be putting pressure on them to go for professional healthcare. These interferences from friends and significant others are very crucial for the student to take a decision on his or her health. Also, the individual's internal motivation, as defined by his personality status and demographic characteristics such as age, ethnic background, culture and religion, may influence his or her health-seeking behaviour.

The Theory of Planned Behaviour (TPB)

The theory of planned behaviour originated from the theory of reasoned action (TRA), whose purpose was to predict an individual's intention to participate in a particular behaviour at a specific spatio-temporal context. This theory seeks to create a link between one's beliefs and his intention to seek health during difficult times. The theory was originally developed from the field of social psychology by Ajzen (1991), and it argues that our

intentions or mind-set about an ill health is the most crucial predictor of a person's behaviour. In furtherance, the theory explains that the aggregate of some three elements forms the intention to take an action: the person's attitude towards performing the behaviour, prevailing subjective norms and the perceived behavioural controls on the individual (Ajzen, 1991).

From the theory, before people exhibit an attitude towards their own behaviour, they consider the extent to which an evaluation is made towards the behaviour, favourable or unfavourable (Ajzen, 1991). On the contrary, subjective norms refer to the opinion about social demands in relation to whether the action was performed or not, whilst perceived behavioural control (PBC) refers to the perception people have about the performance, whether with ease or some level of difficulty.

Ajzen further explained that the individual's intentions to perform a behaviour under consideration increases as long as there are more acceptable attitudes and subjective norms towards the behaviour and a greater perception of behavioural control on the part of the individual. In conjunction with the TPB, health-seeking model is based on intentions as a mediator to seek for healthcare, and this implies that the stronger one's intentions to seek help, the more likely will they consult professionals or significant others in times of health needs, being it medical or psychological. The TPB has a bearing on health-seeking behaviour because it places much emphasis on one's intention as a predictor or mediator of behaviour. For students experiencing psychological disorders to make a decision to seek help, first of all they must conceptualize it in their minds, and this will ignite them to take an action towards addressing their psychological health needs.

The TPB is multifaceted, and this has permitted researchers to assess different factors affecting individuals' behaviour. The theory postulates that positive attitudes, subjective norms and higher perceived behavioural control improve the level of intention to get involved in a particular health behaviour. Therefore, in order for students to make a decision about whether to visit the counselling unit to access its services or not, these three main factors are considered by the individual: their attitudes toward counselling services, their significant others' (such as friends, lecturers, relatives) agreement or disagreement about their help-seeking behaviour, and their time, available sources, etc. The individual is influenced by their priorities, and the most preferred in their options affect their decision. Hence, if a student has a good attitude towards counselling or psychotherapy and she has the ability to manage her resources but her parents do not consent to her seeking for psychological help, she will be discouraged, and this will affect her. She may end up not accessing the services at all if parental approval is her priority.

Various researchers have applied the theory of reasoned action (TRA) and the theory of planned behaviour (TPB) to scrutinize human psychological help-seeking behaviours (Aguirre, 2012; Chebbet, 2012; Hartong, 2011; Roldan, 2013). Therefore, in a similar vein, the Theory of Planned Behaviour was applied for the present study because of the bearing that it has on the health-seeking behaviour of an individual.

Social Interactionist Theory of stigma

Sometimes, people with mental illness are seen in negative ways because of their predicaments. People are tempted to discriminate against them on the basis of the health status, thus discriminating against them.

Discrimination can make such people feel inferior, thus, making them to stick to themselves and discouraging them from seeking help from mental health professionals. Goffman's provided a conceptual framework on social interactionist theory to explain the concept of stigma.

According to Goffman (1963), stigma is a very untrustworthy attribute, and people with labels are treated differently from others. The person also feels an inner sense of inferiority, which is caused by an undesirable difference between his virtual social identity (what the society expects of him/her) and his actual identity (the actual composition of the person). Therefore, stigma can make people less popular and different from those without stigma (Goffman, 1963). The theory also explains that stigma arises when there is a sense of inferiority due to failure to achieve social expectations.

Even though a normal interaction between a normal person and one who is stigmatized can occur at any time and place, Goffman laid more emphasis on 'mixed contacts' which is the immediate social contact of both the normal and stigmatized in the same social situation. When this happens, both persons are expected to adjust their lives to ensure peaceful co-existence, but in such circumstances, it is usually the stigmatised person that adjusts. This can happen in a variety of ways, such as avoiding the fear and anxiety caused by the rejection of the stigmatized person by ordinary people, thereby avoiding social interaction.

Mixed social interaction will cause anxiety between the two. Normal people's anxiety is to avoid any interaction with the stigmatized person. On the other hand, the stigmatized person will also experience a certain degree of

anxiety in an attempt to respond to ostracism. This results in classification, in which the stigmatized person is considered to be better or worse than his or her current state, or is completely ignored.

Goffman (1963) still maintained that stigma is a mark from the public, a reality which can be identified with ease by the rest of the society, and which ends up leaving an individual with a 'spoiled identity'. It creates a notion that one is imperfect within his given societal norms. The recognition of his spoiled identity clarifies that the stigma comprises a universal attribute about being bad. Lewis and Appleby (1998) explain that the spoiled identity describes the result of a certain condition or behaviour. Therefore, the stigma reflects the humiliating identity of the destroyed, making the same and the stigma more likely to reflect the unfortunate identity, regardless of the notion that the stigma is noticeable or not. Goffman's conceptualisation of stigma is more general, embracing different groups of people, such as ex-criminals, people with different sexual orientations, people with disabilities, etc. His stigma theory is often regarded as a social construction, paying more attention to the social interaction module and the way the concept works in it. He opines that:

> *The standards he (the person with stigma) has incorporated from the wider society equip him to be intimately alive to what others see as his failure; inevitably causing him to agree that he does indeed fall short of what he really ought to be. Shame becomes a central possibility, arising from the individual's perception of one of his own attributes as being defiling things to possess, and one he can readily see himself not possessing* (p. 7).

Stigma is based on the perceptions of others towards the stigmatised person. Stigmatisation is more evident when the stigmatised interacts with other people (mixed social contacts) (Lewis & Appleby, 1998). Stigma is,

therefore, a public mark or label which is significantly visible and marked by social interactions.

The concept of stigma is very crucial in this current study because it is a determinant that makes students to shy away from seeking psychological healthcare. The concept is all about social interactions, which are very common on campus. Students come together during lectures, seminars, church activities and so on, and any form of labelling will adversely affect a student's chain of interaction, resulting in a decline in his academic endeavours. This may make a student to coil into his/her shell and avoid social interactions on campus for fear of being stigmatized. Counselling units on some university campuses have recorded various forms of psychological problems among students, such as addiction, masturbation, drug abuse, relationship issues, and anxiety. Students with such problems, when stigmatized by their friends, may find life on campus very disturbing.

Stigma discourages students from going to their counselling units for help when the need arises. Students, therefore, confide in their friends when they have issues which need psychological attention. Only few students muster courage to break through and approach their counsellors for help, and even with that, they find it very difficult to divulge very sensitive information which will be very useful to their counsellors. Such information, when withheld, will not yield very good therapeutic results.

The Attribution Theory

The attribution theory offers explanation on people's explanation of the cause of a behaviour and events. The theory, for instance, tries to investigate the cause of people's annoyance. Here, the theory attempts to

explain whether the problem concerns the person's personality traits or an unfortunate occurrence. Attribution theory involves how social perceivers utilise information to explain the cause of events (Fiske & Taylor, 1991).

Heider (1958) was the first proponent of attribution psychology. His view is that people are like amateur psychologists who are trying to derive meaning from the actions of others by collecting special information about them until they can provide reasonable justifications for their actions (Harvey & Weary, 1985). Attribution theory explains how people depend on available information to explain the causes of events (Lewis & Daltroy, 1990). It processes and merges information to form causal judgments (Fiske & Taylor, 1991). It assumes that people often look for the reasons for their daily events (Weiner, 1980).

According to the theory, culture influences the decisions of individuals (Morris & Peng, 1994). Thus, the causes attributed to events are contingent on the cultural background of the people involved. African Americans have the tendency of explaining some sicknesses within the context of their religious/cultural beliefs (Gregg & Curry, 1994; Klonoff & Landrine, 1996). As a result, they may not send such illnesses to health centres or hospitals. Similarly, Africans tend to attribute mental problems to spiritual causes, which makes them seek help from spiritualists rather than health (Madge, 1998; Twumasi, 2005). This was evident in a study in Ethiopia (Mulatu, 2000).

In the present study, attribution theory is utilised to explain how people seek the causes or origin of their health issues in order to determine the appropriate treatment options. University students may want to know the origin or the cause of their psychological challenges, probably to be able to

explain it better to their counsellors for better therapeutic results, or to seek for other alternative health care from non-professionals, friends or relatives.

Conceptual Framework

The Concept of Health-seeking Behaviour

Health-seeking behaviour is a very broad concept which has several facets, and in order for one to comprehend the concept very well, it is very necessary that the various facets are discussed for easier understanding. As individuals there is the tendency for us to be faced with health challenges in our lifetime which will attract an intervention from a health facility. There are many such health care facilities such as the allopathic (general) and traditional or herbal medicine to healing through faith (Ahmed, Adams, Chowdhury & Bhuiya, 2000; Marsh, Mutemi, Muturi, Haaland et al., 1999; Ryan, 1998). The choice of a health care pattern basically depends on the type, timing and the quality of health service that one is seeking for or expects to receive, and this fact cannot be overlooked (Debas, Laxminarayan & Straus, 2006).

It is very certain that individuals with health challenges have a singular desire in common, and this is either to get better or totally healed from their illnesses. This notwithstanding, not all the health facilities offer the same degree of opportunities to help improve their patient's health condition. Some of the avenues may rather increase the severity of the illness or even lead to fatalities, in cases involving emergencies (Ruiz, 2010). It therefore becomes imperative for one to gain an insight into the factors that affect the health-seeking behaviours of individuals, in order to come out with intervention programs that will help health practitioners to improve upon their health care delivery.

Some Factors that Affect Health Responses

According to the World Health Organization (2017), worldwide, there are a lot of personal, socio-economic, and environmental factors which collectively affect people's health. While some of these factors relate to the biological and behavioural characteristics of the individual, others relate to policy-making (Healthy People, 2014). While biological factors cannot be altered, behavioural ones and those related to policy-making can be modified (Healthy People, 2014; World Health Organization, 2017).

According to Blazer and Hernandez (2006), some diseases, including cancer, result from biological factors traceable to the patient's family history. This means that certain individuals are more likely to suffer from such diseases. Specifically, these diseases are associated with biological and genetic factors such as sex, age, and ethnicity (Bortz, 2005; Phillips, 2005; Kimbro, Bzostek, Goldman & Rodriguez, 2008). For example, research shows that women, as compared to men, are more likely to suffer from breast cancer (Jemal, Siegel, Ward, Dao, Xu et al., 2008). Similarly, there is evidence that cases of heart disease are likely to be higher among the aged (Idris, Deepa, Fernando & Mohan, 2008), and the sickle cell disease is very common and popular among African Americans (Brousseau, Panepinto, Nimmer & Hoffman, 2010).

Greene (1984) is of the opinion that there are some human behaviours that can affect health and health outcomes. These behaviours, which include smoking and alcoholism, can be modified, and as such, are the focus and target of many public education programs (Cawley & Ruhm, 2011). Selivanova and Cramm (2014), for example, have revealed that smoking and

physical activity are significant determinants of health outcomes. In the study, it was revealed that smoking negatively affects health outcomes whereas fruit consumption has a positive effect on the health of individuals.

The quality of health service as well as access to the health service can also affect health and health outcomes. When the access to quality health service is very limited, it has the tendency of posing a setback to desirable health outcomes (Gulliford et al., 2002). Devoe, Baez, Angier, Krois, Edlund and Carney (2007) have underscored the need to deal with barriers that militate against access to quality healthcare. Other studies have also stressed the importance of quality medical care (Dayaratna, 2012; Turner & Roy, 2013). A study in Nigeria revealed that inaccessibility of quality healthcare among mothers increased the likelihood of infant mortality (Fadeyibi & De Wet, 2014).

Factors such as educational attainment, housing, sexual violence, poverty, unstable family conditions, and unemployment have been reported as correlates of health outcome (Braveman & Gottlieb, 2014; CDC, 2017; Pickett & Pearl 2001; WHO, 2008). This claim has even been made with respect to mental health, in particular (Fleitlich & Goodman, 2001). Blazer and Hernandez (2006) posit that there is a bidirectional relationship between social factors and health outcomes, indicating that social factors can have either a positive or negative effect on health outcomes. To cite an example, they explained that an individual who has recently been diagnosed of HIV may automatically lose his basis for social support because of the stigma associated with the virus, and at the same time, social networks can influence the way

people seek health by advising affected people on the types of health care to seek.

Stigmatisation and Health

Mental health patients all over the world are affected by stigma, which diminishes their life opportunities. Due to the fear of stigma, people with various conditions ignore effective treatment, which eventually worsens their conditions and also adds more burden to the society. The conceptualisation of stigma focuses on dimensions, such as the psychological and interpersonal social processes of mental health patients, as well as large-scale socio-political processes. These three dimensions serve as pathways through which stigma affects mental health patients (Yang, Kleinman & Morita, 2017). Stigmatisation of mental health patients leads to status loss and discrimination (Link, Struening, Neese-Todd, Asmussen & Phelan, 2001). It is, therefore, critical to assess the individual and structural effects of stigma, coupled with self-stigmatisation, on the help-seeking behaviour of mental health patients.

Any form of negative, differential behaviour or attitude an individual may display towards a member or members of a stigmatised group constitutes individual discrimination. On the other hand, structural discrimination results from unjust socio-political systems that negatively affect members of a stigmatised group (Link & Phelan, 2001; Pincus, 1996). With regard to self-stigmatisation, it occurs when a member of a stigmatised group internalises issues of stigmatization in his or her socio-political environment. Stigma itself is conceptualised as the contextual stereotypical judgement that an individual suffers from others (Bhugra & Cutter, 2001). Thus, stigma involves the social discrimination meted out to some individuals because of some social attributes

that they possess (Bhugra & Cutter, 2001). This implies that both the attributes and stigma are socio-cultural-constructs, which makes them negotiable.

In ancient Greece, stigma was conceptualised as bodily signs that was given negative meanings. Thus, based on stigma, some individuals were set apart from the majority and some negative attributes were attributed to such individuals. Those with stigma suffered rejection and discrimination in the society. People may, therefore, suffer stigma based on age, race, sexual inclinations, drug abuse, mental illness etc. Stigmatisation negatively affects target individuals or groups. Stigmatised individuals are considered to be outsiders of the society. Thus, such individuals suffer unacceptance or scapegoating from the society. In effect, stigmatisation affects the society's attitudes towards some illnesses, which, in turn, affects help-seeking behaviour of patients Bhugra & Cutter, (2001). Stigmatised individuals hardly get full acceptance from society. They suffer discrimination, which further has emotional, socio-economic and health implications on them.

Stigma also affects the treatment outcomes of mental health patients. Stigmatised individuals often delay in seeking medical help. This delay further intensifies the harshness they suffer at the hands of medical practitioners, especially when the delay deteriorates the health condition further. Stigma also makes patients nervous, especially when they are to undergo some therapeutic processes. On the other hand, mental health patients who are not stigmatised successfully go through medical therapies, which leads to effective treatment Hwang, (2016). Ensuring confidentiality also helps in the treatment of mental health patients (Hwang, 2016).

Culture and Health

Culture determines people's perception of sickness and health (Arnault, 2009). The literature shows that help-seeking for illnesses differs across cultures, given that different cultures have different perceptions of sicknesses. In the field of medical anthropology, culture-specific experience of psychosocial and physical suffering is termed "idioms of distress". According to Arnault (2002), culture can be seen as constituting four intertwined dimensions, and culture ideology is the culture-specific belief about what is right or wrong. It constitutes the available symbols and ethical beliefs of people of a given culture. Given that ideologies are beliefs, members of a culture do not always achieve the ideals of such ideologies (D'Andrade, 1995; Geertz, 1977; Hodder, 1986; Lutz, 1988; Schneider, 1980; Turner, 1969). Culture has a political and economic aspect, which involves the distribution of resourced and acquisition of wealth in the society. It also involves the perception and regulation of acceptable social behaviour among those in authority. The cultural ideology determines the economic and political aspects of culture. This is because it is the ethical dimensions of culture (i.e., what is right or wrong) that explains the nature of power or authority in society (Dirks, Eley & Ortner, 1993; Grimasi, 1992; Harris, 1979; Lindenbaum & Lock, 1993). Culture also involves practice, comprising power and ideals. Power and ideals are evident in gestures, forms of speech, dressing, and health behaviours. Practice embodies tradition. In effect, practice is the representation of cultural ideologies and the economic/political aspect of culture (Berger & Luckmann, 1967; Bourdieu, 1977; Foucault, 1982).

Cultural Determinants of Help-Seeking Model

Cognition, emotion and action are influenced by cultural models (Holland & Quinn, 1987; Markus et al., 1996; Moscovici, 1988; Nisbett & Norenzayan, 2002). In infancy or childhood, people are encultured to perceive noticeable emotional and/or physical sensations or features of the social environment. For example, through this process, individuals are made to pay more attention to some issues, rather than others. Understanding how a specific culture model affects attention is necessary to predict the maintenance of health and also the experience of distress (Arnault, 2009).

Conceptual Framework

The conceptual framework seeks to establish the hypothesised relationship that exists between locus of control, stigmatisation and culture and how they can affect the psychological health-seeking behaviour of students. These relationships have been demonstrated as a framework in Fig 1 below:

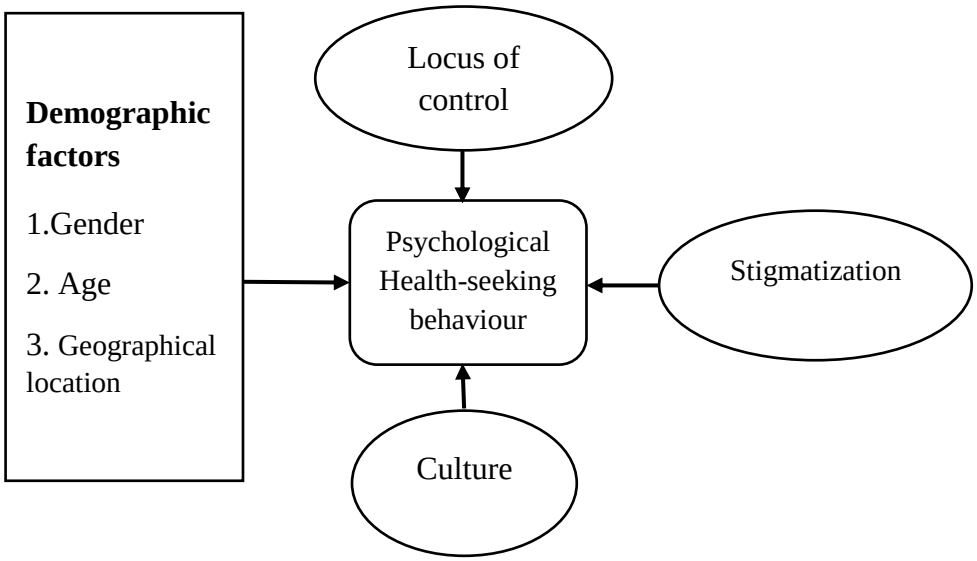

Figure 1: Conceptual framework of the study
Source: Author's construct

The study in addition hypothesized that one of the three demographic variables namely, age, gender and geographical location can best predict psychological health-seeking behaviour and this was informed by previous empirical findings.

Health-Seeking Behaviour among University Students

The overall well-being of university students is very crucial for their success in their academic endeavours. In effect, the mental health of university students is critical, because even if they are physically fit but are having challenges with their mental health, it could interfere with the progress of their academic work. Various researchers around the globe have, therefore, found it necessary to delve into the health-seeking behaviour of university students.

Health-seeking behaviour among students has been researched widely by various researchers on different contexts in the Middle East. In Lebanon, El Kahi, Rizk, Hlais and Adib (2012) examined the health-seeking behaviour of students in Saint-Joseph University, focusing on various aspects of health. The study, which examined health-seeking behaviour along the formal, informal and informal-personal dimensions, revealed that students were more likely to seek informal help. The study also examined barriers to health-seeking behaviour and found that accessibility and relational issues as impeding students' access to healthcare. The study recommended the provision of specific health services to students, coupled with the assurance of confidentiality, as ways of encouraging students to use formal sources of assistance.

A similar study, which was conducted at the University of Sharjah (UOS) in the United Arab Emirates, focused on health-seeking behaviour among medical students. The study, which used quantitative methods, found self-prescription as the most prevalent health-seeking behaviour among the students. Other behaviours identified include paying no attention to the symptoms of the disease, using the internet to seek for cure of the ailment, and reading about the sickness. The study also revealed a wide variety of factors that affected the students' health-seeking behaviour. These factors include orientation to self-care and medical education, as well as gender, education level, ignorance of available health services, and having a chronic disease. Based on these findings, the study recommended that students need to be educated on the implications of some health-seeking behaviours (Sawalha, Sawalha, Salih, Aboukalam, Bakie, Alkilani & Hussein, 2017).

Another cross-sectional quantitative study, which was conducted in a college in India, examined health-seeking behaviour among 281 students. The health-seeking behaviours identified include self-investigation and self-medication. The study recommended the need to provide formal healthcare services, health guidelines, and the provision of medicines to the students. The study additionally recommended the critical need for awareness creation among students to enable them to know the implications of self-medication and investigation (Vaz, Ferreira, Kulkarni, Perni, Dsouza & Dsouza, 2012).

Another study by Raida, Ivonne, Ilana, Anneke, Ifrah, Muhammad, Sylvana and Alan (2019) focused on a school in Arab, which admitted Arab adolescents. The study collected used questionnaires to gather quantitative data from 1,639 students and interviews to collect qualitative data from the

mothers of the children. It was found that students with high-risk emotional and psychological problems were more likely to seek professional assistance, especially from a school nurse. In relation to consulting a school source, similar results were found among Muslim students as compared to Druze students. The study also revealed that students who felt uncomfortable at home were more likely to seek for medical help. Again, among those with high-risk conditions, health-seeking behaviour was associated with. The study revealed school counsellors and grade teachers as the specific sources of assistance the students consulted most. In Malaysia, Suradi (2010) examined the psychological help-seeking attitudes of students. The study, which relied on a sample of 2,508 tertiary-level students, found that students hardly sought medical help from health professionals, especially the counsellor. The author attributed this finding to the fact that the students failed to recognise the importance of counselling services to students.

Watanabe, Nishida, Shimodera, Inoue, Oshima and Sasaki (2012), whose study focused on students in Japan, examined the prevalence and corelates of poor health-seeking. The study used a questionnaire to collect data from a sample of 18,104 students (8,620 aged 12–15 years, 9484 aged 15–18 years). The study reported that a number of the students had self-harmed, with some of them having poor health-seeking attitudes. This was especially the case among students who never sought help for their psychological problems as well as those with suicidal tendencies. A few of the students who self-harmed also sought assistance from their family members, while many of them consulted school nurses. The study recommended that students be educated on

the need for mental health screening among the students and training of school nurses on preventive care.

Some studies on health-seeking behaviour among students have also focused on the United States of America. As an example, Dyrbye, Eacker, Durning, Brazeau, Moutier and Massie (2015), who examined health-seeking behaviour among medical students in the USA, also compared the stigma perception among the students with such perceptions among the general U.S. population and age-matched individuals. The study revealed that close to 34 percent of the students exhibited mental health-seeking behaviours. The perception of stigma also dominated among students with burnout, compared to their colleagues without burnout. Concerning emotional problems, the study also found health-seeking among a smaller number of the students, compared to the general population and age-matched individuals.

Diverging slightly from the studies reviewed so far, Zivin, Eisenberg, Gollust and Golberstein (2009) relied on brief screening instruments to assess the prevalence of mental health problems among college students. The study found a high prevalence of mental health problems among the students, with about half of them having received treatment. Another study by Sawyer, Borojevic, Ettridge, Spence, Sheffield and Lynch (2012) investigated the possible variations in health-seeking behaviour among depressed US adolescents. Having analysed data from a sample of 5,362 adolescents, the authors found a lower likelihood of intension to seek health care among those with high symptoms of depression. The study highlighted the need for families to actively engage with depressed adolescents.

Other researchers from Europe have also delved into health-seeking behaviour of their university students and have come out with different findings. For example, Fröjd, Marttunen, Pelkonen, von der Pahlen and Kaltiala-Heino (2007), whose study focused on Finish adolescents, found a very low health-seeking behaviour among the studied sample (Frojd et al, 2015). The authors recommended routine depression screening as a means of ensuring adequate intervention for the adolescents. Similarly, in France, Verger, Guagliardo, Gilbert, Rouillon and Kovess-Masfety (2010) studies health-seeking behaviours among students of six universities. The study, which adopted a cross-sectional design, found the prevalence of depressive, anxiety and substance use disorders to be 8.9%, 15.7% and 8.1% respectively. Again, the study reveals the prevalence of health-seeking among the studied sample to be 30.5%.

Marie, Nilsson, Stotzer and Runeson (2011), whose study focused on students studying medicine and business in Sweden, specifically concentrated on help-seeking behaviour among students with mental distress and alcohol use. The study collected data from 1000 students, 500 from each category of students. In terms of the prevalence of mental health issues, the study findings varied across the two categories of students—77.9% and 80.7% for medical students and business students respectively. As compared with females, males recorded a higher likelihood of reporting no mental health problem. With regard to help-seeking behaviour, the study found variations with regard to the use of student health services. Specifically, it was found that compared with business students, medical students were more likely to use student health services. Again, the study revealed that, compared to men, women were more

likely to seek help from psychologists or psychiatrists. The study also revealed that generally, 7.7% of students did not seek help even when the need arose. Based on the findings, the study highlighted the need for mental health screening and preventive care among university students.

