INTERVIEW: How Fake And Substandard Drugs Get To Nigeria – Kristin Peterson

August 31, 2015 Premium Times

Kristin Peterson

Last year, Duke University Press published "Speculative Markets: Drug Circuits and Derivative Life in Nigeria" by Kristin Peterson, who teaches at the University of California, Irvine. It is a well researched book on the dynamics of Nigeria's pharmaceutical markets.

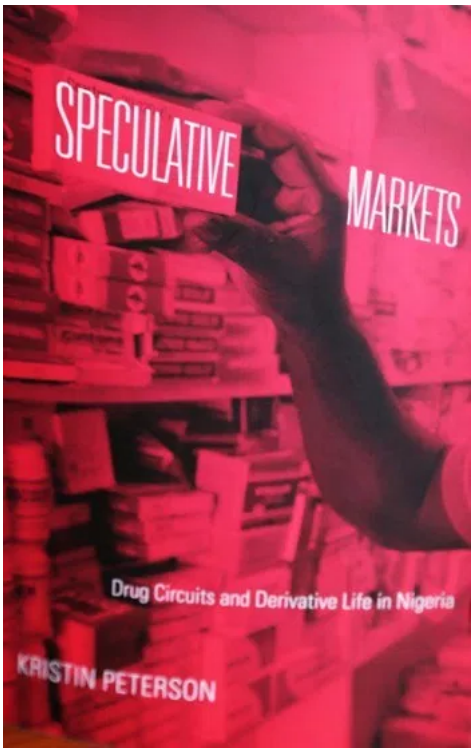
It seamlessly traces the connection between the Structural adjustment programme, SAP, and the collapse of the brand name pharmaceutical industry in the 1970s. Using Idumota in Lagos as a focus of her research, she reveals how some multinational drug companies, driven essentially by profit motives, conspire with desperate drug dealers in Nigeria to bring fake, substandard drugs and narcotics to the country in a way that is difficult to detect and stop. On a recent trip to Lagos, she spoke with KUNLE AJIBADE, Executive Editor of TheNEWS and PM NEWS. EROMOSELE EBHOMELE transcribed the interview and IDOWU OGUNLEYE took the photos.

Ajibade: Your book is a product of a vigorous investigation into what you describe as ''speculative practices" in the Nigeria's drug market. How appropriate is this description of Nigeria's drug markets? In the context of the drug market, you also describe Nigeria as a country of ''risky populations". Could you expatiate on these two descriptions?

Kristin: Let me first take "risky populations." In the 1970s, prior to the implementation of the structural adjustment programme, American and European brand name pharmaceutical companies saw the Nigerian population as buoyant purchasers. And, of course, at that time, the naira was at par with the dollar and the pound. There was a fairly robust middle class and people were able to afford many of the products produced by those corporations. But the moment the economy started to take a downturn after Babangida's 1986 implementation of structural adjustment, many things changed. On the one hand, the private sector could no longer cope because the value of the naira was crashing. It

their drug products. Because of that risk, the brand name multinational drug companies abandoned the Nigerian market that they themselves created.

On the other hand, the population was expecting social welfare entitlements like pensions and free education, both of which they were receiving. But dictatorship and austerity led to mass protests as Nigerians' sense of security was slipping fast out of sight. Instead of viewing the population as something to be protected via social entitlements, Nigerians posed risks to the military government's objectives and sense of purpose. And so, I use the term "risky populations" as a phrase to capture this historical transition: government and corporations once provided services to the public, and after structural adjustment, they turned against Nigerians via market abandonment and military violence.



I used the term 'speculative practices' to talk about how people who work in markets – whether multinational corporations or traders in Idumota market – anticipate market volatility (fueled by currency fluctuations, changing labor costs, or changing demands within corporations or among consumers). They then take risks by speculating on how the market will play out. Usually such speculation anticipates that one will come out on top in terms of profit and outcompeting others. I found this to be true of both multinational drug companies and wholesale Nigerian pharmaceutical traders. It's not just profit that matters, but whether you can stay completely on top of the game. Not doing so could mean losing everything. I wondered why the stakes were so high in each case, which required me to go back to the 1980s in order to understand how this all works. At that time, the global brand name drug industry was experiencing a serious downturn and needed finance capital. In order to get this finance capital, it turned to Wall Street investment firms and banks. Wall Street gave drug companies finance capital in exchange for meeting new and impossible rates of growth – some of which are as high as 13% per year. Making profits is one thing, but growing at this rate would mean bringing 4 or 5 new drugs to market each year. Because it takes 10 to 15 years to develop a new drug and bring it to market, it is impossible for drug companies to meet these demands.

