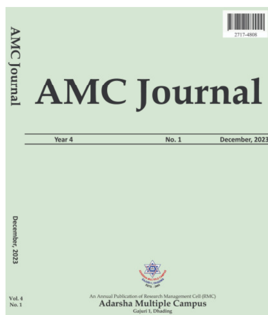

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# Medicine Users' Perspectives on Self-medication

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**Abstract**

*This paper provides an anthropological assessment on self-medication practices. It seeks to investigate representations associated with self-medication and identify contextual elements which can reinforce or inhibit such practice by employing medicine-users' perspective on the non-compliance of prescription. Primarily based on the informal conversations/interviews with 10 informants, it analyzes how socio-cultural and different forces shape our understanding of and actions towards health, illness and healing and the ways of wondering and behaving related to self-medication. It explores a few determinants for self-medication including the influence of medicine-sellers, circle of family members and friends, the role of pharmaceutical marketing, notion of the health problem as transitory and a minor issue, familiarity with and easy access to certain medicines, and difficulties in access to health care professionals. It concludes that the ubiquity of cultural practice of self-medication is the function of the concept of people on inaccessibility, time consumption, unaffordability and dissatisfaction in the delivery of formal health care services.*

***Keywords*****:** anthropology, disease, illness, medicine, self-medication.

## Introduction

Self-medication is a common human behavior and an important form of self-care in the health care system. Self-medication refers to the scenario where a person uses non-

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prescription medicines or other approaches to cope with illness conditions or a treatment of oneself without professional help to alleviate an illness or a condition (Van der Geest, 1984a; Zhao & Ma, 2016). This definition clarifies that self-medication includes the utilization of medicines for the treatment of the disease or symptoms or for disease prevention without a professional prescription. Self-medication can take place through the consumption of varieties of modern medicines such as allopathic, *ayurvedic* and homeopathic medicines or the use of homemade remedies like green teas and herbal extractions. Besides acquiring medicines without a professional prescription, self-medication also involves cultural foundation as 'resubmitting old prescriptions to purchase medicines' (Greenhalg, 1987) or sharing medicines with family members, relatives or members of one's social circle or friends (Van der Geest, 1984b). However, this paper analyzes the beliefs and practices related to the usage of cutting edge allopathic medicines.

Self-medication is common in both developed and developing countries (Van der Geest, 1988; Bradley & Blenkinsopp, 1996; Tripathi, Bapna, & Tekur, 1996). According to Van der Geest (1984a), self-medication is natural because of its convenient, economic and easy availability, even in small villages, people can purchase painkillers, antibiotics and medicines against malaria, worms, and diarrhea or common health problems. Within the growing nations like Nepal, experts may not be available or time consuming, so self-medication is vital. As many people store some medicines at home (Pellegrino, 1976; Uglade & Homedes, 1994), it may additionally involve the use of leftover medicines stored at home. Medicines as things, according to Van der Geest, Reynolds, and Hardon (1996), circulate effortlessly from 'one regime of value and knowledge to another'. Subsequently, as they point out, it is important to know that how knowledge about medicines is actually disseminated and/or constructed and to what extent a medicine carries over one context of social life to another.

Medicines also mark people's identity as do other material goods (Appadurai, 1986). Medicines can affect people as intimately as food and shape people's sense of being (Nichter & Vuckovic, 1994) and belonging, and can be used to facilitate and reinfore social relationships (Van der Geest, Reynolds, & Hardon, 1996). Hence, as an anthropologist, I am interested to examine the sociocultural and psychological efficacy of allopathic medicines in Nepali context.

At pharmacies/medical halls, the pharmacist/medicine-seller is generally the person who determines which medicine is used, as a consequence demonstrating that people trust in his/her ability to prescribe. Studies have additionally shown that, in developing countries, quantitative and qualitative methods were used to investigate how interactions between

customers and medicine-sellers and medical representatives can influence self-medication (for examples, Kafle et al., 1992; Goel, Ross-Degnan, Berman, & Soumerai, 1996; Tripathi, Bapna, & Tekur, 1996; Kamat & Nichter, 1998; Oldani, 2002; Oldani, 2004; Dokania & Dokania, 2014). Therefore, the role of medicine-sellers together with representatives of pharmaceutical companies may be the leading factors for self-medication. Similarly, production and marketing nevertheless constitute the maximum conspicuous gap inside the anthropological study of medicines (Van der Geest, Reynolds, & Hardon, 1996). However, those data/facts have attracted little attention from anthropologists (Kamat & Nichter, 1998).

