

NEW RELEASE

## Anthropology and the Pharmaceutical Nexus

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Adriana Petryna, Andrew Lakoff, and Arthur Kleinman, *Global Pharmaceuticals: Ethics, Markets, Practices*. Cambridge University Press, January 2006, 312 pp.

**M**edicines constitute a meeting point of almost any imaginable human interest: material, social, political and emotional. They are medical, of course, and symbolic (which is also medical). As chemical substances, they bring about physical changes in the body. As ritual symbols, they express concern and give comfort. They are indeed emblems of concern but also commodities in a hard and merciless market. They are political weapons in the hands of the powerful. They play their many roles at different levels of social and political organization: in international policy and funding, in national politics, in local health institutions, in consulting rooms and shops, on the street corner, in households and, ultimately, in the private lives of individual patients. They are merchandise in formal and informal, public and secret, legal and illegal transactions. Thus one may indeed speak of a “pharmaceutical nexus” as do the editors of this fascinating new book on *Global Pharmaceuticals* (Petryna et al. 2006).

Studying medicines in order to know how the world functions, and understand the work of medicines in the wider context of culture and society, seems an obvious choice for anthropologists, but it has taken some time to realize this. With very few exceptions, medicines were only mentioned in

passing; they were always “traditional medicines,” magical remedies and herbal concoctions. One such exception was Evans-Pritchard (1937:424-78) who devoted more than average attention to the typology, perception and use of Zande local medicines in order to make his point about the rationality of Azande reasoning.

The fashion and convention of early anthropology—especially the sentimental focus on exoticism—prevented researchers from looking at ubiquitous Western-produced pharmaceuticals as cultural phenomena worthy of anthropological scrutiny. One of the few exceptions was Cunningham (1970) who wrote about “injection doctors” in Thailand, a topic that was apparently exotic enough to capture his attention, even though it concerned a familiar Western practice, injection.

I became interested in pharmaceuticals during my fieldwork on sexual relationships and birth control in a Ghanaian rural town (Bleek 1976). I discovered that young people were putting their trust in a contraceptive that had a social life of its own, entirely outside the world of professional medicine and/or official Family Planning services. Tracing that “contraceptive,” I made a second discovery: it was a laxative. From that moment onward my own cultural blinders were lifted and I started to see pharmaceuticals everywhere: in “provisions” shops selling daily necessities, in market stalls, in drugstores that were supposed to sell “over the counter medicines” only but were in fact selling an abundance of prescription-only medicines, including antibiotics. I was amazed both at their omnipresence in daily life and their almost total neglect by anthropologists who claimed to describe that very same daily life. At the same time, however, I realized that this negligence formed part of a general pattern. Anthropologists had turned away from phenomena that seemed too familiar to them: schools, Christian churches with their “boring” religious services, hospitals and everything related to what was assumed to be “Western medical practice,” including pharmaceuticals.

My interest in the familiar (yet unfamiliar) world of pharmaceuticals coincided with (1) the gradual home-coming of anthropology, (2) the birth of medical anthropology as a distinct specialization, (3) a world-wide outcry about the practices of multinational pharmaceutical firms and (4) the launching of the WHO’s Action Program on Essential Drugs. Here, I will discuss only the two last two of these phenomena.

## Pharmaceutical Companies

At the end of the seventies, multinational pharmaceutical firms became the target of public criticism. They were accused of unethical marketing practices, especially in developing countries. The dumping of inferior medicines that had fallen out of favor in Western countries was one of the charges. Another one was that they adjusted the texts of inserts of medicines exported to poor countries to facilitate marketing. Indications for use were expanded while counter-indications and side-effects were reduced. A notorious example of such a skewed insert was the information provided by the Dutch-based company Organon about its product Orabolin, an anabolic steroid that was recommended for “pediatric use in conditions like marasmus, malnutrition, poor weight gain, retarded growth, kwashiorkor, etc.” (Melrose 1982:103).

Advertisements were another source of information available to anthropological research. In his study about the construction of power and knowledge through pharmaceutical in the Philippines, Tan (1999) made extensive use of the (biased) information that pharmaceutical companies were spreading through TV commercials.

