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Bioethics in Africa: A contextually enlightened analysis of three cases

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Abstract

Across sub-Saharan Africa, bioethics is an emerging field of scholarly inquiry, informed by contextual features distinct to the region. A cultural mix comprised of Euro-American influences, indigenous traditions, Christian faiths and Muslim communities, a bioethics for the sub-Saharan region must be responsive to this milieu. This paper asks, what values and methods can best promote the practice of bioethics in Africa? We set forth a strategy that leans one way or another in response to contextual features of a particular setting. Since our aim is to be responsive to context, we begin with a series of cases and develop values and methods in response to each case as we work through its ethical analysis. Section I introduces a case involving setting priorities for public funding of services that produce large benefits for a small group of people, using the example of dialysis in Ghana. Section II presents a situation involving determining the permissibility of a double standard of quality for healthcare devices in rich and poor nations, using the example of explanting pacemakers from deceased people in wealthy nations for use by people in low- and middle-income nations. Section III describes a scenario where international groups clash with religious and spiritual healers over the chaining of people with severe mental illness at prayer camps and healing centers in Ghana. Section IV articulates a three-pronged strategy for engaging in bioethics brought to light by the case analyses and defends it against objections. Throughout the paper, we tag certain views 'African' and others 'Western' to indicate ethical beliefs commonly found in these regions and less commonly found elsewhere. We do not mean to imply that all Africans hold a certain ethical stance or that all Westerners do; nor do we mean to suggest that people outside these regions do not hold the views in question.

KEYWORDS

African bioethics, *ubuntu*, dignity, solidarity, resource allocation, bioethics, developing world bioethics

1 | DIALYSIS FOR END-STAGE KIDNEY DISEASE IN GHANA

The first example involves setting priorities for public funding of services that produce large benefits for a small group of people, using the example of dialysis to treat patients with end-stage kidney disease in Ghana. Ghana's National Health Service, instituted in 2004, does not currently cover the cost of hemodialysis for end-stage kidney failure, leaving Ghanaians with this life-threatening condition to face the stark choice of raising private funds and paying out of pocket or foregoing dialysis and dying of their disease. Some patients seek traditional medicine and faith healing, although they are generally advised

against it due to lack of evidence that these alternatives are effective.[1] The cost of hemodialysis in Ghana is roughly between $50-65 USD per session; yet most (80%) chronic kidney disease patients in Ghana earn less than $125 USD monthly.[2] Ghanaians with end-stage disease generally turn to family, community, corporate organizations and religious groups in search of funding. For those who overcome financial barriers, the frequency of sessions they can afford might be suboptimal and the duration of dialysis they can pay for might be limited. Even with some ability to fund dialysis, access is challenging. A country of roughly 30 million people, Ghana had eight nephrologists and 15 centers offering in-center hemodialysis services in 2017, with a total of 103 functioning hemodialysis machines.[3] Many who can pay for dialysis must leave the country to obtain it.

What values should guide the distribution of dialysis services for Ghanaians with end-stage kidney disease? Much of the bioethics debate about allocating scarce resources in Western nations focuses on qualities of individuals and makes these the determining basis for a distributive scheme.[4] For example, appealing implicitly or explicitly to a person's age, ability to pay, place of residence, life expectancy, healthy life years remaining, social contributions, or lifestyle choices illustrates a focus on distinguishing features of individuals. One source for this approach is Aristotelian ethics, which characterizes formal justice as requiring that like cases be treated alike, and different cases be treated differently.[5] Using this standard, the question of how to distribute scarce resources becomes, 'what makes people different in morally relevant respects?'

1.1 | Community and Solidarity

An African ethic avoids focusing on individual differences, because doing so pits one individual against another. Instead, it views persons as part of a community and, in some respects at least, inseparable from it. The givenness of communal life is one of a family of concepts in African ethics that fall under the general heading of *ubuntu*. A Nguni word, *ubuntu* has no exact English equivalent, but is often translated as 'humanness' or 'I am because we are.' Although sometimes associated narrowly with Southern and Eastern Africa, we interpret *ubuntu* broadly as an umbrella concept covering the deep structure of African collectivist values.[6] Tersely captured by adages such as, *Motho ke motho ka batho; umuntu ngumuntu ngabantu* ('A person is a person through other persons'),[7] an *ubuntu* ethic tends to conceive of community as both ontologically and normatively prior to individuals. According to this way of thinking, persons are *derivative* of a community in the sense that an individual exists only corporally at birth, acquiring full moral standing gradually as they are incorporated into a community. So understood, *ubuntu* places individuals' lives in the context of social roles and relationships and their responsibilities flow from their community membership. Metz renders *ubuntu* as an ethic holding that "the superlative value and dignity of human beings arises by virtue of their capacity for community.[8] As a normative principle, he interprets *ubuntu* as holding that "[a]n action is right insofar as it produces harmony and reduces discord; an act is wrong to the extent that it fails to develop community.[9] While not without critics,[10] we use Metz's account as a working definition.

A further feature of an *ubuntu* is *ubumwe*, translated from the Bantu as 'solidarity'. Solidarity in the African communal tradition indicates 'we-ness,' meaning a shared feeling and attitude of responsibility towards each other among members of a group.[11] When members of a group evince this feeling and attitude, a victory of one group member is experienced as a victory of the whole group. Although inequalities exist, the group takes responsibility to ensure that no member falls beneath a threshold of human dignity and participation in community. Reflecting this, it is common to be expected to assist distant relatives and others perceived to be part of a solidary circle; a phenomenon often referred to by urban Africans as a 'black tax'.[12]

How might an *ubuntu* ethic so understood help with the problem of distributing limited dialysis services in Ghana? When allocating scarce resources, an *ubuntu* ethic is broadly communitarian. While some interpret African communitarianism as rooted in political movements oriented toward establishing socialism and an emancipatory politics aimed at independence from European colonialism,[13,14] we side with Wiredu[15,] and Ramose,[16] who hold that the capacity to commune is not necessarily linked to any particular political order, but to a moral order requiring regard for others' interests

[1]Boateng, E.A., East, L., & Evans C. (2018). Decision-Making Experiences of Patients with End-Stage Kidney Disease (ESDK) Regarding Treatment in Ghana. *Biomedicine Central* 19(1).

[2]Tannor, E.K., Norman, B.R., & Adusei, K., et al. (2019). Quality of Life Among Patients with Moderate to Advanced Kidney Disease in Ghana. *BMC Nephrology* 20:122.

