

10 Self-medication versus consultation

Individual autonomy and dependence in health decisions

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Introduction

Individuals can address their health problems in one of two ways: on their own, in their home or close social environment; or with the help of specialists, which as a rule involves payment. Medications play an important role in both the intimate sphere of the home and the professional sphere outside, regardless of where the drugs lie on the spectrum, from biochemical molecules to standardized or nonstandardized herbal treatments. Both therapeutic and commercial, they are used by individuals to treat their own health and by professionals who write prescriptions based on their diagnoses. A focus on medications allows us to analyze the ways in which people manage their health and to understand the choices they make to do so. What interests us as anthropologists, epidemiologists, and public health specialists in the context of our research in Benin and Ghana is understanding the mechanisms that explain why people either treat themselves at home or seek out a biomedical professional and the temporalities and logics they use to move from one to the other.¹

The literature in the social sciences, social epidemiology, and public health on health-care-seeking behavior is vast, in contexts in both the Global South (Fournier & Haddad, 1995; Mahendradhata, Souares, Phalkey, & Sauerborn, 2014; Ridde et al., 2018; Sams, 2017) and the Global North (Chaix, Navaie-Waliser, Viboud, Parizot, & Chauvin, 2006; Goldberg, Melchior, Leclerc, & Lert, 2002; Jacquet et al., 2018; Vallée & Chauvin, 2012), to name but a few. A whole series of context-specific social, economic, and structural factors have been proposed to explain behaviors. The premise of a recent study in France, based on the work of Robert Castel (2009), was that health-care practices can be understood as being shaped positively by individuals' own choices or negatively by the constraints to which they are subject, depending on their characteristics (Brutus, Fleuret, & Guienne, 2017). In his study of undocumented migrants in the United States, Nolan Kline describes how the political context of immigration influences health-care utilization and leads to the development of informal structures and alternative practices (Kline, 2017). In countries of the Global South, the emphasis is generally on economic, structural, and even "cultural" constraints, favoring

a “single story” rather than alternative accounts that go against this dominant narrative (Mkhwanazi, 2016).

For the purposes of this chapter and to answer our question, we will examine three important concepts. The first is the *social determinants* that shape individuals’ objective conditions (social class, income, education level, family situation, etc.).² The health-related institutional and social supports that individuals can mobilize must be taken into account as well, i.e., insurance mechanisms, characteristics of health-care offerings and medication availability, and belonging to social networks (Castel, 2009).

The second is the concept of *autonomy*, a basic definition that highlights “the capacity to think, decide, and act on the basis of such thought and decision freely and independently and without let or hindrance” (Gillon, 1985, p. 1806). Here again, institutional and social supports must be incorporated when analyzing autonomy with regard to health issues. The concept of autonomy and medication use has been researched extensively in relation to the issue of self-medication, the subject of several studies in France in recent years (cited throughout in this chapter), a country with its pharmaceutical monopoly under pressure from the European economic community (see [Chapter 3](#)). Self-medication may be defined narrowly (the use without a prescription of commercial specialty products to treat a health issue) or broadly (the use of any existing health products, or even health-care practices, including “prescriptions” written by other actors—from social circles or distribution or care facilities that are not legally authorized to do so—as well as “disguised self-medication,” when the patient asks his or her doctor to include specific products on the prescription) (Brutus et al., 2017; Bureau-Point, Baxerres, & Chheang, 2020; Fainzang, 2012; Moloney, 2017). We consider self-medication by individuals to be the use of health products without the supervision of a professional who individuals recognize as being able to “prescribe,” whether or not that person is actually authorized to do so.

The third concept of *popular knowledge* will be useful for us to understand what guides individual practices. Raymond Massé defines popular knowledge as “sociocultural constructs that reflect the vision that populations have of the world of health and illness.” It is authentic knowledge, collected in a true “cultural system of common sense.” “Constructed from a set of basic elements (beliefs, attitudes, values, etc.),” this cultural system “allows the individual to interpret the illness” and “to build models that explain the causes, progression, and treatment of his or her illness” (Massé, 1995, pp. 14 and 236).³ While not particularly novel, these three concepts will be important in our discussion here of public health.

In this chapter, we will show how, in the Beninese and Ghanaian contexts we studied, medication is an indicator both of individuals’ autonomous and positive management of their health, and of inequalities in their personal health and utilization of health services by socioeconomic status, urban or rural context, and country of residence. We will see that, depending on the health services and medication available to them and the health issues they face, people make different

trade-offs in varying temporalities between several forms of self-medication and consulting a professional. These trade-offs may reveal individuals' *autonomy* with regard to health or their *dependence* on the health-care system⁴ in relation to their *social determinants*. These determinants also highlight that autonomy and dependence are not contradictory but instead are extensively interrelated. Although the overall logic of health-seeking behavior appears to be relatively universal for people in both Benin and Ghana, we will see that structural and especially economic constraints affect some more than others. To understand these, we must first set the scene and describe the health-care services and medicines available in the two countries.

Differing health-care services and medication options in Benin and Ghana

The Ghanaian biomedical health-care system took root during colonial times led by the British (UK colonization: 1874–1957). In 1923, the Gold Coast Hospital, Korle Bu, was built, and for many years considered the most advanced facility in Africa (Arhinful, 2003). The biomedical health-care system in Benin was also launched during the colonial period (French colonization: 1894–1960) but a bit later than in Ghana, at the beginning of the 1930s (Baxerres, 2013). While these two countries share a similar geographic location, and have been confronted with similar Global Health actors and policies (Baxerres & Eboko, 2019), several national differences seem important in the types of health-care services and pharmaceuticals that are available in both countries.

