UNEQUAL ACCESS TO PHARMACEUTICALS IN SOUTHERN CAMEROON: THE CONTEXT OF A PROBLEM

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If we want to understand health care problems in developing countries, we should study pharmaceuticals(1) which play such a key role in the organization and functioning of many Third World medical services. Primary health care that does not guarantee a regular supply of medicines loses its credibility. Mamdani and Walker (1985:1) remark that shortage of - curative - drugs weakens people's confidence in preventive health services and undermines the morale of primary health care workers. Nichter (1986:349) found that in South India health auxiliaries were not allowed to hand out any medicine. They felt that, as a result, both their status and people's receptivity to their medical advice were seriously reduced. In Cameroon, where I carried out research, modern medical treatment without drug prescription was out of the question. Services that ran out of drugs, also soon ran out of patients.

But what do we want to know about pharmaceuticals? What kind of research is most likely to enable us to formulate suggestions for meaningful change? Problem

number one is problem identification. Are difficulties mainly economic, pharmacological, political, technical, or infrastructural? Or a matter of customs and beliefs? Or do they have to do with social relationships? The awkward answer is that probably all these possibilities need to be taken into account.

In this paper I shall demonstrate that the provision and the use of pharmaceuticals are intricately linked up with a confusing array of factors and circumstances. So-called modernization and economic development mean in practice that different groups in society enjoy extremely unequal access to medicines. Because it is virtually impossible to deal with the whole gamut of relevant contexts, I will restrict myself to considering contextual forces which seem of particular political and economic importance in the rapidly modernizing state of Cameroon. These include the survival imperative for this young state to increase political cohesion among its population, the problem of over-bureaucratization leading to 'corruption', intertwining relations between formal and informal sectors in the economy of health care, contrasts between public and private supply of medicines, the role of multi-national industries, and the influence of WHO policy guidelines.

A second, simultaneous, aim of this paper is methodological: I shall plead for more 'contextuality' in health care research, in particular in studies on the distribution and use of pharmaceuticals. Unfortunately the removal of people and things from their context for study has become all too persistently typical of Western research, a development I will now turn to examine briefly.

CONTEXTUALIZATION

Since the time long ago when the political adage Divide et impera first made its entry into human science, it has managed to maintain its popularity. For more than three centuries, we appear to have accepted that scientific progress depends on ever increasing specialization of research, an ever-finer demarcation of one's object of study.

The development of Western science might perhaps be characterized as a continuous yielding to the temptation of

simplifying reality by cutting it up and then reducing it to a basic principle. The advantage of such manipulations is that 'reality' becomes so manageable, predictable and amenable to control. The drawback, of course, is that such partitioning changes the subject matter into something which exists only in the mind of the researcher. The result of this approach has been a diversity of biological, chemical, psychological, sociological, etc. 'explanations' for different aspects of subjects studied, without a way to integrate these various partial explanations into an over-all view. Yet the embarrassing fact of our inability to understand the subject-matter as a whole has failed to spur scientists into a dialogue, as might have been expected. To the contrary, they have preferred to practically ignore the work of other disciplines and to regard the theories and findings of scientists in other fields as irrelevant to their own limited work. It has even become normal practice to speak 'as a biologist' (chemist/psychologist/sociologist/etc.). In this way we encourage ourselves to imagine that such things as a biological, chemical or sociological world actually exist.

In their defense it should be said that practicing scientists have had no alternative. Popper (1961) rightly pointed out that a holistic method is a logical impossibility, because it leads to a regressio ad infinitum. It is not possible to study a subject by taking all its relations into account. Phillips (1977) rubs salt in the wound by asserting that holism is both imperative and unworkable. While philosophers have found it perhaps easy to criticize scientism and historicism in scientific research, scientists themselves have seen no other choice than to carry on with their rigid specializations, undisturbed by work in other disciplines.

Summarizing, there are two closely related aspects of this drift towards compartmentalization in scientific research. We need to consider, in the first place, the conscious sub-division of reality into an ever-increasing number of disciplines and specializations within disciplines and in the second place, a less conscious dividing of subject matter into partial aspects often treated as if they were whole.

