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HEALTH SEEKING BEHAVIOUR AMONG COMMERCIAL SEX WORKERS IN ADUM IN THE ASHANTI REGION OF GHANA.

BY

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DECLARATION

I, Portia Durowaa Boateng declare that this thesis work is my own, with the exception of references that have been acknowledged. The outcome of this work is a genuine independent work done by me with the help of my supervisor. A full list of the references employed has been included. I further declare that it has neither in full nor in part been presented for any degree / award in this university or elsewhere.

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DR. PHYLLIS DAKO-GYEKE DATE

SUPERVISOR

DEDICATION

To my lovely parents Mr. & Mrs. Boateng, Professor Martin Oteng-Ababio, Professor Issabella Quakye, Mrs. Abigail Serwaa-Akoto Ennin, Richmond Ensiwoyie Owusu, Patrick Boateng, Sophia Boateng and God-mother Miss Margaret Oteng who were my strongest associates. The progress of my studies was their concern. They are the source of my dream, success and joy. Their encouragement has helped me to attain a remarkable educational excellence. I am blessed in life to have this wonderful family. I dedicate my thesis work to other friends and loved ones for their fervent prayers and moral support.

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ABSTRACT

Background: Female commercial sex workers are a group of people who are important in the transmission of sexually transmitted infections (STI's). Studies have shown that, both their commercial and non – commercial partners are sources of STI infections and other diseases. Regular health seeking behaviour to health facility has been proven to remarkably reduce the transmission of sexually transmitted infections (STIs) and therefore its important for the success of any STI control. A recent review of research on stigma and discrimination against Female CSWs revealed that this leads to their exclusion in the use of health facility. This study is therefore designed to assess the health seeking behavior of sex workers in Adum in the Ashanti Region of Ghana.

Objectives: This study seeks to assess the health seeking behaviour among commercial sex workers in Adum in the Ashanti Region; determine the association between socio demographic characteristics of commercial sex workers (age, educational level, number of children) and utilization of health care facility; identify sources of healthcare utilized by commercial sex workers; examine commercial sex workers perception of various healthcare options; identify health conditions often experienced and assess the health action taken when sick.

Methods: A cross-sectional study on health seeking behavior among commercial sex workers was conducted among 140 female sex workers in Adum-Kumasi in the Ashanti Region of Ghana. Data were collected using questionnaire and responses analyzed using IBM version of the Statistical Package for Social Sciences (SPSS) software. Information gathered included socio-demographic, sources of healthcare utilized, perception of various healthcare options and health action taken when sick.

Results: Out of the 140 respondents, all had history of malaria infection. 47 percent responded that they had syphilis. Eighty-one percent of the respondents indicated that

they had Gonorrhoea. With regards to Candidiasis, 70.7 percent of the respondent indicated that they had this disease. For Hepatitis and Diabetes, all respondents indicated that they did not have these two ailments.

A binary logistic regression analysis was used to determine the relationship between socio-demographics and utilization of orthodox health facility, the results showed that only education had a significant relation with utilization of orthodox health facility and this was highly reported by those who had tertiary education.

Conclusion: This study has identified some of the factors, which hinder the health seeking behaviour of commercial sex workers. Most of the respondents self- medicate because there are no strict rules in Ghana governing the purchase of antibiotics in the drug stores, pharmacy shops and from drug peddlers. Treatment is sought as soon as symptoms occur and this is a good behavior demonstrated by the sex workers in the brothel.

Recommendations: District Health Management teams should develop interventions that will enable commercial sex workers to understand the importance of using health facility in cases of any disease condition. Since this study did not include qualitative study, further studies should include mixed methods of health seeking behavior and associated factors.

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LIST OF ACRONYMS

AIDS	-	Acquired Immuno Deficiency Syndrome
CSW	-	Commercial Sex Worker
FSW	-	Female Sex Worker
HBM	-	Health Belief Model
HIV	-	Human Immuno Deficiency Virus
HSB	-	Health Seeking Behaviour
STI	-	Sexually Transmitted Infection
UNAIDS	-	United Nations Programme on HIV/AIDS
WHO	-	World Health Organisation
HCP	-	Health Care Practitioner

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background

As rightly noted by Mahmood et al., (2009), HSB is a process that commences on the "onset of an illness and getting in contact with a healthcare professional, type of healthcare provider patients sought help from, adhere patient with the recommended treatment, reasons for choice of healthcare professional and reasons for not seeking help from healthcare professionals". Essentially, many factor influence individuals seeking care for their health. The factors that controls individual's behaviour in an environment is mostly distinctive in the context of the environment that they find themselves. Thus, suffice to indicate that a population health care seeking practices have as much geographical spatiality as individual livelihood connections.

Commercial sex work is one such distinctive profession and it defines extensive sequence of actions taken in the barter of economic gains, received goods such as clothes or appliances, or an evening out in exchange of sex (Pope, 2013). The different types of sexual services provided by sex workers are grouped into direct and indirect sex work (Phrasisombath, Thomsen, Sychareun, & Faxelid, 2012). Direct sex work includes services, such as indoor and outdoor prostitution as well as escort services and involves the barter of sex for a fee in which genital contact is common in guesthouses, hotels or brothels (Phrasisombath et al., 2012).

Put differently, female sex workers can either be categorized as seaters or quasi seaters and roamers. In most cases, the 'seaters' work from their homes with an average age of 35 while roamers work in bars, brothels, hotels, streets and other locations, and have much younger average age of 25 (Onyango et al., 2015). The quasi seaters are those who have their own homes and therefore able to take a client there (Obeng-Odoom, 2014).

Prior studies have indicated that, commercial sex workers are often prone to key disease conditions like Chlamydia, gonorrhea and syphilis (Musyoki et al., 2015), these studies suggest that, over 30 million adults globally between the ages of 15 – 49 years are living with sexually transmitted infections - STIs (Baral et al., 2012). Majority of the people infected with STIs are resident in Sub – Saharan Africa, although the rates of transmission for STIs including HIV infection vary globally (Ramjee & Daniels, 2013). Similarly, a research conducted in Abidjan (Côte d'Ivoire) showed that places where treatment is sought for symptoms of STI's have effects on the control of diseases. Sex workers were ranked by the Ghana AIDS Commission as second in the STI prevalence in Ghana at 11.1% in 2011, equated to a 1.5% national average (Agambire, 2013). Hence, the objective of this study is obtained from this perspective to determine the HSB of commercial sex workers in Adum, a neighbourhood in Kumasi, notoriously known for its ever-flourishing commercial sex trade.

1.2 Statement of the problem:

A study on STI including HIV conducted amongst commercial sex workers in the two major cities of Ghana, Kumasi and Accra showed prevalence of 75 percent and 80 percent respectfully (Agambire, 2013). However, actions people take especially CSW's when they show symptoms or have a suspicion of STIs have key implications for transmissions and as a result for disease control (Agambire, 2013). Impediments in trying to find and receive recognition for treatment of symptoms may permit for extended transferral and a larger possibility of developing a harmful illness condition.

Moreover, a review of patients' records at the Suntreso STI clinic from January to December 2000 showed that more than 50% of the patients' had symptoms of STIs (namely syphilis, gonorrhoea and chlamydia) for a week or more before reporting to a regular clinic and had spent another week before coming to the referral centre (Agambire, 2013). As most STIs are asymptomatic, infected people especially CSWs may continue to have sex thereby increasing the transmission cycle.

Meanwhile, many reasons account for why CSW will not seek care in the health facility / orthodox and these includes, stigma and discrimination that contribute to their exclusion and discourage health service access (WHO Regional Office for Africa, 2011). Human rights abuses and violence aimed at sex workers, mostly by clients and law enforcement officers occur commonly and contribute to disempowerment and reduce their ability to negotiate condoms use (among other effects) and use of health services, particularly where sex work is criminalized (Scheibe et al., 2012).

However, this marginality makes CSW infected with STIs to self-medicate, use treatment in the informal health sector (like traditional healer, drug vendor and quack doctors), over the counter purchases of antibiotics at pharmacies, drugstores and chemist shops (Agambire, 2013). The alternative sources of treatment may not cure but rather allow the infection to progress to the chronic stage. Therefore, the alternative forms of healthcare needs to be assessed considering the economic and social implications of increased levels of transmission of STI at the local level.

1.3 Justification

Behavioural change may be a useful approach in reducing infections. A better understanding of why individuals seek or not seek treatment is critical for effective STI and other health related disease control. Understanding these factors could assist in developing health education initiatives and public health programmes to control STIs and other health related diseases amongst CSWs. Sex workers must continue to get the sexual health support they require to enable them to play their role in preventing sexual health epidemics (Bekker et al., 2015). Since CSWs and their partners constitute a population that is central in the transmission of STIs, it is therefore important to study the prevalence and determinants of their health seeking behaviour and the different treatment options sought.

Also, understanding how people make decisions about their health can help to identify obstacles to diagnosis an effective treatment of STI and other diseases (Phrasisombath et al., 2012).

1.4 Objective

1.4.1 General objective

This study seeks to assess health-seeking behaviour among commercial sex workers in Adum in the Ashanti Region.

1.4.2 Specific objectives

i. To determine the socio demographic characteristics of commercial sex workers.
ii. To identify sources of healthcare utilized by commercial sex workers.
iii. To examine perception of commercial sex workers on various healthcare options accessible to them.
iv. To identify health conditions often experienced by commercial sex workers.
v. To assess the health action taken by commercial sex workers when sick.

1.5 Research Questions

i. What types of healthcare facilities do commercial sex workers commonly use?

ii. How does a commercial sex worker perceive health seeking behaviour?

iii. What is the knowledge of commercial sex workers about the various healthcare facilities or options?

iv. Do commercial sex workers use the health facility or not when they are not well?

1.6 Conceptual Framework

The researcher adopted relevant aspects of the Health Belief Model (HBM) by Hochbaum as reviewed by(Gerend & Shepherd, 2012) to develop the framework of this study. The Health Belief Model (HBM) is an intrapersonal theory employed in the design of health promotion intervention and avoidance initiatives. The aim of the HBM is to determine individuals' health behavior by focusing on the attitudes and beliefs of an individual towards disease and the pessimistic outcomes of a particular behavior. The HBM is value – expectancy theory. The HBM presupposes that transformation of behavior happens in three forms:

1. Perceived susceptibility and severity: This admits that there are enough grounds for an individual to accept that a particular health condition could affect him / her and if it does it could be severe.

2. Perceived threat: An individual understands that he or she may be vulnerable to a negative health condition.

3. Perceived benefits and barriers: The individual understands that behavior modification and the benefits of that modification can be advantageous and this will be more than the costs of carrying out such behaviors. However, for an individual to adopt a new behavior, that individual needs to believe the benefits of the new behavior outweigh the

costs of continuing the old behavior (Gerend & Shepherd, 2012). This enables an individual to overcome barriers and the new behavior to be adopted.

