Geoeconomics of illicit medicines in West Africa

Challenges and prospects

Antonin Tisseron

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Abstract

The issue of illicit medicines in Africa: a multifaceted reality • The spread of “fake medicines" is often presented as one of West Africa's major challenges in the 21st century. Beyond the fear-mongering and reports of seizures of hundreds of tonnes of pharmaceuticals during law enforcement operations, the issue of illicit medicines is a complex one.

A mirror of the tensions inherent to the global and African pharmaceutical markets • On one hand, it encompasses a variety of realities which, after focusing on counterfeiting, is reflected in the distinction made in 2017 by the WHO between falsified, substandard and unregistered/unauthorized medical products. On the other hand, the illicit medicines market mirrors the tensions inherent in the pharmaceutical marketplace in the global and West African contexts. As such, it reflects both the competition and commercial logic driving globalised healthcare markets and access to medical care, the intensified cross-border flows in West Africa driven by “bottom up” integration, and West African circuits of production and distribution.

The market functioning and control at the heart of the problem • In this respect, the issue of illicit pharmaceuticals cannot be reduced to a matter involving a handful of crooks, just as it cannot be limited to an examination of shortcomings, malpractices or failings on the behalf of States or regional organisations. As a mirror of market tensions, it calls for multi-layered responses that distinguish between the different underlying issues, but require a central focus on manufacturers, quality control and international cooperation.

Introduction

During 2020, in the context of the Covid-19 pandemic, the issue of access to quality medicines and the activities of criminal groups in the manufacture and marketing of "fake medicines" have received increased attention. As Interpol has warned (1): "*With the exponential growth in demand for personal hygiene and protection products, criminals are seeking to make money by selling counterfeit or substandard products, such as surgical masks or even fake 'coronavirus medicines'.*" Similarly, the 2020 edition of Operation Pangea, an international initiative targeting the online sale of pharmaceuticals coordinated by the global crime fighting organisation, showed an increase in seizures of unauthorized antivirals of around 18% and a surge of more than 100% in unauthorized chloroquine (2).

Although Covid-19 has highlighted that access to quality medicines, vaccines and, more generally, pharmaceutical products is a major public health issue, this problem is not a new one. At the turn of the 20th century in British colonial India, "*the adulteration of medicines was considered a major problem and became one of the chief topics of discussion in the local pharmaceutical market*" (3). More recently, according to a joint report by the OECD and the European Union Intellectual Property Office (EUIPO), sales of counterfeit medicines –i.e., deliberately and fraudulently produced or incorrectly labelled to mislead the consumer– amounted to €4 billion in 2016 worldwide, although this figure is a conservative estimate since it does not reflect counterfeit medicines manufactured and consumed in the same country, nor does it take into account medicines that are stolen in transit and shipped to a different market or country (4).

While the fight against "fake medicines" is gaining increasing attention and has been fuelling alarmist and questionable public debate for several years (5), this paper takes West Africa as an example to present the many facets of this geo-economic issue that has political, regulatory and social implications. What is the nature and origin of the illicit medicines circulating in West Africa? How are they channelled? Who are the stakeholders? What does this economic and commercial activity ultimately tell us about globalisation in the pharmaceutical industry and the underlying power issues? Rather than being reduced to the activity of organised criminal groups attracted by the prospect of large profits, illicit medicines are in fact part of the global slump in world health markets and access to care in a context of intensifying competition for access to consumer markets. In West Africa, this is related to the intensity of transnational movements in the region and to border-related trade practices. Finally, at national level, it echoes both the multiple vulnerabilities of local authorities and the mismatch between public demand and the supply of medicines through official channels.

(1) Interpol, « Fake medicines » page, available here.
(2) Interpol, "Global operation sees a rise in fake medical products related to COVID-19", press release 19 March 2020. For a background on the circulation of chloroquine in West Africa in recent years, see: Antonin Tisseron, "Circulation et commercialisation de chloroquine en Afrique de l'Ouest", IFRI, 3 July 2020.
(3) Mathieu Quet, *Impostures pharmaceutiques. Médicaments illicites et luttes pour l'accès à la santé*, Paris, La Découverte, 2018, chapter 2. Mathieu Quet cites the work of historian Nandini Bhattacharya.
(4) OCDE and EUIPO, *Trade in Counterfeit Pharmaceutical Products*, Paris, OECD Publishing, May 2020 (revised version).
(5) Mathieu Quet, *op. cit.* and Carine Baxerres, "Contrefaçon pharmaceutique: la construction sociale d'un problème de santé publique", in Alice Desclaux and Marc Egrot, *Anthropologie du médicament au Sud. La pharmaceuticalisation à ses marges*, Paris, L'Harmattan-IRD, 2015, p. 129-146.

To explore these dimensions and their interrelationships, this paper is structured in five parts (1). After presenting the extent and nature of illicit trafficking of medical products in West Africa, we will examine the origin of the products in circulation, the routes and methods used to import them, before concluding with the various stakeholders involved and the implications of this form of market structure (2).

(1) This framework follows the approach adopted in UNODC, *Transnational Organized Crime in West Africa: A Threat Assessment*, Vienna, February 2013.

(2) The author would like to thank Laurent Amelot, Hélène Giraud and Nina Krotov-Sand for their review of a first draft of this text.

What is the **scale and nature?**

According to the World Health Organization (WHO), between 2013 and 2017, 42% of substandard or falsified medicines reported worldwide were found in Africa (1). Of all the continent's regions, West Africa seems to be particularly afflicted by this "scourge". According to a 2011 WHO study on the quality of antimalarial medicines used in Africa and other regions, West Africa had the highest treatment failure rates (2). While anti-malarial drugs have received particular attention, illicit medicines are far from being restricted to this area. Thus, according to the European Union, 60% of the West African medicines market (by value) is believed to be counterfeit or of inferior quality (3).

A large number of confiscations have been made in recent years. One such example is Interpol's 2018 regional operation Heera –involving Benin, Burkina Faso, Côte d'Ivoire, Guinea, Mali, Mauritania, Niger, Nigeria, Senegal and Togo– which resulted in the seizure of USD 3.8 million worth of medicines products (4). 67.8 tonnes of "counterfeit" pharmaceutical products, seized between June 2018 and June 2019, were also burnt in Lomé in July 2019, while in Côte d'Ivoire a 200-tonne haul of illicit medicines was seized in November of the same year in Abidjan by the Ivorian gendarmerie (5).

Many reasons are given for the preponderance of illicit medicines in West Africa. Firstly, and this argument is not specific to this part of the world, counterfeit medicines represent a very lucrative market, even more so than hard drugs. According to the IRACM (*Institut de Recherche Anti-Contrefaçon de Médicaments*), an association under the French law of 1901 linked to the private sector and several international organisations active in the fight against the trafficking of medicines, the illicit pharmaceuticals market is worth up to twenty times more than heroin trafficking (6).

Secondly, medicine trafficking is less risky than drug trafficking, mainly due to less severe criminal sanctions. It is also easier, since orders can be placed online with a just a few clicks from producers or wholesalers in other continents, especially Asia (7), when not relying on the Asian diaspora in West Africa or the West African diaspora in Asia, and the legal supply chain offers opportunities to legally export or import products destined for the informal market.

Finally, a large proportion of these medicines are sold outside pharmacies, in specialised or non-specialised markets, on street corners, etc. These channels include travelling salesmen offering medicines among other everyday products, as well as permanent and well-known establishments, some of which have a national and even regional presence. As summed by in 2019 by the Chairman of the Togo Pharmacists' Association: "*Sub-Saharan Africa concentrates all the vulnerabilities that favour substandard or falsified medicines: weak governance of health systems, inadequate health care provision and pharmacy coverage, the existence of a parallel market that is largely tolerated, and an impoverished population*" (8).

