Health Care Seeking For Hypertension In South West Nigeria

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ABSTRACT
Hypertension, also known as high blood pressure, is one of the most common non-communicable diseases affecting adults all over the world. It is now being widely reported in Africa, posing a different kind of health care challenge from infectious diseases. As a chronic disease that has to be managed (not cured), affected people have a life-long challenge to have the condition under control so as to prevent complications. The current study aims to study care seeking behaviour for hypertension in an urban Nigerian community. The study was a community based cross-sectional study that included a survey of 440 community residents who have hypertension; these comprised 65.2% women, about half had had no formal education, and half were traders. Key informant interviews were conducted with 23 health care workers, patent medicine vendors and indigenous healers in the community. A large proportion (63.4%) of the respondents reported that they sought care for their condition from a hospital/health centre while 5% said they go to the patent medicine vendor (PMV). Remarkably, all respondents used a combination of two or more of these facilities. About 1 in 10 of the respondents who visited the hospital still made use of traditional medicine, while 7.3% used both the PMV and traditional medicine. Findings from the key informant interviews show that the preference of hypertensive subjects for these health care providers (in contrast to going to hospital) because of ease of access, time savings and reduced costs. In conclusion, hypertensive subjects seek health from a wide variety of sources beyond the formal health care system. These findings have potential implications for programmes and policies to control hypertension and reduce complications in this and other similar developing settings.

Keywords: Hypertension, Care Seeking Behaviour, Indigenous Medicine, Nigeria

INTRODUCTION
Hypertension (also known as high blood pressure) is one of the most common non-communicable diseases affecting adults all over the world. It is now being widely reported in Africa and is the most common cause of cardiovascular disease on the continent. It is also a major factor in the high mortality of adults in sub-Saharan Africa (WHO, 2003). Hypertension remains a major global public health challenge that has been identified as the leading risk factor for cardiovascular morbidity and mortality as well as all-cause mortality (WHO, 2004; Joint National Committee (JNC) 7, 2003; Kearney, Whelton, Reynolds, Muntner, Whelton, He 2004). By itself, hypertension has no early recognizable symptoms and, as a result, patients with hypertension often come to medical attention late when they already have developed complications such as strokes, heart attacks, heart failure and kidney failure, all of which are major causes of death in the adult population. For this reason, hypertension is often called a ‘silent killer’ (Hoel and Howard, 1997). The burden of Non-Communicable Diseases (NCD) is rising rapidly nationally and globally constituting a major challenge to development (WHO, 2007). An increasing number of studies suggest that NCD will soon be the most important...
cause of morbidity and mortality in developing countries (Kadiri, 2005; Commission on Health Research for Development, 1990; Feachem, 1992; Manton, 1988; World Bank, 1993). At the beginning of the 20th century, cardiovascular disease (CVD) was responsible for fewer than 10% of all deaths worldwide. Today, that figure is about 30%, with ~80% of the burden now occurring in developing countries. So prevalent is hypertension in Sub-Saharan Africa today that hypertensive heart disease might in fact be the most common form of CVD in Africa (Bradshaw, Groenewald, Laubscher, Nannan, Nojilana, Norman, Pieterse, and Schneider 2003; Cruickshank, Mbanya, Wilks, Balkau, Forrester, Anderson, Mennen, Forhan, Riste, McFarlane-Anderson, 2001).

Care Seeking Behaviour

Care seeking behaviour can be defined as personal actions to promote optimal wellness, recovery, and rehabilitation (Iyalomhe and Iyalomhe, 2010). Health-seeking behaviour is a part and parcel of a family or community identity being the result of an evolving mix of personal, experiential and socio cultural factors. It varies for the same individuals or communities (Iyalomhe and Iyalomhe, 2010). Multiple channels of health care exist in most countries. Although homeopathic and other forms of alternative medicine (for example herbal medicine) are utilized in some industrialized countries, the major channels of health care in the developed countries are cosmopolitan, western-style health care institutions like clinics, general and specialist hospitals. This is in contrast to the situation in Nigeria and in other developing countries where the channels of care which are utilized are more varied, consisting of indigenous healers, spiritual churches, pharmacies, Patent Medicine Vendors (PMVs) and hospitals (Erinosho, 1998). Various factors such as ethnicity, class, gender and other aspects of people’s backgrounds (including family factors) seem to have a strong influence on health care-seeking behaviour (Bucquet and Curtis, 1986). With regards to hypertension, failure to achieve blood pressure (BP) goals – the target of treatment - may be attributable to the poverty of patients’ knowledge, perception, attitudes and life-style practices (Mari, Ukai, Yamamoto, 2006; Iyalomhe, 2007; Ong et al, 2007; Petrella, Merikle, Jones, 2007).

