Decolonizing bioethics via African philosophy:
Moral neocolonialism as a bioethical problem

Rebecca Bamford

Global bioethics combines medical professional work with responding to ecological and social problems across geographical and cultural boundaries, and requires interdisciplinary collaboration, use of diverse perspectives, and clear understanding of the interplay of existing value systems (ten Have & Gordijn, 2014, 11; Verkerk & Lindemann, 2011, 94). However, it is less clear whether, or how, to accomplish this. Universal ethical approaches may not be sufficiently inclusive of cultural diversity, and may foster cultural imperialism. Yet there is doubt that concerns about cultural or moral imperialism address any substantive problems in bioethics.

I argue that moral neocolonialism is a real problem for bioethics, and that it merits continuing investigation as part of developing bioethics in African contexts. I consider why some scholars reject moral neocolonialism as a problem. I use evidence from Widdows (2007) in conjunction with resources from African philosophy to differentiate between direct and indirect moral neocolonialism. I show how both forms occur in African bioethical contexts, and how African philosophy supports treating moral neocolonialism as a real problem. I consider and respond to some anticipated objections to my view from bioethics and from moral philosophy before suggesting further directions for inquiry.

Denying moral neocolonialism is a problem for bioethics

A helpful definition of 'moral neocolonialism' is found in Widdows (2007). Widdows uses 'moral' "in a straightforward sense of a value system which upholds specific actions and attitudes," and 'neocolonialism' to indicate values being presented not "as superior, but as universal, requiring not conversion to an alternative (presumably better) value system, but recognition of universal values" (2007, 306). She treats this conversion process as "covert," rather than overt as in straightforward colonialism in which there is "the attempt to openly convert people to one's own moral ideas," for example by enforcing one's own religious code (2007, 306). If moral neocolonialism exists, it involves a dominant Western framework covertly promoting "certain codes of ethics and particular types of rights, while appearing to assert universal values", as in the case of human rights as universal values (2007, 306). I shall have more to say on defining moral neocolonialism below; meantime, I acknowledge three approaches to denying that moral neocolonialism is a real problem for bioethics.

One denial appeals to universalism. In ethics, this is the position that ethical principles apply to everyone, regardless of their background or particular cultural values. Moral neocolonialism cannot "describe the transcultural imposition of values" if ethical judgments have cross-cultural validity, and must be rejected as a product of relativism (Macklin 1999, 25). Additionally, moral neocolonialism risks making bioethics inconsistent with the biomedical sciences, because its relativism legitimizes views that are inconsistent with the "naturalistic commitments of Western biomedical sciences" such as suspending pain medication that interferes with prayers, or parental demand for painful surgical procedures to be performed on children because of parents' beliefs about health or chastity (Bracanovic 2013, 648-649).

The second denial treats theoretical debate as less valuable than practical bioethical problem-solving (Widdows & West-Oram, 2013). Since it is unclear that Western ethics is

indeed alien to ethical systems grounded in cultures beyond the West, theoretical debate contributes little of use. For instance, Widdows gives the examples of virtue ethics, "a picture of morality which has at its heart many of the aspects of morality which have been claimed to belong to the ethics and worldviews of the developing world; namely the importance of moral virtues embodied in the experience of moral living and as part of a way of life" (2007, 310-312). Detailed comparison of virtue-based approaches from diverse ethical traditions would reveal substantial overlap; given such overlap, then at most there is a spectrum of value priority in which some ethical systems tend to prioritize certain values and other systems prioritize other values (Widdows & West-Oram, 2013).

The third denial attributes misunderstanding of globalization to defenders of the existence of moral neocolonialism and suggests that this explains the emphasis they place on debating a common framework for values ahead of practical problem-solving in bioethics (ten Have & Gordijn, 2014). On this account, a universalist global normative bioethical framework already includes sufficient respect for cultural diversity, and need not involve wealthy and powerful countries imposing their values on less advantaged peoples (ten Have & Gordijn, 2014). UNESCO's 2005 Universal Declaration on Bioethics and Human Rights exemplifies this: the call for the declaration was initiated by developing nations concerned about their vulnerability to coercion; 191 nations negotiated to develop 15 bioethical principles over 2 years (ten Have & Gordijn, 2014, 13-14). The contemporary relationship between global and local contexts is not antithetical: the global and the local shape one another to promote the development of a human moral community (ten Have & Gordijn, 2014, 12). Those who claim moral neocolonialism exists misconstrue the global-local dialectic as one-way, powerful to powerless, and so underestimate the power of local value systems, fail to appreciate how indigenous rights activists use universal

human rights resources to support their work, and ignore the ongoing dialogue between global and local values (ten Have & Gordijn, 2014, 12).

Widdows's account incorporates two possible ways of recognizing moral neocolonialism as a problem in global bioethics. First, bioethics may be directly morally colonialist in that those who fail to accept dominant values as universal, or who challenge the universality of the relevant values, run a risk of censure by the international global ethics research community (2007, 306). Second, bioethics may be indirectly morally colonialist: here the real danger of moral neocolonialism arises through implementing ad hoc solutions to practical issues in global ethics without sufficient "theoretical consultation and involvement" with ethics from beyond the West (Widdows 2007, 314). Even with dialogue between global and local values across cultures, insufficient consultation will perpetuate existing problems as the new value framework would be largely informed by a dominant Western ethical system (2007, 314).

