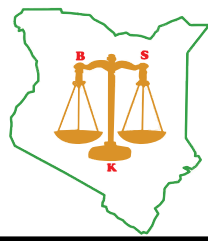


***B.S.K***



***News***

Vol 1, Issue 5, 2022

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***Clinical  
Ethics***

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The BSK NEWS is a quarterly newsletter of the Bioethics Society of Kenya. We welcome a wide variety of submissions, including short articles in all areas of bioethics (broadly construed), opinion pieces, previews, latest news and relevant announcements.

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# Contents

1. From the Editors
2. Clinical Ethics: Do We Need Professionalization?
3. The Kenyan Constitution and Public Health: Can Distributive Justice in Health Services be achieved in Kenya?
4. Are Global Public Health Practitioners Entrenching Health Inequities?
5. Prenatal Genetic Diagnosis: Towards an Interdisciplinary Approach
6. BSK Café at Egerton University
7. BSK mourns a committed member
8. Western Medicine amid African Traditional Medicine (TM): Partnership or Confrontation?

# From the Editors

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Welcome to the 2022 issue of the BSK News.

We had an eventful year despite the persisting setbacks occasioned by the COVID 19 pandemic. In March we held a very successful annual conference under the theme “Bioethics and Public Health” and in October we initiated the development of the society’s strategic plan, which is now almost ready. In addition, we held a bioethics café at Egerton University, which was very well attended. The topic of discussion was ‘Decolonising Bioethics in Africa’, a theme that attracted a very lively debate.

In this issue, you will find five articles addressing the following topics: professionalization of clinical ethics, distributive justice, global health inequities, prenatal genetic diagnosis, and traditional medicine.

You will also find two tributes in honour Professor Anna Karani, who passed away in September. Professor Karani was an active and committed member of the BSK and will be best remembered for promoting research ethics and development of nursing education in Kenya.

This newsletter is now in its fifth issue and is still going strong. With its impact set to grow, we look forward to bringing you authoritative and timely articles on current bioethical issues. We invite our readers to send short articles and news items that are of interest to the bioethics community in Kenya

Last but not least, we would like to invite you to our annual conference, scheduled for March 9-10, 2023. All the details about the conference, including registration can be found in this issue.

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# Clinical Ethics: Do We Need Professionalization?

*Simon K. Langat, Bioethics Society of Kenya*

A report by the Kenya National Commission for UNESCO (KNATCOM) in 2018 emphasised the need to establish Hospital Ethics Committees (HEC) in more hospitals in Kenya. The report highlighted the near absence of ethics committees in hospitals. All the 47 counties have level five referral hospitals and many faith-based health institutions. Some 44 private hospitals were sampled and only 10 of them had ethics committees of some nature. More striking was that none had among their members persons trained in ethics nor were the committees structured in a fit for purpose manner (unesco.org).

Value concerns and interests of patients and their families remains an important consideration for every hospital in the country especially during the post COVID period. In Kenya research ethics developed in the country earlier than clinical or hospital ethics possibly because of the higher standards of informed consent required in research. Thus, the University of Nairobi Medical School established an ethics committee in 1972. Development of research ethics committees continued in earnest since then with the setting up of one at the Kenya Medical Research Institute (KEMRI) in 1983 and at Moi University in 1985. The National Bioethics Committee (NBC) was formed in 2009. Currently, there are over 30 research ethics committees around the country. As research ethics committees sprouted around the country, very little happened in the hospital arena. The KNATCOM report is a pointer of what must now happen.

Elsewhere in Europe, Asia and America, clinical ethics consultation has become a profession complete with regulatory guidelines and even professional ethics for practitioners. Clinical ethics committees address the issues

of treatment decisions, goals of care, best-interest decisions, confidentiality, and defining-criteria for prioritisation of services and organ allocation amongst others. These are weighty matters and need the committees to have in its membership persons having adequate grounding in ethical decision making to enable amicable resolution.

