# Globalisation, Failed States and Pharmaceutical Colonialism in Africa.

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*"All animals are equal, but some animals are more equal than others"*

*(George Orwell, Animal Farm)*

Within the discourse of failed states, is the perennial debate about definitions of what makes a weak or failed state. The capacity of the state to protect its citizens from forces both within and outside its borders is one criterion relevant here. Another criterion is the economic and social vulnerability of the people. The significance of these two criteria of weak states in the age of globalization is because global corporations can take advantage of weak policies and institutions within that state in order to exploit the poverty and to be examined here the case of diseases of the people to use them as 'guinea pigs' in clinical drug trials, in many cases for drugs destined for the western market, for western illnesses.

Indeed the pharmaceutical industry and its operations in developing countries have come to light in the wake of the success and publicity of the film *The Constant Gardener* (2005), based on John le Carre's novel (2001) of the same name, and following from this, the release of Sonia Shah's non-fiction version of the same issues in the *Body Hunter: Testing New Drugs on the World's Poorest Patients* (2006). It will be argued here that this (dysfunctional) marriage between global corporations and weak states, especially across Africa, creates a form of 'pharmaceutical colonialism', that is enabled by the processes of globalization that impact upon the many vulnerable nations that have once endured colonization and now must survive a 'new-colonialism'.

This process, enhanced by globalization, can be clearly seen in the case which inspired John Le Carre's fiction novel *The Constant Gardener*, the case of the clinical drug trials for Trovan (trovafloxacin), tested on children in Kano state, Nigeria in 1996. This

exemplifies opportunities created by globalization for the benefit of pharmaceutical companies to profit from the African poverty. That is, the pharmaceutical company Pfizer exploited a poverty induced medical crisis in Nigeria to extract data and profits, in a medical experiment that left a number of children dead or seriously ill. This is typically a one-way colonial extraction. In 1996 there was an outbreak of meningitis in Kano state Nigeria, that affected thousands of children and Pfizer took advantage of this opportunity to test a new oral antibiotic called Trovan (Trovafloxacin). The problem was, according to SOMO, that "Pfizer arrived several weeks after Médecins Sans Frontières" creating some confusion about their role as doctors and researchers.

> The drug was tested on children without parents' informed consent, patients were unaware of the experiment, and the trial was not approved in advance by an ethical review committee. Out of 190 children that were enrolled in the trial, five receiving trovafloxacin and six receiving the existing treatment ceftriaxone [the injectable Rocephin] died. Others suffered brain damage and paralysis[1].

As Chippaux has noted, the justifications for the study protocols were weak, because they "overlooked the fact that the cost of the product and the limited chances of its commercialization without state subsidy ma[d]e its use in Africa highly unlikely"[2]. According to Shah, there were also warnings from within Pfizer, about the effectiveness of an oral drug on these particular children who were already sick, not only with meningitis but other illnesses, because the pre-existing injectable drug Rocephin worked more rapidly[3]. Despite the results indicating that study drug Trovan was no better than the preexisting drug Rocephin, the problem was that the researchers did not respect the rights of the participants, and as such, South African bioethicist Solomon Benetar has

[1] Somo, "Briefing paper on ethics in clinical trials, #1 Examples of Unethical Trials", February 2008, http://www.somo.nl/html/paginas/pdf/Examples_of_unethical_trials_dec_2006_NL.pdf, (accessed May 14th 2008). Also see Jean-Phillipe Chippaux, "Pharmaceutical Colonialism in Africa" *Le Monde Diplomatique*, August 2005, translated by Donald Hounam, http://mondediplo.com/2005/08/11pharma (accessed 25 March 2008).
[2] Chippaux, 2005
[3] Sonia Shah, *The Body Hunters: Testing New Drugs on the World's Poorest Patients,* (New Press, New York: London, 2006), pp.144-145

argued that this lack of respect is 'colonial'[4], because despite the questionable ethical conduct of this trial in Nigeria, and an unresolved class action put by 30 Nigerian families against Pfizer, the US Food and Drug Administration accepted the data from this trial[5].

From this example, we can ask if the big pharmaceutical companies and their contract research organizations (CROs), are exploiting the citizens of weak and/or developing states due to a failure or lack of ethical policies and rules designed to protect against unethical clinical drug trials? If big pharmaceutical companies can exploit the citizens of weak states, is this because globalization is a hindrance to state strength and of benefit only to global corporations? How can weak African states survive globalization, if globalization means 'pharmaceutical colonialism'? Indeed is 'pharmaceutical colonialism' an indicator of weak or failed states in Africa?

Or do African states support the intervention and investments by pharmaceutical companies trialing new drugs in their health systems? Does it make the state weak for approving clinical drug trials that would not be approved of in the western world, because they provided access to something (some drugs), which was better than nothing (no drugs)? Is this 'better than nothing' approach to health development enabling the Millenium Development Goals of Global Health for All?[6] Or does it signify a patronizing and colonizing outcome for weak and developing states in the age of globalization?

