# A Study on the Attitudes Toward Health Care and Curative Practices of People in an Urban Area

## *ŞEHİRDE YAŞAYAN KİŞİLERİN SAĞLIĞIN KORUNMASI VE TEDAVİ İŞLEMLERİ HAKKINDAKİ EĞİLİMLERİ ÜZERİNE BİR ARAŞTIRMA*

Osman HAYRAN*, Melda KAYHAN*, Akile GÜRSOY**, Seçil AKSAYAN***

* Dept. of Public Health, Medical School of Marmara University,
** Dept. of Anthropology, Marmara University,
*** Marmara School of Nursing, İstanbul, TURKEY

**Summary**

*This cross-sectional study was carried during October-November 1991 in city center of Kocaeli province, western Turkey. Attitudes of randomly selected households (n=812) toward secondary prevention and curative practices were searched during house visits and reasons for attendence to the 6 pharmacies (n=1331 attendences) in the same region was recorded. Majority of the study group knew the meaning and importance of regular check-ups while only 7% had ever experienced. Self medication was found to be the dominant mode of help-seeking behaviour especially for painful conditions. The proportion of unprescribed drugs to the prescribed was 1/1.75 and analgesics, antipyretics, expectorants and antitussives were the most commonly requested unprescribed drugs.*

**Key Words:** Secondary prevention, Unprescribed drugs, Help seeking-behaviour

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**Özet**

*Çalışma Kocaeli il merkezinde Ekim-Kasım 1991'de kesitsel olarak yürütüldü. Rastgele seçilmiş ev halkı üyelerinin (n=812) erken tanı ve tedavi edici işlemler hakkındaki eğilimleri ev ziyaretleri ile ve aynı bölgedeki 6 eczahaneye başvuru (n=1331 başvuru) sebepleri kaydedildi. Çalışma grubunun çoğunluğu düzenli kontrolün anlamını ve önemini bilmesine rağmen o ana kadar ancak %7'si bu amaçla hekime başvurmuştu. Özellikle ağrılı durumlar için kendi kendini tedavi etme baskın yardım arama durumu olarak bulundu. Reçete edilmeyen ilaçların reçete edilenlere oranı 1/1.75 olarak tespit edildi. Analjezikler, antipiretikler, ekspektoranlar ve antitussifler en sık reçetesiz olarak istenen ilaçlar olarak tespit edildi.*

**Anahtar Kelimeler:** Erken tanı, Reçetesiz ilaçlar, Yardım arama davranışı

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Concepts of disease, illness and health have been changed parallel to the sociocultural changes and scientific developments (1,2). The interpretation and explanation of the causes of ill health varied among human populations in different ages. However despite these variations the major concern was always the treatment and cure of the ill. Prevention of diseases began to become more important as the causes of ill health were better understood, and today it is believed that prevention is better than treatment.

Three levels of prevention, primary, secondary and tertiary have been distinguished when discussing the scope of preventive activities and modalities. Primary prevention is defined as, the activities undertaken to reduce the circumstances that would result in the subsequent development of a disease or illness. Secondary prevention means the early detection of disease, before it has had time to progress and cause irreversible damage. Tertiary prevention refers to rehabilitative activities and the monitoring of treatment regimens to prevent complications or iatrogenic diseases.

Secondary prevention or detecting disease in its earliest, asymptomatic stages is believed to reduce the medical, social and psychological costs of a disease (3,4).

Early detection activities may be planned by health professionals in terms of population screenings or regular check-ups. On the other hand, people's concepts of health and illness are the key is-

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**Yazışma Adresi:** Dr.Osman HAYRAN
Marmara Üniversitesi Tıp Fakültesi
Halk Sağlığı AD, İSTANBUL

sues for the cost-effectiveness of such activities. Because the health is influenced by numerous sociocultural and behavioral factors, perception and interpretation of illness symptoms vary among populations and individuals. Everyone has a personal and subjective understanding of their self and also of their disease (5). Illness concepts (interpretations, explanations and prediction with regard to one's health status) can be described under formal, phenomenological and psychological functional aspects. On the basis of clinical experience, various illness concepts were defined (6).