There are four important activities that will have to be addressed by relevant authorities and promoters like the BSK. These are: ethics education, ethics guidelines and policies development, clinical ethics theoretical and empirical research and clinical ethics consultation. We highlight the import of each activity to the national health services as follows:

- a) Ethics education- it is important to ensure that persons sitting in committees in hospitals have the necessary grounding to enable them to make clear choices for their clients being a patient or hospital administration. This would create a role for the BSK or other consultants to carry out training. Financing would be required; hospitals or government may have to cater for the inevitable cost of improving ethics in health care.
- b) Development of guidelines and policies- the health Act No. 21 of 2017 has already provided some specifics of what the guidelines will look like in several articles dealing with consent and responsibilities of various personnel in the health sector. Policies will be developed along the lines of the Act and adhered to by hospitals and other players.
- c) Theoretical and empirical research- It is important to continuously engage in research to assist in defining new ethical dilemmas that will arise with the ever-changing medical tech-

nology besides providing a foundation for sound decisions on current ethical concerns.

d) Consultation- ethicists and scholars in ethics will make valuable contributions linking with the practitioners. Their role will be to train undertake consultation and research and step in whenever needed by hospitals to deliberate on crucial questions. They constitute a critical link in the national system that facilitates growth and development.

The country is ripe for growth of HECs now to move in tandem with the maturing devolution of health services and the inevitable complexity of needed decisions occasioned by technology development and cultural differences.



# The Kenyan Constitution and Public Health: Can Distributive Justice in Health Services be achieved in Kenya?

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University of Nairobi

Violet Nanyu  
Moi University

## Introduction

Bioethics – the study of ethical, social, and legal issues that arise in biomedicine and biomedical research - can be divided into three broad areas: medical, environmental and public health ethics. Research ethics is the most developed aspect of bioethics in Kenya with Institutional Review Boards (IRBs) established in research institutions and universities. They provide guidelines for research and enable compliance with international norms (Azetsop, 2011). Public Health is the science and art of how society collectively aims to improve health, and reduce inequalities in health. The basic functions of public health are essentially government functions. When the government fails, public health including clinical health services fail. Public health ethics is therefore concerned mainly with the principle of distributive justice and requires that health services are accessible to individuals according to need and within the context of resource availability (Hanson et al., 2022).

## The Kenyan Constitution and Public Health

Kenya's constitution establishes the right to health services. Article 43 (1) states that "every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care". Article 56 (5 e) states that "the state shall put in place affirmative action programmes designed to ensure that minorities and marginalised groups have reasonable access to...health services..." (The Government of Kenya, 2010). A key policy goal of the Kenya government is universal health coverage (UHC). Universal coverage is defined as access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access.

Kenya's spending on health at roughly two percent of GDP is higher than its peers in the region,

but it is relatively lower than the average for lower middle-income countries and lower than the average for countries to which Kenya aspires (Giorgio, Yoo, & Maina, 2022). County governments account for over 60 percent of total government spending on health. GoK prioritizes financing of specialized care rather than PHC, the foundation to achieving UHC. Furthermore, substantial inefficiencies related to human resources for health (HRH) are noteworthy. Kenya has the highest rate of absenteeism in Africa and inadequate capacity to correctly diagnose and treat patients for common health conditions (Giorgio et al., 2022).

The relative inefficiency of health service provision and inadequate health financing point to potential problems of distributive injustice. This is likely to be exacerbated by provision of health services that follow African moral theories, particularly the partiality tenet that holds that we ought to give preference to those with whom we have close relationships, such as family and friends (Behrens, 2017). In interrogating whether distributive justice is being achieved three problems are identified.

## Distributive Justice, the Bioethical Dilemma

How should bioethicists engage with government? As discussed earlier the clinical level of healthcare has an established structure of IRBs for bioethicists to engage with clinicians. However, the constitutional structure of public participation to engage government policies, plans and budgets does not have an independent, established, funded infrastructure. This means that any bioethical interrogation of government and private providers of health services is likely to be ad hoc and weak.

Where does responsibility lie when political failure to deliver on health financing leads to health service delivery ineffectiveness? The political level of government including the judiciary often rely on

the health professions to determine which health interventions are relevant in our context. So, the clinician, the non-political part of government, is tasked to promote fair distribution of health care resources but only partially reliant on their professional ethics. In addition, many of these clinicians formulating policies and setting practice guidelines, are not in the frontline of care subject to IRB oversight, but work in bureaucracies reporting to non-clinical (political) people. Their professional ethics may be in conflict with their other fiduciary responsibilities in government which raises questions of power and accountability.

What moral theories should be applied in deciding if distributive justice is being achieved? A bigger challenge is for the bioethical community to agree on the moral underpinnings that guide engagement with government. The principle of

distributive justice requires that health services be accessible to individuals according to need and within the context of resource. An ethical African approach to equity in access to healthcare would be defined not only by the individual right to access services but also a principle of communal responsibility. This is what article 43 and 56 of Kenya's constitution are about. But which should be pursued? The individual right or the communal right?

