PHOBICULCATIC MORALITY AND BIOETHICS

A PHILOSOPHICAL STUDY OF THE ETHICS OF RESEARCH IN INDIGENOUS MEDICINE IN EAST AFRICA

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DECLARATION

I, Kanakulya Dickson hereby consciously declare to the University of Bergen, Norway through the Department of Philosophy – Faculty of Arts that this thesis, except where acknowledged, is my work. I certify that this thesis is product of my critical and original thought in the field of bioethics. Never before has it been published or submitted to any university or institution for the award of a degree.

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Bergen, Norway
May, 2007

DEDICATION

This work is dedicated to those people who are unjustifiably suffering at the hands of medical injustices and experiments.

ACKNOWLEDGEMENTS

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ABBREVIATIONS AND ACRONYMS:

AHK – Association of Herbalists in Kenya

AIDS – Acquired Immunodeficiency Virus Syndrome

BTHA – Buganda Traditional Healers Association

CIOMS – Council for International Organizations of Medical Sciences

CIOMS – Council for International Organizations of Medical Science

CODESRIA – Council for the Development of Social Science Research in Africa

EAC – East African Community

GDLC – Global Distance Learning Center

GDP – Gross Domestic Product

HIV - Human Immunodeficiency Virus

IEIDE – Institute of Elahi International Initiatives for Development and Education

IIACM – International Institute of Alternative and Complimentary Medicine

IK – Indigenous Knowledge

IM – Indigenous Medicine

KEMRI – Kenya Medical Research Institute

MoH – Ministry of Health

NACOTHA – National Council of Traditional Healers and Herbalists Associations of Uganda

NCRL – Natural Chemotherapeutic and Research Laboratory

NDA – National Drug Authority

NEMA – National Environment Management Authority

NIH – National Institutes of Health (USA)

NURRU – Network of Ugandan Researchers and Research Users

PHC – Primary Health Care

REACH – Regional East African Community Health-Policy Initiative

RITAM – Research Initiative on Traditional Anti-Malarials

TBAs – Traditional Birth Attendants

TM – Traditional Medicine

UBOS – Uganda Bureau of Statistics

UDMPC – Uganda Dental and Medical Practitioners Council

UNCST - Uganda National Council for Science and Technology

WHO – World Health Organization

WKC – World Kobe Center

WMR – World Malaria Report

CHAPTER I

GENERAL INTRODUCTION

1.1 Introduction

This chapter is a general overview of the premises upon which the study was conceived and its direction. This section furnishes the reader with a background to the problem that the research was concerned with. It also presents the research problem which the investigation pursued plus the scope of the study in terms of geography, time and discipline. This introduction also gives the objective(s) that the study set out to achieve and the methodology that was used. In addition to the theoretical framework that guided the research, I also present the justification and significance of the study in this section.

1.2 Background

In medical circles there is increasing concern about the resurgence of indigenous/traditional medicine which seems to be different from modern western medicine.[1] This has not only caused tension between practitioners of these two types of medicine as its being reported[2], but it has also brought to the fore peculiar research challenges that apparently defy traditional analysis by ethicists. Just like in modern western medicine, beneath these challenges lies the perennial issue of ethics. When modern scientists query traditional medicine one of the key issues that do not usually attract as much attention as necessary is the research practices that take place in this type of medicine. This study sought to philosophically investigate the ethics of the research done in indigenous medicine vis-à-vis modern medical ethical guidelines or requirements.

It is reported that, 'defining the role of traditional medicine' in the East African country of Uganda is becoming a key issue that is being raised in medical policy. In other cases, indigenous medical practitioners complain that they are being neglected by government officials yet they think that they are contributing a lot to health provision.[3] However, modern western medical practitioners like those at the Makerere Medical School (a key school in the

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[1] David, Dickson. 2002. "Traditional Knowledge and Modern Science", http://www.scidev.net/Editorials/index.cfm?fuseaction=readEditorials&itemid=11&language=1, accessed on 24th May 2006.
[2] Njoroge, James. 2002. "Kenya Doctors Oppose Herbal Remedies", http://www.scidev.net/News/index.cfm?fuseaction=readnews&itemid=574&language=1, accessed on 24th May 2006.
[3] Makokha Timothy. 2006. "Traditional Medicine Ignored – Medics", *The New Vision*, 12th April 2006, The New Vision Publications Ltd, http://www.newvision.co.ug/D/9/34/492555., accessed on 12th April 2006.

East African region) are concerned about 'unscrupulous medicine men' who are fleecing the population.[4] Because of these concerns the region's governments, lead by the Kenya, are developing national strategies to regulate traditional medical research and practice.[5]

Likewise, the ethical challenges involving traditional medicine have not escaped the attention of the WHO, which has been prompted to issue guidelines that can inform governments as they incorporate traditional/indigenous medicine (TM/IM) in their main stream health policy.[6] The *Guidelines on Developing Consumer Information on Proper Use of Traditional, Complementary and Alternative Medicines* (2004), recognizes the importance of TM but warns about the risks involved in using it without caution and calls on governments to regulate it. Apart from concerns such as adverse drug reactions, lack of regulation, among others, one of the risky aspects of indigenous/traditional medicine (IM/TM) is to be found in the area of research, particularly the risk of abuse of persons.

Basically, modern medical research ethics has been a struggle between empowering individuals on one hand and upholding the authority of medical practitioners and clinicians and researchers on the other. But in most cases much of the concern over TM does not go further to investigate its research ethics. One such study has been done by Norman[7] in which he discusses what he refers to as 'Indigenous Research Ethics'. Using feminist and communitarian assumptions Norman discusses and proposes a 'performance ethics' in which the indigenous peoples are let to determine the ethics with which the work of the researcher is evaluated.[8] We can refer to this argument as setting research ethics within local morality. The implication of that proposal is that research ethics guidelines is set within the morality that is found in these indigenous communities and this raises the issue of the relationship between morality and bioethics.

On the other hand there are researchers who believe that the agenda for research ethics should be set by international global standards. The most prominent of this is the 'Four-Principle' approach (Principlism). These four principles include; autonomy, beneficence, justice and

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[4] Ibid.
[5] Chege, Kimani. 2004. "Kenya to Develop Traditional Medicine Action Plan", http://www.scidev.net/News/index.cfm?fuseaction=readNews&itemid=1461&language=1, accessed on 24th May 2006.
[6] Brahic, Catherine. 2004. "WHO Issues Traditional Medicine Guidelines", http://www.scidev.net/News/index.cfm?fuseaction=readnews&itemid=1451&language=1, accessed on 24th May 2006.
[7] Norman, K. Denzin. 2003. "IRBs and the Turn to Indigenous Research Ethics", http://www.law.uiuc.edu/conferences/whitepaper/papers/CHPT_14-1401-CAS_1.pdf, accessed on 24th May 2006.
[8] Ibid., p. 4-5.

nonmaleficeince. In setting forth the four-pronged approach in bioethics, the Georgetown team which included Beauchamp and Childress argued that the set of principles that they had proposed could be traced from both the Kantian moral philosophy and the outcome-based ethics of Jeremy Bentham and J. S. Mill.[9] This stream of research ethics is mainly from the technologically advanced West where challenges with indigenous or traditional medicine may not be as pronounced as elsewhere. In contrast to discussions such as the one of Norman above which argue for research ethics to be founded in local moralities, principlism is an example of discussions that want to place research ethics within a 'global morality'.

Although most discussions of research ethics are concerned with the applicability of the various bioethical approaches to practical problems in medicine and related fields, there has not been as much attention given to the relationship between morality (whether local or global) and bioethics. This study has been dedicated to analyzing that relationship. It sought to answer questions such as: how does and to what extent does morality impact bioethics; to what extent is morality responsible for the ethical problems found in research in IM/TM?

1.3 Scope of the Study

This is a delimitation of the geographical, temporal and academic scope of the study. In geographical terms I describe the area within which this study was carried out and give reason why this particular area was chosen. In temporal terms, I present the time frame within which the study falls while in academic terms I give the disciplinal boundary of the study.

1.3.1 Geographical Scope

Geographically, this study is set in East Africa (see map). The study was on those natural and humanly constructed phenomena relative to a spatial dimension referred to geographically as East Africa. This study was particularly concerned with the three core countries of the East African Community (EAC), namely, Kenya, Tanzania and Uganda. This is because apart from being identical in terms of history, morality and ethnicity, these three countries share similar ethical challenges in medical research and practice and in addition they are increasingly merging into one geo-political entity which is most likely to lead to a single policy framework in medical research.[10]

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[9] Beauchamp & Childress. 1994. *Principles of Biomedical Ethics*, 4h Edition, Oxford University Press, p. 125-6.
[10] The REACH-Policy Initiative is an example of increasing merging of the health policy in the three countries. The framers

1.3.2 Temporal Scope

In terms of temporal scope, this inquiry reached not only into the pre-colonial time of the region but also the colonial period. Reaching into the past was necessary in order to understand the roots of the dominant morality in the region whose relationship with bioethics was the focus of the study. The study also reached into the recent history of bioethics as a discipline. It is within the timeframe of roughly the last 40 years that bioethics has emerged as an area of enquiry.[11]

1.3.3 Disciplinal Scope

The study falls under applied philosophy; within the realm of applied ethics. Within applied ethics, the study was concerned with issues of bioethics and particularly medical ethics, which is concerned with resolving those ethical challenges associated with medical practice and research. However suffice it to note that, as current trends in academic inquiry go, the study used a multi-interdisciplinary approach so as to capture the complexity of the challenges involved. As a consequence, the study looked to various disciplines such as history and cultural studies to provide insights into the problem at hand where it necessitated.

1.4 Purpose and Objectives of the Study

The task of this study was to philosophically examine the ethical implications of the relation between morality and research ethics in indigenous medicine in East Africa. To that end the researcher hopes that these findings will render research in indigenous medicine more ethical. The study sought to bring clarity to the debate surrounding medical research and practice in indigenous/traditional medicine. In particular, the research endeavored to meaningfully investigate the impact and reconfiguring effect of morality on bioethics in East Africa and perhaps give policy framers in the region vital information to guide medical policy.

1.4.1 Objectives

The investigation was particularly targeted towards the following objectives;

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of this policy initiative officially recognized the fact that the three countries share similar health characteristics, disease burden, among others.

[11] See: Reich W. T. 1994. The Word 'Bioethics': Its Birth and the Legacies of Those Who Shaped It, *Kennedy Institute Ethics Journal*, Vol. 4.

- To bring indigenous biomedicine to mainstream global bioethical discourse.

- To contribute to rendering research in indigenous medicine more ethically accountable.

- To inform policy analysis and formulation as far as medical research is concerned in East Africa.

1.5 Theoretical Framework

In terms of theoretical framework the study used two strands pertaining to; i) theory of the development of bioethics, and ii) normative approach to bioethics. Under theory of development of bioethics the study employed Edmund Pellegrino's evolutionary model of the development of bioethics and under normative approach to bioethics the research was informed by principlism and communitarian ethics.

1.5.1 Pellegrino's Evolutionary Theory of Development of Bioethics

Edmund Pellegrino is considered an authority on the development of bioethics because of having been among the pioneers of the domain in the early 1950s. In his article, "The Origins and Evolution of Bioethics: Some Personal Reflections" which appeared in the, *Kennedy Institute of Ethics Journal*, (1993), Pellegrino set forth the basic tenets of his evolutionary model of the development of bioethics. In this article he identified three phases that he considers to characterize the evolution of bioethics from its early stages to the present and these include: the phase of "proto-bioethics" (1960-1972), that of philosophical bioethics (1972-1985) and that of global bioethics (1985-present).[12]

By 'proto-bioethics' Pellegrino meant the period 1960-1972 during which the language of human values dominated discussion of 'bioethics' (or medical ethics). In this phase studies and inquiry in what we know today as bioethics were generally referred to as 'medical humanities'. This was followed by that of philosophical ethics (1972-1985) during which philosophical inquiries and language dominated the ethics of medicine. It was during this period that approaches to bioethics such as principlism emerged. The next phase, according to Pellegrino, was 'global bioethics' (1985-present) which has seen the inclusion of various disciplines in bioethics discourse and the emergence of branches such as feminist bioethics.

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[12] Pellegrino E. D, "The Origins and Evolution of Bioethics: Some Personal Reflections" in *Kennedy Institute of Ethics Journal*, 9:1 (1993), pp. 73-88.

Pellegrino's evolutionary model of the development of bioethics was employed in the study to examine the place of philosophy in bioethics and in so doing, to determine what the contribution of philosophy should be in this field of inquiry. The same model was used to discuss and promote the position that bioethics ought to take place within the continuum of morality. Likewise, this evolutionary model was employed in the analysis of the 'globalness' of the global phase of bioethics as advanced by Pellegrino.

1.5.2 Principlism and Communitarian Ethics

Principlism supplied the first aspect of the normative-approach-to bioethics strand of the theoretical framework of the study. As mentioned earlier, principlism derived from the four-principle approach to bioethical challenges advanced by the Georgetown school. Principlism is derived from the term 'principles'. Principles are on the whole taken to be, "general statements from which particular decisions are to be drawn by a process of deduction".[13] In bioethics principlism is an approach to solving bioethical dilemmas through a deductive reasoning that applies basic guidelines to various situations or fields.

Principlism as an approach to solving ethical dilemmas, has gained prominence in bioethical circles because it is thought to be: neutral, pluralistic and all-embracing.[14] Although the application of principles to various fields of human life can be traced from a long way back in philosophy, bioethical principlism is relatively a recent development. It was after the Commission appointed under the US President Ford's reign in 1974 had issued the Belmont Report of 1978 that 'principlism' came into mainstream bioethics. The Commission had identified and defined three ethical principles that would guide health research and practice and these included: respect for persons, justice and beneficence.[15] These principles have now come to be four, namely, autonomy, beneficence, justice and nonmaleficeince.

Communitarian ethics supplied the second aspect of the normative-approach-to bioethics strand of the theoretical framework of the study. Communitarian ethics is best understood when contrasted with extreme ethical atomism or individualism; it calls for considering the

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[13] Stan Van Hooft. 1999. "Socratic Dialogue as Collegial Reasoning", in *Practical Philosophy*, Vol. 2, No. 2 July 1999.
[14] Miyasaka Michio. 2002. "A Broader Definition of Justice in Global Bioethics", http://www.clg.niigata-u.ac.jp/~miyasaka/narrativejustice/EPMH2002.html., accessed on 20th April 2006.
[15] Dianne N. Irving. 2001. "The Bioethics Mess", http://www.lifeissues.net/writers/irv/irv_37bioethicsmess.html, accessed on 27th June 2005.

collective within which the individual is. It is generally taken that this type of ethics is more dominant in developing countries than in the developed ones. The basic underlying principle of communitarian ethics is that each individual should be integrally concerned not only with the pursuit of his or her own personal interests but above all, with the promotion of the well-being of as many others as possible.[16]

In the study principlism was employed in analyzing the impact and reconfiguring effect of morality on bioethical guidelines. Principlism supplied the case study in trying to answer the question: How does an environment of a phobiculcatic morality affect bioethical guidelines in the conduct of research? Communitarian ethics provided the fabric within which the nature and emergence of a phobiculcatic morality was considered and generated.

1.6 Justification of the Study

Because of the increase in official interest in traditional medicine and the peculiar challenges that research in this type of medicine presents coupled with the impact of morality on bioethics, the need for a philosophical examination of the ethical implications of the relationship between morality and bioethics in IM/TM was realized by the researcher. The justification of this study was setting out to investigate that relationship. It was the hope of the researcher that the findings of this investigation would help provide vital information to bioethicists and health policy makers.

1.7 Methodology

This study applied a three-pronged methodology reflecting the major approaches to inquiry in philosophy, (i.e. the analytical, descriptive and prescriptive approaches), which were expected to enrich the research and help the research to carry out an investigation that would be as philosophically deep as possible. On that note therefore, the study endeavored to employ the philosophical instruments of rationality, critique and systematicity to properly analyze the concepts involved, to decipher through the common arguments that are being used in the debate so as to identify fallacious positions and non-fallacious ones.

The analytical element of the methodology was meant to help in the clarification of the major

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[16] Basant K. Kapur. 1999. "Harmonization between Communitarian Ethics and Market Economics", *Journal of Markets and Morality*, Vol. 2 No. 1, Spring 1999, http://www.acton.org/publicat/m_and_m/1999_spr/kapur.html., accessed on 20th May 2006.

concepts involved and highlighting their meaning. The study applied this aspect because, in philosophy, the fundamental purpose of engaging in conceptual clarification is to help us comprehend the meaning of the major notions that we use in our discourses. Without a fairly good grasp of the key concepts used in a philosophical study, neither effective examination nor meaningful conclusions can be made.

The study used the descriptive approach to look into the empirical features of the various aspects of the ethical challenges in indigenous medicine in East Africa that were deemed relevant. These facts on the bioethical challenges were obtained from extensive search in scholarly sources. The empirical date was meant to encourage an appreciation of the seriousness of the bioethical crisis in the region.

With the philosophical insights generated from a combination of the analytical and descriptive approach, the study diagnosed the problem and finally applied the prescriptive element of the methodology to point towards some solutions to the problem.

The study utilized secondary data and available information in form of; journals, books, articles, government policy papers and publications, international instruments, web-pages, among others. In order to access these sources, the researcher visited a number of libraries in the region where research in medicine is currently being carried out.

1.8 Significance of the Study

Since the study was set in the discipline of philosophy, its significance is expected to derive first from its philosophical nature. The study was motivated by the understanding that although other disciplines (such as medicine, biology and others) have and can contribute significantly to the debate concerning bioethics in East Africa, nonetheless by their nature, they are not well-equipped to: i) identify the fundamental nature of the concepts being used in the debate; and ii) to point out the fallacious positions that are being used as arguments from each of the perspectives that are being used to approach this debate.

This study is also expected to derive its significance from the fact that it sought to place indigenous medicine at the forefront of global bioethics discourse. We should take note that much of the discussion pertaining to the bioethical debate is mostly concerned with challenges

posed by modern technological advancement and their effect on western medical practice and research. This usually leaves indigenous biomedicine out of the much of bioethical discourse. Much of bioethics discourse is underlaid with an assumption that modern western medicine is the norm globally[17] and this denies room for discussing the ethical challenges in other forms of medical practices and research such as traditional/indigenous medicine.

Finally the study is also expected to derive its significance from the fact that it generates a novel understanding and approach to defining morality which has led to the differentiation between phobiculcatic morality and non-phobiculcatic morality. This has been a result of a fresh look at the process by which morality is transferred from one generation to another.

1.9 Conclusion

In this chapter I have presented a general overview of the premises on which this study was grounded. I have given the background of the study and a demarcation of the scope of the research. In addition I have discussed the theoretical framework of the study. The introduction has also stipulated the methodology that was used, plus the justification and significance of the study.

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[17] Doris Schroeder. 2005. "Human Rights and Their Role in Global Bioethics", *Cambridge Quarterly of Healthcare Ethics*, Vol. 14, p. 221-3.

CHAPTER II

LITERATURE REVIEW

2.1 Introduction

This review is a survey of selected and indicative literature aimed at identifying the problem that the study focused on. The first section reviews the literature on the rise in interest and research in indigenous medicine. The second section reviews selected literature dealing with the development of bioethics and approaches to ethical challenges in medicine.

2.2 Literature on interest and Research in Traditional Medicine

In, *WHO Traditional Medicine Strategy 2002 – 2005*, the World Health Organization observes that TM is widely used and of rapidly growing health system and economic importance. In Africa up to 80% of the population uses TM to help meet their health care needs. The book reports that this is the trend in many developing countries with majority depending on TM for primary health care. In Uganda and Tanzania, for example, it was reported that TM is used by 60% of the people in those countries. The WHO also indicated that there is growing use of alternative medicine in the developed countries with Canada having the highest incidence at 70%.[18] In the book, the WHO adds its voice to other international groups such as the EU that are calling upon their member states to promote official recognition of this type of medicine.[19]

However, the WHO also points out that there are challenges that surround the theoretical and practicalities of TM. The book classifies these challenges into four categories i.e. i) national policy and regulatory frameworks, ii) safety, efficacy and quality, iii) access and iv) rational use. An example of the challenges placed under the first category is lack of recognition of TM providers; under the second category we find the lack of methodology; under the third we find the lack of data measuring access and affordability and in the last we find the lack of information for public on rational use of TM.

This book by the WHO represents the increasing appreciation of the place of TM in health care not only in poor countries but also in the rich ones. This study shares the same

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[18] World Health Organization, 2002, *WHO Traditional Medicine Strategy 2002 – 2005*, WHO, Geneva, p. 9-11.
[19] Ibid., p. 18.

appreciation of TM and therefore endeavors to demonstrate its importance in primary health care in East Africa. However, it is noteworthy that the WHO's discussion of the problem in research in TM was lacking in pointing out the impact of morality on the research ethics in this domain. Under research, the book pointed out problems such as low levels of research and inadequate clinical trails in TM; it also indicated some priority areas for research as the following reproduced table shows:

Fig 1: WHO Priority areas of Research in TM

Priority areas for research
• Effects of each individuals therapy: efficacy, safety and cost-effectiveness   • Research into mechanisms of action of individual therapies, including patterns of response to treatment.   • Research into TM/CAM genre itself, including social research into motivation of patients seeking TM/CAM and usage patterns on TM/CAM.   • Research into new research strategies which are sensitive to the TM/CAM paradigm.   • Research into efficacy of diagnostic methods used.   • Research into implementation and effects of TM/CAM in specific health care settings.

Source: *WHO Traditional Medicine Strategy 2000-2005.*

The priority areas that WHO adopted and promoted in the above table are lacking in an important aspect, namely, the ethics of research in this type of medicine. The ethics of research in TM need to be on the priority list of areas of research because TM is not exempted from possible abuse of participants. The fact that TM is being incorporated into official health care policy in many developing countries makes it even the more important to promote ethical conduct of research in this type of medicine.

Robert H. Bannerman et al., have argued that traditional medicine can help countries get solutions to the challenge of how they could make health and medical care available to all their citizens. In the introduction to, *Traditional Medicine and Health Care Coverage: A Reader for Health Administrators and Practitioners* (1983), they have observed that there is a "…reawakening of interest in the…[and]…rediscovery of local traditional systems of health care and the importation of traditional practices from abroad" in many scientifically advanced

societies.[20]

In the same book, Mamadou Koumare in his article, "Traditional Medicine and Psychiatry in Africa" discusses the nature of this type of medicine in African context. He argues that African TM is a distillation of African culture and its character can not be independently understood without looking at the "environment and social evolution" within which it emerges. Using this backdrop, he goes ahead to discuss the fundamental tenets of African TM such as the idea of balancing elements of nature among others. However, he cautions about becoming overexcited by the "picturesque" aspects of TM arguing that this can end up destroying this type of medicine.

This study agrees with Mamadou's observation and cautions about becoming overexcited by African TM. It is understandable that there has been general frustration with modern western medicine in most parts of the world due to promises that it has not fulfilled. (Actually at the time of publication of this book, 1983, many WHO officials were arguing that TM was going to help a lot in achieving the goal of health for all by the year 2000. This is yet to be seen to come to pass). However, our guard should not go down and neither should we waiver the ethical demands that have been exacted on modern western medicine when it comes to traditional medicine. There is possibility of misconduct in traditional medicine just as it exists in modern western medicine if not worse. That is why we need to place TM under bioethical scrutiny just as the case is under modern western medicine.

Despite being wholly dedicated to traditional medicine, it is important to note that the book does not pay focused attention on research in traditional medicine. The analysis of dynamics surrounding TM should not be only on the practice but there is need to also examine research in this type of medicine. It is a fact that a lot of money is spent on research on TM especially herbal medicine to extract therapeutical components in the development of new medical products; this makes it all the more important to focus on research in TM and to understand the ethical challenges involved.

