

PHARMACEUTICALS IN CAMEROON

THE CONTEXT OF PROBLEMS AND SOLUTIONS

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Summary

The paper pleads for a contextual approach in the study of pharmaceuticals and in pharmaceutical policy. The example of medicine distribution in rural South Cameroon is presented. It is shown that the existing problems are linked with national and international policies, with multinational marketing practices, with bureaucracy, with urban-rural relationships and with various economic factors.

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If we want to understand the problems of health care in developing countries, we should study pharmaceuticals. Pharmaceuticals play a key role in the organisation and functioning of health care services in many of those countries. In Cameroon, where I carried out research, modern medical treatment without drug prescription was out of the question. Services which ran out of drugs also ran out of patients.

But what do we want to know about pharmaceuticals? What kind of research approach is most likely to present us with insights that enable us to formulate suggestions for change? The problem is: what is the problem? Is it economic, pharmacological, political, technical, infra-structural? The awkward answer is that it probably is all of these.

Contextualisation

The impressive development of Western science could perhaps be characterised as a continuous yielding to the temptation of simplifying reality by cutting it up and then reducing it to a basic principle. Science, one could say, derives its successes from disconnecting its study objects, taking them out of their context, their 'natural environment'. The partitioning of science in disciplines also led to a partitioning of 'reality'. People and things were studied from the perspective of one discipline, sociological, psychological, economic, physical, medical, chemical, etc., but little was said about them as people, as things.

The contribution of anthropology to the study of human phenomena should be to draw the attention again

to the 'natural state' of people and things, to view them in their original context. Anthropology should be a persistent attempt of 'contextualisation'. This sounds trivial, because it is only natural that people understand each other and the world around them contextually. In scientific research, however, this is no longer trivial; there it is not any more a natural thing to do. It demands a special effort.

The anthropologist working outside his own group (what applies to almost every anthropologist) is required to view the people, their actions, their words and ideas, their culture, as the 'natives' themselves do. Contextualisation, therefore, is somewhat similar to what has been called 'the emic point of view'. Contextualisation does not mean that the research approach should be 'holistic' in the sense of taking everything into consideration. Popper (1961) has rightly rejected this as an impossibility. Contextualisation means primarily that we should acquire the 'natural gaze', which members of a culture use spontaneously to understand each other, to speak and act meaningfully. That 'natural gaze' is of course a 'cultural gaze', because people have learned it. It is a way of looking which takes into account a context that is considered 'relevant'. The trick of culture is that it prompts us as to what is 'relevant'. There is no need to examine everything to find that out. Belonging to a culture means agreeing on what we consider as relevant. That is what the anthropologist must learn.

But the anthropologist remains also an outsider while trying to become an insider. He combines the emic point of view with the insights from his 'other life'. While learning contextualisation in the native way he also applies contextualisation from the etic point of view. Belonging to two cultures he uses the criteria of both of them to decide on what the relevant context is of his research problem. Seeing both the visible and invisible context he tries to be more clever than the native.

Suggestions for solutions of a problem are useless if the relevant context of the problem has not been studied.

Both the problem and its 'solution' have a context which may not be neglected. This brings me back to the theme of this paper: the broad context of drug distribution in Cameroon. I do not pretend to have described its whole relevant context in my research. The present paper does however sketch a number of important circumstances in which the distribution and use of pharmaceuticals become more intelligible. At the same time, I am painfully aware that crucial aspects of the context are missing. The most conspicuous gap is the cognitive context of medicine use, the way in which people view and appreciate Western pharmaceuticals. I hope that this brief note, in spite of its limitations, succeeds in conveying the message that pharmaceuticals are not just substances to be studied by pharmacologists, or commodities exclusively fit for economic analysis. Pharmaceuticals are a bit of everything; they are cultural products. Studying them out of context is misunderstanding them.

The Research

The fieldwork for the research took place in 1980 in the Ntem Division on South Cameroon. A brief follow-up and up-dating was done in 1983. The fieldwork was carried out on many different societal levels, ascending from the peripheral family and village life up to the divisional and national centres of administration. It meant that observations and interviews took place in the houses and kiosks of villages, on markets, in health centres, hospitals and pharmacies, and in the offices of the Ministry of Health. I have already discussed some of the research findings elsewhere¹⁾. Here I only want to outline six relevant contexts or 'linkages' of medicine distribution in that particular rural area of Cameroon.

