Sociocultural, economic and regulatory influences on medicine use by consumers in a rural township in Cameroon

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Abstract

Objectives: The objective of the study was to analyze the sociocultural, economic and regulatory factors influencing access to and the use of medicines by consumers in Tiko, Cameroon.

Method: Using focus group discussions information was obtained from members of Plantain Traders Association, Township Taxi Drivers Association and Teachers of Government Bilingual High School (GBHS) Tiko. This information was triangulated with those obtained from key informant interviews with sellers of medicines in community pharmacies.

Results: Key influences on medicines use were reported to have emanated from the sociocultural and economic background of the people and also from inappropriate regulation on medicine distribution and sales and included the perceived need for medicines, the cost of medicines, the purchasing habits, the medicine use culture, medicine supply channels and poor medicines regulation and control.

Conclusion: Consumers’ perceived need for medicines generated a pattern of use that included medicines sharing attitudes and polypharmacy. Their medicine purchasing attitudes were greatly influenced by their financial constraints. The lack of proper regulation also contributed towards the irrational use of medicines.

Keywords: Medicines, medicines use, consumers, patients, community pharmacies, self medication, Cameroon.

Introduction

Essential medicines, or drugs, are those which satisfy the priority health care needs of the population¹. They should be of good quality, available at all times and affordable. When used properly, these medicines provide simple cost-effective solutions to our health care needs¹. “The rational use of medicines requires that patients receive medications appropriate to their clinical needs, in doses that meet their own individual requirements, for an adequate period of time, and at the lowest cost to them and their community.”² Unfortunately, studies indicate that on a global level, more than 50% of all medicines are prescribed, dispensed, or sold inappropriately and 50% of patients fail to take them correctly³.

The inappropriate use of medicines results in increased morbidity and mortality, especially in disease conditions like hypertension, diabetes and epilepsy where it is critical that medicines are taken regularly and appropriately³. It also wastes resources and results in poor patient outcomes and adverse drug reactions³. Antibiotic resistance is on the increase due to overuse of antibiotics, and inappropriate use of injections, especially non-sterile injections, has resulted in increased transmission of HIV/AIDS and hepatitis⁴. The rational use of medicines is one of the core components of the pharmaceutical policy of Cameroon⁵. The strategic document for the implementation of a National Pharmaceutical Policy in Cameroon recognizes that, despite the creation of a Central Pharmaceutical Store for the nation, health units still
run out of stock of essential medicines\(^1\). In addition, the illicit trade in pharmaceuticals, most especially counterfeit medicines is increasing and no public health programs exist to educate actors involved in medicine use on the appropriate use of pharmaceuticals, a problem which is further exacerbated by the lack of sufficient number of health professionals. In 2000, it was estimated that the pharmacist to population ratio was 1:26930 persons while for doctors (general practitioner) it was 1:12,500 persons and for nurses 1:2083 persons\(^5\). This is a particular cause for concern because modern medicines are found everywhere and can be sold by anyone\(^6\). Previous studies conducted in Cameroon to promote rational use of medicines have focused on health worker prescribing and dispensing. Enhancing optimal practices by health care workers can only partly improve the use of medicines, because Cameroonian, instead of going to the formal health sector when sick regularly self-medicate or visit a street vendor, traditional or faith healer\(^7\). It was noted that when consumers self-medicate, they obtain their medicines from informal drug distribution channels and from pharmacies. It was estimated in 2006 that 44% of sick patients in Cameroon relied on self treatment, 26% and 17% respectively went to state-owned health facilities and private health facilities while 8% of patients went to an informal health facility, mainly illicit drug retailers, traditional healers and religious healers\(^8\). In addition, the use of medicines is not rationalized and constitutes 81% of the total health expenditure\(^8\).