The concept 'pharmaceutical colonialism' surfaces clearly in the literature on these questions and themes (often no more than a simple headline used to capture attention, and more often it is an accusation flung at big pharmaceutical companies for their alleged unethical practices in developing countries). They are also criticized for creating an economic dependence on the west via the creation of a need for life saving drugs against illnesses of poverty, rather than more local remedies or strategies to alleviate poverty. It was an article written by Jean-Phillipe Chippaux entitled "Pharmaceutical Colonialism in

[4] Solomon Benetar quoted by Shah, 2006, p.153. Also see Jeremy Laurance, "The True Story of how multinational drug companies took liberties with African lives", in The Independent/UK, September 26th, 2005.
[5] Shah, 2006, p.153.
[6] see David Bloom "Governing Global Health", in *Finance and Development*, December 2007.

Africa" published in *Le Monde Diplomatique*[7] that appears to consolidate the evidence against pharmaceutical companies in their actions within Africa and other developing countries. While Chippaux has not been the first author to use this term[8], he does appear to be the first to coin the phrase in relation to clinical drug trials in Africa. Within the article he refers to the actions of pharmaceutical companies as 'strategic imperialism'. Either of these terms indicates global power imbalances between developing countries' peoples and global corporations that seek the former out for exploitation of one kind or another. Chippaux's argument is straight forward:

> the developing world is now a place where pharmaceutical companies ignore ethical considerations and the health of patients. Without the informed consent of their subjects who receive only the most basic information and usually inadequate therapeutic supervision, they conduct clinical trials with limited benefits to specific patients or the local population as a whole.[9]

Chippaux's 'strategic imperialism' implies that it is no longer necessary to colonise an entire country, as foreign forces (global pharmaceutical companies) only need to target the specific resource (in this case, poor, sick, treatment naïve populations) in order to extract the profits (data for new drug approvals). Cumbersome colonial administrations have been replaced by the sophisticated and dynamic processes of globalization, which enables corporations (rather than countries) to operate within a nation-state (however

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[7] Chippaux, 2005. Nonetheless, it could also be the result of *Le Monde Diplomatique's* editors coining this term, as it is only used in the title to his article.

[8] Contributing to the discourse on this concept included references claiming that the Pill, or oral contraceptives used "to control the population of ethnic others, smacks of pharmaceutical colonialism". See Sharra Vostral, "Reproduction, Regulation and Body Politics", in *Journal of Women's History*, Summer 2003, Vol.15, Issue 2, p.197. Also, an earlier reference from Milton Silverman et al., describes "Drug Colonialism" as "the wanton manner by which the huge multinational pharmaceutical industry openly extracts an exorbitant profit by knowlingly trading on the health needs and even the lives of Third World nationals". See Zachary Gussow's "Review of 'Prescriptions for death: The Drugging of the Third World' (1982)", in *Medical Anthropology Quarterly*, Vol 14, No. 3, May 1983, pp.24-25. Further evidence on the discourse of 'pharmaceutical colonialism' includes references to the search for new drugs and new biological resources by the pharmaceutical industry as a form of "neo-colonialism". That is, it is simply a "continuation of the colonial tradition of appropriating indigenous knowledge and resources", by extracting knowledge and genetic material from the developing world, in order to benefit the west. See John Merson "Bio-Prospecting or Bio-Piracy: Intellectual Property Rights and Bio-Diversity in a colonial and postcolonial context", in *OSIRIS*, 2nd Series, Vol. 15, Nature and Empire: Science and the Colonial Enterprise, 2000, pp.282-296.

[9] Chippaux, 2005. Also see David Rothman, and Sheila Rothman, *Trust is Not Enough: Bringing Human Rights to Medicine*, (New York Review of Books, New York, 2006).

weak or strong), with or without official invitation or permission, and certainly with little ethical scrutiny[10].

Since 1990 the number of drug trials that have been conducted in developing countries has risen dramatically[11]. There are a number of factors that have led Clinical Research Organisations (CROs), on behalf of pharmaceutical companies to conduct more trials in developing countries. They are the fact that now "80% of deaths from chronic non-communicable diseases now occur in developing countries"[12]; western illnesses have appeared in developing countries like cardiovascular problems (ie there are 20 million Africans suffering from hypertension) and diabetes (ie 90% of the world's diabetes occurs in India and China); and AIDS - being "the first modern infectious disease to strike the developed and developing world simultaneously and to give both a large stake in finding a cure"[13]. Furthermore, these locations are cheaper to operate in, and there are less regulations; also in places like India and China they do have some kind of health infrastructure making them very attractive destinations. Importantly, these larger populations are not as exposed to other treatments – they are 'treatment naïve' – making them ideal participants for various drug trials. As Shah has pointed out these factors create great opportunities for drug trials to be conducted in those areas[14], in particular because CROs can test more drugs relevant to the western markets[15].

