



Out of the reach of children? Young people's health-seeking practices and agency in Africa's newly-emerging therapeutic landscapes

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ABSTRACT

Despite a dominant view within Western biomedicine that children and medicines should be kept apart, a growing literature suggests that children and adolescents often take active roles in health-seeking. Here, we consider young people's health-seeking practices in Ghana: a country with a rapidly-changing therapeutic landscape, characterised by the recent introduction of a National Health Insurance Scheme, mass advertising of medicines, and increased use of mobile phones. Qualitative and quantitative data are presented from eight field-sites in urban and rural Ghana, including 131 individual interviews, focus groups, plus a questionnaire survey of 1005 8-to-18-year-olds. The data show that many young people in Ghana play a major role in seeking healthcare for themselves and others. Young people's ability to secure effective healthcare is often constrained by their limited access to social, economic and cultural resources and information; however, many interviewees actively generated, developed and consolidated such resources in their quest for healthcare. Health insurance and the growth of telecommunications and advertising present new opportunities and challenges for young people's health-seeking practices. We argue that policy should take young people's medical realities as a starting point for interventions to facilitate safe and effective health-seeking.

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Introduction

Children, young people and medicines

'It is generally assumed that children and medicines should be kept apart' (Geissler et al., 2000:1772). The dominant view within Western biomedicine is that children are vulnerable and in need of adult protection, while medicines are powerful, dangerous and should be controlled by experts (Geissler et al., 2001:363; Van Der Geest, 1999:255). However, the construction of 'children' as passive recipients of adult care has come under recent scrutiny. Children and adolescents are increasingly recognised as strategising agents, who actively reflect on and construct their social worlds (James & Verstag, 2007, which extend to the domain of health and medicine (Prout & Christensen, 1996)).

In this paper, we report on the health-seeking practices of young people (aged 8–18 years) in Ghana. 18 is the legal age of majority in Ghana and those under 18 years are defined under the UN Convention on the Right of the Child (UNCRC) as 'children' (OHCHR, 1989); by contrast, the WHO distinguishes between children (0–9 y) and adolescents (10–19 y) (WHO, 2003). In practice, categories of childhood, youth and adolescence in Sub-Saharan Africa (and elsewhere) are highly dynamic and contingent (Ansell, 2005; Dehne & Riedner, 2001; Fatusi & Hundin, 2010). We therefore refer to study participants usually as 'young people', while highlighting the contextual nature of age and life circumstances in differentiating their experiences.

Recent studies in Western contexts have highlighted young people's active participation in health-seeking. Many have ready access to medicines stored at home or purchased from drugstores, and report taking medicines independently and sharing them with friends (e.g. Bush & Ianotti, 1988; Chambers, Reid, McGrath, & Finley, 1997; Hämeen-Anttila & Bush, 2008; Sloand & Vessey, 2001). Even very young children may actively resist adults' attempts to intervene, for example, by refusing to swallow a medicine (Prout & Christensen, 1996).

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Less research has focussed on young people's health-seeking practices in developing countries. Important work by Geissler et al. (2000, 2001) and Prince et al. (2001) indicates that school-aged children in Kenya and Uganda take considerable responsibility for their own healthcare. Geissler et al. (2000) found that Kenyan schoolchildren (aged 11–17 y) accessed numerous healthcare options, often without consulting adult carers, including cheap pharmaceuticals from local shops, herbal practitioners, and medicines stored at home. Boys and older children with more income-earning opportunities used pharmaceuticals more than girls and younger children, who frequently resorted to herbal treatments. Young people generally used medicines systematically and rationally, although not always 'correctly'.

Young people's responsibility for health-seeking in Africa should be understood within a context where children take active roles in domestic work, sibling care and income generation, and where acquisition of medical knowledge, through assisting parents, forms part of socialisation (Geissler et al., 2001; Prince & Geissler, 2001; Van der Geest & Geissler, 2003). Moreover, throughout much of Africa, the state's limited capacity to provide effective healthcare, coupled with poor infrastructure and poverty, obliges many people (young and old) to manage their own healthcare.

However, there are potentially serious risks involved. Young people's self-medication, based often on limited knowledge and funds, can lead to misuse of pharmaceuticals, which can be highly toxic if taken incorrectly (in excessive doses, too frequently, or in combination with other drugs), while under-dosage can lead to pathogen resistance (Abuya et al., 2007; Geissler et al., 2000, 2001; Van Der Geest, 1999). According to the WHO (2003), adolescents are less likely than adults to recognise symptoms and are more likely to under-estimate their importance, leading to sub-optimal decisions and delays in treatment seeking (see also Cherry, 2010). Children and adolescents generally have fewer economic resources at their disposal than adults; in poor communities in particular this can severely constrain their effective treatment-seeking options.

Shifting therapeutic landscapes

Geissler et al. (2001:363) portray Kenyan schoolchildren as 'competent agents in a pluralistic medical field, mov[ing] actively between different medical traditions, including local herbal and hospital medicines'. In contemporary Africa, the 'pluralistic medical fields' are becoming increasingly complex, giving rise to newly-emerging health systems and therapeutic landscapes that incorporate, not just 'local herbal and hospital medicines' but a vast array of healing options, local and distant, that can be accessed in person or remotely, via mobile phones, radios, the internet and other technology.

Our use of the term 'therapeutic landscape' diverges from Gesler's (1992) original formulation, and instead draws on Leach, Fairhead, Millimouno, and Diallo (2008:2158) definition: 'the field of available forms of health provision as experienced, understood and constructed through practice by the population that live with them' (see also Madge, 1998). We extend the concept to include virtual, as well as physical, landscapes. The growth of telecommunications means that people can access geographically-distant health resources: therapeutic landscapes can therefore transcend geographical locale.