People's reactions to illness are different. Illness behavior depends on cultural ideas about health and disease, so that treatment and prevention follow logically from beliefs about causation. There is usually a sequence of events which can be summarized as the stages of illness. First is the experience of symptoms, secondly these experienced symptoms may be asked from friends or relatives-what is called 'lay referral'. And thirdly, the person may seek professional advice from a doctor, who can confirm that he is ill (7).

According to Kleinman each society has a health-care system of some kind. This system is a network of relationships between illness episodes, individual and social responses, and the beliefs and practices linking illnesses to recognized forms of therapy. Thus the health care system embraces all those therapeutic resources available to ill persons and their families. Kleinman subdivides the system into three inter-related sectors. Briefly, the popular sector which includes the beliefs and practices of lay-persons, the professional sector which encompasses the knowledge and practices of organized health agents as represented by cosmopolitan medicine and other institutionalized forms and which, at state level, are generally subject to review and licensing by the Ministry of Health; and the folk sector consisting of the knowledge and practices of health agents which are socially recognized as therapists, but generally not recognized by the State (8).

People who become ill, and who are not helped by self-treatment, make choices about whom to consult in the popular, folk or professional sectors for further help. Illnesses such as colds are treated by relatives, supernatural illnesses by sacred folk healers and natural illnesses by physicians-especially if they are very severe. Ill people are at the centres of therapeutic networks, which are connected to all three sectors of the health care system. Advice and treatment pass along the links in this network, beginning with advice from family, friends, neighbours, friends of friends, and then moving on to sacred or secular folk healers, or physicians (9). Community studies show that at any one time about three-quarters of people will complain of some kind of ill-health. But only one-third of these will be attending to a family doctor and the health care is frequently initiated with home/self treatment (7,9,10). Due to this fact the use of unprescribed drugs are more common than the prescribed drugs (11-15).

In a national survey it was found that 21.7% of the sample -representing Turkish population- had a "poor" or "fair" self perceived health status and a considerable percentage of Turkish people apply non-physicians as first contact person for medical help. Among non-physicians pharmacists are considerably used. Population pharmacist contact rate per person per year was 0.45 in Turkey (16). Several studies indicate that Turkish people have a tendency towards using popular and folk sector and seek medical help from non-physycians, particularly the pharmacists (17-19). As a result of this fact the annual physician contact rate per person was found to be 2.44 in the survey mentioned above which is very low when compared with the rates in developed European countries (20).

The aim of this study was to search the attitudes of people toward early diagnosis, and the modes of help-seeking behavior for different symptoms and complaints in an industrialized urban area of Turkey.

## Material and Method

This cross-sectional study was carried out in two stages during October-November 1991 in the city center of the Kocaeli province, Turkey. At the first stage 900 households were randomly selected by cluster and systematic sampling methods, of whom 812 were interviewed. The subjects were interviewed in their houses by intern medical students and a questionnaire form was filled during the face-to-face interviews. The most responsible person present at home -the head of the household or the spouse-was interviewed during house visits

**Table 1.** Socio-demographic characteristics and ever experience of periodic check-up percentages of the study group (Kocaeli, 1991)