Concerning the challenges encountered in traditional medicine, Iwu Maurice has identified the need to "format a strategy that will make traditional medicine available to a wider

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[20] Robert H. Bannerman, John Burton & Ch'en Wen-Chieh, eds. 1983, Traditional Medicine and Health Care Coverage: A Reader for Health Administrators and Practitioners, WHO, Geneva, p. 12.

population while preserving the cultural bases of the healing systems"[21]. Iwu discusses the challenge presented to conventional western medicine of understanding the spiritual healing aspect of TM; he particularly discusses the tension that exists between practitioners of conventional western medicine and traditional medicine. He advises however, that, "Regardless of the preferred form of treatment, a common underlying tenet is that the selection of the therapeutic agent should be based on solid evidence of efficacy and safety."[22]

Iwu's discussion of the challenges surrounding TM points to the need to set safety standards just as in the case conventional western medicine. He observes however, that the establishment of parameters of safety is not an easy undertaking. This study shares the conviction that the issue of safety is a grey area when it comes to traditional medicine and there is need to demystify it by investigating into the nature of this kind of medicine. Iwu observes that setting safety standards that could apply to both conventional western medicine and traditional medicine presents a challenge because of "…the huge differences in both the fundamental framework of the two systems and the methods of practice."[23] It is therefore important to understand the framework in traditional medicine that renders it elusive to safety parameters and accountability because without this the people who use TM face great risks of abuse.

The Indigenous Peoples' Research Center has produced a report on the place of ethics in research on indigenous peoples and their knowledge: *The Ethics of Research Involving Indigenous Peoples.*[24] In this dossier the authors decry the unethical conduct of research in research involving these people. The report is one of the most comprehensive studies on the ethics of research involving indigenous people and their knowledge; it discusses the nature of the ethics and draws from the history of breaches of the rights of those peoples.[25] While condemning the way in which indigenous peoples have been treated in research, the report recommends giving them jurisdiction over their property and knowledge; advancing the conceptual domain of research ethics; among others.[26] The basic line is that these people need to be empowered to control research involving them.

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[21] Iwu Maurice, "Introduction: Therapeutic Agents from Ethnomedicine", in Iwu Maurice & Wootton Jacqueline (eds.) 2002 *Ethnomedicine and Drug Discovery*, Elsevier, p. 3.
[22] Ibid., p. 5.
[23] Ibid.
[24] Willie Ermine, Raven Sincliar, & Bonnie Jeffrey. 2004. *The Ethics of Research Involving Indigenous Peoples*, Indigenous Peoples' Health Research Center, http://www.iphrc.ca/text/Ethics%20Review%20IPHRC.pdf., accessed on 20th April 2006.
[25] Ibid., p. 9
[26] Ibid., p.45-7

However, the report is wanting in terms of dealing with research carried out by the indigenous people themselves. The presupposition of the report is that foreigners are the only ones who abuse indigenous peoples during research. But as observed above, government are realizing that there is a great deal of abuse being done by practitioners of indigenous medicine; for example in Uganda and Nigeria. Even in the West where alternative forms of medicine are increasing; there is concern about the ethical implication of these non-conventional forms of medicine.[27] As countries in Africa, such as Uganda are preparing to incorporate indigenous medicine into the mainstream health system[28], there are also increasing concerns over the actual and possible abuse of persons and misuse of the practice.

In the article, "Ethical and Regulatory Issues Surrounding African Traditional Medicine in the Context of HIV/AIDS" Aceme Nyika presents another discussion of the challenges that surround TM. Aceme discusses the nature of TM (pointing out the differences between the spiritual aspect and the herbal aspect) and applies this discussion to the treatment of HIV/AIDS. He discusses this from the background that Africa carries 60% of total number of people living with HIV/AIDS. Aceme decries the practice of combining the magical branch of TM with ordinary herbalism which complicates application of ethical and regulatory guidelines.[29] Aceme also criticizes the "paternalistic, numinous approach in the practice of traditional medicine which violates ethical principles of autonomy, beneficence and non-maleficence"[30] In addition to the ethical challenges that Aceme discusses, there are also therapeutical problems that are pointed out in this article among which are the complications that arise from combining TM and ARVs in the treatment of HIV/AIDS.

The challenge of ensuring accountability in traditional medicine is a great one as Aceme and other scholars do recognize. This study also shares this concern but places particular emphasis on the challenges that exist in the area of research in traditional medicine. Aceme observes that because of the lack of information on TM, "…patients may be used for 'experimentation' without their knowledge or consent. Consequently, the practice of TM, without standardization, could be perceived as perpetual, poorly designed 'experimentation' with

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[27] Dónal P. O'Mathúna. 2001. "Spirituality and Alternative Medicine in the New Millennium",
http://www.cbhd.org/resources/healthcare/omathuna_2001-04-12_print.htm., accessed on 12th May 2006.
[28] Op. cit.
[29] Aceme, Nyika. "Ethical and Regulatory Issues Surrounding African Traditional Medicine in the Context of HIV/AIDS" in *Developing World Bioethics*. Vol. 7 No. 1, 2007, p. 27.
[30] Ibid., p. 28.

human patients."[31]

By this statement Aceme touches a tip of the iceberg of uncertainty that surrounds research in TM. Many investigations have been carried out concerning research in TM but they are mainly concerned with international researchers who come to carry out research in Africa. However, there is another side to this and that is the research carried out by the practitioners of TM themselves which usually escapes scrutiny. There is rarely any discussion of the peculiar ethical challenges posed by research in TM in the dominant bioethics discourse. There is therefore need to bring these challenges to the forefront of bioethics discourse.

2.3 Literature on Bioethics

In his article on the history and development of bioethics, "The Origins and Evolution of Bioethics: Some Personal Reflections" Edmund Pellegrino divides the development of bioethics into three stages the first of which he calls educational, the second ethical and the third is the global stage. Pellegrino's identification of these eras is from the perspective of a pioneer in bioethics thus a general indicator of the trend in bioethics discourse.

> *In the educational era, bioethics focused on a perceived "dehumanization" of medicine by the rising power of science and technology. Remedies were sought by introducing humanities, ethics, and human "values" into the medical curriculum. Ethics was one among the humanistic disciplines, but not the dominant one. In the second era, ethics assumed a dominant role as ever more complex dilemmas emerged from the rapid pace of biological research…Philosophically trained ethicists had an obvious role…In the third – and present – period, the breadth of problems has become so broad that ethicists must, themselves draw on disciplines well beyond their expertise – e.g., law, religion, anthropology, economics, political science, psychology, and the like.[32]*

Pellegrino's view of the development of bioethics is representative of the dominant view in bioethics. However, it is worthwhile to note that when in discussing the "global era" the 'globalness' is more about other disciplines and their contribution to the bioethics discourse. But there is another aspect of this 'globalness' that needs to be included and that is in the discipline of medicine itself. A lot of discussions in bioethics is on conventional or modern western medicine and not adequate attention is paid by bioethicists to the ethical challenges in

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[31] Ibid.
[32] Pellegrino E. D., op. cit., p.73.

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other types of medicine that are unconventional such as indigenous/traditional medicine. Given the fact that many people are still using this type of medicine, it becomes imperative that it is placed under investigation by bioethicists to ensure proper conduct within this type of medicine.

Discussion of the evolution of bioethics rarely includes indigenous biomedicine. Current debate on principles of research ethics is in most cases only concerned with conventional medicine. The growth in discussion of the place of human rights in a global biomedical consensus[33] is an indication of the increasing concern with the ethics of research across national boundaries. This implies that other types of medicine are gaining prominence hence presenting new ethical challenges which need to be investigated. In that vein, this study picks on the challenge of research in traditional medicine as a case of non-western medicine and the challenges it poses.

The Helsinki Declaration states that, "medical research is subject to ethical standards that promote respect for all human beings and protect their health and rights" (par.8)[34]. This declaration presents a problem that is usually not given as much attention as it warrants, namely since the term "medical research" includes research in non-conventional medicine such as traditional/indigenous medicine, how far possible is it to apply standardization in medical research in TM? If we agree that TM is a big part of global medicine as it is increasingly receiving official recognition, then as a matter of necessity, we must apply the same standards to this type of medicine as to any other. However, the question is: is it possible to do so? What are some of the difficulties that are encountered in trying to subject this type of medicine to bioethical accountability?

Under the chapter, "Research Ethics" in their book, *Medical Ethics*, Campbell, et al discuss the challenges found in research in medicine especially in the light of the post-war revelations of the atrocities committed by Nazi doctors and the Third Reich in the name of research. From a predominantly deontological standpoint they use cases of research that they consider unethical to analyse the ethical challenges encountered in medical research. One of the basic tenets of their discussion of research ethics is that without, "…clear enunciation of principles

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[33] Roberto Andorno. 2002. "Biomedicine and International Human Rights Law: In Search of a Global Consensus", Bulletin of the World Health Organization, Vol. 80, No. 12, pp. 959-63.
[34] World Medical Association Declaration of Helsinki, 2004, paragraph 8.

and guidelines…"[35] there can be a lot of abuse of persons in the medical research.

The principles that they advance to guide medical research include; scientific validity, risks and benefits, information and consent, among others. They argue that a research cannot be ethical if it lacks scientific validity and cautions against 'marketing exercises' for products such as new drugs which can wrongly be passed for research. Their understanding of validity is the existence of, "a clear and *prima facie* useful hypothesis to be tested" The issue of validity is also contentious in TM and this study shares the concern over this aspect of research. However, the understanding of validity on which Campbell and colleagues premise their discussion may present even more problems if it is applied to the case of TM. The nature of TM is quite complex to fit into this understanding of validity and this creates a problem in trying to justify research in this type of medicine.

From the discussions that Campbell and colleagues advance, the argument that TM defies the application of bioethical principles is further augmented. Apart from the complications that I have pointed above in terms of scientific validity, as they discuss, for example, the risks and benefits of research; and information and consent more complications emerge. When it comes to therapeutic research, they argue that the viability of such a project comes from balancing between risks and benefits. However good this sounds it is quite another story when it comes to TM because of the complexity of assessing the risks and benefits involved. This is why it is important to investigate the nature of TM as a step towards simplification of the assessment of the risks and benefits involved. It is important for ethics committees to understand the nature of TM such that if they have to either approve or disapprove a project, they do so from an informed position. When it comes to informed consent, there are still complications because knowledge about TM is hidden in mystical language and kept secret thus making it hard even to tell patients or participants of what may be going on in case of research.

The complications that TM presents when it comes to the application of principles of bioethics can also be observed in relation to the popular four-principle approach. Beauchamp and Childress, who were the first to extensively propound and defend the four-principle approach, have now had five editions of their book, *Principles of Biomedical Ethics*, which shows the popularity of this approach.

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[35] Campbell A., Gillet G., & Gareth J. 2001 *Medical Ethics*, Oxford University Press, p. 219.

But despite this popularity, the four-principle approach (principlism) has had little impact on research in TM in terms of rendering it more ethically accountable. To understand why this is so, we need to take into consideration the key issue of morality. In earlier editions they presented a view of "common morality" (the basic tenet on which their universalistic four-principle approach is based) as norms and customs that are socially sanctioned while in the most recent edition (fifth) they have defined it as "norms that all morally serious persons share."

One of the premises of this study is that morality precedes principlism; meaning that before principlism emerges, morality is. It is therefore important to analyse the application of the four-principles within the continuum of morality. But most importantly, it is imperative to understand how this "common morality" comes to be and how this process impacts on the application of the four-principles (or any principles that may be generated). This is an aspect that the authors and defenders of principlism do not give adequate attention. Could it be that the inculcation of morality creates an environment which renders the application of principlism difficult? This study tries to answer such a question examining how morality is inculcated and also sets out to determine the extent to which this process impacts on the application of principlism.

In a research report on the ethics of research in developing countries titled, *Globally Speaking: Report on the Ethics of Research in Developing Countries*, Ulrich George starts from a good observation as a premise which is that research conducted in developing countries is widely perceived to be associated with a number of "uncharacteristic ethical complications." [36] He thinks that this is a result of: i) underlying global inequalities; ii) vulnerability of impoverished population groups; and iii) culturally determined communication gaps. He is of the view that there is inadequate attention being paid to how the above factors manifest themselves in actual research situations. He also calls on thinkers to properly address the ethical complications that arise from this situation.

In response to those challenges Ulrich argues that effectively responding to the ethical difficulties associated with research in developing countries means framing a genuinely global

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[36] George Ulrich, 1999, *Globally Speaking: Report on the Ethics of Research in Developing Countries*, Danish Council for Development Research (RUF), p. 200.

perspective on professional ethics.[37] With the help of numerous examples for illustration, he then develops a taxonomical classification of the types of ethical issues that confront researchers in developing countries. The four categories of ethical issues that he generates are those that pertain to; i) protection; ii) communication; iii) relevance; iv) collaboration. He argues that this categorization deals with concrete issues of ethical complications. One of his pieces of advice towards resolving these complications is that "current international discourse on research ethics needs to become much more interactive and responsive to the concerns and perspectives of researchers in developing countries."[38]

In that vein this study sought to bring to the attention of international bioethics discourse the concerns that the dominant type of medicine (i.e., traditional medicine) in developing countries (in this case Kenya, Tanzania and Uganda) presents. This may help in resolving the ethical complications that surround medical research in these countries. The study also recognizes the importance of bringing out certain perspectives on the moral challenges in medical research which mainstream bioethics discourse may not be paying adequate attention to.

2.4 Conclusion

The foregoing review has been of selected literature that I thought was representative of the major thoughts and ideas in the two main areas that this study is concerned with, namely, traditional medicine and bioethics. The study derives its justification from the issues that have been raised in this review which are considered to demand for more attention. In all a number of issues have emerged in this review and the following are key among them: i) given the fact that traditional medicine is used by the majority of people in developing countries, it is useful to place it under the scrutiny of bioethics in order to protect persons who use it. This is even more necessary since there is growing research in TM; ii) application of principles that guide biomedical research to TM has not yielded much in terms of rendering it more ethical because proponents of the dominant approach to bioethics, (i.e., principlism) have not paid adequate attention to the issue of how morality is inculcated and how this process impacts on bioethics in this type of medicine.

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[37] Ibid., p. 201
[38] Ibid., p. 202

CHAPTER III

BIOETHICS DISCOURSE: FROM 'PROTO' TO 'GLOBAL'

3.1 Introduction

In this chapter I discuss three main points as premises for subsequent chapters. The first point is that looking at the dominant account of the development of bioethics, the general understanding of the 'global' era of bioethics tends to incline towards the inclusion or infusion of other disciplines (especially the behavioral sciences) into the bioethics discourse at the expense of leaving 'other' forms of medicine in the cold. This raises a question on the 'globalness' of the dominant discourse. For bioethics to claim a global stance (and to remain relevant to all medical domains), it necessarily has to include other non-western forms of medicine such as indigenous medicine. The second point is that despite bioethics getting more inclined to resolving practical dilemmas, the centrality of the philosophical in bioethics remains irrefutable and beckons for more attention because of the underlying philosophical questions that keep coming up. The third point is that engaging in bioethics necessarily entails engaging in the moral life and thus making morality a continuum within which bioethical challenges can be viably analyzed.

3.2 Demarcating Bioethics

Currently any discourse on bioethics faces the challenge of defining what is meant by 'bioethics' especially given the fact that it is a nascent area of inquiry and a number of disciplines are having increasing input into its discourse. The question: 'what is bioethics?' is quiet important. The imperativeness of this question has prompted a key writer in bioethics to state that, "The practical importance of bioethics is such that its definition is more than a semantic or pedantic diversion."[39] As bioethical discussions get into mainstream political discourse, it becomes even more imperative to demarcate what bioethics stands for, as the U.S. Congress observed,

> *Once generally the province of philosophy and religion, discussions about these and other highly complex and contentious issues have entered the political arena. During the past two decades, such discussions have crystallized into a discipline referred to, alternatively, as "biomedical ethics" or "bioethics". Today, how to set boundary rules for policy purposes amidst a web of ethical complexity has become*

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[39] Pellegrino E.D., "Bioethics as an Interdisciplinary Enterprise: Where Does Ethics Fit in the Mosaic of Dicsplines?" in Ronald A. Carson & Chester R. Burns, eds. (1997) *Philosophy of Medicine and Bioethics: A Twenty-Year Retrospective and Critical Appraisal*, Kluwer Academic Publishers, p. 2.

extremely critical.[40]

There could still be some confusion concerning what bioethics means or what its scope is and what it is not. It is claimed for example that some writers are interpreting bioethics to mean 'biological ethics'.[41] To be able to establish the scope of bioethics we need to look at how this area of inquiry called 'bioethics' has developed over the last couple of decades. It is therefore necessary to investigate how the bioethics discourse has evolved over time.

3.3 The Evolution of Bioethics

One of the key persons who have written authoritatively about the emergence of bioethics is Edmund Pellegrino because he is considered one of the pioneers of bioethics. He has identified three eras that he considers to characterize the evolution of bioethics and these are: the era of "proto-bioethics" (1960-1972), the era of philosophical bioethics (1972-1985) and the era of global bioethics (1985-present).[42] He based these stages on the language and method that are predominant in a given period. Below is a figure summarizing Pellegrino's evolutionary model of the development of bioethics

Fig 2: Pellegrino's Model of the development of bioethics

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[40] U.S. Congress, Offices of Technology Assessment, (1993) *Biomedical Ethics in U.S. Public Policy – Background Papers, OTA-BP-BBS-105*, (Washington, DC: Government Printing Office, June 1993), p. 2.
[41] Op. cit., p. 15.
[42] Pellegrino E. D, op. cit.

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┌─────────────────────────────────────────────────┐
│               Bioethics (Pellegrino)            │
│                                                 │
│                  Proto-ethical                  │
│                   (1960-1972)                   │
│                 Educational phase               │
│             Language of human values            │
│         Religion and Philosophy predominate     │
│                      │   │                       │
│                      ▼   ▼                       │
│               Philosophical Bioethics           │
│                   (1972-1985)                   │
│                   Ethical phase                 │
│           Language of philosophical ethics      │
│           Decision making based on principles   │
│               Backlash against principles       │
│             (virtue ethics, narrative ethics)   │
│                        │                         │
│                        ▼                         │
│                 Global Bioethics                │
│                  (1985-present)                 │
│                   Global phase                  │
│          Broad problems require many disciplines│
│            Language of social/behavioral sciences│
│        Law, literature and social sciences predominate│
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Source: *Swisher (2002).*

Studying the complex ethical dilemmas that more clinical autonomy presents to physical therapists, Swisher analyzed the evolution of knowledge of ethics in physical therapy from 1970-2000 by looking at peer-reviewed journal articles cited in the MEDLINE (or Cumulative Index to Nursing and Allied Health Literature databases during the said period or those referenced in *Ethics in Physical Therapy*). Swisher compared those articles with the evolutionary models proposed by Purtilo[43] in physical therapy and by Pellegrino in bioethics.[44] However, our interest in Swisher's study is in the comparison of articles with the evolutionary model of bioethics that is advanced by Pellegrino. To have a clearer analysis of the evolution of bioethics we need to look at Swisher's comparison of these three eras that Pellegrino has advanced with the selected articles.

Apart from finding that the philosophical 'thread' remained dominant in the years under study, Swisher observed that the developments in bioethics as could be observed in the articles supported the evolutionary model proposed by Pellegrino. The following is an

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[43] Purtilo writes about the evolution of professional ethics in physical therapy in the changing social environment focusing on commitment and accountability on which he bases his classification. However our interest in this study is on the evolution of bioethics that is advanced by Pellegrino.

[44] Swisher Laura Lee, 2002, "A Retrospective Analysis of Ethics of Knowledge in Physical Therapy (1970-2000)", *Ethics in Physical Therapy*, Vol. 82, No. 7, 2002, pp. 692-706.

adaptation of Swisher's findings:

Fig 3: Swisher's Study of Pellegrino's Evolutionary Model of Bioethics

Pellegrino's Evolutionary Period	1970-1979 (n=14)	1980-1989 (n=24)	1990-2000 (n=43)
Values ('Proto-bioethics')	1(7.1%)	3(12.5%)	1(2.3%)
Philosophical Ethics	12(85.7%)	20(83.3%)	26(60.5%)
Social Scientific ('Global-bioethics')	1(7.1%)	1(4.2%)	16(37.2%)

Table adapted by author from Swisher's study.

In the above table, 'n' stands for the total number of articles or publications that Swisher considered in the given period which were relevant to her study according the criteria that she used. (Her criteria excluded publications that were focused on a topic that was outside United States). She placed the publications alongside Pellegrino's evolutionary stages to find out the extent (or percentage) to which they confirmed it.

From the results of Swisher's study it can be said that to a large extent Pellegrino's model represents the general trend in bioethics. As discussions in bioethics started, expositions were more religious and as time progressed discussions became more philosophical in nature but today the social/behavioral sciences have increasingly gained more space in the discourse albeit philosophical questions still concern many scholars.

3.3.1 'Proto'-Bioethics

By the era of 'proto-bioethics' Pellegrino meant the period 1960-1972, which is considered the beginning of bioethics. Bioethics was generally pursued under the rubric of 'medical humanities'. According to him during this period the language of human values dominated discussion of 'bioethics' (or medical ethics). Although in this era most of those concerned about the dehumanizing effect of technological advancement on medicine were not professional scholars of philosophy, they shared a common belief.

> *…they shared a conviction that, if introduced into medical education, the humanities…with their focus on 'humanity' and 'human values,' could temper, if not reverse the dehumanizing and depersonalizing effects of technology on patient care and raise the ethical sensitivities of future physicians.*[45]

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[45] Pellegrino, 1997, op. cit., p. 5.

A.R Jonsen has also written to the same effect that by the end of the last hundred years scientific discoveries in physiology and bacteriology had radically changed the understanding of health and disease and this had effect on the simple traditional morality.[46] With advancement in medical technologies, the argument that medicine could be carried out indifferently to morality was no longer sustainable. This explains the call for the humanities to temper technological medicine. With developments in medical technology new ethical questions emerged; things such as transplantation, in vitro fertilization, among others either caused new concerns to arise or made old medical moral challenges take on a new form. There was greater need for an ethic that could back the new regulations in healthcare policy in the West because the old justifications seemed less appropriate.[47]

3.3.2 Philosophical Bioethics

The next era in Pellegrino's evolutionary model of the development of bioethics is that of philosophical bioethics (from 1972-1985). During this period bioethics debates were dominated by philosophical ethics. He claims that it was in this era that the term 'bioethics' was almost simultaneously coined by Van Rensselaer Potter of the University of Wisconsin and the Georgetown University duo of Andre Hellegers and Sargent Shriver. According to him, the discourse and conceptual evolution of bioethics that took place in this era centered on the theoretical substratum for bioethics.[48]

During this period, bioethics tended to became a branch of mainstream philosophy using the same method as philosophy. The focus was on normative ethics in the resolution of concrete ethical dilemmas in medicine. One of the most significant developments in this era was the emergence of the 'Georgetown mantra' of the four principles of bioethics, namely autonomy, justice, beneficence and nonmaleficeince. The four principles became popular because, "…the orderliness and relative clarity of Principlism…had a special appeal for practical-minded clinicians who adopted it widely".[49]

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[46] Jonsen, A.R, "Introduction to the History of Bioethics" in Nancy S.J, Jonsen A.R, Pearlman R.A, eds. 1997, *Bioethics: Introduction to the History, Methods and Practices*, Jones and Bartlett Publishers.
[47] Tristram Engelhardt, Jr., "Bioethics in the Third Millennium: Some Critical Anticipations" in *Kennedy Institute of Ethics Journal*, 9:3 (1999), pp. 225-243.
[48] Pellegrino E.D, 1993, op.cit. p.82.
[49] Ibid.

3.3.3 'Global' Bioethics

As 'principlism' (championed by Beauchamp and Childress) came under attack for being too abstract and narrow, there arose calls for alternatives to the four principles which 'could' capture the complex challenges in medical practice and research. This era (1985-present) has seen the inclusion of various disciplines in bioethics discourse such as law, behavioral sciences, literature, among others and the emergence of branches such as feminist bioethics. Elsewhere, in writing about the relationships of the disciplines in bioethics, Pellegrino has mentioned a model which is similar to the 'global' era of bioethics, namely the '*Eclectic-syncretic*' model. In discussing this model, just like in the global era of bioethics, he mentions scholars who call for the merging of disciplines such as biology and literature with bioethics. But some questions still remain to be explored such as: what is 'global' in bioethics; what are the implications of globalizing bioethics; is the bioethics discourse really global?

