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# Social support in the practices of informal providers: The case of patent and proprietary medicine vendors in Nigeria

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ABSTRACT

The social and institutional environments in which informal healthcare providers operate shape their health and business practices, particularly in contexts where regulatory enforcement is weak. In this study, we adopt a social capital perspective to understanding the social networks on which proprietary and patent medicine vendors (PPMVs) in Nigeria rely for support in the operation of their shops. Data are drawn from 70 in-depth interviews with PPMVs in three states, including interviews with local leaders of the PPMV professional association. We find that PPMVs primarily relied on more senior colleagues and formal healthcare professionals for informational support, including information about new medicines and advice on how to treat specific cases of illness. For instrumental support, including finance, start-up assistance, and intervention with regulatory agencies, PPMVs relied on extended family, the PPMVs with whom they apprenticed, and the leaders of their professional association. PPMVs' networks also provided continual reinforcement of what constitutes good PPMV practice through admonishments to follow scope of practice limitations. These informal reminders, as well as monitoring activities conducted by the professional association, served to reinforce PPMVs' concern with avoiding negative customer health outcomes, which were perceived to be detrimental to their business reputations. That PPMVs' networks both encouraged practices to reduce the likelihood of poor health outcomes, and provided advice regarding customers' health conditions, highlights the potential impact of informal providers' access to different forms of social capital on their delivery of health services, as well as their success as microenterprises.



## 1. Introduction

Due to the limited capacity of health systems in many low- and middle-income countries (LMICs), there has been growing interest in the role of private, informal providers in filling gaps in health service delivery. Informal providers span a variety of retail and practitioner types, including drug shops, private clinics, midwives and traditional birth attendants, and traditional healers practicing in a range of medical traditions (Bloom et al., 2011; Sudhinaraset et al., 2013). Although a variety of definitions exist for what 'informal' means in the context of health service provision, most definitions agree that informal providers are those who perform services for which they have not received formal training, and who in some way operate outside of established regulatory boundaries (Bloom et al., 2011; Sudhinaraset et al., 2013). Whether those regulatory boundaries recognize informal providers at all, or whether the providers are operating outside the bounds of their legal regulatory scope, is heavily context- and time-dependent (Cross and MacGregor, 2010). Yet the limited data available suggest that informal providers constitute over half of all healthcare providers in some LMICs (Sudhinaraset et al., 2013). Their practices therefore have broad implications for access to and quality of healthcare in many contexts.

Numerous studies have documented the characteristics, utilization, and quality of service of informal providers (for reviews, see Shah et al., 2011; Sudhinaraset et al., 2013; Wafula et al., 2012). Yet it is informal providers' location on the "margins of legitimacy" (Cross and MacGregor, 2010, p. 1594) that has sparked the most debate about how to work with this sector of the health system. Standard economic approaches focus on the profit motive of private healthcare providers, arguing that this may lead to excess or inappropriate provision of services (Arrow, 1963; Sloan, 2000). The assumption of self-interested profit maximization has been

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widespread in the literature on informal providers, particularly given that many operate in contexts where regulatory enforcement is weak (Bloom et al., 2008; Cross and MacGregor, 2010). Recently, several scholars have challenged this narrow conception of provider motivations, arguing that the tenuous position of informal providers in relation to formal regulatory structures leads to a broader range of influences on their practices. These scholars have pointed out that informal providers are socially embedded actors whose practices are influenced by their relationships with their host communities, position within professional networks, and ties to formal institutions, in addition to economic incentives (Bloom et al., 2008; Cross and MacGregor, 2010; George and Iyer, 2013). Greater contextualization of informal providers within the social and institutional environments in which they function is therefore key to understanding their practices.

However, few studies have explored how informal providers relate to social and institutional structures in specific empirical contexts. Those that have suggest that informal providers rely on a range of professional networks in different aspects of their practices. In India, rural medical practitioners (RMPs) have been found to maintain ties to the providers under which they apprenticed (George and Iyer, 2013), and to rely on referral relationships with other providers as means of continued learning (Ecks and Basu, 2014; George and Iyer, 2013). Village doctors in Bangladesh and RMPs in India obtain information about medicines from drug detailers (Ecks and Basu, 2014; Rahman et al., 2009; cited in Bloom et al., 2011). Several studies have also noted that different types of informal providers self-organize through professional associations (Ecks and Basu, 2014; George and Iyer, 2013; Sudhinaraset et al., 2013). Although studies of these associations are few, one exception is the association of patent medicine dealers in Nigeria, which we discuss in greater detail below.

