

INTRODUCTION

PHARMACEUTICALS IN THE THIRD WORLD: THE LOCAL PERSPECTIVE

SJAAK VAN DER GEEST

Anthropological-Sociological Centre, University of Amsterdam, O.Z. Achterburgwal 185,
1012 DK Amsterdam, The Netherlands

Abstract—This introduction is a plea in favour of social field research into the local context of the distribution and use of pharmaceuticals in developing countries. This local perspective is conspicuously absent in studies and policy recommendations concerning drug use in the Third World.

Key words—pharmaceuticals, field research on pharmaceuticals

Recently the international action group Health Action International (HAI) published a consumer guide on 'Problem Drugs' [1]. It recognised how problematic the term 'problem drug' has become:

The plain fact is: *all* drugs are 'problem' drugs... What makes a drug a problem is not so much its inherent pharmacological risks, but the way in which it is used. It is impossible to talk about the 'safety' of medicines as if it was a laboratory problem. In the wrong hands or at the wrong time, even the most carefully quality-controlled medicine becomes transformed from a life-saver to a life-threatener [1].

This remark contains no new vision, indeed, it might be called a truism. The warning is generally believed to apply to Third World drug users in particular. It is surprising, however, that despite such a consensus about the dangers of the misuse of medicines, this shared awareness has motivated hardly any field research into the way drugs are actually used in the Third World.

THE ABSENCE OF A LOCAL PERSPECTIVE

Discussions on pharmaceuticals in the Third World usually take place on a level that is far removed from the local scene. Arguments are for the most part based on reports and studies that focus on international policy, transnational industry and national government. Although the lamentable position of drug users in the Third World is the concern of all these deliberations, the fact is that their position is largely unknown. Research into the socio-economic and cultural context of drug consumers in developing countries has scarcely begun.

Only during the past few years, does it appear to have dawned on Western-based critics of present pharmaceutical practices that distribution and problems of use in the Third World often differ sharply from those in the West. Examples repeatedly mentioned include lack of quality control, inaccessibility of physician-prescription, free availability of prescription-only drugs, predominance of self-medication, lack of information on drug use and general poverty. Clearly, such commentary is impres-

sionistic, expressed in sweeping generalisations, usually based on extremely lean evidence.

Western critics' principal contribution to the improvement of drug use in the Third World has consisted almost entirely of their activities at home: exposing dubious practices by their own industries and pressing for more effective international control of the production and marketing of valuable, affordable drugs. The victims of 'irrational' or 'unhealthy' drug use in the Third World still remain largely unidentified. We have only vague notions about their plight and how they perceive it. *If* valuable field research into the conditions of drug use is carried out by Third World groups it is not documented in a sufficiently systematic way to receive international publicity.

In November 1985 in Nairobi, WHO held a 'Conference of Experts on the Rational Use of Drugs'. The 'experts' included representatives of governments, pharmaceutical industries and patients' and consumers' organisations. Outspoken critics of drug policies held another conference in anticipation of the one in Nairobi on 'Another Development in Pharmaceuticals' (organised by the Dag Hammarskjöld Foundation in Uppsala, Sweden). The contributions to that Conference have been published in a special issue of *Development Dialogue* [2].

In the accompanying editorial 'all the concerned parties' in the pharmaceutical crisis were mentioned: governments, the pharmaceutical industry, health care workers and researchers, consumer and activist groups, and the lay public. About the last mentioned—and largest—category, it was said

"... against a background of proliferating drug sensations and scares in the mass media, (they) often fail to understand what pharmaceuticals are doing in their bodies and fear the effects, rightly or wrongly" [2, p. 2].

This may apply to a fair proportion of 'ordinary people' in Western societies, but we really lack enough information to extend the observation to people in Third World communities. The picture we have of them is confused and incomplete. Some observers indeed report a growing concern about the

proliferation of dangerous and useless—but expensive—drugs in the Third World; others emphasise that such concern is on the whole conspicuously absent and that people, infused with misguided optimism about the miracles of Western medical technology, engage in most dangerous and 'irrational' forms of self-medication. One thing is certain: systematic research into people's ideas and practices with regard to Western pharmaceuticals have yet to be carried out and documented on any scale worth mentioning in the Third World. Almost nothing is known about drug use or users in local communities.

Our lack of understanding of drug use is especially complex. Several contributors to the Uppsala conference spoke of 'needs'. Sterky [3, p. 9] wrote that "in many cultures in the Third World people already want what they do not *need*, while lacking knowledge and understanding of the potential benefits of appropriate pharmaceuticals". Medawar [4, p. 16] pleaded for "... providing drugs that people really do *need*; also restricting the supply of drugs to people who don't *need* them". And Shiva [5, p. 72] remarked that "The drug production pattern has very little to do with the drug *needs* of the majority" (all emphases are mine). These confident references to people's (real) *needs* seem premature. Is a 'need' something which can be established from a distance, say in a medical research centre? It is perhaps a biochemical concept, one which obtains and can be calculated for the entire human race? Anthropologists would instead protest that 'need' is a cultural concept, in two respects. What people 'really need'—including what their bodies need—is what they have *learned to need* as members of a particular culture with a specific way of life. 'Natural needs' beyond air and water and some form of nourishment do not exist, not in a pure sense. When we choose to call something 'natural', we are essentially applying a cultural concept. To be sure every culture and sub-culture may claim certain phenomena are natural, but there are large differences between the 'natural things' which different cultures identify. This brings me to the second respect in which need is a cultural concept: scientific definitions of 'need', e.g. drug need, medical need, are themselves cultural products, for science is a cultural phenomenon. The growing literature on the placebo effect confirms the cultural aspects of drug needs.

