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Training Shopkeepers and Schoolchildren in Medicine Use: Experiments in Applied Medical Anthropology in East Africa

A five-day workshop, “People and Medicines,” was held in November 1998 in Mbale, Eastern Uganda, which brought together researchers from different disciplines working in Uganda, Kenya, and Tanzania in the field of medicines. The aim was not only to generate new research questions and methodologies, but also to discuss possible interventions to improve medicine use.

In 1980 when I started anthropological research on the use and distribution of pharmaceuticals in an African country, this was a relatively new topic. Anthropologists traditionally have studied indigenous medicines, including the use of herbal concoctions and magic objects. In 1980 aspirin, chloroquine, and tetracycline were considered unusual things to study—too ordinary. But when anthropologists started to publish their research findings on pharmaceuticals, they revealed that these familiar tablets and capsules had turned into exotic substances. Pharmaceuticals were being used outside the controlled domain of medical doctors, in ways that were far remote from the biomedical rules (van der Geest 1981). Herskovits’s term *cultural reinterpretation* was resuscitated to describe the different perception and taking of Western medicines in non-Western cultures (Bledsoe and Goubaud 1988). Others spoke of the “indigenisation of pharmaceuticals” (Haak and Hardon 1988).

Now, almost twenty years later, the ethnography of pharmaceuticals is well established (see van der Geest et al. 1996). It is generally known, for example, that prescription-only medicines are freely available in unlicensed drugstores and general stores and on open markets in most countries of the world. It also is well known that these medicines are sometimes used in highly imaginative ways, or, to put it more bluntly and from a biomedical point of view, wrongly—that is, for the wrong purpose, in a wrong manner, and in a wrong dosage.

The cultural differences in medicine use have placed the anthropologist in a difficult position. On the one hand, he or she respects a particular people’s point of view with regard to medicines and argues for its rationality. On the other hand, he or she cannot deny the harmful consequences of “inappropriate” drug use. Medicine taking has proven to be an awkward test case for the anthropological virtue of cultural relativity.

An appropriate reaction for the medical anthropologist should be to apply his or her cultural understanding to improve the methods of medicine use in the community, but application has been more honored in words than in practice. Anthropologists have largely restricted themselves to publishing, in the best cases adding some recommendations for policy. They have rarely gotten their hands dirty by getting involved in practical action. Medical doctors and social scientists, united in the International Network for Rational Use of Drugs, have attempted to improve doctors' prescription habits, but it is clear that better prescription can improve drug use only minimally in countries where people generally bypass doctors and prescriptions when they purchase their medicines.

Recently, however, medical anthropologists have begun to add their weight to the improvement of medicine use. At the workshop in Uganda various intervention initiatives were presented and the first results were discussed. The starting point was ethnographic research, which showed that up to 70 percent of medicines used for health problems were purchased outside medical settings and without any involvement of qualified prescribers. The main sources proved to be drugstores and general stores. This was particularly true for antimalaria drugs. Malaria is the most common cause of death among children in Uganda (Odoi Adome et al. 1996), Kenya, and Tanzania.

Together with pharmacologists and other colleagues, anthropologists in East Africa have now directed intervention programs to where the medicines are dispensed: in the household and in shops. In addition, they plan to experiment with teaching correct medicine use in local schools.

A researcher from Uganda described the difficulties encountered in attempting to organize training for shopkeepers. In the view of medical authorities, shopkeepers should not touch medicines. According to the law "no person should mix, compound, prepare or dispense any restricted drugs unless that person is a registered pharmacist, medical practitioner, dentist, veterinary surgeon or a licensed person." Action researchers, therefore, should certainly not teach shopkeepers how to handle medicines. It would only legitimize an illegal and dangerous practice. The fact that most medicines are distributed by shopkeepers was something anthropologists should ignore. Moreover, asked Ugandan authorities, why should researchers bother about policy? It was their task to write books and articles and pursue Ph.D.s. They should stick to that.

In spite of this opposition, Ugandan project personnel are now starting to train drug shopkeepers, but they cannot get permission to train the keepers of the ordinary shops that supply a large proportion of the drugs people use for the most common symptoms. The training has started in one district.

In Kenya, in a rural coastal area, more progress has been made. In April 1996, 46 shopkeepers from 23 shops were trained during three workshops, each lasting three days. They were taught how to determine correct medication against malaria and how to advise their customers on correct use. The results of this training, which were measured a few months later, were spectacular: the percentage of sales of antimalarial drugs in appropriate dosages rose from just over 30 percent before the training to over 80 percent after the training. The percentage of childhood fevers treated with a correct dosage of chloroquine rose from 4 to 66 percent.

The results suggest that the training of shopkeepers has a tremendous effect on appropriate use of medicines in the household. The project continues and in

January 1999 a much larger number of shopkeepers started their training. The enthusiasm of the shopkeepers is remarkable. Clearly, they expect to benefit from their training. As members of the community, they gain respect and trust through participation in the course, and they will attract more customers.

As noted, a second idea under consideration is to teach children in schools how to use certain medicines. Children in Africa may be at the bottom of the social hierarchy, but they are given responsibilities in the household, and in various social situations they act as adults. Research has shown that some do handle medicines independently (e.g., Geissler 1998). A program to train teachers to instruct children in correct medication is now being developed. It will certainly meet a lot of resistance: like shopkeepers, children are supposed to be kept away from medicines.

I regard these instances of participatory training in East Africa as exemplary experiments in applied medical anthropology. They are successful attempts to overcome ethnocentric, medicocentric, and adult-centric views in the application of anthropological research.

NOTE

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