Frequently consumers request capsules or tablets of medications ranging from anti-infectious agents such as antibiotics and antimalarials to analgesics and, for various reasons, not all of these patients buy the full course of therapy and even when they do, they may not take all the medicines as prescribed. In 2008 and 2009, it was estimated that households were paying 77% to 90% of the annual total health expenditures of Cameroon and that 94.8% of this contribution came as out-of-pockets spending during illness episodes\(^9\) in the formal and informal health sectors. Successful strategies to improve the use of medicines by consumers must be based on a clear understanding of consumers’ beliefs, expectations and approaches to medicines, so that specific issues can be targeted. This study therefore investigates the ways consumers’ in Tiko Sub division, Cameroon, use medicines and the factors influencing them to do so. The study took place in Tiko Sub-division, a rural sub-division in the South-West Region, one of the two English speaking regions of the Republic of Cameroon. Tiko Sub-division is a coastal plain and has a hot climate. The population size is approximately 55,914 inhabitants\(^9\), made up of approximately 47.8 % males and 52.2% females. The principal sources of income of the Tiko population are trading, farming and plantation wage earnings. Plantation wage earners and farmers make up 81% of the poor population in Cameroon\(^10\). As in other parts of the country, malaria, pneumonia and diarrheal diseases are the leading causes of death especially of under-5 mortality\(^11\) while HIV/AIDS and tuberculosis are also common. Tiko is an easy access point to neighbouring countries like Nigeria and Equatorial Guinea. English and French languages are the two official languages in Cameroon. However, there are about 250 ethnic groups, each with its own language. *Pidgin* is a frequently spoken language and is used in various settings across Cameroon by all age groups but more frequently nowadays, by the uneducated.

**Pharmaceutical Situation in Cameroon**

In Cameroon, only pharmacists registered with the Pharmaceutical Society of Cameroon are legally authorized to import, stock, distribute and dispense medications. However, in reality all doctors in private practice and some in the public sector stock and dispense medicines to patients. Cameroon runs a district health care system. Tiko health district is governed by a district management committee and services are provided in both the formal and informal sectors. The formal sector consists of all accredited hospitals, health centers and community pharmacies. The state owned health care services in the formal sector consists of one district hospital, three maternity units with facilities for out-patient consultations and seven health centres. Private institutions in the formal sector include two faith-based hospitals, two private surgeries and five community pharmacies. There also exists a health service complex owned by Cameroon Development Corporation (CDC) which is intended to take care of employees of CDC. Apart from CDC health staff, there are ten medical doctors working in both the public and private sectors. The informal sector is made up of medicine sellers in stalls, kiosks, hawkers and medicine peddlers. Throughout Tiko Sub-division, it is estimated that there are approximately 100 people involved in this informal trade in medicines. Trading informally in medicines is against the law; however, this practice thrives. Those involved in the informal trade in medicine are not under the jurisdiction of any professional body and do not need any formal qualification to participate in the trade. The medicines they sell range from simple over the counter medicines, like paracetamol, to the most costly antibiotics like the third generation cephalosporins. In this context, the present study was conducted. The objective of the study was to analyze the sociocultural, economic and regulatory factors influencing access to and the use of medicines by consumers in Tiko, Cameroon.

**Methodology**

This study was exploratory. The sample was selected from men and women, aged 18 years and above, living in one of three zones (Tiko town, Likomba and Mutengene) in Tiko Sub division. The three zones of Tiko Sub-division were chosen because they have more than 70% of the population, and about 80% of the hospitals, community pharmacies and informal private medicine stores and it was easy to commute within them.
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Table 1. Process regarding focus group discussions