| Socio-demographic characteristics | Periodic check-ups n | rate (%) |
|---|---|---|
| *Age* | | |
| <29 (n=139) | 8 | 5.7 |
| 30-39 (n=157) | 17 | 10.8 |
| 40-49 (n=191) | 14 | 7.3 |
| 50-59 (n:200) | 11 | 5.5 |
| >59 (n=125) | 7 | 5.6 |
| | $X^2$=4.951 | p=0.2924 |
| *Gender* | | |
| Female (n=499) | 25 | 5.0 |
| Male (n=313) | 32 | 10.2 |
| | $X^2$=7.232 | p=0.0072 |
| *Level of Education* | | |
| Illiterate (n=115) | 3 | 2.6 |
| Primary school (n=477) | 17 | 3.6 |
| Secondary school (n=147) | 9 | 6.1 |
| University (n=83) | 28 | 33.7 |
| | $X^2$=104.26 | p<0.0001 |
| *Presence of Health Insurance* | | |
| Yes (n=650) | 44 | 6.7 |
| No (n=162) | 13 | 8.0 |
| | $X^2$=0.1503 | p=0.6982 |
| Total (n=812) | 57 | 7.0 |

**Table 2.** Reasons for not attending for regular check-ups (Kocaeli, 1991)

| Reasons | n | % |
|---|---|---|
| Negligence | 318 | 42.1 |
| Not necessary | 213 | 28.2 |
| No time | 140 | 18.5 |
| Economic reasons | 84 | 11.1 |
| Total | 812 | 100.0 |

and a total of 499 females and 313 males were interviewed.

The attitudes toward early diagnosis, periodic check-ups and curative practices, modes of help-seeking behavior in the presence of various symptoms and complaints are asked and recorded during these interviews. The interview data included the experiences and attitudes of the interviewed person, but not the other family members. Qualitative research methods, which are more valid for such studies, are used because of the limited number of persons experienced in this area.

At the second stage 6 pharmacies in the same region were randomly selected and intern medical students recorded the reasons for attendence and drugs requested by the customers during 10 work-days. These pharmacies were located in the same region with the interviewed households. A total of 1331 attendences in 10 work-days were classified and analysed.

## Findings

The socio-demographic characteristics of the study group is given in Table 1. Majority of the subjects were female, literate and had any kind of a health insurance. We found that 68.5% of the study group knew the meaning and importance of early diagnosis while only 7% had attended a physician without any complaints, just for check-up, at least once in their life. None of the respondents were replied that they go for check-ups periodically.

As it is seen in Table 1, regular check-up experience rate is significantly higher for males than females ($p<0.01$), and such practices found to be significantly higher among the more educated people ($p<0.0001$).

Main reason for not attending regular check-up was negligence (Table 2). Some of the subjects found it unnecessary, or had no leisure time. The striking point is that relatively a very small proportion of the study group expressed economic reasons. Lack of interest, knowledge and time seem to be more important than the lack of money at least for our study group.

In Table 3, help-seeking behaviors of the subjects in the presence of different symptoms and signs are given. The most important symptom for attending a physician is found to be “blood in the stool”, an the least important is “headache”. In general, it seems that self-medication is the dominantly preferred behavior for subjective complaints such as headache, disuria and abdominal pain.

Attending a physician is the mode of help seeking behavior mainly for objective symptoms such as blood in the stool, genito-urinary discharge and dermatologic problems. As it is seen from the Table 3 none of the respondents replied to attend a

**Table 3.** Help-seeking behaviors for various symptoms and complaints (Kocaeli, 1991)

| Symptoms and complaints | Modes of behavior | | | |
|---|---|---|---|---|
| | Self medication %* | Physician advice %* | Pharmacist advice %* | Nothing %* |
| Headache | 69.8 | 10.6 | 5.2 | 14.4 |
| Disuria | 42.5 | 37.4 | 0.0 | 20.1 |
| Abdominal pain | 41.0 | 13.8 | 4.5 | 40.7 |
| High fever | 36.6 | 49.0 | 6.2 | 8.2 |
| Cough | 34.6 | 39.0 | 10.4 | 16.0 |
| Fatigue | 10.9 | 70.9 | 0.0 | 18.2 |
| Dermatologic rash | 6.2 | 62.4 | 0.0 | 31.4 |
| Chest pain | 6.0 | 74.8 | 2.3 | 16.9 |
| Genitourinary discharge | 2.7 | 69.0 | 0.0 | 28.3 |
| Blood in the stool | 0.1 | 94.8 | 0.0 | 5.1 |

**: Row percentages (N:812)*

non-physician professional, except the pharmacist. This result may be concluded as responder bias, because the interviewers were medical students.

