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ENHANCING HEALTH AND WELL-BEING OF YOUNG PEOPLE IN GHANA

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DECLARATION

I declare myself to be the author of this work. Authors and works consulted are properly cited in the text and are included in the listing of references.

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ABSTRACT

Background

There has been a sense of urgency driving recent discussions and improving the health and well-being of young people in our societies. There are various global goals and objectives aimed at improving the lives of these young people. Despite this, little has been done to improve their health and well-being.

Objective

This study explores the current state of health and well-being among a section of Ghanaian young people, variables that affect young people's health and well-being, factors and risky behaviors that contribute to their current state, and how to enhance their overall health and well-being.

Methods

A sample of young people (aged 15-24) were randomly selected from four educational institutions in Ashanti and Central regions in Ghana. A questionnaire composed of four sections measured health-related quality of life (HRQoL), satisfaction with life, personal well-being, and sociodemographic profile. Descriptive statistical analyses were carried out to describe the sample and the respondents' quality of life as well as satisfaction with life and well-being. Inferential statistical analyses included Pearson Correlation Coefficient, T-tests and ANOVA tests to analyze the sample.

Results

Results showed that the current health state of the respondents is good but young people do not have excellent conditions of life. In terms of HRQol, the study indicated that young people do not have issues with mobility, self-care, doing their usual activities, pain/discomfort and anxiety/depression. Moreover, the study showed that there is a clear relationship between gender and quality of life as males reported a higher quality of life than females.

Conclusion

This report recommends that the government, policymakers, and stakeholders strengthen the health care provision of the country for young people. Moreover, evidence from this

report indicates the importance of implementing various strategies to improve the quality of life and life satisfaction of the younger population.

Keywords: Health, well-being, young people, quality of life, satisfaction with life, Ghana

RESUMO

Contexto geral

A saúde e o bem-estar dos jovens são factores-chave que determinam o desenvolvimento dos jovens numa sociedade. As prioridades de saúde do Gana melhoraram ao longo dos anos como resultado das muitas pesquisas e campanhas feitas para impulsionar o setor da saúde e expandir a prestação de serviços de saúde em todo o país. A introdução do Sistema Nacional de Seguro de Doença (SNSD), uma cobertura universal de saúde, ajudou a reduzir as disparidades de saúde e a melhorar o acesso à saúde em geral. Embora o SNSD tenha ajudado a reduzir alguns dos desafios enfrentados pelo setor da saúde, desafios como a sustentabilidade das políticas, o financiamento, a oferta limitada de trabalhadores qualificados, especialmente em áreas remotas, e instalações e equipamentos médicos inadequados são algumas das principais questões que precisam ser abordadas. No que diz respeito aos jovens, a maioria das escolas do segundo ciclo presta serviços de aconselhamento, serviços religiosos e serviços de saúde, numa tentativa de melhorar a saúde e o bem-estar dos alunos.

A Organização Mundial de Saúde considera como jovens os indivíduos com idades compreendidas entre 15 e 24 anos. Um terço da população da África Subsariana, à qual o Gana pertence, inclui pessoas com idades compreendidas entre os 10 e os 24 anos. Estes jovens estão a crescer num contexto marcado pela pobreza generalizada, oportunidades educativas limitadas, elevada prevalência de SIDA, conflitos generalizados e fracos controlos sociais (Kabiru, Izugbara e Beguy, 2013). É necessário um esforço coordenado dos setores público e privado para aumentar a conscientização pública sobre a necessidade de melhorar as políticas e programas que atendam às necessidades dos jovens adultos. A satisfação das necessidades específicas dos jovens adultos exigirá uma maior compreensão pública dos desafios que enfrentam e um investimento público e privado sólido na sua educação e oportunidades de emprego (Bonnie et al., 2015). Na realidade, tem havido um sentimento de urgência com vista a melhorar a saúde e o bem-estar dos jovens nas nossas sociedades.. Existem várias metas e objetivos globais que visam melhorar a vida dos jovens. Apesar disso, pouco tem sido feito para melhorar a sua saúde e bem-estar. A investigação publicada sobre as diversas questões que afetam a saúde e o bem-estar dos jovens na África Subsariana é, de facto, limitada e centra-se essencialmente na saúde sexual e reprodutiva (Kabiru, Izugbara e Beguy, 2013). Tendo em conta a parca

investigação nesta área, este estudo vem colmatar uma necessidade existente, desenvolvendo estudos anteriores realizados, uma vez que se centra no estudo da saúde em geral e no bem-estar da população jovem do Gana,

Objetivo

Assim, este trabalho explora o estado atual de saúde e bem-estar dos jovens ganeses, identifica as variáveis que afetam a saúde e o bem-estar desses jovens, os fatores e os comportamentos de risco que contribuem para seu estado atual.

Metodologia

Uma amostra de jovens, com idades compreendidas entre os 15 e os 24 anos, foi selecionada aleatoriamente em quatro instituições de ensino (duas escolas secundárias e duas instituições de ensino superior) nas regiões Central e Ashanti. As escolas estavam localizadas numa mistura de ambiente urbano e rural em ambas as regiões. Cento e vinte e cinco jovens foram selecionados aleatoriamente para representar os jovens ganeses.

Foi elaborado um questionário para recolher os dados. O questionário estava dividido em quatro secções: qualidade de vida relacionada à saúde (medida pelo EQ-5D-5L), escala de satisfação com a vida, bem-estar pessoal e perfil sociodemográfico (idade, sexo, escolaridade, região de residência, área de residência, estrutura familiar e número de membros do agregado familiar). Foram realizadas análises descritivas (média, desvio padrão, mediana, frequências e percentagens) para descrever a amostra e a qualidade de vida dos entrevistados, bem como a sua satisfação com a vida e o seu bem-estar. As análises estatísticas inferenciais incluíram testes T e ANOVA para analisar a amostra.

Resultados

Os resultados apontaram para o facto de que a saúde e o bem-estar atuais da população jovem precisarem de ser melhorados. Os resultados mostraram que o estado de saúde atual dos respondentes é bom, mas os jovens não têm excelentes condições de vida. Os dados indicaram que a maioria dos jovens não tem problemas de mobilidade, nos seus cuidados pessoais, em realizar atividades habituais, de dor/desconforto e de ansiedade/depressão. A maioria dos respondentes concordou que suas vidas estão próximas do seu ideal na maioria dos casos. No entanto, nenhum deles respondeu que estava satisfeito com a vida. Em termos de qualidade de vida relacionada à saúde, verificou-se uma clara relação entre o sexo e qualidade de vida, uma vez que os homens

reportaram um índice EQ-5D-5L médio maior do que as mulheres. Além disso, percebeu-se que os indivíduos que vivem em áreas urbanas têm maior qualidade de vida do que os habitantes rurais, mas têm menor satisfação com a vida. Esta situação tem sido designada por "paradoxo do bem-estar rural-urbano", em que os habitantes das cidades relatam condições de vida mais elevadas, mas menor satisfação com a vida do que os residentes rurais. Outra descoberta importante foi que a maioria dos participantes afirmou estar envolvida em comportamentos de risco (como consumo de álcool, abuso de drogas e práticas sexuais inseguras) que podem, potencialmente, influenciar a sua saúde e o seu bem-estar geral. Mais de metade dos inquiridos afirmou envolver-se no consumode drogas (ex. analgésicos, cocaína, marijuana, etc.). O estudo revelou ainda que a maioria dos jovens não consome as quantidades recomendadas de frutas e legumes, o que mostra a falta de uma dieta equilibrada adequada na maioria dos pratos locais. Por mais essenciais que sejam os cuidados de saúde, ainda existem grandes desafios que afetam a sua prestação.

Conclusão

Este estudo recomenda um fortalecimento da prestação de cuidados de saúde do país para os jovens, bem como uma melhoria do seu bem-estar geral. Além disso, este estudo aponta para a importância de acompanhar e implementar várias estratégias para melhorar a qualidade de vida e a satisfação com a vida da população mais jovem. Devem ser adotados cuidados de saúde holísticos que abranjam, simultaneamente, as partes física, mental, emocional e social para melhorar o bem-estar geral dos jovens do Gana.

Palavras-chave: Saúde, bem-estar, jovens, qualidade de vida, satisfação com a vida, Gana.

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CHAPTER ONE

INTRODUCTION

Health is undoubtedly one of the most crucial aspects of our lives. It has been stated that health is more a result of lifestyles related to living and working environments than of healthcare. For a healthy life in the future, there must be a strong solid foundation on health and overall well-being built during the younger years.

There are distinctions between childhood and adulthood (WHO, 2012). After birth, a person goes through numerous stages and periods of life until eventually becoming an adult. The World Health Organization (WHO) defines a young person as within the age range of 10-24 years and adolescents (10-19 years). The United Nations (UN) also classified youth as being between the ages of 15 and 24. These phrases for identifying young people transitioning from childhood to adulthood are frequently used interchangeably and may have various definitions in different countries. Age and gender are significant criteria that are conveniently used by most people to describe young individuals (WHO, 2014).

Ghana as a sub-Saharan country has most of its population being young people. However, health support and services are severely under-equipped to meet their needs. Poverty, violence, and a scarcity of child-serving resources on the African continent can intensify the load on young people and hamper the provision of necessary support. As African children and adolescents grow older and become the key drivers of educational, economic, and health well-being in nations across the continent, more emphasis is being placed on fulfilling the population's health requirements, particularly those of youngsters.

1.1 BACKGROUND TO THE STUDY

According to statistics, Ghana has a total population of about 31 million, and 6.9 million are between the ages of 10-19 years (The situation of adolescents in Ghana summary report Analysis of data from the MICS 2017/18 and other recent surveys). Population projections from 2021 by the Ghana Statistical Service, estimate the country's population in the 0-18 age group to be nearly half of the country's total population of just over 31 million (www.myjoyonline.com, 2021). In 2020, it was reported that Ghana's population aged 15-24 was 5,997 million.

A recent study shows Ghana is now home to almost 6.5 million young people aged 15-

24 years (Sasu, 2023). Additionally, this age bracket represents a lesser percentage compared to the population aged 14 years and younger but a greater percentage in comparison with the elderly (Sasu, 2023).

In addition to advancing equitable and sustainable development for communities and societies, this young demographic offers a significant opportunity to impact health and well-being into adulthood and for the coming generation (UNICEF MENARO and Burnet Institute, 2023).

One's health and well-being as an adult are greatly influenced by the physical, mental, social, and emotional skills and abilities that are developed during adolescence. Additionally, the socioeconomic development of families, communities, and societies is greatly impacted by these skills and abilities as well (campus.paho.org).

Three benefits arise from investing in the health and well-being of youth: today's healthy adolescents, tomorrow's healthy adults, and the health of future generations (campus.paho.org). Teenagers face a significant cost of avoidable morbidity and mortality despite their significance, and their distinct health needs are often largely invisible in policy and programming (UNICEF MENARO and Burnet Institute, 2023).

Given their difficulties in a changing world, young people's health and wellness have gained importance in recent years. Young people may be more vulnerable during the transition from adolescence to adulthood as they deal with physical, mental, and social changes. It is important to encourage optimal health and well-being during this crucial stage.

For young people, maintaining physical health is essential since it has a direct impact on their well-being. The prevention of chronic diseases and the promotion of healthy physical functioning depend heavily on regular exercise, a well-balanced diet, and preventive healthcare practices. The young people of Ghana are the cornerstone of the country's future development. It is imperative that the health and well-being of Ghana's youth, who currently make up most of the country's population, improve. Globally, large youth populations represent a historic opportunity to introduce progress and adopt innovative solutions to ignite change (Osotimehin, 2016).

Young individuals are vulnerable and frequently face unique health challenges. Growth brings about a lot of changes, each of which carries a certain amount of risk. During this

stage of development, young people go through considerable physical, cognitive, and emotional changes (campus.paho.org). The choices taken throughout youth may have a continual effect on the young person's health and well-being as an adult. The rapid growth and development experienced during adolescence can sometimes lead to unique health risks, including nutritional deficiencies, musculoskeletal injuries, and issues related to body image and self-esteem. To encourage better health outcomes for young people, it is helpful to comprehend and offer essential assistance throughout this crucial stage.

In the past, Ghanaian youth tended to uphold traditional values and cultural customs, which had a big impact on how they lived their lives. They deeply appreciated and cherished the importance of family, community, and respect for elders in their daily lives (Umassmed.edu, 2019). Family is a very strong bond in Ghana and is the primary source of identity, loyalty, and responsibility (Umassmed.edu, 2019). Therefore, individual conduct is seen as having an impact on an entire family, social group, and community (Umassmed.edu, 2019). The entire family shares any loss of honor, making the culture collective. To protect this sense of face there is a need to maintain a sense of harmony; people will always act with decorum to ensure they do not cause anyone embarrassment (Umassmed.edu, 2019). Families and communities relied heavily on agriculture as a source of income, and it had an impact on young people's lifestyles and aspirations. For young Ghanaians, social gatherings, festivals, and cultural events were an integral part of daily life. Families and communities were vital in promoting young people's wellbeing. Communities and extended family networks served as a safety net and a sense of belonging. However, due to the rapidly shifting societal dynamics, sociocultural changes have impacted how modern young people behave and lead their lives. Young people's lifestyle is governed by the globalization of society and the rapid growth of technology. Young people in Ghana largely prefer more processed and less nutritious alternatives because of the transition from rural lives and traditional diets that were frequently rich in locally obtained and fresh foods. This change is a factor in the rise of diet-related health problems in young people, including obesity, diabetes, and cardiovascular illnesses. Despite all the technological, cultural, and social advancements of the last few decades, we have lost sight of this most fundamental fact: If children eat poorly, they live poorly (“Poor diets damaging children’s health worldwide, warns UNICEF”, www.unicef.org).

The emergence of modern technology in recent years, particularly smartphones, computers, and other electronic gadgets, has profoundly changed how young people interact with the outside world. A large proportion of youth engage in intensive smartphone use and media multitasking, leading to chronic sleep deprivation and poor results in cognitive control, academic performance, and socioemotional functioning. (Abi-Jaoude, Naylor and Pignatiello, 2020). Due to the accessibility of entertainment, information, and social media platforms, many young people tend to spend more time sitting and passively engaging in screen time. The decline in young people's levels of physical activity is one of the main effects of this sedentary lifestyle. Indoor, technology-based hobbies have replaced the traditional outside games and physical activities that were once popular. Many young people today spend more time on social media, streaming movies, playing video games, or just browsing the internet than they do playing sports or participating in physical play with peers (Abi-Jaoude, Naylor and Pignatiello, 2020).