Ghana's therapeutic landscape is changing rapidly. Across Africa, there has been a surge of interest in mutual health insurance schemes to overcome the obstacle of user-fees (Ansah et al., 2009; Franco et al., 2008; Ridde & Haddad, 2009; Ridde, Haddad, Yacoubou, & Yacoubou, 2010). Ghana's National Health Insurance Scheme (NHIS) was introduced in 2003. By December 2006 (the start of our field research) it had achieved 38% coverage of the

population (Agyepong & Adjei, 2008), and latest estimates (June 2010) put coverage at 59.5%. Details of the scheme can be found elsewhere (<http://www.nhis.gov.gh/%3FCategoryID=159%26ArticleID=91>; see also Agyepong & Adjei, 2008). Briefly, the NHIS consists of locally-managed mutual health insurance schemes, which set annual premiums, typically ranging from GHC 12–35 per adult (£1 = 2.2 GHC). Under-18s are covered, subject to a processing fee of 2–5 GHC, provided their parents are registered. The benefit package covers most outpatient and inpatient services at state-provided health facilities and accredited private facilities (interview with the Central Region NHIS Monitoring and Evaluation Officer, 1/12/09).

The past decade has also seen an information and telecommunications revolution across Africa. Mobile phone subscriptions in Africa rose from 54 M to almost 350 M between 2003 and 2008 (Smith, 2009). By the end of 2009, 63% of Ghana's population were mobile phone subscribers (Ghanaweb, 2010). Mobile phone use in Africa vastly exceeds subscription rates, since phones are often shared (James & Verstag, 2007), and the common practice of 'flashing' (intentionally missed calls) enables people to keep in touch relatively cheaply (Donner, 2008). While there has been considerable recent research interest in the social/economic effects of Africa's 'mobile phone revolution', the role of mobile phones in health-seeking practices remains largely unstudied (see Burrell, 2010, for an exception).

Finally, liberalisation of broadcast media in Ghana has led to a proliferation of radio stations and mass advertising of pharmaceutical and herbal medicines. Private radio stations broadcast daily phone-in shows with herbalists, adverts for medicines, and live faith-healing events. Research (mostly in Western contexts) on the effects of medicine advertising on young people remains inconclusive, but Almarsdóttir and Zimmer (1998:277) suggest that advertising induces 'irrational beliefs' about medicines, without increasing factual knowledge or understanding. Geissler et al. (2000:1780) assert that drug marketing in Kenya has 'a considerable and not always beneficial bearing on the children's choice of medicine'.

Here we consider young people's health-seeking practices within the context of these changes. We are concerned in particular with the degree that young people demonstrate agency by engaging in treatment-seeking, and the implications of this. We draw on Barfield's (1997:4) definition of agency as 'the capacity of human beings to affect their own life chances and those of others and to play a role in the formation of the social realities in which they participate'. In relation to health-seeking, we considered young people's decisions and actions regarding their (and others') healthcare. We focused specifically on treatment-seeking for acute illnesses and injuries. The main thrust of our argument concerns *processes* rather than *outcomes* (although, as indicated below, outcomes and processes are dynamically inter-related). Although this study was situated in Ghana, the changes we describe are taking place across Sub-Saharan Africa; the implications are therefore potentially far-reaching.

Research sites and methods

We draw here on material from the Ghana component of our study on 'Child Mobility in Sub-Saharan Africa' [www.durham.ac.uk/child.mobility] and a smaller follow-up study in Ghana. Eight study sites were used for the Ghana Child Mobility Study, comprising four different settlement types (urban, peri-urban, rural with services, and remote rural) in two contrasting agro-ecological zones: Central Region (coastal savannah) and Brong Ahafo (forest belt). Poverty was a major focus of the Child Mobility Study; as such, sites with relatively high levels of economic deprivation were

selected. The majority ethnic groups were Bonos (forest zone) and Fantes (coastal zone), but with substantial numbers of migrants from other ethnic backgrounds.

The Ghana Child Mobility study entailed three fieldwork phases in 2006–2008:

- (1) 18 young people (11–18 y) were trained to conduct peer research on mobility in their own communities. Supervised by adult academics, they used a range of methods, principally interviews, accompanied walks and photo-diaries (see Porter et al., 2010, for more details of this component).
- (2) Adult academic researchers undertook qualitative research on young people's mobility in relation to health, education, livelihoods and transport in all field-sites. 323 individual in-depth interviews were conducted with young people (aged 8–18 y), parents and key informants, along with 31 focus-group discussions. Here we draw principally on the individual health interviews ($N = 84$ across the eight sites); the other interviews and focus groups provided contextual information.
- (3) A questionnaire survey was conducted with a 1005 young people aged 8–18 y across all sites, to test key hypotheses emerging from the qualitative work. A sample of approximately 125 respondents per settlement was obtained by taking households along transects. Household-level socioeconomic and demographic data were elicited from the household head or another adult, after which one young person in each household was selected at random to complete the survey by interview. The survey questions included items such as: use of different health services within the preceding 12 months and reasons, method of travel to health facilities (mode of transport, accompanied/unaccompanied travel) and perceived barriers to health service access.

Interviews, focus groups and the survey were conducted in local languages (usually Twi or Fante). Survey data were cross-checked for consistency and then analysed using SPSS. Interview transcripts were translated into English, coded and analysed using grounded theory (Glaser & Strauss, 1967). Young people's health-seeking agency emerged as an important theme in Ghana, despite not being the focus of interviews. Interviewees often related their quest for healthcare to recent changes, specifically health insurance, advertising of medicines and use of mobile phones. This analysis led to the development of new working hypotheses about young people's decisions and actions to seek treatment, which were tested qualitatively by further interviews with 47 young people, aged 9–17 y, in the same study sites (Sept–Dec 2009). In these later interviews (denoted*), participants were asked to recount recent illness episodes and the pathways through which treatment was or was not sought. Subsequently, questions about health insurance, media advertisements and mobile phone use were asked, if these topics did not emerge spontaneously.

Ethical permission for both studies was granted by participating universities. Parents'/guardians' consent was sought for all

interviews with under-18s (except those in child-headed households). Interviews and the survey with young people were conducted within sight of parents/guardians, but out of ear-shot.

Results

Socio-economic and educational profile of study sites and participants

As noted above, settlements with relatively high levels of economic deprivation were selected for this study. Farming was the major economic activity in all rural and peri-urban sites, with other informal-sector economic activity dominating in urban settlements; only 12.1% of men and 2.1% of women (parents of survey respondents) were employed in the formal sector. Our survey data indicated high enrolment rates in school for under-15s across all settlements (96–97% in urban/peri-urban settlements; 90–93% in rural settlements). However, fewer than half (46%) of 15-to-17-year-olds were in school, and almost all of these were still in 'Basic Education' (primary and junior high schools, aimed at ages 6–14 y); only 5% were enrolled in Senior High School. Parents' educational status was generally low: 51% of mothers and 38% of fathers reported having no formal education, and only 5.4% of fathers and 1.1% of mothers had any secondary education, with substantial rural-urban differences.

