After 2010, two Indian generic companies started local plants in South Africa, attempted to partake in the morally loaded politics of antiretroviral therapy, and complied with broader affirmative action policies there. This article analyses a variety of sources and tries to lay bare the nexus between drug manufacturers, the state, and civil society organisations and tries to contextualise them in the anthropological theories of public health and humanitarian aid.

This article documents the ways in which Indian pharmaceutical companies have transformed themselves into humanitarian organisations—rather than being mere business ventures with “commercial” interests in South Africa. At least two of them—I shall call them Shitala and Sigma—act like handmaidens to an African National Congress (ANC) led transfer welfare state (Burger 2013: 176).1 Shitala and Sigma also co-opt civil society activism, and humanitarian politics related to HIV/AIDS to do business.

Chari (2015: 95) has observed that the new Indian capital influences the power centres of Africa. Rather than bypassing huge areas while expanding, as observed in the case of the mining companies in Africa, the Indian pharmaceutical capital expands to the common people (Ferguson 2005: 380). In my case study, the common people historically resided in the “townships” such as Soweto, and elsewhere during apartheid in Johannesburg. Many of these areas are currently identified as “emerging markets” in Johannesburg by the generic industry. Accurately, these spaces may be referred to as “weakly governed humanitarian hinterlands” in the wake of the humanitarian crisis of HIV/AIDS.

Of course, various new laws such as the amendment of the Medicines and Related Substances Act (MRSA) of 1965 in 1997 enabled processes of generic substitution, and more pervasive biomedicalisation in South Africa. Yet, I am afraid that these companies always have a tendency to institutionalise their humanitarian politics. This might threaten the political potency of Indian generic pills to magically penetrate rural hinterlands and cure the poor (Biehl 2007).

In the context of the history of South Africa, Marsland and Prince (2012) observe that the market value of pharmaceuticals protected by patent laws invariably weighed inferior to the humanitarian value of antiretroviral therapy (ART). In this specific situation, organisations like the Medecins Sans Frontieres (MSF), Treatment Action Campaign (TAC) and the state joined hands.

I explore the intersections of moral and economic values of generics seen in the process of circulation in Johannesburg. I begin with the discussion on the background of the treatment campaign.

Political Economy of HIV/AIDS in South Africa
Investment by various Indian generic companies by setting up branches, and local manufacturing facilities in the early 2000s...
echoed a new political message for providing medicines to those suffering from HIV/AIDS, and multi-drug resistant TB. The initial entry by Sigma and Shitala marked a political statement so far as South Africa’s history of access to medicine is concerned. In those days, Indian interventions on the patent laws and the advent of Indian generic companies were seen as a part of the solution (Tomlinson and Rutter 2014).

During the 1990s, research and development (R&D)-based Western pharmaceutical companies attracted a lot of global concern because of the high price of HIV/AIDS drugs. Even though innovator companies might have enjoyed huge profits by way of being first movers in the market, gaining royalty, and directly entering into partnerships with generic companies, it was observed that the lack of ideal “commercial prospects” inhibited their direct participation in the antiretroviral medicine (ARV) manufacturing in South Africa (Jogee 2009).

This established a nuanced literature. Broadly, the “AIDS denialism” of Thabo Mbeki, and profit motives behind big pharma’s move to take the issue of intellectual property rights into the South African court to protect proprietary rights over the ARVs (for an argument in favour of big pharma (Reekie 2000)) have attracted criticism in resonance with the politics of “therapeutic citizenship” (Marks 2007; Geffen 2010; Lofgren and Williams 2013; Mahajan 2008; Hill 2014).

The post-apartheid South African state, starting from the time of Mandela’s regime, broadly adopted a liberal method for economic development with reduced state intervention known as the Growth, Employment, and Redistribution (GEAR) Programme. It moved away from the apartheid model of state-run companies (Clark 2014: 104). The investment by various Indian generic companies by setting up branches and local manufacturing facilities in the early 2000s assimilated well into this.

By then, despite taking a controversial position on HIV/AIDS, the Mbeki government sought Parliament’s intervention to enable the local production of generic drugs by private generic pharma capital (Amusan 2015: 71). Later, the Jacob Zuma government approached the issue of availing cheap ARVs in a proactive way from December 2009 onwards. This is known as the “mass ARV roll out” (Coombes 2011).