So how do they cope? They engage in speculative practices, like merging and acquiring other companies; they offshore much of their businesses to India and China to save on costs; they pursue drug development that will lead to blockbuster profits and skip making other needed drugs such as those for neglected tropical diseases; and like in Nigeria, they dump assets, drug products, and entire markets that may not be serving them well. Nigerian drug traders may engage in very similar kinds of speculative practices – ones that require them to anticipate and then bet on risky investment strategies in hopes of high returns. So the point here is that everything begins with Wall Street pressures, which result in intense incentives to respond to market volatility and downward pricing pressures. This is all about surviving the market and not producing new products that respond to and adequately address health needs.

Ajibade: You also argue convincingly in the book that the Structural Adjustment Programme, SAP, forced on Nigeria by the IMF in 1986 under General Ibrahim Babangida has had a very negative impact on Nigerian pharmaceutical industry. For the benefit of those who haven't read your book, what is the connection between SAP and the Nigeria's drug markets?

Kristin: The global brand name drug industry at one time did exceptionally well in Nigeria. Companies such as Pfizer, Roche, Upjohn, Ciba, among many others came to Nigeria as early as the 1940s and 50s. By the 1970s, Nigeria's oil boom attracted the major drug companies around the world and they distributed and manufactured products within Nigeria. In some cases, they made a lot of money – in fact, some products that sold in Nigeria were the highest selling products in the world. Much of what I learned about the relationship between SAP and Nigeria's drug markets came from reading Nigerian academic (pharmacy and medical) and industry literature especially from Pharmanews. I also interviewed a number of Nigerian industry managers who were working for drug companies at the time SAP was implemented. They all tell in painful detail how investment turnover could not be met mostly due to currency devaluation and the public's increasing inability to purchase

I wondered why U.S. and European-based brand name companies would be in favor of implementing structural adjustment when clearly it meant the end of their lucrative market in Nigeria. This is where 1980s speculative capital comes back into the picture. The brand name companies believed that Wall Street capital, along with the emerging biotechnology sector, would be enough to produce new products and new profits. Unfortunately for the companies, new products and profits never materialized in any significant way. This meant that the Nigerian market was abandoned in favor of pursuing what amounted to hyped up, speculative fantasies. And so, two factors played into making Nigeria unnecessary to the drug industry's future plans: the declining national Nigerian market as a result of structural adjustment as well as the false promise that finance capital would transform the pharmaceutical industry. For me, it is not enough to talk about structural adjustment, but rather to see it completely intertwined with the politics of speculative finance. After all, African debt repayments went straight into Wall Street firms – money that then was loaned to the drug and biotechnology industries. In other words, the companies had to destroy their own markets in Nigeria and elsewhere in order to remake themselves in the face of increasing global competition.

Ajibade: How do fake and substandard drugs get to Nigeria and how are they being sold? How do they increase what you regard in the book as "the burdens of disease"?

Kristin Fake drugs come from a number of places; they are not usually manufactured in Nigeria. It is hard to pin down exact locations and exact percentages because they move in shadow economies. But the busts that NAFDAC and drug task forces have recently made indicate that a good chunk may be coming from Asia—especially from lesser known or hidden companies or small factories in India and China. One aim of the book was to shift away from this idea that fake drug traders (as well as Indian and Chinese companies) are evil and unleashing havoc on society. Certainly some of that exists, but when we talk about the medical violence of fake drugs, we need to also talk about the violence of the market – the very thing that incentivizes the making of fake drugs. There are two main points here that have to do with the Nigerian drug trade and brand name industry practices – they both actually overlap and China and India are key to this.