1. Health care/pharmaceuticals and state formation

From a political point of view, health care should be regarded as an eminent tool for establishing state influence without physical force. Like education it can be regarded as a "peaceful penetration" by the state apparatus on the local level and a means to promote the social cohesion needed for a state to become viable. Godelier (1978)

has pointed out that political power does not exist in the physical force of those claiming to have power but in the acceptance of that power by those subjected to it. Power should be regarded as legitimate before we can call it power. If it appears as a service by the rulers, the subjects will consider it their duty to serve those who serve them (Godelier 1978: 177). Weber (1947) would call this "uncoerced obedience".

The state of Cameroon is confronted with serious centrifugal forces. One would, therefore, expect it to invest considerable efforts in the setting up of an efficient health care system to make itself acceptable as an indispensable provider of welfare and health for all. There are several indications that the state is indeed aware of the political importance of "health for all". In government institutions health care, including pharmaceuticals, is free of charge. The government is setting up an extensive primary health care program and it has pledged to give priority to the extension of rural health care.

In reality, however, the public health care system in the rural areas is notoriously inefficient when compared with urban facilities, but also in comparison with rural health services provided by church related private institutions. Instead of underscoring the common good of the state, public rural health care has become a source of anti-propaganda for the state. For the rural population, but also for health workers (Hours 1982), public medical services sometimes have become proverbial examples of the state's failure to cater for its people. The fact that this failure contrasts sharply with the relative success of private institutions in the field of medicine makes

the anti-propaganda even more painful.

One of the main factors leading to the problems in rural health care is the deficient supply of pharmaceuticals. Rural health centres are short of medicines during a great deal of the year. The rule of free distribution of drugs becomes meaningless when health workers have to send patients away with prescriptions for a commercial pharmacy, which may be located far away.²⁾ Getting the necessary medication may then entail the loss of a considerable amount of time and money.

The background to this failing system of drug supply will be further clarified in the discussion of other linkages. What interests us here is that the linkage between the political domain and the provision of rural health care does not work out as would be expected. To explain this paradox we must weigh the political importance of medicines and health care against other factors in the process of state-building.

Three considerations may shed light on this, at first sight, contradictory situation. The first is that the state of Cameroon has not yet completely moved to the stage of legitimation of power by extending public welfare, but that it still relies on the (threat of) use of physical force. The second consideration is that the Cameroon authorities are most concerned about the potential resistance among the urban population and particularly among those in the army and police force. The quality of health care for these groups is conspicuously higher than for the rural population. The fact that 50% of health budget goes to the central administration and the two central hospitals in Yaoundé and Douala and that only 7% is spent on rural health care speaks for itself. These figures illustrate the relatively minor im-

portance attached to the political role of the rural population. The third consideration is that, until recently, the Cameroon government has consistently tried to prevent political consciousness among the rural population by following a strictly centralist policy and discouraging local initiatives. The penetration of state influence on the local level was mainly pursued in a negative way by the threat of force and by forestalling local self-reliance.


A similar insight is gained when we view the inequality in health care provision between urban and rural areas from a center-periphery perspective. The research revealed that the more peripheral a health center is, the fewer drugs it receives. The most remote health center I visited received just over half the drugs it should have received. A center in a rural town of about 5000 inhabitants received 87%, the hospital in the divisional capital an estimated 90 to 100% and the central hospitals of Yaoundé and Douala even more than 100%. Personnel working in peripheral health centres did not even know which and how many medicines they were entitled to receive and, as a result, were not aware of the fact that their assignment of drugs was incomplete. Their peripheral situation, in a geographical, communicative and bureaucratic sense, made it impossible for them to ameliorate their condition. The parasitism of the town on the countryside clearly shows itself in health care.

2. Pharmaceuticals and 'corruption'

'Corruption' (briefly defined as: illegal private use of public means) constitutes an integral part of most, if not all, societies, including Cameroon. Corruption poses extra problems in developing

countries, not because it occurs more frequently (which would be hard to prove in any case), but because these countries, ^{with their jejune resources,} can afford less corruption than the industrialized ones.

