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# KNOWLEDGE AND USE OF NON-MEDICAL PRESCRIPTION MEDICATIONS AMONG INTERNALLY DISPLACED WOMEN IN AKWA IBOM STATE, NIGERIA

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## Abstract

*Non-medical prescriptions medications are widely used outside health facilities and in pharmacies. However, their usage and safety among internally displaced women have received little attention. This study examined the knowledge and use of non-medical prescription drugs by women in humanitarian settings in AkwaIbomState, South-South Nigeria. The study was conducted in two (2) Bakassi refugee camps (IkotAdaidem and IkotEdiom). A convenient sample of 130 respondents participated in the study. Focus Group Discussions (FGD) and Key Informant Interviews (KII) were used to elicit information for the study. Socio-demographic characteristics of participants were analysed using simple percentages, and competing qualitative narratives were presented verbatim as raw data. Findings revealed that the majority of the women indulged in the use of unprescribed medications. The reasons for this health behaviour were availability, affordability of these drugs and familiarity with service providers (pharmacists, drug hawkers), among other factors. The findings indicate the need to empower internally displaced women educationally and economically to enable them access quality and safe medications, particularly during pregnancy and childbirth.*

**Keywords:** Perception, non-medical, prescription drugs, internally displaced persons.

## Introduction

Non-medical prescription medication is conceptualised in this study as the use of drugs without prescription‘ from a professional health care provider or _use for purposes other than what the medication is intended for. However, this conceptualisation does not encompass the use of herbs or visiting some traditional care attendance, but it is mainly from the perspective of western or orthodox medicine, and it is in line with World Health Organization‘s (WHO) definition. According to WHO (2000), –self-medication is the act of using medications by patients or individuals to treat self-diagnosed disorders or symptoms on their own initiative without getting advice from health care provider (WHO, 2000).

A study by Attahiru et al. (2018) described the feature of epidemiology of use of non-medical prescription medication in Nigeria as alarmingly high, stating that, the practice is more prevalent among the rural populations in the country. Many other studies conducted by

scholars in the field, such as Arikpo et al. (2009) and Ayanwake et al. (2017), provided the foundation of Attahiru, *et.al*. (2018). According to a study by Mbarambara et al. (2016), both modern and herbal medicines are commonly used for self-medication in developing countries.

Globally, the practice of self–medication or non-medical prescription medications among women has been very high, especially pregnant mothers (Baghianimoghadam, 2013; Bohio et al., 2016). Medicines are the most commonly used therapeutic intervention, and it is one of the most cost-effective interventions. Access to essential medicines has been defined as a human right and is one of the targets of the Millennium Development Goals (United Nations, 2010). According to WHO report in 1999, about one third of the world's population lacks access to essential medicines (WHO, 2004). Access to medicine is an important indicator of the functioning of good healthcare systems and has been identified as one of the most significant barriers to accessing medicines (Ruiz-Rodríguez et al., 2012). In many developing countries, out-of-pocket expenditure is the most common form of health care financing, and many households spend more than half their income on medicines and sometimes sell assets to obtain medicine (Kruk et al., 2009).

On the other hand, internal displacement is a demographic phenomenonthat informed a change of traditional habitation to a new location by force without crossing national borders (Usoro, 2016). In Nigeria, insurgency, floods, communal clashes, ethnic skirmishes, and the Bakassi episode arguably, have swelled the coast of displaced populations in recent times (Usoro, 2017). Internally displaced people have historically lived below the poverty line, have limited opportunities for human development, and are subject to psychosocial risks due to the socio-political context of displacement (Porter & Haslam, 2006).

