12 Anthropologists and the sociality of medicines

In this book we have been following the social lives of medicines in the hands of different actors: mothers of children in Manila, villagers in Burkina Faso, women in the Netherlands, consumers in London, shopkeepers in Cameroon, pharmacists in Mexico, injectionists in Uganda, doctors in Sri Lanka, industrialists in India and policy makers in Geneva. One important category of actors has been left implicit, however: we ourselves, the authors of these chapters. For us, anthropologists, medicines have still another meaning and another type of life; in our hands and on our paper they are intriguing cultural objects. They embody anthropological ideas about the power things have over people, and about the power relations between people mediated through objects, about symbolization, about medicalization, and about the process of globalization.

If medicines are life-saving objects to mothers with children, symbols to explain the world to African farmers, profitable commodities to traders, pharmacists and manufacturers, and tokens of concern to prescribing physicians and their clients, they are first of all topics for writing and reflection to anthropologists; they are good to think and good to write about. In people's ways of dealing with medicines all facets of cultural reasoning and action come to the fore, as we have tried to show in these chapters. At the same time, however, medicines are not purely an academic issue for anthropologists. We too accept their power to alleviate suffering and their significance for the people with whom we work.

Anthropological lives with medicines

Each of us encountered medicines as worthy of research in situations that were as much 'everyday life' as 'anthropology'. During our research medicines 'struck' us as being of the utmost importance for survival to the people we were staying with. We *had* to focus our attention on them. Ignoring pharmaceuticals, we realized, was the result of an inverse type of ethnocentrism among anthropologists who were only interested in

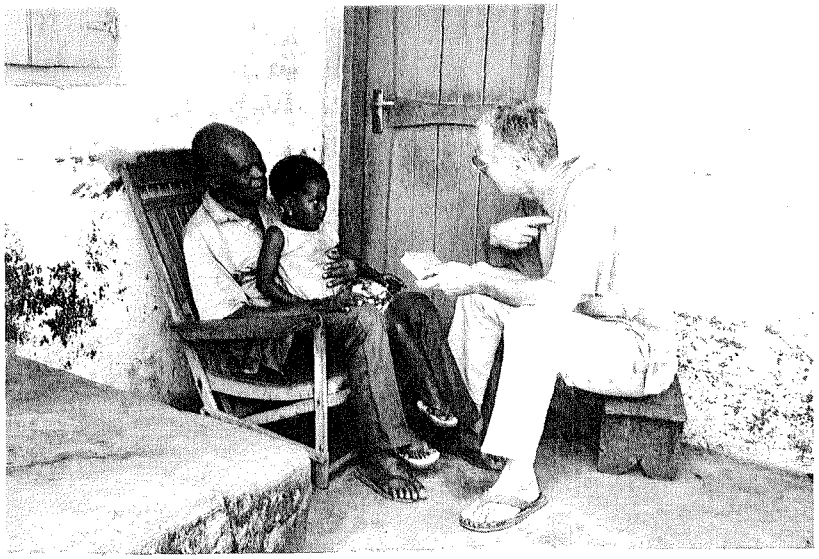

Fig. 12.1 Ethnography as an approach to the social lives of medicines: one of the authors during fieldwork.

'difference', in exotic phenomena, and who did not have to worry about access to medication when they were sick.

Sjaak van der Geest was first drawn to the study of pharmaceuticals when he was doing fieldwork on sexual relationships and birth control in a rural town in Ghana. During that research young people repeatedly told him that they used a certain medicine to prevent pregnancy and that they used the same medicine to terminate a pregnancy which they had failed to prevent. Students at the university, he soon found out, were using the same medicine for the same purposes. The name of the medicine was 'Alophen'; it was for sale in all drugstores he visited, in Accra as well as in rural towns and villages. Alophen, he discovered, was a purgative produced by a company in Detroit. How this product had come to play the role of most popular contraceptive for Ghanaian youth was a riddle. His curiosity – and concern – grew further when he found out that doctors and other medical professionals were unaware of the social life of Alophen; worse, they had never heard of it. The popularity and wide-spread use of foreign-produced medicines outside the knowledge and control of the professional medical world proved not only intriguing to him but also of life importance to those using them. Suddenly he began to see pharmaceuticals everywhere: in shops, at the market, in small kiosks and in private houses. Some of them were relatively harmless,

others were dangerous prescription-only ones. A few years later he started his research on the distribution and use of pharmaceuticals in Cameroon.

