9 Pharmaceutical representative activities in Benin and Ghana

Promoting firms while helping construct the pharmaceutical economy of African countries

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The sales representatives used by the pharmaceutical industry first appeared in the United States in the 1850s and in Europe shortly thereafter (Greffion, 2014). They emerged in the context of two distinct phenomena: one was the increasingly stiff competition between the nascent industry's "specialty" products and the compounded preparations made by community pharmacists (Bonah & Rasmussen, 2005); the other was the development of an internal sales department in industrial companies (Cochoy, 1999). These pharmaceutical companies achieved success through improved formulations and advertising, at a time when patents did not yet protect their pharmaceutical specialties (Chauveau, 1999; Greffion, 2014). In that era, pharmaceuticals were first advertised in the mainstream press and later in the medical press. Those industry representatives were called "detail men," "drug representatives," or "pharmaceutical sales representatives" in the United States (Dumit, 2012), while in France they were called "medical sales visitors" (since they visited doctors' offices), or "medical delegates" (Chauveau, 1999). This new sales tactic of the "medical visit" developed alongside press advertisements, and industry representatives became the predominant method of pharmaceutical firm promotion in Western countries around World War II.

In Africa, the pharmaceutical representatives' activities have gradually evolved in conjunction with the markets for medicines in the various countries since the introduction of manufactured industry products in the first half of the 20th century. This activity was initially performed by Western pharmaceutical firms that targeted exports of their products to countries under their influence: French firms to French colonies, English and American firms to the Commonwealth countries.[1] Sophie Chauveau (1999) notes that when Europe found itself in an economic crisis in the 1930s, the primary export market for France's pharmaceutical companies was their colonies. Even though these products were less expensive than those sold in Europe or in the United States (antiseptics, quinine-based treatments for tropical diseases, and other universal panaceas), they nonetheless represented one-third of the volume and one-quarter of the value of French drug

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exports. In the 1950s and 1960s, the subsidiaries and assembly plants that Western multinationals set up in certain countries, sometimes at the instigation of young African States, as in Ghana (see Chapter 1), also acted as their pharmaceutical reps. In West Africa, these were mainly Nigeria (May and Baker, Pfizer, and GlaxoSmithKline in the early 1950s; Ciba, Bayer, Wellcome, Boots, Hoechst, etc. in the 1960s), Ghana (Major & Company and Pharco Industry in the late 1950s; J.L. Morrison & Sons, Sterling Products, Kingsway Chemist, and Dumex Limited in the 1960s), and Senegal (Valdafrique Laboratoire Canonne—SA, established in 1942, Pfizer, Sanofi, and Institut Pasteur) (Peterson, 2014; Pourraz, 2019).[2] Starting in the 1970s, a period of massive upheaval in the global geography of the pharmaceutical industry (Abecassis & Coutinet, 2008; Cassier, 2019; Mulinari, 2016; Chapter 5 of this book), trade representatives from the emerging generic drug industry in Asian countries entered the fray. Their activities evolved over time as they penetrated the markets, first in English-speaking countries, then (in the late 2000s) in French-speaking countries (Baxerres, 2013; Singh, 2018). Some Indian firms and entrepreneurs also opened or bought out manufacturing companies in English-speaking countries during this period; examples from Ghana include Letap Pharmaceuticals, created in 1983, and M&G Pharmaceuticals, opened in 1989 (Pourraz, 2019). By the mid-1990s, local industry began developing in West Africa, especially in anglophone countries, through what has been described as the "Africanization" of pharmaceutical production (Mackintosh, Banda, Tibandebage, & Wamae, 2016; Pourraz, 2019). Local industry, too, uses pharmaceutical representatives.

In this chapter, we define pharmaceutical representatives as individuals whose job is to promote pharmaceutical companies' products to increase their prescription, sale, and consumption. We are using this basic definition because it allows us to account for the current dynamics in the contexts of the Global South that we study, in addition to those of the firms themselves. These contexts differ from those of the countries of the Global North, where similar studies have been conducted. This work highlights the stranglehold pharmaceutical firms have on doctors through their representatives, who in the vast majority of cases are direct employees of the firms (Greene, 2006; Greffion, 2014; Ravelli, 2015). We are of course interested in the facilities where the pharmaceutical representatives we observe in West Africa work, and we will describe them in detail. However, by starting with the actors closest to the field, the individuals themselves, we are able to study the actions they take in addition to promoting the firm's products; as we shall see, it is often these individuals who are the catalyst for the structures that subsequently develop. We use the term "representative" to reconcile the terms used in the analyses between Ghana, where it is the accepted term (in English), and Benin, where the usual term is "delegate" (from the French for "medical delegate"), which has an undertone of value that we would like to eliminate, as will be discussed later.

In this chapter, therefore, we are interested in the social dynamics generated by pharmaceutical representatives' activities in West Africa. This activity has evolved differently depending on the national contexts and the pharmaceutical

legislation adopted within them. We will first analyze the differences and similarities in how this activity is structured in Benin and Ghana. Next we will examine the activities of pharmaceutical representatives in these two contexts to describe the logics used to monopolize markets by the various firms with a local presence, be they Western multinationals; Asian, European, or North African generic manufacturers; or local manufacturers from sub-Saharan Africa. Finally, we will highlight the effects of these representatives' activity, which extends beyond the companies, on the pharmaceutical economy of the two countries.[3]

Benin and Ghana: Different operating modes of pharmaceutical representation

Pharmaceutical promotion is regulated differently by the laws of Benin and Ghana. In Benin, as in the other French-speaking countries of West Africa and in France, pharmaceutical promotion is legally completely decoupled from distribution. Wholesalers cannot legally promote medicines; only representatives of pharmaceutical companies can. In France, health authorities passed legislation in 1962—following the expansion of social security that began in 1945—in order to strictly regulate wholesaler activities, recognize the specific nature of the "wholesaler-distributor" profession, and prohibit them from pharmaceutical promotion (see Chapter 3). In Benin, the first wholesalers set up shop in the 1980s without any specific laws on their activities (see Chapter 2); legislation was adopted in the early 2000s.[4] Although there is no express provision for pharmaceutical promotion, this legislation is modeled on French law. Thus, in Benin as in France, the activity of pharmaceutical representatives is wholly linked to that of drug manufacturers. These francophone countries emphasize the medical, rather than the commercial, nature of this activity (Fournier, Lomba, & Muller, 2014). Pharmaceutical representatives constitute a professional group that has been and is being constructed "in contrast to the downgraded and downgrading categories of sales" (Greffion, 2014, p. 84).

In Ghana, where the authorities have expressly allowed considerable leeway for economic actors invested in medicines, pharmaceutical products can be promoted not just by the companies themselves, but by importers and wholesale companies as well (see Chapter 3). Numerous companies of different kinds are therefore involved. Legislation in that country has allowed companies to combine the activities of drug manufacturers, wholesalers, and representative-importers since 1957. "The purpose of this legal provision is to improve the viability of companies by allowing several trading and manufacturing activities to be combined, thus encouraging the establishment of economically viable firms" (Pourraz, 2019, p. 79). In Ghana, the term "sales representative" is used in the pharmaceutical sector just like it is in other business sectors.