Many studies have revealed poor living and health conditions for IDPs residing in urban reception zones (Arias,2002; Mogollon et al., 2003; Mogollon-Perez &Vazquez-Navarret, 2006; Puertas et al. 2006), as well as low level of access to curative and preventive medical care (Arias, 2002, Ruiz-Rodriguez et al., 2008). A study in Colombia found that around 70% of IDPs are of ethnic Afro-Colombian and indigenous background and that women, children and black people are most affected by this demographic process (Gomez-Builes et al., 2008). Besides, studies analysing access to health services in Colombia found that utilisation of health services by IDPs with health problems was lower than in the general population, indicating the existence of access barriers (Ruiz-Rodriguez et al., 2006) which affect access to essential medicines as well as other services (Ruiz-Rodríguez et al., 2012).

Nigeria, particularly, has been finding it increasingly difficult, and is almost failing in its task to manage its large number of IDPs. Out of about 12.5million IDPs in Sub-Saharan Africa as at the end of 2013, which is over one third of the world's total number of IDPs, Nigeria accounts for about 3,300,000 IDPs as of March 2014. With this figure, Nigeria tops the list of the three countries with the largest population of IDPs in Africa, followed by Democratic Republic of Congo and Sudan, respectively (Usoro,2016). According to UNFPA report, Borno, Yobe and Adamawa, are the three most affected states by the Boko Haram insurgency. In 2017, it was estimated that 53 percent of internally displaced persons are women and girls. Of this 53%, about 1.73 million are of childbearing age, with 276 000 pregnancies expected (UNFPA 2017). Women in displaced conditions are most vulnerable and have numerous health challenges exarcebated by poor or non-existent medical care during pregnancy and delivery (Alvarez et al., 2009; Ononokpono et al., 2014).

Lack of access to medicines among internally displaced populations suggests several reasons for concern: AIDS/ other sexually transmitted diseases due to exposure to physical danger, violence, and risk of becoming sexual prey (Population Report, 2000); and indulgence in self-medication.Considering that the quest for global health for all might continue to be a mirage except urgent step is taken to see the health needs of all category of

persons as very important; there is need for a rigorous and holistic examination of the use of non-medical prescription drugs among vulnerable population such as internally displaced women.

**Statement of the Research problem**

Self-medication or the use of non-medical prescription medications is a public health concern. The World Health Organization estimated that about 80 to 180 billion dollars were expended in treating adverse drug reactions caused by self-medication (WHO, 2002). The prevalence of non-medical prescription medications usage varies across countries and communities (6%-73%) (Corrêa-Fissmer et al., 2014). In Iran, the prevalence of self-medication was between 76.6% to 83% (Jafari et al., 2015). Sema et al. (2020) noted that in sub-Saharan African countries where health care resource is very limited, people live with extreme poverty, and illiteracy rate is very high; the usage of non-medical prescription drugs could be high and with attendant greater negative impacts, particularly when practiced by vulnerable population like women. The low awareness of the potential risks of medication due to low level of educational attainment, lack of knowledge, attitude, and socio-cultural condition could cause variations in the prevalence of self-medication in different settings (Sema et al. 2020).

A study in Ethiopia indicated that nearly half (40.8%) of pregnant women practiced self-medication during pregnancy. The prevalence of non-medical prescription medication among pregnant women, as indicated by a Nigeria study, ranges from 83.1% for analgesics, 66.7% for antibiotics to 28.9% for antimalarial drugs. The women also self-medicated for Nausea and vomiting (90.4%), diarrhoea (67.8%), back pain (62.1%) and fever (28.8% (Babatunde et al.,2021).

Notably, the use of non-medical prescription medication in Nigeria is alarmingly high, and the practice is more common among the country's rural and vulnerable populations, including internally displaced women (Attahiru et al., 2018). Given the poor health care system in the country and difficulties faced by internally displaced population in meeting their health care needs, and lack of access to safe medicines, most of the women in humanitarian settings resort to non-medical prescription medications.

**Theoretical Framework /Literature Review**

Theoretically, this study incorporated the work of (Niriayo, et al. 2021), which emphasized the need for data on the use non-medical prescribed medicines among vulnerable groups. The authors also argued that it is important to examine the knowledge of out-of-counter (OTC) medication with the practice of self-medication. This examination is helpful in the identification of high-risk groups with regard to self-medication.

