*Original Article*

# ANTHROPOLOGY AND PHARMACEUTICALS IN DEVELOPING COUNTRIES

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In the past few years we have seen the publication of a spate of books and articles denouncing the sale of pharmaceutical products to Third World countries. The authors are economists, pharmacologists, physicians, and journalists. Remarkably, medical anthropologists have been virtually absent from this highly topical discussion. In this regard I want to briefly summarize some of the most important publications on the topic and to discuss why anthropologists remained passive and what their future role could be.[1]

## Pharmaceuticals in Developing Countries

One of the pioneering studies in this field is Silverman's (1976) *The Drugging of the Americas,* which simply shows that the information attached to drugs distributed in Latin America differs considerably from the information provided to consumers in the United States. In the Latin American countries it was found that indications for use of the drug are far more numerous than in the United States and that contraindications are fewer. The implicit accusation is clear: pharmaceutical firms alter their drug inserts in developing countries to sell more of their products. It seems that this book has had a considerable impact in pharmaceutical industry and U.S. government circles.

Two years later, Earthscan, a British information unit on development and environment issues, published a simple offset document, *Drugs and the Third World* (Agarwal 1978). This useful document provides a collection of very concise statements about facts and developments regarding drugs in the Third World. The issues touched upon include the structure of the pharmaceutical industry, the WHO basic drugs policy, bulk purchasing of drugs, traditional herbs, and appropriate drug technology.

Gish and Feller (1979) discuss how the supply of pharmaceuticals in developing countries ought to be adapted to primary health care needs. They carefully explain how pharmaceutical production and marketing work. They distinguish three phases in this process: the supply by the industry, the procurement by Third World countries, and the utilization by health workers and patients. The authors show that obstacles to a more suitable drug distribution lie in all three phases. The pharmaceutical multinationals are difficult to control because of their oligopolistic tendencies. Their sales promotion, the patent system, and their ingenious pricing methods are discussed. As a result, governments often fail to implement WHO guidelines (1977, 1979) for the procurement of essential and cheap medicines. Other results are that doctors overprescribe (cf., Barnett et al. 1980) and that pharmacy workers and unqualified drug traders sell potent drugs straight to the public without a doctor's prescription. The authors plead for increased self-reliance in the production of essential drugs and for integration of drug distribution in primary health care services.

Melrose (1981) has written a case study of medical problems in North Yemen. The colorful title of her booklet, *The Great Health Robbery,* indicates that she addresses the general public and not a limited group of academic "insiders." She relates Yemen's medical problems to some peculiar economic factors. About one-third of the Yemeni men have migrated to work in the rich oil-producing Gulf states. Agriculture at home is being neglected, but people in Yemen have more cash money than a decade or longer ago. The outcome is ironic: more cash has worsened people's health because people spend their money on products that damage their health. Dangerous bottle-feeding has frequently replaced breast-feeding and expensive Western drugs, many of which are wrongly used, cause considerable damage. Life expectancy in Yemen is now 39 years, one of the lowest in the world.

At least five important books on pharmaceuticals were published in 1982. Medawar and Freese (1982) give a detailed description of the polemic between an action-research unit and a pharmaceutical company on the sale of Lomotil, an antidiarrhea drug, in developing countries. Lomotil is an example of a drug which, in an industrialized country, under doctor's supervision, may be useful, but which proves dangerous and harmful in a developing country where it is sold freely over the counter and used for self-medication. The title of the book, *Drug Diplomacy,* refers to the way in which the company defended the use of Lomotil by children in the Third World. The company's use and manipulation of "scientific" research tests to defend its case is particularly interesting.

Muller (1982) has written a popular book that covers most of the information collected so far on the conduct of pharmaceutical firms in Third World countries. A serious consequence of their sales policies is the harmful medical effect resulting directly from the use of their drugs. But even more serious, according to Muller, is that the purchase of useless drugs costs so much money that people no longer have the means to take the necessary measures for real health improvements. Muller distinguishes between "effective," "efficacious," and "efficient" drugs. "Effective" drugs are those capable of producing result, as proven in the laboratory. Whether a drug is "efficacious" depends on how it is taken. An effective drug will not be efficacious if it is wrongly used. A drug is "efficient" if people can afford buying it. Expensive drugs in poor countries are therefore inefficient for most of the population. Muller, too, recommends the adoption of the WHO guidelines on essential drugs and the development of a pharmaceutical industry in the Third World countries.