In the next sections, we will see how these legislative differences in Benin and Ghana have affected the way pharmaceutical promotion is organized in the two countries.

In Ghana, firm reps are active but eclipsed by importer reps

There are two types of pharmaceutical representation in Ghana, based on the types of pharmaceutical companies and importer-distributors involved.

Big Pharma's "ethical reps" and distributors

European and North American multinationals use their own medical representatives (reps) for the scientific promotion of their products. These reps all have a pharmacy degree and are employed either directly by the company through a scientific office that it opens in Accra, or by one of its distributors on the company's behalf. This is the case for a dozen or so multinationals with a strong presence in Ghana: the British AstraZeneca and GlaxoSmithKline, the American Pfizer, the Swiss Novartis and Roche, the French Sanofi and Servier, the German Bayer and Denk, and the Danish Novo Nordisk.[5] Their products are distributed in the country through a few distributors—each company has three to six—who share the highly valued market for these drugs, which are considered to be very high quality. This explains the use of the adjective "ethical" that these representatives associate with the products and the promotion methods they claim to use, which we will come back to later. The scientific offices that these multinationals open in Accra, in the central and affluent districts of the city, generally include a country manager who is responsible for all operations, an accountant, sometimes several first-line managers who are focused on specific product lines, and several medical reps (between 10 and 60 depending on the company), who spend most of their time "in the field."

There are two types of importer-distributors for these "Big Pharma" products in Ghana: international groups and local wholesalers; these latter are among the largest such companies operating in the country. We encountered the two international groups invested in pharmaceutical distribution in Ghana: Gokals Laborex, the major shareholder of which is the French group Eurapharma that has been established in Ghana since 2008[6]; and World Wide Health Care Limited, a company that opened its doors in Ghana in 2011. This latter group had been created by, and at the time of our research belonged to, the Anglo-Indian Chanrai Summit Group based in Dubai, but was in the process of being acquired by a South African company, Imperial Logistics.[7] Some five or so Ghanaian wholesalers are invested in Big Pharma distribution, mainly Ernest Chemist, East Cantonment, and Oson's Chemist, which were established in the 1980–1990s.[8] These companies have either specialized in the import and distribution of these highly valued products, or are developing other strategies in parallel with products from other firms. These will be discussed later.

Each of these importer-distributors uses sales reps and medical reps for the Big Pharma products they represent. Distributors are carefully selected by pharmaceutical firms through calls for tenders and on the basis of criteria such as their financial capacity and the quality of their facilities. They are in direct competition with each other yet share the objective of maximizing the distribution of the

Big Pharma products they represent on the Ghanaian market.[9] They do not handle the administrative procedures for products' marketing authorization (MA) with the Food and Drugs Authority (FDA) of Ghana. They only conduct the necessary procedures for importing the products.

The medical reps responsible for promoting Big Pharma products work by product portfolio (most of those we met covered five or six products) and by territory (neighborhoods, cities, or regions). They are only responsible for scientific promotion and ordinarily do not get involved with sales, which are handled by the distributors' sales reps (discussed later). Since the 1990s, these medical reps have been under the umbrella of a professional association, the Association of Representatives of Ethical Pharmaceutical Industries or AREPI. The purpose of this association is to distinguish its members from other medical reps working for other pharmaceutical companies in Ghana, and to regulate the profession by publishing a code of ethics that, at the time of our research, they wanted to place under the aegis of Ghana's FDA. Their use of the term "ethical" skillfully combines the concepts that the products should be high-quality, innovative (not generic), prescription (not over the counter or OTC), and that the companies promoting them should have particularly ethical practices.[10]

Medical reps and sales reps of local wholesalers with a "monopoly" on Asian, European, and African firms

Alongside the Big Pharma companies, the other pharmaceutical firms that put their products on the Ghanaian market, whether Asian, European, or African, all go through a locally operating wholesaler to whom they give the exclusive right to import and distribute their production. These wholesalers are said to have the "monopoly" on these firms' products. Some wholesalers, who are generally quite robust financially, also engage in contract manufacturing with one or more firms, mainly Asian but also European, which manufacture products for them under their own brand name.[11] Most local Ghanaian firms combine distribution with their production activities and therefore also have wholesaler status (Pourraz, 2019). In addition to the promotion and distribution of their products, firms leave the administrative procedures for MA to these various wholesalers as well.

These wholesalers hire medical reps and even greater numbers of sales reps to promote the different products; their numbers vary depending on the size of the company and the number of products they have to promote. Tobinco, one of the largest, promotes about 200 products from 8 different pharmaceutical firms (5 based in India, 1 in the United Kingdom, 1 in China, and 1 in Indonesia) and employs 80 sales reps and 20 medical reps for this purpose. In comparison, Biotic Pharmacy, which distributes around 20 products from 2 companies (1 Pakistani and 1 German), employs 6 sales reps and 4 medical reps. In one instance, the director of a small company that recently started importing a single product from a foreign firm promotes that product alone, filling both the sales rep and the medical rep roles.

In theory, these two types of representatives perform very different functions. Medical reps interact with prescribers in hospitals, clinics, and health centers and scientifically promote the products. Sales reps are responsible for the actual sales activities. "It's a two-way affair, the sales rep is basically a business person, his interest is in the business, and then the medical rep is an expert. All the medical reps are pharmacists, registered pharmacists, so it's more about trying to draw attention of the medical doctor to what products are available, what new compositions are there, what the advantage is… so they are more the people who generate the business, generate the orders, and then the sales reps come in to look at those orders and handle the transaction. So they pick the order, do the order, process the order, do the delivery, follow up on payment" (interview with the brand manager at a Ghanaian wholesaler, Accra, February 2015).

Of course, the type of representative who is sent to the field will be different depending on whether the products being promoted are prescription or OTC, innovative or generic. Innovative prescription products, regardless of how innovative they actually are, will require many medical reps, while generics, even prescription generics, and especially OTC products will mainly require sales reps. For this reason, and unlike the promotion of Big Pharma products by medical reps presented earlier, sales reps play the essential role for the products of Asian, smaller European, and African firms.[12] They are organized by territory (by neighborhoods in major cities or by regions of the country) and by type of customer (hospitals and clinics, wholesalers, and retailers).

A shifting landscape of pharmaceutical representation in Benin

There are currently three kinds of pharmaceutical representatives in Benin, organized around the type of structure that employs them. We will describe the respective importance of each and how it has changed as this area of activity has evolved in the country.

Direct-labos: Professionals employed by the firms themselves

An emblematic figure of pharmaceutical representation, *direct-labos* are employees of the firm they represent. They are responsible for visiting prescribers and pharmacists, tracking MA applications with the pharmacy directorate (Directorate of Pharmacies, Medicines, and Diagnostic Investigations [DPMED] at the time of our research),[13] and gathering sales statistics from wholesalers. Being a *direct-labo* in a multinational company is the dream of all young people entering the profession. It is the most highly valued and coveted position in pharmaceutical representation in Benin, and the origin of the profession in the country.

