Drug information for patients in the community

The failure of patients to follow drug regimens may be due to lack of information or the negative attitudes of patients and health care providers. We have found that most patients in rural areas did not ask for information about their treatment because they felt their health carers had little time for such matters. These problems will continue unless practitioners at all levels make better efforts to understand their patients’ perceptions of illness and treatment, and especially whether compliance with drug treatment is feasible.

The failure of patients to keep to a well-founded drug regimen is one reason for unsuccessful treatment. In the developed world up to half of all patients do not take drugs as prescribed and may stop treatment prematurely when they feel better. This may be a deliberate act by the patient; or it may occur through misinterpretation or inadequate information (1). Compliance is known to be higher when patients have some understanding of their condition and treatment (2): verbal instructions which reinforce any written information may increase knowledge and improve outcome (3). In one study carried out in the Orange Free State (South Africa), 83.6% of the patients interviewed felt that more involvement on their part would lead to greater trust in their health care provider and more confidence in the treatment (4).

To eliminate low compliance, the health care provider must first determine whether the patient willingly accepts the treatment and then decide what kind of information he or she needs on the drugs given. In general, health care workers tend to respond only to specific questions the patients may ask. In a baseline study we found that only 20% of patients received some kind of drug information from their community health team.

Household survey

We therefore decided to investigate the extent to which patients were given details of their treatment, the primary source of this information, and the type of information which they sought out on their own initiative.

Using systematic cluster sampling, we studied 910 households in urban (300), rural (300), and commercial farming (310) areas.

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in the Mashonaland West Province of Zimbabwe. Whenever possible, heads of households were interviewed with a standardized questionnaire concerning the following:

- knowledge about common diseases in the community, e.g., etiology;

**People’s beliefs about illness causation governed their health-seeking behaviour.**

- health-seeking behaviour;
- medication taken;
- type and source of medication;
- type of information given by health worker.

The interviews covered all relevant drugs and remedies; with each drug mentioned, we recorded whether it was available over-the-counter or on prescription only. Details of traditional remedies were also noted to see how these were perceived by the respondents as compared with proprietary medicines.

The questionnaire interviews were followed a few weeks later by group interviews on the same topics. This allowed us to verify and supplement the data obtained earlier. As far as possible, members of all the groups sampled were representative for age, sex, education levels, religion, and socioeconomic status in the community.

**Medication knowledge**

The diseases or symptoms most commonly recognized in both rural and commercial farming communities were diarrhoea, influenza, coughs, hypertension, and malaria. The respondents were also aware of chronic conditions such as epilepsy, asthma, and diabetes. In general, the illnesses were ascribed to natural or supernatural causes. These views on etiology determined the health-seeking behaviour in both rural and urban populations who, on the basis of previous experience, tended to choose a form of therapy which they believed would help a particular disorder.

The desired information concerning their health problems was related to the respondents’ personal history. Some 80% of the rural people claimed not to trust their health provider and did not ask questions about the medication or therapy. Most of those interviewed in rural districts and commercial farms were semi-literate. In contrast, 60% in the urban area had some general knowledge about the action of various medicines and were aware of their high cost when private practitioners or pharmacists issued the prescription. There were no private pharmacies in the rural areas, and drugs were either bought from a general store or obtained from the rural health centre.

As to why a majority of the rural sample felt there was no need to have further information on medications apart from details about dosages, the reasons given included:

- health carers were too busy to explain;
- the information was too difficult to understand;
- the patient was too ill to discuss anything at the clinic or hospital.

When questioned again about the kind of general information they would like to have about medication, the respondents suggested the following.
• Cause of the disease.
• Treatment schedule and duration.
• Names of prescribed drugs and the best way to take them.
• Action to take when there are side-effects.
• Proper way to store the medicines.

The specific types of drugs requiring more detail were:

- anti-infective agents, e.g., penicillins, chloroquine;
- non-steroid anti-inflammatory drugs, e.g., acetylsalicylic acid;
- vitamins;
- cough mixtures (expectorants and antitussives).

**How, why and what?**

A number of studies in different social settings have addressed the issues of how much patients should be told about the drugs they take: whether there should be written material about medication, how might the information best be given, and who should give it.