Until the Bamako Initiative was implemented in this country in 1988, Benin provided free biomedical health services for its population, whereas Ghana charged people for health care from the late 1960s/early 1970s and in 1985 reintroduced full user fees and cost recovery for medication.⁵ The privatization of health care can be seen in Benin beginning in 1986 based on World Bank and International Monetary Fund recommendations. From that time, the national government limited the number of public servants in the health sector (Savina & Boidin, 1996). Young medical professionals were compelled to find new job prospects, which most frequently meant setting up their own practices or working in an already existent private health center. This led to an increase in small private health facilities in Cotonou and in Southern Benin from the late 1980s. These small private health centers often function in ways that are at odds with the legislation that defines them. Yet, it is not easy to categorize them into two groups of formal and informal health centers (Baxerres, 2013).⁶

Since 2003, Ghana has implemented the National Health Insurance Scheme (NHIS), which is still today one of the most advanced public health insurance systems in sub-Saharan Africa (Antwi, 2019). In Benin, it was not until 2017 that the Insurance for Building Human Capital (ARCH) was launched, but things do not seem to be happening quickly (Deville, Fecher, & Poncelet, 2018; Gbénahou, 2019).⁷ While these policy-level factors are not the only influences of how health-care services are used by people, they are very important in determining what

In the small city of Lobogo, population 17,000, there were at least 6. However, this was very different in rural Ghana; in Breman Asikuma and the surrounding areas, only one private health center was found: a maternity home that also offered general health-care services. Most of these facilities were different levels of public facilities (district hospital, health center, community-based health planning, and services [CHPS] compound), or occasionally a mission facility such as the one found in the district capital, Breman Asikuma, where the public district hospital is a mission hospital (see [Figure 10.2](#) below).

Unlike in Benin, there were no small, informal private health facilities in rural Ghana. The “injection doctors” described in the past (Senah, 1997) did not seem to be continuing their activity in the research sites during the time of data collection. While the Government of Benin favored a policy of community health workers to share health advice and products with people, as promoted by many Global Health actors (WHO, USAID, Global Fund, etc.), in Ghana, rural populations were mainly reached through CHPS compounds (nurses, health assistants), that, when possible, sometimes conducted outreach visits to remote villages and hamlets.

Examining the pharmaceutical medications that are available at these health facilities in both countries is interesting. Officially, in Benin, medication can only be distributed by public or mission facilities. Private health centers can only prescribe medications for patients who go on to purchase from private retailers. In Ghana, private and public outlets of pharmaceutical distribution were intertwined and all facilities that offered health care were also authorized to sell pharmaceuticals. Apart from these different actors in health-care services, pharmaceuticals are also (and primarily) available to the population from private retailers: private



Figure 10.2 Public district mission hospital of Breman Asikuma in Ghana.

Source: © IRD/Carine Baxerres, November 2015

pharmacies, mainly in cities (exclusively in the case of Ghana); over-the-counter (OTC) medicine shops in rural areas and in working-class neighborhoods in cities in Ghana; pharmaceutical depots in rural areas in Benin; and informal sellers in urban and rural areas in Benin.⁹

We will now analyze how people navigate these biomedical health-care services and drugs to manage their own health and that of their family. What logics emerge and which actors play a significant role in the two countries and in the urban and rural contexts we investigated?

Understanding “essential” management of family health events

The population survey we conducted among approximately 600 families in each of the different contexts—urban and rural in Benin and Ghana—allowed us to quantify families’ needs for health care, health management practices, and the realities of health-care-seeking behavior.¹⁰

These surveys indicate that in the various study areas, 70–90% of the ailments adults encounter on a daily basis are treated at home without requiring any biomedical consultation.¹¹ This rate is significantly higher in rural areas in both countries—90 versus 78% in Benin, 77 versus 70% in Ghana—likely due to a lower availability of health care and perhaps also to the lower availability of quickly accessed cash that is associated with agricultural and livestock activities (Baxerres & Le Hesran, 2010).

It is interesting to note that in all four of the contexts studied, the people we spoke to mentioned very similar day-to-day health problems. Our survey covered “health events” experienced in the previous 7 days.¹² People mostly reported very general symptoms: headache (12–30%), aches and pains (15–30%), fatigue (2.5–11%), and stomachache (4–9%). Symptoms indicative of infectious diseases (runny nose, cough, fever) (5–11%) were also reported. Popular nosological entities associated with malaria, known as *palu* in Benin and *malaria* in Ghana (see Chapter 7), also ranked high on the list of the most frequently encountered ailments (15–26%). Underscoring once again the discrepancy between “biomedical” and “popular” disease entities, this was true regardless of the local malaria epidemiological facies, despite higher parasite transmission in rural areas and more limited transmission in urban areas, due to pollution and a less favorable environment for mosquitoes. The chronic disease most often mentioned by the families surveyed was hypertension, commonly known as *tension* in Benin and *pressure* or *BP* in Ghana. It is significantly more prevalent in the city of Cotonou (6%) than in the other sites surveyed (between 1 and 3%), where it nevertheless represents a major health concern (reports are made on a weekly basis).¹³ When we ask people about the origin of the health events, the causes evoked may differ between urban and rural environments and relate to people’s living conditions: city dwellers more often associate their symptoms with pollution, noise, and stress (physical and mental fatigue) while rural inhabitants attribute them to harsh working conditions (heat, sun, physical fatigue). There also seem to be different

ways of talking about symptoms in Benin and Ghana: “Fatigue” was more often mentioned in Benin, and “headaches” and “pain” in Ghana.

For these very common daily ailments, the same therapeutic classes of drugs were generally used by families that did not first consult a biomedical professional in the four contexts studied: analgesics (20–30%), antimalarial drugs (10–16%), anti-inflammatory and antirheumatic drugs (5–10%), vitamins and tonics (6–10%), and antibiotics (4–6%). Several particular molecules from these therapeutic classes are mainly used: paracetamol (analgesic), ibuprofen (anti-inflammatory), quinine and artemisinin-based combination therapies (antimalarial drugs),¹⁴ and amoxicillin and metronidazole (antibiotics). These six molecules or combinations account for more than 50% of the drugs consumed by people in all of the areas.

Why do so many treatments involve these specific drugs? Because they are on the list of essential medicines defined by the health authorities of both countries. They have a long history as effective compounds and are available in generic form. They are also the drugs most frequently prescribed by health professionals. These molecules have very broad indications (fever, pain, broad-spectrum antibiotics) and are effective against numerous health problems. They therefore constitute an “essential” pharmacopoeia, one that is minimal and safe for families and can be used to treat most common ailments, similar to what health centers offer, and in many people’s minds just as effective. A study we conducted in Cotonou of nearly 14,000 medical visits in three public health centers clearly shows that people consult providers primarily for infectious or parasitic problems such as acute respiratory infections (13.1%), malaria (21.8%), and infectious syndromes (30%). The notation of “infectious syndrome” on health center records indicates that the origin of the infection is unknown. This is a “catch-all” diagnosis that shows how difficult it is for providers to make an accurate diagnosis in the absence of additional tests (such as blood cultures). We will come back to this point in the conclusion.