(1) WHO, "1 in 10 medical products in developing countries is substandard or falsified", press release, 28 November 2017.
(2) ONUDC, *Transnational Organized Crime in West Africa: A Threat Assessment, op. cit.*, p. 40. See also the data published by the *WorldWide Antimalarial Resistance Network* , available here.
(3) European Commission, "The EU launches a new project to fight falsified medicines in developing countries", press release, 4 April 2014.
(4) For an overview of the different Interpol operations, see here. Not all member countries participate in every operation.
(5) AFP, "Togo: un sommet contre le fléau du trafic de faux médicaments en Afrique", 16 January 2020.
(6) Éric Przyswa, *Contrefaçon de médicaments et organisations criminelles*, IRCAM, 2013, p. 17.
(7) For background on online pharmacies, see Aline Plançon *Faux médicaments. Un crime silencieux*, Paris, Cerf, 2020, chapter 5.
(8) Cited in Anne Prigent, "'Faux' médicaments en Afrique: la mort au bout du trafic", *Le Monde*, 31 July 2019.

Focus 1 • The formal market... and street markets

According to the Ivorian authorities, 30-40% of medicines consumed in the country are purchased off the street (1). Since the 1980s, several researchers have examined street markets in terms of their origin, their functioning and the rationale of their users. These practices gradually arose in French-speaking African countries, mainly as a result of colonial practices of allowing shopkeepers to sell medicines because of the scarcity of pharmacists (2), before gathering pace in the 1970s and 1980s as a result of internal and external factors: shortages in the formal sector and, more generally, a limited number of sales outlets or access, economic crises and the rising price of imported medicines, the emergence of Asian producers and the gradual structuring of the informal economy (3). The main street markets are well organised, with their own regulations and policing. In the market of Keur Serigne Bi (Dakar), for example, there is a disciplinary committee made up of vendors tasked with enforcing the internal rules, and anyone engaging in practices, attitudes or behaviour contrary to these rules is sanctionable. For example, leaving the premises to canvass for customers is forbidden and any vendor who breaks this rule is fined and may lose their customer to another vendor (4). Some of these markets have regional scope, like Idumota and Onitsha in Nigeria or Madina in Guinea Conakry. While the market of Cotonou has been shut down in recent years, others have remained open, such as in Conakry, Abidjan and Niamey, even though on several occasions law enforcement agencies have made seizures and arrests in these locations, not without encountering hostility from vendors and consumers, pre-operation tip-offs, and sometimes even political interference (5). Finally, the researchers identified several reasons for turning to street markets: economic (lower box prices, small scale sales, etc.), geographical (better territorial coverage), pragmatic (availability, opening hours, possibility of purchasing without a prescription), social and cultural (relationship with vendors, long-standing customs, etc.), as well as a lack of confidence in the formal system (6).

(1) "Côte d'Ivoire: plongeon dans le trafic illicite et très lucratif des faux médicaments", *France 24*, 9 December 2016.
(2) Lauraine Rocher, *La contrefaçon des médicaments dans le monde: situation actuelle et perspectives*, thesis presented for the State Diploma of Doctor of Pharmacy, defended on 13 June 2014, Université Claude Bernard Lyon 1, p. 62-63.
(3) Carine Baxerres, "Pourquoi un marché informel du médicament dans les pays francophones d'Afrique? ", *Politique africaine*, vol. 123(3), 2011, p. 117-136; Carine Baxerres and Jean-Yves Le Hesran, "Where do pharmaceuticals on the market originate? An analysis of the informal drug supply in Cotonou (Benin)", *Social Science and Medicine*, 73/8, 2011, p. 1249-1256; Kristin Peterson, *Speculative Markets: Drug Circuits and Derivative Life in Nigeria*, London-Durham, Duke University Press, 2014.
(4) El Hadji Malick Sy Camara, *La vente illicite des médicaments au marché parallèle de "Keur Serigne bi"*, Master's thesis in sociology, Université Cheikh Anta Diop, Dakar (UCAD), 2007.
(5) Various telephone interviews with experts on West Africa, in 2020.
(6) Sjaak Van der Geest and Susan Reynolds Whyte, "Popularité et scepticisme: opinions contrastées sur les médicaments", *Anthropologie et Sociétés*, Vol. 27(2), 2003, p. 97-118; Didier Fassin, "Du clandestin à l'officieux. Les réseaux de vente illicite des médicaments au Sénégal", *Cahiers d'études africaines*, vol. 25(98), 1985; Yannick Jaffré, "Pharmacies des villes, pharmacies 'par terre'", *Bulletin de l'APAD*, Vol. 17, 1999, p. 63-70; Sjaak Van der Geest, Anita Hardon and Susan Reynolds Whyte, "Planning for Essential Drugs: Are We Missing the Cultural Dimension? ", *Health Policy and Planning*, Vol. 5(2), 1990, p. 182-185; Carine Baxerres and Jean-Yves Le Hesran, "Le marché parallèle du médicament en milieu rural au Sénégal. Les atouts d'une offre de soins populaire", *Anthropologie et Sociétés*, Vol. 30(3), 2006, p. 219-230; Augustin Pale and Joël Ladner, "Le médicament de la rue au Burkina Faso: du nom local aux relations sociales et aux effets thérapeutiques racontés", *Cahiers Santé*, Vol. 16(2), 2006, p. 113-117; Carine Baxerres *et al.*, "Trente-cinq ans d'anthropologie du médicament en Afrique: retour sur l'étude des marchés informels, des hôpitaux et des usages pharmaceutiques", *Anthropologie & Santé*, Vol. 14, 2017; Jean-Pierre Olivier de Sardan, Nassirou Bako Arifari and Adamou Moumouni, "6. La corruption dans le domaine de la santé", in Giorgio Blundo and Jean-Pierre Olivier de Sardan (ed.), *État et corruption en Afrique*, Paris, Éditions Karthala, 2007, p. 225-247.

However, these discourses on the significance of the flows of illicit medicines and, by mirror effect, their impact on public health for local populations, are not without limits. First, they question the sources used and the scientific validity of the figures reported in the press and by those engaged in the fight against trafficking in medicinal products. A number of social science researchers have denounced the performance-based rhetoric on "fake medicines" and "counterfeiting", based on estimates that are primarily motivated by political, economic and social interests, with a twofold aim: to mobilise and defend these interests by reconfiguring the issues at stake and redefining the solutions (1).

Secondly, and echoing the first point, the discourse on "fake medicines" combines three different phenomena that need to be differentiated.

- The first phenomenon is counterfeiting or falsification. These medicines are manufactured with an intention to deceive (distributors, authorities, physicians, patients, etc.), and for profit. They are present in both formal and informal/illicit channels. Although the correlation between counterfeiting and poor quality is neither automatic nor systematic, it is often found to be the case. Not only may a counterfeit pharmaceutical contain the incorrect dosage of active ingredient, but it can also contain other lower-cost active ingredients, or ineffective or harmful substances (2). The primary characteristic of falsification is its intentionality.
- The second phenomenon concerns the quality of these medicines. The manufacturer of a substandard –i.e. non-compliant– medicine may indicate the right product on the packaging and documents, but its contents are inherently inferior at the manufacturing and/or distribution stage through defects or deterioration. This defectiveness may be the result of errors, negligence and/or inadequacies in equipment, premises, know-how, etc. Substandard medicines may be over- and/or under-dosed medicines, unstable medicines (e.g. when active substances are degraded due to faulty or unsuitable packaging), non-bioavailable medicines (when the active substance is not released correctly in the body), contaminated or non-sterile medicines, medicines degraded by inappropriate transport and storage conditions, or medicines mislabelled due to packaging errors (3).
- The third phenomenon concerns the flow and distribution of medicines outside the formal framework imposed by the state and the country's regulated health system, or that are present in that formal framework but as a result of practices that bypass regulatory systems. This includes medicinal products that are sold in street markets. These medicines can enter West Africa illegally or be licensed in one country (i.e. they have a marketing authorisation and have been imported in accordance with the regulations) and resold in another where they lack the necessary licences. Alternatively, they may have entered the country legally as licensed products, but are sold through unauthorised resellers. They may well be of substandard quality or counterfeit.