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[10] Ethical considerations and regulations in relation to medical experiments and in particular pharmaceutical testing around the world, have been slow to develop and often only "in reaction to scandals and accidents" ( See Jean-Phillipe Chippaux, 2005). For example, the Nuremberg code was only adopted after the horrific experiments conducted by Nazis during the Holocaust ( See David Rothman and Sheila Rothman, 2006). In 1964 the Helsinki Declaration was adopted as the next international regulatory model. And the 1981 Manila Declaration was aimed at clinical trials in developing countries. The problem with any of the recommendations made to ensure participants in trials are informed and give consent, is that they are "only recommendations and no sanctions [a]re proposed" (See Chippaux, 2005).

[11] Jean-Phillipe Chippaux, 2005: David Boath cited in Patrick McGee "Clinical Trials on the Move" Drug Discovery & Development - June 12, 2006 http://www.dddmag.com/clinical-trials-on-the-move.aspx : accessed May 9th 2008: Patrick McGee, 2006: See Peter Lurie and Sidney Wolfe, "Unethical Trials of Interventions to Reduce Perinatal Transmission of the Human Immunodeficiency Virus in Developing Countries", *New England Journal of Medicine*, Vol. 337, September 18, 1997, pp.853-856

[12] Sonia Shah, "Outsourcing risks: testing new drugs on the world's poor", in *Le Monde Diplomatique*, June, 2007, accessed from www.global-sisterhood-network.org/content/view/1800/59/ March 25th 2008.

[13] Rothman and Rothman

[14] Sonia Shah, June 2007. Particularly popular are placebo trials that can quickly demonstrate that those given the active drug have fewer adverse events than those who do not (in the placebo arm), and this latter group need to have these events (eg. heart attacks) to prove that the drugs works. Shah also points out that up to and over 40% of volunteers in trials in the west drop out or refuse to participate. This demonstrates

The Quintiles website for example, boasts of their ability to access patients from 'non-traditional regions' -

> For faster trials, start farther from home: More and more customers are discovering the advantages of conducting trials in the diverse nontraditional regions of the world, where patient populations, well-trained investigators and high-quality communications systems are readily available[16].

As a type of 'strategic imperialism' in Africa it may not be as dominant as the scramble for Africa, because despite African countries being amongst the poorest and most disease burdened developing nations of the world, in 2001 only 1% of clinical trials were conducted in Africa[17], and it is the other developing regions that are deemed more suitable, for example, in India which has a "1 billion body bounty"[18]. Nonetheless, despite there being lesser opportunities in Africa, there are many notable exceptions and examples where these poorest and weakest countries have offered valuable 'data' to drug development companies and indeed future profits for the 'imperial' pharmaceutical corporations. For example, in 2003 CROs started flocking to South Africa where "cashed starved medical facilities welcomed them with open arms"[19].

Chippaux argues that Africa will be targeted by 'unscrupulous' drug companies seeking quick and cheap locations with fewer regulations to test their drugs[20]. The view is that African populations have less access to drugs, and while any existing health structures are weak at best, they still create ideal "epidemiological conditions" for clinical trials[21].

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that in developing countries where the retention rates are much higher, they cannot be fully aware of their volunteer status, or indeed they are not voluntarily consenting in the first place.

[15] David Rothman and Sheila Rothman, 2006, p.69.

[16] Quintiles website: http://www.quintiles.com/SpotlightPages/PatientAccess.htm (accessed March 25th 2008).

[17] Chippaux, 2005.

[18] Shah, 2006, p.112. Also see Marcia Angell, *The Truth About the Drug Companies: How they deceive us and what to do about it*, (Random House, New York, 2004).

[19] Shah, 2006, p.104

[20] Chippaux, 2005.

[21] See Quintiles website, www.quintiles.com/Locations/Africa/SouthAfrica/ (accessed March 25th 2008): and Shah, 2006.

The major problem or ethical consideration is not so much the number of trials but the relevance of the drugs being trialed on African populations[22]. Are they drugs aimed for use in the African or western markets? For example, between 1972 and 1997 there were 1,450 new medicines marketed globally, but "only 13 were for tropical diseases"[23]. Most African governments do not have any ability to control which drugs get tested in their countries, since it is the pharmaceutical industry that 'finances and organises' these trials. As Joel Lexchin has pointed to the obvious, "the primary obligation of pharmaceutical corporations is to their shareholders, not to the people of the developing world"[24]. It is simply about profit extraction – 'strategic imperialism'! According to Chippaux "by the end of the 1990s the pharmaceutical industry's global turnover ($480bn) was greater than the GDP of all of the countries of Sub-Saharan Africa ($380bn)"[25].

Nundy and Gulhati have argued that this new focus on outsourcing clinical trials to these developing countries is a 'new colonialism', and it seems to be an indicator of a 'weak state' in particular, in relation to its health systems apparatus[26]. As Shah argues, often even just the availability of clinical trials in developing countries is perceived as offering better health care than local health systems can provide[27]. For example, in a Quintiles Fact Sheet on South Africa it claims that,

> Clinical trials in South Africa can be a blessing to patients as well as a boon to sponsors. First, they provide access to sophisticated care for a large portion of the

[22] While the 1990s and 2000s have seen critics lambaste the unethical conduct of pharmaceutical companies testing drugs in developing countries, the literature and the critics of the pharmaceutical industry in the 1980s tended to focus on the issue of the pharmaceutical corporation's responsibility in providing relevant drugs to the developing world, and not to allow them to become the dumping ground for drugs not legal or not prescribed in the west. See Mike Muller, *The Health of Nations: A North-South Investigation*, (Faber and Faber, London, 1982); Dianna Melrose, *Bitter Pills: Medicines and the Third World Poor*, (Oxfam, Oxford, 1982);Surendra Patel (ed) *Pharmaceuticals and Health in the Third World*, (Pergamon Press, Oxford, 1983; and also ee Shah, 2006, p.103.

