

# Gender and Health: A Social Movement's Agenda for Big Pharma

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## **Abstract:**

Social movements have an important new campaigning and organizing competence in new information communication technologies. These technologies also enable the members of social movements to readily research the accuracy of information: knowledge becomes globalized and readily accessible. In relation to Big Pharma, women's social movements and social movements of the medicated intersect, and there is now a substantial challenge to Big Pharma both within developed and developing countries from the terrain of gender and health. This paper documents those challenges and looks towards their consequences in the future both in respect of Big Pharma but also in terms of 'academic' research.

## **1. Introduction: Health, gender and the globalizing of knowledge**

Not one of the chief scientists or heads of research at any of the major pharmaceutical companies is a woman. Why that's the case is much less clear. (<http://www.sciencemag.org/cgi/content/summary/309/5735/724>)

Let's start by visiting the International People's Health University, an on-line facility operated from Nicaragua (<http://www.phmovement.org/iphu/>) and one of its courses (<http://www.phmovement.org/iphu/en/short>). We can see that not only is health knowledge being globalised but there are social movements which are strategizing the globalization of health knowledge. The International People's Health University provides resources and training for health activists on a global platform and within its concerns are issues of gender and health. It provides courses and knowledge on the range of global health action and in doing so counteracts and compensates for inequitable health practices by other organizations, institutions and agencies.

The new information communication technologies provide a new space for discourse and organization by activists and new parameters for action and challenge. On-line activist health personnel linked to universities provide one form of new social action in health, global social movements and meeting the challenge of AIDS/HIV provides another (<http://www.globalaidsalliance.org/>). Health organizing through and around web sites generates open and searchable knowledge: it creates paths to knowledge for those affected by health conditions

and prevents such knowledge from being confined to the professional portfolios of experts.

In this context, Big Pharma has come under challenge and within this challenge it is recognized that there has been a persisting gender bias of drug development consistent with the decade-old medicalizing of women's bodies ([http://www.thenhf.com/articles\\_169.htm](http://www.thenhf.com/articles_169.htm) ; <http://orlando.women.it/quarta/workshops/epistemological4/pizzini.htm> ). But even as Big Pharma comes under challenge, and there are indeed signs of the success of activist challenge to the industry<sup>1</sup>, Big Pharma pushes into new domains and engulfs traditional areas of women's power and health knowledge. The regulation of food supplements, and its removal of many traditional food supplements from the marketplace altogether, can be viewed as an undermining of the last bastion of the alternative modality of the health knowledge of women - the unregulated traditional health space of 'wise women'<sup>2</sup> has finally disappeared ([http://www.naturalnews.com/027297\\_corn\\_food\\_the\\_FDA.html](http://www.naturalnews.com/027297_corn_food_the_FDA.html) ; <http://www.newswithviews.com/Howenstine/james24.htm> ; [http://www.newmediaexplorer.org/sepp/2005/07/12/european\\_court\\_decides\\_food\\_supplements\\_directive\\_may\\_go\\_ahead.htm](http://www.newmediaexplorer.org/sepp/2005/07/12/european_court_decides_food_supplements_directive_may_go_ahead.htm) ).

The loss of women's power over health practice through the masculinization, medicalization and regulation of health over centuries is now, however, under challenge by women's increasing power as consumers and by their knowledge of health matters as trained professional practitioners and through new information communication technologies. Social movements around gender and health are now a feature of the modern political scene (<http://www.womens.studies.uconn.edu/ManishaDesai1100028a.pdf> ) and have consequences for the commercialization of medicine and treatment. Social justice issues have been firmly placed on the Big Pharma agenda.

## **2. HIV/AIDS: From pricing out survival to ensuring gender equity in provision**

A major challenge to the pharmaceutical industry has lain in the pressure orchestrated by social movements and developing countries around the costs of HIV/AIDS medication (Little and Grieco, 2006). Brazil, India and South Africa are

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<sup>1</sup> Drug companies have recognized the problem. This is clear because they have promised to make drugs affordable and available to those living in poverty in the Global South. But so far they have taken few concrete steps to realize this promise—and those they have taken, like Gilead's extension of its Access Program under pressure from activists, aren't enough. HIV/AIDS drugs remain highly cost prohibitive. Pharmaceutical companies refuse to grant licenses to allow generic drugs to be produced, which would significantly reduce prices and increase access to lifesaving medications. [http://www.globalaidsalliance.org/cd\\_action.cfm](http://www.globalaidsalliance.org/cd_action.cfm) (decayed link).