As mentioned above, economic, political, and cultural factors have stimulated a constant increase in self-medication worldwide (Bradley & Blenkinsopp, 1996), turning this practice into a major public health trouble. The relevance of self-medication can be a strategy for consumption of medicines for health wellbeing of an individual. From anthropological perspective, however, I argue that there is more to investigate on self-medication practices and the way diseases and the people suffering from them and verify other related statistics here in our context. Similarly, knowledge regarding broad social relations associated to beliefs and practices of self-medication can be gained from the study of the ‘subtle messages, the metaphors, the anecdotes, and the interpretations’ of narratives that are provided in popular accounts of ailment traits and patterns of self-medication (Lantz & Booth, 1998).

As self-medication is a common practice worldwide, social and cultural consequences of medicines should be taken into account by using ethnographic examples of medicine use, prescription, distribution and production looking at medicines as social and cultural phenomena (Uddenberg, 1990; Banerjee, Das, & Chakrabarti, 2011). Although self-medication is probably the dominant therapy worldwide lying outside the domain of formal health care services, it has obtained little research attention. Most users tend to take self-medication as a matter of course and can forget about instances of self-treatment in their own lives. Since self-medication is coping with health problems at the most primary level, it should be an important theme in pharmaceutical anthropology; a ‘paradigmatic shift’ in medical anthropology of Nepal (Banerjee, Das, & Chakrabarti, 2011).

The anthropological approach of contextualization is fruitful to understand use of medicines (Van der Geest, Reynolds, & Hardon, 1996) and self-medication, specially contextualizing several research themes along with the role of pharmaceutical marketing practice and medicine-sellers, prescriptions via medical doctors and the others which includes nurses and paramedics. Similarly, the context of medicine uses can also be

linked with different wider factors such as socio-economic, cultural, religious, family, kinship, and medical pluralism. Therefore, self-medication must be understood within the total health seeking process of the individual as a part of social group and wider network/community and anthropological approach is necessary to grasp empirical knowledge on it.

## Objective

This paper seeks to explore representations linked with self-medication and identify contextual elements which can underpin such practice by employing medicine-users' perspective on the non-compliance of prescription.

## Theoretical Orientation

It is considered that classical anthropology was confined with the study of 'other's culture' or alternative way of life. Until very recently, maximum anthropologists have not taken their own culture for granted before the time of Margaret Mead, Ruth Benedict, Clifford Geertz, Claude Levi-Strauss and Marvin Harris. Earlier than them, 'scientific papers primarily based on empirical studies' had not been in practice (Harris, 1978 cited in Ortner, 1984, p. 126) without gaining deeper understanding of their own way of life.

This applies in medical anthropology too. Until almost seventies or even later, ethnographic work by medical anthropologists (for examples, Caudil, 1953; Scotch, 1963; Fabrega 1971; Colson and Selby, 1974 cited in Van der Geest, 1988) was almost exclusively devoted to traditional medical phenomena and within the framework of 'witchcraft, sorcery, and magic' (Van der Geest, 1988). As a result, medical anthropologists have paid little attention to research in pharmaceutical anthropology or anthropological scrutiny on western allopathic medicines. This trend continued when the distinction between disease (western scientific definition of health problem) and illness (a cultural category and a set of culturally associated activities) was introduced (Fabrega, 1971 cited in Van der Geest, 1988). Only recently, anthropologists have started out to conduct study on medicine as an object for cultural research dealing with important themes such as medical pluralism (Subedi, 2008), therapy choice and the cultural hegemony (Van der Geest, 1988).

Anthropologists studying medicines look at medicines as social and cultural phenomena (Cohen, McCubbin, & Collin, 2001; Van der Geest & Hardon, 2006). Using Appadurai's (1986) concept of the 'social life of things, Van der Geest, Whyte and Hardon (1989, 2002) have used a popular metaphor to capture the social and cultural life of medicines.