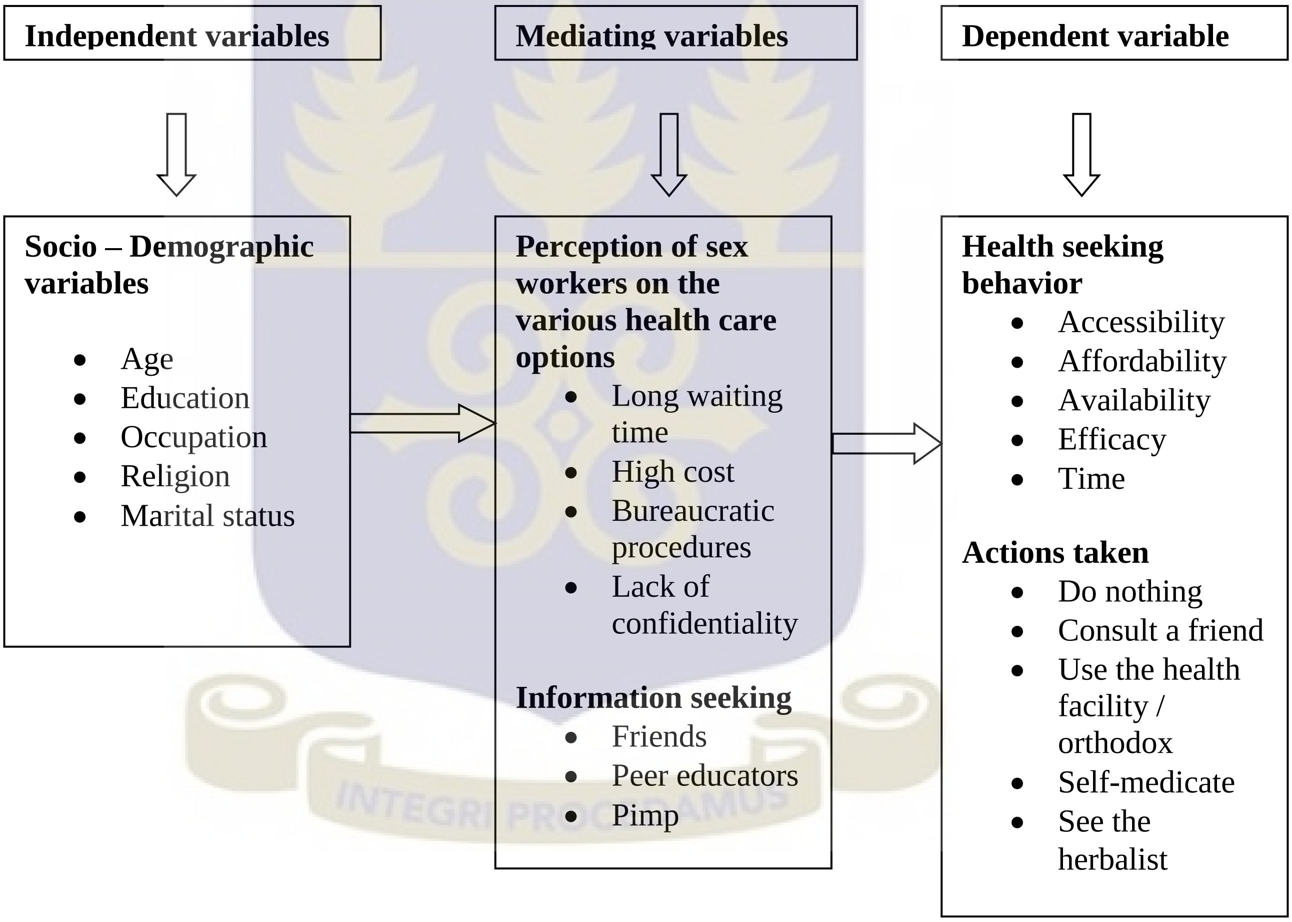
The adopted framework places interest on the demographic, socio – cultural and physical factors that determine commercial sex workers HSB in Adum for diseases including sexually transmitted infections (STI's). With the construct of susceptibility as in the HBM, the adopted framework considers commercial sex workers to have a greater chance of contracting STI and other related diseases due to their regular contact with different clients. This is represented in the framework as age and for the sex was not specified because the emphasis is only on female sex workers in the seater establishment.

Again the level of the individuals' education could make them susceptible to some diseases and STI's than others. Education teaches the scientific mode of disease causation and its prevention and control. Consequently, studies on HSB are concluding that conventional and unprofessional practitioners ought to be identified as part of the key providers of healthcare (Sundberg et al., 2014) to other health problems in middle income countries like Ghana. Also, the seriousness of the disease condition determines the patient's health seeking behaviour.

As most STIs are asymptomatic at the early stages of infection, knowledge of the symptoms, how long these symptoms persist in the patient and the individual's cultural belief as to what is ill – health and the difficulties that a disease would create or the effects it would have on his or her life. The perception of seriousness is often based on medical information or knowledge about a particular disease condition, known to an individual. The knowledge of the severity of STI among CSWs may initiate a health seeking behaviour for STI's and other diseases.

The perceptions on healthcare facility option variables as per this model were included since their existence directly influences the patient's choice of place in time of health seeking for STI's and other diseases symptoms. The various factors and the health behaviours have been presented below.

Figure 1: Diagrammatic conceptual framework: Health seeking behaviour among commercial sex workers.



CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter reviewed related literature on the health seeking behaviour among commercial sex workers. The chapter further examined the literature and situated the literature in the context of the present study. Key words such as “Help seeking”, “Health seeking behaviour”, the Boolean operators (AND, OR, NOT) and the wildcards (*, ‘’) were used in the articles and publications search. Search engines like HINARI, PubMed and Google scholar. Articles published from 2000 to 2015 were reviewed. Selected references obtained from these articles were looked up. In addition, useful websites such as WHO, UNAIDS were visited for relevant documents. The reviewed literature has been organized thematically under the following headings; health and sex work, health seeking behaviour, issues affecting health seeking behaviour, types and social contexts of sex work.

2.1 Socio-demographic characteristics of sex workers

Sex work is a work or job concerning barter of sexual services for financial reward or material profit like a place to sleep or receiving of goods (Jewkes, Morrell, Sikweyiya, Dunkle, & Penn-Kekana, 2012). Sex work is connected with the transmission of STIs, stigma, violence and other health problems, this is mostly described as the “risks of the trade” (Jewkes et al., 2012). Sex workers in Ghana can be categorized as either seaters or roamers (Onyango et al., 2015). Usually, there is a common venue that some of their activities take place. For instance, a brothel remains one of the commonest words associated with the trade. A brothel is a place or a building where people may come to engage in sexual activity with a sex worker. However, for legal or cultural reasons, such establishments are occasionally described as massage parlors, bars and strip clubs (Pitcher, 2015). Among the categories of CSWs in Ghana, seaters are seen as a freely structured unit of women who tend to work from a shared compound, attracting customers by sitting in the doorway of their rooms (Onyango et al., 2015). They normally report to the chief who settles quarrels, indifferences or raises funds if one sex worker must pay a police fine. It is worth noting that seaters are largely 30 – 45 years old and are usually found in urban centers. This setting describes the Adum establishment for CSWs. However, roamers tend to be 20 – 30 years old and highly educated. As the name suggests, they move around and are at a lower risk of contracting STIs including HIV due to their excessive charges and the correspondingly lower number of clients they attend to in a day. Roamers have clients who are aware of STIs and have higher degrees of condom use (Onyango et al., 2015).

The medical organization have failed to look at such day-to-day conditions and illnesses as repetitive stress injuries and other musculoskeletal problems, bladder infections, and work-related stress that may be of more immediate concern to sex workers" (Scorgie et al., 2013). Sex workers recognized musculoskeletal injuries as an important work-related vulnerability, including wounds to the joints due to activities repeatedly done with the hands; pains of the knee associated to standing in a hooked situation for prolonged hours (Scorgie et al., 2013). Furthermore, unusual levels of risk are related with different types of sex work and thus have distinctive consequences for health. Sex work actions that are low risk, such as working in the strip clubs and lap-dancing of sex workers in the strip clubs, are slightly probably not related with harmful health conditions (Scorgie et al., 2013). Within the sex work literature, lesser risk actions are not discussed in any immense length possible because the enormous number of studies that emphasizes on behaviours of sex workers that require advanced extents of hazards to both the general population and sex workers. Few studies have looked at the repercussions of sex work on workers' health and the general health of commercial sex workers. Circumstances such as the social and economic factors that people are born into, work, raised and stay all impacts on the health of the individual. People from poorer nations' life expectancy on the average is seven years lower than those in richer nations (Marmot, 2011).

A study conducted in Laos found most of the adolescent sex workers not seeking treatment for STIs. However, this group is particularly at risk of STIs due to the undeveloped nature of the genital tract, negotiation for condoms use is little and higher number of sexual customers compared to their older counterparts as depicted in other studies (Gupta, 2009). Consequently, sex workers found in the adolescent category are not knowledgeable about the implications of unsafe sex (Goldenberg et al., 2014). Another study in Thailand showed that minors in sex work reported high cases of violence compared to their older colleagues (Decker, 2011).

2.2 Sources of healthcare utilized by commercial sex workers

There are many sources of healthcare in practice utilized by commercial sex workers around the globe. Common amongst these include, the drop-in-centers, public hospitals, private hospitals, pharmacy or licensed chemical sellers and the herbalist. Some others largely resort to self-medication as an alternative source of care. Over the years, Drop-in-centers have been an additional source of healthcare for vulnerable groups with some of them mostly establishment within public hospitals. The idea for the establishment of the drop-in-centers for commercial sex workers was to improve their health seeking behavior because of the perception that they do not want to be recognized by other patients (Phrasisombath et al., 2012). To avoid this, the drop-in-center could be located outside the health facility and a neutral name phrased to avoid negative perceptions (Phrasisombath et al., 2012).

In another study, it was suggested that the need for secrecy and privacy in STI services is vital and efficient technique for individual compliance to treatment, as it significantly increased STI patients' attendance (Tan et al., 2008). More so, a study conducted by Sihavong (2011) in Laos revealed one-fifth of respondents used private clinics or pharmacies. Thus, it was noted that there was no recognized STI clinics, therefore, pharmacists/drug sellers remain the commonest and frequently used avenue for medical advice and information (Sihavong, 2011). Nonetheless, the same study revealed that the medicine procured from the pharmacies were inefficacious in curing the STI patients (Sihavong, 2011). This is probably substantiated by the Phrasisombath et al (2012) claim that pharmacists and drugs sellers do not have sufficient knowledge and competence in the management of STI. It is therefore not out of place to reckon a need of training for STI treatment and prevention by STI service delivery staff in both public and private health sectors.

Traditionally, close relations have been an important and integral part of the human social life. Similar to other social settings, the relevance of close relations cannot be over-emphasized when it comes to sources of health care for CSWs. It is noted that many sex workers receive health information from their friends, pimps and in some cases from peer educators. Looking at the mobile nature of some categories of sex workers like the roamers, delivering health information and STI service becomes a challenge (Phrasisombath et al., 2012). This was found in a study conducted in Lao where HCPs had ill feeling toward FSWs with STI symptoms, with majority of HCP with the notion that: 'even if FSWs are counselled, they would continue to infect others' (Phrasisombath, 2011). Therefore, the close relations serve as important source of information and help for treatment in times of need. This may be the case because such people are able to empathize with victim.

2.3 Perception of sex workers to the various healthcare options

Common problem encountered by sex workers using public-sector facilities include access. The problems include long waiting times, high cost, shortage of medicine, bureaucratic procedures, lack of money, judgmental attitudes, lack of confidentiality and inconvenient location (Phrasisombath et al., 2012). Sex workers experience several additional barriers to receiving the appropriate care. Providers are most at times harsh and refusing treatment and referring sex workers unreasonably and in some cases blaming them for their illnesses (Scorgie et al., 2013). In a study, commercial sex workers did not clearly mention stigma but their responses to providers' manners and that of stigma are the same in their language (Phrasisombath et al., 2012). In that same study, respondents who had not sought treatment stated obstacles that could have risen from prior negative incidents when using healthcare services such as long waiting times at the clinic and inconvenient location.

However, long waiting times in some cases may encourage FSWs to leave the clinic without seeing Health Care Practitioner (HCP) as reported in a study by Phrasisombath et al. (2012). Also, "structural" barriers to FSWs' use of health services included inadequate information about the available services and inconvenient opening hours of the clinic (Phrasisombath et al., 2012). Personal obstacles in other areas include fear of being judged, huge service cost and the risks involved in getting to the health facility (Phrasisombath et al., 2012).

2.4 Health conditions experienced by commercial sex workers

The spread of STIs are mainly through sexual contact, involving vaginal, anal and oral sex. The predominant conditions they cause include; gonorrhea, genital herpes, genital warts, human immunodeficiency virus (HIV), chlamydia, syphilis, trichomoniasis, chancroid and hepatitis B infection. STIs like gonorrhea, chlamydia, hepatitis B, HIV and syphilis can be transmitted vertically. That is, from mother to child during pregnancy and delivery, and through tissue transfer and blood transfusion (Hsieh et al., 2014). Globally, STIs are key to socio – economic and reproductive health setbacks. Issues drawn from the problems of untreated, unattended or inappropriately treated STIs involve; pelvic inflammatory diseases, adverse pregnancy outcomes such as abortions, ectopic pregnancies and stillbirths; infertility; lower abdominal pain; and cervical cancer (Samuels, Blake, & Akinrimisi, 2012). Management of STIs which is syndromic conducted in Low – income and middle – income countries like Ghana is mostly centered on the recognition of regular sets of symptoms and easily determined features to direct treatment, in the absence of laboratory tests (Hseih et al., 2014). This method relies mostly on clinical algorithms, where diagnoses of a specific infection by health care practitioners are on the basis of observed syndromes (Hseih et al., 2014).