<sup>2</sup> <http://www.susunweed.com/susunweedarticles.htm#an1>

all locations where Big Pharma has lost substantial ground around its traditional pricing policies which effectively priced out the survival of the affected in the Third World. But these gains are not yet sufficient to ensure that the coverage given meets the epidemic character of the problem and there are real concerns that women are not well placed to obtain their share of coverage where coverage is made available.

The involvement of the US government in the 'war on HIV/AIDS' has both produced resources for tackling the epidemic but has also created new and negative pressures on women's reproductive health and well being. The restrictions placed on health clinics result in those clinics which provide abortions not being eligible for the available US resources and the focus on funding abstinence campaigns draws resources away from treatment possibilities. In its war on HIV/AIDS the US government invoked a close relationship with Big Pharma by its hiring of Randall Tobias, a major Big Pharma player, to be the US Global AIDS Coordinator – a post which carries Ambassadorial Status. The placing of the US international HIV/AIDS program in the hands of the previous 'head (of) Eli Lilly and Company, one of our nation's largest and most innovative pharmaceutical companies' by the Bush administration raised many questions about the program in a context where Big Pharma continues to receive a very negative press for its high pricing of critical drugs and high profitabilities in the health sector.

The restrictions around the US HIV/AIDS program and the proximity of the leadership of this program to the structures and interests of Big Pharma make the issue of HIV/ AIDS prevention, treatment and coverage in respect of women particularly important. One justification for the involvement of a Big Pharma player might be that such a player has the ability to identify issues concerning HIV/AIDS that Big Pharma is well placed to address and innovate. Research into differences in male and female patterns of exposure in Africa and the development of drug marketing programs which better reach women are two areas in which we might hope to see developments. It is not clear that an over-concentrated focus on abstinence will deliver either of these.

There are many and useful discussions of the extent to which HIV/AIDS can be classified as women's disease within Africa - for example, there are particular features of the female body which make women more vulnerable to the disease (<http://appweb.cortland.edu/ojs/index.php/Wagadu/article/view/242/448> ). The involvement of Big Pharma in research which would better protect women given these differences would represent a useful contribution to the new declared social agenda of eradicating AIDS.

Concerns about ensuring gender equity in the treatment of AIDS most particularly within US funded treatment initiatives have found public and visible expression: the Center For Gender and Health Equity has its 2004 submission to Tobias Randall, the then US Global AIDS coordinator on the web (see Gender,

AIDS, and ARV Therapies: Ensuring that Women Gain Equitable Access to Drugs within U.S. Funded Treatment Initiatives  
(<http://www.genderhealth.org/pubs/TreatmentAccessFeb2004.pdf> ).

**Box 1: Putting the facts on the US agenda: an excerpt**

On February 20<sup>th</sup>, 2004, the Office of the Global AIDS Coordinator at the U.S. Department of State will make public the draft strategy guiding implementation of U.S. global AIDS policies authorized by the United States Leadership Against AIDS, TB, and Malaria Act of 2003 (.AIDS Act, P.L. 108-25). The law tasks the Global Coordinator with developing programs to provide antiretroviral (ARV) treatment to at least 2 million individuals by the end of 2006 (with a goal of reaching 500,000 people with ARV treatment by the end of 2004) (AIDS Act §402 (a)). In support of the Coordinator's strategy, Congress has provided \$2.4 billion for global AIDS initiatives in 2004 (Consolidated Appropriations Act, 2004, P.L. 108-199) and directs that 55% of these monies be used for the treatment of individuals with HIV/AIDS (AIDS Act §402(b)(1)).

Even with increased commitment, funding, and coordination, U.S. AIDS treatment efforts will fall far short of what is needed to provide ARV treatment even to a significant minority of suffering from AIDS today. Currently, there are an estimated 40 million people living with HIV worldwide. In sub-Saharan Africa, where an estimated 4.1 million people are infected with HIV, only 50,000 currently have access to treatment (Attawall and Mundy 2003). The U.S. initiative therefore represents only a modest beginning to what must be an international commitment to prevent and treat HIV and AIDS.

