In this issue:

Letter from the Editor Pg2

COVID-19, NCDs, and Climate Change - The 2020 Connection
By Joy St. John, BSc, MBBS, MPH
Executive Director, CARPHA Pg3

Ethics, Food, and Health: A Caribbean Perspective
By Cheryl Machpherson, PhD
Professor and Head, Bioethics Division
St. George’s University, Grenada Pg5

Clinical Research Participation and the Limits of Moral Obligation
By Victor Chidi Wolemonwu, ACMLB, MA PhD (Cand.)
Department of Philosophy
University of Sheffield, UK Pg7

Are Ethics Committee Members in the English-Speaking Caribbean Concerned about Payment Being Inducement?
By Sharmella Roopchand Martin DPT, MSc, Rehabilitation Sci., MSc. Bioethics
Head, Mona Academy of Sport, Mona Campus
The University of the West Indies, Jamaica Pg10

A Review of Regulations Governing Human Participant Research in Jamaica
By Kelly-Ann Gordon-Johnson DPT, MSc, Epidemiology, MSc. Bioethics,
Sharmella Roopchand Martin DPT, MSc, Rehabilitation Sci., MSc. Bioethics
Th University of the West Indies, Mona Campus
Jamaica Pg13

CREEi Graduate is PANCAP’s New Director Pg16

Instruction to Authors Pg17

Conferences Pg18
Welcome to our 2020 Bulletin, which combines both issues in one publication. Our biannual publication schedule has been disrupted by the challenges of COVID in the Caribbean, and, in our efforts to adapt, we are in the good company of our friends and colleagues engaged in health practice and research across the region and beyond. So, the content of these issues has been COVID-affected but is not explicitly COVID-themed. I anticipate that future contributions to the Bulletin will showcase lessons learned from our collective response to the pandemic.

I want to acknowledge that many contributors to (and readers of) this volume have been engaged in truly exemplary service during regional response to COVID. This is evident in the actions of research ethics bodies to develop rapid review mechanisms for studies related to or altered by the pandemic, and in the revitalization of the CARPHA Research Ethics Committee. The creative efforts of our colleagues to provide thorough review of high-stakes, time-sensitive projects in an environment of extraordinary professional and personal demands should be celebrated. Their achievements give essential support to public health and have refined responsive review processes to build resilience in our ethics infrastructure that will bring future benefits in the context of other natural disasters, particularly those related to weather and climate. Along that line, the lead articles in this volume speak to threats posed by climate change (especially to small island developing states) and discuss important policy issues related to NCDs and food production.

See also engaging contributions in other areas, including empirical research on attitudes of Caribbean REC members toward potential inducement of research participants (Roopchand-Martin) and a practical, and constructive, critique of research ethics regulations and procedures in Jamaica (Gordon-Johnson and Roopchand-Martin). Interest from readers and contributors outside the Caribbean continues with an applied philosophical consideration of the moral obligation to participate in clinical research from the University of Sheffield (Wolemonwu).

The pandemic has reminded us of the multiple roles and responsibilities that come with health leadership in small organizations and societies. Members of RECs have balanced critical roles in public health, higher education, direct clinical service, mental health, and emergency management with the demands posed by urgent research proposals. Many of you reading right now have made multifaceted, too often underacknowledged, contributions to national and regional health during unprecedented challenges.

On behalf of CANREC, and personally, sincere thanks and best wishes for a resilient 2021.
COVID-19, NCDs, and Climate Change - The 2020 Connection
By Dr Joy St. John, BSc, MBBS, MPH, Executive Director, CARPHA

“As it is accepted that air pollution causes or exacerbates NCDs, it has been worthy of note that the environmental determinants of climate change and NCDs have been diminished by the non-public health COVID-19 control measures commonly known as the lockdown.”

2020 has been the year a microscopic virus brought the world to its knees. COVID-19 has had and continues to have harsh impacts on health of vulnerable populations and spin off crippling effects on our global economies, especially the economies of travel and tourism-dependent small island developing states (SIDS). Serendipitously, COVID-19 has been good at decreasing impacts that precipitate climate change. This has been an ironic twist to this tale of the COVID-19 pandemic.

The wide cross-section of sectors affected is amazing, and all have had to develop guidelines for safe return to activity. The silver lining in CARICOM has been the leadership shown by the individual ministries of health to prevent importation and spread of disease and, collectively, to ensure coordination of action and understanding of this disease among many sectors. The all-of-society approach to addressing the COVID-19 pandemic has been the hallmark of leadership of the Heads of Government, who have tangibly demonstrated their respect for the scientific guidance of the health sector.