Moreover, extended sitting or screen usage might harm mental health. Excessive screen usage has been linked in studies to a higher risk of sadness, anxiety, and sleep problems in adolescents. Additionally, feelings of loneliness and low self-esteem, and excessive technology use can lead to social isolation (Abi-Jaoude, Naylor and Pignatiello, 2020). Social media can affect adolescents' self-view and interpersonal relationships through social comparison and negative interactions, including cyberbullying; moreover, social media content often involves normalization and even promotion of self-harm and suicidality among youth (Abi-Jaoude, Naylor and Pignatiello, 2020).

1.2 STATEMENT OF PROBLEM

Despite widespread recognition of the significance of the health and well-being of young people, there are still major challenges that prevent the population from reaching its full potential. In Africa, poor health risks are higher compared to other developed parts of the world. Many factors come into play to contribute to these differences. According to WHO, in 2021 the probability of young people aged 10-24 dying was highest in sub-Saharan Africa and lowest in Europe and Northern America (World Health Organization, 2023). Furthermore, compared to North America and Europe, the average global likelihood of a 10-year-old dying before the age of 24 was around six times higher in sub-Saharan Africa. (World Health Organization, 2023).

Young people's health and well-being are not the sole responsibility of health professionals but a collective effort of society. Health inequalities must be drastically reduced and prevented, especially for the younger generation. There is therefore the need to recognize the many efforts of government and stakeholders aimed at enhancing and improving. However, we still compare badly internationally. Young people must be heard, seen, engaged, and involved to ensure that their health is improved for the better. Understanding and implementing comprehensive health and wellbeing programs, interventions, and services that respond to their very needs and development should be a priority.

A thorough grasp of the underlying causes and effective implementation methods is necessary to address the concerns of the health and well-being of young people in Ghana. The study is to investigate the current state of youth health and welfare in Ghana, some of the issues surrounding this subject, and the general obligation of society and youth to promote better health conditions for themselves for national development. By conducting in-depth research and implementing evidence-based interventions, we can strive towards creating an environment that is supportive of the promotion of the health and well-being of all young individuals in Ghana.

1.3 PURPOSE OF THE STUDY

This study aims to investigate and comprehend the current situation of health and well-being of young people in Ghana to bring improvement to this area. This study sought to:

1. Find out the importance of enhancing health and well-being for younger people in Ghana.
2. Identify the important variables that affect young people's health and well-being in Ghana, such as gender, age, socioeconomic status, and environmental factors, and comprehend the effects and implications of each.
3. Identify major risky behaviors that young people engage in that affect their health and well-being.
4. To provide suggestions and recommendations based on research to policymakers, healthcare workers, educators, and community organizations so they may create interventions and policies that will effectively improve the health and well-being of young people in Ghana.

5. Contribute to current research and advancements in the field of health and wellbeing and add to the body of knowledge by examining relevant research results.

1.4 RESEARCH QUESTIONS

1. What is the current state of health and well-being of young people in Ghana?
2. What are the key factors that influence the health and well-being of young people in Ghana?
3. How can young people in Ghana be encouraged to avoid risky behaviors that compromise their health and well-being?
4. How well-equipped are the current policies and actions in Ghana to improve the health and well-being of young people?
5. What policies and programs have been implemented in Ghana to support the health and well-being of young people in Ghana?
6. What recommendations and guidelines can policymakers, healthcare professionals, educators, and community organizations do to develop policies that will enhance the health and well-being of young people in Ghana?

1.5 SIGNIFICANCE OF THE STUDY

The study seeks to identify barriers and challenges affecting the health and well-being of young people in Ghana and ways to enhance the health and well-being of young people in Ghana.

Practical implications of the study's findings include identifying and addressing health disparities among young people as well as shedding light on the numerous factors that negatively affect young people's well-being and health in Ghana. The study identifies the dangers involved and advances our understanding of the numerous factors that contribute to the poor health of young people in Ghana. This information will give decision-makers guidance on how to improve healthcare procedures and ultimately raise the general health and well-being of young people in Ghana. Findings will guide health policies and educational initiatives designed to improve the health and well-being of young people in Ghana. The study makes suggestions to aid in creating plans to advance health equity and to create evidence-based treatments, assistance programs, and preventive measures to advance young people's mental well-being. To provide extensive and holistic care to

young people and secure their long-term health and well-being, it is imperative to comprehend the complex relationship between mental and physical health. The study thus provides the required information for policy decision-making, efficient resource allocation, and prioritization of youth health interventions to benefit entire communities, resulting in better youth health and well-being.

1.6 ORGANIZATION OF THE STUDY

The study was divided into five parts; Chapter one dealt with the introduction, which included a statement of the problem, the study's history, its objective, its goals, its research questions, its importance, and its delimitations. The literature review was examined in Chapter two and evaluated conceptually, theoretically, and empirically. The study methodology, research design, target population, study sample, sampling strategies, data collection methods, and a description of questionnaires were all covered in chapter three. The results of the study's outcome were the main topic of chapter four. The examination of the study's outcomes was a major focus of Chapter five. Chapter five also included a summary, conclusions, and recommendations. The chapter also made suggestions for future studies and research that may be conducted.

CHAPTER TWO

LITERATURE REVIEW

The study began by defining health and well-being, noting some of the difficulties facing Ghanaian youth, how these difficulties affect overall health and well-being, and the scarcity of research in this field over the years. This chapter aims to identify some empirical investigations conducted on the subject and provide a summary of the theories and models underpinning the research topics to close the knowledge gap. The study thoroughly explains these ideas because they are the main area of interest. Along with aiding in understanding the vital nature of analysis concerns voiced by many on how to improve the overall wellness of youth as they are the future generation.

This study revealed the research gaps in the body of literature on health and well-being. Much research has been done on just one aspect of young people's health—their mental health and well-being—and very little is known about the concept of health and well-being in Ghana, particularly about young people.

2. THE CONCEPTS AND DEFINITIONS OF HEALTH AND WELLBEING

2.1 Concept of Health

Answers to the question of what health is have proven to be difficult to come by. In the past, individuals believed that being healthy meant not being unwell, sick, or crippled. The difficult process of coming up with an accepted definition came to a conclusion when the World Health Organisation (WHO) defined health as a complete physical, mental, and social well-being and not only the absence of sickness or infirmity (WHO, 1948). Consequently, every human being is entitled to the most attainable health level, irrespective of race, religion, political beliefs, economic status, or social circumstances (WHO, 2001). Despite being widely and universally accepted, the WHO definition of health has its shortcomings and restrictions. With time, contemporary and modern health ideas began to acknowledge that being healthy goes beyond simply being free from illness or disability (Svalastog et al., 2017). According to the author of a British Columbia report on the health and well-being of children and adolescents, physical health and well-being are not limited to the absence of disease. This includes establishing a healthy foundation from conception onwards (breastfeeding, immunizations, prenatal care, maintaining healthy body weights and eating habits, accessing or avoiding preventive dental care,

preventing substance use and STDs, healthy development, secure environments, and more).

This is because many people will not satisfy the criteria set forth by the WHO's definition of "healthy" based on the word "complete" (Leonardi, 2018; Bircher and Kuruvilla, 2014). The fact that health cannot be viewed as a "state" but rather as a continual process of adjusting individuals to their environment and the demands of daily life is another critique of the definition of health given by the WHO. According to Warsop (2009), health is like a power that never stops operating in the background, enabling us to go about our daily lives.

2.2 Concept of Wellbeing

In philosophy, "wellbeing" refers to something that is actually advantageous to an individual. In the end, happiness is what makes a person's life go well, not instrumental goods like wealth, which are only useful to other people (Moorhouse, Plant, and Houlden, 2020). It is important to understand what ultimately makes life suitable since, in principle, well-being matters according to every ethical theory that can be reliably supported, and in practice, we go to great lengths to enhance our own and others' well-being (Moorhouse, Plant, and Houlden, 2020).

2.3 DIMENSIONS OF HEALTH OF WELLBEING

Wellness or good health has multiple facets. It has roughly seven interrelated dimensions: physical, mental, emotional, social, spiritual, intellectual, and vocational.

2.3.1 Physical Dimension

Being physically healthy can simply mean that all of a person's cells and organs are operating at their highest potential and in unison with one another. Physical dimension can also relate to a person's body's functional capacity. But there are steps you may take to keep your physical health in good shape. It entails incorporating exercise into a regular schedule, engaging in healthy routines like twice-daily tooth brushing, frequent hand washing, and maintaining cleanliness in one's surroundings; eating a balanced diet; checking the health of one's bones; getting enough rest or sleep; and maintaining a healthy body mass index (Laurier inspiring lives, 2023). When we state that a person is healthy, we typically speak to this dimension in concrete terms. Physical health is quite simple to recognize and define. It also entails taking responsibility for oneself, preventing sickness,

treating minor ailments, and recognizing when expert medical help is necessary. Some indicators of a person's physical well-being are their clean, bright skin, clear eyes, healthy hair, good oral and neutral-selling breath, regular menstruation cycles, regular bowel and bladder movements, adequate appetite, sound sleep, and other physical traits (Mirajkar, 2021). In this state, the body's organs should continue to function normally, and all senses—including hearing and sight—remain operational. The aspect of health that has drawn the greatest attention is this one.

2.3.2 Mental Dimension

Mental wellbeing is an essential component of total health and well-being. Our mental health encompasses our emotional, psychological, and social well-being (U.S. Department of Health & Human Services, 2020). It affects our feelings, ideas, and actions. This aspect of health is vital because it affects all phases of life—from infancy and adolescence to adulthood—by determining our responses to stress, interpersonal relationships, and decision-making (U.S. Department of Health & Human Services, 2020).

For us to perform our daily activities, we need to be in excellent mental health. The traditional understanding of the mind-body connection duality has been called into question in light of the overwhelming evidence in recent decades that there is a strong correlation between mental and physical health, making it impossible to separate the two (Crinson, 2007).

The nature of this interaction is reciprocal; physical and mental health are impacted by one another (Crinson, 2007). Asthma (Lehrer et al., 2002), gastrointestinal disorders such as peptic ulcer and ulcerative colitis (Salleh, 2008), and a positive correlation between life stress and heart attack and death (Tennant 1999) are just a few of the medical illnesses that have been related to stress.

We can engage in a variety of activities to improve our mental health, such as being mindful and concentrating on the present moment rather than dwelling on the past or the future, exercising frequently, getting enough rest, using relaxation or self-care techniques that work for you, engaging in creative and problem-solving activities, etc. (Laurier inspiring lives, 2023). Additionally, mental health is not just the absence of mental illness, as is true of health in general.

There are precise ways to evaluate mental health, but our understanding of it is still limited. However, there are some early indicators of mental health issues that can be taken into consideration, such as withdrawing from friends and routine activities, feeling hopeless or helpless, having little to no energy, having suicidal thoughts, and so on (U.S. Department of Health & Human Services, 2020).

2.3.3 Social Dimension

Health is more than just being physically and mentally healthy. A healthy person ought to fit in well with the community to which she belongs and ought to be able to contribute to that group's advancement. This aspect of health includes the person's capacity to see himself or herself as a part of a larger community and to embrace social norms and standards of conduct. Maintaining successful relationships involves many different abilities, including conflict resolution, boundary setting, assertiveness, respect for others, and the capacity to balance your time between social and personal needs (Melnyk and Neale, n.d.). According to the WHO definition, the three primary facets of health—physical, mental, and social well-being—are interdependent. Change in one of them typically results in changes in the other elements as well. For instance, being ill might impact your mental and social well-being. Similar to losing your appetite, if you are overly anxious about anything, your physical health may gradually suffer. Other aspects of health have existed that are not covered in the WHO definition. There are three of them: spiritual, emotional, and vocational. Though not clearly defined, these dimensions are gaining popularity. Other elements, such as philosophical, financial, cultural, environmental, educational, and intellectual, have been proposed but will not be considered in this study.

2.4 THEORIES OF WELLBEING

In contrast to advantages that are only advantageous when employed in a specific way, philosophers use the term "well-being" to refer to everything that is advantageous to an individual on its terms, often known as intrinsic or basic welfare goods (Utilitarianism.net, 2023).

For instance, pleasure directly improves your well-being and is therefore excellent for you. Money, on the other hand, can be used to purchase a variety of beneficial items, making it excellent for you indirectly but not directly. (We can also refer to things that are inherently unhealthy, such as suffering, as "welfare bads") (Utilitarianism.net, 2023).

The three categories of well-being theories are hedonism, desire satisfaction views, and objective list views (Parfit, 1984). There is substantial dispute even within each (Moorhouse, Plant, and Houlden, 2020).

2.4 .1 Hedonism

Hedonism gets its name from the Greek word 'hedone,' which means "pleasure."
Hedonism is the belief that happiness is simply a positive balance of happy and negative events (both broadly defined). The hedonistic perspective on pleasure is all-encompassing, covering not only traditional instances of sensory pleasure, like the feelings of 26 indulging in a delightful meal or having sex, but also other positively valenced experiences, like the feelings of problem-solving, reading, or helping a friend (Utilitarianism.net, 2023). According to hedonists, there is intrinsic value in each of these enjoyable experiences. The idea of hedonism holds that happiness is limited to an overall positive ratio of bad events to one good experience (both considered broadly). They are only valuable if they, in a sense, alleviate suffering and make people happier (Utilitarianism.net, 2023). To put it another way, we are at our best when we are filled with joy and pleasure.

2.4.2 Desire Satisfaction Theories

On the other side, theories of preference or desire satisfaction place emphasis on a person's enjoyment stemming from the satisfying of their desires (Moorhouse, Plant, and Houlden, 2020). Crucially, the reality that a desire is gratified is what is considered crucial, not the perception or feeling of a desire being fulfilled. Desire theories say that having what you desire, want, or prefer is what makes life easy.

While life satisfaction theories of well-being are typically seen to be separate from desire theories (Haybron, 2016), life satisfaction may, in reality, be a subset of desire theories.