Susan Whyte's anthropological life with medicines began with the realization that medicines from distant places formed a kind of alternative to the ritual treatments of misfortune she was studying in Uganda in 1970. She was intrigued with the way people attributed special power to medicines from the Indian Ocean island of Pemba, to amulets made of recycled cartridges and tin cans, and even to the fearsome 'batri', said to be extracted from the imported battery cells used in flashlights and radios. She also caught glimpses of specialists in another kind of foreign medicine, the lay injectionists who discreetly administered penicillin to their neighbours and earned a bit of money. Returning two decades later, she found there was nothing discreet about the booming business of 'European' medicines that had spread even in rural areas. Pharmaceuticals had become folk medicines. As Whyte explored the lively trade in pills, capsules and vials of injectable medicine, she was led to problems in the national health services as well as to local conceptions of the power of medicines. The fact that Denmark, where she lived, was supporting the Uganda Essential Drugs Programme challenged her to consider policy implications of what she was learning in ethnographic fieldwork. At the same time, commitment to a community she had known over many years, where infectious diseases continued to bring suffering and death, inspired her to think pragmatically. Together with a team of Ugandan researchers she became involved in the Uganda Community Drug Use Project with the purpose of contributing to improved use of those indigenized foreign medicines.

Anita Hardon was confronted with problems in the use of medicines when she was conducting fieldwork on the complex interactions between nutrition and infectious diseases in small children in a rural village in the Philippines. Mothers repeatedly asked her for advice on medicines, showing her prescriptions, usually with four or five different medicines, mostly unnecessary for common childhood coughs and diarrhoeas. She decided systematically to review treatments given to the children and found that 80 per cent of all children's illnesses were treated without health workers' advice. Trained also as a medical biologist, she was concerned about the risks of uncontrolled use of medicines in self-care and irrational prescribing by doctors. She was asked by a community-based health programme trying to educate consumers on the 'rational' use of medicines in self-care to assess why the interventions were not having much effect. This study resulted in her thesis, which describes how people confront ill-health in an urban slum in Metro Manila. It also impelled her to become an active participant in the international advocacy movement Health Action

International, which aims to increase access to essential drugs globally, to promote more appropriate drug use, to reduce the number of inessential drugs on the market, and to regulate advertising to prescribers and consumers. In her later work, Hardon has turned to the social construction of pharmaceutical technologies, specifically contraceptives. She has been part of the international women's health movement, which calls for reproductive technologies to be developed and provided more in line with women's needs.

Anthropologists handling medicines

The brief sketches above raise issues about how anthropologists studying medicines have positioned themselves in relation to kinds of knowledge and uses of knowledge. Medicines have intrigued us, and fuelled our anthropological imaginations, yet ideas and practices around medicines were not simply data to be analysed. We were concerned about health problems and we felt that what we had learned had implications for health professionals and policy makers. But we did not necessarily think that our knowledge should be used simply to facilitate their agendas. Rather we wanted to use it to interrogate public health paradigms and professional practice, to draw attention to blind spots and biases, including the neglect of consumer agency. We also wanted, at times, to go beyond analysis and critique, to engage ourselves in concrete projects of action. Reflecting on the ways we as anthropologists have handled medicines, we suggest that there are three distinguishable positions, although much anthropological writing straddles more than one (Whyte and Birungi 2000).

As a method of knowing, ethnography demands (preferably extended) periods of engagement in some empirical world of lived experience. Through 'the revolutionary move of joining people where they live' (Hart 1998), ethnography should richly describe the situated concerns of particular people using specific medicines for the problems they think are pressing. That kind of research practice, combined with the broad comparative perspective of anthropology, tends to give a view of all knowledge as contingent. What biomedical researchers believe about antibiotics is just one form of (ethno-)knowledge based in a certain kind of social practice. What customers in a Cameroon market believe about red and black capsules is equally legitimate and worthy of respect and understanding.