Anthropologists argue that it is not possible to speak of people's needs without knowing these people within their cultural context. The common tendency among Western medical workers reflects the basic biomedical bias of their discipline to disregard cultural factors when treating a patient. From the biomedical viewpoint people's cultural concepts and practices are only relevant to health in as far as these may interfere fulfilling their 'real' (bio-medically defined) needs. Social research on health issues thus becomes medico-centric. An illuminating example of this is how so-called 'compliance'—research is carried out. What people do with their drugs is only measured to the extent their actions comply with the physician's prescription, i.e. officially sanctioned behaviour is accepted as a standard for what is 'naturally' correct. Only recently have students of drug use in Western societies begun to question this doctor-centred perspective and to take the patient's

own perspective more seriously. Conrad [6], for example, views so-called non-compliance among epileptics as "a form asserting control over one's disorder". The ultimate meaning of medication is not determined by the doctor writing a prescription, but rather by the person taking—or refusing to take—the medicine.

The biomedical view, which has dominated compliance studies for such a long time, also dominates international debate on pharmaceutical policy. The main issues of this debate concern the chemical substances of drugs and their likely effects on people's bodies [7]. Conclusions and recommendations for changes in drug policy in the Third World are reached without consulting those whom the policy is designed to help in the first place. 'Naturally' such recommendations cannot avoid being both Western-oriented and medico-centric.

Summarising the argument thus far, publications about drug use in the Third World fail to take into account the local perspective. This failure affects analyses in two ways. An obvious first consequence is that their conclusions are not based on firm research evidence. The following statements, for example, remain vague and non-convincing since they do not derive from any reliable field data: "There is extensive misuse of drugs" [4, p. 21]; "The result is gross over-prescribing" [8, p. 44]; "This 'pill culture'... is now spreading to the Third World..." [8, p. 38]; "... myths and half-truths about modern medicine are sold along with drugs" [5, p. 82]. Many such observations with a biomedical purport ring hollow for lack of supportive research evidence. This even applies to many well-meaning recommendations, e.g. the WHO's celebrated Essential Drugs Plan. Knowledge of local customs may in the end reveal that in actual practice essential drugs become harmful substances: 'Essential drugs' (analgesics, antibiotics, contraceptives, etc.) are rightly listed as 'problem drugs' as well [1].

The *second* consequence of policy formation in a vacuum of field research on drug use is more complex: the cultural and symbolic meanings of drugs go unnoticed, so that the biomedical view remains unchallenged. Interestingly, a cultural dimension in drug use was not entirely ignored in the publications under discussion, but 'again' lack of research prevented its implications from being seriously discussed and assimilated in the recommendation [9]. Laporte seems to view the cultural perceptions of drug consumers as wrong—first and foremost a challenge for more effective health education.

To the anthropologist, recommendations for 'healthy' and 'rational' use of pharmaceuticals which overlook the cultural meaning of medication, 'miss a point'. This may sound harsh and unduly critical; one does not wish to belittle the efforts of those involved in actions aimed at improving drug policies in the Third World. I am convinced that the implementation of essential drugs lists, an effective international code for pharmaceutical marketing practice and the setting up of an international 'clearing house' to disseminate drug information are crucial steps and necessary preconditions for the improvement of drug use in Third World countries. But I would also emphasise that tougher problems await beyond these pre-

liminary policy measures, and because we know so little about the perceptions and behaviour of drug users we scarcely recognise even the extent and nature of these problems.

THE PAUCITY OF FIELD RESEARCH

Why has so little research been carried out on local conditions of distribution and use of pharmaceuticals in the Third World? There are at least four reasons.

First, to capture the essence of local user perspective requires long, in-depth interviews with family members, complemented by regular observations that may require a prolonged stay with the people concerned, in a village or poor quarter of a Third World town. It may also involve several days or weeks of observation and interviewing in pharmacies, drug stores, and local markets, and endless sitting in doctors' offices. Apparently few advocates of drug reforms in the Third World feel they can afford the 'luxury' of conducting such research. These parties are usually the staff members of Western Universities, research or policy bodies. When they visit Third World countries, their observations are nearly always limited to what goes on in the conference-rooms and the corridors of ministries. An accurate awareness of local perspectives is harder to acquire than valid information about the pharmaceutical industry—which itself is not easy.

