Care-seeking behaviors among households of different socio-economic classes in urban and rural Ghana

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Introduction

Medications are ubiquitous items in many households and their importance cannot be over-emphasized. Research has shown that about 30 to 40% of health expenditure goes toward medicines. As the most tangible aspect of the therapeutic itinerary, medicines continue to generate much interest among researchers. In recent years, care-seeking behaviors, including treatment decisions, have become an important subject of study to reveal underlying relationships between healthcare providers, medicine sellers, and their patients/clients. In a context such as Ghana, where the establishment of widespread national health insurance is well advanced, studying care-seeking behaviors also allows for a better understanding of how health financing shapes health behaviors.

The aim of this research was to explore how households of different socio-economic classes in urban and rural Ghana treat common illnesses. The following key research questions guide this paper: 1) What are the differences in care-seeking behaviors and use of pharmaceuticals by households of different socio-economic statuses in urban and rural Ghana? 2) How does national health insurance and access to different sources of care and medication impact these practices ?

Methods

A total of 30 households were selected for this study, 15 households of different socio-economic status (five lower, five middle, five upper) in Greater Accra and 15 households (with the same socio-economic distribution) in and around rural Asikuma. Three of these

households were not able to participate or refused participation in the total number of bio-monthly monitoring visits and were replaced, bringing the number of participating households up to 33. These households were identified through purposive and snowball sampling. Criteria for selection included a willingness to participate in interviews and monitoring and having at least one child under the age of five living in the household. Most households were nuclear families made up of a couple and their children.

Two data collectors (Emelia Afi Agblevor and William Sackey) conducted the interviews and monitoring visits, supervised by Daniel Arhinful and Carine Baxerres (PIs). One data collector focused in the rural area, and the other in four urban areas in Greater Accra. Data collection included one semi-structured interview of approximately one hour in length with the "mother" of the household, an optional second interview with another adult in the household, and usually 16 bimonthly monitoring visits. During monitoring visits, study household mothers were asked to report about any medication that had been used by any members of the household since the last visit, why this medication was used, and from where it was procured, and to describe related care-seeking behaviors. Both data collectors and Kelley Sams analyzed these data for themes, and the key findings of the analysis of interviews and monitoring are presented here. Interviews showed that study participants did not differentiate between pharmacies and chemical shops. In the presentation of these findings, we use the word "drugstore" to mean both. It is worth noting that there were no pharmacies located in the rural area where all "drugstores" were OTCMs (Over the Counter Medicines sellers), commonly known as "chemical shops".

Findings

Home treatment was the first step for "not serious" illnesses in households

Most illnesses reported during household monitoring were seen as "not serious" and treated at home in both urban and rural study households and among all socio-economic classes. Most illnesses were first treated at home either with medications from home pharmacies (which consisted largely of leftover medicines from previous illness episodes) or medications purchased especially for the particular illness episode from nearby drugstores.

However, illnesses perceived as "serious" or illnesses that did not respond to initial treatment were brought to nearby clinics or hospitals. One husband from an urban middle-class family explained that his children's illnesses were usually treated at home before the family would consider a visit to a health facility, *"… for the kids when they have an infection and I give them the first aid and it is not going, I take them to the hospital."* (Urban, middle class).

One of the factors influencing self-medication from drugstores as the first step in care and deterring uptake of health facility services was the long waiting times at health facilities. They quality of care and medication given in the health care facilities was perceived by most respondents to be similar to what was found in drugstores. One mother (upper, rural) described that when her children get sick, she normally takes them to the drugstore first, "*...because if you take them to the hospital, that day you won't be able to do any other thing you would have to do at home, you would spend all the day there and the medicine they would give too, its multivitamin and other, so me, I won't send them but if the medicine is 15 cedis at the drug shop I will buy it and if you go to the drugstore, the medicine given would cure the child.*"

Another factor found only in the rural area that deterred the use of health facilities was the perception that mothers who frequently seek care are not good mothers, as illustrated in this interview with Cecilia (middle, rural) :

> Cecilia : *You see sometimes in just some few minutes you would realise that a child is sick, when that happens and people see you often as you are going to the clinic often, I don't like that. So instead of the clinic I go to the drugstore. So on some days I just go to the way of drugstore.*
>
> Interviewer : *why, people...*
>
> Cecilia : *Yes, people would be talking behind my back saying my children like getting sick, what food are we eating that makes us go to the clinic frequently. It is worrying to be hearing that. So with our own money we go to the drugstore.*

Differences in facility-choice related to socio-economic status only existed where there was choice, in the urban area

There did not seem to be any major difference in the care seeking behaviors of families of different socio-economic classes in the rural area, most likely because of a lack of diversity in the sources of health care and treatment, such as no pharmacies and very few private healthcare facilities.

In the urban area, health care facilities included hospitals, private clinics, polyclinics and maternity homes as well as one spiritual center. In the rural area, when more than home treatment was sought, most study participants went to CHPS compounds or, for severe illnesses, the hospital. Health facilities were used to treat a variety of acute conditions: skin problems, malaria, coughing, etc. but only after self-medication had been unsuccessful. Most individuals with hypertension reported regularly receiving follow-up (usually every three months) from a health facility.