In Australia, Wilson and Deane (2010) examined the role of depression, anxiety and hopelessness on help-negation and suicidal ideation among Australian university students. The study, which relied on a sample of 302 Australian university students, found that suicidal ideation obstructs the decision to seek medical help. Another Australian study by Lubman, Cheetham, Jorm, Berridge, Wilson, Blee, Mckay-Brown, Allen and Proimos (2017) focused on the ability of depressed and alcoholic adolescents to identify symptoms related to their conditions. The study also examined barriers that obstructed health-seeking behaviours among these adolescents as well as their plans to urge their colleagues to seek help formal and informal assistance. Their study found health professionals as the main sources of help for the adolescents with depressive symptoms. On the other hand, those who abused alcohol and drugs often sought help from friends, rather than health professionals and family members. The study also found that slightly above half of the adolescents could identify symptoms related to their medical conditions. Again, the study recorded a high likelihood of participants encouraging their peers to seek help from family members. This study, therefore, highlighted the importance of peers as a source of support for people with mental health issues.

Hill, Wilson, Sims-Schouten and Gorczynsky (2016) sought to investigate the levels of mental health literacy as well as its associated

factors among UK university students. With the use of internet surveys, the study gathered data from 380 students. The study reveals lower levels of mental health literacy. Across genders, a higher level of mental health literacy was found among females, compared to their male colleagues. Similarly, post-graduates, compared to undergraduates, were found to be more literate. With regard to sources of help, the study revealed a high likelihood of students soliciting assistance from their partners and family members and some also relied on the internet for mental health information. Based on the findings, recommendations were made on the need to provide university students with online sources of mental health information.

Health-Seeking Behaviour among University Students in Africa

A lot of studies have been carried out in different parts of Africa, to find out how university students respond to their health care needs. In Ethiopia, Gebreegziabher, Girma and Tesfaye (2019) assessed the determinants of help-seeking as well as the sources of help sought by undergraduates with common mental disorders (CMDs) at the Jimma University. The researchers used a sample of 760 students for the study. The prevalence of CMDs found in the study was 58.4%, with 78.4% of patients having sought for help. Among those who sought help, 83.8% consulted informal sources. Again, the study identified levels of satisfaction with life as a correlate of help-seeking behaviours among the students. The study recommended that studies need to be conducted on the barriers to help-seeking from formal sources as well as the consequences of failure to get formal assistance for CMDs symptoms.

Another study done in Ethiopia by Doyore, Chafo and Moges (2015) explored the factors that influence health-seeking behaviour for HIV/AIDS among a public college community. The study relied on focus group discussions and in-depth interviews for data collection from students, teachers and HIV mainstreaming heads in three colleges. The study found low self-susceptibility to HIV among the participants, who regarded others as being more susceptible. The correlates of perception identified in the study include self-efficacy and response efficacy concerning recognition of suggested precautionary messages. Given these findings, it was recommended that appropriate communication strategies must be adopted to address health service-related factors that determined health-seeking behaviour.

In the context of Ghana, a stud has been conducted to examine the use of the internet for health promotion among university students. Employing the cross-sectional design to quantitative research, the researchers gathered data from a sample of 650 students from 3 universities. One significance finding of the study was that university students in Ghana used the internet for health purposes, because it is readily available, guarantees privacy, confidentiality, and is affordable. However, the students identified low connectivity and power outages as barriers to their use of the internet for health purposes. Also, it was revealed that only 39.5% of the study participants consulted health professionals after obtaining online information. Given these findings, the researchers recommended the use of the internet as a reliable way of disseminating health information to students (Osei-Asibey, Agyemang & Boakye, 2017).

To assess the health-seeking behaviour of malaria treatment among international students in the University of Ghana, Lwenge (2018) conducted a questionnaire-based descriptive cross-sectional study. He used a systematic sampling method to select 264 international students. The results show that most of the respondents first used antimalarial only from pharmacy, and their health-seeking behaviour was significantly associated with such factors as health insurance coverage, continent of residence, accessibility of health services and waiting time.

A similar study was conducted by Kuuire, Bisung, Rishworth, Dixon and Luginaah (2015) on correlates of health service utilisation in Ghana. The study, which was guided by Andersen's behavioural model, found wealth quantile and health insurance coverage as the correlates of health services usage. Specifically, it was revealed that the poor who had subscripted to health insurance were less likely to utilise health services. This suggests that the poor still had some barriers that prevented them from accessing healthcare, despite the waiver of medical bills.

Seidu (2015) investigated the health-care seeking behaviour of adolescents in a rural Basic School in Yamoransa, a suburb of Cape Coast. The main aim of the study was to examine factors that influence health care and also evaluate the attitude of adolescents towards the use of health facilities. According to the results from his study, majority of the respondents visit modern health facility when they are sick, and the findings revealed that the major factors affecting adolescent's healthcare seeking were unfriendly attitude of health professionals, long distance to health facility, high cost of treatment and long hours due to long queues at the health facilities.

Aside from Ethiopia and Ghana, Nigeria too has featured in studies of this kind. An example is Afolabi, Daropale, Irinoye and Adegoke's (2013) study which examined health-seeking behaviour with its associated barriers among 1,608 undergraduates in southern Nigeria. It was found that the students preferred to consult their colleagues rather than seek professional assistance. Some students also consulted community pharmacies, while for religious reasons, others avoided medical care. Also, the study identified cost of medical care, long waiting time, unfriendly health professionals, provision of insufficient health information, and drug shortage as barriers militating against their health-seeking behaviours. In concluding the study, the researchers emphasised the need to address the barriers identified. A similar study by Okechukwu and Ubochi (2016) found that sick students usually purchased medicines from the patent medicine stores. The study also revealed that students used hospitals only when they experience unbearable pain. Again, accessibility, effectiveness and promptness were revealed as factors that determined the type of healthcare students used.

Another study by Aluh, Anyachebelu, Anosike and Anizoba (2018) focused on the Federal Government College High School in south-east Nigeria. The study used questionnaire to gather data from 285 students from the college. It was also found that only a few of the students (4.8%) offered a correct identification of the depression vignette, with some few others recommending professional help. Similarly, Obasola and Agunbiade (2016) focused on the impact of online health-seeking on the decision-making of undergraduates in Nigeria. The study revealed average internet use among the study participants, which was attributed to unstable electricity, high cost of

internet and poor internet service. It was also revealed that information was sought on a variety of health issues such nourishment, mental health, and fitness. The study also revealed that the students sought help from a variety of sources such physicians, traditional healers and friends while others preferred self-medication. The study, therefore, recommended the need to provide students with stable internet to enable them access health information when the need arises.

The literature review reveals insightful observations. First, it is evident from the review that a large number of students still rely on informal sources for health information (Lubman, Cheetham, Jorm, Berridge, Wilson & Blee, 2017). Again, several barriers to help-seeking have been identified (Gulliver, Griffiths & Christensen, 2010). Also, gender, socio-economic status, stigma, etc. have been identified as determinants of health-seeking behaviour among students (Zochil & Thorsteinsson, 2018).

Demographic Factors and Health-Seeking Behaviour

Demographic factors are very important to consider when discussing issues concerning health-seeking behaviour because they are the characteristics that define a particular group within a population. Some of the demographic factors discussed in this section include gender, age, socioeconomic status, education, income, marital status, geographic location etc.

Gender and Health-Seeking Behaviour

Gender is a socio-demographic factor that influences health-seeking behaviour. Various forms of discriminations based on gender over the times have affected the health responses of women (World Health Organization,

2010). Women on the whole lack the will power in accessing health care facilities, and this exposes them to higher health risks. Also, they are exposed to discrimination in relation to education, HIV, employment, income, nutrition and gender-based violence. These issues have made it necessary for the elimination of inequities in the health care to be of utmost importance (World Health Organization, 2014).

Using a cross-sectional research design, Otwombe, Dietrich, Laher, Hornschuh, Nkala, Chimoyi, Kaida, Gray and Miller (2015) investigated gender as a determinant of health-seeking behaviour among 830 adolescents in Soweto, South Africa. The study found the likelihood of reporting sexual report to be higher among males, compared to females. The same applied to illicit drug. The study, however, found no significant differences in health-seeking behaviour or being hospitalised. Healthcare was generally sought from medical clinics. Gender variations were also evident in healthcare-seeking behaviour for condom breakage, with male being more likely to seek medical care. On the other hand, females were more likely to seek general healthcare, counselling, and reproductive care services.

Similarly, Chandra and Minkovitz (2006) investigated the inclination of teenagers to use mental health services. The study adopted a quantitative study design and gathered data from 274 students in mid-Atlantic state. Generally, the study revealed gender variations in health-seeking behaviours. Specifically, the likelihood to use mental health services was higher among girls, as compared with their male colleagues. Similar findings emerged with respect to knowledge in mental health. On the converse, girls, as compared to boys, were less likely to perceive stigma. The study also revealed parental

control as a determinant of health-seeking behaviour among the teenagers studied.

Gender inequalities are still an issue of major worry and it can serve as a deterrent for women to seek for healthcare in times of ill health. This is due to the fact that men are still considered as the leader of the family, and decisions concerning money, healthcare and other pertinent household matters are taken by them. In most cases, men go out there to work to enable them to take care of the family, and the women are left in the home to take care of the family and also engage in other domestic chores. In effect, women tend to seek care from informal sources (Caldwell et al., 2014; Nuhu, 2018).

Gender variations in health-seeking behaviour results from differences in gender roles. This was confirmed in a study by Currie and Wiesenberg (2004). In the study, it was found that women's failure to identify the symptoms of diseases affects their health-seeking behaviour. The researchers explained this finding within the context of culture, where socially, women are less valued, as compared to their male counterparts. Additionally, given that women are confined to the domestic space, they hardly find time to visit health facilities. Another study in Canada revealed a higher likelihood for women to seek care for physical and mental health issues, as compared with men (Thompson, Anisimowicz, Miedema, Hogg, Wodchis & Aubrey-Bassler, 2016).

Galdas, Cheater and Marshall (2005) reported on a frequently occurring theme "traditional masculine behaviour" as responsible for the regular delays in health care-seeking behaviour among men. These researchers opine that even though one can explain that gender roles have the tendency of

explaining the differences in the health-seeking behaviours among men and women, other factors, such as the similarities and differences in their ethnic background, and their socioeconomic status can influence one's perception of the dichotomy in health outcomes among different categories of men.

Tanchangya, Khan, Bayashakh and Wichaidit's (2012) investigation into gender variations in health-seeking behaviour among patients undergoing delay treatment for cataracts revealed insightful findings. One significant finding was that there was a higher likelihood for women to seek for healthcare in their delayed treatment. This portrays that gender plays a pivotal role in health-seeking behaviour and the females are more careful to seek for health care at the onset of their sicknesses than men do. However, this study was conducted in Bangladesh, a patriarchal society (Tanchangya et al., 2012). When it comes to decision-making concerning health care, men have the final say. Therefore, for a woman to seek for health care, she remains quiet for her husband or parents to take that decision for her. This finding might differ from the findings from a more civilized society where women are more enlightened, and therefore can take responsible decisions on their own, without depending on anybody for financial assistance (Nuhu, 2018).

Mackenzie, Gekoski and Knox (2006) explored age, gender differences and underutilization of mental health services and how these variables affect help-seeking attitudes. According to their findings, the elderly, especially females, exhibited a more positive health-seeking behaviour. Together with marital status and education, age and gender interacted and invariably affected health-seeking behaviour, with age and gender influencing their intentions to seek professional psychological help. Women were more interested in seeking

for healthcare from professionals than men, with older adults preferring health care from primary care physicians than younger adults. Their findings were in contrast with the findings from the study conducted by Tanchangya et al. (2012) on the same subject matter. This means that there are inconsistencies in the findings on the role of age and gender in predicting health-seeking behaviour.

Ang et al. (2004) examined the impact of gender on health-seeking attitudes of teacher trainees in Singapore. The study additionally investigated the relationship between sex role orientation on attitudes towards health-seeking among the sample. The study revealed that relative to males, females were more likely to seek professional help. The study also revealed femininity as a significant predictor of the level of students' tolerance to stigma. A similar study, which focused, in part, on how gender influenced the health-seeking behaviour of undergraduates also sought to discover the students' initial preferences of sources of healthcare. It was found that females, compared to males, showed positive attitudes towards health seeking. Again, the study revealed that peers constitute the preferred initial source of help (Atik & Yaltyn, 2011).

In India, Arshad, Da-I and Abdallah, (2012) examined Indian students' age and gender as predictors of attitudes toward seeking counselling help. The researchers aimed at finding out how age and gender are related to attitudes toward seeking professional psychological help. A sample of 200 Jawaharlal Nehru University (JNU) students responded to their questionnaires. They hypothesized that the students would have a negative attitude towards seeking counselling help, and also age and gender would have a significant impact on

the attitude towards seeking counselling help. The researchers found out that the Indian university student have a positive attitude towards seeking counselling. Gender was a major predictor, with the female students having more positive attitude towards seeking professional counselling. Age did not play any significant role in their attitude towards seeking help in professional counselling.

In northern Ghana, Asamari and Namale (2018) examined teacher trainees' perceptions of guidance and counselling. The study employed the descriptive survey design to analyse data collected from a sample of 400 students. Their results showed that students perceived guidance and counselling services as beneficial. However, there was no statistically significant gender variations in the perceptions.

In summary, much of work done on gender and health-seeking behaviour established differences in the genders whilst others also maintain some similarities. More work must be done to encourage both males and females to exhibit positive attitude towards all illnesses, whether medical or psychological.

Age and Health-Seeking Behaviour

Age is a factor that cannot be left out in the health-seeking behaviour discourse because the attitude of young people towards health-seeking is sometimes different from the way the older people perceive it. The youth constitute a subset of a population with lower death rates, and they are less likely to fall sick and also have a negative attitude towards healthcare (Coiro, Zill & Bloom, 1994; Wauquiez, 2006). The youth tend to have sensitive health concerns that are most of the time neglected and these may lead to risky

behaviours such as drug and substance abuse, smoking and sexual behaviours. These behaviours, if not curtailed, may develop into risky health behaviours which have a very high chance of extending into their adulthood. All these, if not handled well, may lead to mental health issues such as depression and suicidal ideations (Coiro et al, 1994; Wauquiez, 2006). Even though the youth are considered as a category with a very high risk, there has not been much work done in areas concerning their attitude towards ill health (Sharma et al., 2013; Weeks, 2012).

A study done in rural Bangladeshi by Ahmed, Tomson, Petzold and Kabir (2005) indicated that both the young and the elderly have similar health-seeking behaviours or attitudes. Their results showed that income and level of education predict health-seeking behaviour more than age and gender. In the case of the elderly, Mwabu (1984) revealed that having chronic diseases was a significant predictor of help seeking. Zyaambo et al. (2012) also found in Zambia that there is an association between age and the use of the healthcare system. They concluded that the city dwellers in Zambia between the ages of 30 and 39 were twice more likely to use their healthcare facilities than the youth whose ages fall between 15 to 19 years.

Making inference to the health belief model, Zyaambo et al. (2012) explained that the elderly folks have more awareness about the relevance of their health more than the younger ones, whilst from another angle, one can say that adults are more financially endowed more than the youth and, therefore, are more likely to exhibit a more positive attitude to their healthcare needs. To buttress this assertion, Otwombe et al. (2015), in their South African study using adolescents, found that a smaller percentage sought for

healthcare in the past six months, with majority going to clinics, whilst a smaller proportion sought for healthcare from traditional healers in their communities. From sub-Saharan Africa, as well as Europe, empirical evidence shows that age has an impact on attitude towards health issues, with the elderly folks exhibiting poorer health outcomes (Beogo et al., 2013; Gama, Fraga & Dias, 2010; Hosseinpoor et al., 2012; Musoke et al., 2014). On the other hand, work done by Habibullah and Asfar (2013) in developing countries outside sub-Saharan Africa established that there is no association between health-seeking behaviour and age of an individual, and these could be attributed to inappropriate methodological design, the prevailing environment and the type of respondents used for the study. Despite the discrepancies in the literature on health-seeking behaviour and age, we can still say that there exists a relationship between both of them.

When it comes to health issues, young people find it difficult to seek for healthcare, and their excuses or barriers to these facilities include issues about confidentiality, feeling embarrassed about divulging health issues, lack of health insurance or financial constraints (Elliot & Larson, 2004; Klein, McNulty & Flatau, 1998; Ford, Bearman & Moody, 1999; Zimmer-Gembeck, Alexander, Nystrom, 1997), lack of knowledge about available health services and inadequate trust in the health professionals (Booth, 2004; Elliot & Larson, 2004). These reasons make young people to often seek healthcare informally (i.e., from non-professionals), and they neglect the formal healthcare sectors as their first option (Booth et al., 2004; Pommier et al., 2002). Also, they take their healthcare decisions independently by seeking for information about their healthcare online or resort to self-medication (Pommier et al., 2002).

Health-seeking behaviour among the youth is also sometimes affected by the cost of health services (Pommier et al., 2002), geographical location (Ford et al., 1999; Klein, McNulty & Flatau, 1998; Newacheck et al., 1999; Quine et al., 2003) and gender, with young women seeking help from professionals than the men (Booth et al., 2004; Klein et al., 1998; Zimmer-Gembeck et al., 1997). Studies in Lebanon have portrayed that the youth are likely to participate in risky behaviours such as drug and alcohol use (IGSPS, 2004) and have also experienced suicidal thoughts (Sibai & Kanaan, 1999). The health interventions which must focus on this age group are not the priority for the health policies in Lebanon (World Health Organization, 1995), and this has resulted in lack of health support services for their youth, with the few available for university-based health service. Young people in Lebanon, just like in other countries, seek healthcare from the informal sector rather than the health professionals (El-Kak et al., 2001). Those aged between 10 to 20 years have lowest use of ambulatory care and of usual consultations (Kasparian & Ammar, 2001).

In Turkey, a study by Seyfi, Poudel, Yasuika, Nanishi and Jimba (2013) showed that the likelihood of showing positive attitudes towards seeking psychological help from healthcare professionals was higher in older students than younger ones. The authors explained that this could be as a result of the fact that younger ones find it difficult to identify their emotions. Also, this finding may be due to the independence that characterises entrance into college. The study also revealed that students who had positive attitudes towards professional help-seeking had intensions to seek such help.

Arku (2015) examined the attitude of male students of the University of Cape Coast (UCC) towards counselling on UCC campus. The study used the descriptive survey method and focused on a sample of 345 respondents. The findings of the study suggested that male students of UCC found counselling to be very useful to them. Also, it was realized that the key factors that influenced their decision to access counselling services included the feeling of embarrassment in divulging their problems to the counsellors, cultural differences and issues about self-esteem. Some demographic factors like age, religion and level of education also did not influence their perceived embarrassment that accompanies sharing of their problems with the counsellor. The researcher, therefore, recommended that counsellors must convince students about how confidential their services are, so that students will feel comfortable in accessing the counselling services on campus.

Studies have shown that older adults, even those with health insurance coverage, still have difficulties in accessing medical care in Ghana, due to the cost transportation and some drugs which are not covered by the health insurance (Bosu, 2013; Gyasi, 2015; Kowal et al., 2010; Tawiah, 2011). Also, upon arrival, it will be expected that they will be given a concession by not joining the long queues. However, they rather spend most of their time in queues whilst waiting to be attended to by a healthcare professional (Apt, 2013; Buor, 2004). This becomes a source of discouragement to many older people from seeking proper medical care on time, and some may neglect going to the healthcare centre. According to Macial, Duboz, Montepare and Gueye (2015), the elderly folks are sometimes compelled into the consumption of different un-prescribed medications, which result in unfavourable

consequences. This makes it very imperative for the improvement in the healthcare of the elderly in our communities.

The present study chose to focus on the younger age group, which has been acknowledged in research to be vulnerable to poor health outcomes due to their financial disposition. Most of them fall on their parents and relatives for financial support, and this can be a setback to their health-seeking behaviour. In recent times, a greater proportion of students enter the universities as early as 17-18 years, and graduate by the age of 22 years. Most of them depend on their parents for financial support, and this may deter them from paying attention to their psychological health care needs. Also, most of the public universities have health facilities for the students to access, but sometimes, the staff are unfriendly and students have doubts as to whether their records will be confidential. Some students have also complained of very long queues at the facility. In effect, students prefer to find a means of addressing their health issues in their own way.

Geographical Location

Geographical location, which is rural or urban is a factor that must be considered when discussing the health-seeking behaviour of students. According to the Ghana Statistical Service (2010), a rural area is a town or community with a population of less than 5,000 whilst an urban area is a locality with a population of 5,000 or more.

The university is made up of people from different geographical settings, urban and rural, which affect their perceptions and patterns about psychological health-seeking. Generally, rural households differ from urban ones in terms of socio-economic status. For the purpose of this research,

geographical location refers to the permanent place of residence of the students during vacation, and not the present regional locations of the public universities where they study. This section will, therefore, focus of the health-seeking pattern of rural and urban dwellers in some specific geographical locations.

Some researchers have considered the rural-urban disparities in health outcomes, while others have focused exclusively on the situations of either urban or rural areas. Some have also linked geographical location to health outcomes (Marmot, 2010b; Menec, Shooshtari, Nowicki & Fournier, 2010).

According to Novotny (2006), the three primary factors that affect the provision of mental health services among the rural population are accessibility, availability and acceptability. Also, socio-economic factors such as poverty, literacy level and failure to even identify the nature of the problem that needs to be addressed are also obstacles to seeking for treatment. The literature suggests that in terms of healthcare, urban areas have better opportunities than rural areas, and this has serious implications for the impact of mental health disorders in rural areas (Human & Wasem, 1991). Costly transport fares and shortage of health professionals, for example, make healthcare inaccessible and unavailable in rural settings (Bird, Dempsey & Hartley, 2001). Due to these challenges, mental health patients in rural areas tend to delay in accessing healthcare (Rost, Fortney, Fischer & Smith, 2002).

Morales, Barksdale and Beckel-Mitchener (2020) also reported on rural-urban disparities in accessibility to mental healthcare in the USA. Specifically, rural mental health patients in rural areas, compared to their counterparts in urban areas, receive less frequent medical attention (McCall-

Hosenfeld, Mukherjee & Lehman, 2014; Stewart, 2018). Various reasons have been given to explain this disparity. Prominent among such reasons are unavailability of trained healthcare professional in rural and non-use of the services available in health facilities (Andrilla, Patterson, Garberson, Coulthard & Larson, 2018; Kepley & Streeter, 2018). In particular, rural residents have not been consistent in utilising innovative mental healthcare services (Myers, 2019).

A study in Turkey has also noted some challenges rural residents encounter in their attempt to access healthcare. These challenges include long distance to health facilities, fewer health facilities, and long waiting time (Yikilkan, Gorpelioglu, Aypak, Uysal & Ariman, 2013). These challenges have put the quality of healthcare in rural areas into question. Again, together with lower socio-economic status that characterises life in rural areas, these challenges may prevent rural dwellers from accessing healthcare from modern healthcare facilities (Anderson, Saman, Lipsky, & Lutfiyya, 2015). In effect, rural dwellers may be tempted to use other means to cater for their health needs.

Level of education, household income, availability and accessibility to healthcare have also been found as determinants of the rural-urban disparities in healthcare access (Onyeonoro, Ogah, Ukegbu, Chukwuonye et al., 2016; van der Hoeven, Kruger & Greeff 2012). For example, van der Hoeven et al.'s (2012) study in South Africa found that socio-economic factors determined the differences in healthcare access between rural and urban residents. It was also revealed in the study that urban residents have a wide range of healthcare services at their disposal, compared to rural residents. Also, due to their socio-

economic status, urban residents were reported as being able to patronise expensive private health facilities.

In Sierra Leone, Idriss et al. (2020) researched on the health-seeking behaviours for non-communicable diseases, and delved into the patterns and factors affecting these patterns across rural and urban dwellers. They analysed their data using a prior framework developed in Ghana for the same disease. They found that both rural and urban dwellers had sufficient knowledge about the causes of such illnesses, and they all have access to a wide range of healthcare providers. They identified proximity to healthcare facility, cost, and belief systems as factors affecting care seeking behaviours among the population studied. A similar study by Yaya et al. (2017) investigated client satisfaction of health services among women in Ghana, focusing on rural-urban differentials. The study revealed that close to sixty percent (57.1%) of the women showed satisfaction to the care they received, with no statistically significant differences across rural and urban populations.

A study by Amegbor (2017) in the Asikuma-Odoben-Brakwa District of Ghana found remarkable similarities in health-seeking behaviour among rural and urban dwellers. Specifically, it was found that both rural and urban populations in the study area prefer self-medication to using professional and indigenous care providers. The preference for self-medication was especially evident in respondents from all socio-economic backgrounds, with the exception of those with secondary or higher educational attainment. The study also revealed a weak significant correlation between respondents' place of dwelling and their general health-seeking behaviour.

Williams, Williams, Pellegrino and Warren (2012) have revealed that African Americans are less likely to utilize mental healthcare services despite the fact that they need it and the services are available too. The researchers attributed their attitude to lack of trust in their healthcare professionals and more seriously, the fear of being stigmatized due to their mental health problems. Similarly, a study by Petterson, Williams, Hauestein, Rovnyak and Merwin (2009) on the different levels of rurality found that there are smaller differences in treatment rates for ethnic minorities compared to non-Hispanic Whites. The authors believe that this result may be a consequence of the scarcity of mental health providers in rural areas, which may lead people to rely more heavily on primary care. Following from this, it could suggest that rural dwellers in Ghana have a poor attitude toward seeking psychological health not because of a dislike of it but due to the lack of it.