Seeing medicines as valuable things with multiple meanings, they have illustrated medicines in the hands of different actors such as consumers like patients and caretakers, providers like pharmacist/medicine-sellers, prescribers like medical doctors and nurses, and producers. Additionally, I consider self-medication as a socio-cultural construct because it includes a multiplicity of socio-demographic characteristics such as age, gender, class, education, occupation, and income and other forces such as medical pluralism, health care cost, waiting time, lack of awareness, the approach of pharmaceutical marketing including the role of pharmacist/medicine-sellers and medical representatives.

'Public discussions' about illness and disease have also been powerful vehicles for communicating ideas about diseases symptoms and the medicines used for healing in our society (Lantz & Booth, 1998). As Brown (1995) has noted, illness is socially constructed, I investigate how social forces shape our understanding of and actions toward health, illness and healing in terms of self-medication. Moreover, I learn the way our perceptions of disease and illness are used to explain and the way we practice self-medication to recover from them.

Social constructions of self-medication are powerful channels for the 'expression, legitimization, and expansion of certain groups' social power' (Shore & Wright, 1997; Lantz & Booth, 1998). Similarly, the manufacturing, sharing and dissemination of such discourses about healthy verses diseased serve to establish the authority of professionals (medical, psychological) over the individual (Foucault, 1973). Following Kleinman's (1980) terminology, the notion of healing is the part of the explanatory model which may vary from culture to culture. Consequently, an anthropological study, using ethnographic examples of medicine use, prescription, distribution and marketing, is crucial to discover the role of those traits and above mentioned issues embedded in self-medication practices in Nepal.

As the concept of efficacy is itself a cultural artefact (Van der Geest, 1988), concept of disease and healing practice (self-medication) can be established bounding to be based totally on cultural dominance inside the context of triumphing medical pluralism (Subedi, 1989; Minocha, 1980; Subedi, 2008) in Nepal. Therefore, getting to know and understand the contexts of medicines in terms of self-medication in our context, I want to contribute to a 'practical role' that an anthropologist can fill in medicine offering a holistic view and emphasizing cultural relativism: evaluating and interpreting indigenous practices sympathetically within the context of Nepali culture (Foster & Anderson, 1987, p. 208).

There is 'only a thin line between self-medication and prescribed medication', as Van der Geest, Reynolds and Hardon (1996) opine, and 'a health-practitioner or nurse can never

be sure that patients will take medicines exactly as they were told/instructed. Accordingly, every medication is to some extent self-medication, until the health worker administers it. And, hundreds of studies have been involved viewing compliance in taking medicines from a medico-centric perspective (p. 165) ignoring positive aspects of noncompliance. However, noncompliance needs to be studied from patients/ medicine-users point of view (Trostle, Hauser, & Susser, 1983; Conrad, 1985; Homedes & Ugalde, 1993; Vuckovic & Nitcher, 1997). Consequently, this paper tries to look at non-compliance from medicine-users point of view because they may have accurate motives and good reasons for taking their medicines in a way aside from that indicated through the prescriber (Fineman, 1991; Van der Geest, Reynolds & Hardon, 1996).

## Method

In this study, I have employed informal conversations/interviews to investigate the underlying representations concerning self-medication and identifying the contextual elements that in some way reinforce or inhibit this practice among 10 inhabitants from the city of New Baneshwor, Kathmandu, who have been on self-medication in the previous three months.

Initially, I have employed exit interviews with the family members of informants who had appeared in a pharmacy, which is around the periphery of civil hospital between January and March 2020. I have also employed participant observation to capture/record the actual conversations between buyers (research participants) and medicine-sellers whilst purchasing the medicines in a natural setting to ascertain medicine-related behavior. I call them research participants because they have provided me with 'crucial data' (Denzin & Lincoln, 1998) and have also played proactive role for the 'knowledge production' related to self-medication practices in Nepal (Patton, 1990).