Sexually transmitted infections among women increase their susceptibility to HIV transmission (Samuels et al., 2012). The danger of cervical cancer, numbered among the most dangerous cancers in women, is mostly increased by unprotected sex with multiple partners. It is most often mistaken for STI. The increased danger of HIV and the health consequences is essential for effective detection and treatment of STIs (Samuels et al., 2012). Many STIs like the Chlamydia, trachomatis and Nesseria gonorrhea are contracted without symptoms (Sekoni, Odukoya, Onajole, & Odeyemi, 2013). It takes a longer period in women before symptoms of STI are manifested, moreover, many women may be infected with STIs without their knowledge and therefore do not seek treatment. This makes syndromic management of STIs in women less successful. A study conducted in Nigeria found majority of the people with symptoms of STIs seeking treatment outside the health facilities (Okereke, 2010). Ineffective treatment of STIs among FSWs may in future lead to the problem of spread of antibiotic resistance to some of these STIs such as the epidemic of multiple drug resistant strain of Neisseria gonorrhea (Sekoni et al., 2013). It is imperative to effectively treat any new sexual partner of a person who has STI regardless of presence of symptoms or not. Contact tracing is mostly difficult where the STI may have been contracted through causal or commercial sex with an unknown partner (Samuels et al., 2012). Frequency of sex with multiple partners in which they have limited power in negotiating safer sex, poor healthcare seeking behavior and a high burden of STIs place FSWs at high risk of HIV infection (Sekoni et al., 2013).

Furthermore, there are other occupational health and safety risks that sex workers face. For instance, CSW are usually exposed to HIV, alcohol and drug use, severe stress, urogenital problems, rape and physical violence with musculoskeletal injuries and death in some cases (Scorgie et al., 2013). Worse yet, contraceptive use is often unreliable (Sutherland et al., 2011)and unwanted pregnancy and termination are common as well. For instance, a study conducted among female sex workers in Kenya revealed that 86% had engaged in at least one abortion (Scorgie et al., 2013). Also, majority of sex workers are loosely knowledgeable of how to avoid the spread of STIs. Consequently, the circumstances in which they work give them less power to exercise this STI knowledge. Customers in some situations force commercial sex workers into having sex without a condom or offering huge amounts of money for sex without a condom (Scorgie et al., 2013).

Most sex workers in this part of the continent see violence to be bigger and intense danger than HIV (Scorgie et al., 2013). This shows the day to day hazards and dangerous situations under which commercial sex work normally occur (Scorgie et al., 2013). Most of the research among commercial sex workers in Africa has focused on sex workers likely to infect clients and subsequently client-partners. They are mostly seen as 'vectors of infection' spreading the STIs epidemic rather than on their own needs for health services and their potential to serve as strategic safer-sex educators (UNAIDS, 2011). A little is known about the daily occurrences of sex workers in their quest to access health services in the wider sense and how frequently such access is compromised. This information could be used to improve the strategy of services for this population. These services, with their intent aim to decrease the problem of STIs among sex workers and within STIs epidemic settings. Lowering these burdens would markedly improve the health of sex workers, and could interfere spread of these infections among their clients and the population at large (WHO, 2012).

Amongst the health conditions experienced by sex workers include occupational health problems arising from the particular contexts of sex work. This includes frequent exposure to STIs and the consequent need for proper diagnosis, treatment and follow-up. As evidenced in a study in Kampala, where women reported repeated 'lower abdominal pain' as a sign of untreated STIs or other reproductive health problems (Scorgie et al., 2013).

Additionally, common experiences amongst sex workers include physical, sexual and verbal violence. Violence was seen as normal in many studies conducted in most sex worker's environment. Physical violence was therefore seen as an utmost risk affecting sex workers (Chang & Weng, 2015). More current study reveals high levels of violence.

This study showed that in the United Kingdom two-thirds of the people in the sex industry experience violence (Holly & Lousley, 2014). Harassment by police officers and high levels of violence was found in another study to affect numerous sex workers (Chang & Weng, 2015). Trauma mostly experienced among sex workers is due to poor physical health from physical violence and deprived mental health (Exclusion, 2014). Violence against sex workers at its climax, leads to death. Interest in human sexual behaviour has improved over the years and the factors controlling it has a better understanding to reduce the threat of dangerous epidemic of STIs (Agius et al., 2010).

Commercial sex workers are obligated to participate in prevention behaviours which include the potential to successfully tell clients to withdraw from conditions that do not favour preventive behaviours and proper use of contraceptive methods (Dubois-Arber et al., 2010). Socio-cultural reasons and fear of violence from clients may prevent CSWs in developing country like Ghana from negotiating for safe sex.

2.5 Health seeking behavior among commercial sex workers

Health seeking behaviour can be explained as the actions and inactions identified by people when they have an illness condition and the necessary steps taken to rectify those health conditions (Mahmood et al., 2009). Client satisfaction is an important factor in determining whether a person seeking health cares' meet the terms of healing. Customer fulfillment for a particular treatment can be seen as personalistic to the quality of service that the customer will receive. A report on customer satisfaction, shows the spoken and the unspoken words that exist among health practitioners and the people seeking information about their health (Ofosu-Kwarteng, 2012).

Illness classification and health seeking behaviour studies generally focus on two ways (Grundy & Annear, 2010). The first is through epidemiological reviews (determinants model) using sizeable representative samples. These reviews categorize those using or not using certain types of care and those who engage in particular health, coping and illness practices; they look into how the illness, health seeking behaviour, and other factors are associated. The second involves qualitative methods (pathway model). It uses inadequate samples and more thorough assessments of the different factors influencing the health seeking process and describes them in multiple stages (Grundy & Annear, 2010).

Health behaviour is sometimes confused with health seeking behaviour. Health behaviour is any activity carried out for the purpose of avoiding, discovering disease or for improving health and wellness of an individual (Humphreys, McLeod, & Ruseski, 2014). Such activities include exercise, non-smoking, moderate use of alcohol, condom use, screening and sexual behaviour (Humphreys et al., 2014). To draw the difference, health-seeking behaviour is undertaken in response to an already expressed and perceived disease state while health behaviour is for asymptomatic state of a potential disease (Humphreys et al., 2014). Health seeking behaviour was stated by El Kahi et al., (2012) that a good number of health seekers resort to self-medication and support from colleagues they believe could help them get treatment or healing.

Although there has been little knowledge and understanding around structural influences on HSB, it is appropriate to conceptualize it as a social-structural phenomenon rather than what dwells in the individual. Despite the fact that repeated studies of HSB throw up the centrality of social factors, these problems are recast, and solutions to address them are focused on the individual. A study showed that much information can be obtained by looking at the environmental issues affecting the health of sex workers in their brothel communities and homes by asking specific questions pertaining to their health and their response for the various illness treatment (Mahapatra et al., 2013). This shows that behaviour change is often not dependent on the individual but on the environmental conditions and beliefs of the individual (Grundy & Annear, 2010). Unsurprisingly, the interest in human sexual behaviour has improved over the years and the factors controlling it have a better understanding to reduce the threat of dangerous epidemic of STIs (Agius et al., 2010).

Under-utilization of health care facilities is caused by many factors including inadequate social and economic position, absence of physical accessibility, beliefs and low educational level of commercial sex workers (Aniah, 2015). In many developing countries the patient's first encounter for STI treatment is self-medication and treatment in the informal health sector (Aniah, 2015). For example, a study carried out in Malawi showed that 53% of clients had sought treatment elsewhere with the frequent alternative source being the traditional healer (Mensch et al., 2008). In contrast, a study conducted in Nepal on sex workers health seeking behaviour indicated that 72% preferred to seek treatment in the public hospital or health center, 50% preferred to seek treatment in a private clinic, 13% preferred to seek treatment in health centers (Ghimire, Smith, & van Teijlingen, 2011).

A study on the postponement of care seeking by women sex workers in Vancouver attending health facility indicated higher level of information on postponement of care among women (Socías et al., 2016). This may be due to the panic of shame for the outcome of having an STI and this supersede an individual's susceptibility to an infection (Annang et al., 2010). Similarly, in Kenya, treatment-seeking behaviour for both acute and chronic diseases has been the use of self-prescribed modern medicines from chemical sellers and pharmacies. They are used as the first line of action while waiting to see if symptoms would persist before accessing treatment with an orthodox medical health facility (Chuma et al., 2007). Self-care, home remedies and consulting traditional healers by individuals and commercial sex workers are influenced by cultural beliefs and other practices (Gyasi, Mensah, & Siaw, 2015). The size and evenness of the brothel, besides age, gender, marital status and educational status are as well linked to the health care seeking behavior (Savva, 2013).

Finding in a study revealed different treatment options for different illnesses, for some illnesses individuals will choose conventional healers and untrained health professionals over the health care facility with trained practitioners (Aniah, 2015). Research on self-medication or care, where today's patient becomes tomorrow's healer, and visits to traditional healers' take place when they believe that the illnesses are caused by supernatural beings. Also, emphases should be placed on motivating individuals to seek first the official or formal medical care (Aniah, 2015).

A study in Ghana revealed STI patients including HIV positive persons conceal their HIV-seropositive status to reduce STI associated stigma and discrimination and to maintain the care and support of family members. Ironically, this concealment hinders uptake of treatment of various kinds and support services that can be offered by family member (Avert, 2016).

2.6 Conclusion of literature review

The literature review states the extensive knowledge about the health seeking behaviour, its prevalence across the globe, sources of healthcare utilized by commercial sex workers, the perception of CSWs on the various healthcare options in other parts of the world. In Ghana, data on CSWs seeking healthcare services are few. The aim of this study is to bridge this identifiable gap in knowledge by reporting the health seeking behavior among CSWs in Adum, a neigbourhood in Kumasi.

The literature review indicates a large knowledge gap between CSWs preferences and the actions taken when they have a health condition. Also, there is little information about people who do not attend to health facilities as well as those who do. At the moment relatively little is known about how symptoms are identified and how related conclusions are made to seek help.

CHAPTER THREE

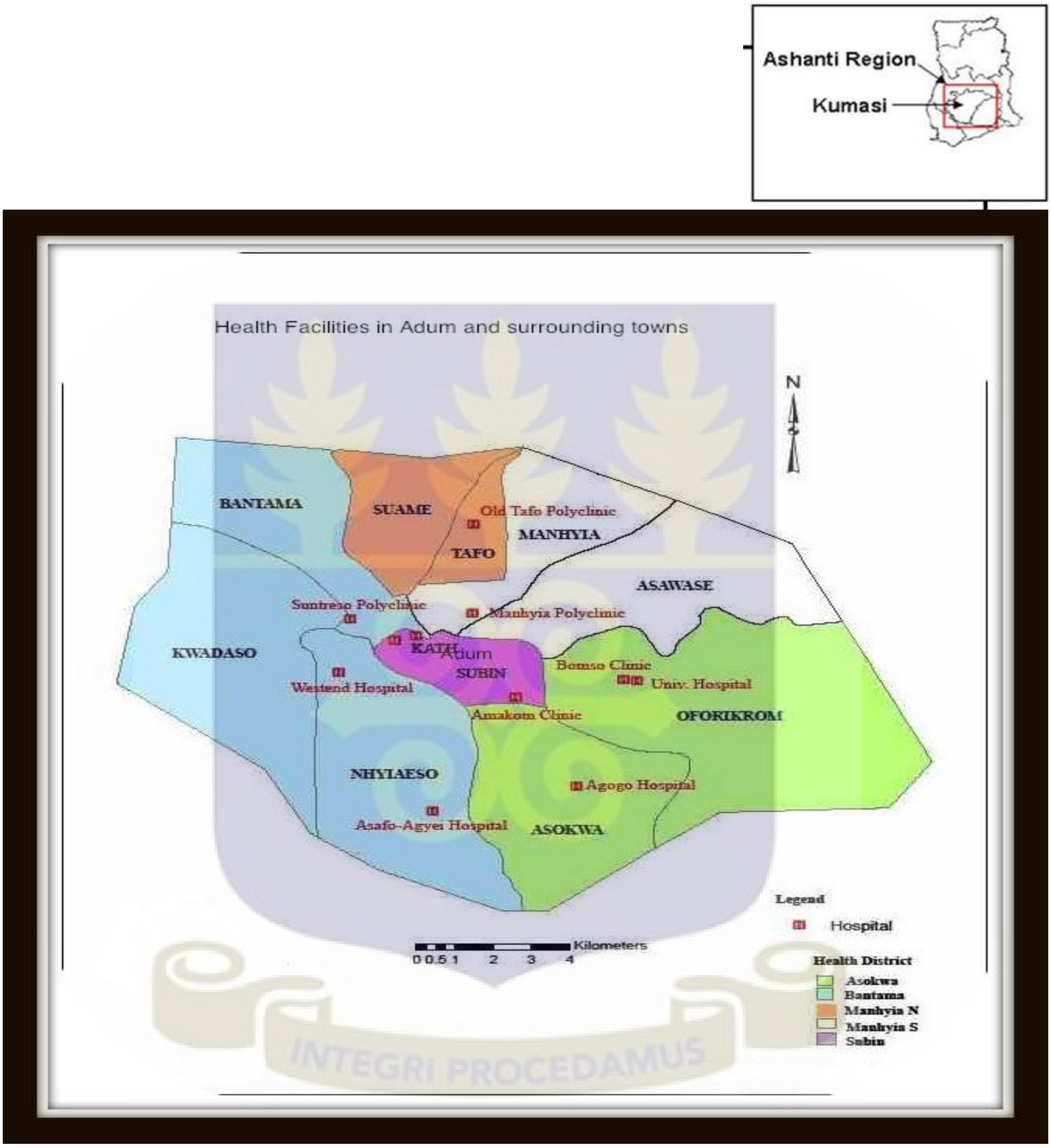
3.0 METHODOLOGY

3.1 The study area

This study was conducted in Adum, a suburb of Kumasi, the capital and cultural center of the Ashanti Region of Ghana. Kumasi is located in the south-central part of the country with a population of about 4,725,046 estimated in the 2010 census. It is approximately 480 km north of the equator and 160 km north of the Gulf of Guinea. Kumasi is currently the second most urbanized city in the country. Ashanti Region lies within the wet semi-equatorial zone marked by double maximum rainfall ranging between 1 150 mm and 1 1750 mm per annum. The major rainfall season is from April to July and the minor season is between September and Mid-November.