So how can we harness this spirit of collaboration, coordination, and respect for science in building sustainable new ways of living that address the social determinants of NCDs?

How can the leadership of the Heads of Government of CARICOM be harnessed in designing a climate smart, sustainable, green economy that promotes safety in public life?

While I admit that this challenge to address living with COVID-19 was created not only for the CARICOM region, but also other parts of the world, the CARICOM region is well known for its leadership in matters of global import. The global acceptance of the importance of NCDs and the need for a global approach to address NCDs effectively originated from the leadership of the CARICOM Heads of Government.

While the CARICOM countries are not proportionately large contributors to NCDs, they do control the agriculture policies of the region. Of note, the Heads of Government mandated the development of a food security policy specific to COVID-19 that pays close attention to avoiding NCDs.

The CARICOM subregion is still grappling with the current globalisation of its determinants of health while coming to terms with some of the historic determinants of its heavy burden of chronic disease and risk factors.

Climate change and NCDs are two defining challenges of the 21st century. SIDS such as those found in the Caribbean are on the frontlines of climate change, suffering disproportionately major impacts. Climate change is undermining the foundations of good health, threatening the food we eat, the air we breathe, and the hospitals and clinics we depend on. (HCC 2019)

Noncommunicable diseases constitute the largest and fastest growing global health burden, with treatment costs placing a massive strain on government and individual resources (PAHO/WHO 2016).

According to PAHO/WHO, in 2016, countries in the Caribbean exhibited the highest NCD mortality rates of the region of the Americas, where 7 countries have mortality rates above 583.5 per 100,000 (PAHO/WHO 2016). More than 70% of deaths in CARICOM member states are due to NCDs (CARPHA 2019).

The human cardiovascular and respiratory systems are sensitive to temperature change. Increase in temperature increases blood viscosity and can lead to high blood pressure and heart rate: risk factors for cardio-vascular disease. Thus, it can trigger heart attacks, strokes, and other vascular events. Temperature changes can also cause constriction of the bronchial tubes, and exacerbate both concurrent acute and chronic respiratory conditions (Ebi et al., 2006; McMichael et al., 2003). Climate change thus has important effects on these NCDs. Adults who suffer from pre-existing cardiovascular and respiratory diseases, the elderly, children, and outdoor labourers are most vulnerable to this category of impact (CARPHA SPHR 2018).

As it is accepted that air pollution causes or exacerbates NCDs, it has been worthy of note that the environmental determinants of climate change and NCDs have been diminished by the non-public health COVID-19 control measures commonly known as the lockdown, so much so, that recent studies have also shown the reduction in air pollution since the lockdowns as a result of COVID-19. (Bauwens et al., 2020)

Target 3.4 of the Sustainable Development Goals for reduction in premature mortality from NCDs through prevention and treatment and promotion of mental health and well-being by 2030 brings into focus all that is happening with mental health issues during this pandemic.

The onset of the COVID-19 pandemic has caused a massive cultural upheaval for the people of the region. We are by nature beings who thrive on human interaction, and the protocols for preventing COVID-19 spread have brought about sudden disruption of life as we knew it. Social distancing, wearing of facial masks, restrictions of travel and movement, and isolation from friends and school and work are a difficult “new normal” for Caribbean people to tolerate.
One group that deserves particular attention is children. We are well aware that children feel change just as deeply but have not matured to develop coping mechanisms to manage as well as an adult. The US Centers for Disease Control describes mental health in childhood as reaching developmental and emotional milestones, learning healthy social skills, and learning how to cope when there are problems (CDC 2020). Each of these aspects of child mental health has been threatened by COVID-19. Now that we are in the hurricane season, the mental health consequences of disasters, such as those caused by hurricanes, can compound this situation. Chronic stress also increases negative health consequences among people with NCDs and can increase susceptibility to NCDs (Portier et al., 2010).

What can be done about this? Governments, non-governmental organizations, and civil society and faith-based organizations can integrate mental health and psychosocial support interventions for children and adolescents into national plans, not only in the health sector but across all sectors, while providing mental health services. Protective measures can be implemented to reduce the risk factors for developing mental health problems and triggering episodes in persons with mental health conditions. Communication and education to raise awareness of mental health needs for children and adolescents and to promote and support mental health and well-being should be ongoing, even beyond COVID-19.

As with any other topic, and especially in the context of climate change and health, there are ethical issues to consider. In response to the growing demand for research, the reactivation of the Caribbean Network of Research Ethics Committees (CANREC) will ensure an ethical approach to CARICOM research on COVID-19 and its impact in our region.

