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'Under-the-counter' medicines in developing countries

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'Under-the-counter medicines' are those that are sold illegally directly to the public but without the authority of a doctor's prescription. In this article the author examines this trade in developing countries and hopes that a serious study of these problems will lead to more appropriate policies for medicine distribution in developing countries.

'Under-the-counter (UTC) medicines' is an obvious derivative from 'Over-the-counter (OTC) medicines'. The latter are non-prescriptive medicines which can be used by clients without the intervention of a physician and which are meant for self-medication. By 'UTC medicines' I mean about the same: medicines which are sold directly to the public; that is to say, without a doctor's prescription. One difference is, however, that this sale is illegal. The medicines may also be those which, in Western countries, do not require a doctor's prescription, but in fact may be prescription medicines.

280 It is well known that UTC medicines are widely

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Il s'agit en l'occurrence des médicaments qui sont vendus directement et illégalement sans la caution de l'ordonnance médicale. L'auteur examine ce 'marché parallèle' dans les pays en voie de développement et espère que de sérieuses études du problème conduiront à une politique mieux appropriée de la distribution de médicaments dans ces régions.

distributed in developing countries. This fact is often mentioned in casual conversations between medical people and in articles of the popular press. At these levels the indiscriminate use of certain dangerous medicines is commonly marked as a major health hazard of people in developing countries. Strangely enough, however, this problem has received little serious attention in sociomedical research.

Another surprising fact is that pharmaceutical firms, which are directly or indirectly involved in the distribution of UTC medicines largely ignore the risks of self-medication in these countries. The proceedings of two recent meetings of the World

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Federation of Proprietary Medicine Manufacturers^{10,11}, show that the speakers simply praised the benefits of OTC medicines for people in developing countries. Little thought was given to the fact that conditions here and there differ immensely and that what good is for 'us' is not necessarily good for 'them' as well. Only one speaker pointed at the risks of misuse and abuse of medicines.

In this article I want to briefly highlight some factors which encourage the use of UTC medicines in poor countries. By doing so, I hope to stimulate thorough social and medical research into the problems of modern self-medication in these societies. My second, more important, aim is that a serious study of these problems will lead to a more appropriate policy of medicine distribution in developing countries.

SELF-MEDICATION AND SHOP MEDICINES

Self-medication has always been the first and prevalent therapy. This applies to the industrialized societies of the West, but even more so to the subsistence societies of Africa, Asia and elsewhere. People in Africa, for example, have a vast knowledge of medicinal plants and practices to treat their sick. Recently, western pharmaceutical products have tended to replace and complement these traditional techniques and many (certainly not all) modern medicines are regarded as superior to the herbs. It is, therefore, not surprising that modern medicines are much sought after; they link up with an old tradition, self-care. An additional reason for the emphasis on self-care with modern medicines is that institutions providing modern medical care are scarce and often hardly accessible to people living in rural areas. As a consequence people are not only in need of simple non-prescription medicines, but also of more dangerous ones; the OTC medicines become UTC medicines.

Licensed pharmacies are usually as scarce as hospitals and concentrated in the urban centres. In most developing countries an informal network of shopkeepers and traffickers provides for the supply of medicines to peripheral places. Invariably they distribute at least analgesics, anti-malarials and antibiotics which can be given both orally and by injection. The variation of medicines and the size of the trade depend on local conditions such as the enforcement of legal restrictions, the financial capacity of the inhabitants, and the disease pattern.

Casual remarks of observers can be divided in two categories. One category states that the informal – usually illegal – trade in medicines is necessary because of the lack of an efficient, medically supervised, distribution system. Authors who hold this view often plead for a legalization of the

existing clandestine practices (e.g. Ref. 6). The other category emphasizes the medical dangers of the haphazard use of medicines¹ (e.g. Ref. 1). Supporters of this opinion recommend that measures be taken to prevent this harmful distribution of medicines.

