

Migrants' Perceptions on Barriers to Treatment Seeking for Hypertension: A Qualitative Study from Delhi, India

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ABSTRACT This study reports the perceptions on treatment seeking behaviour and perceived barriers to treatment for hypertension among the socio-economically disadvantaged migrants in Delhi, India. In-depth interviews with key informants and focus group discussions with community members were conducted. Treatment seeking for hypertension was not adequate. Several patient- and provider-related issues have emerged as barriers in treatment seeking and adherence. The perceived barriers and needs are to be considered by individual practitioners and the public health care systems to bring them into the fold of health care to tackle the problem of hypertension.

INTRODUCTION

Despite the availability of effective medical therapy, over half of all hypertensives do not take any treatment (Inkster et al. 2006) and more than half of those on treatment have blood pressures over the 140/90 mmHg threshold (Falaschetti 2004). The World Health Organization describes poor adherence as the most important cause of uncontrolled blood pressure, and estimates that 50–70% of people do not take their antihypertensive medication as prescribed (Mant and McManus 2006). Given the high prevalence of hypertension among the migrants of Delhi, like any other migrants world-wide (Beune et al. 2008; Poulter et al. 1990; He et al. 1991), there is an urgent need for prevention, control and management of hypertension. Qualitative enquiry is an essential tool in unravelling the people's perceptions, which might contribute in bridging the gap between the people and health care providers. The present study aims to gain insights into the perceptions of socio-economically disadvantaged migrants in Delhi regarding treatment seeking behaviour for hypertension.

METHODS

New Delhi, the national capital of India, has attracted several people and continues to act as a pulling force, particularly for the rural poor. In this study, two groups of migrants (recent-migrants, who have migrated to the city from rural villages within last two years and this being their first migration; and settled-migrants, who have

migrated and residing in Delhi at least for 10 years) were considered. Qualitative methods were used to elicit the reasons and perceived barriers in treatment seeking for hypertension among these communities. A total of 14 key informant interviews, and three focus group discussions were conducted with the help of topic guides (Table 1). Topic guides were developed in English and translated to Hindi, the local language of Delhi. The institutional ethics committee approved this study protocol and informed consent was taken for interview and recording. Standard methods were followed while conducting key informant interviews (Pelto and Pelto 1978; Lengeler et al. 1991) and focus group discussions (Khan and Manderson 1992; Hudelson 1994). All the interviews and discussions were transcribed from audio-cassettes and adjunct notes, and then translated to English. The data were entered into a word processor. The data were subjected to thorough reading. Several codes were identified and relevant text segments were kept under each code while reading the data. Inferences were drawn collectively by careful reading of the coded text. The data were read and re-read to check the appropriateness of the inferences drawn. Also, the inferences drawn were checked through discussions with another anthropologist (who is not involved in the project), who read the data independently.

RESULTS

The key informants and focus groups were aware of the problem of hypertension in their

community. The qualitative enquiry from the participants revealed that some of those who were aware of their hypertension status would go to health facility. The settled-migrants go to the private practitioners, mobile clinic from a government tertiary hospital or other government hospitals for treatment. However, the adherence to hypertension treatment is only for shorter period or for the period for which medicines are prescribed during that consultation. One key informant has told that *"if one (hypertensive, who was on treatment) feels that BP has become normal, then they stop taking medicines"*. A 50-year old female hypertensive (settled-migrant) informed that *"I can feel when the BP becomes high, the blood flows with speed, I can feel that, then I take the medicines...it helps, after few days it becomes normal, then I stop taking medicines."* It was revealed that some do not seek treatment despite being aware of their hypertension status. Among the recent-migrants, the treatment seeking was very uncertain and participants could not respond much about pattern of treatment for hypertension patients. Epidemiological study conducted by me among these, present study migrants revealed that nearly 89% of the recent-migrants, who were hypertensive were not aware of their hypertension status. Regarding failure to seek and adhere to treatment, various reasons have emerged. For convenience of presentation, they were grouped as: patient-related and provider-related issues.

Patient-related Issues: The major perceived barriers related to patients were unawareness regarding hypertension and its consequences, constraints in terms of money and time, attitude of the patient/people such as not taking the problem seriously, longer duration of medication, shyness/hesitation to visit health centre and lack of family care. The participants expressed that people prefer to go to public health facility if free

medicines are given, other wise they would prefer private practitioners. It was expressed that visiting public health facility involved longer queues and waiting time, travel costs and loss of that day's wage. Private practitioners are preferred for several reasons such as convenient time for consultation, trust, acquaintances, availability of credit-based consultation and drugs. However, the discussions revealed that in the back ground of poor economic conditions of the people, private treatment is unlikely to continue and remains non-affordable. Following are some of the typical comments: *"...unawareness... of its (hypertension's) consequences....., the question is that would they go to work to earn their daily food or would they spend half their day to get treatment"* (FGD 3: recent-migrant female). *"...there are several problems like absence of basic amenities, unawareness about the disease, unavailability of medical help despite being aware, unavailability of doctors, etc. People cannot afford private consultation so they go to government hospitals, but seeing the long queues and rush they feel that right now it (hypertension) is not a very big problem so it is not a compulsion to get the check up done and this can be done later"* (ID8:settled-migrant male).