In many respects, the challenges that climate change and COVID-19 present to CARICOM reiterate the need for ongoing discussion about the vulnerabilities in our region and the ways in which research can fuel evidence-based decision making on the new approaches to sustainable development.

The COVID-19 pandemic has magnified the need for a different ethical approach to the challenges of NCDs and climate change. Part of this new approach is the acknowledgement that the drivers of climate change and NCDs are related: Social determinants, globalization, the lack of access of SIDS to resources contribute to both phenomena and, with the latter also being a threat to the management of the pandemic. It is only at the point where the ethics of inequity are frontally addressed and that the rights of all people to access to health are prioritized that the scourges of NCDs, climate change, and COVID-19 will be overcome.

COVID-19 is a great equalizer. All are struggling to control its spread. Perhaps, in the effort to address how the world can survive COVID-19, we will come to realize the effectiveness of global unity of action. I can only hope this will lead to an honest approach to reversing fundamental inequities and inequalities.

References


The initial lockdowns for the Covid-19 pandemic meant fewer vehicles on the road, in the air, and at sea. As a result, and as widely reported in mainstream international media, air quality improved as carbon emissions declined around the world. Subsequent data will no doubt show declines in respiratory illness during this period. Carbon and other greenhouse gas emissions are released by industries in massive quantities and accumulate faster than they can dissipate (Watts et al., 2018). They continued to rise globally despite the slowdown caused by the pandemic. The more they accumulate, the more pronounced are disruptions to Earth’s air, water, and weather systems. This has consequences for our health and healthcare in the Caribbean and everywhere. One Caribbean manifestation of this is the blurring of traditional dry and rainy seasons, which has been observed and discussed by Caribbean people in all walks of life.

Permitting industrial emissions to continue accumulating and failing to change the business-as-usual approach makes the wealthy wealthier and the poor poorer. Simultaneously, this approach jeopardizes health and wellbeing. With a depth of emotion that displays fear for her own future (a fear shared by this author), the remarkable young activist Greta Thunberg publicly asks political leaders, ‘How dare you?’ referring to their denial and inaction that jeopardizes how well her generation can have enjoyable and healthy lives and raise children of their own. Senior-level responses to Thunberg are for the most part platitudes rather than actions or meaningful changes to business as usual. Authors, readers, and editors of CANREC Bulletin include healthcare professionals who can discuss our respective complicity, inactions, and potential actions. Bioethics is all about questions - what can and should we do?

The Caribbean

For centuries, Caribbean people have taken pride in the lush land that has supplied an abundance of vegetables, fruits, and legumes. Many Caribbean families enjoyed productive fruit trees in their yards or gardens (or growing wild) and small plots for growing food. Nutritious food was readily available at home and in markets. No one in a community or village went hungry for long. Today, yards, gardens, and agricultural plots have been replaced by concrete for housing, commercial structures, and car parks. The Caribbean diet consists heavily of imported and processed food from supermarkets, restaurants, and fast food chains. This situation is also the status quo in many other regions and is a financial boon to the food industry.

Globalization of the food industry has changed dietary intake around the world. Staples of the Caribbean diet today, as elsewhere, are produced, processed, packaged, refrigerated, and transported by corporations to distant locations – losing fiber and nutrients along the way. Much of this food is also unhealthy due to excessive sugar, salt, and chemical additives, but it comprises a large percentage of food available in homes, hospitals, and schools. In addition to greenhouse gas emissions, industrial processes of the food system contribute to air, water, and land pollution, each of which generate more emissions via different mechanisms. Let’s consider the associated health impacts and ethical responsibilities.

The Food System

The ‘food system’ refers to the many interconnected activities involved in food production, processing, packaging transport, and consumption; and related governance, economics, sustainability, waste, and impacts on environments and individual and population health (Oxford Martin Program, 2020). Globalization has affected our food system with numerous impacts on environments and health. These impacts vary with geographic, socioeconomic, and other conditions. The food system has been industrialized and intertwines with agriculture, transportation, and energy industries. This not only affects health, health systems, and healthcare institutions but also the nutritional recommendations they make and the food they provide to patients and staff (Macpherson et al., 2020; Willet et al., 2019).

Globally, the agricultural industry generates 30% of emissions, consumes 70% of freshwater, and uses 40% of land (Willet et al., 2019). It contributes to the impacts experienced around the world (heat waves, vector-borne disease, food insecurity, and more) that threaten life, health, and health systems; health professionals must rise to this challenge (Watts et al., 2018).

