

ARTICLES

The Aristotelian model of friendship and the IU-Kenya Partnership

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Abstract

Disparity in economic development between high-income countries (HICs) and low- and medium-income countries (LMICs) has necessitated collaborations, some in health-related activities. Globalisation frameworks indicate that, in fair collaborations, the ultimate aim should be to improve the situation in LMICs. In this paper we present the findings of a research study in which we used Aristotle's concept of friendship among unequal parties as an analytic framework to engage with the issue of inequality in an existing international partnership in health, the Indiana University–Kenya Partnership (IU-Kenya Partnership). This is a collaborative health programme involving a consortium of North American universities and schools of the Moi University College of Health Sciences in Kenya. We carried out in-depth oral interviews and focus group discussions with a sample of 41 partners of various IU–Kenya Partnership programmes. We did a comparison of obtained themes to the Aristotelian pointers of aspects of friendship among unequal parties. We eventually identified good and bad aspects of North–South partnerships as perceived in the IU–Kenya Partnership restricted to the Aristotelian model.

Key terms: health research collaborations, HICs-LMICs Partnerships, IU–Kenya Partnership, inequality, good and bad partnership, Aristotelian model.

Introduction

International collaborations and cooperation between developed countries and developing countries have grown exponentially in all subject areas, thanks to globalisation and to global development paradigms such as Millennium Development Goals and Sustainable Development Goals (1, 2). Among the key areas of international collaborations are healthcare and health research, the focus of this paper.

Through intensified international healthcare and research collaborations, high-income countries (HICs) transfer scientific knowledge, skills, technologies, and strategies to newly developing low- and medium-income countries (LMICs) (3). In so doing, HICs contribute to the achievement of global development goals.

However, such collaborations in health-related activities raise certain pragmatic and ethical issues, particularly stemming from the apparent challenge of inequality between the partnering institutions and individuals. In this paper, we present the findings of a study that was done to analyse issues of equality in an existing global North–global South health partnership, dubbed the “IU-Kenya Partnership.” We used Aristotle's concept of friendship among unequal parties as an analytic framework for engaging with this issue.

The IU-Kenya Partnership is a collaboration between Moi University School of Medicine (MUSOM)—formerly called Moi University Faculty of Health Sciences (2005)—in Kenya, and, initially, the Indiana University School of Medicine (IUSM), in Indianapolis, Indiana, United States. MUSOM and IUSM have enjoyed a partnership in health education, medical care, and research since the beginning of the Kenyan medical school in 1989 (4). The justification for terming this partnership as “unequal” is pegged to the fact that Kenya is categorised as an LMIC by the World Bankⁱ, while North America is an HIC.

Over time, the “collaboration evolved to include a large number of highly developed North American research universities and a medical school in a developing country” (5). Nearly thirty years after inception, the IU-Kenya Partnership has become a consortium and includes all schools of Moi University College of Health Sciences: School of Medicine, School of Public Health, School of Nursing, and School of Dentistry. It has also included Moi Teaching and Referral Hospital (MTRH). The hospital is indispensable because it provides the facility for the medical training practical component of the College. In North America, the consortium includes partners in the United States and Canada, “including the schools of Medicine at Brown University, University of Toronto, and the University of Utah, as well as the Duke University Medical Center and the University of Notre Dame Eck Institute for Global Health.”ⁱⁱ

From the start, the mission of the partnership was clear: To improve the health of the Kenyan public through three inter-related submissions, education, research, and clinical service (5). The success of this mission is evident in programmes that have emerged. Key among these is the Academic Model Providing Access to Healthcare (AMPATH) based at MTRH.

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Through AMPATH, institutions in the IU-Kenya Partnership work together to deliver health services, conduct health research, and develop leaders in healthcare for both North America and Africa.ⁱⁱⁱ

Other notable outcomes of this partnership include: the establishment of the Academic Research Ethics Partnership (AREP) between Moi University and Indiana University; exchange programmes in medical education between Indiana University medical students and their counterparts at Moi University; and the establishment of health facilities in Kenya including the Riley Mother and Baby Hospital; Chandaria Cancer and Chronic Disease Centre; National Chaplaincy Training Centre, and Shoe4Africa, the biggest public children's hospital in East and Central Africa, among other achievements.

This study analysed the IU Kenya partnership in the context of the Aristotelian concept of friendship among partners as spelt out in *Nicomachean ethics*. Aristotle is an outstanding philosopher of the classical Greek period who has made contributions to many areas including ethics, presented in two treatises *Nicomachean ethics* and *Eudemian ethics* (6). The choice of the Aristotelian concept of friendship among unequal parties is deliberate and subjective; this paper is part of a doctoral study in philosophy that sought to analyse the relevance of ancient Aristotelian ideas in tackling contemporary issues. We are aware of the limitations of this kind of approach and acknowledge and appreciate other frameworks concerned with equality of North-South partnerships. For example, the Council on Health Research for Development (COHRED) developed the fair research contracting guidance document and the Research Fairness Initiative (RFI), both of which are aimed at strengthening LMIC institutions' ability to negotiate fair research contracts with their higher income partners.^{iv} This study does not aim at developing any guidance, but offers a critical analysis of the reality of an existing North-South partnership.