The rise of anthropology can perhaps be regarded as an attempt to correct the latter type of division, for

anthropology attempts the contextualization of its subject matter. Anthropologists had hopes of arriving at contextualization by carrying out participant observation in fieldwork and by viewing their study-object in its 'natural context', or, as Geertz would say, in its "semantic context." Ironically, the emphasis on direct observation only led many anthropologists to succumb to further partitioning of their subject matter, failing to link what happened before their eyes to macro-structures outside the communities in which they conducted their research. They continued to be hampered moreover by the methodological problem mentioned by Popper. As a net result, despite possible intentions to the contrary, anthropology has become just another discipline, joining the segregated ranks of biology, chemistry, psychology, sociology, etc.

Dissatisfaction with the progressive dissection of reality and consequent estrangement from the world we 'know' has recently led to a number of proposals to transcend old divisions. Wolf (1982:3), for example, has made the following appeal:

> ...The world of human kind constitutes a manifold, a totality of interconnected processes, and inquiries that disassemble this totality into bits and then fail to reassemble it falsify reality. Concepts like "nation", "society", and "culture" name bits and threaten to turn names into things. Only by understanding these names as bundles of relationships, and by placing them back into the field from which they were abstracted, can we hope to avoid misleading inferences and increase our share of understanding.

This paper will attempt to illustrate the validity of Wolf's vision and concern, offering a rough sketch of the interconnection of several processes that impinge on the accessibility of pharmaceuticals in rural Cameroon. It is my wish to urge my fellow anthropologists to conduct research on various levels of organization, to study linkages among international, national, regional and local processes that affect their object of study, and to embark on interdisciplinary cooperation in fieldwork. Because the scope of this article does not allow for detailed description, its main thrust will be programmatic, pointing out the intercon-

thrust will be programmatic, pointing out the interconnectedness of social processes and the need for a contextual approach in studying these processes.

DISTRIBUTION OF PHARMACEUTICALS IN SOUTHERN CAMEROON

Fieldwork took place in 1980 in the Ntem Division of South Cameroon with brief follow-up visits in 1983. It was carried out at different levels, ascending from peripheral family and village life to divisional and national centers of administration. This meant that observations and interviews took place not only in village houses and kiosks, at local markets and health centers, but also at hospitals and pharmacies, and in the offices of the Ministry of Health.(2) In all, six relevant contexts or 'linkages' of medicine distribution were identified. These appear in brief outline below.

1. Health care, pharmaceuticals and state formation

From a political point of view, health care can be seen as an eminent tool for establishing state influence without physical force. Like education, health care can be regarded as a 'peaceful penetration' by the state apparatus on the local level, 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 must be regarded as legitimate before we can call it such. If power can be made to appear as a service rendered by rulers, then subjects will consider it their duty to serve those who serve them (Godelier 1978:177). Weber (1947) would call such devotion "uncoerced obedience."

The state of Cameroon is struggling to subdue serious centrifugal forces. One would, therefore, expect its rulers to invest considerable effort in setting up an efficient health care system, thereby making central authority acceptable to the people as an indispensable provider of welfare and health for all. There are several indications that the state is indeed aware of the political potential of 'health for all'. In government institutions, health care

initiating a far-reaching primary health care program and has pledged priority to the extension of rural health care.

In reality, however, the public health care system in rural areas is notoriously inefficient not only when compared to urban facilities, but also when compared to rural health services provided by church-related private institutions. Instead of drumming up support for the beneficent state, public rural health care has become a source of anti-propaganda. For the rural population, but also for health workers (Hours 1982), public medical services all too often have provided proverbial examples of the state's failure to cater to its people's needs. The fact that this failure contrasts sharply with the relative success of private institutions in the field of medicine makes the negative demonstration effect even more pronounced.