2.4.3 Objective List Theories

According to all objective list theories, there are things that can make someone's life better but that they neither desire nor find enjoyable. Traditional things on this list include health, success, companionship, education, and ethical behaviour. Because they are focused on facts that transcend an individual's conscious experience and aspirations, these objects might be considered 'objective'. For example, depending on whether I value,

enjoy, or feel I am healthy, certain facts about my physical health may be accurate or untrue (Utilitarianism.net,2023). While proponents of objective list theory concur that there is a single authentic inventory of essential commodities, there is some disagreement among them regarding the specific things included in this exclusive list (Lauinger, 2021).

2.5 DETERMINANTS OF HEALTH

The health and well-being of an individual can be influenced by various variables. Our manner of living is the primary cause of several of these aspects that affect our general health. While the more widely recognised factors like access to and use of health care services frequently have less of an impact on health, a number of other factors, including where we live, the state of our environment, genetics, our income and education level, and our relationships with friends and family, all have a significant impact on health (WHO 2017; Physiopedia, 2015).

According to WHO the determinants of health include**:**

- the social and economic environment,
- the physical environment, and
- the person’s characteristics and behaviors.

2.5.1 Socio-Economic Determinants of Health

According to the World Health Organisation (WHO), "the conditions under which people are born, grow, work, live, and age, as well as the broader set of forces and systems shaping the 4 conditions of daily life," are social determinants of health. The elements of a person's life that have an impact on their health and well-being are known as the social determinants of health. They cover political, social, and cultural characteristics in addition to the ease with which one can obtain healthcare, education, a safe place to live, and nourishing food (Sherrell, 2021). These circumstances are influenced by the distribution of power, money, and resources on a global, national, and local scale (WHO 2012).

Significant factors affecting health include social and economic factors. Our biology, health-related behaviors, environmental exposures, and the availability and use of medical services are all influenced by a complex interplay between income, wealth, education, employment, neighborhood conditions, and social policies (Health of Washington State Report - Social and Economic Determinants of Health, 2013).

According to research published by the National Academy of Medicine, medical care only makes up 10–20% of the factors that influence a person's health outcomes (Magnan, 2017). In contrast, the various social determinants of health, which account for 80–90% of the contributing elements, have a significantly greater impact on a person's health (Sherrell, 2021). There are other components of a society's broader social and economic systems that affect health in addition to the healthcare system.

Social scientists refer to a person's socioeconomic position (SEP) as their rank or standing in the social hierarchy as well as the material and social resources that are available to them (Health of Washington State report - Social and Economic Determinants of Health, 2013). A large body of research shows that those with lower SEPs had greater death rates than those with higher SEPs (Lynch and Kaplan, 2000). Accordingly, being poor can be quite negative for health (Health of Washington State study - Social and Economic Determinants of Health, 2013). This is because people with lower SEPs die at earlier ages than those with higher SEPs (Health of Washington State study - Social and Economic Determinants of Health, 2013).

Marmot and Wilkinson (2003) discussed welfare policies and their effects on people's general health. They pointed out that there are a number of significant life changes, such as going from elementary to secondary school, starting a career, moving out and establishing a family, changing occupations and possibly experiencing layoffs, and eventually retiring. In every shift, those who have experienced disadvantage in the past are most in danger. Health is greatly influenced by socioeconomic factors from early childhood through adulthood. Lifelong health is impacted by poor social and economic conditions (Marmot and Wilkinson, 2003). Lower SEP can have negative health effects that start before birth, build up over time, and last for the rest of a person's life (Wilkinson, 2006). In addition to a person's SEP, the typical level of a neighborhood’s average level of income and education also influences health (Chaix et al.,2007). Recent research reveals that low birth weight, which affects neonates more frequently in low SEP women than in high SEP women, raises the risk of diabetes and coronary heart disease (Barker, 2005). According to a growing body of studies (Braveman et al., 2010, Anda et al., 2006, Shonkoff, 2007), bad childhood experiences can disrupt immunological and brain development, which can have an impact on one's long-term health.

2.6 SOCIAL CONTEXT OF YOUNG PEOPLE'S HEALTH AND WELL-BEING

Understanding how social variables affect or influence can help the numerous efforts being made to ensure that young people have healthy lives. A study by HBSC found a connection between possibilities to enhance young people's health and a range of social environment-related factors. Family communication, peer relationships, school climate, income of parents or family status, age, and gender. neighborhood or residence zone, are only a few of these variables.

All of the previously listed components are vital to the growth and development of young people and have a substantial influence on their overall well-being. However, for the sake of this study, just a select few of them will be taken into account and discussed.

2.6.1. Family

The family will be covered as the first social factor. In order to build the family as a protective unit, parent-child contact is crucial. In their study on parenting and mid-childhood, Waylen and Stewart-Brown (2008) noted that family support helps children deal with stressful situations and protects them from the detrimental effects of some outside influences. In addition, adolescents who say they can communicate with their parents easily are more likely to report some favorable health outcomes, including better self-rated health and more life satisfaction (Moreno et al.,2009) and fewer physical and psychological complaints (Woodhard et al., 2003).

Young people who have absent or abusive parents, on the other hand, may experience emotions of loneliness that are harmful to both their health and well-being (Sherrell, 2021). A more powerful predictor of good health is the accumulation of support from parents, siblings, and peers: the greater the number of sources of support, the more probable it is that the children will enjoy good health (Molcho et al., 2007). Therefore, according to the HBSC study by Currie and colleagues, professionals working on young people's health should not just address health issues directly but also consider how families might assist in the development of health-promoting behaviors. Parental control and support have been associated with lower tobacco and marijuana smoking (Borca et al., 2017) and lower substance use (Hagell et al., 2018). Parental support has also been demonstrated to have a protective influence on health.

Age dramatically reduces how easy it is to communicate with parents. As children get

older, their parents' influence wanes while their classmates' effect grows (Santrock, 2007). Children's general health and well-being can benefit from parents' investments in effective communication (Steinberg and Silk, 2002).

2.6.2. Neighbourhood

Better mental health, more health-promoting behaviors, fewer risk-taking behaviors, better overall perceptions of health, and a higher likelihood of physical activity are all created by neighborhoods with high levels of social capital (WHO, 2008; Boyce et al, 2008).

The surroundings and housing a person lives in have a big impact on their general health. Transportation, access to nutritious foods, water quality, crime, and violence are a few examples of environmental elements that might affect wellness (Sherrell, 2021). The author also pointed out that many people all around the world reside in locations with high levels of violent crime, pollution, and hazardous drinking water. Additionally, marginalized ethnic and racial groups, as well as people from low-income households are more likely to reside in areas where these hazards are present (Sherrell, 2021).

2.6.3. Perceived school performance

Perceptions of students' academic performance are a reliable and significant predictor of their health and happiness (Suldo, Riley, and Shaffer 2006). According to Suldo and Huebner (2006), students who report higher levels of success also report higher levels of life satisfaction, lower rates of bullying, fewer subjective health complaints, and fewer health-compromising behaviors.

A wide range of non-academic outcomes, including health, health behavior, and well-being, can be impacted by students feeling pressured or anxious about their schoolwork, in addition to having a detrimental impact on their learning (Currie et al., 2009). Affected students typically engage in more health-harming behaviors (such as smoking, drinking alcohol, and intoxication), experience more frequent physical complaints (such as headache, abdominal pain, and backache), and have psychological issues (such as feeling depressed, tense, and nervous), according to Torsheim and Wold (2001); Simetin et al. (2010).

2.6.5. Age

During adolescence, young people's health decisions, including eating habits, physical

activity levels, and substance use, alter. Health disparities develop or deteriorate during this stage of development, which results in ongoing health issues and disparities as adults (Woodward et al., 2003). The age inequalities confirm the notion that investments in youth must be sustained to consolidate the successes of early childhood interventions and have significant implications for the timing of health interventions (Unicef Staff, 2011). This is crucial for people as they develop, but it's also crucial for maximizing the results of early investment programs and minimizing the financial costs associated with health issues (Currie et al., 2009).

2.6.6. Gender

Boys' and girls' results from earlier HBSC reports in 2004 were presented separately, giving strong support for gender disparities in health that have persisted or changed over time (Currie et al. 2009). Boys often participate in more externalizing or expressive types of health behaviours, like drinking or fighting, whereas girls typically deal with health difficulties in a more emotional or internalizing fashion, which frequently presents as psychosomatic symptoms or mental health issues. According to Currie et al. (2009), gender disparities in size vary significantly across different countries. For instance, gender differences in psychological and physical symptoms are more pronounced in nations with poor scores on the gender development index (Haugland, 2001). These results highlight the need to include macro-level socio-contextual variables in research on gender health disparities in young people (Torsheim et al., 2006).

2.6.7. Family Affluence

Studies have found family affluence to be an important predictor of young people's health. In general, the cost may restrict families' opportunities to adopt healthy behaviors such as eating fruit and vegetables (Richter et al., 2009; Vereecken et al., 2009) and participating in fee-based physical activity (Zambon et al., 2006). Young people living in low-affluence households are less likely to have adequate access to health resources (Nic Gabhainn et al., 2009) and are more likely to be exposed to psychosocial stress, which underpins health inequalities in self-rated health and well-being (Kuusela et al., 1999). The distribution of wealth within countries also significantly affects young people's health (Currie et al., 2009). In general, young people in countries with large differences in wealth distribution are more vulnerable to poorer health outcomes, independent of their individual family wealth (Holstein et al., 2009; Torsheim et al., 2006; Torsheim et al.,

2004).

The health of young people is greatly impacted by the wealth disparity within nations (Currie et al., 2009). Independent of their individual family wealth, young people in nations with wide disparities in wealth are generally more susceptible to poorer health outcomes (Holstein et al., 2009; Torsheim et al., 2006; Torsheim et al., 2004).

2.7 THE SIGNIFICANCE OF ADOLESCENCE AND YOUNG ADULTHOOD ON HEALTH AND WELLBEING

When adolescents (ages 13 to 17) make the transition to adulthood, their social surroundings and social roles undergo a great deal of change. These changes are likely to hurt the trajectory of healthy behavior. Teenagers who live with parents generally suffer school and home consequences for smoking or binge drinking (Johnston et al. 2008a), which is one of the few challenges to good behavior that they encounter. Parents keep an eye on their children to ensure that they eat healthily, get enough sleep, and live in a setting where parents and peers encourage abstinence from drinking and smoking (Johnston et al. 2008a). Studies of individual healthy behaviors show that between the ages of 18 and 25, which is the time of the transition to maturity, there is an overall decline from levels during adolescence (Park et al. 2008; Harris et al. 2006). These decreases are believed to be related to young adults' growing independence and waning parental supervision. Young adults are still much more likely than adolescents to engage in risky behaviors, and they frequently struggle to establish regular eating and sleeping schedules, which results in lower levels of exercise, weight gain, irregular eating schedules, and insufficient sleep (Johnston et al. 2008b; Nelson & Barry 2005; Hicks et al. 2001). This is true even though young adults report accepting responsibility for their actions as they become more independent (Arnett 2000). Peers rather than parents serve as the primary socializing agents for certain young adults (McDermott et al. 2006), and some young adults do not often identify as adults (Nelson & Barry 2005; Arnett 2000). Risky behaviors and alcohol and drug testing permitted in this environment are more common (Johnston et al. 2008a, 2008b; McDermott et al. 2006), and the level of supervision from parents or other authorities drops (White et al. 2006). As a result, both an increase in risk-taking and a decrease in health-promoting behaviours take place throughout the transition to young adulthood. According to Harris et al. (2006), young adults between the ages of 18 and 25 are more likely to experiment with drinking and smoking than they are to

exercise and eat healthily than they were as teenagers. Psychosocial resources and physical health have a direct impact on adolescents' healthy behaviors; psychological discomfort, low self-efficacy, and poor health or functional limits hinder people from adopting healthy habits (Bandura 2004; Resnick et al. 1997). Peers and parents serve as teenagers' primary socializing agents, while homes and schools serve as the key venues for social interaction (Crosnoe 2004; Barber and Olsen 1997). The larger social environment has an impact on these personal resources. As a result, relationships with parents and peers, as well as factors related to the school and the family of origin, have been shown to affect a variety of adolescent outcomes, such as academic success, emotional well-being, and propensity to engage in risky behaviors (Cleveland et al. 2008; Bond et al. 2007; Crosnoe and Elder 2004; Barber and Olsen 1997). In the opinion of Henry and Slater (2007), McNeely and Falci (2004), and Resnick et al. (1997), adolescents' likelihood to drink alcohol, smoke, engage in delinquency, and start using drugs is influenced by their school connectedness, which is defined as feeling a sense of belonging to a school, feeling safe at school, and feeling that one is treated fairly at school. Peers and peer support can either discourage or encourage risky behaviors like smoking and drinking, and they can have an impact on psychological well-being (Johnston et al. 2008a; Bond et al. 2007; McNeely & Falci 2004; Barber & Olsen 1997; Resnick et al. 1997). Peers and peer support can also exert simultaneous and frequently conflicting influences on adolescents (Crosnoe 2004). However, it is unclear if these factors alter or remain constant over time as social surroundings do.

2.8. HEALTH AND ADVERSE CIRCUMSTANCES IN GHANA

2.8.1 Health and Health behaviors exhibited among young people in Ghana.

More focus is being placed on addressing the behavioral health needs of the population, especially young people, as African children and adolescents get older and soon become the primary drivers of the educational, economic, and health well-being of nations across the continent (Ssewamala, Ozge Sensoy Bahar, and McKay, 2021) According to UNAIDS 2014, Sub-Saharan Africa (SSA), which is home to 71% of all HIV-positive people globally, continues to be the region with the greatest impact from the HIV epidemic. It should be noted that the HIV/AIDS epidemic is still spreading among young people, with teenagers being the only age group where the prevalence of HIV appears to be increasing (UNAIDS, 2013). For instance, the Health Beliefs Model, which is primarily social

cognitive in orientation (Becker & Mainman, 1975; Becker et al., 1977; Rosenstock, 1966), has formed the foundation for the majority of HIV intervention programs.

The core causes and effects of persistent poverty, violence, and co-occurring mental health issues, including depression and trauma, have not yet been adequately addressed by many attempts in SSA, including Ghana (Ssewamala, Ozge Sensoy Bahar, and McKay, 2021). There is also very little research aiming at increasing the health and health behaviors of these young people and eventually their general health and well-being.