Returning to families’ use of pharmaceuticals and what individuals consider to be self-medication, we conducted exhaustive data collection during our participatory observations in urban and rural pharmaceutical distribution sites in Ghana and Benin. Standing at the counter alongside the vendors, we observed that, depending on the distribution site—pharmacies or OTC medicine shops in Ghana; pharmacies, pharmaceutical depots, or informal vendors in Benin—between 62 and 82.5% of drug purchases followed a spontaneous request from customers: either oral, showing an empty drug container (box, blister pack, tube), or presenting a piece of paper with the name of the product(s) (see [table 10.1](#)).¹⁵

Our quantitative and qualitative studies thus clearly show that, regardless of the differences in regulations, pharmaceutical distribution methods, and health-care services, self-medication is by far the most common modality for purchasing medications in both countries. Let us now examine how qualitative studies can help us understand these findings and flesh them out with regard to social determinants and living situation.

Table 10.1 Medication purchase modalities in various distribution sites

Purchase modality	Benin			Ghana		
	Urban pharmacies (n = 972)	Rural pharmacies (n = 1123)	Rural informal vendors (n = 521)	Urban pharmacies (n = 370)	Urban OTC shops (n = 703)	Rural OTC shops (n = 1040)
Spontaneous request (%)	73	65	70	62	82.5	78
Prescription (%)	20	30	0	21.5	0	1.5
Request for advice (%)	7	5	30	16.5	17.5	20.5

Source: Authors.

When people feel in control of their health problems

Self-medication as explained by the importance of popular knowledge

Through the in-depth interviews we conducted with families in various contexts studied in Benin and Ghana, it became clear that, whatever their socioeconomic status, people initially managed their health problems or ailments either on their own or with help from their family and friends. People have extensive knowledge about health and medicines that they logically mobilize when confronted with a health issue. The interviews that we conducted are interspersed with statements like “I took batrim [for Bactrim® or cotrimoxazole], three tablets in the morning for three days, to soothe my stomach ache” (father of a “poor” family, Mono department, Benin, January 2015); or “when I develop boils or have joint pain, I just go to the drugstore to buy medicine like quick action efpac” (grandfather, “middle class” family, Breman Asikuma, Ghana, March 2016); or “because I get hypoglycemia quickly, when time goes by and maybe I haven’t eaten, when I start shaking, I take vitamin C... UPSA-C, that’s what I take. So, if I take that and I still don’t feel better, I take calcium or magnesium in addition” (mother of a “wealthy” family, Cotonou, December 2014). Depending on the families and places of residence, this knowledge includes both pharmaceuticals and herbal remedies, which are taken as an alternative or simultaneously.

Thus, rather than just for mild symptoms or health problems, as have often been reported in the literature, this frequent self-medication is primarily used to treat health issues that people have under control or believe they have under control. This excerpt from an interview with a mother of a “poor” family living in Cotonou talking about her 14-year-old daughter illustrates this point: “Adèle does not get sick very often, the only time she has been sick is with jaundice (*ictère*)¹⁶ (...), she had that last year, (...) it was really serious, if we hadn’t taken good care of her, she would have passed. Her father had to buy the medicines that help the blood, and I sought out coconut and kinkeliba tree roots that I prepared.

That's what I gave her first and it got better" (December 2014). Another example is a mother from an upper class household in Accra who explained how she treated her son's recent illness, and also treated her other children as well: "He was coughing persistently, it was not going, it goes it comes, it goes it comes, it goes it comes, so I just decided to buy the flemex. It wasn't going. I mean after a week, so I bought the antibiotics to add and gave them piriton... because all three [children] have allergies" (March 2015). This observation has also been made in other contexts, including in France and in relation to chronic diseases (Brutus et al., 2017; Fainzang, 2012). "The criterion is that of known rather than benign disorders, as this experiential knowledge may relate to serious disorders, but ones the patient knows and, above all, recognizes" (Brutus et al., 2017, p. 9). Thus, when people are familiar with the health problem, they logically do not turn to a health professional. In some families, initial at-home management even seems like a necessary step, proving that the parents (often the mother) take good care of their children. During a bimonthly follow-up with a "wealthy" family in Cotonou, the mother explained that "she cannot go to the hospital for an ailment for which she knows the treatment; if the child cannot get warm, coughs, or catches a cold she's not going to run to the hospital" (July 2015).

As Brutus et al. (2017) show in French contexts, self-medication is not merely a linear practice, a step in an individual's health-care path before turning to professionals. Yet again indicating the importance of the popular knowledge individuals mobilize for their health, in several situations we studied, individuals decided to combine practices from the domestic sphere with a biomedical consultation. A mother from a "poor" family living in the Mono department in Benin explained that she had given "home" medicines (referring to informal vendors) to her 18-year-old son for "worm problems," then went to the hospital, and upon returning home she gave him more "home" medicines, which was when the problem ended (bi-monthly monitoring, April 2015). In Ghana, we found a similar situation, with a mother in an Accra "middle-class" household who explained, "I remember, there was a time I sent my daughter to the hospital...the [medicines] which were given to me, I came home and gave them to the child but still, at the end of it all, I went with her again to the pharmacy to buy [medicine] for her before she got better" (January, 2015). In both countries as well, we found mothers or fathers who would give herbals in addition to medicines prescribed by health centers.

