THE CONTEXT OF MEDICINES IN DEVELOPING COUNTRIES

Studies in Pharmaceutical Anthropology

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About the cover

**The cover illustration is taken from a flipbook used for educating people in Bangladesh on essential drugs. The text below reads: "Always ask when and how many medicines to take"
The flipbook was prepared by PIACT/PATH Bengladesh and funded by the WHO Action Programme on Essential Drugs. The illustrations are by Kamrun Nahar Rashid.**

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PREFACE

Western pharmaceuticals are flooding the Third World. Injections, capsules and tablets are available in city markets and village shops, from 'traditional' practitioners and street vendors, as well as from more orthodox sources like hospitals. Although many are aware of this 'pharmaceutical invasion', little has been written about how local people perceive and use these products. This book is a first attempt to remedy that situation. It presents studies of the ways Western medicines are circulated and understood in the cities and rural areas of Africa, Asia and Latin America.

We feel that such a collection is long overdue for two reasons. The first is a practical one: people dealing with health problems in developing countries need information about local situations and they need examples of methods they can use to examine the particular contexts in which they are working. We hope that this book will be useful for pharmacists, doctors, nurses, health planners, policy makers and concerned citizens, who are interested in the realities of drug use. Why do people want various kinds of medicine? How do they evaluate and choose them and how do they obtain them?

The second reason for these studies of medicines is to fill a need in medical anthropology as a field of study. Here we address our colleagues in anthropology, medical sociology and related disciplines. Researchers working in non-Western cultures have concentrated on 'exotic' forms of therapy, and on the ways people choose between treatment by biomedical specialists and indigenous healers. They have tended to overlook self-care by medications, even though this is the most common form of therapy and even though pharmaceuticals are in many ways the real 'hard core' of biomedicine. This gap cannot be filled by a single book, but we can make a beginning by pointing to some of the analytical problems that deserve attention. These include the individualization of therapy made possible by buying medicines, and the implications of pharmaceutical pluralism for people's changing perceptions of 'indigenous' medicines. We are confident that this collection of papers can be used as a textbook in courses of social pharmacy and medical anthropology, focusing on the use of medicines in developing countries.

The book is divided into two main sections. The first part, on the transaction of medicines, deals with pharmaceuticals as commodities that are produced, sold and consumed. The roles of drug company salesmen, pharmacists, street vendors, and 'traditional' practitioners are examined. Detailed descriptions show how drugs are exchanged and used outside the control of Western professional medicine. The second section examines the meaning of medicines. Western pharmaceuticals are understood in terms of

local concepts of healing. Their 'foreignness' and 'high tech' modes of packaging and application (capsules, injections) imbue them with special power and efficacy. There is a short introductory essay by the editors and each of the main sections is preceded by an introductory note, which characterizes the contributions for the convenience of 'shoppers'. The concluding chapter is an overview, which sums up five themes in pharmaceutical anthropology, proposing lines for further research, and ends with a discussion of the practical relevance of the field.

In preparing this collection of articles, we have been helped and encouraged by many people. We would like to thank the contributors for their enthusiastic response and particularly Robert Welsch, who did also some editorial work. Cor Yonker and Rimke van der Geest kindly assisted us with the index. Martin Scrivener, of Kluwer Academic Publishers, saw the importance of the endeavor from the beginning and was supportive through it all.

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FOREWORD

This collection of essays deals with the ways people in the developing world today select and use their medicines. The book offers a view from the grassroots, where people are actually taking medicines – not only those of the trans-national companies, but also commercially produced indigenous medicines and locally made remedies. It is pharmaceutical *anthropology* because it seeks to explore the social and cultural contexts in which medicines are produced, exchanged and consumed.

The emphasis on context is the special contribution of the present volume, yet the problem addressed – drugs in the third world – has been of concern for several decades. The role of western pharmaceutical companies has been at the heart of the discussion up to now; little attention has been paid to the manufacturers of non-western medicines. In order to understand the significance of pharmaceutical anthropology and the contributions of the present volume, it may be useful to review some of the issues and developments in the debate about the proliferation of medicines in the developing world.

The modern period of commercial production is often said to have been initiated by German chemical companies in the 1880s, but the manufacture of brand name and patent medicines began in the 17th and 18th centuries, and became a conspicuous and highly profitable market in the 19th century. Muckraking criticism of patent medicines in the United States led to the Pure Food and Drug Act of 1906. The debate has included such things as H.G. Wells' novel, *Tono Bungay*, and in the United States, the highly publicized hearings conducted by Senator Kefauver in the 1940s.