<table>
<thead>
<tr>
<th>Focus Group 1: Researcher contacted and briefed head of plantain traders association regarding the study</th>
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</thead>
<tbody>
<tr>
<td>• The researcher contacted plantain traders and sellers (inclusion criteria explained)</td>
</tr>
<tr>
<td>• The researcher met two focus groups (Dates and venues for focus groups agreed)</td>
</tr>
<tr>
<td>• Participant information sheet read out, informed consent obtained, focus groups discussions conducted</td>
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<tr>
<td>Focus Group 2: Researcher contacted and briefed taxi drivers association on the study</td>
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<tr>
<td>• The researcher contacted taxi drivers association (inclusion criteria explained)</td>
</tr>
<tr>
<td>• The researcher met two focus groups (Dates and venues for focus groups agreed)</td>
</tr>
<tr>
<td>• Participant information sheet read out, informed consent obtained, focus groups discussions conducted</td>
</tr>
<tr>
<td>Focus Group 3: Researcher contacted and briefed vice principal (VP) and a written request for the study was submitted to and approved by VP</td>
</tr>
<tr>
<td>• The researcher contacted teachers (inclusion criteria explained)</td>
</tr>
<tr>
<td>• Teachers met and two focus groups were formed (Dates and venues for focus groups agreed)</td>
</tr>
<tr>
<td>• Participant information sheet read out, informed consent obtained, focus groups discussions conducted</td>
</tr>
</tbody>
</table>

Table 2. Group numbers, names, dates and venues for focus group discussions

<table>
<thead>
<tr>
<th>Serial no.</th>
<th>Group</th>
<th>Name of group</th>
<th>Number of members in group</th>
<th>Study period</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Group 1</td>
<td>GBHS male teachers</td>
<td>10</td>
<td>March 2009</td>
</tr>
<tr>
<td>2</td>
<td>Group 2</td>
<td>Plantain sellers 1</td>
<td>8</td>
<td>March 2009</td>
</tr>
<tr>
<td>3</td>
<td>Group 3</td>
<td>Plantain sellers 2</td>
<td>7</td>
<td>March 2009</td>
</tr>
<tr>
<td>4</td>
<td>Group 4</td>
<td>GBHS female teachers</td>
<td>9</td>
<td>April 2009</td>
</tr>
<tr>
<td>5</td>
<td>Group 5</td>
<td>Taxi drivers 1</td>
<td>7</td>
<td>April 2009</td>
</tr>
<tr>
<td>6</td>
<td>Group 6</td>
<td>Taxi drivers 2</td>
<td>7</td>
<td>April 2009</td>
</tr>
</tbody>
</table>

Table 3. Process regarding key informant interviews

<table>
<thead>
<tr>
<th>Informal sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Researcher and sellers in medicines stores</td>
</tr>
<tr>
<td>• Purpose of study and inclusion criteria explained (date and venue agreed)</td>
</tr>
<tr>
<td>• Participant information sheet was given and informed consent obtained</td>
</tr>
<tr>
<td>• Interviews conducted</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Formal sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Researcher and pharmacists or pharmacy assistants</td>
</tr>
<tr>
<td>• Purpose of study and inclusion criteria explained (date and venue agreed)</td>
</tr>
<tr>
<td>• Participant information sheet and informed consent obtained</td>
</tr>
<tr>
<td>• Interviews conducted</td>
</tr>
</tbody>
</table>

Table 4. Name of community pharmacy, location and the month when the interview was conducted

<table>
<thead>
<tr>
<th>Serial no.</th>
<th>Name of community pharmacy/Medicine store*</th>
<th>Location</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pharmacy A!</td>
<td>Tiko Town</td>
<td>May 2009</td>
</tr>
<tr>
<td>2</td>
<td>Pharmacy B</td>
<td>Likomba</td>
<td>May 2009</td>
</tr>
<tr>
<td>3</td>
<td>Pharmacy C</td>
<td>Mutengene</td>
<td>May 2009</td>
</tr>
<tr>
<td>4</td>
<td>X medicine store</td>
<td>Long street Tiko</td>
<td>May 2009</td>
</tr>
<tr>
<td>5</td>
<td>Y medicine store</td>
<td>Likomba</td>
<td>May 2009</td>
</tr>
<tr>
<td>6</td>
<td>Z medicine store</td>
<td>Mutengene</td>
<td>May 2009</td>
</tr>
</tbody>
</table>

*The names of the medicines stores were kept confidential
! The pharmacist assistant was contacted and interviewed

Sampling Procedures

Consumers of medicines, with whom focus interviews were conducted, were purposively selected to represent the different socioeconomic and educational levels of Tiko population. The data collection process using focus groups has been shown in Table 1.