(1) See in particular: Mathieu Quet, *op. cit.;* Carine Baxerres, "Contrefaçon pharmaceutique: la construction sociale d'un problème de santé publique", *art. cit.;* Carine Baxerres, "Faux médicaments, de quoi parle-t-on ? Contrefaçons, marché informel, qualité des médicaments… Réflexions à partir d'une étude anthropologique conduite au Bénin", *Bull. Soc. Pathol. Exot.*, 107, 2014, p. 121-126.
(2) WHO, "Medical Product Alert No. 3/2015. Falsified Meningitis Vaccines circulating in West Africa UPDATE", 27 May 2015, Ref. RHT/SAV/MD/3/2015.
(3) Jacques Pinel, *Les médicaments de contrefaçons et sous-standards: un danger de mort*, p. 11, available here.

Focus 2 • The WHO and illicit medicines: from counterfeit to falsified and substandard medicines

The notion of "counterfeit" had been used occasionally in the post-war period to describe the problem of illicit medicines. In 1985, the term was officially introduced in WHO texts at the Nairobi conference, before gaining momentum with the first meetings dedicated to counterfeit medicines, in a context of aggressive pressure from the pharmaceutical industry. At a workshop co-organised with the International Federation of Pharmaceutical Manufacturers (IFPMA), the WHO adopted a non-binding definition of "*counterfeit medicine*". Defining it as "*a medicinal product which is deliberately and fraudulently mislabelled with respect to identity and/or source. Counterfeiting can apply to both branded and generic products and counterfeit products may include products with the correct ingredients, wrong ingredients, without active ingredients, with insufficient quantity of active ingredient or with fake packaging.*" This definition has been debated and criticised because of the underlying pharmaceutical patent disputes in geographically different jurisdictions. Four years after excluding "*substandard batches or quality defects or non-compliance with good manufacturing practices/good distribution practices in legitimate and medical products*" from the definition of counterfeiting (1), and to better account for the broad range of phenomena related to the medicines market, the WHO set up an internal working group in May 2010 on "*substandard/spurious/falsely-labelled/falsified/counterfeit*" medical products. As a result of the work conducted and after several months of debate, in 2017 the World Health Assembly adopted the statement on "*substandard and falsified medical products*" (2). Three categories of products are distinguished: (1) substandard products, also known as "*out of specification*", that fail to meet either the stated quality standards or specifications, or both; (2) unregistered/unauthorized products, i.e. that have not undergone evaluation and/or approval by the National or Regional Regulatory Authority for the market in which they are marketed/distributed or used, subject to permitted conditions under national or regional regulation and legislation; and (3) falsified products, that deliberately/fraudulently misrepresent their identity, composition or source (3).

(1) WHO, "Counterfeit medical products. Report by the Secretariat", 124th Session of the Executive Board, EB124/14, 18 December 2008.
(2) This term covers medicinal products, their excipients and active substances, as well as medical devices, their parts and materials and accessories used with these devices. WHO, "Member State mechanism on substandard/spurious/falsely-labelled/falsified/counterfeit medical products. Report by the Director-General", 70th World Health Assembly, A70/23, 20 March 2017, p. 1.
(3) *Ibid.*, Appendix 3 of the Annex.

Where do **illicit medicines originate?**

The geographical origin of illicit medicines reflects the worldwide production patterns. While some of these come from West African producers, most of the pharmaceuticals sold in West Africa are manufactured in China and India, two countries that produce a large proportion of the world's active ingredients and medicinal products. This said, the goods available in street markets nuance this general picture and reflect another aspect of the origin of illicit medicines.

West African production on a small scale

The pharmaceutical industry is poorly represented in West Africa, with a significant lag between English and French-speaking countries. According to a report published in 2020, there are 172 local pharmaceutical companies in the states of the Economic Community of West African States (ECOWAS), including 120 in Nigeria alone, 37 in Ghana, 5 for Senegal and Côte d'Ivoire, and 1 each in Benin, Burkina Faso, Cape Verde and Guinea Conakry (1). Consequently, most medicines are imported, although there are variations from one country to another. Thus, the market share of local products is predominant in Nigeria and Ghana (2). By contrast, in Côte d'Ivoire, according to the authorities, for 2018 the country imported almost 94% of its consumption (3). It is worth noting that illegal "laboratories" coexist alongside the authorised producers, manufacturing various products that are more akin to para-pharmaceuticals. In Niger, for example, the authorities dismantled a clandestine laboratory in 2019 and announced the seizure of ten tonnes of fake medicines "*made from local plants and other components imported from abroad*", including aphrodisiacs, haemorrhoid products and substances intended to make women gain weight and enlarge their breasts and buttocks (4).

This sector faces several challenges. These include access to raw materials - over 90% of active pharmaceutical ingredients for local manufacture are imported - lack of skilled labour, lack of product pre-qualification by the WHO for many producers, uncompetitive production costs, etc. (5) In the fight against falsified and substandard medicines, the regulatory bodies often lack the means and human resources to enforce the standards in force or to control products, not to mention the unappealing prospects of working in public administrations (6). In this context, according to a WHO study (7), the likelihood of fake medicines being manufactured locally is even greater than for imported medicines. In 2009, 84 Nigerian children died after consuming paracetamol syrup produced by Barewa Pharmaceuticals (Nigeria) and containing diethylene glycol, a chemical used in the motor vehicle industry (8). The same year, UNODC's Scientific and Laboratory Section inspected a pharmaceutical

(1) Tom Ogada *et al.*, *Construire une industrie pharmaceutique locale compétitive et socialement inclusive en Afrique de l'Ouest. Stratégies de développement des ressources humaines pour le secteur*, THE SCINNOVENT CENTER, 2020, p. 2.
(2) ONUDC, *Transnational Organized Crime in West Africa: A Threat Assessment*, *op. cit.*, p. 40.
(3) AFD, "Synthèse de conférence Le médicament en Afrique: comment mieux répondre aux enjeux d'accessibilité et de qualité ? ", ID4D, 3 April 2018, p. 2.
(4) AFP, "Niger: démantèlement d'un laboratoire clandestin de faux médicaments", 5 March 2019.
(5) Tom Ogada *et al.*, *op. cit.*, p. 2.
(6) *Ibid.*
(7) WHO, *Survey of the quality of selected antimalarial medicines circulating in six countries of sub-Saharan Africa*, Geneva, January 2011.
(8) AFP, "Un médicament frelaté tue au moins 84 enfants au Nigeria", *Le Monde*, 11 February 2009.

manufacturing facility in Guinea where packaging and cartons resembling those of a European pharmaceutical company were being produced. The medicine boxes were labelled "amoxicillin", but they contained flour-filled gelatine capsules (1).

While European companies are present in West Africa with production structures, companies with Chinese and Indian capital have also moved into the region in recent decades, including China's Tong Mei and the Indian company Sprukfield at the Port of Lomé free trade zone in 1998 and 2007, respectively. This second company has been accused on several occasions of manufacturing and marketing non-compliant and health-hazardous products (2). Meanwhile, Tong Mei was charged by the Beninese courts with not having the necessary permits for its manager in Benin to sell in the country, in other words, with unlawful commercial practices (3). More recently, in 2018, the Chinese company Fosun International – present in the Ivorian market since 2012 through its subsidiary Guilin Pharma–, which specialises in the distribution of pharmaceutical products, announced the construction of an anti-malaria drug plant in Côte d'Ivoire (4).

China and India as top producers

The vast majority of falsified, substandard or smuggled medicines entering West Africa are produced in Asia, particularly in China and India, although in recent years other countries such as Pakistan have also made noteworthy seizures. In August 2020, after tramadol was placed on the control list by India in 2018 (5), the Nigerian authorities seized tramadol, codeine and other restricted substances in a container at the port of Apapa, which had been shipped via Hamburg from Pakistan where the products were manufactured (6). Another example is given by a French group of companies condemned after the discovery in Niger, in 2013, of antimalarial medicines that did not meet the required standards (insufficient active ingredient) and the commercialization of rapid diagnostic tests for malaria for which it had neither the manufacturing nor the marketing authorization (7).