The most complete and best documented study in this field up to now is probably Melrose's (1982) book *Bitter Pills.* She reveals the underlying causes of ill health in the Third World and the unequal distribution of health services. Focusing on drugs, she discusses their marketing and promotion by pharmaceutical firms, their prices, and their hazardous use by uninformed clients. She provides six examples of small-scale attempts at improving the pharmaceutical situation in Bangladesh, India, Nepal, and Mexico. The final chapters are devoted to general solutions and obstacles to the enhancement of drug supply in the Third World. The author's affiliation with the British organization Oxfam has enabled her to consult numerous sources to which it is difficult for ordinary research to get access. More-

over, she has carried out extensive interviews all over the world. The result is indeed an admirably comprehensive book that can be read both by experts and the general public.

A German publication written by an economist (Bühler 1982) focuses on the role of pharmaceutical multinationals in the Third World and on how their influence can be counterbalanced. The most recent publication is a Dutch book by a physician-journalist (Wolffers 1983) on the marketing of anabolic steroids by a Dutch pharmaceutical concern in Bangladesh and some other developing countries.

The last study I want to discuss here is Silverman et al. (1982). The authors add little to what already has been said, but they are less radical in their denouncement of the pharmaceutical industry. They point out that robbing it of its profits would not provide a solution but rather would make things worse. Abolishing patent protection for new drugs, for example, would be "a short-term boon for some countries but a long-term disaster for the world. It would effectively choke off much if not most of the industry's research and the development of better drugs" (Silverman et al. 1982:139). Similar sentiments have been expressed by other critics who fear that a total decommercialization of drug protection will have adverse effects. The most dramatic pronouncement on this issue has been made by Lall, an economist who used to be one of the most influential critics of the pharmaceutical multinationals (Lall 1974, 1975, 1978; Lall and Bibile 1978). In a recent address (Lall 1982) to the International Federation of Pharmaceutical Manufacturers Association (IFPMA), he has admitted that his earlier plans for a comprehensive government control of drug production and distribution were too optimistic.[2] In his own words (Lall 1982:2, 3):

> It is easy to conceive of ideal systems. If we assume . . . that governments are omniscient, incorruptible and flawlessly efficient, we can construct beautiful models of how they can function to society's best interests. The costs of the market system can be avoided. Both short-term and long-term welfare are optimised. . . . Regulation is not, however, a costless process. Regulatory systems which seem ideal in theory turn out to be cumbersome and counterproductive in practice. And some systems are not ideal even in theory: they are founded on mistaken premises and an imperfect understanding of economic phenomena. . . . I came to realize that though the market system does not work perfectly, it works efficiently. A highly regulated system can choke off the mainsprings of economic growth if it attacks the generation of profit and innovation which sustain it. And a highly regulated system which has several conflicting objectives, and which is badly administered, usually ends up by achieving none of its objectives.

The debate between moderates and radicals highlights one of the key questions on pharmaceuticals in the Third World: does profit making by definition lead to the deterioration of health, because profits are put before people? Or can profit making be made subordinate to the improvement of health and medical care? If the former question is answered in the affirmative, new questions arise, the most important being, What workable alternative is there for a commerce-oriented drug production? And do we know examples of countries or societies where such an alternative has proved successful? But if the latter question is answered in the affirmative, under what conditions, how, and to what extent can profit making and health improvement go together?

Here, the absence of solid case studies of drug distribution and utilization in specific communities makes itself felt. The discussion between moderates and radicals threatens to turn into a metaphysical debate as to whether humanity is essentially good or bad. Or it degenerates into trivial political tirades, as have some discussions between the pharmaceutical industry and its critics.

