

OUT OF THE REACH OF CHILDREN? YOUNG PEOPLE'S HEALTH-SEEKING AGENCY IN AFRICA'S NEWLY-EMERGING THERAPEUTIC LANDSCAPES

Abstract

Despite a dominant view within Western biomedicine that children and medicines should be kept apart, a growing literature suggests that children and adolescents (in both Western and developing-country contexts) 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 health insurance, 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 9-to-17-year-olds. We show that many young people take active responsibility for their own (and others') healthcare. However, there is substantial variation in health-seeking practices and associated agency; these processes are shaped by (and also shape) resources available, including economic, social, cultural, psychological, informational and locational forms of capital. Dynamic interactions between resources and health-seeking agency operate within a wider, rapidly-changing therapeutic landscape, which has opened access to a greater range of healthcare possibilities. We conclude by considering implications for health and wellbeing, and suggest possible interventions for facilitating young people to seek healthcare safely and effectively.

Introduction

Children 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 et al, 1998), which extend to the domain of health and medicine (Prout and Christiansen, 1996).

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. Hämeen-Anttila and Bush, 2008; Sloand and Vessey, 2001; Chambers et al, 1997; Bush and Ianotti, 1988). Even very young children may actively resist adults' attempts to intervene, for example, by refusing to swallow a medicine (Prout and Christensen, 1996).

Less research has focussed on young people's health-seeking practices in developing countries. Important work by Geissler and colleagues (Geissler et al, 2000; 2001; 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 11-17y) accessed numerous healthcare options, including cheap pharmaceuticals from local shops, herbal practitioners, and medicines stored at home. Only a quarter of illnesses were reported to adults, while 14% sought treatment themselves. 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'.

Various commentators (Van der Geest and Geissler, 2003; Geissler et al, 2001; Prince et al, 2001) have suggested that young people's responsibility for health-seeking in Africa should be understood within a context in which children take active roles in domestic work, sibling care and income generation, and that children's acquisition of medical knowledge, through assisting parents, forms part of socialisation. 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. 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 generally have fewer economic resources at their disposal than adults; in poor communities in particular this can severely constrain their effective treatment-seeking options. Young people's self-medication, based typically on limited knowledge and funds, can lead to misuse of pharmaceuticals, which can be highly toxic taken incorrectly (in excessive doses, too frequently, or in combination with other drugs), while under-dosage can lead to pathogen resistance (Geissler et al, 2000; 2001; Van der Geest, 1999; Abuya et al, 2007).

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, to mean health-inducing places, and instead draws on Leach et al's (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 address the obstacle of user fees to service utilisation (Ridde et al, 2010; Ridde and Haddad, 2009; Ansah et al, 2009; Franco et al, 2008). Ghana's National Health Insurance Scheme (NHIS), introduced in 2001, had achieved 38% coverage of the population by December 2006 (Agyepong and Adjei, 2008), the start of our field research. Details of the scheme can be found elsewhere (Agyepong and Adjei, 2008; McIntyre et al, 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=2.2GHC). Under-18s are covered, subject to a processing fee of 2-5GHC, *provided their parents are also registered*. The NHIS 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. This includes the rapid spread of mobile phone networks (Coyle, 2005; James and Verstag, 2007; Smith 2009) and liberalisation of broadcast media in Ghana, leading to a flurry of local commercial radio stations, and mass advertisements of medicines.

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 exercise agency in their health-seeking practices, 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 consider young people's ability to take and act upon decisions affecting their (and others') healthcare. We focus 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.

Meanings of childhood and youth in Ghana

We report here on research conducted primarily with 9-to-17-year-olds in Ghana. The UN Convention on the Rights of the Child (UNCRC) defines a child as anyone below the age of eighteen (ONCRC, 1989). In contrast, the WHO distinguishes between 'children' (0-9y) and 'adolescents' (10-19y) (WHO, 2003). However, in practice, categories of childhood, adolescence and youth in contemporary Sub-Saharan Africa are highly dynamic and contingent (Dehne and Reidner, 2001; Langevang, 2008; Fatusi and Hindin, 2010; Johnson-Hanks, 2002; Ansell, 2005). Langevang (2010:2044) reports that young people in Accra move between different generational positions not just over the

life-course, but daily as they fulfil multiple roles. Our study participants, most of who were still in 'Basic Education' (see below), were usually regarded and referred to (by themselves and others) as 'children' or, often, 'small boy' or 'small girl' : a status marked, for girls in particular, by the short haircuts required for school. However, outside school, most assumed considerable 'adult' responsibilities, including managing domestic tasks, care of younger siblings and often income generation. These responsibilities typically increased with age, but in non-linear ways, modified by circumstances such as family position and livelihood requirements.