## Conclusion

In deciding whether distributive justice can be achieved, there is a need to have agreed upon moral theories, established institutional mechanisms for engagement and assign moral/ethical accountability between government and health professionals.

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# Are Global Public Health Practitioners Entrenching Health Inequities?

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Kenya Medical Research Institute

In his book '1984', George Orwell writes: 'If you want a picture of the future, imagine a boot stamping on a human face, forever.' This is a true reflection of the future of Global Public Health as it is currently practiced.

The COVID 19 pandemic has disrupted all facets of our lives, though differently. Without a clear picture of what the future holds, it has become easier to imagine a new normal rather than a return to the 'pre-pandemic normal.' The pandemic has however, disproportionately affected structurally oppressed communities, with studies in the US and in Europe showing higher COVID-19 incidence and mortality rates among Black, Indigenous, and People of Color (BIPOC). This has led to greater interest in the already known role of systemic inequities and injustices as the most important determinants of health. This difference in the burden of COVID-19 among different populations is not a unique attribute of COVID-19, as the trend is replicated across many other conditions such as maternal mortality and deaths from cardiovascular disease. It goes without saying that the next pandemic would affect the world's populations in a similar pattern unless the fundamental principles of public health undergo radical change.

Why are these disparities rife in the 21st Century given the scientific advances in prevention, diagnosis and treatment technologies, as well as the massive investment going into Global Health? Have public health practitioners failed in their duty? While it is known that social determinants of health are the most important factors that drive health disparities among populations, global health researchers are still obsessed with downstream determinants of health such as individuals' biology, behaviors and newer methods to deliver evidence-based interventions. For instance, tuberculosis incidence was on a precipitous decline in Europe and North America well before effective treatment for TB was discovered

while Malaria was eliminated from Europe and the Americas, by not pouring billions on studies focused on individuals without changing people's socio-economic and environmental realities. Another example is death of children before the age of five, where it is also known that under-five mortality is indirectly proportional to the number of school years completed by a woman. Indeed, the sociodemographic index of a country (a blend of per capita income, educational status, and total fertility rate) is the single most important indicator of the burden of disease for most diseases. Instead of advocating for - and implementing- what we know works, public health practitioners' have been co-opted into focusing on downstream determinants of health that are deemed to be cost-effective and that do not disrupt the economic and epistemic order. Public health is today deeply steeped in generating more and more innovative ways to cope with the existing and ever-widening health disparities without taking a clear political or ideological stand to change the root causes.

Eugene Richardson, a physician-anthropologist at Harvard University and writer of the book 'Epidemic Illusions' explores how global health practitioners are blind to the big picture with an example of the response to Ebola in West Africa: "epidemiologists attributed amplified transmission to local populations' beliefs in misinformation or their 'strange' funerary practices—in essence, diverting the public's gaze from legacies of the transatlantic slave trade (or Maafa), colonialism, indirect rule, structural adjustment and extractive foreign companies as determinants." He also argues that "mathematical models of infectious disease transmission do not serve as forecasts but as a means for setting epistemic confines to the understanding of why some groups live sicker lives than others—confines that sustain predatory accumulation rather than challenge it. Similar to the role philanthropy plays in occulting economic exploitation, the modest improvements in well-being offered



by the right hand of public health 'science' often disguise what global elites and their looting machines have expropriated with the left."

Classic examples of moral bankruptcy in medical research include Nazi Germany's medical experiments, the Tuskegee Syphilis experiment, among others. The aftermath of these was the development of principles of research and ethical codes. The obvious deduction from these cases is that professionals should not bend to any overt or covert individual, institutional or professional pressures, but have a moral duty to do what they know

is right. Yet this is arguably what is happening in Public Health, in a different era -only that the system is universal and more efficient.

Public health academics and policy makers should revisit the inherent shortcomings in the structure of global public health institutions rather than spectate in an arena where they wield sufficient power to execute change. They ought to follow the example of the Nuremberg trials that set the tone for research conduct. Public health ethics must thus come of age.

