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The Ethics of Globalizing Bioethics

Stuart Rennie^{1,*} and Bavon Mupenda²

¹Department of Social Medicine & Center for Bioethics, University of North Carolina-Chapel Hill

²Centre Interdisciplinaire de Bioethique pour l'Afrique Francophone (CIBAF), Kinshasa School of Public Health, Kinshasa, Democratic Republic of Congo

Abstract

In the last decade, there have been efforts to globalize the field of bioethics, particularly in developing countries, where biomedical and other research is increasingly taking place. We describe and evaluate some key ethical criticisms directed towards these initiatives, and argue that while they may be marked by ethical, practical, and political tensions and pitfalls, they can nevertheless play an important role in stimulating critical bioethics culture in countries vulnerable to exploitation by foreign agencies and/or their own authorities.

Keywords

bioethics; capacity building; developing countries; research ethics; colonialism; neo-colonialism

I. INTRODUCTION

In this article, after giving a few words on the concept of capacity building, we will briefly explore the origins of some recent initiatives to enhance capacity in bioethics in what Volnei Garrafa has called “peripheral” (poor and developing) countries.¹ We will then describe and evaluate some key ethical criticisms directed toward these initiatives. Partly on the basis of experiences from a US-funded project to build bioethics capacity in Francophone Africa, we will argue that while such initiatives may be ethically contentious, their tensions and pitfalls largely reflect global inequalities, and despite their inherent challenges these initiatives can play an important role in helping to catalyze a critical bioethics culture in peripheral countries that are vulnerable to exploitation by foreign agencies and/or their own authorities.

II. CAPACITY BUILDING: THE VERY IDEA

Talk of capacity building already raises problematic tensions in terms of what capacity building is, what it involves, and who should build capacity. These tensions are present regardless of whether one is talking about bioethics capacity building or capacity building in the domains of research, governance, sanitation, education, medicine, or dentistry. For in all

these cases, there is typically an assumption of a stronger (competent) party having resources and skills to share with or impart on a weaker (relatively less competent) one, where the flow of resources and skills largely flows in one direction, from those building capacity to those whose capacity is being built, from the helpers to the helped. Although the concept of capacity building as such does not rule out the idea of mutual capacity building—the concept was originally introduced to replace paternalistic ideas of development assistance²—in actual practice there often lingers a sense of a builder and what is built, active agents and those passively acted upon.

Capacity building could mean either that nothing exists and one has to start from scratch, or that there are existing resources but they need to be reworked in order to raise standards of quality. In either case, fundamental questions include: who should build the capacity of whom, and from whose perspective and for whose agenda will the standards in question be raised? When the parties involved in capacity building differ significantly in socio-economic status or political power, it is not obvious that their motivations or interests are or can be easily aligned. For example, in international research, researchers from developed countries may have the luxury of concentrating on producing valid data for future health interventions, while their colleagues in developing countries may be relatively more focused on remaining employed and the day-to-day survival of themselves and their kin.

What should be involved in capacity building, in bioethics or any other domain? In Francophone Africa, capacity building is currently conceived in terms of training and providing people and institutions with resources. However, while important, this conception of capacity building neglects problems of local power. For in a resource-poor environment, what does a person become after being trained or receiving resources with management skills? What is that person truly “capable” of? It seems advisable, when feasible, to supplement training (ability in terms of skills and knowledge) and resources (money and infrastructure) with real authority (power to decide without undue interference) and responsibility (ability to respond and to put into practice what is under one’s authority). This means, as we suggest below, effective capacity building requires explicit attention to political questions, and not merely educational or infrastructural ones.