Given limited resources, choices will inevitably be made about who will be treated and when, raising the issues of equity in access to treatment for sub-groups of those infected. In turn, these considerations dramatically underscore the need for specific efforts to ensure that treatment programs reach those groups, namely women and girls and other vulnerable populations, such as sex workers and men who have sex with men, which, due to social, economic, and cultural discrimination and lack of access to health care, already face a disproportionately higher risk of infection. Today, for example, women represent more than half of those infected with HIV worldwide, and more than 60 percent of those infected in sub-Saharan Africa (UNAIDS 2003). In many countries, the rate of new infections is highest among married women and adolescent girls. The failure to understand and address the barriers to treatment access faced by women and girls will undermine investments made by the United States to seek long-term and sustainable solutions to the global HIV/AIDS epidemic.

To ensure that U.S. global AIDS strategies promote justice and equity and reflect international consensus on the ethical principles guiding access to health care, the United States must take proactive steps to address the barriers to access faced by women. There is no consistent

formula for ensuring equity in access to treatment given scarce resources. At the same time, a set of standard considerations, guidelines or questions can and must be formulated and applied within each setting to ensure that concerns for gender equity and social justice are incorporated into treatment access schemes. Such guidelines can be used to ensure consistent application of ethical principles to treatment access, while reflecting specific circumstances, and should be carefully reviewed on a regular basis in response to changes in the dynamics of the epidemic or as treatment access expands.

<http://www.genderhealth.org/pubs/TreatmentAccessFeb2004.pdf>

This submission makes the important call for female controlled prevention technology to be developed in the campaign to eradicate AIDS. From the statistics given in this submission, we can easily view the unmet need in terms of coverage and the extent to which gender plays a part in determining membership of the unmet need category. The call for research and development around microbicides as a technology which would particularly benefit women in the context of HIV/AIDS made in this submission is also made most powerfully by the International Community of Women Living with AIDS ([http://www.icw.org/tiki-read\\_article.php?articleId=25](http://www.icw.org/tiki-read_article.php?articleId=25) ; <http://www.global-campaign.org/> ).

The social movement pressure to lower the prices of critical drugs and to extend coverage of HIV/AIDS treatment ([http://www.afrol.com/html/Categories/Health/backgr\\_medicine\\_poverty.htm](http://www.afrol.com/html/Categories/Health/backgr_medicine_poverty.htm) ) by the direct lobbying of Big Pharma has its counterpart in the lobbying of governments and international institutions. The pressure to discard unjust international arrangements in the context of regional health crises grows; the protection of patents at the cost of public health, including women's health, becomes increasingly unacceptable (<http://www.avert.org/generic.htm> ). The International Community of Women Living with AIDS ([http://www.icw.org/tiki-read\\_article.php?articleId=198](http://www.icw.org/tiki-read_article.php?articleId=198)) is presently active in attempting to end TRIPS-plus provisions which threaten access to medicines:

**Box 2: US Patent Protection: the implications for public health**

International NGO Solidarity Statement: US-Thai Free Trade Negotiations Threaten Access to Medicines; Activists Demand Suspension of Negotiations and End to TRIPS-plus IP Provisions

Jan. 9, 2006. Thai AIDS activists and their international allies are seeking suspension of scheduled trade talks that threaten to undermine Thailand's lawful ability to produce, import/export, and market low-cost generic versions of life-saving medicines. Today, in Chiang Mai, the United States and Thailand are scheduled to start the Sixth Round of negotiations on a proposed Free Trade Agreement and for the first time are holding discussions on a U.S. proposal to dramatically increase intellectual property protections for pharmaceutical products. Simultaneously, ten thousand Thai activists, half of them living with HIV, are protesting the scheduled talks and trying to shut them down, promising to sleep overnight outside the meeting venue for three nights and to block entry to the negotiations.

The U.S. government has consistently refused to release the draft text of its FTA proposals and simultaneously extracts promises of secrecy from its negotiating partners. This shroud of secrecy limits democratic review and civil society participation in the negotiation process. In particular, it denies voice to the tens of thousands of Thais living with HIV/AIDS who need increased access to affordable second-generation antiretroviral and opportunistic infection medicines that are currently patent-protected and cost prohibitive.