The consumers included two groups made up of eight and seven members each of women selling plantain; two groups each of seven members of taxi drivers; and two groups each consisting of ten male and nine female teachers of a public secondary school respectively. Table 2 shows the various focus groups involved in the interviews.

The criteria for inclusion in discussions were that members must be living in one of the three zones of Tiko Sub-division; they must have lived in the area for the past five years; and they must have purchased or used medicines at least once within 30 days of the date of the focus group discussion. For the women selling plantains and the taxi drivers, members for the interviews were recruited with the assistance of the heads of both associations after having been contacted and briefed on the study and inclusion criteria. The vice principal of the government bilingual high school (GBHS) Tiko was contacted and briefed on the study and inclusion criteria. He assisted in recruiting teachers for the study.
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Six key informant interviews were conducted, three each with medicine sellers and pharmacy assistants. Table 3 shows the sampling process for the key informant interviews.

The inclusion criteria for the key informants were that the registered community pharmacy and the informal store must have traded in that locality for at least three years and that the person interviewed must have worked in that facility for at least one year. Because pharmacy assistants often interact with patients in this setting more than pharmacists, they were interviewed. The interviewer personally contacted the key informants. However, those in the informal sector preferred to stay anonymous. Table 4 shows the community pharmacies and the dates of interviews.

Data collection

The focus group discussions were conducted in both English and Pidgin. English language was used during the group discussion with the male and female teachers while Pidgin was used in the discussion with plantain sellers and taxi drivers. The key informant interviews were conducted in English. Interviews were conducted in the community pharmacies and in the medicine stores.

For all the focus group discussions and key interviews, an observer, a social science university student, took notes and recorded non-verbal cues. The interviews were also audio-taped and the recordings transcribed. The focus group discussions and key informant interviews were conducted by the principal researcher. The group discussions for taxi drivers and plantain sellers were conducted in Pidgin and in English for the teachers. The researcher and observer were Cameroonians fluent in both English and Pidgin and they both translated the pidgin version to English.

An interview guide was used for both interviews. The questions focused on the effects of consumers’ health seeking behaviour, access to medicines, the use of medicines and the type and sources of information consumers have for the use of medicines. Ethical approval for the study was accorded by the University of the Western Cape Ethics Committee and supported by the district medical officer of Tiko Health district.

Results

Sociocultural factors

Perceived need for medicines

Consumers’ reported their perceived need for medicines were guided by feeling of ill-health, the feeling of wellness and the desire to stay healthy.

When consumers felt sick “they rushed immediately to get some medicines.” Taxi drivers reported that when they “felt like having fever”, they visited road side kiosks and medicine stores for a prescription and to purchase medicines. They called the medicine they took “first aid” and said that if they did not get better, they would then go to the hospital.

“Me a no di waste time. When ma skin wan just worry me I di go find medicine. A di tell dat boy them wey di sell say make them mix me some merecin for fever. If a take am den a well then fine. If no bi so then a go go hospital. Da merecin them for corner road e just dey like na first aid”

The English version is:

“I do not delay. As soon as I feel sick, I look for some medicines. I tell the sellers in the medicine store to mix for me some tablets. I will go to the hospital only if the medicine I drank did not relieve me of my sickness. Those medicines sold in medicine stores and kiosks are for first aid purposes.”

Plantain sellers said that they often took pain killers when they felt they were going to suffer from generalized body pains. They said that they did so because they did not want to fall sick and “lose market days”.

Pharmacy assistants and medicine sellers reported that consumers often requested medicines because they felt sick or were about to get sick and that they sometimes asked for “a dose of red and yellow capsules to treat a running stomach” and at other times the sellers prescribed and dispensed medicines to consumers.