In the 1970s and 1980s, the pharmaceutical industry was expanding in Asia, Latin America, the Middle East and North Africa. In this context, the West Africa's English-speaking countries are gradually introducing medicines from the "emerging" countries of Asia, particularly India, China and Indonesia (8), driven by the strong growth of generic medicines after their formal recognition in United States legislation in the mid-1990s and, to a lesser extent, by the WHO's promotion of "essential medicines" with proven efficacy, satisfactory value for money and acceptable pharmaceutical safety and quality. In French-speaking countries, the abrupt devaluation of the CFA franc in 1994 also seems to have triggered a search for alternative supply sources. "*At the time, [due to rising prices of medicines,] we started looking*

(1) ONUDC, *Transnational Organized Crime in West Africa: A Threat Assessment*, *op. cit.*, p. 45.
(2) Pierre-Claver Kuvo, "Togo: Quand de faux médicaments sont fabriqués en toute tranquillité", *aLome.com*, 30 April 2020.
(3) "Tong Mei a-t-il été sanctionné au Bénin pour trafic de faux médicaments? ", *Sciences Actu*, 5 August 2018.
(4) Emmanuel Atcha, "Pharmaceutique: Fosun International annonce la construction d'une usine en Côte d'Ivoire", 21 March 2018.
(5) See Antonin Tisseron et Nina Krotov-Sand, *At the Crossroads of Licit and Illicit. Tramadol and other pharmaceutical opioids trafficking in West Africa*, UNODC Research, April 2021; Antonin Tisseron, "Un nouveau trafic très lucratif: le tramadol en Afrique de l'Ouest", in Laurent Guillaume (ed.), *Africa Connection*, Paris, La manufacture de livres, p. 231-249.
(6) Adebayo Folorunsho-Francis, "Nigerian drug traffickers now smuggle tramadol, codeine from Pakistan – NDLEA", *Healthwise* (Nigeria), 19 August 2020.
(7) WHO, *WHO Global Surveillance and Monitoring System for substandard and falsified medical products*, Geneva, 2017, p. 31.
(8) Carine Baxerres and Jean-Yves Le Hesran, "Where do pharmaceuticals on the market originate? An analysis of the informal drug supply in Cotonou (Benin)", *art. cit.*

for more affordable solutions, especially generics", recalls a Cameroonian pharmacist. Although some European generics were already present, "*little by little, Indian manufacturers began to take an interest in French-speaking African countries by responding to calls for tender*" (1).

According to figures from the United Nations Office on Drugs and Crime (UNODC) and reported in the media, 60% of fake and counterfeit medicines sold in Africa are thought to come from China (2). Some of them are said to originate from licensed companies manufacturing either falsified or substandard medicines -in particular due to competitive pressure, distances between production and use areas and the scarcity of inspections in West Africa (3)– or from illegal production facilities. A number of Chinese nationals have been arrested for pharmaceutical trafficking in the region in recent years, including in Togo and Côte d'Ivoire. Thus, among the products seized by the gendarmerie in November 2019 in Abidjan, there were many packages labelled in Chinese and, among the four suspects arrested, one was Chinese (4). Finally, a large West African community has settled in China, in cities like Guangzhou, known for its pharmaceutical industry (5). However, as one researcher who has examined the Chinese pharmaceutical sector in Nigeria noted, "*Chinese companies suffer from a relative handicap [in English-speaking countries]. [...] Their Indian counterparts, on the other hand, are not only better connected to the well-established Indian communities in Lagos, but can also converse in English without difficulty*" (6).

India has the world's third largest pharmaceutical industry in terms of volume and the fourteenth largest in terms of value. It accounts for 20% of the world's output of generic medicines and has the largest number of US-FDA compliant pharmaceutical plants (over 262) outside the US, almost 1,400 WHO GMP compliant pharmaceutical plants and 253 plants approved by the European Directorate for Quality Medicines (EDQM) (7), from a total of 10,500 registered production facilities in the country (8). If we add cosmetics, traditional medicine (Ayurvedic and Unani) and homeopathy, the number rises to 18,000 facilities, for about 800,000 authorized wholesalers and retailers. In this context, India's pharmaceutical sector is particularly strategic, with an impact on attempts at regulation and control. As noted by Indian Prime Minister Narendra Modi in 2020, following the announcement of the results of the fiscal year between April 2019 and March 2020 showing an 8% increase in Indian pharmaceuticals, "*the pandemic has once again demonstrated that the Indian pharmaceutical industry is an asset not only to India but to the world*" (9).

As in China, the Indian production sector is very diverse with producers ranging from artisanal workshops in basic conditions to full-scale industrial operations. It is also extremely competitive, with strong competition between stakeholders for access to distribution channels to reach markets, by taking a few regulatory liberties when necessary.

(1) Séverine Charon and Laurence Soustras, "Vers une industrie pharmaceutique africaine », *Le Monde Diplomatique*, December 2020, p. 12.
(2) "L'Afrique se lève contre le trafic de faux médicaments", *Le Point Afrique*, 15 January 2020.
(3) This refers to the pressure on costs and delivery times, but also to a differentiation of production according to the regulation and consumption areas.
(4) AFP, "Côte d'Ivoire: saisie record de 200 tonnes de faux médicaments à Abidjan", 18 November 2019.
(5) Yang Yang, "African Traders Guangzhou, China: Routes, Profits, and Reasons", p. 1, available here.
(6) Gernot Klantschnig, "Négocier les profits et la facticité: le commerce des produits pharmaceutiques entre la Chine et le Nigeria", *Politique africaine*, 2014/2, n°134, p. 89-110, p. 108.
(7) Official Indian figures, available here. Although production plants already existed in India at the beginning of the 20th century, their expansion really took off after independence. The industry has been closely linked to state assistance and supervision, particularly from the 1970s onwards. In the 1990s, the Indian market was gradually liberalised.
(8) "L'industrie pharmaceutique en Inde – Tendances et opportunités", *India Briefing* (India), 18 April 2019.
(9) Tom Miller, "Inde: le laboratoire pharmaceutique du monde", *Conflits*, 24 July 2020.

In recent years, the Indian authorities have become increasingly involved, with several legally exported containers being reported to West African law enforcement agencies. "*The government knows that in Africa, for example, many of the medicines are ordered online and shipped from Nhava Sheva, Mumbai's container port, are not necessarily falsified but illegal, i.e. they do not comply with the legislation of the recipient countries, and have often deteriorated in quality due to unsuitable transport conditions in the tropical climate*" (1). However, these efforts are hampered by the strategic nature of the country's pharmaceutical industry (at federal and state level), corruption (2) and short-staffed enforcement agencies. There are indeed not enough inspectors. In 2019, for example, at the Central Drugs Standard Control Organisation (CDSCO), through which the government conducts nationwide operations, 64 of the 287 inspector positions were vacant. In total, the number of inspectors in the country was then well below the recommendations of the 2003 Mashelkar report on pharmaceutical regulatory policies (between 2,500 and 3,200 for the country) and did not allow for the statutory annual inspections of retailers and manufacturers (3).

Sources of supply for street markets

The origin of the medicines available on West African street markets, however, provides a counterpoint to this discourse voiced by the main global protagonists in the fight against the illicit medicine trade. Studies on the origins of these products distinguish between two main sources of supply: neighbouring countries and diversions from national distribution channels (4). This last category covers several sub-groups of products. With respect to the Keur Serigne Bi market in Dakar, El Hadji Malick Sy Camara differentiates between medicines sold following robberies on pharmacies, reselling by people who have finished their treatment or who have been prescribed medicines but do not use them and the resale of medicines by health professionals (5). Carine Baxerres, based on a census of 1,492 medicines sold between 2005 and 2007 in the Dantokpá market in Cotonou –which has since been shut down by the authorities– distinguishes 4 types of medicines:

- "*Nigerian and Ghanaian*" medicines, which are low-priced generics with a brand name and manufactured in Nigeria, Ghana or Asian countries, mainly India and Indonesia. They account for 18% of the medicines surveyed.
- "*French*" or "*pharmacy*" medicines, which are brand-name medicines –generic or not– manufactured mostly by North American and European pharmaceutical companies. They represent 42.6% of the medicines.