In recognition of this complex and non-linear navigation of social and generational spaces, we follow Ansell (2005) in rejecting hard-and-fast classification of young people into 'children', 'adolescents', etc. based on chronological age, and argue instead for a more nuanced approach, in which life circumstances and capabilities are more relevant considerations. We therefore refer to our participants usually as 'young people', but we also use the terms 'child', 'adolescent' and 'youth' variously to draw attention to the contextual nature of age and other circumstances in differentiating young people's experiences, and highlight their status under the UNCRC.

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

Poverty was a major focus of the Child Mobility Study; as such, sites with relatively high levels of economic deprivation were selected. Farming was the major economic activity in all rural sites, with other informal-sector economic activity dominating in urban/peri-urban sites; only 12.1% of men and 2.1% of women (parents of survey respondents) were employed in the formal sector. School enrolment rates for under-15s were high 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, theoretically for ages 6-14y); only 5% were enrolled in Senior High School (SHS). Educational status among their parents was generally low: 51% of mothers and 38% of fathers had no formal education, and only 5.4% of fathers and 1.1% of mothers had any secondary education, with substantial rural-urban differences.

The Child Mobility study entailed three fieldwork phases in Ghana in 2006-08:

- (1) 18 'young researchers' (11-17y) 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.
- (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 key informants, parents and children, 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 9-17y across all sites, to test key hypotheses regarding that emerged from the qualitative work. A sample of approximately 125 respondents per settlement was obtained by taking households along transects, and randomly selecting one child per household for interview. After some basic initial information provided by a parent/guardian, the questionnaire completed with respondents out of parents' ear-shot.

The interviews and questionnaire were conducted in local languages (usually Twi or Fante), to ensure good comprehension. 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 and 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 health-seeking practices and exercise of agency, which were tested qualitatively by further interviews with 47 young people, also aged 9-17y, in the same study sites (Sep-Dec 2009). In these later interviews (denoted*), participants were asked to recount recent illness episodes and the pathways through which treatment was (or wasn't) 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 (except those in child-headed households).

Health service provision and utilisation

Ghana, like many other African countries, has a complex mix of healthcare systems. Young people use a wide range of therapies, simultaneously or serially, including treatment-seeking from 'experts' (government-run and private hospitals and clinics, 'traditional' healers and herbalists, and faith or spiritual healers). Self-medication is 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 3-5km of such facilities. None of the rural field-sites had permanent health-posts, and distances to nearest health centre ranged from 10-30km. These rural-urban variations are reflected in young people's uptake of services: Table 1. However, controlling for settlement type, other socioeconomic indicators (schooling, parents' education/occupations) was not associated with service use (independent or otherwise; see below).

TABLE 1 ABOUT HERE

Over half the young people surveyed reported difficulties in accessing healthcare services. The barriers were broadly similar to those reported in other literature on Sub-Saharan Africa (Airey, 1992; Rutherford et al, 2010): principally high fees for consultations and medication and difficulties/expense in travelling to health facilities. These barriers were particularly acute for rural children: Table 2.

TABLE 2 ABOUT HERE

Health-seeking practices and agency

When an illness is perceived to be serious, dangerous or life-threatening, parents/guardians usually take control of health-seeking. However, for other, less (immediately) threatening ailments (e.g. body pains, mild fever, stomach upsets), children/adolescents are often expected to take responsibility for seeking healthcare. Like their East African counterparts (Geissler et al, 2000; 2001), most young people interviewed were very knowledgeable about common infectious diseases, their aetiologies, and various treatment options. A quarter (25.6%) had visited health facilities unaccompanied by an adult (most recent visit). Most commonly (50% of cases), they went alone to buy over-the-counter medicines from drugstores (mostly painkillers, antipyretics and anti-malarials), and many also sought hospital treatment independently: 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, 15y, 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, 11y, urban)*

Visiting hospital alone is more common in urban areas; however many rural children prepare herbal medicines regularly, skills learned from observing and helping parents and grandparents (see Prince and Geissler, 2001). Moreover, children often know where medicines are stored in their homes and have ready access to them. Young people also often seek healthcare for others: they are routinely sent by family members to purchase medicines, but some take 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 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, 14y girl, peri-urban)*