Case, Menendez, & Ardington, (2005) examined patterns of health seeking behaviour of individuals who lived in the Northern KwaZulu-Natal region in South Africa prior to their death. It was discovered that significant positive associations exist between individuals’ socioeconomic status, measured using household ownership of a variety of durable goods, and their use of medical services. The researchers found out that asset ownership correlate significantly to health status and health seeking behaviour. Individuals with greater economic resources are significantly more likely to seek treatment from private doctors, and spend considerably more for all types of health services. Individuals who are ill for a longer period before death are reported to see a greater number of health providers. While almost everyone interacts with Western medicine, those who are ill longer also see traditional healers and take non-prescribed medication. According to Amod, Jimba, Murkami, Silwal, Wakai, Kuratsuji, (2002), when rural Nepalese feel sick, they seek healthcare only when the sickness is considered moderate or severe. Mild illnesses are treated at home. When the villagers seek health care, they preferred to visit traditional healers first, before visiting other health workers. Thus, studies from multiple countries have documented the utilization of multiple sources of health care and factors that influence these choices.

Traditional health practitioners and their role in health care systems are acknowledged worldwide (Mbwanha, Mahunnah and Kayombo, 2007). Utilisation of traditional medicine is apparently on the increase globally and is being given recognition by health insurance providers in developed countries (Ritchie, 2007). In Nigeria, herbal medicine appears to be
strongly considered by hypertensive patients as one of the viable alternative for a cure for hypertension (Oke and Bamidele, 2004). The reported use of herbal medicine in the general population from different parts of the world include 40% in the United States (Esenberg, Davis, Ettnser, Appel, Wilkey, Van Rompay, & Kassler, 1990-1997), 38.5% among the Indian community of Chatsworth in South Africa (Singh et al, 2004) and 48.5% in Australia (MacLennan et al, 1996). Specifically amongst hypertensive subjects, Shafig, Gupta, Kumari, Pandhi, (2003), reported that as many as 63.9% of their hypertensive subjects in a clinic in India took herbal medicines, while in Morocco 80% of patients with hypertension and diabetes used medicine plants to treat their ailments (Eddouks Maghrani, Lemhadri, Ouahidi & Jouad,H, 2002).

Patent Medicine Vendors (PMVs) – vendors that sell medicines - are also a source of treatment in sub-Saharan Africa. The patent medicine vendor (PMV) or “patent medicine seller” can be defined as a person without formal pharmacy training, who sells orthodox pharmaceutical products on a retail basis for profit (Brieger, Osamor, Salami, Oladepe, Otusanya, 2004). Over-the-counter (OTC) drugs which include common drugs like pain relieving tablets, antimalarials, cough syrups and so forth are the only drugs authorized to be sold by the vendors, but they generally sell all types of drugs as determined by their financial capability (Erhun, Babalola, Erhun, 2001) and ordinarily the patent medicines should be sold in their original packs. Notwithstanding, PMVs in Nigeria often stock OTC, controlled drugs (e.g. antibiotics and steroids), and perform procedures that are outside the scope of their licensing (Osamor, 2001). Patent medicine selling in Nigeria predates Nigerian independence in 1960 (Aderuka, 1975). The Pharmacy Law of 1946 requires that PMV be licensed (Nigerian Pharm. Law 1946, Egboh, 1984), and there are grades of licenses. Holders of License C can sell only proprietary or patent medicines such as aspirin, paracetamol, Chloroquine, cough syrups, worm expellers, vitamin tablets, blood tonic and eye drops containing isotonic solutions. Those with ‘B’ may in addition sell selected ‘poisons’ contained in part IV of the first schedule of the Pharmacy Law such as disinfectants (Abiola, Adeyinka,, Alhassan, Famuyide, Nwaorgu, Olujohungbe, and Uche, 1983), while only Pharmacists receive license ‘A’ and sell the full range of medication. Therefore, a PMV could be defined operationally as one duly licensed by an appropriate body or authority to sell patent medicine and who holds a patent and proprietary medicine vendors license in the form B or C as contained in the Pharmacy Law of 1946.