Taxi drivers and male and female teachers also reported that they stopped taking medicines when they felt better while some teachers deliberately did not use up all the medicines because they thought that it was useful to have some medicines left over to use if the sickness returned.

The desire to stay healthy was expressed by participants in all the focus group discussions. They reported that they took medicines “to stay healthy, for cleansing of the system and to have energy”.

Medicine use culture

The consumers reported sharing medicines with one another, taking various kinds of medicines mixed together, and taking medicines kept from a previously uncompleted treatment.

Consumers reported various instances of sharing medicines with their friends and neighbours.

A female teacher reported the way in which she participated in medicine sharing.

“I used ranitidine for my gastric. I wanted to know if it was a good medicine for gastric ulcer before I bought it. A friend of mine gave me some tablets from her house. They were almost expired but I drank some and they helped. However, kindly let me know if it’s a good medicine before I buy because I do not want to continue drinking the medicine which is about to expire.”

Sellers in medicine stores and pharmacy assistants reported that consumers requested for a mixture of various kinds of medicines including, metronidazole for running stomach (diarrhea), or a
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single or multiple dose of mix medication (chloramphenicol, ibuprofen, iron tablet) for fever. They also reported that men drank alcohol while taking their medications (some feeling that there is a therapeutic benefit in doing so) and also that some female students bought menstrogen during holiday periods to terminate unwanted pregnancy. In addition, they reported that females preferred doxycycline while men took tetracycline capsules, which they referred to as “red and yellow capsule” for cleansing of the system and against running stomach (for this they take with a bottle of Guinness, an alcohol). These medications are supposed to be dispensed strictly against a prescription and some of the combinations requested contain medicines belonging to the same therapeutic class. These medicines were usually kept in their homes or purchased regularly from the sellers. Pain medicines were used regularly by all the groups. Male and female teachers and women selling plantains kept medicines at home to treat fever, stomach ache and worms. They reported that they kept paracetamol, metronidazole, amodiaquine, quinine and mebendazole. They did not know the strengths of the medicines. These medicines were used to prevent malaria (reportedly administered every six months) in their children, to treat “running stomach” in addition to taking them as a “first aid measure” before a formal consultation if necessary, with a health worker.

A male teacher said,

“I do keep medicines at home. I buy them from the pro pharmacy in the hospital. I give malaria medicines to my children every six months to prevent them from getting malaria fever. I also give them worm medicines”.

Pharmacy assistants and medicine sellers reported that consumers gave a variety of reasons when they came to purchase medicines. Sellers in the medicine stores said that some consumers bought medicines regularly because their doctor told them to take the medicine for a long time while others requested medicines for specific purposes. For instance: antibiotics were reportedly requested because consumers are using them to clean their system.

Pharmacy assistants also reported that consumers requested refills of anti-diabetic and anti hypertensive without prescription and that consumers requested multivitamin tablets for their children for appetite. It was common for pharmacy assistants, medicine sellers or consumers to make diagnoses and prescribe to anyone in need of medication. A pharmacy assistant reported as follows:

“…a pastor and another lady came here (pharmacy) to buy medicine. After she (pastor) had narrated the problem of her child, I concluded that the child had malaria and I told her. When I was about to give her the anti-malarial medicine, the woman who came with her said that it was “aspergic” (aspergic is lysine acetylsalicylate) that was good for fever. I insisted and told them that aspergic was only to bring down the body’s temperature. She told me to give as her friend had suggested saying that her friend has children at home so she knew it. I gave as they requested. After about 24hours, the pastor came back complaining that she wanted fever medicine and not medicine to cool body temperature. Unfortunately for her, I was the one on duty, and I told her it was her fault. Her friend looked at the counter of medicines again and saw another medicine, pregnatal (a ferrous product for pregnant women). She advised the pastor to get it for the sick child because “pregnatal” it was the best medicine to replenish iron during pregnancy but that when her daughter went to the antenatal clinic they did not prescribed it for her so she took her daughter to the pharmacy and bought it for her”.