TABLE 3 ABOUT HERE

Capital and health-seeking agency

While many young people are active health-seekers, the extent, nature and outcomes of their health-seeking practices vary considerably. Here, we examine the relationships between personal attributes (gender and age), resources available, and health-seeking agency. As Meinert (2004:13) indicates (in relation to work in Uganda), 'children's health practices ... should be understood as interplay between locally-defined resources and competences to mobilise them.' 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*: values attached to particular habits, tastes and predispositions; and *social capital*: 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: a positive psychological state characterised by confidence and self-efficacy (Luthans et al, 2006) and *locational capital*, by which we mean the benefits that can accrue to an individual by virtue of his/her geographical location. We argue that these interchangeable forms of capital mediate the relationship between (effective) health-seeking agency and structural constraints on this.

Personal attributes: Age and gender

In contrast to Geissler et al's (2000) findings from Kenya, gender has no discernible effect on Ghanaian children's health-seeking behaviour. Age, however, is very influential: 15-to-17-years-olds were far more likely to seek healthcare independently than younger children (Table 3). By age 14 or 15, young people assume increasingly adult roles and responsibilities; they are also more likely to have money for treatment and are generally less subject to parental restrictions on their movements. Nonetheless many younger children, like 11-year-old Mary, 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 (she knew where to look), she walked to a nearby village to ask someone for medicine; she was duly given paracetamol.

Economic capital and independent incomes

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

"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, 13y, urban)*

Others managed to 'squeeze' (save) from lunch money given by their parents/guardians to purchase medicines.

Social capital and personal networks

Young people in Ghana employ 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 (See Meinert, 2004). They not only use pre-existing networks; but also actively construct and shape their own networks, which can be mobilised in times of need (see also Morrow, 1999). This 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, 16y, remote rural)*

Informational capital

Information can be the key to seeking appropriate healthcare. While most young people are remarkably knowledgeable about illnesses and healthcare, acquiring appropriate information for 'personal' or stigmatised conditions, can prove more difficult:

'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, 17y, urban)

Peer and other social networks are an important means through which information is transferred (see also WHO, 2003). Broadcast media also play a key role although, as we discuss below, the quality and accuracy of information is an issue.

Psychological capital

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

'If I 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, 13y, urban)

In Ghana, children are typically taught to defer to elders and to be 'seen not heard' (Porter and Abane, 2008), which can seriously impede effective and frank communication with healthcare providers. Attitudes of healthcare providers, who often under-estimate young people's intellectual and health-seeking abilities, can also undermine self-confidence.

Cultural capital and language

Various components of children's cultural capital (for example, wearing clean school uniform, indicating 'educated' status and coming from a 'good family') influenced their interactions with healthcare professionals (see also Meinert, 2004). Moreover, as noted above, the study sites were ethnically diverse, with large numbers of migrant families. Cultural differences between patients and healthcare providers can impact negatively on health-seeking behaviour and efficacy, particularly when patients come from a marginalised group. Shyness and low self-confidence can be exacerbated when ethnic and linguistic differences make 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 frequent the local clinic because she could not speak the local language well.

Locational capital:

Travel difficulties and expenses were widely reported by young people to impede access to health services (Table 2). Those in rural areas were much less likely than their urban counterparts to travel to a health facility without an adult (Table 3); even *with* adult help, reaching a hospital in an emergency can be extremely challenging:

'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.' (16y boy, remote rural)*

However, even in some urban areas, reaching hospital can be difficult, particularly in 'poor areas' without good transport systems and infrastructure. 11-year-old Mary

(above) recalls 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.'*

Relationships between health-seeking agency and capital

While access to particular resources or forms of capital can shape health-seeking agency, young people also exercise agency in developing or modifying those resources. Children and adolescents in Ghana do not simply rely passively on existing social capital; they actively seek, create, develop and mobilise networks to access healthcare. Similarly with economic capital: for many children, earning money represents a deliberate strategy to manage schooling and other expenses, including healthcare. Young people weigh the benefits of an independent income against the time costs and impacts on schoolwork, and make strategic choices about 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.