Statistics show that India invariably gained from the new politics of generics; out of pharmaceuticals valuing R12.97 billion India’s import recorded R1.28 billion in 2008 in South Africa (Deloitte 2010). Deloitte’s report states that the generic market was further “brand driven”—the sale was based on the trust developed on products and the companies. Sigma, after Aspen, and Adcok Ingram stood third in terms of the income gained from pharmaceutical sales in the private market in 2009. Public sector tenders have also been a reliable source of income for Sigma and Shitala. Between 2008 and 2010, the government spent $538 million for the ARV tender alone (Brems et al 2011).

In the Gauteng province (which contains Johannesburg city), according to a certain “generic pharmaceuticals tables,” Indian companies gained 12.41% of the total market share in the R2598.66 million import of pharmaceuticals, and medical equipment in 2013 (Gauteng Growth Development Agency 2014).

According to Comaroff (2007), the access to life saving drugs like that of ARVs had larger significance for people living with HIV (PLHIV). Non-governmental organisations (NGOs) such as the TAC foregrounded access to HIV medicines arguing that the drugs signify “a new life” for the patients.

Indian Generic ARVs in Sub-Saharan Africa

The response of Sigma and Shitala towards the broader humanitarian crisis related to HIV/AIDS in sub-Saharan Africa shows that the South African case can be largely generalised. In Burkina Faso, the duo have had a large share in the ARV market (Camara et al 2008: 243). Likewise, the products of Sigma and Shitala came to be known as “French medicines” or “pharmacy drugs” in the private market in Benin (Baxerrés and Hesran 2011: 1253). France based distributors dominated the circulation of drugs produced by Indian companies such as Sigma and Shitala. The public tenders bought some of the medicines made by Sigma and authorised the brands by their inclusion in the national list of essential drugs to be referred by the public as “pharmaceutical drugs.” While “French medicines” retained the brand names of these two companies, “pharmaceuticals” had only international non-proprietary names (INN) written on the packages.

Even in the case of India, Van Hollen (2013: 250) has noted how Sigma and Shitala have been an essential part of the “Connect project” funded by Global Fund, producing ARVs for distribution in Tamil Nadu in South India.

The following section contains a discussion and critique of the politics of humanitarian good in Johannesburg.

ARVs as Humanitarian Goods

Broadly, Indian generic pharmaceutical companies allowed themselves to undergo a humanitarian turn in the post 2010 mass roll-out era in Johannesburg. This is a different ballgame altogether in comparison to that of the global strategies of innovator companies. Here, the “politics of life”—putting people under a medication regime throughout their lives—joins hands with a global discourse of cheapness (Mintz 1985; Dumit 2012). In general, the substantial cheapness harnessed the value of generics in the circulation. Moreover, the resultant fame gained in the public sector, along with the rhetoric of local production helps the companies to build “commodity images” in the lucrative private sector (Mazzarella 2003).

Ironically, the prices between innovator brands and reputed generic brands in the private market varied only by 20% to 30% (Lakoff 2005; Bateman 2014). Notwithstanding this, Indian generics flowed into the market spaces with great speed. In many of the private sector markets in Johannesburg the poor relied on generics when dispensing situations cut across illicit and licit trade practices (Peterson 2014). These spaces were historically the areas where the poor shopped. It might also be probable that the treatment literacy campaigns around HIV/AIDS (Niehaus 2014) have broadly facilitated the flow of generics at large.

Besides that the further involvement in the moral economy of generic circulation as public goods happened when logistical
availability rather than access per se determined the politics and value of generics (Cowen 2014). When the severe stock-out of drugs such as those used in ART became a political issue, the Indian companies took more risks to bid for public tenders. Thus, in Johannesburg, Indian generic ARVs changed from being global merit goods to become public goods (Kapstein and Busby 2010). By the term Indian generic drugs I mean either the generic drug imported from India or locally produced in South Africa by Indian companies. To be precise, they can be called “branded generics” as they carry the brand-names (Kotwani 2010).

Just as in South Africa and Nigeria, multinational companies historically did not set up factories for producing bulk drugs or formulations in India (Peterson 2014; Horner 2014). However, what Horner (2014) calls strategic decoupling from the rest of the pharmaceutical industry in the world at large from 1970 onwards revolutionised the Indian pharmaceutical industry. This is the Indian legacy that Sigma and Shitala utilised to emerge as multinational companies.

The advent of Shitala in Johannesburg in 1993 and the onset of financial crisis and depreciation of the rand thereafter were mostly coincidental.