[3]Tannor, E.K., Awuku, Y.A., Boima, V., & Antwi, S. (2018). The Geographical Distribution of Dialysis Services in Ghana. *Renal Replacement Therapy* 4(3).

[4]Jecker, N.S. & Pearlman, R.A. (1992). An Ethical Framework for Rationing Health Care. *Journal of Medicine and Philosophy* 17: 79-96.

[5]Aristotle (340 BCE/2017). *Nicomachean Ethics*, Ross, W.D., Transl. Reseda, CA: Enhanced Media Publishing, Book III, p. 72.

[6]Shutte, A. (1995). Traditional African Thought. In A. Shutte, *Philosophy for Africa.* Rondebosch, ZA: University of Cape Town Press: 46-58.

[7]Ramose, M.B. (1999). *African Philosophy Through Ubuntu*. Harare, Zimbabwe: Mond Books, p. 99.

[8]Metz, T. (2011). Ubuntu as a Moral Theory and Human Rights in South Africa. *African Human Rights Law Journal* 11(2): 532-559.

[9]Metz, T. (2007). Toward an African Moral Theory. *Journal of Political Philosophy* 15(3): 321-341, p. 334.

[10]Molefe, M. (2017). Relational Ethics and Partiality: A Critique of Thad Metz's 'Towards an African Moral Theory.' *Theoria: A Journal of Social and Political Theory* 64(152): 53-76.

[11]Jecker, N.S. & Atuire, C. (2021). Out of Africa: A Solidarity-Based Approach to Vaccine Allocation. *Hastings Center Report* 50(2).

[12]Mhlongo, N. (2019). *Black Tax: Burden or Ubuntu?* Johannesburg, Gauteng*:* Jonathan Ball Publishers.

[13]Masolo, D. (2010). *Self and Community in a Changing World.* Indianapolis, IN: Indiana University Press.

[14]Senghor, L.S. (1964). *On African Socialism*, Cook, M., Transl. Westport, CT: Praeger Publishers, pp. 93-94.

[15]Wiredu, K. (1999). Society and Democracy in Africa. *New Political Science* 21(1): 33-44.

[16]Ramose, M.B. (2019). *Motho Ke Motho Ka Batho*, An African Perspective on Popular Sovereignty and Democracy. In L.K. Jeno, M. Idris, & M.C. Thomas, eds., *The Oxford Handbook of Comparative Political Theory.* New York, NY: Oxford University Press.

and enjoining people to live together harmoniously in whatever form of association they are in. As noted, such an ethic would be disinclined to emphasize differences between medically qualified dialysis candidates, which can engender competition and frustrate living harmoniously in a community and standing in solidarity. Yet how can people stand in solidarity when resources are scarce and some must go without? One reply is that African leaning bioethics underscores what makes people *the same*. In the broadest sense, what makes people the same is their shared humanness.

1.2 | Capabilities

A helpful way to further specify 'humanness' is to combine an *ubuntu* ethic with a complementary capability approach found in the West and used already in low- and middle-income nations to track human development.[17,18] Capability approaches understand humanness in terms of the central things that human beings can do and be, i.e., their central capabilities; they measure a nation's development by the extent to which its citizens experience capability gains or shortfalls. Working in a capability tradition, Nussbaum offers a normative interpretation of capabilities, which holds that each member of a community should have enough, i.e., sufficient capabilities to live a life of human dignity.[19] So understood, a capability analysis evaluates healthcare policies by assessing their impact on people's threshold capabilities, such as their threshold ability to be healthy and well-nourished, have bodily integrity, affiliate with others, and move freely from place to place. An *ubuntu* ethic extends the relational aspects of capabilities in a helpful way. Some have gone so far as to say that "relationality is part of the concept of a capability itself," arguing that falling below a threshold in any of the central human capabilities disrupts relationality by undermining an individual's ability to commune with others.[20]

Applied to the allocation of dialysis in Ghana, a combined *ubuntu*/capability account can help address priority setting questions at three levels:

1.2.1 | Macro-allocation

Should Ghana's National Health Service cover all or a portion of the costs of dialysis?

1.2.2 | Meso-allocation

Should the level of dialysis coverage be high, medium, or low relative to other healthcare priorities?

1.2.3 | Micro-allocation

Which patients should be prioritized for dialysis services?

The *macro-allocation* level of setting budgetary priorities within Ghana's National Health Service asks, 'should dialysis be a priority for funding?' One reasonable answer would be to say, 'no.' Even if all one cared about was health, the health of Ghana's population can arguably be better served by investing in public health and preventive health services that have a greater impact on the health of Ghanaians than healthcare treatment does. However, suppose that reasonable investments in public health and preventive healthcare have been made and some level of investment in healthcare treatment will occur; we might ask, at the *meso-allocation* level, 'which healthcare categories merit priority?' Should dialysis be covered in lieu of some other healthcare services? Here again, a reasonable answer would be not to fund dialysis. The meso-allocation argument might hold that priority should go to more cost-effective measures that benefit more people. For example, from a utilitarian perspective, prenatal care would benefit more people, enabling Ghana to reduce its high rates of under-5 mortality, which currently stand at 47.9 per 1,000 live births[21] --by comparison, under-5 mortality in high-income nations, such as Japan[22] and Sweden[23] during the same year were 2.5 and 2.7, respectively.

While this reasoning may seem initially compelling, we submit that an *ubuntu* ethic rejects meso-allocation strategies aimed single-mindedly at benefiting the most individuals, because this strategy is compatible with excluding whole groups of people outright, such as those with less common conditions and those requiring expensive lifesaving procedures, like dialysis. If we stand in solidarity, then each group deserves to be recognized.

Yet, standing in solidarity with people who have kidney disease leaves open the question of what form support ought to take. Clearly, we could potentially help more people with kidney disease by intervening early, before progression to end-stage disease. For example, investing in screening and early detection to identify and treat people with known risk factors for chronic kidney disease, such as hypertension, obesity, dyslipidemia (e.g., high cholesterol), and type II diabetes mellitus would help more people than investing in dialysis to treat end-stage disease. So too would educational interventions to enhance the clinical competence of general practitioners as well as research to better understand the unique causes for

[17]Sen, A. (1984). *Resources, Values and Development*. New York, NY: Oxford University Press.

[18]Nussbaum, M.C. (2011). *Creating Capabilities*. Cambridge, MA: Harvard University Press.

[19]Ibid.