Data collection and subsequent analysis were based on the model of signs and symptoms, meanings, and actions system developed in medical anthropology developed by E. Corin and collaborators (Uchoa & Vidal, 1994) aiming to clarify underlying cultural logics about the group's practices, their meanings and signs related to them. According to this model, contextual elements which include the social dynamic and central cultural codes and norms, among others, delineate the way people recognize and evaluate a health-related problem or event and act towards it. It enables to demonstrate and remark the impact of social and cultural factors on health related perceptions and behaviors to systematize the study of representations (the ways of thinking), behaviors (ways of acting) and practices of communities in health domain (Uchoa & Vidal, 1994) associated with the practice of self-medication.

I started out my informal conversations/interviews with the question 'within the last three months, did you take any of the medicine in the form of tablets/pills, injections, capsules, syrup, or drops?' I asked this question to investigate the diverse modalities of self-medication, their personal characteristics, the medicine used, the health problem treated, and use of and access to health care services. Whilst the research participants reported use of medicines, I asked for the name of the medicine, the reason for its use and who had indicated it to identify their perception of the event. Then, I asked the questions focusing on practices that could facilitate self-medication, like storage of leftover prescription medicines in their home or changes in relation to the prescription itself or reutilization of the prescription.

I have recorded all the informal conversations/interviews in my smartphone receiving their consent. Later, I have transcribed, processed and analyzed the facts. I analyzed all of the set of informal conversations/interviews with a close reading and identified various groups of common analytical categories in the significant units under thematic classifications. Then, they were organized into patterns, categories, and descriptive units and looking for relationships and connections between them (Brewer, 2000). Then, I have tried to explain and interpret the meanings and significance attached with the diverse analytical categories seeking to unveil interactions between conceptual logics and underlying contextual elements in self-medication.

I interviewed a total of 10 research participants, eight men and two women, ranging in age from 28 to 70 years. Six of them belong to caste groups (all Bahun/Chhetri) whereas four research participants belong to ethnic groups. Their different *modalities* of self-medication are consumption of medicines purchased without a professional prescription, reuse of old prescriptions, shared use of medicines by their relatives or friends, non-compliance with prescriptions of medical doctors, and use of 'leftover medicines stored at their home' (Uglade & Homedes, 1994). I have found acquisition of medicines without a prescription as the most frequently (90%) cited modality.

Reutilization of old prescriptions and shared use of medicines have been usually associated with earlier experience with the medication either by the research participants themselves or some of their family members or friends. Hardon (1991) has rightly described how mothers in a poor area of Manila provide medicines to their children when they suffer from colds and coughs. They have also discussed the social context of the use of medicines in multiple tiers: they may help to cure the child faster, they confirm to the mother that she is a good mother, they send a message to the child that the mother cares, they communicate that same message to the husband, neighbors and others, and all these

messages together reinforce the health restoring on the sick child. Similarly, it is not surprising that the manufacturers (pharmaceuticals) of cough and cold medicines emphasize a hacking dry cough in their advertizing in television (Tan, 1999).

In three cases, non-compliance with the professional prescription is associated with a perceived improvement in symptoms (of uric acid, blood pressure and diabetes) and underrating of his trouble as one male research participant of aged 70 opines "I didn't use the prescribed dose (twice a day) the doctor had recommended, I use less (once a day). I said to myself, this should be enough, it is probably nothing serious, right?"

All the research participants have stored their required medicine at their home. Use of leftover medicines kept at their home appears to be a strategy developed to deal with unforeseen needs, specifically when access to medical care is not possible. This trend appears within the opinion of a female research participant of aged 55 as she says: "sometimes a headache, a muscle cramp in my legs, menstrual pain, all of a sudden a toothache or a fever in the middle of the night, there's no clinic open, and in case you visit to the emergency ward of the nearest hospital without cash you can't get treated."

They view the practice of self-medication as a custom and see themselves as complacent and sloppy. However, they all agree that we should not allow self-medication for a child. This fact is a counter argument as that of Hardon's (1991) finding. A female research participant of aged 45 warns us explaining why she doesn't give any medication to her son without a doctor's prescription as "with my kid, how am I supposed to give him just anything? My son has his own system, and another kid's system is distinctive. He could get poisoned, something could happen, and he could die. And it would be my fault." As she teaches chemistry in a college, her educational qualification can contribute to developing such cognizance.