Antibiotics after the Second World War were new 'miracle drugs' that promoted a period of rapid expansion in the international pharmaceutical industry, and the world-wide prestige of injections. Anthropologists began to report this phenomenon in the 1950s, and Clark Cunningham coined the term 'injection doctors' for practitioners that he observed in Thailand in the 1960s. The danger of untrained practitioners prescribing and administering antibiotic injections was immediately apparent, and this initiated the concern among anthropologists and health professionals about the effects of the international pharmaceutical industry on health care in developing countries.

However, nationalist thinkers in at least some Asian countries were concerned about international pharmaceuticals at an earlier time. For example, in India the cost of importing British medicines and other manufactured goods began to be criticized a century ago, and contributed to the Swadeshi movement to buy Indian products. Entrepreneurs who initiated the commercial production of Ayurdevic medicine in the 1880s argued that imported

drugs drained the Indian economy, while indigenous preparations were better suited to local conditions. Similar arguments were advanced by medical revivalists in other parts of Asia, culminating with Mao's endorsement of traditional Chinese medicine and the advent of barefoot doctors.

The post World War II advances in chemotherapy and expansion of the pharmaceutical market are the immediate setting for the current debate on how multinational companies affect health care in developing countries. Since socialist enterprise has contributed almost nothing to modern chemotherapy, the charge is that a few companies in the United States, Western Europe, and Japan dominate the world market. Because most of their sales are in the industrial capitalist world, they design their products for this market. They are said to avoid competition by patent control, or to proliferate useless or marginally useful products which they sell by competitive advertising rather than by lowering prices. Thus, approximately 50,000 brand names are used to sell about 700 generic drugs or chemical agents, yielding an average of 70 different market names for every useful product. These market distortions are most severe in developing countries, where the need for cost-effective therapy is greater because resources are more limited (see Gereffi 1983). Additionally, the companies are charged with selling prescription drugs without regard to problems of regulating their distribution, with dumping obsolete prescription drugs in third world countries, and with having experimentally tried out new drugs in these countries. They are said to use misleading promotional materials, and so on. (These charges have been answered by representatives of the companies – cf. Taylor 1986.)

A task force of United Nations agencies addressed these issues and its report, 'Pharmaceuticals in the Developing World: Policies on Drugs, Trade and Production', was adopted in 1979 as a policy statement by the Conference of Non-Aligned Countries meeting in Havana. Also, in 1977 and 1979 the World Health Organization published a list of approximately 200 essential drugs which would cover 90% of the medical problems in developing countries. The purpose was to provide a standard for rationalizing the production and importation of drugs.

Responding to journalistic criticism, the outrage of international health professions, and the threat of governmental actions, the International Federation of Pharmaceutical Manufacturers' Associations publicized a voluntary code of practices in 1981. The code was concerned with providing information about the effects of drugs, labeling, and other forms of sales promotion. It did not consider the way prices are set for drugs and how they are distributed, nor did it consider issues of research, development and technological transfer.

All of this discussion has been very much oriented around the international role of Western pharmaceuticals. One important contribution of the present volume of anthropological essays is that it makes us aware of the absence in the debate of data on the commercial production of Chinese, Ayurvedic and Unani medicines, and on the international market for them. The *jamu* pharmaceutical companies in Indonesia, and the Nigerian companies whose medicines are widely marketed in West Africa, have been previously overlooked as well. Partly, this is because the critics were big game hunters, and these were small fry by comparison to the allopathic drug companies. But the absence is curious because at the same time that the debate on trans-national pharmaceutical companies ripened in the 1960s and 70s, the Chinese model of primary health care publicized the use of indigenous drugs, and the World Health Organization and other agencies sponsored conferences and initiated projects to study the pharmacopeia of traditional medicine for alternative or supplemental forms of therapy.

Helga and Boris Velimirovic were close observers of this activity, and in 1980 published a skeptical article entitled, 'Do Traditional Plant Medicines have a Future in Third World Countries?' Their answer was no, not much. They wrote that traditional phytotherapy would continue to be used for self-limiting, psychological or incurable chronic illnesses, and that the cultivation of plants used in cosmopolitan medicine could be promoted to supply raw material for industrial production, but that nothing was likely to come from ethnobotanical research. They pointed out that between 1958 and 1970, 93.6% of the 466 new drugs introduced into the world market originated in Germany, Switzerland, the United States and England, and that only one, coming from Mexico, originated outside of highly industrial countries. Their advice was that the priority of third world countries should be (1) to limit the production and importation of allopathic medicines to the WHO list of essential drugs, (2) to encourage the transfer of technology where this is feasible, and (3) to regulate the distribution and quality of drugs, and develop strategies to reduce prices.