[20]Hoffman, N. & Metz, T. (2017). What Can the Capabilities Approach Learn from A Relational Approach to Development? *World Development* 97: 153-164, p. 153.

[21]UNICEF, *UNICEF Data: Monitoring the Situation of Children and Women*. Retrieved May 12, 2021, from https://data.unicef.org/country/gha/.

[22]UNICEF, *UNICEF Data: Monitoring the Situation of Children and Women*. Retrieved May 12, 2021, from: https://data.unicef.org/country/jpn/.

[23]UNICEF, *UNICEF Data: Monitoring the Situation of Children and Women*. Retrieved May 12, 2021, from https://data.unicef.org/country/swe/.

TABLE 1 Two Ways of Helping the Most

	Investment	# Groups	# People
Help the most people	100% Prenatal	1	200
Help the most groups	50% Prenatal 50% Dialysis	2	100

chronic kidney disease in low- and middle-income countries. In addition to non-communicable causes prevalent in richer countries, evidence implicates other sources in poorer regions, such as infectious diseases, secondary to poor sanitation and lack of safe drinking water; environmental toxins; analgesic abuse; the use of harmful herbal preparations; the use of unregulated food additives; and genetic factors.[24] Prioritizing research into the etiologies of kidney disease in low- and middle-income African nations would potentially help more people with kidney disease (or at risk of developing it) in the long run.

We submit that a strategy that aligns with an *ubuntu* ethic should avoid two extremes. First, it avoids focusing only on helping the most individuals without considering solidarity and inclusion of people afflicted with different types of diseases. Second, within the group of people afflicted with kidney disease (or at heightened risk of developing it), a strategy that aligns with *ubuntu* avoids focusing narrowly on rescuing people with end-stage disease and instead shows solidarity with the many people earlier in their disease course. To enact these values, we propose making some investment in a wide range of diseases and within each disease category, helping the most people. This approach lends support to prioritizing public funding of patients with kidney disease (or at heightened risk of developing it) and within that category, prioritizing early detection, screening, and disease management. Our proposal, shown in Table 1, distinguishes two ways of 'helping the most': helping the most groups and helping the most individuals.

Admittedly, even under the best circumstances, some patients will reach end-stage disease and their needs will be unmet by a public system that sets our proposed priorities. In the future, as Ghana develops economically and more resources become available, more subgroups of kidney disease patients should be cared for, including patients with end-stage disease. Yet, in light of present resource constraints, Ghana should not use scarce public monies to make expensive rescue medicine its policy aim. We agree with the sober assessment offered by Luyckx et al., who note, "realistically, with the resources available, an adequate response to the enormous unmet need for treatment of kidney failure in sub-Saharan Africa will not be possible in the short or medium term."[25]

If dialysis does not qualify for public funding at meso-allocation levels, we do not yet reach the micro-allocation stage and the question of how to select between eligible patients for dialysis. However, in the future, Ghanaians are likely to face this question. When they do, one way or honoring *ubuntu*'s focus on community and solidarity would be to give all medically suitable candidates an equal chance to receive dialysis by means of a random method, such as a lottery, or by means of a weighted lottery favoring those with better prognoses (while still allowing each person some chance to receive dialysis).

2 | EXPLANTED PACEMAKERS FOR LOW-INCOME COUNTRIES IN AFRICA

We turn next to a case involving cardiovascular disease. While the case raises a number of ethical concerns, we focus on how to justly allocate scarce resources between and within nations. While cardiovascular disease is a leading cause of mortality worldwide, it is low- and middle-income countries that account for 80% of cardiovascular deaths globally. Many who die in low- and middle-income nations could be saved and their symptoms managed by pacemakers; yet, most individuals residing in poorer nations cannot pay the out-of-pocket cost of $2500 to $3000 USD for pacemakers. A controversial strategy for expanding access is refurbishing devices from deceased people in high-income nations and donating them to people in poorer nations. Suppose a private citizen in the U.S. made aware of a device donation program to bring refurbished pacemakers to Africa wishes to donate a pacemaker from a deceased loved one that has 70% of battery life remaining? Should this be allowed? Since U.S. pacemakers are designed for single-use and by law, are not allowed to be reused in the U.S., refurbishing them for use by people in poorer countries creates a controversial double standard. Critics charge that a double standard violates justice. Yet defenders argue that explanted reused pacemakers produce the greatest good. How might an African ethic contribute to this debate?

2.1 | Kinship

To answer this, it will be helpful to pause briefly to further elaborate *ubuntu* ethics. In addition to emphasizing community and solidarity, an *ubuntu* ethic stresses kinship and kin responsibilities as a central guidepost for ethical life. Importantly, the notion of "kin" extends beyond the immediate nuclear family to encompass a wider community. Thus, rather than indicating blood ties, kinship designates, "identity, or sharing a way of life, and solidarity, or caring for others' quality of life."[26] An expansive conception of kinship is apparent, for example, in the African practice of referring to those outside the

[24] Jha, V., Garcia-Garcia, G., & Iseki, K., et al. (2013). Chronic Kidney Disease: Global Dimensions and Perspectives. *Lancet* 382: 260-272.

[25] Luyckx, V.A., Naicker, S., & McKee, M. (2013). Equity and Economics of Kidney Disease in Sub-Saharan Africa. *Lancet* 382: 103-104, p. 103.

[26] Metz, T. (2012). Developing African Political Moral-Theoretic Strategies. *Philosophia Africana* 14(1): 61-83, p. 69.

nuclear family by honorifics such as 'sister,' 'brother,' 'uncle' or 'mama.' These ways of referring to people express the underlying inclusivity of African communities and their heavy emphasis on a *human* family, in which anyone can be my sister, brother, uncle or mama.[27]

Although within an *ubuntu* ethic, it is generally held that individuals owe more to persons with whom they stand in special relationships, such as close friends, immediate family members, and members of one's own tribe or ethnic group,[28] most proponents of *ubuntu* still see kinship as extending beyond the boundaries of these relationships. Ramose, for example, appeals to the "permeability" of moral boundaries and the duty to extend mutual caring and sharing to all.[29] Another defender of *ubuntu*, Wiredu, dwells on the Akan moral precept, *Onipa hia moa* ('a human being needs help'), to ground a notion of "sympathetic impartiality."[30]

Bringing all humanity under the embrace of kinship affords a basis for solidarity among people of different nations. Linking kinship specifically to justice, Atuire et al. invoke the Ghanaian concept, *biik*, meaning son or filiation, and the corresponding Bulsa sayings, *'nworuk kan nak ku dek biik a paar kobi ya,'* which translates to 'even lightening will never strike its own son to the bone.'[31] They argue that recognizing the filiation of each member of the human community underpins African justice, and is distinct from many Western accounts that base justice on mutual advantage.