Ghana's changing therapeutic landscape

The dynamic interactions between resources and health-seeking agency operate within a wider therapeutic landscape which, 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, 15y, 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 fear about money.’ (Mary, 11y, urban)*

However, the benefits of the NHIS have not reached all children. Under-18s are only eligible for insurance if their parents are registered and their annual premiums are up to date; this is unaffordable for many (see Ridde et al, 2010; Franco et al, 2008). 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 sought 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, 17y, urban)

Some young people proactively sought health insurance, either by cajoling their parents or, in a few cases, by using their own earnings. Sometimes, though, these efforts can be 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 hadn’t received their cards. Even if they manage to register, rural children often fail to reap the benefits of health insurance, since most accredited facilities are located in towns. One rural-dwelling boy (14y) had health insurance but preferred to self-medicate (for debilitating body pains) rather than travel to a distant hospital.

Information and media advertisements

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. Although not all households have a working radio or television, the widespread sharing of such media means that almost all children had regular access to radio at least.

Research (mostly in Western contexts) on the effects of medicine advertising on children and adolescents 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.’ Our work in Ghana supports this contention. Almost all interviewees could recall the names of up to a dozen medicines from advertisements; many spontaneously sang advertising jingles during interviews! Children 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, 10y, peri-urban)*

Many had purchased the medicines advertised. The two brothers who had 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, 17y, peri-urban)*

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

Many 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.

Mobile phones

Over the last decade, a 'mobile phone revolution' has swept Africa. Mobile phone subscriptions in Africa rose from 54M to almost 350M between 2003 and 2008 (Smith, 2009). By the end of 2009, 63% of Ghana's population were mobile phone subscribers (Ghanaweb, 2009). Mobile phone *use* in Africa vastly exceeds subscription rates, since phones are often shared (James and Vertsag, 2007), and the common practice of 'flashing' (leaving intentionally missed calls) enables people to keep in touch relatively cheaply (Donner, 2008). Research on the social/economic effects of mobile phones in Africa is mushrooming (e.g. Coyle, 2005; James and Verstag, 2007), but very little research has considered the role of mobile phones in health-seeking (see Burrell, 2010, for an exception).

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, called to inform her mistress in Accra that she was ill and ask for money/advice. Another 14-year-old boy, in a rural settlement, used his earnings from selling plantain leaves to phone his brother to request medicine for their grandmother.

Discussion

Young people in Ghana are active health seekers. Figure 1 illustrates the dynamic relationships between agency and resources/capital in health-seeking, with implications for outcomes and wellbeing. Young people exercise agency in developing, modifying and mobilising resources in their quest for healthcare; at the same time, access to resources can shape the extent, nature and efficacy of their health-seeking efforts.

These interactions operate within, and are shaped by, a wider, rapidly-changing therapeutic landscape; changes which appear to be influencing young people's health-seeking practices in important ways. Health insurance has radically altered the cost-benefit calculus of using formal health services, and may have increased independent use of hospitals by young people (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) suggest, this information is often biased, misleading and over-enticing for children who may be duped into buying unnecessary products. Mobile phones enable young people to increase 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 precise impacts of these changes 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* of healthcare, and mobile phones can facilitate health-seeking, particularly in emergencies. Advertising may be a more double-edged sword, as we have indicated. Importantly, treatment outcomes can impact back on future health-seeking efforts. For example, money wasted on ineffective medicines, reduced income-earning capacity because of treatment failures, or self-confidence undermined by an unsatisfactory consultation with a healthcare provider, might all constrain future health-seeking agency.

FIGURE 1 ABOUT HERE

This study highlights important tensions in children's rights, specifically between the right to protection and the right to participation and self-determination, both of which, along with the right to health, are enshrined in the UNCRC.

It could be argued that children's independent treatment-seeking is risky and infringes their rights to health and protection. The combination of lack of political will to fund health services adequately, failure to regulate pharmaceutical markets, and the

persistence of appalling global health inequalities, can be seen as a form of structural violence, effectively forcing children (and adults) into inadequate and potentially very dangerous health-seeking strategies. In this view, cultural relativism (the view that justifies children's independent treatment-seeking as part of 'African culture') is a poor excuse to justify children in low-income countries receiving low-quality healthcare. As Geissler et al (2000) indicate, young people's self-treatment is typically based on limited knowledge and funds: a potentially lethal combination. Apart from risks of direct physical harm, young people may waste limited resources on unnecessary medicines. Ironically, while the medicines that young Ghanaians buy from local stores are often marked 'keep out of the reach of children', their constrained agency as children means that higher-quality healthcare is too often 'out of reach'.