Nicomachean ethics is presented in a series of ten books, each of which addresses certain aspects of Aristotle's ethics. Our study focused on Book VIII, Chapter VII, Chapter XIV and Book IX, Chapter I, which discuss a type of friendship that Aristotle calls "friendship among unequal partners." In this study, we analyse the relevance of Aristotle's concept of friendship among unequal parties in the context of the IU-Kenya Partnership. The entire Book VIII of *Nicomachean ethics* is on friendship; it begins by observing that friendship is a necessary virtue in life that humans would not live without. "No one would choose to live without friends, even if he had all the other goods" (7). Partnerships (hereby equated with friendship) are necessary for prosperity, and this would be the rationale behind the emergence of the IU-Kenya Partnership.

In Chapter VII of Book VIII, Aristotle presents what is "friendship among unequal partners" and the expectations thereof; the more useful partner (superior) ought to be loved and honoured; while the inferior party should expect material gain (8). In Chapter XIV of Book VIII, Aristotle observes that:

Differences arise in a friendship among unequal parties since each party expects to get more out of it. The better and useful man thinks that he should get more and claims that the less useful man should not get as much as him. On the other hand, the inferior partner makes the opposite claim; he thinks that it is upon the good friend to help the needy (8).

Challenges on equality abound in the IU-Kenya Partnership (5). Aristotle maintains that in the eventuality of such a stalemate, "the superior person should get more honour, and the person in need more (material) gain, since honour is the reward of virtue and beneficence, while gain is what ministers to need" (7). Throughout this paper we refer to this concept as the model for determining whether the IU-Kenya Partnership is a friendship among unequal parties.

Methods

For this qualitative, descriptive, and analytical study, we collected primary data from a sample population of 41 purposively selected from across various health programmes within the IU-Kenya Partnership between January and April 2017. The study population included: Co-directors and Co-Field Director of AMPATH Research; Director of International Partnerships at Indiana University; the principal sponsor of the Riley Mother and Baby Hospital, Eldoret (from Indiana University); Co-Chairpersons of AMPATH Research Working Groups and Cores; principal investigators in health research and health projects involved in the IU-Kenya Partnership, students in various IU-Kenya Partnership academic programmes, and the coordinator of the IU-Moi AREP from Kenya.

We obtained secondary data from literature in books, journals, and internet sources relevant to the Aristotelian analogy and the IU-Kenya Partnership. We conducted in-depth oral interviews with all categories of participants mentioned earlier, apart from the Moi University School of Medicine students in the IU-Kenya partnership, who were involved in focus group discussions (FGDs). Two FGDs were conducted, each having at least eight members: one with Bachelor of Medicine and Surgery (MBChB) students who had completed the electives programme in North America; the other with MSc. in International Health Research Ethics students under the IU-Moi AREP.

We carried out a systematic transcription of all the data that we had audio recorded from oral interviews and FGDs in the exact verbatim report as obtained from the participants. We then cleaned the raw data. We systematically read each group of transcripts making line-by-line analyses, identifying and highlighting key aspects relating to the benefits and significance of the IU-Kenya Partnership and the emergent challenges affecting the partnership. These key aspects were first obtained from the participants' direct voices, forming the *in vivo (emic)* codes. We then translated them in relation to the study objectives, and these gave rise to analytic (*etic*) codes. We grouped similar analytic codes into categories, which finally enabled the determination of relevant themes related to the issue under study.

We interpreted and made comparisons of the emergent themes to the Aristotelian pointers of aspects of friendship among unequal parties. We selected a few relevant verbatim quotes from the participants and presented them in prose to illustrate key ideas emerging from the interviews and discussions.

The research proposal was reviewed and approved by MUCHS/ MTRH Institutional Research Ethics Committee (approval number 0001753). We obtained written informed consent from the research participants before carrying out oral interviews and FGDs.

Results

The findings presented in this section are largely based on the participants' perceptions of the partnership. These have been grouped into themes reflecting Aristotle's approach to the concept of friendship among unequal parties.

Determining the unequal nature of the IU-Kenya Partnership

Aristotle provides a criterion for determining whether a friendship or partnership is unequal. This criterion involves examining the contribution of each partner vis-à-vis the benefits that each partner gets from the friendship. A majority of participants perceived that the main contribution that Kenya makes to the partnership is providing ready fields and populations for research, service, and learning. Comparatively, Kenya has a greater burden of diseases than North America including tropical diseases like malaria, which are not found in North America.

One Kenyan pointed out that:

Kenya gives North Americans a chance to learn about tropical diseases; the management of tropical diseases; the impact of tropical diseases on HIV status which, I am sure, they may not get in the developed world because there are certain diseases which are quite specific to Africa.

According to another Kenyan,

AMPATH started as an academic partnership; the American faculty would come and work here and support our very young and very small faculty. They [North Americans] would benefit by the fact that they are working within an environment where infectious diseases are rife. So they get the exposure, and their students would also get an encounter with diseases that they only read in books. They don't often see them there, but they come and see them here. So they would benefit from that. Here they see things that they would never have seen in their own environment.