The late 1960s saw the disappearance of small- and medium-sized pharmaceutical companies around the globe and the concentration of companies into what would later be called Big Pharma (Greffion, 2014). These large companies went

on to create their own sales departments, and it was at this point in time that the figure of the *direct-labo* representative, as seen in Benin, was born. Initially these were primarily European expatriates or others assigned temporarily in the countries. In the 1980s and 1990s, firms began to hire young college graduates in the French-speaking countries of Africa to fill these positions. The presence of subsidiaries of the major pharmaceutical companies in Senegal and Côte d'Ivoire was a contributing factor, due to the availability of young people newly trained at those countries' polytechnic institutes, for example. At that time in Benin, *direct-labos* were a kind of all-powerful representative, with high salaries and company cars at their disposal; some were even envied by doctors.

The position of *direct-labo* remains idealized to this day, feeding the imaginary that surrounds the pharmaceutical representative profession in Benin as well as in Côte d'Ivoire, where we also conducted research. But the trend in the pharmaceutical industry, as described in the literature (Greffion, 2014) and as we observed in Benin, is to outsource certain activities, such as research and development, and marketing. As a result, very few of these representatives remain in Benin. At the time we collected our data, only the Servier company was still employing *direct-labos*. In Ghana, however, we noted an apparently recent trend in the opposite direction in which Big Pharma companies contract their representatives directly.

International agencies: Stakeholders in the large and still often French groups

In the early 1990s, the sales figures for these large pharmaceutical firms decreased, and they began to make extensive use of service providers to promote their products (Greffion, 2014). "When the generic companies first entered the system, their profits [Big Pharma] started to go down a bit, so they invested less, and most of these laboratories began entrusting the majority of their products to representation agencies. So that's how the agencies started to take shape" (interview with the head of a representation agency, Abidjan, September 2019).

The international promotion agencies that operate today on the African continent were established gradually during this period. They are cheaper for firms than *direct-labos*, and are more flexible, more efficient, and allow for better organization of the labor market. In fact, they position themselves as a specialized system for managing the human resources of pharmaceutical representatives. Their major selling point is that they have a detailed knowledge of various laws and practices of the francophone countries of West Africa. They can thus ease the burden for the Big Pharma firms, who no longer have to focus on the specific laws of each country, manage relations with each of the national administrations, or deal with the potential hassles of every field agent. Some of these companies were founded by former *direct-labo* employees of Big Pharma, as evidenced in this interview excerpt: "At a certain point, the African market, especially with the arrival of generics companies, well, the African market no longer interested them. So, they entrusted the products they had to former civil servants.[14] That's how Pharmaco[15] was born; Pharmaco was created by a Swiss man (…), who worked in Africa for a

long time for Roche. So Pharmaco was managing Roche's products and now has many other products" (interview with the first-line manager of an international agency, Cotonou, January 2019).

The international agencies each employ an average of 20–50 people in Benin to promote products and, depending on the terms of their contracts with the firms, manage regulatory affairs. Until recently, most of these agencies were French or Franco-Ivorian companies with the legal status of export wholesalers in France. Companies from other countries are gradually getting involved in this activity. The largest of them are part of complex economic groups (holding companies) that include companies involved in the entire drug chain (manufacturing, distribution, logistics, promotion). Some examples with regard to promotion include Eurotech, part of the French group Tridem that was purchased in 2017 by the Chinese company FoSun; Planetpharma Promotion, a Franco-Ivorian company belonging to the Ubipharm group; and Ethica, also Franco-Ivorian, bought by the French group Eurapharma discussed earlier in the Ghana section.[16] These three agencies share the representation contracts for all the Big Pharma companies. The relatively large Asian generics companies, which are positioned in subsidized markets (see Chapters 5 and 6) and present in several French-speaking African countries, do not have the energy or resources to address various laws and customary ways of doing things specific to each country and face a significant language barrier, so they also entrust the representation of their products to these agencies.

Some international agencies set up offices in what they consider to be the "major" countries (Cameroon, Côte d'Ivoire, and Senegal) and subcontract to local agencies or hire field agents who are considered *direct-labos* but who would more accurately be called "direct-agencies." Others choose to set up offices in each country, or one common office for two countries, under the responsibility of a country manager and supervisors.

Local agencies: Emerging Beninese players

Local agencies emerged in the early 2000s in Benin and more broadly in francophone West African countries, during a period in which the patents for several drugs were expiring, pharmaceutical markets in these countries were becoming more liberal,[17] and these markets were being taken over by Asian firms (Abecassis & Coutinet, 2008; Baxerres, 2013; Singh, 2018). One of the representatives we met in Côte d'Ivoire expressed it in these terms: "Today, people understand that it was a job different from sales, and then more and more agencies were created because at the time, to be honest it was only European laboratories… European ones, I mean for the most part. Now, with globalization, there are Indian laboratories here. There are Chinese laboratories, there are Pakistani ones (…) and as they couldn't come here directly, they started by having pharmaceutical representation agencies. And here we are today (…) there are so many now, there are so many…" (interview with the regulatory affairs officer of a European firm, Abidjan, September 2019).

In Benin, local agencies are more numerous (about 50) than the other types described but do not have the highest sales or largest market presence. These agencies were created by former *direct-labos* or employees of international agencies, and their staff size ranges between 1 and 50 employees. They sign contracts with pharmaceutical companies, either directly with firms, or with distributors or international agencies that subcontract activities to them. Local agencies can be divided into two subcategories based on their economic significance and the types of pharmaceutical companies with which they contract.

One subcategory consists of medium-sized local agencies that contract with international agencies or with European, Asian, or North African generics companies. These agencies operate on a relatively structured basis, with fully equipped offices and administrative staff (accountant, secretary, sales manager, etc.) in addition to their "field" representatives. Some of these medium-sized local agencies are also present in Côte d'Ivoire and Togo, and some even compete with the international agencies and the firms they represent in terms of prestige and image. Some have websites, and employees wear uniforms that highlight the agency rather than the client company. Candidates for employment in these agencies must have a car. Representatives have employment or service contracts, receive bonuses, and even get paid time off.

The other subcategory consists of small local agencies that partner with one or more small Asian firm(s), primarily Indian and Pakistani but occasionally Chinese. These agencies have very limited resources and their representatives often travel by motorcycle. Most of the reps are quite young, and their level of formal preparation is often limited to a baccalaureate plus 6 months of training in private schools.[18] For the most part, they work without a written contract, have low salaries—as low as CFA 50,000 (EUR 76) per month—and are not paid on a regular schedule. These agencies' operations are less structured, with no dedicated office for business activities and no administrative staff.

Asian firms that contract with these small local agencies periodically send a country manager to monitor their interests within the agency. The country manager accompanies representatives on their "field" visits and assists the agency head with DPMED administrative procedures. This practice is extremely controversial, including in agencies that host such country managers, who claim to have no choice in the matter. They have very poor relations with other types of representatives, who accuse them of all sorts of dubious practices, including corruption and the practice of paying health-care professionals to prescribe their products. Even so, these country managers play a central role in how small Asian firms construct markets: by carefully studying the markets, products, and practices of their competitors.

