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Drug vendors and their market: The commodification of health in Cameroon

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In Ebolowa, a provincial town in southern Cameroon, people buy pharmaceuticals on the market and in kiosks and stores, as is the case in many African towns. In the marketplace, among the stalls offering vegetables and household supplies, are those displaying capsules, vials, and tablets. I studied this informal sale of medicines in Ebolowa in 1980 and 1983 but – sadly - the situation is not very different today, thirty years later.

Pharmaceuticals are commodities and they go the way of all commodities—the market. The sale of medicines flourishes in many forms, from e-commerce on the internet to the hawker selling pills on a crowded African bus. Many kinds of drugs are legally sold over the counter (OTC) or by prescription in licensed pharmacies. But everywhere in the world, there is an informal market in medicines where nominally restricted drugs are sold without a prescription by people not authorized to do so. In many countries of the South, this weakly regulated trade is an enormous business.

The trade thrives because there is a growing felt need for medication. People world-wide increasingly believe that they need a pill for every ill. This eagerness for medicine assures demand. The globalization of pharmaceutical production and marketing assures supply, and also cultivates desire for drugs. Habitual use of medicines is encouraged by advertising and the experience of their broad efficacy in social life. But that popular enthusiasm for biomedical pharmaceuticals is also found in places where advertising and promotion barely reach.

Commodification of health is the term often used to denote the increasing use of pharmaceutical products to restore and maintain health. Researchers and social analysts point to the way that the focus on commodities obscures the economic, political, and environmental factors that promote health. They are also concerned that the lively business of medicines escapes official control, so that medicines are misused and people waste money. The underlying issue is whether the state should be, or can be, the guardian of its citizens, regulating medicines as public goods, and restricting their circulation as free commodities. In this essay I examine the issue of commodification by looking at drug sellers and their customers in Cameroon. These people's concerns are the direct result of global, national and local misappropriation of pharmaceuticals and a failing health policy. I will argue that the absence of a safe and professional distribution of medicines increases the commodification of health. Let me begin with some field notes which provide a lively picture of this micro pharmaceutical business.

Notes from a Cameroon marketplace

Mr. D. is an old man who sells Western medicines in one of the three markets of Ebolowa. He had been a cocoa farmer, but since losing one of his legs after an accident on his farm, he has tried to eke out an existence by selling medicines. Some forty different Western drugs are spread out on a small table in front of him. Of some kinds of medicine, only a small supply appears available, of others much more is in evidence. Some are in their original packing, others are in jars and boxes without a label. I estimate some 75% of his products would fall under the category of 'prescription-only'.

Many people are passing by, those who arrive in town and those who are waiting for a taxi. Some people leave their luggage with the old man while they do their shopping. The 'market' is a covered place about 10 meters wide and 30 meters long. It holds an estimated ten booths where one can buy snacks, drinks and daily necessities. In two booths medicines are sold. Between the booths are wooden benches where people

sit down to eat or relax in the shade, waiting for transport, conversing, or taking a nap.

I have just spent half an hour sitting with D. While I was there six clients visited him:

- A young boy comes and pays 25 francs and D. gives him three Quinacrine tablets (anti-malaria). These tablets actually cost 10 francs each, but D. explains that the boy is poor.
- Two youths. One of them buys six Tetracycline capsules for Fr. 50.
- A young woman with a child dawdles around and finally purchases six Mintezol tablets (for worms) for 375 francs.
- A man of about thirty-five, purchases without hesitation Nivaquin tablets (anti-malarial) and a vial of Bipeniciline (an injectable antibiotic). I ask who is going to give the injection and he replies: "I am, I'm a nurse." He then goes on to say that he used to be an "infirmier journalier" (a nurse with elementary qualifications) but that he lost his job, after which he became a planter. He now helps his neighbours when they have medical problems.
- A middle-aged woman who speaks in pidgin asks for a remedy for filaria. D. says that he doesn't have anything. He tells her to try the pharmacy. But she complains that she doesn't know which medicine to ask for. Once again, I become aware of the fact that many people are inhibited to go to the pharmacy. You can't casually look around, pick up medicines, and ask: "Have you got anything for filaria?" There are all sorts of people who stare at you, and the people behind the counter are different from yourself. They are not patient and friendly. You do not feel at ease. It is a bit like a hospital.