A third criticism was that pharmaceutical companies did not seem to bother about what happened to their products once they had been shipped. Gross misuse of pharmaceuticals was reported from developing countries but the companies reacted that it was not their responsibility. The implication, suggested by the critics, was that the companies welcomed the misuse as it boosted their sales. Some actively sought the “re-interpretation” of their products in other cultures. Jon Kirby (personal communication) received a number of requests from pharmaceutical firms, including one from South Africa, as to how the color-coded schemata of white, red and black and its use in managing the process of illness and therapy in the African context might affect the coloring and marketing of critical drugs especially antibiotics (see also Radyowijati & Haak 2002).

As an anthropologist who had lived almost five years in a “developing country,” Ghana, I was struck by the paucity of “ethnographic” evidence of the misuse of pharmaceuticals. Their main evidence was written materials such as inserts and merchandizing statistics. Their claims concerning the misuse and harmful effects at the other end of the pipeline was mainly based on journalists’ reports and the impressions of passers-by. Proper contextualized descriptions and interpretations of what happened on the ground were completely missing.

## Essential Drugs

In 1978 the WHO set up a global Action Program on Essential Drugs (APED). Its purpose was:

...to make essential drugs and vaccines available under favorable conditions to governments of the less developed countries in order to extend essential health care and disease control to the vast majority of the population (WHO 1978:3).

They listed around 200 drugs and vaccines that were considered to be safe, effective and affordable. Most of these were no longer protected by patent rights, and were available at low cost in the form of generics.

The implementation of the program proved more difficult than the policymakers in Geneva had anticipated. Resistance came from all levels. Pharmaceutical companies that saw their most lucrative products suddenly excluded from the market lobbied among political authorities and medical professionals to keep their products on the list. Ministries of Health, trying to satisfy the medical profession and the industry, and keeping their own interests in mind, were slow to implement the program or only paid lip service to it. Pharmacists resisted because it meant throwing out their stock of the more expensive medicines. Moreover, both doctors and pharmacists believed that some of the new, “non-essential” drugs were superior to those on the WHO list and protested against the interference in their professional work. Finally, and quite ironically, the patients, those for whom the program had been designed, often felt they were being cheated with inferior or second hand medicines. In most cases where local governments did implement APED it only affected the public sector, allowing private institutions to continue prescribing and dispensing “non-essential” drugs. What exactly happened on the ground, however, no one really knows for it was rarely documented.

When APED’s implementation was evaluated in the late 1980s I found myself a member of the evaluation committee. To my great surprise we were only to study the “paper” documentation and to find out whether or not the essential drugs program was mentioned in the official health policy documents of the selected countries. My suggestion that the success of APED could only be assessed by studying what happened in hospitals, health centers and households was rejected as being an impossible task. In the report and its subsequent publication (Kanji et al. 1992), it was implicitly suggested that if

the essential drug program existed on paper it existed in reality, that it was both available and used by sick people in local communities.

### **Pharmaceutical Anthropology**

This over-simplification of the life of pharmaceuticals and the acute lack of reliable information on local pharmaceutical knowledge and practice in the public debate prompted me and fellow anthropologists to focus our attention on pharmaceuticals in their social and cultural context. This led me to carry out research into the distribution and use of pharmaceuticals in Cameroon.

Interestingly, prior to my departure for Cameroon, I met several Dutch doctors who had been working in that country. I asked them about the presence of prescription-only medicines in local shops and markets, outside the realm of professional medicine. They all denied that such medicines were available outside the formal distribution channels or admitted they had no knowledge of this. In retrospect, it confirmed my initial impression that these medicines followed a life of their own, quite independent of doctors and pharmacists, but it also sowed the seeds of uncertainty. Could it be possible that the doctors *had not even seen* the medicines that my experience in Ghana had shown, were everywhere and so openly available to customers? This *was* possible, as I was soon to find out.

Although I was most interested in the informal, and possibly illegal, distribution of pharmaceuticals, I thought it would not be wise to state this openly in the proposal I submitted to the Cameroonian officials. I emphasized my interest in the distribution and use of medicine in general, and mentioned hospitals, health centers and pharmacies as venues where distribution took place. At the bottom of my proposal, in small print as it were, I also referred to shops and market sites.

After my arrival I started my research in two local hospitals, a pharmacy, and some health centers. My expectation was that the distribution of medicines in those locations would be clear and well documented, allowing me to quickly proceed to the informal circuit. I was wrong. I soon discovered that formal and informal transactions were closely intertwined and it proved impossible to study one without the other. In fact, I remained busy with the so-called formal sector of medicine distribution (cf. Van der Geest 1985) until the end of my fieldwork. The pharmaceutical nexus had made its appearance.