The prevalence of the use of none-medical prescription medication or self-medication varies across different communities and it could be affected by several factors. For instance, a study in Iran revealed that insurance, education level and number of children are key drivers of self-medication among women before pregnancy (Ebrahimi et al., 2017). Studies in Tanzania and Nigeria found that malaria was a commonly reported illness. Another study indicated that lack of access to healthcare service, unregulated distribution of medicines and patients‘ attitudes toward healthcare providers were associated with self-medication (Jafari et al., 2015). In addition, socio-economic factors, long waiting times, cost of the drugs, educational level, age, income, satisfaction, and people‘s beliefs toward medication and disease were the predictors of the use of non-medical prescription drugs (Niriayo et al., 2021).Furthermore, a study among pregnant women showed that higher level of knowledge was associated with a higher likelihood of self-medication during pregnancy (Atmadani et al., 2020). The medical conditions for which drugs were consumed were fever, pain, infection, stomach upset, and bowel irregularity (Abasiubong et al., 2012; Ebrahimi et al., 2017).

Most existing studies have focused on self-medications and risks factors among pregnant women in Iran, Indonesia and Ethiopia (Jafari et al., 2015; Ebrahimi et al., 2017; Niriayo et al., 2021). However, little is known about the use of non-medical prescription medication among internally displaced women in other developing countries including Nigeria. Notably, there is insufficient information on the magnitude of the problem of access to medicine among IDPs, particularly women in humanitarian settings. Studies on self-medication among internally displaced women are sparse. To the best of our knowledge, there are few or no studies on the knowledge and usage of non-medical prescribed medications among internally displaced Bakassi returnees in AkwaIbom State. This study, therefore, examined the knowledge and use of non-medical prescription medication among internally displaced women in AkwaIbom State, using a qualitative approach to fill this gap with the aim to better understand this phenomenon in humanitarian contexts.

**Objectives of the Study**

1. In line with the theoretical framework, our study will inform policy decisions on appropriate interventions to promote the safe use of medication among vulnerable internally displaced women.
2. Specifically, this study examined the knowledge about common drugs used for self-medication; (i) The reasons for the use of non-medical prescription medications; and (i) The kind of illness treated using non-medical prescribed drugs.

**Materials and Methods**

*Study design*

The information on which this study is based was elicited from a qualitative study conducted in two makeshift camps: Ikot Ada Idem and Ikot Ediom, in Ibiono Ibom and Ibesikpo Asutan Local Government Areas respectively. These camps are located at Ibiono Ibom and Ibesikpo Asutan Local Government Areas respectively. This study adopted focus group discussions (FGDs) and Key informant investigation (KII), as major means of eliciting data. Discussions with various FGDs centred on awareness of and reasons for use of medical prescription medication, reason for preference, kind of illness and knowledge about common drugs used for non-medical prescription medication.

*Study Area*

Akwa Ibom is one of the oil-rich states in the Niger Delta region of Nigeria. It is bordered on the south by the Atlantic Ocean. It has 31 Local Government Areas. Across the globe, the major causes of population displacement are both natural and man- made which include war, conflict, famine, earthquake and other natural disaster. Currently in Nigeria insurgency and banditry have displaced more communities than any other factor in the history of our corporate existence. Akwa Ibom State is the home of many IDPs from the Bakassi Peninsula in Cameroon. This is consequence upon the implementation of the Greentree Agreement (GTA) between Nigeria and Cameroon,following the International Court of Justice‘ ruling on the contest of ownership of the oil-rich peninsular by the two countries.