This move entailed internationalisation of business by Shitala in order to grow beyond the domestic market in the 1970s. It also invested in other developing countries such as Indonesia, Poland and China (Bhandari 2005).

Shitala began by establishing a wholly owned subsidiary in 1993 (Jogee 2009). It was initially involved in selling highly priced generics targeting the comparatively higher income groups. Jogee (2009) points out how the acquisition of a local plant called Carrim’s along with many of the lower income population oriented products in 2005 changed the social character of Shitala’s products.

Carrim’s manufactures the ARVs of Shitala. ARVs in South Africa began to be made by various generic companies when innovator companies were granted voluntary licences. This background is to pose questions on the acts of the pharmaceutical companies mystifying the medicines as humanitarian goods.

**Indian Generic ARVs in Johannesburg**

Molecules such as tenofovir and efavirenz have replaced the earlier ARVs like zidovudine (AZT). The former are used as single pills in first-line therapy. Currently, these molecules are reborwn through the form of “single pills” or “fixed dose combination (FDCs) pills.” One of the widely used FDCs contain tenofovir, efavirenz, and emtricitabine (Green 2013).

The advent of the FDCs was meant to “improve” the adherence to medication by patients by ensuring that they do not stop taking medicines because they have to take too many different ones. Most of the pharmacists at public clinics and depots told me that the FDCs also made the stocking of medicines much easier. Thus, the FDCs became the new favourites of the South African government as well as global humanitarian bodies.

I now critique the politics of humanitarian reason—the politics of compassion for the suffering of others, or the “discourses of affect and values” (Fassin 2012: 3) in Johannesburg. Taking inspiration from Ananya Roy, I approach the dynamics of circulation of generics as similar to that of humanitarian goods. How does humanitarian reason, expressed in corporate philanthropy and global therapeutic citizenship alike, endorse processes of corporate investment and sales in generic ARVs and other pharmaceuticals by companies such as Shitala and Sigma in Johannesburg?

Humanitarian politics employs the idiom of aided renaissance of public health initiatives in HIV/AIDS at the heart of South Africa. The present boon is pitted against the dark past of the denial of HIV/AIDS treatment by the post-apartheid Mbeki government (Geffen 2010). As a rejoinder I ask how Shitala and Sigma deploy humanitarian reason as an ideology to sell generic ARVs and transform themselves according to these claims in the context of the state’s increasing control of generic pharmaceutical circulation. What happens to the notion of humanitarian goods when complex commodities such as the ARVs enter into the circulation as a simple solution to the structural problems of public health?

Interestingly, while state tenders collect ARVs through an international benchmarking system at among the cheapest prices in the world, the state mechanism was not successful in circulating them with speed.

There were instances of severe stock run outs as these new pills began being circulated in an already existing quagmire of public sector roll out. Even doctors were not informed about the arrival of the FDCs in the pharmacies and about who was considered eligible for the treatment. Pills such as lamivudine, tenofovir, efavirenz, and even older drugs such as didanosine are still found in vogue in Johannesburg. Undoubtedly, the new insertions of the FDCs into the moral economy of the circulation implicate power/knowledge, and broadly politics.

All in all, the FDCs—despite opposition from physicians such as Francois Venter, Wits Reproductive Health and HIV Institute (WRHI) and HIV Clinician’s Society due to their lack of availability and politics of circulation that accompanied their arrival (Bateman 2014)—entered as eminently simple humanitarian goods. Surprisingly, doctors, policymakers, and politicians soon accepted the totemic value of the FDCs in the moral economy. Thus, humanitarian reason thrives where the masses are deluded.

In this scenario, NGOs such as the TAC, ANOVA health institute, and MSF have shifted the terrain of their activism from ensuring affordability towards interventions in the local exchange of ARVs.

Park et al (2013: 13) in a report for the United Nations Development Programme (UNDP) state the importance of another FDC clearly:

> The existence of patent protection has posed an obstacle to innovation. For instance, Indian generic companies, unhindered by product patent protection in India during that time, were able to develop a single fixed-dose combination of stavudine, lamivudine and nevirapine that dramatically simplified the HIV treatment regimen and allowed for the scale-up of treatment in much resource limited settings.

