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URBAN HEALTH AND PHARMACEUTICAL CONSUMPTION IN DELHI, INDIA

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Summary. This paper interrogates the routine and unproblematic use of terms such as 'self-medication' in biomedical and anthropological discourse. A typical depiction of the social factors that explain the practice of 'self-medication' in India is to put together the supply side factors (such as protection offered by the government for the production of generic drugs, especially in the small scale sector, and expansion of the number of drug store outlets), with the increasing demand for allopathic drugs. The paper provides an ethnographic account of the intricate connections between households and biomedical practitioners in urban neighbourhoods in Delhi. It breaks away from the conventional opposition drawn between the practices of physicians and the beliefs of their patients, and suggests that what constitutes the medical environments of these neighbourhoods is the product of medical practices, household economies and concepts of disease. Thus pharmaceutical use is determined as much by practices of dispensation and by how practitioners understand what constitutes therapy as by household understanding of the normal and the pathological. This paper uses both quantitative data and narrative interviews to provide an in-depth understanding of the circulation of pharmaceuticals within the life worlds of the urban poor.

Introduction

The 'self' in the expression 'self-medication' is often seen in the literature as a bearer of disease whose 'non-compliant' practices endanger not only her own health but also that of the social body. Furthermore, the poor and marginalized are often stigmatized and blamed for this 'non-compliance' (Farmer, 1999). The problem is compounded by the fact that the on one side there is the problem of 'non-compliance', and on the other unnecessary or inappropriate use of drugs. Yet, whereas there have been thousands of studies on compliance there is a relative dearth of studies on physician practices and prescribing patterns in the literature (Trostle, 1996).

The paper provides an ethnographic account of the intricate connections between households and biomedical practitioners in urban neighbourhoods in Delhi. It breaks away from the conventional opposition drawn between the practices of physicians and the beliefs of their patients. It suggests that what constitutes the medical environments

of these neighbourhoods is the product of a range of unintended outcomes from global and national health policies, including perceptions of the health of the poor. The constitution of their health relates to a geography of blame, enabled and articulated by such expressions as 'self-medication'. The paper argues that this places health policy in parentheses and shifts attention to the behaviour of the poor themselves. It facilitates their pathologization.

A typical depiction of the social factors that explain the practice of 'self-medication' in India is to put together the supply side factors (such as protection offered by the government for the production of generic drugs, especially in the small scale sector, and expansion of the number of drug store outlets), with the increasing demand for allopathic drugs. For example, Saradamma *et al.* (2000) explain the demand side factors in the following terms: 'On the demand side it is well documented that medicines in India are attributed powers beyond their active ingredients. The public at once desires the fast relief that 'strong' allopathic medicines deliver and at the same time fears the potential long-term side effects … Consequently people are less inclined to take long-term courses of medicines particularly when symptoms subside … Medicines are often not used as intended …' (p. 892). The evidence for this generic public that 'desires' strong medicines and at the same time 'fears' the long-term consequences, is taken from either household surveys that document the prevalence and frequency of the use of antibiotics (but rarely relate it to the history of the illness episodes), or from exit interviews in pharmacies where patients can often be observed buying drugs without *current* prescriptions. Thus, it is assumed that self-medication is a result of the easy availability of drugs and the decisions of the patients to self-treat their illnesses. This paper argues that these results are in fact an artifact of the survey designs: because the therapeutic practices deployed by practitioners are not built into the investigation, researchers have assumed that what they are witnessing are practices of self-medication. Is there an alternative explanation for this widespread and harmful use of antibiotics, other than the 'desires' and 'fears' of a generic public?