During another visit to D. I see a young man, looking through the vials of injectable antibiotics on the old man's table. He finds Almopen, notices its date of expiration (five years ago) and finally chooses Pénexilline. When I ask why he needs it, his answer is elusive. "It is an antibiotic, you can use it for all kinds of things, rheumatism for example." "But for what will you use it?" I ask. "It is not for myself, it is for my brother, I don't know why he needs it." I: "Why are you buying it here? Isn't there a dispensary in your village?" "Under construction," he replies. "Moreover," he adds, "the nurse is hardly ever at his post". I ask him, "Is the Almopen not good because the date has expired?" "You can't use it any more for an injection," he answers, "but it is still good for sprinkling onto a wound." When I discuss this answer later on with a pharmacologist, he comments that the sprinkling is not a bad idea.

Another young man buys two Penicillin tablets (each 500,000 units). I ask why he needs them. He is a prisoner (some prisoners move freely in town and can be hired for work by the town's notables for very low wages). Yesterday he visited a woman and this morning, when he urinated, he felt pain. So he thinks he has caught '*chaude pisse*' (gonorrhoea). I ask him if two Penicillin tablets are sufficient. His answer is no, but he has no more money. In any event, two are better than none. He asks if I can help him. I give him 200 francs and he buys another two tablets. The doctor with whom I discuss this conversation says that no venereal disease symptoms could appear so quickly. Furthermore, a dose of four such tablets is not sufficient for treating gonorrhoea.

When I arrive at the market, Robert, the other medicine seller, is busy making plastic covers for identity cards. A lucrative job: one for 450 francs. Today, he also sells bananas. When I want to buy four, he refuses to accept my money. He further sells notebooks, sunglasses, trinkets, safety pins, key hangers and portfolios. A woman passes and asks the price of 'white *Folkologo*' (Chloramphenicol). That is 30 francs for one capsule. She leaves without buying. When I ask him about the price he explains that the price may vary depending on how many there are at the market.

A few days ago, he explained to me the difference between red-yellow and white *Folkologo*. Only the red-yellow capsules are Tetracycline, but the people call both types *Folkologo*. The white ones are Chloramphenicol. They are stronger but help only against stomach ache and wounds. Tetracycline is effective against twelve diseases, for example diarrhoea, bronchitis, abscesses, menstrual pains, and gonorrhoea. "When you want to sleep with a woman who you suspect of the disease, you should first take a capsule. That is the most important function of Tetracycline."

A soldier buys six capsules of Ampicillin Totapen. It is his daily dose for gonorrhoea. The price of six is 900 francs. The man wants to reduce the dose to four per day, because he can hardly pay, but Robert convinces him that he should take six, otherwise he will not get healed properly. For one and a half hours the soldier is the only customer who buys medicines. Robert tells him that he should not have sex while taking the medicines.

A taxi driver, in a hurry, buys something which is not openly offered for sale. Robert takes it from below the counter and they argue about the price. With a razor blade Robert cuts a medicine strip into two. I

recognise the product: little silver bullets, Hovotest, a popular medicine to increase the libido. I ask the driver how much he has paid. "Too much," he says, "2500 francs for eight pills." That's why he was arguing. Later on I ask Robert why he hides the Hovotest. "Because it is forbidden." Sometimes they come to check and when they find it, he is in trouble. He does not know why it is forbidden. In actual fact, most of his medicines are 'forbidden'. I suspect that he hides them, because they are expensive and policemen will be more inclined to 'confiscate' them for private use.

A man buys fifty Tetracycline capsules for a reduced price, 10 francs per piece. He says he has an 'autorisation' to run a school pharmacy in his village. He regards himself as a first aid person in his community. He will sell the capsules for 20 francs. Other medicines in his possession are Nivaquin, Chloramphenicol, Penicillin (tablets and injections), Vermox, Piperazine, Combantrin and Solaskil. He buys them from Robert, the official pharmacy in Ebolowa and from the Ministry in Yaoundé.

I spent two hours at the market with a young medicine vendor, a Nigerian boy of about fifteen. It is Saturday afternoon. I note the country of origin, price and, if present, instructions for use for 42 medicines. The boy is very helpful; he knows all the prices by heart and shows me all the medicines about which I enquire. He apparently finds it quite normal that I write everything down. While I am there many people come and purchase medicines. I do not have the impression that they are disturbed by my presence. A lot of *Folkologo* the local term for Tetracycline, an antibiotic, is sold. People keep asking: "Have you got anything for worms?" or "What's that for?" People who do not know very much about medicines but who do not want to reveal their complaint may be able to find the right medicine in this way.