Three generic companies—Sigma, Mylan, and Aspen—won the separate tender instituted for FDCs in November 2012.
Shitala, Adcock Ingram, and others who had not successfully registered their FDCs with the Medicine Control Council (MCC) could not quote for the tender. Initially, the policymakers planned to start the distribution of the FDCs with pregnant women and new patients. This was dropped and all patients were considered eligible to get them in October 2013 (Green 2013). In the context of the state-sponsored heavy roll out of FDCs, even the innovator brand Atripla responded by lowering its price in the market (Leng et al 2015).

However, the devaluation of currency over time in South Africa began to affect the flow of pharmaceuticals, including that of the FDCs. Government tenders have become risky deals for the generic companies. In 2015, Aspen for instance, told the government that the company could not recover the losses incurred due to the higher prices paid for the imported bulk drugs and formulations. A formally agreed increment per year in the contract was rejected as satisfactory compensation. Aspen eventually demanded a 50% hike in the price quoted originally (Bateman 2014).

**Circulation of Shitala’s Generic ARVs**

Here, I explore the performance of humanitarian reason as used by Shitala (Mazzarella 2010; Roy 2010: 133). I will document Shitala’s response to the changing nature of generic ARV circulation in Johannesburg from a global merit good (Kapstein and Busby 2010) or humanitarian good to public goods predominantly circulated by the state, as has been happening in recent times. Shitala and Sigma dominate the sale of generic ARVs among Indian companies with Shitala devoting most of its attention towards the public sector recently. As data furnished in the IMS Health explicated, among FDCs, Sigma acquired significant brand credibility in the private sector in the period between 2012 and 2013.

I have adopted the triangulation method using reports from magazines for health practitioners, advertisements of Shitala and Sigma, and interviews with activists along with ethnography.

The event in focus was held as a part of a three-day celebration of new Indian migrants’ presence in Johannesburg. A cut-out of the “Incredible India” campaign was on display as I entered the neat corridors of the University of Johannesburg’s business school in Park Town in January 2015. As the title “How India Revolutionized the Healthcare Industry: Unpacking the Pharmaceutical and Ayurveda Sectors in India” suggests, the discussions in the event were aimed at introducing India’s healing systems to a wider audience.

The event illustrated the coalescence of national interest, and private capital’s motives also addressed the need for a better public health system and targets to boost feelings of nationalism in South Africa. The scale and enunciative modalities of humanitarian reason will become clearer as I proceed.

The speakers, who represented various Indian generic companies including Shitala spoke about the history of generic manufacturing in India and the present status of their companies in South Africa.

Although it was an official event, the Consul General of India, Johannesburg, attended the event with his family. In his welcome speech, he described how India revolutionised the healthcare industry by making “pharmaceutical innovations” which were at the heart of the “global South.” He said, “most of us believe that pharmaceutical innovations happen in the North to transfer to the South. It is not always the case. One example is that of Eureka’s (an Indian company) tie with a US firm for research and development of a new chemical entity.”

He further highlighted India’s role in accelerating South Africa’s achievement of Millennium Development Goals by way of supply of medicines. Abdulla, the event organiser divided the time equally between those who spoke about Ayurveda and representatives of the pharmaceutical industry. Among the audience were a good number of people who had arrived to forge business connections with the pharmaceutical companies as well some who wanted to start business ventures related to Ayurveda. The latter left soon, whereas the former stayed back to meet company representatives and “to build relations.”

Kumar Malhotra, the regional head of Africa and West Asia for Shitala had circulated his cv at the venue in advance. He started his career as a sales manager for Wyeth, a pharmaceutical company in India born out of a joint venture with a Switzerland-based company called Mundipharma and an Indian firm. After joining Shitala in 2001 he served in China, Morocco, and Romania and was the head of chronic therapies for Shitala in Mumbai before going to South Africa.

Kumar spoke about how Shitala had helped South Africa in “accessing affordable medications” and added: “In South Africa, we have a deep commitment. We started local production here. We invested $100 million in the plant. And in the last tender we were the second largest supplier of ARVs.”

In a power-point presentation Kumar established the success of brand Shitala. He also cited Shitala’s ongoing merger with Taj pharma and the consequent size of its operations worldwide, without talking about the company’s history in detail.

When one of the speakers, a lawyer, turned around and asked a question about his experience of South Africa’s regulatory regime, he replied with a smile that his experience with the legal regime had been good, notwithstanding various delays by the MCC in registering medicines. This question was relevant because one of the constant demands of generic producers and activists affiliated to the TAC and MSF has been an end to the sluggishness in registering the generic brands and factories (Leng et al 2015). He further argued that when Shitala registers generics quickly, South Africa benefits because the government pays less for medicines.