The ethnographic sites and the household sample

This paper uses panel data of 1621 individuals from 300 households in seven different localities of Delhi, where household is defined as co-residential unit with a common hearth. These households were followed for a period of sixteen to eighteen weeks, each year for two years, and then contacted once a month over the rest of the year. Prior to the present survey, initial exploratory fieldwork was conducted by the first author with two field assistants in one of the localities in which survey instruments were tested and ethnographic interviews were done to generate a general understanding of issues relating to health and disease. On the basis of this exploratory phase, the survey instrument was finalized and a group of eight field assistants were trained to administer the questionnaire and to conduct qualitative interviews. The first author accompanied field assistants to supervise the administration of the questionnaire. She also visited the localities for a period of two months to interact with informants and conduct ethnographic interviews. One hundred and fifty adult members were interviewed in depth at least once while the first author and the field researchers

Table 1. Distribution of practitioners by qualifications

Code	Type of practitioners	All localities	Four low-income localities	Three middle- and higher-income localities
1	No formal qualifications	16	11	5
2	RMP	37	29	8
3	BAMS/BUMS/BIMS	120	102	18
4	MBBS and higher degree	189	47	142
5	BHMS/ DHMS	47	14	33
6	Others	82	60	22
Total		491	263	228

Explanation of codes: 1, a variety of practitioners who have no formal education but may have acted as apprentices to a practitioner or may have simply set up shop. 2, Registered Medical Practitioner. 3, holders of degrees (BAMS/BUMS) in alternative medicine (Ayurveda and Unani) given by state-certified institutions. 4, degrees in biomedicine (MBBS/MD) that follow a standard curriculum. 5, degrees in homeopathy (BUMS) comparable to the BAMS or BUMS mentioned earlier. 6, a mixed bag of practitioners including holders of degrees in correspondence courses offered by private institutions without state certification or with a general degree in a non-medical subject.
Source: Survey conducted by ISERDD & World Bank (2002).

also participated in family discussions according to the methods of participant observation.

Four neighbourhoods were chosen through initial research contacts and three through a school health questionnaire. After the initial selection of streets within each neighbourhood, every second house was contacted until the requisite sample number had been recruited. The project was explained to any adult member who was present in the household and their consent was obtained. The rejection rate to the request to join the survey was less than 4%. In addition, 491 practitioners were interviewed about their history, qualifications and typical dispensing and prescribing practices.

Households were classified according to a composite of income, consumption and assets. Those falling in the bottom third of the distribution were placed in the 'poor' category. The majority of poor households were in four localities, one of which, B. Kheda, was selected for detailed consideration concentrating on acute diseases; 75% of sample households in this locality were classified as poor.

The therapeutic strategies and medical care found in B. Kheda are similar to those of the other three low-income localities, and could easily be differentiated from the strategies deployed by households in the more well-off localities. To understand the specific features of the medical environment in which low-income families function, we first examine the distribution of practitioners by qualification in the four low-income localities as compared with the overall distribution in the total sample.

Table 1 shows that there is a concentration of practitioners trained in alternative medicine in the four low-income localities. Of the random sample of 263 practitioners interviewed from these four localities, only 47 had a degree in biomedicine. This

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spatial spread is consistent with that reported in other urban areas. Explaining the popularity of indigenous medical practitioners (IMPs), Ramesh & Hyma (1981) stated that, 'A number of favorable factors support them: they charge less for their services; they are located in centers where effective demand for their services still exists; they provide many dietary prescriptions which are expected by people of Indian culture when they are ill' (p. 78). This claim echoes the policies of the WHO and the Indian Government, that medical care of the poor is best served by training practitioners in indigenous medicine. A well-known statement from the UNICEF/WHO (1975) study on alternative approaches to meeting basic health care needs in developing countries states: 'It is now becoming clear that the ultimate solution to the health problems of the developing nations is a fully integrated type of training embracing the essential principles of both indigenous systems of medicine and modern medical science, so that practitioners can serve the rural populations effectively and understandingly and at a relatively low cost.' Thus the poor are not only seen as resource-constrained but also able to absorb medical care more easily from indigenous healers because of the imagined comfort of a shared culture. In contrast, the argument here is that the dispensing and prescribing practices of all practitioners draw from biomedical resources. The growth in pharmaceutical markets and the legitimacy accorded to practitioners of various streams of medicine to use their biomedical training in their therapeutic strategies, has generated a particular assemblage of state imaginaries, markets and household economies that have shaped therapeutic strategies that the literature calls 'self-medication'. It is to this set of questions that we now turn.