3.4 Appraisal of Pellegrino's Model

Pellegrino's evolutionary model of the development of bioethics can be appreciated to the extent that it captures the milestones that bioethics discourse has covered fairly enough. On the whole, as Swisher's study indicated, Pellegrino's evolutionary model captures the major development that bioethics has undergone. His model appreciates the fact that bioethics is not what it was a couple of decades ago. He rightly recognizes that in the early phase of bioethics it was mainly a concern of religious thinkers. It is also true that philosophical concerns took center stage after some time and of recent bioethics is bringing on board many other disciplines given the postmodern criticism of philosophy's emphasis on foundationalism (and particularly the demise of the influence of the four principle approach).However, with further consideration there are some elements in his account that may not augur well with what has emerged in bioethics over time.

3.4.1 The Place of Philosophy in Bioethics Discourse

In pointing out the era of philosophical bioethics he observes that the Georgetown's 'version' of philosophical bioethics in form of principlism became dominant. The four principles of bioethics, namely autonomy, justice, beneficence nonmaleficeince (the 'Georgetown mantra') became the basis of formal ethical analysis in medical practice and research. He notes that the, "…discourse centered on the theoretical substratum for bioethics…"[50] (even though postmodern

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[50] Ibid p. 81.

thought has challenged this foundationalism). This 'mantra' has come under increasing questioning with some scholars arguing that, "…the four principles are too vague to serve as a common ground for such a gigantic enterprise as global bioethics."[51] The Georgetown mantra was an oversimplification of the philosophical in bioethics.

Nonetheless I agree with Pellegrino's contention that however much the philosophical era of bioethics came under disrepute, there is more in bioethics that is fundamentally philosophical than not. Scholars such as Michael Grodin are increasingly being frustrated by contemporary bioethics because, "as the field has matured it has become increasingly clear that there has been inadequate attention to the historical context and deeper philosophical grounding of the discipline…"[52]

> *In the understandable eagerness to find solutions to practical dilemmas, the underlying philosophical questions often have been by-passed, ignored, or trivialized. Although philosophy's influence is less prominent than it was, the philosophical questions will recur. Ethics and moral philosophy remain central to any enterprise seeking norms of right and good conduct.*[53]

That is why this study approaches bioethics and particularly research ethics from a fundamentally philosophical stance even though it recognizes that other areas of inquiry can contribute substantially to the discourse. Notions of 'justice', 'right', 'the good' and others are fundamentally philosophical and without appreciating this, "…the best the skeptics can do is to fashion a species of moral gnosticism or intuitionism – if they can succeed in avoiding moral nihilism and relativism."[54] To relegate the philosophical in bioethics is to assume that those fundamental questions (such as, 'what is justice?') that philosophy has grappled with for long have been resolved. Takala has raised the same concern by writing that, "political philosophy has struggled throughout its history with the question of what justice is. How can it suddenly become a nonquestion in bioethics?"[55]

3.4.2 The Continuum of Morality
Equally important is to emphasize that discussion on bioethics ought to take place within the

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[51] Tuija Takala, "What is Wrong with Global Bioethics? On the Limitations of the Four Principles Approach", *Cambridge Quarterly of Healthcare Ethics*, 2001, Vol. 10. p. 75.
[52] Michael A. Grodin, ed. 1995, *Meta Medical Ethics: The Philosophical Foundations of Bioethics*, Kluwer Academic Publishers, p. xi.
[53] Pellegrino, 1993, op.cit. p. 83.
[54] Pellegrino, 1997, op.cit. p. 13.
[55] Takala, op. cit., p. 73.

continuum of morality. Ethics and moral philosophy remain central to any enterprise seeking norms of right and good conduct. [56] The questions that bioethics grapples with today are fundamentally questions of moral philosophy and one of the biggest limitations that bioethics could face stems from trying to answer these questions while giving little attention to the contribution from moral philosophy.

We can only end up being shallow and unpersuasive if we claim to try to answer questions such as what good conduct is in medical research without asking ourselves what 'the good' is. This is why it is imperative that we place the bioethics discourse within the continuum of morality because that is the fundamental question which preoccupies medical morality. In fact the very etymological roots of the English word, 'morality' are found in the old French word, 'moralité', which in turn derives from the Latin *moralitas*' meaning 'goodness'. In order to establish or to formulate guidelines for 'good conduct' in medical research, we need to establish what 'goodness' as such is. To try and extrapolate discussions on good conduct in medical research from the wider discussion on goodness or the good is to commit an error in reasoning because the former takes place within the latter.

This is so because the goal of the former activity is to establish 'measurableness' i.e. quantities or qualities (rules and guidelines) by which we can decide whether a given medical research is good or not. However, in the latter activity (discussing 'goodness' as such), we are trying to establish something that goes beyond rules and guidelines. We are trying to establish the very foundations on which the former activity is based. Why is this so? It helps in finding morally justifiable grounds for carrying out a given medical research or for condemning it. It helps to answer complex questions like: is it possible for a researcher to break a guideline and yet remain morally justifiable? That is why what is morally good is of more fundamental importance than to act morally; to establish what the good is precedes establishing what good research constitutes. For that matter, as bioethicists seek to lay down guidelines for good medical research they can not do outside the wider discussion of what the good is.

3.4.3 The 'Globalness' of Bioethics

The underlying understating of the 'global' era of bioethics that Pellegrino presents inclines more towards the infusion of other disciplines into the bioethics discourse at the expense of leaving

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[56] Op. cit.

'other' forms of medicine in the cold. Apparently this is an indication of the prevalence of this assumption in the whole discourse whereby the term 'medicine' is synonymous with merely Western medicine. This implies that discussion of health care and clinical ethics presumes a Western medical background. This raises the concern that global bioethics discourse is a mere discussion of Western medical challenges. For example, in research collaboration between the Northwestern University Program of African Studies and Makerere University in which I participated, one of the key questions of discussion was: 'Is there a distinctive Ugandan or African perspective on bioethics?'[57] Simple as this question may seem, it is nevertheless indicative of a concern that what may be termed 'global bioethics' could actually be Western bioethics.

Pellegrino's evolutionary model of the development of bioethics reveals that he did not give the above concern due consideration. His determination of the 'globalness' of bioethics is based on the extent to which disciplines gain prominence in the bioethics discourse hence his observation that, "…in the era of bioethics globally construed, the social and behavioral sciences have gained greater prominence."[58] It is obvious that his concern was *'disciplinal-globalness'*, which isn't irrelevant given the fact that at the time bioethics was still struggling to establish itself as a distinct area of inquiry. But I would rather think that before considering to what extent other disciplines had gained prominence in bioethics, he should have considered to what extent bioethics discourse has included the various forms of medicine i.e. *'medical-globalness'*. Disciplinal-globalness is used here and elswhere to refer to the extent to which other disciplines gain prominence in bioethics discourse while medical-globalness refers to the extent to which bioethics discourse has included other forms of medicine.

For bioethics to claim a global stance (and especially to remain relevant to all medical domains), it necessarily has to include, in its discourse, other non-western forms of medicine such as African indigenous medicine. It has been interestingly noted that most non-western researchers (especially from Africa) generally approach bioethics as a 'foreign' movement.[59]

> *Bioethics in its present form is rooted in and largely dominated by western culture. The tempo and content of bioethics discourse are largely influenced by the technological creations of the developed*

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[57] See: Uganda Research Ethics Workshop, http://67.151.100.152/forum/topic.asp?TOPIC_ID=36&whichpage=1**,** accessed 20th May 2005.
[58] Pellegrino, 1993, op.cit. p. 74.
[59] Temidayo O. Ogundiran, 2004, "Enhancing the African Bioethics Initiative" in *BMC Medical Education* 2004, 4:21. http://www.biomedcentral.com/content/pdf/1472-6920-4-21.pdf**,** accessed 15th Feb 2007.

world. However, ethics is not exclusively the domain of the west. Core ethical values are essentially the same for all human communities leaving aside each community's customs, culture and preferences.[60]

The issue of bioethics discourse being dominated by western culture has been subject of many articles and discussions as the above quotation shows but one particular concern that needs to be pointed out is inclusion of other forms of medicine in the discourse (especially non-western forms). Accounts of the development of bioethics usually emphasize technological advancements in the 19th century as the background within which bioethics emerged.[61] [62] Important as this may be, it may nonetheless expose future discourse to a lopsided direction in that discussions may focus on bioethical challenges in technologically advanced societies at the expense of the less advanced.

If bioethics remains simply grounded on the premises of 19th century technological advancements in western countries, it can not escape the accusation that it may end up being shallow because the ethical concerns in medicine go beyond that. Apart from the bioethical challenges posed by western technology, there are other complex challenges in areas such as traditional medicine in Africa which also need urgent if not immediate attention. There are questions that for example surround research in indigenous biomedicine which need more investigation if bioethics discourse is to be of help in curtailing the abuses taking place therein. The plight of research ethics in indigenous biomedicine especially in Africa needs to be examined further and brought into the mainstream agenda of global bioethics.

3.5 Conclusion

This chapter pointed out three main issues of concern based on Pellegrino's evolutionary model of the development of bioethics which is representative of the dominant view of the development of bioethics. The first point is that despite bioethics increasingly focusing on resolving practical dilemmas; the centrality of the philosophical in bioethics remains resilient and beckons for more attention because of the underlying philosophical questions that keep surfacing. The second point is that engaging in bioethics necessarily entails engaging in the moral life and thus making morality a continuum within which bioethical challenges can be viably analyzed. The third point

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[60] Tangwa G.B, "Globalization or westernization? Ethical concerns in the whole bio-business", in *Bioethics*, 1999, 13(3 & 4): 218-226; cited in Temidayo Ogundiran, 2004, ibid.
[61] Jonsen, A.R, 1997, op. cit.
[62] Stanley J.R, Carl Mitcham, Shrader-Frechette, "Technology", in Reich Warren Thomas, 1995, *Encyclopedia of Bioethics*, Vol. 5, Simon & Schuster Macmillan, pp. 2472-2490.

is that in such an account of the development of bioethics, reference to global bioethics tends to consider the *disciplinal-globalness* of bioethics at the expense of *medical-globalness*. This last point makes it imperative that we endeavor to include other non-western forms of medicine in bioethics discourse thus placing them on the global agenda of bioethics. This is important because the most of the world's population does not live in technologically advanced communities whose concerns currently set the bulk of the global bioethics agenda. In places such as East Africa there is a lot of dependency on local and indigenous biomedicine. In addition much of the pharmaceutical industry in the technologically advanced countries depends and does research on the local indigenous medicine in places such as East Africa which further justifies why we need to place indigenous biomedicine on the global bioethics agenda. It would be worthwhile therefore to take a look at the current state of health service provision and research in East Africa so as to establish the importance of indigenous biomedicine and also to gain an insight in the nature of the bioethical challenges thereof.

CHAPTER IV

HEALTH SERVICE PROVISION AND RESEARCH IN EAST AFRICA: THE PLACE OF INDIGENOUS MEDICINE

4.1 Introduction

Bioethics discourse can not claim to be global in scope without engaging other non-western forms of medicine. The bioethical challenges that are being encountered in non-western forms of medicine must be included in the bioethics agenda. In this chapter I delve into demonstrating the importance of indigenous biomedicine in the three East African countries of Kenya, Tanzania and Uganda, by looking at the state of the health sector in this region. Looking at the situation of health provision in East Africa helps us appreciate the place that indigenous medicine holds thus making it more imperative to investigate the ethics of research in this domain. Acknowledging the importance of indigenous biomedicine means that we take the ethics of research in this form of medicine to be very important. It is therefore imperative to show the importance of indigenous biomedicine to the local communities.

4.2 Health Care Provision in the three Countries

The World Health Organization (WHO) defined health in 1940 as the "state of complete physical, emotional, and social well-being, not merely the absence of disease or infirmity". This definition has been modified to include: intellectual, environmental, and spiritual health. Health means wholeness or soundness in being and provision is foresighted supply. Health care provision, therefore, can be defined as foresighted supply of means by which a community can realize and maintain physical, emotional, and spiritual soundness.

The burden borne by public health care systems in the whole of Africa is enormous stretching the available resources to the limit[63] such that efforts from the private sector and non-governmental organizations to shoulder some of it are applauded by the respective governments. The landscape of health provision in East Africa is therefore shared by the three sectors, which include: public sector, the nongovernmental sector and the private sector. When we look at the state of health

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[63] Hursh-César G., et. al, "Summary of Country Studies: Private Providers' Contribution to Public Health in Four African Countries", paper for conference on, *Private and Nongovernmental Providers: Partners for Public Health in Africa*, Nov. 28-Dec 1, 1994, Nairobi, Kenya, p. 4.

care provision in the three countries of Kenya, Tanzania and Uganda, it does not take long to realize that the systems are subjected to a great health burden. In looking at the state of the health sector in the three East African countries, I consider two major indicators which include the financial and epidemiological considerations.

Because Kenya is economically better off than her neighbors trends in her health sector are indicative of the general situation of health provision in the sub-region. In 2005 Kenya's Ministry of Health reported that households bear 51% of health expenditure[64] majority of which are poor. This means that the poor (who are mostly rural dwellers) have to look for ways to finance their health needs. According to the WHO in 2001 Kenya spent only 16.4% of its total budget on health.[65] The MoH indicates that by 2000 only 1.44% of the country's GDP was spent on health and by 2005 this increased to a mere 1.91%.[66] By 1996 Kenya's public health per capita expenditure had drastically dropped from US$ 9.55 to 3.09.[67] By 2000 it had increased to 5.05% and it only recovered to just 9.1% in 2005.[68] Kenya spends more on debt servicing than health, and it is obvious that her health care system cannot meet the population's health care needs adequately.

Although funding of Uganda's health sector rose from 6% of the budget in 1999 to 9% in 2002/2003,[69] the government still faces an enormous challenge of providing primary health care. Access to health services is still a problem and life expectancy at birth depreciated from 48 years in 1991 to 46 in 2000[70] and by 2002 it was 43 years[71]. There are 159,071 persons for each Health Center IV (120 in total)[72] since at least 70% of the population is rural where the highest referral facility is the Health Center IV at county level.[73] There are 18,700 persons for every doctor (non-traditional practitioners) and there are 3,065 persons per each nurse or

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[64] MoH - Kenya. March 2005. *Kenya National Health Accounts 2001/02*. Nairobi.

[65] WHO, *Summary Country Profile for HIV/AIDS Treatment Scale-Up*, http://www.aidshealth.org/images/whouganda.pdf, accessed 10th March 2007.

[66] MoH - Kenya, Division of Health Care Financing, *Ministry of Health Expenditures (Gross)*, http://www.health.go.ke/, accessed 20th March 2007.

[67] Kimalu K. Paul, 2001, "Debt Relief and Health Care in Kenya", Kenya Institute for Public Policy Research and Analysis (KIPPRA), paper for conference on Debt Relief and Poverty Reduction, UNU/WIDER, Helsinki, Finland, August 17-18 2001.

[68] MoH – Kenya, Division of Health Care Financing, op. cit.

[69] Ministry of Health (MoH), Government of Republic of Uganda. 2003. *The Health Sector PEAP Review Paper*, Kampala.

[70] USAID. 2003. *Uganda Demographic and Health Surveys (1988/89 – 2000/01)*, Country Health Statistical Report.

[71] MoH – Uganda, *Statistical Abstract (Working Paper) 2002*, Kampala.

[72] Author's analysis of the Ministry of Health Midterm Review Report, 2003 (Especially section on referral facilities and their ownership).

[73] Ongodia, A.O. 2004. "Issues in the Implementation of Sector Policies at Local Level in Uganda: Primary Health Care", *Basic Principles of Decentralization*, GDLC, Uganda Management Institute.

midwife[74].

The situation in Tanzania is similar because the public health per capita expenditure is just US$4. The government spends just 12% of its resources on the health sector.[75] With 37 million peoples where majority are poor, Tanzania still faces an uphill task of improving its health care services.[76] The rural population (almost 90%) still relies on local medical practices. This makes local indigenous medicine an alternative for the poor people and therefore studying the ethics of its research becomes paramount. People do not get a lot of support from the state as far as expenditure on health is concerned and that is why they resort to local medicine which is readily available. The following table represents the finances that are committed to the health sector in these countries:

Fig 4: Financial Indicators for Health in Kenya, Tanzania and Uganda

Indicator	Kenya	Tanzania	Uganda
Population (in millions) – 2004	32.4	36.1	26.7
Per capita expenditure on health (US$) – 2003	20	12	18
Government budget spent of health care (%) – 2001	6.2	12.1	16.4
% GDP spent on health – 2003	4.3	–	7.3

Sources: *United Nations, Population Reference Bureau, UNAIDS, WHO,*
MoH – Kenya, MoH – Tanzania and MoH – Uganda

A consideration of the funding available to the health sector in the three countries indicates that the governments have an enormous health burden to bear. For example the percentage of the official budget that is committed to health care is so small to meet the health needs of the populations in these countries. Of the three countries in this study, Kenya is economically better than the rest yet its health sector is facing huge challenges of adequately providing for its population. At least 40% of the health services in Kenya are provided by church health facilities, which have received no subsidies from the government since 1998[77], although some have benefited from the secondment of staff from state institutions. The poverty level in Uganda is 35% and while that of Kenya is 56%, Tanzania is not any different.

Apart from the challenge of finances, these countries also face a heavy disease burden with

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[74] MoH – Uganda, op. cit.

[75] MoH – Tanzania (2003), *National Immunization Program Financial Sustainability Plan*, p. iv.

[76] Nicolaus Lorenz, Cyprian Mpemba. 2005. *Review of the State of Health in Tanzania 2004* Ministry of Health, PORALG Dar Es Salaam: April, 2005. http://www.muhef.or.tz/articles/ref%20116.pdf, accessed on 14th April 2006.

[77] WHO, 2004, *Perspectives and Practice in Antiretroviral Treatment: Mission for Essential Drugs and Supplies, Kenya*, World Health Organization, p. 1.

both curable and incurable diseases on the rise. Kenya faces a health care crisis caused by a rapidly growing population of reproductive age, and an explosive HIV/AIDS epidemic. At the same time, child mortality rates due to preventable diseases such as malaria are beginning to worsen.[78] This is the trend in all the three countries.

> *The health of the people of the three countries of Kenya, Tanzania and Uganda have similar characteristics, for example, with respect to the disease burden (challenges of new diseases such as HIV/AIDS and old endemic diseases like malaria), delivery systems (decentralized health care delivery through Districts, Governmental and NGO providers), constraints imposed by limited budgets, and other health care services have escalated well beyond the capacity of our respective Ministries of Health.[79]*

To represent the similarity in the health problems that are faced by the EAC we can look at some indicators. The following is a table showing selected epidemiological indicators and the disease burden that these countries are facing:

Fig 5: Disease Burden & other Epidemiological Indicators for Health in Kenya, Tanzania & Uganda

Indicator	*Kenya*	*Tanzania*	*Uganda*
Adult prevalence of HIV/AIDS (15-49yrs) – 2003	7.4%	12%	7.0%
Reported Malaria cases – 2003	–	10,712,526	12,343,411
Persons with TB per 100,000	888	479	646
Physicians per 100,000 persons (2004)	13.2	2.3	4.7

Sources: *Prime Minister's Office – Tanzania, WHO, MoH – Kenya, Globalhealthfacts.org, MoH – Tanzania and MoH – Uganda, WMR-2005*

The above selected indicators of the disease burden when contrasted with the numbers of doctors that are available prove further that the official health care systems can not provide all the health needs of the people.

4.3 Indigenous/Traditional Medicine
The WHO estimates that over almost 80% of the world's poor people rely on indigenous

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[78] See, http://www.engenderhealth.org/ia/cbc/kenya.html, accessed on 13th April 2006.
[79] EAC, *Prospectus for the Regional East African Health Policy Initiative (REACH-Policy)*, EAC Secretariat, Arusha, p. 2.

biomedicine for their primary health care.[80] [81] This is also true in East Africa because as the above information has shown, the formal health care system can not cater for all the populations. Most people especially those living in rural areas rely on indigenous or Ethnomedicine which is readily available, "Many countries are waking up to the reality that indigenous knowledge is a vital resource for the rural poor. It can empower communities…"[82] This waking up in the direction of indigenous knowledge also involves the utilization of indigenous medical knowledge.

> *The twenty-first century has posed several challenges owing to changing disease patterns, increases in chronic and metabolic illness and disabilities, and increasing costs of new health technologies. Modern medicine has failed to meet these new challenges effectively, however, and the utilization of traditional medicine or complementary and alternative medicine (TM/CAM) seems to be increasing in both developing and developed countries.[83]*

Traditional medicine is increasingly becoming important in terms of health care and health sector reform.[84] A big segment of the African population does not have access to modern medicine and traditional medical system still provides a regular source of the medical needs of the rural people.[85]

4.3.1 What is Indigenous Medicine?

The characteristics that are associated with indigenous medicine such as secretiveness, mysticalness, being extremely localized in nature among others have rendered defining it such a daunting task with no precise global definition yet. However, as the WHO recognizes, it is important that a working definition is generated. Earlier anthropological studies of the social and cultural aspects of medicine in Africa produced literature which referred to indigenous beliefs and practices in medicine as 'ethnomedicine'.[86] [87] After entering official WHO medical language ethnomedicine is now used interchangeably with the terms such as *alternative*

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[80] Farnsworth, Akerele, Bingle, et. al. 1985. "Medicinal Plants in Therapy", *Bulletin of the World Health Organization* No. 63, p. 965 – 81.
[81] Koumare, M. 1983, "Traditional medicine and Psychiatry in Africa", in Bannerman R.H, et al, (Eds.), *Traditional Medicine and Health Care Coverage: A Reader for Health Administrators and Practitioners*, WHO, Geneva, p. 25.
[82] Nyiira Z.M, "Rediscovering Indigenous Knowledge", *Indigenous Knowledge Update*, Issue No. 2, September 2001, p. 4.
[83] WHO, *Global Information on Traditional Medicine/Complimentary and Alternative Medicine: Practices and Utilization*, Proceedings of WKC Consultative Meeting on Traditional Medicine, 21 September, 2001, p. 3.
[84] Ibid., p. 28.
[85] Leendert Jan Slikkerveer, 1990. *Plural Medical Systems in the Horn of Africa*, Kegan Paul International, p. 168.
[86] Fabrega, H. 1972 "The Study of Disease in Relation to Culture" in *Behavioral Science*, Vol. 17, pp. 183-484.
[87] Lieban, R.W 1973 "Medical Anthropology", in J.G. Honigmann (Ed.), *Handbook of Social and Cultural Anthropology*, Rand McNally, Chicago.

medicine', *'complementary medicine'* and *'traditional medicine'*[88]. According to the WHO,

> *traditional medicine is the sum total of the knowledge, skills, and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illnesses.*[89]

This definition presented by the World Health Organization is similar to the one advanced by local practitioners of traditional medicine. In the words on the webpage of a local association of traditional herbalists and healers in Uganda (NACOTHA), "the term 'traditional medicine' refers to ways of protecting and restoring health that existed before the arrival of modern medicine with medicinal plants being the world's oldest known health-care products. As the term implies, these approaches to health belong to the traditions of each country and have been handed down from generation to generation."[90]

One of the defining characteristics of traditional medicine is the difference that exists between it and modern western medicine. George Foster cites a definition similar to the one above which hints on the difference between traditional medicine and modern western medicine. To him ethnomedicine stands for, "those beliefs and practices relating to diseases which are the products of indigenous cultural development and are not explicitly derived from the conceptual framework of modern medicine."[91] Modern medicine in this particular definition refers to modern western medicine. Foster's preferred definition differentiates the two forms of medicine (traditional and modern-western) by way of conceptual framework. The western medical conceptual framework is dominated by Cartesian duality which dichotomizes between mind and body. The underlying conception in Cartesian duality promotes the understanding that the mind functions in independence of the body.

