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MARKETING MYTHS

Selling drugs in the third world

Introduction

Pharmaceutical companies have come under increasing criticism for their marketing practices in developing countries. [1-18] Criticism runs from: "*Selling useless and expensive drugs*" to "*causing serious health hazards*". One of the most recent cases leveled against a pharmaceutical company concerns the promotion of an anabolic steroid, Orabolin or Orgabolin, for retarded growth in children in developing countries.[19] The product is marketed by the Dutch firm Organon. Advertisement material from Bangladesh, India, Thailand and other countries showed that Organon calls its products a drug that "*ensures normal growth, stimulates appetite, promotes optimal weight*". Orgabolin is even explicitely recommended against malnutrition and undernourishment. The main criticism was that the company's propaganda misleadingly suggests that this expensive drug can compensate for lack of food, thereby further aggravating poverty, malnutrition and ill health. To this was added that anabolic steroids may cause virilisation in girls and liver damage.[20-21]

In its defence [22] the company emphasized that it used extreme caution to guarantee safe products and adequate information about them. Furthermore it recognized that nevertheless the information about Orabolin has been unfortunate and that it had therefore withdrawn the advertisement. A third element in its defence was the apparent (but silent) assumption that the product was only used under a doctor's prescription. A fourth argument was that a distinction must be made between the public and private sector of health care facilities in a country like Bangladesh. These constitute the four myths which continue to obfuscate the discussion between the pharmaceutical industry and its critics.

Safe products and adequate information

The belief that conditions of relatively controlled and informed use of pharmaceutical products as exist in industrialized countries occur also in developing countries, dies hard. The reason cannot be that conditions in the third world are not known. Publications abound which report about the free sale of prescription-only drugs both in markets and in medical stores in these countries. The risks of wrong self-medication have been amply spelled out.[23] It is plausible that this information about hazardous use of drugs is purposely ignored because it denies the entire structure of safe pharmaceutical production and adequate information on the use of drugs.

Obviously, the safety of a product is not only derived from its substance but also from its use. [24] The former aspect of safety lies in the realm of the pharmaceutical industry, the latter does not. It is true that companies usually provide detailed information on indications and contra-indications of their products, but they cannot guarantee that this information does indeed reach the user of the drug. For the moment we leave aside the question of whether the industry is at all able to provide adequate information, because of its conflicting interests in the matter (commercial verus medical). The problem which occupies us here is that, even if information on the use of drug is adequate, this information will eventually get lost in the complex sales circuit of drugs in most developing countries.

A great deal of the sale drugs in these countries takes place in what economists and sociologists have termed "*the informal market*". This is a sector of the market with a conspicuous absence of certain characteristics which are considered indispensable in the pharmaceutical world, such as formally acquired skills and strict quality control of the

commodities. The informal drug market has a function which is complementary to formal medical services. The modern medical infrastructure in developing countries is often extremely deficient. Health centres and medical personnel are difficult to reach and the need arises for alternative ways of obtaining modern pharmaceutical products. Unqualified drug vendors fulfil this need. They are found all over the third world, in urban centres as well as in remote rural villages.[25-35].

Three features of their practice are particularly noteworthy. In the first place their lack of medical and pharmaceutical knowledge. In spite of this, they are sometimes consulted for medical complaints and prescribe medicines. The second feature is their commerical spirit. They are determined to sell and often do not seem to realize which hazards their sales practices can lead to. The third feature, particularly in poor areas, is that the drugs are retailed in very small quantities and that in the process of selling they are separated from their original package containing the information about correct use. Drugs are often sold from jars and bottles which have nothing to do with the original package. There is no guarantee whatsoever that the drugs are indeed what the vendor claims they are. This fact, in conjuction with the commercial attitude and the pharmaceutical ignorance of the vendor, is sufficient reason for grave concern. Information given in a foreign language makes it worse still. Furthermore, the quality of the drugs themselves may have been affected by poor storage facilities, or other unavoidable circumstances. The conclusion is obvious. Even when pharmaceutical companies deliver safe products and provide adequate information on them, in the actual sales situation there is no longer any question of "*safe products*" and "*adequate information*". Whether this should be regarded as the responsibility of the pharmaceutical industry or not may be a matter for discussion. It must, however, be emphasized that this *fact* should not be denied or concealed. The industry certainly takes a heavy responsibility on its shoulders when it continues to ignore the specific circumstances under which its products are sold and used.

Withdrawing drugs and adverts

The second myth is that a pharmaceutical company can simply withdraw a drug or an advertisement about a certain drug from the market. As we have seen, a manufacturer cannot control the way in which his products are sold in the third world. Neither can he enforce a stop to its selling. The informal market is elusive and difficult to check. For the same reason, beliefs about the effects of certain drugs, which have been inculcated in people's minds by alluring advertisements on posters and pamphlets, cannot simply be "corrected" by a "rectification" campaign or by new information.