Illness and the life world

Information was collected from each household during weekly morbidity surveys about sickness, visits to practitioners, medicines used and costs incurred. In addition, fieldworkers kept a regular diary of reported events and detailed ethnographic interviews were conducted with household members. These provided a unique opportunity to show how illness trajectories intersected with household or individual health care decision-making. The following results emerged.

First, categories for symptoms and diagnosis were shared between practitioners and patients but the lexicon deployed reflected heterogeneity of ideas regarding what constitutes pathology. Starting from experiential terms such as cold (*sardi*) or pain in knees (*ghutnon mein dard*), it could move on to diagnostic terms derived from biomedical terminology such as BP (blood pressure), TB or pneumonia. Despite the concentration of practitioners from the alternative streams of Ayurveda and Unani medicine, the diagnostic categories were invariably drawn from the biomedical lexicon. In other words, people used such concepts as 'low BP' as frequently in their interactions within the context of family and community as they did in reporting their illnesses to the practitioner. However, what they understood by low BP was not a measure but a structure of feelings including sadness, feeling of weakness, inability to engage in regular work etc. This has been described in greater detail elsewhere (see Das & Das, 2003).

Second, all practitioners in low-income localities, regardless of the type of training they had received, showed a similar pattern for dispensing medications (Das & Hammer,

2004). The preferred mode was *dispensation* (rather than prescription) of medicines from the practitioner, usually to cover one to two days with the proviso that the patient should report back if she did not improve. The charges paid by the patient were a composite of the fee for consultation and the cost of the medications. Prescriptions for medicines were given only if these were expensive and the normal fee charged by the practitioner could not cover their costs. Similarly, medicines for two to three days were dispensed by the pharmacist in the government dispensaries in accordance with the names of medicines entered on the OPD card of the patient by the attending practitioner. Only when the medicines were not in stock in the dispensary, did the physician-in-charge write out a script with names of medicines to be bought by the patient at his or her own expense. There was no charge for either consultation or medicines that were dispensed in the government dispensary. Despite the free services, overcrowding made it difficult for people to find the time to access these facilities routinely. An example is offered of a government dispensary in B. Kheda in which one of us, Veena Das, recorded in July 2002 that the attending physician saw 105 patients in two hours, spending less than one minute on each patient and routinely writing out the same set of medications (in this case tetracycline) for patients with a wide range of symptoms such as colds, coughs or intermittent episodes of fever. The patients then queued up to get these medicines from the pharmacist in the dispensary. This case was not exceptional and participant observation in other government dispensaries in all localities shows the same pattern. It is important to add, however, that the physician-in-charge had to manage a large crowd and was constrained by the complete lack of basic facilities such as a washbasin to wash his hands. The expectation of the patients was that they would receive something in exchange for their long wait; what is more, the attending physician could not write a script for free medicines if these were not in stock.

Third, the pattern of employment, household cash flow and therapeutic strategies deployed by practitioners has moulded the 'local ecology' of care. It is this complex that has determined the use of medications rather than any steadfast beliefs about the power of modern medicine as an undifferentiated entity. This is not to say that utterances about the efficacy or side-effects of medicines were entirely absent from informant's accounts but rather that these utterances were like building blocks for an experimentation with therapeutic choices rather than definitive statements about belief and knowledge.

Patterns of illness

An account of the magnitude of illness in the sample population and its implication for therapeutic choices made by households follows. It was necessary to use two measures of morbidity. Because of the sampling design (weekly interview), the number of weeks that an individual reports sick was reported as 'sick weeks', while an illness that spanned a period longer than a week constituted a single episode. For instance, if an individual reported headache for the first week and fever for the two subsequent weeks over a three-week period, this was recorded in the data as *three sickness weeks* but *two episodes of illness.* The relevance of using these two measures is that the former helps to track illness and decision-making as it develops, while the latter