[23] see P.Trouillet et al., "Is Orphan Drug Status Beneficial to Tropical Disease Control?", in *Tropical Medicine and International Health*", Oxford, Vol. 4, 1999, pp. 412-420, cited in Chippaux 2005.

[24] Joel Lexchin, "Ethics, Drugs and the Developing World: What we should expect of the pharmaceutical industry?" Seminar presented to the Ethics Centre of South Australia, Tuesday May 6th, 2008, Adelaide.

[25] Chippaux, 2005.

[26] The drugs being tested are usually either not relevant to the future market setting within those countries, or if they are relevant they are marketed too expensive so become unaffordable to the majority of the population. This lack of relevancy is unethical according to these authors, because it is of no benefit to those societies. See Samiram Nundy and Chandra Gulhati, "A New Colonialism? – Conducting Clinical Trials in India", *The New England Journal of Medicine,* Vol. 352, Iss. 16, (April 21, 2005), pp.1634.

[27] Shah, June 2007.

> population that generally receives only basic medical services and many who have not received previous treatment.[28]

If clinical trials are seen as beneficial to 'medicine deprived' populations, and often "the only way they can get treatment"[29], this suggests that a global pharmaceutical company can provide (strong) services to a (weak) state's people. Is this considered a type of 'welcomed' colonization? Does the global replace the local in terms of the state's responsibilities for its own citizens? However, the fact that the reason for a drug trial is to test its effectiveness which is unproven, hence the need for the trial, determines that it cannot be claimed that patients will be better off if they participate in a trial[30], and as such that said service cannot replace the role of the (ideal) state. Yet, the CRO will still benefit from the data produced, and thus it becomes undeniably a new type of colonial exploitation.

If we accept the argument that CROs and pharmaceutical companies are attempting a form of colonization in Africa, whether it is welcomed by them or not, what are the possible problems associated with that? Firstly, Megan Vaughan offers historical evidence for the perceived 'pharmaceutical colonialism' in Africa and explains one problem as the resistance to AIDS prevention techniques, such as using condoms[31]. She argues that these theories of 'colonialism' emanate from African fears, naivety and misconceptions surrounding vaccinations and other medicines from the west that are promoted for use on African populations. Relevant here is the issue that with the colonization of Africa came a world view about modern bioscience and medicine which was at odds with and clashed with African culture and 'primitive' explanations for disease and subsequent cures. There is no space to entertain the notion of a 'good' strategic colonization (or imperialism). Thus, claims of a 'pharmaceutical colonialism' can cause an anti-western / anti-colonial reaction that is detrimental to the benefits that can be offered by western biomedicine within the gambit of any foreign intervention –

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[28] Quintiles *Fact Sheet: Patient Access: South Africa*, www.quintiles.com
[29] Shah, 2006, p.36.
[30] Shah, June 2007.
[31] Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness*, (Polity Press, Cambridge, 1991).

such as life saving drugs - the 'good' aspects of this perceived 'colonisation'. If exposed to media and public scrutiny as in the Trovan case above, an unintended result of these unethically conducted clinical trials in developing countries can be that western medicine is undermined. For example, in the late 1990s the polio vaccine was rejected in Nigeria, and HIV/AIDS drugs were 'condemned' by the South African government.

This has led to a persuasive (but only to some) account of 'pharmaceutical colonialism', which has come from the title of a book written by Dr. Mathias Rath in South Africa – *End AIDS! Break the Chains of Pharmaceutical Colonialism*. Denounced by medical experts, this book argues that anti-retroviral drugs attack and destroy the body's immune system and it accuses the pharmaceutical industry of using poor countries as a market place for their "toxic and often deadly drugs"[32]. The authors argue that while there is political freedom in South Africa, "it is still been kept hostage by global economic interests, namely pharmaceutical colonialism"[33]. This book reeks of conspiracy theories and lays claim to the debate on the benefits of natural health in combating AIDS, rather than the expensive drugs promoted by the global pharmaceutical industry. Indeed the text of this book and the evidence cited really do not warrant any academic respect, but does need to be examined in its political context in how it influenced government policy to refuse proven drug therapies for AIDS treatment. The former President of South Africa, Thabo Mbeki and his Minister for Health, Peggy Nkonyeni, conferred that HIV does not cause AIDS, anti-retrovirals are toxic, and are no cure for AIDS. Thus, instead of approving the use of proven AIDS drugs, such as Nevaripine[34], they wanted to promote indigenous and affordable remedies such as micronutrients, garlic, potatoes, lemon and olive oil - eating fresh vegetables to boost your immune system. Not coincidentally, the book argues that AIDS is merely a "giant business opportunity" for

[32] cited in Celia Dugger, "Rift over AIDS Treatment Lingers in South Africa", *New York Times*, March 9th, 2008, p.A8
[33] Dr. Rath Health Foundation, *End Aids: Break the Chains of Pharmaceutical Colonialism*, South African National Civic Organsiation (SANCO), 2006, www.dr-rath-foundation.org.za (accessed March 2008).
[34] See Shah, 2006, p.104

foreign pharmaceutical companies, who want AIDS to spread so they can market their drugs, and force African governments to pay for them[35].