2.2 | Equality

How might an *ubuntu* ethic elaborated in these ways help address the question of whether using explanted pacemakers for people in poorer nations is ethically permissible? With its focus on bringing people together in a family-like way, an *ubuntu* ethic is at odds with a double standard for rich and poor nations. Unlike charity, which assumes "asymmetric, top-down interactions, where the overall-more-privileged party gives to the overall-less-privileged party," solidarity emphasizes the language of common humanity which underscores "symmetry in the respect which is relevant."[32] The logic of seeing people as equals suggests we should regard needy people with cardiovascular disease in wealthy nations as equals with their counterparts in poorer nations. The exclusive use of refurbished pacemakers for poorer African nations would signal that refurbished pacemakers

FIGURE 1 'Conjoined Crocodiles'

are good enough for Africans, but not good enough for people in wealthy countries. This is problematic because it conveys that people in rich and poor nations have unequal moral worth.

To avoid this, a single standard is the approach taken by the WHO, which argues that "there should be no double standard in quality: if an item is unacceptable in the donating country, it is also unacceptable as a donation." The WHO sanctions refurbished pacemakers from wealthy nations, such as the U.S., only if they remain suitable for use within the U.S. Similarly, the U.S. Food and Drug Administration holds the view that "[p]acemaker re-use is an objectionable practice," noting that it violates single-use requirements and the same requirements should apply everywhere.[33]

However, in reply it could be argued that strict equality is impractical because poor people in the U.S. have access to *new* pacemakers and therefore do not need refurbished ones. Yet, we hold that a better way for people in the U.S. to stand in solidarity with people in low-income nations is to embrace a single standard -- if pacemakers are safe enough for people in receiving nations, they must be safe enough for people in donor nations too.

Yet it might be thought that by offering explanted pacemakers to people in poorer nations, sending nations *are* standing in solidarity. They are providing poorer people with a medical service that they would not otherwise have. Yet, in reply, we reemphasize the distinction between solidarity and charity. Charity refers broadly to the aid and humanitarian drives that rely on encouraging citizens and governments of rich countries to come to the aid of poorer countries. To achieve this end, such efforts highlight the differences between the 'privileged' and less 'privileged.' Unlike charity, solidarity is based on recognizing similarities and shared fate. In the African tradition, solidarity is sometimes expressed using the Adinkra symbol of *funtunfunefu* (conjoined crocodiles), illustrated in Figure 1, which depicts conjoined crocodiles with a common stomach. In this depiction, the crocodiles' fates are entwined -- what happens to one happens to both. In the case of explanted pacemakers, a single standard expresses solidarity by underscoring the shared human condition of recipients and donors alike.

[27]Gyekye, K. (2004). Epilogue: 'The Ties that Bind'. In K. Gyekye, *Beyond Cultures: Perceiving a Common Humanity*. Washington, D.C.: Council for Research in Values and Philosophy: 80-82, p. 81.

[28]Jecker, N.S. (2020). African Conceptions of Age-Based Moral Standing. *Hastings Center Report* 50(2): 35-43.

[29]Ramose, op. cit. note 16.

[30]Wiredu, K. & Gyekye, K. (1992). *Person and Community*. Washington, D.C.: Council for Research in Values and Philosophy, p. 201.

[31]Atuire, C.A., Kong, C., & Dunn, M. (2020). Articulating the Sources for an African Normative Framework of Healthcare: Ghana as a Case Study. *Developing World Bioethics* 20(4): 1-12, p. 7.

[32]Prainsack, B. & Buyx, A. (2011). *Solidarity: Reflections on an Emerging Concept in Bioethics*. London, UK: Nuffield Council on Bioethics, p. xiii.

[33]Federal Drug Administration. (2015). CPG Sec. 310.100 Pacemaker Reuse, updated 19 February. Retrieved May 12, 2021, from https://www.fda.gov/regulatory-information/search-fda-guidance-documents/cpg-sec-310100-pacemaker-reuse.

2.3 | Dignity

An *ubuntu* ethic might also support a single standard for pacemakers on the basis of respect for human dignity. In the African tradition, human dignity has been understood as consisting of the human capacity for community, which encompasses both the ability to identify with others and to stand in solidarity with them. More broadly, dignity is frequently linked to human rights in the sense that "to observe human rights is to treat an individual as having a dignity" and to violate human rights is to fail to honor this superlative value, frequently by treating a human being merely as a means.[34] A dignity-based conception of human rights is affirmed in multi-national declarations of human rights,[35,36] and in national reports, including the U.S. President's Council on Bioethics' Report on Human Dignity and Bioethics.[37]

Returning to the topic of pacemakers, how might the concept of dignity help with the analysis? Respect for dignity gives grounds for requiring first, that pacemakers meet a minimum standard of safety and efficacy everywhere. In some parts of the world, where resources are more plentiful, the quality of pacemakers may exceed the minimum of respect for dignity, but nowhere should pacemakers fall below this standard. Second, a dignity analysis requires that safe and effective refurbished pacemakers be made available to people in both richer and poorer nations, yet it allows for the possibility that their actual use may be more common in poorer nations because they have less ability to afford new ones.

In response, a utilitarian might object that if a person can prevent something bad from happening without sacrificing something of comparable moral importance, they ought to do it.[38] According to this analysis, if pacemakers in wealthy nations would simply be discarded at death, they should be donated without restriction, because doing so prevents something bad from happening at minimal cost. Yet, in reply, this interpretation is consistent with allowing shoddy standards that violate human dignity, since low quality pacemakers could still create more utility than the alternative, which in poor nations, is death or dysfunction from untreated disease.

A further objection is that unequal bargaining power between rich and poor nations will put the governments of poorer nations in the position of "a beggar who has limited choice" and prompt governments in poorer nations to "accept whatever intervention is offered by the party from a rich country."[39] In reply, we set parameters based on dignity that require using only safe and effective pacemakers, which helps offset the unequal bargaining power between nations. In our estimation, the ideal that should be upheld is not avoiding waste per se, but meeting threshold level human needs.