Following the ceding of Bakassi Penisula to Cameroon by the ICJ, Nigerians residing in the peninsula were given the option to either remain as tenants in their traditional homeland or relocate to Nigeria. Subsequently, some of the displaced persons who traced their origin to Akwa Ibom State were assisted by the Akwa Ibom State Government under the auspices of Akwa Ibom State Emergency Management Agency (AKSEMA), to return to Akwa Ibom State. On September 5, 2008, about ten thousand displaced persons from Bakassi Peninsula returned to Akwa Ibom State (Usoro, 2016) and those who could not trace their families were relocated to makeshit camps in Ikot Ada Idem, IkotEdiom and Ibaka. These

camps are located at Ibiono Ibom and Ibesikpo Asutan Local Government Areas respectively. This development became a land mark event that set the pace for a high concentration of people in humanitarian situations after the Nigerian civil war and its attendant consequences.

*Study Population*

The study population consists of two sets of population categories. First category were young mothers of reproductive age (15-49 years), and the second category were elderly women (50 years and above). Focus group discussions were held in two study sites (Ikot Ediom and Ikot Adaidem camps), four in each of the camp locations making it a total of eight FGD sessions. The small sample size was manageable due to financial and time constraints. In order to promote focused and lively discussions, each focused group discussion session consisted of 10 participants who could engage in active and meaningful discussions. A convenience sample of 130 women took part in the study. Study participants were purposively selected with the help of key informants and accreditation register provided by camp leaders.

Participants were properly briefed about the study objectives and their consent obtained before participation. All participants were familiar with each other and the local community. The FGD sessions were facilitated by two female research assistants. All of them were graduates who had undergone training for the purpose. All discussions were taken down on field notes and recorded on audio tapes. The recorded data were later transcribed and translated by language experts. In-depth interviews were also held with 4 key informants recruited for the study.In order to strengthen the methodology of this study, taking into consideration the fact that findings from FGDs are not always transferable when the population is large, the researchers, therefore, considered it appropriate to supplement FGDs with Key informant interviews (KII) conducted with key informants recruited in the course of the study due to their rich knowledge about the study population and substantive issues bordering on this study. The interview schedule was designed to explore the study objectives. The interviews were conducted in local dialects but recorded in English Language by two trained interviewers whose notes were later compared.

*Data Analysis*

The researchers read the reports several times. Competing narratives from the field were presented verbatim using a conversation analysis template. General themes were discovered and these were categorised under various headings in line with the research objectives.Data on the socio-demographic characteristics of the participants were presented and analysed using simple percentages.The study was reviewed and approved by the University of Uyo Research Ethics Committee. For all data collection activities, appropriate informed consent was obtained from the participants.

## Results

### Socio-demographic characteristics of the study participants

**Table1: Percentage distribution of participants by socio-demographic characteristics**

| Characteristics | No. of participants | Percentages |
|---|---|---|
| **Age(Years)** | | |
| 15-25 | **41** | **31.5** |
| 26-35 | **21** | **16.2** |
| 36-45 | **35** | **26.9** |
| 46-55 | **11** | **8.5** |
| 56-65 | **12** | **9.2** |
| 66 and above | **10** | **7.7** |
| **Age at first marriage(years)** | | |
| 15-20 | **89** | **68.5** |
| 21-26 | **26** | **20** |
| 27-32 | **11** | **8.5** |
| 33- above | **4** | **3** |
| **Educational attainment** | | |
| No education | **30** | **23.1** |
| Primary | **84** | **64.6** |
| Secondary | **16** | **12.3** |
| **Occupational status** | | |
| Civil service | **13** | **10** |
| Farming | **38** | **29.2** |
| Fishing | **10** | **7.7** |
| Unemployment | **69** | **53.1** |
| **Monthly income** | | |
| 10,000 | **114** | **87.7** |
| 15,000 | **10** | **7.7** |
| 20,000 | **6** | **4.6** |
| **Marital status** | | |
| Married | **85** | **65.4** |
| Single | **16** | **12.3** |
| Widowed | **29** | **22.3** |
| **Number of children** | | |
| 1-3 | **8** | **6.2** |
| 3-7 | **20** | **15.4** |
| 8-above | **41** | **31.5** |
| | **61** | **46.9** |

A high proportion of the participants - 41 (16.2 %) were aged 15 - 25 years. A significant number of participants- 89 (68.5%) were married before the age of 25years.The highest level of education attained by the majority of the participants was secondary school-16(12.3%), those who attained primary education were 84 (64.6%) participants. Regarding occupational status, 69(53.16%) participants were unemployed, while 38(29.2) were farmers. From Table 1 above, 114(87.7%) some of the study participants earned less than N15, 000 a month. In terms of marital status, 85 (65.4%) of the women were married. Concerning the number of children ever-born, more than 20(15.4%) gave birth to between 3 or 7 children.