Two different conclusions have been drawn from the results of these earlier studies: the first argues that giving information to an illiterate person is pointless, since the patient is unlikely to understand or be interested in details. This view is supported in part by the results of the group interviews from our study. In contrast, the other holds that patients are unable to make appropriate decisions and are less likely to comply with treatment regimens unless they are fully informed about their condition and its treatment.

However, perhaps the choice is neither to resign in the face of illiteracy nor just to give out routine and standardized information to every patient with a given condition. In the same way that drug dosages are individualized, details and information about medication should be tailored to match the needs of each individual patient.

Not only is it important to determine whether patients understand the nature of their health problem before details of medication are given, but health carers should also be aware of their patients’ beliefs about illness causation. A large body of empirical literature suggests that attitudes and beliefs contribute substantially to a patient’s decision whether to cooperate with treatment plans. It has been claimed that these beliefs can be readily assessed and often altered. However, our results suggest that this process may be difficult especially with semi-literate people who still hold strongly to certain traditional attitudes concerning health and illness. Many people still believe that diseases can be of supernatural origin. This has obvious implications for modern pharmacotherapy in particular and for health-seeking behaviour in general.

It is noteworthy that a majority of the rural population (71%) did not request any information about their medication because they felt that the health care worker had no time for discussion. More seriously, other care providers were thought to be extremely
ill-mannered and the patient decided not to ask for more information to avoid unnecessary conflict.

In developing countries like Zimbabwe, there are few pharmacists who can substitute for the busy prescriber; often, where there is a rural health centre, there is only one health assistant who has to deal with all types of problem. However, much health care will continue to be inappropriate unless the providers at all levels attempt to understand their clients' perceptions. They should determine whether the patient agrees with the diagnosis and the recommended treatment and, more importantly, whether compliance with a drug regimen is feasible (4).

Indigenous health beliefs

We note that there was no apparent problem in accepting a diagnosis when patients were treated in a clinic. However, powerful and well-defined health beliefs (which may be scientifically false) could still influence whether a diagnosis would be readily accepted or not. Often the seriousness of a disease might not easily be perceived by a sick person, and there may have to be some social interaction which influences whether a recommended treatment will be effective or not.

The treatment of patients in societies with strongly held indigenous belief systems might require either appeals to their family responsibility or the provision of information from more credible sources; for example, testimonials from patients where the same treatment had proved successful. We found this to be the case with men who had contracted sexually transmitted diseases and where details of treatment had been relayed from one man to another.

It is not surprising that some literate people, particularly those from the urban area, did not place a high value on oral information, claiming that it was too easily forgotten. However, other studies have shown that well-structured counselling can improve the ability to recall information (5).

A complex process

Decisions about treatment are often more complex than is commonly supposed: both the health worker and the patient approach the situation with degrees of uncertainty. Practitioners are likely to have information which may be valid at the time but which can become outdated as medical knowledge improves. Equally, when a patient takes a drug he or she is taking part in an experiment where the outcome might not be fully understood. Furthermore, the patient may be uncertain about the implications of the diagnosis and its suggested treatment (4). Therefore, a constructive dialogue between the health care provider and the patient is required irrespective of whether the patient is illiterate or not. We consider that the reluctance of many illiterate women to learn more about oral contraception represents such a challenge to health workers.

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Details about medication for patients in a given community must be structured to take heed of local conditions. It is important to
recognize that a wide gap can exist between the objective knowledge of health care providers and the more subjective experience of their patients. Practitioners who fail to make use of the patient’s fund of experience and expertise will do so to their own and their client’s disadvantage.

Acknowledgements

This study was supported by a research grant from the WHO Drug Action Programme. Our thanks go to Professor Caroline Bledsoe, Department of Anthropology, Northwestern University, Evanston, IL, USA; Professor Per Knut Lunde, Department of Pharmacotherapeutics, University of Oslo, Norway; and Professor Peter Folb, Department of Pharmacology, University of Cape Town, South Africa.

References


Snake venoms and antivenoms

Many thousands of deaths from snake-bite occur annually in certain areas of Africa, South-East Asia, the Indian subcontinent, and Central and South America. There is an urgent need for international reference materials for snake antivenoms and defined methodologies whereby preparations of such antivenoms can be tested in these areas. The WHO Expert Committee on Biological Standardization therefore asked the WHO Secretariat to investigate the possible need for requirements for the manufacture and control of snake antivenoms.