Harris and colleagues (2006) tracked the health and health behaviors of adolescents as they entered early adulthood using data from the National Longitudinal Study of Adolescent Health. They stated that, despite some positive health trends, the main trend was declining health, which was mostly evident in health habits and related health statuses. They continued by stating that young people are less likely to regularly engage in physical activity, exercise, and eat breakfast. However, they have a higher propensity to eat fast food, binge drink, use marijuana and other hard drugs, contract STDs, and smoke cigarettes (Harris et al., 2006).

Investments in young people's health, especially mental health, will enable society to achieve future advantages that will materialize in increased national productivity and economic growth because young people are future leaders, innovators, and reformers (Asampong and Ibrahim, 2022). It is therefore crucial that developing nations like Ghana are concerned with the healthy raising of children, their well-being, and their general development, and give behavioral health the required attention and resources starting at a young age. Sadly, despite what we know, Ghana is one of the majority of African nations that neglect attempts to address child behavioral health (Asampong and Ibrahim, 2022).

In past times, biological parents were not the only ones who had to take care of their offspring. Everyone in the household and community did regulate and supervise children to some extent (Dzramedo et al., 2018). Therefore, the socialization of children as they progress through the developmental stages is the responsibility of both parents and community members (Asampong and Ibrahim, 2022). For instance, one can arrive home from school while the parents haven't left for work or from the farm (Asampong and Ibrahim, 2022). Therefore, until the parents came home, these kids would be cared for by neighbors or other members of the neighborhood. It is important to note that in our culture, it was typical for some family elders to reprimand a youngster in our Ghanaian

neighborhoods, and upon the child's parents' return, they would prefer to express their gratitude to elders for instilling discipline in the child (Asampong and Ibrahim 2022). However, parents are now more likely to get into an argument with anyone who corrects their kids when they're not around, which eventually discourages kids from being disciplined as they get older, especially if their parents or guardians aren't around. According to Awinongya (2013), the extended family system is a social structure in which people have wide-ranging obligations and responsibilities to their relationships outside of the nuclear family. Caring for non-biological children was common back then when the social support system was so powerful and effective (Boakye-Boaten, 2010). But as times change, some social and cultural standards start to disappear. For instance, the exponentially expanding rural-urban migration has had a significant negative impact on otherwise stable traditional structures, thus making some children to be cared for by other people and institutions other than their lineage groups (Asampong and Ibrahim, 2022). According to James and Roby (2019), this has the potential to expose such kids to a variety of difficulties that may leave them unhappy and deprived of the care and attention they require.

2.9 ADVERSE CIRCUMSTANCES EXPERIENCED BY YOUNG PEOPLE IN GHANA AND SOME POLICY INTERVENTIONS

2.9.1. Lack of Education and Training

The Ghana Statistical Service (GSS) made public its monthly press release, which provided alarming insights on the educational and job circumstances of the youth population in the nation. The Third Quarter Labour Statistics Report of the Annual Household Income and Expenditure Survey 2022 states that, in Ghana more than 20% of young people between 15 and 24 years were found to be not in education, employment, or training (NEET) in the third quarter of 2022 (Graphic Online, 2023).

More than half of the young NEET population was found in the Greater Accra, Ashanti, Eastern, and Central areas. Greater Accra had the largest number of NEETs at 312,394, closely followed by Ashanti at 300,161 (Graphic Online, 2023). Among this age group, a slightly higher percentage of females (12.0%) had never attended school compared to males (10.2%) (Graphic Online, 2023).

According to Ghana's Constitution of 1992, which is found in Article 25 1b, "Secondary education in its different forms, including technical and vocational education, shall be

made generally available and accessible to all by every appropriate means, and in particular, by the progressive introduction of free education."

The government and the Ministry of Education have made it a priority to guarantee that education is made free from the primary to secondary levels in order to provide more students in Ghana with the opportunity to get high-quality education. When the Free Senior High School program was implemented in September 2017, the Ministry accomplished a noteworthy milestone. That year saw an 11% rise in enrolled students, breaking prior records. With nearly 470,000 pupils enrolled in senior high school, the 2017–18 academic year set a record for senior high school enrollment in the country (The Ministry of Education). This government initiative has bridged the educational gap between the poor and rich as well as those living in rural and urban communities.

The Technical and Vocational Training (TVET) sector has faced numerous difficulties over the years, but as a key driver of our nation's industrialization program, the Ministry is dedicated to making sure that people have the useful skills required for success (The Ministry of Education, Ghana). The TVET industry has experienced an image crisis over the years due to the public's belief that it is a haven for students who lack academic aptitude (The Ministry of Education, Ghana). The government is committed to establishing at least two cutting-edge TVET centers in each region with cutting-edge equipment to equip and enhance young people's creative skills and talents.

2.9.2. Involvement in Economic Activities

It is not unusual to observe young people hawking during times when they are supposed to be in school in various regions of the nation. According to the 2013 Ghana Living Standard Survey (GLSS), 28.8% of children between the ages of 5 and 14 were economically active and employed at the time, while 70.1% were not engaged in any economic activity (Ghana Statistical Service, 2014). The majority of those children's occupations included domestic help, mining and quarrying, apprenticeships, and the services sector. There are typically related repercussions, such as a decreased dedication to learning as seen by student attendance, enrolment, and performance (Odonkor, 2007).

More than three-quarters of the population 15 years and older is economically active (77.1%). The proportion of economically active males (79.8%) is higher than females (74.9%). The population in rural areas is also more likely than those in urban areas to be economically active. (Ghana Statistical Service, 2014). Approximately 75% of people

who are 15 years of age or older work, with the bulk of them working in services (40.9%) and agriculture (44.7%). According to Ghana Statistical Service (2014), own account workers (46.4%) and contributing family workers (22.3%) make up over two-thirds (68.7%) of the working population.

2.9.3. Old Cultural Norms and the Effects on young people's health and wellbeing

Some young people are trafficked from poorer regions of the country to other areas where they are forced into exploitative labour and other practices such as early marriage, and female genital cutting, all of which are detrimental to children's behavioral health (UNODC, 2019). Despite the influence of education carried out, puberty rites that are performed to usher girls from puberty to womanhood are still carried out in some parts of Ghana. For instance, the Dipo rites of passage as practiced by the Krobos of the Eastern part of Ghana. Early marriage for instance is linked to negative health consequences for children such as poorer maternal and reproductive health, increased risk of HIV and other sexually transmitted infections, intimate partner violence, and maternal mortality (Kidman, 2016). This is unfortunately a common practice in some parts of the country. Although the legal age for girls to marry is 18 years, nearly 6% of girls between the ages of 12 and 17 years are married (Domfe and Oduro, 2018).

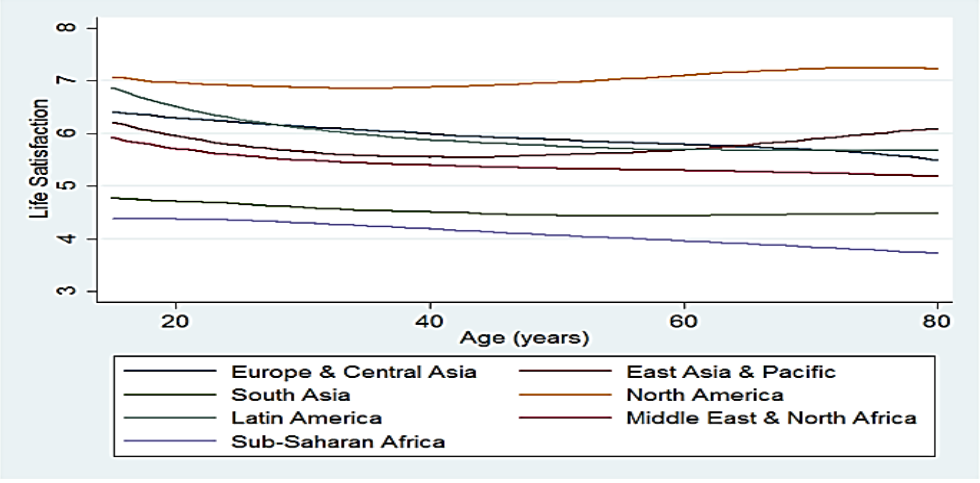
Ghana has created several national policies that all work to ensure the well-being of children. The Ministry of Gender, Children, and Social Protection exists, which is another sign that the importance of young people in the nation cannot be overstated. Practically speaking, however, it cannot be argued that the level of focus on children's behavioral health that is now being given has achieved the desired level. There are no designated locations where young people with behavioral health issues can go to get care without being subjected to stigma (Asampong and Ibrahim, 2022).

In addition, Asampong and Ibrahim offered suggestions that should be taken into account in order to enhance behavioural health and wellbeing. They recommended that behavioural health units be established in every regional and district hospitals in order to provide behavioural health treatments. This will guarantee that behavioural healthcare treatments are distributed fairly and easily to all the regions. Extensive and ongoing research is also required to address behavioural health issues and to promote and avoid them. Collaboration amongst academics, other health institutions, and NGOs will be necessary for this.

2.10. LIFE SATISFACTION AMONG YOUNG PEOPLE

Except for South Asia and sub-Saharan Africa, where overall levels of life satisfaction are already incredibly low compared to the rest of the world, there is no other age range at which life satisfaction declines as rapidly as between the ages of 15 and 24 (Handa, Pereira, and Holmqvist, 2023). The decline in young people's life satisfaction tends to be more pronounced the more economically developed the location, according to a consistent pattern that has been identified (Handa, Pereira, and Holmqvist, 2023). The patterns shown in Fig.1 illustrate life satisfaction among young people by region, considering all that adolescents and young people go through medically, emotionally, and socially.

Figure 1: The Rapid Decline of Happiness: Exploring Life Satisfaction among Young People by Region

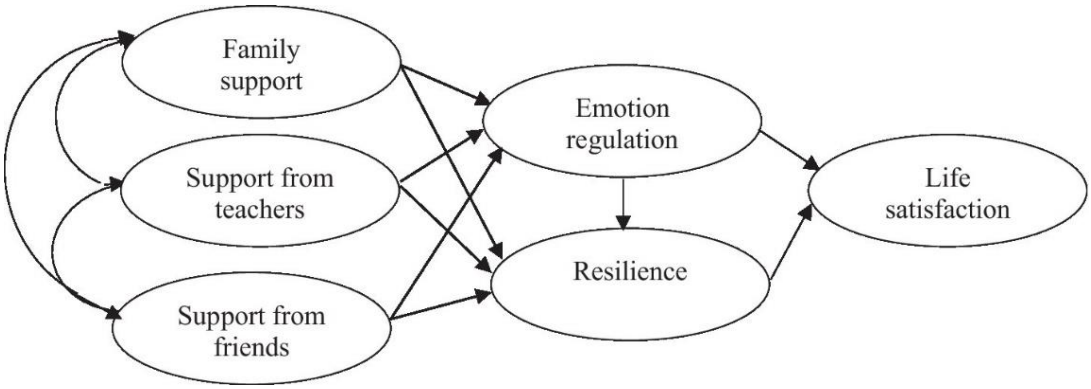


Although a fair amount of research has been carried out in this field with adults, less attention has been paid to adolescents (Tian, Wang and Huebner, 2014). Therefore, identifying the factors that contribute to life satisfaction will help promote positive development during adolescence. Given that some studies have found a notable decrease in well-being during adolescence (González-Carrasco et al., 2017; Orben et al., 2020), as a result of the biological and psychosocial changes associated with this life stage (Morrish et al., 2019), it is vital to identify the factors that boost life satisfaction, which, according to Diener et al., (2017), is a key cognitive dimension of hedonic subjective well-being. Cejudo and colleagues (Cejudo López-Delgado and Rubio, 2016) conducted research that shows that psychological assets such as emotion regulation and resilience influence how individuals in this age group assess their life satisfaction.

The influence of social support may vary depending on the particular source of support analyzed, according to some studies that claim psychological assets like emotion regulation (You et al., 2018) and resilience (Rodrguez-Fernández et al., 2016a) mediate the relationship between the various types of social support and life satisfaction. According to some academics, family support is more important than assistance from friends or teachers for both teenagers' good growth and their ability to control their emotions (Rueger, Malecki, and Demaray, 2010; Siddall, Huebner, and Jiang, 2013). However, a different group of scientists finds that even more than family support, support from friends is a significant predictor of resilience (Park and Park, 2020).

The authors (Azpiazu Izaguirre, Fernandez, and Palacios, 2021) presented a theoretical model describing the interrelationship between the determinants of life satisfaction among young people as shown below.

Figure 2: Proposed theoretical model.



CHAPTER THREE
RESEARCH METHODOLOGY

3.1 INTRODUCTION

One crucial component that serves as the foundation for the investigation is the research methodology used in a study. This section offers a thorough discussion of the study methodology, ethical considerations, data collection techniques, and analysis approaches.

3.2 RESEARCH DESIGN

The study's overall structure and technique are shaped by the research design, which serves as the structural framework. When considering enhancing the health and well-being of Ghana's youth, careful study design selection becomes imperative.

A descriptive survey design refers to the collection of standardized information from a specific population including their characteristics, opinions, attitudes, or previous experiences by asking questions and protocolling answers (Cohen, Manion & Morrison, 2011). In addition, the quantitative component of the study makes use of surveys and evaluations to get a more complete picture, which makes it easier to draw conclusions that apply to more than just the specific cases that were looked at (Creswell & Creswell, 2017).

Using a quantitative procedure is in line with current social science research trends strategically. The study which aims to comprehend and improve the health and well-being of Ghanaian youth, calls for an all-encompassing strategy that can adequately capture the breadth and depth of the phenomenon being studied. The chosen design is a purposeful tactic to enhance the study's validity, reliability, and overall contribution to the area, not just a methodological decision.

3.3 STUDY AREA

Making the right choice for the study area is essential to guarantee that the research findings are applicable and relevant. Within the framework of examining the health and well-being of Ghanaian youth, this research focuses on two separate areas known for their distinct socio-economic and cultural features: Ashanti and Central Regions. Recent assessments from the World Health Organization (WHO) and the Ghana Health Service (GHS) indicate that these regions face a variety of health concerns for young people, from

unequal access to educational resources to insufficient healthcare facilities (GHS, 2021; WHO, 2022).

The Central Region is known for its historical significance as a significant hub for trade and education. It is located along the Gulf of Guinea. Conversely, Ghana's most populated region, Ashanti, is situated in the country's center and is well-known for its rich cultural legacy (Ghana Statistical Service, 2020).