The anthropological study of pharmaceuticals soon became a focus of research in the Medical Anthropology Unit in Amsterdam. My colleague Anita

Hardon, who had a background in medical biology, wrote her dissertation on self-medication in two impoverished neighborhoods in the capital of the Philippines, Manila (Hardon 1990). She emphasized the commercial status of medicines, focusing on advertisements on radio and television and the role of medicines in the daily survival struggle of poor people.

By 1988 we had begun to attract contributions on what we then called “pharmaceutical anthropology.” Soon we were able to publish a collection of sixteen papers on transactions and meanings of medicines in developing countries (Van der Geest & Whyte 1988) covering thirteen different countries in Asia, Africa and Latin America.

In 1994, Mark Nichter, who had done extensive fieldwork in South and South-East Asia, and Nancy Vuckovic, who had studied pharmaceutical use in the USA, sketched an outline of the many connections between medicines and processes of social transformation. Medicines, they wrote, are vehicles of ideology, they change perceptions of health and construct illness identities, they mark social values and relations, they are means of both empowerment and dependency and create consumer demands (Nichter & Vuckovic 1994).

In 1996, in an attempt to give a “state of the art” overview of the anthropological study of medicines (Van der Geest et al. 1996) we concluded that anthropologists had largely failed to extend their research to what we termed the “first phase” of the biography of medicines, namely the manufacture and marketing of pharmaceuticals. This had eluded anthropological observation, for several reasons. One was the reluctance of manufacturers to give anthropologists access to their laboratories and offices. This was clearly because they thought they could derive no advantages from their reports. Anthropologists had made little effort to enter the field of the pharmaceutical industry, partly because they anticipated the latter’s refusal, and partly because they felt more “at home” in the Arcadian setting of rural communities than in the complex and highly technical world of industrial manufacturing.

## **Global Pharmaceuticals**

This omission has been repaired to some extent in *Global Pharmaceuticals: Ethics, Markets, Practices*, a collection of nine chapters on various aspects of pharmaceuticals (Petryna et al. 2006). The book covers most stages of the pharmaceutical biography. Starting with the “pregnancy–stage,” so to speak, Adriana Petryna explores the testing process and the search for human subjects that the industry undertakes to test its medicines. Her research shows that the industry

has relatively easy access to populations in poor countries in contrast to the richer countries where this access is nearly non-existent. The findings are similar to the theme of a recent novel, *The Constant Gardener*, by John le Carré (2000), made into a film some years later. The thriller novel tells the story of the secret testing of a new medicine among AIDS patients in Kenya with the connivance of the British government. A British couple and a Kenyan activist who discover what is happening and want to expose it are murdered. People, Petryna concludes, are particularly susceptible to being used for testing in times of crisis such as the nuclear disaster in Chernobyl or the AIDS epidemic in East Africa. Petryna's article is as much an ethical statement as an anthropological analysis.

Another paper, by David Healy, addresses the subtle—and not so subtle—ways in which the industry structures expert and popular understanding of disease, in this case mental illness. The basic idea of the article is that a pharmaceutical company needs to sell the disease before it can sell the drugs. In other words, the marketing of medicines requires marketing of science. One of the ways to achieve this is exerting influence on the production of scientific literature. Healy describes the case of a company seeking a market for a new drug, Alprazolam (Xanax). The company put its new agent into clinical trials for one of the conditions newly recognized by DSM III, panic disorder. The company sponsored scientific symposia on panic disorder and “supported a burgeoning literature on panic attacks” (62). A similar thing happened in the “marketing” of depression as a condition requiring tranquilizers and other drugs. Companies go to the extent of soliciting scholars to write their articles for them. Healy draws from his own experience when he quotes an email that one company sent him.

Dear David, I am delighted you are able to participate in our satellite symposium... In order to reduce your workload to a minimum we have had our ghost writers to produce a first draft based on your published work. I attach it here...(68).