3 | MALTREATMENT OF PEOPLE WITH SEVERE MENTAL ILLNESS IN GHANA

We turn finally to a third case, involving maltreatment of individuals with mental illness at the hands of traditional and faith-based healers in Ghana. Maltreatment includes well-documented shackling, flogging, and forced fasting measures. These measures gained international attention in the wake of investigative reports by the BBC,[40] *The Guardian*,[41] and Human Rights Watch.[42] The reports occurred subsequent to Ghana's 2012 Mental Health Act 846, which explicitly bans maltreatment, affirming that "A person with a mental disorder has the right to enjoy a decent life as normal and as full as possible which includes, the right to education, vocational training, leisure, recreational activities, full employment and participation in civil, economic, social, cultural and political activities" to the extent that they are capable.[43] Despite the law, inhumane treatment of people with mental illness continued in private homes and residential facilities run by traditional and faith-based healers.

Traditional and faith-based healing reflect a plurality of traditions, including: Pentecostal/ Charismatic Christian faith healers, Islamic faith healers, herbalists, shrine priests and priestesses, and medicine men.[44] Typically, traditional healers treat diseases by using local herbs and pouring libations to 'small gods' in shrines, while faith healers or pastors/imams invoke God's power to heal by prayers, fasting, and the sprinkling of water.[45] Residential facilities, such as prayer camps and healing centers, run by traditional and faith healers offer people with mental illness a place to stay for a short visit or for multiple years. Often, these services furnish food, shelter and clothing, as well as counseling and companionship.

Inhumane treatment at residential facilities arises for a variety of reasons. Rather than being based on cruelty or lack of caring, it often

[34]Metz, T. (2011). Ubuntu as a Moral Theory and Human Rights in South Africa. *African Human Rights Law Journal* 11(2): 532-559, p. 542.

[35]UNESCO. (2006). *Universal Declaration on Bioethics and Human Rights*. Retrieved May 14, 2021, from https://unesdoc.unesco.org/ark:/48223/pf0000146180

[36]World Medical Association. (2013). Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects. *Journal of the American Medical Association* 310(20): 2191-2194.

[37]President's Commission for the Study of Ethical Problem in Medicine and Biomedical and Behavioral Research. (2008). *Human Dignity and Bioethics*. Retrieved May 14, 2021, from https://jamanetwork.com/journals/jama/fullarticle/1760318.

[38]National Academies of Sciences, Engineering, and Medicine. (2016). *Providing Sustainable Mental and Neurological Health Care in Ghana*. Washington, D.C.: National Academies Press.

[39]Ndebele, P. (2017). Standards of Care in Global Health. *Hastings Center Report* 47(5): 28-29, p. 28.

[40]BBC News. (2018). Ghana 'Prayer Camps' Chain Residents with Mental Health Problems. *BBC News* 09 October. Retrieved May 12, 2021, from https://www.bbc.com/news/av/world-africa-45800263.

[41]McVeigh, T. (2020). All We Can Offer is the Chain. *The Guardian* 03 February.

[42]Human Rights Watch. (2019). Ghana: Faith Healers Defy Ban on Chaining. Retrieved May 12, 2021, from https://www.hrw.org/news/2019/11/27/ghana-faith-healers-defy-ban-chaining.

[43]Republic of Ghana. (2012). *Mental Health Act, 2012*, p. 23. Retrieved May 12, 2021, from https://www.refworld.org/pdfid/528f243e4.pdf.

[44]Kpobi, L. & Swartz, L. (2018). Implications of Healing Power and Positioning for Collaboration Between Formal Mental Health Services and Traditional/Alternative Medicine. *Global Health Action* 11: 1445333. DOI: 10.1080/16549716.2018.1445333.

[45]Ae-Ngibse, K., Cooper, S., Adiibokah, E., et al. (2010). 'Whether you like it or not people with mental problems are going to go to them'. *International Review of Psychiatry* 22: 558-567.

reflects desperation and lack of viable alternatives. In 2017, the WHO reported that the number of psychiatrists in Ghana was .06 per 100,000 population and the number of mental health nurses was 7.73.[46] In 2016, the National Academies of Sciences, Engineering, and Medicine identified lack of human resources as a major barrier to accessing mental healthcare in Ghana,[47] due not only to shortages of trained providers but to their heavy concentration in cities, leaving community and rural areas without access.[48] When patients are perceived as violent or threatening to a community, yet lack access to psychiatric and mental health nursing care, and associated treatments, such as anti-psychotic medication or intensive in-patient rehabilitation, chaining may seem like the only way to keep a community safe.

Under these conditions, it is unsurprising that a 2019 Human Rights Watch's report, which examined six residential facilities (prayer camps and traditional healing centers) across Ghana's Greater Accra, Eastern and Central regions, found chaining to be common, including one facility (Nyankumasi prayer camp) where there were "16 men in a dark stifling room, all of them with short chains, no longer than half a meter, around their ankles."[49] Although the Ghana Mental Health Authority sawed the chains off, Human Rights Watch pressed that this was not enough, stating that if the government wants its ban on chaining to be more than "empty words," it must not only ensure chains come off, but ensure mental health services for people who need them.[50] Mental health researchers concur, saying release from chains "marks the beginning of the journey to the realization of rights and freedoms," not the end.[51] Progress is difficult without more resources and trained personnel available to furnish essential mental health services. Ghana is not alone; the WHO reports that mental health services are scarce throughout low- and middle-income regions and attention to human rights for mentally ill people is limited.[52]

3.1 | Humility

Pragmatically, most Ghanaians have little choice when it comes to seeking care for mental health conditions and simply use the more readily available pathways.[53] In 2010, Ghana had one registered traditional healer for every 200 people, compared to one medical doctor for every 20,000 people during the same year.[54] Moreover, resource considerations aside, traditional and faith healing is seen in a positive light by many Ghanaians. A 2017 Gallup poll found the country to be among the most religious in the world, with 94% of the population professing belief in God.[55] Many Ghanaians understand symptoms of mental illness as having a spiritual or supernatural etiology, even while remaining open to different treatment modalities. In a qualitative analysis of 81 semi-structured stakeholder interviews across five Ghanaian regions, Ae-Ngibse et al. reported widespread consensus that mental illness was a form of "spiritual illness" among diverse respondents, including policy makers, health providers, psychiatric service users, teachers, police, academics, and religious and traditional healers.[56] Asamoah et al. conducted semi-structured interviews with 20 Pentecostal/ Charismatic clergy in Ghana and found widespread belief that mental illness was caused by "diabolic manipulations of the soul" that must be corrected by exorcism, which involves expulsion of malign spirits by means of religious rituals and practices, such as prayer and fasting.[57]

This backdrop offers a better understanding of the larger setting in which maltreatment occurs. While graphic portrayals of maltreatment are disturbing, simply closing down prayer camps or shunning religious leaders who chain residents will not help patients with severe mental illness get better. It would simply leave them bereft of a community, without food, clothing or a place to go. Pastor Isaiah Nchiroba, who runs the Nyinbonya prayer camp and Pentecostal church near Ghana's border with Burkina Faso, told *The Guardian* in 2020 that some health professionals label him as 'mad': "Anywhere I go, even at the hospital, my fellow professionals at different departments call me 'mad nurse'," he says.[58] Nchiroba treats about 150 patients, 20 of which were chained to trees when *The Guardian's* 2020 report was filed.