In addition, the seaters in Adum host Ghanaians, Ivorians and Nigerians in their own centralized location just around the Aseda House. A chief, a queen a linguist and a manager heads the brothel. The linguist is the third in command when the chief and queen of the area, is not around. The number of rooms in the brothel equals the total number of sex workers at the time of the study, and the rooms were 215. The sex workers are housed in smaller rooms and they pay 30 cedis weekly as room rent and support. Many pharmaceutical stores (example Kama), drug stores and chemical shops (example Bandy chemist) can be found in Adum. Health facilities around the Adum area include Komfo Anokye Teaching hospital, Manhyia polyclinic, Bomso clinic, Kuffour clinic, and Suntreso polyclinic among others.

Figure 2: Google map of Adum metro showing the various health facilities of the surrounding towns.



3.2 Research design

A descriptive cross-sectional quantitative study was used because it has the advantage of measuring the perception of commercial sex workers on their health seeking behaviour. The reason for using cross-sectional quantitative design is based on the fact that many questions were asked and could reach the entire respondents within a short period of time. The design was chosen for this study as it was expected to determine health-seeking behavior among commercial sex workers in Adum.

3.3 Variables

3.3.1 Independent variables

The following are the independent variables that will determine the health seeking behaviour among commercial sex workers in Adum in the Ashanti Region of Ghana.

- Socio demographics – these included age, educational level, religious status, marital status, occupation and duration of the sex work.
- Health condition – described specific illness conditions like malaria, syphilis, gonorrhoea, chlamydia, candidiasis, hepatitis B, diabetes and the types of actions or inactions taken.
- Awareness – of a particular medical condition or STIs like chlamydia, gonnorrhea, HIV/AIDS, syphilis and candidiasis bacterial informs an individual's decision to seek medical care or not.
- Perception of healthcare sources – this aspect of the study determined the perception of CSWs in Adum using the different types of healthcare sources in terms of accessibility, affordability, availability, efficacy and time.
- Sources of healthcare – included the types of medical treatment CSW's sought when they have a medical condition from traditional (herbal) healers, formal health facility (public or private), consulting a friend, spiritual care and self-medication.

3.3.2 Dependent variable

Health seeking behaviour is the dependent variable and it is the actions or inactions taken to address a particular illness condition.

3.4 The study population

The study population was made up of all female commercial sex workers operating in Adum in the Ashanti Region.

3.4.1 Inclusion criteria

- Sex workers who are seated in the Adum brothel for more than six months.
- The sex worker is 18 years or more.
- The sex worker can speak and understand Twi and English.

3.4.2 Exclusion criteria

- Sex workers who are not permanent in the seater will not be sampled.
- Sex workers who are not willing to disclose information.
- Sex workers who are less than 18 years.
- Sex worker who is very sick to be given consent or to be interrogated.

3.5 Sampling and sample methods

3.5.1 Sampling technique

A simple random sampling technique was used to select the study sample. The rooms in the brothel were numbered from one up to two hundred and fifteen. All the sex workers in the brothel were invited to participate. Participants were selected through the use of Minitab 17.0 software to generate random numbers without replication. Occupant of a room that was among the randomly selected who did not consent to participate was excluded, and then the occupant of the next room was consulted to participate. That was done to achieve the total participants needed for the study.

The Informed Consent Forms were issued to all study participants to be signed. The principal investigator, prior to the starting of the interview, also signed the informed consent forms. Interviews were carried out in separate rooms with assurance of privacy. The questionnaire gathered data on socio-demographic characteristics, years in sex work, common health conditions usually experienced, what is done when a particular condition is experienced, stage that a commercial sex worker seek healthcare when they have a particular illness condition, first line and second line of health seeking, symptoms usually experienced and the factors connected with health seeking behaviour.

3.5.2 Sample size

The sample size (n) was calculated using the formula: $n = [(Z_{1-\alpha}{}^2 \cdot p(1 - p)] / d^2$

Using the Cochran formula, with consideration of the following:

$Z_{1-\alpha}{}^2$ = 95 % confidence level = 1.96^2

(1 -P) using 67% estimated prevalence of sex workers' health seeking behavior for STIs (The prevalence rate of 67% was chosen from earlier study conducted by Samuels et al., (2016) = 0.67 (1 – 0.67) = 0.67 (0.33) = 0.2211

$(d)^2$ for 5% error margin = $(0.05)^2$

Total number of sex workers' N = 215

$n = (1.96^2 \times 0.2211) / 0.05^2$

$n = (3.8416 \times 0.16) / 0.0025$

$n = 0.84937776 / 0.0025 = 339.75$

Modified sample size for finite study population using the formula $S = nN / n + (N - 1)$

$S = 339.75 \times 215 / [339.75 + (215 - 1)]$

$S = 73046.49 / [339.75 + 214]$

$S = 73046.49 / 553.75$

$S = 131.9 \approx 132$

Adding 5% (0.05) recovery to cater for non – responses yielded a sample size of 137 respondents.

That is $(0.05 \times 132) + 132$

$(6.6 + 132) = 138.6$

Approximated to140 respondents, so in this study, a sample size of 140 was used.

3.6 Data collection techniques and tools

After failed attempts to get people from the brothel for the study, my supervisor advised that proper community entry should be done. The consent of the chief and elders of the brothel was sought. Compensation was paid to the chief and elders. Foreign schnapps and other hard liquor were given to the chief and elders. An introductory letter from my department was taken to the chief about my intention to undertake a study in the brothel. This was done after the community entry and familiarisation with the chief and leaders of the brothel. The chief of the brothel accepted the letter and granted me the permission to start with my study.

The study data were collected within the agreed dates of interviews (June). The data were collected using structured questionnaire. The English translations of the structured questionnaire were translated to Twi and then back to English. The data were collected using the English translation. Before the data were collected, pretesting was done with twenty CSWs at Ash-town in Kumasi to determine the clarity of the content, the required time to use in filling a questionnaire and the suitability of the questions. The questionnaire was found to be suitable for the study. Few corrections were made at the

'Section C' part to make it clearer. The participants in the pilot study were similar to those in the main study and were done in a similar setting but they were not included in the field study.

3.7 Data collection tasks

The study was conducted during the day where CSW's (seaters) were going about their routine work in the brothel. The completed questionnaires were collected and kept in a proper place. Two CSW's from the brothel were recruited and trained on the aim of the study and the meaning of the questions. They were further taught on how to complete the questionnaires and how to provide assistance to study participants when required. The maximum duration of time spent by participants in completing the questionnaire was 45 – 50 minutes.

3.8 Data quality control

Supervision of the completed questionnaires was well maintained by the principal investigator for aspect of data quality control. At the end of the day, research team conducted a review meeting to discuss issues raised during the day for a quick assessment of the completed tools. During the fieldwork, principal investigator was available for any needed clarifications based on the study. The Principal Investigator visited each research assistant to oversee data collection process and checked all previously completed questionnaires for consistence and completeness.

3.9 Ethical considerations

Approval was sought from Ethics Review Committee of the Ghana Health Service. All participants were informed about the objectives of the study and that their participation was on voluntarism and none rock-solid for participation. It was also clearly clarified that the information to be provided whether orally or in writing were for research purposes and was strictly confidential. Permission letter for doing research and collecting data was obtained from the department to the head of the brothel. All measure to maintain human rights including informed consent: the right to participate in the study, right to privacy and confidentiality and right to prevention from any type of harm were taken into consideration.

3.9.1 Process of Collecting Data

The interviewee's information was recorded using the structured questionnaires that were administered to 140 female commercial sex workers in the Adum seaters. The responses from the questionnaire were critically examined to ensure that they were complete and consistent. The completed questionnaire was serialized and coded. Data entered was crossed – checked and cleaned using IBM Statistical Package for Social Sciences (SPSS) version 21 software before running the analysis. The responses from the questionnaire were entered and coded using IBM SPSS version 21 software and analysed. The output was organized into tables.

3.10 Data Analysis

3.10.1 Data Analysis Process

Data have been presented using frequency tables and cross tabulations. Important summary statistics were obtained and associations were examined using chi-square test. Significance level of 0.05 (i.e. $P<0.05$) was used to determine the significance of associations being examined.

CHAPTER FOUR

PRESENTATION OF THE RESULTS OF THE STUDY

4.0 Introduction

This section presents findings from the study examining the health seeking behaviour of the respondents and their potential prevention needs. Typically, HSB is defined in its broadest terms as relating to health care access, service use, health outcomes and the way in which people respond to their perceived ill health. In most academic literature, distinctions are made between formal and informal settings and between private and public settings for seeking treatment (Mahmood et al., 2009). In this instance, participants in the study were asked about their preferences for seeking health care.

4.1. Socio-demographic characteristics of the respondents

Table 4.1 presents the socio-demographic traits of the study respondents. The rationale was to establish the socio-demographic background of commercial sex workers operating in the study location to appreciate and understand the underlying motivation for their chosen livelihood. Out of the total sample, 48 (34.3%) and 65 (46.4%) were between the ages of 18 – 25 years and 26 – 35 years respectfully.

In term of their educational level, the respondents provided varied responses. The data shows that 15 (10.7%) had attained no formal education but 45% of the total sample had attained a maximum of Junior High School education. The data further shows that 38 (27.1%) of the respondents had attained Senior High School education, 26 (18.6%) had attained tertiary education. From the results, it goes without saying that in the study area, commercial sex workers are fairly educated with over 30% crossing the tertiary institutional threshold. Regarding occupation, 40 (28.6%) of the respondents declared multiple livelihoods (sex workers and traders) while 83 (59.3%) were solely sex workers.

In addition to the above, 17 (12.1%) of the respondents stated that they were students but sex workers.

Table 4.1: Socio-demographic characteristics of the respondents

Socio-demographic characteristics	Frequency	Percentage
Age (years)		
18-25	48	34.3
26-35	65	46.4
36-45	22	15.7
46-55	3	2.1
56 and above	2	1.4
Level of education		
Pre-school	3	2.1
Primary	30	21.4
JHS	28	20.0
SHS	38	27.1
Tertiary	26	18.6
None	15	10.7
Occupation		
Sex worker and trader	40	28.6
Sex worker	83	59.3
Student and sex worker	17	12.1
Religion		
Christian	114	81.4
Muslim	21	15.0
Traditional	5	3.6
Marital Status		
Single	94	67.1
Married	8	5.7
Divorced	38	27.1

(N= 140). Source: Field data, 2016

4.2. Health conditions and measures used in addressing these conditions

4.2.1. Prevalence of STI among commercial sex workers

This section addresses the health conditions that affect commercial sex workers and measures used in addressing them. Malaria, though not a sexually transmitted disease was included. In most cases, the neighbourhood in which these commercial sex workers operate exposes them to lots of mosquito bites, which transmit malaria parasites. Table 4.2.1 shows that all 140 respondents had malaria infection history.

Again out of the total respondents of 140, 66.4 % responded that they have ever had syphilis. Also, 80.7 percent of the respondents indicated that they had Gonorrhea. With regards to Candidiasis, 70.7 percent of the respondents indicated that they had this disease. For Hepatitis and Diabetes, all respondents indicated that they did not have these two ailments.