Nearly all participants, students and professionals alike, expressed their perception that the North American partners gain a lot from the opportunity to engage in research on these diseases, over and above helping in treating them or managing them where treatment is unavailable.

One of the MSc students under the IU-Moi AREP from Moi University observed the following during an FGD regarding the interest of North America in Kenya:

I think they have big interest in research going on in Kenya and especially in these prevalent diseases, HIV and related cancers. There is a lot of new information from Africa itself.

The opinion of a majority of participants reflected a lot of this kind of contribution from Kenya as benefits that North America gains from Kenya, as it will emerge later in this study.

Evidently, North America contributes massively to the IU-Kenya Partnership. Much of the contribution from North America is in the form of funding, as was pointed out by a number of participants in this study. The principal funder of the Riley Mother and Baby Hospital in Eldoret pointed out the following:

I raised ~\$3 million (with my wife) from private donors to build the Riley Mother and Baby Hospital.

A chapter on international strategic partnerships records that this \$3million donor fund was coordinated by James Lemons, a renowned neonatologist based at Indiana University (9).

A Kenyan, pointing to the huge contribution by North Americans to the partnership observed:

An individual person from North America collected money and came and built the Mother and Baby Hospital (RMBH) here. For the Chandaria building (Chronic Diseases and Cancer Centre), 4 million dollars was pumped in by an individual from the partnership (with some contribution by a Kenyan philanthropist), and across there, you can see the AMPATH Centre and the paediatrics hospital [Shoe4Africa].

Another North American also referred to North America as the source of donor funding for the IU-Kenya Partnership:

I have been working with donors in the West to get money to build a CCU cardiac union at MTRH as a tangible structure, not so much the building, but all the people that are involved in the actual building. So there has been benefit at Moi Teaching and Referral Hospital.

Finally, the funding of the IU-Moi AREP by the Fogarty International Center at the National Institutes of Health in the United States (9, 10) is evidence of how North America has made significant contributions in terms of monetary funding to the IU-Kenya Partnership, which is a great benefit to Kenya. Moi University is one of the only two institutions offering postgraduate training in Bioethics in Kenya.

In terms of benefits that accrue to partners, study participants observed that there are specific types of benefits for each party in the IU-Kenya Partnership: Kenya appears to enjoy more material gain and North America gains non-material benefits akin to Aristotle's "honour." In the following lines we present sample voices from some participants that point to this perception:

Benefits to Kenya

i. Capacity strengthening for Kenyan partners by training, mentorship, and funding

Moi University investigators here get access to North American

mentors and networks, resources they otherwise would not have access to. These would be very important for their training and development. (North American participant)

Mentoring of young Kenyan investigators in research and building capacity for young Kenyan faculty and healthcare providers is one of the major benefits that Kenyans have gained. (Kenyan participant)

There is developed capacity to treat heart diseases through training individual doctors, nurses, technicians etc. (North American participant)

When asked to indicate specific opportunities that have benefitted Kenyans in mentorship and capacity strengthening, many respondents cited the fully-funded undergraduate student exchange programmes for Moi University students:

You know we are fully sponsored. (MBChB student)

We get funding from the respective North American universities for our airfare and accommodation over there which is a benefit to us. (MBChB student)

The exchange programme for undergraduate students referred to by the aforementioned participants is one of the items documented in the memorandum of understanding between institutions in the IU-Kenya Partnership. The memorandum reads: "As part of the bilateral exchange, AMPATH Consortium partners provide full scholarship support each year for selected Moi University medical and dental students to participate in 6 week electives in North America."^{iv}

ii. Increased research activities leading to high university ranking

One criterion for measuring the performance of universities world over is research capacity and research outputs in universities. The IU-Kenya Partnership has contributed to increasing health research activities at Moi University particularly within the College of Health Sciences, thereby boosting the rating of Moi University locally and globally. According to a Kenyan participant:

I think the partnership is good, and it has made the College of Health Sciences to be the top publisher in the whole University, and this raises the university ranking nationally and internationally.

This compares with the observation by Tierney et al (5): "In the development of this institutional culture, momentum has been added by the faculty and administration, noting that the reputation of Moi University has been nationally and internationally enhanced by research publications" (5: p S634). The IU-Kenya partnership has initiated Moi University into the culture of academic publications in high end peer review journals.

In July 2017, Moi University was ranked top in Kenya and 14th in Africa by the Webometric Ranking of World Universities.^{vi} While there are several international university ranking systems that use different metrics the Webometric Ranking is significant as it focusses on online visibility of institutions in terms of

research publications. The publication activities of the College of Health Sciences visible through various online journals, most of which are generated through the IU-Kenya Partnership, contribute much to this ranking.

iii. Healthcare infrastructure and institutions leading to improved healthcare for the community

The major health institutions in Kenya that the IU-Kenya Partnership takes pride in are the Moi Teaching and Referral Hospital (MTRH) and the AMPATH facility. MTRH is the second major public referral teaching hospital in Kenya, serving approximately 25 million people. Within MTRH, a couple of specialised health institutions and facilities have been developed through the partnership including the Riley Mother and Baby Hospital, Chandaria Cancer and Chronic Disease Centre, the Paediatrics Hospital (Shoe4Africa), the National Chaplaincy Training Centre, and the Cardiac Care Unit.