Table 2. Distribution of individuals by illness episodes

Number of episodes	Percentage of individuals	
	All localities	B. Kheda
0	23·72	11·48
1	21·62	18·52
2	17·42	19·26
3	12·91	13·33
4	8·4	6·3
5	6·49	10·37
6	3·83	8·52
7	3·15	8·15
8	1·48	1·48
9	0·43	1·48
10	0·43	1·11
11	0·06	
12	0·06	
Total (%)	100	100
Total individuals	1619	270

Table 3. Distribution of illness episodes by duration

Duration in weeks	Percentage of all episodes	
	All localities	B. Kheda
1	69·65	68·49
2	18·16	17·79
3	5·32	6·63
4	2·31	2·33
5	1·44	1·05
6	1·03	1·51
7	0·52	0·81
8	0·22	0·12
9	0·27	0·12
10	0·11	0·23
11	0·22	0·12
12	0·14	0·12
13	0·08	0
14	0·11	0·12
15	0·05	0
16	0·38	0·59

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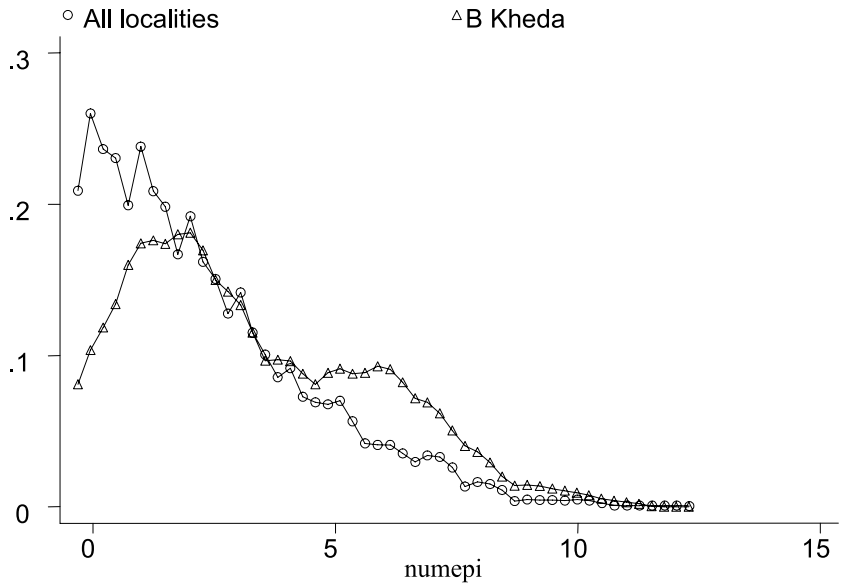

Fig. 1. Kernel densities of individuals by number of illness episodes. The vertical axis represents the percentage of individuals and the horizontal axis the number of episodes (numepi).

measure is important for determining the severity of an illness (in terms of duration, cost etc.). Table 2 gives the percentage distributions of individuals with episodes of acute illness during the first survey period for all localities and for B. Kheda. Thus 23·72% of all individuals in the entire sample suffered no illness in the first survey period. This proportion is 11·48% for B. Kheda. Table 3 gives the percentage distributions of acute episodes by duration. Thus considering all localities 69·65% of episodes lasted one week or less; for B. Kheda this figure was 68·49%. Figure 1 represents the kernel densities fitted to the data in Table 2. This provides a statistically smoother picture of the underlying distributions.

There are two important points that can be discerned here. First, about 52% of the sample population experienced one to three episodes in a four-month period and second, a large proportion of illness episodes (nearly 70%) were of less than one-week duration. Only 24% of the population reported no illness. It is important to observe that in the case of B. Kheda the pattern of duration follows roughly the same pattern as the general population but that there is bulging in the number of individuals who suffered between five and seven episodes in this period. The narrative interviews show that these include cases in which individuals report repeated short-duration illnesses that later turn out to be cases of undiagnosed tuberculosis; or individuals suffering from continuing allergies or wounds report decline in signs and symptoms as a measure of 'cure' and see increases in these as fresh episodes.