The industry's invisible hand in producing scientific literature preparing the market for its products is one of the most intriguing themes in *Global Pharmaceuticals*. Healy made an analysis of articles edited in Current Medical Direction (CMD), a medical information company that “delivers scientifically accurate information strategically developed for specific target audiences” (71). He estimates that up to 75 percent of CMD articles “on randomized controlled trials on therapeutic agents appearing in major journals may now be ghostwritten” (73). A major consequence, Healy continues, is that “the new

method of authorship appears to lead to an omission of negative data on the hazards of therapeutic agents” (p.73).

Recently, Maarten Bode, a Dutch anthropologist, studied the production and marketing of modern/traditional Ayurvedic medicines in India. He described how the Ayurvedic companies run their business by subjecting their products to scientific tests and having the results published in journals financed by themselves (Bode 2004). He concluded that the companies misleadingly tried to emulate the scientific rigor of the laboratories of Western pharmaceuticals and to present that image in the production of their products. Healy’s observations suggest that the similarity between Ayurveda and “allopathic” medicine production is even bigger than Bode suspected.

Kalman Applbaum, in a similar vein, discusses the “launching” of antidepressants in Japan. The company’s strategy is not merely to adapt its drugs and marketing program to the local situation but also to alter the environment in which the drugs are to be used.

The articles in *Global Pharmaceuticals* proceed through the stages in the “biography” of medicines, moving from their production and marketing to distribution and use. Andrew Lakoff looks at the use of audit data by pharmaceutical firms as a means of regulating expertise and constituting the market as a domain of practice. Argentina’s market for antidepressants is taken as a case in point. Lakoff devotes special attention to sales representatives (“reps”) and opinion leaders as brokers that convince doctors to prescribe the company’s new drugs.

Anne Lovell follows the convoluted journey of Buprenorphine, an opiate antagonist, from the doctor’s office through twists and turns to its illegal use in the hands of drug addicts. As it moves along the social life of this medicine turns from public to secret. Veena Das and Ranendra Das also take the topicality of medicine dispensing and use as starting point for their analysis of self medication in the Indian capital Dehli.

The last two chapters of *Global Pharmaceuticals* deal with anti-Aids medicines (ARVs). Yoão Biehl gives an overall description of Brazil’s spectacular success in making ARVs widely available for its HIV/AIDS infected citizens. He focuses on national politics and the economic rationality of the state’s policy but leaves the reader with the question of whether or not this policy actually materializes in the daily lives of people living with HIV/AIDS.

On the other hand, this is the very question that is addressed in the contribution by Susan Whyte and co-authors about the uneven road that ARVs travel in Uganda. They paint a depressing picture of unequal access to anti-AIDS medicines. Poverty coerces patients and their families to make impossible



decisions. The already heavily reduced prices of the ARVs in Uganda are still much too high for the average family. In dramatic case histories the authors illustrate the painful priorities that families and patients have to set. In some cases families sacrifice most of their financial resources to treat their sick relative(s), in others they are simply unable to do so, and in the most desperate the patients help their families by taking their own lives. The pharmaceuticals nexus expresses itself in yet another form: the financial and emotional costs of treating relatives with AIDS. The costs force people to (re)define their relationships thereby making medicines tokens of both kinship quality and the quality of international relations. The authors:

As concrete things ARVs objectify relationships in both subtle and dramatic ways. Hope, concern, solidarity, power, money, selfishness are all enacted as those tablets and capsules move between people. Within families, the virtues of care are most clearly demonstrated by buying medicines for the sick person... On a global level, claims of medical apartheid in refusing to make ARVs truly accessible in poor countries are accusations of injustice and immorality (260).

In spite of the gloomy observations that Whyte and her co-authors make—and which without doubt occur widely in other poor countries—the recent developments around ARVs show that political pressure on the industry is beginning to yield results. The industry is more susceptible to public criticism now than it was 25 years ago. There is sufficient reason for careful optimism that justice and moral decency can no longer be ignored on the market of pharmaceuticals and that medicines will have far reaching societal benefits. Hardon (2005:605) writes:

The distribution of AIDS medicines, which was initially not seen to be cost-effective by global policy makers in sub-Saharan Africa, is now seen to have beneficial effects, such as destigmatising of HIV/AIDS, increasing uptake of voluntary testing and counseling, and better prevention programmes.