In 1951, the PMVs in the former Western Region (Edo, Delta, Oyo, Ogun, Lagos, Osun and Ondo States) of Nigeria came together to form the Nigerian Association of Patent and Proprietary Medicine Dealers, headquartered at Ibadan. The Association received a certificate of incorporation in 1962, and associations in other states have joined in accordance with a 1978 national affiliation agreement (Adeosun, 1988). State, district and town branches have been formed. The Association serves as a mediator between members and local, state and federal government. One effect of the association at local level may be the relative uniformity in pricing. Another may be the speed by which information about drugs spread among PMVs.
It is possible to define the PMV by observing his/her practices. Van der Geest (1987) distinguishes five functional categories of PMVs in Southern Cameroon:

- General shop keepers who also sell patent medicines
- Traders in the periodic markets who sell medicines along with other merchandise
- Drug peddlers who go from village to village
- Merchants who specialize in the sale of medicine
- Health workers who sell the medicines obtained from their institutions

PMVs are not only one of the most viable alternatives for purely rural residents seeking health care (Brieger, Ramakrishna & Adeniyi, 1986), they also sometimes form the first port of call as noted by Abiola et al (1983) and Brieger, (1988). No other distinguishing requirements are written into the law. Apart from administrative regulations, eligibly requirement for obtaining a patent medicine license is contained in the Pharmacy Law is quite general and vague. The State stipulates that for one to be awarded a license one must attain the age of 21 years and that one’s application should be supported by two referees (Nigerian Pharm. Law 1946). The law does not specify any minimal educational qualification; the PMV is expected to have completed primary school. No formal training is demanded or organized, although licensees are given a pamphlet outlining relevant aspects of the pharmacy law. Though their ethics and competence have been challenged (Iweze, 1987), the ability of PMVs to provide accessible services, even in remote areas cannot be doubted.

The current study aims to study care seeking behaviour for hypertension in an urban Nigerian community. Hypertension is a significant and growing public health problem in developing countries, such as Nigeria. As a chronic disease that has to be managed, it is critical to understand the broad sociological context in which hypertension is experienced by individuals, their health care providers and the community. This research addresses an important gap in the knowledge of key sociological aspects of hypertension (the most common non communicable adult disease) in Nigeria: patterns of care-seeking behaviour and what potential factors influence care-seeking behaviour.

**METHODS**

**Study Settings**

This study was conducted in the Idikan community, Ibadan, a city in the south western part of Nigeria, as part of a larger community based study of the sociological aspects of hypertension. Ethical approval for the study was obtained from the Joint University of Ibadan-University College Hospital Ethical Committee. Idikan is located in the indigenous part of the city of Ibadan and has a population of 15,042 (National Population Commission, 2009). The health facilities in the community include an outreach clinic run by the Department of Preventive Medicine and Primary Care of the University of Ibadan, four private clinics and a small dental clinic run by the Dental Centre of University College Hospital (UCH). There are 150 registered patent medicine stores in the area. There are three traditional healing homes, and they are all accessible to members of the community.

**Research Design**

The primary study population were adults (above 25 years of age) residents of Idikan who are known to have hypertension. The study was a community based cross-sectional study. The study collected primary data using a survey, focus group discussion (FGD) and key informant interviews (KIIs). The goal of the FGDs was to capture in-depth information that is complementary to the survey. Eight FGDs were carried out. Key informant interviews were
held with community members with specific roles or occupations that include providing health care to people who have hypertension, namely: clinic nurses, community health workers, Patent Medicine Vendors (PMVs) and indigenous healers. Overall, 23 KIIs were conducted.

**Data Management**

The author reviewed all open-ended portions of the questionnaire; codes were later developed for coding all open ended responses. Data entry and management was carried out using the *Statistical Package for Social Sciences* (SPSS) version 14.0 (SPSS Inc. Chicago, ILL). Frequency distribution and chi-square statistical techniques were adopted to analyse quantitative data in the questionnaire. Univariate analyses were employed in interpreting socio-demographic characteristics of the respondents, while a bivariate analysis was used in cross tabulating variables. Computer assisted qualitative data analysis (CAQDAS) was carried out using the software package ATLAS.ti. In addition, manual content analysis was added to accommodate verbatim quotation in support of ethnographic findings.