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# Prenatal Genetic Diagnosis: Towards an Interdisciplinary Approach

Violet Naanyu,  
Moi University

## Introduction

Prenatal diagnosis checks women and developing babies during pregnancy and provides parents-to-be with information on whether their fetus has any genetic disorders [1]. In this article, perinatal genetic diagnosis (PGD) is considered using transdisciplinary and interdisciplinary lenses. Transdisciplinary approach refers to making connections by getting the same idea across various subjects and explaining it in a practical way, by ensuring inclusion of diverse disciplines and stakeholders [2]. Using a transdisciplinary approach, we move beyond discipline-specific ideas to reflect on, and address PGD problems. Similarly, interdisciplinary/multidisciplinary approach involves drawing from several disciplines (or separate branches of learning/expertise) to redefine problems outside of normal boundaries and reach effective solutions based on a new joint understanding of the matter at hand to ensure an all-encompassing deliberation [3].

## The setting of prenatal genetic diagnosis and relevant stakeholders

PGD occurs in the hospital setting and the tests involve analysis of body fluids/tissues in order to check for genetic likelihood of getting disorders [4]. These tests are done on cells from the fetus or placenta. The stakeholders include the clients/patients, health care workers (e.g. gynecologists, geneticists, genetic counselors, psychologists, psychiatrists, antenatal nurses, gynecologists, sonographers, and laboratory technicians), health insurance firms, and regulatory authorities. Religious/spiritual leaders and philosophers add value as beliefs, attitudes, values and diverse views are distilled into fruitful solutions within specific contexts. It is important to reflect on all internal and external stakeholders when discussing PGD and reflect on the role and stake of diverse agents.

## Interdisciplinary diagnosis of PGD and factors causing the bioethical phenomenon

An interdisciplinary diagnosis of PGD means the joint discussion creates 'a new type of social "ego" in which the changes of the public and personal self-identification are ethically reflected through the relation of the person to life' [2]. Information is co-opted from each discipline and applied to PGD, consequently, enhancing our understanding of PGD.

*Medicine and natural science* provide key input because of the work of health care workers (HCWs) in screening, diagnosis, and broad preventive and curative care during pregnancy. Medical practice and associated ethics are specialized because HCWs are privy to intimate aspects of life that connect life and death. They are therefore expected to uphold life, be confidential, and prioritize the needs of the woman and fetus when reflecting on PGD - benefits should outweigh risks. HCWs ought to observe autonomy, non-maleficence, beneficence and justice [5].

*Psychology and psychiatry* in healthcare are also specific important branches in PGD because of their contributions on mental health of the patient, motivation for PGD, anxieties and potential regrets during and after going through such a procedure. These dimensions help the agents weigh benefits and risks, as well as alternative options. Anthropology influences our definition of health and diseases, and also influences decision making on health care e.g. PGD. Anthropology explains how social, political, and economic aspects influence health and organization of health care. Moreover, anthropological lenses provide cultural values, beliefs and norms that are unique to societies, and the ultimate moral obligation to protect autonomy and dignity of all human beings [3]. This is because ontological arguments show PGD discussions ought to consider the fetus as a dignified human being who is of value just as any other human being.

*Sociology* brings on board important concepts including quality of life of the fetus; social risks to be experienced by the mother and child; stigma associated with tainted selves; and social differen-

tials in access to specialized care associated with PGD and follow up services. *Philosophy* helps us unpack attitudes guiding principles for screening diagnosis and reporting of associated findings. When using the model of philosophical bioethics, we investigate ethical issues such as PGD by applying the principle of moral philosophy to the issues noted [6]. *Religious perspectives* bring to the PGD discussions ideas on people's views and beliefs on human nature, suffering, and limits on autonomous decision-making. They rely on their diverse historical traditions, social backgrounds, cultures, and types of social interactions.

*History and economics* enriches the discussion on PGD through provision of information on the subject matter across different time periods and societies. It shows for instance how PGD services can be discontinued as laws on health care change with new political parties and associated updates on laws/guidelines on health and healthcare. Similarly, changes in economic situations, costs of care, expanding medicalization, and changes in health insurance plans can affect availability of

PGD services and equity in access. *Law and regulations* are key to PGD discussions. A *law* is a system of rules which a people from a specific nation/community recognize as regulating the actions of its members. It provides juridical warranty of human rights for life, health, human dignity, and liberty [3]. Laws are important in discussions on PGD because of the potential for such investigations to result in abortions and other harms. PGD results can also be used to give differential treatment to different patients, or even limit access to health insurance. We also need to pay attention to bioethical issues within/across countries because some patients opt for medical tourism in order to access PGD.