**Knowledge about common drugs used for self-medication**

A participant (23years) during FGD described some of the drugs taken:

> Most of the drugs I take without prescription by doctors are routine drugs (mainly analgesic) such as Paracetamol, Panadol, Ibuprofen, Aspirin among other painkillers.

**Awareness of medical prescription medications**

Awareness of medical prescribed drugs was high among the study participants. However, just a few participants confessed that they are not aware that drugs have to be prescribed by a physician before being taken.A participant (46years) during FGD stated:

> I have been to the hospital for a number of times and I am quite aware of the fact that, after the nurses had collected your health history, the doctor will thereafter examine you and prescribed the drugs for you. It is always a rigorous process.

**Use of non-medical prescription medication**

Most of the women particularly those in their reproductive age narrated that they self-medicate even during pregnancy**.** A participant (24 years) during KII expressed the opinion of majority of the women:

> Many of us patronise the chemists, and other itinerant medicine peddlers (whom they also referred to as doctors). During pregnancy we use a lot of medication to keep healthy and we can easily get them from nearby chemist shops. They also attend to us and treat us accordingly.

**Reasons for the use of non-medical prescription medications**

Narratives from study participants indicated their major attractions to non-medical prescription healthcare services to include availability, affordability, and familiarity with service provider, acceptability, and positive attitude of providers among other socio-cultural attitudinal drivers. All these variables were overwhelmingly supported during FGD sessions.According to a participant (30years):

> I use non-medical prescription medications because they are more accessible and affordable. The relationship with service provider is more humane and friendly, it is easy to access services on credit and payment would be made later.

Another Participants(18years) during FGDs noted:

> I do not go to a doctor for prescribed medications except on very critical health conditions. I prefer buying medications from the chemists or other drug peddlers, ; their services are cheap, efficacious, easily accessible and available at all time.

One of the elderly participants (60 years) during KII stated:

> Personally, I patronise the chemists more than the hospital or clinic…. I even buy medications from itinerant drug peddlers in buses, markets or other public places. To me,

> they are helpful...their products are cheap and readily available

**What kind of illness are treated using non-medical prescribed drugs?**

The researchers collected data on the kind of illness for which non- medical prescribed medicines were being taken; a check list was used to investigate chronic illness for which medicine was taken, without prescription by a physician. But typically, it was a common belief among the study population that, it is the severity of pains and treatment affordability that determines the kind of drugs taken.

According to a participant (16years) during FGD:

> We do not visit the hospital every time that we are ill. We tried to manage the situation by ourselves with drugs from the chemists without prescriptions or other drug peddlers. It is only when the pain becomes unbearable or the sickness reaches the crises point that we consider visiting the hospital as the last resort.

Another participant(19 years) during KII stated:

> Common afflictions like headache, cough, pain, diarrhoea and stomach ache, need not be complained to a physician due to the cost implication in the hospital. I prefer managing them by myself.

According to a key informant (35 years):

> Majority of women are low income earners, their husband survives with menial jobs which do not come regularly. Ability to meet the financial cost of prescribed medications has made the idea of going to hospital for prescribed drugs a very unpopular initiative. So I treat minor health problems at home.