Instead of allowing Thailand to use all existing flexibilities for accessing cheaper medicines under international law as confirmed by the 2001 WTO Doha Declaration on the TRIPS Agreement and Public Health and by the UN Commission on Human Rights, the U.S., based on past practice, will be seeking to heighten patent and data protection in the following ways:

- Extending patent terms beyond 20 years to compensate for administrative delays and easing standards of patentability on new formulations and uses, thereby extending the period of monopoly pricing;
- Restricting rights to parallel import cheaper medicines by codifying patent-holders' rights to contractually limit export/import of previously sold products;
- Potentially restricting the grounds for issuing compulsory licenses;
- Linking marketing approval to the absence of claimed patent rights and imposing 5-10 year data-exclusivity provisions (preventing reliance on proprietors' clinical trial data to grant marketing approval for generic products), thereby potentially restricting compulsory licensing rights;
- Imposing criminal penalties on companies that intentionally or inadvertently violate patents.

The U.S. attempts to down-play the significance of these hard-text treaty terms with an ambiguous and under-inclusive "side-letter" reaffirming trade partners' rights to prioritize access to medicines. Such side-letters make no binding commitments, and the USTR has expressly declined to confirm the obligatory effect of the letters when asked to do so in response to Congressional inquiries.

Consistent with human rights norms requiring access to essential medicines and in response to Thai activist demands, Thailand has initiated a program of universal access to government-subsidized antiretroviral drugs that now reaches 70,000 of 170,000 Thai people living with HIV/AIDS. However, the future costs of expanded treatment with newer patented medicines will be prohibitive if the U.S. succeeds in its objectives to ratchet-up intellectual property protections.

Therefore, we join our Thai colleagues at Chiang Mai and throughout Thailand demanding that the U.S. suspend negotiations on intellectual property rights and that it drop all intellectual property provisions affecting access to pharmaceutical products, specifically all TRIPS-plus terms, in the Thai FTA and in other FTAs as well. In addition, we demand that the U.S. publish its proposed text for the entire FTA and that the Thai people have had a chance to hold public consultations on the proposed agreement.

Signed,

- 50 Years is Enough Network
- ACT UP East Bay, USA
- ACT UP New York, USA
- ACT UP Philadelphia, USA
- ActionAid International, USA
- AIDS Foundation of Chicago, USA
- American Jewish World Service, USA
- Australian Women's Health Movement, Australia

- Boston Women's Health Book Collective, USA
- Canadian HIV/AIDS Legal Network, Canada
- Center for Policy Analysis on Trade and Health, USA
- Community HIV/AIDS Mobilization Project (CHAMP), USA
- Consumer Project on Technology, USA
- Egyptian Initiative for Personal Rights, Egypt
- Essential Action, USA
- European AIDS Treatment Action Group (EATG)
- Gays and Lesbians of Zimbabwe (GALZ), Zimbabwe
- Global AIDS Alliance, USA
- Globalization and Health Project, Centre for Governance of Knowledge and Development
- Harm Reduction Coalition, USA
- Health Action International Asian Pacific
- Health Connections International, The Netherlands
- Health GAP (Global Access Project), USA
- Health Rights Action Group, UgandaHIV/AIDS Task Force, Africa Japan Forum, Japan
- Human Rights Watch, USA
- International Community of Women Living with HIV/AIDS (ICW)
- Medical Action
- Cooperation with Cuba (MEDICC), USA
- Mobilization for Global Justice, USANational Association of People with AIDS (NAPWA)
- USANGO Coalition of People Living with HIV/AIDS, Moldova
- Our Bodies, Ourselves, USA
- Oxfam America, USA
- People's Health Movement, USA
- Public Citizen, USA
- Public Health Association of Australia, Australia
- San Francisco Tobacco Free Coalition, USA
- Saniplan.org, USA
- Soropositividade, Comunicação e Gênero (GESTOS), Brazil
- Southern Initiatives, India
- Student Global AIDS Campaign, USA
- Thai AIDS Treatment Action Group, Thailand
- The Global Network of People with AIDS (GNP+), The Netherlands
- Third World Network, Malaysia
- Uganda Treatment Access Movement, Uganda
- Universities Allied for Essential Medicines, USA

[http://www.icw.org/tiki-read\\_article.php?articleId=198](http://www.icw.org/tiki-read_article.php?articleId=198)

The United States protection of its pharmaceutical industry whilst simultaneously mounting its campaign for the reduction of HIV/AIDS can certainly be viewed as contradictory or at the very least paradoxical. This protection of US trade interests would lead to a reduction in HIV/AIDS coverage: and clearly this conflict replicated across the affected regions of the world represents a major obstacle to any effective campaign for global AIDS eradication.