I shall clarify direct and indirect moral neocolonialism in what follows, in order to develop a way to count moral neocolonialism as a real problem for bioethics by showing that it causes harm (Chattopadhyay & De Vries, 2013).

Direct moral neocolonialism in African bioethical contexts

Kwame Nkrumah (1965) has shown that neocolonialism involves direct covert actions that pursue conversion of people's values, in ways that benefit former or emerging Western colonial powers. Nkrumah writes,

> Faced with the militant peoples of the ex-colonial territories in Asia, Africa, the Caribbean and Latin America, imperialism simply switches tactics. Without a

> qualm it dispenses with its flags, and even with certain of its more hated expatriate officials. This means, so it claims, that it is 'giving' independence to its former subjects, to be followed by 'aid' for their development. Under cover of such phrases, however, it devises innumerable ways to accomplish objectives formerly achieved by naked colonialism. It is this sum total of these modern attempts to perpetuate colonialism while at the same time talking about 'freedom', which has come to be known as *neo-colonialism* (1965).[1]

Unlike "naked colonialism", neocolonialism is covert, because its acts of conquest are intentionally disguised. In Nkrumah's example, the former colony is encouraged to accept the allegedly universal moral and political value of freedom — but what freedom means in practice is the continued advantaging of the former colonizing nation at the expense of the formerly colonized nation. Nkrumah gives Moral Re-Armament, the US Peace Corps, and the United States Information Agency as examples of moral neocolonialist engagement (1965).[2] Development efforts may contribute to powerful nations' control over less powerful nations, through presenting preferred values as universal and providing incentives such as aid to promote their adoption.

Nkrumah's view is recognized in contemporary development studies, where neocolonialism, including moral neocolonialism, is accepted as a problematic dimension of international development, and as a factor in the re-inscription of colonial divisions between developing and developed world nations (Chuwa 2014; Sobocinska 2017).[3] More vulnerable nations or regions are harmed through entrenchment and perpetuation of disadvantage. Medical anthropologists point out that biosocial understanding in medicine shows that social inequalities

become health disparities, and use biosocial approaches to design more effective public health interventions to combat communicable diseases, for example in the US, Haiti, and Rwanda (Farmer et al 2006). The point here is that the theoretical and the practical cannot be separated out to avoid the problem of direct moral neocolonialism.

Harm arises specifically through presenting preferred values as universal and incentivizing their adoption: this can result in practical harms to research and to communities. Researchers may be required to adopt the ethical priorities of funders in order to be able to complete their projects, such as following specific ethics regulations in performing a clinical trial, without being able to make defensible changes, or may be prohibited from attending to the particular health priorities of the communities involved in their research as a part of completing that research (Tangwa 2017). African scientists and researchers in biomedicine who work with Western funding (especially where funding from African governments or NGOs is limited) can achieve a high global professional standing, but are often at the behest of funders whose priorities are commercial, not philanthropic (Tangwa 2017). The economic and practical realities of conducting research trials give rise to direct moral neocolonialism: here, the conversion of researchers' and research subjects' values to those of a dominant ethical system through the disguise of aid or partnership.

A specific, relevant, bioethics development example is a bioethics training program funded by the US National Institute of Health that aims at building capacity in research ethics in African nations (Hyder et al 2007). The program's partnerships include affiliations with Botswana, Uganda, and Zambia (Hyder & Krubiner 2016). While the program has a helpful aim in training scholars in African nations to be prepared to engage in, and advance, research ethics in African contexts, it may at the same time incorporate what I am defining as direct moral

neocolonialism (Hyder et al 2007; Hyder & Krubiner 2016; Fayemi & Macaulay-Adeyelure 2016). The harm was that practical solutions to problems in scientific research were held up by direct moral neocolonialism (Hyder & Krubiner 2016). In mentioning this example I do not mean to dismiss this program's worth overall: project researchers rightly consider concerns about Western-centrism as part of continuous program review (Hyder et al 2007; Hyder & Krubiner 2016; De Vries & Rott 2011). My point is to emphasize why program review should attend to moral neocolonialism. Structurally, program curriculums are generally skewed towards Western values embedded in US bioethics professional and conceptual orthodoxies, even when involving direct application to African bioethical contexts (De Vries & Rott 2011). There is an acknowledged need to improve faculty members' awareness of social and political issues of trainees' countries, in order to facilitate research ethics framework development in these locations (Hyder et al 2007).

Relatedly, while citizens of formerly colonized nations are embedded in Western modes of bioethical practice, discourse, and values through education, training, and clinical practices, they remain dependent on access to funding sources and research programs organized by Western agencies, in order to pursue bioethical or biomedical sciences careers (Campbell 1999; Alora & Lumitao 2001; Chadwick & Schuklenk 2004; Hyder & Krubiner 2016). A study of East Africa-based researchers working in partnership with two Western-funded programs aiming to improve research ethics capacity and access, affordability, and quality of healthcare for economically disadvantaged people in low and middle-income countries, including Uganda and Nigeria, showed up some concerns about direct moral neocolonialism; researchers raised concerns that they would be cut off from funding sources, and from the opportunity to attend or present research at international conferences, if they presented dissent on empirical research

results or conceptual orthodoxies assumed by foreign funders (Hyder & Krubiner 2016). While this conforms to the definition I provided of direct moral neocolonialism as the conversion of people's values through presenting preferred values as universal and providing associated incentives for participation, the harm here is less easy to comprehend. That the researchers and many local communities depend on aid and/or partnership in the form of research funding to complete projects might not mean they were harmed: they agreed to participate and continued to agree even when a problem arose. The difficulty with comprehending harm here arises because not all dimensions of moral neocolonialism are direct. Hence we also need to clarify an indirect form of moral neocolonialism.