Table 4.2.1: Prevalence of STI among commercial sex workers

Do you have any of these diseases	Categories	Frequency	Percentage
Malaria	Yes	140	100.0
	No	-	-
Syphilis	Yes	93	66.4
	No	47	33.6
Gonorrhoea	Yes	113	80.7
	No	27	19.3
Chlamydia	Yes	22	15.7
	No	118	84.3
Hepatitis	Yes	-	-
	No	140	100.0
Candidiasis	Yes	99	70.7
	No	41	29.3
Diabetes	Yes	-	-
	No	140	100.0

(N=140) Source: Field data, 2016

4.2.2. Common symptoms experienced from STI

After examining the prevalence levels of major STI most commercial sex workers are exposed to, the study sought to find out some common symptoms or signs indicating that indeed they had these diseases. Options available to respondents were carefully selected based on the available literature as well as known signs within the practice of public health regarding STI. From the total respondents of 140, 70.7 indicated that they had discharge from vagina. 21.4 percent of the respondents indicated that they experienced scent or wart on the vagina. Meanwhile 22.9 percent indicated that they had burning pain or constant itching. Lastly 16.4 percent of the respondents indicated that they had painful urination as shown in Table 4.2.2.

Table 4.2.2: Common symptoms experienced from STI

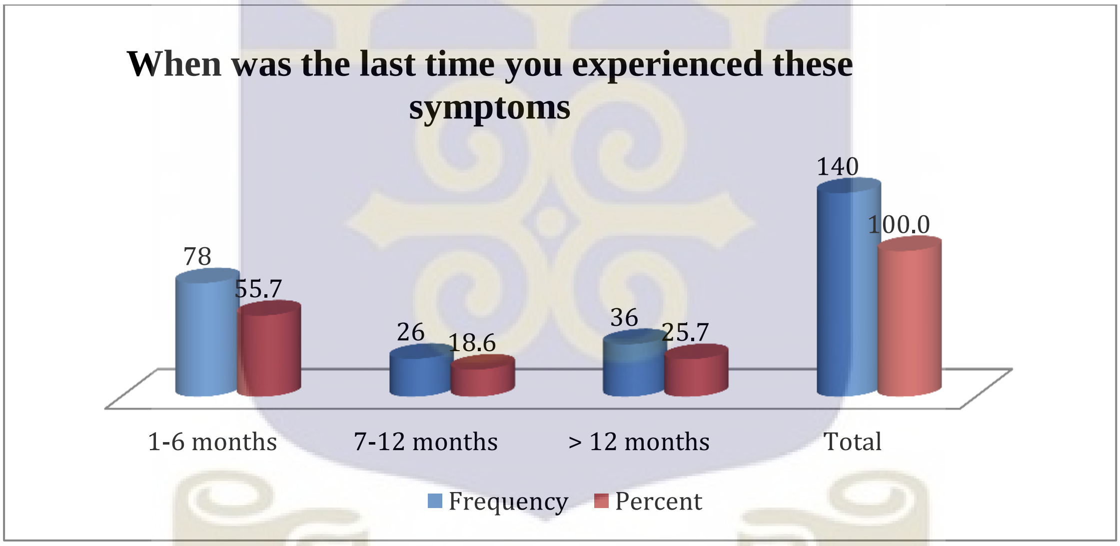
Do you experience the following STI symptoms	Categories	Frequency	Percentage
Discharge from Vagina	Yes	99	70.7
	No	41	29.3
Abnormal vaginal bleeding	Yes	13	9.3
	No	127	90.7
Scent or wart on vagina	Yes	30	21.4
	No	110	78.6
Swelling of groin region	Yes	16	11.4
	No	124	88.6
Burning pain or itching	Yes	32	22.9
	No	108	77.1
Painful urination	Yes	23	16.4
	No	117	83.6

Source: Field data, 2016

4.2.3. Time frame within which these symptoms were experienced

After ascertaining major symptoms about the STIs, the researcher also sought to examine the time frame within which these symptoms were experienced. This is important as it provides an indication of the number of people who might still be harbouring or incubating these STIs. Figure 4.2.3 shows that out of the 140 respondents, 55.7 percent experienced these symptoms within the last I – 6 months. More so, 18.6 percent experienced these symptoms within the last 7-12 months and lastly 25.7 percent of the respondents experienced these symptoms over a year ago.

Figure 2.3.2: Time frame within which these symptoms were experienced



4.2.4. Ways by which a commercial sex worker addresses sexually transmitted infections.

How do respondents deal with STIs? This part of the analysis sought to examine measures taken by the sampled commercial sex workers as a remedy to their medical challenges. For the 113 respondents who indicated that they have had candidiasis before, 59.3 percent indicated that they resorted to self-medication. Similarly, with regards to syphilis, out of the 47 respondents who indicated that they had this STI, 76.6 percent indicated that they resorted to self-medication. More so, out of the 122 respondents who indicated that they have had gonorrhoea before 60.7 resorted to self-medication. The finding largely reveals that the main measure in addressing STIs among commercial sex workers is to resort to self-medication or consult a health facility, probably a hospital as shown in (Table 4.2.3).

Table 4.2.3: Ways by which a commercial sex worker addresses sexually transmitted infections

What did you do when you had the following diseases	Categories	Frequency	Percentage
Candidiasis	Go to hospital	31	27.4
	Self-medication	67	59.3
	Consult a friend	13	11.5
	Go to a herbalist	2	1.8
	Total	**113**	**100.0**
Syphilis	Go to hospital	10	21.3
	Self-medication	36	76.6
	Over the counter medication	1	2.1
	Total	**47**	**100**
Gonorrhoea	Go to hospital	35	28.7
	Self-medication	74	60.7
	Consult a friend	11	9.0
	Go to a herbalist	2	1.6
	Total	**122**	**100.0**
Chlamydia	Go to hospital	9	40.9
	Self-medication	13	59.1
	Total	**22**	**100.0**

Source: Field data, 2016

4.3. Health seeking behaviour among commercial sex workers

This part of the analysis and discussion focuses on the health seeking behaviour among commercial sex workers in Ghana. The first part deals with the first and second remedy taken in addressing STIs among the sampled commercial sex workers and the second aspect deals with specific response as to whether they (respondents) 'do' or 'do not' utilize specific health care measures. Table 4.3 shows that, the first line of health seeking when not well is self-medication, which had about 65 percent of the response out of a total sample of 140, whiles, consulting a health facility accounted for 33.6 percent. Going to see a herbalist was the least used health seeking method as only 1.4 percent of the respondents adopted this method.

Whiles self-medication is the predominant first line of health seeking among respondents, with regards to second source of remedy, responses were not one sided. For instance, 29.3 percent of the respondents indicated that self-medication was the second remedy adopted, 25 percent indicated that they go to the hospital or visited a health facility. Again 21.4 percent indicated that they used over the counter medication. Another interesting finding was that 17.9 percent of the respondents indicated that they consulted a friend.

Table 4.3: Health seeking behaviour among commercial sex workers

Health seeking behavior	Category	Frequency	Percentage
First line of health seeking when not well	Go to see a herbalist	2	1.4
	Go to hospital	47	33.6
	Self-medication	91	65.0
Second source of remedy	Go to see a herbalist	8	5.7
	Go to hospital	36	25.7
	Self-medication	41	29.3
	Over the counter medication	30	21.4
	Consult a friend	25	17.9
	Total	140	100.0

Source: Field data, 2016

4.3.1. Specific health seeking methods

The next result examines respondents' opinion regarding whether they resort to the use of specific health seeking methods when they are not well or when they have STIs. Table 4.3.1 shows that out of the 140 respondents sampled, 52.9 percent indicated that they used orthodox health facility. Regarding self-medication, out of the 140 respondents sampled, 83.6 percent indicated that they used self-medication. Moreover, out of the 140 respondents sampled 93.6 percent indicated that they did not consult a herbalist when they fell sick. Lastly 84.3 percent out of sample respondents of 140 indicated they did not consult a friend when they are sick.

Table 4.3.1: Specific health seeking methods

Factors influencing health seeking option	Categories	Frequency	Percentage
Use of orthodox health facility	Yes	74	52.9
	No	66	47.1
Self-medication	Yes	117	83.6
	No	23	16.4
Do you see a herbalist	Yes	9	6.4
	No	131	93.6
Consult a friend	Yes	22	15.7
	No	118	84.3

Source: Field data, 2016

4.4. Factors influencing commercial sex workers' health seeking behaviour

This part of the analysis examines factors that influence the health seeking behaviour of commercial sex workers. But first the section describes the well-known factors that influence health-seeking options. These well-known factors include accessibility, affordability, availability, efficacy and time. All respondents indicated that accessibility influence the choice of their health seeking option as shown in Table 4.4.

Table 4.4: Factors influencing commercial sex workers health seeking behaviour

Factors influencing health seeking behaviour	Categories	Frequency	Percentage
Accessibility	Yes	140	100.0
	No	-	-
Affordability	Yes	136	97.1
	No	4	2.9
Availability	Yes	140	100.0
	No	-	-
Efficacy	Yes	105	75.0
	No	35	25.0
Time	Yes	125	89.3
	No	15	10.7

4.4.1. Factors influencing the use of orthodox health facilities

Table 4.4.1 presents cross-tabulation showing the relationship between factors influencing health seeking behaviour and the use of orthodox health facilities. Moreover, chi-square test of independence was done for the various factors and the use of orthodox health facilities. A table 4.4.1 show that 74 of the respondents who indicated that they use orthodox health facilities also indicated that accessibility was an important consideration. Regarding affordability and use of orthodox facility, the result shows a not significant relationship between the two variables (X^2=3.672 DF=1 p-value=0.54). A simple interpretation is that, the use or otherwise of an orthodox facility is influenced by whether they can afford or not.

Table 4.4.1 further shows a significant relationship between efficacy as a factor influencing health seeking behaviour and use of orthodox health facility (X^2=41.622 DF=1 p-value=0.00). In other words, the choice of utilizing health facility according to the respondents is because it was efficacious or not in addressing their ailment. Moreover, those who did not opt for orthodox health facility, 33 considered efficacy as an important factor and another 33 did not consider it as an important factor. Regarding availability, there was only one category responded to, and so a chi-square test of independence was not possible to be conducted.

Lastly the result showed a not significant relationship between time and utilization of orthodox health facility (X^2=4.987 DF=1 p-value=0.26). Further interpretation suggests that, 62 of the respondent who indicated that they utilized health facility also indicated time was a factor influencing their choice, whiles 63 of the respondents who indicated that they did not utilize orthodox health facility again indicated that time was an important consideration.

Table 4.4.1: Factors influencing the use of orthodox health facilities

Factors influencing health seeking behaviour	Use orthodox health facilities		Total
	Yes	No	
Accessibility			
Yes	74 (100.0)	66 (100.0)	140 (100.0)
Total	74 (100.0)	66 (100.0)	140 (100.0)
Affordability			
Yes	70 (94.6)	66 (100.0)	136 (97.10
No	4 (5.4)	0 (0.0)	4 (2.9)
Total	74 (100.0)	66 (100.0)	140 (100.0)
Availability			
Yes	74 (100.0)	66 (100.0)	140 (100.0)
Total	74 (100.0)	66 (100.0)	140 (100.0)
Efficacy			
Yes	72 (97.3)	33 (50.0)	105 (75.0)
No	2 (2.7)	33 (50.0)	35 (25.0)
Total	74 (100.0)	66 (100.0)	140 (100.0)
Time			
Yes	62 (83.8)	63 (95.5)	125 (89.3)
No	12 (16.2)	3 (4.5)	15 (10.7)
Total	74 (100.0)	66 (100.0)	140 (100.0)

4.4.2. Factors influencing the use of self-medication

Table 4.4.2 shows a cross-tabulation between factors influencing health seeking behaviour and self-medication. In fact, utilization of orthodox health facility and self-medication were the dominant health seeking option used by respondents. It was impossible to ascertain the level of relationship between accessibility and self-medication because accessibility had just one category.

Meanwhile there was a significant relationship between affordability and self-medication (X^2=20.966 DF=1 p-value=0.00). The result suggests that, all respondents who indicated that they used self-medication considered affordability as the main reason, whiles out of the 23 respondents who indicated that they did not use self-medication, affordability was an important consideration compared to the 4 respondents who did not opt for self-medication.