Now that we have described the structure of pharmaceutical representation activities in the two countries—changing in Benin, more established in Ghana—let us see how these differences affect the way pharmaceutical companies invest locally.

Market-capture strategies: Contrasts and similarities in Benin and Ghana

Benin and Ghana have legislated different legal statuses for medicines, which help us understand the strategies used by pharmaceutical firms. In Ghana, there are three different classes of medicines: "prescription-only medicines" that require a doctor's prescription; "pharmacy-only medicines" that pharmacists can recommend themselves because of their expertise; and "OTC medicines."[19] Although Benin does have a list of drugs sold only on medical prescription and a list of "products on recommendation," the texts do not distinguish by class or table other than for narcotic drugs and psychotropic substances.[20]

Another difference between the two countries that impacts representatives' activity is the legal status of retail distribution actors (strong pharmacist monopoly in Benin, two distribution licenses in Ghana)[21] and how they are located throughout the national territory. OTC medicines sellers are commonly found throughout Ghana—numbering 10,424 in 2015—particularly in the working-class districts of cities and rural areas. Legally, they are only required to distribute a limited list of products including OTCs and medicines included in public health programs (antimalarials, contraceptives, and so forth). In contrast, pharmacies in Ghana are exclusively found in major cities. They distribute all of the classes of drugs provided for by legislation.

In Benin, the main actors in formal private retail distribution are pharmacies. These are found in major urban centers, though in recent years, the increasing number of trained pharmacists in the country has expanded their range to more rural areas. Pharmacies reach rural areas through pharmaceutical depots, which they supervise remotely, but nationwide there are relatively few such depots (165 in 2018). The informal drug sales sector, which previously played a key role in pharmaceutical distribution and access to medicines (Baxerres, 2013; Chapters 3, 7, and 10), had been heavily suppressed by the authorities as we began collecting data about representatives in Benin. We were therefore no longer able to study whether reps had specific strategies for this sector.[22]

A trend toward market segmentation in Ghana and competition in a more homogeneous market in Benin

Ghanaian segmentations by therapeutic class, legal status, and territory

Most of the economic actors in the pharmaceutical sector in Ghana, whether manufacturers or importer-distributors, are highly specialized in terms of medicines' legal status (prescription-only medicines, pharmacy-only medicines, or OTCs) and therapeutic classes (medicines to treat chronic diseases, or acute diseases and common symptoms). These elements determine the investment pharmaceutical reps make with different clients.

Some representatives specifically target health facilities and prescription products. These include Big Pharma's "ethical reps" and their distributors' medical

and sales reps. One example are representatives for one of the multinationals with a local presence, which specializes in Ghana in the treatment of chronic diseases (hypertension, diabetes, cancer, dermatological disorders). But this category also includes the medical and sales reps for the local wholesalers who represent some large Asian generics manufacturers, such as a wholesaler that specializes in prescription products from India (drugs to treat diabetes, hypertension, liver and kidney diseases, etc.). This segment of the pharmaceutical market has the advantage of generating very large orders, via the country's entire public sector through various levels of its health pyramid, but also via private clinics and mission hospitals.[23] The establishment of the National Health Insurance Scheme (NHIS) in Ghana in 2003 provides pharmaceutical companies with a major client, and cornering this market is a major economic issue.[24] However, according to the testimonies of several of the actors we interviewed, the NHIS is experiencing significant difficulties that have resulted in it paying its bills several months late. "The national health insurance, they don't pay… they just don't pay… their reinvestment is very slow… the last reinvestment national health gave to the hospital was April last year (…), so how do you stay in business if after eight months the person still owes you? It doesn't make sense" (interview with the director of operations for an international distributor, Accra, February 2015).

Many firms and wholesalers have therefore decided to focus on the private retail market (pharmacies and/or OTC medicine shops), in which pharmacy-only and OTC medicines represent the large market of self-medication without any medical consultation. The director of a wholesaler-importer explained it this way: "Prescription-only medicine is really hurting me really badly because I don't get my money cycle in good shape. You supply and it takes you between six and eight months to get your money back. It stifles business. Now we want to do OTCs where we can concentrate on the private-sector market, where we can really make payment within a month to get your money" (interview with the manager of a Ghanaian wholesaler-importer, Accra, March 2016).[25] For example, one wholesaler-importer in Ghana, who imports only seven products from an Indian firm (an antimalarial, a deworming agent, three painkillers, a decongestant, and a cough suppressant), only targets private wholesalers as clients.

Drug reps in Ghana—backed by the companies they represent—always decide how aggressively they will focus on the wealthy or poor districts in the capital, other major cities, or rural regions based on their target clients (health facilities, pharmacies, OTC medicine sellers). However, they also consider how extensively they are located around the country and the relative financial status of the end users.

For example, a wholesaler-importer who has signed contract manufacturing agreements with a small German company, two Chinese companies, and one Indian company, and has the "monopoly" on an American company that has generics manufactured in India, owns two wholesale stores in Accra, one in Kumasi (the second-largest city located in the center of the country), as well as an office with warehouses, one medical rep, one sales rep, and one minibus and one driver in each of Ghana's ten regions. This wholesaler-importer thus ensures that

the products it represents are well distributed throughout the country. In comparison, Big Pharma's two international distributors do not have much presence outside Accra. Gokals Laborex has no depots outside Accra and mainly targets public hospitals and private clinics along with all wholesalers. It generally does not directly target retailers, but when it does these are only "high-level pharmacies" in Accra and certainly not OTC medicine shops. The pharmacist superintendent of World Wide Health Care Limited stated in our interview that he prefers to focus on a few large clients, such as the Korle Bu National Reference University Hospital in Accra, rather than spreading out across numerous small clients. So Big Pharma's "ethical reps" are primarily found in Accra and with prescribers in major public hospitals and large private clinics. In contrast, wholesalers who specialize in OTC products manufactured in Asia will send their sales reps primarily to nonimporting wholesalers, pharmacies, and OTC medicine sellers; they take care to have a significant presence throughout the country specifically for these latter clients.

Some of the largest local wholesaler-importers are of course playing on all fields, both in terms of end users' socioeconomic status and coverage of the entire country. A brand manager with Ernest Chemist, a company with 15 wholesale stores in 7 of the 10 regions of Ghana, explains: "We represent different companies and each of the companies has different target markets, so we have companies that we represent that target the top end, the high-class market. We represent other companies that also look at the middle, and then we have locally produced products that look at the middle to lower class. So we look at all the classes involved and we have different products, different prices to cover everybody" (Accra, February 2015). Tobinco, mentioned earlier, which specializes in products made in Asia for acute and common health problems (antimalarials, painkillers, deworming agents, antibiotics), also sends its medical reps but especially its sales reps to both health facilities and nonimporting wholesalers and retailers. It also has a nationwide presence. The extent of their activities and the capital accumulated since their creation means these two major Ghanaian companies have also been investing in pharmaceutical production for several years.