The basic premise of the Rath Foundation book is flawed. It argues that pharmaceutical colonialism is occurring as the continuation of other colonial legacies such as poverty and malnutrition – and these are the "preconditions … being strategically used by the pharmaceutical investment business to conquer and expand these markets for their patented drugs" [36]. The book's emphasis is on economic dependency with the west, and that pharmaceutical colonialism is disguised as "charity for people in need … suffering from diseases", and has "infiltrated government bodies, corporate structures and civil society in many countries", and it can be "recognized by their common denominator, they all seek to cement and expand the monopoly of the investment business with patented pharmaceutical drugs on global health"[37].

The Rath Foundation book does not mention the practice of unethical drug trials in Africa, as a source of this 'colonisation', and instead offers a notable divergence to the debate and definition of pharmaceutical colonialism put forward by Chippaux. Overall, Rath's arguments cannot be taken seriously, but some of the conclusions are similar. Indeed, it is more likely that the anti-retrovirals and other drugs designed to combat HIV/AIDS are simply being tested in Africa and elsewhere, so that they can be sold to those who can afford them in the west, either western HIV/AIDs patients, or to philanthropic organizations (who may redistribute them within Africa). In practice, there is no incentive for the pharmaceutical industry to colonise Africa to market its drugs (as Rath claims), because there is no profit to be made[38]. Indeed, the pharmaceutical industry now relies upon philanthropic organizations such as Bill and Melinda Gates

[35] See Steven Friedman and Shauna Mottiar "A Rewarding Engagement? The Treatment Action Campaign and the Politics of HIV/AIDS", in *Politics and Society*, Vol.33, no.4, December 2005, pp.511-565
[36] Dr. Rath Health Foundation, pp.28-30.
[37] Dr. Rath Health Foundation, p.32
[38] It is not in the financial interests of a drug company to develop a drug that cannot be marketed in the west. Only 1% of available drugs are designed to combat tropical diseases. If the pharmaceutical industry is setting out to find a cure for HIV/AIDS, or other tropical diseases, they claim it is for the 'greater global good', even if only to curtail global health security threats to the west, and not any altruistic good to help poor people.

Foundation to create financial incentives through public/private partnerships to invest in AIDS drugs development, in order to help curtail the spread of HIV in Africa[39].

Therefore, in our attempts to define the concept of pharmaceutical colonialism in Africa, we can now ignore the components of the argument offered by the Rath Foundation, and instead focus our attention on more recent and realistic problems facing the continent in light of unethical drug trials. When Sonia Shah published her book *The Body Hunters: Testing New Drugs on the World's Poorest Patients* in 2006, the concept of 'pharmaceutical colonialism' and the associated unethical actions of global pharmaceutical corporations came together. However, given the above discussion on the various definitions of 'pharmaceutical colonialism, could it also be defined in relation to 'do-gooder'[40] or 'missionary' style colonialism, interventions to save the 'heathens' from their own 'savagery' and 'disease'?

For example, the pharmaceutical industry does have drugs that can help prevent the transmission of HIV/AIDS between mother and baby, and Africa has a very large market for them. The problem of course is financial and political within Africa to afford such modern medical wonders. For example, when South Africa, arguably the strongest state on the African continent, refuses to allow its citizens access to proven western medicines (for whatever political or economic motivations), due to the costs of this 'colonialism' (the costs of the expensive anti-retroviral drugs), and instead they subscribe to the anti-colonial views of the Dr. Rath Foundation, what does this conclude therefore about the role of global pharmaceutical companies in the (re)colonization of, or strategic imperialism in, Africa? Indeed what does it say about the strength of a state to protects its citizens from pandemic diseases? Bob Marsella summarises the answers when he posited the reason for Thabo Mbeki's rejection of successful anti-retroviral drugs, in that

[39] See Bloom, 2007, p.37; Rothman and Rothman, 2006, p.87; Shah, 2006, pp.165-166; and see Nana Poku, "The Global AIDS Fund: Context and Opportunity", in Nana Poku and Alan Whiteside, eds., *Global Health Governance: HIV/AIDS*, (Palgrave, MacMillan, New York, 2004).

