

Populations, Sovereignty, Drugs

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By

This post was contributed by Ari Samsky.

It is adapted from his paper "Medical Humanitarianism Without Humans: How international drug donation programs reshape health, disease, and local law," which won the 2009 [Rudolph Virchow Graduate Paper Award](#).

In Paris in March of 2008 I attended an international coordinating meeting of non-governmental groups involved in the control of onchocerciasis, a blinding parasitic disease also known as river blindness. In March Paris labored under a cold, gray sky. We met daily in a sponsoring pharmaceutical company's headquarters building, in a row of embassies, scant blocks from the Arc de Triomphe. I attended this meeting as part of my dissertation research on the donation of ivermectin (an anti-parasitic medication) for onchocerciasis control. (I also traced another pharmaceutical company's similar donation of azithromycin for blinding trachoma, but this particular meeting didn't concern the trachoma program).

Every morning we convened in a conference room, a dimly lit space decorated with bland French motivational posters. We ate almost comically sumptuous lunches, provided by the host corporation. And we watched countless PowerPoint presentations on tropical disease. Meeting participants, mostly NGDO professionals who managed country offices in Africa, showed color-coded maps of disease endemicity and tables of treatment and prevalence statistics. Here, in a conference room, donation program professional created populations and confirmed their mastery of a disease and the international effort to control it. On the first day of the meeting the president of the French branch of the host company came by to give a very brief opening address. "I am proud to welcome you," he said, "you are, and I hope you will accept the word, missionaries." He expressed fierce pride in what his company was doing for "the human cause."

Later, in Tanzania, I met two brothers who had received the drug that the pharmaceutical company donated. It had saved their lives.

Onchocerciasis, the disease that the drug treats so effectively, is debilitating. It causes full-body itching and turns the skin to hard, hoary

leather—all before it blinds its victims. One of the Tanzanian brothers had spent his days scratching his back on the rough bark of a mango tree. Neither could work effectively until the drug freed them of the parasites. For some, the donations were life-changing and miraculous.

They were very grateful. Other Tanzanians were not. Many drug recipients complained that they had received the free onchocerciasis drugs despite the fact that they did not suffer from onchocerciasis. “Where were the free malaria drugs?” they asked. The donation programs rely on modestly trained local volunteers, not physicians, to carry out the once-yearly mass drug administrations. Volunteers with whom I spoke complained bitterly that they were uncompensated and powerless to choose when the drugs arrived, taking them away from their jobs until the distribution was completed.

These two brief sketches illustrate the poles of my research, and the two bodies of ethnographic evidence on which this Virchow essay draws. The thrust of the essay is theoretical – I wanted to figure out how these donations worked and what they were doing to the relationships between states, pharmaceutical companies, and suffering people. The essay does a number of things, which I will sketch here:

I describe the drug donation programs themselves. These programs were inaugurated by Merck and Pfizer. Merck began the trend by promising, in 1987, to donate its drug ivermectin to control river blindness for as long as it would take to wipe out the disease. Pfizer followed in 1998 by offering its antibiotic Zithromax to control trachoma, a blinding eye infection.

The programs provide free drugs to client NGOs or state governments. Recipients must prove that they are capable of protecting and distributing the drugs, and they must document where the drugs go. Receiving these donations in fact costs a great deal of money, since the drugs must be warehoused, shipped, and superintended through a public health system.

Each drug donation also incorporates a distribution strategy. For ivermectin the strategy is called Community Directed Treatment with Ivermectin (CDTI), and for Zithromax the strategy is SAFE, which stands for Surgery, Antibiotics, Face Washing and Environmental cleanliness. Both programs rely on local volunteers to carry out the actual mass drug administration. This is supposed to ensure that the community has “ownership” of the donation and that it is carried out in culturally appropriate ways. In my essay I contest these widespread assumptions by showing the resentment, resistance and misunderstanding that attend the donations in their local context.

The drug donations appear to be humanitarian programs, separate from

the market. However, close reading of the history of the programs proves that the situation is much more complex. Merck developed ivermectin as a veterinary drug (if you give your cat or dog heartworm medicine, it's likely to be ivermectin). This made a huge profit, which made the donation possible from the corporate, business perspective. Merck reformulated the drug for humans—I want to be absolutely clear on this point: the company did not distribute veterinary drugs to people. P. Roy Vagelos, the CEO of Merck at the time the donation began, carefully shepherded the donation into being, but in an interview with me in 2007 he refused to talk about it in terms of morals or obligations: “Well you know, Ari, in the real world, in my world, I don't talk about ethics, or even think about it. I talk about what is the right thing to do.” Similar ambiguous language about moral, social, or ethical obligation enters much PR about the donation programs, which I theorize is a way to reconcile the humanitarian goals of the donation programs with the conventionally corporate goals of the drug companies.