In conclusion, to exhaustively discuss PGD, involvement of all relevant agents and stakeholders is important. Interdisciplinary approaches allow us to identify important values and priorities, and facilitate consensus building on PGD and associated ethical concerns.

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# BSK Café at Egerton University



*The Bioethics Society of Kenya in partnership with the UNESCO Chair on Bioethics at Egerton University organized a very successful Bioethics Café on 23rd November 2022, under the thought-provoking theme: "Decolonizing Bioethics in Africa". Over 30 participants were in attendance both virtually and physically.*

# BSK mourns a committed member



The BSK is mourning the death of one of its most committed and dedicated members, Professor Anna Karani. She passed away on 6th September 2022 after an illness. She will best be remembered for promoting research ethics and nursing education in Kenya. Below are tributes from her BSK colleagues.

.....  
**Simon Langat**

*Professor Anna Karani served as chairperson of the Nursing Council of Kenya for many years. She applied herself to the development of the Council and the nursing profession in Kenya with dedication. A diligent public servant, she advocated for the use of research to promote the profession and encouraged nurses to always pursue education to improve their work. Those of us privileged to work with her recall her vision and vigor in steering the Council during that period. I had been selected to represent the Ministry of Education’s Department of Research Development in the Council to promote the use of data collected in the daily functioning of the hospitals for the purpose of improving services. Those of us in the council representing other institutions soon felt the keenness and altruism with which she approached her work. With her charming and yet firm decision-making, she laid the foundation of today’s nursing where foreign countries call upon Kenya to provide nurses for their health systems. Her gifts and character embodied and inspired the achievements we now find in the health sector that the current generation are proud of. Her discharge of duty and attendance to people’s needs have made an enduring impression that are a good reference to all who would follow her footsteps in future*

.....  
**Caroline Kithinji**

*Professor Anna Karani joined the Kenya Medical Research Institute/ Ethics Review Committee in 2012 on the recommendation of Prof Kirana Bhatt who had been appointed the Chair of the National Bioethics Committee. When the system of review at KEMRI changed and the Scientific and Ethics Review Unit (SERU) Committees were formed she elected to remain in service and became a member of SERU Committee B, serving with diligence and commitment until her demise last year. Her reviews showed her attention to research methodology, particularly the connecting thread of the proposal from title to methodology. She also reviewed Serious Adverse Events making sure that participants were well protected. Despite her heavy schedule as an external examiner and lecturer at the University of Nairobi she always managed to squeeze in time for reviewing and attending ethics committee meetings. Prof Anna Karani was very stylish in the way she dressed and wore her hair, she was also quite direct and did not suffer fools gladly. She will be missed.*



# Western Medicine amid African Traditional Medicine (TM): Partnership or Confrontation?

John Weru

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## Introduction

According to World Health Organization (WHO), Traditional Medicine (TM) is the sum total of the knowledge, skill, 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 illness. In Africa, 80 per cent of the population still uses traditional remedies rather than modern medicine for primary health-care. This is an often-discussed contemporary bioethics issue in clinical care.

Peoples' reaction to illnesses is linked to their values which have social and cultural meanings. Lack of understanding of the traditional, cultural, and social norms of a people can be detrimental to provision of quality health care due to the limited acceptance by the community. This is particularly the case in multilingual and multicultural Africa. However, there remains a lot of apprehension on how suited traditional healers are to diagnose and treat diseases. This sentiment is shared by many health care professionals who are usually educated using the western model of medical education but serves in a predominantly traditional medicine-oriented populace. There is a significant limitation to the health care system in Africa in terms of western educated personnel and other resources such as drugs and infrastructure. However, the traditional medicine practitioners are readily available and can come in handy to fill this glaring gap. This review assesses these 2 approaches to health care provision within the African context.

## Comparisons

The author practices in the field of cancer care and has realized that traditional healers and herbalists are often the first point of contact for cancer patients in Kenya, an assessment that is corroborated by studies

across Africa according to Mokgobi (2014). Traditional healers use an array of herbs, some of which are applied to cancer wounds, and incarnation of ancestral spirits to treat cancer. Many patients in Africa believe that traditional healers are able to cure their cancer, and they only seek hospital treatment as a last resort. Traditional healing has existed since time immemorial in Africa. This tradition cuts across all facets of life, whether physical, psychological, social, or spiritual. Thus, the essence of holistic approach. This strong belief that traditional healers can cure diseases such as cancer is the strongest reason people visit them. Several countries in Africa have formulated policies to regulate traditional medicine (Gakuya et al, 2020). The WHO has also outlined policy papers towards use of TM with its expert panel recently endorsing protocol for COVID-19 herbal medicine clinical trials.