This narrative illustrates the complex interaction between medicine sellers, consumers and the sick. Pharmacy assistants and medicine sellers reported that consumers gave a variety of reasons when they came to purchase medicines including advice from their doctor to take the medicine “for a long time”.

Economic factors

Cost of medicines

All consumers said that medicines were expensive. The cost of medicines influenced the way consumers’ access and used medicines. Community pharmacies were reportedly the most expensive source, followed by medicine stores and then the public hospital pharmacies. Even though consumers believed that community pharmacies had better quality medicines, they still resorted to other medicine supply channels which had lower cost medicines.

Because of cost, some male teachers said that when they went for prescription from a doctor, they had to know why each medicine was prescribed. While some male teachers reported that they bought medicines from public hospital pharmacies where some bought in bulk to “make sure” they had medicines available when they needed them, others venture to avoid paying high costs for medicines by purchasing them through friends.

“My friend is a nurse in Yaounde. Whenever I need medicine as I needed Oflocet recently I called my friend who gave whom I sent 5000frs CFA to get me a packet. It is the same Oflocet that is sold in the pharmacies for 11,000frs CFA. You know, in the pharmacies they have various taxes they pay. They also have the salaries of the workers to pay. These all put together make the medicine expensive”.

Consumers said that community pharmacies did not split packets of medicines. This made it difficult for them to buy from there unlike medicine stores which retailed from packets and offer a mixture of medicines. Plantain sellers said that before they could go to the hospital they had to be sure that they had sufficient money to buy the medicines to be prescribed. When the prescribed medicines were not available at the public hospital pharmacy, they bought the medicines from community medicine stores except when the doctor insisted that they buy them from the community pharmacies. However, even when the
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doctor insisted, they did not at all times buy all the medicines at once from the community pharmacies. They bought their medicines one after the other as they had the money to pay for it, a process that might undermine therapeutic efficacy of prescribed medicines.

Consumers reported that because of cost of medicines, they sought care where they could get services on credit and also sought alternative sources of healing which some combined with biomedicine. This was reported by female teachers and taxi drivers. Taxi drivers further reported that they often contributed money for a sick colleague who could not afford to go to the hospital or buy his drugs. A female teacher said, “I do not have sufficient money. I am a single mother and I have to take care of the children. I have a friend who is a pharmacist. She burrows me medicines when I do not have money. At times I ask her to select those medicines which are very important so I can buy them. I sometimes ask from her pharmacy that they should give me the same medicine as that of the packet I have”.

Regulatory factors

All consumers interviewed reported that medicines were freely available from a wide variety of sources and that there were no restrictions to purchase. Medicine sellers said that they supplied consumers with whatever medicines they requested, whereas pharmacy assistants reported that they sold medicines according to what they felt was professionally appropriate. All consumers interviewed made out-of-pocket payments for their medicines. Sellers in medicine stores and community pharmacies said that they sold in cash based on the amount of money the patient had.

The male teachers reported that the cost of medicines resulted in everybody taking advantage of the high cost of medicines in pharmacies by getting involved in selling medicines. In the hospital pharmacies for instance, they reported that the medicines which were not supposed to be sold without prescription were sold even in bulk to those whom the sellers knew and to some community medicine store owners. Even nurses in the hospital sold medicines to patients.

Discussion

It was found that the way members of the community obtained and used their medicines appeared to be influenced by the way they perceived their need for medicine. Also it was influenced by their ideas about efficacy, costs and the availability of medicines.

The need for medicines was mentioned in a variety of contexts: to treat illness, prevent an illness and to maintain wellness. It was common for both male and female teachers, taxi drivers and plantain sellers to obtain medicines to treat a variety of symptoms, such as pains and fever. It was also common for them to reserve their medicines without seeking medical advice, when they felt well. Teachers, taxi drivers and plantain sellers also took medicines because they wanted to stay strong and healthy. This finding was similar on one hand to that of Rasmussen et al., 12, who reported that consumers believed that “medicine is needed for every illness. If medicine is not used, the illness will become serious”. On the other hand, it could be said that consumers’ perceived severity of disease seemed to influence their continuation on therapy13.