Families with more money were able to access more expensive health care facilities in the urban area. As shown in the table below, because of the diversity of services available in urban greater Accra, there was a difference in the facilities frequented when illnesses were seen to become "serious" or did not respond to initial drugstore treatment. Households in the upper socio-economic category frequented more expensive private health care options. However, some public health facilities were frequented by all families even in the urban area because of their size and specialized services.

Health care facilities used by urban families by socio-economic status

Socio- Economic Category	Public Hospitals/ Polyclinics	Private Hospitals/ Clinics	Maternity Home/ Health Centre
Upper Class Socio-Economic Category	Korle-bu Teaching Hospital SNNIT Hospital Police Hospital 37 Military Hospital	Ghana-Canada Medical Centre St. Luke's Clinic Ababio Clinic Dziram Eye Clinic	Adjiringanor Health Centre
Middle Class Socio-Economic Category	Madina Polyclinic 37 Military Hospital	Effan Victory Clinic Aton Memorial Clinic Twumasiwaa Memorial Clinic	
Lower Class Socio Economic Category	Madina Polyclinic Alpha Hospital	Aton Memorial Clinic Dela Clinic	Mrs. Djan Maternity Home

The biggest differences in pharmaceutical-use related to socio-economic status were found in the urban area

Proximity strongly influenced the choice of drugstores for all households. However, in the urban area, choice of drugstore was also related to socio-economic class. In the urban area, individuals from lower socio-economic households were more likely to use "chemical shops" rather than pharmacies, due to price as well as flexibility in buying individual capsules or pills rather than entire treatment courses. In the urban area, individuals of higher economic classes were more likely to use more expensive medications bought from pharmacies or certain private facilities for care when self-medication was not effective. In addition, higher socio-economic status households in the urban area purchased brand name medications, which lower resource families purchased cheaper International Non-Proprietary Name (INN) generics.

All households frequently consumed antipyretics and analgesics. In both the urban and rural areas, monitoring visits indicated that these were used more frequently by lower and middle socio-economic status households, possibly related to pain relief caused by blue collar and physically labor-intensive work.

Vitamins and blood tonics were used by most families included in the study to maintain good health. In the urban area, although all socio-economic groups used these products, their use was higher among families with greater resources and a difference was found in the brands used according to socio-economic status.

Knowledge of prescription patterns and easy access to a broad range of medications (beyond Category C) from drugstores encouraged the use of drugstores as the first source of care. Respondents reported that they had learning from health facilities how to treat illness themselves. As Alice described, she reproduced the prescription patterns that she had seen at health facilities, "*...if healthcare providers give you the medicine and you are smart, you would take notice of the medicine so the next time the child is hot, and you have money you just go to the drug store and buy it for the child, so with me I go to the drugstore and buy the medicine.*" (rural, upper)

Many examples were given during interviews concerning the perceived mastery of these prescription patterns. Judith, for example stated "*That is how they give us medicines at the hospital, if it's a headache they would add B-co to the para. So if I can't go there I can likewise buy the para and B-co and give to them.*" (rural, middle)

When Susanna was having pain in her stomach, she went directly to the drugstore to buy amoxicillin and Flagyl, the medications she had received at the hospital. *"No one advised me, but you see, when you give birth, you see, you are given medicines there (hospital) but I saw that maybe it was not enough. It is not enough. You see, they gave me one course. So, I felt that not was not enough that is why I went to buy it. No one advised me." (urban, lower)*

Pharmacists and chemical sellers were used to confirm and complete mothers' knowledge of medication. Safia explained that, although she learned about different medications from her peers, she likes to check with the pharmacist before buying, *"I would go and ask, I would usually ask to be sure because I guess every medicine has its side effect so you don't just give it to... the fact that it works for somebody's child doesn't mean it would work for you. I always get the... most of my directions from the doctor or the Pharmacist."* (urban, upper class)

National health insurance had some influence on prescription patterns in health facilities, but very little on care-seeking behaviors

Although most study households were covered by national insurance and expressed positive experiences with this coverage, having NHIS insurance coverage did not necessarily mean that all study households used the services that were covered by this insurance. This finding highlights the assertion made in the latest NHIA report, which claimed only 38% of the entire population were active members of the scheme (NHIA, 2013). This insurance also did not cover all health problems nor all types of medication. Sometimes medications were not available at health facilities that accepted NHIS insurance and the medication was purchased elsewhere. Many households complained about difficulty in obtaining their NHIS card. One household explained that they had not renewed their insu-

rance coverage because of these difficulties as well as a perception that the insurance was not very useful. This insurance seemed to influence which medications were purchased. For example, NHIS does not cover quinine syrup which some facilities reported prescribing for children with severe malaria. One rural public facility described the care and treatments they offer as "dictated partially by insurance"'. These topics will be explored in depth with future research.