Health service provision and utilisation

Ghana, like many other African countries, has a complex mix of healthcare systems. In interviews, young people reported using a wide range of therapies, simultaneously or serially, including treatment-seeking from 'experts' such as government-run and private hospitals and clinics, 'traditional' healers and herbalists, and faith or spiritual healers. Self-medication was also common: pharmaceutical and herbal medicines purchased from local stores or street hawkers, and home-made herbal preparations.

Both urban field-sites had Regional hospitals and numerous clinics, while peri-urban sites were located within 3–5 km of such facilities. None of the rural field-sites had permanent health-posts, and distances to the nearest health centre ranged from 10 to 30 km. These rural-urban variations are reflected in young people's uptake of services. Of the 1005 young people surveyed, just over a quarter reported having sought medical treatment in the preceding 12 months, but those in urban areas were three times more likely to have done so than their rural counterparts (see Table 1). Moreover, those in rural settlements with basic services were more likely to purchase over-the-counter medicines from drugstores (principally painkillers, antipyretics and anti-malarials) and less likely to attend hospitals, than their urban counterparts (Table 1). Controlling for settlement type, other socio-economic indicators such as schooling, parents' education/occupations were not associated with service use.

Table 1
Reported use of health services by young people (8–18 y) within the preceding 12 months ($N = 943$).

Settlement type	Any health facility	Type of health facility most recently used			
		Regional/specialist hospital	Local hospital	Local clinic	Drugstore
Urban	42.8%	34.0%	27.8%	21.6%	16.5%
Peri-urban	30.8%	33.3%	35.7%	14.3%	16.7%
Rural/services	15.4%	22.2%	2.8%	41.7%	33.3%
Remote rural	13.5%	11.5%	11.5%	69.2%	7.7%
All settlements	26.5%	29.6%	25.1%	27.2%	18.1%
$p(\text{Chi}^2)$	<0.000	<0.000			

Source: Child Mobility Survey, 2007.

Over half the young people surveyed reported difficulties in accessing healthcare services. The barriers were broadly similar to those widely reported in Sub-Saharan Africa (Airey, 1992; Rutherford, Mulholland, & Hill, 2010): principally high fees for consultations and medication and difficulties/expense in travelling to health facilities (see Owusu & Amoako-Sakyi, *in press*, for a fuller discussion of these constraints). These barriers were particularly acute for those in rural settlements (see Table 2).

Self-treatment and unaccompanied use of health services

When an illness was perceived to be serious, dangerous or life-threatening, parents/guardians usually initiated treatment-seeking. However, for other, less (immediately) threatening ailments (e.g. body pains, mild fever, stomach upsets), young people were often expected to take responsibility for seeking healthcare. In interviews, young people frequently reported seeking healthcare without adult help or intervention. Of the 248 survey respondents who had visited a health facility within the preceding 12 months, just over 25% reported that they had not been accompanied by an adult on their most recent visit (see Table 3). Those going to purchase over-the-counter medicines from drugstores were the most likely to be unaccompanied (50% of most recent visits). 30% of most recent visits to a local hospital were also unaccompanied by an adult (see Table 3). The experiences of Abigail and Mary (pseudonyms) are illustrative of many others:

'I woke with pains in my neck. [My mother] massaged the neck with ointment to relieve the pain, but it increased during the afternoon. I could not bear the pains any longer, so I sought permission from my teacher and went straight to the house to pick my NHIS card and went to the hospital myself in a taxi. My mother was in the market at the time.' (Abigail, 15 y, urban)

'I went to the municipal hospital last Thursday. I was feeling body pains, headache and stomach ache. ... My parents were not around. My father was away, and my mother was at the market selling tomatoes. So I went to the hospital alone.' (Mary, 11 y, urban)*

The survey data show that young people living in urban and peri-urban settlements were more likely than their rural counterparts to visit a healthcare facility alone (Table 3). However, many young people in rural areas said in interviews that they regularly prepared herbal medicines, skills learnt from observing and helping parents and grandparents. Many also knew where medicines were stored in their homes and had ready access to them. Young people also frequently sought healthcare for others: they were routinely sent by family members to purchase medicines, but some took more proactive health-seeking roles on others' behalf:

'Once I bought paracetamol for my younger sister. We were in school. I bought her paracetamol because I didn't want to take

Table 2

Difficulties reported by young people (8–18 y) in accessing health services (N = 922).

Settlement type	Percentage reporting difficulty			
	Travel: too difficult	Travel: too expensive	Fees too high	Any difficulty
Urban	4.0%	5.3%	27.8%	34.8%
Peri-urban	7.4%	12.0%	35.3%	56.8%
Rural/services	27.2%	22.6%	36.4%	66.5%
Remote rural	34.7%	32.9%	45.1%	72.2%
All settlements	16.8%	17.0%	36.5%	56.6%
<i>p</i> (Chi ²)	<i>p</i> < 0.0005	<i>p</i> < 0.0005	<i>p</i> < 0.0005	<i>p</i> < 0.0005

Source: Child Mobility Survey, 2007.

Table 3

Young people's unaccompanied use of health facilities during most recent visit (N = 248).

	% of young people visiting facility unaccompanied	<i>p</i> (Chi ²)
<i>By health facility type</i>		
Regional/specialist hospital	14.3%	<0.0005
Local hospital	30.0%	
Clinic/health post	16.7%	
Drugstore	50.0%	
<i>By settlement type</i>		
Urban	34.3%	<0.01
Peri-urban	25.9%	
Rural/services	18.4%	
Remote rural	4.0%	
<i>By age group</i>		
8–11 y	13.2%	<0.001
12–14 y	21.2%	
15–18 y	40.8%	
ALL	25.6%	

Source: Child Mobility Survey, 2007.

her home, because no one was there to look after her: my parents were at the farm, and I didn't want to miss school by going and staying with her.' (Gifty, 14 y girl, peri-urban)*

Capital and health-seeking agency

Interviews with young people suggested considerable variation in health-seeking practices and associated outcomes. Here, we examine the relationships between personal attributes, resources available, and health-seeking practices, focussing in particular on the extent to which young people took the initiative in seeking healthcare.