Attending a pharmacist does not seem to be a significant mode of help-seeking behavior for any of the complaints and symptoms. Pharmacist advice is found to be used in small percentages for the complaints such as cough, fever, and painful conditions, and this result was also supported by the data collected from the pharmacies.

During the 10 work days period a total of 1331 customers had attended to the 6 pharmacies in the region. The reasons of attendences to the pharmacies are given in Table 4. Twenty three percent of the total attendences were for prescribed drugs, 40.3% for unprescribed drugs by giving the specific names of the drugs and 15.9% of the total requests were any medication or advice for the complaints. The proportion of prescribed/unprescribed drugs is found to be 1/1.75.

These results are similar to be Hannay's Glasgow study where the proportion of prescribed and unprescribed medicines were about one-third of those interviewed (11). In another study, it was reported that the use of self-prescribed medication twice as common as the use of prescribed medicines (21). According to the results of various studies the resort of self-medication seems to be more frequent than the resort to traditional and professional medical services in both of the developing and developed countries (22-27).

The distribution of major symptoms and complaints for pharmacist advice is given Table 5. More than half of the advices were for cough/sore throat and dermatologic problems (31.3% and 25.1% respectively). These results were found to be in compliance with Sharpe's study (28).

**Table 4.** Reasons of attendence to the pharmacies (Kocaeli, 1991)

| Reasons of attendence | n | % |
|---|---|---|
| Prescribed drugs | 307 | 23.1 |
| Unprescribed drugs | 537 | 40.3 |
| Advice for complaints | 211 | 15.9 |
| Others* | 276 | 20.7 |
| Total | 1331 | 100.0 |

**: Others include, measurement of blood pressure and weight, injection, family planning methods, test for pregnancy, medical and cosmetic materials.*

**Table 5.** Major complaints and symptoms for pharmacist advice (Kocaeli 1991)

| Complaints and symptoms | n | % |
|---|---|---|
| Cough and sore throat | 66 | 31.3 |
| Dermatologic problems | 53 | 25.1 |
| Stomach complaints | 18 | 8.5 |
| Headache | 16 | 7.6 |
| Arthralgies and myalgies | 15 | 7.1 |
| Diarrhea | 8 | 3.8 |
| Constipation | 8 | 3.8 |
| Chest pain | 2 | 1.0 |
| Others | 15 | 8.5 |
| Total | 211 | 100.0 |

**Table 6.** Unprescribed drugs requested from the pharmacies (Kocaeli, 1991)

| Unprescribed drug groups | n | % |
|---|---|---|
| Analgesics+antipyretics | 157 | 29.2 |
| Expectorants+antitussives | 90 | 16.7 |
| Antibiotics | 34 | 6.3 |
| Vitamins+minerals | 28 | 5.2 |
| Hormonal preparations | 25 | 4.7 |
| Antihelmintics | 24 | 4.5 |
| Psychopharmacologic preparations | 21 | 3.9 |
| Corticosteroids | 20 | 3.7 |
| Cardiovascular+antihypertensives | 20 | 3.7 |
| Oro-rhino-ophtalmologic preparations | 19 | 3.5 |
| Antiseptic solutions | 19 | 3.5 |
| Antiacids+$H_2$ receptor blokers | 18 | 3.4 |
| Anti-migraine preparations | 11 | 2.0 |
| Antihistaminics | 10 | 1.9 |
| Antifungals | 8 | 1.5 |
| Laxatives | 8 | 1.5 |
| Others | 25 | 4.7 |
| Total | 537 | 100.0 |

When the results obtained from the house visits and the pharmacies are interpreted together it seems that pharmacies are the help-seeking places mainly for the people who have cough, headache, abdominal pain and chest pain. Here a contradiction is observed for the help-seeking behaviour in cases of dermatologic problems. None of the respondents had replied to seek pharmacist advice for their dermatologic problems while 25.1% of the attendences to the pharmacies for advice were such reasons. This contradictory result can not be explained with our observations and findings.