Prominent in rural health care delivery is a chronic deficiency of pharmaceuticals on hand. Rural health centers are short of medicines for a great deal of the year. Free distribution of drugs becomes worse than meaningless when government health workers are forced to refer their patients with prescriptions to a commercial pharmacy, one which may be far away.(3) Securing necessary medication may entail the loss of considerable time and money. The failure of the linkage between the political domain and the provision of rural health care is of immediate interest. To understand why, we need to weigh the perceived political importance of drug supply and health care against other factors in the process of state-building.

Perhaps the first thing we need to realize is that the state of Cameroon has not yet completely moved to the stage of legitimation of power by extending public welfare. It still relies on the threat of physical force. In addition in their state-building efforts, the Cameroon authorities are primarily concerned with the potential resistance of urban elements, especially among the ranks of the army and police force. The quality of health care for these groups is conspicuously higher than for the rural population. In fact, 50% of the national health budget goes to the central administration and to hospitals in Yaounde and Douala. Only 7% is spent on rural health care, whereas 71.5% of the population is reported living in rural areas (1976 Census). Finally, we need to realize that until recently the Cameroon

government, by following a strictly centralist policy and discouraging local initiatives, has acted consistently to prevent the rise of political consciousness among the rural population. Penetration of state influence at the local level has been pursued mainly through the threat of coercion and by forestalling local self-reliance.

Similar truths emerge when we view urban-rural inequality in health care provision from a center periphery perspective. Research revealed that the more remote a health center was, the fewer drugs it received. The most peripheral health center I visited received just over half the drugs it should have; a center in a rural town of 5,000 received 87%, the hospital in the divisional capital an estimated 90 to 100%, and the central hospitals of Yaounde and Douala even more than 100%. Personnel in outlying health centers did not even know what medicines they were entitled to receive, nor in what quantity. As a result, they were not aware that their allotment of drugs was incomplete. Their remoteness, in a geographical, communicative and bureaucratic sense, made it impossible for them to ameliorate the situation.

2. Pharmaceuticals and "corruption"

Corruption --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 restricted resources, can less well afford corruption than industrialized ones.

Pharmaceuticals are scarce in Cameroon,(4) and, for that reason, much sought after through corrupt means. Medicines meant for free distribution in public health institutions pass into private hands. This kind of corruption is related to prevailing customs of gift-giving and to how traditional loyalties, mainly kinship ones, prevail over obligations to the state. Another factor is the traditional proprietary view of public office. The most important single force promoting corruption, however, is the overwhelming position of the state as the principle provider of goods, services and employment, coupled with the relative under-

development of the private commercial sector. The education gap between office holders and most citizens, moreover, facilitates corrupt practices.

Pharmaceuticals disappear on a large scale from the public health care system, 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 that in 1979 about 40% of state-owned medicines 'disappeared'. My own observations point in the same direction: a massive disappearance of drugs essential for the functioning of official health care. It should further be noted that this deflection of medicines for private use 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 and corrupt practices suggests a need for research into state bureaucracy and economy. The concept of a soft versus a 'strong' state might provide another important entry into analysis of the problem of unreliable medical supplies. Sampson, who complains that anthropologists have largely neglected bureaucracy and corruption in their research, supports the position, maintained at the outset of this paper:

> The traditional social science division of labor can partly explain the lack of anthropological research on bureaucracy and corruption. Formal organization (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 before him by Scott (1974), is that corrupt practices can both lubricate the formal system and render it ineffective. In the case of pharmaceuticals in Cameroon, the scale clearly tips toward the latter.

3. Formal and informal supply of medicines

My research in Cameroon disclosed a flourishing informal distribution of medicines, partly interwoven with the formal supply system. It became clear that 'corruption' is often nothing more than the passing of a drug from the formal to the informal supply sector. The informal sector differs from the formal one in many ways. Providers of medicines in the informal sector have no - formal- pharmaceutical training. Their practices, though socially accepted, are illegal. In fact, the medical consequences of informal practices often seem a reason for great concern. A further contrast is that activities in the informal sector appear to be addressed much more immediately to the condition of poor people than do those in the formal sector.