The small number of studies on informal providers' network resources is particularly surprising given the broader interest within the development literature in the role of social networks and social capital in entrepreneurial development. We follow Woolcock in defining social capital as the "information, trust and norms of reciprocity inhering in one's social networks" (1998, p. 153). Norms of reciprocity in turn entail the "exchange of social support," (Ferlander, 2007, p. 116) where support is typically categorized as being of four types. Emotional support is the provision of caring or empathy, whereas instrumental support entails the provision of concrete forms of assistance such as finance. Two additional types, related to information, are informational support, the provision of advice or information that helps individuals to manage situations they encounter, and appraisal support, which is the provision of information that specifically helps the recipient to self evaluate their own performance or behavior (House, 1981).

In Sub-Saharan Africa, a social capital framework has been applied to the study of several types of micro-entrepreneurs (Barr, 2000; Fafchamps and Minten, 2002; Lyon, 2000; Zuwarimwe and Kirsten, 2010), pointing to both the effects and the nature of these entrepreneurs' social networks. This literature finds that larger and more diverse networks lead to higher enterprise productivity (Barr, 2000; Fafchamps and Minten, 2002), and that small entrepreneurs rely on their networks both to stabilize their income (Lyon, 2000) and to expand their businesses (Zuwarimwe and Kirsten, 2010). The networks on which micro-entrepreneurs rely to achieve these outcomes in rural Sub-Saharan African contexts are both formal (e.g. associations) and informal (e.g. friends, family and acquaintances) in nature (Lyon, 2000; Zuwarimwe and Kirsten, 2010; see also Ferlander, 2007). This differentiation of the formality of entrepreneurs' networks is distinct from the common categorization of social capital as bonding, bridging or linking. Bonding social capital exists between network members that are similar in terms of their socio-demographic characteristics, whereas bridging social capital exists between members who are dissimilar from one another but are linked through a horizontal (egalitarian) relationship (Szreter and Woolcock, 2004; Ferlander, 2007). Linking social capital connects people across explicit social or institutional power differentials; for example, a healthcare provider and her patient. The presence of respectful, collaborative (as opposed to extractive or suppressive) linking social capital has been argued to be key for service delivery in a range of fields, including health, to effectively meet the needs of the beneficiary population (Szreter and Woolcock, 2004). The overlap between these forms of social capital and network formality can be useful in understanding how micro-entrepreneurs receive different forms of support, a point we return to in the discussion.

None of these previous studies on micro-entrepreneurs in Sub-Saharan Africa, however, address entrepreneurs in the health sector. In this study, we apply a social capital perspective to understand the professional networks of proprietary and patent medicine vendors (PPMVs) in Nigeria. PPMVs are owner-operated retail drug shops that are ubiquitous throughout Nigeria, with an estimated 200,000 in the country (Barnes et al., 2008). Although legal and regulated by the Ministry of Health (Barnes et al., 2008), PPMVs are not required to have formal training in pharmacy or medicine and typically complete an apprenticeship with a more senior PPMV prior to opening their shop (Beyeler et al., 2015; Brieger et al., 2004). Although only primary education is required to open a PPMV, recent studies indicate that the majority hold at least a secondary degree and substantial percentages in fact have formal medical training (Beyeler et al., 2015). Nevertheless, there are significant concerns about the quality of service provided by this highly diverse sector (Beyeler et al., 2015), and studies indicate that compliance with scope of practice regulations (Fajola et al., 2011; Ujuju et al., 2014) and licensing requirements is low (Beyeler et al., 2015; Oyeyemi et al., 2014). These concerns about the quality of care provided by PPMVs, and the role of their social networks in influencing their practices, is significant given that PPMVs are a major source of care in the country, particularly among poor and rural communities (Onwujekwe et al., 2011).

Lack of regulatory enforcement does not mean that the PPMV sector is unorganized; PPMVs have a professional association, the Nigerian Association of Proprietary and Patent Medicine Dealers (NAPPMED) that operates at multiple administrative levels, with branches extending from a national body down to the state, Local Government Area, and local (ward) levels (Oladepo et al., 2007). To our knowledge, only one study has examined the functioning of NAPPMED, which was based on interviews with leaders of 12 local association chapters (Oladepo et al., 2007). These leaders reported that NAPPMED provides opportunities for members to improve their knowledge, helps with problems, and defends members' interests, and that NAPPMED fines members for practices deemed inappropriate, such as selling unapproved drugs or failing to attend NAPPMED meetings. The association also has relationships with local government and regulatory officials, whom they deal with to resolve members' problems (Oladepo et al., 2007). How member PPMVs who are not part of the leadership view participation in NAPPMED, and the contexts in which they rely on the association for support, has not been explored. Other social networks, including informal networks of personal and professional contacts, which PPMVs may rely on in running their shops, have also not been investigated.

Our objective in this study is to understand how and why PPMVs access different forms of social capital that may influence their health and business practices. Specifically, we (1) describe the characteristics of the social networks that PPMVs rely on for support related to both the health and business aspects of their shops,