[40] Martha Nussbaum first refers to "do-gooder colonialism" in her "Introduction", in Nussbaum M, Glover J., eds., *Women, culture and development: a study of human capabilities*, (Oxford, Clarendon Press, 1995), p.4; cited in Leila Toivianen, "Editorial Comment", *Nursing Ethics*, 14, 6, (2007), pp. 715.

it was "more a question of: what are they going to do with all of those orphans and how are they going to support them when their parents both die?"[41]

However, are these best-intentions interventions by global philanthropists such as the Bill and Melinda Gates Foundation, and other PPPs also part of this 'colonisation project'? Are their actions patronizing, colonizing or simply caring? Is this 'do-gooder' colonialism, welcomed by the colonized? Skeptical opponents to western medicine (such as the Dr. Rath Foundation) would reject these interventions as a form of 'genocide'[42]. Sonia Shah has argued that although the quest for simple solutions driven by the PPPs is noble and could improve the lives of people in developing countries, these actions,

> do little to extract the poor from their health care-deprived environments bereft of clean water and electricity. On the contrary, in effect they engineer ways for people to survive them indefinitely[43].

A case of damned if you do and damned if you don't!

However, when the state cannot protect its citizens against encroaching disease epidemics or pandemics (because they are weak states), is there a role for foreign intervention from, for example, philanthropic organizations, even if these interventions result in unethical drug trials, and even if they result in a type of colonization? The dilemma for the drug industry is that while African countries offer a potentially huge market for antiretroviral drugs to combat HIV/AIDS, they simply cannot afford to pay for them, and so they do not invest in the research and development necessary to help them[44]. Hence, this is the role for global philanthropists to provide this incentive to continue research and development into such diseases that affect more people in developing countries, and to promote the strategies to try and provide cheaper generic drugs to those populations.

Perhaps part of the problem could arise from one of the hallmarks of the anti-globalisation tirade, in that these philanthropists and other PPPs are not democratically

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[41] Bob Marsella quoted in Shah, 2006, p.108
[42] The Rath Foundation, pp.80-83
[43] Shah, 2006, p.166
[44] Caroline Thomas, "Trade Policy and the Politics of Access to Drugs", in Nana Poku and Alan Whiteside, eds., *Global Health Governance: HIV/AIDS*, (Palgrave, MacMillan, New York, 2004).

elected representatives of any countries, yet their budgets are bigger (and yes, in some cases their hearts!). While the Gates Foundation donated over $6 billion in 1999, "the entire annual budget of the World Health Organisation is less than $1 billion"[45]. Do we trust or fear these unelected players? Is it 'for their own good' that we must intervene and assist, or should we ignore the plight of millions of Africans suffering from the effects of HIV and other diseases on their lives, and indeed deaths, simply because their 'elected' leaders reject foreign intervention (on whatever grounds)?

In getting the mixture of good intentions and perceived 'colonialism' (or strategic imperialism) right in this new millennium (nearly three decades after fears of pharmaceutical colonialism emerge from the third world), can the Public-Private Partnerships (PPPs) themselves instead be seen as "potentially radical new systems of global governance"[46], and thus play a central role in improving global health for all, where states cannot? Indeed, it would seem that the existence of PPPs reflects a weakness of the state to provide for its citizens, in which case the fears of pharmaceutical colonialism or strategic imperialism are based on the concern that these global players are taking advantage of the weakness in the nation-state with the aim to profit only from the relationship. Tony Evans argues that it has been globalization that has eroded the capacity of the state to provide for its own citizens and therefore,

> the state may no longer possess the capabilities to support the social determinants of health. Whereas people once looked to their own state ordered institutions to provide the infrastructures for organizing economic, social and cultural life today the conditions of globalization have seen the creation of a global order where corporate and financial interests prevail over the interests of populations[47].

Arguably, many African states have never been strong or successful enough to provide such order (and health systems), either during colonialism or in the post-colonial period.

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[45] Nana Poku and Alan Whiteside, eds., *Global Health Governance: HIV/AIDS*, (Palgrave, MacMillan, New York, 2004), p.2.
[46] See K. Buse and G. Walt, "Global Public-Private Partnerships: Part 2 – What are the Issues for Global Governance?" in *Bulletin of the World Health Organisation*, July 2000, cited in Poku and Whiteside, (2004), p. 2.
[47] Tony Evans, "A Human Right to Health?", in, Nana Poku and Alan Whiteside, (eds) *Global Health Governance: HIV/AIDS*, (Palgrave, MacMillan, New York, 2004), p.19.

Thus it is a common global order within Africa that foreign, corporate financial interests have prevailed.