Sockey and Adisah-Atta's (2017) study on the barriers to health information access among residents of the Shai Osudoku District in the Eastern Region of Ghana revealed that the residents accessed health information through various mediums. The health information mediums identified in the study include the internet, radios, posters, relatives, friends, and healthcare professionals. Usage of these mediums differed with respect to the level of education of respondents, with highly educated respondents more inclined to the use of the internet. Language barrier, geographical location and not having mobile phones or televisions impeded their attempts at accessing health information.

Afeadie (2018) studied the health-seeking behaviour rural-urban migrant slum dwellers at Madina, a suburb of Accra and revealed interesting

observations. First, it was found that residents of the slums mostly attributed the causes of diseases to poor shelter and working conditions, with few diseases linked to their places of origin. The study also found variations in health-seeking behaviour across the slums and places of origin. The study found barriers to health-seeking behaviour especially in the slums and noted that residents used a number of comping strategies to deal with such barriers. One key barrier reported was the absence of policy frameworks for health-seeking behaviour.

Perreira (2017) conducted a study on barriers and promoters of health-seeking behaviour in a rural farming village of Humjibre in the Western Region of Ghana. Through the use of observation and semi-structured interviews, the researcher observed that hospitals were located far from the people, and some of the patients were supported financially. Treatment was based on personal knowledge and preference, and the largest factor influencing health behaviours was access in terms of cost, location, transportation and the capacity of the medical facilities. Distance to the health facility, which is about 15 minutes' drive from the village, coupled with bad roads, vehicular accidents and paying bribes at checkpoints further complicated the process, making it costly in both time and money. These barriers affected the health-seeking behaviour of the villagers by discouraging them from accessing the facilities.

Focusing on alternative treatment as the initial care-seeking behaviour for malaria, Awuah et al. (2018) examined the determinants of health-seeking behaviour in James Town, Ussher Town and Agbogbloshie. The study found that relative to females, males were more likely to utilise herbal treatment and

self-medication as their initial response to malaria. The study also found a high tendency of the respondents to self-medicate. The tendency to use alternative rather than orthodox care was higher, and this was associated with the place of residence of the respondents. Based on these findings, the authors recommended the need to check the use of alternative care in such communities.

From the literature reviewed, the prominent finding is that urban populations have better health responses than the rural folks, and due to the three-part problem of accessibility, availability and acceptability, the impact of psychological issues is more pronounced in rural areas more than at the urban centres. The urban areas are more privileged in terms of mental health facilities and better services by adequate health professionals, as opposed to their folks in the rural areas. The cost involved in going for psychological healthcare is also a barrier in the rural areas, as most of them cannot afford due to financial constraints. This may discourage them from going for healthcare at the onset of their illnesses, thus prolonging their health challenges until the situation becomes worse. Other key challenges such as transportation and walking long distances to healthcare locations are identified in rural areas. In extreme cases, traveling from a rural locality to an urban centre for better health care is a problem, and the situation is almost the same in Africa and the United States of America. Despite the inequity in the distribution of health facilities among the rural and urban localities, some similarities have been established between their health-seeking behaviour with regard to their attitude. They both resort to self-care as their first choice of option in times of challenges and are distracted by proximity to their healthcare providers.

Socioeconomic Status and Health Seeking-Behaviour

The socio-economic status of an individual has been known to be correlated with better healthcare seeking behaviour (Baker, 2014). It is defined as the cumulative index of individuals' socio-economic position, which reflects their level of education, income and the type of job they are doing (Baker, 2014). As people climb higher on the education ladder, there exists a significant improvement in their knowledge, health, literacy, beliefs and practices, and all these have roles to play in their health-seeking behaviour (Baker, Leon, Greenaway, Collins & Movit, 2011).

To buttress this point, Desai and Alva (1998) conducted a study on the relationship between maternal education and child health, using a demographic and health survey from 22 developing countries. They observed that children with highly educated mothers had a high turnout rate in their immunisation exercise, as well as improved health outcomes, as compared to children from illiterate mothers. A study by Lasker (1981) also reported that income and level of education improved healthcare access. This notwithstanding, the use of both formal and informal sources of healthcare were found as being used even among the highly educated.

Similar, a cross-sectional study by Kaoser, Khan, Haque, Sizear, Alam and Haque (2016) investigated the impact of socio-economic status on health-seeking behaviour among the inhabitants of a rural community in in 18 Unions of Fatikchhari Upazila. The study revealed that village doctors and nearby health centres were the preferred sources of healthcare among the majority of the respondents (60%), while 35% of them preferred to consult formal healthcare providers with professional degrees approved by the government.

The study also found that residents sought care for a variety of medical conditions, including fever, paralysis and arthritis. Socio-demographic factors, knowledge and perception toward healthcare were also identified as determiners of health-seeking behaviour among the studied population.

It is very evident from research that socio-economic status really affects health-seeking behaviour because one's income determines the type of healthcare facility to use in times of sicknesses. This means that individuals with highly paid jobs are likely to resort to better health facilities, while those with low income will either not seek help at all or resort to traditional facilities and pay less. Students whose parents have a very good socio-economic status will have proper care, whilst those from low-income homes are likely to resort to poor healthcare facilities.

Education

Education is a variable that can have an influence on a person's health-seeking behaviour. According to the WHO (2010), there are basically three reasons that help in explaining why education contributes towards the healthcare of a person. First of all, education implies the acquisition of knowledge, which informs the individual on information on healthcare and the variety of options available in terms of the facilities. Secondly, one is able to predict the future outcome of his or her health conditions, based on his or her past health record or history, as good healthcare helps in promoting better academic results. Lastly, one's level of education indicates how the resources in the family dictate the type, quality and level of education that he or she is exposed to (World Health Organization, 2010). Available literature shows that education has an effect on health (Albert & Divia, 2011). A higher level

of educational achievement is highly related to better maternal and infant health outcomes (Chou, Liu, Grossman & Theodore, 2010), health of adolescents (Viner et al., 2012), and reduced morbidity and mortality (Baker, Leon, Greenaway, Collins & Movit, 2011).

Findings from research from countries in sub-Saharan Africa stipulate that education is very crucial in making a healthcare choice, with lower levels of education directly linked with refusal to seek healthcare (Anselmi et al., 2015; Njuki et al., 2014; Zyaambo et al., 2012). On the other hand, Frie, Eikemo and Knesebeck (2010), after examining the health-seeking pattern of populations in 24 developed European countries, found that people with lower levels of education rather increased their health care activities. Education increases knowledge about a sickness, identification of its symptoms, and facilities available in times of ill-health (Zyaambo et al., 2012). Also, education helps to improve the economic status of an individual, as the higher education laurel one achieves generally results in an increase in the person's employment and income, which gives the individual a variety of options to choose from in times of seeking for healthcare (Zyaambo et al., 2012).

A study by Beogo, Lui, Chou, Chen and Huang (2014) conducted in Burkina Faso found that higher educational levels encouraged people to visit a formal healthcare service provider. This assertion was later expatiated by Caldwell et al. (2014), who also found that misinterpretations and mythologies prevented people from seeking treatment from formal healthcare popularly because the illiterate group regarded western medicine to be too strong for treating their children and had more confidence in the government health facilities as being capable of taking care of their reproductive health needs.

Even though this study was conducted in an urban slum in Bangladesh, it can conveniently be likened to the situation in Ghana, where there is a similar attitude towards western practices by some least advantaged population groups.

In a nutshell, the literature shows education as a significant correlate of health-seeking behaviour (Edwards, 2016) and inequalities in health. Available research suggests that university students are hesitant to consult physicians when faced with mental health challenges. Due to their education status and level of enlightenment, most of them go online to read about illnesses, their symptoms and cure. Therefore, whenever they are confronted with any form of ailment, they know exactly what to do. There is a lot of health information online for them to access, and research shows that most university students prefer to go online when in need of health support because it is very easy for them to have access to the internet than to go and queue in healthcare facilities for their services. Education has, therefore, become a factor to explore when deliberating on issues concerning health-seeking-behaviour of university students.

Occupation/Employment Status

Occupation is a variable that demonstrates a person's social status and income, which have a bearing on the person's health-seeking behaviour. This is because it dictates the financial strength of the person in times of healthcare and its related issues. Also, in some occupations, the higher one's status, the higher his or her chance of enjoying a better healthcare when in crisis. There are also some types of occupations which expose the individual to some amount of risk and psychosocial stress (World Health Organization, 2010).

Sometimes, students and the retired are excluded from this category of people when conducting a study, because even though some students are working, majority of them are unemployed. This notwithstanding, occupation or employment are examined to ascertain its effects on health-seeking behaviour.

In the African context, employment is considered in the literature as a very influential determinant of healthcare. This is demonstrated in the decomposition analysis by Hosseinpoor, Williams, Amin, Carvalho, Beard et al. (2012). They found that among the different categories of populations who dwelt in the sub-Saharan Africa, employment contributed immensely to the differences in their healthcare pattern. To be gainfully employed has been linked with an improvement in physical and mental health (Hosseinpoor et al., 2012; Rueda et al., 2011). Unfortunate conditions like reduced fertility have been attributed to unemployment (Henkel, 2011), lower birth weights of babies (Lindo, 2011) and depression (Jefferis, Nazareth, Martson, Moren-Kustner, Bellon et al., 2011). This is because unemployment is associated with low standards in healthcare decisions, lower standard of living as well as a loss of social resources, which are all setbacks that make healthcare virtually inaccessible (Ahs, Burell, & Westerling, 2012).

Studies conducted outside Africa which examined data from both developed and underdeveloped countries including those in sub-Saharan Africa indicate that among the lower income earning group, being employed is sometimes a problem when it comes to going to seek for healthcare. This is because they are most of the time hesitant to take a time off to go to the clinic or hospital due to the fear of losing their employment status (Edwards, 2016). This has compelled some to opt for the informal health care such as going to

pharmacy shops for over-the-counter drugs at their own convenience and cost (Caldwell et al., 2014). Poor mental and physical health can be attributed to being unemployed as mentioned above. These conditions are so severe that one must have to access the services of a health practitioner (Bono, Winter-Ebmer & Weber, 2012; Henkel, 2011; Jefferis et al., 2011). It cannot be concluded from the literature that the unemployed utilises the healthcare systems more than those who are employed. The cross-sectional study by Ahs et al. (2012), in Sweden, demonstrated that not being employed was associated with a lower tendency of going to access a healthcare facility.

In Vietnam, Lonnroth, Linh and Diwan (2001) investigated the utilization of healthcare among tuberculosis patients. The researchers found that the economically inactive groups such as students and the retired were less likely to go to a private pharmacy, and this could mean that they rather preferred to go to public healthcare facilities. Also, Al-Doghaither, Abdelrhman and Saeed et al. (2003) concluded that students were more likely to access healthcare from private facilities than the public sector. The inconsistencies in these findings could be attributed to the various means by which the economically inactive group was defined by the studies under discussion and the statistical analysis performed. Edwards (2016), therefore, suggested that one must be very cautious in making comparisons in the results from those studies.

In Ghana, most of the public universities have healthcare facilities to support their students in times of need. At the University of Professional Studies and the University of Ghana, hospitals are available on campus for the students' healthcare. The hospitals also render services to inhabitants from the

neighbouring towns. When newly admitted, students patronise such facilities for their medical examinations. Services rendered to students in these facilities are free of charge, and when some prescribed drugs are not available, students buy them from pharmacy shops outside their campuses but come for a refund later on. There are also counselling units which help these students to address their psychological challenges. Some organisations also have affiliated themselves with some hospitals and clinics for their staff and their dependents. Therefore, students with such parents benefit from these opportunities too.

Marital Status

Marital status is a factor that can affect the health-seeking behaviour of an individual. It is also an important social factor that is related to our health. In most of the findings, people who are married show better attitude towards their healthcare than their counterparts who are single (Goldman, 1993; Shor et al., 2012; Solie, Backlund & Keller, 1995), whilst mental health is very weak in the unmarried as compared to the married adults (Davis, Murphy & Neuhaus, 2000). In all, divorcees, widowers and people who have never been married before have poorer health outcomes, compared to their married colleagues (Gomez-Olive, Thorogood, Clark, Kahn & Tallman, 2010; Hosseinpoor et al., 2012; Perkins et al., 2016; Umberson, Crosnoe & Reczek, 2010).

Those who are married exhibit positive attitudes towards their healthcare for several reasons. First of all, it is very prudent that healthier people get married to healthier people and stay longer, whereas the less healthy people stand a very high chance of becoming single, separated or divorced. Secondly, married people get more social and psychological support

from their families and therefore enjoy better health behaviours. Thirdly, marital termination is a very depressive situation that leaves the health status of the people involved in a deplorable condition (Edwards, 2016; Eng et al., 2005; Waldron, Hughes & Brooks, 1996).

Divorce and Single Parenting

Limited studies available have indicated that the use of mental health and other health care in general is higher among people who are divorced or separated than it exists among the married or cohabiting, irrespective of their mental health status (Joung, vanderMeer & Mackenbach 1995; Gouwy, Christiaens & Bracke, 2008). As opposed to the married or people who are just cohabiting, divorcees or those who are separated visit professional healthcare providers like the general practitioners (Joung, vanderMeer & 1999) and most of the time are on admissions (Joung et al., 1995; Prior & Hayes, 2003). Research has also indicated that divorce is more prevalent among those who are highly educated (Poortman & Kalmijn, 2002), and this can be used to explain the high mental healthcare use among them. However, it has been argued that countries with decreased cost of divorce have the lower educated more at risk of divorce, which undermines the previous explanation (de Graft & Kalmijn, 2006; Harkonen & Dronkers, 2006).

Single parents, especially mothers, tend to make frequent visits to mental health professionals. This is because they have numerous health challenges (Wang, 2004). A research conducted in Holland has proved divorcees have a lot of unmet health needs, including mental health challenges (Bijl & Ravelli, 2000). However, a study in Canada found that because single mothers have high rates of psychopathology, they tend to use health

professionals more often when they encounter mental health issues (Cairney & Wade, 2002). Using data from Eurobarometer survey, Bracke, Colman, Symoens and Van Praag (2010) investigated the relationship between marital status and professional health-seeking among the general population in Europe. It was found that compared to married men and women, divorcees and separated couples were more likely to seek professional care, especially in countries with low rates of divorce.

The literature reveals some relations between social support and increased health-seeking behaviour (Ahs et al., 2012). A study by Holt-Lunstad, Smith and Layton (2010), for instance, shows that people with social support are more likely to live longer and quality lives. This finding was supported by the findings of a meta-analysis conducted by Umberson and Montez (2010), who discovered a significant relationship between social relationship and death. In explaining this observation, Carr and Springer (2010) noted couples have relatively stable homes with necessities catered for, as well as access to better amenities such as healthcare.

Other studies have reported contrasting findings. A study by Sharma, Mazta and Parashar (2013), for example, found no association between marital status and health-seeking behaviour. On the converse, in Nepal, Ghimire, Smith and van Teijlingen (2011) concluded from their studies on female sex workers that marital status is a significant factor in health-seeking behaviour. This leads to inconsistencies in the findings on the correlation between the two variables. These disparities could be attributed to the methodologies used, the sample size, environmental differences or the characteristics of the respondents. The present study includes marital status as one of its variables,

because some of the students in the universities are married, and this makes it imperative for a concern to be shown about their health-seeking patterns. Such students have a chance of seeking for health-care from healthcare institutions at their spouse's place of work, or better still benefit from the health facilities at their institutions of study.

Religious Affiliation

Studies have demonstrated the relationship between religion and health-seeking behaviour. A study by Mwabu (1984) has, for instance, found a higher likelihood of the use of modern healthcare facilities among Christians as compared to Traditionalists. This finding was supported by the findings of Koenig's (2012) who discovered that significant relationship between religion and type of medical care sought. The study found that Traditionalists normally attributed mental illnesses to spiritual causes, and this makes them seek religious remedies for mental disorders. The present researcher showed interest in religion as a factor of health-seeking behaviour, since the work is related to university students with different religious orientations.

Religion, as a determinant of health-seeking behaviour, can be looked at from two different angles. Firstly, religious affiliation can have an effect on an individual's health-seeking behaviour and secondly, religion itself has have an effect on one's psychological well-being. Most university students belong to one religious group or the other and the two most dominant religions on Ghanaian university campuses are Christianity and Islam. A study by Wright, Frost and Wisecarver (1993), in Texas, found that less religious people often suffered depression, compared to their counterparts who actively involved themselves in religious services. In another study among high-school students

from West Virginia, the researcher observed an increase of "ego strengths of hope, will, purpose, fidelity, love, and care" among highly religious students (Markstrom, 1999). Thus, being religious is associated with better mental health outcomes (Ellison, Bartkowski & Anderson, 1999).

Race and Ethnicity

Studies have demonstrated some associations between race and ethnicity, and health. It has been found that people of racial backgrounds that suffer discrimination tend to have poorer health outcomes (World Health Organization, 2010). A cross-sectional study was conducted by Ampadu (2016), with the aim of revealing within-group differences in help-seeking intent of Ghanaians living in America. The study found that Ghanaian immigrants preferred to seek help from their friends and close relations, phone helplines and mental health professionals for mental health problems. This could be attributed to their socio-economic status in a foreign land, as well as their cultural orientation, as most Ghanaians give different meanings to the origin of sicknesses, especially mental health illness, and this affects their health-seeking intentions. Thus, instead of seeking healthcare from professionals, due to financial constraints, they prefer to seek help from their friends and close relations.

In summary, demographic factors such as gender, age, education, marital status and others have an immense influence on the health-seeking behaviour of university students. The hospital facilities in most Ghanaian universities are open to all staff and students irrespective of their race and the ethnic groups they belong to. The choice to attend the facilities for healthcare depends solely on the individuals.

Locus of Control and Health-Seeking Behaviour

The personality profile of a person also stands a chance of either undermining or improving the health decision-making process of an individual in times of ill-health. Locus of control is a psychology that tends to determine personal health behaviour. It divides individuals into internalisers and externalisers. An internaliser refers to a person who believes that he can control the outcome of his life, that the reward he gets depends on his behaviour, that he can control his destiny, and that he is responsible for what happens to him (Gan, Shang & Zhang, 2007; McIntyre, Srivastava, & Fuller, 2009; Pruessner et al., 2005). Lorenc et al. (2009) have found that internalisers are highly probable to demonstrate health-promoting behaviours. On the other hand, externalisers attribute the control of their lives to external forces (Burkhart & Rayens, 2005). They hold that rewards have nothing to do with their own actions. Thus, they attribute whatever happens in their lives to external causes, such as the influence of other people or luck (Gan et al., 2007). In effect, they attribute their health conditions to chance (Lorenc et al., 2009).

Various researchers around the globe have explored on the effect of locus of control on students' attitude towards health-seeking behaviour. An example is Roddenberry and Renk's (2010) study in the Southeastern State University. They focused on the influence of locus of control on stress, psychological and physical symptoms, and the utilization of health services among undergraduates. They found a positive relationship between stress and symptoms, while a negative relationship was found between self-efficacy, and

stress and symptoms. A positive relationship was also found between external locus control, and stress and symptoms.

Another study was conducted by Perenc and Radochonski (2016), who focused on psychological determinants of mental health-seeking behaviour among young adults in Polish universities. The study focused on gender, educational attainment, health locus of control as well as sense of coherence as determinants of health-seeking behaviour. The study found a positive relationship between being and internaliser and help-seeking behaviours. A similar finding emerged in relation to sense of coherence. In all, a significant relationship was found between attitudes towards help and variables such as gender, level of education, sense of coherence and internal locus of control.

Focusing on students of Redeemer's University, Tunde and Iyabode, (2013) investigated the impact of locus of control on health-seeking behaviour among students in Nigeria. The study, which adopted the survey method for data gathering, collected data from 170 undergraduates. The research attributed 21% of changes in illness behaviour to locus of control. Specifically, illness behaviours differed significantly across students who fell within the two types of locus control. This highlights the relevance of locus of control in determining illness behaviour. Focusing on residents New Juaben Municipality of Ghana, Sarfo and Acquaye (2016) investigated the effects of locus of control on health-seeking behaviour of Ghanaians. The study found no significant relationship between locus of control and health-seeking behaviour. On the other hand, it was found that health-seeking behaviour was determined by socio-cultural factors.

In a high school in the Volta Region of Ghana, Worlanyo (2017) conducted a correlational research into students' problems, locus of control, personality. These factors are predictors of psychological counselling-seeking behaviour. The study found a significant relationship between students' problems and health-seeking behaviour. The survey results and conclusions show that there is a significant correlation between the student's problems and the behaviour of seeking counselling. The study further revealed that with the exception of stigma, locus of control served as an important predictor of all the other variables used in the study. Again, a significant association was found between health-seeking behaviour and social support and students' issues. Finally, the study reported a positive significant association between social support and counselling-seeking behaviour.

On the impact of locus of control on the utilisation of health services, AzFredrick (2017) revealed interesting findings in Nigeria. The study specifically sought to investigate the association between psychological factors and use of reproductive health services among female adolescents in high schools. The study found an association between the studied variables. Also, the study found little variations across internalisers' and externalisers' use of reproductive services.

In summary, locus of control has an effect on the health-seeking behaviour of university students. Students with internal locus of control believe that their health outcome depends on them, and therefore are likely to be very careful and conscious of their health. They are also more likely to seek help from professionals in times of health challenges. On the other hand,

students with external locus of control attribute their health outcome to others, and such students may resort to non-professional sources in times of ill health.

Stigma and Health-Seeking Behaviour

University students stand a risk for developing mental health issues, and this is capable of affecting their way of life. Mental disorders such as depression, low self-esteem and others can affect the way they relate with their peers and the entire university community. Their transition from secondary school to the tertiary institutions may be a new experience to some of them, and stigma may pose as a barrier to their determination to seek professional health care.

Stigma, according to Deane and Chamberlain (1994), is the fear of being branded negatively if one seeks counselling for mental health issues. On the other hand, Corrigan (2004) opines that a person who seeks counselling considers him/herself less socially acceptable. According to some studies, people who sought counselling services became labelled as anxious, uncomfortable, protective, reliant, awkward, unhappy, antisocial, worried, insane and poor (Sibicky & Dovidio, 1986). This implies that for fear of being labelled with these negative names, people will be a little bit hesitant to seek for counselling because they think they are less acceptable in the society (Kuok & Rashidnia (2019).

Mental health patients all over the world face issues of stigmatisation (Pasupuleti, 2013). There are various definitions of stigma in the mental health literature. Again, the literature identifies various types of stigma.

Public stigma refers to the general public's common negative views and perceptions towards mental illness, as well as the extent to which they

prejudice against people with mental illnesses (Lally, Quigley, Bainbridge & Mcdonald, 2013). Public stigma is characterised by negative stereotypes and prejudices, which include statements such as, "people with mental illnesses are dangerous and unreliable" (Eisenberg et al, 2009).

Perceived public stigma concerns the degree of an individual's perception about the stigma that the public has about mental health patients (Lally et al, 2013).

Personal stigma (self-stigma) is conceptualised as a person's beliefs and perceptions towards mental health patients. Personal stigma results in public stigma (Lally et al., 2013). Self-stigma can affect an individual's self-esteem, which can, in turn, lead to underachievement (Pasupuleti, 2013).

Label avoidance involves a situation where a mental health patient avoids seeking a better treatment, in an attempt to avoid being stigmatised or labelled mentally ill (Pasupuleti, 2013).

Internalized stigma. This is when a mental health patient starts having negative perceptions about himself/herself due to the stigma he or she suffers (Lally et al., 2013).

The literature shows that the stigmatisation suffered by mental health patients on campuses According to literature, mental health patients become silent about their hardships due to the stigma they suffer on campuses. A study by Eisenberg, Downs, Golberstein and Zivin (2009) on 13 university campuses revealed a predominance of perceived mental health stigma, compared with personal stigma. However, personal stigma dominated among male, young, religious, and Asian students. It was also found that people with personal stigma were less likely to seek professional help. Another study

revealed that people who attributed their disorders to mental health patients got angry at them and refused to help them (Cooper et al., 2003). Regarding mental health patients as dangerous, approaching them with fear and approving intimidating treatments against them were not significant correlates of health-seeking behaviours (Cooper et al., 2003). On the other hand, perceived stigma and personal stigma were found to be determinants of health-seeking behaviour (Corrigan & Rusch, 2002; Vogel, Wade & Hackler, 2007).

Using the survey method of quantitative research, Venson, (2014) sought to examine the determinants of mental health stigma among graduate students reading Public Health Administration students in Pace university. As the study revealed, more than forty percent (42%) of the sample indicated that people will be hesitant to embrace a close friend who has undergone mental health therapy. Based on the findings, the researcher stressed the need to strengthen efforts aimed at reducing stigma among university students.

Adopting a cross-country approach, Vogel et al. (2017) aimed to study the correlation among self-stigma and public stigma as well as psychological help-seeking attitudes. The study, which relied on a sample of 3,276 students, revealed that self-stigma determined the association between public stigma and health-seeking attitudes across countries. Another study that examined health-seeking attitudes of students across countries was conducted by Kuok and Rashidnia (2019), who focused on Iran and China. Examining data from a sample of 300 college students, the researchers found various determiners of health-seeking attitudes in Iran. In the case of China, the study found stigma as the most negative correlate of counselling-seeking attitudes.