**Discussion of Findings**

Attempts have been made in this study to examinethe knowledge and use of non-medical prescription medications among internally displaced women in IDP camps in AkwaIbom State. Theuse of non-medical prescription medication found in this study could be due to poor access to modern health care facilities. This is consistent with previous studies that examined poor living and health conditions for IDPs residing in urban zones as well as a low level of access to curative and preventive medical care (Porter & Haslam,2005; WHO,2004). The result of the study showed that women in the study camps indulge in non-medical prescribed medications. This finding corroborates a study elsewhere that states that poor doctors' access and other variables push women to perpetuate non-medical prescription medications. (Azuh, Iwela, Adeloe, Akanbi & Mordi, 2017).

This study also shows that, although women have adequate awareness about medical prescribed medications, most of them reported usage of non-medical prescribed medications. The plausible explanation could be poor access to modern healthcare services which tend to deter or make it difficult for women to seek prescribed medical treatment, especially in emergencies. This finding corroborates Okolocha et al. (1998) position that attitude, practices, and situations may keep women away from, or delay the decision to use prescribed medications by health care providers particularly in emergencies. This submission is also supported by other studies within and outside Nigeria such as Babalola

and Fatusi (2009), Roy et al. (2013), Shehuet al. (2016), Workuet al. (2013), and Sajedinejad et al. (2015), which have identified these factors as barriers to proper use of prescribed medication by women in all situations. Other previous studies (Ogundairo&Jegede, 2016; Onosoga et.al., 2014; Tanya et.al., 2016; Kebedeet al.,2012) also corroborate these results.

The target population are people with low education levels; therefore, it was not easy to recognize the need for medicines and consequent access to it. The Bakassi returnees could not take medical prescribed medicines probably because of cost and poor access to modern health facilities. Health problems such as headache, cough, pain, diarrhea and stomach ache were were the major reported illness and the non-medical prescribed medications commonly used for treatment include analgestics- Paracetamol, Panadol, Ibuprofen, and Aspirin among other painkillers.

The results further showed that the most commonly reported reasons for using non-medical prescribed medications were availability, accessibility, affordability, familiarity with service provider, acceptability, and the positive attitude of providers. These findings are in line with a study in Ethiopia (Niriayo et al. 2021); and may reflect Nigeria's poor health care system. For instance, the issue regarding availability and the ease of access to non-medical prescribed drugs as a predictor of self-medication could indicate the poor drug regulatory system in the country and thus suggests the need for health policymakers to pay more attention to the dangers or risks associated with use of drugs without medical prescriptions among internally displaced populations and particularly women.

Notably this study has some limitations. The information given by the participants on the non-medical prescribed drugs used is limited because it was difficult for some of the women to remember and mention the name of the drugs. Data used for this study were translated from local language to English, and although verified, some of the original words could have lost their original meaning during translation. However, this was mitigated by emphasizing overarching themes present in the transcripts rather than specific words or phrases used by participants.

## Conclusion

This study established substantive reasons for the use of non-medical prescription medications among the study population. The FGD and KII used in this study were very useful in providing information on the use of non-medical prescription drugs. Most of the non-medical prescription medication used were routine drugs (mainly analgesic) such as Paracetamol, Panadol, Ibuprofen, Aspirin, and other painkillers. From the narratives emanating from this study, it is important to note that the use of non-medical prescription drugs can be situation-induced. Although most of the study participants recognised the need for a proper approach to medication, low socio-economic status, poor access to adequate healthcare services, affordability, and availability were the major factors influencing the use of non-medical prescription medication.

## Recommendations

1. Policies for access to modern healthcare services and safe medications should target displaced people and also on individuals who live in similar conditions.
2. There is need to empower internally displaced women educationally and economically. This will enable them to access quality and safe medications particularly during pregnancy and childbirth.
3. Government and other stakeholders managing the affairs of the displaced population should address all the deficiencies that characterize health centres proximal to the displaced people.

4. There is a need to strengthen the drug regulatory system and enforce regulations to reduce the practice of self-medication in humanitarian settings.
5. Sensitization on the dangers of non-medical prescribed medications should be given a priority if there must be a reduction in maternal mortality among vulnerable populations in Nigeria and particularly women in humanitarian settings.

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