**Results**

A total number of 440 respondents were studied, comprising 287 women and 153 men. The ages of respondents ranged from 25 to 90 years, with a mean of 60 (SD 12) years. Most of the respondents (71%) were married, while 25%, 2%, 2% and 0.5% were widowed, single, divorced and separated, respectively. There was no significant relationship between the sex of respondents and their age distribution (Figure 1). Majority (61.4%) of respondents were Moslems, 38.4% were Christians and 0.7% was a traditional religion adherent. Respondents with no formal education constituting the highest cluster, representing 51.1% of the total respondents. Those with only primary education constituted 19.5% while those with higher national diploma or bachelor’s degree constituted 17.5% and 11.1% for those with secondary school level. However, those with other types of education like Arabic school constituted only 0.7%. Majority (50%) of the respondents were traders, while those who have retired and not working constituted 25.7% (Table 1).
Figure 1: Relationship Between Sex Of Respondents And Their Age Distribution
Table 1: Demographic Characteristics Of Respondents

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Islam</td>
<td>270</td>
<td>61.4</td>
</tr>
<tr>
<td>Christianity</td>
<td>169</td>
<td>38.4</td>
</tr>
<tr>
<td>Traditional</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>440</td>
<td>100</td>
</tr>
<tr>
<td><strong>Ethnic Group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yoruba</td>
<td>434</td>
<td>98.6</td>
</tr>
<tr>
<td>Ibo</td>
<td>5</td>
<td>1.2</td>
</tr>
<tr>
<td>Isoko</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>440</td>
<td>100</td>
</tr>
<tr>
<td><strong>Educational Level</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No formal Education</td>
<td>225</td>
<td>51.1</td>
</tr>
<tr>
<td>Primary</td>
<td>86</td>
<td>19.5</td>
</tr>
<tr>
<td>Secondary</td>
<td>49</td>
<td>11.1</td>
</tr>
<tr>
<td>Post Secondary</td>
<td>77</td>
<td>17.5</td>
</tr>
<tr>
<td>Others (Arabic school)</td>
<td>3</td>
<td>0.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>440</td>
<td>100</td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trading</td>
<td>220</td>
<td>50.0</td>
</tr>
<tr>
<td>Artisan</td>
<td>49</td>
<td>11.1</td>
</tr>
<tr>
<td>Teaching/Civil Servant</td>
<td>43</td>
<td>9.8</td>
</tr>
<tr>
<td>Retired/not working</td>
<td>113</td>
<td>25.7</td>
</tr>
<tr>
<td>Religious Teachers</td>
<td>15</td>
<td>3.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>440</td>
<td>100</td>
</tr>
</tbody>
</table>

**Care Seeking Behaviour**

In order to document the source of health facilities that respondents consulted for care for their hypertension, respondents were asked where they normally seek care for their hypertension. Figure 2 illustrates the different health facilities respondents consulted. A large proportion (63.4%) of the respondents reported that they sought care for their condition from the hospital/health centre (University College Hospital (UCH), community health centre and private hospital); while 5% said they go to PMVs. It was interesting to note that all
respondents used a combination of these facilities. Despite the fact that none of the respondent reported using indigenous healer exclusively, 9.5% of the respondents who visited the hospital still made use of traditional medicine, while 7.3% used both the PMV and traditional medicine.

Figure 2: Sources Of Health Care Facilities Utilised By Respondents

Some pertinent issues on the subject of choice of health care utilization were raised during the FGD session. One discussant said:

‘I always rely on the research team. They give us free drugs. But since the project finished, some people go to UCH, only that the wahala (stress) to see doctor in UCH and the money to pay is too much. Sometimes, the nurses are shouting at you. As for me, since the research finished, I just go to the chemist (PMV) to buy my drug when I have the money.’

The moderator of the group session asked how he knew what drug to buy from the chemist and he said:

‘I go to the chemist and tell them I want to buy drug for hypertension and show them the type they gave us in research clinic. I also know the shape and colour. Some people take their old prescription to the chemist to buy what they can afford’
A discussant from another group session had this to say:

‘If you are told that you have hypertension, you can take traditional medicine and it will be cured. After the research team left, I use herbal medicine when I cannot buy the recommended drug. Traditional medicine is cheaper and if you do not have money, you can always go back and pay later. Nobody will give you medicine in the hospital on credit. Many people go to the chemist and babalawo (traditional healer) to complain and get help. It is faster and cheaper’

Another discussant from the same group session stated:

‘I believe in prayers. I normally go to pray on the mountain because hypertension is from the devil and only God can deliver us. We have been going to the hospital for years and it is still there. Many people have died. Don’t you see we can only ask God for help?’