These observations show the kaleidoscopic character of the informal (and in most cases also illegal) sale of medicines. A wide variety of medications are available to customers trying to solve their health problems. Medicine vendors were making a living while offering a convenient, friendly service for which there was considerable demand. How are we to understand this example of medicines in the market? Two aspects of the context for drug marketing in Ebolowa provide a beginning: first, the realities of health problems; and second, the articulation of the formal and informal sectors of health care.

The context of drug vending in Cameroon

Ebolowa was the capital of the Province (*Division*) of Ntem. For the majority of the population who lived in the surrounding villages, agriculture was the most important means of subsistence. Ebolowa, with its 20,000 inhabitants, was not only the administrative centre but also the main place of trade, education, medical care, and other services.

The health situation in the villages left much to be desired. There was a shortage of clean drinking water and sanitary facilities. Pigs, goats, and other domestic animals wandered freely around; refuse disposal was insufficient; and the housing was often of bad quality. Certain food habits, such as that whereby the best food was reserved for the adults, especially the men, formed an extra threat to child health and was a cause of infant protein calorie deficiency. About twenty percent of the children under five years were malnourished and five percent were anaemic. Malaria and intestinal helminthiasis were the most common diseases for which the people in Ntem consulted the medical services. They were followed by skin diseases, colds and influenza, rheumatic complaints, bronchitis, and gonorrhoea. Measles with complications such as pneumonia, malaria, or encephalitis was by far the most important cause of death among children. Child (under five) mortality was estimated to be 150 per thousand and infant mortality 86 per thousand.

The health care system upon which people relied to deal with these problems was a composite one. In Ntem Province were three hospitals offering 450 beds together. The two largest, with a total of four hundred beds, were both situated in the capital Ebolowa, about five kilometres apart. In addition to this, there were 45 health centres and only one officially recognised pharmacy. Other facilities, especially primary facilities such as herbalists, traditional midwives, informal medicine sellers, neighbourly help, and of course self-help, could not be expressed in figures. The formal sector included those facilities operated by or authorised by the state, while the informal part of the health care system comprised all the rest including Mr. D. and his colleagues selling medicinal commodities in the marketplace.

Elsewhere (Van der Geest 1988) I have argued that the informal trade was intrinsically connected to the formal sector (which also included private mostly church-related, hospitals and health centres and commercial pharmacies) and could not be understood unless that articulation was taken into account. The public health services did not function as they should. They were often short of medicines and other materials and many of their nurses and doctors felt frustrated about their jobs. They could not do their work due to these shortages and their living conditions were often poor. Their patients blamed them for not being able to provide proper care. In the period of my research medicines and treatment in the public services were officially free of charge, but often patients had to pay something in order to get help. Not infrequently patients also discovered that no medicines were available at all and they had to travel to the nearest shop or pharmacy to buy the prescribed medications. 'Nearest' could mean up to a day of travel, including the time spent waiting for transportation. Sometimes they did not even find anyone present at the health centre. In actual practice, therefore, the so-called free service often proved to be quite expensive because it forced people to pay for transportation and to buy their medicines elsewhere. It also cost them considerable time.

Solutions to these problems were available in the *informal* private sector where medicines were traded. Those taking part in this trade constituted a heterogeneous group. Most were ordinary vendors who sold general provisions, including medicines, in shops and kiosks. In Ebolowa there were approximately 75 such shops and kiosks where one could purchase at least one or two types of medicines. A second category consisted of market vendors who sold medicines alongside other products. A third group could best be referred to as 'hawkers'. They travelled from village to village during the cocoa harvest season when the villagers had some extra money at their disposal. These hawkers provided a variety of articles in addition to medicines. A fourth category consisted of traders like Mr. D. who were specialised in the sale of medicines and had a much larger assortment than the previously mentioned groups. In Ebolowa four such traders were encountered. They not only sold medicines but also gave medical advice when asked. One of them gave injections as well. A fifth group comprised medical institution personnel. Some of them privately sold medicines (in their homes), which were supposed to be provided to the patients free of charge.