Some Big Pharma companies also do not limit themselves to prescription products and chronic diseases, or to the city of Accra, but are positioning themselves on the OTC market throughout the country. The portfolio of a Sanofi medical rep we met consists solely of OTC products (antacids, vitamins, cough medicines). She works exclusively with wholesalers and pharmacy salespeople and, at the time of our interview, was thinking about how to best position herself with OTC medicine sellers. Only 9 of the 60 medical reps working for this firm are based in Accra; the other 51 are posted across the country. Similarly, Novartis' scientific office in Accra has two first-line managers, one of whom specializes in cardiovascular products, the other in painkillers and antimalarial drugs. They each manage several medical reps, although this latter manager explained that when talking about painkillers and antimalarials we should really refer to these representatives as "pharmacy reps" since that is where the market for these products is found.

Activities in Benin are concentrated yet distributed throughout the hierarchy of health facilities and formal retailers

As we saw earlier, there are fewer legal categories for medicines in Benin than in Ghana. Because OTC medicines are not recognized, pharmaceutical companies tend to all target the same therapeutic markets.[26] Formal retailers are also mainly located in Benin's cities. These two elements show that the activities of drug reps are overall much more concentrated therapeutically and geographically in Benin than in Ghana. Even so, here too we find that end users with different financial means are targeted within the hierarchy of the health facilities and formal retailers that are available.

The representatives of the Big Pharma firms and their generics branches mainly focus on large private clinics and public university hospitals. Their second choice of clients are medium-sized private clinics and so-called zone public hospitals, which are also reference centers, where they mainly target well-known professors and doctors, as well as hospital pharmacists who place orders for the products used internally. But university and zone hospitals are also a true competitive arena between Big Pharma and the large generics companies, as this excerpt from an interview with a former employee of the American firm Pfizer illustrates: "I had an account at the CNHU [national university hospital center], I had an account in dialysis. And the CNHU ordered about 1000 boxes of Almor[27] per year. Then those guys came [Macleods, a major Indian generics company] to take that client away from me. No, but I did everything I could. I used all my connections, because the person who places that order is a pharmacist, a dean… who was the hospital pharmacist. When I heard about the problem, I made an appointment with him and I went to see him and I said, 'Dean, I'm your little brother, I'm a pharmacist like you. You can't take this account away from me and give it to the Indians. Come on, you're a health professional', and I tried to convince him. I kept the account there until I left the company. They couldn't change" (interview, Cotonou, June 2019).

We can see that the large generics firms are competing with multinationals in university and zone hospitals. If they are unable to win over the well-established doctors, who are in the habit of prescribing Big Pharma products, the generics representatives mainly target interns, doctors studying to be specialists (DES)[28] and midwives who write a significant number of prescriptions. "There are others who really only prescribe European products. The older doctors for example, with new products, you can go see them 10,000 times, they will never prescribe them. Those guys are very attached to the old products" (interview with the representative of a European generics manufacturer, Cotonou, June 2019). These generics manufacturers—from every continent—have the largest market shares and are present throughout the prescription chain, from reference hospitals to small health centers. In each prescribing site, representatives observe, learn, listen to prescribers and adjust their visit schedule based on the end client's purchasing power. As the rep quoted earlier expressed it, "There is all this information that we are trying to find out, and then they [the prescribers] themselves tell us, and

at the nearest pharmacies too, we conduct surveys to find out their prescribing habits (…) so when you go to see him [the prescriber], he'll tell you straight out, 'I don't prescribe expensive things because here, the population here, people can't afford them' (…). My products are even a bit expensive. In the range of CFA 3500 to 21,000 [EUR 5.5–32]."

Representatives working for small Asian firms position themselves mainly in district public health centers and small private practices run mostly by midwives and nurses. These practices, located in working-class neighborhoods, attract a clientele with meager means. This same representative expressed it this way: "Some prescribers, it depends on the area where they are. They don't like expensive products so they have to prescribe Indian products. So if they are in an area where there are only people with low purchasing power, they have to make do with Indian products."

Various firms construct markets around pharmacies as well as health centers. Some agencies have representatives who exclusively solicit pharmacies. In a pharmaceutical market that mainly comprises generics and where the law on substituting originator drugs with generics by retailers dates back to 1999, a significant part of the market construction strategy involves working with pharmacies. Pharmacies are also the main category of authorized retailers. For some firms, particularly the smaller ones, salespeople in pharmacies may be more important than prescribers. The representative of a Franco-Ivorian generics company we shadowed rarely visits health centers. "We then went to a health center, a small clinic in Godomey [a suburb of Cotonou]. I told him I thought he only did pharmacies. He told me that they are his main target, but that he also goes to health centers where clients have low purchasing power. For example, it wouldn't do him any good to go to upmarket health centers where people use insurance most of the time. His products will not be prescribed there" (field notebook, Cotonou, August 2018).

Note that 169 of the 276 pharmacies (61%) in Benin are located in either the city of Cotonou (97) or its surroundings (43 in Abomey-Calavi, 29 in Porto-Novo).[29] Representatives therefore logically concentrate their activities in this geographic area. They generally target their clients first by type of health center and second by type of prescriber. If the main client targets appear insufficient to meet the monthly or quarterly goal, they broaden their actions to encompass less lucrative and hard-to-reach areas. "The delegate told me that he also goes to completely remote centers like Zinvié [a lakeside village on the outskirts of Cotonou] to round off the ends of the month" (field notebook, Cotonou, July 2018).

Once a month, representatives visit the secondary cities located within a radius of 100–300 km of Cotonou. For cities located beyond this perimeter, the largest agencies use the services of "multi-card" representatives (who represent several firms simultaneously) who are based in those areas. In addition to the informal sector, the formal market in rural areas is composed of a few private pharmaceutical depots and, more recently, a few pharmacies. Public health centers distribute essential generic drugs, sold under international nonproprietary names (INNs), which are prescribed by a health-care professional. These products are

not promoted by company representatives but are subject to other market rules, such as calls for tender (see Chapter 2). This excerpt from an interview with a physician sums up the situation in remote areas: "In my four years of working in Segbana [a small commune in northwestern Benin], I have never seen a single delegate. So in order to stay informed about the products, I ask the Kandi pharmacy to regularly send me the catalog of available products. Otherwise, I work a lot with the CAME [Central Purchasing Office for Essential Medicines and Medical Consumables] products that are available in the center. (…). The pharmacy is really the last resort" (March 2019).

Strategies in both countries: Scientific but primarily commercial and relational

Scientific promotion

Traditionally, pharmaceutical representatives primarily focus their activities on prescribers and the scientific promotion of products (Greene, 2006; Greffion, 2014; Ravelli, 2015; Scheffer, 2017). That is the raison d'être for Big Pharma's "ethical reps" in Ghana as well as all pharmaceutical representatives in Benin, at least in theory. This activity can take place at a variety of venues: a scientific symposium organized when a product is launched; smaller group meetings,

Figure 9.1 Promotional stand at a scientific event in Cotonou.