A second reason why so little field research on drug use has been undertaken is related to the disciplinary backgrounds of those involved in drug policy discussions, predominantly people with a medical-pharmaceutical training. Research within their domain has never been oriented to social or cultural aspects of health. The 'clinical gaze', to use Foucault's term, still accounts for the myopia of medically-trained observers of drug usage.

But why have cultural anthropologists not taken up the challenge? The answer provides a third reason for the poverty of research to date. Anthropologists have long been mainly interested in foreign cultures, or, to be more precise, in what makes a culture 'foreign'. Medical anthropologists kept themselves busy largely with so-called traditional medicine. It did not occur to them at first that drugs and the way people perceived and used them might be an 'exciting' as well as a useful research topic.

Finally, from an action-oriented point of view, social and cultural questions about medication have been deplored as awkward and annoying. For some, such questions seem to be born out of academic luxury and merely serve to delay concrete action. This attitude was expressed in a remark by W. A. Bongers, a pioneer of Dutch sociology:

If natural scientists had only started their work after having solved the problem 'What is nature?', they would now probably have been as far as then [10].

If the questions of anthropologists delay action, their answers paralyse it! Their views on the local social and cultural context of medication in the Third World are likely to complicate the practical situation. Catchy fashionable concepts such as 'rational drug use' and 'real drug needs' are questioned. The 'causes' of problems prove to be less unequivocally self-

evident than before. Anthropological analysis of drug use, in short, makes its politicisation doubtful. Anthropology breeds relativism, the arch-enemy of political action. It is not idly that Kleinman [11], citing Raymond Firth, calls it an 'uncomfortable science'.

CONTRIBUTIONS TO THIS ISSUE

In spite of these varied obstacles, however, anthropological research into pharmaceutical use in the Third World has gradually been launched in widely-scattered locations. Most of the researchers involved have concentrated on the distribution and sale of medicines [12–17], and on popular perceptions of pharmaceuticals [18–21]. So far the limited data gathered about local perspectives has gone largely unnoted by activists for drug reforms. This should not come as a surprise, however, when we consider the uncomfortable relationship between anthropology and political action mentioned earlier. A laudable exception is Melrose's [22] publication in which a wide array of material about local drug practices has been compiled into an extremely readable account of problems related to pharmaceuticals in the Third World, and their solution [23].

This issue of *Social Science & Medicine* contains three articles and one research note presenting local perspectives on pharmaceuticals in four developing countries: the Philippines, India, Cameroon and Sri Lanka. The articles sketch the complex setting within which ordinary people obtain and use Western pharmaceuticals. A special effort has been made in each instance to trace the identity of the drugs which are commonly used. The articles, which do not discuss the cultural perception and symbolic meaning of medicines, are intended in the first instance as case studies to supplement information already available to those engaged in international discussions of drug policy. Two of the articles pay special attention to prescription by physicians, a cultural act tied up with professional-medical symbolism and commercial interests. Doctors' prescriptions are particularly important in developing countries for they serve as blueprints for lay people who practice self-medication. All three articles deal with self-medication, the most widespread and least studied form of illness management in both the Third World and the West.

Hardon's contribution describes how mothers in a Philippine village act when one of their children develops a cold, cough, or diarrhoea. Either no medication or self-medication, are by far the most common responses. Hardon reviews the drugs used from the medical-pharmaceutical point of view. Her paper is a rare example of pharmaceutical-anthropological research in which incidents of home medication have been registered over a prolonged period of time (five months). The author is now involved in new research about self-medication in two urban communities in the Philippines.

Whereas Hardon's research is home- or family-based, van der Geest conducted his research mostly in places where medicines were sold: in small shops, the market and the pharmacy. He describes the workings of the informal sector for drug distribution in South Cameroon and discusses the pros and cons

of self-medication. His paper includes a list of 70 pharmaceuticals for sale in the informal sector with information about their ingredients, the names of their manufacturers and their prescribed use.

Greenhalgh's research took place in hospitals, the offices of general practitioners, and in pharmacies in five Indian cities. Her paper examines the prescribing and dispensing of medicines to 2400 patients/clients. She analysed pharmaceuticals prescribed or used in self-medication, compared them to patients' complaints and physicians' diagnoses. She concluded that overprescription is common and that—from a biomedical point of view—many of the drugs used and prescribed are dubious and dangerous. Detailed lists of pharmaceuticals are presented.

Wolffers' brief note on Sri Lanka is of special interest for it describes a method for research in pharmacies. He reports that whereas tetracyclin, an antibiotic, was obtainable without a prescription in all the pharmacies which team members visited in Colombo, no information on correct use was given and pharmacy sales personnel were not qualified to do their jobs properly.

Three reviews of a report on the export of pharmaceuticals and pesticides from the European Community to the Third World plus a rejoinder by the author and two other reviews conclude this selection of papers.

We hope that these studies will inspire other researchers to pay more attention to the local conditions of distribution and use of pharmaceuticals in developing countries.

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