Who should build capacity? This is an important question in a globalized world marked by numerous inequalities. When building capacity, parties need to be able to share competences, experience, resources, authority, and responsibilities as far as possible. “Resource-poor” countries are rich in valuable local knowledge—including knowledge of local values, beliefs, and concerns—that “capacity builders” ignore at their peril. If capacity-building projects seem to involve only one party imparting knowledge, resources, authority, and responsibility, disempowerment rather than empowerment may result. At worst, the “recipient” party of capacity building may be unable to take the process of capacity building seriously and, if dependency is created or initiative is stifled, the purpose of capacity building may be defeated altogether.³

III. ORIGINS OF GLOBAL BIOETHICS INITIATIVES

Important developments in bioethics often originate from ethically challenging events or scandals. The influential *Nuremburg Code* (1946) was a response to the abusive experimentation conducted on Jews and others deemed undesirable by the Nazi regime. The influential *Belmont Report* (1979), produced by the National Commission of the Protection of Human Subjects of Biomedical and Behavioral Research (1979-1979), was partly a reaction to the ethical shortcomings of the infamous Tuskegee syphilis study, and the report forms the moral basis of current US federal regulations on research involving human participants. More recently, in response to the discovery of abusive US-funded research conducted in Guatemala (1946-48), the US government has requested the Presidential Commission for the Study of Bioethical Issues to review federal and international regulations governing medical research. The commission's recommendations were due to be released in late 2011.

Initiatives to build capacity in bioethics worldwide are partly a response to the increasing awareness of the globalization of research involving human participants. Just as clothes purchased and used in one country are often conceived in, manufactured in, and distributed from many other countries, the production and distribution of biomedical knowledge and its products currently involves numerous stakeholders and middlemen dispersed around the globe. Clinical trials to test new drugs—once largely the mainstay of academic research centers in the West—have become the engine of a vast, multinational, and highly profitable enterprise.⁴ The analogy between clinical trials and consumer goods is also apt because pharmaceutical companies often establish sites in low-income countries for the same reasons clothing companies establish factories in Bangladesh or Eastern Europe: lower operating costs, ease of recruitment, less strict laws or regulations, and subsequent potential for greater profits. The globalization of research involving human participants takes place in an interconnected but culturally diverse world marked by political, social, economic, and health inequalities between and within societies.⁵

Against this background, a defining moment for initiatives to build bioethics capacity in developing countries occurred in the late 1990s. Researchers in the United States established that administration of AZT (zidovudine) prenatally to HIV-positive women and then postnatally to their babies reduced the risk of mother-to-child transmission of HIV by two-thirds. Researchers, backed by World Health Organization recommendations, decided to conduct randomized placebo-controlled trials of a shorter (and less expensive) course of AZT among HIV-positive women in low-income countries with high HIV prevalence. Although highly successful in scientific terms, the trials sparked a furious debate about the appropriateness of the trials using placebo when a standard of care had already been established, and whether research participants in these trials were victims of exploitation.⁶⁻⁷

This high-profile ethical debate had, relatively speaking, a conspicuous absence of participation from low-income countries. The debates, workshops, publications, codes, and recommendations that ensued from the mother-to-child HIV transmission studies largely originated from developed countries with strong bioethics traditions: United States, Canada, United Kingdom, continental Europe, and Australia. Voices from the developing world were

scarcely heard, not because concerns about exploitation of vulnerable persons were new, but presumably because translation of the issue of exploitation into bioethics discourse was unfamiliar. There are three global institutional initiatives that were at least partly motivated by this uncomfortable situation: the Fogarty International Center bioethics program (2000-present); the Erasmus Mundus program in Western Europe (2004-present); and the international bioethics grants offered by the Wellcome Trust in the United Kingdom (2002-present). Each in its own way, these European and American programs aim to provide professionals from low-income countries with bioethics knowledge and skills, with the expectation that development of these capacities will have a positive impact on their home institutions.

IV. DEVELOPMENT OR COLONIALISM?

The main criticism of bioethics capacity-building initiatives such as those mentioned above is that the bioethics being taught is mainstream Western (Anglo-American) bioethics, and therefore what is claimed to be local capacity building may in reality be export of a specific intellectual tradition. The alleged exportation is believed to be problematic in two ways: first, it does not do what it is intended to do, namely empower people in developing countries to identify, debate, and resolve issues that arise in the local practice of medicine, public health, and research involving human participants. Second, it is unethical, because it assumes that the exported intellectual tradition is inherently superior to indigenous ways of thinking about ethics and ought to be adopted in order for developing countries to properly address the problems they face. For these reasons, some commentators have dubbed Western-based bioethics capacity-building efforts “ethical colonialism,”⁸⁻⁹ “moral imperialism,”¹ and “missionary work.”¹⁰