### Anthropology and Pharmaceuticals

Why have anthropologists largely remained passive while students of other disciplines conduct research into the problems of pharmaceutical distribution in developing countries? In a recent survey of literature on illegal drug distribution in developing countries (Van der Geest 1982a) I came across only one anthropological study focusing on the use of pharmaceuticals, Ferguson's (1981) case study of a town in El Salvador. Another study (Cosminsky and Scrimshaw 1980), which I noticed only after completing the survey, deals with the growing acceptance of pharmaceuticals in Guatemala. My own anthropological fieldwork on drug distribution in the southern part of Cameroon has led to some publications (see, for example, Van der Geest 1981, 1982b), but most of the results still have to be published. The issue of the informal sale of pharmaceutical products is briefly mentioned in some medical anthropological studies (e.g., Alland 1970:170-173; Buschkens and Slikkerveer 1982:53-55; Janzen 1978:92; Kleinman 1980:13, 179-202; Maclean 1974:107-108; Warren 1974:205) without being given the attention it deserves. Medical anthropologists have been much concerned with the study of processes of therapy choice. They have also come to the conclusion (Kleinman 1980:182) that self-treatment is the first and often the only treatment applied to medical problems. It is, therefore, surprising that self-medication through Western pharmaceuticals has received so little attention from medical anthropologists. Once again the question, Why?

I can think of two possible explanations. In the first place, anthropologists working in Third World countries have always been biased toward research issues with an exotic tinge. They studied traditional medical theories and practices *insofar* as these differed from the "scientific" theories and practices they found at home. Loudon (1976:2) refers to this phenomenon as "an obsession with magical theories of causation as the basis for indigenous therapeutic procedures." A curious reflection of this bias among ethnographers can be found in Murdock's (1980) world survey of illness theories. Murdock reaches the absurd conclusion that 32 of the 139 selected societies had no natural explanation at all for illness, and that supernatural explanations for illness were twice as common as natural ones. The sobering truth is, of course, that twice as many anthropologists took exclusive interest in so-called supernatural illness theories. Studies of indigenous disease classifications, traditional priest-healers, herbalists, healing prophets, witchcraft, and sorcery are innumerable, but anthropological research on modern medical services and modern self-medication is scarce. Apparently the latter topics carry too little exotic attraction for the ethnographer.

A second plausible explanation for the rarity of anthropological studies of pharmaceutical problems in the Third

World seems to be the reluctance to cross disciplinary boundaries. Although medical anthropology claims for itself an interdisciplinary ethos, this theoretical stand proves to be more intention than reality when it comes to actual research. It is true that the number of interdisciplinary studies is increasing, mainly because of the multidisciplinary training of researchers, and sometimes because of the multidisciplinary composition of research teams. For reasons unknown to me, this rapprochement of disciplines has, however, been largely restricted to anthropology at the one side and to medicine and psychiatry at the other. Cooperation between anthropologists and pharmacologists is still a rare phenomenon. Is the distance between the two disciplines too large? The "thingification" commonly applied to the use of pharmaceuticals may indeed give the impression that these synthetic products are a far cry from the living society studied by anthropologists. I hope to make clear that such an impression would be a tragic mistake. Pharmaceuticals are indeed anthropological items.

## NOTES

[1] This article is a spin-off from anthropological research on the distribution and use of pharmaceuticals in a rural district of Cameroon in 1980. The research was financed by the University of Amsterdam and the Netherlands Foundation for the Advancement of Tropical Research (WOTRO). It was made possible through a permit of the Cameroon government (DGRST, Authorization 288). A preliminary report of the research (Van der Geest 1981) has been distributed among a limited group of people.

[2] Lall defended his views in front of a critical audience at a congress on the role of the pharmaceutical industry in the Third World held in Amsterdam in May 1983. This time the tenor of his argument was that poor countries should also pay commercial prices for their drugs, because they must help pay for the innovation in pharmaceutical production. Lall's argument was criticized by Melrose, Herxheimer, Medawar, and Bühler. The Workgroup Medical Development Cooperation (Wemos; address, PO Box 4098, Amsterdam), which organized the congress, intends to publish a report of the congress.

[3] An attempt at a more complete picture of corruption with respect to drug distribution is found in Van der Geest (1982b). It describes both the efficiency and the inefficiency of corruptive practices in the southern part of Cameroon.

[4] Four important advocates of the regulation of health care are Navarro (1976), Elling (1977, 1980, 1981), Doyal (1979), and Waitzkin (1981). With regard to drug distribution in developing countries, some form of regulation seems to be favored by, among others, Ledogar (1975), Haslemere Group (1976), Heller (1977), Medawar (1979), the editors of *Mother Jones* (1979), Melrose (1981, 1982), Medawar and Freese (1982), and Muller (1982). The discussion about competition versus regulation in health care is also the subject of a special issue of the *Milbank Memorial Fund Quarterly* (see for example McClure 1981 and Vladeck 1979).