Some participants in this study identified how the IU-Kenya Partnership contributed to the establishment of MTRH as a healthcare facility that Kenyans benefit from in terms of availability of health services.

The building (MTRH) you are sitting in right now is part of the outcome of this collaboration. (North American)

The contribution of the IU-Kenya Partnership to the establishment and continued development of MTRH cannot be overemphasised. Before the partnership,

MTRH had only a 6-bed medical-surgical intensive care unit, and no adult cardiologists. A paediatric cardiologist ran a half-day paediatric cardiology clinic, whereas general internists staffed the adult cardiac clinic. Diagnostic equipment included 1 electrocardiogram machine, a treadmill, and an echocardiogram machine (HP Sonos 2500 [Hewlett Packard, Palo Alto, California])—all nearing the end of life. There were no monitored beds or defibrillators outside of the intensive care unit and operating rooms. There were no trained cardiac nurses, and there was no formal training for echocardiography technicians. Even routine diagnostic tools, such as portable chest x-ray and ultrasound machines, were often unavailable, and stock-outs of medications and laboratory reagents were frequent (11).

Today, MTRH has an 800-bed inpatient capacity; a busy casualty/emergency department; and medical, surgical, paediatric, maternal, and outpatient clinic facilities providing care to more than 600,000 patients annually (11).

On its part, AMPATH began with a mission of identifying and treating HIV among infected persons in MTRH's catchment area. This expanded the clinical service mission of the IU Kenya Partnership, and it also embarked on research and development missions (5). This mission has since been transformed into addressing primary care and chronic disease management (9). A North American participant in this study underscored how the transitional progress of AMPATH from concentration on HIV management to the current expanded

health services is a benefit in terms of promotion of healthcare in Western Kenya. The same was observed by a Kenyan participant:

Think about the care programme of AMPATH: providing free treatment to close to 100, 000 HIV patients; providing care to diabetes patients. The oncology programme, one of the biggest we have in the country, is run under the auspices of AMPATH care programme, and it is highly subsidised.

The presence of these healthcare institutions and facilities has been of great benefit in enhancing accessibility and improved healthcare services in Western Kenya, a region with a high burden of disease. For example, with reference to the Riley Mother and Baby Hospital in Eldoret, a North American participant observed:

The quality of care has improved dramatically over the years, in part because of the facility ... growth of ordinary birth to over 20,000 deliveries annually with over 100 babies in the neonatal intensive care unit daily.

Another North American participant observed:

We were caring for people who had advanced heart disease in the general medical ward, which is not ideal. Now we have a Cardiac Care Unit where we can treat those patients the way they need to be treated.

This suggests that the partnership has improved health service delivery in Kenya through the provision of additional needed facilities and expertise at MTRH.

iv. Ethics capacity strengthening

As mentioned earlier, through the IU-Kenya Partnership, a research ethics capacity programme was established through a research and training grant by Fogarty International Center/NIH (NCD-LIFESPAN (D-43) Fogarty ethics training grant. This programme, referred to as the IU-Moi Academic Research Ethics Partnership (IU-Moi AREP) is a bioethics training programme that runs simultaneously in Moi University and Indiana University (10). IU-Moi AREP established twin Master of Science courses in International Health Research Ethics at Moi University in Kenya and Indiana University in the United States, respectively. The present authors are beneficiaries of this course and do hereby declare conflict of interest. In the course of their discussion in this paper, they may share and express subjective experiences of being in the programme, but they have made considerable effort to ensure the objectivity of the analysis, findings, and conclusions. The ethics capacity strengthening programme of the IU-Kenya Partnership is a reflection of the effort to strengthen the research ethics training programmes in sub-Saharan Africa, mainly supported by the United States (US) National Institutes of Health. It is part of the fulfilment of the recommendation by the US National Bioethics Advisory Commission (NBAC) to US research sponsors to, among other objectives, build the capacity of research ethics committees in developing countries to conduct scientific and ethical review of international collaborative research (12).

In addition, the IU-Moi AREP initiated a series of annual research ethics capacity strengthening workshops targeting various stakeholders in health research in Kenya and North America. The workshop series popularly known as Teaching Skills in International Research Ethics (TaSkR) is an annual three-day teaching workshop on pedagogical skills in research ethics that would rotate between Indiana and Kenya (10). There are also short courses in health research ethics customised for researchers, ethics reviewers, and students.

Even though the programmes at Moi University and Indiana University are meant to benefit each side of the partnership, evidently Moi University and Kenya, in general, seems to benefit more because, this is not only the maiden programme but also one of the few postgraduate research ethics training programmes in Kenya. One of the students in the IU-Moi AREP MSc programme opined in an FGD that "much effort for capacity building is put in Kenya." In total, since its inception in 2010, the programme has enrolled more than 40 students in Moi University. At Indiana University, only 3 students have been trained. Following this training, some graduates in Kenya have shown excellence in Bioethics.