Another response that will do little to stem the suffering of people with severe mental illness is insisting on obtaining informed consent from patients or family members on the assumption that inhumane practices would end, because no one would consent to them. Guided by a Western ethic which emphasizes respect for individual autonomy, this position is enshrined in the language of Act 846, which established a Mental Health Review Tribunal, whose functions include investigating complaints about informed consent processes or involuntary admission or treatment abuses. However, in a Ghanaian context, the type of disclosure required by Western biomedical models of informed consent would be

[46]WHO. (2017). *Mental Health Atlas 2017: Ghana Member State Profile*. Retrieved May 17, 2021, from https://www.who.int/mental_health/evidence/atlas/profiles-2017/GHA.pdf?ua=1.

[47]National Academies of Sciences, Engineering and Medicine. (2016). *Providing Sustainable Mental and Neurological Health Care in Ghana and Kenya*. Washington, D.C.: National Academies Press.

[48]Eaton, J. & Ohene, S. (2016). Providing Sustainable Mental Health Care in Ghana. In National Academies of Sciences, Engineering and Medicine, *Providing Sustainable Mental and Neurological Health Care in Ghana and Kenya*. Washington, D.C.: National Academies Press: 183-232.

[49]Human Rights Watch, op. cit., note 42.

[50]Ibid.

[51]Read, U. & Kpobi, L. (2021).The Interdependence of Human Rights in Mental Health in Ghana. 08 February. Retrieved May 12, 2021, from https://www.youtube.com/watch?v=1fMJWlVMTeQ&feature=share&fbclid=IwAR1tZ8_09WvtjCkhGQJq6kLPKrIN6EEenJlHY0I9UBlEjKaINBtJw97l1hs.

[52]WHO. (2009). *Mental Health Systems in Selected Low- and Middle-Income Countries*. Geneva, CH: World Health Organization.

[53]Bantu, E., Mitchell, R., & O'Brien, A.P. (2019). Pathways to mental Health Treatment in Ghana. *International Journal of Social Psychiatry* 65(6): 527-538.

[54]Ae-Ngibse, K., Cooper, S., Adiibokah, E., et al., op. cit., note 45.

[55]Gallup. (2017). Religion Prevails in the World, 10 April. Retrieved May 12, 2021, from https://www.gallup-international.bg/en/36009/religion-prevails-in-the-world/.

[56]Ae-Ngibse, K., Cooper, S., Adiibokah, E., et al., op. cit., note 45.

[57]Asamoah, M.K., Osafo J., & Agyapong, I. (2014). The Role of Pentecostal Clergy in Mental Health-Care Delivery in Ghana. *Mental Health, Religion & Culture* 17(6): 601-614.

[58]McVeigh, op. cit., note 41.

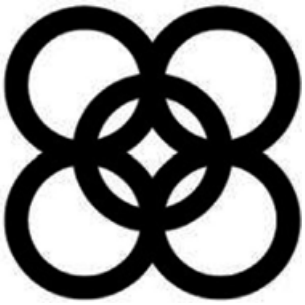

FIGURE 2 'Puffed Up Extravagance'

difficult to extract from traditional herbalists, whose curative powers lie in tightly held formulas that are not patent protected. Moreover, it is a fair question to ask, what happens if a violent person with severe mental illness or their family refuse chaining? Nchiroba, the Pastor at Nyinbonya prayer camp, says that, "shackling is necessary for those who 'can frighten people and even cause injury…'."[59] Perhaps this is why *The Guardian*'s investigative reporting found 'chain makers' common throughout Ghana, present in "every third or fourth village."[60]

Our analysis establishes an urgent need for understanding and humility to solve problems. It cautions against what the Akan call, *kintinkantan* ('puffed up extravagance'), depicted in the Adinkra symbol in Figure 2. Puffed up extravagance is reflected in some Western reactions, such as of sawing off chains without providing safe alternatives; requiring informed consent signatures without helping to expand services; or shunning healers, rather than joining forces with them to better serve people with mental illness.

3.2 | Consensus Building

An *ubuntu* ethic can guide people with different approaches to mental health by bringing them together to advance the common goal of helping the sick. Emphasizing that the whole community has a stake in the well-being of each member can facilitate not only understanding, but change. An *ubuntu* ethic points to humane alternatives that draw on the strengths of diverse practitioners by building consensus toward achieving shared goals, such as expanding public funding for community-based mental health, including people with mental illness within the life of a community, and forging partnerships between healers and biomedically trained practitioners. While mental health services have been a relatively low priority in sub-Saharan Africa since pre-colonial times,[61] Act 846 has set the stage for positive change through decentralizing mental health services and endorsing community-based mental health.

Yet delivering on the law's promise requires an influx of funding to train and deploy mental health professionals and increase facilities for treatment within communities. Rather than eliminating resources already in place, we propose expanding them though collaborations with healers to affirm their vital roles and draw on their knowledge of a community. This approach recognizes healers' successes, such as reaching out to stigmatized and abandoned people living on the street and ensuring they are fed, clothed and housed. It recognizes spiritual and faith-based healers' efforts to include people with severe mental illness in social relationships and interactions, which play such an essential role in realizing a better, more dignified, human life. Ea-Ngbhise et al. report that traditional and faith healers often function "like 'clinical psychologists', providing 'talk therapy', counselling' and 'asking questions and providing solutions';" whereas biomedical approaches "just give drugs and then send you away."[62] Seen in this light, healers are assets, offering both a point of entry into healthcare systems, and a pathway for people suffering from mental illness to return to communities and live within them. An *ubuntu*-based strategy of consensus-building does not entail agreement with faith-based or herbal treatment techniques, but instead focuses attention on working in partnership to realize a common goal of helping needy people.