This brings us to another distinguishing mark of indigenous medicine which is premised on the understanding of life as, "the union of body, senses, mind and souls". The practitioners of IM are reported to describe health as, "the blending of physical, mental, social, moral and spiritual

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[88] WHO, op. cit.
[89] WHO, 2000, *General Guidelines for Methodologies on Research and Evaluation of Traditional Medicine*, Geneva.
[90] http://www.blackherbals.com/nacotha1.htm, accessed 22 March 2007.
[91] George M. Foster, "An Introduction to Ethnomedicine", in Bannerman R.H et al, (Eds.), 1983, *Traditional Medicine and Health Care Coverage: A Reader for Health Administrators and Practitioners*, WHO, Geneva, p. 17.

welfare."[92] This holistic description of health has a tremendous impact on the approach IM practitioners have towards health care. This wholistic/holistic approach to life", is claimed to target equilibrium between the mind, body and the environment with an emphasis on health rather than on disease. Such a unique vision is not common in the Western "scientific" approach to health.[93]

4.3.2 Indigenous Medicine in Primary Health Care

More and more people in developing countries such as East Africa are resorting to traditional medicine due to increasing disillusionment with modern western medicine and this seems to be the trend in developed countries too. This is mainly because of the uneasiness about the technocratic, 'impersonal' treatment, over-medicalisation and the staggering cost of the dominant biomedical system.[94] Apart from western medicine being expensive to the local people, modern health care facilities such as hospitals and clinics are far away from the people. In Uganda, for example, access to health services is still a problem with 159,071 persons for each Health Center IV (120 in total). [95] [96] In rural Uganda traditional birth attendants (TBAs) are the major source of medical care to pregnant women. It is being reported that at least 60% of women in rural districts in Uganda prefer to deliver under the watch of traditional birth attendants (TBAs).[97] [98]

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[92] Bannerman R.H et al, (Eds.), *Traditional Medicine and Health Care Coverage: A Reader for Health Administrators and Practitioners*, WHO, Geneva, p. 9.
[93] http://www.blackherbals.com/nacotha1.htm, accessed 22 March 2007.
[94] Leendert Jan Slikkerveer, 1990, p. 13.
[95] Author's analysis of the Ministry of Health Midterm Review Report, 2003 (Especially section on referral facilities and their ownership).
[96] Ongodia, op. cit.
[97] Kavuma Richard, "600 Traditional Birth Attendants Trained", in *The Weekly Observer*, Observer Media Ltd, 21st Nov. 2006.
[98] Nankoma Jacqueline, "Butaleja ladies prefer giving birth the Traditional Way", in *The Daily Monitor*, The Monitor Publications Ltd, 11th March 2007

Fig 6: Residents of Kabale (Uganda) carry a patient to a nearby clinic

Source: *The New Vision*, 16th March 2007

The concept of Primary Health Care (PHC) was adopted at the Conference of Alma Ata (former USSR) in 1978. In the Alma Ata Declaration, article ii recognized that there is, "… gross inequality in the health status of the people particularly between developed and developing countries as well as within countries..."[99] Because of the gross inequality the Declaration encouraged governments to provide adequate health care to their people in terms of primary health care. In this Declaration the term Primary Health Care was defined as:

> *…essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.[100]*.

According to the Declaration PHC forms an integral part both of a country's health system, (of which, it is the central function and main focus), and of the overall social and economic development of the community. PHC is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.[101]

There are inherent contradictions in this definition of PHC. The first is that it is not always the case that what is practical and scientifically sound is socially acceptable. This definition gets

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[99] *Declaration of Alma Ata 1978*, article ii.
[100] Ibid., article vi.
[101] Ibid.

further complications because it does not describe what is scientifically sound. However the most important point we get from that definition is that the communities should be able to get PHC that is affordable on the basis of self-reliance and self-determination. This is where local resources such as TM come in to help the local people especially from poor countries to provide themselves with PHC and this is where governments from these poor countries are justified for encouraging TM. Robert Bannermann writes that,

> *A number of these countries in Africa…are therefore exploring the possibility of developing their well known and tested herbal medicines for use in primary health care centres. These medicinal plants are generally locally available and relatively cheap, and there is every virtue in exploring such local and non-toxic, safe, inexpensive and culturally acceptable to the community.*[102]

Provision of modern western PHC is very expensive for most governments in Africa and using western medicine for PHC leaves only the elite segment of their communities to benefit from the services yet it takes a big percentage of their budgets. The ratio of physician to persons compounds the problem of meeting PHC needs by means of western modern medicine; there are very few formally trained doctors and nurses/midwifes to meet the needs of the populations. In countries such as Uganda, there is at least one traditional health practitioner for every 200-400 people compared to one orthodox medical practitioner for every 10,000 people.[103] [104] [105]

Indigenous medicine has been incorporated into mainstream PHC in all the three East African countries. The MoH in Uganda, for example, is encouraging the traditional practitioners to get registered and subject themselves to accountability (Health Policy 1999). Traditional practitioners are encouraged to treat uncomplicated diseases and illnesses such as diarrhea, but to consult with formally trained physicians when it comes to more complicated cases especially those which necessitate laboratory test or surgical operations. Traditional herbal medicine is even being incorporated in the treatment of HIV/AIDS and related sicknesses with increasing research being focused on mixing dosage of herbal and western medication at

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[102] Robert H. Bannermann, "The Role of Traditional Medicine in Primary Health Care", in Bannerman R. H et al, (Eds.), *Traditional Medicine and Health Care Coverage: A Reader for Health Administrators and Practitioners*, WHO, Geneva, p. 319.
[103] http://www.blackherbals.com/nacotha1.htm, accessed 22 March 2007
[104] Nyiira Z.M, et al (Eds.) 1999, *Indigenous Knowledge for Sustainable Development: Towards a National Strategy and Framework of Action for Uganda*, Uganda National Council for Science and Technology (UNCST) p. 23.
[105] WHO, 2002, *WHO Traditional Medicine Strategy 2002-2005*, Geneva, p. 2.

the National Chemotherapeutics Laboratory.[106] There are also private traditional medicine research clinic such as Kamengo Herbal Research Clinic found in one of Kampala's suburbs called Ndeeba.[107]

TM has even gone a step further in Uganda with the opening of the International Institute of Alternative and Complimentary Medicine (IIACM). The institute is said to conduct, "…continuous research on traditional systems of medicine qualities, clinical trials of traditional medicine and manufactures natural medicines with international quality standards." [108] The institute's website (www.iiacm.kabissa.org) reports that Dr. Jjuuko Ndawula the director of the institution is a consultant in traditional, folk, alternative and complementary medicine and also trained in Naturopaths. Another prominent IM practitioner in Uganda is '*Musawo*' (Dr.) Yakobo Lukwago who has gained reputation for providing health services and even treating complicated diseases such as high blood pressure, among others. He has a family medical service business with various branches across the country and in other parts of Africa such as South Africa and Kenya.[109]

In Kenya the Association of Herbalists in Kenya represents similar efforts to apply traditional herbs and medical practices to meeting the health needs of local people.[110] Studies have shown that herbalists in Kenya treat various ailments such as malaria allergies, kidney complications, erectile dysfunction, asthma and many others, abortions included.[111] There are more indications that combining traditional medicinal plant knowledge with modern medicine's treatment could yield better results in combating diseases such as malaria. For example in Kenya, researchers at the Kenya Medical Research Institute (KEMRI) have been testing a combination of both traditional and modern medicine to treat malaria parasites that have become resistant to usual drugs such as chloroquine and they are realizing positive results.[112]

Similar efforts to harness TM for health care can also be found in Tanzania. In Tanzania it is reported that ancient remedies are being sought out to help in the treatment of HIV/AIDS among

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[106] Uganda AIDS Commission, 2005, *Reporting the Present, Preparing the Future*, Forum Report, The 3rd HIV/AIDS Partnership Forum, Kampala International Conference Center, 29-30 Nov. 2004, p. 11

[107] This research centre does research on HIV/AIDS and its related sicknesses plus other diseases.

[108] "Uganda: Training in Indigenous Medicine", http://allafrica.com/stories/200702210279.html, accessed 23rd March 2007

[109] Lukwago Yakobo, "Eby'obulamu", CBS – Radio Station. Kampala. 22nd March 2007, 10:00-11:00am (local time).

[110] Kibet A. Ng'etich, "Indigenous Knowledge, Alternative Medicine and Intellectual Property Rights Concerns in Kenya", CODESRIA, 11th General Assembly, Maputo, Mozambique, 6-10 Dec. 2005, p. 6.

[111] Kareru, P. G, et al, "Traditional Medicines Among the Embu and Mbeere Peoples of Kenya", *African Journal of Traditional, Complementary and Alternative Medicines*, Vol. 4, No. 1, 2007, pp. 75-86.

[112] Ocheing' Ogodo, 2004 "Research Confirms Medicinal Promise of Kenyan Plants", http://www.scidev.net/News/index.cfm?fuseaction=readNews&itemid=1674&language=1, accessed 23rd March 2007.

other diseases that the country is facing.[113] TM is also being looked at as key in treating malaria. In a conference on '*Research Initiative on Traditional Anti-Malarials*' (Moshi, Tanzania 8th-9th Dec. 1999) participants were informed that, "In investigating traditional health systems, it is important that they be studied not simply as a source of new molecules leading to synthetic drug development or as sources of viable herbal treatments for malaria, but also as offering potentially important concepts of the disease and explanatory models for its progression and cure."[114] This observation shows the importance that is increasingly being placed on TM.

Makundi, et al found that majority of mothers (75%) in the Tanzanian districts of Kilosa and Handeni believed that a condition of severe fever (locally known as *degedege*) that is a feature of malaria is caused by evil spirits.[115] Because of this belief mothers in this region consulted traditional healers in seeking a treatment for malaria although it was also interesting that these mothers at the same time consulted modern health care providers. The authors argue that rather than hinder the treatment of malaria by modern health care providers, the traditional healers provide "bio-medically accepted first-aid" which increases chances of survival for the children. To that end they argue in favour of encouraging a combination of both the services of modern health care providers with those of traditional healers so as to combat malaria. An illustration of this is the report that the WHO has decided to help Tanzania to produce a certain herbal medicine which has been used to fight malaria successfully on a commercial basis. The production of this plant-based anti-malaria drug, dihydro-artemisinin, was supposed to start in Tanzania in 2003.[116]

4.4 Research in Traditional Medicine in East Africa

As the use of TM is acknowledged and allowed into official policy on the provision of health care, research in this field is also reported to be on the rise. Acknowledging the importance of indigenous biomedicine means that we take any research in this form of medicine to be very important. When we realize the importance of research in indigenous medicine then we can no longer ignore the ethics thereof. The increase in interest and use of indigenous medicine takes us into the area of research in TM. Basing on categories of researchers in indigenous medicine, in

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[113] "Tanzania Draws on Ancient Remedies to Fight HIV",
http://www.scidev.net/Features/index.cfm?fuseaction=readFeatures&itemid=223&language=1, accessed 23rd March 2007
[114] First International Meeting of the Research Initiative on Traditional Anti-Malarials (RITAM), 8th-9th Dec., 1999, Moshi, Tanzania, http://www.mim.su.se/english/partnerships/ritam_program.pdf, accessed March 2007
[115] Makundi, et al., 2006. "Role of Traditional Healers in the Management of Severe Malaria among Children Aged Below Five Years of Age: The Case of Kilosa and Handeni Districts, Tanzania", in *Malaria Journal*, 2006, 5:58.
[116] WHO/AFRO, 2003, "WHO to Support Production of Indigenous Anti-malaria Medicine in Africa"
http://www.afro.who.int/press/2003/pr2003042502.html, accessed 23rd March 2007.

this section I use examples of research projects in East Africa to demonstrate the ethical problems that are associated with research in this form of medicine.

4.4.1 Categories of Researchers in TM

For purposes of analysis we need to categorize those who are involved in researching on indigenous medicine. The categories that we shall develop in this study are based on the broad divisions of international researchers and local researchers. We can therefore propose two broad categories of researchers, namely *Primary* and *Secondary* researchers.

By 'Primary' researchers I mean the local medicine men and women who have gathered the knowledge of traditional medicinal herbs and techniques over time within their localities. I am persuaded that there is a lot of commonsense evidence to indicate that these local traditional medicine practitioners used a certain form of 'research' to accumulate such a wide range of knowledge on medicinal herbs. We need to know how this vast knowledge came to be and how it is applied otherwise we may not be able to hold them ethically accountable. If we take it as a given that in all human communities life is taken as a precious thing, then commonsense as far as human life is concerned demands that for one to advance a prescription **A** as a cure for ailment **B** it is most likely based on some justifiable evidence that the prescription does not terminate life.

We can sub-divide primary researchers into; i) those who pursue '*organic-cause*' in treatment of ailments, ii) those who pursue '*inorganic-cause*' to use in their practice and iii) those who combine both. Probably to understand what we mean by 'Organic-cause' primary researchers we should throw some light on this category by alluding to those that George Foster writes about who use what he calls '*naturalistic*' explanations to describe the causality of a given ailment.[117] He explains that in this category illness is explained in impersonal systemic terms which are natural in contrast with supernatural and magical explanations. Examples of these can include; herbalists, traditional birth attendants (TBAs), among others. The category of 'Inorganic-cause' primary researchers refers to those who pursue extra-natural explanations to determine causality of illness. Foster writes that these ones use '*personalistic*' explanations of illnesses referring to agents such as spirits, ghosts, among others.[118] They usually attribute their abilities to supernatural powers and they normally practice by identifying the evil deity or spirit that is believed to be the cause of the illness. Examples of these can include; witch-finders, priests,

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[117] George Foster, 1983, op. cit., p.19.
[118] Ibid., p. 20.

mediums among others.

The second major category is that of 'Secondary' researchers. By secondary I mean those who do research on the plants and herbs after knowing about their medicinal properties from the local traditional medicine men and women. These usually see the vast knowledge possessed by traditional medicine as raw-materials for manufacturing modern western medicine. Among these secondary researchers there are those from the international community and the local ones who are trained in modern western medicine. There are many medications such as tablets, syrups and others in modern western medicine which were developed from local herbs after acquiring that knowledge from indigenous medicine men and women.

4.4.2 Secondary Research in TM in East Africa
4.4.2.1 International Secondary Research in TM
Interest in research in TM has not left out the international community. Almost all over the world drug companies are investing more in finding chemical components in traditional medicines that have therapeutical properties. Many chemicals for making highly profitable drugs are being discovered in local herbs and shrubs. Well known chemicals such as quinine and quinidinine have been discovered to have a long history of usage in ethnomedicine. Medicinal ingredients such as arecoline (from the Betul-nut) and ajmalicine (from the snakeroot) are being used as a diuretic (vascodilator) and circulatory stimulant respectively. Of the 119 chemicals extracted from higher plants used in medicine, 74% have the same or related use in local ethnomedicine. [119] Because of the benefits from indigenous medicinal knowledge, more researchers from developed countries are finding research in the Third World, especially Africa, a lot cheaper than in their home countries.[120] The above examples are of discoveries of organic drugs in traditional medicine but there are also those whose interest lies in the inorganic treatments of illness that exist in TM. We therefore find two types of researchers from the international community i.e. those who are searching for organic medicine and those researching in inorganic medicine.

The first example we consider is that of the case of the collaboration between a team from the University of Victoria in British Columbia, Canada headed by Prof. Budd Hall and the

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[119] Farnsworth, Akerele, Bingle, et al, *Medicinal Plants in Therapy*, Bulletin of the World Health Organization 63, 1985, p.965-981.
[120] Silje Gripsrud, 2001, "Ethical Guidance in Medical Research", *UiB Magasinet*, http://www.uib.no/elin/elpub/uibmag/en02/guidance.html, accessed on 9th, Dec. 2005.

Mpambo African Multi Varsity in Busoga, Uganda headed by Prof. Wangoola Patrick. This particular case of research is reported to be interested in both organic and inorganic medicine in Africa. The group claims that this project aims at liberating the marginalized by promoting traditional science and medicine. The project leaders say that, "We want to show the world that African knowledge and thinking are capable of moving the world forward", through such a project whose, "…aim is to liberate the marginalised through traditional think-tanks, languages, medicine and science."[121]

Fig 7: Prof. Budd Hall and fellow researchers at a ritual ceremony

Source: *The New Vision*, 7th March 2007

The next example of a group that has taken up research collaboration with traditional healers in East Africa is Shaman Pharmaceuticals. Some years ago their research team started a collaborative project with Ugandan traditional physicians, healers and botanists – specifically those under the Buganda Traditional Healers Association (BTHA). The purpose of this research was drug discovery using the ethnobotanical approach (especially in the treatment of diabetes) under the Shaman Diabetes Program.[122] In this research, the herbal medicine collected from the Baganda traditional healers yielded positive result for the treatment of diabetes; "…five species were found to be active…based on the lowering of glucose, triglycerides, and study of animal weight and food consumption."[123]

The conduct of the Shaman–BTHA Collaborative Diabetes Project highlights some of the challenges that are encountered in research in indigenous medicine. One of the complaints that the local Ugandan healers voiced was that usually researchers do not return the results of

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[121] Mwangu Alex & Kisiki Bob, 2007, "When Whites Bowed to Black Spirits", in *The New Vision*, 7th March 2007.
[122] Suzan Tarka Nelson-Harrison, et al., "Ethnobotanical Research into the 21st Century", in Iwu Maurice & Wootton Jacqueline, (eds.), 2002, *Ethnomedicine and Drug Discovery*, Elsevier, pp. 283-307.
[123] Ibid., p. 303.

the research to the healers. In this particular project it is reported that the data and results of the screening of the medicinal plants were returned to Uganda accompanying them with explanation of the results. This was done with each individual healer involved in the project with results translated in Luganda (a local language) to the understanding of the local healers.

This project exhibited an awareness of the misconduct that usually takes place when international researchers go to source countries to pursue drug discovery possibilities. Although in this particular case it is evident that great care was taken to avoid such misconduct, it nonetheless provides us with indicative information about the misconduct in research in TM by international researchers. The most common accusation, as already mentioned above, is that international researchers do not share the data and results with the local healers. That is why one of the healers is reported to have said, "There will be no secrecy in meetings. Everything must be established in the open. It is the way we work here in Uganda. It is the only way we agree." [124] The fear expressed here is that international researchers conceal their real motives when it comes to involving local healers; traditional medical practitioners are usually not told that their knowledge is being stolen from them without due acknowledgement and neither do they get a feed back on what the results of the research are. The international researchers go ahead to appropriate themselves patent rights of the therapeutical components extracted from the medicinal plants provided by the indigenous healers.

This is in consonance with the ethical challenge highlighted by Silje Gripsrud when it comes to research in developing countries to make drugs that are sold in developed countries. In his article, "Ethical Guidance in Medical Research" [125], Silje reports about an interview he conducted with Prof. Reidar Lie a prominent bioethicist. He reports that it is becoming cheaper to carry out research in poorer countries because the guidelines for research in these countries are not as strict as in developed countries. Local people in poorer countries such as Gabon and Thailand are used in trials of drugs for the treatment of disease such as hepatitis A or malaria but the actual drugs get to the market at very high prices that the people who were involved in its testing can not afford it. Lie says that even the payment given to them as compensation is not commensurate with the risks involved. He believes that the international instruments that guide such research are the ones to blame for being too general to apply to

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[124] Ibid., p. 305
[125] Silje, 2001, op. cit.

specific cases.

> *We may well ask ourselves whether research of this sort can be defended at all. According to current international guidelines, which were drawn up by the Council for International Organizations of Medical Sciences (CIOMS) and the Declaration of Helsinki, the answer must be "No". The guidelines state that research may only be performed if it is of potential benefit to the country in which it is done. However, Lie believes that this cannot be treated purely in black and white terms... The challenge for us is to draw up guidelines that will prevent people from being exploited, while taking into account the legitimate objections that have been raised against the Declaration of Helsinki.[126]*

Although the concern of Lie is not particularly with indigenous medicine, the problems that is raised is similar to the one that the healer quoted earlier was raising in the Shaman-BTHA project, namely that local people and their resources are used to make drugs for profits that go to pharmaceutical companies without much benefit to the locals. In many cases such research by international researchers ends up abusing the local people and the local communities.

The problem raised above by Lie indicates that in most cases those who come from outside the local communities to do research usually come with a superiority complex and a kind of paternalistic attitude towards those communities. Modern western science has over time developed an attitude of superiority to traditional medicine because usually local knowledge of medicine is perceived as crude and backward and in need of purification. This process is usually referred to as 'drug discovery' which denotes that TM is not in acceptable modern drug form and therefore in need of being transformed into drugs by the 'purification' work of modern western medicine. This 'purification process' which modern western medicine has developed over time involves the use of human beings as guinea pigs to test the trails of the drug until a form considered 'modern' is made. The morality of modern western medicine does not give room enough to ask whether TM itself would be possessing conceptions of drug discovery that would reduce the human cost of the 'drug discovery'.

4.4.2.2 Local Secondary Research in TM

In this sub-section I look at the experiences with research in indigenous medicine in East Africa. Earlier on we saw that researchers in Kenya were realizing positive results from testing a combination of traditional and modern medicine to treat malaria parasites that had

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[126] Ibid.

become resistant to usual drugs such as chloroquine. Still at KEMRI researchers are also testing the efficacy of extracts from the African Cherry (*Prunus Africana*) and the Chinaberry (*Melia azedarach*) trees in treating herpes simplex virus (HSV).[127] These investigations are based on local knowledge of medicinal plants that have been in use for centuries.

Fig 8: The Researcher at KEMRI – Kisumu, Kenya

Photo by Author

Uganda is among those countries considered to have made commendable strides in terms of policies and regulations pertaining to TM.[128] The government is encouraging research in traditional medicine to help fight diseases such as malaria. At the state-run Natural Chemotherapeutic and Research Laboratory (NCRL) research is being conducted on local herbs which have been in use by local communities to treat malaria. The director of NCRL Nambatya-Kyeyune says that they are testing various formulations of herbs to combat malaria. These formulations are derived from local herbs such as '*kapapula*' (Aristolochia elegans) and '*mululuza*' (Vernonia amygdalina) and the researchers are trying to establish the clinical safety of these drugs.[129] If they are found to be safe they will be given a green light for industrial production.

However, such local initiatives of research on indigenous medicine in these East African

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[127] Ocheing' Ogodo, 2004, op. cit.

[128] "Global Experiences Traditional Medicine" http://www.sahealthinfo.org/traditionalmeds/traditionalpart2.pdf, accessed 24th March 2007

[129] Wamboga-Mugirya Peter, 2005, "Uganda Tests its Anti-malarial drugs", http://www.scidev.net/Features, accessed 26th March 2007

countries are not without ethical problems. In Uganda, for example there are various cases of herbal researchers who have been accused of misconduct and these are representative of the ethical challenges that are associated with this kind of research in the whole region. The late Prof. Ssali of the Mariandina Clinic in Kampala, Uganda caused a stir when he claimed that his herbal drug, 'Mariandina' could cure HIV/AIDS. He was arrested and charged and his drug banned for having deceived the public that his drug was a cure.[130] Subsequent tests of the drug by experts found that the so-called drug was actually a food supplement. A judge dismissed Prof. Ssali's appeal against the Uganda Dental and Medical Practitioners Council (UDMPC) which had suspended him for two years because of having violated the ethics of dental and medical practice. The judge said that Prof. Ssali was liable to charges of misleading the public adding that,

> *Anyone buying MARIANDINA preparations would buy mere food supplement in the mistaken belief that he was buying drugs and the purchase would be a result of Dr Ssali's information.*[131]

In a related incidence a Ugandan-based Iranian who was selling a drug called 'Khomeini' which he claimed could cure HIV/AIDS was arrested and charged for selling a drug not approved by the National Drug Authority (NDA).[132] Sheik Elahi Allahgholi was charging US$1,650 per dose of 'Khomeini' which the authorities later tested and found out to be a mere concoction of olive oil and honey.[133] The Institute of Elahi International Initiatives for Development and Education (IEIDE) claimed that the herbal medicine could cure HIV/AIDS and tuberculosis in three weeks.[134] But the NDA banned the herbal drug after tests by Mulago Hospital (Uganda's main research hospital), the Uganda Virus Research Institute and the UK-based Medical Research Council proved that 'Khomeini' was neither a drug nor a cure.