As with colonialism, ulterior motives could be at work and offer an alternative explanation of the origins of global bioethics initiatives. In the name of bringing civilization to benighted peoples, colonial powers largely sought to exploit human and natural resources to enrich themselves. Similarly, one may suspect that current bioethics capacity-building initiatives have the function of facilitating foreign-led and/or -funded biomedical research in developing countries, particularly when they emphasize establishing local research ethics committees that primarily review foreign research protocols.¹ Certain considerations point in this direction: obtaining local ethics committee approval is strongly encouraged by US federal regulations; having local ethics review may help distribute or deflect responsibility if something goes wrong; Western funders are far more inclined to finance projects on biomedical research ethics in developing countries than public health ethics or medical ethics; promoting bioethics capacity can also have a public relations function, i.e., marketing how powerful research agencies care about protection of research participants and the provision of benefits to communities in peripheral countries. In this way, bioethics capacity-building initiatives can be seen as attempts to neutralize potential accusations of exploitation, and facilitate “business as usual” among powerful players in global health research.

¹The bioethics capacity building program of the European Union’s European and Developing Countries Clinical Trial Partnership (EDCTP) has, with some exceptions, increasingly favored the creation and strengthening of research ethics committees in Africa.

Related to ethical colonialism is the older philosophical question of whether there can be a “global bioethics.” For if there is a core set of values and methods that serve as touchstones for thinking about bioethical problems, there could be an ideal curriculum every person seeking bioethics training ought to follow, with perhaps some adjustments for local contexts. Learning these core elements would not give rise to issues of ethical colonialism. On the other hand, if there is no such core set, then any given set will be marked by the assumptions of some particular culture.¹¹ Learning these would effectively involve assimilating (to greater or lesser extent) local conceptions of what is worth caring about in health-related matters and how to reason about them. This debate about global bioethics is unresolved, but there is considerable recent skepticism about its possibility or desirability,¹²⁻¹³ notwithstanding proposed universal bioethics codes¹⁴ or frameworks.¹⁵ As long as there are doubts about the possibility of a global bioethics, global bioethics training programs funded and conducted by American or European institutions will remain open to suspicions of ethical colonialism.

There is no way, by means of rational argument, to effectively counter the accusation that bioethics capacity building in peripheral countries is an impractical and unethical imposition of Western ideologies, values, and norms. Given the current dominance of Western bioethics in funding opportunities, bioethics centers, programs, journals, pedagogical materials, and so on, bioethics capacity building in non-Western settings is unsurprisingly marked by hegemonic tendencies. But regarding these initiatives as “one-way traffic” of ideologies and values simplifies the realities of collaborative attempts to build bioethics capacity across religious, political, social, and economic divides.

V. CAPACITY BUILDING AS ETHICALLY MESSY INTERVENTION

Griggins et al.¹⁶ describe two traditional models of bioethics capacity building in peripheral countries: (1) offering training grants to select individuals to study bioethics in established centers and academic programs in Canada, Australia, and the United States, and supporting some activities (setting up ethics committees, design of curricula) when they return home; (2) assistance with short-term workshops in peripheral countries themselves, targeting local health professionals. The Fogarty bioethics funded project in Francophone Africa uses a third model, which focuses primarily on development of local *institutional* capacity. The project—an NIH-funded collaboration between the University of North Carolina, the Kinshasa Ecole de Santé Publique, and the Centre Interdisciplinaire de Droit, Ethique et Sciences de la Santé (Namur, Belgium)—has facilitated the establishment of a center for bioethics at the Ecole Santé Publique and helped develop a concentration in bioethics into the school’s MPH program, as well as added bioethics modules into the curricula of various faculties at the nearby University of Kinshasa. The project has similarly worked together with the Institute National de Santé Publique et Communautaire (INSPC) in Antananarivo, Madagascar, to establish a bioethics unit devoted to ethics-related research and curriculum development.