The converse argument is that children and adolescents have always been active participants in healthcare, but this has usually gone unrecognised by adults. Rather than denying their health-seeking agency, substantial benefits might accrue to young people, families and communities from developing the *effectiveness* of that agency. Geissler et al (2000:1782) have described Kenyan children as 'active and knowledgeable, curious learners and agents of health'. Likewise, in Europe, Christensen (2004:379) suggests that we should develop strategies to facilitate children becoming 'health-promoting actors ... pro-active in health processes as they grow up'. This potential has been recognised in Africa through child-to-child health education schemes, aimed at building health knowledge and effective agency (Onyango-Ouma et al, 2005; Ayi et al, 2010).

One way of reconciling apparent tensions between protection and participation is to distinguish carefully between 'agency' and 'autonomy' (see Prince et al, 2001). While Ghanaian children/adolescents demonstrate considerable health-seeking *agency*, their quest for effective treatment frequently involves others: soliciting help from family members by phone, using NHIS cards obtained by parents, or asking friends for advice or information. The role of families is also highlighted by Christensen (2004), who suggests that future research focus on situating children's active participation in health promotion within both inter-generational and intra-generational relationships.

While the UNCRC accords all those under 18 with the same set of rights, the way in which they operate differs according to age, developmental/life stage, and specific capabilities. There is clearly a world of difference between the 5-year-old girl who requested paracetamol from a neighbour, and a 17-year-old working mother. The same balance of protection and participation, rights and responsibilities is not applicable across (UNCRC-defined) 'childhood'. Christensen's (2004:379) suggestion that children become 'pro-active in health processes *as they grow up*' (emphasis added) is pertinent. Enabling young people to acquire the necessary skills and experience to seek effective healthcare, in partnership with parents, health professionals and other care-givers, has the potential to enhance health and wellbeing, both immediate and longer-term (see also WHO, 2003).

Implications for policy and practice

Whether or not children and adolescents in Ghana (and elsewhere in Africa) *should* take responsibility for healthcare, the fact remains that they do. Changes in Ghana's therapeutic landscape, which mirror those taking place across the continent, are likely to increase young people's health-seeking agency over coming years. Regulating rapidly expanding pharmaceutical markets and associated advertising is notoriously difficult, which means that children (and adults) have increasingly easy and cheap access to a range of restricted drugs, without necessarily knowing how to use them appropriately. The pragmatic question is how best to facilitate young people to seek healthcare safely and effectively.

Over the last decade, the WHO and other international agencies have advocated for 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-judgmental communication are key features of adolescent-friendly services (Ibid; Dickson et al, 2007; Tylee et al, 2007). Ensuring that existing formal health services in Ghana meet the needs of children and adolescents is an important starting point; this will involve investing resources in training and supporting staff to improve inter-generational communication skills and empathetic approaches (WHO, 2003).

Appropriate youth-focused training should also be extended to informal healthcare providers, much frequented by children and adolescents. 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 children (and adults). The Ghanaian shopkeepers we interviewed were often unsure about the legality of prescribing and selling different medicines to under-18s, indicating an important information gap. However, 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 schooling in Ghana (and elsewhere in Africa), schools offer an important forum for health education and services (WHO, 2003; Renju et al, 2010). 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.

User-fees and health insurance also require 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 and 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 barrier to health-service use for young people, particularly those living in rural areas (Airey, 1992; Ridde et al, 2010; Franco et al, 2008). Even with health insurance, for those without effective access to appropriate, affordable services (both formal and informal), good quality healthcare is still as out of reach as ever.

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**Table 1: Young people’s reported use of health services [within last 12 months]
(N=943)**

Settlement type	<i>Any health facility</i>	<i>Type of health facility most recently used</i>			
		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%
<i>All settlements</i>	26.5%	29.6%	25.1%	27.2%	18.1%
p(Chi2)	<0.000	<0.000			

Table 2: Difficulties reported by young people 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%
p(Chi²)	p<0.0005	p<0.0005	p<0.0005	P<0.0005

Table 3: Young people’s unaccompanied use of health facilities [most recent visit] (N=248)

	% of children visiting facility unaccompanied	p(Chi²)
<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>		
9-11y	13.2%	<0.001
12-14y	21.2%	
15-17y	40.8%	
ALL	25.6%	