Another graduate of this programme observed the following during an FGD:

IU-Moi AREP has made us start participating in national bioethics policy formulation. A student is expected to graduate and start giving input to the community. Secondly, it has given us exposure, and it has trained personnel who could teach research ethics at the universities.

Ethics capacity strengthening is seen through tangible contributions by both continuing students and graduates of the programme in Kenya. Some of the graduates of the IU-Moi AREP have excelled in various fields after the training (13). For example, this paper titled "The Aristotelian model of friendship and the IU-Kenya Partnership", and another published paper by the same authors titled, "Relevance of international collaborations in promoting sustainable development: The case of IU-Kenya Partnership" (13) are products of a doctoral study by one of the authors; while the co-author is serving as a member of the *Medecins Sans Frontieres* Ethics Review Board (MSFERB) (13). Other trainees in the programme have joined institutional research ethics committees in various universities across the country.

Benefits to North America

North America would benefit from the aspects that Kenya contributes to the partnership. These are discussed in the following paragraphs.

I. Improvement of capacity and knowledge on tropical and other infectious diseases

As has already been mentioned above, some Kenyan and American participants expressed their perception that although the IU-Kenya partnership promotes local capacity to make contributions towards addressing challenges in Kenya, it

also provides opportunities for North Americans to learn about tropical and other infectious diseases. This strengthens their capacity to manage diseases in their work across the world and in North America, should they face similar health challenges.

II. Improvement of university status/ranking in North America and academic progress for faculty members and researchers

Kenyan participants indicated that when North American partners do research, teach, or serve in Kenya, they boost their individual curriculum vitae and the standing of their institutions. Confirming this, a North American participant observed:

It [the partnership] is a wonderful source of training, education and research opportunities for young North American physicians and researchers. It is, hopefully, continuing to be a major source of support and collaboration for senior medical educators like me. I'm primarily in patient care and education, but it is the same thing that we benefit by being able to work with our seniors and trainees here. For the academic careers, the universities and faculties, I think, it provides support, encouragement, and collaboration for their academic careers (advancement of North American partners' academic career). When you are in academics your promotion depends on whether you are productive. North American academic careers are built here. There are people who would not be where they are now in North America if it were not for their work in Kenya.

A similar perception was shared by one MBChB student from Moi University:

When the North American students come here, they learn more on how to carry out physical diagnosis of diseases; how to look at the physical symptoms, do medical examination different from the way they do it back to their country, which is by use of medical equipments and machines.

Evidently, Kenya provides teaching and learning opportunities for North Americans, which goes a long way in contributing to their capacity strengthening in healthcare and research. McIntosh and Kamaara (9) observe that it is common to hear United States' medical students and residents reflect on how much better they have become as medical practitioners as a result of their hands-on experience in Kenya. Instead of relying on exhaustive tests, which are not freely available in Kenya, the students learn to rely on their eyes, ears, and hands for their diagnoses and treatment.

North American universities and partners also benefit in marketing their institutions. A North American participant explained:

At a broader level, it made all of us who've worked here progress in our careers; our careers are largely predicated upon this model, and this has created all these opportunities for us. My university has made AMPATH partnership one of the big projects, and that is why most of the incoming students actually choose [the] University [in North America].

This observation alludes to the idea that a North American University became visible because of its engagement in the IU-Kenya Partnership. This is reflected in all other North American universities within the consortium.

III. Pride and the satisfaction of altruism

Beyond the tangible benefits mentioned above, North American institutions as well as individuals within the IU-Kenya partnership take pride in partnering with institutions and individuals from the global South. This leads to self-realisation and personal satisfaction. A North American participant opined:

Most of the North American universities would like to take pride in their international collaborations and partnerships. I know for a fact that what is happening here at Cardiac Unit at MTRH is something the Duke Global Health partners are proud of, and I am happy to see it happening, and I am happy to have been part of it. One way that translates into more tangible benefit is the opportunity for exchange of trainees between Eldoret and Durham.

A Kenyan participant concurred. She observed:

Whether it is that personal feeling that they have done some good or just recognition that they are working with an African nation; to me that is still a benefit, but how to quantify that I can't tell compared to what our communities are receiving here.

One MBChB student from Moi University shared what she discussed with some students from one of the partnering North American universities on how they benefit. According to her, one of the students said:

I develop the sense of wanting to help the less fortunate in the world.

The data given in Table 1 about the kind of contribution and the type of benefit that partners in the IU-Kenya Partnership experience places the partnership at the level of unequal friendship under the Aristotelian spectrum. The "good" in this partnership is represented by the benefits that each partner gets from the other and the continued cordial relationship among the parties.

However, the partnership also faces what can be termed as the "bad." The trajectory created by the inequality in the partnership represents the "bad" in the friendship because it is the basis for other challenges as pointed out by participants as presented below.