We can now juxtapose the image of the 'great white hunter' from colonial Africa, with the pharmaceutical 'body hunters' of today. Pharmaceutical corporations are 'colonizing' African countries and other developing regions to some extent, however strategically. Poor and disease burdened people from developing countries are being exploited for resource extraction through the processes of globalisation and pharmaceutical colonialism. Contract Research Organizations taking advantage of the processes of globalization have outsourced clinical trials to developing countries, and enlisted as 'subjects' the world's poorest, most disease burdened and vulnerable communities. In the various drug trials that have been conducted (such as for Tenofovir[48] and Nitazoxanide[49]) participant's bodies become colonial subjects. Rothman and Rothman note that "abject poverty is harsh enough without having to bear the additional burdens of serving as research subjects"[50], but that is the harsh reality of globalisation on developing countries. However, unlike the 'Scramble for Africa' in 1885, the pharmaceutical industry these days does not need to colonise any of these countries, because they can still get their data simply through the processes of globalization[51], combined with a 'strategic imperialism', which "imposes rules upon the poor without their consent"[52]. Chippaux points out the existence of an "unacceptable relativism", which argues that you cannot "apply the rules of the rich to those who are not in a position to endorse them"[53]. Just because they are poor, black Africans susceptible to disease, but without a strong state with strict health guidelines and ethical regulations, does not mean that they can be exploited for experimentation, and be 'volunteered' as subjects in drug trials to benefit others, and indeed drug trials that would not be approved of in the west, and if so, would find no volunteers there.

[48] See Chippaux 2005; and Somo, February 2008.
[49] See Shah, 2006, p.19.
[50] Rothman and Rothman, 2006, p.74
[51] See Shah, January 31, 2007
[52] Chippaux, 2005
[53] Chippaux, 2005

Ironically, medical research is about improving global health for all, and saving lives. As Rothman and Rothman illustrate, AIDS researchers have argued that AIDS "is so dreadful … [they] must be given a relatively free hand in order to find useful treatments"[54]. Are those researchers who are conducting trials of questionable ethics 'enthusiastic or reluctant colonisers'?[55] This is the patronizing colonial project – ultimately it is for their own good, that some must suffer. But this has resulted in "exploitation and human rights violations"[56], where profit driven pharmaceutical corporations can take advantage of the developing world, "not to cure AIDS but to increase their returns"[57]. After all they are businesses, not charities. There is no time for altruistic participants to come forth to develop new drugs. Profits are required now. This is central to the concept of 'pharmaceutical colonialism'.

If the economic conditions were different, and African governments could afford western standards of health care and buy the drugs necessary for the best method of treatment, for whatever disease or illness, would the CROs still prefer those populations to test their drugs? Without needing to agree to the outrageous claims made by the Rath Foundation, the processes involved in global clinical trials do suggest that globalization enables pharmaceutical colonialism in weak states.

Thus, it would seem that the relationship between the global pharmaceutical corporations and the potential pool of bodies available to them in the developing world is not just simply 'colonial'. If the pharmaceutical company was colonizing the country (or its people) then they would be able to control or manipulate local governments for the purpose of their exploitative resource extraction (human bio-data). However, it is more a process of globalization because it can also involve the actions of the local government or associated health institutions, doing deals with the big pharmaceutical companies to invest in their ailing health infrastructure at whatever costs to the pool of poor human resources. If the local government approves of the 'foreign intervention' (through the

[54] Rothman and Rothman, 2006, p.73
[55] Perhaps one could ask those Pfizer researchers eventually arrested in Nigeria over the Trovan trials in Kano, 1996.
[56] Shah, 2006, p.175
[57] Rothman and Rothman, 2006, p.73

existence of an ethics committee), invites the pharmaceutical company to test its drugs (in return for something, like access to drugs, a new medical ward, or a Mercedes) then this suggests a combination of globalization and colonialism is at work in the activities of the global pharmaceutical industry. The concept of "globonialism" could thus be coined here, as a short hand term for the global activities of clinical research organizations, exploiting poor people in developing countries with dubious and unethical clinical drug trials, that intend only to benefit markets in the west. However, what is more likely is that Chippaux's 'strategic imperialism' will continue in weak nations, while global corporations gain increased strength through increased profits.

**Bibliography**

*Australian National Statement on Ethical Conduct in Human Research* (2007)

Angell, Marcia, "The Ethics of Clinical Research in the Third World", in *New England Journal of Medicine*, Vol. 337, 1997, pp.847-849

Angell, Marcia, "Excess in the Pharmaceutical Industry", in *Canadian Medical Association Journal*, December 7, 2004, 171(12), p.1451-1453

Angell, Marcia *The Truth About the Drug Companies: How they deceive us and what to do about it*, Random House, New York, 2004

Bloom, David "Governing Global Health", in *Finance and Development*, December 2007.

Chippaux, Jean-Phillipe, "Pharmaceutical Colonialism in Africa" *Le Monde Diplomatique*, August 2005, translated by Donald Hounam, accessed from http://mondediplo.com/2005/08/11pharma, accessed March 25, 2008

Dugger, Celia, "Rift over AIDS Treatment Lingers in South Africa", *New York Times*, March 9th, 2008, p.A8

Evans, Tony, "A Human Right to Health?", in Poku, Nana and Whiteside, Alan (eds) *Global Health Governance: HIV/AIDS*, Palgrave, MacMillan, New York, 2004.

Friedman, Steven and Mottiar, Shauna, "A Rewarding Engagement? The Treatment Action Campaign and the Politics of HIV/AIDS", in *Politics and Society*, Vol.33, no.4, December 2005, pp.511-565

Gussow, Zachary, "Review of 'Prescriptions for death: The Drugging of the Third World' (1982)", in *Medical Anthropology Quarterly*, Vol 14, No. 3, May 1983, pp.24-25

Halsey, Neal et al. "Ethics and International Research: research Standards are the same throughout the world; Medical care is not", *British Medical Journal*, October 18, 1997

Laurance, Jeremy, "The True Story of how multinational drug companies took liberties with African lives", in *The Independent/UK*, September 26th, 2005.