Sellers of medicines in the informal sector mainly obtained their products from three sources: medicines were smuggled into Cameroon from neighbouring Nigeria and distributed throughout the country; they were purchased -without prescriptions- from legally established pharmacies and sold at a profit; and they were bought from medical service personnel who thus tried to earn some extra income.

These private services—both formal and informal—were living proof of the malfunctioning of public health care. They existed because and where the public services did not achieve their objectives. I estimated that about one-half of all modern health care delivery in Cameroon occurred outside the public (state-owned) services. The informal circuit had acquired a crucial position in daily health care, next to the private hospitals and health centres.

There were at least four reasons why informal drug vendors responded better to the needs of poor people than the formal institutions. All four were related to availability and attainability. First, drugs from vendors were more affordable. Clients could purchase as little or as much as they needed for self-treatment at that moment. In contrast, the pharmacist in town only sold medicines in their original package which could be too costly for some clients. Second, drug vendors were geographically more accessible than other sources. A vendor could always be found within a radius of a few kilometres from where one lived, but a pharmacy or health centre with drugs might be 50 or more kilometres away. Third, most vendors were available day and night. Their shops only closed when everybody had gone to bed; even after 'closing', it usually was possible to buy medicines if necessary. This flexibility contrasted sharply with the strict time schedule to which the formal services adhered. The fourth reason for the drug vendors' popularity was that the social distance between provider and client was much smaller than in the formal sector. In a shop it was possible to look around, examine various products and ask questions about how they should be used. Such behaviour was not possible in a hospital or professional, well-regulated pharmacy where social distance between users and providers was pronounced.

However, there were also disadvantages in buying from an unauthorised drug vendor. Clients knew, for example, that the products they bought were often of inferior quality. The choice of medicines was limited and vendors were known to have little medical knowledge. The preference for a drug vendor should, therefore, be viewed within the context of the total range of

therapeutic choices. People with a medical problem would first try a treatment which cost them little. Only when this failed, would other, more costly and more inconvenient, steps be taken. The process of commodification should be understood within this particular context of a failing health care system.

The commodification of health

The thriving sale of drugs in Ebolowa has parallels in many low-income countries. In African towns and rural areas, medicines are sold in shops, markets, by vendors in bus and lorry parks, and by sellers who peddle their bicycles from village to village (Fassin 1987; Senah, 1997; Alubo 1987; Akubae and Mbah 1989). In Asia and Latin America, the business of medicines is equally or even more lively. Biomedical drugs are even sold by 'traditional healers' and 'traditional' or natural medicines are packaged and sold on the model of biomedical commodities (Wolffers 1988, Miles 1998, Afdhal and Welsch 1988; Tuchinsky 1991, Bode 2002). The increasing availability of medicines as products for sale has been called commodification or 'commoditization'.

Making medicines common

The first set of concerns has to do with the way medicines are made *common*. The theoretical approach here starts with cultural economics and focuses on the way things are imbued with use and exchange values. Appadurai suggests a definition of commodity as "any thing intended for exchange" (Appadurai 1986:9). His methodological focus on 'the social life of things' makes it possible to ask questions about their 'commodity-hood' (ibid: 13): that is, when and how their exchange potential is realized.

Kopytoff (1986) proposes that we understand commoditization in terms of a contrast between the singular and the common:

To use an appropriately loaded even if archaic term, to be saleable or widely exchangeable is to be "common" - the opposite of being uncommon, incomparable, unique, singular, and therefore not exchangeable for anything else. (Kopytoff 1986: 69)

He suggests that categories of things may be more or less commoditized, that is, more or less freely exchangeable. Money, as a technology of exchange, tends to facilitate commoditization; Kopytoff writes of the 'drive to commoditization' — 'to extend the fundamentally seductive idea of exchange to as many items as the existing exchange technology will comfortably allow' (ibid.73). Kopytoff sees commoditization as a pressure exerted against cultural tendencies to particularize value.