(1) "L'Inde, laboratoire mondial des médicaments non conformes", *Le Monde*, 11 January 2018.
(2) An example of public sector corruption is the Indian government's decision to dismiss 15 customs officers for corruption in June 2019 (PTI, "Crackdown on corruption: Govt sacks 15 customs, central excise officers on charges of corruption, bribery", *The Economic Times* (India), 18 June 2019).
(3) Shree Agnihotri and Sumathi Chandrashekaran, *Drug Regulation in India. The Working and Performance of CDSCO and SDRAs*, Thakur Foundation, September 2019, p. 45.
(4) See in particular the work of Sjaak Van der Geest, Didier Fassin, Carine Baxerres or Donna Patterson.
(5) El Hadji Malick Sy Camara, *La vente illicite des médicaments au marché parallèle de "Keur Serigne bi"*, *op. cit.*

- "*Pharmaquick*" medicines, which are inexpensive generics marketed under their international non-proprietary names and produced by Benin-based pharmaceutical firms (hence the name given to these medicines, derived from a local manufacturer) or in neighbouring countries (Ghana, Nigeria and Togo) as well as in Asian countries (India and China). They represent 37.9% of the medicines sold in the market.
- The last and least prominent category is "*Chinese medicines*". It represents 1.41% of the medicines (1).

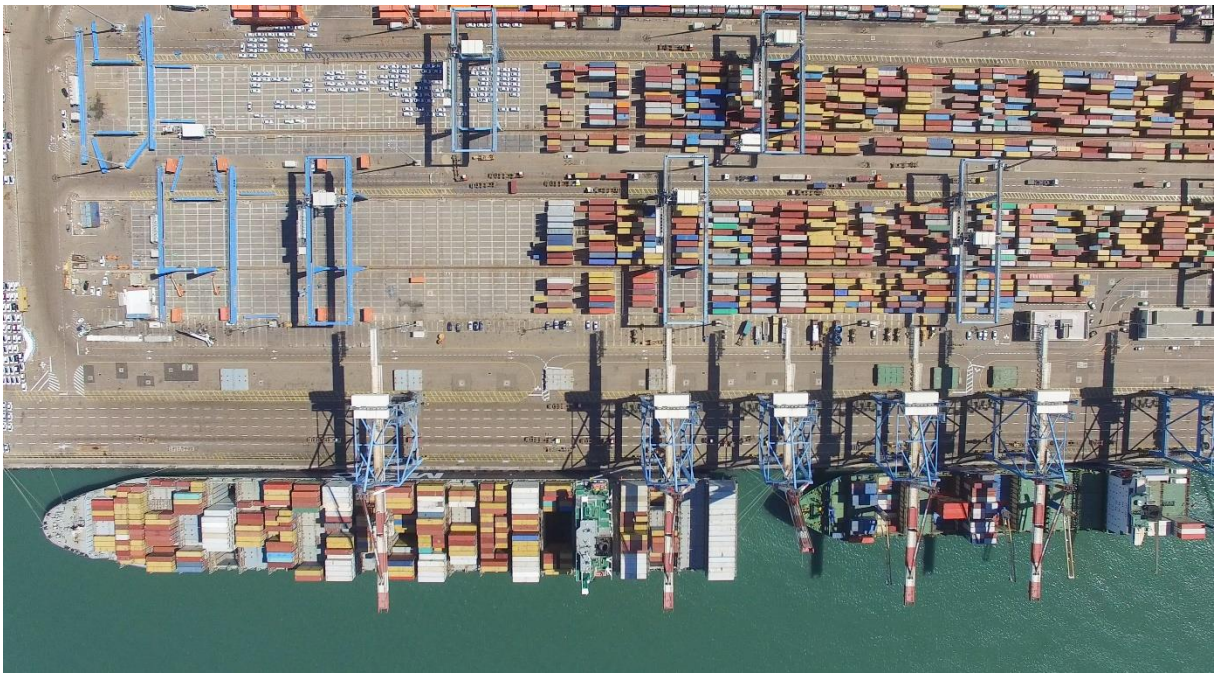
This means that the main sources of supply for the Dantokpá market between 2005 and 2007 were: (1) formal channels in Benin and neighbouring French-speaking countries (Burkina Faso, Niger and Togo), having been diverted after authorised intermediaries (health professionals) have purchased them from public and private wholesalers in these countries; (2) formal channels in Nigeria and Ghana, with medicines purchased in markets such as Idumota (Lagos) and Okaïshie (Accra), where formal wholesalers distribute products authorised by the national regulatory agencies in these countries (the National Agency for Food and Drug Administration and Control (NAFDAC) in Nigeria and the Food and Drugs Authority (FDA) in Ghana), but which are mostly not authorised for sale in Benin. These figures are out of date and comparable work should be carried out in other French and English-speaking countries. However, the reports emerging from the region point in the same direction and suggest that we should be wary of the recurrent association between street medicines and the problems of counterfeiting and falsification.

Admittedly, the consumer on the informal market is at greater risk due to storage conditions, lack of controls, lack of knowledge on the part of many sellers and the presence of products smuggled into the sub-region, such as high-dose tramadol tablets and capsules (over 100 mg). However, the majority of medicines that are distributed through informal markets can be purchased from local pharmacies or from a neighbouring country. The Upsa group, whose product Efferalgan can be found on the shelves of illicit traders, agrees: "*These are primarily bona fide medicines that have been diverted from the official local distribution channel. We have never had any reports of falsified products involving Efferalgan*" (2). Beyond the falsification of medicines, the problems posed by medicines sold in street markets are linked to the diversion mechanisms of official supply chains, the heterogeneity of the West Africa's pharmaceutical systems and registration procedures, as well as the illicit flow of products from one country or continent to another.

(1) Carine Baxerres, "Faux médicaments, de quoi parle-t-on? Contrefaçons, marché informel, qualité des médicaments… Réflexions à partir d'une étude anthropologique conduite au Bénin", *art. cit.*, p. 124.
(2) Cited in Séverine Charon and Laurence Soustras, *art. cit.*

Focus 3 • Distribution in the French- and English-speaking markets

Two distribution systems for medicines are generally distinguished in West Africa. In French-speaking countries, like Benin, Côte d'Ivoire or Togo, the system is mostly centralised with a limited number of public and private importers. In Benin, for example, there is one semi-public wholesaler, CAME, and five private wholesaler-distributors. In English-speaking countries, on the other hand, the market is broader with multiple operators. In Ghana, for example, the Ministry of Health (MoH) has two state-run units: the Central Medical Store3 and the Stores Supplies and Drugs Management. They import and distribute medicines through regional branches and through calls for tender, transnational suppliers and private Ghanaian wholesalers. In addition, there are 640 private wholesalers, of which 398 are both wholesalers and retailers. Unlike their counterparts in Benin, Ghanaian wholesalers are not obliged to distribute a large proportion of the medicines purchased in the country, partly explaining their high numbers (1). However, this is a mixed picture, at least as far as the number of authorised importers is concerned. Some French-speaking countries have several dozen official importers, including Mauritania (more than 50) and, until recently, Guinea (a hundred or so wholesale importers a few years ago, 50 or so at the beginning of 2021, 10 following the closure of 40 companies by a decree of 18 March 2021) (2). Guinea has also been a source of supply for informal markets in Senegal, Côte d'Ivoire, Burkina Faso and even Niger in recent years.



(1) Stéphanie Mahamé and Carine Baxerres, « Distribution grossiste du médicament en Afrique: fonctionnement, commerce et automédication. Regards croisés Bénin-Ghana", in *Actes des Rencontres Nord/Sud de l'automédication et de ses déterminants*, 2015, p. 24-34.
(2) "Importation des médicaments en Guinée: Pr Falaye Traoré brise le silence….", *Flammeguinée.com* (Guinée Conakry), 12 February 2020; decree of Ministry of Health of Guinea dated 18 March 2021, A/2021/357MS/SGG.