Indirect moral neocolonialism in African bioethical contexts

Widdows (2007) acknowledges that moral neocolonialism might happen indirectly when a pressing practical problem receives an ad hoc solution without sufficient theoretical consultation with, and involvement of, ethics from beyond the West (in cases where such consultation is necessary). She uses the example of informed consent in research ethics to support this possibility: even if efforts to recognize non-individual-based approaches to consent are made, insufficient rethinking of the basic premises of the ethics of consent may be done; for instance, communal consent might be sought in places where communitarianism is highly valued, but individual informed consent continues to be treated as key to research being counted as ethical (2007, 314). As she points out, "the danger is that Western ethics is simply regarded as a 'base' which is 'added to', and thus the individual presumptions remain largely unquestioned and the critiques of this dominant framework and the insights of non-Western and alternative forms of Western ethics continue to be peripheral"; if this were to be the sum of efforts to recognize

values from diverse cultures beyond the West, she suggests, then fears of global bioethics as morally neocolonialist would be substantiated (2007, 315).

In brief, then, indirect moral neocolonialism is the inadvertent conversion of people's values to those of a dominant ethical system, without direct intent. I suggest this can be explained as systemic injustice (Young 1990), and is compounded by epistemic injustice (Fricker 2007; Dotson 2011; Mason 2011) and global white ignorance (Mills 2015).

Iris Young explains systemic oppression in terms of the disabling constraints experienced by members of vulnerable groups: exploitation, marginalization, powerlessness, cultural imperialism, and violence (1990, 40). These types of oppression are systemic, rather than tyrannic, because there is no single group or person targeting the oppressed group or person: systemic oppression operates in and through institutions and systems, and occurs even when agents act with good intentions (Young 1990). Medical practitioners and researchers may promote Western values ahead of either indigenous or reconstructed values from cultures beyond the West as a matter of habit, or out of conviction, in either case acquired through education and training. Even if dialogue between ethical systems does occur, insufficient consultation and dialogue with values from beyond the West and pressure to find the simplest possible solution will perpetuate existing problems; new frameworks, like current frameworks, would be largely informed by the dominant system (Widdows 2007, 314).[4] The harm here lies in part in loss of insight that could develop and refine existing problem-solving resources, as well as in the injustice experienced by local agents. An increasing volume of scholarship indicates that African thought has been marginalized and underdeveloped within bioethics, either because African scholarship is taken less seriously because it is done by Africans, using African concepts, or within African contexts, or because even within African contexts there has been a historical bias

against taking African thought seriously (Fanon 1952; Gbadegesin 2009, 2013; Metz 2010; Behrens 2013; Tangwa 2017). Hence people's values can be converted to those of a dominant system inadvertently through systemic injustice, even when those contributing to the conversion do not intend to do so, have good intentions, and may be unaware of what is happening.

This harm is compounded by epistemic injustice. Miranda Fricker defines epistemic injustice as involving wrongs done to people in their capacity as knowers (2007). In testimonial injustice, a hearer's prejudice causes them to give less credence than is warranted to a speaker's testimony; in hermeneutical injustice, a gap in collective interpretative resources disadvantages a speaker who is trying to make sense of their social experiences (Fricker 2007). People experience epistemic injustice in bioethical contexts (Carel & Kidd 2014). A patient or a research subject's testimony may be ignored by an epistemically privileged healthcare professional or researcher; testimony could be heard but not treated as worthy of epistemic consideration; patient or research subject testimony could be heard but judged irrelevant by the professional; patients or research subjects may lack the capacity to express testimony (Carel & Kidd 2014).

Fricker's account of epistemic injustice has been extended in two important ways. First, it has been shown that marginalized groups can be silenced relative to dominant discourses without being prevented from understanding or expressing their own social experiences (Mason 2011). Patients or research subjects might, for instance, discuss and analyze first-person experiences of a medical problem or intervention effectively with family or friends using their first language, but might find it challenging to get a medical practitioner or researcher who lacks their cultural background or language or whose professional orthodoxy is grounded in a different language and associated culture/s to hear their reports of these if expressed in their second or third language. In

order to avoid supporting inadvertent value conversion through this kind of silencing, dialogue between stakeholders, and critical reflection on the fruits of such dialogue, would have to determine whether "socially shared moral understandings under examination really are shared by all those who enact them" — and whether such understandings are equally intelligible to all involved (Verkerk & Lindemann 2011, 94). The harm of indirect moral neocolonialism is further compounded by silencing.

Second, it has been suggested that the explanatory burden in cases of epistemic injustice should be shifted from speakers to socio-epistemic circumstances (Dotson 2011). Testimonial quieting occurs when an audience fails to identify a speaker as a knower (2011, 242). Testimonial smothering occurs when a speaker perceives that their immediate audience is either unwilling or unable to gain the appropriate uptake of the speaker's testimony, and so truncates their testimony (2011, 244). Marginalized patients or research subjects testifying across language and culture barriers might not be identified as knowers, or might truncate their testimony because they recognize that their interlocutor is unwilling or unable to achieve uptake of what they have to say. A professional with epistemic privilege in one context, for example in care-giving or instruction-giving dialogue with a patient or research subject, may find that they lack such privilege depending on factors in their socio-epistemic circumstances. For example, returning to the example of researchers in East Africa working in partnership with a Western funding organization: the researcher must adhere to the organization's values and so truncates their testimony rather than proposing changes in values (Hyder & Krubiner 2016). If this happens consistently, as seems likely from the evidence, then it counts as a harm (Dotson 2011).