Even with all tests showing that 'Khomeini' was not a cure for HIV/AIDS people were reported to support Prof. Elahi's herbal 'drug'. It is reported that at least 400 patients were willing to pay for the drug and interestingly 76 persons sent a petition to the president of

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[130] Nsambu Hillary, 2003, "Kkooti enkulu egobye okujulira kwa Polof. Ssali", in *Bukedde*, 2nd August 2003, The New Vision Publishing Limited.

[131] Nsambu Hillary, 2003, "Ssali violated Medical ethics", in *The New Vision*, 2nd March 2007, The New Vision Publishing Limited.

[132] Kimono Godfrey & Candia Steven, 2006, "Prof. Elahi re-arrested over AIDS drug", in *The New Vision*, 26th Nov. 2006, The New Vision Publishing Limited.

[133] Wamboga-Mugirya Peter, 2006, "Iranian faces trail in Uganda over AIDS 'cure'", http://www.scidev.net, accessed 24th March 2007.

[134] "Uganda Bans Iranian HIV/AIDS, TB Herb", http://www.medicalnewstoday.com/medicalnews.php?newsid=42161, accessed 20th March 2007

Uganda to not only cancel the ban on the drug but also to subsidize it so that more patients could access it.[135] This is what makes the ethics surrounding herbal or indigenous medicine complicated especially because most people in these communities think that what the herbalist says is true even when scientific tests indicate otherwise. This perception that most local people hold towards herbal or indigenous medicine is ingrained deep in their psyche and morality whereby traditionally a practitioner of indigenous medicine was rarely or not questioned at all.

4.4.3 Primary Research in TM

It is a nearly an impossibility to come across any systematic historical accounts of research done in traditional medicine in East Africa. Therefore it is not that easy to locate and describe the kind of 'research' that the local medicine women and men carry out in order to ascertain the efficacy of a given traditional medication. However, as indicated earlier, it is important to know how this vast knowledge about various medications came to be and how it is applied if we are to be able to engage this traditional medicine in any meaningful ethical discourse. Under the category of primary researchers we have three sub-categories, namely those who pursue organic-cause, those who concentrate on inorganic-cause and those who combine both. Below we look at only the first two sub-categories because establishing the ethical challenges embedded in the first two means establishing the challenges of the last sub-category.

4.4.3.1 Organic-Cause Primary Research in TM

It ought to be noted that most of the traditional medical practitioners that fall under this sub-category are herbalists who basically deal with mixing various herbs and formulations in treating patients. Kareru, et al,[136] have documented various medicinal plants and the diseases to which they are applied among the Embu and Mbeere people of Eastern Kenya. During their study ethnobotanical data was collected for a whole year from a total of 110 local herbalists. We can determine that Kareru and colleagues were dealing with organic-cause primary practitioners because they report that, "All the herbalists interviewed were Christians. Non-Christian herbalists were said to combine herbal medicines with witchcraft and were therefore avoided."[137] Those who are said to mix herbal medicine fall under our sub-category of those who pursue inorganic-cause explanations of causes of diseases.

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[135] Tebajjukira Madinah, 2006. "Khomeini clients petition President Museveni on ban", in *The New Vision*, 5th May 2006, The New Vision Publishing Limited.
[136] Kareru, P. G, et al, op. cit.
[137] Ibid., p. 78.

Forster writes that those herbalists whose medicine does not involve magical or supernatural treatments, "…usually acquire their knowledge of herbs and their skills in treatment procedures from older practicing curers; supernatural or magical elements are absent in their repertories."[138] However, this stops short of telling us of how the 'older' curers acquired their knowledge in the first place. Kareru and colleagues seem to point this source. In their study Kareru and colleagues write about what we can glean as a way of researching in traditional medicine by those who pursue organic-cause treatment for disease. They baptize this way of finding out about herbs with medical potential, '*traditional taxonomy*'. They report that,

> *The herbalists were able to identify poisonous plants, by observing the foliage which domestic animals avoided while grazing. In addition, birds and bees avoided nectar from flowers of toxic plants, and through this "traditional taxonomy" plants with thorny leaves were regarded as "male", that is, naturally poisonous. On the other hand, plants without thorny leaves were regarded as non-poisonous.*[139]

In the study by Kareru and colleagues there are no particular ethical problems that are pointed out. However, the ethical challenge in this particular case may arise from one of the diseases that these traditional medical practitioners purport to deal with. It was reported that the herbalists use '*terminalia brownii*' to treat complicated medical cases such as abortion.[140] I think here is a case of traditional herbalists dealing with medical conditions which ought to be handled by more trained personnel and in clean environments and moreover the issue of abortion is not legally allowed in the East African region. In fact this issue has caused problems between some local governments in Uganda and TBAs. Recently TBAs in the district of Rakai in Uganda were warned against the ethical and legal implications of dealing with such complicated cases such as abortion.[141]

Another example of an organic-cause primary researcher in traditional medicine is a Ugandan herbalist, Br. Anatoli Wasswa of St. Luke Ganda Traditional Medical Clinic and Research Centre in Kyotera, Masaka district. At this rural research center, Wasswa and his team are involved in developing herbal medicine using local knowledge that has been applied for long and passed on for generations. In an article that appeared in the Ugandan daily, *The New*

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[138] George Foster, 1983, op. cit., p. 21.
[139] Ibid., p. 83.
[140] See: Table 3 in Kareru et al., ibid.
[141] Mambule Ali, 2007, "Local Birth Attendants Warned on Ethics", in *The New Vision*, 6th Feb. 2007, The New Vision Publishing Limited.

Vision, it was explained that this group is trying to demonstrate that herbal medicine can be used even by Christians who usually think that it is satanic.[142] This is blamed on pre-colonial missionaries who tagged all herbal medicine 'satanic' since they could not differentiate a witchdoctor or diviner from a herbalists. In this article it is explained that there are herbalists who dub both in organic herbal medicine and inorganic-cause practices such as explaining diseases in terms of witchcraft and these are the ones who bring into disrepute the use of genuine organic herbal medicine.

4.4.3.2 Inorganic-Cause Primary Research in TM

This refers to those traditional medicine men and women who give inorganic explanations for causes of illnesses. They pursue extra-natural or supernatural explanations and causes of diseases. Causes usually include ghosts, evil spirits, spirits of the dead, witches, etc. This is the most problematic category when it comes to investigating research in traditional medicine because in most cases their practices and techniques are usually out of the bounds of systematic scientific inquiry. This could most likely be traced from the source of the abilities (or powers used) to treat ailments and illnesses. It is reported that the magical power of this kind of practitioners is acquired supernaturally through possession by a tutelary spirit.[143] This spirit is the one which endows the healer with extra-natural abilities to aid the sick.

However there are many cases of abuse that are reported daily in East Africa of patients and those who consult these practitioners. We can use the case of a traditional healer who handles psychiatric illness in Uganda to demonstrate how 'researching' (or searching for inorganic-cause explanations of illnesses) in this category of TM can be abusive. A certain traditional healer commonly known as Ndaula in Wakiso district (Uganda) had his shrines raided by police in 2006 for abusing patients that are brought to him for treatment by tying them with chains and subjecting them to hard labour on his vast corn farms, building projects and coffee plantations.[144] [145] [146] The raid by the police revealed that he had over 100 patients of various degrees of mental disorders that he was subjecting to hard labour as a form of treatment payment for the services that he was rendering to them. He argued that he was subjecting them to such treatment because they were mentally ill people who needed hard labor to stabilize them such that they do not end

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[142] "Are Herbal Drugs Satanic?", in *The New Vision*, 3rd Feb. 2007, The New Vision Publishing Limited.

[143] George Foster, 1983, op. cit., p. 20.

[144] Lukwago Juliet, 2006, "Poliisi Ezinze Jjajja Ndaula", in *Bukedde*, 28th Nov. 2006, The New Vision Publishing Limited.

[145] Ziribaggwa Margaret, 2006, "Poliisi Egudewo Fayilo ku Ndaula", in *Bukedde*, 29th Nov. 2006, The New Vision Publishing Limited.

[146] "Ndaula Aggya wa Obuyinza Obusiba Abantu ku Njegere?", in *Bukedde*, 28th Nov. 2006, The New Vision Publishing Limited.

up engaging in criminal activities. What is of more interest is that it was reported that the police could not proceed with prosecution because the local people were not willing to come out and provide witness for the case. [147]

This type of practitioners usually present no history of research and their treatment is in most cases non-conventional. Their acquisition of knowledge on how to treat various illnesses is said to be through means that are 'sacred' to the general public. (These may include dreams, trances, visions, etc.) They are usually not subject to questioning from the public or debate because of cultural sacredness with which they are regarded. The morality within which they practice does not encourage the patients to ask whether the medications and concoctions being used on them could be harmful or not. This morality is mostly embedded in the cultural milieu within which these practitioners live. The moral milieu of current western medicine provides no room within which to question its attitude towards TM (i.e. seeing it as simply a crude source of raw material for drug discovery) in the same way the TM gives clients little or no room for asking about the harmfulness or usefulness of its medications. This indicates that both forms of medicine are within the same morality, namely one in which there exists little questioning of what the experts of life (in the case of TM) and drug discovery (in the case of modern western medicine) do. There is generally a 'halo of sacredness' that surrounds those dealing with indigenous medicine whether it is those local practitioners who are treating patients or those researching in it for drug discovery.

4.5 Conclusion

In this chapter we have looked at health provision and research in traditional or indigenous medicine in East Africa. Under this we have examined the state of the health sector in this region and looked at why indigenous medicine is gaining prominence in official health policy and also we have looked at research in indigenous medicine. From this examination there are key points that have emerged. We have noted that globally there is increasing interest in traditional medicine. It is also been demonstrated that the official health sectors in the three East African countries of Kenya, Tanzania and Uganda are overwhelmed with great financial constraints and disease burden. This explains why the majority of the local people rely on traditional medicine for their primary health care needs, which is readily available and makes them self-reliant.

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[147] Lukwago Juliet, op. cit..

At the same time it has been pointed out that research in traditional medicine in this region is on the rise with both local and international researchers taking keen interest in this form of medicine at primary and secondary levels respectively. Primary researchers are the local healers and herbalists who through various indigenous means acquire knowledge of the medicinal properties of the herbs and techniques that they use to treat illnesses. Secondary researchers (both local and international teams and individuals) deal with medicinal knowledge that is already possessed by the indigenous medicine women and men. We have also categorized them into those who seek for organic causes and treatments for illnesses and those who seek for inorganic explanations and solutions. In most cases the local and international researchers who are from a background of modern western medicine perceive TM as a crude practice from which they can 'discover' drugs by their means of 'purification'. The medical morality from which they come looks down on TM and allows little or no room for being questioned. But at the same time we have observed that the local cultures from which the practitioners of TM come create a morality which gives them a 'sacredness' that does not equally allow for questioning. This is the underlying environment within which both forms of medicine operate that is conducive for abusing persons. This makes the morality from which research in traditional medicine is perceived and approached very important if we are to render this research bioethically accountable. It therefore becomes imperative that we look at the relationship between the morality from which a researcher approaches research in traditional medicine so as to understand roots of the bioethical challenges that exist in traditional medical research.

CHAPTER V

PHOBICULCATIC MORALITY AND BIOETHICS IN EAST AFRICA

5.1 Introduction

In the previous chapter I demonstrated the importance of indigenous medicine in the East African health sector thus augmenting the view that it should be at the center of bioethics agenda. Having come to the realization that the root of misdeeds and abuse of persons in research in indigenous medicine can not be separated from the morality within which this research takes place, in this chapter I expound on the relationship between morality and bioethics. In this chapter I develop the idea that the morality of a given people or region affects the ethics and ultimately bioethics and in our case research ethics. Focus is placed on that type of morality I refer to as 'phobiculcatic'; I explain what it means and how it bears on research ethics in indigenous medicine. In a diagnostic approach emphasis is placed on connecting morality with bioethics as the relationship from which to trace the root of abuses and misconduct in research in indigenous medicine.

5.2 On the Relationship between Morality and Bioethics

Before proceeding to the definition of morality it is imperative that we establish why morality is important in investigating bioethics. Earlier on in third chapter of this study I pointed out that the questions that bioethics grapples with today are fundamentally questions of moral philosophy and that bioethics would be seriously limited if bioethicists tried to answer these questions while giving little attention to the contribution from moral philosophy. Moral philosophy tries to answer questions that relate to fundamental concepts such as: 'good', 'right', etc. To know what the 'good' is, is to get closer to defining 'good conduct'. On the other hand, the gist of bioethics especially as it relates to research is to determine guidelines to good conduct in research. Therefore to try and extrapolate discussions on good conduct in medical research from the wider discussion on goodness or the good is to commit an error in reasoning because the former takes place within the latter. Morality provides the meaning of good conduct in general and bioethics endeavours to establish guidelines for its particular application in medical research. For that matter, the relationship between morality and bioethics is of a profound nature.

Those who try to drive a wedge between morality and bioethics have a key assumption they

hold, namely that bioethics is a form of 'practical scientific ethics' which should be above the usual 'distracting' discussions of relativism vis-à-vis universalism in traditional moral philosophy. This assumption is mainly traceable from the contributions (to bioethics) of those from a non-philosophical background. Pellegrino has observed that this represents the old feud between the concrete and abstract.[148] There are even those who are proposing that 'bioethics' should be interpreted as 'biological ethics'.[149] Underneath all this is a deep-seated mistrust of the methods of philosophy (with the argument that they are not practical enough). To make it even more interesting, some thinkers are beginning to argue that, "…moral philosophy [is a] branch of bioethics…"[150] Without entering into detailed explanation due to limitation in space, I can only comment that this trend is absurd because in today's academics distinction of disciplines is being bridged with a growing trend towards multi-disciplinary approaches with no discipline having a monopoly of knowledge.

5.3 On the Nature and Definition of Morality

One of the earliest efforts at defining and establishing a morality for guiding human conduct that we have become accustomed to is to be found in ancient Egypt[151] in such doctrines as the transmigration of souls which was popularized in the ancient Greek world by Pythagoras after coming under Egyptian influences.[152] (This position is based on scholars such as the celebrated Frenchman, Count C.F Volney who argued that the Egyptians were the first people to "attain the physical and moral sciences necessary to civilized life."[153])

Doctrines such as the transmigration of souls were the basis of many a morality not only in ancient Egypt and many African communities but also in Indo-Chinese traditions and cultures. It is reported that Pythagoras started a strict ascetic religious group to which he taught a strict morality that included teachings such as the sinfulness of eating beans, not to look in a mirror besides fire, etc. We learn that he was concerned with placing morality on a higher ground from reports about, "Pythagoras' ambition to reveal in his philosophy the validity and structure of a higher order, the basis of the divine order, for which souls return in

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[148] Pellegrino, op. cit., p. 9
[149] Ibid., p. 15
[150] Chiarelli B., "Global Bioethics: A Suggested Distinction Between Ethic and Morality", Institute of Anthropology and Ethnology, University of Florence, http://biospace.nw.ru/bioethics/be11.htm, accessed 8th April 2007
[151] Kemet was the original name for Egypt, which in Greek meant 'ancient land'.
[152] Scholars such as G. Massey, Count C. Volney, Cheikh A. Diop, George G.M. James, etc have successfully argued that the earliest Greek philosophers developed their ideas after coming under Egyptian influence.
[153] Count C. F. Volney, (1787), *The Ruins of Empires*, cited in John Henrik Clarke, "Cheikh Anta Diop and the New Light on African History", in *Transition*, 46, 1974, Duke University Press, pp. 74-76.

a constant cycle."[154] This is one of the earliest records in Greek philosophy of the debate over whether to define and found morality on universalist/religious grounds or particularistic/humanistic grounds.

In classical Greek philosophical writings we encounter one of modern times' most referenced debates on morality in the disagreement between Plato and the mobile teachers called the Sophists.[155] Plato was disturbed by their teaching because of the emphasis on material values and especially the amorality of their teachings. Plato was convinced that man ought to make morality his ultimate concern if he was to reach true happiness. These accounts provide us with evidence that there has always been a disagreement over what constitutes morality or how humans define morality. To be able to investigate this aspect of morality and establish what morality is, we need to look at the different positions from which scholars approach the topic of morality.

5.3.1 Approaches to Defining Morality

In trying to define morality or to defend various positions that they advance, philosophers approach the subject of morality from different angles. The direction from which a thinker approaches the subject of morality is instrumental in determining the manner in which s/he defines morality. The following are some of the most common lines along which the definition of morality takes course. Note should be taken that these are just general lines along which debates of defining morality run; this does not mean that each thinker takes precisely a dichotomized discussion. Some discussions involve more than just two sides.

5.3.1.1 Universalist-Relativist Dichotomies in Defining Morality

Almost all discourse on morality over time has been characterized by the dichotomy between universalism and pluralism (or particularlism). Most discussions on the definition of morality take these lines. Those on the side of relativism argue that morality is relative to a given culture thus limited to time and space. In this view, notions such as 'right', 'good', 'wrong', etc are determined by the approval or disapproval in a particular social milieu. To this view there are no universally binding values hence no universal meaning of morality. Some argue

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[154] "Pythagoras [Samos, 582 – 500 BC]", http://www.thebigview.com/greeks/pythagoras.html, accessed 5th April 2007

[155] Sophists were professional teachers who were always on the move and charged monetary value for their services. They taught rhetoric and other related subjects that aimed at teaching the students skills of debate and survival mainly in the democracy of the Greek city-states at the time. Some of the key tenets of their teachings were that knowledge was subjective and that truth was relative.

that each one chooses the moral framework from which they define their morality. "What is morally right in relation to one moral framework can be morally wrong in relation to a different moral framework."[156]

On the other hand the Universalists argue that morality can have a universal meaning. To this view there are moral standards that are binding in every human society irrespective of time and space. To them moral universalism, "requires that rational beings accept the same standards and rank or weigh them in roughly the same way."[157] Under this category we find the moral absolutists who hold that there are basic ethical principles that do apply to each and every society. They argue that there could be difficulty in discovering these basic moral principles thus explaining the apparent differences in moral values and standards.

The disagreement between Plato and the Sophists provide us with some of the earliest written accounts of this dichotomy. The teaching of moral relativism by the Sophists had its roots in their skepticism when it came to knowing the truth. To them knowledge is subjective. Since they believed that man could never attain objective knowledge of anything, then he could never claim to know universally binding moral values. Plato, however, was convinced that it was possible to attain objective knowledge and he believed that morality should be based on objective truth. To him the position of the Sophists would lead to moral chaos.

5.3.1.2 Religious-Atheist Dichotomies in Defining Morality

The debate over whether to define morality by religion or not is also as old as the one between Universalists and Relativists. There are thinkers who reject the idea of morality being founded on religion. They hold as untenable the idea that any law requires a lawgiver.[158] To these thinkers, man can found morality without necessarily appealing to any nonhuman higher being such as God. They stripe moral values of any 'God-origins' and found them on purely humanistic grounds; to some of them virtues such as courage, compassion, charity are not a result of motivation from God but are from human efforts.[159] The basic tenet of atheistic moralists is that this world of human beings does not need some God in order for morality to exist; morality can be, even without God. Perhaps David Hume is the best example of a philosopher who argued in favor of a morality found on humanistic grounds. By Hume's

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[156] Harman G. & Judith J. Thomson, 1996, *Moral Relativism and Moral Objectivity*, Blackwell Publishers, p. 3.

[157] Michael Philips, 1994, *Between Universalism and Scepticism: Ethics as Social Artefact*, Oxford University Press, p. 20.

[158] Theodore Schick, Jr., "Morality Requires God…Or Does it?" in *Free Inquiry*, summer 1997, pp. 32-34.

[159] See: Michael Martin, 2002, *Atheism, Morality and Meaning*, Prometheus, p. 33.

argument morality is a human construct which arises out of the interplay between human sentiments and human reason. Morality's essence in human society emanates from passions that drive us to act in certain ways. Human reason by itself can only help in discussing morality but it has to obey the dictates of our passions and sentiments (the feelings of approval and disapproval). Through experience these passions and sentiments allow customs and habits to develop thus forming the basis of morality.[160]

On the other side of this dichotomy are those who think that without religion there can not be morality i.e. Objective Morality. For objective morality to exist there must be Objective Moral Values and these values can only be put in place by God because man's own moral values can only be subjective. Without objective values (and these can only be founded on God) there is no reason to have any values at all. According to this school, (at least from the perspective of monotheists), the 'good' (which Plato sought so much to know) is to be found in God; God is goodness and therefore giving meaning to morality is to place it on the foundation of God. To this view, human beings are not just more evolved beings whose level of evolution allows them to make their own morality; rather they are spiritual beings with moral obligations that make them accountable to a moral God.

5.3.1.3 Normative-Descriptive Dichotomy in Defining Morality

Another common dichotomy that characterizes debates on defining morality is that of normative morality on one side and descriptive morality on the other. The simplest representation of this dichotomy is the definition of two words that are found in traditional philosophy. The descriptive is usually defined as what '*is*' while normative is used to mean, the '*ought*'. We are told that,

> when 'morality' is used simply to refer to a code of conduct put forward
> by a society, whether or not it is distinguished from etiquette, law, and
> religion, then it is being used in a completely descriptive sense.[161]

A descriptive attempt at defining morality involves community-specific study of what a particular community puts forward as a guide of the conduct of the members of that community. In this sense many and different moralities can be found and this gives credit to moral relativists.

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[160] See: David Hume, 1910, *An Enquiry Concerning Human Understanding*, Harvard Classics, Vol. 37, Section V, par 5.

[161] "The Definition of Morality", http://plato.stanford.edu/entries/morality-definition, accessed 15th March 2007.

On the other hand is normative definition of morality which is essentially what ought to be. A normative definition of morality uses the term 'morality' in a global prescriptive and universal sense. To this view there is a universal code of conduct that all rational persons would put forward for governing behavior of all moral agents.[162] On this basis they can even judge that some societies have defective moralities.

5.3.1.4 Comments on the Traditional Dichotomies in Defining Morality

The foregoing survey of the major dichotomies that have characterized most discussions of defining morality is instructive to the present study in the sense that it reveals to us where this discourse has been lacking. We can point out some of the problems in the traditional dichotomies in the morality discourse.

We illustrate the challenge posed by these dichotomies using the universalist-relativist dichotomy. When it comes to bioethics, this dichotomy creates problems for both those who argue on the side of universalism and those on the side of relativism. I can illustrate this by what transpired in a research in which the author took part under the Program on African Studies in collaboration between Northwestern University and Makerere University.[163] During the discussions it occurred to me that those of us coming from Uganda were finding it hard to defend the view that there existed local ethical guidelines for research in indigenous Uganda. At the same time it was difficult to admit to the global bioethical guidelines because that meant that we had to adhere to a set of guidelines developed within a different society which was far technologically different. I viewed it as a kind of '*cul de sac*' to argue on either side for those from Uganda. Arguing in favor of a local bioethics (relativism) meant promoting local arbitrariness and abuse of persons which actually exists and needs to be tempered by international instruments that guide bioethical research. At the same time many researchers claiming to be following international guidelines have ended up abusing the persons of research participanrs because they were locally incompatible, an indication that what passes for 'international' may actually be 'local'. Local authorities can abuse persons in the name of moral relativism but at the same time international authorities can do the same in the name of moral universalism.[164]

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[162] Ibid.

[163] See: Uganda Research Ethics Workshop, http://www.northwestern.edu/african-studies/index.html

[164] Chih-yu Shih discusses this dichotomy to some depth in terms of human rights; See: Chih-yu Shih, 2002, "Opening the Dichotomy of Universalism and Relativism", in *Human Rights and Human Welfare*, Vol. 2:1, Winter 2002, Center on Rights Development, pp. 13-24.