Provider-related Issues: Provider-related issues that were raised by the key informants as well as focus groups included doubt over the efficacy of medicines and lack of trust in the treatment. In addition, they expressed that while the private practitioners prescribe too many diagnostic tests for the sake of money, the doctors and staff at public hospitals do not pay attention to the patients and do not show any respect for the poor and this has been perceived as a barrier in accessing services at the public health facilities. Also, public health hospitals are either not available in their locality or people are not aware of the facility.

Table 1. Details of key informants and focus groups

	Settled-migrants	Recent-migrants	Total
<i>Details of KIs</i>			
Male	3	3	6
Female	5	3	8
Age Range	38 – 50 years	22– 40 years	38 – 50 years
<i>Composition of FGD</i>	<i>FGD 1</i>	<i>FGD 2</i>	<i>FGD 3</i>
Gender	Female	Male	Female
Number of participants	6	8	6
Age range	25 – 50 years	30 – 50 years	25 – 40 years
Migration status	Settled-migrants	Settled-migrants	Recent migrants

KI=key informant, FGD=focus group discussion

In the words of a recent-migrant man, *"At government hospitals... be it doctors, nurses or compounders, do not respect the labourers... no body pays any attention towards poor people"*. Also, the participants informed that generally the consultation is done in a hurried manner and several times patients receive prescription of medicines only, and hence, they generally consume the medicines as per the initial prescription, and do not revisit the doctor for further consultation. *"Some times drugs are not available at the health facility; they simply write a prescription and ask us to buy medicines from pharmacy shop. But everybody is not in a position to spend money to buy medicines... If free medicines are not given, what is the purpose of standing in long queues at government hospital? Some office going people hesitate to stand in lines due to lack of time and even housemaids for that matter cannot spend time standing in queues"* (ID2: settled-migrant female). The constraints in terms of money, time, inadequate and inaccessible services, etc. have resulted in developing certain coping attitudes and other sorts of coping. A recent-migrant man expressed that *"The main thing is that nobody takes care to look after these labourers. If they do not work for a single day, then they will not get their daily wage to run their family. We think that we have to die anyway, then why not die happily and take life as it comes"* (ID14: recent-migrant male). In certain instances, lack of trust in the given treatment has also added to develop and stick to certain attitudes. During discussion with settled-migrant women focus group, it was expressed that *"Some people seek treatment, while many do not seek treatment. Whatever you do, what has to happen will happen"*.

DISCUSSION

The present qualitative study highlights the barriers to seek and adhere to hypertension treatment from people's perspective. It was understood that treatment seeking for hypertension in these communities was not adequate. Treatment costs along with longer duration of treatment were major concerns to the people along with other patient-related and provider-related factors. Similar situation of perceptions leading to poor treatment seeking behaviour was reported from some migrant groups (Beune et al. 2008; dela Cruz and Galang

2008). The perceived doctor-patient communication gap can be tackled, provided the health care provider recognizes that patient's understanding is an important element in treatment adherence. In the words of one key informant (ID1, settled-migrant female, hypertensive) *"Some people do not like taking medicine everyday... Even I also never used to take this problem seriously until a doctor helped me to understand its consequences. Now, I take my problem more seriously. Doctor told me that BP can result in brain haemorrhage, paralysis of any body part"*. This highlights the importance of positive outcome of the interaction between doctor and patient. Boutin-Foster et al. (2007) noticed that personal experiences, experiences of family and friends, and encounters with the healthcare environment influenced patients' perceptions of hypertension and their willingness to its management. Hence, effective community education programmes are vital to increase public knowledge and awareness of hypertension and related cardiovascular diseases.

Besides lack of awareness and inadequate health care facilities, several patient-and provider-related issues were influencing the treatment seeking behaviour. The patient-related issues were unawareness of hypertension status and its consequences, financial and time constraints, not taking the problem seriously, longer duration of medication, shyness/hesitation to visit health facility, lack of family care, etc. Lack of drugs along with long waiting time, behaviour of the health staff at public health facilities, doctor-patient communication gap, non-availability/non-visibility of public health services have been perceived as a major barriers to seek treatment at public health facilities. Financial constraints and treatment costs were perceived as barriers to seek private health care.

These barriers need to be considered by individual practitioners as well as the public health care system for providing treatment as well as to bring them into the fold of health care to combat hypertension and related cardiovascular diseases. Studies of this kind are useful while planning the programmes for prevention and management of hypertension under primary health care system. The present study will have implications for people-centred health care provision, particularly for those who are marginalized for the reasons of social and economic status, migratory status, ethnicity, etc.

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