Testimony can also be given too much credence, which reinforces how indirect moral neocolonialism harms via testimonial injustice. For example, disease feigned for psychological

reasons is only revealed as such after repeated visits to the doctor show that patient reports do not match test results (Carel & Kidd, 2014). Similarly, surveying research subjects in a clinical trial can yield answers that are misleading for complex reasons. For example observable research study fatigue was reported amongst subjects in multiple studies drawn from East African communities and resulted from two factors: experienced human research subjects developed "standard" ways to answer study questions, skewing researchers' data, and subjects were over-researched owing to duplication of studies and competition between funding agencies, which wrongly over-burdened the local communities from which research subjects were recruited (Hyder & Krubiner 2016). The communities continued to provide research subjects and the research teams in East Africa continued to study them, because they were guided by the value system in operation — and this led to harm in the form of subjects being over-researched, their communities unfairly burdened, and Western-funding-dependent researchers feeling powerless to address these issues. This illustrates direct moral neocolonialism as the conversion of researchers' and research subjects' values to those of a dominant ethical system through the disguise of aid or partnership and at the same time, indirect moral neocolonialism as the inadvertent production of value conversion to the dominant ethical system through the erroneous weighting of testimonial credence, prompted by systemic and epistemic factors.

Systemic and epistemic injustice and the harms they cause are further compounded by global white ignorance, which Charles Mills defines as involving a nominal, and sometimes genuine, acceptance of nonwhite equality that is combined with cultural prejudices and deracialized conceptions of social causality (2015, 219). In cases of global white ignorance, the history of white racial ideology and white global dominance is denied, and the "foundational miscognition" of white superiority spreads through white "perceptions, conceptions and

theorizations, both descriptive and normative, scholarly and popular" (Mills 2015, 219). Mills argues that overcoming the status quo of white ignorance requires a systematic investigation into how past theory (social sciences, humanities, and relevant natural sciences) and practice (law, public policy, government) have been shaped by racial ideology and racial liberalism, and also mandates an "uncompromising" examination of what purging its legacy would involve today (2015, 221-222). While Mills (2015) does not explicitly mention bioethics or moral philosophy, both fall within the disciplinary scope of his call to investigate and challenge the racist conditioning of theory and practice. We cannot know what the framework of a demonstrably racially just global bioethics would be without conducting the investigation for which Mills calls. The harm of epistemic disadvantage and loss caused by global white ignorance is to inadvertently perpetuate racist colonialist value systems, including within bioethics, if colonialism and racism are inextricably intertwined as e.g. Fanon (1952) shows.

African philosophical resources for overcoming moral neocolonialism

I have argued that direct moral neocolonialism converts people's values to those of a dominant ethical system covertly, through aid or partnership, e.g. via a government, NGO, or research organization. Indirect moral neocolonialism produces the conversion of people's values to those of a dominant ethical system through systemic and epistemic injustice, and global white ignorance. Both forms of moral neocolonialism may be present at once and may reinforce one another's effects. If bioethics accepts moral neocolonialism as a problem, then it may benefit from attending to African philosophical resources, both within and outside of African bioethical contexts.[5] Remember, those who defend moral neocolonialism a problem for bioethics and those who reject this view can both already agree that dialogue between traditions is both possible and

desirable, and that cross-cultural ethical dialogue must involve more than a minimal adding of values to an existing Western ethical base that leaves ethical systems from beyond the West on the periphery of inquiry (Widdows 2007; ten Have & Gordijn, 2014).

African philosophy has already been tied to a project of values revision. Fanon provides a compelling counter-colonial account of the psychology of anti-black colonialist racism (1952). Eze treats African philosophy as intrinsically counter-colonial, describing it as "a representative voice of counterhegemonic histories of modern philosophy" (2001, 207). More recent work reiterates that African philosophy emphasizes pursuing and promoting health, since health is often harmed or undermined by the effects of colonialist violence and oppression (Tabensky 2008; Oelofsen 2015). More argues that *ubuntu*, which has formed the basis of a number of recent engagements with the possibility of a distinctively African ethics, is both an ethical and a politico-ideological project: this is because as a moral principle it aims to consider and enhance human well-being, and as a politico-ideological principle, it guides social and political relationships in healthy, harmonious, directions (More 2005, 156-157). Grounded in values revision and in a concern for health promotion and restoration, African philosophical resources are therefore well-placed for effective engagement in cross-cultural dialogue concerning the ethical principles that should frame global bioethics.

There is already such dialogue, which opens up some opportunities for mitigating moral neocolonialism. One approach has been to propose using African philosophy as a means of supporting cultural pluralism in bioethics. This approach holds that we can aim at universals, but pay more attention to the role of phenomenal experiences in place in shaping ethical engagements, including in African contexts (Oelofsen 2015; Verkerk & Lindemann, 2011). Gbadegesin proposes a version of this approach that he calls "transcultural" bioethics, in which

resolutions to perceived conflicts between Western ethics and African ethics, along with diverse perspectives from other ethical traditions worldwide, could be arrived at (2009). Bioethical issues and questions are acknowledged to cut across cultures, but specific ways of responding to bioethical issues may vary from culture to culture (2009). This approach to bioethics cannot be grounded in any form of moral imperialism, because moral adequacy cannot logically be based on claims of cultural superiority; similarly, it cannot be grounded in cultural relativism, as the relativist simply and wrongly assumes that there is no objective basis for cross-cultural judgment of values (Gbadegesin 2009).