### **Capturing the Producer's Point of View**

That “careful optimism” is absent in the contributions to *Global Medicines*. It is striking how much the tone of the first articles about the industry resembles the accusations of the 1980s. Pharmaceutical companies are still por-

trayed as shrewd and greedy organizations interested only in selling their products and hardly concerned about people's health. Apart from the fact that such demonization is clearly biased and one-sided, one wonders if anthropologists should not have more "imagination" and put into practice their age-old axiom of capturing the native's point of view. Why not delve deeper into the views and motivations of medicine manufacturers? Anthropological research should strive for an ever-more nuanced and holistic insight into the entire culture of pharmacology, including much maligned area of manufacture. Capturing *their* point of view may reveal that manufacturers believe in their products and that they take professional pride in putting a new and "better" product on the market. In any case, they produce not only the medicines themselves but also the meanings attached to them.

The lack of the emic perspective in the observations about drug manufacturers may be partly the result of limited access. Anthropologists are not able to write emically if they are not able to establish rapport with employees of the pharmaceutical industry. Interestingly, however, two of the authors in *Global Pharmaceuticals* did develop such a rapport. Healy reports about his correspondence with one company that offered to ghostwrite his articles (What is wrong with it, as long as the author remains the final editor?). Applbaum quotes some candid and lively conversations with researchers and managers from various firms. Let me cite a few lines:

"You ought to write a whole book not just an article about this," cried one of the managers. I dispensed with my questions for a time and let the conversation flow.... I paraphrase their conclusions: The Japanese practice poor clinical science—"junk science," in fact—resulting in inferior treatment of Japanese patients since excellent drugs that would under objective testing conditions become available are instead delayed and not approved.... "There is no sense of urgency about patient need in Japan," said one (96).

Did the managers not have a point? Why reduce their arguments to mere profit making? And why not acknowledge the moral and cultural logic of their commercial practice? The contributions about industrial practices breathe a somewhat outdated anthropological suspiciousness of money as the great destroyer of culture or at least as a noncultural phenomenon. Entrepreneurship, however, is one of the principal movers of culture, at the level of local communities as well as in international trade. Anthropologists studying pharmaceutical

business should become more “innocent,” that is, open to ideas that are completely alien to them, more willing to take those ideas seriously, less ethnocentric in short.

### **The Innocence of Anthropologists**

The articles in *Global Pharmaceuticals* exhibit another type of “innocence”: that of the morally superior observer, the outsider with clean hands. Since *Global Pharmaceuticals* makes strong moral claims, I may make some as well. It strikes me that the authors have devoted little reflection to their own role and position in the pharmaceutical nexus. If we focus on the various social lives that pharmaceuticals are leading in the company of different human actors, we anthropologists should not exclude ourselves. In our hands, medicines become interesting objects of study: symbols, means of control or liberation, weapons, gifts commodities, means of communication—a kaleidoscope of shades and contexts, but always on paper.

A while ago, I referred to the lip service of policymakers who produced plans and reports about essential medicines. The culture of policymakers is mainly the production of documents. A well composed text, delivered before the deadline to the Minister to cite in his speeches or accounts to higher authorities is indeed the first priority of policymakers. Having accomplished this makes them feel satisfied. The actual realization of the plans in health care is the responsibility of others. It should concern them but less than one might expect. The procedure of evaluating the Essential Drugs Program—namely, the reading of texts—confirms this.

The position of anthropologists is not so different. Their task, too, is to write about medicines. Medicines are indeed good to write about, to allude to the by now somewhat overused Lévi-Straussian catch-phrase. The “charm” of medicines for anthropologists is first of all that they epitomize the complexity of culture and allow us to capture that complexity in an attractive and convincing metonym. The pharmaceutical nexus intrigues anthropologists and enables them to carry out *their* business: writing. Loosening the knots of pharmaceutical problems and dilemmas is usually not in the interest of ethnographers who need problematic situations for their prose.

Overcoming the “temptation” of just writing about the intriguing nexus should be a first concern of medical anthropologists. We owe it to our informants to contribute to the actual improvement of distribution and use of pharmaceuticals. Ironically, however, that imperative of turning our paper medicines

into medicines that cure and protect people is not exactly what mainstream anthropology encourages us to do. Applied medical anthropology is somewhat slighted as diluted anthropology and as too subservient to policy and medical science. My view, however, is that uncommitted ethnographers lack reflexivity and fail to see themselves in the nexus of pharmaceuticals and of culture in general. Their methodological innocence gives way to epistemological naïveté.

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