Kumar added that for the rest of the African countries his company made life-saving drugs such as a new FDC for malaria launched in 2015. Shitala, according to his presentation, wanted a humanitarian business throughout Africa. Kumar’s travels in India and Africa contribute to a “R40 million” industry of travel agents in Johannesburg, his agent present at the event told me.

The deployment of idioms in Kumar’s speech is in alignment with broader pharmaceutical aims, that is, the organised efforts of pharmaceutical companies to manipulate the market.
situation in calculated ways through pharmaceutical relations and myth-making (Lakoff 2005). In other words, the rhetoric of pharmaceutical reason was found enmeshed with a new shift to a “humanitarian reason.” The deployment of corporate philanthropy gives an easy explanation to enter into the competitive realm of sale in generics in Johannesburg (Fassin 2012; Rajan 2003). Moreover, this shift also manifests the transformations that state-sponsored mass tenders wrought on Shitala. Kumar’s speech is an ethnographic example.

An advertorial appeared in the Mail & Guardian, a highly rated newspaper in South Africa, stating that Shitala has been providing “international quality, affordable medicines to the people of South Africa” since 1996 (Advertorial Supplement 2013).

The discourse focusing on the moral high ground of Indian generic companies in South Africa has been an ongoing one throughout the period of my fieldwork. When I interviewed Kumar at his office in Marlboro at the beginning of 2014, he initially introduced me to what I call “moral claim” in the following words:

95% of the ARVs circulated in South Africa are generics. (And) they have a very thin margin. (In South Africa) winning (government) tender is important because it is for a large quantity. The margin of profit for ARVs is very low since the government always goes for the cheapest bidder. We have invested a lot of money in the plant in the last four and half years. We expanded our capacity to produce the required stock. When we do not get tender the capacity lies idle. Then you suffer (lose).4

He justified his right to win public tenders on grounds of setting up a local firm, “creating a lot of employment,” and “ensuring a lot of flexibility in the supply.” In relation to this strategy, I will make the next analytical move to use the framework of humanitarian goods (Redfield 2012) to analyse Indian generic pharmaceuticals.

The function incorporated Ayurveda and the pharmaceutical industry into the rhetoric of India’s national progress. The Consul General of India seemed to validate the acts of the pharmaceutical industry. Following Julia Hornberger’s suggestion I argue that this is an act of translation. The Consul General translates the generics to the South African nationalist framework. The event also signifies a revival of India’s national achievements in health. This revival enhances the entrepreneurship of Indian companies.6

Before I move on, let me note that anthropologists have already noted the relevance of ethics in the industry. Specifically, Appibaum (2006: 447) states that pharmaceutical companies use “ethical justification for marketing” their products. This is because illness is a “tangible form of suffering.” Hence, according to him the industry uses claims of rescuing “mankind.” In turn, they use disease as “an opportunity” to make profits. A more culturally specific deconstruction of ethics is important. I understand ethics as a verbalisation or bodily performance of morality that converses with high culture already existent in South Africa in the context of the HIV/AIDS pandemic. The manipulation of the collective conscience is very selective. Since pharmaceutical companies have the power to speak about medicines the rhetorical performances are enunciations (Foucault 1972).

The aim of this article is to connect rather far-fetched prescription drugs such as ARVs to those commodities conventionally referred to as humanitarian goods such as solar lamps, and poo-poo bags (Cross 2013). The molecular structures of ARVs are complex and the processes of making them require advanced technology. Then, in what way are ARVs simple goods?

Let us look at facts. In 2012, Shitala manufactured didanosine, tenofovir, efavirenz, nevirapine, and lamivudine to supply to the state. Kumar told me that these ARVs were manufactured according to a voluntary agreement between the originator and Shitala. Shitala agreed to pay 5% of the net profit as loyalty.8

The newspapers in India and South Africa have abundantly covered the putative benevolence of Indian pharmaceutical capital that offered to circulate cheap ARVs in South Africa and other AIDS-prone countries in 2001 (Versi 2012).

Mike Ludwig’s (2014) report on the truthout website summed up the importance of Indian generic companies by observing how their initial offer to supply ARVs to developing countries has reduced the cost of ARV for a single patient from $10,000 a year in 2000 to $140 in mid-2014.