Hilliard (2019) also examined stigma and health-seeking attitudes among a sample of 325 student athletes. The study found self-stigma and attitudes as factors significantly associated with health-seeking behaviours. A similar study by Greenidge (2007) focused on health-seeking attitudes towards professional counselling among English-speaking Caribbean students in colleges in the USA and the findings were compared with Caribbean students in Caribbean colleges. It was found that attitudes towards counselling seeking were dependent on tolerance for stigma. It was also found that anticipated risks predicted attitudes towards seeking counselling services among Caribbean students in the USA.

In the United Kingdom, Catriona (2016) also investigated the attitudes of college students towards mental health. The study, which was correlational in design, revealed no significant association between stigma and health-seeking behaviour. On the other hand, gender and ethnic background were found to predict health-seeking behaviour among the students. In Saudi Arabia, Alyousef (2016) investigated stigma related to mental health as well as the attitudes of mental health professionals towards mental health patients. It was found that varied degrees of stigma towards mental health patients exist among mental health professionals. The study identified a number factors that influenced stigma among health professionals, including 'exclusion', 'rejection and caution' and 'risk and fear'.

A qualitative study by Jamar (2013) explored African American clinician's perceptions of stigma of mental illness within the African American community. The study, which gathered interview data from nine clinicians, discovered the dominance of stigma and negative attitudes towards

mental health patients. The study also revealed a little change towards positive attitudes over time. In a study that used data collected from a sample of 682 students of Midwestern University, Vidourek, King, Nabors and Merianos (2014) investigated students' perceptions on the benefits and challenges to accessing healthcare for mental disorders. The study found that compared to males, females perceived that mental healthcare services have more benefits. Similarly, relative to males, females had lower negative attitudes that related to stigmatisation. Again, more barriers to accessing mental healthcare were identified by students who had ever undergone such health services, compared to their colleagues who had never undergone such services. Based on these findings, the authors recommended the need to educate students on the benefits of mental healthcare services.

In the context of Sri Lanka, Abhayasinghe (2014) investigated undergraduates' knowledge and attitudes towards guidance and counselling services. The data for the study were collected from a sample of 177 students of the Faculty of Allied Health Sciences at the Kotelawala Defence University. The study revealed that a significant number of the students had knowledge about the guidance and counselling services provided by the university, with over half of them demonstrating negative attitudes towards the services provided by the guidance and counselling unit in their university. This portrays that the students have a negative attitude towards the guidance and counselling services provided by their institution, with stigma being one of the variables that contributes to their attitudes.

As indicated in several studies done on health-seeking behaviour, stigma has an influence on the health-seeking intention and attitude of most

students, and because of that, for fear of being labelled, many students may not go for healthcare when faced with psychological challenges. Stigma causes social exclusion and isolation for those afflicted (Gaebel, Baumann, Witte & Zaesje, 2002), and this may even worsen their situation when they refuse to go for healthcare. Much work has not been done on stigma and health-seeking behaviour among university students in Ghana. Therefore, the current study will add to the literature on stigma and how it influences on the health-seeking behaviour of public university students in Ghana.

Culture and Health-Seeking Behaviour

Patients' understanding of health concepts, taking care of their health, and making decisions related to their health can be influenced by culture, religion, beliefs and ethnic customs. According to Simon (2006), healthcare professionals recognise the impact of culture on health behaviour. To Simon, culture is referred to as the "stuff" which is the total composition of human's attitudes. Culture provides the human content and serves as the medium through which people perceive and live their lives. It is, therefore, important to consider people's cultural background when administering care to them.

Leong, Weiland and Dent (2010) conducted a cross-sectional study on culture and found that cultural background was seen as informing health outcomes by affecting the mindset about illness, attitudes toward health professionals, and patient's behaviour as well. Cultural orientation of health professionals may also interfere with that of their clients during healthcare provision. Therefore, differences in the cultural disposition of clients and their healthcare providers may result in unfortunate health outcomes, making it very necessary for healthcare professionals, including psychologists, to acquaint

themselves with the cultural norms of their clients before deciding on which approach to use during counselling and psychotherapy sessions.

Leong et al. (2010) also believed that more focus should be on the client or patient, as this can produce interpersonal care, which will be unique to the needs and expectations of the patient or client. Patients must be understood in their own unique and cultural context and must be appreciated as well. When that level of cultural competence is achieved, patient-focused orientation will be maintained, and this will lead to a patient-provider relationship and effective communication, with particular emphasis on language and literacy (Leong, Weiland & Dent, 2010). Psychologists as well as physicians can erroneously offer healthcare to their clients if proper care is not taken in terms of taking information on client's cultural background and orientation. Culture has a relationship with the health beliefs of an individual, and one is likely to choose a particular type of remedy based on that individual's cultural background.

Lim, Gonzalez, Wang-Letzkus and Ashing (2009) explained cultural health beliefs as a media through which individuals conceptualize sickness, perception of their pain, and the meaning they give to quality care, as well as their choice of a suitable health caregiver. Cultural perceptions and experiences about an illness dictate the way a person lives his or her life and engages in certain lifestyle attitudes. Even though the cultural disposition of an individual has an impact on his/her health-seeking behaviour, minimal research exists on the influence of culture on the psychological health-seeking pattern of university students. Culture has always been linked to a society's system of belief and a number of researchers have examined how a specific

group of people's cultural values can influence their attitudes towards seeking psychological healthcare.

Globally, various researchers have looked at culture as a concept with respect to the origin or aetiology of some illnesses. In a study by Pramukh and Palkumar (2006) among the Bogatha, it was revealed that the participants ascribed diseases to which they have no reasonable description to some abnormal actions of self and others towards elders, nature and divine rules. This means that their utmost priority, when they notice an ill-health, is to resort to spiritual cure in a traditional way. There is a heavy belief in the power of prayers and rituals that enable some herbs to act as medicines to heal diseases among them.

Carteret (2011) investigated culturally-based beliefs about illness causation and found that the health beliefs of patients can highly influence their clinical care. This can discourage efforts aimed at prevention, delay or even worsen medical care which may lead to the use of informal treatment that can either be disastrous or beneficial. Core belief systems about illness causation, i.e., naturalistic, Ayurvedic, biomedical, etc. result in culturally-based attitudes towards seeking treatment and believing traditional medicines and folk remedies. People's depth of understanding of the causes of illness is quite extensive. It ranges from witchcraft and soul loss to the work of germs and weak immunity. This is in sharp contrast with other philosophies where health is perceived as a state of balance between the physical, social, and super-natural environment.

The research work of Toliver-Weddington (2000) focused on cultural considerations for the treatment of cardiovascular disorders among African

Americans. It was seen that people still believe in magic, folk medicine, spirits, and other signs of witchcraft. The idea of supernatural causation of incapacitating situations continues to persist to some magnitude. There is also the view of divine intervention. These beliefs reiterate the perception that when men displease their gods in some way, they are consequently punished. This assertion was confirmed by Walker (2006), who revealed that members of a Nigerian tribe called Ngwa believe that the spirits of their loved ones and enemies from the spirit world come back to exact punishment. According to Akinkugbe (2004), Nigerian women, for instance, had the belief that hypertension was caused by evil spirits, explaining that whenever mothers stayed in the sun for too long, the spirits became angry or the spirits were sent by others. Orthodox treatment is not an option with this belief system. The women tend to resort to treatment from divine healers who are perceived to have remedies to their difficulties. Some cultures and researchers agree to the fact that allopathic medicine can only describe some disease conditions within the confines of their own medical model and by regularly violating local cultural understandings. However, Yawney (2005) opines that medical science may explain sickness clinically without reference to cultural factors, but it cannot describe or treat all sicknesses efficaciously without considering non-biological features.

A number of researches have shown that recognition/definition of hypertension is influenced by the people's belief system (Mwenesi, 2003). The root of categorisation of illnesses into serious, mild or mundane is formed by the belief system. This also determines a number of things such as the swiftness with which care is sought and the type of care sought (i.e., home,

traditional or modern) and the social network that will be included in decision-making for seeking treatment.

Some studies conducted in Tanzania, Kenya and Ghana have shown that a substantial percentage of caregivers believe unfussy malaria, for instance, to be a mild sickness for which household solutions are largely required. However, people from these areas connect severe or cerebral malaria to evil spirits (Ahorlu, Dunyo, Afari, Koram & Nkrumah, 1997; Asenso-Okyere, Dzator & Osei-Akoto, 1997; Hausmann & Muela, 2000; Mwenesi, Harpham, Marsh & Snow, 1995). Spiritual and other traditional healers are usually contacted in such situations for healing. D'Andrade (2005) discovered that when cultural values are linked to all sicknesses such as cardiovascular disorders, the culture, beliefs and values of a group impact views about the meaning of the illness. Consequently, it may also influence the types of treatment or remedies seen to be beneficial, and the probable results of health behaviours connected to the inhibition and control of diseases (Coreil, Wilke & Pintado, 2004).

With respect to hypertension, Konadu (2008) observed that an ethnic group in Ghana called the Akans have some cultural beliefs which influence their health-seeking behaviour. In their part of the world, the people's ideas and behavioural pattern often conflicts with their knowledge on illness, making it possible for the underutilization of health services, and a number of healthcare directions are disregarded. In addition, Weller (2007) found that the perception people have that hypertension is caused by supernatural power is predominant, and this may cause them to resort to treatment from traditional healers. This situation is not quite different from the cases that occur in many

parts of Indonesia, even though western allopathic medicine is gradually gaining more acceptance (El Bashir, 2008). However, there is still the belief in supernatural powers. Hence, they perceive the western allopathic medicine as a model that only caters for symptomatic or supportive therapy. Among these cultures, health-seeking behaviour is not determined by factors such as its affordability, accessibility or proximity but the people's belief system plays an essential role in making decisions that relate to their health.

Sarfo (2015) examined the health-seeking behaviour among people suffering from cardiovascular disorders in the New Juaben Municipality in the Eastern Region of Ghana. The study found cultural belief systems as a factor that significantly determines the health-seeking behaviour of the people. The study also found the perception of the aetiology or origin of cardiovascular diseases was influenced by cultural beliefs. This highlights the need for clinicians to be sensitive to cultural issues when providing healthcare to people.

In another case, Treviño (2001) revealed in Guatemala that the blood of a person can turn black after the person has been terrified and was called *nervios* or 'nerves', which was a prevalent culture-bound disease. Consequently, prayers are said by traditional healers who are invited from the book called *Santa Cruz de Caravaca*. The patient usually recovers after the prayers have been offered. They believe that since the nerve-related condition is caused by supernatural powers, offering prayers is more efficacious compared to any other remedial action. Put in another way, Treviño (2001) says that the people perceive that since the source of the condition is purely supernatural, seeking help from the orthodox source is completely ruled out.

The setting of this study was very traditional where access to modern healthcare was also impossible. The study, therefore, did not consider the probability of seeking assistance from the modern healthcare system as a result of the lack of exposure.

Beal (2006) conducted a study to investigate community responses to mental illness in Ghana. It was revealed that using traditional healers to treat gynaecological problems amongst women was prevalent among all cultures. Geissler (2000) stated that these cultural practices and beliefs have been predominant, irrespective of age, socio-economic status of the family and level of education. It has been established by Hasan and Khanum (2002) that beliefs also influence knowledge and understanding of the intensity of sickness as well as acceptability of the service. Again, Stekelenburg, Jager, Kolk, Westen, Kwaak and Wolffers (2005) explained that the cooperation, empathetic attitude and active listening skills exhibited by the traditional healers entice more clients, as compared to modern allopathic specialists. The Savaras, Bogatha, Konda, Valmiki, and Koya tribes in India believe in the power of prayers and rituals that have the ability to make some herbs function as medicines to heal heart-related diseases (Pramukh & Palkumar, 2006). They believe that disease outbreaks occur as a result of some deviant acts of individuals and others towards elders, nature and divine rules. This means that getting spiritual cure from a traditional source was of essence. The study, however, showed that there was no sign of the accessibility of other health amenities and whether or not the people patronised them.

Furthermore, Chanita et al. (2006) revealed in their study that cultural differences do not essentially have any impact on health-seeking behaviours.

These findings have shown that although ethnicity is significant to some cultural values such as religiosity, clinical experiences with disease may also be equally significant to values connected to temporal orientation. The researchers, thus, stressed the essence of assessing the situation within which cultural values are communicated, counting to depicting ethnic group differences. A critical examination was not done on the respective belief systems and cultural values which affect health-seeking behaviour and consequently, this influenced every healthcare decision taken by the people.

Weller, Ruebush and Klein, (2005) focused on predicting patient's treatment-seeking behaviour in Guatemala. They found that culture has a little influence on people's health-seeking behaviour. The efficacy of treatment determined their choice of treatment and not their cultural beliefs. In a literature review by Johnson, Elbert-Avila and Tulsky (2005) on the influence of spiritual beliefs on treatment decisions of Africans, it was revealed that sources of comfort, coping and support were spiritual beliefs and practices. The medical doctor is perceived as an instrument God uses to heal and God is held accountable for people's physical and spiritual health.

Nyamongo (2002) stated that in rural communities, people who hold cultural beliefs resort to the use of self-medication, home medications and traditional healers. Women also pay serious heed to advice given by elders (Delgado, Sorenson & Van der Stuyft, 1994). This brings about delay in seeking treatment and it is very prevalent with women, not only for themselves but particularly for their children's illnesses as well (Nakagawa et al., 2001). Besides, age, gender and marital status, etc. have been found to be linked to health-seeking behaviour (Goldman & Heuveline, 2000; Nyamongo,

2002; Yip, Wang & Liu, 2000). Cultural factors have been dominant regardless of these other factors (Geissler, 2000). They also influence responsiveness to healthcare (Aday & Anderson, 1974).

In Kenya, Arika and Osuga (2017) examined the correlates of health seeking behaviour among fecund women. The study relied on quantitative research design and used data from 228 women. The study found culture, religious beliefs and socio-economic status as the determinants of health-seeking among the women. This can create the key concern for government health policy makers. The study also found a negative association between the use of antenatal care and distance to health facility. Finally, it was discovered that spouses and mothers-in-law were instrumental in women's healthcare decision-making.

Chapter Summary

The review of studies on health-seeking behaviour among university students outside Africa shows that these students prefer informal consultations from their friends, partners and parents, a situation that is not different from the attitude of students towards health-seeking behaviour in Africa. Others also find their own means of solving their mental health challenges (self-help), whilst some students also ignore that they are having health challenges which require professional help. University students have been accessing mental health information online due to the availability of vast health information on the internet. Their barriers to health-seeking behaviours fell into two categories, accessibility and relational. Thus, if students are aware of the availability of health facilities and are very well assured of confidentiality, there will be an improvement in their health-seeking behaviour.

In Africa the situation is not completely different with regard to health-seeking behaviour among students. Available literature reveals that most of the students consult their peers, whilst some also prefer to go to pharmacy shops in times of health challenges, with few Nigerian students consulting a traditional healer. Others also attended to their healthcare issues themselves. Some students also will not go to hospital until their condition becomes worse. Students also go online to search for information on health issues especially among the Nigerians. Therefore, when faced with any health challenge, they go online to seek for remedy. Among the Africans, the most common factors that affect their inability to seek professional healthcare were the cost involved, long waiting time and sometimes the unfriendly attitudes of the healthcare professionals such as nurses. It is also very clear that most of the students do not have the necessary information about their health facilities on their campuses. The introduction of the National Health Insurance Scheme in Ghana has also influenced the health-seeking behaviour of some students in Ghana, as students who have signed up unto the scheme are quick to seek healthcare as opposed to those who are yet to enrol unto it.

Generally, mental health literacy among the universities in Africa including Ghana is very low. Therefore, efforts must be put in place to educate students on the early symptoms of mental challenges and the need to seek help at the early stages of the illness, not when the symptoms escalate. Also, the belief systems of a society are linked to its cultural values. Belief systems are those aspects of culture that attach meaning to events, things and people. With a better understanding of why people use or do not use particular healthcare

services, healthcare providers can seek to improve on the quality of human lives through proper appreciation of their belief systems.

Most of the works done on health-seeking behaviour among university students, both in Africa and in the other continents, looked at stigma, locus of control and culture as individual variables that affect an individual's attitude towards seeking for psychological healthcare. However, this study seeks to do more explorations on locus of control, stigmatisation and culture, and intends to find out how these three variables affect the health-seeking behaviour of university students. It also intends to find out how demographic factors like age, gender and geographical location of the students affect their health-seeking behaviour.

CHAPTER THREE

RESEARCH METHODS

Introduction

This chapter presents the research design and methods for addressing the set objectives and hypotheses. It explains the methods employed in answering the various questions the research seeks to answer. The chapter begins with the research paradigm, design, study area and target population. It continuous with sampling procedures, data collection instruments and the four scales used in the study are discussed in detail. The chapter concludes with quantitative and qualitative data processing and analysis, and the statistical tests employed to test the set hypotheses as well as ethical considerations made in the design of the research fully discussed.

Research Paradigm

Every research is guided by the worldview the researcher adopts. It is the worldview that functions as the foundation of the study, guiding which research design is to be used, the nature of the data needed and the kind of the analysis technique to be utilised (Creswell & Plano-Clark, 2007). In research, such worldviews are termed research paradigms and include positivism, interpretivism, pragmatism, etc. The study employed a mixed method approach; hence, it was guided by pragmatism.

Pragmatism focuses on "what works" to answer the research question. Pragmatism shifts energies away from philosophical underpinnings and focuses on actions. The goal of mixed methods research is not to replace

qualitative or quantitative approaches but, rather, to combine both approaches in creative ways that utilize the strengths of each within a single study. By mixing methods in ways that minimize weaknesses or ensure that the weaknesses of one approach do not overlap significantly with the weaknesses of another, the study is strengthened (Ary, Jacobs, Sorensen & Razavieh, 2010). Since the current study seeks to investigate the determinants of psychological health-seeking behaviour among public university students in Ghana, the use of quantitative data alone was not enough to address the problem. The views of some participants were obtained and added, thereby aligning to pragmatism.

Research Design

Research design is the master plan that guides the entire study, specifying how to collect and analyse data to achieve the objectives of the research. Thus, the research design adopted guides on how respondents or participants are selected as well as the modes of data collection adopted (McMillan & Schumacher, 2001). In view of this, a sound research design is the one that produces reliable or credible results. In the same vein, Durrheim (2004) explains that research design is the action plan that links study objectives to how the study is to be conducted in order to attain such objectives. Therefore, developing an effective research design requires the researcher to be strategic and have a good appreciation of the research problem.

Research designs emanate from a research problem. There are three main research approaches, namely quantitative, qualitative and mixed method approaches (Creswell, 2014). This was an exploratory study that adopted the

sequential explanatory mixed method design because this was in line with the purpose of the study which sought to explore some factors as determinants of psychological health-seeking behaviour among public university students in Ghana.

The design is a two-phase mixed method that has an initial quantitative phase followed by a qualitative phase. This design sought to gather more of quantitative data and supported it with qualitative data in order to gather reliable and valid results (Alhassan, 2007; Bernard, 2002).

This design, however, has its own challenges. One major challenge is that a researcher cannot use it if he or she is not an expert. For example, the design can only be used by experts and researchers who possess specialised skills, time, resources and expertise for extensive data collection and analysis. Both quantitative and qualitative phases of the research design need certain expertise and some precision from researchers who carry them out (Plano-Clark, 2005).

Again, a researcher should be able to merge two or more sources of data with little or no difficulty. Thus, since the main aim of the design is to gather data from both quantitative and qualitative sources, the final segment will be to merge the two data sources for conclusions to be drawn. As such, an individual who does not have the merger qualities will not be able to use the design.

Another challenge of the sequential explanatory design is the possibility of a researcher having different samples and different sample sizes when merging two data sets. Both the quantitative and qualitative phases

employ different sampling techniques and sizes; therefore, merging the two might be problematic for one who is not an expert.

To overcome these challenges of the design, I did an extensive study of how to combine these two methods in a single study and this provided me with relevant knowledge and skills (expertise) which subsequently led to the successful completion of this study. The different instruments, samples, sampling techniques and sample sizes were merged successfully with no difficulty by following the recommended (set) rules. Also, even though the process was complex and time consuming, the researcher made judicious use of the time that was available to her for the study. This became a solid reason for the adoption (application) of this design in spite of its weaknesses.

In the first phase of employing the mixed method approach, there was the quantitative description of the determinants of psychological health-seeking behaviour among public university students in Ghana. The quantitative results were then followed by an in-depth qualitative study that complemented the initial quantitative findings as postulated by Cresswell and Plano (2007) and Leedy and Ormrod (2005) in the second phase. Greater emphasis was placed on the quantitative methods than the qualitative method. This is illustrated diagrammatically in Figure 2 below from the perspectives of Cresswell (2003) and Cresswell, Plano-Clark, Gutman and Hanson (2003).

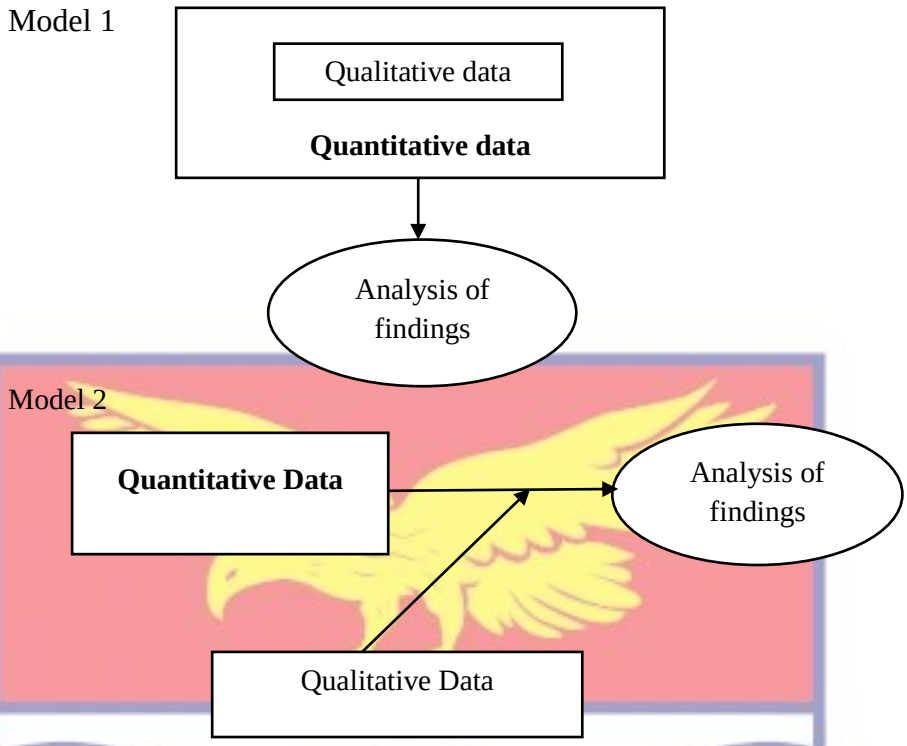

Figure 2: Visual Models of Sequential Explanatory Research Design

Study Area

The research setting involves four regions in Ghana. These are the Greater Accra Region, the Central, the Ashanti and the Northern Regions. The choice of these regions is justified by the shared numbers or large students' concentration in those regions.

Population

The population of a study is the total of the individuals or elements under consideration. In this study, the population is undergraduate students from all public universities in Ghana. The target population is the population that the researcher has interest in, which is also a subset of the population. The target population for this study was all undergraduate students from four selected public universities in Ghana. The four selected public universities from the research area are the University of Professional Studies (UPSA) in the Greater Accra Region, Kwame Nkrumah University of Science and Technology (KNUST) in the Ashanti Region, University for Development

Studies (UDS) in the Northern Region and the University of Cape Coast (UCC) in the Central Region. These public universities have well equipped counselling centres that are also accredited by the Ghana Psychological Council. This is often not the case with most private tertiary institutions in Ghana.

The accessible population was all students offering Business programmes with Accounting option in the four selected public universities, in order to get participant with similar academic characteristics for the study. The Accounting option was selected given that it was offered in all the selected universities, and also for the sake of convenience. The total number for the accessible population from these four selected public universities as at 2018/2019 academic year was 5,369. These public universities were purposely chosen to cover the entire geographical area of the country: the coastal belt, forest zone, and savannah area. Along the coast, universities from Accra and Cape Coast were chosen, and for the forest zone, KNUST in Kumasi was selected, while University for Development Studies in the Northern Region of Ghana was chosen to represent the savannah zone.

Kwame Nkrumah University of Science and Technology (KNUST)

The Kwame Nkrumah University of Science and Technology (KNUST) is the foremost Science and Technology University located in the Ashanti Region of Ghana. Since its establishment, KNUST has trained a number of scientists for Ghana and other countries. KNUST covers a land area of around 18 kilometres square. With its vision, KNUST intends to remain a giant among universities for science and technology. Its mission is to improve the quality of life of Ghanaians by serving as a conducive space for

conducting significant research as well as for engaging in quality teaching, promotion of entrepreneurship and community service. In 1993, the KNUST established a Counselling Unit which has currently become a Counselling Centre, with the aim of providing quality mental health services to members of the university community and the general public. Located in the J. Harper Dean of Students building around the Commercial Area, the Counselling Centre has eight counsellors including clinical psychologists (KNUST, 2019).

University for Development Studies (UDS)

Established in May 1992 as the first public university in the Northern Region of Ghana, the University for Development Studies (UDS) was to serve as a university for the promotion of national development and the development of the Northern Region, in particular, through a blend of gender-sensitive, practical academic work and community service (University for Development Studies, 2018). Thus, the establishment of UDS was predicated on the assumption that universities need to be instrumental in providing solutions to societal problems, especially in rural areas (Effa, 1998). Just like the other public universities, the UDS has a Counselling Unit that renders quality services to its staff and students.