The *choice* of medication can be influenced by various factors. In most of cases, the pharmacist or medicine-seller recommends the required medicines for self-medication (Logan, 1983; Oldani, 2002, 2004). Sometimes, it is the physician himself who authorizes the use of a given medicine if a given symptom appears or persists. However, often times it is laypeople who influence the choice of medication because all of my research participants have consumed medicines on the basis of advice by family, friends, or even neighbors. This means that the input of family members and friends has been decisive than that of medical doctors. The major reason behind it is the efficacy of medicines to cure the perceived symptoms.

Some cultural attributes of a medicine (Uddenberg, 1990) can also make it particularly prone to use in self-medication. They have strong belief that people generally tend to

favor medicines with which they have prior experience or which they used previously in similar conditions and which worked previously and could probably work again. The place where the medicine can be acquired and the ease in obtaining it also are determinants in the choice as one male research participant of aged 60 opines "it is common, isn't it? Everybody has that medicine (e.g., analgesics like '*citamol*' and antimicrobials like '*metron*'), everybody keeps it at home."

A negative assessment of a medicine's efficacy is the predominant cause for non-compliance with a physician's prescription and for deciding to abandon treatment. A male research participant of aged 50 supports this as he opines: "she (doctor) prescribed some medicines, and I took them, but I didn't get any better. Then, I purchased some other medicine that someone else had advised me was good as it had worked to him." Again, this assertion verifies the trust on the conversation between them as the use of medicines worked well to cure the perceived symptoms.

Studies conducted by a number of medical anthropologists (such as Van der Geest 1988; Vuckovic & Nitcher 1997; Cohen, McCubbin, & Collin, 2001) suggest that 'irrational prescribing' that is 'prescribing medicines which people cannot purchase' is another purpose for non-compliance and self-medication, that is equally genuine in our context, too. It is obvious that people are not able to buy the prescribed medicines because of their unaffordability or economic reason. People fail to purchase prescribed medicine if they consider it expensive. As a result, patients can select some of the prescribed medicines that they could pay for and leave the others. Even though such medicines are 'effective', they are now not efficient (Muller, 1982 cited in Van der Geest, 1988). As social act, prescribing a medicine can also demonstrate the prescribers' concern (Pellegrino, 1976; Smith, 1980). This observation offers two other areas to be studied: socio-psychological gap between prescribing medical doctors and poor patients and commercial interests of the medical doctors or medicine prescribers (Kleinman, 1980; Melrose, 1982).

Aches and pains such as headaches, common colds and fever, diarrhea and high blood pressure have been observed as the major types of *health problems* most frequently referred to as the targets of self-medication. In general, my research participants view self-medication as an indication for the treatment and 'management of minor', transitory, non-serious or familiar health problems (Maitai, Guantai, & Mwangi, 1981). However, they do not see self-medication as indicated for more serious health problems such as chest pain and diabetes or arthritis. They think that more knowledge is needed about patterns of self-care and such knowledge changes over time in utilizing medicines safer and more effective (Brudon-Jacobowicz, 1994).

According to my research participants, self-medication is practiced as a substitute for formal medical/health *care* when the latter is perceived as inaccessible, time-consuming and unaffordable or unsatisfactory. They believe that it is much simpler to take some medicines than going to the medical doctors. They prefer to stay home rather than stand to wait on line for an appointment of a doctor wasting an entire day. Sometimes, self-medication is a spin-off from dissatisfaction with the quality of care received as one male research participant of aged 55 shares: "his (the doctor) prescription does not work well to me, so I spoke to my daughter-in-law, who brought me these medicines."

## Discussion

Purchase of medicine without prescription from the pharmacies/medical halls is found as the utmost regularly model of self-medication. As there is no provision designed for regulatory mechanism of the Nepal government to disallow medicine-seller to sell medicines for self-medication, the medicine-seller is generally the person who determines which medicine is used, for that reason demonstrating that people trust in his/her ability to prescribe. Kamat and Nichter (1998) also describe various modalities of this behavior, highlighting the cultural and socioeconomic context in which it occurs and the way among pharmacy/medical hall owners, medicine-sellers, and medicine company sales representatives have an influence on it.

Keeping medicine at home is a common practice in our context. The medicines that are stored at home may be left over from a previous prescription or have been acquired specifically for this purpose, that is, potential future use. Based on the above findings, we can characterize the medicine chosen for self-medication because it ought to be familiar that everyone can comprehend it, common that everyone has, effective that has worked before, and easy to acquire that has been found anywhere.