So, to first take the brand name industry. One way that U.S. and European brand name companies keep their costs down is to offshore operations to India and China. In these offshored sites, local companies also outsource part of the manufacturing chain to smaller companies. In this scenario, the biggest problem is that offshoring and outsourcing are so massive and prolific, it is impossible to inspect all the manufacturing premises. For example, there are over 80,000 chemical and drug companies in China (some of which are foreign owned) and national regulatory agencies might inspect 20 or 30 of them per year. What does all this mean for fake drugs? Fake drug manufacturers take advantage of the real inability to regulate drug manufacturing and drug transit. Some examples include the fact that both licit and illicit drugs can be manufactured in the same place. From there, they get distributed through several companies who trade them extensively (especially in Europe, which has very loose parallel importation laws) such that their manufacturing origins get obscured. Both licit and fake drugs travel on the same distribution routes in ways that make it difficult to determine the difference between them; they can pass through free-trade zones where all kinds of relabelling and other activities hide fakes.

While the brand name industry relies on Indian and Chinese companies for offshoring, the Nigerian market relies upon these Asian industries for the bulk of its drugs (mostly from India) and the bulk of its raw materials and medical technologies (mostly from China). The distribution chains that bring these licit drugs into the country can also facilitate fakes. Moreover, fakes do well in a market where there are mostly very low cost drugs. The borders and the port can be quite porous and the fact that wholesaling is deeply prolific rather than centralized in Nigeria means that there are multiple ways that the drugs can scatter and get lost to regulatory officials. Like the intense pressure that multinationals experience to bring down costs, there is also immense pressure to manage volatile price dynamics as well as reduce drug costs in Nigeria simply because of the massive competition that exists among wholesalers and retailers. One way to drive down costs and survive the market is to manufacture fakes.

This is the underbelly of a liberalized global economy, one that is highly deregulated and is increasingly determined by the dictates of the finance industry. It all begins with Wall Street pressures that incentivize drug companies to offshore manufacturing, which creates chaos for drug regulation

poorest people in the world and the richest corporations in the world are tied together in a struggle to stay afloat in their respective, yet connected economies – a perfect storm for fakes to easily get produced and distributed.

Ajibade: Is that why the NDLEA and other agencies find it very difficult to really stop the illicit trade of fake drugs?

Kristin: Absolutely. It is within NAFDAC's purview to deal with fake drugs. Over the years, Mrs. Dora Akunyili, who is now late, attempted to curb the fake drug distribution. She made it more expensive for fake drugs traders to engage in their trade, rather than outright eradicate fakes. She and others in NAFDAC certainly know what they are doing. But there are two problems that make it difficult to eradicate fakes: the nature of market volatility and the fact that drug price is not regulated in Nigeria. Even the US Federal Drug Administration is highly concerned about fake drugs entering the U.S. The massive offshoring and outsourcing make it impossible to curb fakes and even regulate licit drugs because no regulatory agency on the planet is equipped to handle inspecting the tens of thousands of drug manufacturing premises that make up the offshore and outsourcing chains.

Ajibade: Substandard goods get recalled by manufacturers in the global North. Why is that difficult, if not impossible, to do in the global South?

Kristin: It depends on the country. Here in Nigeria, there are several issues with drugs in particular. One, there is no drug recall mechanism. This means that if a drug is substandard or fake, there is no national action taken to remove it from the market probably because they are too difficult to locate. NAFDAC dedicates its resources to market closure rather than searching for problematic products. Only occasional announcements in the newspaper can alert one to dangerous drugs. Two, the very definition of "substandard" drugs needs to be qualified. In Nigeria, substandards are different from fakes in that they are not intentionally meant to deviate from standard chemical ranges. So for example, a drug may be considered standard if it has 90-110% of active pharmaceutical ingredients. Fake drugs are usually those whose chemical ingredients fall well below the 90% minimum. A substandard drug can also be on the low end, but in Nigeria they often can surpass the upper 110% limit. This means that they have more active ingredients than they should. Why does this happen? It is possible that scales are old and in order to compensate for weighing inaccuracy, manufacturers may add more active ingredients – having less pharmaceutically active ingredients could indicate faking and being accused of faking drugs would be bad for business. Moreover, substandard drugs are not necessarily illegal – given the greater concern over eradicating fakes, NAFDAC devotes less energy to regulating them. Over the longer term, such drugs could lead to drug resistance. For example, some of the most common drugs (like amoxicillin, an antibiotic) are highly ineffective due to resistance issues. Yet if a drug doesn't work, one is quick to blame fake drugs rather than raise questions about whether well-known and popular drugs are actually efficacious.