Inequality as a major challenge in the IU-Kenya Partnership

Inequality emerged as a major challenge in the IU-Kenya Partnership. A Kenyan participant expressed a variety of ways in which inequality is manifested in the IU-Kenya Partnership:

The big one is about compensation, the other one could be publishing. We don't have time, and the internet is not as fast, so you cannot get information fast like the people in North America. So that is a challenge. Another challenge is that, if you are in a project you can't access the data they have taken because all the data is managed in IU.

The following table summarises the preceding discussion.

Table 1 Comparing contributions and benefits of partners within the IU-Kenya Partnership		
Partner	Contributions	Benefits
Kenya	<ul style="list-style-type: none"> ✓ Ready field for research ✓ Population for research ✓ Teaching and learning opportunities ✓ Strengthening capacity of North Americans 	<ul style="list-style-type: none"> ✓ Capacity strengthening for Kenyan partners by training, mentorship, and funding ✓ Healthcare infrastructure and institutions ✓ Increased research activities leading to high university ranking ✓ Improved healthcare for the community ✓ Ethics capacity strengthening
North America	<ul style="list-style-type: none"> ✓ Funding from private donors to build the Riley Mother and Baby Hospital, Shoe4Africa, and (partly) Chandraia Chronic Diseases Centre ✓ Millions of dollars in the form of funding to sustain projects and programmes of the IU-Kenya Partnership ✓ Looking for, writing, and bringing in grants 	<ul style="list-style-type: none"> ✓ Improvement of capacity and knowledge of tropical and other infectious diseases ✓ Improvement of university status/ranking in North America and academic progress for faculty members and researchers. ✓ Pride and personal satisfaction for altruism

Tierney et al (5) and McIntosh and Kamaara (9) have also mentioned differences in income as one of the challenges to equity and fairness in the IU-Kenya Partnership.

However, a North American participant had a different perspective on the specific issues of compensation or differences in income. According to her, this is only a perception:

Some partners think that just because we come from North America, we make a lot of money. But most of my Kenyan research collaborators make a lot more than I do. Their expectations about their salary support are unrealistic and inconsistent with reality of grant funding.

A North American participant also raised the challenge of authorship, which sometimes leads to conflict between Kenyan and North American partners. He pointed to a possible cause of this:

English is sort of the "lingua franca" of science globally, while in Kenya, English is often people's secondary or third language. This makes it very difficult for Kenyans to get grant funding and have their papers published in high impact journals. That creates some sort of structural inequality, whereby people here are much disadvantaged and almost excluded without a lot of additional support and not succeeding in such kind of an environment, with exceptions obviously.

Another North American participant mentioned difference in training between North America and Kenya as another cause of inequality. He observed:

We may both have a PhD in epidemiology, but what you may have accomplished in your epi-PhD may have been very different and does not position you to be a successful researcher globally because the training was not adequate, not because you are not capable, but because the training that you received was weak and was just not adequate, not enough to really prepare you to be a global health researcher.

This aspect may be the perception of an individual participant; but perceptions matter. The perception suggests an element of superiority in the North American educational system over the Kenyan education system, which propels the issue of inequality further.

One of the issues related to the struggle to maintain equality of partners was pointed out by another North American participant when he explained:

Trying to ensure that there is parity in the relationship with my counterpart is a real struggle. Think of it, I'm always away, coming in from North America, I think people automatically look at me differently, and when I am dealing with leadership here, I'm viewed differently from how my Kenyan counterpart is viewed.

He expounded:

I come probably from what is perceived to be a privileged position, and as North Americans, we do have a lot of resources, and there are disparities, which we are working hard to try and mitigate. I try hard to ensure that my Kenyan counterpart is involved in the conversation so that we are viewed together and that she is given the same respect that I get.

According to Grant (14), the existing disparities of power, based largely on resource availability (or the lack of it), between partnering institutions in different national contexts may be the main cause of inequality, real or perceived, in academic North-South partnerships.

A Kenyan participant indicated why she thinks inequality should be expected in such an unequal partnership as the IU-Kenya Partnership:

I mean they are the ones [North Americans] who come in with the money; we don't have Kenyan philanthropists giving money to such projects. So, of course, they feel like they should have the upper hand; and indeed, they should because it's

their money we are benefiting from. So such things sometimes bring a lot of conflict.

In an FGD, MBChB students from Moi University who had done an exchange programme in North America indicated a direct form of inequality in the relationship: they would not be allowed to engage in some learning activities while in North America, but North American students would engage in similar activities in Kenya. One of the MBChB students from Moi illustrated:

The difference comes in where we don't get to give medications and dressing wounds, while I have noticed that they (North American students) do it here. When we were there [North America] we could only clerk (vii Orientation manual: p 68) patients, but we would not prescribe medication.

An incidence of inequality is implicitly evident in this situation. It implies a fundamental difference between the way Kenyan and North American students are treated, and it appears that North American students are treated as superior.

Discussion

The IU-Kenya Partnership is a prototype of the successful collaboration between HICs and LMICs in healthcare and health research. Its "good" aspect is seen in the perception that, by and large, the North American partner has striven to live up to the expectation of the global development paradigms by advancing the agenda of improving the health situation of a developing country (15). The "bad" aspect of this "friendship" is evident through the negative aspects emanating from the perceived inequality between the partners involved in the partnership.