What **routes and methods are employed?**

To present the routes and main operating procedures a distinction should be made between two very different stages, even if the vulnerabilities exploited are comparable. The first concerns the entry routes to West Africa, and the second addresses flows within the region.

Delivering to West Africa

Illegally imported medicines mainly arrive by sea, with 80% of the world's trade taking place via container ships (1). The journey is often long, with multiple stopovers (United Arab Emirates via Dubai, Egypt, etc.). However, it is difficult to talk about actual trafficking "routes", as the corridors are shifting, constantly evolving to reduce the risks of being traced, and the trafficking of medicines is interwoven with global trade.

The *modus operandi* used in transcontinental maritime transport is multifaceted (2): (1) misleading information on the cargo manifest ("general" goods, legal medicines, medical equipment, vehicle spare parts, etc.); (2) falsification of documents such as import licences (false declaration, falsified consignee details, etc.); (3) fraudulent packaging (concealing illegal tablets in boxes marked as transporting sundry foodstuffs or mentioning an international organisation); (4) concealment of illicit products alongside legally imported and authorised pharmaceutical products; (5) declaring transhipment to a hinterland country in the West African port of arrival to reduce the risk of checks by customs and law enforcement agencies. While a manifest may be altered in transit to indicate a different destination from the one initially declared (3), other information may be changed such as the nature of the goods carried by the container. Medicine repackaging is another method used in transit (4).

Only a minority of containers in West African seaports are checked and searched. In Cotonou, for example, the UNODC-supported Mixed Container Control Unit has a theoretical inspection capacity of 1% of incoming containers, while only 10% of containers are scanned (5). Moreover, in a context of heightened competition between West African seaports, priority is given to efficiency and speed, resulting in pressure on law enforcement agencies not to hamper the movement and unloading of goods. Another challenge is ensuring cooperation between the different services operating in seaports. For example, in June 2018, NAFDAC publicly protested against Nigerian Customs' refusal to grant the agency access to 24 containers suspected of containing unauthorized medicines (6).

Some of the illicit medicines entering (legally or not) West Africa are transported by air freight. The operational modes are relatively similar to those used in maritime transport: false declarations, falsification of documents, repackaging, etc. Freight forwarders sometimes have accomplices at the airports themselves, as illustrated by the seizure of 4 tonnes of high-dose tramadol (250mg per tablet,

(1) United Nations Conference on Trade and Development, *Review of Maritime Transport 2016*, New York and Geneva, United Nations, 2016, p. 6.
(2) Camille Niaufre, *art. cit.*, p. 9-11.
(3) Devesh K. Pandey, "Global trail: Tramadol high on drug enforcement agenda", *The Hindu* (India), 15 July 2018.
(4) Camille Niaufre, *art. cit.*, p. 7.
(5) Axel Klein *et al. Tramadol in Africa. Scarcity and Excess of Pain Medication in a Poorly Regulated Market*, ACK Consultants, 2018, p. 18.
(6) "Customs seized 35 containers of tramadol but handed only 9 to us", *The Vanguard* (Nigeria), 10 June 2018.

whereas national law allows for 50 and 100mg tablets) at Lagos International Airport in May 2018. In addition to false and incomplete information on the manifest, neither the importer nor the clearing agent came to collect the goods despite the fact that the National Drug Law Enforcement Agency (NDLEA) had launched a surveillance operation based on information received from another country (1).

Medicines can be transported by human mules on commercial flights (2). However, the main transhipment agents of illicit medicines rely on maritime container transport to export large volumes at lower cost, while passenger transport is more associated with individual acts and small-scale criminal networks.

A regionalised West African market

In 2014, placebo medication was seized at Ouagadougou airport. Nigerians had concealed them in their suitcases in order to scam potential consumers. While some illicit medicines circulate in West Africa by air, overland routes are almost always the preferred method (3). Many different means of transport are used: trucks, buses (as freight or with passenger transport), taxis, cars, motorbikes, bicycles, etc. Many different means of transport are used: trucks, buses (as freight or with passenger transport), taxis, cars, motorbikes, bicycles, etc.

- Two types of roads can be distinguished: the main commercial corridors and secondary roads and tracks. Traffickers use collusion and corruption to get through checkpoints (4). The goods are intermingled with the flow of vehicles, hidden under other goods such as clothes or fruit (5). Trade facilitation mechanisms between states make this trafficking more feasible. In an article published in 2013, Carine Baxerres mentioned the case of Beninese retailers travelling to Nigeria to buy medicines from a wholesaler before hiring Nigerian middlemen to handle the storage of the medicines, their transport to Benin and their customs clearance for a fixed price regardless of the type of goods transported (6).
- Some traffickers avoid busy road links, like the Togo-Burkina Faso border. They cross the bush on motorbikes at high speed and when threatened with arrest, abandon their motorbikes and products to flee on foot. They can travel in groups of 30 to 40 individuals (7). Another example involves the Niger-Nigeria border, where traffickers also have a network of lock-ups in private dwellings on both sides of the border (8).

(1) "NDLEA impounds four tonnes of imported Tramadol at Lagos airport", *PUNCH.ng* (Nigeria), 18 May 2018. The tramadol entered the country through the same airline on two occasions. The first batch entered Nigeria on 23 April 2018, the second two days later.
(2) ONUDC, *Transnational Organized Crime in West Africa: A Threat Assessment*, *op. cit.*, p. 41.
(3) Jérémy Lachartre, "Le trafic illicite de médicaments au Burkina Faso, une menace grandissante? Faiblesses structurelles et conjoncture défavorable", *Sécurité Globale*, n°22, 2020, p. 7-23, p. 10-11.
(4) *Ibid.*
(5) Mouhamadou Kane, "How COVID-19 is fuelling the trafficking of fake chloroquine in Senegal", ENACT, 6 July 2020.
(6) Carine Baxerres, "L'introduction différenciée des génériques entre pays francophones et anglophones d'Afrique de l'ouest: une illustration de la globalisation du médicament à partir du cas de Bénin", *Autrepart*, Presses de Sciences Po, No. 63, 2013/1, p. 51-68, p. 56.
(7) Jérémy Lachartre, *art. cit.*, p. 11.
(8) Telephone interview, aid worker based in Nigeria, February 2021.

These modes of transport are usually used in combination with each other. In December 2018, Niger's drug enforcement agency, the *Office Central de Répression du Trafic Illicite des Stupéfiants* (OCRTIS), dismantled a criminal network operating between Burkina Faso and Libya. On the Ouagadougou-Niamey stretch, the tramadol tablets were hidden in a truck carrying other goods. In Niamey, the tramadol was picked up and forwarded to Agadez and Libya via passenger buses (1). Another example, although not of medicines but of arms, is the case of sugar smuggling between Burkina Faso and Côte d'Ivoire. "*The process began with a telephone call from a 'boss' or 'trader' asking for help in unloading the sugar from a truck at a specified location. [...] After receiving the initial call, the transporter organized sufficient numbers of friends, colleagues, other drivers, or even teams of drivers he knew to be both trustworthy and skilled enough to complete the job. At the appointed time the crew of transporters arrived at the specified location in small groups, to avoid arousing suspicion. The crew then unloaded the truckload of sugar, breaking it into manageable portions. [...] From the rendezvous point, the transporters [used] various routes winding across the savannah, [using] dried out river beds and other natural camouflage, until they were able to safely use more formal routes*" and, in small groups, reached Bouaké, in Côte d'Ivoire, where they delivered the goods (2).

Who are **the traffickers?**

One of the main characteristics of the illicit medicines market is the overlap between the formal and informal sectors. More specifically, the researchers have identified two points of convergence (3). The first concerns the origin of the products. In Nigeria, for example, in a BBC documentary on the non-medical use of codeine cough syrup, a representative of the state-owned Emzor Pharmaceuticals company bragged that he could sell a million cartons of syrup on the black market in a week (4). Similarly, medicines arriving illegally in West Africa have been exported legally and manufactured in licensed plants, exemplified by the case of tramadol with a dosage above 100 mg in recent years.