The knowledge that people mobilize for health and medicines in the different contexts we have studied is built through a syncretism between practices transmitted from generation to generation and biomedicine (Baxerres, 2013). As Laurent Brutus et al. noted in French contexts, the relationship with biomedical professionals is also important in Benin and Ghana. "Self-medication is not so much characterized by the absence of medical advice, but by how it is transformed, and the use the patient makes of it" (2017, p. 9). Thus, in Benin and Ghana, people acquire knowledge when they go for a consultation in a biomedical health facility. They then follow that same advice again in the future for symptoms they consider to be similar. They also learn from the biomedical

professionals in their social environment who have a broad range of skills (from the specialist physician to the nurse, midwife, nursing assistant, and even the pharmacy salesperson, medical representative, or hospital administrator). People also learn from and are influenced by their entire social environment: neighbors, colleagues, and immediate and extended family, as previously described in the literature (Jansen, 1995; Quintero & Nichter, 2011). Marion David and Véronique Guienne talk about “collective prescriptions for behavior or consumption” (2019, p. 3). The Internet and social networks, particularly WhatsApp, are now increasingly used in Benin and Ghana to convey information about health, illness, and treatments. Finally, the media (radio, television, newspapers) are another significant vector of information, through public health awareness messages, information about health development projects, and even advertisements for different kinds of health products.¹⁷

Similar to what recent research conducted in France has demonstrated, we find in the context of our research that self-medication also occurs through experimentation or testing that people perform on themselves when they experience symptoms. “If you want to use leaves, use them to clearly see how they work. In the same way, you’re going to focus on a single drug for a while and see how it works... that gives you a clear idea of what really cured the disease” (father of a “middle-class” family, Mono department, January 2015). Laurent Brutus et al. talk about a “daily experimentation on one’s own that is primarily based on experience,” which is to be understood both in the sense of “having the experience of,” as we saw above with regard to consultation experiences, and in the sense of “experimenting” (2017, p. 10). Sylvie Fainzang (2014) evokes a true “experience-based-medicine.” People perform these tests by self-medicating, which if effective, enables them to avoid consulting specialists. A mother in a semirural Breman Asikuma “middle-class” household explained, “when [my husband] notices that any of the children is sick then he tells us to use herbal medicine for a while to see if there would be a good result. If there’s anything more to do then we would take them to the hospital...most times he wants to see the result first. And most of the time too it doesn’t get to that, to take them to the hospital” (interview, November 2014). The concept of “experiential knowledge” may be interesting to consider here. Without wanting to mobilize a “fashionable” notion, used outside its usual health domain (chronic diseases, disability), it seems to us that by evoking this idea for frequent daily drug consumption rather than to treat acute symptoms, we are able to demonstrate how individual “testing” of the body is important in these situations and that it results in collectively constructed knowledge that is transmitted to the individual.¹⁸

Products and purchase sites conditioned by social determinants

Self-medication is widespread in Benin and Ghana, regardless of socioeconomic status, context, and place of residence. However, the products and pharmaceutical distribution sites utilized differ depending on the families and their country (Benin or Ghana) and context (urban or rural) of residence.

“Wealthy” families in Cotonou and Accra are more likely to go to pharmacies, while “poor” families in these two capital cities are more likely to go to OTC medicine sellers (in Ghana) or informal vendors (in Benin). The medicines used for self-medication in rural areas are commonly purchased from OTC medicine sellers in Ghana and informal vendors in Benin, regardless of socioeconomic status. Our quantitative data show that in rural Benin these sources account for 70% of the pharmaceuticals used to self-medicate versus 30% in the city of Cotonou.

In Benin, the drugs used for self-medication are sometimes purchased from health centers, more often in rural areas than in cities, without a prior consultation. The percentage of sales following a “spontaneous request” for drugs by the “patient,” who then becomes simply a “client,” can be as high as 15–20% of total sales in the pharmacy of certain health centers (a public neighborhood health center and a small mission health center that we observed, for example). Indicative of the phenomenon of drug commodification in health centers in Benin (Baxerres, 2013), these centers—whether private or public, urban, or rural—are never utilized for the purposes of practicing self-medication in Ghana.¹⁹

We also observed a kind of gradation in the self-medication practices of families that may involve a succession of different types of products, purchased in different places. Some people start self-medicating with plants before using pharmaceuticals (or vice versa) and then may return to other herbal remedies later. Others start with one type of pharmaceuticals (e.g., analgesics) before turning to others (e.g., antimalarials) later when the fever, in this example, does not go down. Some people start self-medicating with leftovers from previous prescriptions before going to buy other products if the problem persists. Others in Benin start by using drugs purchased from informal vendors before using those purchased at the pharmacy, at times interspersing these with drugs purchased in a health center (without prior consultation).²⁰ “Poor” families are generally the most likely to self-medicate multiple times before consulting a professional.

Herbal treatments are an important object that warrants some attention. Our quantitative studies show very different realities on this subject in Benin and Ghana. In Cotonou, households self-medicated with herbal treatments in response to the “health events” in the previous 7 days 4% of the time, compared to 94% for pharmaceuticals (2% combined both types of remedies). In the rural area of Lobogo, 14.8% of the treatments used were herbal, versus 66% for pharmaceuticals and 8.6% combining the two. In contrast in Ghana, herbal treatments were much more widely used in Accra, in nearly 30% of cases, compared to 15% in rural areas. Phytotherapy was more frequently used alone (not in combination with pharmaceuticals) in Ghana, where a nonnegligible percentage of herbal medicines are standardized (see [Chapter 8](#)). In Benin, the phytotherapy used was mainly prepared at home (concocted with ingredients bought at the market or collected from the surrounding environment). Offering standardized phytotherapy products thus seems to modify the public’s understanding and exclusive use of them vis-à-vis pharmaceuticals.

When individuals feel the need for outside professional advice

Comparable logics but inequalities in temporality and options

A similar logic for when to seek help from biomedical professionals was used in both countries and regardless of socioeconomic status. Individuals will consult a professional when the health problem does not go away, returns, or worsens after one or more self-medication practice(s). A father of a “poor” family living in the Mono department of Benin explains: “after three days, if it doesn’t get better, it isn’t working, you have to know that it’s beyond the pills you buy, then you have to go to the hospital” (interview, January 2015). A mother from an upper class semirural family in Ghana used a similar logic to explain seeking help: “After I heard the child cough...I thought maybe it is just a small unexpected cough. Later the cough persisted so I went to a drugstore nearby...he gave [me] cough medicine for the child. After I gave the medicine to the child, he started vomiting phlegm... later we took the child to the hospital, and there we heard it was asthma” (interview, November 2014). Similar logics were expressed in Cotonou and Accra, irrespective of socioeconomic status. A mother from an Accra upper class household explained, “when someone is not feeling well, you have to know a particular place. If for example it is headache, you go to the pharmacy... The first aid is a painkiller to calm it down. If it is not working, you go to hospital” (interview, February 2015).