Gender and health issues around HIV/AIDS are many and social movement activity around each of these issues is substantial. In this short section, we have indicated that there are good reasons for Big Pharma to pay attention to these issues of gender and health in the context of this global epidemic: the transparency of profit in situations of endangered public health, the visibility of industry and government alliances which threaten declared ethical and moral

global health agendas and the mounting global public discontent with these arrangements are all made more tangible by the new information communication technologies. The sustainability and continuous accessibility of this expression of discontent too is enabled by these technologies. The public representation of the impact of the action of Big Pharma on the women of the world is no longer confined to the well funded public relations of the industry itself but has other alternative and more negative manifestations with which the industry's own marketing must now interact.

### 3 A directable market?: The medicalization of 'women's problems'

In contrast to the HIV/AIDS situation where women need the services of Big Pharma at affordable prices, there are also many situations where women receive the attentions of Big Pharma but where it can be argued that these attentions are misplaced. There is a growing literature which speaks to the medicalization of 'women's problems' by Big Pharma through its highly aggressive marketing strategies. The targeting of doctors through 'perks' and aggressive public relations so as to result in the prescribing of unnecessary medications for women has received substantial attention in the literature. Hartley's (2003) work on the medicalization of women's sexual problems by Big Pharma provides the reader with a good starting point (see "Big Pharma" in our bedrooms: an analysis of the medicalization of women's sexual problems (H. Hartley) [http://www.elsevier.com/wps/find/bookdescription.cws\\_home/680869/description#description](http://www.elsevier.com/wps/find/bookdescription.cws_home/680869/description#description)).

Recently the work of Moynihan and Cassel (2005) has drawn attention to the Big Pharma syndrome of 'selling sickness', however, in their analysis they fail to engage with the gender dynamics involved. Abby Lippman provides the following review of their work:

Lessons learned from the women's health movement (then and now) offer models for how to deal with today's sickness- and drug-sellers. But Moynihan and Cassels don't sufficiently acknowledge the persisting gender bias of drug development and the decades-old medicalizing of women's bodies, even though six of the 10 conditions analyzed in *Selling Sickness* are conditions experienced by -- and treated more in -- women than men.

This is not coincidence: Women are sold sickness and also use drugs more often than men. Moynihan and Cassels are at their best detailing how selling sickness is happening. But their analytic lens isn't sufficiently wide, so they don't connect their themes to ongoing activities with huge potential to create diseases-in-waiting for drugs of the future (e.g., brain imaging to "see" why we [mis]behave as we do, or gene mapping to seek DNA patterns that make us "susceptible" to just about anything). Moreover, while *Selling Sickness* has abundant references to the actions of the U.S. Food and Drug Administration, the Canadian content sometimes feels more like an "add on" than part of an integrated whole.



A range of well-intentioned proposals is now under consideration in Canada and elsewhere to rein in some of the worst practices described in *Selling Sickness*. These include mandatory public registration of all drug trials, mandatory reporting of adverse drug effects and updated requirements for declarations about sources of funding by researchers, "expert" advisers and patient groups. If these come into practice, perhaps they'll alleviate some problems. But by themselves, they can't prevent the growing health burden caused by the continued massive selling of sickness -- and of harmful drugs. @  
[http://www.naturalhealthcoalition.ca/big\\_pharma.htm](http://www.naturalhealthcoalition.ca/big_pharma.htm) (decayed link)

The 'persistent gender bias of drug development' identified here by Lippman is well exemplified by the history of Hormone Replacement Therapy to 'counteract' the menopause. A recent review provides an indication of the scale of the medicalization of a normal female condition:

### ***A hot flush for Big Pharma***

*How HRT studies have got drug firms rallying the troops*

So the headlines have dealt another blow to the image of hormone replacement therapy (HRT). Will the drug companies be able to revive the fortunes of one of their most lucrative products? Will the big guns of the pharmaceutical industry be blazing, eager to counteract the latest volley of bad publicity? Or will the industry construct its defences more subtly? .....But what exactly can the PR machine do in the face of evidence that now says long term HRT use increases women's risk of blood clots, strokes, heart attacks, breast cancer, and dementia, and has no quality of life benefits? Probably what it has always been doing—promoting the idea of HRT both as a cure for a medicalised menopause and an elixir even in the absence of scientific data. ....More than 100 million women worldwide—1.5 million in Britain—took HRT in 2001 and global sales amounted to \$3.8bn (£2.4bn; €3.4bn). But after the first wave of publications from the WHI study, Wyeth, which accounts for more than 70% of the global market, saw its share price plummet. The stock, which traded as high as \$58.48 (£36.48; €51.66) in May 2002, fell by almost half to a low of \$28.25 in July.

