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Ethical issues in global health engagement

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A B S T R A C T

With an increasing number of clinicians participating in global health work, such engagement is now more than ever in need of critical ethical scrutiny. Exemplary initiatives in research, academics and publication, and other special considerations, provide potential approaches for overcoming ethical challenges in global health work. These methods demonstrate that successful global health work includes a commitment to foundational ethical principles such as trust, honesty, open communication and transparency, sustainability, capacity building, and appreciation for multiple perspectives – principles that surpass the traditional considerations of clinical practice. From this perspective, successful interventions to reduce neonatal and perinatal mortality must be strategically focused on building in-country capacity and sustainability.

1. Ethical principles

The United Nations has indisputably defined health as a human right, stating that the elimination of maternal and early neonatal mortality is requisite for all women around the world as a foundation of the Sustainable Development Goals. With an increasing number of clinicians, academics, institutions, and non-governmental organizations engaging in efforts to eliminate preventable maternal, neonatal, and perinatal mortality, a solid foundation in the ethical principles of global health work becomes indispensable. Conventional clinical principles of "do no harm", autonomy, social justice, privilege and power, and cultural humility [1,2] need to be further scrutinized in order to address even broader, significant ethical underpinnings: sustainability, accountability, honesty, respect, direct communication, clarity, capacity building, trust, and equitable bilateral exchanges between low-income and high-income stakeholders [2]. An emphasis on ethical principles can also be utilized to effectively benefit organizations and individuals seeking to eliminate disparities in other health-related fields.

As the interest in global health has grown, an increasing number of individuals face pressure to contribute to research, policy, and interventions in marginalized settings; however, this global health movement has more frequently progressed without adequate discussion of the ethics regarding such work. Global health has broadened from being the responsibility of public health and missionary work to encompass clinicians; this is due to increasing complexity of global health work that often requires strong clinical knowledge, education and training, or policy knowledge [3]. Thus, whereas clinicians are often familiar with and are guided by the clinical principles of 'do no harm', generosity, honesty, and preservation of autonomy as defined by Beauchamp and Childress for case-based approaches, they are asked to move beyond that when engaging in a global health setting, where power-dynamics play a greater role and disparities are higher [1,2].

Over the years, several ethical frameworks relevant to global health have been proposed to guide practitioners. Childress et al. suggests five principles to guide implementing interventions in marginalized communities: "effectiveness, proportionality, necessity, least infringement, and public justification." [4] Moreover, Kass states six ethical questions for examining public health interventions including "examining goals, questioning effectiveness, assessing burdens and who bears them, and judging fairness of implementation." [4] However, the field of global health ethics is relatively new and a recent area of concern to practitioners who wish to engage in improving health outcomes at a global level. Global health ethics, as defined by Stapleton et al., is "a term that is used to conceptualize the process of applying moral value to health issues that are typically characterized by a global level effect or

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require action coordinated at a global level." [5].

The high rates of maternal, neonatal, and perinatal mortality are thus a violation of global health ethics. The landmark 1985 article "Where is the M in MCH" by Alan Rosenfield and Deborah Maine served as a major call to action, deeming maternal mortality a neglected tragedy [6], and giving rise to the Safe Motherhood Initiative. Since then, all over the world, major initiatives have been implemented to achieve the goals set out by the Millennium Development Goals, international declarations and country obligations to improve maternal and child health. In 1990, it was estimated that 532,000 maternal deaths per year were occurring globally, with more than 99% of deaths occurring in developing countries [7]. Though the global maternal mortality ratio (MMR) in 1990 was an unacceptable 385 per 100,000 live births, Sub-Saharan Africa held an unimaginable MMR of 987 [7]. Over the last two decades, the MMR worldwide has fallen by 44% [8]. Although under-five mortality is decreasing in nearly all countries, neonatal mortality is an increasingly significant and largely preventable contributor to overall under-five mortality [8]. According to the World Health Organization's Neonatal and Perinatal Mortality Report, four million infants die in the first month of life; three million of these deaths occur in the early neonatal period, with the majority of these deaths in developing countries [8]. Africa and south-central Asia have the highest rates of neonatal mortality. Additionally, approximately 3.3 babies are stillborn every year. Regrettably, about one-third of these deaths occur during delivery, and are thus likely largely preventable [8]. Moreover, it is estimated that there are 6.3 million perinatal deaths occurring per year globally, nearly all of which are occurring in developing countries [8]. An observable cause for the disparity between developed and developing countries is the shortage of skilled health professionals, birth attendants and resources. Only half of all deliveries in developing countries occur in the presence of a skilled health professional [8]. Furthermore, most deliveries in developing countries occur away from health facilities [8]. Thus, though there has been progress in reducing perinatal and neonatal mortality globally, the problem is far from resolved.