The second point of overlap concerns those involved in distribution and sales. Health professionals are clandestinely selling medicines without a prescription to clients or resellers. Some of the medicines available on Côte d'Ivoire's street markets come from pharmacies. "*Some genuine medicines from the legal circuit end up on the street through the fault of certain pharmacists*", observed an Ivorian professor a few years ago (5). These professionals can also act as middlemen for third parties. In November 2017, following the seizure of 13 tonnes of counterfeit medicines in Niger, local media reported that the medicines had arrived from India via a Ghanaian port and that, to ensure that the products entered Niger, the traffickers had paid a pharmacist to use his name and business license number (6).

(1) Tcherno Madjo Abarchi, "Niger: sur les routes du Tramadol», CENOZO, 11 March 2019.
(2) Roberto Sollazzo and Matthias Nowak, *TRANSIT TRIFRONTALIER. Les trafics et la contrebande à la frontière du Burkina Faso, de la Côte d'Ivoire et du Mali*, Security Assessment in North Africa and Small Arms Survey, October 2020, p. 13.
(3) See in particular: Sjaak van der Geest, "The intertwining of formal and informal medicine distribution in south Cameroon", *Canadian Journal of African Studies*, vol. 19, 3, 1985, p. 569-587; Sjaak van der Geest, Anita Hardon and Susan Reynolds Whyte, "The Anthropology of Pharmaceuticals: A Biographical Approach", *Annual Review of Anthropology, art. cit.*
(4) BBC Afrique, "Emzor suspend la distribution d'un sirop incriminé au Nigeria", 1st May 2018.
(5) Professor Anglade Malan, director of the Ivorian national public health laboratory, interviewed in "Côte d'Ivoire: plongeon dans le trafic illicite et très lucratif des faux médicaments", France 24, 9 December 2016.
(6) AFP, "Niger: 3 tonnes de médicaments contrefaits en provenance d'Inde", 20 November 2017.

The connection between the country of production and the country of import can be achieved in different ways. The path followed by Nigerian importers of Chinese medicines provides an example. First, they went to China to seek "partners". Gradually the trips became less frequent and trusted agents in Asia began to place orders on behalf of these Nigerian importers (1). Diasporas also play an important role. As a result, the Chinese authorities brought charges against a Nigerian businessman residing in China who had ordered fake antimalarial medication from a Chinese exporter. He in turn outsourced the contract on to an employee of a pharmaceutical company, to experts in packaging, and to a courier who consolidated the goods with another shipment of counterfeit medicines (2). In another example, in 2012, 40 cartons of Coartem seized from an electronics shop in Lagos had been shipped by a Nigerian trader living in the Chinese city of Guangzhou, known for its street markets (3). Several cases also highlight the role that members of the Indian and Chinese Diasporas play in the illegal importation of goods into West Africa. For instance, in February 2012 the Nigerian authorities arrested an Indian trader of non-pharmaceutical products and indicted him for importing two containers from India containing tramadol not approved in Nigeria (4).

Several cases in recent years have revealed ties with the state apparatus. In Benin in December 2017, during a search following the apprehension of a vehicle carrying large quantity of medicines, the police discovered nearly 1,000 cartons of generic medicines in warehouses belonging to MP Mohammed Atao Hinnouho, which were not registered –and therefore not declared– in the customs databases (5). The role of the Senegalese Mouride brotherhood in the organisation of informal markets and their supply in the country further illustrates the nexus between the trafficking of medicines and the authorities (6). After two trucks loaded with illegal medicines were detained on 11 November 2017 in Touba Belel, the Senegalese Private Pharmacists' Union denounced the existence of several hundred illegal warehouses in the city of Touba and its vicinity, as well as the prevailing culture of impunity surrounding the Mouride marabouts and their political influence (7). The observation made by the authors of a report by the West Africa Commission on Drugs (WACD) about drug trafficking is also broadly applicable to medicines because of the amounts at stake: "*Traffickers seem to connect easily with people of influence and are able to establish and operate informal social networks, allowing them to avoid detection by the formal security apparatus or co-opt it when necessary*" (8).

There is no evidence of the involvement of traditional mafias (triads, 'Ndrangheta, etc.), although the methods employed are sometimes highly sophisticated. While this lack of involvement reflects the limits of available knowledge and investigations, the trafficking of medicines in West Africa seems to bring together networks of limited size interacting with each other, and whose members represent a wide variety of profiles operating in the formal or informal sector or at the crossroads of the two (manufacturers, middlemen, freight forwarders, importers, small-scale distributors, carriers, sellers and dealers), to which we can add corrupt state officials. A study carried out in Togo has revealed the

(1) Gernot Klantschnig, "Négocier les profits et la facticité: le commerce des produits pharmaceutiques entre la Chine et le Nigeria", *art. cit.*, p. 100.
(2) ONUDC, *Transnational Organized Crime in West Africa: A Threat Assessment*, *op. cit.*, p. 45.
(3) OECD, *Illicit Financial Flows. The Economy of Illicit Trade in West Africa*, Paris, OECD Publishing, 2018, p. 90.
(4) "NDLEA Intercepts Container-load of Tramadol in Apapa Port", *This Day* (Nigeria), 25 February 2021.
(5) Hermann Boko, "Au Bénin, un député soupçonné d'être un "baron" du trafic de médicaments", *Le Monde*, 7 August 2018.
(6) Didier Fassin, "Du clandestin à l'officieux. Les réseaux de vente illicite des médicaments au Sénégal", *art. cit.*; Donna Patterson, "The illegal Trade in Pharmaceuticals: Historical Cases from West Africa", dans Gernot Klantschnig *et al.* (ed.), *Drugs in Africa. Histories and Ethnographies of Use, Trade, and Control*, Basingstoke, Palgrave Macmillan, 2014, p. 125-143.
(7) "Touba – Affaire des faux médicaments d'une valeur de 1,335 milliards saisis: l'Ordre et le Syndicat des pharmaciens exigent une réaction de Macky Sall", *Le Quotidien* (Senegal), 17 November 2017.
(8) Lansana Gberie and Camino Kavanagh, *Not Just in Transit. Drug, the State and Society in West Africa*, WACD, June 2014, p. 22.

attractiveness of regional medicines trade in West Africa for "amateurs" who turn their hand to trafficking. A doctor involved in the study recalls that "*we came across a case where antimalarials had been counterfeited and then shipped here and into neighbouring Ghana, and we discovered that the person who was importing the medicines had originally been trading in construction materials. When he went to Asia on business, he realised that trafficking in medicines was more profitable and took the plunge!*" (1)

The involvement of armed jihadist groups in the trafficking of medicines is among the topics under debate. Some reports linked to the pharmaceutical industry mention the involvement of Hezbollah and the Irish Republican Army (IRA) in this activity (2), while journalists have claimed that armed jihadist groups are allegedly trafficking medicines to fund their cause (3). One of the arguments put forward is that al-Qaeda leaders have called on their supporters to engage in smuggling activities to finance the group's operations (4). However, there is no evidence that armed jihadist groups are structurally involved in trafficking in West Africa and it seems highly unlikely. Although it is true that their fighters need medication and pain killers. They can levy taxes on products transiting through their territories and some of them are said to have infiltrated local buying and reselling circuits, such as those between Nigeria and the Diffa region (Niger) (5). Following the example of West African societies, some combatants in these groups consume products like tramadol or diazepam, and it cannot be ruled out that certain commanders give these products to their men for leverage purposes (to pressure them through the dependence or disinhibition created, etc.), even if fractured lines seem to divide the movement and the probable coexistence of different approaches. However, the discourses that tend to present jihadist groups as the main actors and beneficiaries of medicine trafficking are reminiscent of the "narcoterrorism" argument by downplaying the involvement of other stakeholders with a far more structured role in the value chain (6) or, depending on the source, by seeking, on the contrary, to involve major international players.