One key advantage of institutional capacity building is its potential for sustainability. The lasting impact of individual training in bioethics or short-term workshops is uncertain. Embedding bioethics into the everyday operational life of research and educational

institutions can enhance the possibility of integration of bioethics in local practices of public health, medicine, and health research over the long term. This institutional approach, however, has its own significant challenges. We will discuss three problematic areas below: (a) material and infrastructure constraints; (b) institutional hierarchies and power relations; and (c) cultural and conceptual differences.

A. Material and Infrastructure Constraints

Academic institutions in Francophone African countries are often inadequately funded by their governments, and generating income through tuition is difficult when many students are themselves poor. While bioethics capacity-building projects can supply these institutions with much-needed supplies and resources, weak local infrastructure can limit and dilute their actual utility. In Kinshasa, electricity is notoriously unreliable and (costly) Internet services are prone to frequent disruption. Shipping or mailing supplies (such as printers or photocopiers) into the country is expensive or impractical, considering that the DR Congo has not had an official mail system since colonial times and customs agencies have a reputation for corruption. Even when supplies successfully arrive at their intended destination, other parties at the local institution may want to “borrow” or “share” them;² for newly formed bioethics units in established institutions, it is hard to say no, especially when bioethics units depend on their home institution’s supportive administration and infrastructure for sustainability. In addition, when institutionalizing bioethics requires an actual physical space, jealousies can be easily created: why should this new, strange, and unscientific “discipline” suddenly have a strong institutional presence? Competitive hiring of individuals to work in newly established bioethics units can also be a source of disruption, particularly if the salary of new and unfamiliar hires is equal to or greater than those higher up in the institutional chain of authority.

Making bioethics sustainable in low-resource settings requires not only institutional capacity building, but also development of a supportive network of stakeholder institutions, including the local ministry of health, the national AIDS or TB societies, health-related non-governmental organizations, members of the popular media, academic faculties, and biomedical research agencies. However, because those employed by these stakeholders may be poorly paid, ethical problems soon emerge. For example, should they be paid a per diem to come to bioethics workshops, in addition to compensation for transport costs and refreshments? In settings of poverty, it may be difficult to attract stakeholders to an unfamiliar field (whose practical utility seems uncertain) without contributing to a “per diem culture” where people may attend educational activities for purely extrinsic, self-interested reasons. In a similar vein, the local research ethics committee has the mission to protect human participants in biomedical and other research. These committees are often composed of poorly paid members, who are working overtime. Are they supposed to review submissions to the ethics committee on a purely voluntary basis, as is the case with better paid research ethics committee members in more affluent countries, or should they be paid for reasons of fairness and to keep them motivated?

²In such contexts, it is not surprising to see that when material is borrowed or shared, it is only returned when broken. Sharing usage may not extend to sharing costs of repair or maintenance.

B. Hierarchies and Power Relations

Official institutions in central Africa, particularly medical and academic institutions, tend to be very hierarchical. Attempts to build capacity in bioethics within these hierarchical structures poses a number of difficult challenges. For example, even when an individual has been trained in bioethics at prestigious Western universities, it does not mean that he or she will be taken seriously at the home institution, particularly if he or she has not yet obtained a PhD. Established professors may be averse to being “told how to be ethical” by a younger and junior faculty member, even if (or especially if) the latter objectively possesses greater knowledge in this domain. Another flashpoint for potential conflict is curriculum development. If new educational courses or programs are developed, involvement of experienced local faculty is indispensable. However, local faculty is likely to be unfamiliar with bioethics, and the very idea of teaching senior faculty can be politically sensitive. The nature of ethics itself may also cause friction and resistance. Senior faculty members in hierarchical African institutions are commonly expected to know “the right answer,” and as health professionals rather than philosophers, they are likely to be more comfortable dealing with facts than values. There can be reluctance to deal with the uncertainty inherent in exploring complicated ethical issues, and yet the “buy-in” from senior faculty is crucial for institutional capacity building in bioethics.

C. Cultural and Conceptual Differences

As one can imagine, cultural differences about what to teach in bioethics and how to teach it easily arise in a collaborative project involving North American, European, and African partners. We will concentrate here on two fundamental issues: topic selection and differing conceptions of philosophy and bioethics.