(<http://bmj.bmjournals.com/cgi/content/full/327/7411/400> )

The rapid impact of negative research findings on pharmaceutical fortunes is easily seen from this case. Equally, the inadequacy of previous research into side effects is also revealed. Similarly, the history of Depo Provera, an injected contraceptive, provides a case history of inadequate investigation into and publication of the drugs side effects by Big Pharma The failure of Big Pharma to provide adequate information on the side effect of drugs has been met by the development of consumer or user websites where the difficulties are reported and recorded by those who have experienced them. These sites provide a counterweight to the glossy public relations materials of the industry and a record where the industry has failed to follow up on user experience. Women's

experiences and views of Depo Provera can be found at <http://womenshealth.about.com/cs/birthcontrol/a/depoproverabc.htm> : this includes the opportunity to join on-line petitions. Scattered users can coordinate through the new technology and exchange experiences: the side effects of Depo Provera become widely discussed through this forum.

The dangers of Depo Provera have been recognized by US authorities but this does not prevent the contraceptive being aggressively marketed in the Third World:

### **Pushing Depo-Provera**

Halcion is not the first Upjohn drug which has endangered women and whose clinical tests have generated charges of misconduct. Upjohn's contraceptive Depo-Provera is marketed throughout the world, even though the FDA has refused to approve it for use as a contraceptive in the United States.

Injected into the arm or buttock in a 150 milliliter dose, one shot of Depo-Provera prevents conception for at least three months. Upjohn aggressively markets the hormonal contraceptive outside the United States, particularly to women in the Third World. According to Upjohn, Depo-Provera is currently registered or approved in more than 90 countries.

Critics of Depo-Provera believe Upjohn is exposing Third World women to serious dangers [see "The Case Against Depo-Provera," *Multinational Monitor*, February/ March 1985]. Animal tests of the drug required for the FDA approval process found breast tumors in dogs and endometrial cancer in monkeys. According to the National Women's Health Network, animal and clinical studies further link use of the drug with infertility, diabetes and hypoglycemia, anemia, increased risk of blood clots and excessive bleeding leading to a need for hysterectomies.  
(<http://multinationalmonitor.org/hyper/issues/1991/11/knaus.html> )

The aggressive marketing of drugs targeted on vulnerable social groups such as illiterate women is a feature of Big Pharma's agenda long ripe for reformation. In closing this section, let us take a glimpse at the latest item on the Big Pharma gender agenda for medicalization – female sexual dysfunction. Moynihan, one of the author's of *Selling Sickness* draws our attention to the problems experienced in the attempts to launch this blockbuster medicalization of women's biology:

Robert Wilson's bestselling book *Feminine Forever* helped persuade the modern world that the menopause was a "disease" of hormone deficiency, to be cured with hormone replacement.<sup>1</sup> The book's 1966 front cover promised, "Every woman no matter what her age, can safely live a fully-sexed life for her entire life," and the hormones sold by Wilson's sponsor duly became best sellers. Forty years later, long term hormone replacement has been exposed as doing more harm than good,

drug sales have collapsed, and Wilson's thesis is rightly ridiculed as corporate sponsored disease mongering.<sup>2,3</sup>

In the shadows of this overmedicalisation, the pharmaceutical industry is meeting unexpected resistance to its attempts to sell women the next big profitable "disease," female sexual dysfunction. This condition is claimed by enthusiastic proponents to affect 43% of American women,<sup>4</sup> yet widespread and growing scientific disagreement exists over both its definition and prevalence. In addition, the meaningful benefits of experimental drugs for women's sexual difficulties are questionable, and the financial conflicts of interest of experts who endorse the notion of a highly prevalent medical condition are extensive. These controversies have been brought into focus by the rejection of Proctor and Gamble's experimental testosterone patch by advisers to the US Food and Drug Administration in December 2004.<sup>5</sup>

(<http://bmj.bmjournals.com/cgi/content/full/330/7484/192> )

Once again the technology enables women to organize and coordinate their own experiences into a body of health knowledge which challenges the public relations of the industry. Individual negative experiences can be aggregated and are. Informed materials can be accessed readily through the technology and governments, international agencies and companies can be targeted, petitioned and lobbied through the use of the technology with minimum effort by women's social movements.