'INJECTION DOCTORS'

Unqualified people, who not only distribute but also administer medicines, particularly injectable medicines, have been coined 'injection doctors' by Cunningham³ who studied such practitioners in Thailand. It seems that 'injection doctors', albeit with local variations, have become a common phenomenon in many developing countries. In Turkey they are called 'needlemen' by Taylor *et al.*⁷, in Ghana they call themselves, respectfully, 'dispensers' and in Liberia people refer disparagingly to them as 'black-baggers'. A vivid account of Nigerian 'injection doctors' is given by Maclean⁵.

It should be noted that the rise of 'injection doctors' is a logical development where injectable medicines are in popular demand and can be obtained without the intervention of qualified doctors. The alternative is that people inject themselves, which is in fact also commonly done in many societies, particularly in rural places.

INDUCED ABORTION

A particular type of self-medication is inducing an abortion with the help of abortifacients. Unwanted pregnancy is a common setting for the clandestine use of medicines. In most developing countries induced abortion is legally prohibited and women seeking an abortion have little or no opportunity to appeal to the official institutions.

Reasons for procuring an abortion often relate to the completion of education or extra-marital pregnancies. The reasons are usually strongly influenced by feelings of shame and honour.

Studies about clandestine-induced abortion in developing countries do exist but hardly ever contain information about the medicines which have been used. Most studies have been carried out from a demographic point of view and are mainly directed toward frequencies and socio-economic parameters.

A case study by Bleek² in a rural town of Ghana mentions the use of 12 Western-manufactured abortifacients among a total of 53 different abortion methods and he remarks that some of these 'abortifacients' are not effective (for example laxatives). Ironically, unwanted pregnancies often follow the use of ineffective contraceptives bought 'over- or under-the-counter' from unlicensed drug traders.

FURTHER INVESTIGATION NEEDED

This brief survey of factors and actors promoting the illegal distribution of western medicines in developing countries gives rise to five questions which merit further investigation:

1. *What role does the pharmaceutical industry play in this field?* Recent publications have strongly criticized the policies of certain pharmaceutical firms. Although these critiques are often one-sided, it cannot be denied that certain practices (cf. Ref. 4) of pharmaceutical companies work against an improvement of medicine distribution in developing countries, for example, the biased orientation towards the needs of Western countries, the production of superfluous medicines, and the dumping of expensive and outmoded medicines. The weak infra-structure and the absence of an efficient quality control system make these countries particularly vulnerable to aggressive sale tactics.

2. *To what extent do governments, local authorities and health personnel in developing countries contribute to the problems of medicine distribution?* There are clear indications that inefficiency and corruption greatly contribute to the lack of medicines. The uneven distribution of medical services over the country is a case in point. National budgets for medicines could be used much more profitably if recommendations by the WHO¹² for the acquisition of essential medicines were followed. It seems likely that a more frugal policy in the purchase of medicines runs counter with the private interests of the decision-making officials. Another factor is the widespread pilfering of medicines at all levels of distribution. As a result, the amount of medicines reaching the patients is sometimes only a fraction of the allotted supply. The consequent shortage of medicines further necessitates an informal, and medically unsupervised, distribution of medicines.

3. *What explanation can be applied to the widespread phenomenon of illegal medicine use?* This question has already been dealt with in the course of this article, namely a logical preference for self-care, and the unavailability of qualified medical services.

However a puzzling question remaining is: Why do people with more serious complaints often prefer to rely on clandestine medicines even if a qualified doctor is available? Various answers have been suggested by different authors. Thomas⁸, who carried out fieldwork in Kenya, emphasizes that (in contrast to official medical institutions) medicine shops are often just 'around the corner', the service is quick and the transactions are not stressful because the traders are usually acquaintances. To this can be added that medicines in shops are retailed in any desired quantity which may reduce the total expenses considerably. Some authors have

expressed the view that people are particularly inclined to resort to self-medication if their complaint is, in one way or another, shameful and embarrassing. Some studies indeed show that complaints of the genital and defecatory organs such as impotence, venereal disease and hemorrhoids are over-represented among users of shop medicines. It is clear that contraception and induced abortion fit into this category as well. A last relevant view, presented among others by Alland¹³, is that people may have more confidence in western medicines than in western, or western-trained, doctors. Alland found that people in the Ivory Coast considered the doctor as an 'unnecessary adjunct to the distribution of medicine'.