We draw on Bourdieu's (1997[1986]) concept of capital as individually-held sets of resources that are convertible into other forms. Bourdieu's original formulation distinguished three interchangeable forms: *economic capital*, directly convertible into money; *cultural capital*, namely values attached to particular habits, tastes and predispositions; and *social capital* or social networks and individuals' ability to mobilise them effectively. We extend Bourdieu's framework to incorporate: *informational capital* (equated by Munk, 2009, to academic qualifications, but which we broaden to include any information that facilitates effective health-seeking); *psychological capital*, namely a positive psychological state characterised by confidence and self-efficacy (Luthans, Avey, Avolio, Norman, & Combs, 2006) and *locational capital*, by which we mean the benefits that can accrue to an individual by virtue of his/her geographical location.

Personal attributes: age and gender

In contrast to Geissler et al.'s (2000) findings from Kenya, gender had no discernible effect on health-seeking practices among survey respondents. Age, however, was very influential: 15-to-18-year-olds were far more likely to seek healthcare independently than their younger counterparts (survey data, Table 3). By age 14 or 15, young people assumed increasingly adult roles and responsibilities; they were also more likely to have money for treatment and were generally less subject to parental restrictions on their movements. Nonetheless many younger interviewees, like 11-year-old Mary, also sought healthcare independently. And one mother from a remote rural settlement reported that, while she was out one day, her five-year-old daughter had developed a headache. After finding no medicine at home in the usual place, she walked to a nearby village to ask someone for medicine; she was duly given paracetamol.

Economic capital and independent incomes

As noted above, the survey data suggest that lack of money for consultation fees, medicines and transport represent major barriers to young people's health-seeking. The young people we interviewed typically had very little disposable income, often rendering even the small sums charged by local traders for basic drugs unaffordable. However, many earned small incomes, mainly from manual labouring tasks (boys) or petty trading (girls). Their earnings went mostly to household budgets or to meet schooling expenses, but some were able to save small amounts for other requirements, including healthcare:

"I went to the drug store to buy cough mixture for myself. [...] It cost GHC 3.50. I earn some small money working in a chop bar. [...] My grandmother was not around then and my cough became very bad. I was suffering too much so I went myself to the drug store." (Samuel, 13 y, urban)*

Others managed to 'squeeze' (save) from lunch money given by their parents/guardians to purchase medicines. Many young people made active and strategic economic choices, managing schooling and other expenses and balancing competing priorities. Thus, Gifty (above) chose to spend her own money on medication (paracetamol) for her sister in order to avoid having to miss school herself. She kept the money 'with a friend' in order to retain control over her earnings, which she feared would otherwise be absorbed into the household budget.

Social capital and personal networks

In interviews, young people reported using a wide range of personal networks to access otherwise unobtainable health resources: soliciting medicines or money for medicines, lifts from taxi-driver acquaintances and other forms of support. Not only did they use pre-existing networks; many also actively constructed their own networks. One boy, whose stepmother was unresponsive to his needs, described developing a filial relationship with his friend's mother, which he then used when needing healthcare:

"This month I fell sick. ... When I reached my friend's house, I was shivering. I informed my friend's mother and she went to the drug store to buy medicines for me. ... I have been helping her to fetch water each morning. I'm taking her like my mother. I often eat there. It has become my second home. I just started helping her with chores and it happened like that. She bought [medicine] for me and then I came to school." (Kwaku, 16 y, remote rural)*

Informational capital

Information can be the key to seeking appropriate healthcare. Levels of knowledge about common illnesses and healthcare were quite high among interviewees, with information coming often from friends or broadcast media. However, acquiring appropriate information for 'personal' or stigmatised conditions was often less straightforward, leading sometimes to delays in appropriate treatment seeking:

"I have experienced some 'whites' [candida]. I went to the hospital after two months. The time lag was because I did not know it is treatable at the hospital. It was a friend who told me." (Florence, 17 y, urban)

Psychological capital

Lack of self-confidence and self-efficacy seriously affected some young people's ability to seek healthcare independently and effectively:

"If I get sick I am sent to the drug store. I am always accompanied by my grandmother because sometimes I think I cannot explain my illness situation very well to the druggist." (Grace, 13 y, urban)

Children are typically taught to defer to elders (see also Porter & Abane, 2008), and some reported that they were not confident to speak openly to healthcare providers. Others said that the attitudes of healthcare providers were not always helpful in facilitating open communication.

Cultural capital and language

Interviews with young people suggested that various components of cultural capital (for example, wearing a clean school uniform, indicating 'educated' status and coming from a 'good family') influenced their interactions with healthcare professionals. Moreover, as noted above, the study sites were ethnically diverse. Shyness and low self-confidence was often exacerbated when ethnic and linguistic differences made communication with healthcare providers more difficult. One 17-year-old girl, for example, whose family were recent migrants to the area, said she felt afraid to attend the local clinic because she could not speak the local language well.

Locational capital

Travel difficulties and expenses were widely reported by young people in the survey to impede access to health services (Table 2), and those in rural areas were much less likely than their urban counterparts to travel to a health facility without an adult (Table 3). The difficulty of reaching hospital in an emergency, even with adult help, was a common theme in interviews in rural settlements:

"In an emergency, the child would be taken on someone's back to [village], two hours away, then take a taxi to [town]. But it is long and, if it is serious, the child may die before reaching". (16 y boy, remote rural)*

Even in some urban areas, reaching hospital can sometimes be difficult, particularly where affordable transport systems and infrastructure are lacking. 11-year-old Mary (above) recalled that she had to walk to hospital because there was no money for transport: 'I went alone. It took me about two hours because I had to keep stopping along the way as I was feeling ill.' A boy from the same urban settlement worried about traffic dangers: 'If you are a child and walk slowly across a road because you are sick, a vehicle may knock you down.'

Ghana's changing therapeutic landscape

The dynamic interactions between resources and health-seeking agency operate within a wider therapeutic landscape that, as we have indicated, is changing rapidly in Ghana. Here, we consider three changes that appear to be particularly influential in shaping young people's health-seeking practices: the National Health Insurance Scheme, widespread advertising of medicines, and use of mobile phones.