#### **4. Engulfing the alternative: The battle of the supplements**

In the introduction to this presentation we drew attention to the history of wise women and their use of local plants and natural substances in the practice of medicine. Folk practices of medicine making have been identified by pharmaceutical companies and with relatively little transformation harnessed as product under patent to substantial profit without regard or payment to the owners of indigenous knowledge ([http://www.bayeraspirin.com/questions/hundred\\_aspirin.htm](http://www.bayeraspirin.com/questions/hundred_aspirin.htm) ): the San people of South Africa have broken this pattern and receive remuneration for the development of a diet drug from a plant that they have used to suppress hunger while on trek for generations:

**South Africa's indigenous San peoples have signed a deal ensuring they will profit from a diet drug being developed from a plant they have used for generations.**

Under the terms of the agreement, the San people will receive regular fees as the drug - developed from a plant used to suppress the appetite - passes various stages on the way to market.

They will also receive a proportion of the royalties if and when it becomes commercially available, which could be in as little as five years.

The San people hailed the agreement as a "joyous moment".

"In the past, it used to be the norm to exploit their knowledge and culture but today is an example of how things have changed," said Kxao Moses, chairman of the Working Group of Indigenous Minorities in Southern Africa.

(<http://news.bbc.co.uk/1/hi/world/africa/2883087.stm> )

This represents the first deal of its kind and its occurrence is to be welcomed, though no doubt the anti-obesity drug will be marketed heavily and aggressively for women, however, this occurs at the same time as food supplements have come under international regulation. Such supplements had been part of the ground of alternative medicine and alternative health practices – an extension in some ways of wise women practice – but the regulation of these supplements advantages Big Pharma as the producer of such supplements with increasing prices of some and the eradication of others.

**Box 4: the battle of the supplements**

## **CODEX ALIMENTARIS ENDS U.S. SUPPLEMENTS IN JUNE 2005**

By Dr. James Howenstine, MD.  
March 6, 2005  
NewsWithViews.com

Working stealthily BIG PHARMA has rapidly pushed their legislative program (Codex Alimentaris) in Europe that will eliminate the free choice Americans now have to purchase vitamins, herbs, minerals, homeopathic remedies, aminoacids and nutritional supplements. This elimination of all competition for the pharmaceutical industry will produce an enormous increase in the already exorbitant profits earned by the pharmaceutical firms. *Of even greater significance the lack of free choice to stay well by taking effective nutritional substances will promptly be followed by a sharp increase in illnesses that will only be treated in the future with pharmaceutical drugs.*

The new Codex Alimentaris adopted in a secret meeting in Europe in November 2004 is scheduled to take effect in June

2005. Because the United States belongs to the World Trade Organization WTO any changes approved in Europe automatically become law in the United States superceding our own laws (we are no longer a sovereign nation). Failure to comply with these changes institutes lawsuits which can not be won as they are settled in international courts which care nothing about U.S. laws. Incidentally, Europe has been very leery of genetically modified foods because of serious concerns about their safety. By this same WTO mechanism Europe will be forced to accept importation of U.S. GMO foods even if they know they are bad for health.

The features of Codex Alimentaris are:

- No supplements can be sold for *preventative or therapeutic use*.
- Any potency higher than RDA levels (pathetically low) is *a drug that requires a prescription and must be produced by drug companies*.
- Codex regulations are binding internationally
- New supplements are banned unless given Codex testing and approval (*certain to expensive and lacking in scientific merit*). Norway and Germany are already operating under the new Codex regulations. The price of zinc tablets has gone from \$4 to \$52. Echinacea has risen from \$14 to \$153.
- Codex regulations *are not based on science or research findings*. These regulations were developed by 11 appointed persons. Guess who appointed them?

<http://www.newswithviews.com/Howenstine/james24.htm>

Supplement use is consistently higher in women than in men and it is this group that the regulation of supplements will affect. In the battle of the supplements, Big Pharma is well placed to encompass and engulf its last existing competitor. "Folk" suppliers of supplements as matters stand appear set to disappear.

## 5. Conclusion: Purchasing authority

In the course of this argument, we have seen that the combination of gender and health social movements have presented a challenge to Big Pharma both in political terms and as departing consumers. We have seen that there has historically been a failure to adequately inform women of the side effects of the drugs with which they are medicated, that there has been a failure to research

thoroughly and follow up on side effects of widely prescribed medications and that there has been a failure to develop appropriate medication for public health where profitabilities were judged to be low.