Such an approach could be called populist in its sympathetic portrayal of the lay users of medicines. At its best it unfolds lifeworlds and worldviews; it shows how people experience symptoms and what choices and constraints guide their actions. Rational Drug Use? Users have their own form of rationality, as good ethnography reveals. The populist position

emphasizes the agency of consumers of medicines. It tends to describe their criticisms of the professional providers of medicine and how they popularize it by obtaining medicines and knowledge on their own terms. A beautiful example is the citation of a statement made by an informant in Sri Lanka:

> Medicine cures, doctors control the knowledge of medicines and we are made dependent. We do not receive health education about medicines, only about using soap, drinking boiled cool water, and taking immunizations – things from which there is no profit. There are many things we want to learn, but they teach us only what they want us to know. Yet we are not helpless. Just as we have learned to use *Sinhala Behet* (herbal medicines) so we will learn about *ingirisi* (allopathic) medicines through experience. (Nichter and Nordstrom 1989:367)

In the chapters of this book, the populist approach is strong. The sceptics who do not take their medicine in London, the Ugandans going to a trusted neighbour for an injection, the Cameroonians finding a way, when the formal health care system lets them down: we are trying to understand their reasoning in those situations.

The populist view valorizes consumers' capabilities and agency. In contrast, the 'enlightened' one doubts them. It reveals people's knowledge of medicines as inadequate; their medication practices are irrational, and they are likely to be victims of commercial interests. These criticisms are based on an informed position against which popular knowledge is measured and found wanting. Much applied anthropology takes an 'enlightened' stance, almost of necessity. When we co-operate with biomedical planners, policy makers and practitioners in projects whose aim is to improve health and health services, we often adopt biomedical standards for evaluating medication practices. Although 'critical' medical anthropology deplores the tendency of anthropologists becoming the 'handmaidens-translators to biomedicine' (Morsey 1996:32), it also seems perverse to refuse in principle to accept the knowledge of biomedicine when it has the potential to save lives. There are high rates of self-medication in countries where infectious diseases claim many children's lives. There is growing microbial resistance to safe and cheap drugs for infectious diseases. In these situations many anthropologists accept that it is important to compare lay people's knowledge and use of drugs to biomedical orthodoxy. But most would not focus only on the 'shortcomings' of lay people *vis-à-vis* biomedical ideals of rational drug use.

A critical version of the 'enlightened' position problematizes the knowledge and practice of *both* specialists and lay people. The proliferation of medicines is related to a transformation in consciousness whereby professionals and lay people alike come to believe (or know) that

medicines are the answers to their problems. From this position, as we have seen, some speak of 'false consciousness' generated by health commodification – the belief that health can be secured through medicinal commodities (Nichter 1989:235–6). Notions of ideology, hegemony and complicity are invoked in discussing the medicalization and pharmaceuticalization of suffering. Health professionals play the role of intellectuals, 'sustaining commonsense definitions of reality through their highly specialized and validating forms of discourse' (Scheper-Hughes 1992:171). Lay people are 'complicit' in that their everyday knowledge and practice, indeed their bodily experience, are oriented towards medicinal commodities as solutions to their problems. The knowledge and practices of both users and providers of medicines are found wanting.

Against what standards are they measured? Neither Nichter nor Scheper-Hughes is explicit about this. But it seems safe to say that their criticisms are based on classic public health principles: recognition of the social/political/economic bases of health, social justice, disease prevention and health promotion, and rational drug use (pharmacological efficacy plus economic efficiency).

Much of the 'critical enlightened' view of medicines is directed against situations where people are using tonics, vitamins or other drugs deemed unnecessary, rather than taking steps to change the political economy of health. The critique is just as relevant to the use of 'indigenous' medicines. As Charles Leslie once wrote:

> The bottom line in the discussions . . . is how much choice people in poor countries should have in spending their pennies. Of course health care planners believe that they should not buy tonics to prevent premature ejaculation, or to make their sons more intelligent. They should deal realistically with the terrible problems in their countries, with malnutrition and infectious disease. (Leslie 1988:xii)

At some point, this discussion gets uncomfortable for practising anthropologists. The public health concept of rationality and progress can be taken to imply that rituals, symbols and other concepts of efficacy are at best irrational, at worst deceptive. Where that point lies is highly debatable.