The conventions that restrict certain kinds of drugs to professional control provide examples of the tendency towards singularization. Prescription-only drugs are discriminated as having a particular value. In Appadurai's terms they are 'enclaved commodities' whose social life is restricted in that they are not meant to be made common through free exchange. However, that is exactly what has happened in Ebolowa and many other settings. Drugs that are supposed to be dispensed by trained health workers in authorized medical facilities are 'illegally' bought and sold in free markets. Appadurai and Kopytoff give us abstract analytical frames for asking about the general commodity status of categories of medicine. Ethnography, like that from Cameroon, reveals the historical circumstances in which drugs become common as the public formal system with its conventions and restrictions is weakened and intertwined with the informal system of drug vendors.

The 'fundamental seduction' of commoditization is evident in an increasing commercialization of medicine. More and more types and forms of medicines are commonly available for sale. But this fundamental seduction takes the form of particular attractions in specific situations. As Van der Geest suggested, the residents of Ntem Province were charmed by the availability and easy attainability of the medicinal commodities offered by the vendors, which they compared to the shortages and restrictions of medicine in the formal sector where its commodity career was more limited. They liked the convenience of time and place, they appreciated being able to buy according to their means, they were persuaded by discussions in which they could participate.

In so far as commoditization makes medicines common, it makes them all the synonyms of common: popular, general, ordinary, familiar. In the Ebolowa market people were able to examine

and handle a large variety of drugs; as commonalities they were up for discussion, open to interpretation, and easy to acquire. Tetracycline, chloramphenicol, and ampicillin are treated like bananas and safety pins—as ordinary wares. The implications of this are enormous: the drive to commoditization is a motor by which substances—*materia medica*—become more and more popular as ways of understanding and managing health and illness.

Making health a commodity

This leads to the second set of concerns about medicines as commodities, the critique that health itself is being commodified through the business of medicines. Here we move beyond a focus on the social life of things, to ask about the cultural and social implications of medicines as commodities. Are they being used in an attempt to solve problems that should be addressed in other ways? Are people deceived to think that health can be attained through medicinal commodities?

In the Ebolowa market, one could say that sexual health had been commodified. The taxi driver who bought the little silver bullets known as Hovotest was buying sexual potency, he hoped. Others purchased antibiotics to prevent and treat sexually transmitted infections (STIs). The prisoner who had visited a woman the day before and now feared gonorrhoea was trying to ensure sexual health by means of a commodity. In principle, there are other ways. He could have refrained from visiting the woman. The state could distribute free condoms and offer an effective programme of information, education, and communication about STIs. Hospitals and health centres could avail user-friendly free treatment that would bring down the frequency of STIs and obviate the need to go shopping for antibiotics in the market. In practice, the other alternatives were purely hypothetical for the vendors and their customers. The question is whether they would have been pursued if sexual health had not been commodified in this way.

These were issues powerfully raised by Scheper-Hughes (1992) in her study of the violence of everyday life for poor urban people in north-eastern Brazil. She showed how poverty, hunger, and worry were defined as medical problems and treated with drugs, in an argument similar to the medicalization issue discussed in Chapter 4. 'If hunger cannot be satisfied, it can at least be tranquilized, so that medicine, even more than religion, comes to actualise the Marxist platitude on the drugging of the masses' (ibid.: 202-203). She speaks of the complicity and bad-faith of health workers and pharmacists who supply drugs to people in far greater need of decent living conditions. But she also writes of people's own faith in drugs which have a 'lethal attractiveness' as a means to fortify bodies ultimately weakened by social injustice (ibid.: 200).

Nichter, who did fieldwork in India and Sri Lanka, extensively discusses the popular belief that health can be obtained and maintained through the consumption of commodities, medicines (Nichter & Nichter 1996, Nichter and Nordstrom 1989). Buying medicines is viewed as a "quick fix", the most convenient and cost effective way of taking care of one's health for those who do not have the time and the means to live a truly healthy life. Nichter emphasizes the 'false consciousness' involved in this type of behaviour: 'a false sense of health security is fostered by the inflated claims of medicines...' (Nichter 1989: 235). He introduces the term 'Pharmaceuticalization', a process which he regards as a form of 'fetishisation' (cf. Ellen 1988): attributing power to medicines beyond their active ingredients. Like Scheper-Hughes, he emphasizes that the focus on medicinal commodities is promoted by the pharmaceutical industry and supported by those with political power who want to be seen as providing health. But it distracts people from recognizing and dealing with the sources of their problems: 'The false consciousness generated by health commodification serves to undermine the impetus to participate in ecological-environmental based popular health movements in a context where they are of crucial and immediate importance' (ibid.).