National Health Insurance Scheme (NHIS)

Several interviewees mentioned spontaneously that the NHIS had increased their independent access to formal healthcare, illustrated by these accounts from Abigail and Mary (introduced earlier):

"The doctor requested a laboratory test and then prescribed some drugs for me. I did not pay any money because of the NHIS. I was also confident going through the process because of the

NHIS. The scheme has allowed more children to go to health facilities alone, because the authorities will not ask you to pay for the service. It is a good scheme for us children.' (Abigail, 15 y, urban)

'I have had the [NHIS] card for two years. I have used it twice. My mother keeps the card, but I know where she keeps it, so I can take it if I need it. So that day I took my card ... and went to the hospital. I explained all to the doctor, who prescribed some drugs. I was not afraid because I have the NHIS card, so I know I will not have to pay. ... Once you have the card, you don't fear illness: you can just take the card and go. There is no need to worry about money.' (Mary, 11 y, urban)*

However, the benefits of the NHIS have not reached all young people. Under-18s are eligible for insurance only if their parents are registered and annual premiums are up to date; this is unaffordable for many (see Franco et al., 2008; Ridde et al., 2010). Abigail went on to say that her NHIS card had since expired, and her father could not afford to renew it. Florence, the young woman who received treatment for 'whites', had a similar story:

'I went to the hospital and the doctor gave me some medicines. When I finished taking it I could not go to the hospital again because my health insurance had expired and I could not raise the money again to pay the premium. Recently I acquired some herbal concoction, but it has not worked. (Florence, 17 y, urban)

Some young people proactively sought health insurance, either by cajoling their parents or, in a few cases, by using their own earnings. Such efforts were sometimes frustrated by bureaucracy: two brothers (peri-urban) said that they had spent GHC4 between them, earned from weeding fields, on NHIS registration, but they still had not received their cards. Even if they manage to register, those in rural settlements often fail to reap the benefits of health insurance, since most accredited facilities are located in towns. One boy (14 y), in a remote rural settlement, said he had health insurance but preferred to self-medicate (for debilitating body pains) rather than travel to a distant hospital.

Information and media advertisements

As noted above, liberalisation of broadcast media in Ghana has led to a flurry of local commercial radio stations and mass advertisement of pharmaceutical and herbal medicines. Although not all households own a working radio or television, the widespread sharing of such media means that almost all young people have regular access to radio at least. Almost all interviewees could recall the names of up to a dozen medicines from advertisements; many spontaneously sang advertising jingles during interviews! Others described adverts in great detail, and strongly desired the products:

'I saw an advert on TV for a medicine. The medicine was on a motorbike and fell off, and lots of people were scrambling to get it. ... If I get that drug, I would take it. That one is good for children because when people were scrambling, it was a child who managed to get it'. (Frank, 10 y, peri-urban)*

Many young people interviewed had been persuaded by advertisements to purchase medicines. The two brothers who tried to register for the NHIS also used their earnings to buy medicines after listening to adverts, ironically to treat illnesses and wounds that they had acquired while working:

'I've seen many adverts [names 8 products]. [Medicine] is a blood tonic. I went to buy it because of the advert. I had money and I gave it to my mother and asked her to buy [medicine] for me. It cost GHC 3. I thought I needed something to boost my

blood levels, because I felt weak [after weeding]'. (Kwabena, 17 y, peri-urban)*

'I have used [medicine]. It's a cream for sores and pimples. I'd seen an advert on TV. Then a car with a loudspeaker came round and I bought it for GHC1 to treat a cutlass wound'. (Daniel, 14 y, peri-urban)*

Others used money they had earned, 'squeezed' or borrowed to buy advertised medicines. Some were so seduced by adverts that they bought medicines even if they were not suffering from the indicated disorder. 16-year-old Kofi, for example, was saving up his money to buy *Pilex*, despite suffering neither from piles nor 'visual impairment':

'I want to buy *Pilex*. I have been convinced by the advert, and I know someone who saw the advert and bought it and it was good. It is used to cure piles and visual impairment. The way they run the advert, it is convincing'.

Mobile phones

Although only 2.4% of young people surveyed owned a mobile phone, 27.9% had used one within the last month (from over 50% of urban respondents to 5% of rural ones). Phones were mostly borrowed from a household member (45.3%) or from other relatives, friends or neighbours (34.5%). Reception can be patchy, but even remote rural settlements are usually within reach of some network coverage. Several interviewees reported calling relatives to obtain healthcare for themselves or others. One 14-year-old housemaid, for example, said she called to inform her employer in Accra that she was ill and ask for money/advice. Another 14-year-old boy, in a rural settlement, reported using his earnings from selling plantain leaves to phone his brother to request medicine for their grandmother.

Discussion

Young people in Ghana appear to be active health-seekers. Fig. 1 illustrates the dynamic relationships between agency and resources/capital in young people's health-seeking practices, with implications for outcomes and wellbeing. Young people's ability to secure effective healthcare depends in part on their access to, and ability to mobilise, a range of resources (see Meinert, 2004:13, who made a similar point regarding Uganda). Those with little or no money, or who live far away from a health centre, typically have fewer options available than others with better economic and locational capital. Similarly, young people with limited social networks (in terms of either range or 'quality'), or who lack appropriate cultural capital, may be constrained in their ability to access appropriate, high-quality healthcare.

However, young people also take an active role in developing, modifying and mobilising resources in their quest for healthcare. Many of our interviewees did not simply rely passively on existing social capital; like Kwaku, they actively sought, generated, developed and mobilised networks to access healthcare. Similarly, although most young people we interviewed had very limited access to economic resources, they made strategic decisions to earn and save money, in order to manage schooling and other expenses, balancing competing priorities which included healthcare. Many young people also used multiple strategies to acquire health information (albeit of varying quality and accuracy) from friends, family, teachers and broadcast media (see also WHO, 2003).