As some have noticed, the common topics in mainstream bioethics tend to reflect the concerns and interests of the countries in which bioethics has been historically dominant, particularly the United States.¹⁷ Many of the cutting-edge topics in the leading bioethics journals, such as enhancement, nanoethics, neuroethics, stem cell research, genomics, or face transplants, are far less relevant than the ethics of decision-making in the face of scarcity, epidemics, food insecurity, gender inequality, government and health care system corruption, civil conflict, or exploitation in health research. Furthermore, publications and pedagogic materials in bioethics are predominantly in English, meaning that educational materials in Francophone Africa tapping into the existing literature often have to undergo a “triple translation”: from English to French, from less relevant topics to more relevant ones, and from relevant topics to those most pertinent for particular audiences in specific contexts.

In his discussion of African bioethics, Karori Mbugua argues that since bioethics is a sub-branch of philosophy, it is important to understand how philosophy is conceived in many African countries.¹⁸ Mbugua distinguishes four main orientations in African philosophy: professional philosophy, ethnophilosophy, philosophical sagacity, and nationalist ideological philosophy. The constructs of professional philosophy and ethnophilosophy are the most relevant here. According to Mbugua, ethnophilosophy is the intellectual task of carefully distilling and articulating the world view or thought system of a particular community. The job of philosophy is to faithfully reveal the shared beliefs, values,

categories, and assumptions implicit in the languages and practices of particular ways of life. The resultant philosophical view is considered communal property rather than an individual creation. Professional philosophy, on the other hand, is modeled on academic philosophy in Western universities: philosophy consists in the production of knowledge through rational interrogation of all aspects of reality. Here philosophy aims to defend and attack arguments through criticism and debate, and the resulting views (while sharable) are regarded more as a result of the philosopher's own creativity. Those who practice professional philosophy in Africa may regard ethnophilosophy as unworthy of the name "philosophy," because it is too culturally specific and descriptive; those who practice ethnophilosophy may accuse professional philosophers of merely mimicking Western philosophy and assuming the latter is the gold standard for any conceivable philosophical activity.

This tension between underlying conceptions of philosophy can manifest itself in bioethics capacity-building activities. For example, in Western philosophy, a distinction is sometimes made between morality and ethics, where morality refers descriptively to traditional or widespread views of right and wrong, whereas ethics is the rational, normative examination of claims about right and wrong. Bioethics, accordingly, would be the rational, normative examination of claims about right and wrong within the domains of medicine, public health, and biomedical research, and the development of rationally defensible arguments, codes, and standards. But from the perspective of philosophy as ethnophilosophy, the conception of bioethics looks quite different. Bioethics here is the articulation of the moral values implicit in the ways that medicine, public health, and biomedical research are already practiced, and which are in keeping with the general moral views of a certain community. In our project in Francophone Africa, we have often seen this tension at work. Those practicing bioethics may, for example, articulate religion-influenced views from the community about sexual morality and condom use in the context of ethical discussions about HIV/AIDS, and conclude that it is wrong to promote condoms because it encourages pre-marital sex. Another kind of philosophy would likely arrive at different conclusions. In short, what counts as success and failure in bioethics in Africa depends on the underlying conception of philosophy being used, and the conceptions may conflict in the minds of those doing bioethics as well as those with whom they are interacting.

VI. CONCLUSION

Initiatives to build capacity in bioethics in the developing world are marked by complex ethical challenges. These challenges are largely rooted in the significant differences in culture, resources, and power between the parties involved. However, the existence of these challenges does not entail that such initiatives are irreparably compromised. Achievements in the form of successful bioethics workshops, creation of relevant curriculum materials and educational programs, strengthening of competent ethics committees or important contributions to the scholarly literature—centrally involving the efforts, viewpoints, and institutions of scholars and health professionals from the developing world—can and do take place. Such initiatives can improve ethical conduct of health research, clinical practice, and public health activities in developing countries, as well as throw a critical light on how bioethics is practiced in more affluent societies. Positive mutual transformation can take place despite global inequalities. Nevertheless, reflecting openly on capacity building in this

particular context is ethically important, because unless underlying assumptions and interests are regularly examined and challenged, accusations of “moral imperialism” may come to have more than a grain of truth.

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