As an example, Gbadegesin uses the Yoruba principle of "*ikuyajesin*," which he defines as "death is preferable to the loss of dignity," to clarify the middle pathway between universalism and relativism that he proposes (2009). He shows that *ikuyajesin* applies to four discrete cases: (i) a woman refusing surgical intervention for breast cancer on the basis that she would be left without a breast, (ii) a man paralyzed from the waist down in a car accident committing suicide, (iii) the daughter of a 90-year-old woman refusing permission for her mother's surgery on the basis that her mother was old enough to die peacefully in her own home, and (iv) relatives of an elderly woman deciding to kill her on their own because they are so concerned about her 'confessions' of past 'wickedness' (2009). Unlike a universalist or a relativist, a cultural pluralist can allow that there is consistent and intelligent application of the principle of *ikuyajesin* in each of these cases; hence, ethical space is available in which we may try to understand and appreciate the perspective of a given standard before we judge it (Gbadegesin 2009). Gbadegesin points out that Western-centrism could be mitigated if bioethicists engaged in and coordinated more dialogue across diverse ethical systems, and facilitated the research focus of regional bioethicists on their community's area/s of pressing

need while helping to ensure researchers do not merely export Western priorities to nations facing different realities (2009).

A second specific approach has been to examine whether ethical principles drawn from Western ethics provide at least equally effective tools for contemporary bioethical analysis compared with principles drawn from African ethics; it remains an open research question as to whether these may prove more effective than Western ones. Metz appeals to *ubuntu* to argue that a distinctively African approach to bioethical inquiry can be developed (2010, 2017). By "African", Metz means a reconstructed account "informed by salient beliefs and practices of many sub-Saharan peoples" (2010, 50). Metz reconstructs a principle based on *ubuntu*: "an action is right just insofar as it is a way of living harmoniously or prizing communal relationships, ones in which people identify with each other and exhibit solidarity with one another; otherwise, an action is wrong" (2010, 51). He discusses several bioethical cases showing that an African moral theory may entail a similar conclusion to Western moral theories, but for a different reason that is at least as plausible as Western theories (2010, 50). In the case of free and informed consent to participation in research, for example, a deontologist might argue that it would be disrespectful of a person's autonomy to treat them or involve them in a research study without first gaining their voluntary and informed agreement to participate (2010, 54). In contrast, an African moral theorist on Metz's reconstructed account might conclude likewise, but for very different reasons: it would be "unfriendly" to treat or study a person without their free and informed consent because, in "genuinely identifying with others", we "cannot share a life with others in a meaningful way when they are unclear about the basic terms of one's interaction with them" (2010, 54). This line of inquiry has been further explored in moral philosophy; its

intersectional capacity has been interrogated though attention to whether a feminist account of *ubuntu* can be offered (Cornell & van Marle, 2015; Gouws & van Zyl, 2015).

Research subjects or patients are more likely to understand ethical reasoning and to accept and follow associated recommendations if such reasoning is accessible to them, which is more likely to happen if they can easily connect ethical reasoning with their own lives and experiences (Behrens 2013, 33). Moreover, the complexity and diversity of African and European languages in use in African nations and regions means that those working with human subjects in African contexts have a responsibility to acquire at least a rudimentary command of relevant languages, in order to facilitate communication with their interlocutors, participate effectively in cross-cultural dialogues, and ensure participants can identify "unjust imbalances of power, manipulation, or even force" (Verkerk & Lindemann 2011, 95). Use of reconstructed African moral principles might well support research subjects and patients in engaging more actively and with greater empowerment with the relevant scientific study or healthcare initiative in which they are involved, and mitigate structural, historical, and epistemic injustices. As such, it is worth continuing to examine the efficacy of African ethical concepts within bioethical contexts, including through empirical study of their efficacy.[6]

Objections and replies

Based on the systemic and historical factors combining to produce indirect moral neocolonialism, it is unsurprising that there is significant resistance to recognizing moral neocolonialism. And yet such resistance may still find support.

First, someone might argue that we all present our values as universal, on the basis that if we are persuaded that a particular norm or a particular value is right, then we claim it as such.

From this it might follow that everyone would be a moral neocolonialist. Yet it is not obvious that all of us do always present our values as universal. It assumes that moral nihilists, or the morally confused, do not exist. It involves an empirical question: for a full answer, we would need to provide evidence to show whether everyone (or at least a substantial number of people) is truly certain of what their values are, and whether or not they are certain that these values are absolutely right rather than simply values that they live by for the sake of convenience, in the absence of more compelling values.

Second, universalists might worry that acknowledging moral neocolonialism would make it unclear how to present values in a non-imperialist way. We could be more careful about how we present our values, but pointing out that value talk may need (constant) revision to help us avoid moral neocolonialism is not a strong objection to treating moral neocolonialism as a problem. The history of racism, white supremacy, and colonialism, along with systemic oppression that further perpetuates such injustices, means that values (and specific articulations of values) supported and nurtured by injustice have been wrongly assumed to be universal; that they continue to be privileged at the expense of other values; that attending to historically less privileged voices and value systems is complicated by epistemic injustice; and that these forms of injustice cause harm to persons and communities (Young 1990; Fricker 2007; Mason 2011; Dotson 2011, 2012; Mills 2015; Alcoff 2015). Lack of clarity about non-imperialist presentation of values should therefore rather be addressed.