For example, in its defence, Organon stated that it had withdrawn a certain reprehensible advertisement for Orabolin Drops as soon as it had come to its notice.[22]. When a few months later Orabolin Drops were banned from Bangladesh by the government of that country[4], Organon complied and said it would withdraw the drug. In actual fact, however, the criticized advertisement can still be found in pharmacies and drugstores of Bangladesh and people still believe that Orabolin helps against the undernourishment of their children. As a matter of fact Orabolin can still be bought in Bangladesh. Its price has even gone up because it has become scarcer and people still want it.[19].

A similar story can be told about Menstrogen, another product from Organon which has been banned from Bangladesh. Menstrogen, a drug for treating secondary amenorrhoea (cesstion of periods) was recommended as a pregnancy test until 1976, although the risk of foetal malformation had been known for some years. The fact that in 1976 Organon included the contra-indication of pregnancy [22] seems to have had little effect. Menstrogen is still being used as a pregnancy test.[19].

The fact that the marketing of a pharmaceutical product in a developing country turns into an *apprenti sorcier* which cannot be stopped, calls for the utmost caution before a product is declared fit for use in the third world. It further casts serious doubt on the present practice of manufacturers providing information about the use of their own drugs. Herxheimer, a member of the medical group of the International Organization of Consumers Unions, has proposed to entrust a government body with the drawing up of the essential information:

> *Drug companies cannot be expected to take the responsibility for the safety of their product upon themselves. A conflict between their own interests prevents them from assuming that responsibility. In any case they have too narrow a view. So who should take the*

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responsibility? Should it be the prescriber? Although the prescriber is responsible for what he or she prescribes, he does not have enough information about the drug, especially if he depends entirely on the pharmacetical manufacturer for his information. The responsibility for the information essential to safe use needs to be taken by a government body, or one financed and organised by the government though not directly governmental. [24].

Prescription-only medicines

The third myth, closely entwined with the other two, is that manufacturers supply developing countries with prescription -only drugs. The truth, however, is that a large part of these products is distributed without any doctor's supervision. Although meant for use with a doctor's prescription they in fact become over-the-counter, or rather, under-the-counter drugs. Here again we are dealing with the assumption, convenient for the manufacturer, that conditions in the industrialized world occur also in the third world.

One cannot help thinking that this assumption is based on bad faith. Evidence that prescription-only drugs are freely sold all over the third world is by now overwhelming. One wonders if this condition should not be also taken into account when a policy is set out for the production and marketing of a pharmaceutical product. The neglect by the manufacturers of the socio-economic aspects of ill-health in developing countries in the delivery of drugs directly interferes with the companies' professed medical aims. The fact that they can afford to turn a blind eye to this thorny problem shows that the supply of drugs is to serious to be left to the manufacturers alone.

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The Private sector

When in June 1982 the government of Bangladesh decided to ban about 1750 drugs, the pharmaceutical companies warned that this measure would seriously damage the public health situation of the country. One of the arguments put forward was that the banned drugs occured only in the private sector, which is formed by that part of the population which can afford the purchase of non-essential drugs. The poor of the country, according to this argument, are served by the public sector of drugs supply. Since 90 percent of the drugs supplied by the pharmaceutical industry go to the private sector, there is no need to restrict the supply of drugs. The banning order does not affect the public (read: poor) sector and deprives those who are financially better off of drugs they want and can pay for. Conclusion: the measure does not improve public health.

This argument constitutes an example of blatant distortion and biased interpretation of certain facts. It is not true that 90 percent of the drugs supplied to the so-called "private sector" are used exclusively by those who are better off. The source of this "misunderstanding" is that it is assumed that there is a clear distinction between a public sector for the poor and a private sector for the non-poor. Leaving aside whether such a situation would be desirable, we can simply establish the fact that the "private sector" is busily used by the poor of the country. In a recent case study of three villages in Bangladesh [26] it was found that in two villages with a public health centre a majority of the admittedly small sample of inhabitants used private practitioners more frequently than the "free" public services. The reasons provided by the authors are probably symptomatic for the whole of Bangladesh as well as for other developing countries.

The reasons are, among others, that the drugs supply at the public health centres is very limited and irregular and that often the services are not really free of charge. In a number of studies of the public health system in India [36-37] it is further emphasized that certain characteristics of social relationships discourage the poor from visiting public services.

> *It follows that the state health services, which are intended to serve only the poor, are never more than a second choice. The idea that good treatment depends upon some sort of mutual obligation explains why people always prefer going to a private doctor (whom they approach, preferably, by means of a personal introduction) to going to the bureaucratic state health centres even though these state centres do not always give worse service.* [36].