In the Mail & Guardian, Sitaraman Shankar wrote about how Sigma won global acclaim by offering “poor countries with a triple-drug anti-Aids cocktail at $350 per patient per year—one thirtieth of prices then charged by multinational drug makers” (2002). The central theme of the report was the deals planned for a mining company called Anglo American by Shitala and Sigma.

I will now provide a description of advertisements by Shitala and Sigma to show how the duo found these political milieus and the related response of the South African government as potential market spaces to do “commerce”—a term in the industry for doing profitable business, by taking this humanitarian turn. Advertisements are modern myths. Advertisements also mystify the harsh realities of HIV/AIDS in the following case.

**Moral Claims in the Generic ARV Advertisements**

The advertisements of generic pharmaceuticals explicate the nuances of moral claims that Indian pharma companies make in South Africa (Chorev 2012; Tomlinson and Rutter 2014).

Newspaper articles show how the price of ARVs had been important in determining access to South Africa in the early 2000s (Price 2010; Nagarajan 2013). The locus of politics has shifted lately towards the availability of FDCs as there are incidents of stock outs. For instance, Moses, the sales representative of Sigma, told me that the company overhauled its ARV distribution system recently as South Africa as a whole contributed 14% of the total ARV sale globally.

However, drug advertisements have taken the middle ground by focusing on the humanitarian character of the drug as well the low prices.

The packaging of the FDC is made “simpler” than that of the older non-nucleoside reverse transcriptase inhibitors (NNRTIs) such as efavirenz. Watermeyer (2008: 56) has pointed out how HIV/AIDS patients closely connected to the familiarity of “pill boxes, and containers, as well as pills themselves” in Johannesburg. When Aspen supplied Strocin (efavirenz) to public clinics in

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**References**


Sitaraman Shankar. Mail & Guardian. Sitaraman Shankar wrote about how Sigma won global acclaim by offering “poor countries with a triple-drug anti-Aids cocktail at $350 per patient per year—one thirtieth of prices then charged by multinational drug makers” (2002). The central theme of the report was the deals planned for a mining company called Anglo American by Shitala and Sigma.

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**Notes**

1. Kumar at his office in Marlboro at the beginning of 2014, he introduced me to what I call “moral claim” in the following words:

2. He justified his right to win public tenders on grounds of setting up a local firm, “creating a lot of employment,” and “ensuring a lot of flexibility in the supply.”

3. In relation to this strategy, I will make the next analytical move to use the framework of humanitarian goods (Redfield 2012) to analyse Indian generic pharmaceuticals.

4. Before I move on, let me note that anthropologists have already noted the relevance of ethics in the industry. Specifically, Appibaum (2006: 447) states that pharmaceutical companies use “ethical justification for marketing” their products. This is because illness is a “tangible form of suffering.”

5. In turn, they use disease as “an opportunity” to make profits. A more culturally specific deconstruction of ethics is important. I understand ethics as a verbalisation or bodily performance of morality that converses with high culture already existent in South Africa in the context of the HIV/AIDS pandemic.

6. Since pharmaceutical companies have the power to speak about medicines the rhetorical performances are enunciations (Foucault 1972).

7. Mike Ludwig’s (2014) report on the truthout website summed up the importance of Indian generic companies by observing how their initial offer to supply ARVs to developing countries has reduced the cost of ARV for a single patient from $10,000 a year in 2000 to $140 in mid-2014.

8. Mike Ludwig’s (2014) report on the truthout website. Mike Ludwig’s (2014) report on the truthout website summed up the importance of Indian generic companies by observing how their initial offer to supply ARVs to developing countries has reduced the cost of ARV for a single patient from $10,000 a year in 2000 to $140 in mid-2014.

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**Further Reading**


2008 people remembered the image of “a man holding a ball” on the packaging jar.

The advertisement of Odimune (an FDC) complies with the regulations on advertising of S4 drugs. Generics are copies. Something generic is also something ordinary. Yet, the jar and packaging is oversized to contain 30 pills. The beautiful and big packaging is the first step towards the mystification.

As mentioned before, FDCs replaced the older generation of ARVs. The advertisement of Sigma's Odimune, shows the price (that is, R 390/$27). It also states “FDA approved-who prequalified;” and additionally quotes Henry David Thoreau: “Simplify, simplify.” There is also a shadow picture of seven hands in different colours. It quotes a clinical study and refers to the “South African antiretroviral treatment regimen” as seen in many pharmaceutical advertisements including that for over-the-counter drugs. (This is a simple advertisement with a picture of the package and the labelled jar.) Sigma HIV basket's tagline says: “none shall be denied.”