Developing countries share a high proportion of maternal, neonatal, and perinatal mortality; in order to decrease preventable mortality in these regions, attention must be focused on tailoring interventions to be applicable and successful in developing countries. However, this is often easier said than done as there are numerous ethical challenges that can hinder the implementation of effective interventions. Global health interventions that fail to adequately address such ethical challenges can negatively impact the community.

According to *Global health ethics: key issues*, access, cultural relativity, and research are three areas of ethical challenges in global health work [9]. First, regarding access, the authors point out that whereas good health may be a human right and ethical principle, it is often unavailable to most people due to social determinants of health, such as poverty and lack of sanitation [9]. The authors also note that the lack of access to healthcare is aggravated by "brain drain" in low-resource settings, a phenomenon in which health professionals are recruited to train or work in developed countries, leaving an enormous deficiency in their home country. Effective capacity-building programs in low- and middle-income countries (LMICs) with high retention which appear to be sustainable and have broad public health impact, and which may even reverse brain-drain, have recently been described [10–12]. What is the role of high-income countries in providing opportunities for LMICs? Such options for LMIC individuals should not be at significant cost to their own countries. Second, are ethical principles universal, or are they influenced by local values? What is the boundary between protecting human rights and ethical imperialism? Last, the authors consider the ethics of researchers from high-income countries conducting research in low-resource settings [9]. Local populations with increased vulnerability or language/cultural barriers can complicate matters of informed consent. In such low-resource settings where most individuals are lacking basic health, ethical considerations for providing care to controls or benefits to participants in study must come into question [9]. Though overcoming such ethical considerations in low-resource settings is challenging, there are certain methods or examples that fundamentally encompass global health ethics in some form. By examining practices in research, academics and publication, and other special considerations, potential avenues for doing ethically sound global health work can be recognized.

2. Research

One approach to conducting research in marginalized communities that strongly encompasses ethical principles is formally described as "community-based participatory research" (CBPR). According to Israel et al., CBPR is a "partnership approach to research that equitably involves, for example, community members, organizational representatives, and researchers in all aspects of the research process in which all partners contribute expertise and share decision making and ownership." [13] The goal of CBPR is to benefit the communities involved in the research in some manner – whether that be by facilitating capacity building or by utilizing research findings as evidence to inform interventions, policy change, or social change that can improve the quality of health and wellbeing of community members.

Israel et al. presents nine guiding principles of CBPR with the stipulation that members of a partnership must mutually select and expand on only relevant principles, as all will not pertain to every project. The principles are:

- "CBPR acknowledges community as a unit of identity
- CBPR builds on the strengths and resources within the community
- CBPR facilitates a collaborative equitable partnership in all phases of research involved in an empowering and power-sharing process that attends to social inequalities
- CBPR fosters co-learning and capacity building among all partners
- CBPR integrates and achieves a balance between knowledge generation and intervention for the mutual benefit of all partners
- CBPR focuses on the local relevance of public health problems and on ecological perspectives that attend to the multiple determinants of health
- CBPR involves systems development using a cyclical and iterative process
- CBPR disseminates results to all partners and involves them in the wider dissemination of results
- CBPR involves a long-term process and commitment to sustainability" [13].

Though a CBPR approach often requires a substantial time investment, especially to build up-front relationships and find consensus while including several perspectives, there are several benefits that seemingly outweigh the costs [14]: CBPR promotes selecting research questions that are most important and relevant to the community; it facilitates a strong mutual understanding of challenges faced by community members; and it fosters the creation of high-quality, culturally sensitive data collection instructiveness which in turn contributes to higher-quality data [14]. Furthermore, CBPR modifies any preconceived bias of the

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