The ethnographic interviews showed a pattern in which boundaries between health and illness were consistently blurred, and the experience of illness was split between days when people had access to small amounts of money and hence could consult a

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practitioner versus the days when symptoms were endured because money had run out. Thus the idea of 'the normal' was powerfully mediated for low-income families by issues such as what constituted normality and pathology under conditions of poverty and precariousness of income flows, rather than in a standardized break in the continuum of health and illness. Among the low-income families in the sample only 20% of adults had jobs in the public or private sector; 30% were engaged in the informal sector working as hawkers, rickshaw pullers and housemaids, or in unskilled labour in factories and shops. Forty-four per cent were outside the labour force but sometimes engaged in household production, doing piecemeal jobs for household industry in the area. The dominant experience of work then was of intermittent employment – of being on a threshold, of being in danger that one would not get work, or that a serious illness will throw one into debt, or that the nexus of relations through which one maintains one's job or raises debts or finds a doctor in a public hospital could somehow collapse. Cash flows to households were irregular. While even the poorest households managed to have some disposable income, any large expenditure propelled them into debt. Thus the typical pattern of health-seeking behaviour related to the availability of cash: if there was money available, then treatment for diseases that were not considered as severe or life-threatening was sought from a practitioner in the locality; otherwise attempts were made to absorb that within the notion of the normal.

Table 4. Patterns of action consequent upon illness reported that week in B. Kheda

Action	Frequency	Percentage	Cumulative
No action taken	319	21·75	21·75
Only practitioner visit	508	34·63	56·3
Consulted pharmacist only	48	3·27	59·65
Medicine bought without current prescription	389	26·52	86·16
Two or more actions	203	13·84	100
Total	1467	100	

A general picture of therapeutic choices and decision-making in B. Kheda is shown in Table 4, which gives the distribution of various types of action taken when an acute illness was reported in any one week. Subsequent to a reported illness *that week*, in only 21·75% of cases was no action taken. Though it is commonly stated in the literature that people tend to visit pharmacists for consultation, here they consulted a practitioner (35% of total actions) rather than a pharmacist (3·27%) for diagnosis. In addition, there were 389 illness weeks in which patients bought medications without current prescription. The weeks when such self-medication was combined with other actions (that week), results in a total of 592 illness weeks when patients bought medications without prescription. When these cases were disaggregated it was found that in 207 cases a previous prescription was used and in 184 cases the person claimed to have bought a medicine that they had taken earlier and had got

better. In other cases people were on maintenance dosages for ongoing aches and pains, and a small number bought a medicine on the recommendation of a family member or some other person.

Of the 207 cases when a medicine was bought on a previous prescription it was found that the person bought an antibiotic only in 37 cases; other medicines frequently bought with previous prescriptions were analgesics, tonics and skin ointments. The typical scenario where a person used a previous prescription was in the middle of an episode that lasted longer than one or two weeks. For example, a patient may be receiving medications from a DOT centre free of charge but a family emergency may make it impossible for him or her to go to the DOT centre that week, in which case they may buy medicines from a local pharmacy with a previous script. There are other cases in which symptoms recur: patients consult practitioners and buy medications with the prescriptions they have because they feel that they can predict the behaviour of the practitioner. 'K', a woman in her thirties, had complained of recurrent episodes of cold, cough, loss of appetite and fever – reporting sick for 11 weeks out of a total of 16 and consulting a practitioner five times. She was diagnosed alternately with flu and then with pneumonia and along with dispensed medications she had also received a prescription for antibiotics. In this entire period she was not asked to undertake any diagnostic tests. Thus she bought antibiotics on a current prescription three times and used the previous prescription in two of the other weeks. There is a certain temporal rhythm in her experience of illness – fever diagnosed as flu – dispensed medications – patient feels better first then feels sick again – goes back to practitioner – is told she has pneumonia and is given prescription for antibiotics – buys a few tablets because of lack of money – gets better – feels sick again – uses the same prescription to buy another round of antibiotics – goes back to the practitioner – and so on. The intermittent use of the practitioner, interspersed with self-medications, is indicative of the fact that individuals with multiple episodes as in B. Kheda suffer from diseases that simply do not receive a correct diagnosis and treatment and hence report what may be a single episode of sickness such as TB as repeated episodes of one or more diseases.