Some common health problems to be dealt with preferentially with self-medication have been found to treat headaches and colds (Beckerleg, et al., 1999), fever, high blood pressure, diabetes and menstrual issues. Kasulkar and Gupta (2015) have also found that women seek self-treatment whilst having menstruation problems.

A distinction among health problems can be traced for which self-medication is or is not allowed is based on the perception of certain attributes of the problems along with length, familiarity, degree of severity, and intensity of clinical signs and symptoms. Transitory and familiarity indicate the opportunity of self-medication as medical care. A serious health problem together with chest pain can be interconnected with the notions of impossibility of cure and the risk of demise as we culturally recognize it as critical

organs, particularly the lungs and the coronary heart. Sooner or later, the disappearance of signs has been interpreted as a signal of cure.

As Subedi (2008) argues, the profit making orientation associated with the allopathic medicines and the concentration of services in medical complexes can also be connected with the self-medication practices. My research participants have established a complicated relationship among self-medication and recourse to formal health care services thinking about medicines as commodities and vehicles of modern fashions of health being in the context of globalization (Ferguson, 1981; Miller, 1987).

Self-medication is seen as a first step within the search for resolution of health problems and a more accessible substitute for medical care (Kamat & Nichter, 1998). Furthermore, dissatisfaction with the quality of the care received from health care services has also encouraged the practice of self-medication to my research participants specially the time spent to secure a medical doctor's appointment, consultations being too brief, medical doctors hardly ever speak to the patients, omit orientation of gender, caste/ethnicity and culture and opinions/critiques, and deny patients the opportunity to effectively express their problems. Allowing continuous use of a medicine with the aid of medical doctors themselves can be interpreted as encouragement and approval of self-medication (Nichter & Vuckovic, 1994).

## Conclusions

As is elsewhere, self-medication is practiced outside the control of medical professionals, typically at home in Nepali context. The ubiquity of cultural practice of self-medication is the function/consequence of the perception of people on inaccessibility, time consumption, unaffordability and dissatisfaction within the delivery of the formal health care services. As an example, I have found the practice of self-medication among individuals regardless of age, sex, caste and ethnicity with a chronic ailment diagnosis and among those with fewer medical visits within the preceding year. These results are consistent with the notion that chronic and serious health problems are not prone to self-medication, and that self-medication is used instead for formal health care.

Although the medical doctors' understanding and competencies are recognized, underlying the self-medication practice is the concept that the medical doctor is not the handiest one who knows the way to prescribe. Most frequently, medicine-sellers, circle of family members, friends, and neighbors are heard. Consulting the medicine-sellers, keeping medicines at home, and sharing medicines with family members are reported as profound strategies for self-medication.

The localized nature of society, limited access to, and relatively low quality of public health institutions and the prohibitive costs of allopathic medicines and modern health services are a few factors influencing the choice of self-medication. The good judgement governing consumption of non-prescribed medicines is linked more closely to representations of the health problem as experienced and the availability of medical care than to the traits of the person experiencing the trouble or the medicine used.

Medication use at the local level is determined by much more than the prevalence of ailments and the provision of pharmaceutical remedies to address those illnesses. Even though, there is no provision designed for regulatory mechanism of the Nepal government to disallow pharmacists to sell medicines, permitting continuous use of a medicine by using doctors themselves can be interpreted as encouragement and approval of self-medication.

The localized character and gravity of illness are often expressed in terms of the political economy, type and socio-cultural, and psychological efficacy of medicines as commodities most urgently needed enabling Nepali patients/medicine-users with confident that something is performed about his/her health problem through self-medication in the globalized context. And, non-compliance is not the end result of patients/medicine-users' misunderstanding the prescriber's records however it is the end result of patients/medicine-users having one of kind ideas and interests which includes familiarity with common health problems and their preventive measures, personal autonomy and a subtle form of medicalization through which people become themselves dependent not on the medical profession but on the pharmaceutical industry. This study evidences that patients/medicine-users practice self-medication responsibly by means of recognizing and respecting nonprescription medicines, and use them carefully.

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