These locations' demographic variety and the pervasive health inequalities among youth motivate the choice to carry out a case study there. Both regions show unique patterns of health concerns among the youth, according to a recent study by Addo et al. (2020), which makes them appropriate focal points for an in-depth investigation into variables impacting the health and well-being of this group. Moreover, these areas' inclusion follows Ghana's National Adolescent Health and Development Strategy (MOH, 2016), which outlines the country's overall health objective. This approach highlights the need to attend to the health needs of youth, promoting focused interventions and policies that take local differences into account.

The decision to conduct a case study in these areas is driven by the demographic diversity of the area and the widespread health disparities among young people. According to a recent study by Addo et al. (2020), Ashanti and Central regions both exhibit distinctive patterns of health issues among the youth, which makes them suitable focal points for an in-depth investigation into determinants impacting the health and well-being of this population. Additionally, the inclusion of these categories aligns with Ghana's overall health goal as stated in the National Adolescent Health and Development Strategy (MOH, 2016). This method emphasizes the need to attend to young people's health needs by supporting targeted treatments and localized policies.

The selection of Central and Ashanti as the study regions aims to contribute to a wider knowledge of the health and well-being concerns encountered by young people in Ghana by offering insights that go beyond localized consequences. The selection of these areas improves the study's external validity by enabling the application of findings to other comparable situations across the nation. The choice is in line with government policies and is supported by recent data that highlight health issues that young people in these

regions face. This puts the research in a position to significantly improve the health and well-being of Ghanaian youth.

3.4 DATA COLLECTION METHODS

3.4.1 Population and Sample

Any study's robustness depends critically on properly defining the population and choosing a representative sample (Creswell & Creswell, 2017). The target demographic of persons in Central and Ashanti who are between the ages of 15 and 24 was carefully selected to improve the health and well-being of young people in Ghana. This choice stems from an understanding of the health issues this age group faces (Patton, 2015).
To ensure variety within the sample and represent the diverse urban and rural contexts of both regions, a simple random sampling procedure was adopted.

It is essential to justify the significance of the sample size determination procedure.
(Cohen, Manion & Morrison, 2011) stated that the quality of research is determined by the appropriateness of technique and instrumentation, as well as the suitability of the sampling strategy utilized. The sample size was determined using simple random to avoid the high risk of research biases like sampling bias and selection bias. Participants were carefully selected from urban and rural areas. Also, the researcher employed the services of two teachers each from the two regions who participated in the data collecting.

3.4.2 Data Sources

A careful selection of data sources is necessary for the thorough investigation of health and well-being. A dual strategy using primary and secondary data sources was used in this investigation. Primary data guarantees a first-hand account of the experiences of the participants and is gathered through questionnaires, interviews, and physical health assessments (Creswell & Creswell, 2017). This methodology is consistent with the current recognition of the value of firsthand data collected from people who are directly experiencing a certain phenomenon (Creswell & Creswell, 2017).

3.4.3 Questionnaire Development

Carefully crafting the survey instrument is essential to guarantee the accuracy and consistency of the information gathered (Dillman et al., 2014). To make use of the psychometric qualities of already-existing instruments, questions were developed using preexisting, validated scales (Fowler Jr., 2014). To improve and validate the questionnaire, a pilot test with thirty participants was carried out (Creswell & Creswell,

2017).

A questionnaire was designed to collect data on the health and well-being of young people in Ghana. The instrument consisted of four sections. The first section assessed young people's well-being which consisted of HRQoL and satisfaction with life scale. The second section consisted of questions on factors that affect health and well-being. This included risky behaviors, access to health care, family and support systems, and health behaviors. The third section asked respondents about their knowledge of policies and programs available to Ghanaian young people. The fourth and final section comprised the socio-demographic profile of respondents.

HRQoL was measured using the EQ-5D-5L. This instrument measures the health status of individuals by providing the opportunity to rate their overall current health in five dimensions, with each dimension consisting of five response levels where the participants tick one of the five responses that best describes their current health under each dimension (EQ-5D-5L User Guide, 2019). The five dimensions include mobility, Pain/Discomfort, Self-care, Usual activities, and Anxiety/Depression.

To measure well-being satisfaction with life scale (SWLS) was used It is a short 5-item instrument used to measure an individual's satisfaction with life (Diener et al., 1985). Participants were asked to indicate their level of agreement or disagreement by ticking the appropriate box from strongly agree to strongly disagree.

To access factors that influence health and well-being, questions on the support of family and friends were asked. Health behaviors such as physical exercises, nutrition, hydration, and sleep/ rest were assessed. Participants' involvement and knowledge of risky behaviors such as substance abuse, unsafe sexual practices, and alcohol drinking were enquired. Additionally, questions on access to health care and support systems were asked.

Finally, to test their knowledge of policies, programs, and interventions available to young people, questions were asked about their awareness of any policy and intervention by the government to improve young people's health and well-being. Respondents were also allowed to rate their overall health based on their responses with a scale numbered from 0 to 100.

The sociodemographic profile of the sample was assessed by variables such as sex, age, region of residence, current educational level, family structure, and, whether they live in a rural or urban neighborhood.

In total, 40 questions were presented in English Language to respondents for the survey. The questions employed the use of close-ended and a few open-ended questions as well as the use of dichotomous and 5-point Likert scales (satisfaction, good-bad, frequency, likelihood, agreement, effectiveness) in which respondents were required to select a particular level of agreement or disagreement. The clarity and comprehensibility of the questionnaire were improved by appropriate revisions based on feedback from the pilot test.

The instrument's clarity and comprehensibility were improved by appropriate revisions based on feedback from the pilot test.

3.5 DATA ANALYSIS

To convert gathered data into insightful conclusions, the data analysis process is essential (Creswell & Creswell, 2017). A modern, rigorous method of data analysis that included quantitative and qualitative aspects was chosen to improve the health and well-being of Ghana's youth.

3.5.1 Statistical Methods

Using the Statistical Package for the Social Sciences (SPSS), a comprehensive statistical analysis was carried out on quantitative data. To make sense of the patterns and correlations in the dataset, both descriptive and inferential statistics were applied. Descriptive statistics, such as measures of central tendency (mean, median), frequencies, percentages, and dispersion (standard deviation, IQR, and interquartile range), were first used to summarise the dataset. These descriptive measures, which offered valuable information on the distribution and characteristics of the variables under consideration, set the groundwork for subsequent inferential investigations.

Inferential statistics, such as Pearson Correlation Coefficient, and T-tests/Anova were then used to measure the correlation between two sets of data, whereas descriptive statistics were first used to give a clear perspective of the dataset. The study questions and objectives informed the choice of particular statistical procedures, demonstrating a sophisticated comprehension of the analytical instruments (Creswell & Creswell, 2017).

According to Creswell & Creswell (2017), the study's research questions and aims informed the selection of certain statistical techniques, demonstrating a sophisticated comprehension of the analytical instruments most appropriate for addressing the hypotheses being examined. This project intends to give a thorough knowledge of the determinants impacting young people's health and well-being in Ghana by utilizing a combination of descriptive and inferential methodologies. This will help inform evidence-based policies and intervention initiatives.

3.6 RESEARCH RIGOR AND VALIDITY

The validity and rigor of the research are crucial for the study conclusions to have credibility (Creswell & Creswell, 2017). Many steps were taken to strengthen the validity and rigor of research to improve the health and well-being of Ghanaian youth. To ensure variety in research samples, the sampling approach was created with representativeness in mind, utilizing data from both urban and rural contexts (Creswell & Creswell, 2017). To reduce enumerator bias and increase the dependability of the data collected, random checks were included during the data-collecting process (Guest et al., 2006). For a nuanced interpretation of the results, it is essential to acknowledge potential biases, such as self-reporting bias, honesty in reporting, and resolving constraints (Maxwell, 2013). Together, these metrics support the study's scientific rigor and strengthen the findings' applicability to Ghana's juvenile health and well-being.

3.7 ETHICAL CONSIDERATIONS

The inquiry was carried out strictly in accordance with ethical guidelines. With a focus on the significance of their voluntary participation and the confidentiality of their responses, each participant provided their informed consent. Security protocols were implemented to guarantee the privacy of participants and the integrity of their information. Furthermore, the appropriate institutional ethics committee examined and approved the study procedure. Every possibility of harm to the participants' health was reduced, and measures were implemented to protect more susceptible populations. As per ethical guidelines for research, participants' autonomy, dignity, and rights were upheld to the highest degree during the whole procedure (Creswell & Creswell, 2017).

3.8 DATA MANAGEMENT

Important steps in the research process that significantly impact the reliability and

consistency of study findings include data management, storage, and security (Creswell & Creswell, 2017). To enhance the health and well-being of Ghana's youth, meticulous data processing was employed in this study.

Establishing a methodical coding approach improved the dataset's coherence and accessibility through data organization (Creswell & Creswell, 2017). This is consistent with current methodologies that highlight the need for methodical data organizing for effective analysis (Maxwell, 2013). It is not only a sensible decision to store data in safe electronic databases, but it also protects against data loss and unwanted access (Dillman et al., 2014). In order to preserve important research data, regular backups were performed, which is currently considered a best practice in data management (Creswell & Creswell, 2017).

As a crucial component of data management, data cleaning required thorough examinations for anomalies and inconsistencies, which enhanced the dataset's general dependability (Creswell & Creswell, 2017). This methodical approach to data cleaning aligns with current perspectives on the significance of high-quality data in generating reliable research findings (Guest et al., 2006).

Overall, the data management practices used in this work are compliant with current research technique standards. The focus on organized systems, safe storage, and thorough data cleansing is indicative of a dedication to generating high-caliber research results concerning the health and welfare of young people.

3.9 SUMMARY

In summary, the study approach investigated possible ways that young people in Ghana could enhance their health and well-being using a meticulous and demanding methodology. The study's validity and its contribution to the body of knowledge are ensured by the integration of qualitative and quantitative approaches, methodological reflection, and ethical considerations.

CHAPTER FOUR

RESULTS

4.1 INTRODUCTION

The analysis and findings of the study that investigated the health and well-being of Ghana's young people are presented in this chapter. The analysis and interpretation of data were carried out based on the five (5) research objectives. The analysis was based on the 100% return rate data obtained from 250 students. The quantitative data were analyzed using descriptive statistics (means, standard deviations, median with IQR, frequencies, and percentages) and correlation coefficients (Pearson Correlation Coefficient,). The chapter starts with a summary of the respondents' demographic characteristics before analyzing data for the study objectives.

4.2 DEMOGRAPHICS OF RESPONDENTS

Table 4.1 below provides a demographic profile of the 250 respondents, including information on their age, gender distribution, employment status, educational attainment, place of residence (urban and rural), family structure, and size of household.

Table 4.1: Demographic Profile of Respondents

Quantitative Variable(s)	**Summary Statistics**	
Age	**Median (IQR)**	20.00(18-22)
Members in household	**Median (IQR)**	5.0 (4-7)

Qualitative variable(s)	**Frequency**	**Percentage (%)**
Gender		
Male	125	50.0
Female	125	50.0
Current educational status		
Senior High School	117	46.8
Tertiary level	133	53.2

Region of residence		
Central	123	49.2
Ashanti	127	50.8
Area of residence		
Rural	96	38.4
Urban	154	61.6
Family structure		
Nuclear family	168	67.2
Extended family	54	21.6
Single parent	28	11.2
Total	**250**	**100.0**

Field Survey (2024). IQR – Interquartile range.

The sample was made up of 250 individuals between the ages of 15 and 24 years old. Table 4.1 presents a detailed analysis of participants based on several demographic parameters. The data show a median age of 20 with falls in the IQR (18-22). The median for household members is 5 with an IQR of (4-7).

Moreover, the frequencies and the percentages of the qualitative variables are also presented. The respondents are divided into male and female, each accounting for 50% (125 individuals), the gender representation in the responder pool is balanced. This is to ensure gender inclusiveness in the research. Another major aspect differentiating respondents based on their academic ambitions is their educational level, the data includes respondents with different educational backgrounds. 117 respondents (46.8%) have reached Senior High School whereas 133 respondents (53.2%) are at the tertiary level. This distribution emphasizes the importance of educational achievement in shaping attitudes and actions, and it raises the prospect of disparities in opportunities and information availability among educational levels. . Regional representation offers insight into geographic diversity. The area of residence distinguishes between urban and rural areas, with more respondents living in cities (61.6%) than rural areas (38.4%). This disparity emphasizes the urbanization trend and its impact on communities.

Family structure and household composition help us understand society's institutions and living circumstances even further. The prevalence of single-parent families (11.2%), extended families (21.6%), and nuclear families (67.2%), among others, demonstrates the

diversity of family configurations, each with its own dynamics and support networks.

In summary, Table 4.1 gives a full overview of the respondent population's demographic characteristics, including information about its composition, distribution, and dynamics. The summary of the quantitative variables was first analyzed, the median and the IQR were reported since both quantitative variables were not normally distributed. This extensive analysis lays the groundwork for well-informed policy formation, decision-making, and future research projects aimed at addressing the diverse needs and challenges that modern society faces.

4.3 Current state of health and well-being of young people

The main goal of the first research objective was to examine the current health and well-being of young people in Ghana. To achieve this, SWLS and EQ-5D-5L index and EQ-VAS) were utilized .

4.3.1. Satisfaction with Life Scale

Table 4.2 below shows the respondents' satisfaction with life utilizing the SWLS. The SWLS is a 7-point Likert scale that enables respondents to self-assess their satisfaction with their life based on five statements, respondents are allowed to choose from the 7-point Likert scale (Strongly agree, agree, slightly agree, neither agree or disagree, slightly disagree, disagree, strongly disagree). These responses provide insights into how individuals perceive their overall life satisfaction.