In addition to the difficulties observed in the above '*cul de sac*' argument, applying universality to defining morality may place local moralities in a precarious position because as Michael McGhee argues, they may be branded 'pre-moral'. He has made a very important statement about the issue of the 'universal' in morality in the following words:

> *We should also distinguish the universality feature from the universalizability of moral judgment, which is a logical feature of the relationship between practical judgments and reasons for action. But making universality a criterion of 'morality' requires us to regard cultures that lack it as 'pre-moral'. It seems more reasonable to acknowledge their moralities and to see universality as a development within morality.*[165]

McGhee's overall concern (according to the article) is to argue that our feelings are part of morality just as reason is. Nonetheless, in this statement he points out one of the problems that are associated with using the universal-particular dichotomy in defining morality. By this statement, he views universality simply as merely a 'development within morality' without the defining characteristic that it is usually accorded as far as the traditional discourse of defining morality goes.

Another concern that we can raise is that of overlooking the importance of how morality is transferred on the definition of morality. This means ignoring the mode in or by which morality is transferred from one generation to another or one group to another. Most discussions of the nature of morality pay little or no attention to the effect of the transfer of morality on the definition of morality itself. The passing on or transmission of a morality from one generation to another should be taken to be as important as the morality itself because the process contributes a lot to the nature of the resultant morality. It thus becomes imperative that we look into how the mode in or by which morality is transferred determines its definition.

5.4 Defining Morality by the Notion of Transfer

The notion of 'transfer' as far as morality is concerned is used here and henceforth in reference to the passing on of morality from one generation (or group) to another. The transfer of morality has a big impact on defining morality itself and it goes a long way in distinguishing one morality from another. That is why I consider it a key element that ought to

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[165] Michael McGhee, 1999, "Moral Sentiments, Social Exclusion, Aesthetic Education", in *Philosophy*, Vol. 74, 1999, Royal Institute of Philosophy, p. 89.

feature prominently in the discourse of defining morality. From the Latin, '*transferre*' the word transfer means to bear across, to carry over. It means to cause something to pass on from one end to another and in this case, from one person to another or from one generation to another. In terms of this study, therefore, the transfer of morality means the process by which what is considered morality in a given community is passed on from one generation to another or from one person to another; it involves the passing on of values, norms, customs and even mores from the older to the younger.

At this point it is normal for anyone to ask: why should we give the issue of 'the transfer of morality' an important place in the discourse of defining morality? The answer is that this is how morality has lived on from generation to generation in different communities wherever man is found. I think that in order to understand morality we need to have a good grasp of the process by which it was transferred from our predecessors down to us. I think so. Morality is not to be taken as a 'compact unalterable whole' that one generation hands down to another as one would pass on a shirt or dress to one's child. Even in this example the shirt or dress may take on more meaning than a mere shirt or dress to the child depending on the manner and environment in which it is passed on. For example, it is possible that the shirt or dress could take on the meaning of an untouchable souvenir which ought to be held in sacredness.

This particular example may be accused of oversimplifying of morality. Morality is a complex issue (as I have demonstrated by the various dichotomies above) but the value in this example lies in magnifying the importance of the process of transferring something from one person to another. We can observe that if it is that important in the transfer of a 'simple' thing as a shirt or dress, then is gets all the more important when it comes to morality.

5.4.1 The Process of Transferring and its Impact on Defining Morality

It is important that we investigate the process of the transfer of morality because it is by this process that I intend to differentiate between one morality from another. There are two elements of this process of transferring that I will consider in this study, namely *agency* and *media*. I discuss 'agency' in terms of the end from which the transfer commences, while 'media' is discussed in terms of the channels used by the agent in the transfer process.

5.4.1.1 Agency in the Transfer Process

The etymological roots of the word 'agent' bring out the meaning of 'one who acts'. To be an agent is to set into motion or to drive. It implies conscience knowledge of the responsibility of initiating. If we take this conception of agency to guide us then we are not discussing '*instrumental agency*' (i.e. acting as a mere conduit of morality) but instead we are discussing what we can refer to as '*engaged agency*'. By instrumental agency I mean the agent having the perspective of itself as a mere channel through which morality in terms of values, norms, etc are passed on from one end to another. As far as morality is concerned, this type of conception of agency is the one that would lead some to take morality as a compact whole which is transferred from one end to another without alteration. In this conception the agent holds the view that what they are transferring to the next person is not their making but they are merely passing it on. It implies carrying out the transferring with the attitude of one who adds or subtracts nothing from the thing being transferred. Instrumental agency also entails the idea that the agent makes no moral choices in the process but they are passive (and sort of amoral). To understand this further, we ask the question: can any human activity be amoral? We ask ourselves such because it is only nonhumans that can engage in an activity and add no moral value to it. As we can observe, this conception of morality is not in tandem with humans given the fact that no human activity can ever be taken to be amoral.

Instead of instrumental agency we are considering engaged agency. What do we mean by "*engaged agency*"? The term is taken from the word 'engage' and this indicates the depth of involvement in the process of transferring. An engaged agent is profoundly and deeply involved in both the transmission and the making of the thing that is being transferred. In this case the agent is deeply involved in both the transferring and the defining (or giving character) to morality. We can relate this conception of agency to the one that Heidegger defines in terms of the new age of the media and technologies of representation[166] [167] even though his conception does not fit our present study to the extent that it inclines towards being more of a collective agency than an individual agency. In this account of agency Heidegger presents what a type of agency (which includes all of us as a collective of observers) has made through representation and spectating (or observation). In this case the agency of the humans is what makes the world as such. To a great extent, therefore, in Heideggerian agency the individual agent is overshadowed by the collective agency. Nonetheless, Heideggerian agency

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[166] Heidegger, Martin. "The Age of the World Picture", in The Question Concerning Technology and Other Essays, 1977.
[167] See also: Taylor Charles, Taylor, "Engaged Agency and Background in Heidegger." in Charles Guignon. (Ed.) 1993. The Cambridge Companion to Heidegger. Cambridge University Press. Cambridge Collections Online. http://cco.cambridge.org/extract?id=ccol0521385709_CCOL0521385709A014, 28 March 2007

captures to a good extent the conception of agency that I refer to when I use the term 'engaged agency' because it engenders an agent with capacity to modify the object of agency.

When it comes to morality the engaged agent is active and consciously or unconsciously part of the process of deciding the format in which morality is passed on from one end to another. This kind of agency involves not only the format but also the means of transfer. For example, when it comes to format the agent may decide to pass on morality by means of short mythological stories for easy remembrance or as elaborate explanation of moral motivation. The agent can decide to pass on morality in form of anecdotal wisdom or discussion; per chance by way of storytelling, ceremonies, rituals, or otherwise. It is also possible to pass on moral values through the medium of fear or mutual understanding. Whatever the choice our observation is that engaged agency can not but have a profound impact on defining the object of transfer.

5.4.1.2 Media in the Transfer Process

The conception of media that I choose in the present study is in many ways related to that of agency; I take media to mean '*intermediate agency*'. Media does not only lie between one end and another but also equally shapes the object being transmitted. The type of media employed in the transfer does not only implicate on the meaning that the one on the receiving end of the transfer constructs but it also determines the vivacity of the object of transfer.

This view of media may present difficulty in terms of fathoming, especially these days when the most prominent forms of it are usually presupposed to be 'transparent' and a given. Julian Darley raises this point in reference to electronic media by writing that,

> *…electronic media have become so "normal" that they are regarded as transparent or rather invisible, part of the given, ground zero conditions of life. When something is thus normalized it is hard to ask questions of its being, hard to explore an ontology or a modality, in other words, to ask "what is it?" or "should it be?"*[168]

From Julian's concern about the present lay person's view of media, we realize that in most cases media is taken as a given and as transparent and disconnectable from the object of transmission. However, my contention is that media is not neutral when it comes to defining

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[168] Julian Darley, 1997, *Toward a Philosophy of Media: An Investigation into the Relationship between Electronic Mass Media (Television) and the Construction of Subjectivity*, MA. Dissertation, The University of Texas, 1997, http://www.metafoundation.org/theses/mass_media.php, accessed 8th April 2007

the object it is being used to transfer. Julian reminds us of the difference in nature of media in writing about two categories of media, namely *innate media* and *non-genetic extension media*. The examples given of innate are bees dancing (which they use to communicate) and human talking while the non-genetic extensions include tools like a telephone, a computer and a television. According to Julian these different kinds of media achieve different kinds of communication.

The examples cited by in Julian's investigation, are mostly drawn from modern society; media such as telephones, computers, and televisions are artifacts of present society. However, when it comes to investigating morality in relation to traditional medicine in East Africa we can not but refer to traditional media such as folklore, initiations, rites, rituals and others.

In investigation media, Julian argues that we should not shy away from discussing ends which is a moral question. This is a perspective that indeed fits this study especially because it deals with morality. Our concern is how morality acquires definition in the process of being transferred from one generation or group to another. In most cases discussions of media presume them to be neutral and mere means or channels but I want to hold that this is not the case. I am persuaded that the object of transfer (that which is being transferred) acquires in terms of its definition from the very media through which it is being transferred.

Defining a type of morality that may be found in a given society to a large extent depends on the process through which it is transferred from one generation to another. This process affects morality such that over time it develops that character bestowed on it by the agents and media involved in passing it on from generation to generation or from group to group.

5.4.1.3 Fear and the Categorisation of Morality

Having demonstrated and understood the importance of the process of transfer in defining morality, we can use the outcome of this process to define the kind of morality that we find in any given human society. In going about this we can borrow a leaf from Michael McGhee whose work I referred to earlier in this study. He writes about how to identify a moral judgement not by mere categories of normativity or descriptiveness (such as 'ought' or 'is') but also takes into consideration what he calls 'its grounds' and its 'context'. He writes that,

> *We do not identify a moral judgment by its form alone, by the presence of an 'ought' or 'should' or even of a 'right' or 'wrong', but need to see its grounds and its context.*[169]

My take of this is that the 'grounds' and 'context' within which a moral judgment should be seen is intricately inseparable from the process by which it is passed on from one group or generation to another. Defining a moral judgment should not only be done on the basis of its 'form' but more so, on the basis of how it acquires that particular 'form'. The acquisition of the form is preceded by the process of transfer.

Using the 'grounds' and 'context' argument McGhee goes ahead to advance two of what he calls aspects (or modes) of morality. The first is what he calls a '*defensive, reactive (and exclusive) mode*' while the second one he calls, '*a constructive, creative (and integrative) mode*'.[170] These modes, according to McGhee, are actually sensible responses to inculcation or passing on of moral paradigms. He aims at tracing what he calls 'sources' of morality from the 'collective' reaction to its inculcation. The two modes represent two different responses to how moral views are passed on from one person to another; to him the former is response to 'oppressive coercion or domination' while the latter is a response to a 'liberating participation in collaborative creative endeavour'.[171]

McGhee's classification has ingredients that would prove useful in our present study in that it can help identify the nature of the outcome of the process of transfer. If the process is characterised by oppressive coercion and domination, this implies the use of fear to pass across moral paradigms. On the other hand if the process is characterised by participatory collaboration, then the passing on of moral paradigm is a liberating process. From this one clear distinguishing mark becomes clear, namely, employment or no employment of fear.

5.4.1.4 Understanding Fear and its Effects

Since I have chosen fear as a defining factor of morality it is imperative that we understand what fear is and its effects on human society. Fear is an emotion. It is usually described as an unpleasant feeling of anxiety, apprehension, or dread. It has been observed that, "For most people, fear has a significant effect on behavior…."[172] It is therefore important that we factor

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[169] Michael McGhee, op. cit., p. 88.
[170] Ibid., p. 93-4
[171] Ibid., p. 94.
[172] John F. Tanner, et al., 1991, "The Protection Motivation Model: A Normative Model of Fear Appeals", in *Journal of Marketing*, Vol. 55, (July 1991), p. 36.

fear into our discourse on morality so as to give us a better understanding of how it shapes (or it has shaped) our moralities.

Where does fear come from? Peter Preston insinuates that fear is a creation of culture in his review of the book, *Fear: A Cultural History* (2005) by Joanna Bourke. To him, perhaps the only time when we are free from fear is when we are in the womb and in our early years of childhood.[173] In contrast, most proponents of evolution hold that fear developed as an instinct of survival which helped species to pass on their genes to successive generations. However, what is usually not pointed out is that fear ought to apply in genuine things not imaginary ones. (Genuine fear is useful unlike imaginary fear). The problem with fearing imaginary things is that it increases vulnerability and reduces survival, (which evolution claims that it promotes) because unfounded fear leads to wrong decisions. It is reported that after experimenting with a snake (a puff adder), Darwin, the most known proponent of evolution, said that his will and reason were powerless against the imagination of a danger which had never been experienced.[174] This implies that since fear renders our will and reason powerless then it can not promote our survival. Physiological studies of the brain indicate that during bouts of fear the brain is forced to remove attention from other tasks and to concentrate on determining the source and nature of the threat. This suggests that if our lives are spent in constant fear, our capacities for coping with life's challenges could get prolonged less-than-normal usage or even possibly, malfunctioning. .[175] [176]

The effects of fear that we observe are usually the opposite of enhancing survival. In reviewing a recent conference (organized by the American Enterprise Institute) with the theme: "Panic Attack: The New Precautionary Culture, the Politics of Fear and the Risks of Innovation", Ronald Bailey noted that participants expressed concern that unfounded fear retarded innovativeness or creativity.[177] This conference raised concern about the fact that there is indication that today's world is getting more fearful and this fear is impeding innovation which is a key factor if society is to cope with its problems. This is an example of

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[173] Peter Preston, 2005, "The Fright of Our Lives", in *The Observer Review*, 13th February 2005, http://observer.guardian.co.uk/review/story/0,6903,1411634,00.html, accessed 9th April 2007
[174] See: Glyn Dadis, 2005, "Fear: A Cultural History", http://www.theage.com.au/news/Reviews/Fear-a-cultural-history/2005/05/06/1115092634475.html, accessed 9th April 2007
[175] See: Gersley, Erin. "Phobias: Causes and Treatments." *AllPsych Online*. http://allpsych.com/journal/phobias.html
[176] "Fight-or-Flight Response." McGraw-Hill Higher Education. http://highered.mcgraw-hill.com/sites/0072562463/student_view0/abnormal_psychology_image_gallery.html, accessed 9th April 2007
[177] Ronald Bailey, 2006, "Culture of Fear: Dealing With Cultural Panic Attacks", http://www.reason.com/news/show/35017.html, accessed 9th April 2007

how fallacious the evolutionary view that fear increases survival is; instead of increasing survival it may lead to incapacitation as far as innovatively coping with challenges is concerned. Fear also causes moral problems. One of the recent studies of fear by Joanna Bourke explores the cultural history of fear and its application in such spheres such as public policy. Looking at how fear has been historically applied as a public policy tool Joanna makes an interesting observation when she mentions "moral panics" as a consequence of fear.[178]

Although Joanna's book is not precisely about morality as such, the above single observation by itself is indicative of the effect that fear can have on morality. Using fear as a tool of public policy is a parallel of using it to inculcate morality in others. For fear to be created there must be a scary stimulus which could be in form of an object, imagination, a story, etc. According to our earlier discussion of transferring or inculcating morality, this scary stimulus could be provided by the agent and this stimulus is transmitted by the media or could be the media itself. If the transfer process is permeated with fear and more so if the media is fear itself, then the object of transfer will be characterised with fear. In the case of morality, a morality that is transferred or inculcated by means of fear is also most likely to be characterised with fear.

In using media tools that engulf the transfer process with fear, the agent of transfer inadvertently ensures that the object of transfer turns into a domineering force, especially in terms of morality. On the other hand, however, if the agent employs media that do not engulf the process with fear and unquestionablness, the outcome does not become a fearful and oppressive force. In other words, the former inculcates morals by way of fear while the latter does not do so. We can name the resultant two types of morality as '*Phobiculcatic*' on one hand and '*Non-phobiculcatic*' on the other.

5.5 Phobiculcatic and Non-phobiculcatic Morality: Meaning

The above discourse makes it easier to differentiate between a phobiculcatic morality and a non-phobiculcatic one. The word 'phobiculcatic' is a portmanteau derivation by the author of this study. It is derived from two words, namely *phobia* and *inculcate*. From 'phobia' the portion '*phobi*' is joined to the portion '*culcate*' taken from inculcate to form '*phobiculcate*'. The Latin '*phobia*' means fear or horror and in English '*phobia*' denotes an abnormal irrational fear. While the Latin '*inculcare*' from which inculcate derives, means "press in" or

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[178] Joanna Bourke, (2005) *Fear: A Cultural History*, Virago, p. 27.

"stamp in" thus getting the meaning of pressing upon the mind by frequent repetition. To phobiculcate, therefore is to frequently and repetitively use fear or horror to impress something on the mind.

Phobiculcatic morality, for that matter, is a morality impressed upon another by frequent and repetitive use of fear or horror. A non-phobiculcatic morality, on the other hand, is one which does not use fear in pressing moral paradigms onto another. In simple terms, a phobiculcatic morality is a product of fear and it spreads fear while a non-phobiculcatic one exudes security because the agents and media with which it is transferred encourage security. The element of fear usually goes with a lack of proper understanding and in this case due to the fact that fear is central in passing on morality, those who adopt it (on the receiving end) do so without proper understanding of that morality. On the other hand, those who adopt a non-phobiculcatic morality do so from a position of security because they are allowed to understand that morality. For now it is necessary that we delve into what characterizes a phobiculcatic morality since our main concern is to look into its effects on bioethics.

5.5.1 The Nature of Phobiculcatic Morality

To elaborate on the nature of morality I use the two elements that I advanced earlier which may define the process of transfer of morality. These two elements are agency and media. The nature of a phobiculcatic morality can be known by the way agency and media interrelate in the process of transferring that morality.

For a phobiculcatic morality to be, the agency that most suits it is what I referred to as engaged agency. In this morality an engaged agent applies fear to impress a given moral paradigm on another or on the next generation. The agent of inculcating morality may consciously or unconsciously use fear in the process; what matters is not the conscious or unconscious use of fear but the fact that fear is employed. This employment of fear is what characterizes a phobiculcatic morality. In some cases the agent may take on a fearful character itself because the agent may see this as a viable way of inculcating morality.

In like manner the media employed in a phobiculcatic morality exudes fear if not being fear itself. The media that could be used includes stories, songs, ceremonies, etc. These media repeatedly impress moral paradigms on consequent generations and in such a morality they do

not encourage a deliberative engagement or discussion but fear. Such media are usually in short and easily memorable form, carrying anecdotal wisdom and knowledge and ideas that have been passed on down from generation to generation.[179]. Instead of encouraging a development of a reasoned acceptance of the moral paradigm (a liberating acceptance), these media engender a fearful acceptance.

Note should be taken that both phobiculcatic and non-phobiculcatic moralities emerge or develop because of the deep desire of the older generation to inculcate their moral paradigm into the subsequent generations. The difference between them arises due to the use of different tools in the inculcation of morals. A phobiculcatic morality emerges in an environment that requires ingenious ways to preserve a lot of moral information in as economical a way as possible. Short anecdotal stories, proverbs, songs, etc help to cut short the inculcating of morals which would have taken long if there was discussing and allowing questioning of the moral paradigms. Circumstantially, this is an ingenious way of keeping moral paradigms going on and in that respect the agents of such a morality can be commended for an economical way of inculcating morals.

However, one of the major unintended effects of a phobiculcatic morality is the high likelihood of persons who have grown up in such an environment to loose any incentive let alone capacity to genuinely critique[180] their morality. This choice of inculcating morals does not equip its adherents as individuals with adequate rational tools and resources or skills to raise necessary questions about morality. The one at the receiving end of the inculcation is encouraged to take every aspect of it as it is presented to them; there are rare occasions when such a moral paradigm is critiqued thus having an increased likelihood to perpetuate undesirable practices or customs for a long time.

5.5.2 Phobiculcatic Morality in East Africa

We find many societies in the East Africa which have a phobiculcatic morality. I can demonstrate this by looking at some examples in a few selected societies in East Africa and how they inculcate moral paradigms. My observation is that indigenous morality in East

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[179] It is most likely that the desire to teach a lot in a short time and in most cases unstable times necessitates the application of tools that can effectively and economically transfer information.

[180] The word 'critique' here is not meant to carry a negative connotation. The sense in which I use the word critique is that which comes from the etymological root of the word, namely the Greek, '*krino*', which meant to assess, to evaluate. In this sense, therefore, I refer to the idea of equipping the subsequent generation with the capacity to assess their morality with the view of improving it.

Africa was not more or less phobiculcatic before invasion by colonialists than after. Although indigenous morality can not be absolved of phobiculcatic tendencies, it is quite clear that the process of colonizing this region and maintaining colonial hegemony exerted a lot of phobia on the minds of the people and entrenched a phobiculcatic moral system. This was mainly because colonial masters had to enforce a certain type of morality that could entrench their rule and at the same time the colonial experience transformed the local people into a fearful lot. We can find this at the root of much of the abuse that takes place in research in indigenous medicine and it also explains why there is little effective resistance to it.

5.5.2.1 Examples from Uganda and Tanzania

Buganda is one of the biggest indigenous Kingdoms in the East African region and it is found in present-day Uganda covering most of the Lake Victoria basin. Like any indigenous society in Africa, most of the history of the Baganda has been passed on through what has come to be called the "oral tradition".[181] The oral tradition gets its importance, as Elizabeth Allo Isichei has observed, not from asking which one is true but by asking what kind of truth they embody.[182] According to oral tradition as recorded by Keebungero[183], Baganda get their name from Buganda which was the name of the father of Ssekabaka Kato Kintu who is widely believed to be the first Kabaka (King) to assemble the Baganda into a well organized centralized pre-colonial kingdom. The Kingdom of Buganda is thought to have started to acquire its pre-colonial structure between the 14th and 16th Centuries (probably 1400 AD.)[184]

The most prominent example of inculcating morality in Buganda is how they use media such as name, etc, to instill respect for the Kabaka (King). The Baganda elders use names to instill respect of the Kabaka in their people. It is possible for someone to ask: Why the focus on the Kabaka? In Buganda the Kabaka is considered the chief of many things: households, lands, spirits, etc. Understanding the person of the Kabaka is important because it says a lot about the character of the cultural set-up and organization of the kingdom. He is the fountain of everything including morality; it is expected that if the young learn to respect the Kabaka then

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[181] Note should be taken of the fact that using the "oral tradition" to pass on information from generation to generation does not make one morality inferior to another. I do not consider any morality superior to the other because it has written accounts by which ti inculcates moral. As mentioned earlier in the text, instead of being a derogatory reference, the "oral tradition" is an indication of the ingenuity of the people who use it in passing on valuable information to subsequent generations.

[182] Elizabeth Allo Isichei, 1997. *A History of African Societies to 1870*, Cambridge University Press, p. 8.

[183] Keebungero E. S. Chelirenso, *Ssekabaka Kintu ne Bassekabake ba Buganda Abamusooka*, Crane Publishers Ltd.

[184] This is based on oral tradition and estimates from the 36 Kings that are recorded to have ruled so far. wwww.buganda.com reports that, historians have used information from oral traditions coupled with calculations of the expected duration of a typical king's reign, the life expectancy, and the generational overlap that occurred when siblings assumed the throne to estimate that the kingdom must have been established in the early to mid-14th century AD.

they will respect all their customs and norms. This is indicated in names and titles given to him such as: '*Lukoma-Nnantawetwa*' (the unbreakable), '*Ssabasajja*' (chief among men), '*Ssabataka*' (chief owner of land), '*Maasomooji*' (the-all-seeing), '*Bemba-Musota*' (ruthless snake, or the chief of gods), etc. According to Baganda oral folklore, Bemba was a pre-Kintu king who was very ruthless and disliked by his subjects to the extent that they decided to unite under a rebel prince Kintu in order to get rid of him. It is therefore interesting to know that such a name has been retained as one of the titles of the Kabaka. These names indicate a larger-than-life personality that is invincible who is to be feared by all. Since this invincible personality is the source of customs this means that those customs are respected and observed.