Practical concerns such as speed and ease of access contributed to a general preference of seeking care for illnesses perceived as "not serious" (such as malaria in its simple/early stages) at drugstores rather than health facilities. However, the presence of insurance (and free insurance for the elderly) may have positively influenced the use of health facilities for chronic illnesses such as hypertension. Study participants reported that doctors prescribed medicines for patients with regard to their ability to pay, socio-economic class, and whether patients were using the national health insurance card or not.

Regina summarized, *"...if you are sick and you go to the hospital, you see that money that you would have paid is no more it is gone, cut away. At first someone might sick, if the person has no money, the person would sleep at home for a long time and suffer before going to the hospital, but now because of the insurance if you notice that any part of you is not fine you can go to the hospital, so its introduction has cut many things."* (Rural, lower)

Since this insurance was only taken at public facilities, many families reported that they would not want to go to private clinic because these provide the same services, but more expensive. Several urban families also had private insurance provided through employers. One family had two types of private insurance (related to the employment of the mother and father) as well as the national insurance that the mother said she bought in case she was ever outside of Accra and needed care.

However, findings reveal that all study households, even this family with three types of insurance, often chose to pay for medications out of their own pocket by buying directly from nearby drugstores without a prescription, regardless of social status. In the rural area the only health facilities that accepted the national health insurance were the hospital, health center, and CHPS compounds. In Accra, several hospitals and pharmacies accepted national insurance with a prescription.

The National Health Scheme influenced which medications were prescribed with its essential medicines price list which allows for only generics and branded generics to be sold. In urban private hospitals where both national health insurance and private health insurance is used, it was reported that doctors prescribe medicines based on the kind of insurance presented. Generics were reported to be prescribed for National Health holders and more expensive branded generics or brand names were reported to be prescribed for middle and upper-class households.

Conclusion

Findings from the data showed that most illnesses were treated at home in both urban and rural households, regardless of socio-economic class or insurance coverage. Perceptions about "not serious" illnesses that could effectively be treated at home, long waiting times at health facilities, perceived mastery of prescription practices, perceived expertise of drugstores and availability of a wide range of medications at drugstores led to many illnesses being treated by those suffering from illness or their families.

The greatest differences in the types of health facilities frequented and the brands of pharmaceuticals used was found in the urban area, most likely related to the diversity of choice that existed. A greater difference in the types of facilities visited and of pharmaceuticals purchased was seen between different socio-economic classes in urban Accra, most likely because of the greater diversity of types of medication and sites available in this area compared to rural Breman Asikuma, where all the families visited similar health facilities. In addition, likely because of the wide and free availability of herbal ingredients, home-made herbal medicine was an important aspect of disease treatment in rural Asikuma.

There was a great difference between urban and rural Ghana in the types of health facilities available, with almost no private facilities in the rural area. In both research sites drugstores fulfilled an important role in healthcare and were usually the first place visited for health problems. Most household members were covered by national health insurance, but due to practical reasons and perceived mastery of prescription practices, preferred to purchase medication from drugstores rather than seek care from health facilities for illnesses not considered to be "serious", even if this meant spending more money than at a health facility. National health insurance did, however, seem to influence prescription practices of health care providers.

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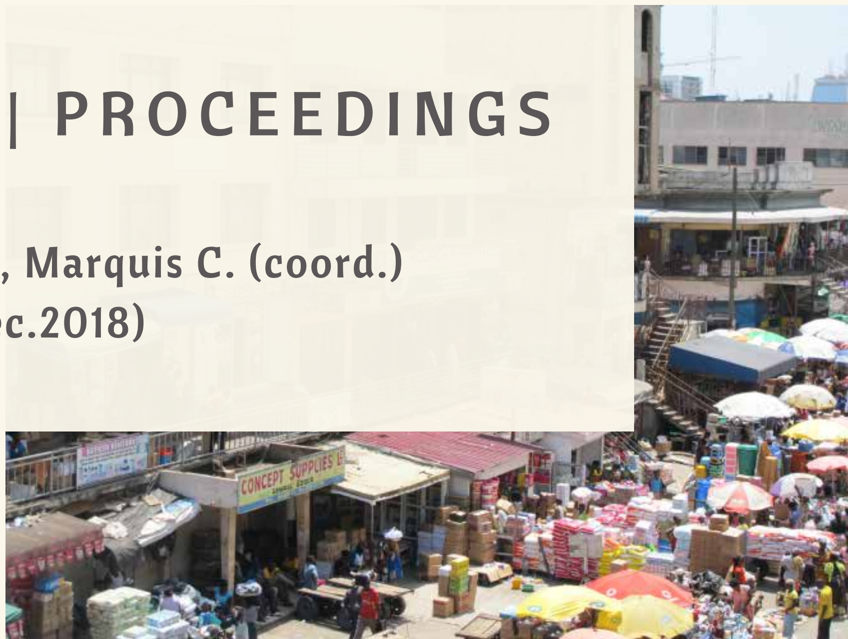

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