To what extent should anthropological research simply ignore biomedical judgements about rational use of drugs, in order better to engage the perspectives and practices of the consumers and providers? At what point, if at all, should they make judgements about 'irrationality', unwarranted medicalization, incompetence or exploitation? There is not going to be agreement on this question. In fact, individual anthropologists are not even consistent with themselves in this regard. But we want to point out that this question arises more insistently for an anthropology of

materia medica than it does for anthropological studies in other domains of culture. Drugs are special commodities.

A third anthropological position is possible, one we have called pragmatic. It emphasizes the participation part of participant observation, and takes applied research as an opportunity both to work for limited change and to create knowledge through practical grappling with problems. The attraction of this position is that it is contingent and processual: it is oriented to the 'truths' of a given situation as they happen over time. It requires an appreciation of differentiated perspectives and interests; and it learns about them by trying to change them. But there are difficulties here, too. The action researcher has to make a decision – at least a tactical one – about what practices should be changed, and s/he has to make alliances with parties interested in altering them. In doing that, anthropologists place themselves in a social relation to medicines and to other actors. They handle them not only on paper, but in the strategizing and exchanges of social life.

An ethnographic agenda

However we choose to position ourselves in relation to the sociality of medicines, anthropologists have a unique contribution to make in the form of rich and careful ethnography. Let us conclude, therefore, by supplementing Nichter and Vuckovic's (1994) research agenda with some suggestions for field research that arise from the foregoing chapters.

To say that medicines are social is to remind ourselves of two sides of the same coin. First, medicines take on meaning through common social experience in the context of social relations. Second, their use in social life has implications, immediate and long term, for those relations. Stressing the sociality of medicines raises certain kinds of research questions to be answered through ethnographic research.

The logistics of meaning

The first set of questions has to do with how medicines come to mean for people in particular situations. We have seen that medicinal substances link conventional images from everyday life (tethered donkeys) or from imagined worlds (pure nature, scientific laboratories) to bodily experience. But how do those images get confirmed as meaningful? Answering that question requires attention to the ways people learn about medicines in the course of their daily lives. Researchers have been most concerned with what medicines mean and what people know about them. They are only now beginning to ask how people acquire different

kinds of knowledge through social practice – and how they revise their knowledge.

Much of what people understand about medicines is learned at home from family, neighbours and friends. Children in Manila assimilate knowledge about cough medicine in the course of being treated by their mothers. Mossi women sitting around a cooking fire exchange advice about the ashes of forked sticks as medicine for fissures around a child's anus. But we have also seen how people learn through other kinds of relationships. Those Manila mothers saved the prescriptions they received from doctors, in case their child developed the same symptoms again. The authority of doctors, exemplified in that precious bit of script, was one among several social contexts for learning. Ugandans have learned about injections by going to the health centre, where injections have been the 'best treatment' for generations.

The growing forces of commodification have opened up new channels for getting to know medicines. The challenge for fieldworkers is to trace out empirically what kinds of social relations are involved. In some cases, familiarity and lack of social distance between seller and consumer seem to facilitate developing a common popular knowledge, as is the case with drug vendors and their customers in Cameroon. Advertising provides images to the public; but this seemingly anonymous communication may be personalized through discussions with the attendant in a neighbourhood drug shop about the merits of various brands. The commercial interests in manufacturing meanings for medicinal commodities present difficulties for this social logistics approach. But it is crucial to do ethnography along these lines in order to find out how images are formulated and communicated.

The social efficacy of medicines

A second set of research questions about the sociality of medicines concerns their social uses and effects. If we use the term efficacy, it is to raise the issue of whether the social workings of medicines are intended or seen as desirable. And by whom. Again, for ethnographers, these are empirical questions that require trying to understand the situated concerns of social actors as well as attempting to analyse connections of which the actors themselves may be unaware.