The Kabaka in Buganda is held in high esteem such that traditionally he was presented as one who never died but simply disappeared or rested. For example, traditionally when the Kabaka dies the word '*afudde*' (the equivalent of 'he has died' in English) is not supposed to be uttered when announcing his demise; rather the expression, "*Kabaka akisiza omukono*" (literally: "the Kabaka has rested") is the one used. In fact in the old days when the Kabaka died the place where his remains were laid to rest turned into a shrine and the Kabaka's personality took on a spiritual entity with worshippers. That is why there are many shrines named after past kings. Those who look after these places are viewed as a sort of 'priesthood' for that particular spirit. This was meant to instill respect for the spiritual world which is believed to be ancestral spirits. When these ancestral spirits give directions on customs, they are therefore supposed to be observed and incorporated into daily life. This includes medicine men and women and what they say is believed to be from the 'spiritual kings' and therefore must be obeyed.

One of the numerous deities which get its name from a Kabaka is called Ndawula. Ndawula was the name of the 19th Kabaka of Buganda who later turned into a deity after demise. This particular deity has one of the largest numbers of followers in present Buganda. Actually one of the cases of abuse of persons in traditional medicine that I considered in the previous chapter was committed by a medium of the spirit of Ndawula.[185] It is reported that this deity has adherents among the top officials of the government in Uganda and therefore when cases of abuse were reported to the police nothing much could be done. The people in authority who would have prosecuted and deterred these medicine men from exploiting the local people are also fearful because of the phobia-like respect that they accord to the deity. It was reported in

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[185] Lukwago Juliet, op. cit. [Translation by author]

the news that the medium/medicine man boasted about this.

> *Ndawula yalaze poliisi ekitabo mw'awandiika abagendayo okuli abanene mu Gavumenti. "Abenene bangi bajja mu kifo kino kyokka tebalina kye bakolawo. Nsazeewo okwongera okwetegereza ebintu bya Ndawula", Ssemakula bwe yategeezezza. Poliisi tewali gweyakutte wadde okuggya abawala ku njegere.*[186] [Ndawula showed the police a book in which he keeps records of his visitors and it contained highly placed people in the government. "Big people in the government come to this place and they turn a blind eye. I have decided to study the situation more closely", said Ssemakula (police official). No one was arrested by the police nor did it release the girls from the chains.]

The medicine man showed the police records of big people in the government who consult with his spirits and this scared off the police from following up the investigation further. The police even failed to take the chains off the girls who were being tied like slaves working for the medicine man. This indicates the challenges that exist in trying to deter these traditional medical practitioners from abusing people whom they are supposed to be treating. A morality that is inculcated by way of fear can hinder government authorities from ensuring that bad conduct is eliminated in the practice of traditional medicine.

To make matters complicated the coming of foreigners or colonialists in the region did not help but entrenched further a phobiculcatic morality in the modern sense. This was mainly because colonial masters had to enforce a certain type of morality that could entrench their rule and at the same time the colonial experience transformed the local people into a fearful lot. This was done either directly through ruthless imposed leaders or agents of the colonial masters. It is arguable that Africans became a more fearful people after the coming of colonial master than before. Writing about the effect of colonialism on the morality of Africans in 1929, Torday wrote that the African, "…no longer knows how to live, and death has terrors hitherto alien to his mind."[187] The terror which was visited on the African by colonial invaders coupled with the psychological trauma that went along with it created deep fear in his soul to the extent that he lost faith in their humanity.

Torday argued to the effect that prior to being invaded by colonialists Africans had learnt to live with their deities [even though there were a number of mischievous deities] which they had tamed as ancestral spirits. But the coming of the colonialist brought to them a deity that

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[186] Ibid.

[187] Torday E. "The Morality of African Races", *International Journal of Ethics*, Vol. 39, No. 2 (Jan. 1929), pp. 168

was terrifying because of the terror visited on them in the name of that deity. He wrote that the African,

> *...has learned by bitter experience that there is something above them* [colonial officials]*, some invisible, nameless power not unlike the mysterious bwanga* [a local deity] *with which the cunning medicine man energizes his "fetishes". This evil principle thwarts his natural protectors whenever they make a stand in defense of the native's rights and supports ruthlessly those who, according to his ideas, have robbed him of his land...The Negro asks himself why he has been treated thus? What has he done to be punished so cruelly? He does not know and nobody can tell him. The Blackman is dazed. No wonder he is stupid.*[188]

To the African who was invaded, the deity of the colonialist was a ruthless god to be feared and avoided where possible. Ruthlessness and cunningness was applied to impress certain moral paradigms in the minds of Africans such as accepting that the Whiteman was better than the Blackman. The colonialist had the "sacred trust of civilization" and was therefore mandated to carry out what Nakanyike writes about as the project of "civilizing the savages."[189] This carried with it a certain moral agenda. In a footnote, Nakanyike writes that the missionaries had a "moral agenda" to fulfill whose aim was to entrench the power of the colonial master.[190]

This brings us to the second example of how a phobiculcatic morality is inculcated. In his article, "*Do You Really Want in German East Africa, Herr Professor?*" Zimmerman writes about how a German professor called Weule in the company of a Norwegian commando, Herr Knudsen, carried out experimental anthropological research on the Africans in Tanganyika (German East Africa) at the time when the area was a German colony. They carried this out in a program code named, "*Kultur*" and "*Hebung*" aimed at increasing the superiority of the "Fatherland". Although this particular example is not about research in traditional medicine, it gives us great insights into the relationship between force and research in East Africa. In this example Zimmerman demonstrates that science and espionage were mixed to promote the power of the Germans in Tanganyika. The German wanted to 'teach' the Africans the higher morals of working hard on plantations and to pay taxes which resulted in the famous *Maji Maji* uprising in the South. In crushing the uprising, the German did not only use brutal force but also enlisted the services of Prof. Weule.

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[188] Ibid., p. 168-9 (Emphasis by author)
[189] Nakanyike B. Musisi, "Morality as Identity: The Missionary Moral Agenda in Buganda, 1877-1945", *The Journal of Religious History*, Vol. 23, No. 1 (Feb. 1999), pp. 54.
[190] Ibid., p.51.

> *The counterinsurgency operations continued through 1907 and employed scorched earth tactics that were responsible for the further deaths up to two hundred thousand Africans. The German government found that the immediate provocation for the uprising was resistance specifically to cotton growing and generally to the beginnings of the German program of "Kultur" and "Hebung" in the south. Governor Go¨tzen concluded that the uprising was the "reaction of the 'bush Negro' against the advances of Kultur," and especially the higher labor demands by German agriculture, a judgment echoing the report of an official commission that interviewed African and German participants in the conflict.[191]*

Weule carried out what he called "colonial folk research" (kolonialen Volksforschung).[192] Prof. Weule is reported to have said that the research helped him to "push into soul of the people." He was assisted by Herr Knudsen a Norwegian '*Ruga Ruga*' commando who had assisted the German government to violently crush the uprising by the local people against German rule in South Tanganyika. In addition, Weule moved about with an entourage of colonial soldiers. These travels have been termed a "martial expedition."

> *As they marched into villages, local leaders assembled their people so that the military could mete out punishments to suspected insurgents, including whippings, sentences of forced labor, and death by hanging. The assembled people offered Weule "photographic subjects that would never come before the camera of a private researcher on his own."[193]*

Weule's research was meant to assist the Germans in counterinsurgency operations.[194] He wrote about how he "crawled into hundreds of Negro's huts and searched every corner". He believed that what he was doing was for the benefit of science and the "Fatherland". He wrote of what he had gathered in his research that it was,

> *…the task of the colonial government to employ them for the benefit of science and the glory of the fatherland.[195]*

We find in Weule and Knudsen's work an example *per excellence* of how a morality of fear mixes with research. The colonial masters wanted to force onto the Africans what they called the "higher values" of hard work in the plantations and payment of tax. Alongside this, there

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[191] Zimmerman Andrew, *"What Do You Really Want in German East Africa, Herr Professor?" Counterinsurgency and the Science Effect in Colonial Tanzania*, Comparative Studies in Society and History, a. 48, 2006, 2. Cambridge University Press, p.446.
[192] Ibid., p.448.
[193] Ibid.
[194] Ibid., p. 449.
[195] Ibid.

was this research which rode on the same vehicle of a morality of phobia in the name of promoting science. Zimmerman exhibits drawings by the African porters who moved with the researchers. They are the depiction of how Africans were punished infront of the researchers while they recorded. The punishments included floggings, hard labour, killing by hanging, etc which were handed out arbitrary to anyone simply because the area had tried to revolt against the colonial masters. Apparently Weule was carrying out experiments on the effects of brutal punishment on the locals. The images depict a people punished to the point that they could no longer put up anymore resistance.

The above example is typical of research in most of colonial Africa. What we learn from all this is that a phobiculcatic morality undermines a person's will to stand against abuse.

5.6 The Impact of Phobiculcatic Morality on Research in TM

Having established the nature of phobiculcatic morality and seen how it is entrenched with the help of examples from East Africa, it is necessary for us to examine the kind of effect the environment of phobiculcatic morality has on medical research and particularly indigenous medical research. In examining this I have started with looking at the effect that phobiculcatic morality has on bioethical guidelines that are supposed to guard against abuse of participants in medical research. I have particularly looked at principlism as a case study. Secondly I have looked at the effect of phobiculcatic morality on the researchers themselves both at the primary and secondary level.

5.6.1 Impact on Bioethical Guidelines: The Case of Principlism

How does an environment of a phobiculcatic morality affect bioethical guidelines for research? To answer this, I relate the definition of morality that we have established above with bioethics in the East African region. To understand the effect of phobiculcatic morality on research ethics I have chosen to look at principlism as an example of how morality affects the implementation of ethical guidelines for medical research.

From examples in the region, we have seen that both the indigenous and colonial moral legacies tended towards a phobiculcatic morality. Today one of the dominant theoretical approaches to biomedical research is principlism. Principlism has become a dominant theory in global bioethics and its proponents think that it can help curb misconduct in biomedical

research. It is therefore necessary for us to examine the application of principlism in a phobiculcatic moral environment.

The term 'principlism' has emerged over the last quarter century to stand for the four-principle normative ethical approach to resolving bioethical challenges. The four principles include: nonmaleficeince, autonomy, beneficence and justice. Nonmaleficeince asserts an obligation not to inflict harm on others. Autonomy refers to the individual's freedom from controlling interferences by others and from personal limitations that prevent meaningful choices. Beneficence refers to actions performed that contribute to the welfare of others. Justice refers to the fair, equitable, and appropriate treatment in light of what is due or owed to any person.

Beauchamp and Childress, who were the first to extensively propound and defend the four-principle approach, write that the label "principlism" was coined in the late 1980s by Clouser K. Danner and Bernard Gert to refer to all accounts of ethics comprised of a plurality of potentially conflicting prima facie principles.[196] Beauchamp and Childress explain that what they defend,

> *…is sometimes called the four-principles approach to biomedical ethics and is increasingly called principlism. The four principles derive from considered judgments in the common morality and medical traditions…Both the choice of principles and the content ascribed to the principles derive from our attempt to put the common morality and medical traditions into a coherent package.*[197]

Perhaps it is of our interest in this study to note that Beauchamp and Childress claim that the four principles derive from what they call "common morality". Concerning the notion of common morality, they had not defined it until the fifth edition of their book. They define *common morality* as, "…the set of norms that all morally serious persons share…"[198] However, this definition begs some questions such as: who are the morally serious persons? And in any case, what is the nature of the sharing of these norms? How do they come to share these norms?

They are to a certain extent right to argue that virtually everyone grows up with a basic

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[196] Beauchamp T. L & Childress J. F., 2001, *Principles of Biomedical Ethics*, Fifth Edition, Oxford University Press, p. 388.
[197] Ibid., p.23.
[198] Ibid., p. 3

understanding of the institution of morality. The question however is how this basic understanding is inculcated into their moral consciousness. They also argue that all persons who are serious about living a moral life already grasp the core dimensions of morality.[199] It is agreeable that common morality contains moral norms that bind all persons in all places. Beauchamp and Childress use the universal-particular dichotomy[200] in defining morality to augment their position to the effect that those who are morally serious are to be found in every community.

The use of '*common morality*' as the foundation on which to found the four-principle approach to bioethics indicates that Beauchamp and Childress started their defense from a less fundamental level. A more fundamental level would need to first of all ask how this common morality comes to be shared (even before inquiring into the nature of or what constitutes this "common morality").

Our earlier investigation into the nature of morality indicated that morality being universal or community-specific is not what determines whether members in that morality can stand against abuse or not. Rather, our investigation drew us to the realization that what determines whether persons can stand against abuse in research is how the morality they find themselves in was inculcated into them. To that effect we can argue that if persons (they can even be "serious" ones) came to share the "common morality" (whether universal or community-specific) by way of fear, then they are inadequately equipped to stand against abuse. Their capacity to genuinely critique the abusive aspects of their morality is diminished due to the fact that morality was inculcated into them (the process by which it became "common morality") by agents and media that exuded fear.

In this case we are actually primarily not attending to the issue of whether the four principles can really ensure justice in research; rather we are dealing with whether the persons who are involved are adequately equipped to use those principles to challenge any misconduct in research. In order to ensure justice in medical research that involves human beings, it is not enough to develop good principles (or guidelines for that matter) but we should also endeavour to equip the subjects with adequate tools that enable them stand against abuse. That is why we have to start from questioning how morality is inculcated and this is where

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[199] Ibid.

[200] Beauchamp and Childress differentiate between "universal morality" and "community-specific morality". To them morality in this universal sense refers exclusively to the norms in the common morality.

principlism is found wanting especially as it is propounded by Beauchamp and Childress.

Principlism assumes that both the researcher and the subjects (humans) belong to a "common morality" within which members are well equipped to stand against misconduct during research. In addition principlism does not only assume that the research ethics committees and the researcher are able to utilize their discretion and apply the four principles to ensure justice in research but also that the subjects (humans) of research are able to stand against abuse on the basis of the same principles. This assumption can be seen to be 'sinking sand' because in most cases of research in medicine that have involved abuse, i) ethics committees verified the research and ascertained that they were not going to be abusive; ii) the researcher are "morally serious persons" who share the "common morality" hence not expected to abuse others; and iii) the subjects of the research would go for members who share the "common morality" to whom the norms of that morality applied.

The problem is how do we explain the fact that the "morally serious persons" who share the "common morality" with prima facie principles that supposedly apply to all, abuse their fellow members? This concern has led to many scholars to ask whether these principles apply to all or a few persons. Could it be that there are members in this "common morality" who are more "morally serious" than others? This concern is what is echoed by Rothman when he contrasted research participants from more developed countries with those from poorer ones. He writes that,

> *…the people recruited for those trials very seldom get the kind of medical care the participants in trials in prosperous countries can expect. Whether Western principles covering the treatment of people who are the subjects of research can and should be applied in Africa and Asia has become a bitterly debated question.*[201]

The sharing of a "common morality" seems unable to deter some sharers of that morality from abusing other fellow sharers who happen to be participants in medical research. Likewise it does not seem able to equip the participants from poorer countries with capacities to stand against abuse let alone enabling ethics committees to protect the participants.

In the case of the well known AZT[202] [203] research to which Rothman is referring in the above

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[201] Rothman J. David, 2002. "The Shame of Medical Research" presented at the 10th Annual Conference on "The Individual vs. the State" Central European University, Budapest, 14-16 June 2002, p. 1.
[202] Connor E. M., et al., "Reduction of Maternal-Infant Transmission of Human Immunodeficiency Virus Type I with

quotation, it is interesting to note that in Uganda (one of the countries where the AZT research was conducted) the local ethics committee defended the abuse of participants from Uganda (due to the risk of exposing their unborn babies to HIV/AIDS infection that a third of the pregnant mothers in the control group[204] faced). Rothman writes the following about it;

> *Local ethics committees, they claimed, were competent to review research projects, and since Africans and Asians had approved these trials, outsiders should not second-guess them. Varmus and Satcher quoted from a letter written by the chairman of the Uganda Cancer Institute research committee: "These are Ugandan studies conducted by Ugandan investigators on Ugandans...It is not NIH conducting the studies in Uganda but Ugandans conducting their study on their people for the good of their people."[205]*

If the competency of these local ethics committees is thought to be based on principlism, then the same challenges apply. Are they adequately equipped to critique any aspect of their morality that may be abusive (in this case abusive to participants in medical research). It is important to remember as we observed earlier that in indigenous morality, what the medical practitioner does is not questioned in most cases. That is why the context of the how local morality is inculcated has a lot of bearing on the application of principlism despite its claimed universalist foundation.

On that note therefore, it is necessary to consider what the *International Ethical Guidelines for Biomedical Research Involving Human Subjects* has to say about the issue of local morality. The Guidelines state that;

> *Investigators must respect the ethical standards of their own countries and the cultural expectations of the societies in which research is undertaken, unless this implies a violation of a transcending moral role. Investigators risk harming their reputation by pursuing work that host countries find acceptable but their own countries find offensive. Similarly, they may transgress the cultural values of the host countries by uncritically conforming to the expectations of their own.[206]*

Zidovudine Treatment," The New England Journal of Medicine, Vol. 337 (1994), pp. 1173-80.

[203] AZT refers to a drug first used in clinical trials in USA and France in 1994 to test the possibility of preventing mother-to-infant transmission of HIV. Due to the reported success, similar clinical trails were conducted in almost a dozen developing countries with support from the NIH and other agencies. Kenya, Tanzania and Uganda were among the participant countries. However, later this research came under attack from ethicists mainly because of the risk that the unborn babies in the control group faced and because the drug would eventually be very expensive for those participant countries.

[204] Peter Lurie and Sidney Wolfe, "Unethical Trials of Interventions to Reduce Perinatal Transmission of the Human Immunodeficiency Virus in Developing Countries," NEJM, Vol. 337 (1997), pp. 853-856.

[205] Ibid., p. 5

[206] CIOMS, 1993 *International Ethical Guidelines for Biomedical Research Involving Human Subjects*, 8, v.

What the guidelines mean by "moral role" is unclear but we may take it that what is meant is the morality of the community where the international researcher is carrying out research because further down, the guideline exhorts the researcher to be careful not to transgress the "cultural values of the host countries". But this leaves a lot to be desired in light of our earlier discussions because what if the local "cultural values" do not encourage the critiquing of what a medicine man or woman does? Does respecting such "cultural values" help to curb misconduct or the abuse of persons or not?

5.6.2 Impact on Primary and Secondary Researchers

In chapter three I developed a categorization of researchers in traditional medicine as a means of making analysis of research in traditional medicine easier. I divided them into two categories, i.e. primary and secondary researchers. By 'Primary' researchers I meant the local medicine men and women who have gathered the knowledge of traditional medicinal herbs and techniques over time within their localities. Primary researchers were divided into those who search for organic explanations of (and solutions to) sicknesses and those who search for inorganic ones. By 'Secondary' researchers I meant those who do research after knowing about their medicinal properties from the local traditional medicine men and women. These are understood to be trained in modern western medicine. I divided these into local and international researchers.

The first point to consider is what we observed earlier that in most cases secondary researchers look at indigenous medicine as a mere source of raw material for drug discovery. Traditional medicine provides cheap raw material for transnational profit oriented pharmaceutical companies.

> *Higher plants are still regarded as potential sources of new medicinal compounds. About half of all known drugs are derived from natural products and their semi-synthetic derivatives…Enormous costs are saved by the use of plant materials as starting materials in the manufacture of complex molecules than when they are prepared completely from synthetic substances.*[207]

Most international researchers approach traditional medicine with the attitude that is it not medicine but just crude plants or techniques that need a "purification process" to make it real

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[207] Iwu M. Maurice, "Ethnobotanical Approach to Pharmaceutical Drug Discovery: Strengths and Limitations" in Iwu Maurice & Wootton Jacqueline, (eds.), 2002, *Ethnomedicine and Drug Discovery*, Elsevier, p. 309.

medicine. As we observed earlier this attitude does not only involve the medicinal plants and traditional medicinal techniques but it also includes the human persons that are found in these indigenous communities. The example of Weule and Knudsen and their research in German East Africa that we examined above demonstrates this. The entrenchment of a morality based on fear by the colonialists coupled with this attitude is a recipe for abusive research in indigenous medicine.

We find the same attitude in the local secondary researchers. This attitude is found in the letter quoted above from the chairman of the Uganda Cancer Institute research committee. The chairman is reported to have written that the investigations (which involved exposing unborn children to the risk of contracting HIV/AIDS during the AZT research) should not raise concern from the international community because it was about "Ugandans conducting their study on their people". This particular statement is indicative of the attitude that secondary researchers hold towards the people in the places where they carry out the research. In this instance the chairman took on the role of speaking on behalf of all Ugandans defending the view that it was okay to sacrifice human persons in the name of "drug discovery".

Since when did Ugandans become the property of the chairman and his team of researchers such that they can be used in "drug discovery" which puts them in harm's way because of the high risk involved? The attitude with which the chairman of the Uganda Cancer Institute wrote the said letter reveals the nature of the views that researchers have of the local people. But more so it reveals the kind of morality within which they operate when it comes to research in such communities. These researchers are seen as "doctors" or "medicine men or women" by the local people (who are desperate for healing from a disease which still carries superstitious connotations).[208] One can not fully understand where such an attitude originates until one understands the perception of a "medicine man" that is inculcated in the young of these communities.

In '*Luganda*', for example, the most widely spoken local language in Uganda, the word used for a traditional medicine man or woman is the same used in reference to a modern western

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[208] It should be noted that despite various campaigns to demystify HIV/AIDS one can still come across mystical and superstitious explanations of the causes of HIV/AIDS among the wider populations, especially in rural areas where most of the research participants come from. Likewise it is interesting to note that in the early 1980s when the disease first appeared in the rural areas of Uganda, the cause of HIV/AIDS among the locals was rumored to be witchcraft. That is why to hold the view that these people participate in research with a mindset with which they approach traditional medicine men or women is not far from the truth. It is therefore arguable that the local participants look at these researchers through the same lenses with which they visit their local medicine man.

trained medical doctor. In the eyes of the local people these researchers are called "doctors". The local word used for "*doctor*" is "*omusawo*". "Omusawo" is a traditional medicine man or woman in Buganda. In Luganda, "*musawo*" stands for "*omuwonya*", meaning the "healer". The "musawo" (doctor) does "okusawula" which connotes one who capable of generating all sorts of concoctions that treated all sorts of ailments ranging from diseases to casting out bad omens. Up to now this "omusawo" is expected to provide solutions for all kinds of ailments that is why you can find people going to a medicine man for remedies ranging from stomachaches to HIV/AIDS; they also go there for other remedies such as when a business is failing, passing exams, etc. The word of the "musawo" is authoritative and not questioned lest one displeases the spirits that have given the healer the powers to solve one's problems.

This is what Mbiti, a renowned writer on African philosophy and religions, captured when he wrote that in most of traditional African societies traditional healers are defined as: "the friends, pastors, psychiatrists and doctors of traditional African villages and communities". These traditional medicine men and women, "symbolize the hopes of society; hopes of good health, protection and security from evil forces, prosperity and good fortune, and ritual cleansing when harm or impurities have been contracted." [209] In these communities the traditional healers are the answer to almost all their problems and they are held in unquestionable esteem as those entrusted with the secrets of life by the spirits.

This is the perception with which the local participants come to take part in medical research. They perceive that these "doctors" have remedies to many of their problems. That is why it is common to find them asking for things such as school fees, salt, soap, sugar, etc as payment for participation in research. The participants take the researchers ("*abasawo*") as remedies to all their problems and therefore they dare not raise any objection to what they do. One researcher who participated in the *Uganda Research Ethics Workshop*, (a collaborative venture between the Northwestern University and Makerere University) lamented over this trend in these words:

> *I went to carry out research on malnutrition and it need*[ed] *to get blood samples to test there* [their] *HB levels, weighing and taking measurements and to make mothers happy, there* [they] *were given a bar of soap so that they don't rebel against we* [us] *the research assistants. This is the kind of trend that bioethics* [biomedical research] *is taking and I don't know whether this is the right way to do it and this may not*

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[209] Mbiti S. John. 1969 *African Religions and Philosophy*, Heinemann, 1969, p. 171.