Ajibade: Idumota is largely the site of your investigation. One of the significant narratives in your book is the court case between the Lagos State Medicine Dealers Association and the Pharmacists Council of Nigeria represented by the Attorney-General of the Federation. I find it curious and interesting that Justice Yaya A. Jinadu, a Lagosian, delivered a judgement in which he said Idumota is not a market and that it is, indded, a street. It is a very politically loaded judgement. This is why Idumota market, as chaotic as it is, has not been relocated. Could you re-visit this court case and its implications for the drug trade in Nigeria and the world?

Kristin: In that chapter, I began talking about the way urban space itself got remade in the aftermath of structural adjustment. With people losing jobs and with precarious household security, folks turned to the market in order to make a living. The market technically is a legally designated area where one rents a stall, pays taxes, and pays various fees – this is what could be called an "official market." After structural adjustment, the marketplace extended into what could be called an "unofficial" market meaning that it is not legally designated by the state. Unofficial markets can be found on the side of the road, on or under bridges, in neighbourhoods, or even appearing or disappearing with Lagos traffic. Idumota essentially became one of these unofficial markets where commerce and residential living overlap with each other – hence the transformation of urban space. This is important for the court case. In the early 1990s, fake drugs were on the rise (by 1997, the highest estimate for fake drugs was 70% of the entire market). Pharmacists, who no longer controlled the drug distribution system as they did along with brand name companies in the 1970s, were eager to take back the market and control the fake drug trade. The major point of entry of all fakes in Nigeria come through the unofficial markets.

So, in 1992, the Pharmacists Council of Nigeria revoked Idumota traders' licenses to sell drugs – a strategy to end fake drugs. The PCN claimed that the traders sold in an open (or unofficial) market which violated a new regulatory law. The traders union asserted in court that they do not sell in a market. They claimed that they sell in a neighbourhood with proper lock-up shops. They also declared

lives in a market is an insult. If you look at the final ruling, PCN did not defend its case very well. But its lawyers probably did not expect the traders to come back and say: this is no market. PCN was unable to give testimony that Idumota is a market. Yet everyone in Lagos knows that this Idumota is a market. Instead of referring to the federal regulatory laws, the judge looked to Lagos State laws that cite the location of official markets – all of which were created during the colonial period. His ruling favoured the traders – he declared that Idumota is not a market since it is not legally demarcated by Lagos State government.

In telling this story, my point was to show that the law has difficulty accounting for transformed urban space in the aftermath of structural adjustment. What counts as a market and a neighbourhood is hard to distinguish, which makes drug premises hard to regulate. It also must be noted that trying to shut down Idumota market by revoking licenses means that the Yoruba traditional elite who own the property in the neighbourhood do not get their relatively high rents. It means that that those who sell drinks and phone credit would terribly suffer any market closure. And importantly, because Idumota is the main entry point for the wholesale trade, shutting it down would mean dramatically impacting business throughout the entire West African region. Whether these issues played out in the final ruling is anyone's guess. But as you can see, the stakes of remaining open and closing down are both very high.

Ajibade: So what are the implications, to go back to what you describe as "the burdens of disease" ? Drugs are sold in an unhygienic place and the law cannot deal with it. What are the implications for the drug users?

Kristin: The burdens of disease go well beyond the premises where drugs are sold. The drugs that are sold in the private Nigerian market are mostly antibiotics, antimalarials, over-the-counter pain killers, and nutritional supplements. Many of these are older generation, are not very efficacious, and are of low quality – and I am not talking about fakes, I'm talking about licit, standard drug products. Why do these drugs make up the bulk of pharmaceuticals (about 80%) on the Nigerian private market? These drugs are low cost catering to a low income population. Moreover, some of them have been around since the 1970s and command public recognition; prescribing patterns also make them popular. More effective, advanced, and expensive drugs are available on the Nigerian market but they are in far less supply than the well-known, less effective ones. (Not to mention that there are very few pharmacies in the rural areas and some states in Nigeria do not even have up to five pharmacies where one can obtain drugs).