University of Cape Coast (UCC)

The University of Cape Coast (UCC), which was established in 1962, was originally to train graduate teachers for Ghanaian second-cycle educational institutions. This was because the University of Ghana and Kwame Nkrumah University of Science and Technology, the then two universities in Ghana, were not fitted for such a purpose. Presently, UCC is run by a collegiate system and aside from the education-related programs, UCC admits students to other programs in a wide range of disciplinary areas including medicine, agriculture and business. UCC's vision is to become a

globally recognised university noted for inventive teaching, as well as research, outreach and professional development (University of Cape Coast Website, 2018). The university has a Counselling Centre which provides counselling services to students, and the Centre also runs academic programs (MA, MEd., MPhil and PhD degrees) in Guidance and Counselling to help train more competent counsellors for the nation.

University of Professional Studies, Accra (UPSA)

The UPSA is located at Madina, near Presbyterian Boys' School. Established in 1965 as the Institute of Professional Studies (IPS), the University of Professional Studies, Accra (UPSA) has gained a reputation as the oldest Business, Management and Professional education provider in Ghana. With a student population of about 15,000, UPSA is currently the fastest-rising public university in Ghana uniquely mandated to deliver both academic degrees and business professional qualifications. The vision of UPSA is to provide world-class academic and professional disciplines that are nationally entrenched, regionally recognised and globally relevant. To support the growth, development and wellness of students, the University has a functional Counselling Unit that provides counselling services and support to its students and staff (UPSA RCC Directorate, 2020).

The distribution of the population from the various universities has been displayed in Table 1.

Table 1: Distribution of the accessible Population by Academic Class, Level and Gender

Institution	Class	Male		Female		Total	
	Level	Freq	%	Freq.	%	Freq.	%
KNUST	100	210	19.96	175	21.63	385	20.69
	200	195	18.53	143	17.67	338	18.16
	300	297	28.23	209	25.83	506	27.19
	400	350	33.26	282	34.85	632	33.96
	Total	**1,052**	**100.00**	**809**	**100.00**	**1,861**	**100.00**
UCC	100	190	24.35	61	24.11	251	23.68
	200	200	25.64	66	26.08	266	25.09
	300	205	26.28	64	25.29	269	25.38
	400	185	23.71	62	24.50	274	25.85
	Total	**780**	**100.00**	**253**	**100.00**	**1,033**	**100.00**
UDS	100	62	25.10	57	24.89	119	25.00
	200	74	29.95	69	30.13	143	30.04
	300	68	27.53	63	27.51	131	27.52
	400	43	17.40	40	17.46	83	17.44
	Total	**247**	**100.00**	**229**	**100.00**	**476**	**100.00**
UPSA	100	241	21.44	196	22.4	437	21.86
	200	215	19.12	167	19.08	382	19.11
	300	348	30.96	260	29.71	608	30.42
	400	320	28.46	252	28.8	572	28.61
	Total	**1124**	**100.00**	**875**	**100.00**	**1999**	**100.00**

Source: KNUST, UCC, UDS and UPSA Students Records (2019)

Table 1 shows the population of the Accounting students from the various universities, with KNUST recording the highest and UCC recorded the lowest.

Sampling Procedure

Out of the students' population of 5,369, a sample of 550 students, made up 328 males and 222 females, were supposed to participate in the study. Krejcie and Morgan's (2006) table for sample size estimation was used to determine the sample size. According to Krejcie and Morgan, the minimum figure that could be sampled from a population of 5,000 was 537. This was

rounded up to 550 participants to increase the external validity of the study. Krejcie and Morgan's (1970) formula was used in calculating the sample size.

$$s = \frac{X^2 NP(1-P)}{d^2(N-1) + X^2 P(1-P)} \text{ where,}$$

s = required sample size.

X^2 = the table value of chi-square for 1 degree of freedom at the desired confidence level (3.841).

N = the population of business students in the selected four public universities.

P = the population proportion (assumed to be 0.50 since this would provide the maximum sample size).

d = the degree of accuracy expressed as a proportion (0.05).

This estimated sample size has been rounded up to a sample size of 550. This is because as the sample size increases, the result becomes more credible (Cohen, 1992).

A multistage sampling procedure was employed. Multistage sampling refers to sampling plans where the sampling is carried out in stages using smaller and smaller sampling units at each stage (Frey, Botan & Kreps, 2000). The study employed the purposive, simple random and proportional stratified sampling techniques in selecting the participants for the quantitative data. The study again employed the convenience sampling technique to obtain the qualitative data. The multistage sampling procedure has been illustrated in Table 2.

Table 2: Tabular presentation of Multistage sampling technique

Method	Units
Purposive sampling	Public Universities
Proportionate stratified sampling	Sample sizes to the Universities
Simple random sampling	University Students

Regarding the quantitative data, from Table 2, the first phase utilised the purposive sampling technique to select the four public universities across the country as well as students offering Business programmes with Accounting option.

With respect to the second phase, the proportionate stratified sampling technique was used. Here, a proportionate number of respondents based on gender and academic level in each university was determined by the formula:

$$\frac{\text{Sample size}}{\text{Total Population}} \times \text{Total number of males/females for each level}$$

In the third phase, the convenience sampling was used to collect data. According to Lavrakas (2008), convenience sampling is a type of nonprobability sampling in which people are sampled simply because they are convenient sources of data for researchers. In the present study, the convenience sampling method was used to sample available students who were willing to take part in the study. This became necessary because due to the COVID-19 pandemic only a few students were available since the majority were having online lectures from their homes.

Regarding the qualitative aspect, out of the 550 students sampled for this study, 8 of the participants were conveniently selected to take part in the interview (i.e., 2 each from the 4 universities used in the study). Four (4) of them were males and 4 were females. The sample distribution has been presented in Table 3.

Table 3: Distribution of Sample by Academic Level and Gender

Level	KNUST			UCC			UDS			UPSA		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
100	22	18	40	6	6	12	19	6	25	25	20	45
200	20	15	35	8	7	15	20	7	27	22	17	39
300	30	21	51	7	6	13	21	7	28	36	27	63
400	36	29	65	4	4	8	19	6	25	33	26	59
Total	108	83	191	25	23	48	79	26	105	116	90	206

Source: Field Survey, (2019)

From Table 3, the students have been grouped into strata, namely gender and levels for each university. Under each stratum, a proportional allocation was used to select a sample size from that stratum as indicated on the Table 3.

Data Collection Instruments

The study used questionnaire and a semi-structured interview guide to collect quantitative and qualitative data necessary to answer the research questions and test the hypotheses.

Questionnaire

The questionnaire was divided into five parts: (a) Students' bio-data and demographic characteristics, (b) Locus of control instrument, (c) Stigma scale for measuring the level of stigmatisation, (d) Intentions/attitudes toward help-seeking instrument, and (e) Cultural beliefs towards help-seeking. The incorporation of these sections on the research instrument was based on the belief in their ability to accurately measure the variables or characteristics under discussion in this research.

Locus of Control Scale

The locus of control scale revised by Ma'arif, Setyosari, Sulton and Sihkabuden (2016) was adapted to measure one's belief about whether events are controlled internally or externally. It was originally in a dichotomous form, with two options, yes and no. The scale, which was adapted for the

purpose of the present population, still consists of 40 items on a four-point Likert-type scale format. The response options are: 4= Strongly Agree, 3= Agree, 2= Disagree and 1= Strongly Disagree. The total score ranges from 40 to 160. The criterion mean value determined was 2.50 for each item since the entire instrument was measured on a four-point Likert-type scale. A score of 100 and above means that a respondent has a high locus of control, thus, a strong belief that he/she has a firm belief in their ability to influence his outcome. A score between 40 and 99 implies that the respondent has low locus of control, thus, a weak belief that events are beyond his/her control. The scale has a reliability coefficient of 0.83 recorded by most researchers (April, Dharani & Peters, 2012; Ma'arif et al., 2016).

Stigma Scale for Measuring the Level of Stigmatisation

To measure the stigmatisation level of participants, the stigma scale was adapted for the study. The stigma scale was first developed by Dinos et al. (2004) based on the experiences of people who have suffered psychological distress. King et al. (2007) used the scale to provide a standardised measure of the stigma of mental illness. The stigma scale or instrument focused on the feelings of respondents about the distress and particularly other people's reactions to stigma. It was developed in stages by first talking in depth to people with psychological problems in order to understand how other people had reacted to them. These narratives were then put into this questionnaire format and tested in a large population of people who had experienced psychological problems (McKeague, 2015). Each of the 28 items is measured on a four-point Likert-Type scale format. The response options are: 4= Strongly Agree, 3= Agree, 2= Disagree and 1= Strongly Disagree. Since there are twenty-eight questions, the total maximum score is 112 and the minimum score is 28. The mid-point score is 70. Therefore, a respondent with a higher

total score between 70 and 112 implies that he/she perceives highly that people with mental health challenges are more affected by the stigmatisation whilst the respondent with a lower total score between 28 and 69 means that he/she perceives people with mental health challenges to be less affected by the stigmatisation.

Attitudes Towards Seeking Professional Psychological Help-Short Form (ATSPPH-SF)

The attitudes towards seeking professional psychological help short form (ATSPPH-SF) instrument revised by Heaslip (2016) was adapted to explore the relationship between attitudes towards seeking professional help. The scale is a 10-item version of Fischer and Turner's 29-item scale for assessing attitudes on seeking psychological help (Fischer & Farina, 1995). Each item is scored on a 4-point, Likert-type scale, ranging from 1 ("strongly disagree) to 4 ("strongly agree"). A total score is the sum of the scores of each individual item. A high score on this scale between 25 and 40 is related to favourable attitudes towards seeking professional help for psychological issues while a score between 10 to 24 is related to unfavourable attitudes towards seeking professional help for psychological issues. The ATSPPH-SF has an adequate internal consistency for the author's original sample (a = .73) (Fischer & Farina, 1995; Lillios, 2010).

Cultural Beliefs towards Help-Seeking Instrument

The instrument for collecting data on the cultural beliefs of respondents was constructed by the researcher, as there was no specific scale available in the literature for culture and health-seeking behaviour. The scale was to measure the cultural beliefs of respondents towards psychological help-seeking. The scale is made of 29 items measured on a four-point, Likert-type

scale. The response options are: 4= Strongly Agree, 3= Agree, 2= Disagree and 1= Strongly Disagree. The maximum score of the scale is 116. The mid-point score is 72.5 whereas the minimum score is 29. A score between 29 and 72.5 means that a respondent has favourable cultural beliefs towards mental illness while a score between 72.5 and 116 indicates an unfavourable cultural belief towards mental illness. I came out with the culture scale after reviewing lots of literature and also by interviewing colleagues and students to meet the Ghanaian setting of respondents. Questions on the beliefs of causes of mental illness and beliefs about treatment preferences in relation to culture were put together to measure the cultural beliefs towards mental health.

Semi-Structured Interview Guide

A semi-structured interview guide was employed as a way of overcoming some of the weaknesses of the questionnaires (Kvale, 1996). Borg, Gall and Gall (2007) describe a semi-structured interview technique as "asking a series of structured questions and then probing more deeply using open-form questions to obtain additional information" (p. 240). Here, each participant is asked the same set of pre-determined questions, often interspersed with impromptu follow-up queries, intended to clarify participant responses. In this study, the interview guide was designed for the students. The guide contained 3 items in all, with 1 question on each of the variables that were measured (locus of control, stigmatization and culture). An item was also formulated to measure why students do not engage the services of the counsellors on campus.

The interview was set up in advance through verbal means and by appointments. They were used to probe critically and thoroughly responses of the students on what factors they deemed to be the determinants of

psychological health-seeking behaviour. The students were allowed to express their own opinions freely. The researcher was, therefore, able to probe further for detailed information in order to make truer assessments of what they really believed regarding psychological health-seeking behaviour.

The purposes of using interviews are many and varied. They may be used as the principal means of gathering information that have direct bearing on research objectives (Tuckman, 1972); they might be used as explanatory devices to help identify variables and relationships (Barker & Johnson, 1998); and they might be used to follow up unexpected results, or to validate other methods, or to go deeper into the motivations of respondents and their reasons for responding as they do (Kerlinger, 1986). It is more flexible and reflective and emphasizes categories and concepts rather than using mere frequencies, and identifying relationship (s) between variables (Patton, 2002). Finally, they are to assess individual persons in some respects; to test or develop hypotheses; to gather data; and to sample respondents' opinions (Cohen et al., 2007). In this study, the interview helped in gathering different kinds of information (Gall et al., 2007; Walliman, 2005).

There are, however, some problems in conducting interviews. Studies have shown that race, religion, gender, sexual orientations, status social class and age in certain contexts can be potent sources of bias. Both interviewers and interviewees bring their own experiences and emotions into interview situations (Cohen et al., 2007; Lee, 1993; Scheurich, 1995). In other words, most often, the sources of bias are the characteristics of the interviewer, the characteristics of the respondents, and the substantive content of the questions (Cohen et al., 2007).

Validity

It is essential to ensure that a research is valid (Ary, Jacobs & Razavich, 2002). In research, the concept of validity is used to describe what is involved in ensuring that the study measures exactly what it intends to measure (Kumar, 1999). Validity comes in two forms: face validity and content validity. In ensuring face validity of research, researchers attempt to make sure that the research logically measures what it intends to measure. On the other hand, content validity concerns the attempts of the researcher to ensure that the research instrument covers items that can sufficiently measure what the study intends to measure (Pallant, 2005). Face and content validity of the instrument was carried out with my supervisors at the Department of Guidance and Counselling, University of Cape Coast.

Pilot Testing

Basically, pilot testing means investigating about the survey, key information, interview guide or observation that will work in the "real world" by trying it out first on a few people. The researcher wanted to ensure that all the students in the study really understood the items on locus of control, stigmatization, and culture in the questionnaires. It was also to make sure that every individual in the sample not only understood the questions, but understood them the same way. According to Conelly (2008), extant literature suggests that a pilot study sample should be 10% of the sample projected for the larger parent study. This study therefore used 60 students from University of Ghana campus to pre-test the questionnaires. They were made up of 31 males and 29 female students. This was done to improve the validity and also ascertain the reliability of the data collection instruments employed for the study. The respondents were made to verbally and frankly discuss any

statement they do not understand about any aspect of the questionnaires with the researcher. The necessary corrections were made after the pilot testing.

Apart from the questionnaire, the semi-structured interview guide was the second instrument to collect qualitative data for the study. The interview guide (schedule) which consisted of 3 items were tried in order to check vocabulary, language level as well as respondents' understanding and reactions to the questions. Interview trustworthiness (validity) and dependability (reliability) were checked in several ways. They were first transcribed verbatim (Kvale, 1996) and content validated by my supervisors who modified the questions in wording and number which prevented ambiguities and helped to restructure the interview items.

The pre-testing of the instrument helped the researcher in many ways. For example, with the pre-testing, the researcher got to know the amount of time involved in the administration of the questionnaire and conducting the interview. It also helped to identify and restructure questions that the respondents considered as ambiguous or irrelevant (Cohen et al., 2007).

Reliability

The Cronbach coefficient alpha measure of internal consistency was used to determine the reliability of the tried-out questionnaires. The reliability test was employed to test for consistency of the responses of all the data collecting instruments considered. Since the items on the questionnaire are multiple-scored, especially on the Likert-type scale, the Cronbach's coefficient alpha was deemed most appropriate. Hair, Black, Anderson and Tatum (2006) set the threshold of acceptable level of reliability at an alpha level of 0.5 and above for exploratory social research.

Table 4: Reliability Test for the Consistency of the Tried-out Instruments

Variables	Number of items	Cronbach's Alpha
Locus of Control	40	0.602
Stigmatization	28	0.823
Attitude Towards Help-seeking	10	0.461
	10	0.759
Culture: Causes of Illness	18	0.839
Culture: Treatment Preferences	6	0.606
Culture: Cultural Beliefs	8	0.610

Data Collection Procedures

The data collection techniques employed were the administration of questionnaire to the respondents and conducting interview. Firstly, the questionnaire was used to collect data on the demographic characteristics of the respondents. Locus of control scale, stigmatisation scale, attitude towards seeking professional psychological help and cultural beliefs towards help-seeking scale were supposed to have been administered physically to students in the four public universities considered. Since the educational background of the participants was tertiary and all could read and understand, research assistants were trained to assist the students to answer the questionnaire correctly. The items on the questionnaire were thoroughly explained to the research assistants during the training, and they were educated on how to establish a good relationship with the respondents and explain to the respondents the main goal of the study for them to confidently answer the questions correctly.

The second stage of data collection involved interviewing selected students through a focus group discussion. Since the researcher employed the sequential explanatory mixed method design, interviews were conducted after retrieving the completed questionnaires. This was done in order to obtain more in-depth qualitative information to compliment the quantitative data.

The researcher held a focus group discussion with eight participants, comprising two students from each of the four selected public universities in the study. Due to the Covid, the focus group discussion was held through a zoom meeting. The questions were asked separately, and representatives from the universities were allowed to share their views in turns through a very common and acceptable medium of instruction in higher education in Ghana which is English. The session was mainly in the form of a conversation with more open-ended questions which compelled the participants to express their views on the topic under discussion. Also, in order to get to the root of most of the issues, the researcher employed probing in order to capture other vital information which may be necessary and relevant for the study. The entire zoom session lasted for about an hour, and it was audio recorded with the consent of the participants. At the end of the discussion the researcher verbally appreciated the participants for their time and contributions towards the work. The responses from the focus group discussion were used to cross-check the views expressed by the participants on the questionnaire items.

Online Data Collection

In March 2020, Ghana recorded its first case of COVID 19 victim. This compelled the President of Ghana to announce a total lockdown of all educational institutions in the country including the universities. The universities, therefore, introduced online lectures for their students to receive their lessons in the comfort of their homes. This unforeseen situation compelled the researcher to administer questionnaires to the students online. The questionnaire was developed into a link which was later sent to the students in their class groupings to respond. After some weeks, the President announced that the universities which could not complete their academic work could go back to school and finish for the semester, and this made some of the

students to fill their online questionnaires at home, whilst others responded to theirs whilst on campus. In all, 588 students from the four universities responded to the online questionnaire, and all of them were used in the study instead of the original sample size of 550 students. This was done to widen the external validity of the findings.

Data Processing and Analysis

The software packages used for data analysis, editing, coding and computation is the Statistical Product and Service Solution (SPSS version 20). The questionnaires were entered by trained research assistants one-by-one and edited to make sure that the data were free from errors. All the questionnaires were numbered, so that they can be easily verified in case of any error. Frequency tables, pie charts, bar graphs and descriptive summary statistics were used to summarise the dataset, especially the demographic characteristics of the respondents. The following statistical tools were employed to test the hypotheses.

1. Hypotheses 1 was tested using independent samples t-test. This tool was used to test the gender variation in the health-seeking behaviour of the students.
2. Hypothesis 2 was tested using the independent samples t-test. This was used to test the geographical variation in the health-seeking behaviour of the students.
3. One-way Analysis of Variance (ANOVA) was used to test hypothesis 3, to find out if there is a significant age variation in the health-seeking behaviour of the students.
4. Hypothesis 4 was tested using the Structural Equation Model (SEM). The SEM was used to find out whether locus of control,

stigmatisation and culture will significantly predict public university students' psychological health-seeking behaviour.

For the qualitative approach, the interviews were transcribed and analysed using the thematic approach. Thematic analysis is a method of identifying, analysing and reporting themes or patterns within data set (Braun & Clarke, 2006).

Ethical Considerations

Social research requires a high degree of ethical practices. Creswell (2009) emphasised the importance of researchers protecting respondents and building trust between themselves and their respondents whilst prohibiting any fallout that may tarnish the image and integrity of their respondents. In this research, steps were taken to seek permission/consent from the respondents before the data were collected through their online platforms and also during the interview. None of the respondents was coerced into participating in this study. All the respondents were told to participate voluntarily. They were also made to fully understand what the research was about and what the data was going to be used for. Again, steps were taken to conceal the identity of the respondents as promised before participation by channelling all the electronic responses to my email. Lastly, the data collected during this research were strictly used for the purpose for which they were given, as no part of this data was used in any other work except for academic literature only. Considering the lengthy nature of the questionnaire, the respondents were given 5.00 worth of airtime to motivate them to elicit acceptable responses to the questions.

CHAPTER FOUR

RESULTS AND DISCUSSIONS

Introduction

This chapter presents results and discussions on the set objectives and conceptual framework of the study. The frequency distribution table is used to present the demographic characteristics of the respondents. The independent t-test and one-way ANOVA were used to investigate the health-seeking behaviour among tertiary students with respect to their demographic characteristics such as gender, geographical location during holidays and age group. Finally, a structural equation model was used to model the conceptual framework in determining the extent to which locus of control, stigma, cultural beliefs and demographic characteristics relate to health-seeking behaviour of students. The chapter ends with discussions on the findings in relation to the set objectives and hypotheses.

Demographic Characteristics of Respondents

The study considered five demographic characteristics, namely type of university, gender, age group, geographical location during holidays and academic level of the respondents. The demographic characteristics of the respondents are presented in Table 4. Table 4 presents the frequency distribution of the respondents on the basis of five characteristics. The distribution shows that UPSA recorded the highest number of respondents, with 36.7 percent, followed by KNUST with 30.4 percent. UDS recorded 20.7 percent whilst UCC recorded the least, with 12.1 percent.

Table 2: Frequency Distribution of Demographic Characteristics

Variables	Category	Frequency	Percent
University	UPSA	216	36.7
	UCC	71	12.1
	KNUST	179	30.4
	UDS	122	20.8
	Total	**588**	**100.0**
Gender	Male	305	51.9
	Female	283	48.1
	Total	**588**	**100.0**
Age Groups	18-24	485	82.5
	25-29	79	13.4
	30 +	24	4.1
	Total	**588**	**100.0**
Geographical Location	Urban	392	66.7
	Rural	196	33.3
	Total	**588**	**100.0**
Academic Level	100	111	18.9
	200	203	34.5
	300	146	24.8
	400	128	21.8
	Total	**588**	**100.0**

The distribution of respondents according to their universities was based on the population of Business Administration students in these selected universities.

It was found that there were more male respondents than females in the sample. The distribution of the age category showed that majority of them (82.5%) were between the ages of 18-24 years. The age group of 25-29 years recorded the second highest, representation 13.4 percent, whilst 30 and above years represents the least, with 4.1 percent. The study categorised the age of respondents into three groups based on the standard age of entering the university. The distribution of the geographical location of the respondents shows that two-thirds of the respondents live in urban centres during their holidays and the remaining one-third live in rural areas. It was found that

Level 200 represents the majority, with 34.5 percent of the sample, whilst Level 100 recorded the least inclusion in the sample (Table 4).

In measuring the reliability of variables or research instrument, one's main objective is to establish the degree of inconsistency in test scores, which may have resulted from errors in measurement (Singh, 2007). The internal inconsistency of responses to a research instrument can be estimated with Cronbach's alpha. A "high" value for alpha does not imply that the measure is unidimensional.

The values of Cronbach's alpha range from 0 to 1, and if alpha is greater or equal to 0.9, it is known as excellent (High-stakes testing). If alpha is between 0.7 and 0.9, it is known as good (Low-stakes). If alpha is between 0.6 and 0.7, it is known as acceptable, and it is regarded as poor if alpha is between 0.5 and 0.6 but unacceptable if alpha is below 0.5 (Santos, 1999).

Table 3: Reliability Test for Consistency of the Responses

Variables	Number of items	Cronbach's Alpha
Locus of Control	40	0.841
Stigmatization	27	0.833
Attitude Towards Health-Seeking	10	0.600
Cultural Beliefs	29	0.834

Table 5 shows the reliability test for internal consistency in the responses of the respondents at various levels under consideration. There were 588 respondents who answered the questionnaires on the four instruments studied. The locus of control instrument comprises 40 items or questions, the stigmatisation instrument consists of 27 items whilst attitude towards health seeking-behaviour and cultural beliefs comprise 10 and 29 items, respectively.

Table 5 shows that there is good (Low-stakes) internal consistency in the responses for locus of control, stigmatisation and health-seeking behaviour since their reliability coefficient for internal consistency is approximately 0.83. However, the internal consistency coefficient for health-seeking behaviour responses is 0.60 and is considered acceptable and could be as a result of the fewer items under this instrument. The study established that the composite reliability score for the four instruments is 0.86. This value is appropriate for assessing the health-seeking behaviour of tertiary students (Sekaran, 2000). Based on this finding, the four instruments employed are highly reliable measurement tools for measuring the health-seeking behaviours of the undergraduate students.

Results of Hypotheses Testing

Hypothesis One:

$H_0 1$: There is no statistically significant gender variation in the psychological health-seeking behaviour of public university students.

$H_A 1$: There is a statistically significant gender variation in the psychological health-seeking behaviour of public university students. The hypothesis was tested using the independent t-test with psychological health-seeking behaviour as response variable. The result is presented in Table 6.

Table 4: Independent Samples t-test on Psychological Health-Seeking Behaviour on the Basis of Gender

	N	Mean	SD	t	df	Sig. (2-tailed)
Male	305	27.61	3.78			
				-0.30	586	.764
Female	283	27.70	3.43			

Table 6 shows the independent samples t-test of psychological health-seeking variables with gender. The Levene's test for equality of variances for all the four variables tested produced a p-value of at least 0.05. This means that at 5% significance level, there is an equal variability between males' and females' scores for the four health-seeking variables tested and, therefore, equal variances assumption can be held.

Table 6 revealed that the mean for the males was 27.61, with a standard deviation of 3.78, while that of females was 27.70, with a standard deviation of 3.43. This shows there is no significant difference or variation in the psychological health-seeking behaviour of public university students on the basis of gender: t(df=586)=-.030, p>.05. It can, therefore, be concluded that both male and female students have similar psychological health-seeking behaviours. This result upholds the null hypothesis, given that the p-value (0.764) is more than the level of significance (0.05).