> *resolve ethical dilemmas in health research in Uganda*[210] [Emphasis by author]

The fact that these local people grow up viewing the healer as one who can solve all problems and in a morality that does not encourage them to question what the '*musawo*' says or does is an underlying reason why they ask for and accept such things as a bar of soap and why they never challenge what the researchers are doing. From this we conclude that a phobiculcatic morality does not help to decrease abuse in research.

5.7 Conclusion

In this chapter, I have followed up what was observed in the previous chapter, namely to investigate bioethics within the continuum of morality (especially its definition). I have looked at phobiculcatic morality and its effect on bioethics in East Africa and have endeavored to make this investigation bridge the gap between the theoretical and practical realms as much as possible. Starting with a follow up of the observation made in chapter three and explaining why morality and bioethics should not be separated, I proceed to examine the nature and definition of morality. Having laid the ground from which to define morality I then define what is meant by phobiculcatic morality and finally discuss its reconfiguring effect on research in traditional medicine.

The first key observation which emerged from this chapter is that morality and bioethics are inseparable. Attempts at separating them are misconceived and proponents of that separation are denying bioethics discourse the rich contribution that would come from investigating them together. The second is that the traditional dichotomies within which the discourse of defining morality is being carried are insufficient. In this chapter I develop the notion of '*transfer*' as more viable ground on which to base our definition of morality. Using those grounds, two types of morality emerge, namely *phobiculcatic* and *non-phobiculcatic*. I have explained what the two mean and then concentrated on phobiculcatic morality. I have demonstrated how a phobiculcatic morality comes about using examples from both indigenous morality in Buganda (Uganda) and colonial morality in Tanzania. The final aspect of the chapter has investigated how a phobiculcatic morality reconfigures research in traditional medicine. At the level of normative bioethical guidelines I have investigated the reconfiguration effect of a phobiculcatic morality using the example of principlism. At the practical level I have used the

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[210] Contribution from a researcher at the *Uganda Research Ethics Workshop*, (see: Northwestern University Program for African Studies, http://67.151.100.152/forum/topic.asp?TOPIC_ID=36&whichpage=2, retrieved 4th April 2005)

example of primary and secondary researchers. In all, what emerges from this chapter is that to develop viable solutions to challenges experienced in research in traditional medicine, there is need to grasp how morality affects this research.

CHAPTER VI

TOWARDS ETHICAL RESEARCH IN TRADITIONAL MEDICINE

6.1 Introduction

In this chapter I discuss how to engender ethically accountable research in traditional medicine in East Africa following the challenges that have been raised in the preceding chapters. I think it is necessary and important that the study points towards solutions to the problems in research in TM, as the old medical adage goes: a good diagnosis should point to a cure. In this section I first deal with the challenges in TM at a theoretical level before generating some practical ideas to solve the problem and finally I point out some areas that I think could be followed up for further research as a result of the points this study has raised.

6.2 On Critique in Traditional medicine

The study has endeavored to trace the roots of the bioethical challenges encountered in research in indigenous medicine. It is important that the nature of this problem is understood if we are to realize ethical research in this type of medicine. The study has pointed out that the problem is basically a moral one deeply rooted in philosophy. Although the study appreciates the input of other disciplines in solving the bioethical challenges in research in indigenous medicine, it points out that the moral nature of the problems require that philosophy takes a central role in resolving them because philosophical questions keep coming up in the debates.

The study has demonstrated that, by and large, in East Africa, research in traditional medicine does not seem to be subjected to the same level of accountability as modern western medicine despite the fact that the majority of the people in the region use it for their health needs yet countless incidences of abuse of persons are being reported within this type of medicine. This is the discrepancy that has emerged in this study which is compounded by the dominance of a phobiculcatic morality within which this medicine is practiced. Because of this environment, research in TM is in most cases carried on without adequate critique or questioning as far as its efficacy and protection of participants is concerned. Another reason to explain this is that much of discussion of TM is usually approached from a mystical stand point; it is taken to have a bloom of 'sacredness' around it. This has to be dealt with if we are to see ethically accountable research being carried out in TM.

To deal with this challenge adequately we need to understand how the 'sacredness' that surrounds TM affects the extent to which this type of medicine is subjected to ethical critique. Unlike modern western medicine where Cartesian dualism sowed seeds that increasingly led to the dichotomy between body and mind, in African traditional medicine there is no clear dichotomy between these two elements.[211] In the case of modern medicine, when people accept therapy or participation in medical research they expect to treat only the body. Consequently, an individual's mind and will is, in a sense, detached from the medical intervention. This detachment allows for an autonomous position in face of the medical authority. In this autonomous position, a patient or participant can question any aspect of the therapy they may not agree with. However in traditional medicine the patient or participant gets involved in therapy or in medical research with the holistic approach. Traditional medicine demands a complete involvement of the participant's mind and will. This situation prevents the patient's autonomy in face of the therapist, and he or she can not effectively criticize what may be unbecoming or suspicious conduct.

It is typical in African traditional medicine to combine the spiritual and physical properties or techniques in the treatment of ailments. As the study demonstrated earlier, succeeding generations in local communities are told that their TM is enabled by the gods and this ends up blurring the demarcation between organic-cause and inorganic-cause TM. This means that people approach TM with the same sacredness with which they approach religious ceremonies.[212] Because of the promise to deal with all sorts of ailments from physical to spiritual, those who consult traditional healers are encouraged to surrender their faculties (body, mind and spirit)[213] to the healing agent. It is not uncommon to find cases where patients are castigated for not surrendering themselves fully to the deity behind the medicine which is thought to render the medicinal properties ineffective. Patients are encouraged to allow the deity behind the 'potency' of the medicine to 'work' in the patient by surrendering themselves. In some cases TM is combined with mental and psychic exercises that border on suppression of the patient's will. Sometimes the patients are led into a trance-like state

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[211] Aceme, Nyika. "Ethical and Regulatory Issues Surrounding African Traditional Medicine in the Context of HIV/AIDS" in *Developing World Bioethics*. Vol. 7 No. 1, 2007, pp. 26.

[212] In fact the in most communities those who act as mediums of ancestral spirits in religious ceremonies are the same individuals who administer traditional therapy or medicine. In the minds of the local people, this merging further entrenches the view that TM is also to be taken as sacred as religious ceremonies where critique is rarely allowed.

[213] Probably it is worth mentioning that there are differences among philosophical anthropologists concerning the compositions of a human person; some argue that a human person is only the body and the spirit while others add the mind/soul as the third component.

because that is the way the deity works to heal the patient. That is why it is common to find that former patients suffering from chronic or grave illnesses turned into mediums.[214]

This trend promotes an environment where a patient is pushed to surrender his/her will and this incapacitates the person's ability to critique wrong conduct; it also creates a cloud of fear over TM. It implies that practitioners of TM can abuse and get away with it without being questioned by society.

6.2.1 Autonomy in Research TM

The above observation concerning the position in TM in which the patient or participant's mind and will is compromised shows one of the biggest challenges to be found in this type of medicine. The problem of autonomy is a central one in research in TM. Concerning the problem of autonomy, Aceme has noted that in most cases patients are treated without knowledge of what is being done not only because the therapist in TM keeps this knowledge secret and mystical but also because sometimes the patient is treated through representatives.[215] (This does not only jeopardize the principle of autonomy but also that of confidentiality).

More analysis and investigation into the holistic and communal emphasis in TM is needed so as to generate ways through which to respect autonomy. Although principlism tries to push for the respect for the autonomy of patients or participants, we noted earlier this effort is compromised in principlism because it pays little attention to how morality is inculcated in different communities. A way of propagating morality which uses fear engenders a situation where the articulation and respect of the autonomy of a patient or participant is undone. A phobiculcatic morality undoes principlism as long as those who articulate principlism do not pay adequate attention to how the process of inculcating this morality affects bioethics in general. (Those who articulate principlism argue that it assumes the existence of a "common morality". But this is not enough when it comes to ensuring ethical conduct in medical research, especially when it comes to the principle of autonomy. Without looking into how this 'common morality' comes about, the efforts of those who articulate principlism can not go far because they are dealing with 'leaves' other than the 'roots')

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[214] Forster G. M., 1983, op. cit., p. 20.
[215] Aceme, op. cit., p. 28

African TM is permeated with over-bearing paternalism. This paternalism can possibly be defended, i) when it comes to treatment with known positive effects; or ii) where the patient or participant is incapacitated in terms of ability to take a right decision. But when it comes to research and experimentation there is a big challenge because the outcomes can not be ascertained. It is therefore important for medical research policy makers and ethics committees to insist that researchers in TM tell their participants what they are actually doing and to seek the consent of the individual but not the community. However, to achieve a more fundamental solution, research policy makers in TM must generate ways of countering the negative effect of a phobiculcatic morality on the autonomy of the individual. For example, legal instruments can be established to empower individuals and to make it possible to hold the therapists in TM accountable in case they abuse participants. The law must recognize the practitioners of TM and demand that they make their practice in the open and strip them of any mystical cloud around them. It must be insisted that the practitioners of TM decide between being registered as religious organization or as medical therapists.

6.2.2 Accountability in TM

The over-bearing paternalism in African traditional medicine is not medically sustainable because it pushes medicine into religion; it blurs the difference between medicine and religion and in the long run it curtails the progress of research. Cloaking traditional medicine in religious ritual and jargon is problematic because it can discourage research and investigation on the medicinal properties of TM. To borrow a leaf from modern western medicine, one of the things that have promoted research in that type of medicine is the constant questioning that is inherent in it.

Modern thinking in the west, particularly as exemplified by Descartes' concern with the gap between mind and world, has always been under the spell of skepticism. Skepticism became in-built in modern western thinking and this created an 'anxiety' that ensured that any claim to knowledge had to be validated. In one of his books, the contemporary philosopher McDowell has referred to this as the "deeper anxiety" about knowledge in modern philosophy.[216]

Modern western medicine owes a lot to this constant skepticism towards knowledge claims

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[216] McDowell John 1996 *Mind and World: With a New Introduction*, Harvard University Press, p. xiii.

because it meant that sound grounds had to be presented and the skeptics had to be convinced before any claim of knowledge was accepted and this encouraged scientific research. Although not apparent at the time, with hindsight, this 'in-built' anxiety is now seen to have been a necessity in modern philosophy. There would not have been such advancements in knowledge as has been the case in the last century if this anxiety were not there. It is therefore arguable that this demonstrable benefit of modern skepticism was useful to the extent that it engendered an ever-present need for epistemic accountability.

This environment (which demanded for accountability) within which modern western medicine grew was permeated with skepticism towards any claim of knowledge of whatever type and this attitude towards any form of epistemic advantage helped to ensure the growth of healthy debate in medicine. Thus any therapeutical development in medicine or any claim to medicinal properties had to be validated lest it be discarded. Engendering this attitude is useful in medicine because it goes a long way in guarding against unscrupulous practitioners and in protecting lives.

To realize ethical research in traditional medicine it is imperative that such an attitude is encouraged. There is need to subject each and every claim to medicinal properties in traditional medical herbs or techniques to rigorous investigation. Questioning TM should be encouraged by medical research policy framers and also in schools. Skepticism towards the claims of medicinal properties in traditional medicine should not be taken in a negative sense but rather as a means of pushing for more rigorous research in this type of medicine thus leading to the growth of knowledge in this field. However, this can not take place if traditional medicine is not allowed more room in mainstream bioethics discourse.

6.3 Placing TM in mainstream Bioethics Discourse

To be able to ethicise research in traditional medicine there is need to give it room in mainstream bioethics discourse. This investigation has observed that the bioethical challenges that are encountered in traditional medicine are not given the attention they deserve in dominant bioethics discourse. Apparently in mainstream bioethics, the term 'medicine' is synonymous with modern western technological medicine. There exists an underlying assumption that bioethics should be concerned with issues that arise from western technological medicine.

This is a misnomer because of two basic reasons: the first is that the majority of the world's population use indigenous medicine to meet their primary health care needs. It would be logical for bioethicists to concentrate their resources to resolving the ethical challenges that are found in that type of medicine which affects the majority of the world's population. Why is this the case? It is difficult to understand precisely why major discussions in bioethicists push research in traditional medicine to the periphery or even ignores it completely yet it is used by many people in the world. It is interesting to note also that indigenous medicine (sometimes referred to as 'unconventional medicine') is increasingly being used in the west. Studies by the WHO indicate that the tendency to use indigenous medicine is growing in the west; that is why bioethicists need to engage traditional medicine.

The second reason is that modern western medicine depends on traditional medicine a lot that it is illogical to ignore it. The study has discussed the fact that to many researchers and pharmacists, traditional medicine is a source of raw materials. It would therefore be unreasonable if the ethical challenges within traditional medicine are ignored by mainstream bioethics.

6.4 Teaching Research Ethics in TM in medical schools

There is need to include TM in the teaching of medical research ethics. During my investigations I was surprised to find that apart from the Institute of Traditional Medicine at the University of Dar El Salaam, some medical and nursing schools in the region that I chose to check out were not teaching research ethics in traditional medicine. This is ironical given the fact that 80% of the population in the region depend on indigenous medicine for primary health care.

For example, at Makerere University medical school (Uganda), which is taken to be one of the trend setters in medical scholarship and research in the region[217], I found no official text in the bioethics section in the library on research ethics in traditional medicine. At Kampala International University (Uganda) I found no text on research ethics in traditional medicine. One of the administrators at the Lake Institute of Tropical Medicine in Kisumu (Kenya) told me that they did not have traditional medicine on the bioethics course outline. A search

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[217] For more on the place of Makerere University medical school, see: Williams A. W. "The History of Mulago Hospital and the Makerere College Medical School", *East African Medical Journal*, July 1952, Vol. 29, No. 7, pp. 253-63.

through the KEMRI (Kenya) library yielded almost the same results with just a handful of texts that devote a couple of lines or a few pages to traditional medicine and almost nothing particularly devoted to research ethics in that area.

It is important to bring to the attention of medical and nursing students the ethical challenges that are found in traditional medicine. Majority of the people in East Africa depend on this type of medicine and these students need to join the discussions surrounding ethics in research in indigenous medicine. This is more relevant to their practice than studying the bioethics of technologically advanced countries which some of them may never use. These students are more likely to face challenges of decision making in relation to traditional medicine than in relation to technologically advanced medical practices. Many modern doctors in the region are working in rural areas and they face these challenges daily; an example is that of a doctor based in Busoga – Iganga (a rural area in Uganda) who wrote in *The New Vision* newspaper complaining of traditional healers who are claiming to own mobile research laboratories.[218] The doctor was asking the government to intervene because the healers were claiming to heal complicated medical conditions such as diabetes, kidney failure, etc.

6.5 Understanding the Nature of Research in TM

For one to be in a better position to work towards ethicising research in traditional medicine, there is need to understand the nature of this research. Ethicising traditional medicine is considered a difficult task mainly because there is scanty investigation into the nature of this research and the little understanding of research in TM that exists is rarely discussed. On top of that, TM is often clouded in mythical discussions. Nonetheless, knowing the nature of this research can help in understanding the ethical challenges therein and devising the appropriate means of mitigating them.

This study has identified and categorized the nature of research in indigenous medicine. The categories that have been developed in this study are based on the broad divisions of international researchers and local researchers. On that basis the study proposes two broad categories of researchers, namely Primary and Secondary researchers. By 'Primary' researchers the study refers to the local medicine men and women who have gathered the knowledge of traditional medicinal herbs and techniques over time using indigenous means. Primary

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[218] Kyobe P. "Investigate Activities of Herbalists in Busoga sub-region" in *The New Vision*, The New Vision Publishing Limited, 20th March 2007.

researchers have been sub-divided into; organic-cause researchers and inorganic-cause researchers. The former seek for organic explanations and cures for ailments in contrast to the supernatural or magical explanations that are sought by the latter. Examples of those in the first category include; herbalists, traditional birth attendants (TBAs), among others. Examples of those in the second category include; witch-finders, mediums, among others.

The other major category of Secondary researchers refers to those who do research on the plants and herbs after knowing about their medicinal properties from the local traditional medicine men and women. These usually see the vast knowledge possessed by traditional medicine as raw-materials for manufacturing modern western medicine. Among these secondary researchers there are those from the international community and the local ones who are trained in modern western medicine. There are many medications such as tablets, syrups and others in modern western medicine which were developed from local herbs after acquiring that knowledge from indigenous medicine men and women.

This categorization has importance when it comes to issues such as policy and legislation. Without clear analysis of the nature of the research in traditional medicine policy makers find it hard to make appropriate policies. The study earlier on cited the example of the dossier published by the U.S. Congress in which congress members expressed the importance getting clarity out of the ethical complexity that surrounds biomedicine for purposes of policy.[219] This challenge does not only apply to policy makers but other entities such as ethics committees. Ethics committees need to be clear about what kind of research they are regulating. For example, when ethics committees appreciate the difference in organic-cause and inorganic-cause research, it becomes easier for them to set regulations that would govern either of them.

When it comes to legislation, understanding the nature of research in indigenous medicine can be of great instruction. It helps legislators to realize that there is need for differentiation in the laws that apply to organic-cause and inorganic-cause research. The former could easily be subjected to the laws of natural science thus making verifiability possible. However, when it comes to the latter the laws of natural science may not apply and verifiability could be made difficult thus necessitating a difference in legislation. Practically this means that traditional healers need to be classified and required to register in the category that they claim to belong

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[219] U.S. Congress, Offices of Technology Assessment 1993, loc. cit.

to. This would make holding them responsible in case of unbecoming conduct easier.

6.6 Implications for Future Research

The study investigated the impact of morality on bioethics and has contended for the position that bioethics guidelines need to be generated with consideration of the nature of morality within which they are generated. In that vein, the study has demonstrated that due to neglect of this observation, efforts at generating and applying bioethics guidelines have not done much in terms of shielding human persons from abuse in research in traditional medicine. The study shows that traditional medicine presents a big challenge to bioethicists because of the morality within which it exists.

The challenge posed by phobiculcatic morality to bioethics in traditional medical research calls for further investigations to explore ways in which this impediment could be transcended so as to safeguard persons in research. There is particular need to examine the impact of fear on both investigators and participants in medical research given the sharp rise in the incidence of fear in the general society. What is also necessary to mention is that the study has explored in depth the implications of its findings in terms of policy; there is therefore need for further research to find out how policy makers would practically use these findings to ensure ethical research in indigenous medicine.

6.5 Conclusion

In a practical prescriptive fashion, this chapter has advanced some proposals that may lead to ethical research in traditional medicine. These proposals have been presented as directions that can, if applied, help not only to render research in this domain more accountable but more importantly to make TM part of the dominant bioethics discourse. All in all the above discussion indicates that it is important to: i) encourage a positive critique of traditional medicine's claim and ii) to allow more room to discuss the challenges faced in traditional medicine in the mainstream bioethics discussion.

CHAPTER VII

GENERAL CONCLUSION

The task of this study was to philosophically examine the ethical implications of the relation between morality and research ethics in indigenous medicine in East Africa. The study sought to bring clarity to the debate surrounding indigenous medical research and morality with the hope that this would render research in indigenous medicine more ethical by informing bioethics discourse and health research policy in the region.

In fulfilling that task the study first of all raised three points based on Pellegrino's evolutionary model of the development of bioethics which is representative of the dominant view of the development of bioethics. The first point was that despite bioethics' increasing focus on resolving practical dilemmas, the centrality of the philosophical in bioethics remains irrefutable and beckons for more attention because of the underlying philosophical questions that keep surfacing. The second point was that engaging in bioethics necessarily entails engaging in the moral life and thus making morality a continuum within which bioethical challenges can be viably analyzed. The third point was that in Pellegrino's account of the development of bioethics, reference to global bioethics tends to consider the *disciplinal-globalness* of bioethics at the expense of *medicinal-globalness*. This last point brought to the surface the imperativeness of including other non-western forms of medicine in mainstream bioethics discourse and agenda.

This was considered important because most of the world's population does not live in technologically advanced countries whose health concerns currently set the agenda of global bioethics. The study also observed that in places such as East Africa there is a lot of dependency on local and indigenous biomedicine. In addition, it was observed that a large percentage of the pharmaceutical industry in the technologically advanced countries depends on the local indigenous medicine as a source of raw materials and carries out research in places such as East Africa, which further justified the need to bring indigenous biomedicine to feature prominently in global bioethics.

To demonstrate further the importance of indigenous medicine in the region the study

examined its place in health provision and research. It was observed that indigenous medicine has gained more recognition within official health policy circles and more research is being carried out in this type of medicine. The reliance on traditional medicine by most people in the region for their primary health care needs was seen as an indication of the desire for self-reliance in face of failure by governments to adequately provide western type health services.

Looking at research in traditional medicine the study pointed out that there is increase in both local and international interest. For purposes of analysis, researchers in TM were categorized, first into the broad divisions of international and local researchers and then into the categories of Primary and Secondary researchers. By Primary researchers the study referred to the local medicine men and women who have gathered the knowledge of traditional medicinal herbs and techniques over time. Primary researchers were further sub-divided into organic-cause researchers and inorganic-cause researchers. The study defined organic-cause researchers as those who look for organic explanations and cures for ailments in contrast to the supernatural or magical explanations that are sought by the inorganic-cause researchers.

By Secondary researchers the study referred to those who do research on traditional techniques of healing and plants and herbs after knowing about their medicinal properties from the local traditional medicine men and women. It was observed that these researchers usually see the vast knowledge embedded in traditional medicine as raw-materials for manufacturing modern western medicine. These were further categorized into international and local researchers both with a background or training in modern western medicine. In examining the nature of research in TM, however, the study emphasized the importance of doing so within the continuum of morality if a proper understanding of the bioethical challenges encountered is to be attained.

In examining the bioethical challenges found in TM within the continuum of morality it was observed that morality and bioethics should not be separated and attempts at doing so were shown to be a result of misconceptions of the fundamental nature of bioethics. The importance of examining the discourse of defining morality was also demonstrated as a background from which a novel differentiation of morality could be generated. After finding the traditional dichotomies which have dominated the discourse of defining morality insufficient, the study used the notion of 'transfer' as the ground on which to base the differentiation of morality.

Arguing that the media used in the transfer of morality from one generation or group to another is not neutral, the study noted that fear pervaded much of the media used and the transfer process itself. Using fear (i.e. its presence or absence in the process of inculcating morality) as a key factor in the differentiation of morality two types of moralities were identified, namely, phobiculcatic and non-phobiculcatic morality. These two types were defined it was noted that the phobiculcatic morality is the dominant type in the region. Using examples from East Africa in pre-colonial and colonial times, the study demonstrated how fear pervades the transfer of morality both contemporary and past times.

The study then investigated how a phobiculcatic morality reconfigures research in traditional medicine. At the level of normative bioethical guidelines investigated the reconfiguration effect of a phobiculcatic morality using the example of principlism. At the practical level the examples of primary and secondary researchers were used to demonstrate the reconfiguring effect of phobiculcatic morality on research in TM. What emerged overall was that to develop viable solutions to challenges experienced in research in traditional medicine, there is need to grasp how morality affects this research. Principlism (and other efforts to generate guidelines to research) needs to pay attention to the inculcation of morality and how this inculcation predisposes people against the goals of bioethics guidelines (namely to protect the persons involved in research) such that the purpose of those guidelines is not achieved.

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APPENDIX

Fig 9: Map of East Africa

Source: http://www.nystromnet.com/

Note: The study considered the three core countries of the East African Community, namely, Kenya, Tanzania and Uganda. According to the community's website, these three countries were the original signatories to the Permanent Tripartite Commission for East African Cooperation in 1967, which was given the name East African Community. Although it was later to collapse in 1977 due to political disagreements, the idea was revived in 1993 and the EAC was re-established in 1999 in Arusha,

Tanzania. Burundi and Rwanda were not allowed into the Community until a later date.