More important than contrasts, however, are the linkages between formal and informal drug distribution. The two are closely intertwined and mutually dependent. This intertwining shows itself in both the 'wholesale' and the 'retailing' of medicines. Drug vendors in the informal sector, for example, purchase their stock from authorized pharmacies and from personnel working in the formal health sector.(6) The transactions involve reciprocal interests. The pharmacist increases his turnover by selling medicines to far-off villagers 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 interconnection between the two sectors. By selling 'free' medicines to patients in their homes, health workers become informal distributors. Knowing no medicines are available at the health center, patients often buy medicines before they visit the center and bring them along. Pharmacists sell prescription-medicines over-the-counter and thus function similarly to informal and unqualified vendors.(7)

The formal, legal supply of medicines relies on and makes use of 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

Perhaps the most startling of my research findings was that the supply of medicines functions far better in the private than in the public sector. In the private sector patients pay for medicines. It is in the interest of those who sell to maintain their stock, whether pharmacist, private health center or informal drug vendor. In public health institutions, however, where drugs are given free of charge, personnel have little vested interest in assuring a constant supply of drugs on hand. The unavailability of drugs does not really represent any loss to them; even if health services break down because of lack of drugs, the situation will not affect their source of income. In fact, personnel in public institutions often derive material benefit from such drug shortages: drugs privately sold may add to their income; drugs distributed among friends and relatives may provide future advantages; drugs given to important figures may safeguard their own social and economic security. A temporary collapse of the medical services, moreover, allows health workers to undertake additional economic activities.

A national investigation into the distribution of pharmaceuticals cited lack of a commercial spirit in the public sector (from top to bottom) as the root cause of overall inefficiency.(8) It reported that when drug orders were sent to the central pharmacy in the public sector, delivery took from eight months to more than two years, while orders to commercial suppliers were delivered in three weeks (MSP 1980).

In practice, the Cameroon health care system, designed to serve the poor by providing free services, has turned out to be all too expensive, failing to provide required services and obliging patients to resort to other institutions, at times with considerable loss of time, money and health. Ironically, public health care, with full state support, functions defectively, whereas private health care, with virtually no state funding, functions satisfactorily (cf. Hours 1982, 1985).

5. Pharmaceuticals and Multinationals

During the past ten years numerous publications have analyzed and criticized the marketing of pharmaceuticals in the Third World by multinationals.(9) A leading criticism has been that pharmaceutical companies act purely out of commercial motives while hiding behind a humane facade of wishing to cure illness and relieving pain. Their profit-making is made all the easier by the weak position of consumers in developing countries.(10)

All modern pharmaceutical products in Cameroon are imported; the country depends fully on the international drug industry for its supplies. Studying the shortage of medicines in rural health centers and the abundance of dangerous and useless medicines in the informal sector, it is not immediately clear how these problems are related to the role of drug multinationals. Reports from other developing countries about the proliferation of non-essential (often a euphemism for 'useless') drugs and aggressive market practices by pharmaceutical industries do not seem to hold as true for Cameroon. Yet my research did not include a survey among doctors, pharmacists and other drug prescribers about promotion activities by the pharmaceutical industry. Some caution is necessary, therefore. Elsewhere critics have extensively documented double standards in marketing and revealed the exorbitant sums spent on drug promotion in the Third World. One example is Tanzania where the drug industry spent £12,500 per doctor on promoting its products, an amount far exceeding the annual income of most doctors (Mamdani & Walker 1985:41).

With regard to Cameroon it should be noted that, because the Ministry of Health spends too much of its budget on expensive, non-essential drugs, it is not able to purchase a sufficiency of medicines that are needed. Apparently irrational drug purchasing is owing, among other things, to the industry's ability to manipulate the Ministry's policy which advances the interests of individual policy-makers and the urban elite at the expense of the rural population. This at least, I should point out, was the situation in 1980. Since 1984 a restricted drug list has been introduced for the public sector. Nevertheless this measure seems likely to prove insufficient to restore the drug supply in government health institutions to even minimal levels.

Evaluations from various other developing countries show that exemption of the private sector from an essential drugs program leads to the failure of the entire program, for prescribers as well as users of pharmaceuticals continue to resort to non-essential drugs available in the private sector (Mamdani & Walker 1985:46).