Clearly, the services offered by trained mental healthcare workers must also be part of the mix. The range of conditions represented, which include psychosis or schizophrenia; older people with neurodegenerative diseases, such as dementia; younger people with substance abuse disorders; and individuals with epilepsy, cannot be successfully managed without the treatments biomedically trained healthcare workers prescribe. However, mental healthcare alone is not sufficient. It is ill equipped for reintegrating people into communities or deciphering the complex overlay of cultural and spiritual beliefs that inform their illness. For example, consider the case of older women in the Ashanti and northern regions of Ghana accused of witchcraft who reside apart from others in shrines or witches' camps.[63] When they develop witchcraft related depression, their care must be responsive to the cultural context of beliefs about being bewitched and work with, rather than against, these cultural influences. Responsive treatment requires community alliances.

Building alliances and trust takes time and commitment, but when successful, it can help people suffering from mental illness suffer less. Maltreatment should teach us to recognize that things can go badly wrong when families and spiritual leaders are left to fend for themselves. Without solidarity and backing from government and mental health professionals, individuals with mental illness grow more vulnerable. The Adinkra symbol, *sankofa* ('return and get it'), shown in Figure 3, encapsulates our perspective. It shows a bird turning around to find its lost egg, symbolizing looking back to remember mistakes and learn from them. Shackling

[59]Ibid.

[60]Ibid.

[61]Kpobi, L., Osei, A., & Sefa-Dedeh, A. (2014). Overview of Mental Health Care in Ghana. In A. Ofori-Atta & S. Ohene, eds., *Changing Trends in Mental Health Care and Research in Ghana*. Oxford, UK: African Books Collective: 4-12.

[62]Ae-Ngibse, K., Cooper, S., Adiibokah, E., et al., op. cit., note 45, p. 561.

[63]Aikins, A.D.-G. (2015). Mental Illness and Destitution in Ghana. In E. Akyeampong, A.G. Hill, A. Kleinman, et al., eds., *The Culture of mental Illness and Psychiatric Practice in Africa*. Indianapolis, IN: Indiana University Press.

FIGURE 3 'Return and Get it'

people with severe mental illness is a mistaken way to help people and its persistence should warn and remind healers, families, healthcare workers and government officials what is at stake and why collaborating with one another is so vital. *Sankofa* can also be understood as looking back to traditional teachings, such as *ubuntu*.

4 | DOING BIOETHICS IN AFRICA

Stepping back from the three examples, what general insights have we gained about doing bioethics in Africa? Since the continent of Africa is comprised of 54 diverse countries with varied ethical traditions and diverse healthcare practices, when we refer to 'doing bioethics in Africa,' it is helpful to distinguish broad differences across the continent.

4.1 | A Contextually Enlightened Framework

One way of going about this is to group healthcare practices into three types: Western style biomedical healthcare, traditional medicine, and modern religious spiritual healing.[64] Bioethics in each of these healthcare settings should be responsive to distinct contextual and cultural features. Western style biomedical healthcare, which is widespread throughout Africa, will often be best served by combining Western and African bioethical values and concepts, sometimes leaning Western and sometimes leaning African. Where Western-leaning bioethics is called for, Western frameworks may still require cultural adaptations. A combined bioethics characterized the approach we took in analyzing the first case, involving the use of dialysis for Ghanaians with end-stage kidney disease. In the first case, we combined an African ethic of *ubuntu* with a Western capability view of justice.

TABLE 2 Doing Bioethics in Africa

Type of Healthcare	Type of Bioethics		
	Western Leaning	African Leaning	African
Western biomedical	✓	✓	
Traditional medicine			✓
Religious spiritual healing			✓

In other settings, Western-leaning approaches may clash with values on the ground and a model that leans African will suit the setting better. Our approach leaned African in the second case, involving the use of explanted pacemakers. Here, we emphasized an African approach to justice that underscored kinship, equality and solidarity between people of all nations, rather than a utilitarian approach that focused on aggregating individual utilities.

Finally, in some situations, where religious and faith based healing is practiced, Western bioethics may not suit the situation of stakeholders, such as patients, families, or communities, and African bioethics should guide. In our third case, where traditional medicine and spiritual healing was practiced in prayer camps and healing centers, we invoked *ubuntu* and applied it at the community level, appealing to humility and consensus building, rather than autonomy-based strategies, like informed consent. The overarching aim in all three examples is for bioethics to be responsive to the varied settings in which it is practiced and to the interests and values of people holding stakes. Table 2 summarizes these three general strategies for doing bioethics in Africa. According to our proposed framework, the underlying rationale for leaning one way or another is contextual- and stakeholder-based.

Our proposal carries weighty implications in regions of Africa where the majority of a population prefers or has greater access to traditional, rather than Western, medicine. Referring to Africans who obtain their care primarily from traditional doctors, Murove claims that what "bioethics" in fact means to them is "peripheral to most of our scholarly discourses on bioethics" and charges that academic bioethics has "turned a blind eye" to African bioethics as it practiced in traditional settings.[65] Likewise, Frimpong-Manosh finds a "restrictive focus on biomedically-related bioethics" problematic in African contexts, because it neglects bioethical issues raised by traditional systems of health and healthcare.[66] Nor is this problem isolated to Africa; according to a 2019 WHO Report, 88% of WHO's 194 member states acknowledge using traditional and complementary medicine.[67] While it is tempting to simply use the Western bioethics at hand, doing so can further entrench Western hegemony and risk exacerbating epistemic injustices associated with a

[64]Atuire, C.A. (2019). A Prolegomena to Bioethics in Africa. In Y.A. Frimpong-Manosh & C.A. Atuire, eds., *Bioethics in Africa*. Wilmington, DE: Vernon Press: 1-29.

[65]Murove, M.F. (2005). African Bioethics. *Journal for the Study of Religion*: 16-36, p. 17.

[66]Frimponog-Mansoh, Y.A. (2019). Bioethics: Traditional African Perspective. In Y.A. Frimpong-Mansoh, C.A. Atuire, eds., *Bioethics in Africa*. Wilmington, DE: Vernon Press: 31-56, p. 32.

[67]WHO. (2019). *WHO Global Report on Traditional and Complementary Medicine*. Geneva, CH: World Health Organization.

prevailing discussion's framework.[68] We have argued that a better strategy is building capacity for African bioethics and leaning African in settings where this is called for. We envision an African bioethics that is diverse, nimble and context aware.