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*Original Article*

# INDIAN ALCOHOLISM TREATMENT PROGRAMS AS FLAWED RITES OF PASSAGE

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Treatment of alcoholic American Indians has been given high priority by both the National Institute of Alcohol Abuse and Alcoholism (NIAAA) and the Indian Health Service (IHS). Numerous studies have assessed the success rates of the Indian alcoholism treatment programs developed in the last decade in response to this national health concern. The results range from mixed to disappointing (Albaugh 1973; Alday 1971; Bittker and Metzner 1973; Wolman 1970). Even though treatment personnel, the National Task Force on Alcohol Abuse among Native Americans, and most evaluative survey reports call for development of Indian alcoholism treatment programs sensitive to tribal, acculturational, age, and sex differences of their clienteles, Western medical model treatment perspectives predominate (Albaugh and Anderson 1974; Bouche 1979; Everett 1973; Stone 1980; Weibel and Weisner 1980a, 1980b). For the most part these treatment philosophies go unappreciated by Indian clients who are labeled "alcoholic" by their treatment counselors but who see themselves as neither diseased nor alcoholic. Definitional, motivational, and cultural differences between treatment personnel and clients create treatment contexts in which staff morale is low and client recidivism is high.

In 1980, members of the Indian Drinking Patterns in California Project[1] made systematic ethnographic observations of five institutions in Los Angeles directly involved in service to and treatment of alcohol-abusing urban Indians. We viewed the entire recovery process as a rite of passage (van Gennep 1960) and recovery home residency as the transitional phase or state of liminality (Turner 1964) in the rite of passage. Van Gennep's theoretical model identified social and individual-psychological factors necessary for successful passage from one social status and its associated roles to another. This analytical framework helped us to identify those structural, motivational, social, and valuational factors important to a successful status passage that are either missing or flawed in the alcoholism intervention programs we observed. Implications of this analysis include suggestions for alternative intervention, and support strategies that may more effectively sustain long-term sobriety among former Indian alcohol abusers.

## Field Methods

Our data collection methods included systematic observations of counselor-to-client, and client-to-client interactions during visits to two recovery homes, as well as life and drinking history interviews with program personnel and clients. Visits were made to the Los Angeles Indian Recovery Homes[2] at least once a week for a one-year period. During three-hour visits to the treatment centers, program activities were observed and recorded. We also attended Indian Alcoholics Anonymous meetings at least once a week during the field period.

In the summer of 1980 two anthropology students[3] at UCLA volunteered as administrative aides in the men's and women's alcoholism recovery centers. During their six-week internships, the students systematically observed and recorded daily program activities, as well as the content and context of the scheduled treatment and counseling sessions. The generalizations about the treatment process and the modal behaviors described in this paper are based on over 400 hours of observations in treatment and support group settings.

## The Los Angeles Urban Indian Service Delivery System

The five programs in Los Angeles (three recovery homes, a skid row sanctuary/shelter, and the county-funded Indian Alcoholism Commission) that specifically serve Indians who abuse alcohol or drugs comprise a microsystem within the macrosystem of alcohol and drug service delivery programs serving a community of pan-ethnic alcohol and drug abusers at state and national levels. These programs constitute a social system in that their activities and clienteles are not mutually exclusive, but rather interlock, support, cooperate, and under certain circumstances, function in concert as a political constituency.

All Indian alcoholism treatment programs in Los Angeles subscribe to the Western medical model of alcoholism as a disease. All have strong affiliations with Alcoholics Anonymous and program personnel encourage former abusers to invest themselves in the role of sober, recovering alcoholic. The goal of each program and the criterion on which an individual's recovery success is determined is commitment to total abstinence as a "life career."[4]

## Indian Alcoholism Programs as Flawed Rites of Passage—The Theoretical Model

According to van Gennep (1960), the dynamism of life processes requires transition across boundaries from one social status, or from one life phase to another. Transition or passage can be effected by ritual, dramatic actions that not only shift the individual from one social category to another but are in themselves expressive, symbolic enactments of the transformations.

In brief review, van Gennep (1960), in his classic model, divides rites of passage into three distinct and sequential segments: separation, transition, and reincorporation. At the onset of rites of passage, the initiate is symbolically removed from his[5] former social status and roles. The act of separation often includes physical removal from the context