As we have already observed, the existence of an informal sector for the supply of medicines bears a direct relation to drug shortages in the formal sector. Some drugs sold informally compensate for shortages in health centers, others enter the informal sector from those very health centers, thus aggravating their shortages. Moreover, such drugs are usually exempt from proper medical supervision once they pass into the informal system. As a result, valuable drugs may become worthless, even harmful, because they are misused.

It may seem far-fetched to link these problems to the marketing policies of pharmaceutical firms. These firms have reiterated that they cannot be held responsible for what happens to their products in the countries of the Third World. They can only guarantee the safety of their products and the accuracy and adequacy of the information which they provide.(11) They assume that certain designated drugs can indeed only be purchased with a doctor's prescription and that delivery of pharmaceuticals to the private health care sector does not detract from the public sector. This stance, however, pays no regard to the complexity of the health care situation in most developing countries. No company can be sure what will eventually happen with its products, certainly not in the Third World. There are clear indications that, up to 1984, the sale of expensive medicines to the government of Cameroon was detrimental to the supply of drugs needed in rural health care. Since 1984, when an essential drugs program was implemented, the sale of non-essential drugs through the private sector has continued to hamper attempts to achieve an adequate drug supply in public rural health centers. Moreover, how much are 'the safety of products and adequacy of information' claimed by the industry worth, if these products are sold outside prescribed medical outlets?

The policies of pharmaceutical companies may not consciously be directed to promote a haphazard and

maladapted distribution of medicines in countries of the Third World, but many present problems in drug supplies certainly derive from that policy. Multi-national companies consistently disregard the problems of drug procurement in the Third World and fail to look for appropriate measures to prevent or to reduce the hazardous and wasteful use of their products.

Recent attempts by developing countries to improve their own public drug supply systems have been resisted by pharmaceutical companies when indicated measures threatened a reduction of their market.(12) One development of particular interest is the International Federation of Pharmaceutical Manufacturers Associations'(IFPMA) announcement that 40 to 50 companies are prepared to supply cheap essential drugs to a selected number of developing countries, including Cameroon. It seems clear, however, that this offer was meant to buy time and forestall anymore radical changes to be possibly imposed upon the industry by the WHO and developing countries themselves. The IFPMA is still 'negotiating', six years after the initial offer. One reason for delay in implementation of the plan is, as a representative of the industry has said, the "completely inadequate organization and systems for procurement, distribution and storage of pharmaceuticals" in those developing countries (HAI 1982: 6). It is significant, of course, that pharmaceutical companies were never known to be bothered by inadequate infrastructures as long as they could sell all the products they wanted to sell.

In conclusion, a linkage between the international pharmaceutical industry and health care in Cameroon villages may not be as directly visible as other linkages, but it certainly is part of the contextual reality which concerns us. It should further be noted that the very unobtrusiveness of the connection contributes 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, so widely applauded, has hardly been implemented anywhere, at least not in an effective way. Its world-wide support is not difficult to explain. Limitation of medicines to specific essential drugs would solve numerous health care problems, particularly in the Third World. It would enable governments with restricted budgets to buy sufficient medicines to supply the entire health care system while appreciably reducing the risk of inappropriate drug use. Why then has this admirable WHO plan so rarely been put into effective practice?

By April 1982 (Melrose 1982a:148), 70 countries had adopted restricted drug lists, but in almost all of them these lists could easily be circumvented. Circumvention could be achieved, for example, by allowing "unrestricted" lists in the private sector or by leaving it entirely up to doctors what drugs to prescribe. Underlying reasons for reluctance to enforce restricted lists should be sought in other contexts of drug distribution, particularly those which have to do with political pressure groups (see 1) and multi-national companies (see 5). Policy-makers in Cameroon are caught between two groups with conflicting interests: on the one hand the established elite (commercial, medical, pharmaceutical and political) to which they themselves belong, and on the other the non-organized, most rural, masses. For policy-makers then, the most attractive solution to this predicament seems, for the time being, to be 'rhetorical implementation' of the WHO plan, a solution which has now been put into practice; with the approval of medical and pharmaceutical professional groups the Ministry of Health has drawn up a list of essential drugs. The result is a compromise which leaves physicians free to continue prescribing non-essential medicines, and pharmacists to continue buying - and selling - them. Sufficient appropriate medicines are therefore unlikely to become available in Cameroon villages in the near future.