Table 4.2: Respondents' Satisfaction with Life Scale

Characteristic	**Frequency (Percentage)**
In most ways, my life is close to my ideal	
Strongly agree	0 (0%)
Agree	81 (32%)
Slightly agree	54 (22%)
Neither agree or disagree	28 (11%)
Slightly disagree	40 (16%)
Disagree	26 (10%)
Strongly disagree	21 (8.4%)
The conditions of my life are excellent	

Characteristic	Frequency (Percentage)
Strongly agree	0(0%)
Agree	39 (16%)
Slightly agree	76 (30%)
Neither agree or disagree	62 (25%)
Slightly disagree	33 (13%)
Disagree	9 (3.6%)
Strongly disagree	31 (12%)
I am satisfied with my life	
Strongly agree	0 (0%)
Agree	50 (20%)
Slightly agree	83 (33%)
Neither agree or disagree	33 (13%)
Slightly disagree	40 (16%)
Disagree	21 (8.4%)
Strongly disagree	23 (9.2%)
So far, I have gotten the important things I want in life	
Strongly agree	0 (0%)
Agree	49 (20%)
Slightly agree	76 (30%)
Neither agree or disagree	44 (18%)
Slightly disagree	47 (19%)
Disagree	13 (5.2%)
Strongly disagree	21 (8.4%)
If I could live my life over, I would change almost nothing.	
Strongly agree	6 (2.4%)
Agree	45 (18%)
Slightly agree	66 (26%)
Neither agree or disagree	27 (11%)
Slightly disagree	53 (21%)
Disagree	17 (6.8%)

Characteristic	Frequency (Percentage)
Strongly disagree	36 (14%)

Field Survey (2024).

The table above elicits a comprehensive report that examines respondents' satisfaction with life based on their responses to the statements provided in the table. Analysis of the response's distribution and the implications for overall well-being are done. The respondents were first questioned on whether their life is close to their ideal in most ways; none (0.0%) of the respondents strongly agreed that their life is close to their ideal in most ways nevertheless, the highest proportion of the respondents (32%) agreed that their life is close to their ideal in most cases, (11%) of the respondents were indifferent on their life being close to their ideal. Surprisingly, a substantial proportion of young people in Ghana (8.4%) strongly disagree that their life is close to their ideal. Generally, Ghanaian youths are optimistic that their life is close to their ideal in most cases. The conditions of life of the young people in Ghana were also rated. Here too, none of the respondents have an excellent condition of life. Most of the respondents believe that their conditions of life need a lot of improvements, and it is therefore not excellent so, most of the respondents slightly agreed (30%) or were neutral (25%) above their conditions of life being excellent. On a lighter note, young people in Ghana are not convinced their conditions of life are excellent and (12%) strongly disagreed that their conditions of life are excellent.

Furthermore, the respondents rate their satisfaction with life, it was found the highest percentage (33%) falls into the category slightly agree, suggesting moderate satisfaction, (20%) of respondents agreed that they are satisfied with their life followed by (13%) of respondents expressed neutrality, (16%) of respondents slightly disagreed, (9.2%) and (8.4%) of respondents strongly disagreed and disagreed respectfully that they are satisfied with their lives and in the same vein as the first two statements, none of the respondents strongly agreed that they are satisfied with their lives. Overall, these findings provide insight into people's contentment with their lives and their inclination toward change. No respondents strongly agreed that they were satisfied with their life.

The respondents were then asked to rate their satisfaction with life based on the statement: "So far, I have gotten the important things I want in life." No respondent strongly agreed, most respondents either agreed (20%) or slightly agreed (30%) that they have obtained

important things in life. (5.2%) of the respondents disagreed, expressing a stronger sense of unmet desires, and (8.4%) of respondents strongly disagreed, implying significant dissatisfaction with what they have obtained in life.

Lastly, respondents were asked about their desire to change their life if they could live it over; unlike the initial questions, very few respondents (2.4%) strongly agreed that they would change almost nothing, most respondents (26%) indicated that they slightly agreed that they would make minimal changes and few respondents disagreed or strongly disagreed that they would change almost nothing.

These responses provide insights into how individuals perceive the excellence of their life conditions. While some feel positive, some express disagreement or neutrality. It's important to recognize the diversity of perspectives when assessing life satisfaction.

The SWLS questionnaire allows the calculation of a total score by adding up the scores for each item (Diener et al., 1985). There is a 5-35 possible score range. When a person has a score of 5 to 9, it means they are extremely dissatisfied with life, whereas a score of 31 to 35 indicates they are extremely satisfied, 25 to 29 indicates that they are satisfied, 20 to 24 indicates that they are slightly satisfied, 15 to 19 indicates they are slightly dissatisfied and 10 to 14 means they are dissatisfied (Diener et al., 1985). Cutoff scores are shown in Table 3 below which were used as standard measures.

Table 4.3: Distribution of SWLS Category

Characteristic	**Frequency (Percentage)**
Extremely Satisfied	26 (10%)
Satisfied	10 (4.0%)
Slightly Satisfied	61 (24%)
Neither agree or disagree	23 (9.2%)
Slightly dissatisfied	65 (26%)
Dissatisfied	53 (21%)
Extremely dissatisfied	12 (4.8%)
Total	250 (100%)

Field survey (2024)

According to table 4.3 above, most of the respondents (26%) responded to be slightly dissatisfied and slightly satisfied (24%) with their lives. Out of the 250 respondents, only

10 (4%) were satisfied with their lives representing the lowest level of satisfaction. 23 of them responded to be neutral, neither satisfied nor dissatisfied with their lives.

Table 4.4. Summary statistics of each item of SWLS

Question	Mean	SD
In most ways, my life is close to my ideal	3.756	1.672
The conditions of my life are excellent	3.960	1.526
I am satisfied with my life	3.872	1.565
So far, I have gotten the important things I want in life	3.848	1.492
If I could live my life over, I would change almost nothing.	4.084	1.728
Overall satisfaction with life	3.904	1.341

Field Survey (2024) SD- Standard D

According to Table 4.4 above, the estimated average total SWLS or life satisfaction score is 3.9 points (1-7) scale. This means that the young people are between being slightly dissatisfied with their lives and neutral given that the score 3 falls under slightly dissatisfied category and 4 is neither agree or disagree.

4.3.2. Heath-related quality of life

The EQ-5D-5L is a standardized tool for assessing generic health status. In this study, responses from 250 participants across five health-related dimensions were analysed: Mobility, Self-Care, Usual Activities, Pain/Discomfort, and Anxiety/Depression and the index for the EQ-5D-5L was also computed utilizing the Portugal tariffs (Ferreira et al., 2019) since there is no tariff for Ghana. The results are presented in Table 4.5 below.

Table 4.5: Distribution of responses to EQ-5D-5L dimensions and EQ-5D-5L index

Characteristic	Frequency (Percentage)
MOBILITY	
No problem	190 (76%)
Slight problem	48 (19%)

Characteristic	Frequency (Percentage)
Moderate problem	4 (1.6%)
Severe problem	6 (2.4%)
Unable to walk	2 (0.8%)
SELF CARE	
No problem	222 (89%)
Slight problem	19 (7.6%)
Moderate problem	6 (2.4%)
Severe problem	2 (0.8%)
Unable to wash or dress	1 (0.4%)
USUAL ACTIVITIES	
No problem	187 (75%)
Slight problem	44 (18%)
Moderate problem	10 (4.0%)
Severe problem	6 (2.4%)
Unable to do usual activities	3 (1.2%)
PAIN OR DISCOMFORT	
No pain or discomfort	137 (55%)
Slight pain or discomfort	78 (31%)
Moderate pain or discomfort	24 (9.6%)
Severe pain or discomfort	10 (4.0%)
Extreme pain or discomfort	1 (0.4%)
ANXIETY OR DEPRESSION	
Not anxious or depressed	140 (56%)
Slightly anxious or depressed	80 (32%)
Moderately anxious or depressed	23 (9.2%)
Severely anxious or depressed	4 (1.6%)

Characteristic	Frequency (Percentage)
Extremely anxious or depressed	3 (1.2%)
TOTAL	250 (100%)

Field Survey (2024).

From the table above 190 out of the 250 respondents who completed the EQ-5D-5L survey stated they have no problems with mobility. This is not surprising since the respondents are young people. This signifies low mobility problems among the respondents however 19% of the respondents complained of having slight mobility problems and the remaining indicated that they have moderate, and a respondent indicated an inability to walk which might imply that the study included a physically challenged individual. For self-care, 222 respondents representing 9%) have no problem with Self-care which also indicates that almost all young people in Ghana can take care of (dress and wash) themselves.

The respondent's ability to go about their usual activities was also assessed, the study found that 75% of the respondents had no problem going about their usual activities whereas the remaining had slight problems (18%), moderate problems (4.0%), severe problem (2.4%) and even unable to do usual activities (2.0%); this indicates there is a fair problem among young people in Ghana in going about their usual activities For pain/ discomfort and depression, the respondents indicated that there is an issue of concern in these two areas. Surprisingly, slightly more than half (55%) of the respondents indicated that they have no pain or discomfort whereas the remaining indicated that at least there is pain or discomfort. In a similar vein, 140 (56%) of the respondents indicated that they are depression free, while a sizable number of young people indicated that at least they are battling with depression or anxiety.

Most respondents stated that they have no issues with EQ-5D-5L concerning mobility and self-care since young people are mostly energetic and exuberant, there was a slight problem among young people in going about their usual activity however there is a cause of alarm about the feeling of pain/discomfort and anxiety/ depression which is usually common among young people around the world.

The Portuguese tariff (Ferreira et al., 2019) was used to compute the EQ-5D-5L index for

young people in Ghana in this study since there is no tariff for Ghana. The result is illustrated in table 6 below.

Table 4.6: EQ-5D-5L Index and EQ-VAS

Variable	***Mean (S.D)***	***Confidence Interval***	***Range***
EQ-5D-5L index	0.913 (0.123)	[0.898, 0.928]	[0.372,1.0]
EQ-5D VAS	76 (17.654)	[73.801, 78.199]	[10, 100]

There are 3,125 possible health states defined by the combination of one level from each dimension in the EQ-5D-5L instrument ranging from 11111(full health) to 55555(worst health). The health states are converted into a 'utility score' (McCaffrey et al., 2016). The values are anchored at 1 (full health) and 0 (state regarded as bad as being dead). Values less than 0 are regarded as worse off than being dead (EuroQol, n.d.). The study used Portuguese value set to calculate the utility score as there is yet to be one available for EQ-5D-5L in Ghana. The mean utility score calculated was 0.913 and 0.123 was the standard deviation. With a 95% confidence level, their EQ-5D-5L index lies between 0.898 and 0.928 with a maximum value of 1 and a minimum value of 0.372. Therefore, it can be deduced that the health state of the respondents is good since the mean index obtained is closer to 1. The mean score of the EQ-5D-5L Index reflects the health status of the respondents based on the Portuguese tariffs while the percentages highlight the distribution of responses based on the EQ-5D-5L.

Participants were allowed to rate their overall health on the EQ-VAS, a vertical visual analogue scale with values ranging from 100 (best imaginable health) to 0 (worst imaginable health). The results of their self-assessment on their health status are displayed in table 4.6 above. The average health state of young people in Ghana is 76.0 (17.654) which lies within 73.801 and 78.199 with a 95% confidence level. The worst imaginary health state out of 100 happens to be 0 whereas 100 is the best imaginary health state of young people in Ghana

4.4 Variables that affect young people's health and well-being

The second research objective aimed at identifying important variables associated with young people's health and well-being. These variables were determined using the EQ-5D-5L Index and were estimated from the EQ-5D-5L using the Portuguese tariffs. The means and the standard deviation of the EQ-5D-5L Index were presented in accordance with the various demographic variables. To determine the relationship between demographic characteristics and the EQ-5D-5L index, the Pearson Correlation Coefficient was used. The results are presented in Table 4.7 below.

Table 4.7. Pearson Correlation /T-test/ ANOVA of Demographic Characteristics and EQ-5D-5L Index

Demographic Variable	Mean	SD	(Test value) P-value
Age of respondents	0.913	0.123	(R = 0.061) 0.334
Gender			
Male	0.931	0.088	**(T = 2.343) 0.020**
Female	0.895	0.149	
Current educational level			
Senior High	0.908	0.133	(T = -0.607) 0.544
Tertiary Level	0.917	0.114	
Area			
Urban	0.938	0.074	**(T= 3.229) 0.001**
Rural	0.889	0.154	
Region			
Central	0.909	0.105	(T = -0.396) 0.692
Ashanti	0.915	0.134	
Family Structure			
Nuclear family	0.915	0.136	(F = 2.080) 0.127
Extended family	0.889	0.104	
single parent	0.947	0.051	
Members in household	0.913	0.123	(R = -0.151) **0.017**

Field Survey (2024). R = Correlation Coefficient, T = t value, F= F- value

Based on Table 4.7 above, it could be intuited that there is a positive no to weak relationship between the age of the respondents and EQ-5D-5L Index (r = 0.061), gender and EQ-5D-5L Index are statistically significant (p-value = 0.02) which implies that there is a statistical difference between the means of the gender based on the EQ-5D-5L Index, from this, it can be said that males have a better health state than females.

The educational status among the students was also assessed against the EQ-5D-5L Index, Senior High school students had a lower mean index than tertiary students. However, there was no statistical difference in their mean index

Between the two regions (Ashanti and Central), respondents from Central region had a lower mean index compared to respondents in the Ashanti region nevertheless their differences are statistically not significant that is, there is no disparity between EQ-5D-5L index across the two regions.

The majority of the respondents residing in the urban areas had a higher mean index than those in the rural areas, and it is highly statistically significant (0.001) indicating the need for urbanization.

According to the table, single parents have the highest mean index compared to nuclear and extended family which is therefore not statistically significant (p-value = 0.127). Lastly, in assessing the differences in the means of EQ-5D-5L among the number of household members, there was a statistical difference (p-value = 0.017) in the mean index among the number of household members, there was a negatively weak relationship between the EQ-5D-5L Index and the number of household members (r = - 0.151).

Table 4.8: Demographic factors and SWLS Score

Demographic Variable	Mean	SD	P-value
Overall	**19.520**	**6.707**	
Gender			
Male	19.384	7.104	0.745
Female	19.656	6.312	
Age Group			
less than 17 years	19.667	6.396	<0.001
18 - 20 years	21.711	7.597	
21 - 23 years	17.120	5.133	
above 24 years	19.229	6.404	
Current educational level			
Senior High	20.650	7.450	0.012
Tertiary Level	18.526	5.828	
Area			
Urban	17.707	5.536	<0.001
Rural	21.276	7.274	
Region			
Central	19.344	7.185	0.744
Ashanti	19.630	6.414	
Family Structure			
Nuclear family	18.929	6.254	0.119
Extended family	20.407	6.674	
single parent	21.357	8.849	
Members in household			
less than 5	20.537	6.253	0.117
5-8 members	18.358	6.223	
9-12 members	20.522	8.617	
more than 12	19.654	7.904	

Field Survey (2024). SD-Standard Deviation

Based on Table 4.8 above, it can be said that females report a slightly higher satisfaction with life than males. However, there was no statistical difference between males and females.