The fact that the health problem is considered serious at this point (the symptoms are multiplying and/or prolonged, the patient appears to be quite unwell) and that it is a cause for concern justifies going to see a doctor in all the contexts studied. Therefore, in some situations, when the problem appears to be severe from the outset or when people cannot explain it or do not understand it, the self-medication stage may be skipped or considerably shortened. Patients may also consult a professional early on when they are seeking a specific biomedical technique, whether they believe they understand the health problem (when they request an injection) or not (when they request a medical examination).

Although these logics of health management are broadly similar across families, it is when individuals seek help from the external sphere that social and residence-based inequalities are most clearly expressed. In the various contexts studied, we found that when the problem was not solved through self-medication, the more precarious the person’s socioeconomic status, the longer it took to see a professional. Our bimonthly monitoring visits with the various families show that this most often ranges from a few hours to 1 day for “wealthy” families to possibly several days (more than 1 or 2 weeks) for “poor” families. The anxiety that leads to the consultation often appears to be more pronounced in “poor” families than in “wealthy” ones. A mother from a “poor” family living in Cotonou explains, “I don’t go to the hospital like this myself; before going, I have to know that it is really out of my league. If an illness arrives and I treat it at home myself without any improvement, I take it to the hospital. That’s how it is, but that doesn’t happen very often” (interview, February 2015).

Thus, the connection families develop with health facilities, which we observed for about a year, often appears characteristic of their socioeconomic status in both urban and rural areas. In Benin, for example, Myriam's family—consisting of herself, her husband, and their three children—is “poor” and lives on the outskirts of Cotonou. She explained in an interview that they had not been to the hospital for a very long time. During the bimonthly follow-up, Myriam was the only one to have had a consultation; she was supposed to go back for a checkup, but since she had no money, she prepared herbal tea instead. When her youngest (3-year-old) son had “measles,” she gave him herbal tea and went to a small private health center to buy medicine without a consultation. Her 10-year-old daughter had a health problem that worried them considerably, but they did not go to the hospital; instead they gave her a variety of pharmaceuticals and herbal teas. In comparison, Aubierge's family, which is “wealthy,” resides in the Mono department and consists of both parents and their five children, ranging in age from 17 years to a few months, regularly visit the health center. During the bimonthly monitoring period they had gone in a total of seven times. Two of the children (ages 4 and 14) were brought directly to the clinic when they had a fever. In Ghana as well, lower class households visited health facilities less than upper class households. Discourse about care-seeking was very different between the socioeconomic categories, with upper class families insisting on the importance of a biomedical approach. For example, one mother from an Accra lower class household stated, “as for me in particular, I have never been to the hospital. I don't know if I was taken when I was young but as far as I can remember, anytime I am sick, I either go to the pharmacy or the drugstore; then I buy what I need to buy and go, but when I realize that the medicines from those places are not working, then I get my herbs and cook it and drink it” (interview, January 2016). In contrast, a mother from an upper class Accra household stated, “The adults, I will be honest with you, we like to self-medicate, but when it comes to the kids, we don't take chances. We go [to the clinic]...I take them” (interview, March 2015). Generally in both countries, “wealthy” families more frequently (or quickly) bypass the self-medication stage.

A family's socioeconomic status also influences the type of health centers they use. However, the urban or rural context and the country of residence also have a strong impact on this point. In both Accra and Cotonou, for example, “wealthy” families are more likely to go to expensive private clinics or to the major public national reference hospitals to consult specialist physicians. “Poor” families are more likely to go to public health centers where they see nurses, or, in Cotonou, to small, inexpensive (often partly informal) private health centers. By contrast in rural areas, as we have seen, families do not have as many health-care options. Regardless of their socioeconomic status, all the families we studied in Breman Asikuma in Ghana go to public health centers for consultations or to the local mission facility.²¹ This is also predominantly the case for the families studied in Benin's Mono department, even though they also have a few private health centers at their disposal.

The range of health-care options in a specific context may, as with self-medication practices, lead to a kind of graduated reliance on biomedical professionals. A mother from an urban upper class household in Accra described how she sought care from a private hospital for illnesses that seemed serious or unfamiliar, otherwise she would go to a public hospital or self-medicate. Families in Benin may first go to a small private health center close to home before seeking care at one or more other health facilities seen as having a higher level of competence, if necessary. We were told several stories of families navigating grueling obstacle courses to obtain health care. For example, a father from a “poor” family in Cotonou told us about his 11-month-old child, who had a fever he thought could be *palu*. He gave the boy paracetamol and ibuprofen, followed by moringa tea made from leaves he had taken from a tree near his home. When the fever did not go away, the next day he took the child to a small private health center nearby where he received several injections morning and evening for 3 days. But there was still no improvement so they went to a second small private health center where the child received another injection, but since he was really sick at this point, the father was advised to go to the nearest public district hospital.

Deciding which type of health center to visit is also heavily dependent on whether or not the family has health insurance, and the agreements this insurance has with specific health facilities. Contrary to expectations, the NHIS in Ghana did not have a strong impact on health-care utilization at the time of our studies. People are much more likely to have insurance coverage in Ghana than in Benin (our quantitative surveys show that nearly 70% of Ghanaians have insurance, mainly through its NHIS, compared to 10% of people living in Benin’s capital and less than 4% in its rural areas).²² However, many appear to be behind in their payments (only 44.24% of the families in Accra in the quantitative survey had renewed their annual membership). But even among those who have insurance, the fact that their expenses may be covered does not necessarily mean that they consult a biomedical professional more quickly or more often, particularly for the acute health issues on which our surveys were more specifically focused. Indeed almost half of the people with health insurance who we surveyed in Accra declared they had not used it during their last health problem. This may be due to the fact that not all health expenses are covered by insurance. Furthermore, seeking help from a biomedical professional for frequent health issues that are perceived as not being (too) serious did not appear to represent a sufficient advantage, but in fact may be seen as a waste of time (indirect costs) compared to visiting a pharmaceutical retailer (pharmacy, OTC medicine shop). “When we do lab tests, for that you have to pay money...At times when you go there [to the hospital], they say ‘this medication is not covered by the Health Insurance’ or ‘that medication is out of stock’. And the medicines they will give you are those that cost 3 and 4 cedis [USD 0.5–0.7] but for the expensive ones, there is no way you’re going to get it. (...) So if I have the money and I can [go to] the pharmacy, it’s better than me going to waste much time over there. At times, maybe you’ll come [from the hospital] and you wouldn’t have that money to go buy medicine

at the pharmacy for the child...which means that, the hospital you visited, what was the use?...So I feel that the pharmacy is where I should go and show them the children for medication to be given to them. It is better for me” (interview with a mother from an urban Accra “middle-class” household, January 2015). Despite very strong political will for the NHIS in Ghana, one of the most advanced insurance programs in Africa, the program appears to have stagnated in growth while raising concerns of equity and sustainability (Antwi, 2019).