Now if you read Nigerian scientists, they show that over time, drug resistance has increased with some of the best-selling products on the market. Treating drug resistant strains of bacteria, for example, is highly difficult because it requires the use of more expensive and difficult to find products. At the same time, there is a dearth of drugs for other diseases, such as neglected tropical worm infections. There are tens of millions of such infections occurring in Nigeria every year, making it one of the highest burdens in the world. This example is in part a result of the dynamics of the drug market but mostly due to the fact that drug companies put little to no investment into research for tropical infections unless they are provided incentives in the form of public-private partnerships. So there is an excess of inefficacious products (especially antibiotics) and a dearth of highly needed drugs for neglected diseases and drug resistant infections. The point is that the market and disease burden are highly intertwined – there's no escaping that.

Ajibade: What has the Nigerian Briafran War got to do with the Idumota drug market?

Kristin: I asked myself, how did Idumota transform from being a neighbourhood to becoming one of the largest markets in West Africa? Documentation may exist to answer this question but I was unable to find it. So, I did some oral histories with Idumota traders and what emerged was a fascinating story. During the war, the local government area of Orlu (in what is now Imo State) was the headquarters for the Red Cross and several churches that administered emergency aid to people during the war. Many of the folks living in that area didn't actually go into the war to do the actual fighting. They stayed back and got trained by these international organisations to do medical triage. At the end of the war, folks from Orlu moved into towns and cities including Lagos and became patent medicine dealers. At the same time this urban migration was taking place, those controlling the drug distribution system were the brand name pharmaceutical companies and Nigerian pharmacists. Once the economy began to crash, pharmacists, through a set of complicated events, lost control of the drug distribution system. The traders basically stepped in to take over the wholesale trade. Now in Idumota market, traders estimated to me that

You now have a generation of those people with skills learnt during the war who have trained other generations of drug dealers…

In fact, there are now a third and fourth generation of traders. These are children and grandchildren who not only participate in the family business as traders but many are going to university to become pharmacists and physicians. In order to have any pharmaceutical shop in Nigeria, a pharmacist has to be on the books in order to register the business.

But the apprenticeship training still takes up to five to seven years…

In Idumota, I was told by apprentices and former apprentices, that it takes eight to nine years. It means they get trained for a longer time than the university trained pharmacists in Nigeria. Exactly!

Ajibade: So what does that say of the dynamics of the trade itself?

Kristin: The traders are not learning pharmacy per se. They are learning how to do business. They may specialise in liquids or just antibiotics – although the big time players are more generalists. They may not know much about drug chemistry or bioequivalence or pharmacovigilance, but they may know something about the products that they sell. I don't know why the apprenticeship is so long, but it does slow down the increasing number of traders in the market, essentially putting the brakes on what is already intense competition.

They always get some start-up money from their bosses.

They do, but it is usually not enough to get started – you need lots of capital to really get going. One option in coping with such circumstances is that apprentices who are released from their service come together and do what is called baranda (meaning buying for quick sale in Hausa). They pull their resources together in order to collectively buy and sell products, a strategy that helps to grow their businesses over time. Pooling resources helps to prevent the market from becoming much bigger than it is. That is, it slows down competition. So there are plenty of logics at work in terms of how labour and market structure work.

Ajibade: Why is it difficult to stop the sale or trade in narcotics which is thriving in Nigeria in spite of the institutions like the National Drug Law Enforcement Agency, the Nigerian Customs, the National Narcotics and Counterfeiting Federal Task Force, the National Agency for Food and Drug Administration and Control and even the World Health Organisation? And in what way is the narcotics trade connected to the pharmaceutical industry in Nigeria?