Source: © IRD/Stéphanie Mahamé, Cotonou, February 2019

frequently organized to train various prescribers (doctors, nurses, midwives) on a specific health issue; over a working lunch; at a training session at the beach; and of course during the well-known "medical visit," which remains the key tactic.

Each one requires specific strategies. Kristin Peterson's studies in Nigeria (2014, ch. 6) illustrate how, when a pharmaceutical innovation is introduced (regardless of the actual degree of innovation), marketers must first approach specialist physicians—recognized opinion leaders in the therapeutic field concerned—who will be able to introduce the product and thus influence their colleagues, especially those who are younger and less experienced. Clinical meetings are then key to promoting the product. They often report on the clinical trials that companies have conducted on their products and that will help representatives convince their clients of these products' usefulness (Dumit, 2012; Ravelli, 2015).

One ethical rep explained his approach during visits: "So you interact with the physicians and try to understand their practice. If it is an antihypertensive I am supposed to sell that day, [that] I want him to prescribe that day, I ask him questions about hypertension, his practice. What he looks out for in the medicine before he prescribes. So as I listen to him, I find the loopholes where my product comes in, with the advantages. (…). Yes he may know of it but I will just draw his attention to those benefits he is looking for in the product. (…). Some of them will tell you (…) they prefer other drugs they want to use. They give you their reasons (…), so you just end the call then make plans for how to tackle their objections. Whatever reasons why he decided to choose another product, you go back, then find reasons why when you meet him again he should now consider your product" (interview, Accra, December 2015).

In Benin, these various scientific promotion activities are grouped under the term "public relations." Although the relationship between representatives and prescribers is described in the Global North as being increasingly difficult,[30] in the contexts we studied medical visits always seem to produce significant results with prescribers. This is why reps try to stop by often to keep their products "front of mind" and prevent competitors from supplanting them in the minds of prescribers they previously won over, as these observation notes show: "The delegate says to them 'I heard that you are prescribing my competitors'. One of the two midwives replied 'we don't see you anymore, your competitors are here every day, we can't remember everything, you have to come by and remind us of the products'" (field notebook, Cotonou, April 2019). A maximum of four products are presented at each visit to avoid overloading the client with too much information at one time. Several elements are used to leave the prescriber with a strong memory of the visit and particularly of the products presented. For example, references to WHO prequalification are often made in relation to artemisinin-based combination therapies (ACTs) against malaria.

Social activities related to the sale itself

In Ghana today, however, these traditional scientific activities of pharmaceutical representation no longer occupy anything close to the bulk of

representatives' working time. An Indian expatriate explains why, based on his experience in both Indian and Ghanaian markets: "Initially, around 10 to 15 years back, when we were all working as medical representatives, (…) meeting with a qualified doctor and talking about our products, our promotion, was enough to get the business and recommendation from them. Now, that is not the case. It has been totally changed. (…). Because of the Internet and electronic media, if a doctor wants to have any information about any molecule, it's easily available. (…). So they are easily getting the information which was earlier being imparted by the medical representatives, so their role has been minimized" (interview, Accra, May 2015). In the Ghanaian context, sales-centric activities are considerable: checking that stocks are moving properly, collecting checks once the payment period is due, offering customers the opportunity to reorder, negotiating payment methods (cash, credit, granting varying lengths of credit), and so forth. These sales activities are supposed to be carried out exclusively by sales reps, which explains some testimonials stating that sales reps are ultimately more important than medical reps. However, medical reps also engage in these activities. One ethical rep described himself to us as a "medical sales representative."

In Benin, there is a certain hierarchy in promotional activities. While representatives, most of whom are fairly young, are responsible for medical visits and maintaining social relations with doctors, sales-related activities are more the responsibility of supervisors, sales managers, or agency heads. They go "out in the field" to maintain social relations with pharmacists involved in retail and wholesale distribution, monitor stocks with wholesalers, and record sales statistics. Representatives also work on some sales-related activities. They cultivate social relations with counter salespeople, frequently check the availability of "their" products in pharmacies, and try to place their products in pharmacies and health centers that do not yet sell them. Although in Benin they do not make direct sales, companies set monthly, quarterly, and annual sales targets for them. They call this "making their numbers," which amounts to what they refer to as "indirect" sales.

These sales-centered activities (direct in Ghana or indirect in Benin) require reps to invest in very significant social engagement. In Ghana, these are referred to as business relations. Sales reps for wholesaler-importers spend a great deal of time "in the field" greeting customers, maintaining contacts, expressing birthday and anniversary congratulations, and attending ceremonies for both happy events (marriage, birth) and unhappy ones (funerals), all the while conducting various sales-related activities. The brand manager of a Ghanaian wholesaler-importer quite convincingly explains it this way: "You look at customer service quality, and then customer reception. Those are the things that are competitive now, and then customer care in general, how much we know about our customers, what is the relationship, how do we nurture the relationship between the two: yourself and the customer, so that it does not become like once in a while when they need something then they walk in. But then it's a constant friendship, what I call 'a professional marriage that does not end'. Whether you need something from me

or not, we have a relationship, and we would continue to nurture and grow it, and automatically, any day or anytime, I will be the first one on your mind" (Accra, February 2015). Our data thus strongly demonstrate the social construction of the market and the relational dimension of competition, as described by sociology and economic anthropology (Steiner, 2005).

Logically, these activities do not primarily target prescribers but rather vendors, those behind the counters of retail and wholesale stores in Ghana and behind pharmacy counters and in wholesaler-distributor offices in Benin. A Big Pharma representative in Ghana explains: "The other side [of our work] basically has to do with talking to the pharmacies, number one, why they shouldn't do substitution; number two, how to keep the products to ensure that we can maintain that efficacy throughout the lifespan of a product. (…). And we do a little bit of the marketing aspect, how to display your goods at the pharmacy to make sure that when customers walk in they can see what they want so that at least, they can also say 'ok, I want this; I've used this before, this is what I prefer'" (interview, Accra, March 2016). Work sessions, training sessions, and product launches are organized specifically for these front desk sellers, as they are known. The people in charge of placing orders for hospitals, clinics, and wholesale companies, and the accountants working in these various facilities are also "targets" that should not be overlooked.[31]

In Benin, representatives do not hesitate to use their relationships with doctors practicing in a specific area to influence the people in charge of pharmacy orders, as we were able to observe during several shadowing sessions with a doctor in a mission health center: "While we were there, a pharmacy called him to ask for advice on product placement, to which he responded warmly. He said that he had no problem with it, but that he did not know what the other doctors preferred. (…) The delegate who was in the pharmacy for the placement of a product and had asked the pharmacy to call the doctor came by after leaving the pharmacy. He came to thank him for helping him to convince the pharmacy" (field notebook, Cotonou, August 2018).

Gifts and special attention to boost sales

Commercial strategies, described previously in the literature (Fugh-Berman & Ahari, 2015), help to maintain these social relations: offering promotional items (pens, jackets, mugs, caps, T-shirts, hand sanitizer,[32] umbrellas, calendars, bags, cell phone covers, etc.), remembering birthdays (cakes) or holidays (chocolates and flowers for Valentine's Day), invitations to luncheons, and providing free samples, which an "ethical rep" in Ghana told us was the main promotional tool for the firm he represents.