Respondents were further asked if they used other methods of treatment other than western medicine. The finding showed that 70% said ‘No’, while 29.1% said ‘Yes’. Table 2 represents the different methods used by respondents in addition to western medicine.

<table>
<thead>
<tr>
<th>Other methods used</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional method (Herbs/concoctions)</td>
<td>83</td>
<td>18.9</td>
</tr>
<tr>
<td>Garlic</td>
<td>27</td>
<td>6.1</td>
</tr>
<tr>
<td>Herbs and Prayers</td>
<td>10</td>
<td>2.3</td>
</tr>
<tr>
<td>Prayers</td>
<td>5</td>
<td>1.1</td>
</tr>
<tr>
<td>Urine concoction</td>
<td>2</td>
<td>0.5</td>
</tr>
</tbody>
</table>

Interviews With Health Workers, PMVs And Indigenous Healers

Interviews with the community health care workers revealed that some of their patients do not like going to the nearest university teaching hospital (the University College Hospital, Ibadan) because the hospital visits are too stressful, including having to arrive early, waiting for hours before seeing the doctor and often not being able to go to work or attend to their trade for that day. They also said that they are made to do a lot of tests, which they often cannot afford. Often, they do not have enough money to buy their drugs and transport themselves back home. For these reasons, they prefer visiting the community health clinic to check their blood pressure (especially when they know when the doctor will be around) because the clinic visit is free, it is less crowded and they get attended to quickly so they can go to their place of trade or rest for the day. They then go to one of the PMV shops to buy as little antihypertensive medicine they can afford.

The interviews also revealed that some of these patients do not understand how serious hypertension is. When they feel better, they do not bother to go for their clinic appointments or even use their drugs.

One of the nurses interviewed said:
'Most people do not keep to their clinic appointment for two major reasons: Firstly, when they feel better, they do not see the need to go back for their appointment or go to see the doctor. They believe that the illness is cured. The second reason why there is poor utilization by hypertensive patients is money. Many people cannot afford to be going to the hospital every month and be collecting prescription to buy drugs. These things cost money. I also think that some people do not use health facilities because they forget or they traveled.'

Another nurse from the private clinic stated:

‘Hypertension is not like many other sicknesses like malaria that is easy to manage and cure. You just take your medicine for a couple of days and you feel better. It is not easy to be going to hospital all the time and also swallowing medicine. When the research clinic was still going on, these people keep appointment because they are given free drugs and treatment free of charge.’

Interviews with the PMVs revealed that many hypertensive patients do not like going to the hospital and that is the reason they go to the PMV with old prescriptions to buy drugs when they feel sick. The PMVs also said that some of these people with hypertension believe that once they take their medication for some days, the hypertension will go away. But when they are sick, they come to the PMV to buy drugs and start again. As stated by one of the interviewed PMVs:

‘People go to the hospital only when they are very sick and have no choice. In this Idikan, most people use the community health centre or private hospitals. Some others use traditional medicine. It is mostly when the case is serious that they go to the hospitals. Not many people comply with their clinic appointment. Once they have an old prescription, they just come to the chemist [PMV] to buy the medicine.’

The PMVs mentioned that there are times they ask their clients to go see a doctor because of the nature of some of their complaints. These people often refuse to go to the doctor because they claim they will still be given the same medicine in the hospital. So instead of (in their view) wasting time and money, they go to the PMV to buy their medications. In another interview, a PMV indicated that some of their customers use the health facilities and keep to their clinic appointment because they always come with new prescriptions from the hospital. The only problem is the fact that they do not always buy full medication dosage written on the prescription sheet because of lack of cash.

The indigenous healers on their part stated that many people do not like going to the hospital because it is expensive, and to see the doctor takes a long time. Even when they write the prescriptions for the drugs, the clients cannot afford to buy all, hence they prefer to go to the indigenous healer.

One of the indigenous healers interviewed said:

‘Since the research where they were giving people free drugs finished, it is difficult for people to go to the hospital, hence they come to us. Even if they do not have money, we give them medicine and they can always come back to pay later. After all, we are all in this community and we know ourselves.’