Hypothesis Two:

$H_0 2$: There is no statistically significant geographical variation in the psychological health-seeking behaviour of public university students.

$H_A 2$: There is a statistically significant geographical variation in the psychological health-seeking behaviour of public university students.

In this section, the study presents the result on the impact of place of resident (urban or rural) on health-seeking behaviour of undergraduate students of the selected public universities. The study employed an independent samples t-test to test the scores for psychological health-seeking behaviour and geographical location. The result is presented in Table 7.

Table 5: Independent Samples t-test of Psychological Health-Seeking Behaviours on the Basis of Geographical Location

	N	Mean	SD	T	df	Sig. (2-tailed)
Urban	392	27.34	3.71			
				-2.991*	586	0.003
Rural	196	28.28	3.33			

*Significant, p< 0.05

Table 7 shows the independent samples t-test of health-seeking variables with geographical location. The Levene's test for equality of variances for the two variables tested produced a p-value greater than 0.05. This means that at 5% level of significance, there is an equal variability between respondents' geographical location (urban and rural) scores for psychological health-seeking variables. Therefore, equal variances assumption can be held.

Table 7 also shows the independent samples t-test for psychological health-seeking behaviour against the geographical location: urban and rural. The table revealed that the mean score for respondents who lived in urban areas was 27.34, with a standard deviation of 3.71, while that of the rural dwellers was 28.28, with a standard deviation of 3.33. It can be concluded that there is a statistically significant difference in the psychological health-seeking behaviour of public university students on the basis of geographical location t(df=586) =-2.991, p<.05(2-tailed). This means that students who lived in urban and rural areas differ in their psychological health-seeking behaviours. Again, since the p-value (0.003) is not more than 0.05, it is logical to conclude that the null hypothesis is rejected.

Hypothesis Three

H_03: There is no statistically significant age variation in the psychological health-seeking behaviour of public university students.

H_A3: There is a significant age variation in the psychological health-seeking behaviour of public university students.

This section presents the analysis of the impact of age on the psychological health-seeking behaviour of public university students. It is the goal of the study to investigate the effect of age on the psychological health-seeking behaviour of the students. The ages of the respondents were grouped into three categories: 18-24 years, 25-29 years, and 30 years and above. The study employed a one-way analysis of variance (ANOVA) to investigate the possible significant age variations in the mean scores of the psychological health-seeking behaviour of the students. The result is presented in Table 8.

Table 6: ANOVA Tests for Psychological Health-Seeking Behaviours on the Basis of Age

Variables	Source of Variations	Sum of Squares	Df	Mean Square	F	p-value
Psychological Health-seeking behaviour	Between Groups	5.86	2	2.93	.224	.799
	Within Groups	7653.97	585	13.08		
	Total	7659.83	587			

Table 8 presents the ANOVA tests to investigate the difference in age on the psychological health-seeking behaviour of the students. The ANOVA test for the scores on psychological health-seeking behaviour recorded an F-statistics of 0.224 and a p-value of 0.799. Since the p-value is greater than any alpha level of significance, the null hypothesis is accepted, which implies that no significant difference existed among the mean scores for the three age groups. This means that at 5 percent level of significance, the age of the respondents does not significantly differ from the psychological health-seeking behaviour of the university students in Ghana.

Hypothesis Four:

H_0 4: Locus of control, stigmatisation and culture will not statistically significantly predict public university students' psychological health-seeking behaviour.

H_A4: Locus of control, stigmatisation and culture will statistically significantly predict public university students' psychological health-seeking behaviour.

The main aim of the study was to investigate the extent to which stigmatisation, locus of control and culture determine the health-seeking behaviour of university students in Ghana. To achieve this objectives, the study employed a structural equation modelling technique to determine the effects of locus of control, stigmatisation and cultural beliefs on the health-seeking behaviour of the university students.

Figure 2 is a graphical representation (path diagram) of the conceptual framework model for measuring the effects of locus of control, stigmatisation, cultural beliefs and the demographic characteristics in determining the health-seeking behaviours of university students. The double arrows (that is an arrow pointing in two directions) measure the bivariate relationship between two variables whilst the single arrow measures the causal relationship. With respect to the structural equation model and path diagram, they help to assess the causal relationships of the three independent variables on the health-seeking behaviour of the students.

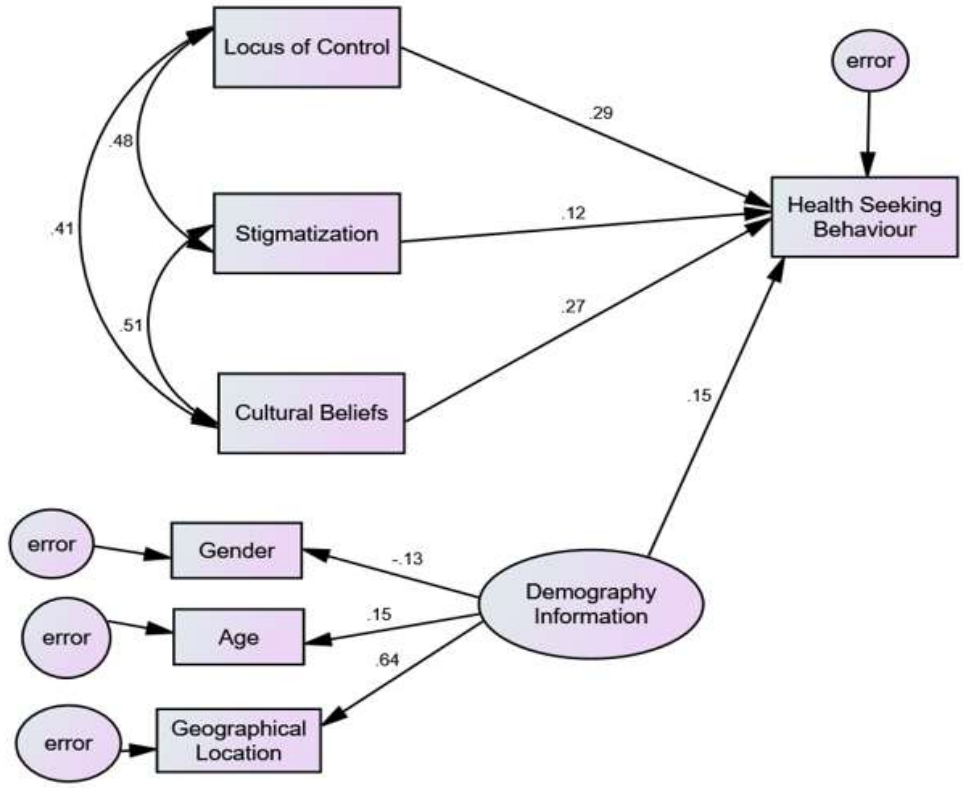

Figure 3: Path diagram of the four independent variables on Health-Seeking Behaviour.

The path diagram recorded 0.48 correlation coefficient between locus of control and stigmatisation, 0.41 correlation coefficient between locus of control and cultural beliefs, and 0.51 correlation coefficient between stigmatisation and cultural beliefs. The moderate correlation among the three variables implies that there is little or no multi-collinearity occurring in the determination of the extent of the effect of the three variables in determining the health-seeking behaviour of the respondents.

Figure 2 shows that locus of control contributes 29 percent in determining health-seeking behaviour, stigmatisation contributes 12 percent, cultural beliefs contribute 27 percent and demographic information contributes 15 percent in defining the health-seeking behaviour of university students. The values recorded on the single headed arrows measure the causal relationships or impact of the three variables in determining the health-seeking behaviour of

the students. The path diagram shows that the demographic information (gender, age and geographical location) and the three health-seeking factors (culture, locus of control and stigmatisation) influence the psychological health-seeking behaviour of public university students in the study.

Table 9 shows the t-test for the causal relationship or impact of the health-seeking factors (culture, locus of control and stigmatisation) and demographic information on the psychological health-seeking behaviour of the university students.

Table 7: Statistical Test for Causal Relationship or Impact

Variable	Estimate	S.E.	t-Statistic	p-value
Locus of Control	0.29	0.013	7.301	0.00
Stigmatization	0.12	0.018	2.703	0.01
Cultural Beliefs	0.27	0.016	6.588	0.00
Demographic information	0.15	0.026	5.769	0.00

In Table 9, the t-tests for the four variables recorded $p < 0.05$ and this shows that the four causal relationships or impact of the variables on the psychological health-seeking behaviour are significant at 0.05% level. This means that the psychological health-seeking behaviour of university students is significantly determined by their locus of control, stigmatisation, cultural beliefs and demographic information.

Discussions

This section considers discussions on the results from the three demographic variables: gender, geographical location and age. Two of the variables (gender and geographical location) were tested with independent t-test whilst age was tested with one-way analysis of variance (ANOVA). Also, the discussion on the results from the independent variables (locus of control, stigmatisation and culture) has been presented. In brief, the section discusses the results from the four hypotheses tested in the study.

Gender and Health-Seeking Behaviour

Available literature shows that gender has a relationship with health-seeking behaviour of an individual. The first hypothesis states that there is no significant difference in the psychological health-seeking behaviour of public university students based on gender, and it was tested using the independent t-test with locus of control, stigma, cultural beliefs and health-seeking behaviour as response variables. The results from the independent t-test shows that there is no significant difference between the mean scores of males and females for the locus of control, stigmatisation, cultural beliefs and health-seeking behaviour of the university students at 5% level of significance, which further explains that gender has no significant influence on the psychological health-seeking behaviour of the students under this study. This result reveals that both males and females have the same attitude towards health-seeking behaviour in times of psychological distress. A similar finding has been reported by Asamari and Namale (2018). These researchers, specifically, found no significant gender variation in Ghanaian teacher trainees' perceptions towards guidance and counselling services as a form of psychological health-seeking. This finding can be explained to mean that Ghanaian tertiary-level students have the same characteristics irrespective of their gender when it comes to attitudes towards psychological help-seeking.

The result of this current study is in contrast with the findings from the work done by Otwombe et al. (2015) in Soweto, South Africa. They defined health-seeking behaviour as accessing medical services, including psychological healthcare. From their results, 85% were enrolled in schools, implying that 15% were either school dropouts or were not enrolled in school at all. Also, their work focused mainly on sexual debut and illicit drug use, flu-like symptoms, HIV, reproductive healthcare and counselling. The

researchers also highlighted their choice of healthcare, whether from formal or informal sources. According to their findings, relative to males, females were more likely to utilise general healthcare services and counselling, in times of psychological health challenges.

Similarly, Chandra and Minkovitz (2006) investigated the inclination of teenagers to use mental health services. The study adopted a quantitative study design and gathered data from 274 students in mid-Atlantic state. Generally, the study revealed gender variations in health-seeking behaviours. Specifically, the likelihood to use mental health services was higher among girls, as compared with their male colleagues. Similar findings emerged with respect to knowledge in mental health. On the converse, girls, as compared to boys, were less likely to perceive stigma. The study also revealed parental control as a determinant of health-seeking behaviour among the teenagers studied.

Otwombe et al. (2015) used a younger population between the ages of 14-19 years, who may probably not be matured enough to handle issues concerning their general healthcare as well as their psychological well-being, and as a result may depend on their parents for directives in times of health challenges. This current study considered the general attitude of university students who are between the ages of 18 years and above and, as a result, are advanced enough to take concrete decisions about their health issues.

The differences between the current study and the study done by Chandra and Minkovitz (2006) could be attributed to the fact that the current study used samples from university students between the ages of 18 years and above 30. University students above the age of 18 years are considered as adults who are old enough to take decisions on their own and also to use their own sense of discretion in times of psychological health challenges, even

though most of them are living with their parents. Their attitude towards health-seeking may not necessarily depend on their parental influence since they have facilities such as hospitals and counselling centres on their campuses which they can access at any point in time.

The work done by Nuhu (2018) on gender inequalities indicated that women are disallowed from freely involving themselves in seeking their own healthcare and that of their children. This is because men are still considered as the leaders of the family and decisions concerning money, healthcare and other pertinent household matters are taken by them. In most cases, the lives of women are restricted to the domestic domain, allowing them less time to cater for their own health. Nuhu's findings were also confirmed by Currie and Wiesenberg (2004). In the study, it was found that women's failure to identify the symptoms of diseases affects their health-seeking behaviour. The researchers explained this finding within the context of culture, where socially, women are less valued, as compared to their male counterparts. Additionally, given that women are confined to the domestic space, they hardly find time to visit health facilities.

The present study contracts with the findings of Nuhu (2018), in that in terms of population, Nuhu used older respondents for his study. Majority of the women in his study were mainly housewives, and the geographical setting depicts that of a patriarchal environment where men are basically the heads of the family, and as such, decision-making, including one's willingness to seek health-care, is mainly taken by the men. Women do not have much right in taking decisions concerning their own healthcare without the consent of their husbands. The current study focused on university students, with most of them living independent lives when they come to campus. Both males and females on campus have the same and equal rights and opportunities to all the services

and facilities available on campus, and their intentions to seek any form of healthcare including psychological healthcare depend on each student as a matter of choice. This could account for the reason why both male and female students have almost the same attitude towards health-seeking behaviour in this present study.

The finding from this study is different from the results from the study done by Currie and Wiesenberg (2003). Most university students are able to identify the symptoms of their ailments, when they visit their healthcare facilities on campus. Some of the students even attempt to seek for healthcare from pharmacy shops first, before deciding to visit their clinics on campus when the situation gets worse, as some of them access the symptoms of their ailments online, and even try to google for the type of drugs to buy. Most students, both males and females, walk to the counselling units in their universities to seek for solution to their problems without anyone forcing them to do so. In the university, there is equity in the use and access to healthcare, as both males and females have equal access to all services, hence the differences in the findings from the two studies.

The study by Thompson et al. (2016) in Canada on gender differences in health-seeking behaviours shows that there is a significant difference in gender with regard to health-seeking behaviour between men and women. The researchers used over 7000 patients from 10 provinces, and their findings showed that majority of the women sought for healthcare for both their physical and mental health challenges as opposed to their male counterparts. The differences in the work done by Thompson et al. (2016) and the current study could be due to the approaches the researchers used to analyse their data as well as the social, economic and demographic characteristics of their respondents. The researchers used over 7000 patients from 10 provinces,

whilst the current study used 588 university students from 4 regions in Ghana. The health conditions of the respondents, who are patients, may also influence their response.

The study done by Galdas, Cheater and Marshall (2005) reported on a frequently occurring theme "traditional masculine behaviour" as responsible for the regular delays in health-seeking behaviour among men. According to the researchers, aside from gender, ethnic background and socioeconomic status can also have effects on the dichotomy in the health outcomes. Similarly, results from the work done by Tanchangya et al. (2012) in Bangladesh (a country very well known to practice a patriarchal and more conservative social system) showed that women, as compared to men, were more likely to utilise surgical services, portraying that gender plays a pivotal role in health-seeking behaviour, as the females were more careful to seek for healthcare at the onset of their sicknesses than the men would do.

The result from the study done by Galdas et al. (2005) is different from the current study. In Ghana, university students, whether male or female, seek for healthcare. The social and economic situations in Ghana such as free health care, gender equality and the discouragement of gender-based discrimination on Ghanaian campuses encourage students to seek for psychological healthcare. Gender roles do not have any influence on campuses. Also, the researchers used older respondents, but the current study focused on the health-seeking pattern of a younger population. Young people, especially university students, have the same attitude towards health-seeking. Probably, when they grow old, their attitudes may change, making room for the gender differences among older populations. Also, a lot of factors may account for the differences in the results from the work done by Tanchangya et al. (2012) and the present study. Although Ghana is also a patriarchal country,

there are cultural differences between the two countries, Bangladesh and Ghana, which could also affect the health responses of their respondents. The researchers used older population with their ages above 65 whilst the current study used a younger population made up of students. Ghanaian universities have more liberal environments where both men and women are exposed to a better approach towards health-seeking.

In order to assess the determinants of substitute remedies for malaria, Awuah et al. (2018) conducted a research at James Town, Ussher Town and Agbogbloshie, all in the Greater Accra Region. The researchers found that more males than females demonstrated better responses towards their health, which, according to the literature, has not been the norm. Most of the time, it is women who show more positive and better attitude towards their healthcare. The results from their findings are still in contrast with the current study, as university students have the same attitude towards their healthcare despite their gender.

Mackenzie, Gekoski and Knox (2006) explored the effects of age and gender differences on help-seeking attitudes. According to their findings, the elderly, especially females, exhibited a more positive health-seeking behaviour, which is also in contrast with the current study. The researchers of the previous study combined marital status and education, with age and gender influencing their intents to search for expert psychological help more, but the present study, which used students within the age brackets of 18 to above 30 years, focused on age, gender and geographical location as the demographic variables, excluding marital status.

Like the present study, some previous studies on gender variations in health-seeking behaviour focused on university students. In Singapore, Ang et al. (2004) reported that females have more positive overall attitudes towards

professional help-seeking. Ang et al.'s finding was confirmed in the context of Turkey by Atik and Yaltyn (2011). A similar finding was reported in India by Arshad et al. (2012), who observed that gender substantially help-seeking behaviour among university students, with the female students having more positive attitudes about going for expert counselling.

In brief, even though most of the work done on gender and health-seeking behaviour show that there are differences in the pattern of male's attitude and that of females towards healthcare, most of the researchers used the elderly as respondents, and their works were mostly on the choice of healthcare (i.e., either formal or informal) and also on some particular health issues. Only few researchers such as Mackenzie, Gekoski and Knox (2006) explored professional psychological health-seeking behaviour. In Ghana, much work has not been done on gender and psychological health-seeking behaviour. The current research will, therefore, add to the literature on psychological health-seeking behaviour, and how it is influenced by variables such as gender, locus of control, stigma and culture.

Geographical Location and Health-Seeking Behaviour

Geographical location is an important variable that needs attention when discussing issues pertaining to health-seeking behaviour of students. In the context of the present study, "geographical location" is conceptualised as where the students live when they are on vacation. The hypothesis is to investigate the possible geographical variations in the psychological health-seeking behaviour of the students. An independent t-test was employed to test the scores for geographical location in relation to locus of control, stigma, cultural beliefs and health-seeking behaviour.

The findings from the study show that the geographical setting of the students has a significant impact on the health-seeking behaviour of the

students at 5 percent level of significance. This means that the health-seeking behaviour of students from the urban centres is different from the health-seeking behaviour of the students from the rural centres. Obviously, it can be explained that students from the urban centres have positive health-seeking behaviour than their counterparts from the rural regions. Even though some of the students are from rural origins, they have the opportunity of schooling in universities located at urban centres, and as such, it is expected that they would acquaint themselves with the way of life of their urban folks, as students have different ways of influencing each other.

The differences in the health-seeking pattern of the urban and rural dwellers could be attributed to the low socio-economic status of the parents of students from the rural areas, which sometimes makes it almost impossible for them to access professional healthcare. Also, some of these rural students might have inherited the health-seeking behaviour of their parents as a way of continuing with their family health pattern, and this may prevent them from paying much attention to their psychological healthcare needs. Another factor responsible for the negative health-seeking behaviour among rural folks is the location of psychological healthcare centres. Most of them are located at the urban centres, making it very difficult and expensive for the rural folks to access, and this discourages them from attempting to access the health facilities at the urban centres. The cost of transportation and other costs incurred whilst traveling to an urban centre for psychological healthcare will deter a lot of the rural dwellers from accessing these facilities.

Various researchers have looked into the psychological health care of rural and urban dwellers and have come out with findings similar to the current study. For example, van der Hoeven et al.'s (2012) study found that socio-economic factors determined the differences in healthcare access

between rural and urban residents. It was also revealed in the study that urban residents have a wide range of healthcare services at their disposal, compared to rural residents. Also, due to their socio-economic status, urban residents were reported as being able to patronise expensive private health facilities. These findings are comparable with the findings from the present study even though the current study used university students as its population. A greater percentage of the population for this study are youths, who probably depend on their parents for their healthcare. According to van der Hoeven et al. (2012), there were differences in the socio-economic variables of their respondents from both rural and urban centres, health beliefs and utilisation patterns, and all these variables are in favour of the urban settlers. Therefore, the urban dwellers have a better health response. The current study did not explore the socio-economic status of the students, because most of them are youth and unemployed.

The findings of the present study also share some similarity with the findings of Yikilkan et al. (2013) in Turkey. They tried to establish the differences between facilities for both rural and urban dwellers in Turkey and found out that the inadequate facilities at the rural areas are responsible for their poor health care responses. Additionally, Yikilkan et al. (2013) also noted long distance to health facilities and long waiting time as other challenges faced by rural dwellers. Although the current study used university students as its population as opposed to the former study which used elderly people, the results from both studies are the same. The rural population in this current study, which is made up of students, have the opportunity of schooling at tertiary institutions located at urban centres, but this did not affect their attitude towards their psychological healthcare. It can further be explained

that these students have become adjusted to the conventional way by which rural dwellers respond to their health needs.

The research conducted by Afeadie (2018) showed that due to financial constraints, the respondents are forced to resort to different means to overcome their health challenges. This means that rural people show some attitude towards their health care but probably might resort to informal or non-professionals for help. Afeade seems to have used the same category of population as in this current study, rural people, specifically adults who have migrated to an urban centre, just as the current researcher also used rural people as part of her population, majority of whom are younger university students who have come to school at urban centres. The similarities in the findings could be due to the fact that the rural students do not have access to better health facilities when they vacate and go home. This buttresses the fact that the rural communities have a similar problem of proximity and lack of adequate facilities in their communities, hence their negative attitude towards healthcare.

Another similar work by Perreira (2017) on health-seeking behaviours in a rural farming village of Jumjibre in the Western Region of Ghana produced a result that is similar to the results from the current research. The researcher observed that hospitals were located far from the people. This increased the cost involved in an attempt to seek healthcare, and this affected their health-seeking behaviour. The respondents in his research were rural adults with a lukewarm attitude towards healthcare due to the multiple barriers, whilst in the current study, the rural people used as respondents are university students. Despite their status as students, they have the same attitude towards their health-seeking behaviour.

Despite the similarities established between the current study and previous studies done by researchers on health-seeking behaviour among rural and urban dwellers, some differences have been identified. Results from the work done in Sierra Leone by Idriss et al. (2019) on health-seeking behaviour among rural and urban districts indicated that respondents lacked adequate knowledge the causes and symptoms of the disease in both areas. Also, both rural and urban communities had the same level of accessibility and it was further established from their results that both areas were affected by the same characteristics of care seeking. The implication from their studies is that both rural and urban dwellers have the same mind-set about health-seeking, which is different from the results from the current study. Even though the researchers did not use a younger population as the case is in this current study, university students of both rural and urban origin in Ghana have different attitudes towards their health-seeking, and it can be attributed to the uneven distribution of the psychological health facilities across the country.

Sockey and Adisah-Atta's (2017) study on the barriers to health information access among residents of the Shai Osudoku District in the Eastern Region of Ghana revealed that the residents accessed health information through various mediums. The health information mediums identified in the study include the internet, radios, posters, relatives, friends, and healthcare professionals. Usage of these mediums differed with respect to the level of education of respondents, with highly educated respondents more inclined to the use of the internet. Language barrier, geographical location and not having mobile phones or televisions impeded their attempts at accessing health information. The findings from his study share some similarities as well as differences with the current study. From the relevant literature reviewed so far, the main source of health information for university students is the use of

the internet, and students may contact family and friends for health information. The current study did not look into the health information of the respondents but researched into their general attitude towards health-seeking behaviour. Health information is also an aspect of health-seeking attitude, and the rural students used in this study have access to the internet for information on their healthcare. This makes his findings similar to the findings from the current study.

On the contrary, students may not necessarily encounter language as a barrier, as they are all likely to express themselves very well at the health centres. Locations of health facilities at the universities are within the reach of the students and almost every student has a mobile phone in possession with free Wi-Fi on campuses, making is easier for them to access any information at their own convenience. The geographical location of his study site was limited to a rural area in the Eastern Region of Ghana, with a limited sample of 201 community members who are all likely to be adults, whilst the current study considered respondents from four different regions across the country, with a population size of 588 students dominated by young people from both rural and urban settings but with different attitudes towards psychological health-seeking.

In summary, most of the studies done on health-seeking behaviour between rural and urban dwellers used older people who are working as their respondents, and as such, the researchers were able to explore the strength of the socio-economic status of their respondents. They also worked on availability of healthcare facilities in both rural and urban centres and found that there are more healthcare facilities in urban areas with more medical personnel, but the situations in the rural areas are different and these accounted for their healthcare differences. Despite the fact that the current

study used a younger population of university students from both rural and urban origins who have the same options and access to quality health services and information concerning their health care, there were still some differences in attitude towards their psychological health-seeking behaviour.

All the public universities under the current study have health facilities and counselling centres on their campuses and this makes it very easy for the students to have access to their psychological healthcare services whenever they are free. Accessibility to the healthcare facilities in terms of distance, transportation and operational time, as well as joining long queues at the health facilities, is not an issue of concern among university students. The distribution of the age brackets in the current study shows that most of the students are between the ages of 18-24 who are likely to be unemployed and, therefore, depend on their parents when their respective universities are on recess. Therefore, access to healthcare becomes limited to students from the rural areas.