Larger gifts may also be offered to good clients, such as televisions, air conditioners, refrigerators, water fountains, microwaves, or "scientific" trips abroad for conferences or pharmaceutical fairs. Discounts may be given for large purchases; good clients may even receive extended credit periods or credits for "fast moving products," which is not the usual practice.

Figure 9.2 Pharmacy seller's white shirt in Accra.

Source: © IRD/Carine Baxerres, Accra, September 2015

In Benin, since sales are decoupled from promotion, these commercial strategies are an extension of the public relations mentioned earlier and are therefore mainly focused on prescribers personally ("scientific" trip abroad), but also on medical societies (pediatrics, ophthalmology, surgery, etc.), hospitals, and health centers (support pledges for various activities). "On the way out of the midwives' on-call room, we stopped in front of a classroom where the DES students and the professor had just finished a meeting. We greeted them and they all responded, smiling. The delegate had told me on the way there that they had provided a large digital screen and a computer for their classes. Now they can run course content or any presentation right from a smartphone. The prof asked his DES students 'do you prescribe their products? Because we should return people's favors'. They hastened to answer yes, yes, yes" (field notebook, Cotonou, January 2018).

All representatives in Benin and Ghana engage in such sales and promotional activities for the market segments or types of end users targeted by the firms they represent. Big Pharma reps say they do not engage in "unethical" promotional practices and seek the proper balance between incentives and legality. "We are a multinational company; we are listed on the stock exchange, not in Ghana, so we are bound by all those corruption laws and all of those things. (…). So we try and weigh, we are not giving gifts above 20 dollars, those kinds of things (…), to our disadvantage because our competitors can easily give ACs and fridges and all that but we can't" (interview, Accra, February 2015).

Figure 9.3 Samples for medical visit in Benin.

Source: © IRD/Stéphanie Mahamé, Cotonou, September 2018

Conclusion

In Europe and North America, there is talk of the "medical visit crisis" (Ravelli, 2015, p. 70). Due to the global decline in pharmaceutical companies' capacity for innovation, increased international competition linked to the growing numbers of generic manufacturers, the decline in public spending, and the deterioration of the industry's image with prescribers, since the mid-2000s companies have tended to employ fewer and fewer pharmaceutical representatives.[33] In West Africa, however, pharmaceutical representation activity is far from on the decline. The fact that it is not only focused on scientific promotion but also more broadly on sales, whether direct or indirect, undoubtedly has something to do with this. Also contrary to what is described in the Global North, this activity is aimed at a broad range of actors that goes well beyond just physicians: nurses, midwives, nurses' aides, salespeople in pharmacies and OTC medicine shops, accountants and order managers in health facilities, wholesalers, and so forth. Finally, in the Global North when products move into the public domain and their prices drop drastically, promoting them is no longer profitable (Ravelli, 2015). In West Africa, where the pharmaceutical market is even more dominated by generics than in the Global North, this is not a major consideration, especially since the labor costs of representatives are much lower.

More established in Ghana, changing in Benin, tied to national pharmaceutical regulations, different economic actors in both countries are the keystone of this pharmaceutical representation: wholesaler-importers in Ghana and promotion agencies in Benin. Beyond the very significant issue of the international economic actors invested in pharmaceutical promotion and distribution, many of

whom are still French in this region of the world where that country's influence is undeniable,[34] it is striking to note that in both countries, the key economic players in pharmaceutical promotion are largely national players with national capital. The importance of the definition of "pharmaceutical representative" adopted in the Introduction is now quite clear. Our work highlights that, although in different proportions in Ghana and Benin, these field professionals themselves generate definite and endogenous pharmaceutical dynamics in their country, independently of the firms they represent.

In Ghana, our research shows that the pharmacy field has been built through the activity of sales reps, who, as one pharmacist dismissively stated, do "trading… trading, anybody can buy and sell" (interview, Accra, March 2016). The most important economic players today, many of whom are now involved in pharmaceutical manufacturing, started out as sales reps (Baxerres, 2018).[35] The promotion of medicines, whatever the products or companies involved, from whatever corner of the world, has led to the construction of Ghana's pharmaceutical economy, strengthening and advancing local actors. The Tobinco company discussed in this chapter has grown by promoting the products of a small Indian firm that a pharmacist told us "is not known in India… when I say it's not known, it hasn't got a name; in fact it's not a big company… it's a very small company" (interview, Accra, October 2014).

In Benin, the dynamics of pharmaceutical representation are still emerging and the pharmacy field is currently so disrupted that it is difficult to imagine its future. Moreover, the government regulation in place up to this point has tended to limit economic actors' room to maneuver (see Chapter 3). Despite this, representatives are playing an increasingly important role in local pharmaceutical dynamics, which are no longer dominated by wholesaler-distributors alone. The rise of representative agencies is certain. Paid between 10% and 18% of the firms' sales figures, agencies achieve a financial power that allows them to diversify. Some local agencies have obtained approval to import and sell medical equipment (beds, gynecological tables, electric respirators, surgical equipment, etc.), and others have founded training schools in the fields of pharmaceutical promotion and pharmacy sales.[36]

Through their representatives, pharmaceutical companies from different regions of the world are setting up local operations in Africa and gaining market shares in a highly competitive context.[37] While still based on governmental regulation and the country's pharmaceutical distribution structure (whether or not the ubiquitous OTC medicine shops are formally included), the firms develop territorial and therapeutic strategies: segmentation in Ghana, concentration in Benin. But beyond these differences, in these contexts where health care is still mainly the responsibility of end users,[38] similar underlying strategies appear in how these users are targeted based on their financial situation. Product pricing and brand reputation determine how aggressively firms in both Benin and Ghana target health facilities and retail distributers, and whether these are centrally located or in rural districts, high-end or low. Through the intermediary of their representatives, they even intervene in people's private lives to recommend medications.

This intermediary is skillfully constructed not only through prescribers and the many actors involved in distribution and health care that representatives so carefully cultivate, but also through those actors' friends, neighbors, colleagues, and families.[39]