Young people's health-seeking practices in Ghana also need to be understood within the context of a wider, rapidly-changing therapeutic landscape. Health insurance has radically altered the cost-benefit calculus of using formal health services, and may have

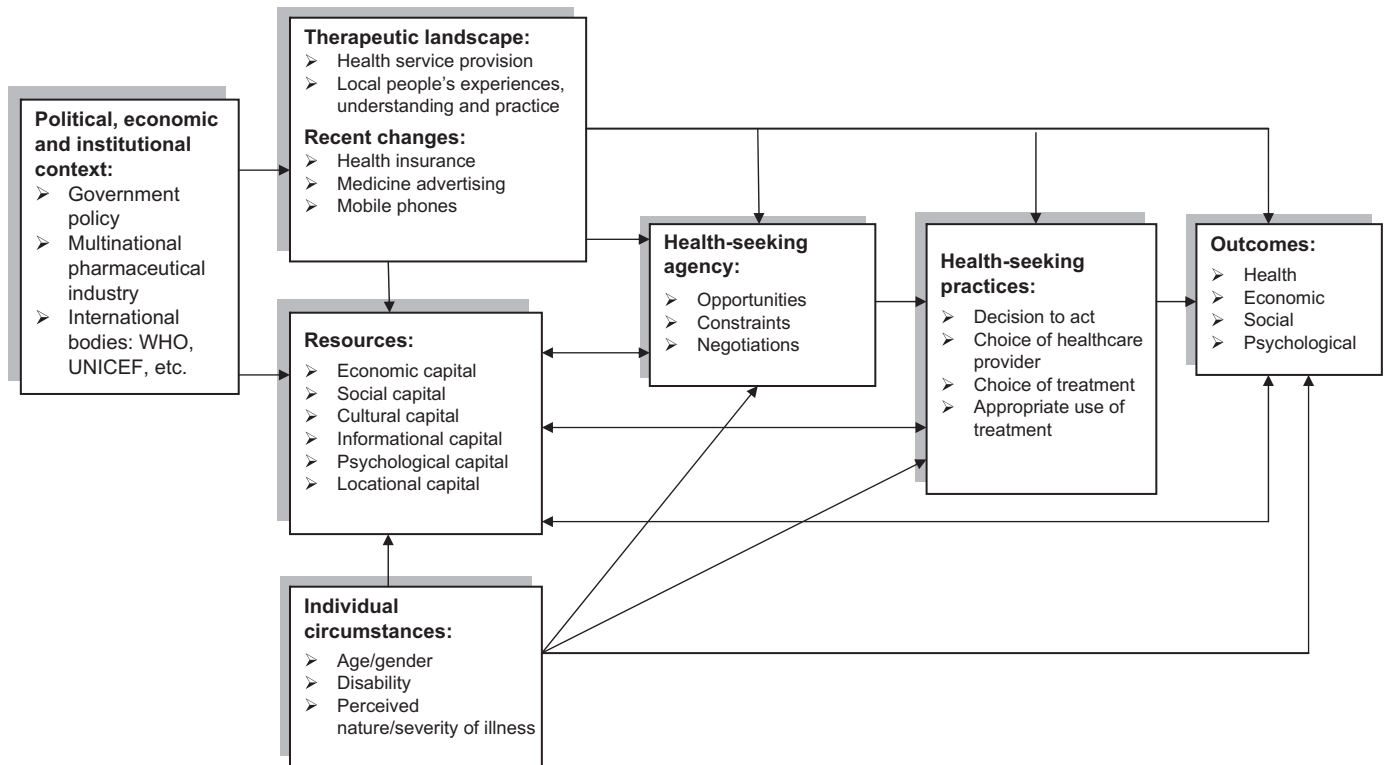


Fig. 1. Young people's health-seeking practices in Ghana: resources, agency and outcomes.

increased independent use of hospitals by young people, especially in urban areas (at least for those insured). Health insurance might also have increased psychological capital for some: recall 11-year-old Mary, who was 'not afraid' to consult a hospital doctor because she had her NHIS card. Advertisements for medicines have the potential to increase relevant informational capital but, as Geissler et al. (2000:1780) suggest, this information is often biased, misleading and over-enticing for young people who may be duped into buying unnecessary products. Mobile phones enabled some young people in our study to build social, informational and locational capital, mobilising dispersed social networks to obtain health information and resources within and beyond the immediate geographical locale. None of our study participants (of all whom were relatively resource-poor) had used the internet to access health resources; however, in other West African (urban) contexts, the internet is becoming an important source of healthcare information for young people (Nwagwu, 2007).

Our cross-sectional, qualitative study design precludes measuring any impact of these processes on young people's health and wellbeing, but interviewees' accounts suggest variable consequences. Health insurance, for those who are registered and live within reach of accredited services, may improve access to higher-quality healthcare; and mobile phones can facilitate health-seeking, particularly in emergencies. Advertising may be a more double-edged sword. As we have indicated, several interviewees reported buying and using medicines because they were impressed by the advertisements, regardless of whether they were suffering from the indicated disorder. The sale of herbal and pharmaceutical medicines, in markets, general stores and even chemists or pharmacies, is (in practice) largely unregulated; products are sold over the counter, often without reference to medical indications or contra-indications. As Geissler et al. (2000) note, young people's self-treatment in resource-poor settings is typically based on limited knowledge and funds: a potentially lethal combination. Apart from

the risks of direct physical harm, many young people in our study appeared to be wasting limited resources on unnecessary medicines.

Implications for policy and practice

Changes in Ghana's therapeutic landscape, which mirror those taking place across the continent, are likely to increase the array of health-seeking options available for young people over coming years. Rapidly expanding pharmaceutical markets and associated advertising mean that young people have increasingly easy and cheap access to a range of restricted drugs, without necessarily knowing how to use them appropriately. This is set within a wider structural context of a lack of political will to fund health services adequately, failure to regulate international pharmaceutical markets, and the persistence of appalling global health inequalities, which effectively force many young people (and adults) into inadequate, and potentially dangerous, health-seeking strategies. An important pragmatic question is how best to facilitate young people in this situation to seek healthcare safely and effectively.

Over the last decade, the WHO and other international agencies have advocated the expanded provision of high-quality adolescent-friendly health services, which are accessible, culturally acceptable, appropriate, inclusive and affordable to young people (WHO, 2003). Confidentiality and effective, non-judgemental communication are key features of adolescent-friendly services (Dickson, Ashton, & Smith, 2007; Tylee, Haller, Graham, Churchill, & Sancu, 2007; WHO, 2003). Ensuring that existing formal health services in Ghana meet the needs of young people is an important starting point; this will involve investing resources in training and supporting staff to improve inter-generational communication skills and empathic approaches (WHO, 2003).

Appropriate youth-focused training should be extended to informal healthcare providers, much frequented by young people.