Shitala’s factory, the rival Indian firm, is called “Carrim's.” The ARVs, however, are marketed by another small company that has been registered as an ARV distributor. This company is a Broad-Based Black Economic Empowerment (B-BBEE) venture along with Carrim's, and is called Ujamaa.

Ujamaa is a “fully owned subsidiary of Shitala” as the company website informs. Compliance with affirmative action policies helps the companies. The department of health grants up to 10 points for satisfying different requirement of Black empowerment moves. In the processing of the pharmaceutical tender the maximum point is usually 100; and hence 10% of the score is calculated in this way.

Ujamaa's leaflet on the ARVs says “high quality, effective and accessible HIV treatment for the people.” The tag line is “towards a healthy future—together.” This tag line denotes how the company had totally oriented their products towards a humanitarian line as early as 2013, and by 2014, there was a clearer shift in its focus towards winning the ARV tenders rather than selling in the private market. This strategy indeed won the company a tender for the FDCs in 2014.

Except the text, “South Africanness” is all over the pamphlet. Beadwork visible on the coffee cup and the AIDS symbol connotes communities and social status among people in general. Hence, a feeling of being ordinary, mundane, and simple has been attached to the ARVs.

Redfield (2012) notes that humanitarian goods are simple commodities. They circulate as an easy solution to problems in the developing countries and, especially in Africa they are an easy solution to poverty and prevention of diseases born of unhygienic conditions. The ARVs are not “simple commodities” per se, as they are regulated and prescribed by doctors. However, as Sigma’s advertisements, newspaper reports, and who documents pronounce, they have become “simplified” commodities and simple solutions to the problem of HIV/AIDS infection.

Profits and Moral Claim

The following is a discussion on the statement made by Kumar on the margin of profit. In a personal communication with me earlier in 2014 he said that the margin of profit for the ARVs is very low.

However, at the public event held a year later Kumar justified the high prospects of the pharmaceutical industry stating that the “knowledge based industry” that mobilises “good molecular chemists, mathematicians, and IT professionals in India” has the highest scope for returns in the hierarchy of business. It is also important to note that his opinion might have changed over the span of a year since Shitala won the public ARV tender at the end of 2014.

There is no dispute over the fact that the rate of the generic ARVs were much lower in the public sector in comparison to their retail price in the private market even in 2012. However, there are various places in which Kumar’s first claim of low profit does not hold. Madhav says9 “the ARV business is highly profitable. Once you win the tender the government wants high output.”

He and his colleagues remember making 50 batches per month; one batch being 1.72 million tablets approximately. Madhav, who oversaw the production of the ARVs when Shitala had won a tender and had claimed that his ARVs are “complicated medicines,” justified the high margin of profit10 saying “There are further processes of coating and encapsulation as additional finishing. They are also highly profitable medicines for the company.”

The assertion of the regional manager in 2013 contrasted with the observations of Madhav. I interviewed some workers in the factory as well.

According to Tetenda, a young permanent worker at the factory, they used to make three million tenfotiv and 1.5 million lamivudine11 a day.12 The notion of value in the discussion here by the pharmacist follows the logic that cost of production can be equated to the value of commodities. In other words, since they are biomedicine generics, they are fetishised. I recount this discussion to show how even simplified logic can complicate the rhetoric of value and provide impetus to move towards a more nuanced analysis of corporate business.

Winning tenders ensures a smooth reproduction of capital through renewed performance of humanitarianism as well as production. Besides, public sector circulation boosts the sale in the private sector. The ARVs circulate massively and add to the brand value of the product.

Winning government tenders means a lot. The product reaches a larger group of people including a larger number of households and it is the government that circulates it. Only the price will be different (in the private sector) and of course the government will handle the marketing. The company only pays for any selective services in the distribution chain.

This was stated by Steven, a former sales manager of Ujamaa, as we talked about generic ARVs at his house in a middle-class suburb in Randburg, in September 2014.13

Steven elaborates on the circulation of the ARVs as public goods and how the spillover effect can bring profit to the shareholders of Shitala.