Distribution actors involved in health-care service provision

In both countries, certain actors in the pharmaceutical distribution sector have significant influence on how families use outside professionals. As illustrated in the [table 10.1](#), OTC medicine sellers in both rural and urban areas of Ghana, and informal vendors in rural Benin, offer advice in a relatively high number of cases (17–20% of cases in Ghana and 30% in rural Benin).

Because they are able to offer treatments for common health problems without the downside of a consultation in a health center—especially a public facility, with its long waiting times, direct and indirect costs, poor reception, and tense relations between providers and patients (see Bogart et al., 2013; Jaffré & Olivier de Sardan, 2003)—some consider these distribution actors to be professionals people can turn to when home remedies have failed to solve the problem. Individuals therefore view this as consultation and not as a form of self-medication. These pharmaceutical retailers’ broad accessibility, both geographic (they are numerous) and financial (their products are generally less expensive than those of pharmacies), surely explains their popularity. In Accra, OTC medicine sellers are especially important for “poor” families.²³ However, in rural areas in both countries, where they are often the only outlets for medications (there are no pharmacies in rural Ghana; informal vendors are the most common retailers and often the only ones found in rural Benin), OTC medicine sellers in Ghana and informal vendors in Benin influence the health-care practices of the vast majority of families, whether they are “poor,” “middle-class,” or “wealthy.”

In Benin, we did not conduct systematic observations of informal vendors in Cotonou as part of the Globalmed research program. However, our previous study in this city (Baxerres, 2013) found that they only play a minor role as health advisors, likely due to the greater connections that people have with health professionals in Cotonou than in rural areas and the greater media influence in that city.²⁴ This was confirmed by the family interviews conducted as part of this study. Of the 15 families we worked with in Cotonou, only two, both “poor,” showed signs that their health-care practices were influenced by informal vendors. In rural areas, on the other hand, interviews found this influence to be significant. The mothers and fathers of families living in the Mono department, regardless of their socioeconomic status, often told us that they had learned about a particular drug they were taking through the informal vendors. “It was a night that I was so cold²⁵... I bought para [paracetamol] that I took for two or three days but it didn’t



Figure 10.3 Stand of an informal saleswoman in Benin rural area.

Source: © IRD/Carine Baxerres, April 2014

work, so one day I went to see a lady who sells at a sidewalk pharmacy. I told her about it, and she recommended that I take para C. Later that evening, the cold came back and I was shivering, then I drank that tablet and 15 minutes later I started sweating and the cold stopped... I was so happy, if I had had any money I would have gone and given it to the lady... that's when I started taking this tablet" (interview, "middle-class" father, December 2015).

The prescribing or even consultation role that the saleswomen play is evident in this statement by a "poor" father: "If you go over there and say 'sell me pills for body pain', she'll sell you this. They are the ones who know the names... if you only have pain in a particular area, tell them the part where it hurts, and they will sell you their medicine... even when you go to the doctor, they will ask, 'where does it hurt?'" (interview, December 2015).

In Ghana, many owners of OTC medicine shops have a very positive reputation and are seen in their neighborhood as preferred advisors regarding health. Some families indicated that they have a lot more confidence in attendants of OTC medicine shops than doctors. "I remember, there was a time I sent Princess [her daughter] to the hospital, I gave her the medicines which were given me, but still, she did not feel better... at the end of it all, I went with her again to the drug-store²⁶ to buy medicine for her before she got better, so I don't depend on hospitals most of the time... he [the owner of OTC medicine shop] is really knowledgeable about medicines" (interview with a "middle-class" mother, Accra, January 2015).



Figure 10.4 A very popular OTC medicine shop in rural Ghana.

Source: © IRD/Eunice Ayimbila, May 2016

OTC medicine sellers play an even more important role in health care than informal medicine sellers in Benin. Indeed not all attendants have health backgrounds (few of them were retired midwives or nurses, for example), but some effectively combined their activity of selling medications with medical care such as giving infusions and injections, in spite of these practices not being officially permitted. At one OTC medicine shop in Accra, the owner had a small room behind the store where injections were given. There were beds where patients could be detained for a while. The owner compared the quality of health care to that received at the hospital. “Because of the treatment here, having time for you, talking to you, and doing all these things for you. People come from far. It is just like you have gone to the hospital but they don’t pay for consultation...” (interview, OTC medicine seller, Accra, November 2015). Most OTC medicine sellers said they maintained excellent customer relationships and offered the best of care to their clients. Perceived expertise of the OTC medicine sellers then also contributed to the use of these shops as a primary resource. The mother of an Accra lower class household described a women medicine seller who she liked purchasing medications from, “She usually comes in the evening. She is very good. She gives a lot of advice before she gives the medicines. If it is too much for her too, she would tell you that you should go to the hospital” (interview, January 2016).

Conclusion

In this chapter, we first discussed the dialectic of peoples’ health-related autonomy/dependence or empowerment/vulnerability in the Global South contexts in which we worked. Studies in recent years in France illustrate both the normative

context of contemporary individualism, which promotes autonomy, and the fact that modern-day patients take responsibility for their own health, thus freeing them from the yoke of “medical paternalism” and “the mirage of autonomy.” They highlight the fact that autonomy is often manipulated by governments for economic purposes in a desire to control health-care spending, and that it therefore remains relative, particularly in the irrevocable link between patients and biomedical professionals (Brutus et al., 2017; Fainzang, 2012).