Following Van Der Geest (1999), we argue that this should include training in medicine use (dosage, indications and contraindications) for local shopkeepers, who are often the first port of call for young people. The Ghanaian shopkeepers we interviewed were often unsure about the legality of prescribing and selling various medicines to under-18s, indicating an important information gap. Such training programmes are potentially controversial, since many shopkeepers sell restricted drugs illegally. The challenge of balancing legality with making existing practices safer needs careful consideration.

With dramatic recent rises in school enrolment in Ghana (and across Africa), schools offer an important forum for health education and services (Ayi et al., 2010; Onyango-Ouma, Aagaard-Hansen, & Jensen, 2005; Renju et al., 2010; WHO, 2003). Geissler et al. (2001) have argued that school-based health education should be extended beyond the usual health promotion messages to cover safe and appropriate use of medicines, taking as its starting point schoolchildren's medical realities which often involve using medicines without professional advice. This approach also carries risks, such as further undermining drug control legislation and enhancing an existing tendency for over-medication; close collaboration with Ministries of Health is important to ensure legal compliance.

Involving families and communities is also crucial. Agency should not be confused with autonomy (Prince et al., 2001). While many young Ghanaians are proactive health-seekers in their own right, their quest for effective treatment usually involves others: soliciting help from family members by phone, using NHIS cards obtained by parents, or asking friends for advice or information. Enabling young people to acquire the necessary skills and experience to seek effective healthcare *in partnership with parents, health professional and other care-givers* has been highlighted by the WHO (2003) as an important strategy to enhance adolescents' health and wellbeing, both immediate and longer-term. Recent work has also drawn attention to the role of young people as 'agents of health' (Geissler et al., 2000:1872) or 'health-promoting actors' within families (Christensen, 2004:379), and school-based health education programmes have been shown to lead to wider improvements in health practices in communities in Ghana (Ayi et al., 2010) and Kenya (Onyango-Ouma et al., 2005).

User-fees and health insurance are another issue requiring careful reflection. Our findings indicate that health insurance, which reduces up-front costs of healthcare, might increase urban adolescents' independent use of formal, accredited health services. However, many young people are not covered by insurance because their parents cannot afford the premiums (see also Ridde & Haddad, 2009). Removing user-fees for under-18s would be an important step to facilitating *effective* health-seeking and ability to access higher-quality services, in Ghana and elsewhere. However, as we have indicated, user-fees are not the only barriers to health-service use for young people in Ghana and elsewhere in Africa (Airey, 1992; Franco et al., 2008; Ridde et al., 2010). Even with health insurance, for those without access to appropriate, affordable services (both formal and informal), good quality healthcare is still effectively as out of reach as ever.

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References

- Abuya, T. O., Mutemi, W., Karisa, B., Ochola, S. A., Fegan, G., & Marsh, V. (2007). Use of over-the-counter malaria medicines for children and adults in three districts in Kenya: implications for private medicine retailer interventions. *Malaria Journal*, 6, 57.
- Agyepong, I. A., & Adjei, S. (2008). Public social policy development and implementation: a case study of the Ghana National Health Scheme. *Health Policy and Planning*, 23, 150–160.
- Airey, T. (1992). The impact of road construction on the spatial characteristics of hospital utilization in the Meru district of Kenya. *Social Science & Medicine*, 34(10), 1135–1146.
- Almarsdóttir, A. B., & Zimmer, C. (1998). Children's knowledge about medicines. *Childhood*, 5, 265–281.
- Ansah, E. K., Narh-Bana, S., Asiamah, S., Dzordzordzi, V., Biantey, K., Dickson, K., et al. (2009). Effect of removing direct payment for health care on utilisation and health outcomes in Ghanaian children: a randomised control trial. *PLoS Medicine*, 6(1), 48–58.
- Ansell, N. (2005). *Children, youth and development*. London: Routledge.
- Ayi, I., Nonaka, D., Adjovi, J. K., Hanafusa, S., Jimba, M., Bosompem, K. M., et al. (2010). School-based participatory health education for malaria control in Ghana: engaging children as health messengers. *Malaria Journal*, 9, 98.
- Barfield, T. (1997). *The dictionary of anthropology*. Oxford: Blackwell Publishing.
- Bourdieu, P. (1997[1986]). The forms of capital. In A. H. Halsey, H. Lauder, P. Brown, & A. Stuart Wells (Eds.), *Education: Culture, economy, society* (pp. 46–58). Oxford: OUP.
- Burrell, J. (2010). Evaluating shared access: social equality and the circulation of mobile phones in rural Uganda. *Journal of Computer-mediated communication*, 15(2), 230–250.
- Bush, P. J., & Ianotti, R. J. (1988). Origins and stability of children's health beliefs relative to medicine use. *Social Science & Medicine*, 27(4), 345–352.
- Chambers, C. T., Reid, G. J., McGrath, P. J., & Finley, G. A. (1997). Self-administration of over-the-counter medication for pain among adolescents. *Archives of Pediatric and Adolescent Medicine*, 151, 449–455.
- Cherry, M. J. (2010). Parental authority and pediatric bioethical decision making. *Journal of Medicine and Philosophy*, 35(5), 553–572.
- Christensen, P. (2004). The health-promoting family: a conceptual framework of future research. *Social Science & Medicine*, 59, 377–387.
- Dehne, K. L., & Riedner, G. (2001). Adolescence – a dynamic concept. *Reproductive Health Matters*, 9(17), 11–15.
- Dickson, K. E., Ashton, J., & Smith, J.-M. (2007). Do adolescent-friendly standards improve the quality of care in clinics? Evidence from South Africa. *International Journal for Quality in Health Care*, 19(2), 80–89.
- Donner, J. (2008). Research approaches to mobile use in the developing world: a review of the literature. *The Information Society*, 24, 140–159.
- Fatusi, A. O., & Hundin, M. J. (2010). Adolescents and youth in developing countries: health and development issues in context. *Journal of Adolescence*, 33, 499–508.
- Franco, L. M., Diop, F. P., Burgert, C. R., Kelley, A. G., Makinen, M., & Simpara, C. H. T. (2008). Effects of mutual health organizations on use of priority health-care services in urban and rural Mali: a case-control study. *Bulletin of the WHO*, 86(11), 830–838.
- Geissler, P. W., Meinert, L., Prince, R. J., Nokes, C., Aagaard-Hansen, J., Jitta, J., et al. (2001). Self-treatment by Kenyan and Ugandan schoolchildren and the need for school-based education. *Health Policy and Planning*, 16(4), 362–371.
- Geissler, P. W., Nokes, K., Prince, R. J., Acieng' Odhiambo, R., Aagaard-Hansen, J., & Ouma, J. H. (2000). Children and medicines: self-treatment of common illnesses among Luo schoolchildren in Western Kenya. *Social Science & Medicine*, 50(12), 1771–1783.
- Gesler, W. M. (1992). Therapeutic landscapes: medical issues in the light of the new cultural geography. *Social Science & Medicine*, 34(7), 735–746.
- Ghanaweb. (2010). Ghana's mobile phone penetration reaches 63% in 2009. Retrieved 14.07.10. <http://www.ghanaweb.com/GhanaHomePage/NewsArchive/artikel.php%3FID=179562>.
- Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York: Aldine.
- Hämeen-Anttila, K., & Bush, P. J. (2008). Healthy children's perceptions of medicines: a review. *Research in Social and Administrative Pharmacology*, 4, 98–114.
- James, J., & Verstag, M. (2007). Mobile phones in Africa: how much do we really know? *Social Indicators Research*, 84(1), 117–126.
- Leach, M. A., Fairhead, J. R., Millimouno, D., & Diallo, A. A. (2008). New therapeutic landscapes in Africa: parental categories and practices in seeking infant health in the Republic of Guinea. *Social Science & Medicine*, 66, 2157–2167.
- Luthans, F., Avey, J. B., Avolio, B. J., Norman, S. M., & Combs, G. M. (2006). Psychological capital development: towards a micro-intervention. *Journal of Organizational Behaviour*, 27(3), 387–393.
- Madge, C. (1998). Therapeutic landscapes of the Jola, The Gambia, West Africa. *Health and Place*, 4(4), 293–311.
- Meinert, L. (2004). Resources for health in Uganda: Bourdieu's concepts of capital and habitus. *Anthropology and Medicine*, 11(1), 11–26.
- Munk, M. D. (2009). Transnational investments in informational capital. *Acta Sociologica*, 52(1), 5–23.
- Nwagwu, W. E. (2007). The internet as a source of reproductive health information among adolescent girls in an urban city in Nigeria. *BMC Public Health*, 7, No.354.