Again Table 4.4.2 shows a significant relationship between self-medication and efficacy as a factor influencing health-seeking option (X^2=9.174 DF=1 p-value=0.02). Thus, that 82 respondents, who indicated that they used self-medication, also indicated that efficacy was an important factor influencing this choice. Again table 4.4.2 shows that 23 respondents who indicated that they did not use self-medication considered efficacy as the main factor influencing their choice. There was also a significant relationship between self-medication and time (X^2=11.174 DF=1 p-value=0.01). In other words, whether a respondent will or will not opt for self-medication will depend on the time taken.

Table 4.4.2: Factors influencing the use of self-medication

Factor influencing health seeking option	Self-medication Yes	Self-medication No	Total
Accessibility			
Yes	117 (100.0)	23 (100.0)	140 (100.0)
Total	**117 (100.0)**	**23 (100.0)**	**140 (100.0)**
Affordability			
Yes	117 (100.0)	19 (82.6)	139 (97.1)
No	0 (0,0)	4 (17.4)	4 (2.9)
Total	**117 (100.0)**	**23 (100.0)**	**140 (100.0)**
Availability			
Yes	117 (100.0)	23 (100.0)	140 (100.0)
Total	**117 (100.0)**	**23 (100.0)**	**140 (100.0)**
Efficacy			
Yes	82 (70.1)	23 (100.0)	105 (75.0)
No	35 (29.9)	0 (0.0)	35 (25.0)
Total	**117 (100.0)**	**23 (100.0)**	**140 (100.0)**
Time			
Yes	109 (93.3)	16 (69.6)	125 (89.3)
No	8 (6.8)	7 (30.4)	15 (10.7)
Total	**117 (100.0)**	**23 (100.0)**	**140 (100.0)**

Source: Field data, 2016

4.5. Predicting health seeking behaviour: A binary logistic regression

This part of the analysis explores further the relationship between factors influencing health seeking options and two of the health seeking options (i.e. utilization of orthodox health facility and self-medication) using a binary logistic regression analysis.

In the binary logistic regression, individual or socio-demographic variables were also included. This was premised on the notion that individual level factors could be influencing health-seeking options. Again the choice of the binary logistic regression was based on the fact that, the dependent variables (utilization of orthodox health facility and self-medication) were dichotomous variables. The odds ratio was used in interpreting the result since the binary logistic coefficient lacks substantive interpretation for categorical variables. Odds ratio less than 1 indicate a decrease in the odds of being in the category of the dependent variable with the largest response (yes).

Regarding the relationship between utilization of orthodox health facility and the predictor variables, the model i.e. Table 4.5 shows that among all the socio-demographic variables only education had a significant relation with utilization of orthodox health facility, and even this, it was those who responded that they have had tertiary education. The result suggests that, if you compare the reference category (i.e. none) with all other categories of education, those who have had tertiary education are 72 times likely to opt for or utilize an orthodox health facility. Again the result suggests that those who considered efficacy as an important factor are 1.02 times likely to opt for or utilize an orthodox health facility.

Table 4.5: Predicting the use of orthodox health facility

Predictors	Beta	Odds	sig
Age			
18-25	-82.249	.000	.999
26-35	-83.586	.000	.999
36-45	-84.610	.000	.999
46-55	-64.588	.000	.999
(56 and above)			
Education			
Pre-school	-83.157	.000	.999
Primary	.462	1.587	.665
JHS	-1.895	.150	.184
Secondary	1.157	3.180	.272
Tertiary	4.290	72.987	.017
(None)			
Occupation			
Sex work and trader	.850	2.340	.520
Sex work	2.398	10.996	.068
(Student work)			
Religion			
Christian	-21.610	.000	.999
Muslim	-23.378	.000	.999
(Traditionalist)			
Marital status			
Single	-.709	.492	.455
Married	1.860	6.421	.600
Divorced			
(Work status)			
Seater	-.975	.377	.278
Roamer	.475	1.608	.703
(Both)			
Work experience			
1-4	-.743	.476	.734
5-9	-.127	.881	.948
(10-14)			
Affordability			
Yes	37.040	1.22	.999
(No)			
Efficacy			
Yes	3.771	1.023	.002
(No)			
Time			
Yes	.979	2.661	.462
(No)			
Constant	90.872	3.918	.999

4.5.1. Predicting the use of self-medication

Regarding the relationship between self-medication and the predictor variables, the model (Table 4.5.1) shows that among all the socio-demographic variables, only occupation had a significant relationship with self-medication. The result shows that if you compare student work with the other categories of occupation those doing purely sex work are 1.04 times likely to use self-medication.

Table 4.5.1: Predicting the use of self-medication

Predictors	Beta	Odds	sig
Age			
18-25	71.802	1.524	.999
26-35	72.950	4.807	.999
36-45	55.894	1.881	.999
46-55	19.390	2.635	1.000
(56 and above)			
Education			
Pre-school	34.649	1.116	.994
Primary	16.959	1.319	.999
JHS	17.561	4.233	.997
Secondary	17.715	4.935	.996
Tertiary	-16.830	.000	.998
(None)			
Occupation			
Sex work and trader	-2.192	.112	.125
Sex work	3.055	1.047	.032
(Student work)			
Religion			
Christian	19.854	4.119	.999
Muslim	20.382	7.118	.999
(Traditionalist)			
Marital status			
Single	.825	2.283	.520
Married	18.937	1.675	.997
(Divorced)			
Work status			
Seater	1.328	3.772	.233
Roamer	1.964	7.130	.174
(Both)			
Work experience			
1-4	-36.966	.000	.995
5-9	-37.529	.000	.994
(10-14)			
Affordability			
Yes	-72.809	.000	.994
(No)			
Efficacy			
Yes	54.116	3.180	.997
(No)			
Time			
Yes	-.314	.731	.779
(No)			
Constant	-54.508	.000	.999

4.6. Chapter Summary

The survey results have enabled a picture to be developed of the health seeking behavior and practices of commercial sex workers in Adum, a neighbourhood in Kumasi, in the Ashanti regional capital. Using the binary regression model, the study highlights that affordability was an important consideration influencing their health seeking choices. This definition of affordability as set out in the National Health Insurance Scheme was ambiguous as most of the diseases confronting the respondents were not covered under the scheme. The research thus shows that to understand why a practice is performed in a certain way, you have to look at adjoining practices, in this case, most respondents who cannot afford the costs of health care resulted to self-medication. The findings show that those who have had tertiary education are 72 times likely to opt for or utilize an orthodox health facility. Again the result suggests that those who considered efficacy as an important factor are 1.02 times likely to opt for or utilize an orthodox health facility.

CHAPTER FIVE

DISCUSSION

5.0 Introduction

This chapter discusses the health seeking behaviour and the factors associated with the various healthcare options use among commercial sex workers in Adum.

5.1 Socio-demographic characteristics of commercial sex workers

The fieldwork covered all eligible and consenting commercial sex workers involved in the sex trade at Adum, Kumasi. In general terms, it was difficult to consent and complete the questionnaire for most of the workers of interest, perhaps due to the stigma embedded in the social fabric of most Ghanaian society. The data presupposes that most commercial sex workers in the study area are mainly youthful, with those falling within the ages of 18 – 35 years accounting for about 80% of the total respondents. The age profile of commercial sex workers thus appears to corroborate the findings made by (Onyango et al., 2012), which indicated that in most cities, commercial sex work appears to be the preserve of or usually dominated by young people. The data further shows that commercial sex workers above the age of 46 accounted for less than 4% of the total sample. The findings resonate with earlier study, which revealed two different groups of sex workers, namely the seaters and roamers (Obeng-Odoom, 2014). According to these studies, the former are older women (around a median age of 37 years), often divorced or widowed, and they tend to operate from their homes, have dedicated clients and have been in the business much longer. In contrast, according to these studies, the roamers are younger (around a median age of 21 years), have been around for only a short time, and frequent hotels, bars, and other entertainment centers.

The relatively high percentage of Christians among the respondents may be explained by locational and other factors. The study area, Adum, is in the heart of the indigenous neighbourhood of Kumasi who are mostly christians, and is also close to the central market and the central business district (CBD); it is therefore not surprising that so many youths from all over the metropolis migrate to community to eke out a living. The case of the Moslem and the Traditionalists might not necessarily be due to poverty, but to the merging culture of entrepreneurship and wealth accumulation amongst the people. Today, most of the youth from the north are migrating to the south to seek greener pastures for which several empirical works have been done (see Yato, 2008; Kwakye, 2009; Awumbilla et al., 2014). The study findings indicate that majority (89%) of the respondents have had at least some form of formal education with most of them having post basic level education. This is plausible revelation as it supports the widely acclaimed reports in the country that literacy level and school enrolment is generally increasing in Ghana (GSS/CF macro 2014). More interesting is the fact that female education may also be on the rise, a development that may be encouraging for the area of public health in terms of family and reproductive health and the development of Ghana generally (GSS/CF macro 2014). There is empirical evidence that there is a positive correlation between education and many health indicators such as long life expectancy, good nutrition, low incidence of communicable diseases, etc. (Cowell, 2006). Nonetheless, given the high risk that is associated with commercial sex work, questions may be raised about why the educated enter into such venture?

This study revealed that majority of the respondents was between the ages of 26 – 35 years and minority 2 (1.4%) were above 56 years. This may be due to sexual activeness of that age group (18 – 35 years). At this age the female may be more sexually attractive compared to their later ages and as such stand a better chance of winning more clients than their advanced age counterparts. More so, beyond 18 years, many females begin to bear some financial responsibilities either for themselves or their siblings and this brings additional pressure that may push young girls into this venture (Karamouzian et al., 2016). It is however not surprising that the number of women beyond the menopausal age (49 years) are not many as the results showed (See Table 4.1). Thus beyond this age the natural biological changes that takes place in the female reproductive system makes sexual activities a bit difficult for them and it stands to reason that it may reduce their interest in CSW as well. The small number of this group also could be attributed to the social expectation that women at this age group should act as role models to the younger ones in society (Nappi & Lachowsky, 2009).

It is believed that Ghana is a country with heterogeneous religions in which Christianity dominates. The finding of this study affirms that indeed the respondents had different religious affiliations with majority being Christians. This result is consistent with the most recent Population census, which indicates that majority of Ghanaians are Christians (GSS/CF macro 2014). Moreover, the results show that more than two-thirds (67.1%) were single. Generally, in many communities in Ghana, sex outside marriage is considered unacceptable. Nonetheless when a person is unmarried and is indulged in sex it is not as abhorred as a married person being involved in the same act especially for commercial purposes. Therefore, it is of little wonder that majority of the respondents are single. It is however, worthy of note that a few were married, a finding that may warrant further investigation as to whether their partners have consented to their work or they do it in secret. More importantly, the over a quarter respondent who admitted that they were divorced also need to be studied further to examine whether they were divorced before starting CSW or their involvement in the CSW might have contributed to their divorce. A study conducted in the United States indicated that husbands' without a full-time employment is associated with higher risk of divorce, but neither wives' full-time employment nor wives' share of household labor is associated with divorce risk (Killewald, 2016).

5.2 Sources of health care options available to commercial sex workers

In the current study, it was observed that majority of participants self-medicate for STI's and other diseases. Self-medication has been shown as a factor influencing delay in seeking care from the health facility (Samuels et al., 2012). In this study, respondents ranked self-medication first (41%) compared to the results from other studies where 9% (Phrasisombath et al., 2012) self-treated their current symptoms. This was due to the perceptions by commercial sex workers that drugs purchased from pharmacy shops have reduced efficacy in curing STIs (Phrasisombath et al., 2012). On the contrary, it is easy to get antibiotics from licenced chemical sellers, pharmacy shops and drug peddlers in Ghana that the efficacy is high. That may be one of the several reasons why most CSW's self-medicate. Even though there are rules that regulate selling drugs over the counter in Ghana, its enforcement may not be as desired. The increased ease of access to drugs from nearby sources may be a major contributing factor to self-medication by CSWs. Other empirical evidence about self-medication in Ghana points to the fact that it is less expensive compared with hospital treatment whereas others believe hospital treatment is also associated with long delays, a reason they think influences their decision to self-medicate (Donkor et al., 2012). This finding about high prevalence of self-medication corroborates other findings in other populations in Ghana (Donkor et al., 2012). Moreover, given the background of the study participants which shows that majority of them can read and write, it becomes easier for them to access information either through internet or friends, so they can easily know which kind of treatment may be helpful for their conditions. The high prevalence of self-medication among CSWs in this study may be of policy significance, which calls for health education to be an integral part of dealing with self-medication problem among vulnerable groups such as CSWs.