Lexchin, Joel, "Ethics, Drugs and the Developing World: What we should expect of the pharmaceutical industry?" Seminar presented to the Ethics Centre of South Australia, Tuesday May 6th, 2008, Adelaide.

Lurie, Peter and Wolfe, Sidney, "Unethical Trials of Interventions to Reduce Perinatal Transmission of the Human Immunodeficiency Virus in Developing Countries", *New England Journal of Medicine*, Vol. 337, 1997, pp.853-856

Mangquku, Luleka, "Drug Trials Raise Concern", *eAfrica*, March 2005, South African Institute of International Affairs, www.saiia.org.za/modules.php?op=modload&name=News&file=article&sid=546 accessed May 2nd 2008.

Menikoff, Jerry and Richards, Edward, *What the Doctor Didn't Say: The Hidden Truth About Medical Research*, Oxford University Press, Oxford: New York, 2006

Merson, John, "Bio-Prospecting or Bio-Piracy: Intellectual Property Rights and Bio-Diversity in a colonial and postcolonial context", in *OSIRIS*, 2nd Series, Vol. 15, Nature and Empire: Science and the Colonial Enterprise, 2000, pp.282-296

McGee, Patrick "Clinical Trials on the Move" *Drug Discovery & Development,*June 12, 2006 http://www.dddmag.com/clinical-trials-on-the-move.aspx, accessed May 9th 2008.

Melrose, Dianna, *Bitter Pills: Medicines and the Third World Poor*, Oxfam, Oxford, 1982

Muller, Mike, *The Health of Nations: A North-South Investigation*, Faber and Faber, London, 1982

Nundy, Samiram and Gulhati, Chandra, "A New Colonialism? – Conducting Clinical Trials in India", *The New England Journal of Medicine,* April 21, 2005, Vol. 352, Iss. 16, pp. 1633-1636

Patel, Surendra (ed) *Pharmaceuticals and Health in the Third World*, Pergamon Press, Oxford, 1983

Poku, Nana, "The Global AIDS Fund: Context and Opportunity", in Poku, Nana and Whiteside, Alan (eds) *Global Health Governance: HIV/AIDS*, Palgrave, MacMillan, New York, 2004.

Poku, Nana and Whiteside, Alan (eds) *Global Health Governance: HIV/AIDS*, Palgrave, MacMillan, New York, 2004.

Quintiles website: http://www.quintiles.com/SpotlightPages/PatientAccess.htm, accessed May 9th 2008

Quintiles *Fact Sheet: Patient Access: South Africa*, www.quintiles.com, accessed May 9th 2008

Rath Health Foundation, *End Aids: Break the Chains of Pharmaceutical Colonialism*, South African National Civic Organsiation (SANCO), 2006, www.dr-rath-foundation.org.za (accessed March 2008)

Rothman, David and Rothman, Sheila, *Trust is Not Enough: Bringing Human Rights to Medicine*, New York Review of Books, New York, 2006.

Shah, Sonia, *The Body Hunters: Testing New Drugs on the World's Poorest Patients,* New Press, New York: London, 2006

Sonia Shah, "Body Hunting: The Outsourcing of Drug Trials", January 31, 2007, www.theglobalist.com/DBWeb/StoryId_aspx?StoryId=5637 accessed May 2nd 2008

Shah, Sonia, "Outsourcing risks: testing new drugs on the world's poor", in *Le Monde Diplomatique*, June, 2007, accessed from www.global-sisterhood-network.org/content/view/1800/59/ March 25th 2008.

Somo, "Briefing paper on ethics in clinical trials, #1 Examples of Unethical Trials", February 2008, http://www.somo.nl/html/paginas/pdf/Examples_of_unethical_trials_dec_2006_NL.pdf, accessed May 14th 2008

Thomas, Caroline, "Trade Policy and the Politics of Access to Drugs", in Nana Poku and Alan Whiteside (eds) *Global Health Governance: HIV/AIDS*, Palgrave, MacMillan, New York, 2004.

Leila Toivianen, "Editorial Comment", *Nursing Ethics*, 2007, 14, 6, pp.713-715.

Varmus, H. and Satcher, D. "Ethical Complexities of Conducting research in Developing Countries", in *New England Journal of Medicine*, Vol. 337, 1997, pp,1003-1005

Vaughan, Megan, *Curing Their Ills: Colonial Power and African Illness*, Polity Press, Cambridge, 1991.

Vostral, Sharra, "Reproduction, Regulation and Body Politics", in *Journal of Women's History*, Summer 2003, Vol.15, Issue 2 pp.197-209

Zumla, Alimuddin and Costello, Anthony, "Ethics of healthcare research in developing countries" *Journal of the Royal Society of Medicine*. 2002 June; 95(6): 275–276.