The situations we described in Benin and Ghana, in contexts where health expenditures are only infrequently covered by an insurance system, underline different realities. Here, self-medication reflects a form of positive autonomy, regardless of socioeconomic status or life contexts. Mobilizing their extensive “experiential knowledge,” individuals draw on a wide range of health products at their disposal: pharmaceuticals offered in various distribution outlets, and herbal remedies either purchased or gathered from nearby courtyards, gardens, or bushes. Without dismissing the potential risk inherent to some of these practices (for example, overconsumption of anti-inflammatory drugs to treat aches and pains as we noted),²⁷ our data show some actual room for individuals to maneuver in how they manage their health. We believe this is not highlighted enough in the Global South.²⁸ However, it should be recognized, following first Anne-Marie Mol, then Emmanuelle Simon, Arborio, Halloy, and Hejoaka (2019), that this autonomy is essentially built collectively, as we have seen in Benin and Ghana, which may seem contradictory. These authors prefer to speak of “the logic of care” and “associated knowledge.”

However, when people do not or no longer feel able to manage their health problems either on their own or in their social environment, this autonomy is largely constrained by their social determinants and place of residence. Socioeconomic inequalities in health are very clearly expressed in the contexts we studied, including in Ghana with its NHIS. We indicate the issue of the delay in seeking care: in both countries, the poorest people sometimes find themselves in significant distress that can lead to human tragedy, as evidenced by the high malaria mortality rate among children under 5 years of age in Africa.

Our comparative study in two countries that are close geographically but far apart in terms of health-care services and medicine availability allows us to make original observations about territorial inequalities in health. We have seen that the inhabitants of the capital cities and the semirural and rural areas we surveyed do not have the same options for health care. In these latter geographical contexts, we do not see socioeconomic inequalities in the choice of which pharmaceutical retailers or health professionals to consult, as available services are largely the same regardless of socioeconomic status. This is especially true in Ghana, where people only have access to OTC medicine shops and public health centers or mission hospitals. However, we do find inequalities in how promptly families seek professional treatment. Privatization of health care, very visible throughout Accra and Cotonou, and less evident in semirural Benin, is virtually non-existent in the research site that we studied in semirural Ghana. Health facilities that are present in Brehmankor appear to be considerably “nationalized” since it is almost exclusively public.

This leads us to one final discussion: the place of providers. As we have seen in Benin, all kinds of health centers sometimes sold medications to individuals who had not been examined by staff at the center. The sale of pharmaceuticals appears to have gained a position there in the provision of care. In Ghana, health facilities were not visited solely to purchase medication, which was done at OTC medicine shops, or pharmacies. Unlike in Benin, there were no small private informal health facilities in rural Ghana. From another point of view, OTC medicine sellers are key actors in the distribution of pharmaceuticals but also in basic health-care services (injections, IVs). Then, it appears that, much more than in Benin, the distribution of pharmaceuticals in Ghana gained importance as a type of care. The presence of the numerous OTC medicine shops seemed to thwart the drive for the small private informal health-care centers that were found in Benin. This means that most providers do not even have access to basic clinical training (nurses, health-care aides).

One might legitimately question the place and role of biomedical professionals in the contexts we studied, where pharmaceutical retailers have a substantial presence, whether formal as in Ghana or informal as in Benin. According to a “disempowerment of the doctor” dynamic described in Western contexts, such as occurred between the two World Wars when American antibiotic manufacturers favored broad-spectrum molecules, thus encouraging less specific diagnosis (Podolsky & Kveim Lie, 2016), or when, more generally, the pharmaceutical industry relies on direct-to-consumer advertising campaigns (Dumit, 2012), one wonders whether the extensive and omnipresent pharmaceutical distribution in the Global South contexts we studied is a factor in devaluing the status of biomedical expertise. Given the current disenchantment with health services (our quantitative survey in public health centers in Cotonou found there were often fewer than 20 consults per day), cursory clinical examinations, and stereotypical prescriptions limited to a few essential drugs, it is important that health authorities reverse this trend by increasing what biomedical professionals can offer so that their clinical diagnoses are seen as providing true added value to patients beyond what they can do for themselves in their social environment or in their homes.

Notes

1. The health-care professionals we have chosen to focus on in this chapter are biomedical and pharmaceutical practitioners. Although other types of professionals may be consulted in the contexts we studied (e.g., traditional healers, practitioners of Chinese medicine, and religious healers), this is relatively rare. Traditional healers are more often consulted about family, relationship, or professional problems, while herbal medicine in the domestic sphere is frequent. The use of herbal remedies will be discussed. It should also be pointed out that people make extensive use of health products to prevent future illnesses or to maintain their good health (Baxerres, 2013). These practices are more highly developed in Benin than in Ghana. However, they will not be described in this chapter, as we wanted to focus on how individuals manage current health problems.