Relatedly, it may seem that if harms caused by moral neocolonialism are less extreme than those of colonialism, then moral neocolonialism is unworthy of attention. However, moral neocolonialism perpetuates historic harm; it does not only create fresh harm. In a discussion of

the physical and mental health effects of colonialist violence upon black people, Frantz Fanon quotes from a medical study included in a 1948 book on *Colour Prejudice* by Sir Alan Burns:

> Dr. H. L. Gordon, attending physician at the Mathari Mental Hospital in Nairobi, declared, in an article in the *East African Medical Journal* (1948) "A highly technical skilled examination of a series of 100 brains of normal Natives has found naked eye and microscopic facts indicative of Inherent new brain Inferiority. … Quantitatively, he added, "the Inferiority amounts to 14.8 percent" (Burns in Fanon 1952, 30).

Fanon — a qualified psychiatrist — mentions this racist colonialist claim made in a scientific journal as part of showing how medicine and its ethics in African contexts are and continue to be, shaped by the history of colonial violence. Hence, even if moral neocolonialism is less easily recognized than colonialism, it should not be dismissed as harmless.

Third, there are also concerns to note with regard to recognizing and overcoming moral neocolonialism in African bioethical contexts. The diversity of African cultures and languages and associated diversity of ethical principles involves a risk of generalizing about the 'African-ness' of a value (Fayemi & Akintunde 2012). This concern has already been pointed out in efforts to develop "an" African approach rather than "the" African approach to ethics, and explore ways of implementing it in the broad range of African bioethical contexts; such efforts are explicit in their efforts to avoid the assumption there is only one way to account for African ethics, or that everyone living in a particular African nation or region accepts values associated with the history or culture of that region (Metz 2010; 2017). Continuing to work to avoid

exceeding epistemic warrant when discussing African ethics, while attending to history and location in order to facilitate performing philosophical analysis in place, responds to this concern (Oelofsen 2015, 139).

Moreover, the impact of colonialism on African nations and regions and the fact that cultures are fluid and internally heterogeneous means that we might wrongly assume, or romanticize, the cultural specificity —the 'African-ness' — of a value, or engage in stereotyping discourse regarding such African-ness (Jaggar 1998; Fayemi & Akintunde 2012; Chattopadhyay & De Vries, 2013). Treating African cultures as museum pieces reinscribes the historical harm of denying agency to African peoples (Gbadegesin 2013). Yet African peoples have not been fully assimilated into Western cultures (Oelofsen 2015, 139). Hence it remains possible to explore how dialogues between indigenous and reconstructed African ethics, and between these and other ethical systems, might be mutually beneficial and might properly recognize the full diversity of humans' phenomenal worlds, while still aiming at a transcultural, less relativist, more universal, way of responding to ethical and bioethical problems (Gbadegesin 2009; Metz 2010; Behrens 2013; Oelofsen 2015).

Additionally, bioethicists could raise the concern that a global framework for ethical decision-making could be made impossible if moral neocolonialism were accepted as a substantive problem, as it would then be unclear how to resolve urgent bioethical problems requiring international solutions, such as the black and grey market in human body parts, and the spread of HIV or other communicable diseases (Widdows 2007, 313).[7] While practical problems need quick and effective solutions, it is hard to see how attending to a factor that negatively impacts scientific efficacy and ethical correctness could possibly eliminate bioethical problem-solving. Raising and assessing reasonable concerns regarding priorities in practical problem-

solving that are sensitive to location and context seems exceptionally unlikely to render global ethics utterly impossible: therefore, this concern is overstated. The need to respond effectively to practical problems does not make critical engagement with the issues raised by systemic and liberal racist structuring of values, including in bioethics, unnecessary (Mills 2015; Myser 2003). Appeal might be made to UNESCO's 2005 Universal Declaration on Bioethics and Human Rights as already having mitigated concern about moral neocolonialism; however, values used in the declaration, such as 'justice', are culturally conditioned, even though general formulation of the declaration's principles using these leaves room for cultural diversity (Andorno 2007). So, appealing to UNESCO's universal declaration doesn't clearly protect against direct moral neocolonialism.

Fourth, even if we admit the problem exists, efforts to counter moral neocolonialism might unintentionally perpetuate it. Perspectives from outside Western bioethics might be welcomed because they shed light on multicultural dimensions of dominant Western nations, as well as broadening and enriching Western bioethical analysis (Verkerk & Lindemann 2011). Yet bioethics should avoid perpetuation of cultural and racialized stereotypes, for example by contrasting individualist with communalist values as if all people in a particular region must identify as such or make their moral decisions on this basis, and as if reassessment of individualist or communalist cultural emphasis never happens (Widdows & West-Oram 2013). A willingness to continue to learn and reflect as part of the profession may mitigate this; thus, bioethicists might more easily recognize that they are not divorced from all cultural influences, that they too are raced, gendered, and classed, that they are dependent for parts of their lives, and that their perspectives are shaped by experience (Verkerk & Lindemann 2011). As we have already seen, perspectives are further shaped by systemic and historical-social factors. Hence in

self-reflection, bioethicists should pay more attention to their social location and its assumptions and privileges as a means of coming to understand how ethics — including bioethics — can examine what the best way of living really might be, inclusively (Verkerk & Lindemann 2011).