In many cases, especially for illnesses of long duration such as TB, patients who were accessing private practitioners used a prescription to buy medicines in small quantities rather than a full course at one time because that was all they could afford that week. Further, for diseases such as allergies with recurring symptoms, patients use mixed strategies of consulting the practitioner some weeks and buying medicine from the pharmacists in other weeks. Such patterns of use reflect the character of medical practice in the locality, as it also shows the limits of household capacity to buy a full course of medication at one time. They are indicative of the inability of many practitioners to recognize that recurring episodes are part of the same illness that requires a different line of treatment rather than dispensation of antibiotics or analgesics for symptomatic relief.

The case of B. Kheda makes it clear that most of the medicines consumed by patients were either dispensed by practitioners or bought under some medical supervision, even if a current prescription was not being used. While it was not always possible to determine with precision what medications were actually dispensed by a simple examination of capsules or tablets, since these were often crushed and mixed,

interviews with practitioners in these localities confirmed that the most frequently dispensed medications were analgesics followed by antibiotics. In interviews practitioners were asked to give the names of up to five medications that they regularly dispensed or prescribed. Most practitioners from the low-income localities named only two or three medications: the most frequently cited were analgesics followed by antibiotics. Interestingly this pattern of dispensation was consistent across all practitioner categories with the exception of those trained in homeopathy. From our ethnographic observations in the field, it seems clear that the majority of analgesics and antibiotics used by the households are those *dispensed* by the practitioners in low-income neighbourhoods. The analytical strategy of combining household interviews with practitioner surveys allows us to see this pattern of therapeutic strategies where others have seen only self-medication.

Finally, the case materials collected for this study show that regardless of the type of training a practitioner has received there is no difference in the pattern of dispensing or prescribing. Consider the cases of Dr S., who holds an MBBS degree from a premier university and practises in B. Kheda. He was the most frequently visited private practitioner in the category of physicians trained in modern medicine in the area. In the eighteen survey weeks Dr S. received 53 visits from members of the sample households in B. Kheda for a variety of complaints ranging from fever, rashes and tuberculosis, to weakness and pain. There was only one case in which he did not dispense or prescribe any medicine despite the large number of cases of coughs, colds and short-duration fevers. He gave a prescription in nine cases and dispensed medicines in 43 cases. When the packaging of the medicines was intact, it was found that these included antibiotics such as ampicillin, gentamicin and ciprofloxacin. He also dispensed medicines that had been withdrawn from the market by some pharmaceutical companies in the US for possible adverse impacts such as the various compounds of Cisapride. There did not seem to be any correlation between the severity of a disease and the medicines that were dispensed. In the same period Dr L. from the same area, who has a BAMS degree, received 108 visits. In three cases he did not prescribe or dispense any medication, because two of the patients reported that they had left-over medicine (such as Septran) from their previous visits and they were advised to use these for their complaints such as colds, coughs and flu. Dr L. gave prescriptions in fourteen cases for such mediations as ciprofloxacin, neomycin, ampicillin and Bludrox. In all other cases he dispensed medications. It is again to be noted that medicines were dispensed or prescribed on a symptomatic basis without any clear correlation between the diagnosis and the treatment. For instance, Bludrox, a medicine for severe skin or respiratory infections, was prescribed in one case for a cold and cough and in another case for a septic wound. It seems that practitioners dispense or prescribe antibiotics for short durations and are frequently unable to diagnose serious diseases. The short-term therapeutic patterns that have become established in these localities result from a complex assemblage of the various factors that include poor regulation by the state, the pattern of cash flow to households, and the mutation of both biomedicine and traditional medicine to create a specific local ecology of care. What is at stake in local worlds with regard to the use of pharmaceuticals can be comprehended only within this complex ecology.