In brief, in this article I have attempted to elucidate the virtue or moral value of generics as the distribution process plays
out in Johannesburg. Recent anthropological literature around humanitarian goods really helped me to compare and contrast. The humanitarian reason hence is an ideology of recent pharmaceutical circulation as Didier Fassin (2012) observed.

Using these concepts I have shown how Indian pharmaceutical companies such as Shitala consider philanthropic concerns as a means to build their business interest. In this pursuit, complex medicines such as the ARVs become simplified humanitarian goods. This is even beyond Biehl’s (2007: 10) narration of the way the Brazilian government uses ARVs as a “magic bullet,” by the “delivery of technology regardless of health care infrastructure” or Kalofonos’s (2010: 375) observation that the ARVs flow to Mozambique as “postcolonial palliatives” for free along with food from the rich countries. The ARVs and other generics of Shitala exist in the continuum of broader trends in which “commerce” and “morality” intersect and interact with globally produced “local” milieu of “vulnerability.” While writing this article in 2015, I saw that there is a clearer transition of the ARVs towards becoming more of a public good rather than a humanitarian good in the strict sense of the term.

**Conclusions**

In the above discussion I dwell on the poverty of “humanitarian reason” and the disillusion of the ideology of compassion leveraged on biomedical knowledge and related commodity fetishism of the pharmaceutical companies. The circulation of generic ARVs in Johannesburg shows that there is an elective affinity between the profit-making ethics of the branches of Indian corporates, and the passion of grass-root level health workers, and broader political actors to provide medicines for citizens.

The lack of established local pharmaceutical manufacturing firms, and a rather insufficient infrastructure to distribute medicines has only promoted the growth of private generic pharmaceutical companies; chain, retail and courier/mail pharmacies; and various NGOs over the last decade.

Let me add here that the state legislations and broader civil society movements created the scene for these dynamics in Johannesburg. Section 22 F of the MRSC Amendment Act 1997 legalised generic substitution if accompanied by a doctor’s permission. The National Drug Policy 1996 directs promotion of local generic pharmaceutical production ventures. In fact, the original MRSC of 1965 was further amended many times after 1997. All these amendments seem to have promoted generic substitution. The amendment in 2002 introduced an international benchmarking system to procure medicines at the lowest price. As a critic of the present situation, I would argue that AIDS patients as subjects of compassion have acquired extreme coherence in these discourses. They have become the microcosm of the relationship between the state, capital, and civil society because the abstract patient who receives, transmits, and lives with AIDS has dogmatic coherence imputed by biomedical reason. The adoption of HIV prevention methods such as condoms and self-initiated changes in lifestyle by individuals are far from gaining recognition.

**NOTES**

1. The South African state spends a sum of R1 billion ($696 million) every year (Simelela et al 2013: 260). The ART programme was historically forced upon the state. Anyway, the state is at the helm by availing medicines cajoling generic companies that have local manufacturing facilities. Almost 80% of bulk drugs or finished formulations are India’s import.
2. Usually, pharmaceutical companies establish wholly owned to subsidiaries to protect their products from a weak IP regime and to play safe according to the domestic rules and regulations (see Jogee 2009).
4. Kumar Malhotra, regional head of Africa and West Asia for Shitala Pharmaceuticals, personal communication, 26 February 2014, Marlboro, Johannesburg.
6. I attended a second function organised by Indian High Commissioner on December 2015 in the same business school. This time the Chief Financial Officer of Sigma repeated a similar set of humanitarian rhetoric.
7. When I interviewed the pharmacists who work as production managers and procurement officers at Carrim’s, they presented a narrative of the commodity in terms of their cost of production and biomedical property. They usually described to me about the cost of the raw materials such as active pharmaceutical ingredients that go into it and procedures such as granulation, and coating. Warren, personal communication (24 April 2014; also see Bateman 2014).
8. The need for research and development has made the contribution of originator companies important in the industry as well in the broader moral community of humanitarian exchange—a point he and activists at MSF and TAC at Johannesburg shared with me. Rajan (2015: 58) calls this a “market discourse” of innovation. Innovation narrowly connotes making new drugs.
10. Charley, the medical representative of Shitala, justified the higher price of certain dosage of a generic drug with the argument that “they are complicated” when she explained about them to doctors. Ethnography conducted on 10 September 2014.
11. Tenofovir and lamivudine are two first-line antiretroviral medicines frequently circulated in the public sector of South Africa.

**REFERENCES**


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