In an immediate sense, social efficacy is about what giving and taking medicines does for the social relationships of those involved. What are their intentions beyond getting rid of symptoms? Or rather, do the symptoms have social implications that are part of the problem? We have seen how complicated even these seemingly simple questions can be. Mothers in the Philippines were caring for their children in a context of high child mortality where they might be blamed for negligence. Women in the Netherlands were trying to exert some control over their lives so that they could manage their jobs, children and husbands. Many Americans 'buy time' with medicines, in order not to miss work (Vuckovic 1999). Doctors may give medicines so as to end a consultation, please a patient or avoid having to listen to a lot of misery that cannot easily be helped.

How is the enactment of medication understood? Whatever the intentions of people interacting through medicines, the social meaning of offering and receiving medicine can differ. To be a compliant patient in a Dutch psychiatric hospital may be virtuous in the eyes of the staff and a total loss of autonomy in the experience of an 'inmate'. To reject biomedicine as artificial and turn instead to Bach Flower remedies is to perform a small statement about cultural politics. We have to enquire about the sense in which taking medicine is a social act as well as a medical one. Within relationships qualities like trust, authority, respect, concern and generosity are at stake. As a social actor, the consumer of medicines indirectly conveys something about his or her social identity as modern, enlightened, conventional, traditional, disciplined, critical or indifferent.

These kinds of research questions focus on direct interaction and immediate implications. But some of the most controversial aspects of social efficacy are about indirect and longer-term implications of medicine use for social relations. Like other forms of technology, medicines seem to be at the disposal of people; but people are also disposed by medicines to understand and deal with their problems in a certain way (Van der Geest 1994). This insight is the basis for the arguments that the mounting commercial availability of all kinds of medicines has far-reaching social effects. The growing presence of medicines creates an awareness of the need for medicines. This increases the wealth and power of those who supply them. And it also encourages people to define and manage their problems medicinally, emphasizing some kinds of social relations (with drug sellers and doctors) at the expense of others (such as environmental and social justice activists). We want to emphasize, however, that such conjectures about social efficacy should be subjected to empirical research in specific instances. That would mean examining the social effects of the composite, intertwined system of drug provision in general as we have sketched out in the cases of Cameroon and Uganda. Ideally ethnography on this topic would follow processes over time so that changes could be seen in historical perspective.

We hope that future anthropological work on medicines will produce ethnography on questions like these and thereby create a better basis for the development of theory and the application of knowledge.

as drug dealers, pickpockets and sex workers are cases in point, but politicians, salesmen and medical doctors may also not tolerate an anthropologist in their midst. Another problem may be that the people under research will present a false picture of their ideas and practices once they know they are being 'watched'. In such situations researchers are likely to resort to a more liberal interpretation of their ethical code. 'Classic' examples of undercover research in medical anthropology are Caudill (1958) and Rosenhan (1973), who did fieldwork in psychiatric hospitals (before the professional code existed). Tomson and Sterky (1986) and Wolffers (1987) made their research assistants pose as clients in order to collect reliable information on sale practices by pharmacists and drugstore keepers. This technique of using 'simulated clients' is often used to study health providers, especially the relatively powerless small-time drug retailers in developing countries (Madden *et al.* 1997).

4. A recent thriller by the popular author John Le Carré (2000) is a scathing indictment of multinational pharmaceutical companies that use the people in Africa as unwitting research subjects for new and expensive medicines.
5. The conflict of interests between manufacturers, patients, insurance companies and policy makers emerged clearly in the case that the pharmaceutical industry brought before the South African court to prevent the country from providing cheap anti-AIDS drugs to its citizens. The industry eventually dropped the case (April 2001) because of the negative publicity it produced.

11 HEALTH PLANNERS

1. Health Action International is an umbrella of consumers organizations, which specifically aims to 'further the safe, rational and economic use of pharmaceuticals world-wide, to promote the full implementation of WHO's Action Programme on Essential Drugs and to look for non-drug solutions to problems created by impure water, poor sanitation and nutrition'.
2. Country case-studies were done in Colombia, Nigeria, Tanzania, Kenya, Zimbabwe, Mozambique, Burundi, North Yemen, South Yemen, Sudan, Bangladesh, Indonesia and Vietnam.

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