Conclusion

I have argued that moral neocolonialism is a real problem for bioethics, including for bioethics in African contexts. I differentiated between direct and indirect moral neocolonialism, and showed how both arise within African bioethical contexts. I suggested that both of these forms of moral neocolonialism count as problems because they cause harm. This is supported by analysis of the need for systematic engagement with the history of racial oppression and global white ignorance in our conceptions of theory and practice, a need of pressing importance within the broad set of challenges associated with clarifying and pursuing ethical ways of living today (Tabensky 2008; Oelofsen 2015; Alcoff 2015; Mills 2015). It is further complicated by epistemic injustice (Fricker 2007; Dotson 2011; Mason 2011).

Further analysis would engage in greater depth with issues of intersectional justice in bioethics in African contexts, for example by continuing work to develop feminist approaches to ethical analysis in African contexts and explicitly connecting these with bioethical issues (Cornell & van Marle 2015; Gouws & van Zyl, 2015). In addition, further analysis would give more attention to moral neocolonialism in healthcare provision and public health policy development (e.g. Komparic 2015), as well as in research ethics and in research ethics capacity-building efforts. In particular, empirical as well as conceptual assessment of the degree of testimonial injustice between professionals and patients and/or research subjects in African

bioethical contexts, and between African professionals intra-nationally and intra-regionally compared with internationally, needs attention.[8]

References

Alcoff, L. 2015. *The Future of Whiteness.* Cambridge: Polity Press.

Alora, A. & Lumitao, J. 2001. *Beyond a Western Bioethics: Voices from the Developing World*. Washington: Georgetown University Press.

Andorno, R. 2007. Global bioethics at UNESCO: in defence of the Universal Declaration on Bioethics and Human Rights. *Journal of Medical Ethics* 33: 150–154.

Behrens, K. 2013. Towards an indigenous African bioethics. *South African Journal of Bioethics and Law* 6(1): 32-35.

Bracanovic, T. 2013. Against culturally sensitive bioethics. *Medicine, Health Care and Philosophy* 16: 647-652.

Carol, H. and Kidd, I. J. 2014. Epistemic injustice in healthcare: a philosophical analysis. *Medicine, Healthcare and Philosophy* 17(4):529–540.

Chadwick, R. & Schuklenk, U. 2004. Bioethical Colonialism? *Bioethics* 18(5): iii-iv.

Chattopadhyay, S. & De Vries, R. 2013. Respect for cultural diversity in bioethics is an ethical imperative. *Medicine, Health Care, and Philosophy* 16(4): 639-45.

Chuwa, L. 2014. *African Indigenous Ethics in Global Bioethics: Interpreting* Ubuntu. Dordrecht: Springer.

Cornell, D. & Van Marle, K. 2015. Ubuntu feminism: Tentative reflections. *Verbum et Ecclesia* 36(2), Art. #1444, 8 pages.

De Vries, R., and Rott, L. 2011. The Export of Western Bioethics to Developing Countries. In *Bioethics around the Globe*, ed. Catherine Myser, 3-18. Oxford: Oxford University Press.

Dotson, K. 2011. Tracking Epistemic Violence, Tracking Practices of Silencing. *Hypatia* 26(2): 236-257.

Eze, E. 2001. African Philosophy and the Analytic Tradition. *Philosophical Papers* 30(3): 205-213.

Fanon, F. 1967 [1952]. *Black skin, white masks*. Trans. R. Philcox. New York: Grove Press.

Farmer, P. E., Nizeye, B. Stulac, S., Keshavjee, S. 2006. Structural Violence and Clinical Medicine. *PLOS Medicine* 3(10): 1686–1691.

Fayemi, A. & Akintunde, F. 2012. On the myth called 'African Bioethics': Further reflections on Segun Gbadegesin's account. *Bangladesh Journal of Bioethics* 3(3):4-11.

Fayemi, A. K. and Macaulay-Adeyelure, O. C. 2016. Decolonizing Bioethics in Africa. *BEOnline* 3(4): 68–90.

Fricker, M. 2007. *Epistemic Injustice: Power and the Ethics of Knowing*. Oxford: Oxford University Press.

Gbadegesin, S. 1993. Bioethics and Culture: An African Perspective. *Bioethics* 7(2-3): 257-262.

Gbadegesin, S. 2009. Bioethics and culture. In *A Companion to Bioethics*, ed. Kuhse, H. & Singer, P., 257-262. Oxford: Blackwell.

Gbadegesin, S. 2013. Bioethics and an African value system. *Keynote Address: Teaching Skills in International Research Ethics (TaSkR) V Workshop, April 17, 2013 (Indiana University Center for Bioethics).*

Gouws, A. & van Zyl, M. 2015. Towards a feminist ethic of ubuntu. In *Care Ethics and Political Theory*, ed. Engster, D. & Hamington, M. Oxford: Oxford University Press.

Hyder, A.A., Harrison, R.A., Kass, N., Maman, S. 2007. A case study of research ethics capacity development in Africa. *Academic Medicine* 82(7):675-83.

Hyder, A. A. & Krubiner, C. 2016. Ethical Challenges in Designing and Implementing Health Systems Research: Experiences from the field. *AJOB Empirical Bioethics* 7(3): 209-217. DOI: 10.1080/23294515.2016.1182236.

Jaggar, A. M. 1998. Globalizing Feminist Ethics. *Hypatia* 13(2): 7-31.