Consumers’ perception of the ‘power’ of medicines seems to influence their desire to acquire medicines. On the one hand, consumers believed that medicines were powerful and could “cure” certain conditions. For instance, medicine sellers from both the formal and informal sectors reported that consumers used antibiotics to “cleanse their systems”, especially after sexual intercourse; and they also took multivitamin products to prevent the skin of their palms from peeling off. Plantain sellers took paracetamol to cure fever and body pains. Some of these uses are inappropriate and it is uncertain how this misinformation got into the community. It does however illustrate a lack of reliable information about medicines which was found in similar research in Ghana14 and in a Filipino village15,16.

Polypharmacy was also found to be rife with consumers requesting mixtures of medication to treat their illnesses. This seemed to indicate that they did not have sufficient trust in one medicine to treat their illness and so they would “make sure” by taking two or three medicines together - hoping that at least one will work. For example, sellers of medicines from the informal sector reported that a mixture of medicines that included “buta” (an analgesic), indocid® (another analgesic and anti-inflammatory), some quinine (for malaria), multivitamins and chloramphenicol were put together in a medicine sachet given for the treatment of typhoid and malaria. It was a common practice for consumers to take antibiotics with Guinness when they have “running stomach” (diarrhea). Guinness (an alcoholic drink) was attributed by consumers in this community to “cause a tight stomach” (constipation) - a counter to the running stomach. In other settings polytherapy has been reported to be the outcome of the uncertainty people have on the cause of their illness and choice of therapy17. As has been observed in this study and in addition to the above, it could be suggested that polytherapy was practiced because people wanted to get well fast in order to be relieved of the discomfort associated with their illness and also, for economic reasons - so that they didn’t have to be absent from their daily activities. This was particularly true of the poorer groups - the plantain sellers and taxi drivers who depended on their daily income. Some of the taxi drivers reported using pain killers and traditional treatment when they had sprains. Using such combination might lead to therapeutic interaction or people may abandon one and move on to the other. This may have an implication in chronic diseases condition where the medicine has to be taken for a long time.

Sharing of medicines with neighbours and friends was a common practice. Consumers did this by supplying medicines from those stored at home from previous or current treatments. Whilst sharing possessions and helping your neighbour was expected
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by community members, it is not appropriate behaviour with regard to medicines use. It may mean that individuals do not get a full course of treatment, say for malaria or a sexually transmitted infection, or they may receive below the therapeutic dose for conditions like hypertension or epilepsy. This illustrates lack of understanding of treatment regimens and may lead to treatment failure and bacteria resistance in the case of the use of antibacterials.

Consumers and sellers of medicines in the informal sector believed that medicines have power to treat diseases and heal the sick. However, because of the monetary value attached to medicines, they treated medicines as objects of trade. Even though medicines are treated in this manner all over the world, it is not appropriate in the current setting because of poverty and consumers make more than 80% out of pocket payment for treatment. It was common in this study for consumers to request for a “few tablets of...” and for sellers to offer a “few tablets of antibiotics” for treatment of diseases. Trading in medicines seemed to be seen as a means of making a living by some medicine sellers. The study found that consumers wanted to stay healthy - medicine was thought to be a tool to achieving this and thus many people were trading in pharmaceuticals.

In Tiko Sub-division, financial considerations seemed to have played a key role in consumers’ access and use of medicines. In Cameroon, consumers pay all costs including the costs of medicines when they visit health facilities. The system of user fees was introduced to decrease unnecessary demand for health care services, raise additional funds for the health system and improve efficiency, especially the availability of essential medicines. Prior to the implementation of user fees government pro-pharmacies always ran out of stock of essential medicines.