Pharmaceuticals are scarce in Cameroon and, for that reason, much sought after through corrupt means. Medicines meant for free distribution in public health institutions pass into private hands. Elsewhere (Van der Geest 1982) I have discussed this problem more extensively. Here it should be sufficient to point out that this kind of corruption is linked with existing customs of gift-giving and with the preponderance of traditional, mainly kinship, loyalties over obligations to the state. Another factor is the traditional proprietary view of public offices. The most important single factor promoting corruption is however the overwhelming position of the state as main provider of goods, services and employment and the relative under-development of the private commercial sector. This factor will return in the discussion of other linkages. The education gap between office holders and most citizens further facilitates corrupt practices.

Pharmaceuticals disappear on a large scale from the public health care thus crippling the entire service. A national investigation carried out for the Ministry of Health (MSP 1980) concluded that only about half of all medicines destined for rural health centers arrived there in a state which allowed them to be actually used. The Minister of Health estimated in 1979 that about 40% of the medicines 'disappeared'.  My own observations point in the same direction: a massive disappearance of drugs which are essential for the functioning of health care. It should further be noted that this private use of medicines occurs from the highest to the lowest level


in the distribution chain, although such practices at the top are almost impossible to prove.

The linkage of pharmaceutical supply to corrupt practices suggests the need for research into state bureaucracy and economy. The concept of 'soft' versus 'strong' state may provide another important entry into the problem of a failing supply of medicines. According to Sampson anthropologists have hardly focussed any research on bureaucracy and corruption. His explanation underscores what has been said at the outset of this note.

The traditional social science division of labor can partly explain the lack of anthropological research on bureaucracy and corruption. Formal organizations (even in their most corrupt forms) have been considered the province of sociologists, political scientists and economists. Anthropologists are left with the peripheral peoples, strange customs, deviant cases, and otherwise anomalous groups (Sampson 1983: 65-66).

An important point put forward by Sampson (1983), and long before him by Scott (1974), is that corruptive practices can both lubricate the formal system and render it ineffective. In the case of pharmaceuticals in Cameroon the scale is clearly tipped toward the latter.

3. Formal and informal supply of medicines

Insight into the character of the informal sector of the economy provides another perspective from which drug distribution can be studied fruitfully. The Cameroon research revealed a flourishing informal distribution of medicines, partly interwoven with the formal supply system. It became 

clear that what I have called "corruption" is often nothing more than passing from the formal into the informal sector. The informal sector can be contrasted with the formal one in many ways. Providers of medicines in the informal sector have no - formal - training and ^{their practices,} though ~~socially accepted,~~ ~~are illegal.~~ Another contrast, derived from the previous one, is that the medical consequences of informal practices A third contrast is that the activities in the informal sector tend to be much more geared toward the needs of poor people than those in the formal sector.

More important, however, is to study the interlinkages between formal and informal drug distribution. The two are closely intertwined and mutually dependent. This intertwining shows itself both in the 'wholesale' and in the 'retail' of medicines. Drug vendors in the informal sector, for example, purchase their products from authorized pharmacies and from personnel working in the formal health sector.³⁾ The transactions involve mutual interests. The pharmacist increases his turnover by selling medicines to far-off villages through unauthorized vendors. Health workers augment their income by selling medicines which were to be given to patients free of charge.

The drug supply to patients is characterized by a similar connectedness of the two sectors. Health workers turn into informal providers of medicines by selling "free" medicines to patients in their private homes. In the knowledge that there are no medicines in the health centre, patients often buy their medicines before they visit the centre and bring them along. Pharmacists sell prescription-medicines over the counter and thus become very similar to informal and unqualified vendors *see further Van der Geest 1985).*

The formal, legal supply of medicines implies and makes use of the informal, illegal distribution. The two cannot be separated. Suggestions for the improvement of drug distribution must take the existence of both sectors into account. Formal and informal transactions with medicines are not mutually exclusive, as is sometimes believed, but support one another.

4. Public versus private drug supply

The most conspicuous outcome of the research was that the supply of medicines in the private sector functions much better than in the public sector. In the private sector patients have to pay for medicines. It is in the interest of those selling the medicines to have a constant stock of them. This principle holds true for the pharmacist as much as for the private health centre and the informal drug vendor.