The researcher wanted to know how often these community health care workers, PMVs and indigenous healers refer patients to the hospital. The nurses from the community health centre said they occasionally refer patients that are very sick and their blood pressure very high to the hospital. The community health centre is a clinic run by the Department of
Community Medicine, UCH, as a community outreach and it does not have facilities for admissions. On the other hand, a nurse from the private clinic said they do not often refer patients with hypertension to other hospitals because they have admission facilities and doctors. It is only when the patient is very sick that they refer them to UCH. Likewise, two of the indigenous healers said they do not send their customers away or refer them to hospitals for treatment. They only send them to the health centre to go and check their blood pressure. One of the healers said:

‘I do not send them away or anywhere. They come to me for help and I give them medicine. Why should I refer them to another place?’

Another indigenous healer has this to say:

‘When I give them medicine, I ask them to go to the community health centre once in a while to check their blood pressure. I do not refer them. I treat them myself and some are well and cured.’

Yet another indigenous healer interviewed had a slightly different opinion about referral:

‘When they are too sick, I ask them to go to the hospital so that nobody will die in my place. But when they can still walk around, I do not refer them or send them away.’

All the PMVs interviewed indicated that they do not have to refer anybody because the patients only come to buy drugs and not to be treated. The PMVs claimed they are not doctors and so cannot refer anyone. On the other hand, a couple of them said if they see any of their patients who look very sick, they just ask them to go and see the doctor.

DISCUSSION

Today it is recognized that, instead of being presented to health professionals, many symptoms are ignored, tolerated or self-treated: a phenomenon known as the “symptom iceberg” (Hannay, 1979). Health seeking is worse for illnesses that are asymptomatic like hypertension. A feature of contemporary health care is the diversity in sources of help available. For example, an individual who feels unwell may consider contacting a hospital (formal or private), over-the-counter consultation (patent medicine vendors), indigenous healers or do nothing at all. In Nigeria, and in other developing countries, channels of care which are utilized are more varied, including indigenous healers, spiritual churches and pharmacies (Erinosho, 1998). Results from this study show the use of a combination of health care facilities among respondents. Despite the fact that none of the respondents reported using indigenous healers exclusively as a primary source of health care, 9.5% of the respondents who visited the hospital still made use of traditional medicine, while 7.3% used the PMV and traditional medicine. In a recent study (Harding and Taylor, 2002), of over 1,000 adults in Britain, 32% used an over-the-counter product or previously prescribed medication, 9% used home remedy or alternative medicine while under half (46%) dealt with their illness by taking no action. The present study and others show that various factors, such as previous experience with the medical system and financial burden were crucial to whether or not respondents choose to consult their doctors. According to Chuma, Thiede, & Molyneux, (2006), an important influence over treatment seeking behaviour is household ability to pay for health care. Other findings from a household survey conducted in Tbilisi, Georgia, in 2000 reported that health care services are a financial burden. Members of the poorer households are less likely to seek care than people from more affluent households, and devote a higher share of household monthly expenditure to health care. According to Amod, Jimba, et al (2002), when rural Nepalese feel sick, they seek healthcare only when
the sickness is moderate and severe. Mild illnesses are treated at home. When the villagers seek health care, they preferred to visit indigenous healers first, before visiting other health workers. Thus, studies from multiple countries have documented the utilization of multiple sources of health care and factors that influence these choices.

The present study also revealed that patent medicine sellers were another main source of health care for the respondents. Patent medicine sellers or vendors (PMV) have become widespread sources of obtaining medications for various conditions and even for health care in many sub Saharan countries. Originally meant to sell only over-the-counter and non-prescription medications, their role has evolved to include the sale of prescription medications for multiple diseases (Ongore and Nyabela, 1996; Werner, 1981). In the present study, the reasons for the use of PMVs by respondents are practical: the patient saves time (no long waiting lines to see the doctor or at the pharmacy) and they can purchase any quantity based on the amount of money he/she has (does not have to “fill a prescription”). The downside is that they miss professional evaluation of their hypertension and the often-needed time to time adjustment of their medication types and dosages, which may make them more prone to poor control and complications.