2. Although “social determinants of health” is becoming increasingly important in public health, some scholars such as Gregory Simon have noted that this term does not take in account the role of resilience and hope. Simon advocates for the term social “influencers” rather than “determinants.” See: <https://medium.com/@KPWaResearch/whats-wrong-with-the-term-social-determinants-of-health-8e69684ec442>, accessed September 2020.
3. The concepts of “popular” or “local” knowledge in health are more frequently used in Global South contexts, while “lay knowledge” is used more often in the Global North and is considered in the provider-patient relationship. The two are essentially equivalent.
4. As Sylvie Fainzang (2012) reminds us, “dependence” is used as an antonym of “autonomy” in the field of disability, when, following an accident or illness, a person becomes dependent on outside help for their daily activities. We find it relevant to our argument here, to emphasize that people’s health care practices may be largely dependent on external factors and that their ability to decide and make free choices is thus biased.
5. In 1992, the “cash and carry” system was introduced. Health facilities were required to pay for drugs that they collected from medical stores, and patients were required to pay for services before being treated, all as a way of efficiently managing the drugs at a sub district level (Arhinful, 2003).
6. Indeed, whether or not a center has been authorized to operate does not strictly depend on the quality of care, the apparent cleanliness of the facility, or the status of its director (doctor, nurse, or midwife) and his or her actual presence in the health center. Many small health centers have obtained authorization through improper means: the reported director is not the one who actually runs the facility, authorizations are granted to nursing care facilities or childbirth clinics even though they offer a wider range of services and prescriptions. Some hospitalize patients without being authorized to do so; others perform deliveries without midwives on staff.
7. In 2008, before the ARCH, the Beninese authorities had established the Universal Health Insurance Scheme (RAMU), but implementation was quickly aborted. At this time only formal sector workers and their dependents are covered by Benin’s National Pension Fund (FNRB) or private insurance companies. They still represent less than 10% of the country’s population (Gbénahou, 2019).
8. Note that our data were collected between 2014 and 2017. However, there have been significant changes in Benin since 2017, related to reforms by the administration of President Patrice Tallon, such as the current ban on performing biomedical functions in both the public and private health sectors and the closure of many private health centers. These reforms undoubtedly impact the biomedical services currently available in that country.
9. See [Chapter 3](#) for more information on these different actors in pharmaceutical distribution. In Ghana, OTC medicine shops are managed by non-pharmacists with a minimum academic level who must attend mandatory post-registration training sessions on a regular basis and are authorized to sell only OTC medicines and some public health program products such as antimalarials or contraceptives. They were numerous in the country (10,424 at the time of our study). Private pharmaceutical warehouses in rural Benin are also managed by people who do not have a degree in pharmacy. Owners are authorized to sell essential medicines from a limited list and are under a pharmacist’s supervision. They shut down if a pharmacy opens within a 10-km radius. Linked to this strict legislation, their number is very few in rural Benin (165 in 2018). In Benin, the large number of informal vendors distribute medicines outside the formal channels imposed by the State: in markets, shops, stalls, on the side of busy roads, door-to-door, at home, on public transport, etc.
10. See the Introduction of this book for more information on the methodology used, quantitative and a combination of qualitative and quantitative here, and qualitative next.

11. We are discussing adults here so that we can analyze the numerous quantitative data points we have for the four different sites (two per country). This is not to suggest that these practices are very different for children (self-medication rates are between 70 and 84% for children in the four contexts), but that we have chosen to focus here on adults.
12. We created this “health notion” in social epidemiology for the purposes of this study. The idea was to ask families about broader issues than just the “health problems” defined by biomedicine. By using the term “health event,” we can include all the reasons why people use medication.
13. However, hypertension can be hard to gauge. If the disease is treated properly, it does not cause acute symptoms. If not, its symptoms are nonspecific (headache, shortness of breath, swelling in the legs). This suggests that popular perceptions of *tension* or *pressure/BP* and treatment practices and the use of preventive medicines to prevent this disease are particularly fruitful to study regarding the issue of (non)-diagnosis and (non)-biomedical monitoring.
14. Quinine is used mainly in Benin (see [Chapter 7](#)).
15. These pieces of paper show that this was either an order placed by a third party with the person, advice from a relative, or a prescription from a health professional by telephone or without a prescription pad. In the latter cases, which were few, the person is not self-medicating. Since we were unable to distinguish between these situations, we counted them as “spontaneous requests,” so this category may be slightly overestimated.
16. The French term was used in this interview conducted in the Fon language.
17. In a French context, Sylvie Fainzang discusses the multiple sources for gaining knowledge that people mobilize when they self-medicate, of a “baroque, composite, and recomposed knowledge.” She also discusses a specific form of “circular knowledge” between patients and their physicians, in which the latter are able to reappropriate the testimonies of the former regarding the effectiveness and effects of treatments and use them during subsequent consultations (Fainzang, 2012).
18. The first use of the concept of experiential knowledge in health dates back to the 1970s, but it has increasingly been the subject of scientific production since the 2000s (Simon, Arborio, Halloy, & Hejoaka, 2019). Such knowledge “is developed through collective and sustained sharing among peers and is the result of a personal reflective process and work. Experiential knowledge automatically emerges in an interactional configuration between the patient and other patients within various mediation spaces such as peer groups, support groups, or the Internet and social networks” (p. 59). Emmanuelle Simon et al. note that there is no gap between experiential and scientific knowledge, as health-care professionals also develop experiential knowledge. Simon et al. also emphasize that experiencing the illness is not enough to develop experiential knowledge. Like us, Marion David and Véronique Guienne (2019) also utilize this notion in relation to self-medication.
19. However, unused prescribed drugs are commonly later taken for self-medication in both countries, as described in other contexts (Brutus et al., 2017; Fainzang, 2012).
20. [Chapter 11](#) discusses the concept of a drug’s “subjective quality,” which in Benin partly explains these gradations of use by the various distribution points.
21. Although Breman Asikuma had limited health services, families in the study did not report traveling to seek care. One husband from a rural upper class family described seeking care and buying medication in Accra, but he was already in the city for other reasons. He did not travel there specifically for treatment.
22. In rural areas, however, 46.55% of respondents were affiliated with a *tontine*, a local savings system.
23. Note that pharmacy vendors in Accra also play a significant advisory role (16.5%), just behind OTC medicine sellers, which is not the case in Benin in Cotonou or even in the Mono department, where pharmacy vendors recommend products to

- their clients in only 5–7% of cases. Regulation of pharmaceutical distribution combined with the health care services offered in both countries seem to allow formal retailers in Ghana greater free rein in offering advice than in Benin.
24. Data collected from a retailer in one Cotonou neighborhood showed that out of 205 customers, 82% had approached the retailer with a direct request for the drug they wanted. In the pharmaceutical sector of Cotonou's central market, this was true of 94% of the 260 “lay customers” (non-professionals) observed.
 25. *Avivo* in the Mina language, which means “cold” or “shivering.”
 26. The term “drugstore” was used by respondents to refer to both pharmacies and OTC medicine shops, and many respondents described not knowing the difference between these two categories. In this case, the mother was referring to an OTC medicine shop.
 27. These risks appear relatively minimal in French contexts (Brutus et al., 2017), unlike in North America where they are seen more broadly, such as in the opiate crisis.
 28. Our research in Cambodia revealed very different realities. Linked to the country's political history, particularly the Khmer Rouge regime, people have developed much less room for maneuvering in terms of health care and a heavy dependence on pharmaceutical retailers (Bureau-Point et al., 2020). The inclusion of herbal medicine in the analysis might have demonstrated a form of autonomy restricted to that type of health product.

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