5.3 Stage of seeking health care

An encouraging revelation from the study indicate that majority of the respondents readily seek treatment immediately they realize they are suffering from a particular health condition. Thus whether syphilis, chlamydia, candidiasis etc., respondents seek immediate treatment as long as symptoms persist. Here, apart from the discomfort and pain that these patients may suffer which might push them for immediate treatment, it might also be that any knowledge of such conditions by their clients may deter them from transacting business with them; a situation, which they are aware, is to their detriment. Better yet, it is possible their knowledge of the dire consequences of delayed treatment of such conditions might be the influencing factor here. A study conducted among CSWs in Bangladesh showed that majority of the respondents 93% had heard about STIs, but knowledge regarding STIs among respondents was not sufficient (Karim & Mona, 2013). This indicates that majority of the respondents have felt these symptoms within a short period of time. This reveals thoughtful health concerns as most of these commercial sex workers may still be having these diseases. Therefore, there is a high likelihood these diseases being transferred to their multiple sexual partners. Some might not even have gone for any check up in a hospital or a health facility. This threatens not just their lives but also the lives of their numerous clients.

Treatment for sexually transmitted infections (STI's) was generally sought when symptoms were recognized for syphilis (79%), gonorrhea (90%), and chlamydia (100%). Findings in this study are in contrast with this study (Matovu & Ssebadduka, 2012) where treatments were delayed for more than 3 days before treatment was sought. Also, in a study in the Laos (Southeast Asia), 41% of the sample delayed seeking care by more than 4 weeks (Phrasisombath et al., 2012). This study revealed that, 21% and 2% of the respondents sought treatment for syphilis and gonorrhea respectively after one week. One study reported that 58% of CSW's delayed treatment for syphilis and gonorrhea after a week (Phrasisombath et al., 2012). In the Laos study, 19% delayed for more than 2 weeks (Phrasisombath et al., 2012) About 100% of the respondents who had chlamydia sought treatment as soon as symptoms revealed. Participants saw STI's as common illnesses that can be treated through self-medication.

In a cross-tabulation of factors that influence respondents in their choice of a health care option, it was discovered that accessibility, availability and affordability were paramount in respondents' decision to self-medicate. As mentioned in previous studies (Sihavong et al., 2011), people's ability to purchase drugs without prescription, low cost of over the counter medicines compared with hospital medication all influence decision to self-medicate. The availability of medicine from leftover of drugs purchased to treat the same or similar condition. Once patients' conditions reoccur, they resort to them because they are readily available. In addition, it was revealed that in the event of respondents' decision to self-medicate, efficacy of the medicine is the least influencing factor. This may simply be due to the reason that the patients at that time want to try something that might work for them once those medications are available for use. However, in situations where respondents decide to visit the hospital, efficacy was revealed as an important factor that influences their decision. Thus, with the perception of high cost of treatment when visiting the hospital, it only makes sense that any single additional factor that will make these patients make such expenditure will be that their condition will be well treated. Friends were also identified as important option for respondents when they need to seek treatment. In a society where the legal and cultural framework do not favour such group, it is of no surprise why friends are a reliable resort, their availability and accessibility are critical influencing factors (Morisky & Tiglao, 2010).

An intriguing finding indicates that amongst all health care options available to respondents the two most important factors that influence them are accessibility and availability. Thus, once there are no barriers to physical access and treatments are readily available, it automatically attracts respondents. This may be an important revelation with policy significance when it comes to dealing with HIV/STIs prevention and treatment among key populations at risk of which CSW are part. Due to the unfavourable environment that these groups are presented with, the Drop-in-Centers (DIC) was adopted by Ghana to enhance accessibility and availability of services for KAPs including CSWs. In addition, affordability was ranked second (see table 4.5) which indicates that before respondents think of their ability to pay, they consider whether services are accessible and available. A reason for affordability not being the most influential factor could be that, CSWs are able to mobilize some amount of money through their activities that can cater for their health care needs. Hence, once the service is available they are ready to pay (Zhuang & McQuaide, 2013).

Overall, self-medication was discovered as the most important health care seeking option utilized by CSWs in Adum, followed by hospital based care. Consequently, it was revealed that some of the CSWs consulted herbalists. This comes as no surprise because herbal medicine has been an integral part of the health care system of Ghana and other parts of the world (Shirwaikar, Govindarajan, & Rawat, 2013). Over the years, there have been efforts to integrate it into the mainstream health care delivery system with the Ghana Health Service establishing a directorate for it. Even though, the result indicates that not many people use this, which may be attributed to the location of the study, as generally, it is believed more people in the rural areas, use herbal medicine than their counterparts in the urban centers (Wardle, Lui, & Adams, 2012).

In conclusion, it was observed that self-medication is the first resort when it comes to the health seeking options available to CSWs. They prefer to self-treat before they think of any other alternative option. There were significant differences between the choices of treatment for specific health conditions such as gonorrhoea, candidiasis, syphilis and chlamydia. Furthermore, it was observed that accessibility and availability were prioritized over affordability, time and efficacy in CSWs decision to use a particular health care option. In addition, it was discovered that most of the respondents preferred to seek early treatment for the health conditions they suffered, nonetheless some waited beyond three weeks.

5.4 Implications of study findings in relationship with conceptual framework

The findings of the study confirm some of the reported concepts in the conceptual framework that socio – demographic characteristics like tertiary education, occupation (mainly sex work) and efficacy of the medicines or drugs are associated with the use of orthodox health facility. However, age and marital status were not factors that were significantly associated with the use of orthodox health facility.

The study also found a significant relationship between occupation (sex work) and self-medication. Other predictors like age, education, marital status, work status and work experience were not significantly associated with self-medication.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.0. Introduction

It is generally agreed that health issues in urban areas often merit attention regardless of the socio-economic status of the countries involved. This is against the backdrop that in most cases certain conditions such as pollution, congestion and overcrowding exacerbate the burden of both communicable and non-communicable diseases. Additionally, human lifestyle and behaviour tend to generate some health hazards, for example it is generally known today that diabetes has reached epidemic proportions while cancer incidence is rising. Additionally, tobacco and illicit drug use continue to pose challenges for some communities while sexually transmitted infections are also common among commercial sex workers.

It is against this background that the study sought to examine the health challenges confronting commercial sex workers using those operating in Adum, Kumasi as a case study. The study adopted quantitative methods to get maximum information from the 140 interviewees. This final chapter presents a summary of the findings, conclusion and recommendations of this study, including limitations and directions for future research. This chapter is presented under these sections; summary of the findings, conclusion, recommendations, limitation of the study and future research considerations.

6.1. Summary of the findings

The study revealed that commercial sex business has clearly had a negative effect on the health of participants. Finding indicates that 80.7 percent of the respondents indicated that they had Gonorrhea. Additionally, with regards to Candidiasis, 70.7 percent of the respondents indicated that they had history of the disease. The reason for the candidiasis spread was due to the use of a common public toilet in the brothel. In terms of symptoms, a total of 70.7 percent of the overall sampled population indicated that they had discharge from vagina. On the other hand, 21.4 percent out of the respondents indicated that they experience scent or wart on the vagina.

The result presented here was useful to gain further understandings of the impact of commercial sex workers and how they influence city authorities and policy-makers with regard to urban health issues.

In terms of ways through which commercial sex workers address STIs, the 113 respondents who indicated that they have ever had candidiasis, 59.3 percent indicated that they adopt self-medication, while 27.4 percent use a medical facility. Similarly, with regards to syphilis, the study established that 76.6 percent out of the 47 respondents who have had the disease indulge in self-medication while 21.3 percent confer with a medical facility. In this population, all the survey respondents (100%) overwhelmingly indicated that accessibility influence their choice of health facility option. Additionally, 97.1 percent indicated affordability as an important consideration influencing their health seeking options. The findings complicate the studies which assumes that informal health care in the form of traditional medicines and self-medication is somehow negative and that it is used only by those with lower education or literacy or limited financial means or those that are marginalized in some other way, such as the rural area they reside in.

In the current study, the overall results showed that the choice of, or utilizing a health facility is based on its perceived efficacy. In other words, people use self-medication because of its efficacy. And while finances have been cited as a reason for self-treatment, that is informal health care, the current study found regular income had no bearing on the use of formal health care services. Also there are differing definitions of illness, which can be cultural and even gender related, which could lead to reporting bias. The factors significantly associated with preferring the use of orthodox health facility if given the choice, is education and having a previous experience of being unable to reach the nearest health facility.

6.2. Conclusion

This study has been useful in identifying some of the factors, which hinder the health seeking behaviour of commercial sex workers. The socio-demographic characteristics of commercial sex workers were identified, sources of healthcare utilized by commercial sex workers were also identified, the perception of the various healthcare options were examined, the various health conditions experienced were identified and the health action taken was also determined. A significant proportion of the respondents for the study sought treatment as soon as symptoms were recognized for syphilis (79%), gonorrhea (90%) and chlamydia (100%). Eighty-eight percent of the respondents also sought treatment for candidiasis as soon as symptoms were recognized.

What can be learned from this study in terms of health seeking behavior for commercial sex workers? Only qualified drug peddlers should be allowed in the brothel to sell drugs, since most of them self-medicate. Majority of the respondents preferred self-medication to the other options like hospital and herbal clinics. This was because; self-medication was affordable, available and accessible. The herbal clinics and hospitals should also make their services more affordable, available and accessible to enable commercial sex workers' patronize their services. It thus stands to reason that health seeking behaviour among commercial sex workers could be facilitated through improved basic knowledge regarding sexually transmitted diseases and other diseases over one's own sexual behavior and social support for early health seeking.

6.3. Recommendations:

Following from the conclusions drawn, the recommendations are proposed for policy consideration. First, the study revealed the common disease conditions experienced by commercial sex workers in Adum, where most of these conditions can be transmitted to their sexual partners. Therefore, it is recommended that, public health practitioners and non-governmental organizations to target these sub populations through programmes targeted at STI control. The intention of the programme is to make condoms available and affordable, promote their use and reduce barriers to utilization. Also, behavioural interventions can be used by public health practitioners and non-governmental organizations to target condom promotion. Here, messages to men about the risks of STIs from unprotected commercial sex will increase condom use and lower infection rates.

More so, the Ghana Health Service in collaboration with the Ministry of Health should consider pre-exposure vaccination among this sub-population. Pre-exposure vaccination is one of the most effective methods for preventing transmission of some sexually transmitted diseases like genital wart which was reported among some of the commercial sex workers and it also prevents hepatitis B.

Partnerships between the brothel community, health care organizations and non-governmental organizations, for example, will lead to the reduction of STIs among commercial sex workers. Health care organizations and non-governmental organizations should organize health educational programmes advocating behavioural change among CSWs through the promotion of the importance of seeking appropriate and effective STI treatment and emphasis on the health consequences of inappropriate treatment of STI concerning the medicines / drugs (antibiotics). Commercial sex workers should be made aware of the effects of ineffectual treatment of STIs, which may contribute to the growing problem of the spread of antibiotic resistance to some of these STIs.

Furthermore, educational programmes need to be developed for CSWs highlighting the likely effects of self-medication on their health with possible abuse of medicines like antibiotics from drug peddlers and the advantage of seeking healthcare from trained health workers at the orthodox health facility. However, CSWs should be informed that ineffective treatment of STIs through self-medication or by a drug peddler increases their risk of HIV infection.

6.4 Limitation of the study

The participants were not to be compensated as stated in the ethical review proposal but that did not hold since participants felt reluctant to disclose any information. This was because another research project was ongoing that had given money after the interview.

One important limitation of the data was that the measurement of health seeking behavior was based on reported illness and treatment action, and not directly observed as the illness process unfolds.

6.5 Future research considerations

Based on the findings of the study, future studies on health seeking behavior need to include a combination of qualitative and quantitative methods. Future studies should also look at homosexuals and male sex workers, since the study did not involve male sex workers and homosexuals. Further studies are needed to determine the extent of their health seeking behavior and the associated factors for the various healthcare options.

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APPENDICES

Appendix I: Questionnaire

The principal investigator for this research study is Portia Durowaa Boateng, a student from the University of Ghana, School of Public Health. It is an academic exercise carried out in partial fulfillment for the award of a Master of Science in Applied Health Social Science degree by the University of Ghana. This structured questionnaire is intended to assess the **"Health Seeking Behaviour among Commercial Sex Workers in Adum in the Ashanti Region".** You are requested to respond to these questions after you have consented to be a participant in this study.

Date of interview: _____/______/________ Form ID No: ____________

SECTION A

Socio-Demographic Characteristics of Respondents

Indicate participants' responses to the following questions by writing and/or ticking (√) appropriately in the spaces or boxes provided after each item in this questionnaire.