In public health institutions, however, drugs are given free of charge, and their personnel have little personal interest in keeping a constant supply of drugs in their service. The disappearance of drugs does not really harm them and the fact that the service breaks down because of lack of drugs does not affect their source of income. On the contrary personnel in public institutions often derive material benefit from drug shortages. Drugs privately sold add to their income, drugs distributed among friends and relatives may provide future advantages and drugs given to socially important people will safeguard their security. Moreover, the temporary collapse of the medical service may allow the health worker to undertake additional economic activities.

A national investigation into the distribution of pharmaceuticals mentioned the lack of a commercial spirit in the public sector

(from top to bottom) as the root cause of the overall inefficiency. It reports that drug orders sent to the central pharmacy in the public sector took from eight months to more than two years to arrive, while orders to commercial suppliers were delivered in three weeks!

The ironical result is that a health care system designed to serve the poor by providing free services turns out to be the most expensive, because it fails to provide the required services and forces people to resort to other institutions, sometimes with considerable loss of time, money and health.

Another ironical outcome is that the public type of health care, with full support from the state, functions defectively, where-
as private health care, with virtually no financial support ^{from the state} functions satisfactorily.

Whether drug distribution is linked to a private or public system has far-reaching consequences for its performance. In the conclusion we shall see how this insight impinges on measures to improve the drug supply system.

5. Pharmaceuticals and the multinational industry

The past ten years numerous publications have analysed and criticized the marketing of pharmaceuticals in the third world by multinational companies.⁴⁾ The main criticism is that the pharmaceutical industry conducts a purely commercial policy behind a facade of curing and relieving pain. Profit-making is facilitated by the weak position of consumers in the third world.

All modern pharmaceutical products in Cameroon are imported, so the country depends fully on the international industry for its drug supply. Studying the shortage of medicines in rural health centres and

the presence of dangerous and useless medicines in the informal sector, it is not immediately clear how these problems are related to the role of the multinational industry.

With regard to the shortage of drugs it should be noted that the Ministry of Health does not succeed in purchasing sufficient drugs because it spends too much of its budget on expensive, non-essential drugs. Apparently this irrational policy of drug purchasing is due ^{, among other things,} to the industry's ability to manipulate the Ministry's policy which serves the interests of individual policy-makers and urban elites at the expense of the rural population.

The existence of an informal sector for the supply of medicines is directly related to the drug shortages in the formal sector, as we have seen before. Some drugs sold informally complement the shortages in health centres, other ones arrive at the informal sector from those health centres, thus aggravating their shortages. Moreover, these drugs are usually withdrawn from medical supervision by passing into the informal system. The result is that useful drugs may become useless and even harmful because they are used wrongly.

It may seem far-fetched to link these problems to marketing policies by pharmaceutical firms. These firms have reiterated that they cannot be held responsible for what happens to their products in a country of the third world. They can only guarantee the safety of their products and the adequacy of their information.⁵⁾ They further assume that prescription drugs are indeed purchased only with a doctor's prescription and that their delivery of drugs to the private sector of health care does not affect the public sector. These claims and assumptions, however, pay no regard to the complex situation in

most developing countries. No company can be sure what happens to its products, and certainly not in the third world. There are clear indications that the sale of expensive medicines to the government of Cameroon is detrimental to the supply of drugs in rural health care. Moreover, "the safety of their products and the adequacy of their information" get lost if their products are sold outside the prescribed medical context.

The policy of pharmaceutical companies may not be consciously directed to a haphazard and ill-adapted distribution of medicines in countries of the third world, but the present problems are certainly a logical result of that policy. Multinational companies consistently disregard the problematic character of drug procurement in the third world and refuse to ^{look} for appropriate measures to prevent or reduce the hazardous and wasteful use of their products.

Recent attempts by third world countries themselves to improve their drug supply system have been resisted by pharmaceutical companies when the measures implicated a reduction of their market.⁶⁾ A particularly interesting development is that the International Federation of Pharmaceutical Manufacturers Associations (IFPMA) has announced that 40 to 50 companies are prepared to supply essential drugs to a selected number of developing countries, including Cameroon. It has become clear however that this offer was meant to buy time and to forestall more radical changes imposed upon the industry by the WHO and the developing countries. The IFPMA is still 'negotiating', five years after the offer. One of the reasons for delaying the implementation of the plan is, as a representative of the industry said, the "completely inadequate organization and systems for procurement,

distribution and storage of pharmaceuticals" (HA1 1982: 6). Significant is of course that pharmaceutical companies never bothered over inadequate infrastructures, when they could sell the products they wanted to sell.