Kristin: Narcotics are qualitatively different in that their governing jurisdiction comes under criminal law whereas pharmaceuticals come under regulatory law. Narcotics were important for the rebuilding the Nigerian drug market after the brand name companies left Nigeria. At the time the structural adjustment programme was implemented, a lot of young Nigerians didn't have the opportunity to work and subsequently some entered the narcotics trade. At that time, Nigeria became the staging point between the coca trade in the Andean region and the opiate trade in the Asian triangle. Narcotics traders sold these illegal drugs in Europe and of course, big money was made. How did they get the cash back into Nigeria? They could not go through the banking system nor could they carry it back home. Instead, they laundered it by buying licit pharmaceuticals, second hand luxury cars, and computers, much of which landed in unofficial markets. I couldn't tell you the status of narcotics in Nigeria now.

Ajibade: Is it possible for Nigeria to have a sane drug industry that we used to have in the 1970s when the big brand name pharmaceutical companies were here?

Kristin: I think there are several Nigerian companies that are very, very good; you have Fidson, you have Swipha and others. Some have WHO certification which means they can manufacture drugs like anti-retrovirals for HIV/AIDS and a number of other diseases. We are talking about some state-of-the-arts facilities. But the biggest challenge is that they have to provide their own infrastructure like electricity and water, which is very costly. The other thing too is the intense disparity of the naira to the dollar right now. If those challenges can be surmounted, Nigerian companies could not only acquire the bulk of the market, but provide for much of West Africa. If Nigerian companies were ever to collaborate with Nigerian research scientists then the possibilities for drug development are even more immense – but possibilities that would require a great deal of government and other financing. There is much expertise in the country so that is not a concern. It is more about infrastructure, collaboration/political will, and economic challenges.

Ajibade: Your love for Nigeria shows abundantly in the book. What attracts you to Nigeria?

Kristin: The biggest thing that attracts me is the incredible tenacity of people to manage and surmount their incredibly challenging circumstances. You don't find that in many parts of the world. I

of coming back and forth, to understand Nigeria – this very complicated yet poignant place. And I have had to rely on scholars, commentators and journalists, yellers in traffic, the gate man, the house help, the bus drivers and taxi men, rich people, those just making their way, artists, friends and loved ones to show me how to make sense of it. As an academic, what I have learned has often defied theories of the global, of liberalism, of postcolonialism that are popular back home. And as a human, I've been forced to rethink potential and possibility in the world.

AjibadeThe Book I notice a subtle left- leaning perspective in your book. Where and how did you get conscientised?

Kristin: I lived in West Germany as an exchange student in a household where the father is Syrian and pro-Middle East; and the mother's family members were anti-fascist activists in WWII Germany. I was 18 years old and I was living in the U.S. occupied section of West Germany during the Reagan-Thatcher era. That was the beginning of seeing U.S. domestic politics, geopolitics, and the global position of the U.S. in a different way. My training is in anthropology, whose primary method is to really just listen, absorb, and attempt to understand where people are coming from and what's at stake for them and their lives (what we call "participant observation"). The combination of my own political development and anthropological approaches are very complimentary in this regard.

Ajibade: What efforts are you making to get the book published here?

Kristin: I want a Nigerian edition very much. I know the issue of fake drugs in Nigeria is a very big one and I think the book adds another dimension to an already rich corpus of Nigerian research on the topic. While the book is an academic one, I made attempts to make it readable to multiple audiences. So I do hope that getting it republished here will happen in the near future.

This interview was first published by PM News. It is republished here with PM News' permission.

More in Features And Interviews

INTERVIEW: Theft of Senate mace is attempted coup – Ex-Senator Waku

How to buy property in Lagos without being duped

SATIRE SATURDAY: How to scam Nigerian job seekers ahead of 2019 (1)

INTERVIEW: What Nigeria must do to take its rightful place in Africa – Foremost Pan-Africanist Scholar

INTERVIEW: How we're saving billions of dollars — NPA boss

Why Bill Gates was blunt in Nigeria speech – Country Director, Gates Foundation

Top News

Court threatens to close $1.6 billion fraud case against Omokore, others

How to make business easier among Commonwealth countries – Buhari

Appeal Court gives EFCC permission to freeze Fayose's account