Modern Western Medicine on the other hand was built around the model of running tests on sick patients to determine which drug or medical procedure would best deal with some illness. The medical infrastructure we have today was designed with infectious agents in mind. The treatment decisions are founded on a scientific evidence base. However, the sentiment that it should be applied across all diseases and all facets in health as Jenicek recommended in 2019 could bring about a conflict with those who believe in the traditional healing process.

There are notable differences between traditional and modern medicines from formulation, manufacture to utilization. The legal protection given to knowledge for the western medicine in terms of intellectual property contradicts the TM approach where knowledge is given freely.

In undertaking studies, Western medicine has a clear structure on how to do so with research ethics being a key guidance. This is not the case for TM where approaches to study the medicine ingredients are not as clear. Determining doses of

the drugs in TM is done based on experience and no clear guidelines on dosage. Western medicine has a pre-determined dose calculation, and once tested in clinical trials cannot be changed unless re-tested. Regulations are clearly articulated for western medicine for marketing and manufacture, but this is non-existent for TM. Although both systems of medicine require lengthy training over many years, with traditional medicine, knowledge is often passed one-to-one through families, and practitioners are often born into a family of healers and apprenticeship is critical. The efficacy and effectiveness of western medicine has been written about and documented. However, the jury for TM is still out there. Further, TM is available for all those who seek it with the cost not as exorbitant as Western Medicine. In some cases, payment for TM is in form of goods, food, animals etc. This challenges the concept of equitable access to Western Medicine

Although calamities befall an individual and they are treated as such in the Western Medicine thus respecting the principle of autonomy, some TM approaches are directed to families as a whole or several individuals especially where it is believed

that the cause of the disease is a familial factor. Thus, confidentiality and privacy are not paid much attention to as is done with the Western Medicine.

## Conclusion

TM has much to offer to improve global health in these times of scarce resources and personnel. But this will need them to be well understood and studied. This is particularly urgent in these times when new drugs are urgently needed. Both developed and developing countries should collaboratively undertake research to enable development of the much-needed health care capacity.

Policies and regulations also need to be formulated to ensure that both approaches are complementary rather than conflicting. It will be interesting if the western trained health care professionals can also go through courses on TM. This would enhance their understanding of the alternative treatments and thus approach health care provision collaboratively and in a holistic manner. TM practitioners can also be trained in basics of science of diseases and the development of drugs.

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# 7<sup>TH</sup> BIOETHICS

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- ✓ ELSI of Genetically modified agriculture
- ✓ One Health and Climate Change
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Branch: **Nairobi Business Centre**

For more information, please contact us on:

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DATE: **9TH -10TH MARCH 2023**

VENUE: **SWISS LENANA MOUNT HOTEL, NAIROBI**

**CPD POINTS WILL BE AWARDED**



# Master of Bioethics (MBE) and PGD Bioethics Programs (PGDBE)

Amref International University is offering MBE and PGDBE programs with intakes in January, May, and September. The MBE is a two-year blended program (face to face and distance learning) delivered in 4 semesters, which PGDBE is a one-year blended program (face to face and distance learning) delivered in 2 semesters. The goal of the programs is to develop scholars and specialists in bioethics who are knowledgeable, competent and transformational leaders with professional values and ethics who have the ability to teach, manage and undertake research in bioethics disciplines of study for the well-being of the society.

After completion of the course, the prospective learners are expected to be able to:

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- *Demonstrate familiarity with the major concepts and theoretical perspectives in bioethics.*
- *Develop and use critical thinking skills to analyze information and situations in order to respond and act ethically with regard to scientific research, practice, and technology.*
- *Analyze and interpret quantitative data using statistical methods.*
- *Communicate scientific bioethics information effectively in a variety of formats, including verbal and written communication.*
- *Locate, analyze, interpret, critically evaluate, summarize and use appropriately bioethics information in the scientific literature.*
- *Apply the scientific method, including the roles of inductive and deductive logic and the applications and limitations of the scientific method, to generate hypotheses, then test those hypotheses by designing and evaluating experiments*

For more details on entry requirements and fee structure, visit <https://amref.ac.ke/course-category/postgraduate/>