(1) Cited in "Faux médicaments: la plaie de l'Afrique", *France Culture*, 19 June 2020.
(2) Éric Przyswa, *Contrefaçon de médicaments et organisations criminelles*, *op. cit.;* Union des Fabricants (Unifab), *Counterfeiting and Terrorism. Edition 2016*, Paris, 2016.
(3) See in particular: Angela Giuffrida, "Italian police intercept €50m Tramadol haul potentially bound for ISIS", *The Guardian*, 3 November 2017. This example is reminiscent of captagon, wrongly described as the jihadists' drug of choice (Laurent Laniel, *Captagon: déconstruction d'un mythe*, OFDT/OEDT, July 2017).
(4) Union des Fabricants (Unifab), *op. cit.*
(5) Telephone interview, expert researcher on Niger, December 2018. This integration does not imply that the hierarchy endorses it.
(6) Wolfram Lacher, "Challenging the Myth of the Drug-Terror Nexus in the Sahel", West African Commission on Drugs, Reference Document No. 4, 2013.

What are **the implications?**

There is no magic bullet to address the multiple challenges of access to quality medicines in West Africa. A great deal has also already been written on the subject, including the importance of the population's right of access. The preceding pages, however, highlight two issues. Firstly, the illicit pharmaceuticals trade involves more than just a handful of crooks. It is part of the contraction of healthcare markets and access to care. It cannot be reduced to an analysis of the shortcomings, deviant practices or failures of states or regional organisations, but is rather a consequence of the structuring of markets on multiple scales revealing their inherent (1).

Secondly, it is important to distinguish between two very different issues that require different responses.

- Falsification is the work of criminal organisations, and it is therefore up to the services responsible for security and justice to act at national level (police, gendarmerie, customs, etc.) and at international level (Interpol, Europol, World Customs Organisation), based on legal frameworks criminalising the trafficking of illicit medicines and introducing deterring sanctions. "*At present, traffickers can just be sentenced to absurdly lenient fines or prison terms. This means there is no deterrent effect. Each Member State must be encouraged to enact new offences specific to trafficking and distribution*," asserted former anti-terrorist judge Jean-Louis Bruguière at the Lomé Initiative in January 2020 (2). This is one of the aims of the Council of Europe's MEDICRIME Convention, introduced in January 2016, which "*criminalises not only counterfeiting but also the manufacture and distribution of medical products placed on the market without a licence*" (3).
- The circulation and marketing of substandard and illegal products is linked to the functioning of markets and the limitations of national enforcement systems. The specific regulation governing medicines must make it possible to avoid substandard products and ensure quality through legal instruments (legislation), regulatory instruments (registration, licensing, inspections) and technical instruments (quality controls). Unfortunately, this is often not the case due to the lack of institutional resources in the countries concerned[4], resulting in a negative image of the formal sector among some of the population as well as a lack of trust.

In this context, the priority should be to reinforce the powers of regulatory agencies in place and to regularly control the quality of medicines at the different tiers of the pharmaceutical system (manufacture, import, distribution, sale). This issue is all the more important because it is linked to the creation of a West African pharmaceutical industry capable of producing quality medicines. Without effective control, as several examples over the last two decades have shown, many products will be of inferior quality or will fuel the informal sector. Given the flow of medicines from one country to another, a regional approach to the regulation and procurement of pharmaceuticals could also help to simplify the work of domestic regulatory agencies. By creating a regional list of approved/banned products and producers, or by setting up regional quality control and marketing authorisation mechanisms, it would also be possible to reduce the number of legal medicines in circulation, to put an end to discrepancies in

(1) Mathieu Quet, *Impostures pharmaceutiques*, *op. cit.*, chapter 6.
(2) Cited in "Faux médicaments: la plaie de l'Afrique", *France Culture*, 19 June 2020.
(3) For more details on the MEDICRIME Convention and the status of signatures and ratifications, see here. One limitation –far from being specific to the pharmaceutical field– refers however to the gap between the adoption of legal provisions and their implementation, i.e. the legal frameworks and practices.
(4) Jacques Pinel, *op. cit.*, p. 20.

products between states, which traffickers rely on, and to reallocate a proportion of national regulatory officials to enforcement tasks.

However, these initiatives raise the question of the role and mobilisation of ECOWAS, the West African Health Organisation (WAHO), the cooperation between the manufacturing countries and West African countries, and furthermore, will require a strong political commitment from these countries. Several signals testify to a progressive mobilisation in recent years, as illustrated by the Lomé Initiative or the ratification process of the treaty establishing an African Medicines Agency under the aegis of the African Union in 2019. However, this is still limited on a regional scale, due in particular to the social and financial stakes associated with illicit medicines, and often depends on the support of private sector or international operators whose interests only partially coincide with those of the states and populations concerned, thus running the risk of prioritising national security issues to the detriment of health safety issues.

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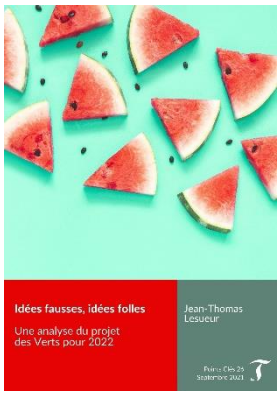

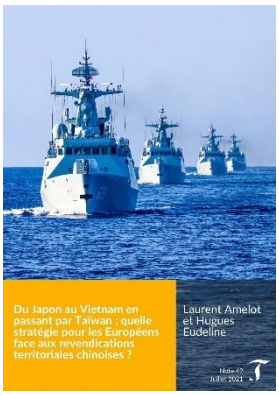

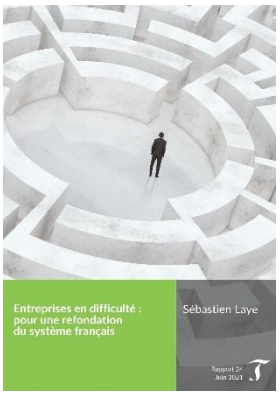

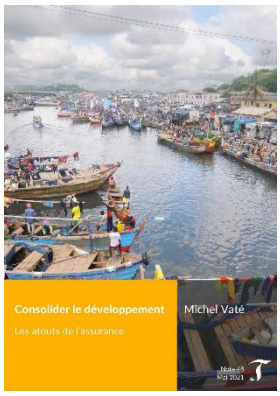

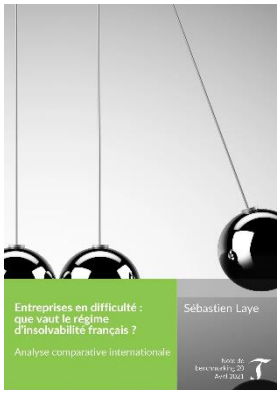

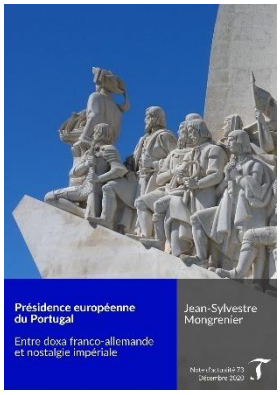

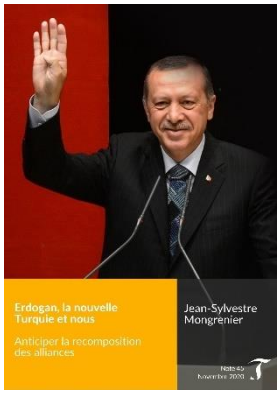

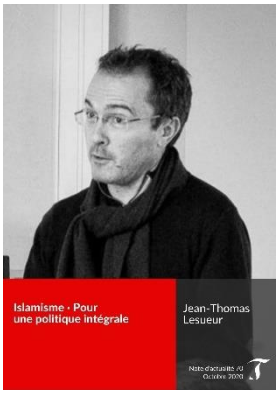

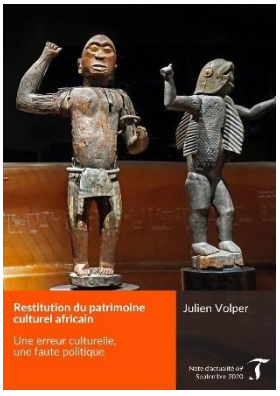

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