In public hospitals, essential medicines are sold in pro-pharmacies and they are substantially cheaper when purchased here than from other sources. However, consumers said that they did not obtain medicines from the pro-pharmacies for various reasons which included the fact that sometimes doctors prescribed medicines that were not on the essential list and therefore not stocked at the pro-pharmacy. So, this left them with the option of having to obtain medicines either from a range of informal traders or registered community pharmacies. Both of these options posed problematic issues for the rational use of medicines in this community.

Consumers reported that the medicines from the community pharmacies were good quality but expensive. Van der Geest compared prices of medicines sold at the community pharmacies with those sold at the government pro-pharmacies and found that those sold through community pharmacies were about 400 times higher. This resulted in consumers asking pharmacists about which medicines to buy from a list of prescribed medications. This would result in patients not following the prescribed regimen. This could have been different if pharmacists were stocking generic medicines at affordable prices or consumers educated to insist on generic medicines from community pharmacies. Pharmacies are challenged to provide cheaper generics where they can make generic substitution. Even though consumers should get quality medicines and advice from a community pharmacy this source is not accessible to many due to cost.

Many consumers said they visited medicine stores or hawkers as their first port of call because medicines from these places were cheaper than in community pharmacies. In addition they said medicine sellers were ‘more flexible’ and amenable to selling part of packets. The medicine store owners opened up packet of medicine and sold part of its content to the patient. Splitting a patient-ready pack of medicines is forbidden by law in Cameroon. The system is highly problematic, accounting for the problematic nature of medicine consumption by individual. More so, this practice of selling by the pill does not promote rational medicines use because most patients do not come back to complete their course of medicines. It was also reported that roadside sellers and kiosk owners put expired medicines into packets which had a valid date and sold them to unsuspecting consumers. Whilst selling of medicines by the pill could help alleviate immediate symptoms, it may not treat the underlying cause of the disease and in case of infectious disease; this might result in resistance to the microorganism.

Regulatory decisions about medicines are supposed to restrict the handling and use of medicines as a means of contributing to the safe and appropriate use of medicines but regulations are not enforced. More so, a comprehensive pharmaceutical policy for Cameroon detailing who does what and how is yet to be developed. This study found that consumers in Tiko Sub-division bought their medicines, in ascending order, from hawkers, street corners, medicine stores, pro-pharmacies and community pharmacies. Community pharmacies are the only officially licensed outlets to sell drugs to the public. Pro-pharmacies are to issue drugs to the sick who visit public hospitals. However, the illicit trade in pharmaceuticals is unbridled. The illicit trade in pharmaceuticals in the Cameroon and other African countries, Ghana and Nigeria, has been reported in other studies. In the uncontrolled sale of medicines causes the circulation of poor quality medicines, compromising patient safety and rational use.

Consumers reported that medicines found in the various medicine sales outlets were not of same quality. Poor quality medicines were reported in the community medicine stores and with hawkers. In community pharmacies, although the medicines were of good quality, consumers reported, they were expensive. In pro-pharmacies, the medicines were invariably out of stock. It has been reported elsewhere that when medicines were out of stock dispensers dispensed what they have in stock. Sometimes they dispensed branded products when international non-proprietary names (generic names) were prescribed. Consequently, it is frequent in these settings that dispensers and patients do not adhere to prescription regimens.

It was reported by male teachers that in Tiko Sub-division doctors were few compared to population size and that some doctors did not understand English or pidgin, which are the common...
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languages of community members. Holloway 25 suggested that setting educational standards for health professionals and developing and enforcing codes of conduct would improve medicines use. Medicine use by community members is unlikely to be appropriate if prescribers do not communicate adequately with patients.

Conclusion

Sociocultural factors that affected consumers' use of medicines were found to relate to the perception that they needed medicines to stay healthy and when they felt sick. The consumers would also abandon their medicines when they felt they were well again. As a result and because of their financial constraints and the cost of medicines they adopted coping mechanisms which included purchase of medicines in small quantities, practiced polypharmacy/polytherapy, shared their medicines with one another and also to self medicate with prescription medicines. In conclusion consumers' medicine purchasing were greatly influenced by their financial constraints.

References