Summary and Conclusions

This distribution and use of pharmaceuticals have numerous linkages with national and international politics and policies, with the marketing practices of multi-national

firms, with the operational problems of bureaucracy, with urban-rural relationships and with various economic factors. Further linkages with the social, domestic and individual cognitive domain of drug consumers, not discussed above, are equally important.

We have seen that effective public health care can be a powerful political binding agent for governments in a relatively early phase of state formation. An adequate drug supply is generally regarded as one of the most prominent features of an effective health care system. In Cameroon, however, the government does not accord a high priority to providing satisfactory health care to the rural areas. Access to necessary medicines is extremely limited in rural communities. It seems that the government is more concerned with the political loyalty of the urban population and of "vociferous" elements which pose a potential threat to its hegemony. For the rural population the main inducement to allegiance still seems to be negative: (the menace of) physical force in the event of disobedience.

Another factor impeding equal access to pharmaceuticals is over-bureaucratization and subsequent corruption. Non-organized small farmers and wage labourers undergo numerous forms of petty oppression at the hands of government-paid officials and health care personnel who have direct access to the medical resources that they need.

Corrupt practices are closely linked with the existence - and intertwining - of a formal and informal sector of drug supply. Pharmaceuticals unlawfully diverted from the - free - formal supply-line become available again in the informal sector, but now at a price and usually without medical supervision. Rural patients are thus at a double disadvantage: financial and medical.

Bureaucratization in public health care is propelled by lack of incentive for efficient fulfillment of tasks. Various kinds of profit that accrue to health workers who perform well in private institutions are absent in public ones. The pursuit of private gain by government health workers rather encourages inefficiency in public services. A shortage of drugs is the most acutely felt consequence for the general public.

The role of the international pharmaceutical industry in the unsatisfactory drug supply is not always easy to pinpoint. My preliminary impression in Cameroon is that the industry's responsibility for inequality in drug access is largely a question of unsalutary neglect: the absence of any concern about the actual usage of its products. How can the industry claim in good faith that it guarantees the safety of its products while at the same time it is so blatantly indifferent to the widespread unsafe use of pharmaceuticals? The question to what extent industry actively contributes to the present problem of unequal drug distribution in Cameroon needs further research.

WHO policy is another international force affecting drug distribution in Cameroon. Developing countries have played an important role in drawing the WHO's attention to their health problems. Indeed the WHO's policy document on essential drugs (WHO 1977) is a forward-going tangible result of concerted efforts to devise ways to alleviate the problem of drug shortage. At the same time, however, most developing countries themselves effectively continue to thwart the WHO's 'prescription' for the realization of a more just and equal distribution of needed medicines. This apparent anomaly in national health policy can best be understood if we view drug distribution in a broad context of political and economic interests. Refusal to implement a restricted drug list for both the public and private sectors, for example, seems to be the result of self-interested pressure by doctors, pharmacists, the pharmaceutical industry, the urban affluent, and various other politically powerful groups.

One of the most intriguing aspects of the unequal drug supply problems not yet touched on in this paper is how rural villagers themselves often help to maintain a situation so detrimental to their well being. Of relevance here are popular notions about the use and efficacy of Western pharmaceuticals, but also the priority given to family loyalty over correct 'behavior' in public office. Mapping the linkage of these cognitive and domestic factors - the 'lowest' levels of social organization - to the higher levels described in this paper presents a formidable challenge for further research.

Technological and economic development in Cameroon has had an ambiguous impact on people's access to health. It has made people more dependent on externally produced pharmaceuticals but, at the same time, it has restricted the access to these pharmaceuticals considerably for a large proportion of the country's population. It has been my purpose to sketch a few lines and linkages to point out the complexity of factors that impede equal access to pharmaceuticals. A second purpose was to encourage a contextual approach to the study of drug distribution in Third World countries. Interdisciplinary research on the context of pharmaceuticals should enlist the services of medical, pharmacological, political and economic scientists and anthropologists.