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Observations made in the West African country of Cameroon [38] dovetail with those made in Bangladesh. [26]. The inefficiency of public health centres forces people to visit private practitioners. It should however be taken into account that this term does not always refer to qualified medical doctors but also to unqualified practitioners, often simply drug vendors. Thus the informal private health sector

has come into existence as a service complementary to formal public health services. Our research in Cameroon has shown that the formal public sector has grown inextricably interwoven with the informal private sector. [39] Public health workers combine their work with running a private practice (a phenomenon also reported for Bangladesh [26]) and sell free drugs from their institution to drug vendors. The closest symbiosis is however that informal private vendors (as well as the formal ones) provide the drugs which are short in the public sector.

Cursory reading and conversation have established the impression that similar conditions also exist elsewhere in the third world. With the possible exception of the extreme poor [26] who have no means at all to spend on drugs, it seems likely that the private medicine market is visited by the rich as well as by the poor.

If, therefore, the government of Bangladesh, or any government for that matter, decide to sanitize the supply of drugs, this sanitation will benefit the entire population. Checking the morbid growth of the drugs-selling industry will be particularly wholesome in those situations where the selling takes place beyond qualified medical supervision. A drastic limitation of the drugs available in the informal sector will reduce the health hazards and enhance the possibility that sellers and clients learn that exact use of the few essential drugs which will have been left.

Conclusion

A number of myths are continuously created about the circumstances under which pharmaceutical products are marketed in developing countries by multi-national pharmaconcerns. The myths provide the drug manufacturers with an excuse to continue their marketing policy. Four of those myths have been briefly discussed in this article. They are (1) that manufacturers can guarantee the safety of their products and the adequacy of their information; (2) that they can withdraw or correct the information on certain drugs if the need arises; (3) that prescription-only drugs are indeed purchased with a doctor's prescription; and (4) that there is a clear distinction between the private and public sector of drug distribution. The tenor of all four myths can be summarized as attempts to close the eyes to the real circumstances of drug procurement in developing countries by assuming that pharmaceutical conditions in the industrialized world prevail the world over.

It is high time that both manufacturers and government policy-makers recognized the problematic character of drug purchasing in developing countries and take appropriate measures to prevent as much as possible the hazardous and wasteful use of pharmaceuticals in those countries. Initiatives, such as the one taken by the Bangladesh government, must be openly applauded and supported. The proposals contained in the WHO report on the selection of essential drugs [40] and the WHO Drug action program [41] also need the serious attention of all third world governments, and a recent initiative by the International organization of Consumers Unions (IOCU) [42] deserves serious study as well. The IOCU has listed 44 "problem drugs", which may not necessarily be problematic merely because of their substance but because of the total socio-economic and medical context in which they will be used. The list is not meant as a definitive statement on problem drugs but "*as a 'starter' to provide consumer activists particularly in third world countries with a quick reference to essential information on 44 problem drugs*" (p. 2)

A difficult question is where the proliferation of drugs in the third world should be tackled first in the third world or in the industrialized world where the drugs are manufactured and from where they are marketed. The specific multinational character of the pharmaceutical industry makes it unlikely that restrictions on its production and marketing methods will meet with results. For that reason, attempts to establish an international code of pharmaceutical marketing practice [43] do not seem very likely to succeed. Nevertheless these attempts should be continued as well. Even if they do not yield direct concrete results in the sense that the pharmaceutical industry will change its policy *because* of the code, the code and the discussion surrounding it will contribute to a more critical information to third world consumers and government about the wasteful and hazardous character of the present drug marketing. We are convinced that the present problems can only be effectively tackled by the third world itself. The fact however that government representatives and ministry officials in those countries often seem to share interests with the drug manufacturers makes the future look rather gloomy.

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The 44 "problem drugs" identified by IOCU[42] are listed below. In the original publication a fact sheet and relevant literature is provided for each drug.

Aminophenazone
Berberine
Bismuth Salts
Boric Acid and Borax
Broxyquinoline
Cephaloglycin
Chloramphenicol
Chloroform
Chloroquine
Clindamycin
Clioquinol
Clofibrate
Clonidine
Clozapine
Cyproheptadine
Dextropropoxyphene
Dihydroxymethylfuratrizine
Diphenhydramine
Diphenoxylate
Dipyrone
Ergotamine Tartrate
Fenfluramine
Furazolidone
Gentamicin
Halothane
Hexachlorophene
Kanamycin
Lincomycin
Methapyrilene
Neomycin
Nitrofural
Novobiocin
Oxyphenbutazone
Oxyphenisatin
Pentazocine
Phenacetin
Phenformin
Phenylbutazone
Pizotifen
Reserpine and other Rauwolfia Alkaloids
Santonin
Streptomycin
Sulphapyridine
Tetracycline

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