Komparic, A. 2015. The Ethics of Introducing GMOs into Sub-Saharan Africa: Considerations from the Sub-Saharan African Theory of *Ubuntu*. *Bioethics* 29(9): 604–612.

Macklin, R. 1999. *Against Relativism: Cultural Diversity and the Search for Ethical Universalism*. Oxford: Oxford University Press.

Mason, R. 2011. Two kinds of unknowing. *Hypatia* 26: 294–307.

Metz, T. 2010. African and Western Moral Theories in a Bioethical Context. *Developing World Bioethics* 10(1), 49-58.

Metz, T. 2017. Ancillary care obligations in light of an African bioethic: from entrustment to communion. *Theoretical Medicine and Bioethics* 38(2): 111-126.

Mills, C. 2015. Global White Ignorance. In *Routledge International Handbook of Ignorance Studies*, ed. Matthias Gross and Linsey McGoey, 217-227. London: Routledge.

More, M.P. 2005. Philosophy in South Africa Under and After Apartheid. *A companion to African philosophy*, ed. Kwasi Wiredu, 149-160. London: Blackwell.

Myser, C. 2003. Differences from Somewhere: The Normativity of "whiteness" in Bioethics in the United States. *American Journal of Bioethics* 3(2):1–11.

Nkrumah, K. 1965. *Neo-Colonialism, The Last Stage of Imperialism*. London: Thomas Nelson & Sons, Ltd. Retrieved from <https://www.marxists.org/subject/africa/nkrumah/neo-colonialism/>

Peace Corps. South Africa. Retrieved from <https://www.peacecorps.gov/south-africa/>

Oelofsen, R. 2015. Decolonization of the African Mind and Intellectual Landscape. *Phronimon* 16(2): 130-146.

Selgelid, M. 2008. Ethics, Tuberculosis, and Globalization. *Public Health Ethics* 1(1): 10-20.

Sobocinska, A. 2017. How to win friends and influence nations: the international history of Development Volunteering. *Journal of Global History* 12(1): 49-73.

Tabensky, P. 2008. The Postcolonial Heart of African Philosophy. *South African Journal of Philosophy* 27(4): 285-295.

Tangwa, G. B. 2017. Giving voice to African thought in medical research ethics. Theoretical Medicine and Bioethics 38(2): 101–110.

ten Have, HAMJ, & B. Gordijn. 2014. Global bioethics. In *Handbook of global bioethics*, 3-18. Springer Netherlands.

USAID. South Africa. Retrieved from < https://www.usaid.gov/south-africa>

Verkerk, M. & Lindemann, H. 2011. Theoretical resources for a globalised bioethics. *Journal of Medical Ethics* 37(2): 92-96.

Widdows, H. 2007. Is Global Ethics Moral Neo-Colonialism? An Investigation of the Issue in the Context of Bioethics. *Bioethics* 21(6): 305-315.

Widdows, H. 2011. Western and Eastern Principles and Globalized Bioethics. *Asian Bioethics Review* 3(1): 14-22.

Widdows, H. & West-Oram, P. 2013. Why Bioethics Must Be Global. In *Global Health and International Community: Ethical, Political and Regulatory Challenges*, ed. John Coggon and Swati Gola, 43–62. London: Bloomsbury Academic.

World Health Organization. Social determinants of health. Retrieved from <http://www.who.int/social_determinants/en/>.

Young, I. M. 1990. *Justice and the politics of difference*. Princeton, NJ: Princeton University Press

[1] I do not rule out that powerful nations from outside of the West could engage in some form of colonial or neocolonial activity, but lack space to discuss this possibility here.

[2] MRA and USIA are now disbanded, but the Peace Corps continues to operate as a program for volunteers to help promote world peace and friendship and to help interested countries to meet their needs, including in many African nations. For example, 1,539 Peace Corps volunteers have served in South Africa since 1997, and there are 129 volunteers currently serving in the nation (Peace Corps).

[3] For example, USAID plans to provide $268,912,000 in aid to South Africa in FY 2017 as it is an important strategic partner of the US (USAID). At a session on ending violence against women sponsored by the South African Mission to the United Nations, held as part of the Committee on the Status of Women's 60th session in New York (March 2016), discussion between a USAID representative and South African government representatives on the issue of the best approach to an SA government-USAID relationship demonstrated that while local values do have global power, as pointed out by ten Have & Gordijn (2014), the kind of moral and social neocolonialism to which Nkrumah (1965) and Sobocinska (2017) refer remained a primary discussion point.

[4] This does not exclude that in some contexts, the dominant system may not be Western.

[5] My focus on bioethics in African contexts notwithstanding, other contexts are no less important. Similar accounts could be developed for further bioethical contexts in which dialogue between stakeholders could produce progress towards greater inclusivity (Oelofsen 2015).

[6] I cannot give the debate concerning difference between indigenous and reconstructed African ethical or philosophical principles, and implications of this debate, the attention it deserves here. I have sought not to confuse indigenous with reconstructed ethical principles in this essay.

[7] Tuberculosis, and its multi-drug-resistant and extremely-drug-resistant variants, is a good example of a communicable disease with profound public health implications that requires collaborative global action (Selgelid 2008).

[8] I thank George Hull, along with audience members at the International Society for African Philosophy and Studies conference in 2015, the University of Cape Town in 2016, and Rhodes University in 2016, for helpful comments on earlier versions of this paper.