4. *What are the medical consequences of illegal medicine use?* Many authors are pessimistic. Most of them point out that the frequent and haphazard use of antibiotics leads to unnecessary resistance. Negative consequences also follow from wrong doses, wrong medicines, wrong administrations (for e.g. unsterile syringes), diluted medicines and useless medicines if they are taken instead of effective ones. At the same time it should be taken into account that patients often have no alternative. As one speaker at the WFPMM Conference¹¹ quoted a Philippine peasant: 'I am not scared of side effects. I am scared about the death of my child'.

5. *Why do so few serious studies exist about the illegal distribution of medicines in developing countries while there is a general awareness of its widespread incidence and problematic character?* The most obvious answer to this question is exactly the illegal character of this practice. The phenomenon does not alone entail practices which are only in the strict sense of the law 'illegal', but also includes more criminal activities such as stealing, smuggling and bribery. Moreover, certain practices result in medical complications and even death. It is not surprising that such illegal practices are as long as possible hidden from outsiders, including anthropologists. Punishable acts are likely to be the most resistant to sociological interrogations.

Another explanation for the paucity of literature is the exoticist bias of antropologists. Anthropological field workers have, until recently, been most interested in subjects which they did not find at home. They studied traditional medicine in its colourful entourage but felt little attracted by practices including the use of their own, western medicines. Medical doctors and sociologists, on the other hand, occupied themselves almost exclusively with formal medical institutions.

As a result the very important and vast area of

modern self-medication in developing countries remained largely unexplored. As an anthropologist I have tried to redress the imbalance by carrying out research into the distribution and use of western medicines in Cameroon. Some of the results of this research have been published in a preliminary report⁹.

It is hoped that this brief communication will draw more attention to this field and will eventually contribute to improving medicine distribution in developing countries.

Note. This contribution is based upon a more extensive, not yet published, article entitled 'The illegal distribution of western medicines in developing countries: pharmacists, drug pedlars, injection doctors and others. A bibliographic exploration'. The article contains an elaborate bibliography.

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Prescription drug information for the elderly

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The recent efforts of the Food and Drug Administration (FDA) to provide written information about prescription drugs to patients has drawn considerable attention to the impact on certain special populations. Language groups, the physically handicapped, and especially print-impaired or visually impaired, have received attention. However, other special population groups have not received such attention. One particularly important group for consideration is the elderly.

The assumption was naively made that the topic of written information transfer about drugs to the elderly would be a rapidly researched topic, but this was quickly changed. There is a body of knowledge about drug use in the elderly, there is a body of knowledge about receipt of information by the elderly, and there is a body of experience about drug information for the elderly. The three do not necessarily intersect. The sum total of the experience is that clearly there is a need for important research in the area of information transferred about drugs to the elderly.

Les efforts récents qu'a faits l'Administration des Aliments et des Médicaments des États-Unis (FDA) pour fournir des renseignements écrits sur les médicaments délivrés sur ordonnance ont fait ressortir la question de l'effet produit sur certaines populations spéciales, comme par exemple des groupes linguistiques, les infirmes, et surtout ceux dont la vision est troublée. Pourtant, d'autres groupes spéciaux de la population n'ont pas été tellement considérés, dont le plus important est celui des vieux.

BACKGROUND

The population in the U.S.A. continues to be an aging cohort. The proportion of older people in our society has grown from 4% (about 3 million) at the start of the century to 10% (about 23 million) today, and will reach 20% by the year 2030, one generation from today. While the population of the U.S.A. has tripled during this century, the elderly population has multiplied seven times.

This growing number of older persons can be attributed to several factors. First, there has been a substantial increase in the number of live births over