We have analysed perceptions on the desired and undesired aspects of the IU-Kenya Partnership. The analysis suggests that both North America and Kenya make contributions to the partnership and they both get commensurate benefit from the partnership. The contributions and benefits are significant in sustaining the partnership and justifying continued international partnerships in healthcare and health research.

However, North America appears to make a huge contribution to the IU-Kenya Partnership, particularly in terms of donor funding. This funding is largely derived from a broad base in North America, including federal grants such as USAID, the Presidential Emergency Plan for AIDS Relief (PEPFAR), the National Institutes of Health (NIH), individual donations, local Indianapolis institutions, and private and public foundations (v Orientation manual: p 11). A great part of the kind of contribution that North America invests in Kenya is in terms of tangible resources, including healthcare facilities and infrastructure, donation and funding for healthcare, and research and capacity strengthening of Kenyan partners. Kenya, on the other hand, makes a different kind of contribution: it provides fields and populations for health research, healthcare, and medical education reflecting the

mission of the IU-Kenya Partnership. It would appear that this is a desirable global partnership between "unequal partners."

There seem to be particular benefits associated with each partner. The contribution of one partner translates into a benefit for the other partner. Benefits to Kenya mainly resulting from the contributions by North Americans may be summarised as capacity strengthening for Kenyan partners by training, mentorship and funding, healthcare infrastructure and institutions, increased research activities leading to high university ranking, and improved healthcare for the local community. On the other hand, North America gets intangible benefits from the partnership, including knowledge of tropical diseases, improvement of university status/ranking in North America, and academic progress for faculty members and researchers. Another perceived benefit for the North American partners that was identified by some participants is the sense of personal satisfaction through their philanthropic acts of assisting a developing country.

The variance in contributions and benefits of the partners within the IU-Kenya Partnership is interpreted using Aristotle's concept of "friendship among unequal parties." As discussed earlier, in a friendship based on inequality, even though each party expects to get benefits, the superior partner gets more honour, and the inferior party gains more material benefits since honour is the reward of virtue and beneficence, while gain is what ministers to need (8)

Inequality as the undesired aspect of the IU-Kenya Partnership is brought out largely in terms of the various disparities in treatment between the North American and the Kenyan partners. Perhaps one observable reality in the conceptualisation of the IU-Kenya Partnership that may ultimately point to inequality, though it did not come up in the primary data, is the naming of the partnership, IU-Kenya. Why is the partnership called "IU-Kenya"? Indiana University (IU) is one university but instead of matching it with another university, Moi University (MU), it is matched with a country, Kenya. The name IU-Kenya Partnership may create an impression that a single North American university is on par with a country, pointing at an element of inequality.

However, bearing in mind that the IU-Kenya Partnership involves partners from diverse socio-cultural, economic, political, and geographical backgrounds, these challenges are bound to arise. As Tierney et al (5) observed, given the noble mission of the partnership, the challenges encountered could be termed as "Good problems to have..." Still, there are efforts to address the negative aspects of the partnership. For example, there are efforts to harmonise the roles of partners, and there is constant consultation within the partnership. Equitable counterpart relationships is an aspect that has been desired in various projects within the IU-Kenya Partnership as one of the keys to the success of the partnership (v Orientation manual: p 13). But as it is, the aspect of inequality will remain for years to come given the reality of different backgrounds and the contexts of various partners.

Conclusion

From the foregoing, we conclude that the IU-Kenya Partnership, a North-South partnership, in the purview of Aristotle's analogy, is perceived as friendship among unequal parties. That Kenyan institutions in the partnership (Moi University and MTRH) receive major tangible benefits like healthcare infrastructure and institutional capacity strengthening in healthcare, research, and ethics, while the North American institutions and individuals gain from enhanced institutional and individual profiles and enjoy pride of assisting Global South institutions serve to engender such a perception. Each of the parties receives what is commensurate to their status in an unequal friendship; gain (material benefit) for the "inferior" party and honour for the "superior" party. The long standing relationship between the partners in the IU-Kenya Partnership (30 years) suggests that it is a satisfactory and working partnership. This suggests that although the IU Partnership is perceived as a friendship among unequal partners, it is desirable to both partners and therefore a good partnership.

Notwithstanding these benefits, there are challenges that bring out the "bad" of the friendship. The main challenges that remain a bottleneck to establishing an outstanding global collaboration in the IU-Kenya Partnership relate to the intrinsic inequality as observed by various participants in this study. This inequality is perceived through the claims of differences in income between partners, and disparities of power among partners and institutions.

Notably, there have been reports of concerted efforts to overcome inequality challenges in the IU-Kenya Partnership. The desire for mutual partnership is expressed through the acknowledgement that these challenges are a "good thing to have" since both partners recognise that the difficulties provide learning points and opportunities to improve. The effort to harmonise partner roles and to promote equitable counterpart relationships is perceived as the right step towards overcoming the inequality challenge in the partnership.