When the local fails

Though 70% of the illness episodes lasted less than one week, more than 6% of episodes lasted three or more weeks. In such cases, faced with life-threatening illnesses, families begin to despair of the therapy within the local context. While chronic conditions that are not life threatening can be absorbed within the idea of the normal, the worsening of illness to the point that it becomes life threatening always leads to a search for therapy outside the local into the world of specialists and hospitals. It is not possible to describe this journey in terms of any straightforward model of vertical or horizontal resort (see Kleinman, 1980). The study households did not act with a coherent explanatory model of which illnesses were best treated through which kind of therapeutic system (e.g. allopathic for acute diseases and homeopathy for chronic diseases) but rather which networks of information and influence they could activate. The following example shows the contingent character of the way patients access medical care and the consequences of the poor competence of practitioners in low-income areas of Delhi.

What is to be cured? Sangeeta's encounter with tuberculosis

Below is the transcript of an interview with a woman in her mid-twenties on her experience of being cured of tuberculosis. The interview was conducted in Hindi in her house by Rajan Singh and translated by Veena Das:

How did you discover you had TB?

I had many problems, a lot of weakness, so much so that it was difficult for me to sit.

So you had weakness – did you have any other problem?

No brother, but it was that I did not feel like eating, nothing seemed to interest me, my heart did not engage.

And fever?

Yes there was constant fever, there was also coughing.

For how long did you have this?

Some days, some weeks. See, first I started to take medicines – private [in English, referring to a private practitioner rather than *sarkari* or government hospital] *was started.*

So, which practitioner did you go to first?

See first medicines from here and there. The local doctor gave medicines – I was not getting better. Then my daughter was born – because I was feeling quite sick, they took me to hospital for the birth – I would feel great pareshani [*trouble*] *in my throat – so they took me to hospital for my throat – first they roamed here and there (*idhar udhar le ke dole*). Then my daughter was born – still I could not eat anything – so then I had gone to my mummy's place. I could not still eat anything. So mummy took me to* sarkari *hospital there they did an X-ray – so in the hospital an X-ray was done. Then it was known. So then in the government hospital they said I had TB. They told us to go to this TB hospital for medicines.*

So you did not have to take any private medicines?

No, first mummy thought that the private medicines will be better. See there were problems with my throat – there was swelling, difficulty in swallowing – no appetite – so we also had it seen from a

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private doctor in Mayur Vihar [an upper middle class neighbourhood] *but there the doctor said, don't worry – it is just a cold you will get okay – so he gave some medicine but it was very expensive and anyway there was no improvement.*

As the interview progressed, she described how some people said that it was magic or sorcery and they should have it blown away through a diviner or a healer, and how others recommended other private doctors.

Then my mummy said that I would just take her to the sarkari [government] *hospital – the TB hospital where they had told us to go. She said that she would not listen to anyone.*

You mean you decided to go to the TB hospital – the one where doctors from the hospital where your daughter was born asked you to go?

Yes, that is the one. People said go here, go there, but mummy said whatever anyone says – I will take her to that government hospital.

What happened there? Did you get medicines? X-ray?

Yes, they gave medicine – two tablets a day. The doctor there said that the medicines must be taken. He said you can forget to eat your food but you cannot forget to take your medicine. So my husband did not have time to take me there to get medicines – so I stayed with mummy.

From Sangeeta's interview it appears that she received free medications from the government hospital for two years – though they had to buy tonics from a private pharmacy. She stayed for long periods with her mother in the course of her illness – at the time of the interview she pronounced herself to have fully recovered after two years. Rajan and she discussed whether she had experienced any hostility from other family members, whether the stigma of the disease had affected her and she said that her husband did not care about such things. Towards the end of the interview Rajan asked, as a matter of courtesy, 'So your daughter who was born at the time that your TB was discovered – is she okay?'

No, she died when she was two years old. Everyone said I should not feed her my milk – she became weak. She hardly spoke. See, you have to listen when people say things. I became pregnant again and had a son but he too could not survive.

Did the doctors in the TB hospital advise you not to feed your daughter breast milk – did the doctors tell you anything about what to do when you became pregnant?

No, the doctors did not tell me anything but everyone said that my milk was not good because of the disease.