Notes

1. As colonization was ending, the main sources of medicines for Ghana were the United Kingdom, West Germany, Italy, Switzerland, the Netherlands, and the United States (Pourraz, 2019). In Dahomey, medicines at that time came primarily from France, but also arrived from Senegal and Morocco, where some companies had established manufacturing sites (Baxerres, 2013).
2. These companies could also engage in representation activities for other pharmaceutical companies for whom they import and distribute medicines in African countries; this was the case of Major & Company and J.L. Morrison & Sons in Ghana (Pourraz, 2019).
3. See the Introduction of this book for more information on the data collection methodology.
4. See Decree 2000-450 of September 11, 2000 regarding the application of Law 97-020 of June 11, 1997 regarding the conditions for practicing the medical and paramedical professions with private clients and relating to the opening of wholesaler-distributor companies in the Republic of Benin.
5. The opening of scientific offices seems to be a fairly recent trend among multinational drug companies in Ghana. For example, Novartis opened its scientific office in 2014, and Denk did so after 2010.
6. Eurapharma was discussed in Chapters 1 and 2 and appears below in the discussion of Benin. The policy of this pharmaceutical company, long a fixture in the French-speaking countries of Africa, is to associate itself with an existing local company and purchase more than half of its shares. In Ghana, Laborex—a name often used by Eurapharma subsidiaries in various countries—has joined forces with Gokals Limited, a Ghanaian company founded in 1998 by a Ghanaian entrepreneur of Indian origin. A section of Gokals Limited that specialized in generics was not affected by this takeover and has continued on its own path. It continues to operate today under the name Gokals Limited.
7. For more on these two international companies, see https://www.chanraisummitgroup.com/home.html and https://www.imperiallogistics.com/overview.php, accessed in July 2020.
8. Other companies may be mobilized for specific actions, such as programs related to Global Health, like the AMFm (Affordable Medicine Facility-malaria) discussed in Chapter 6.
9. For example, they may distribute products at the lower end of the price range set by the Big Pharma companies. Some explain that in order to keep these firms as clients, they may agree to pay for their medical reps to promote products that are at the end of their life cycle or no longer sell well, or OTC products that do not necessarily need scientific promotion. Competition is fierce between importer-distributors in Ghana, and the local actors who were there first take a very dim view of the competition from international wholesalers, which they consider unfair.
10. This is objectively not always the case. The Big Pharma products that they promote are not all innovative and not all prescription, far from it. The quality and promotion of these products will be discussed in the next section of this chapter as well as in Chapter 11. Here again, as with the term "specialty," which we discussed previously in French-speaking contexts (Baxerres, 2013), there is some linguistic ambiguity (or abuse of language) adroitly used for commercial purposes in the pharmacy world.

11. These issues of "monopoly" and "contract manufacturing" are discussed in Chapter 6.
12. Sometimes agents who act as medical reps for these firms do not have a pharmacy degree or training in medicine or pharmacy.
13. The DPMED was reorganized in early 2020 and renamed the Beninese Agency for Pharmaceutical Regulation (ABRP: https://www.abrp.bj/organisation.php). For more on this subject, see Chapter 1.
14. In Benin, the term "civil servant" covers both public and private sector employees who have open-ended contracts and are firmly established in their place of work.
15. Pharmaco is an international agency based in South Africa that operates in several countries in sub-Saharan Africa. See their website: https://pharmaco.co.za, accessed September 2020.
16. See the websites of Tridem Pharma (https://www.tridem-pharma.com/), Ubipharm (http://www.ubipharm.com/fr), and Eurapharma (http://www.eurapharma.com/fr/), accessed in September 2020.
17. In the early 1990s, several countries, such as Benin, Burkina Faso, Mali, and Niger, transitioned to a more democratic political regime, which resulted in the opening of their markets. On the pharmaceutical front, the State ceded its monopoly on supply, which allowed private initiatives to develop, such as the establishment of private wholesale companies and representation agencies.
18. Since the mid-2000s, Benin has witnessed an explosion of "pharmaceutical delegation" training schools, a trend that originated in Côte d'Ivoire and quickly spread to Benin. These schools are usually founded by people who have no ties to the world of medicine but who think it will be a profitable niche. In fact, beginning in the 1990s, private initiatives in the health and education sector have spiraled out of control in Benin as in other French-speaking African countries (Baxerres, 2013).
19. The list of medicines included in each of these three classes can be found here: https://fdaghana.gov.gh/wp-content/uploads/2017/06/NEW-DRUG-CLASSIFICATION-LIST.pdf, accessed March 2019.
20. See Law 97-025 of July 18, 1997 on the Control of Drugs and Precursors.
21. These aspects are extensively developed and analyzed in Chapter 3, where the various actors involved in retail distribution in Ghana and Benin are described in detail.
22. In their work on the construction of the antidepressant market in India, Stefan Ecks and Soumita Basu describe how reps behave toward rural practitioners who are not licensed to prescribe these drugs. In that context, informal markets are not a barrier to the reps' activity (Ecks & Basu, 2014).
23. The types of care facilities available in Ghana and Benin are presented in detail in the following chapter.
24. Note that the prices of products reimbursed by the NHIS are set by the NHIS, unlike other products in Ghana whose prices are set by free market forces. Competition between economic actors is therefore not a factor in this specific market segment on prices.
25. Interviewees stated that repayment times have been long from the very inception of the NHIS, and that they have gradually worsened since 2003. This was not the case when the policy at health facilities was "cash and carry" (cost recovery).
26. However, we have seen a tendency for Big Pharma reps to focus more on promoting molecules for the treatment of chronic diseases and mental health and to somewhat neglect the promotion of their older products, which have garnered strong reputations but are now largely generics.
27. Amlor® is the originator product of amlodipine, an antihypertensive patented by Pfizer.
28. Interns are students in their 6th year of medical school while DES [*diplôme d'études spécialisées*] are doctors who have obtained their general practitioner degree and are studying in a specialty field.

29. Source: list of authorized pharmacies in the Republic of Benin, DPMED, January 2018.
30. In Western countries, although firms know just how much they can push to be available without being invasive, the various industry scandals make relations between pharmaceutical representatives and doctors increasingly difficult (Greffion, 2014; Greffion & Breda, 2015).
31. The pharmacist superintendent of a wholesaler-importer in Ghana explained how, to solidify his relationships with health facility administrators, he volunteers his own time to help them prepare bids.
32. Some of our research took place during the Ebola outbreak in West Africa.
33. Jérôme Greffion (2014) explains that there have been three phases of expansion followed by decline in the number of pharmaceutical representatives since 1945. However, the decrease seen from 2005 onward is the largest of these.
34. This observation may perhaps also be explained by French pharmaceutical regulation of wholesale distribution and by the specificity of the "wholesaler-distributor" profession it regulates (see Chapter 3). It should be still noted that these two activities are performed jointly in the large French international groups discussed in this chapter, including in Benin where promotion and distribution must be separated and where companies with a local presence perform one or the other exclusively.
35. An upcoming book by Carine Baxerres focusing on the Ghanaian history and contexts will be dedicated to these dynamics, both pharmaceutical and economic.
36. These dynamics are the subject of the thesis that Stéphanie Mahamé is writing about pharmaceutical representatives and their activities in Benin. It will be defended in 2021 and is jointly supervised by the Abomey-Calavi University of Benin and the EHESS of Paris in France.
37. In a Latin American context, Cory Hayden illustrates the confrontation between representatives of multinational pharmaceutical companies and those of the "similar medicines" industry in Mexican markets (Hayden, 2015).
38. As we have seen, including in Ghana where the NHIS is one of the most successful in Africa, it faces many challenges. These will also be discussed in the next chapter.
39. Quentin Ravelli (2015, p. 36) writes on this subject of the "values of informal use" of drugs, "in particular those of doctors whose scientific authority will then act in domino fashion on the uses of their patients, and subsequently their relatives." In the contexts that we study, the "informal use values" that influence large sections of society are those of all the actors involved to some degree in health care presented in this chapter, in addition to physicians.

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