Findings from research from sub-Saharan Africa contend that education is very critical in taking a healthcare decision, as lower level of education is directly related to one's refusal to seek healthcare (Anselmi et al., 2015; Njuki et al., 2014; Zyaambo et al., 2012). Education enhances the knowledge about a sickness, symptoms identification and also the creation of awareness on the opportunities available in times of ill-health (Zyambo et al., 2012). University students are regarded as educated, and their level of education, irrespective of their geographical location, can also make them have a similar attitude towards their psychological healthcare. Their level of education has the tendency of increasing their ideas about different types of illnesses and their corresponding symptoms, and this makes them to do more explorations on the facilities available in times of health challenges. Students

from both rural and urban centres have equal access to healthcare and other facilities on campus, as the university does not discriminate against any student on the basis of their geographical location. With the installation of Wi-Fi on campuses, access to online psychological healthcare such as counselling has also been made very easy for all categories of students in times of difficulties.

The health education programmes in senior high schools in Ghana have also improved students' awareness about health issues, including their psychological health challenges. Because of these health programs, most of the students acquire some knowledge on health issues during their secondary education before they enter into the universities. This association between health education and health knowledge was confirmed in a study by Ngwu (2017) in secondary schools in Nigeria. School health programs can serve as a means of preventing health problems. This is because the school is regarded as one of the educational channels through which the students are equipped with the necessary information that prepares and exposes them to a more reliable way of managing their healthcare effectively in order to become healthier and productive adults (Stateuniversity.com, 2016).

Age and Health-Seeking Behaviour

The age of a person has an influence on his/her health-seeking behaviour. The review on the related literature on age has made it clear that the younger population is most of the time associated with some risky behaviour such as smoking, drug addiction, relationship issues, etc., and these behaviours expose them to psychological challenges such as depression, insomnia and suicide ideation. An exploration into the age of the respondents will help psychologists in coming up with appropriate interventions to solve their health care needs. This study investigated the relationship between age

and health-seeking behaviour, and according to the results from the table, the p-value (0.799) is greater than any alpha level of significance, which implies that there is no significant difference between the mean scores for the three age groups. At 5% level of significance, the age of the respondents does not significantly impact on their psychological health-seeking behaviour. This can further be explained that all the students, both the younger and the older ones, have the same attitude towards their psychological health care.

This result is similar to the findings from a work done in rural Bangladeshi by Ahmed, Tomson, Petzold and Kabir (2005) on health-seeking between the elderly and the young. Their findings indicated that both the young and the elderly have similar patterns towards their psychological healthcare. Their findings further revealed that the income level of the elderly encourages them to have a positive attitude towards their healthcare, whilst the educational level of the younger population also leads them to have a good attitude to their healthcare. This reinforces confidence in the findings from the current research because it is consistent with the results from other findings elsewhere.

Similarly, Arku (2015) examined the attitude of male students of University of Cape Coast (UCC) towards counselling on UCC campus. With a sample size of 345 respondents, the findings suggested that male students perceived counselling to be beneficial to them. Also, age did not have any significant impact on the on their attitude towards psychological help-seeking, which makes his results similar to the results from the current study. Interestingly, UCC is part of the population for the current study, and even though Arku (2015) considered only male students in his research, his result is not totally different from the results from the current study.

On the contrary, the work done in Zambia by Zyambo et al. (2012) demonstrated that city dwellers in Zambia whose ages are above 30 years were twice more likely to use their healthcare facilities than their youth whose ages fall between 15 and 19 years. This was buttressed by the research done by Otwombe et al. (2015) in South Africa using adolescents. The researchers found that a smaller percentage of the adolescents' sought for healthcare. The researchers explained that it is likely the elderly folks have more experience about the relevance of their health issues than their younger folks, whilst another school of thought is of the opinion that adults are more economically stable and, therefore, will show a more positive pattern with regard to their health care.

In Turkey, Seyfil et al. (2014) also recorded a higher likelihood of positive attitudes towards psychological health-seeking among older university students, compared to their younger colleagues. The researchers explained that younger students were less likely to have a positive attitude towards psychological help, and this could be due to difficulties in identifying and describing their emotions, and also due to the challenges that come with transition to college life. This result is contrary to the findings from the current study, which used only undergraduate students, with a greater percentage of the younger students. The differences in the findings could be due to the inclusion of the graduate students in the former work, which probably might have increased the number of the older respondents in their research.

In sub-Saharan Africa, like Europe, it has been ascertained empirically that age has an effect on health issues, with the elderly folks showing poorer health outcomes. These findings indicate that there are inconsistencies in the findings from researchers with regard to age and health-seeking attitudes,

because in some findings, the elderly folks show better attitudes (Zyambo et al., 2012), whilst in other findings, the younger folks have better health-seeking behaviour than the elderly, who show poorer attitudes (Beogo et al., 2013).

In Ghana, most people working in organisations have their workplace affiliated to some hospitals, and the workers, together with their children and other dependents, go for medical care free of charge in those health facilities. In places where there are no such affiliations to healthcare, staff members could go for healthcare in any health facility of their choice and bring their medical expenses to their employers for a refund. This can also help in explaining why the elderly people have a better attitude towards health-seeking behaviour. The age brackets in this study were distributed into three categories (18-24, 25-30 and above 30 years), with the 18-24 category considered at the youngest and 25 and above regarded as the older age. The younger age bracket constituted the highest 82.5% of the population. This could be due to the availability of health facilities in the universities for all the age categories, with access and free healthcare. In cases where students have to pay for a particular health service, their bills are sent to the universities for refund. Also, counselling units are available for students on campus to help them deal with their psychological issues.

Effect of Locus of Control, Stigmatisation and Culture on Health-Seeking Behaviour

This section discusses the independent variables, locus of control, stigma and culture, and how each of them influences the health-seeking behaviour of the students in the four public universities in Ghana. Generally, the study tries to investigate whether locus of control, stigma and culture significantly predict or determine the psychological health-seeking behaviour

of public university students in Ghana. In order to find out this, the structural equation model (SEM) was used in this study to measure the impact of locus of control, stigma and culture on the health-seeking behaviour of the respondents. Some researchers have used simple linear regression to measure only one variable and its impact on health-seeking behaviour. Others have also used different models such as multiple linear regression to determine the impact of these variables on health-seeking behaviour. The structural equation model was used for this research because it is more robust and accurate, and it produces better results than just the linear regression.

Locus of Control (LOC) and Health-Seeking Behaviour

Locus of control is a personality profile of an individual which also has an effect on his or her attitude towards health issues. The concept puts individuals into two classes, internalizers and externalizers. The internalizers have a perception that they are in charge of their own lives, and so whatever happens to them is caused by themselves. Therefore, they have to find solutions to their problems. This signifies that internalizers believe that their healthcare is their own responsibility and, therefore, they must find antidotes to cure themselves since they caused it. If one's internal locus of control is high, there is a more likelihood that that individual will carry out health-promoting attitudes (Lorenc et al., 2009). On the other hand, externalizers believe that they are controlled by circumstances or external forces and factors such as luck and chance. Such people attribute their health concerns to chance and, therefore, are not likely to seek for healthcare in times of ill health.

The locus of control scale measures one's belief about his or her ability to influence his or her health outcome. A higher score means that one has a strong belief that he or she can influence his or her health outcome, and a lower score means that one has a weak belief that events are beyond his or her

control. The hypothesis was to test whether locus of control has an effect on health-seeking behaviour of the respondents. From this study, it was observed that there is a positive significant effect of locus of control on health-seeking behaviour of the students. According to the frequency distribution of locus of control scores of the respondents, majority of them scored between 60-70% of the total locus of control scores. This is illustrated in Table 10.

Table 8: Frequency Distribution of Locus of Control Scores of Respondents

Percentage of Scores	Frequency	Percent
40.1-50.0	2	.3
50.1-60.0	55	9.4
60.1-70.0	329	56.0
70.1-80.0	176	29.9
80.1-90.0	17	2.9
90.1-100.0	9	1.5
Total	588	100.0

It is observed from Table 10 that the respondents scored high values in the locus of control variable, confirming the positive effect of locus of control on the health-seeking behaviour. However, only 9.7% of the respondents scored below 60.1 percent score of the locus of control. This implies that the locus of control of the respondents has a positive significant effect on their health-seeking behaviour. This finding was supported by findings from the interviews where students expressed their views on how locus of controls affects their health-seeking behaviour. The excerpt below shows what one respondent said about how the ability to control one's destiny affects health-seeking behaviour:

> *Your ability to control your destiny can affect your attitude towards going for counselling. Four years ago, a lady in my university failed in the first year, and so she decided to go back to level 100. In her mind she was thinking of changing course or maybe switching on to another course. She consulted one of the lecturers and told the lecturer, who counselled her to continue her program. He told her that getting DD in level 100 is not the end of her career. She listened to the lecturer*

> *and she became the valedictorian. This lady allowed the lecturer to control her destiny, which originally was to drop the program and start all over again. We can control our destiny, and sometimes, we can also allow other people to help us shape our ideas* (***Participant B)***.

Another respondent explained that people are able to control their destinies but when they encounter problems, they seek assistance in the form of counselling:

> *Assuming someone knows that he wants to be a Dr., and so she has to do so many things to become the doctor, the only time the person will go for counselling will only be when the person needs help as a result of things going bad. People are able to manage their own destinies themselves, but at a point when they realize that they need more knowledge to make their destinies better, they consult other people to help them. So if I am not able to manage my affairs well, I will go for counselling if necessary (**Participant C)***

In addition, one respondent noted that our ability to control our destinies concerns our commitment to be successful. Thus, people who are committed to their goals seek counselling where necessary:

> *I think our ability to control our destiny has to do with our level of commitment and discipline to what we want to achieve. Someone who is really committed to achieving his goals would always seek psychological health to keep his motivation high. This ability is enhanced after every challenge that I go through. I have control over things which happen as a result of my actions. Yes, I believe that there are external forces that influence my life. Because I cannot control everything that happens in my life, there are other factors that impact some events. Depending on my reactions, these forces might be either beneficial or detrimental (**Participant E)***

One person also indicated that life is a game where everyone needs a coach to be successful. Thus, counsellors are like coaches that lead us to success.

> *Usually, I have learned that everybody is a champion, and is good at what he or she does. But there is no champion without a coach. In a way, it works hand in hand. You need somebody to lead and direct you. As a Christian, there is nothing new under the sun, meaning someone has experienced what you have experienced, and so you need someone to give you*

> *guidance. May be you have read so many things online, but you need someone to take you through the practicalities in life, so that you can beat expectations. So we all need somebody. So for me personally everybody needs a counsellor because it works hand in hand. You may be stuck and you'll need someone to advise you on the next step to take* ***(Participant G).***

The result from this study is very similar to the work done by Perenc and Radochonski (2016) among Polish young adults. Their findings established a significant association between attitudes towards psychological help-seeking and locus of control (both internal and external locus of control). The researchers used a larger sample of 1,706 university students from Poland and also explored their psychological help-seeking just like this current work, and this current study used 588 students, almost a third the Polish population, but the results from both studies are the same. This means that university students are affected by their locus of control, irrespective of their country of origin.

Another work with similar findings is the work done by Tunde and Iyabode (2013) among 170 undergraduate students from Redeemer University students in Nigeria. The researchers addressed their illness behaviour from their psychological perspectives with focus on locus of control. From their findings, those reported as internals had different illness patterns when compared with the externals. Tunde and Iyabode (2013) concluded from their studies that locus of control plays a significant role in explaining the differences in their attitude towards their health, implying that locus of control impacts significantly on their psychological health-seeking behaviour, and this agrees with the findings of the present study.

In the Volta Region of Ghana, Wolanyo (2017) came out with findings that are very congruent with the results of this current study. From his study, locus of control positively and significantly predicts the counselling seeking

behaviour of the SHS students used as his population. Students seek for counselling when they have psychological issues, and this happens to be one of the key focus areas of the current study. Moreover, the researcher used SHS students from just one region in Ghana, with 218 active responses retrieved. This, in addition to the secondary status of the students, could not alter the influence of locus of control on their psychological health-seeking behaviour. The current research used students from tertiary institutions who are more advanced in knowledge of health issues more than students in secondary schools, and as a result, it would be expected that some basic differences will exist in their responses. The similarities in the responses of the university students and the SHS students reveal that education plays an active role in the personality profile of both secondary and tertiary students. It can be conveniently concluded that the school health programs have a bearing on students' mindset on issues concerning their psychological healthcare.

A study AzFredrick (2017) undertook in Nigerian secondary schools also found locus of control as a correlate of students' utilisation of health services. This means that locus of control has an impact on their use of the health facilities. Although AzFredrick used a larger sample size of 3,065, all of whom were females, she explored on a link between a psychological factor (locus of control), which makes it similar to the present study. AzFredrick also utilised a younger population composed of female adolescents because the focus of her work was on reproductive health services unique to females. The current study used tertiary students, both males and females, whose ages vary from 19 years and above, with a lesser population strength of 588 students, and considered the effect of locus of control on health-seeking behaviour.

Contrarily, Sarfo and Acquaye (2016), who focused on a general multi-ethnic population in the New Juaben Municipality of Ghana, found that locus of control did not have any significant impact on their health-seeking behaviour. The researchers further explained that the cultural practices of the respondents rather had a significant effect on their locus of control. Also, the type of health system practiced over a long period of time accounted for their current locus of control predicaments. The findings from their study are in contrast with those of the current study, and the differences could be attributed to the multi-ethnic background of the respondents as well as the type of cultural practices they have been exposed to over a long time. Even though the educational level of their respondents was not explored, it is likely to determine it from their addiction to their cultural norms, as this is very peculiar with people living in a rural locality. Also, the researchers used a small population from only one region in Ghana, whilst the current study used more respondents, all students from four regions in Ghana. These students are enlightened on modern trends in health issues because they are exposed to health information and are schooling in tertiary institutions located in urban centres. This explains the differences in the impact of locus of control on their health-seeking behaviour between their study and the current study.

In summary, it can be concluded that locus of control has a significant impact on the psychological health-seeking attitude of students in both secondary and tertiary institutions. These findings indicate that education has a way of influencing the personality tendencies of an individual, therefore informing their locus of control to attain better perceptions in their healthcare choices. It has also been ascertained that cultural values and orientation can also affect the locus of control of people who are more culturally inclined and

used to their cultural practices and norms, and this may adversely interfere with their healthcare options.

Stigma and Health-seeking Behaviour

Students at the tertiary institution are at a risk of developing stress-related issues because of the nature and scope of their academic work. Due to their transition from secondary schools to tertiary institutions, some go through new experiences associated with stress, and the fear of stigma may reduce their desire to seek psychological healthcare. Stigma is explained as a cognitive behavioural process which is exhibited through various means. Stigma has no concise definition to bring out its meaning to the fullest and it causes exclusion and isolation for those afflicted (Gaebel et al., 2002).

The stigma scale or instrument focuses on the feelings of respondents about the distress and particularly other people's reactions to stigma. The stigma scale helps to understand the psychological problems individuals have in terms of stigma reactions or related problems. A higher total score implies that an individual perceives highly that people with mental health challenges are more affected by the stigmatisation whilst a lower score indicates that he/she perceives people with mental health challenges to be less affected by the stigmatisation. The study investigates whether stigmatisation has any influence on the health-seeking behaviour of the university students. The results on the stigma variable in Table 11 show that 42.3% of the respondents recorded 60.1-70 percentage stigma score and 40% of the respondents recorded 70.1-80 percentage stigma score.

From Table 11, 14.4% of the respondents recorded at least 80.1 percentage stigma score. These high percentage scores of the respondents with stigma show that stigma affects health-seeking behaviour among tertiary

students. However, only 3.4% of the respondents recorded lower stigma scores (less than 60 percentage score).

Table 9: Frequency Distribution of Stigma Scores of Respondents

Percentage of Scores	Frequency	Percent
0-40	2	.3
50.1-60.0	18	3.1
60.1-70.0	249	42.3
70.1-80.0	235	40.0
80.1-90.0	66	11.2
90.1-100.0	18	3.1
Total	588	100.0

The findings show that stigmatisation positively impacts the health-seeking behaviour of students significantly. This means that the higher the level of stigmatisation, the lesser the students are likely to seek help in times of psychological challenges. Stigmatisation will, therefore, deter students from seeking for healthcare, and even if they do, they are more likely not to open up to their healthcare professionals.

This finding is supported by the findings from the interviews. One participant noted that stigma prevents people from seeking help because of the fear of being labelled:

> *Stigma can affect someone in the sense that when someone feels demotivated, he/she will not have that desire to come out with her problems. I will be afraid of being labelled if my friends see me coming from the counselling unit. I have not really experienced any form of stigma on campus yet, but I see it being done to a lot of people on campus. On campus, people who are extremely fat are made fun of, and as a result they feel stigmatized and so sometimes they find it difficult to come for lectures. You don't see a lot of students going near such students (**Participant A**).*

Other participants noted that stigmatized people fear to go for counselling because they fear that people will make fun of them:

> *Stigma is when you get yourself into a bad situation, and because of that people begin to reject you. Such people will not go for counselling because they are afraid that people will make fun on them. They also fear because they don't know if*

*the counsellors will keep their problems secret, or if the counsellors themselves will make them feel stigmatized more. Personally I have not been stigmatized before but stigma comes in many forms and not necessarily in counselling alone. I see students making fun of their friends, especially the males and someone can get stigmatized when you make fun of him, and it may make the person to coil into his shelves. Also, when lecturers embarrass students in the class, they feel ashamed and this can also make them feel stigmatized and they will not talk during lectures (**Participant B**).*

*Stigma is when maybe something happens to you and you feel bad. Sometimes you want to get closer to people and they don't want you to come near them, you can feel stigmatized. Sometimes what is happening is not even your fault, but you are innocent, people still reject you. I will feel that these people will make fun of me, and so I will not go for counselling at all. Stigma makes people to shy away and decide to live on their own (**Participant C**)*

*Stigma is when you feel humiliated and embarrassed about a situation that you find yourself in, and as a result your own colleagues are making fun of you and calling you names. As a youth I have problems, and when I tell some of my friends they make fun of me. Because of this, I feel discouraged to go to the counselling unit for counselling, because even my friends that I know are making fun of me, how much more people who I do not know and they are totally like strangers to me? (**Participant H**)*

Others indicated that because of stigma, they will like to keep their problems to themselves, rather than going for counselling:

*Stigma is a very bad thing. Because if everyone gets a very bad conception about you they will all shy back. Somebody who feels stigmatized will not go for counselling at all because when people see them coming from the counselling unit, it will rather worsen their problem. Personally, I will find it difficult to go for counselling because if I feel stigmatized because I will rather prefer to keep my problems to myself rather than disclosing it to another person like a counsellor. Stigma makes people to feel humiliated and ashamed, and also, some people are not very comfortable telling others about their problems because they do not know what people will think about them. On campus people get raped, and for fear of stigmatization they keep quiet and endure the pains alone, because they are afraid that if they tell the counsellors, their secrets will be out and people will laugh at them (**Participant D**)*

Stigma is when people begin to reject you because they have noticed something very peculiar about you which is not very common with others. As a person, I will not go for counselling for fear of being stigmatized. This is because I will not want

more people to know about my problem, and so I will prefer to stick to myself and find a way of solving my problems myself ***(Participant F)***

Stigmatisation is one of the most commonly cited barriers to professional help-seeking (Corrigan, 2004). In view of this, most researchers have looked at stigma as a concept and how it interferes in the lifestyle of university students when psychologically challenged. There are so many variations of stigma: public stigma, perceived public stigma, personal stigma, label avoidance and internalized stigma (Lally et al., 2013). Some researchers have looked at the differences in the various levels of stigma and the extent to which it will prevent their respondents from going for psychological healthcare, whilst others concentrated on stigma as a concept and how it affects an individual. Eisenberg et al. (2009) realised that stigma of mental illness perceived from peers was more than the personal or self-stigma. However, personal stigma was correlated negatively with people's chances of seeking professional support for psychological health issues.

Jamar (2013) revealed that stigma has an effect on the African American community and members also have negative attitudes about mental illness. The researcher did a qualitative study with nine clinicians and discussed the stigma of mental illness within the African American community from their perspective. It was observed that stigma was one of the inhibitors to their attitude towards healthcare. This finding is related to the current study, as stigmatisation has a significant impact on the psychological health-seeking behaviour of the population. Even though Jamar (2013) did not use university students as his population as in this current study, stigma is a universal phenomenon humanly related, and irrespective of an individuals' background, the impact seems to be the same.

Vudourek et al.'s (2014) assessment of college students' perception about benefit and barriers to obtaining mental health treatment and stigma-related attitudes found that females held a significantly lower stigma-related attitude than their male counterparts. This implies that the impact of stigma on the females is lower, and more females will seek professional healthcare than their fellow males. This could also account for gender differences in psychological health-seeking behaviour in some studies. The current research did not consider the impact of stigma on gender but looked at the influence of stigma on the health-seeking pattern of students in the public universities in Ghana. Despite their focus of stigma on gender, the two studies have similar findings: they both used tertiary students as their population, and stigmatization influenced the health pattern of the students in both studies.

Venson (2014) used the survey method to examine the determinants of mental health stigma among graduate students reading Public Health Administration in Pace University. As the study revealed, more than forty percent (42%) of the sample indicated that people will be hesitant to embrace a close friend who has undergone mental health therapy. Based on the findings, the researcher stressed the need to strengthen efforts aimed at reducing stigma among university students. Venson used postgraduate students for his study to assess the perception about mental health victims among the students, whilst the current researcher used undergraduate students from all the levels. This did not affect the results from both findings.

The research done by Kuok and Rashidnia (2019) in two developing Asian countries, Iran and China, reported that stigma has a significant impact on the college students' attitude towards counselling. Similarly, Hilliard (2019) confirmed from his studies on mental health services among 325 college student-athletes that stigma significantly correlates with health-seeking

behaviour. These results were in furtherance consistent with a previous work done by Greenidge (2007) among Caribbean students. The study conducted in Sri Lanka by Abhayasinghe (2014) buttresses the results from the current research, pointing out that globally, university students exhibit the same characteristics when it comes to issues concerning stigma and health-seeking behaviour.

Alyousef's (2016) study in Saudi Arabia confirms that stigmatisation of mental health patients is evident even among healthcare experts. This finding demonstrates that mental healthcare providers have a stigmatising perception about their patients, and this is very likely to affect their relationship with their patients in the course of administering treatment to them. One may expect that psychological healthcare providers should be more informed about stigma and its related issues, as well as its impact on their patients, but the study from Saudi Arabia proved otherwise. Stigmatisation, therefore, has a significant impact on some healthcare providers the same way it influences the health-seeking behaviour of students, as evidenced in the findings from the current research.

In summary, evidence from works done by researchers and the findings from the current study signify that stigmatisation has a great impact on the psychological healthcare of students, healthcare providers and some individuals. University students have various mental health problems, such as suicide ideation, stress, depression and other issues attributable to the cumbersome nature of their academic responsibilities, and the fear of being stigmatised is considered a major reason for their reluctance to seek help for mental health problems. This calls for more measures to be put in place to minimise the stigma associated with such health issues.

Cultural Beliefs and Health-Seeking Behaviour

Culture is a phenomenon that influences the health intentions and outcome of an individual. It has diverse effects on health, as it affects perceptions, beliefs about causes of an illness and the type of intervention that an individual will prefer. The culture scale was constructed by the researcher (after a thorough review of the literature) with the help of her supervisors. It considered items such as the causatives of mental illness such as supernatural powers, adjusting to culture, cultural differences, family related issues etc., as well as some treatment options such as medication, counselling, psychotherapy and other alternative therapies. This was done to find out whether students' cultural orientation will have an impact on their health-seeking behaviour.

The scale is to measure the cultural beliefs of the students towards psychological help-seeking. A lower score implies that a respondent has favourable cultural beliefs towards mental illness while a higher score indicates unfavourable cultural beliefs towards mental illnesses. This means that a person with a lower score on the culture scale is less affected by cultural entanglements and, therefore, will seek for help in times of challenges, whilst a person with a higher score might not seek for healthcare due to her cultural beliefs about the aetiology of issues such as sicknesses. The researcher hypothesised that cultural beliefs have no influence on the psychological health-seeking behaviour of the students. The results from the study show that culture has a positive significant effect on the health-seeking behaviour of the university students. The results in Table 12 show that majority (54.6%) of the respondents scored between 60.1-70 percentage on the culture scale.

Table 10: Frequency Distribution of Culture Scores of Respondents

Percentage of Scores	Frequency	Percent
0-40	2	0.3
40.1-50.0	5	0.9
50.1-60.0	39	6.6
60.1-70.0	321	54.6
70.1-80.0	178	30.3
80.1-90.0	36	6.1
90.1-100.0	7	1.2
Total	588	100.0

Table 12 shows that 37.6% (70.1-100) of the respondents scored at least 70.1% and above on the culture variable. These high culture scores of the respondents confirms the positive effect of culture on the health-seeking behaviour of the respondents. However, only 7.8% of the respondents scored below 60.1 percent score on the culture scale. This implies that students who score higher on the culture scale are those who are more inclined to their cultural practices, and even during their psychological health challenges, may allow their cultural orientation to interfere with their psychological healthcare options.