Viewing pharmaceuticals in a broad context does not only deepen our understanding of problems in drug supply, but also provides important clues for the improvement of drug distribution. The example of Cameroon suggests that 'technical' reforms will not achieve positive results if the wider contexts to which pharmaceuticals are linked do not change. Policies for improvement of the situation should be as 'connected' and 'contextual' as the problems are.

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NOTES

1. The term 'pharmaceuticals' in this paper refers to modern products. One might legitimately ask whether traditional medicines should not be included in any discussion of the political implications of unequal access to pharmaceuticals in Cameroon. The WHO (1978) has advocated the integration of traditional medicine in primary health care, a suggestion which has been widely applauded (e.g. Bannerman et al. 1983). An occasional note of objection, however, has also been sounded (e.g. Velimirovic 1984). On the other hand practical follow-up of this idea of integration has been almost universally neglected. The popularity of the idea should probably be understood as a sign of respect for traditional non-Western medical cultures, whereas the lack of concrete action to apply the idea seems an indication that Western-educated medical and

confidence in these very same medical cultures. In Cameroon some strongly support the idea of cooperation between Western and indigenous medicine (e.g. Lantum 1979) and the country has an institute for traditional plant medicine research. Yet, no practical results have yet led to changes in the country's national health policy. Outside the formal system of health care, however, people continue to use traditional medications, either because for the treatment of particular ailments these are preferred to modern ones, or because modern drugs are not available. More precise information on the use of indigenous medicines, compared with modern ones, however, is lacking. It seems likely that such use is declining and that- perhaps valuable - traditional medical knowledge is disappearing.

2. Research results have previously been published elsewhere. See, for example, van der Geest 1981, 1982, 1985, 1986 and n.d.

3. To alleviate this geographical problem the government encourages local communities to set up 'propharmacies', small medicine shops near public health centers. These propharmacies, which have a non-profit character, have by and large proven to be a dubious means of drug distribution (van der Geest 1983).

4. The Cameroon government spends 12% of its health budget on medicines (1980). Most developing countries spend considerably more. Information on this issue is contradictory, but for many countries WHO reports figures as high as 40-60% of the health budget (Melrose 1982a:207).

5. Elsewhere (van der Geest 1982) I have discussed this problem more elaborately.

6. 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),

7. The intertwining of formal and informal drug supply in Cameroon is discussed extensively in van der Geest 1985.

8. The lack of incentives and rewards as a debilitating factor in the public health sector of Cameroon is also mentioned in two unpublished World Bank reports (Awantang 1981 and 1983). Similar views are expressed by Ugalde and Homedes (n.d.) with regard to public health care in the Dominican Republic.

9. It is impossible to mention them all, but among the most important 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.

10. The consumer movement is a common phenomenon in Western industrialized countries but not in the Third World. Only recently have Western-based consumer action groups started to extend their activities to developing countries. A prominent example is Health Action International (HAI) which has been particularly active defending Third World consumers against expensive, useless and dangerous pharmaceuticals. An awkward problem, however, is that very little is known about the needs and wishes of Third World consumers themselves. Much socio-medical research remains necessary to ascertain "the interests of Third World consumers".

11. The adequacy of information on drug indications and counter indications has been challenged as well (see, for example, Silverman et al. 1982).

12. The case of Bangladesh is well known. When the government of that country implemented a new drug policy stressing banning the sale of expensive, non-essential drugs, pharmaceutical firms exerted considerable pressure to have the policy repealed (Chetley 1982; Melrose 1982b; Rolt 1985; Tiranti 1986).

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SUMMARY

The author pleads for a contextual approach to the study of pharmaceutical use and policy. To illustrate this approach, distribution of medicines in rural South Cameroon is examined. Discussion shows how existing problems are linked to national and international policies, multinational and international policies, multinational marketing practices, bureaucratic entanglements, urban-rural relationships and various additional economic factors.