In conclusion, the linkage between the pharmaceutical industry and health care in Cameroonion villages may not be visible as directly as the other linkages, but it certainly is there. It should further be noted that the inobtrusiveness of the connection adds to its efficacy.

6. Pharmaceuticals and WHO policy


In 1977 the WHO published its first official report about a plan for the selection of essential drugs (WHO 1977). The basic idea of the plan was "that the single most important measure needed to cut costs and ensure that drugs are used effectively is to limit the number available to those 'most necessary for the health care of the majority of the population' " (Melrose 1982a: 148). It is remarkable that this plan has been widely applauded but hardly implemented, at least not in an effective way. The world-wide support for it is not difficult to explain. A selection of essential drugs would solve numerous problems in the field of health care, particularly in the third world; it would enable governments to buy sufficient medicines for the entire health care system and would reduce the hazards of inappropriate use of drugs. It is more difficult to explain why this WHO plan hardly has been put into effective practice.

In April 1982, according to Melrose (1982a: 148), 70 countries had adopted restricted drug lists, but in almost all of them these lists could be easily circumvented, for example by allowing "unre-

stricted" lists in the private sector or leaving it entirely to doctors what to prescribe. Reasons for the reluctance to enforce restricted lists should be sought in other contexts of the drug distribution, particularly with respect to political pressure groups (see under 1) and multinational companies (see under 5). Policy-makers in Cameroon are caught between two groups with opposite interests: on the one side the established elite (commercial, medical, pharmaceutical and political) to which they belong themselves, on the other side the unco-ordinated, mainly rural, masses. The most attractive solution for the time being seems to be a 'rhetorical implementation' of the WHO plan. This solution is now being put into practice: the Ministry has drawn up a list of essential drugs with the approval of the medical and pharmaceutical professional groups. The result is a compromise which will leave physicians free to continue prescribing non-essential medicines, and pharmacists to continue buying - and selling - them. It is unlikely that sufficient appropriate medicines will become available in the villages of Cameroon in the near future.

Conclusion

I have attempted to show that the distribution and use of pharmaceuticals has numerous linkages with national and international politics, with the marketing practices of multinational firms, with bureaucracy, with urban - rural relationships and with various economic aspects. Other linkages, with the social, domestic and individual cognitive domain of pharmaceutical consumers, were not discussed in this note, but are equally important.

Viewing pharmaceuticals in a broad context  does not only deepen our understanding of problems in drug supply, but provides

also important clues for the improvement of drug distribution. The example of Cameroon suggests that technical reforms in drug distribution will not effect positive results, if the wider context to which pharmaceuticals are linked does not change. Policies for improvement should be as 'connected' as the problems are.

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Notes

1. See for example Van der Geest 1981, 1982 and 1985.
2. To alleviate this geographical problem the government encourages local communities to set up 'propharmacies', small medicine shops, near public health centres. Many of these propharmacies, which have a non-profit character, prove to be a problematic means of drug distribution (Van der Geest 1983).
3. This phenomenon has been observed in almost all countries of the third world. To mention a few examples: Mexico (De Walt 1977; Logan 1983), El Salvador (Ferguson 1981), ^{Jamaica} (Mitchell 1983), Brazil (Group for Defense 1984), Ethiopia (Kloos 1974), Mauritius (Sussman 1981), Thailand (Weisberg 1982), and the Philippines (Hardon n.d.).
4. It is impossible to mention them all, but some of the most important ones are Gish & Feller 1979; Melrose 1982a; Muller 1982; and Silverman et al. 1982. Health Action International (HAI), a consumers organization, has published a considerable amount of evidence against the pharmaceutical industry.

5. But the adequacy of information on drug indications and counter-indications has been criticized as well (see for example Silverman et al. 1982).
6. The case of Bangladesh is well-known. When the government of that country implemented a new drugs policy stressing banning the sale of expensive inessential drugs, pharmaceutical firms exerted considerable pressure to have the policy reversed (Chetley 1982; Melrose 1982b; Rolt 1985).

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