Interestingly findings from the table above shows that there was a statistical difference (p-value <0.001) among the various age groups.

The educational status among the students was also assessed against the SWLS, Senior High school students report a higher satisfaction with life than tertiary students with significant difference in their mean index (p<0.012).

Between the two regions (Ashanti and Central), respondents from Central region have a slightly lower satisfaction with life compared to respondents in the Ashanti region nevertheless their differences are statistically insignificant.

The majority of the respondents residing in the rural areas had a higher satisfaction with life than those in the urban areas, and it is highly statistically significant (0.001).

According to the table, single parents have the highest satisfaction with life compared to nuclear and extended family which is also not statistically significant (p-value = 0.119). Lastly, among the number of household members, those with less than 5 members showed a higher satisfaction with life.

Overall, this table provides insights into how demographic characteristics relate to life satisfaction.

4.5 Risky behaviors and health behaviours that affect young people's health and well-being

The third research objective was to identify some health and risky behaviors that can potentially affect young people's health and well-being. The results are presented in Table 4. 9 below.

Table 4.9. Frequency distribution of some risky behaviours that affect young people

Characteristics	Frequency (Percentage)
Nutrition/day	
Twice	88 (35%)
Thrice	133 (53%)
Four times or more	29 (12%)
serves of vegetables/day	
One serve	129 (52%)
Two serves	84 (34%)
Three serves or more	29 (12%)
4 serves or more	8 (3.2%)
serves of fruit/day	
One serve	174 (70%))
Two serves	37 (15%)
Three serves or more	39 (16%
junk foods/week	
None	18 (7.2%)
1 day	68 (27%)
2 days	62 (25%)
3 days	48 (19%)
4 days	25 (10%)
5 days	29 (12%)
Average glasses of drinking water/day	
1	11 (4.4%)
2	7 (2.8%)
3	11 (4.4%)
4	28 (11%)
5	71 (28%)
6	73 (29%)
7	12 (4.8%)

Characteristics	Frequency (Percentage)
8	37 (15%)
Average sleeping hours per night	
less than 6 hours	73 (29%)
6-8 hours	165 (66%)
more than 8 hours	12 (4.8%)
Average minutes for breaks daily	
15 - 30 minutes	81 (32%)
30 - 45 minutes	82 (33%)
45 - 60 minutes	48 (19%)
more than 60 minutes	39 (16%)
Engaged in risky behaviors	
Yes	105 (42%)
No	145 (58%)
Alcohol consumption	
Yes	81 (77%)
No	24 (23%)
Substance/drug abuse	
Yes	65 (62%)
No	40 (38%)
Unsafe sexual practices	
Yes	70 (67%)
No	35 (33%)

Field Survey (2024).

Table 4.9 presents some of the health behaviours that young people exhibit. Comprehending these behaviours is crucial in evaluating the holistic lifestyle and overall well-being of young people within the research setting as well as pinpointing areas that require intervention to foster better habits and enhance health.

According to the statistics, three meals a day are consumed by the majority of young people (53%), 35% said they eat twice a day with only 12% claiming to eat four times or more a day. The distribution of vegetable intake can be seen in the table where one serving (52%) is the greatest proportion. Only 8(3.2) of the participants said they ate 4 serves or more of vegetables a day. Junk food consumption. Similarly, majority of the respondents (70%) consume just one serve of fruit each day with only 15% and !6% consuming two serves and three or more serves daily respectively. On junk food consumption, results showed that 7.2% do not consume any junk food while the 27% which is the highest consumed junk foods two days in a week.

Hydration levels of the participants showed that majority consume 5-6 glasses a day with only 15% consuming 8 glasses daily. From the table most of the respondents (66%) sleep at least 6-8 hours daily

Alarmingly, according to the table, 42% are engaged in risky behaviors whereas 58% are not. 77% consume alcoholic beverages and 62% engage in drugs (painkillers, inhalants, cocaine, marijuana, heroin etc). 70 participants (67%) out of the 105 who responded to engaging in risky behaviours are involved in unsafe sexual practices.

4.6 Health care, policies, and programs available to young people

Table 4.10: Frequency distribution of Health Care, Policies and Programs

Characteristic(s)	**N = 250 (Percentage)**
Any long-term health problems	
Yes	49 (19.6%)
No	201 (80.4%)
Faced any barriers to accessing health care services	
Yes	151 (60.4%)
No	99 (39.6%)
Rate the quality of health care services	
Excellent	4 (1.6%)
Good	97 (38.8%)
Fair	106 (42.4%)
Poor	43 (17.2%)
Aware of any government policies on health	
Yes	178 (71.2%)

Characteristic(s)	N = 250 (Percentage)
No	72 (28.8%)

Field Survey (2024). N = Frequency

Table 4.10 above elicits information on the respondents' knowledge or perception of Ghana's health care, policies, and programs. The majority (80.4%) of the respondents have no long-term health problems with only 49 (19.6%) of the respondents indicating that they have long-term problems. Many of the respondents (60.4%) faced barriers (such as cost, and distance) to accessing healthcare services whereas 39.6% responded to not facing any barriers.

Surprisingly, only 4(1.6%) of participants rated the quality of health care services as excellent. 97(38.8%) of participants believe the health care services are good whilst only 43 respondents (17%) rated health care quality as poor and 42.4 % as fair.

Respondents were asked to state their awareness of any government intervention and health policies. The majority of respondents, 178 representing 71.2% answered in the affirmative with only 72 (28.8%) not aware of any government policies. Government policies that were stated are the National Health Insurance Program (NHIS), Free maternal care, and Reproductive and child health.

CHAPTER FIVE

DISCUSSION

This section discusses the findings of the study on the health and well-being of Ghanaian young people. The study's objectives are the primary focus of the analysis, which also provides insights into the significance of improving health and well-being, factors influencing the health of young people, significant dangerous behaviors, areas for improvement, healthy behaviors, and ideas and recommendations for stakeholders.

5.1 Current State of Health and Well-Being of Young People in Ghana

The results of the EQ-5D-5L and of the SWLS on the current state of health and well-being among young people in Ghana provide a thorough investigation of the current state of health and well-being among this category of people. The data shown in Table 4.2 indicated that most of the young people have no issues with their mobility, self-care, doing their usual activities every day, pain/discomfort, and anxiety/depression. Also, the health status of the young population is questionable state of health because they fall slightly below the mean score.

5.2. Variables that affect young people's health and well-being.

The study's findings demonstrate a direct correlation between gender and life satisfaction. 4 Compared to women, men reported a higher index. This result is in line with study 4 (Michel et al., 2009), which found that the gender difference grew stronger as age increased. When it comes to HRQOL and subjective health, female adolescents are recognised to be in a poorer situation than male adolescents starting at age 12. Together with an imbalance in hormonal status and the menarche (Patton & Viner, 2007), stressful life events are common (Peterson, Sariagini and Kennedy, 1991). The biological, psychological, and emotional differences between girls and boys may account for the inferior quality of life experienced by girls (Magiera and Pac, 2022). Girls' inferior quality of life may be explained by biological characteristics such as earlier puberty and brain development (Bisegger et al., 2005). According to Svedberg, Eriksson, and Boman (2013), girls suffer all the physical changes that males do, such as the first menstrual cycle and an increase in exterior body fat, more adversely than boys do. According to Gaspar and colleagues (2009), boys' physical activity with friends—such as group games and other activities—possibly contributes to their greater quality of life (QoL) than girls' in

the physical well-being component. HRQoL is negatively correlated with age, indicating that younger people value their leisure time.

Interestingly, there was no statistical relationship between age and EQ-5D-5L as it was with gender. Age is negatively associated with HRQoL, suggesting that younger participants scored higher on HRQoL compared to older participants (Wang et al., 2022). However, the older they get the more satisfied with their life they become. The early years between the ages of 20 and 29 are frequently linked to major life changes and responsibilities as a person works towards his or her goals, such as emancipation, marriage, obtaining a higher education, and job, according to Switek & Easterlin. That being said, the results of this study refute the notion that happiness increases with age.

There was no statistical relationship between EQ-5D-5L and academic levels. However, senior high school students showed a lower quality of life than tertiary students. Most students in the tertiary are deemed as adults and start to take responsibility for themselves. This can be why they show a higher mean index than senior high school students.

The results of this study do not support studies of other scholars (e.g.Powdthavee, Lekfuangfu, and Wooden, 2015; Owusu Ansah et al., 2022) who reported higher levels of life satisfaction as one's education level increases. This can be because of economic challenges, higher levels of education do not guarantee job opportunities or employment. Therefore, most young people in tertiary institutions are usually burdened with seeking a job even before graduating. Another factor that may explain why an increase in educational level does not mean higher levels of satisfaction can also be because of carrying more financial responsibilities at home after graduation especially if the young person is gainfully employed

The quality of life of an individual can be linked to securing a job opportunity or earning an income even though the study did not show any statistical association between quality of life and one’s employability. However, it is inconsistent with other research studies indicating life dissatisfaction, anger frustration, and unhappiness are associated with unemployment (Extremera and Rey, 2016). Employment can explain the variation in life satisfaction since unemployment or fear of unemployment reduces people’s life satisfaction and happiness (Aysan and Aysan, 2017).

The study showed that individuals living in urban areas have a higher quality of life than rural inhabitants. It comes as no surprise in developing countries like Ghana since basic

social amenities are lacking in rural areas than in urban areas. Living in a rural area is characterized by a hard life due to a lack of basic amenities like roads, water, electricity, and services (Celestin Ndikumana, 2024). Literature has also documented an 'urban well-being paradox', according to which city dwellers report higher material conditions, but lower life satisfaction than rural residents, on average (Berry & Okulicz-Kozaryn, 2011; Burger et al., 2020; Shucksmith et al., 2009). This is consistent with the study as it reports that rural dwellers have a higher quality of life due to the availability of good living conditions but have lower satisfaction with life.

Being resident in the Ashanti region was associated with a higher chance of life satisfaction compared to the Central region. This can be due to the fact that it is predominantly urban, highly industrialized, and has the second busiest city, Kumasi as its capital. Ashanti region often offers its dwellers greater social, economic and employment opportunities as compared to the dwellers in the Central region.

It is well established fact that two-parent families generally provide more emotional resources to children than single-parent families (Amato, 2005; Biblarz & Stacey 2010).

With the rate of single parenthood becoming increasingly common in our modern-day society, it is surprisingly shocking to see that young people from single-parent family structures have a higher satisfaction with life and a higher mean index to quality of life. Africa has an extremely high number of children living in single-parent homes (Nkyi, 2013). Single-parent families experience significant social and economic disadvantages (Nkyi, 2013). Results from this study are inconsistent with many research studies suggesting an association between lower satisfaction with life and single parenthood. However, there was no significant association between life satisfaction and family structure as well as the number of members in a household.

5.3 Risky behaviors that affect young people's health and well-being

The examination of the main risky activities among Ghanaian youth provides insight into the most common health issues.

A common concern is substance abuse, which includes the use of drugs such as cocaine, marijuana, pain meds, alcohol, and other legal substances. Three-quarters of the respondents claim to indulge in alcohol consumption. Additionally, more than half (62%)

also engage in drug intake. These results align with worldwide patterns that underscore substance abuse as a critical public health concern (World Health Organization, 2018).

Unsafe sexual practices are also alarmingly high and dangerous to the young generation. This is similar to the situation in the U.S. where the Center for Disease Control and Prevention (CDC) reported that many young people engage in health-risk behaviors and experiences that can result in unintended health outcomes (CDC, 2023). Moreover, engaging in risky sexual behaviors can lead to HIV infection, sexually transmitted diseases, and unintended pregnancy among youth (CDC, 2023).

Because they (young people who use drugs) deviate from typical behavior (Doku, 2012), health-compromising behaviors like substance abuse might be classified as problem behaviors (Chassin et al., 2007; Jessor & Jessor 1977).

The scores for intake of fruits and vegetables are not very encouraging. Despite the importance of an adequate intake of fruits and vegetables during adolescence, large

population groups, including children and adolescents in most African countries do not eat enough recommended amounts of fruits and vegetables (Peltzer & Pengpid, 2010).

Fruits and vegetables have long been known to provide health benefits for the gastrointestinal tract, help control weight, protect against metabolic and cardiovascular diseases, improve lung health, and promote high bone mineral density, among other ailments and diseases (Dreher, 2018).

Despite being impactful on their overall health, these actions might not necessarily be seen as extremely dangerous when contrasted with substance misuse or risky sexual conduct. However, their cumulative impact on health underscores the importance of addressing them comprehensively.

5.4 Health care, Policies, and Programs available to young people.

Disparities in healthcare access still exist, as Table 4.5 illustrates, with a large number of young people having difficulty accessing basic medical services. The data shows that 60.4 % of respondents said they faced barriers like cost and distance in accessing basic medical services. This data emphasizes how urgently policymakers must give projects to enhance the healthcare system's infrastructure and guarantee service affordability a top priority. Though health care is essential to health, research shows that health outcomes are driven

by multiple factors, including access to healthcare (Ndugga and Artiga, 2023). Addressing disparities in health and health care is important from an equity standpoint and improving the nation's overall health and economic prosperity (Ndugga and Artiga, 2023).

As shown in Table 4.10, only 1.6% of young people rated the current healthcare services as excellent. The majority of the respondents rated the healthcare services as fair. Improving healthcare services to provide enhanced access and affordability for young Ghanaians is very crucial to ensuring that the health and well-being of young people are enhanced.

CHAPTER SIX

CONCLUSION, SUMMARY AND RECOMMENDATIONS

6.1 Introduction

This chapter presents an overview of the study results on the topic "Enhancing health and well-being of young people in Ghana" Based on the findings, conclusions were drawn, and recommendations were provided which enabled appropriate suggestions to be made for further research.

6.2 Summary of the study

Enhancing the health and well-being of young people is vital to the development of every society. The future of every society rests on its younger population and as such the right support and investment must be put in place to promote the health of young people holistically. Primarily, the health and well-being of every individual depend on attitudes, behaviours, and lifestyle patterns. These factors coupled with other factors such as socio-demographic characteristics, socio-economic impacts, and policies and interventions come together to influence the well-being of the young individual.