4.2 | Objections

Important objections might be raised against our proposal and we turn next to address these. First, it might be argued that the dominant approach to bioethics is principlism, as discussed by U.S. philosophers Beaucahmp and Childress,[69] and it is unclear why principlism is inadequate in an African context. In reply, principlism draws heavily on the discipline of Western philosophy, which omits all of the philosophy of Asia, Africa, India and the Indigenous Americas from its curriculum and thereby "convey[s] the impression --willingly or not—that no other culture was capable of philosophical thought."[70] To avoid what Solomon calls the "export problem,"[71] or the attempt to transplant Western bioethics to developing regions, what is needed is a view "from below," that is, with less affluent nations and less wealthy members.[72] The problem with exporting principlism to Africa is that it generates tensions when it is out of synch with African values. For example, principlism's emphasis on autonomy and individual informed consent may clash with African values that emphasize family, community, and respect for elders; it may ignore realities on the ground, such as poverty and illiteracy.[73] Taking seriously these concerns, we submit that bioethics should incorporate ethical values beyond the West when it is practiced in Africa.

A further objection holds that authentic bioethical principles are universally valid and a contextually oriented bioethics ignores this. In reply, our proposal is compatible with a range of metaethical stances. For instance, it is consistent with our contextually enlightened account to hold that bioethical principles are univerally valid but must be contextualized, specified and internalized at a particular time and place they are nonetheless universal.[74] Tangwa argues along these lines when he claims that scholars can derive universalizable insights from various cultures that enrich bioethics.[75] A contextually enlightened account is also congruent with a metaethical view that rejects universal principles and regards the truth or falsity of an ethical claim as objectively dependent on particular features of a case.[76] Setting such debates aside, whichever metaethical stance one adopts, we submit that it will be crucial for bioethics to avoid what Widdows calls, "moral neocolonialism," or employing a dominant Western moral framework covertly, under the guise of 'universal values.'[77] In practical fields like bioethics, moral neocolonialism can result in practical harms to communities.[78]

A third objection holds that by drawing on traditional African beliefs we are engaging with a form of ethnophilosophy, or beliefs indigenous to a culture, and this differs from authentic philosophy, which requires critical appraisal. Wiredu, for example, cautions that a spoken folk philosophy generally consists of "bald assertions without argumentative justification;" it takes the form of "This is what our ancestors say..."[79] He argues that folk belief cannot be elevated to philosophy without the addition of critical analysis and argument. Likewise, Houtondji argues that African ethnophilosophy is not rigorously subject to philosophical methods. "One is no more spontaneously a philosopher," he writes, "than one is spontaneously a chemist, a physicist or a mathematician, since philosophy, like chemistry, physics or mathematics, is a specific theoretical discipline with its own exigencies and methodological rules."[80] In contrast to Houtondji, Oruka defends a form of African ethnophilosophy associated with the Sage tradition,[81] a tradition that is largely oral and transmitted through symbols, myths, pithy sayings, stories, and religion. Oruka refers to African sages as philosophers when they are not only "versed in the beliefs and wisdoms of their people," but thinkers, who are "rationally critical...and... recommend only those aspects of the beliefs and wisdoms which satisfy ... rational scrutiny."[82]

In reply, regardless of how this wider debate is settled, the analysis of this paper does not accept at face value the moral beliefs of indigenous people, but instead references written reflections on those beliefs and draws out their implications in practical bioethical domains. Testing ethical concepts and principles by assessing their implications in particular cases represents a form of critical inquiry, sometimes known as 'reflective equilibrium'.[83] The aim of such deliberation is coherence between general and particular beliefs. By employing the tools of reflective equilibrium, this paper has contributed a critical reflection on African thought, rather than an unreflective description of it.

[68]Fricker, M. (2007). *Epistemic Injustice*. New York, NY: Oxford University Press.

[69]Beauchmap, T. & Childress, J. (2019). *Principles of Biomedical Ethics, 8th ed.* New York, NY: Oxford University Press.

[70]Van Norden, B.W. (2017). *Taking Back Philosophy.* New York, NY: Columbia University Press, p. xix.

[71]Solomon, D. (2006). Domestic Disarray and Imperial Ambition. In H.T. Engelhardt, ed., *Global Bioethics: The Collapse of Consensus*. Salem, MA: Scrivener Press: 335-361, p. 337.

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[75]Tangwa, G.B. (2004). Between Universalism and Relativism. Journal of Medical Ethics 30(1): 63-67/

[76]Ross, W.D. (1930). *The Right and the Good.* New York, NY: Oxford University Press.

[77]Widdows, H. (2007). Is Global Ethics Moral Neo-Colonialism? *Bioethics* 21: 305-315.

[78]Bamford, R. (2018). Decolonizing Bioethics via African Philosophy. In G. Hull, ed., *Debating African Philosophy*. London, UK: Routledge: 43-59, p. 43.

[79]Wiredu JE, How Not to Compare African Thought With Western Thought, In RA Wright, ed., *African Philosophy: An Introduction, 3rd ed*. University Press of America: 133-147, pp.140, 141.

[80]Hountondji, P. (1996). *African Philosophy: Myth and Reality.* Indianapolis, IN: Indiana University Press, p. 47.

[81]Oruka, H.O. (1991) Sagacity in African Philosophy. *International Philosophical Quarterly* 23(4): 383-393, p. 384.

[82]Oruka, H.O., op. cit., note 81, p. 386.

[83]Rawls, T.J. (1974). The Independence of Moral Theory. *Proceedings and Addresses of the American Philosophical Association* 47: 5-22.

5 | CONCLUSION

In closing, we began by asking, 'what values and methods can best promote doing bioethics in Africa?' We situated this question in the context of three cases: (1) setting just priorities for hemodialysis for end-stage kidney disease in Ghana; (2) using refurbished pacemakers from wealthy nations for people in low- and middle-income African nations, and (3) shackling of severely mentally ill people by religious and faith-based healers in Ghana. Appealing to an African ethic of *ubuntu*, we introduced a family of concepts to shed light on these examples: community, solidarity, kinship, equality, dignity, humility, and consensus building. Throughout our discussion, leaning African or Western led to a more contextually enlightened analysis and demonstrated the advantages of a more culturally attuned bioethics.

COMPETING INTERESTS

The authors declare no competing interests.

ETHICS APPROVAL STATEMENT

This study does not involve human participants.

CONTRIBUTOR STATEMENT

All authors contributed to developing ideas and arguments contained in the paper, researching, and writing the manuscript.

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