This case reveals the 'outside space' of therapy to be made up of a criss-crossing of possibilities. Suggestions and counter-suggestions come from all directions – you do not know whom to trust. In this case the medicines dispensed by the local doctor did not make any difference to the symptoms. The narrator was taken to the hospital because of a difficult birth and the TB was discovered accidentally. And though Sangeeta managed to complete the anti-TB regime of medication, she could not provide breast milk to the children born during her illness and they both died of unspecified diseases.

The deaths of her two children do not seem to belong to the narrative of TB, which is not to suggest that she does not mourn for her dead children. Yet the overall effect of the story is about the care she received from her mother and the success of the therapy. The case suggests that her identification of therapy as *successful* involves

putting to one side the death of her children to whom she may have transmitted TB. The failure of the medical system to take the overall condition of the patient into account – concentrating instead on the strict protocol of the DOT centre, and the poorly regulated medical practice that allowed local practitioners to treat symptoms of TB as if the patient had a simple cough or fever – is written large in this story but is not explicitly mentioned. As for Sangeeta, the positive outcome arises from the fact that she considered her social relationships to have endured through the course of the illness. Such is the face of success.

There were other cases where although the illness was cured, the social relations were not. A brief example will illustrate this point. Ballo was an old woman whose husband had died before the surveys started. Whenever we visited Ballo's house, we found her lying in bed with multiple complaints. Sometimes she suffered from gas, and demanded that her son get her medications. At other times she said she felt feverish. Her main complaint was that her son's wife did not pay any attention to her ailments. Sometimes she suspected that her son's wife did not wish her well and that the reason that the medications did not work was because they were not given with the proper attitude of service (*seva*) that was her due from her son's wife. Her son's wife, on the other hand, felt that the old woman exaggerated her illnesses to get her son's attention. During the survey period Ballo went away to live with her daughter's conjugal family in a neighbouring village where she insisted that the Ayurvdic practitioner, a *vaid*, had seen her and diagnosed her as suffering from a 'little bit of TB'. It was his medications, she proclaimed, that had begun to work for her. In this case the illness and the cure were a reflection of the social relations – her insistence on getting the medications from her married daughter's conjugal home was a reproach against the son and his wife. This is why, while living in her son's house, she would feel temporarily better but then again come down with another symptom as a sign of the fraught social relations within her kinship universe.

The full implications of this entanglement of illness and sociality cannot be drawn here, but it is important to note that forms of belongingness in the urban context are fraught with tensions. An individual cannot be said to 'belong' to her kinship network, community or neighbourhood as, say, water belongs to the bottle or clothes belong to the wardrobe. The 'voices' of the community, the repeated quests for therapy for illnesses for which only temporary relief seems possible, and the constant need for brokers through which the outside world can be accessed, all contribute to an individual's experience. A dependence on the medial system exists alongside a tremendous distrust of the services received. The 'self' in self-medication is a composite of these experiences – in which the real seems to constantly elude the hold the poor can establish over it. Unlike Johansson (1991), who believes that high morbidity rates are largely a consequence of the availability of more categories of disease, our material suggests that they are also affected by the local ecologies created by the interaction of the state and markets, such as those encountered in B. Kheda. It is only within these local ecologies that one can comprehend the experience of illness and patterns of use of pharmaceuticals, for language cannot be analysed independently of the forms of life that grow it. Rather than the generic desires and fears of a public – as if these were the ghostly forces that propel patterns of therapy – experiments with illness categories and medicines take place in specific

worlds in relation to concrete questions about the problems of life, labour and language that confront people in *a* rather than *the* world. This study's survey results and ethnographic interviews show how the local ecology mediates experiences of illness and the therapies that are sought. Outside the local world lie hospitals and specialists who are available only through brokered forms of sociality. The experience of illness and cure, and the patterns of pharmaceutical use, take place predominantly within local worlds, though the hospitals and specialists to which patients are taken in emergencies are never absent from people's consciousness. These are the worlds of the poor – produced through complex configurations of policies and programmes, shaping medical realities that lie beyond the bedside of the patient.

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