Sri Lanka adopted a rational program of state controlled importation of allopathic drugs in 1972, but it was resisted by a large segment of the medical profession which was convinced that brand name drugs were superior, and became a major political issue. The law was compromised by an illegal market, and was eventually modified. Meanwhile, the commercial production of Ayurvedic medicine has flourished.

More recently, Bangladesh adopted similar priorities to those pioneered by Sri Lanka. The importation and manufacture of allopathic medicine was limited to a list of 150 essential drugs for primary care, and 100 supplementary drugs for tertiary care. The 1982 law required the withdrawal of 1700 drugs as the existing stocks were exhausted, and put an immediate ban on 237 drugs that an expert committee considered harmful. The Expert Committee reported that in 1981 the people of Bangladesh spent about $75 million on allopathic drugs. This was about 60% of health expenditure, yet the committee estimated that 70% of these drugs would be described as therapeutically useless by authorities in Great Britain or the United States. Only 10% of drugs sold were purchased by the governmental health services; the remaining 90% were taken up by the private sector, distributed by fee-for-service

physicians and 14,000 retail pharmacies. Eight multinational companies produced 70% of these allopathic drugs, with an additional 15% produced by 25 medium sized companies among the remaining 158 licensed manufacturers.

Unani, Ayurvedic and homeopathic companies had been exempted from governmental control in Bangladesh. The Expert Committee asserted that they manufactured some "unethical, harmful and uncertain quality products", but it seemed to ignore them when it estimated health care expenditures. In 1982, a WHO consultant reported that 20 Ayurvedic pharmaceutical companies in Bangladesh sold approximately $30 million worth of medicines annually. This figure was only an educated guess; nonetheless an estimate of $75 million for allopathic drugs and $30 million for Ayurvedic drugs indicates that the commercial production of indigenous medicine was a significant part of health care in Bangladesh. This is comparable to the finding of Ahmad Fuad Afdhal and Robert Welsch in the present volume that the companies manufacturing traditional *jamu* medicines in Indonesia control approximately one-third of the total pharmaceutical market of that nation.

In India, by 1972, the Ministry of Health reported that approximately 900 companies manufactured indigenous medicines, with nearly 300 of them reporting sales of 500,000 rupees or more. The products of these companies could be purchased in various African, Asian, South Pacific and Caribbean countries; I have even bought Ayurvedic soap in Manhattan. Chinese pharmaceutical companies have a similarly broad international market.

Several thousand Asian pharmaceutical companies manufacture many thousands of tonics, pills, capsules, salves, powders, teas and cosmetics. Some products follow ancient or medieval formulations, others are new medicines based on humoral traditions; even the soaps, toothpastes, and hair oils have humoral uses or associations. I cannot read the literature published by these companies without thinking of 19th century patent medicines in Europe and the United States. Such a variety of aphrodisiacs, and preparations to enhance and prolong sexual powers! So many panaceas, laxatives, and cures for diarrhea! The Velimirovics would not approve, and the Bangladesh Expert Committee recommended banishing products of this kind, including Vicks Vaporub, which is marketed as an Ayurvedic medicine in South Asia.

The bottom line in the discussions by these and many other specialists is how much choice people in poor countries should have in spending their pennies. Of course health care planners believe that they should not buy tonics to prevent premature ejaculation, or to make their sons more intelligent. They should deal realistically with the terrible problems in their countries, with malnutrition and infectious disease.

The perspective of this book is somewhat different. The emphasis of these contributions is less on what people *should* do, than on what they *do* do. The articles show how people choose their medicines, where they get them, and what kind of guidance they seek and receive. In order to understand what

people are doing, it is necessary to take seriously the question of what they think they are doing. What meanings do the different varieties of medicines have for people in various cultures? How do they perceive the efficacy of imported pharmaceuticals and the difference between them and indigenous medicines? Answers to these kinds of questions provide the missing context for the debate about pharmaceuticals. That context is first of all the local one of cultural meanings and face-to-face transactions. Important as global considerations are, they leave many issues untouched. In addressing these other issues of what medicines mean and how they are used in local contexts, the editors and contributors to the present volume have initiated a new field of anthropological research. This field has much to contribute to the great debate about drugs and health care in developing countries.

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