Yet Nichter also points out that the commodification of health through pharmaceuticals cannot be explained simply as an invasion by drug companies or a deception perpetrated by the politically powerful. His rich ethnography continually shows that people as social actors make use of commodities for their own ends. While they may neglect the political economic sources of ill health, they are using commodities to deal with other problems. His writings contain two tendencies that Miller (1995) finds in much of the anthropological work on consumption and commodities: on the one hand, an ethical (moralizing) stance that sees commodification as a danger to be resisted; and, on the other, a recognition that commodities may be actively appropriated for social projects.

The cases Nichter describes are mainly set in bustling Asian cities with stark contrasts between poor and rich inhabitants. For the worker who cannot afford to stay home sick, a wonder

pill or injection seems the best alternative. Hardon (1991) too describes how people in the slums of Manila, facing the dilemma of poverty and poor health, see no better choice than consuming drugs. What may be irrational and harmful from a medical point of view makes sense in a particular social and economic context.

Several factors promote the commodification of health according to Nichter. The hectic pace of life in the city and the harsh working conditions increase the demand for tranquillisers; and the polluted environment motivates the use of medicines which clean the blood, remove gas and improve digestion. The easy access to medication – a doctor's prescription is not required – further encourages a high rate of routine self-medication.

Especially in the eyes of the poor, having money seems the best guarantee for good health, because one can buy medicines. Nichter illustrates this graphically with the reaction of a young boy who had the chance to peek into his first aid kit: "He sighed and told me that with such medicines one could go anywhere without fear" (Nichter & Nichter 1996:275). Medicines seem to offer the possibility of control, as suggested in Chapter 4. If life is uncertain and dangerous, there is security in these little but powerful objects. The prisoner in Ebolowa market, worried about the health consequences of having visited a woman the day before, was trying to exert some control over his situation.

Rejecting this attitude as false consciousness, bad faith, complicity, or deception is not entirely justified. For people living in a hostile and unhealthy environment, using medicines may be the only means left to keep going and maintain their self-respect. Medicines are not only placebos in a medical sense; they also have social and political effects, as we saw in Chapter 2. They are a way of coping with situations of social and economic stress. Reeler (1996), who carried out fieldwork in rural and urban communities in Thailand, points out that money, however little, can be a crucial mode of empowerment in the struggle for health. It allows people to make an exchange, to choose a commodity without being dependent on an inconvenient, patronizing and demeaning formal health care system.

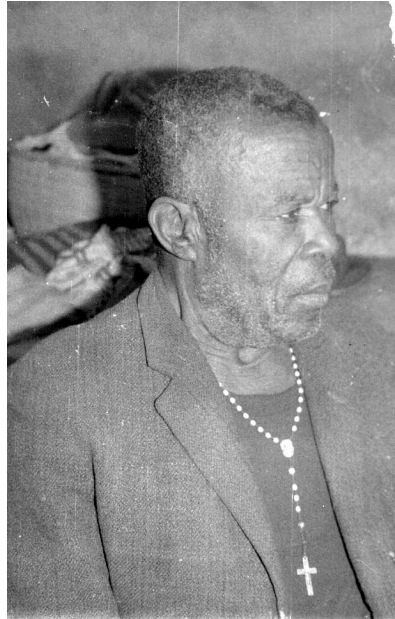
Conclusion

The contrast between the throbbing life of an Asian city and the sleepy atmosphere of a Cameroonian rural town may look great, but both show us conditions in which commodification and Pharmaceuticalization of health seem to flourish. In both situations environmental health is poor, sex is dangerous, food expensive, work insecure and proper health care difficult to come by, while pharmaceuticals are easy to get in local markets and simple kiosks around the corner. It is true that Mr. D.'s 40 different drugs do not resolve the problems of sanitation and nutrition in Ntem Province. But there, as elsewhere, commodification is a solution to other immediate difficulties in accessing health.

Ironically, the exaggerated expectations of pharmaceuticals keep not only the customers but also—even more so—the drug vendors going. To them, pharmaceuticals are not so much products to alleviate suffering and improve health but first of all things to sell and, for that matter, valuable ones. They too need them to survive. Commodification proves 'salutary' to buyers and sellers alike in a setting where the state is responsible for injustice and suffering in general living conditions and fails to guarantee decent health care.

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