The tangible contribution made by North America, which ultimately leads to improved healthcare, health training, and health research in Kenya, is expressed as a constructive outcome from the partnership. The contribution of Kenya in providing fields and populations for health research, which ultimately contributes to the advancement of health for humanity, is also perceived to be significant. Ultimately, IU-Kenya Partnership emerges as a prototype of global collaboration between HICs and LMICs.

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Declaration regarding prior publication of similar work:

This article is based on the data from the doctoral studies of David Nderitu and guided by Eunice Kamaara on the theme of 'An

analysis of the Aristotelian analogy of friendship among unequal parties: the case of the IU-Kenya Partnership'. We have published a paper (13) drawing part of this data set and we have cited the same in this manuscript.

Notes

- i See <http://data.worldbank.org/country/kenya>
- ii See AMPATH: Leading with Care. Our Partners (<http://www.ampathkenya.org/our-partners/consortium-members>)
- iii See <http://medicine.iupui.edu/kenya/>
- iv See <http://www.cohred.org/wp-content/uploads/2012/04/COHRED-guidancebookletv-web-ISBN.pdf> and Carvalho et al (2018) <https://gh.bmj.com/content/3/5/e000978.abstract> (accessed 31/03/2019)
- v Indiana University and Moi University School of Medicine, 2016 Orientation Manual www.ampathkenya.org
- vi See <https://www.mu.ac.ke/index.php/resources/2014-12-08-08-22-47/news/588-moi-emerges-top-best-universities-ranked-in-2017-webometrics> accessed on 08/12/2017 The "Webometrics Ranking of World Universities" is an initiative of the Cybermetrics Lab, a research group belonging to the Consejo Superior de Investigaciones Científicas, the largest public research body in Spain. The basic activity of the organization is to carry out a quantitative analysis of the Internet and Web contents specially those related to the processes of generation and scholarly communication of scientific knowledge. See http://www.webometrics.info/en/About_Us accessed on 08/12/2017
- vii 'To clerk' in Kenya means to take a patient's complete history and physical examination. See http://www.ampathkenya.org/media/60910/2013-2014_orientation_manual.pdf accessed on 19th July 19, 2017

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Minor gifts from pharmaceutical companies to doctors: A comparison between psychiatry and general medicine

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Abstract

Pharmaceutical companies in countries that have community-oriented models of healthcare, unlike other countries with highly privatised healthcare systems, such as the United States, cannot legally advertise medications directly to patients. Thus, the physician is entirely responsible for choosing the right medication, and needs to take important professional and ethical concerns into consideration during this decision-making process. Pharmaceutical companies invest considerably in marketing products to physicians. Often, this is in the form of "minor gifts" to the physician. This study examines variations in the number and type of such minor gifts present in the offices of psychiatrists and internists in various medical contexts in Israel. Our results showed that psychiatrists received more minor gifts than physicians in general hospitals. No significant differences were found between inpatient and outpatient psychiatric departments. It is important to increase awareness and highlight the impact of exposure to minor gifts as advertising products on doctors in order to avoid bias and maintain objectivity in clinical judgement regarding pharmacological management of patients.

Keywords: Pharmaceutical, gifts, ethics, physicians

Introduction

A complex and interdependent relationship exists between pharmaceutical companies and the medical system. At the

most basic level, pharmaceutical representatives play an important role in the medical ecosystem as they regularly update healthcare providers about the development of new drugs. Pharmaceutical companies use this opportunity to market medications to physicians and hence influence their prescription decision-making. In the US alone, the pharmaceutical industry invests approximately \$15 billion a year on material regarding their product, gifts to physicians, medication samples, excursions, honoraria and other incentives in order to encourage product prescription (1). In Israel, estimates show that pharmaceutical companies invest more than \$100 million a year in marketing drugs to medical doctors. This averages to a cost of approximately \$10,000 per doctor per year (2).

In Israel, the Ministry of Health introduced a directive in 2018 severely restricting contact between physicians and pharmaceutical representatives, and prohibiting the marketing of prescription drugs directly to the consumer (3). Nevertheless, representatives of pharmaceutical companies continue to provide doctors with a variety of "small gifts" (ranging from pens, notepads, calendars, to laser printers, bags, and decorative accessories) in order to ensure that their company's medications remain foremost in the physician's mind. Thus, whenever doctors are in office, they are surrounded by these marketing gifts, and are hence unknowingly exposed to implicit and explicit advertising.

Many ethical dangers may arise when physicians' prescribing behaviours are at risk of being unduly and disproportionately influenced by pharmaceutical companies (4). This is especially so when many doctors themselves indicate that their prescribing behaviours are influenced by their interactions with pharmaceutical companies and their representatives (5, 6). It may be argued that such marketing is even more dangerous than estimated, since many physicians think that their prescribing practices are not influenced by pharmaceutical companies even though they do accept the contact and their gifts (7).

The study aims to evaluate an important aspect of marketing of pharmaceutical products to physicians. We do this by quantifying so-called "minor gifts" present in physicians' offices in various medical care contexts. Furthermore, we

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