1. Age of respondent (years)

   (a) 18 - 25 [ ] **1**

   (b) 26 – 35 [ ] **2**

   (c) 36 – 45 [ ] **3**

   (d) 46 – 55 [ ] **4**

   (e) 56 and above [ ] **5**

2. How long have you stayed or lived in this brothel community?

   (a) 1 – 5 years [ ] **1** (b) 6 – 10 years [ ] **2**

   (c) 10 years and above [ ] **3**

3. What is the highest level of school you have attended?

   (a) Pre – school [ ] **1** (b) Primary [ ] **2**

(c) JHS [ ] **3** (d) Secondary / Tech / Voc [ ] **4**

(d) Higher [ ] **5** (e) None [ ] **6**

4. What is your occupation?

(a) Sex work and trader [ ] **1** (b) Sex worker [ ]

(c) Student and sex worker [ ] **3**

5. What is your religion?

(a) Christian [ ] **1** (b) Moslem [ ] **2**

(c) Traditionalist [ ] **3** (d) Others (specify) [ ] **4**

6. What is your current marital status?

(a) Single [ ] **1** (b) Married [ ] **2**

(c) Separated/ divorced [ ] **3** (d) Other (specify)………… **4**

7. Please indicate which category you represent

(a) Seater **1** (b) Roamers **2** (c) Both **3**

8. How long have you been in this work (years)?

(a) 1 – 4 [ ] **1** (b) 5 – 9 [ ] **2**

(c) 10 – 14 [ ] **3** (d) Other (specify)………… **4**

9. How many children do you have?

(a) 1 – 3 [ ] **1** (b) 4 or more [ ] **2** (c) No child [ ]**3**

SECTION B

Health Seeking Behaviour among commercial sex workers.

This part is concerned with what is done among commercial sex workers in the form of seeking health care facility.

10. WHAT HEALTH CONDITIONS/ILLNESS DO YOU USUALLY EXPERIENCE? Please tick as many as possible?

I. Malaria

II. Syphilis

III. Gonorrhoea

IV. Herpes

V. Hepatitis B

VI. Candidiasis (white)

VII. Diabetes

11. What do you do when you have malaria? (Please provide only one answer)

(a) Do nothing [ ] **1**

(b) Go to hospital / clinic [ ] **2**

(c) Self – medicate from drug store [ ] **3**

(d) Over the counter medication [ ] **4**

(e) Consult a friend [ ] **5**

(f) Go to see the herbalist [ ] **6**

12. What do you do when you have candidiasis (white)? Please provide only one answer

(a) Do nothing [ ] **1**

(b) Go to hospital / clinic [ ] **2**

(c) Self – medicate from drug store [ ] **3**

(d) Over the counter medication [ ] **4**

(e) Consult a friend [ ] **5**

(f) Go to see the herbalist [ ] **6**

13. What do you do when you have hepatitis B? Please provide only one answer

(a) Do nothing [ ] **1**

(b) Go to hospital / clinic [ ] **2**

(c) Self – medicate from drug store [ ] **3**

(d) Over the counter medication [ ] **4**

(e) Consult a friend [ ] **5**

(f) Go to see the herbalist [ ] **6**

14. What do you do when you diabetes? Please provide only one answer

(a) Do nothing [ ] **1**

(b) Go to hospital / clinic [ ] **2**

(c) Self – medicate from drug store [ ] **3**

(d) Over the counter medication [ ] **4**

(e) Consult a friend [ ] **5**

(f) Go to see the herbalist [ ] **6**

15. What do you do when you have syphilis? Please provide only one answer

(a) Do nothing [ ] **1**

(b) Go to hospital / clinic [ ] **2**

(c) Self – medicate from drug store [ ] **3**

(d) Over the counter medication [ ] **4**

(e) Consult a friend [ ] **5**

(f) Go to see the herbalist [ ] **6**

16. What do you do when you have herpes? Please provide only one answer

(a) Do nothing [ ] **1**

(b) Go to hospital / clinic [ ] **2**

(c) Self – medicate from drug store [ ] **3**

(d) Over the counter medication [ ] **4**

(e) Consult a friend [ ] **5**

(f) Go to see the herbalist [ ] **6**

17. What do you do when you have gonorrhoea? Please provide only one answer

(a) Do nothing [ ] **1**

(b) Go to hospital / clinic [ ] **2**

(c) Self – medicate from drug store [ ] **3**

(d) Over the counter medication [ ] **4**

(e) Consult a friend [ ] **5**

(f) Go to see the herbalist [ ] **6**

18. At what stage do you seek health care when you have malaria? (Please provide only one answer)

(a) As soon as the symptoms are recognized [ ] **1**

(b) When symptoms persist for one week [ ] **2**

(c) When symptoms persist for two weeks [ ] **3**

(d) When symptoms persist for three or more weeks [ ] **4**

19. At what stage do you seek health care when you have Syphillis? (Please provide only one answer)

(a) As soon as the symptoms are recognized [ ] **1**

(b) When symptoms persist for one week [ ] **2**

(c) When symptoms persist for two weeks [ ] **3**

(d) When symptoms persist for three or more weeks [ ] **4**

20. At what stage do you seek health care when you have gonorrhoea? (Please provide only one answer)

(a) As soon as the symptoms are recognized [ ] **1**

(b) When symptoms persist for one week [ ] **2**

(c) When symptoms persist for two weeks [ ] **3**

(d) When symptoms persist for three or more weeks [ ] **4**

21. At what stage do you seek health care when you have herpes? (Please provide only one answer)

(a) As soon as the symptoms are recognized [ ] **1**

(b) When symptoms persist for one week [ ] **2**

(c) When symptoms persist for two weeks [ ] **3**

(d) When symptoms persist for three or more weeks [ ] **4**

22. At what stage do you seek health care when you have hepatitis b? (Please provide only one answer)

(a) As soon as the symptoms are recognized [ ] **1**

(b) When symptoms persist for one week [ ] **2**

(c) When symptoms persist for two weeks [ ] **3**

(d) When symptoms persist for three or more weeks [ ] **4**

23. At what stage do you seek health care when you have candidiasis? (Please provide only one answer)

(a) As soon as the symptoms are recognized [ ] **1**

(b) When symptoms persist for one week [ ] **2**

(c) When symptoms persist for two weeks [ ] **3**

(d) When symptoms persist for three or more weeks [ ] **4**

24. At what stage do you seek health care when you have diabetes? (Please provide only one answer)

(a) As soon as the symptoms are recognized [ ] **1**

(b) When symptoms persist for one week [ ] **2**

(c) When symptoms persist for two weeks [ ] **3**

(d) When symptoms persist for three or more weeks [ ] **4**

25. What will be your first line of health seeking when not well? (Please provide only one answer)

(a) Go to herbalist [ ] **1**

(b) Go to hospital / clinic [ ] **2**

(c) Self – medicate from drug peddler [ ] **3**

(d) Over the counter medication [ ] **4**

(e) Consult a friend [ ] **5**

26. What will be your second source of remedy if your first source fails to cure you? (Please provide only one answer)

(a) Go to herbalist [ ] **1**

(b) Go to hospital / clinic [ ] **2**

(c) Self – medicate from drug peddler [ ] **3**

(d) Over the counter medication [ ] **4**

(e) Consult a friend [ ] **5**

27. What symptoms do you usually experience (multiple responses allowed)?

(a) Discharge from vagina [ ] **1**

(b) Abnormal vaginal bleeding [ ] **2**

(c) Sore or wart on vagina [ ] **3**

(d) Swelling of groin region [ ] **4**

(e) Burning pain or itching [ ] **5**

(f) Painful urination [ ] **6**

28. When was the last time you experienced any of those conditions?

(a) 1 – 6months (b) 7 – 12 months (c) > 12 months

SECTION C

Factors Associated with Health Seeking Behaviour among commercial sex workers.

29. In SECTION B above, you have shown your sequence of care seeking. What are your reasons for using those sources of health or non-health facility? Explain these terminologies to the respondent as follows:

(1) **Accessibility** means easy to come by.

(2) **Affordability** is your capability to buy or pay for something or service.

(3) **Availability** means what is readily found all the time.

(4) **Efficacy** is how effective the source treats "Sexually Transmitted Infections".

(5) **Time** is how long it takes you to get the care you seek at that source.

(a) Which of the following health seeking methods do you use? Multiple responses allowed

(Consult a friend, use the health facility / orthodox, Self-medication, See the herbalist)

(b) What are the reasons of using those sources of health or non-health facility? Multiple responses allowed

(Accessibility, Affordability, Availability, Efficacy and Time)

	Accessibility (1)	Affordability (2)	Availability (3)	Efficacy (4)	Time (5)
Consult a friend					
Use the health facility/orthodox					
Self-medication					
See the herbalist					

(30) In this brothel, who decides where to seek health facility for sexually transmitted infections and other diseases?

(a) Friends [ ] **1**

(b) Head of the brothel [ ] **2**

(c) On your own [ ]

Appendix II: Participant Informed Consent Form

ID. No ______________________

Consent to participate in this study

Study topic: Health Seeking Behaviour among commercial sex workers in Adum in the Ashanti Region.

Informed consent form: Information sheet for commercial sex workers

Consent for questionnaire with

Address:

Box LG 13,

Department of Social and Behavioural Science,

School of Public Health,

College of Health Sciences,

University of Ghana, Legon.

Tel: 0208440032

Email: akuadurowaa@yahoo.com

I am ...**Portia Durowaa Boateng**… a student from the School of Public Health, University of Ghana, Legon. I am conducting this study to determine the health seeking behaviour among commercial sex workers in the Ashanti Region.

Purpose of the study

The goal of this research study is to determine what kind of treatment sex workers in Adum in the Ashanti Region opt for when they have an STI or when they are sick.

Participant role

Participation in this study is voluntary**.** If you agree to participate in this study, you would be interviewed for about 45 minutes or less. The interview includes questions about Health Seeking Behaviour and how the various health facilities are utilized.

Confidentiality

The information you will share with us if you participate in this study will be kept completely confidential to the full extent of the law. Your information will be assigned a code number that is unique to this study. No body from outside will be able to see your interview or even know whether you participated in this study. When the study is completed and the data have been analysed, the list linking participant's to study numbers will be destroyed. Study findings will be presented only in summary form and no name will be used in any report.

Contacts

If you have any questions about this study, please contact Portia Durowaa Boateng (Principal Investigator) at akuadurowaa@yahoo.com or on telephone number 0208440032. This study is to seek Ethical Clearance from the Ghana Health Service Ethical Review Board. If you have questions about your rights as a research participant, please contact the administrator of the Ghana Health Service Ethical Review Board at:

GHS-ERC Administrator: Hannah Frimpong (0507041223).

Potential risk or benefits

This study poses no risk to participants. The questions are mainly based on their health seeking behaviour, which does not pose direct risk to the participants.

Participating in this study may not benefit you directly, but it will help us learn. You may find answering some of the questions upsetting, but we expect that this will not be different from the kinds of things you discuss with friends or other close relations. You may skip any questions you don't want to answer and you may end the interview at any time.

Compensation

Eligible persons who consent to participate in this study will not be given any compensation in the form of money.

Declaration of conflict of interest

The researcher's personal values and morals will not affect the results and findings of the study in any way, looking at the sensitive nature of the study.

Proposal funding information

The research will be self-financed by the researcher with the support of family and friends.

Volunteer agreement form

The above document describing the benefits, risks and procedures for the research on health seeking behaviour among commercial sex workers in Adum in the Ashanti Region has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

……………………………………..

Date and signature or mark of volunteer or,

……………………………………..

Thumb-print of volunteer

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits; risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

………………………

Date and signature of witness or,

…………………………………

Thumb-print of witness.

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research will be explained to the above individual.

…………………………………….

Date and signature of person who obtained consent or,

…………………………………….

Thumb-print of person who obtained consent.

Ghana Health Service Ethics Review letter

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
Tel: +233-302-681109
Fax + 233-302-685424
Email: ghserc@gmail.com

My Ref. GHS/RDD/ERC/Admin/App
Your Ref. No.

Portia Durowaa Boateng
University of Ghana
School of Public Health
Legon, Accra

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

GHS-ERC Number	**GHS-ERC 33/12/15**
Project Title	"Health Seeking Behaviour among Commercial Sex Workers in Adum in the Ashanti Region"
Approval Date	9th May, 2016
Expiry Date	8th May, 2017
GHS-ERC Decision	**Approved**

This approval requires the following from the Principal Investigator

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report **after completion** of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.

Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED...
PROFESSOR MOSES AIKINS
(GHS-ERC VICE-CHAIRPERSON)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra