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Planning for essential drugs: are we missing the cultural dimension?

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Introduction

The World Health Organization's (WHO's) essential drugs policy is now more than ten years old. The plan has been widely praised, and more than 80 developing countries have taken steps to follow the WHO recommendations (although very few have fully implemented them as yet).[1,2] In this first decade, the assumption seems to have been that the main problem to be solved is that of *supplying* suitable and adequate drugs to all health facilities. Very little attention has been given to the question of what actually happens to the medicines provided. We suggest that the time has come to reorientate essential drugs policies towards the improvement of drug *use.* By this we do not merely mean the upgrading of health workers' prescribing habits, although that is important too. The more radical approach we advocate here is based on the recognition that social and cultural forces shape both the distribution and use of drugs. Essential drugs provided to developing countries are subject to local patterns of transaction and modes of understanding that must be taken into account in programme planning.

In examining the cultural contexts of pharmaceuticals, it is helpful to distinguish two kinds of processes: commoditization and cultural reinterpretation. By commoditization, we refer to the fact that medicines have a life as commercial items.[3] As highly valuable commodities, they easily pass out of the control of biomedical professionals. Drugs undergo cultural reinterpretation when they are fitted into locally existing frames of understanding; they move from one context of meaning to another. All drugs, including those which reach peripheral rural health facilities as part of an essential drugs programme, may be subject to commercial transactions and locally specific interpretations.

The commercial context of medicines

Since the commercial interest in medicines is so great and the medical infrastructure in many developing countries relatively weak, it is not surprising that medicines are easily diverted from the formal distribution channels controlled by professionals to the free market. In most third world countries, there is a lively trade in medicines which flourishes despite official restrictions.[4] It is well known that drugs which are supposed to be dispensed only with a doctor's prescription, are recommended and 'prescribed' by people who are not qualified to do so. In this situation the public and private, and the formal and informal, sources of drugs are closely related.

This was examined in research in Cameroon,[5,6] where shortages of medicines are frequent in government facilities, particularly in the rural hospitals and health centres. When people hear that a health facility is without drugs, they do not bother to attend. The informal sector provides an alternative. Shops, kiosks and market booths have drugs among their stock. A jar with red and yellow tetracycline capsules between the heaps of fruit and vegetables is a familiar sight. Pedlars,

on foot or bicycle, move from village to village, selling textiles, shoes, ornaments - and medicines. Doctors, nurses and other personnel in hospitals and health centres 'redistribute' supplies obtained at work to relatives, friends and 'relevant others'. Sometimes they sell drugs clandestinely to drug vendors in the market. Information about how the drugs should be used is passed by word of mouth. In brief, pharmaceuticals meant for use under medical supervision have become part of a comprehensive self-help pattern in Cameroon.

The paradoxical effects of this situation are common to many developing countries. On the one hand, the informal transactions undermine the established health system, as when scarce medicines move from the formal to the informal sector, thus aggravating the shortages in the health services. On the other hand, the informal activities fill the gaps in the formal sector; they have become indispensable, particularly in the rural areas, where the existing services function badly and are poorly accessible.

What will happen when an essential drugs policy is implemented? *If* a steady, sufficient supply of medicines is ensured in the public health facilities and *if* primary and secondary health care function efficiently, then there would be little need for an informal trade in pharmaceuticals. These conditions are still a long way off in most developing countries. In the meantime, it is likely that essential drugs will be diverted into the informal sector, where all kinds of people try to improve their health, finances and social situations by selling, buying and using medicines.

It is significant that most countries working on an essential drugs plan seem to exclude the private sector. In that way, opposition is diminished from doctors, who wish to maintain their freedom of prescription, and businessmen, who want to maintain profits. In fact, they may even see advantages in the programme. The pharmaceutical industry is increasingly willing to support essential drug policies that do not restrict drug distribution in the private sector. Essential drug programmes represent an expansion of the market for cheap generic drugs that are supplied to people who could not previously afford any pharmaceuticals at all. For local politicians, the supply of valued goods to health centres in remote rural areas is attractive, as it gives the impression of active concern. Attempting to control the private sector would almost certainly be politically unpopular; furthermore many politicians and civil servants (including government health workers) have economic interests in the private sector.

It is unlikely that the essential drugs plan will succeed if the reforms are limited to one sector only. Doctors will continue to prescribe 'non-essential' drugs because they believe them to be better - their main source of information is the drug industry - or because they can make more profit from them.[7] Obviously, sellers of medicines, both pharmacists and informal vendors, will continue to recommend the more profitable pharmaceuticals, which may not include essential drugs. (For example, see Wolffers' report on the sale of allopathic drugs by Ayurvedic practitioners in Sri Lanka.[8]) And clients will continue to buy 'non-essential' drugs because they are made to believe that they are better and perhaps also because they are more readily available.

Cultural reinterpretation of medicines

It is well known that items from one cultural context may be given a very different meaning when they are introduced into another one. Pharmaceuticals developed according to scientific paradigms are separated from their biomedical context and integrated into other culturally specific modes of understanding. There are always pre-existing concepts about treatment and medicines which form a basis for the cognitive appropriation of new drugs. When drugs are 'freed' from the control of professional health workers, through the processes of commoditization described above, it becomes particularly important to be aware of the popular beliefs that guide self-medication.

Since Logan's pioneering discussion of how Guatemalan villagers categorize western drugs as 'hot' or 'cold' in accordance with their own illness classification,[9] a number of studies on the process of cultural reinterpretation of pharmaceuticals have appeared. Examples may be found in Sierra Leone,[10] Jamaica,[11] Brazil,[12] and other parts of the developing world.[13]

Hardon,[14] who did fieldwork in two poor quarters of Metro-Manila, Philippines, observed that her informants were often directed by the idea that medicine must 'suit' them (in local terms, be *hiyang*). People believe that a drug which is good for one person can be wrong for another. So, if people come to the conclusion that a particular medicine is not good for them, they will refuse to take it, even if the drug seems 'essential' from a biomedical point of view. For the same reason, they may decide to take a medicine which is 'wrong' according to the doctor. For lay people, the concept of *hiyang* can conveniently explain the inefficacy of a therapy. If the drug does not work, then it was apparently not suitable for the individual. It also provides people with a way of choosing between the many drug brands on the market.

Cultural reinterpretation is never simply a matter of fitting new items into consistent and unchanging 'traditional' modes of thought. Lay people's ideas about drugs are formed according to their experiences and situations; a number of different conceptions about a particular drug may coexist in the same local culture. Field research suggests that medical beliefs, far from being characterized by conservatism, are an area of great cultural creativity.

In South Cameroon, for example, the head nurse at a leprosarium explained that local villagers were keen on buying medicines taken by the lepers, especially Disulone (Dapsone).[6] Some people were interested because they thought Disulone would give them more energy for hard work, having seen how active the lepers were in agriculture and handicrafts. Others thought the medicine would increase their sexual energy or fertility.

During recent fieldwork in Eastern Uganda, a lively pattern of self-medication was found to be flourishing alongside the essential drugs programme.[15] Consumers developed their ideas about how to use the 'essential' and 'non-essential' medicines for sale in shops and private clinics, through discussions with relatives, neighbours, shopkeepers and government health workers (many of whom were in private business in addition to their main employment because of the low salaries in government service). The notion that wounds heal best if one empties antibiotic capsules into them, and the idea that a powerful treatment should be composed of many different kinds of tablets and capsules crushed together, were part of a popular culture.

Conclusion

Although drugs are understood in local terms, those terms are constantly being revised. There are two implications for an essential drugs programme. First, if education about drug use is to be relevant to lay people, it needs to be tailored to local conceptions and practices. Second, providing information about drugs is appropriate because people are open to new ideas in this area. They are already observing, experimenting and seeking information from the sources available to them.

The essential drugs policy has used concepts like 'need', 'rational' and 'essential' as they are defined in western biomedicine. The possibility that consumers of these drugs might be assessing them in very different terms does not appear to have been considered. Anthropological research has shown that 'competing definitions' of drugs abound and that other interpretations lead to other uses of medicines.

Changing the way the consumers use drugs cannot be accomplished simply by tighter controls. In most developing countries, government authorities lack the resources for systematic enforcement of drug regulation. Information about medicines must be disseminated so that people themselves have a better basis for deciding how to use the drugs available.

A first step is restricting the number of drugs, not only in the public, but also in the private sector. This is not only a control measure; it is a pedagogic one, in that it is easier to educate people about a smaller number of medicines. It must be accompanied by better training of both public and private health workers in sound principles of prescribing.

Awareness of this need is increasing, but the importance of health education for lay people on drug use is not yet widely recognized. It is no good pretending that patients in developing

countries take only medicines prescribed by trained practitioners and that there is no need to teach them about self-medication. Effective health education involves a dialogue about actual conceptions, practices and problems. A constructive dialogue is necessary if medication issues are to be incorporated in community health care. In this way the consumers of drugs may be brought into the essential drugs programme.

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