This study specifically sought to;

- Find out the current health and well-being status of the young person in Ghana.
- Identify variables that affect young people's health and well-being in Ghana such as gender, age, and socioeconomic status, and comprehend the effects and implications of each.
- Identify major risky behaviors that can affect young people's health and well-being.
- Assess how equipped health the current policies and actions in Ghana to improve the health and well-being of young people are.

To achieve this, the study was rooted in the descriptive design, where quantitative data were collected and analyzed. A total of 250 questionnaires were distributed, retrieved, and returned for analysis. A questionnaire consisting of two internationally validated questionnaires and other self-developed questions comprising 40 questions formed the basis for the data collection. The quantitative data were analyzed using descriptive statistics (mean, median, standard deviation, frequencies, and percentages) and correlation coefficients (Pearson Correlation Coefficient) -

6.3 Conclusions

The following findings emerged from the study:

Firstly, it was found that most young people do not have challenges with their mobility, self-care, doing their usual activities every day, pain/discomfort, and anxiety/depression. This is not surprising as between the ages of 15-24, young people are still in their prime years.

Furthermore, the results from the study showed that quality of life has nothing to do with the age of the respondents. However, gender affects one's quality of life. A person living in an urban area will tend to have a higher quality of life than in rural areas. Rural areas on African soil are almost always cut off from development, so the story is not different in Ghana. There have been numerous calls on governments to bridge this gap to help reduce rural-urban migration due to the lack of basic social amenities. Educational level has less impact on quality of life according to this study. However, it can be noted that tertiary students have a higher quality of life than senior high-level students. Moreover, an employed student has a higher quality of life than an unemployed young Ghanaian student.

Risky behaviors affect young people's health and well-being. Substance abuse has been a major concern, and this study shows why. Health and well-being can be affected by some choices one makes and that includes being careful to avoid the abuse of drugs, alcohol, etc.

In addition to substance abuse, one major growing concern is unsafe sexual practices. Ghana has traditions, values, and customs that abhor immoral behavior like engaging in sexual practices at younger ages and even before marriage. With time, customs and values that were once upheld have faded out. This has exposed young people to engage in unsafe sexual practices. This has been shown to affect the health and wellbeing of young individuals.

The likelihood of a young person enjoying fast food is higher. Most of these foods are junk and have fewer nutritional benefits for good health. This is a growing concern that needs immediate attention. Young people should be encouraged to eat more nutritious and balanced foods that includes an intake of fruits and vegetables. It is very typical of a

Ghanaian meal to exclude more fruits and vegetables at a serving and that should also be encouraged as it can help in improving quality of life.

One major factor affecting one's, health, and well-being is facing barriers in accessing health care services. The majority of young people have difficulties accessing basic medical services due to financial constraints caused by economic crises or the distance caused by the lack of health facilities in many rural areas. This poses a great threat to health and safety and must be addressed with immediate attention.

Therefore, it is not surprising when less than 2% of young people rated the current healthcare services as excellent with the majority rating it as fair. This shows that the current healthcare services are not good enough to help enhance young people's health and well-being.

6.4 Recommendations

Based on the findings, the following recommendations are proposed to enhance the health and well-being of young people in Ghana.

1. **Improving access to healthcare services**: Efforts should be made to enhance healthcare infrastructure and service delivery, particularly in rural areas to ensure equitable access to healthcare services among young people in Ghana.
2. **Addressing Socioeconomic Disparities**: Policies aimed at reducing socioeconomic inequalities, including access to nutritious foods, health services and educational opportunities should be implemented to improve health equity among Ghanaian youths.
3. **Preventing Substance abuse**: Multifaceted interventions targeted at substance abuse prevention, treatment, and harm reduction should be tailored to the needs of young people. Policy measures to regulate alcohol availability to the young population and public health campaigns to promote responsible drinking are recommended.
4. **Promoting a Healthy lifestyle**: Comprehensive strategies to promote physical activity and overcoming barriers to exercise are recommended. Education on nutrition and healthy eating should be taught extensively in schools to encourage healthy dietary habits, increase vegetable consumption, and reduce the consumption of junk foods.

6.5 Strengths and Limitations of Study

Examining the health and well-being of the Ghanaian young population is a clear strength of this study given the lack of previous research exploring, In fact, the author only found a study that previously addressed the Ghanaian adolescents' meaning of health and well-being (Glozah, 2015). This research also provides wider/more generalizable insights into the health and well-being of young people between the ages of 15 and 24. The sample size for the study was considerably large with 250 participants from four educational institutions. Moreover, existing validated instruments were used to measure satisfaction with life and HRQoL. Therefore, comparisons can be made in the future.

However, this study has some limitations. Firstly, the sample used in this study was not representative of the general Ghanaian young population as they were conveniently sampled from specific educational institutions. Using only two regions instead of all sixteen regions further reduced the ability to generalize results. Literature is an important part of every research, however, due to the limited nature of research on the health and well-being of young people in Africa especially in Ghana, achieving the research objectives was challenging. Although the study's usage of a broad age range (15-24 years) provides insight into this group, future research should focus on health and well-being across many age groups. Lastly, time constraints impacted the study as the researcher had to meet a deadline.

6.6 Areas for Future Research

While the study provides valuable insights into the health and well-being of young people in Ghana, several areas warrant further research.

1. **Longitudinal studies**: Long-term studies that track the health and well-being of young people in Ghana over time would provide valuable insights into the effectiveness of interventions and policies tailor-made for young people.
2. **Qualitative research**: Qualitative research exploring the lived experiences, perceptions, and attitudes of young people regarding health and wellbeing would complement the quantitative findings and provide a deeper understanding of the underlying factors influencing health behaviors.
3. **Policy Evaluation**: Accessing the impacts of existing policies and interventions aimed at improving young people's health outcomes would provide valuable lessons for future policy development and implementation.

By addressing these research gaps, future studies can contribute to the ongoing efforts to enhance the overall health and well-being of young people in Ghana and promote sustainable development and prosperity for all.

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HEALTH AND WELL-BEING QUESTIONNAIRE

TITLE: ENHANCING HEALTH AND WELL-BEING OF YOUNG PEOPLE IN GHANA.

Dear Participant,

Thank you for participating in this study aimed at understanding and enhancing the health and well-being of young people in Ghana. Your responses will contribute valuable insights to inform policies and programs to support the youth in your community. Please answer the following questions to the best of your ability. Your responses will be kept confidential and used for research purposes only.

SECTION 1: HEALTH AND WELL-BEING

1. Satisfaction with Life Scale (SWLS)

Below are five statements that you may agree or disagree with. Indicate your agreement with each item by ticking (√) the appropriate box, from strongly agree, to strongly disagree. Please be open and honest in your response.

	Strongly agree	**Agree**	**Slightly agree**	**Neither agree or disagree**	**Slightly disagree**	**Disagree**	**Strongly disagree**
	7	6	5	4	3	2	1
In most ways, my life is close to my ideal	○	○	○	○	○	○	○
The conditions of my life are excellent	○	○	○	○	○	○	○
I am satisfied with my life	○	○	○	○	○	○	○
So far, I have gotten the important things I want in life	○	○	○	○	○	○	○
If I could live my life over, I would change almost nothing.	○	○	○	○	○	○	○

EQ-5D 5L

Under each heading, please tick the ONE box that best describes your health TODAY.

2. **MOBILITY**

I have no problems in walking about ❑

I have slight problems in walking about ❑

I have moderate problems in walking about ❑

I have severe problems in walking about ❑

I am unable to walk about ❑

3. **SELF-CARE**

I have no problems washing or dressing myself ❑

I have slight problems washing or dressing myself ❑

I have moderate problems washing or dressing myself ❑

I have severe problems washing or dressing myself ❑

I am unable to wash or dress myself ❑

4. **USUAL ACTIVITIES** (e.g. work, study, housework, family or leisure activities)

I have no problems doing my usual activities ❑

I have slight problems doing my usual activities ❑

I have moderate problems doing my usual activities ❑

I have severe problems doing my usual activities ❑

I am unable to do my usual activities ❑

5. **PAIN / DISCOMFORT**

I have no pain or discomfort ❑

I have slight pain or discomfort ❑

I have moderate pain or discomfort ❑

I have severe pain or discomfort ❑

I have extreme pain or discomfort ❑

6. **ANXIETY / DEPRESSION**

I am not anxious or depressed ❑

I am slightly anxious or depressed ❑

I am moderately anxious or depressed ❑

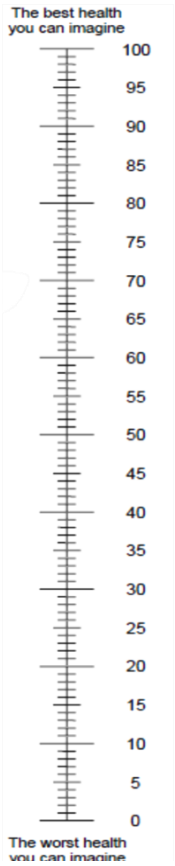
I am severely anxious or depressed ❑

I am extremely anxious or depressed ❑

7.

- We would like to know how good or bad your health is **TODAY.**
- This scale is numbered from 0 to 100.
- 100 means the best health you can imagine.
  0 means the worst health you can imagine.
- Mark an X on the scale to indicate how your health is **TODAY**
- Now, please write the number you marked on the scale below

YOUR HEALTH TODAY = ☐



SECTION 2: FACTORS INFLUENCING HEALTH AND WELL-BEING

8. Do you feel supported by your family in matters related to your health and well-being?
   - Yes, strongly supported ☐
   - Yes, somewhat supported ☐
   - No, not supported ☐

9. How would you rate the level of community support for young people's health and well-being initiatives?
   - Strong support ☐
   - Moderate support ☐
   - Minimal support ☐
   - No support ☐

1. Health Behaviours

a) Nutrition

10. How many times do you eat in a day?

- once □
- twice □
- three times □
- four times □

- 1 serve of fruit = medium-sized apple/orange/banana or 2 apricots/kiwi fruit or ½ cup tinned fruit
- 1 serve of vegetables = ½ cup cooked vegetables or 1 cup salad vegetables

11. How many serves of vegetables (including fresh, frozen, and tinned vegetables) do you usually consume

-One serve or less □
-Two serves □
-Three serves □
- Four or more □
- Don't eat vegetables □

12. How many serves of fruit (including fresh, frozen, and tinned fruit do you usually eat each day

- One serve or less □
- Two serves □
- Three or more serves □
- Don't eat fruit □

13. How many days of the week do you usually eat junk foods high in fat salt or sugar (such as deep-fries, hot chips, pies, pastries, chocolates, lollies, etc.)

- None □
- One day □
- Two days □
- Three days □
- Four days □
- Five days or more □

b) Physical Exercise

14. Please indicate why you are NOT more physically active (tick all that apply).

-Too tired □

- Not enough time □

- Lack of facilities □

- Not encouraged to □

- No shower facilities □
- Not Motivated □
- Not enough flexible time in work hours □
- Health issues □
- I am already active enough □

c) Hydration

15. On average, how many glasses (250 ml) of fluid (water, cordial, soft drink, juice, milk, coffee, tea) do you consume during the day? (Please circle one)

1 2 3 4 5 6 7 8+

16. On average, how many glasses (250 ml) of plain drinking water do you consume daily? (Please circle one)

1 2 3 4 5 6 7 8+

d) Sleep/ Rest

17. On average, how many hours of sleep do you get per night?
- Less than 6 hours □
- 6-8 hours □
- More than 8 hours □

18. On average, how many minutes do you have for breaks daily?
-15-30 minutes □
- 30-45 minutes □
-45-60 minutes □
- over 60 minutes □

2. Risky Behaviours

19. Have you ever engaged in risky behaviors that may compromise your health and well-being? (e.g., substance abuse, unsafe sexual practices, alcohol drinking, etc.)
- Yes □
- No □

If **NO** proceed to question 30

20. Do you drink alcohol at all?
- Yes □
- No □
- Sometimes □
-Occasionally □

21. How many days of the week do you drink?

- 1-4 days □
- 5-7 days □

22. Do you use drugs (marijuana, cocaine, heroin, stimulants, painkillers, inhalants, etc.)
-Yes □
-No □
-Sometimes □
- Rarely □

23. Do you engage in Unsafe sexual practices
-Yes □
-No □
-Sometimes □
- Rarely □

24. Are you aware of Sexually Transmitted Diseases (STIs) like Gonorrhea, syphilis, HIV, etc.
-Yes □
-No □

25. To what extent are you aware of the potential consequences of engaging in risky behaviors, such as substance abuse, alcohol drinking, unsafe sexual practices, etc.?
- Very aware □
- Somewhat aware □
- Not very aware □
- Not aware at all □

3. Support Systems

26. If you have engaged in risky behaviors in the past, did you feel you had access to adequate support systems or resources to help you address or overcome these behaviors?
- Yes, I had access to support □
- No, I did not have access to support □
- Rarely had any support □

5. Health Care

27. Do you have any long-term health problems or disability that limit your daily activities
- Yes □
- No □

28. Have you faced any barriers to accessing healthcare services? (e.g., cost, distance)
- Yes □
- No □

29. How would you rate the quality of healthcare services available to young people in your community?
- Excellent □
- Good □
- Fair □
- Poor □

SECTION 3: POLICIES AND PROGRAMS

30. Are you aware of any government policies or programs aimed at improving the health and well-being of young people in Ghana?
- Yes □
- No □

31. If yes, please specify the policies or programs you are aware of.

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32. In your opinion, how effective are these policies or programs in addressing the health and well-being needs of young people?
- Very effective □
- Somewhat effective □
- Not very effective □
- Not effective at all □

Section 4: Demographic Information

33. Gender:
- Male □
- Female □

34. What is your age? _____

35. What is your current educational status?
- Senior High School □
- Tertiary Level □

36. What is your current employment status? Tick the ones that apply to you
- Employed □
- Unemployed □
- Student □

37. Which region do you reside in?
- Central □
- Ashanti □

38. Are you currently living in an urban or rural area?
- Urban □
- Rural □

39. What is your family structure?
- Nuclear family □
- Extended family □
- Single-parent family □

40. How many members are there in your household? _____

Thank you for your time and participation in this survey. Your input is highly valued and will contribute to meaningful insights for improving the health and well-being of young people in Ghana.