It is important to highlight the importance of indigenous or traditional medicine in many sub Saharan African societies. This study identifies some of the factors that may be helpful to understand respondents’ motive to use other method of treatment outside the orthodox treatment. The result suggests that the decision to use indigenous healers is influenced by perception of their effectiveness, barriers regarding visiting the hospital and availability of affordable medicine. In support of this, Oke and Bamidele (2004) in a survey on misconceptions about hypertension amongst 1365 Nigerians hypertensives, noted that 21% of the respondents were of the opinion that they would achieve a permanent cure of hypertension only from alternative medicine practitioners. Our findings were also similar to other studies were patients’ perception of the therapeutic efficacy of alternative medicines were assessed. In these studies, more than half of these alternative medicine users perceived that the alternative health care was responsible for some noticeable improvement in physical or psychological well being (Kappauf et al, 2000; Harnack et al, 2001).

**Findings In The Context Of Health Care Providers**

This study used qualitative methods to gain a better understanding of key informants (community health workers, indigenous healers and PMVs) as they have interacted with and cared for people with hypertension in the community. Understanding their perception of hypertension in the community and other recurrent issues is necessary as they are a link between the community they serve and the health sector. These key informants seemed to have insufficient knowledge and health information on the cause and curability of hypertension and, similarly to the hypertensive respondents, attributed stress as the cause of hypertension. A recurring theme is that of combining medical treatment with other remedies including traditional and use of over-the-counter medication. The respondents used the non-Western indigenous medications alongside the prescription medication in contrast to the findings of another Nigerian study (Olisa & Oyelola 2009) who found that patients discontinue prescribed medication in favour of traditional medicines. Data from the study revealed that people fail to understand why they should continue with hypertension treatment for life, especially when they do not experience pain. Therefore, they conclude that the western medicine is not very effective, and start looking around for the cure for the condition. The data with these key informants confirm that respondents often combine treatment from various sources, sometimes because they believe they will get cured using indigenous medicine.
Interesting group-specific findings emerged from the key informant interviews. As a group, indigenous healers strongly believed they could cure hypertension in contrast to the nurses in the community who said hypertension can only be controlled, not cured. PMVs saw their role as the sale of medicine and not that of treating patients, in contrast to the other two groups who saw themselves as health care providers. A noteworthy finding from this component of the study is that these health workers have developed ideas about hypertension from long-term observation of their client’s behaviours and interaction with their clients. Illustrative of this is the indigenous healer who stated that he does not think hypertension can be cured because he has clients who still have hypertension despite being treated for a long time with both indigenous and Western medication. It was instructive how frequently during the key informant interviews that the community health workers, indigenous healers and PMVs cite or quote their clients. This implies that these key informants have a view of the experiences of people with hypertension that the health professionals in hospitals and medical centres do not see. In summary, the findings from the key informant interviews confirm and extend many of the findings from the survey of hypertensive respondents.

There are some limitations to this work. While this study generated a wealth of useful data on sociological aspects of hypertension, it is not certain how generalizable these findings are to other communities, which may have different demographic, cultural and other characteristics. Therefore, the findings should be regarded as reflecting primarily this study community and may be generalizable to other southwest Nigerian communities only to the extent that they resemble the study community. Given the known differences between men and women in health care seeking behaviour, it would have been useful to enroll equal number of men and women. This is a limitation of this study.

More studies of the sociological aspects of hypertension are needed. However, because hypertension does not display any major symptoms, there is the need for community screening in order to detect the condition and improve awareness in the community. Without these preliminary steps, it may be quite difficult designing and conducting sociological studies of hypertension because the lack of awareness means no experience of care-seeking, treatment or living with the disease. Therefore, community screening is an essential step that will facilitate future sociological studies. A key finding in this study, in common with several such studies from developing countries, is the role of multiple community based care providers (clinic nurses, PMVs, indigenous healers) in the treatment of hypertension. In contrast, hypertension care is hospital/clinic based and access to health care is near-universal in most industrialized nations. These differences (as well as others) suggest that it would be desirable to develop and evaluate models of community based management of hypertension in our environment. Such studies would link sociological research with action to control hypertension in the community.

In conclusion, this work has produced both quantitative and qualitative data on care seeking behaviour, a key sociological aspect of hypertension as experienced in a Nigerian community by people who have hypertension and their health care providers in the community. The findings provide a resource for understanding the context of hypertension care-seeking behaviour in this urban Nigerian environment and could serve as input into health policies and programmes designed to control hypertension.

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