Unprescribed drugs those were namely requested from the pharmacies are given in Table 6. As it is seen in Table 6, most commonly requested unprescribed drugs are analgesics, antipyretics, and drugs for the respiratory symptoms. Similar results were found in several studies which were done both in developed and developing countries (11-15).

## Results and Conclusions

We found that a small percentage (7%) of the study group had attended at least once in their life for the check-up of their health when they are healthy. The majority of the group knew the meaning and importance of the early detection but not attended to a professional mainly because lack of interest and lack of time. Males and more educated people seem to be more interested in such practices.

The data collected from the house visits suggest that the physician advice is the most important source of help for any kind of symptoms and complaints in our study group. We found that the most significant symptom for physician advice was "blood in the stool". Self medication was preferred especially in the presence of "headache" and pharmacist advice for "cough". None of the respondents had replied to seek help from the folk healers. This is probably due to respondent's bias and according to our observations during interviews we concluded that "nothing" group includes some amount of advice from folk healers particularly for abdominal pain and dermatologic problems, but is was not possible to estimate this amount quantitatively.

Generally it is accepted that self-medication emerges as of prime importance and the decision to seek treatment elsewhere is taken only in the case of serious illness (22-27). In our study we found that physician advice is preferred more than self medication for any kind of symptoms and complaints. This may be due to respondents' bias because the interviewers were intern medical students.

The extent of self-medication compared to prescribed medicine-taking is an indication of the use of professional medical services. In a cross-cultural study between Britain, America, and Eastern Europe, similar patterns of medicine-taking were found in spite of very different systems of primary care (7). In a British survey Dunnel and Cartwright reported that the use of self-prescribed medication was twice as common as the use of prescribed medicines. Self-medication was most commonly taken for fever, headache, indigestion and sore throats. These and other symptoms were common in the sample, but while 91% of adults reported one or more "abnormal" symptoms during the previous 2 weeks, only 16% of them had consulted a doctor for this. Self medication was often used as an alternative to consulting the doctor, who was expected to deal with more serious conditions. Fifty-seven per cent of the sample thought the local pharmacist a good source of health advice for many conditions (21).

This is confirmed in Sharpe's study of a London pharmacy where, in a 10 day period, 72 requests for advice were received, especially for skin complaints, respiratory tract infection, dental problems, vomiting and diarrhea (28).

In another study, by Jefferys et al, in a working-class housing estate, two-thirds of people interviewed were taking some self-prescribed medications often in addition to a prescribed drug (29). These results were similar to the Hannay's Glasgow study where the proportion of prescribed and unprescribed medicines were about one-third of those interviewed (11). The commonest unprescribed medicines were antipyretics, followed by analgesics, cough medicines and laxatives.

These studies and our results indicate that majority of the health care occurs within the popular sector and self-medication and pharmacist advice are the dominant modes of behaviour especially for painful conditions, respiratory symptoms and dermatologic problems. Pharmacies seem to have a significant role in the treatment of such illnesses. It is obvious that such medicines may have many negative side effects when used in inappropriate dosage and frequency. We recommend that the pharmacists must be trained and supervised about unprescribed drug usage -if can not be prohibited-, and that the integration of pharmacy services within the primary level of curative services seem to be necessary and would be effective for the health of the public.

Our study was carried out in an industrialized, urban region in western Turkey and it is not correct to generalize these findings. Also it would be more useful and scientific to study the attitudes of the people by qualitative research methods such as interview-indepth, focus group discussions. Nevertheless, this study indicates that health professionals need to be interested and should study popular and folk sectors of health care, because most of the health care occurs within these sectors.

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