The quantitative results were supported by the qualitative findings which point to the fact that culture affects the psychological health-seeking behaviour of students. Some students indicated that their cultural orientations make them seek assistance from elders rather than going for counselling:

> *Culture I think can affect counselling. Our cultural orientation encourages us to listen to our elders, and so we are used to them. When they advise us we heed to their advices and so when we have a problem we go to them for solution. Because of this, there will be no need for me to go for counselling because in the first place I do not need it (**Participant A)***
> *In my opinion, culture affects counselling…. In our tradition, women are supposed to be submissive to their husbands, and as children we also have to obey those who have the rule over us. If we have a problem, it is solved within the family, you have to go and see the one who is ahead of you for solution to your problems. There will therefore be no need for any counselling intervention at all (**Participant B)***
> *I think that traditionally, I will say yes, culture can affect counselling. Our elders are the counsellors. The Chiefs,*

> *Ebusuapanin, Okyeame etc are our elders, and we obey them. When we have challenges, we go to them. They counsel us according to our cultural set up. To me I think it moves hand in hand to an extent in a traditional community. By the time we grow up, we get used to them and so we do not get used to counsellors. We have more confidence in them because we grow up and get used to them. They are able to solve any form of problems that you send to them (**Participant C)**.*

Another student indicated that culturally, there is a need for mutual understanding between the perceptions of the counsellor and the patient. Lack of that understanding will create mistrust on the part of the patient, which can affect the health-seeking behaviour:

> *Yes, in my opinion, culture affects counselling. From my understanding of counselling, both the counsellor and the client must be corporative; so if the counsellor's advice contradicts the client's views, it is likely to cause distrust and decrease the client's confidence in the counsellor. This mainly has to do with religion. The counsellor's perceptions will be shaped mostly by his or her cultural experiences, traditions, and beliefs (**Participant G)**.*

The results from the current study show that counsellors and other health caretakers should be culturally competent, so as to be able to administer their services to their clients without bias and prejudice (Leong, Weiland & Dent, 2010). Leong et al. (2010) also believed that more focus should be on the client or patient. With this, health professionals need to initiate and maintain interpersonal communication with patients. Patients must be understood in their own unique and cultural context and must be appreciated as well. Cultural competence leads to good interpersonal relationship between health experts and patients as well as effective communication.

Some researchers have looked at culture and how it affects the health-seeking behaviour of their respondents. A work done by Pramukh and Palkumar (2006) among the Bogatha revealed that the participants attribute diseases beyond their description to some abnormal actions of nature and

divine rules. This, therefore, makes it incumbent for them to resort to spiritual cure. Similarly, Cataret's (2011) study revealed that the health beliefs of patients can significantly influence their clinical care, which can also adversely affect efforts aimed at prevention. This was confirmed by Sarfo (2015), who found that students' belief system about the cause of an illness results in culturally-based attitudes, and they tend to believe in traditional medicines in times of ill-health. The findings from the two researches above are consistent with the results from the current study. Culture has a significant impact on the health-seeking behaviour of the respondents and this affects their choice of health care. In the current study, culture significantly affected the health-care of the students. Although the researchers considered purely medical issues, the current study is looking at the psychological health pattern of university students. The students may not necessarily look for the cause of their psychological illnesses before deciding to go for counselling or not, but their decision may be taken with inference from their cultural background.

Toliver-Weddington (2000) focused on cultural considerations for the treatment of cardiovascular disorders among African Americans. His findings proved that people still believe in magic, folk medicine, spirits and other signs of witchcraft. This assertion was confirmed by Walker (2006) who also revealed that a Nigerian tribe called Ngwa believe that when their loved ones and enemies die, their spirits come from the spirit world to execute punishments. The results from these two researchers are consistent with the results from the current study on culture. Akinkugbe (2004) also found from his studies that Nigerian women believed that hypertension was caused by evil spirits. This was because when mothers stayed in the sun for a long time, the spirits became annoyed. With this type of cultural belief, orthodox treatment is not an option.

Even though the work done by these researchers was purely on medical illnesses, their findings were similar to the current study, which is on psychological healthcare. This means that culture affects the health behaviour of groups of people, and as a result, medical doctors as well as psychological health workers must acquaint themselves with the cultural background of their patients and clients before addressing their health challenges. Yawney (2005) concluded that medical science may explain sicknesses clinically without reference to cultural factors, but it cannot describe or treat all sicknesses effectively without considering non-biological features.

In summary, mental illness and culture cannot be separated from each other, as culture plays a very vital role in the way mental illness is perceived (Jimenez, Bartels, Cardenas, Dhaliwal, & Alegría, 2012; Scott & Marshall, 2004; Scott & Marshall, 2004). On this basis, cultural relativists stress culture as a concept that is socially constructed and differs across borders. Different cultures have their own perceptions and beliefs associated with the aetiology of mental illnesses and their corresponding treatment and intervention procedures (Scott et al., 2012). This explains why healthcare providers such as psychologists must probe more into the cultural background of their clients before considering an appropriate intervention for their healthcare needs.

The study revealed that two of the demographic variables, age and gender, did not significantly impact on the health-seeking behaviour of the public university students in the study. Geographical location was the only demographical variable that independently influenced the health-seeking behaviour of the students, and this is illustrated in Figure 3. It was, however, observed that the three demographic variables jointly influenced the health-seeking behaviour of university students.

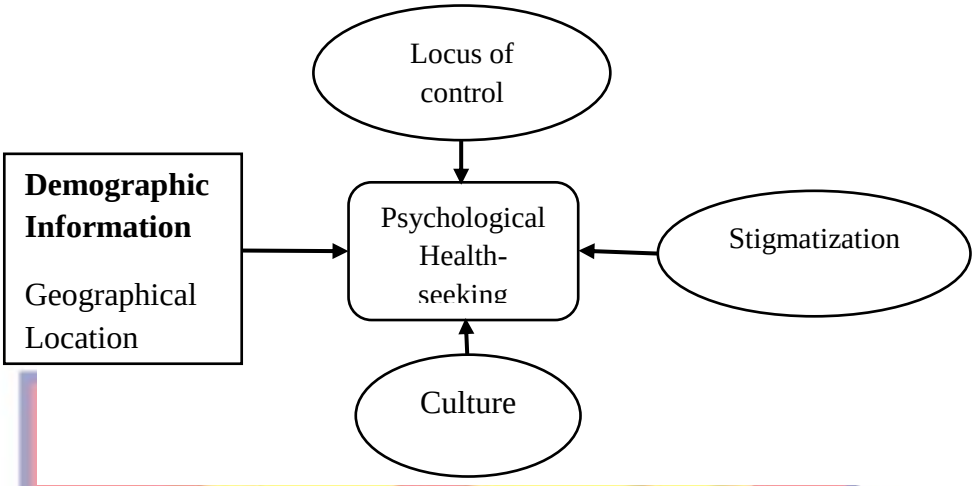

Figure 4: The observed conceptual framework of the study
Source: Author's construct

Figure 3 is an illustration of the observed conceptual framework of the study, indicating the variables that influenced the health-seeking behaviour of the students. From the figure, age and gender have been expunged from the diagram because they did not statistically affect the health-seeking behaviour of the students significantly. However, geographical location, locus of control, stigma and culture are maintained on the observed conceptual framework due to the fact that they influenced the psychological health-seeking behaviour of the students.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Overview

This chapter presents the summary, conclusions and recommendations based on the findings from the research. The main aim of this thesis was to investigate whether locus of control, stigma and culture have an influence on the health-seeking behaviour of students in some selected universities across the country. It also tried to establish whether some demographic characteristics such as age, gender and geographical location have a role to play in the psychological health-seeking behaviour of the respondents.

Summary of findings

The study was guided by 4 hypotheses. The first hypothesis was to test whether there is a significant difference in the psychological health-seeking behaviour of public university students on the basis of gender. The independent t-test was used to analyse this, and the results show that gender has no significant influence on the psychological health-seeking behaviour of the university students.

The second hypothesis was set to establish whether geographical location of the respondents has any significant effect on the psychological health-seeking behaviour of the students in the study. Using the independent t-test for the analysis, the results show that geographical location has a significant impact on the health-seeking behaviour of the respondents.

Hypothesis Three aimed at finding out whether the age of the respondents has a significant impact on their psychological health seeking-

behaviour. The ages of the respondents were classified into three categories, and, therefore, one-way ANOVA was employed to analyse the data. The results revealed that the age of the respondents has no effect on their psychological health-seeking behaviour.

The fourth hypothesis was to find out whether locus of control, stigmatisation and culture will have a significant effect on the psychological health-seeking behaviour of the respondents. The structural equation model was used to examine the causal relationships of the three independent variables on the health-seeking behaviour of the students. The findings show that the causal relationships or impact of the variables on the psychological health-seeking behaviour of the students are significantly determined by their locus of control, stigmatisation and culture.

Conclusions

In summary, the results from the study suggest that gender has no significant impact on the psychological health-seeking behaviour of the selected public university students.

The health-seeking behaviour of the students did not vary according to their ages, because the study showed that age did not affect the psychological health-seeking behaviour of the students.

Geographical location, that is, living in a rural or an urban area, has a significant influence on the health-seeking behaviour of the students, with urban dwellers exhibiting better attitudes as opposed to their counterparts from the rural areas.

The findings also portrayed that locus of control, stigmatisation and culture have significant effects on the health-seeking behaviour of the students.

Recommendations

Based on the findings from this research, the following recommendations have been made:

1. Training programmes must be organised for students on mental health issues without considering gender.
2. The university management must liaise with professional bodies of counsellors, psychiatrists and psychologists to create programs which aim at giving lectures to Senior Members, Deans and Directors on some basic knowledge and requisite skills in counselling in order to be able to render counselling services to students who need help.
3. More sensitisation programmes on mental health issues need to be organised by health workers in rural areas. Again, the location of mental health centres in rural areas should be strategic, as centres located in the open may discourage people from accessing them for the fear of being stigmatised.
4. The counselling units in the universities must organise seminars on mental health related issues such as stress management, substance abuse, depression, suicide and other psychological issues for students irrespective of their ages, as the study showed that all the students showed the same attitude towards health-seeking despite the differences in their ages.
5. Locus of control has an effect on the health-seeking behaviour of the students, implying that counsellors should test the locus of control of their students and use it as the basis for a better counselling assessment.
6. Stigmatisation has an effect on the health-seeking behaviour of the students, implying that stigma may deter the students from going for

counselling, and even if they manage to visit the counsellors and school psychologists, they may find it difficult to open up and share their problems with them for fear of being stigmatised. This suggests that anti-stigma interventions must be put in place by counsellors to help curtail the situation. The counselling units must organise programs that aim at improving the willingness of the students to seek counselling and psychiatric care at any point in time.

7. The findings from the study indicate that culture has an effect on the health-seeking behaviour of the respondents and this calls for a more comprehensive insight into the cultural orientation of the students for proper counselling interventions. Healthcare practitioners such as counselling psychologists should acquaint themselves with the culture of their clients and make sure that their own cultural background will not conflict with the cultural orientation of their clients during counselling. This will help psychologists to help their clients in making good informed choices.
8. In order to help in improving the psychological healthcare of rural dwellers, it is recommended that general hospitals in rural areas should attach mental health units to their facilities. Counselling services should be made available for the youths to patronise.

Suggestions for Further Research

This study examined some determinants of health-seeking behaviour of university students, and it should be viewed as a starting point for further research. It is suggested that future studies will explore other variables such as religion, ethnic background and academic level of students. It should also consider the socio-economic background of parents of the students and also research into the student's patronage to the Guidance and Counselling Units in

their universities. Researchers could also investigate whether differences exist in the health-seeking behaviour among students in the different universities. A deeper insight into locus of control of the students, to identify internalizers and externalizers as well as their choices of healthcare, whether formal or informal, will help in planning counselling interventions for better outcomes.

A study of this nature would have produced more accurate results if the research design was purely qualitative, instead of the mixed method approach. In view of this, for further research, a purely qualitative method should be employed for such studies considering the variables involved. Other variables that affect health-seeking behaviour such as religion, marital status, education etc. can also be explored.

Counselling Implications

1. Locus of control, a personality profile which describes the innate characteristics of individuals, influenced the health-seeking behaviour of the students in the study. This calls for a more thorough knowledge about the personality profile of clients before therapeutic measures are meted out to them. Counsellors must painstakingly do more exploration into the personality profile of their clients and assess them before rendering services to them.
2. Counselling psychologists must advocate the eradication of stigma associated with seeking psychological healthcare. Stigma has harmful effects of making the individual feel hopeless, which may lead to isolation, and this may further make the person feel reluctant to seek help in times of psychological distress. In view of this, more interventions must be designed to reduce stigma associated with seeking for psychological help and care. Students must be encouraged

to make use of the counselling facilities available to them on their various campuses.

3. Acknowledging the role of culture during counselling is very important since it helps to shape specific outcomes during counselling. Probing deeper into the background of the clients, such as making enquiries into their belief systems, religion and values, will help in giving the clients better informed choices. As therapists, there is the tendency for our own background to interfere with our counselling techniques. Therefore, knowledge about the cultural background of clients will empower counsellors to be aware of the appropriate techniques to employ.
4. Geographical location impacted positively on the health-seeking behaviour of the students in this study. More attention must be given to students from the rural areas since they have a poorer attitude towards health-seeking than their counterparts from the urban centres. Counsellors must organise more educative programs on psychological issues which target students from the rural areas.

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APPENDICES

APPENDIX A: Research Questionnaire

This questionnaire is designed to solicit information on *Locus of control, stigma and culture as determinants of psychological health seeking behaviour among public university students in Ghana*. It is voluntary to take part in the study, and I assure you of confidentially and anonymously.

Instruction: Tick [√] the correct response from each of the alternatives provided for each statement.

Part I: Participants Bio-Data and Demographic Characteristics

1. **University:**
   - UPSA ☐
   - UCC ☐
   - KNUST ☐
   - UDS ☐
2. **Gender:**
   - Male ☐
   - Female ☐
3. **Age range**: 18-24 [ ] 25-29 [ ] 30+ [ ]
4. **Place of abode after school**
   - Urban ☐
   - Rural ☐

Part II: Participant's Locus of Control

Instruction: Tick [√] one of the responses for all the statements. The response options are Strongly Agree (SA); Agree (A); Disagree (D); Strongly Disagree (SD).

No.	ITEMS	SA	A	D	SD
1	It is my belief that my problems will be solved by themselves, considering I don't fool with them				
2	It is my belief that I can prevent myself from catching a cold				
3	I believe some people are just born lucky				
4	I mostly place premium on getting good grades				
5	People usually blame me for things that happen by no fault of mine				
6	It is my belief that every subject can be passed provided the student studies hard				
7	I have the feeling that it is not worth trying hard, as things do not turn right anyway				
8	I have a feeling that once things start well in the morning, it is automatically going to be a good day.				
9	I feel that parents mostly pay heed to what children say				
10	It is my belief that good things can result from wishes				
11	I usually don't see any good reason why I get punished				
12	Most of the time, I find it difficult to change a friend's (mind) opinion				
13	I assume that it is more likely for a team to win when they're cheered than luck.				
14	I have a feeling that it is virtually unlikely for me to get my parents change their minds about something.				
15	It is my belief that parents need to give children the freedom to make decisions				
16	I feel that it is virtually impossible for me to right my wrongs				
17	It is my belief that people get sports abilities at birth				
18	I believe that I am weaker than most of my age mates				
19	I think problems can best be avoided by not thinking about them				
20	I feel I have the freedom to decide on who becomes my friend.				
21	I believe that I can get good luck from monies I find on the ground				
22	I feel that grades I get depend on me doing my homework				
23	I assume that I can do just a little to prevent my age mates from getting angry with me				
24	I believe I can get good luck from charms				

25	It is my belief that my actions can make people like or not like me				
26	I normally get help from my parents when I ask them				
27	I think people usually get angry with me for no reason				
28	It is my belief that my actions today can change what might happen tomorrow				
29	I believe that I have no ability to stop bad things from happening				
30	I think that with consistent trying, one can succeed at something				
31	I mostly find it unworkable to try to get my own way at home				
32	I have a feeling that good things arise from hard work				
33	I feel that I can hardly prevent my age mate from becoming my enemy				
34	I feel I can easily get friends to do my bidding				
35	I usually feel that I have a little choice when it comes to what I eat at home				
36	I have a feeling that I can hardly do something about someone not liking me				
37	I have a usual feeling that it is not worth it to try in school, since most of my colleagues are apparently more intelligent than me				
38	I believe that things can get better once I plan ahead				
39	I mostly feel that I barely have a say in my family's decisions				
40	I think it is better to be smart than to be lucky				

Part III: The Stigma Scale

Instruction: Tick [√] one of the responses for all the statements. The response options are Strongly Agree (SA); Agree (A); Disagree (D); Strongly Disagree (SD).

No	Statements/Questions	SA	A	DA	SDA
1	People with mental health issues encounter educational discriminations				
2	People speak patronizingly to mental health patients				
3	Mental health patients are more understanding of others				
4	I have no bad feelings about mental health patients				
5	Mental health patients may get worried with getting others informed about their psychological treatment				
6	Mental health patients are dangerous				
7	People with mental health problems experience fear				
8	Mental health patients experience discrimination from the police				
9	Employers discriminate against mental health patients				
10	Mental health patients suffer loneliness				
11	Mental health patients are often afraid of people's possible reactions to their mental health issues				
12	Mental health patients would have had better chances in life if they had not had the condition				
13	Mental health patients show concern for how neighbours perceive their conditions				
14	Mental health patients will open up about their conditions when seeking employment				
16	Mental health patients worry about informing others about the medicines/tablets they take				
17	The way people react to mental health patients make them keep to themselves				
18	People's reactions to mental health patients make them angry				
19	Mental health patients receive no trouble from others because of their condition				
20	Mental health patients receive discrimination from health professionals				
21	People normally avoid mental health patients				
22	People normally insult mental health patients				
23	Mental health patients derive strength from their condition				
24	Mental health patients do not experience embarrassment resulting from their condition				
25	Mental health patients do not tell others about their condition				
26	Mental health patients feel life is not fair				

27	Mental health patients feel it's needful to hide their conditions from their friends				
28	Mental health patients have difficulty informing others about their condition				

Part IV: Cultural beliefs towards Help-Seeking

Instruction: Read each statement carefully and indicate your degree of agreement. Tick [√] one of the responses for all the statements. The response options are Strongly Agree (SA); Agree (A); Disagree (D); Strongly Disagree (SD).

Cultural Beliefs

No.	Statements: I believe that:	SA	A	D	SD
1	Supernatural powers can cause mental illness				
2	Disturbance of body, mind and spirit can result in mental illness				
3	Something done in the past can cause mental illness				
4	Moving to a different place can cause mental illness				
5	Cultural differences can cause mental illness				
6	Adjusting to a different culture can cause mental illness				
7	A loss (e.g. family, friends) can cause mental illness				
8	Lack of pleasurable activities can cause mental illness				
9	Family-related issues can cause mental illness				
10	Financial challenges can cause mental illness				
11	Stress can cause mental illness				
12	Medical illness can cause mental illness				
13	Infectious disease can cause mental illness				
14	Nutritional deficiency can cause mental illness				
15	Chemical imbalance can cause mental illness				
16	Genetic dispositions can cause mental illness				
17	Mental patients do not ever get treated				
18	A mental patient who has ever ate food or anything from the ground cannot be treated				
19	A mental patient treated and discharged will still possess what it takes to scare children				
20	Mental illness can be inherited from parents				
21	I will call off the marriage if my partner has mental illness				
22	I will not marry from a family with mental illness history				
23	Mental illness can be transmitted to another person through friendship or relationship				
24	Mental illness can be treated with medications				
25	Mental illness can be treated with herbal remedies				
26	Mental illness can be treated through counselling				
27	Mental illness can be treated through psychotherapy				
28	Mental illness can be treated through spiritual advice				
29	Mental illness can be treated through alternatives therapies (acupuncture, massage etc)				

Part V: Attitudes Toward Seeking Professional Psychological Help Scale Short-Form (ATSPPHS-SF)

Instruction: Tick [√] one of the responses for all the statements and do not leave any blank. The response options are Strongly Agree (SA); Agree (A); Disagree (D); Strongly Disagree (SD).

No.	STATEMENT	SA	A	D	SD
1.	If I believed I was having a mental breakdown, my first inclination would be to get professional attention.				
2.	The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.				
3.	If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.				
4.	There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.				
5.	I would want to get psychological help if I were worried or upset for a long period of time.				
6.	I might want to have psychological counseling in the future.				
7.	A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.				
8.	Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.				
9.	A person should work out his or her own problems; getting psychological counselling would be a last resort.				
10.	Personal and emotional troubles, like many things, tend to work out by themselves.				

APPENDIX B: Interview Guide

1. How does culture affect your psychological health-seeking behaviour?
2. How does stigmatization affect your psychological health-seeking behaviour?
3. How does the ability to control your destiny affect your psychological health-seeking behaviour?
4. How does the control of your life by external forces affect your psychological health seeking behaviour?
5. Why will you not seek for counselling even though you have psychological challenges?

APPENDIX C: Letter of Introduction

UNIVERSITY OF CAPE COAST

COLLEGE OF EDUCATION STUDIES

FACULTY OF EDUCATIONAL FOUNDATIONS

DEPARTMENT OF GUIDANCE AND COUNSELLING

Telephone: 0332091854
E-mail: dgc@ucc.edu.gh

UNIVERSITY POST OFFICE
CAPE COAST, GHANA

Our Ref: DGC/L.2/VOL.1/128

Your Ref:

June 19, 2020

TO WHOM IT MAY CONCERN

LETTER OF INTRODUCTION

We introduce to you, Patience Araba Mba a student pursuing a Ph.D Programme in Guidance and Counselling at the Department of Guidance and Counselling of the University of Cape Coast. As a requirement, she is to submit a Thesis on the topic: ***"Locus of Control, Stigma and Culture as Determinants of Health Seeking Behaviour Among Public University Students in Ghana".*** We are by this letter affirming that, the information she will obtain from your Institution will be solely used for academic purposes.

We would be most grateful if you could provide her the necessary assistance.

Thank you.

Dr. Stephen Doh Fia
HEAD OF DEPARTMENT

APPENDIX D: Ethical Clearance

UNIVERSITY OF CAPE COAST

INSTITUTIONAL REVIEW BOARD SECRETARIAT

TEL: 0558093143 / 0508878309
E-MAIL: irb@ucc.edu.gh
OUR REF: UCC/IRB/A/2016/860
YOUR REF:
OMB NO: 0990-0279
IORG #: IORG0009096

9TH DECEMBER, 2020

Ms. Patience Araba Mba
Department of Guidance and Counselling
University of Cape Coast

Dear Ms. Mba,

ETHICAL CLEARANCE – ID (UCCIRB/CES/2020/88)

The University of Cape Coast Institutional Review Board (UCCIRB) has granted **Provisional Approval** for the implementation of your research titled **Locus of Control, Stigma and Culture as Determinants of Health Seeking Behaviour Among Public University Students in Ghana.** This approval is valid from 9th December, 2020 to 8th December, 2021. You may apply for a renewal subject to submission of all the required documents that will be prescribed by the UCCIRB.

Please note that any modification to the project must be submitted to the UCCIRB for review and approval before its implementation. You are required to submit periodic review of the protocol to the Board and a final full review to the UCCIRB on completion of the research. The UCCIRB may observe or cause to be observed procedures and records of the research during and after implementation.

You are also required to report all serious adverse events related to this study to the UCCIRB within seven days verbally and fourteen days in writing.

Always quote the protocol identification number in all future correspondence with us in relation to this protocol.

Yours faithfully,

Samuel Asiedu Owusu, PhD
UCCIRB Administrator

ADMINISTRATOR
INSTITUTIONAL REVIEW BOARD
UNIVERSITY OF CAPE COAST

APPENDIX E: Request for Data on Regular Undergraduate Students Population

C/o Department of Guidance and
Counselling
University of Cape Coast
Cape Coast

11th December, 2019.

THE HEAD
STUDENTS RECORDS SECTION
UNIVERSITY OF CAPE COAST

Dear Sir/Madam,

REQUEST FOR DATA ON REGULAR UNDERGRADUATE STUDENTS POPULATION

My name is Patience Araba Mba offering Ph.D in Guidance and Counselling. I am working on the research topic "Stigmatization, locus of control and culture as determinants of health-seeking behaviour of university students in Ghana". In view of this, I need data on the population of regular undergraduate UCC students based on the various colleges and departments of the University.

Please you can forward it to me via email: **mansamba@yahoo.com** or patience.mba@stu.ucc.edu.gh.

I hope my request would receive the kindest consideration.

Thank you.

Yours faithfully,

PATIENCE ARABA MBA
(0244 509 521)

APPENDIX F: Request for Information on Students: KNUST

PATIENCE ARABA MBA
UNIVERSITY OF PROFESSIONAL STUDIES
ACCRA

9th December, 2019

DR. MRS. ROSEMARY BOATENG COFIE
EXAMINATIONS OFFICER, KSB
KWAME NKRUMAH UNIVERSITY OF
SCIENCE AND TECHNOLOGY
KUMASI

Dear Madam,

REQUEST FOR INFORMATION ON STUDENTS

I humbly write to request for an information on the total number of undergraduate students at the KNUST by gender, level and program, preferably students at the Business School offering Accounting.

Please I need this information to help me with my PhD project work on how Stigmatization, Culture and Locus of Control affect the Health Seeking Behaviour of students in some public universities in Ghana.

Hope my application will attract a favourable response from you.

Thank you.

Yours faithfully,

PATIENCE ARABA MBA
0244 509 521

APPENDIX G: Request for Information on Students: School of Business, KNUST

PATIENCE ARABA MBA
UNIVERSITY OF PROFESSIONAL STUDIES
ACCRA

10th December, 2019

PROF. NATHANIEL BOSO
KWAME NKRUMAH UNIVERSITY OF
SCIENCE AND TECHNOLOGY
SCHOOL OF BUSINESS
KUMASI

Dear Sir,

REQUEST FOR INFORMATION ON STUDENTS

I humbly write to request for an information on the total number of undergraduate students at the KNUST by gender, level and program, preferably students at the Business School offering Accounting.

Please I need this information to help me with my PhD project work on how Stigmatization, Culture and Locus of Control affect the Health Seeking Behaviour of students in some public universities in Ghana.

Hope my application will attract a favourable response from you.

Thank you.

Yours faithfully,

PATIENCE ARABA MBA
mansamba@yahoo.com
0244 509 521