We are now in a time when Big Pharma has come under visible pressure for its 'ethical' behavior, whilst at the same time Big Pharma's controls over many areas of its activity, perversely, have strengthened. These strengthening controls are coming under increasingly forceful and forcible pressure and the contradictory position of the US government in terms of strengthening the power of US drug patents whilst eradicating AIDS is increasingly transparent.

The technology, we have argued, makes a radical difference to the ability of social movements to both track and display the activities of Big Pharma and women's social movements have made maximum use of this technology as have gender and health organizations and activists. But the technology is also revealing the business of the link between the academy and the industry. Historically, the academy or university was seen as the location of independent and accurate research but recent events around Big Pharma and a British University portray a tale of purchased authority and legitimacy by the industry.

Procter and Gamble had placed research with the university and received data back from the university but proceeded to publish findings from this research without involving the primary researcher in the processing and analyzing of the data whilst at the same time placing his name amongst others on the findings which were very favorable to their product – a product to be used by women. The researcher asked for access to the data set which was being published under his name amongst others and was told that the industry standard was that he be not given such access. He protested to the company and to his university and eventually took his story to the press as a whistleblower. His University placed him under disciplinary procedures and then attempted to terminate his employment with a package: the pharmaceutical company was a major source of research funding.

The researcher has continued to draw attention to the issue and has gained support for his campaign within the United States:

Box 5: Purchasing authority – Big Pharma standards

Blumsohn works for Sheffield University in England, where he is a senior medical faculty member specializing in bone health. In 2002, Sheffield entered into a contract with P&G to collect Actonel data – the purpose of which was to determine how the drug prevented bone fractures, and how this related to change in bone resorption (the rate at which bone is removed) and bone mineral density. Consistent with research protocols in collecting data, Blumsohn was blind to which research subjects received Actonel and who got placebos. To later analyze the data, he needed its key, P&G's "randomization codes." Despite his repeated requests over 18 months, P&G denied him access to the data, even as it published ghost-written abstracts in his name

falsely implying the therapeutic equivalence of Actonel to Merck's Fosamax, the industry leader.

Researchers are supposed to be granted access to full data sets to reach informed conclusions. In 2001, an international coalition of the world's leading medical journal editors called for all journal article authors to pledge that they had "full access" to drug study data. This was recommended in order to avoid data manipulation by corporate sponsors of product information. That editorial appears in the September 18, 2001 edition of the Annals of Internal Medicine.

In 2004, P&G allowed Blumsohn to review, at one of its British facilities, what the company purported to be the actual data set. In reviewing the data, Blumsohn realized that numerous graphs (illustrating Actonel's effectiveness in preventing bone fractures) omitted 40 percent of a data set, apparently manipulating results to suit P&G's marketing objectives. P&G officials told Blumsohn that if these additional data were included in the results, the study would have favored a competitor's drug – Merck's Fosamax.

Since that time, Blumsohn has kept raising his concerns regarding P&G with Sheffield University, which subsequently offered him a large sum of money to leave his post. He refused because the settlement agreement required his silence; he was suspended by the university for speaking out about the issue to the BBC. GAP accepted him as a client earlier this year.

"This is all about the way in which science is conducted," states Blumsohn. "Pharmaceutical companies have succeeded in overturning the usual safeguards and procedures of science for corporate purposes. These drug companies use universities to give research a veneer of respectability and credibility."

<http://www.commondreams.org/news2006/0222-05.htm>

The actions of this researcher laid bare and revealed suspect practices within the industry. After some considerable time and only after the press campaign had begun did the pharmaceutical company adjust its behavior:

A pharmaceutical giant has promised to give a full guarantee of independence to academic researchers whose work it funds in a move that follows widespread concern over the company's handling of a major UK drugs study.

([http://observer.guardian.co.uk/uk\\_news/story/0,,1718179,00.html](http://observer.guardian.co.uk/uk_news/story/0,,1718179,00.html) )

The globalizing of awareness around suspect practices by Big Pharma creates the need for reform and for a new public relations which better meets and respects the real needs of the gender and health agenda. The globalizing awareness also has consequences for Big Pharma's partners including the

Universities. Big Pharma surely represents an important ground of challenge for the new Obama administration with its commitment to an improved health agenda, an agenda which must surely engage with the experience and evidence so abundantly provided by the gender and health social movements not least in respect of HIV/AIDS.

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