- OHCHR. (1989). *Convention on the rights of the child*. Retrieved 26.03.09. <http://www2.ohchr.org/english/law/crc.htm>.
- Onyango-Ouma, W., Aagaard-Hansen, J., & Jensen, B. B. (2005). The potential of school children as health change agents in rural western Kenya. *Social Science & Medicine*, 61, 1711–1722.
- Owusu, S.A., & Amoako-Sakyi R.O. Mobility and economic constraints as key barriers to children's health seeking in Ghana. *Society, Biology and Human Affairs*, in press.
- Porter, G., & Abane, A. (2008). Increasing children's participation in transport planning: reflections on methodology in a child-centred research project. *Children's Geographies*, 6(2), 151–167.
- Porter, R. E., Hampshire, K. R., Bourdillon, M., Robson, E., Munthali, A., Abane, A., et al. (2010). Children as research collaborators: issues and reflections from a mobility study in sub-Saharan Africa. *American Journal of Community Psychology*, 46(1), 215–227.
- Prince, R., & Geissler, P. W. (2001). Becoming "one who treats": a case study of a Luo healer and her grandson in Western Kenya. *Anthropology and Education Quarterly*, 32(4), 447–471.
- Prince, R. J., Geissler, P. W., Nokes, K., Maende, J. O., Okatcha, F., Gringorenko, E., et al. (2001). Knowledge of herbal and pharmaceutical medicines among Luo children in Kenya. *Anthropology and Medicine*, 8(2–3), 211–235.
- Prout, A., & Christensen, P. (1996). Hierarchies, boundaries and symbols: performance of childhood sickness. In P. J. Bush, D. J. Trakas, E. J. Sanz, R. L. Wirsing, & T. Vaskilampi (Eds.), *Children, medicines and culture* (pp. 31–54). New York and London: Haworth Press Inc.
- Renju, J., Nyalali, K., Andrew, B., Kishamawe, C., Kimaryo, M., Remes, P., et al. (2010). Scaling up a school-based sexual and reproductive health intervention in rural Tanzania: a process evaluation describing the implementation realities for the teachers. *Health Education Research*, 25(6), 903–916.
- Ridde, V., & Haddad, S. (2009). Abolishing user fees in Africa. *PLOS Medicine*, 6(1), 12–14.
- Ridde, V., Haddad, S., Yacoubou, M., & Yacoubou, I. (2010). Exploratory study of the impacts of mutual health organizations on social dynamics in Benin. *Social Science & Medicine*, 71(3), 467–474.
- Rutherford, M. E., Mulholland, K., & Hill, P. C. (2010). How access to healthcare relates to under-five mortality in sub-Saharan Africa: systematic review. *Tropical medicine and International Health*, 15(5), 508–519.
- Sloand, E. D., & Vessey, J. A. (2001). Self-medication with common household medicines by young adolescents. *Issues in Comprehensive Pediatric Nursing*, 24, 57–67.
- Smith, D. (2009). Africa calling: mobile phone usage sees record rise after huge investment. *The Guardian*, Retrieved 14.07.10. <http://www.guardian.co.uk/technology/2009/oct/22/africa-mobile-phones-usage-rise>.
- Tylee, A., Haller, D. M., Graham, T., Churchill, R., & Sanci, L. A. (2007). Adolescent health 6: youth-friendly primary-care services: how we are doing and what more needs to be done. *Lancet*, 369(9572), 1565–1573.
- Van Der Geest, A. (1999). Training shopkeepers and schoolchildren in medicine use: experiments in applied medical anthropology in East Africa. *Medical Anthropology Quarterly*, 13(2), 253–255.
- Van der Geest, S., & Geissler, P. W. (2003). Editorial: should medicines be kept away from children? African considerations. *Tropical Medicine and International Health*, 8(2), 97–99.
- WHO. (2003). *Adolescent friendly health services: An agenda for change*. Available from http://whqlibdoc.who.int/hq/2003/WHO_FCH_CAH_02.14.pdf.