The donation programs also involve NGOs and national health systems in problematic practices of mapping and surveillance. The advent of the donations created new population categories (onchocerciasis-endemic, donation eligible, etc), which local people are invited (or in many cases required) to inhabit, with predictably ambiguous results. New categories of being come into existence with the donations, populations take shape based on political or geographical boundary-makings, and arbitrary thresholds of endemicity include or exclude masses of people in the free treatment schemes. People who live “outside” “endemic areas” (presuming, of course, that people and areas are immobile) are not eligible for the mass drug donations even if they have the disease. (Donation officials in Merck's program do provide for “compassionate” donations, under which a physician can request free ivermectin for small groups or individuals suffering from onchocerciasis, even if they do not live within endemic areas—for instance, if they have emigrated but are still sick). Conversely, people who live in endemic areas but do not have the disease in Tanzania's case must still take the donated drugs at the same time as everyone else. In a very powerful way the donations make populations.

Ultimately, out of all this information, I have started to sketch an idea that I call “scientific sovereignty.” In the donation programs this is the process by which biomedical concerns (disease control) position themselves as implicitly good, highly cost-effective (because of the “value-added” of the free drugs), unimpeachably legitimate interventions. This pressures states into adapting public health programs to account for the donations, rather than (to be pointedly critical) the needs of their citizens (though the two things are not necessarily opposed).

I recently re-read Bruno Latour's wonderful [“Give me a Laboratory and I will Move the World”](#) for a seminar that I am teaching. In it, Latour shows

persuasively how Louis Pasteur changed the political and social landscape of France by working in (and outside of) his laboratory. Latour describes a lab process that invents a new force and appoints a scientific interest as the only reasonable spokesman for it. The scientific sovereignty of the donations does things very differently. The donation programs did not invent a new force in the way that Pasteur did by cultivating the anthrax bacillus and therefore getting ownership of a disease and its etiology. With both onchocerciasis and trachoma the donations entered a picture in which the diseases were well-understood medically, and in which modestly successful control programs had previously existed.

The critical ingredient of this sovereignty is the drug; the drug means that one no longer has to ask or answer questions about the intervention; it makes the intervention a fact, reframing inquiry from “what controls these diseases? How can we control them?” to “these drugs control the diseases, how can we expand the programs?” Pasteur got ownership of anthrax by cultivating the disease and making it into something visible, and then, slowly, by developing his inoculation. The donations got ownership of their diseases with free, effective chemotherapy, through well-documented public health arguments that showed that the drugs were effective, and less explicit economic arguments that made treating the disease (on a population scale) without the free drugs seem impossible (it may well be impossible, though as I’ve mentioned, public health officials had attempted interventions on both diseases before the free drugs came on the scene).

Making one treatment technique seem indispensable is part of what I am calling scientific sovereignty. This sovereignty sidelines ethical questions by making ethics, morals, and social responsibility implicit and labile; the drug itself is a “good” in every possible sense, so taking the drug must be “good,” it must be “care” and “disease control,” both of which are constructed as inherently positive and self-evidently beneficial. This makes local resistance to donations into operations research problems to be overcome through superior public health technique rather than any kind of legitimate objection to a peculiar form of pharmaceutical intrusion.

The donations and their attendant sovereignty are also epiphenomenal, where Pasteur’s work on anthrax was actually directed toward anthrax. Merck developed ivermectin for veterinary medicine, mostly canine heartworm. Pfizer developed Zithromax as a powerful, broad-spectrum antibiotic. Both began their careers as commercial drugs, to be sold for profit, and both were successful. The donation stories were sequels or afterlives, rooted in market processes, and connected to corporations (though both donations take some pains to show the meaningful symbolic distance between the corporations’ business concerns and the donations). The donations, despite their long history and sophisticated

scientific trappings, have an improvisational, rushed quality to them. They are implicitly the answer to the questions posed by these diseases, and once this orientation becomes a given, uncontested fact it is only necessary to figure out how to make the programs work better, cover more area, and reach more people.

Ari Samsky completed a Ph.D. in anthropology at Princeton University in 2009. His dissertation charted the creation and impact of two international drug donation programs. He is currently a Postdoctoral Research Scholar in the [Global Health Studies Program](#) at the University of Iowa, where he is developing a new research project on the history of corporate philanthropy in the United States.

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