By 2050, the world will have 10 billion human mouths to feed. Scientific and public health experts tell us that our food system is not sustainable enough to feed them all, but that it is possible to transform the food system into a sustainable one capable of doing so (Willet et al., 2019). This would mean that globally: i) we cannot increase the amount of land used for agriculture; ii) we must reduce food loss, food waste, water waste, and fertilizer use; and iii) in regions where meat or sugar are consumed in greater volume than necessary for health, we must consume 50% less of each.

The percentages of global emissions produced by agricultural, food, healthcare, and energy industries is considerable to say the least. That these industries and their leaders profit in money and influence arguably means that they have special responsibilities to give back, and to protect, the resources of the countries that host them and the health of the institutions and individuals that consume their products (Macpherson et al., 2020). They also have responsibilities to compensate for harms they’ve done, damage they’ve caused, and free riding on public resour-

“Permitting industrial emissions to continue accumulating and failing to change the business-as-usual approach makes the wealthy wealthier and the poor poorer. Simultaneously, this approach jeopardizes health and wellbeing.”
ces, including water, land, and air. Like those of us in healthcare or academia, they face a moral imperative to reduce their personal, professional, institutional, and industrial environmental impacts. Changing how we eat is one way to achieve this.

**Caribbean Food and Health**

Caribbean nations have for decades had high rates of diabetes and cardiovascular disease. These are at least partly affected by dietary intake. As diets change in response to globalization, these noncommunicable diseases are worsening in the region. Mental health is also affected because our emotions are influenced by the type and quality of food we eat and the social context in which we obtain, prepare, and eat it. Many Caribbean people take less pleasure (and nutrients) from their gardens and more from a run to the supermarket. This has consequences for both mental and physical health and wellbeing.

Caribbean people on large and small islands have come to rely on bottled water; they do not keep small farms because they can buy foods in the supermarket; and food prices keep rising in response to increasingly frequent and severe floods that disrupt water safety and what remains of local agriculture and subsistence farming (Macpherson & Akpinar-Elci, 2015). Caribbean health professionals perceive health impacts on the communities they serve of i) changing seasonal patterns; ii) more extreme floods and droughts; iii) subsequent decreases in agricultural production and food security; and iv) increased hospital admissions for mosquito-borne, water-borne, heat, respiratory, and mental illnesses.

To engage in health promotion means that health institutions and professionals must acknowledge and audit their respective contributions to emissions and engage in related policy, education, and advocacy. We cannot promote health without resources from natural ecosystems, and some of the few remaining undisturbed ecosystems are in Caribbean nations. Our healthcare systems, leaders, and staff have responsibilities to conserve energy, water, and food in their institutions and homes; to protect environments from plastic, pharmaceutical, digital, and other forms of waste and pollution; and to educate and advocate for others to engage in such actions.

No one person or breakthrough will catalyze the changes needed to the food system. Industries, institutions, and professionals therein must work across disciplines and borders to reorient priorities, sustainably intensify food production, partner and coordinate governance of land and oceans, and reduce food losses and waste by 50% (Willett et al., 2019). Caribbean agriculture, food services, and healthcare must engage – and do so now - if we are to have any realistic hope of a healthy and happy future for ourselves, our children, and Thunberg’s generation.

**References**


Oxford Martin Program (2020). Available from: [https://www.futureoffood.ox.ac.uk/](https://www.futureoffood.ox.ac.uk/).


**Resources**

Clinical Research Participation and the Limits of Moral Obligation

Victor Chidi Wolemonwu, ACMLB, MA
PhD Candidate
Department of Philosophy
University of Sheffield, United Kingdom

“If some clinical investigations are exploitative, or even not, is human participation in clinical research morally necessary? Some bioethicists argue that involvement or use of human subjects for clinical research is morally unjustifiable.”

Introduction
Medical research is indispensable for the advancement of scientific knowledge about human biology and enhancement of health and well-being of people through the development of safe and effectual preventive, therapeutic, and diagnostic interventions. However, medical research is a risky enterprise requiring the participation of human subjects. Research shows that some medical research activities are morally problematic because they expose participants to exploitation (Lemmens and Elliott, 1999; Wemos, 2017). Remote and recent past medical research (e.g., the Tuskegee syphilis study in the US, the Pfizer trovafloxacin trial in Nigeria, and the Synflorix trial in Argentina) evidence researchers inhibiting the voluntary consent of research participants by enrolling them using coercive, deceptive, and manipulative means. They exposed the participants to excessive risks in pursuit of some benefits; and the research benefits, which the participants received in the form of incentives, are minimal compared to the risks to which they are exposed.

If some clinical investigations are exploitative, or even not, is human participation in clinical research morally necessary? Some bioethicists argue that involvement or use of human subjects for clinical research is morally unjustifiable. One of the foremost proponents of this view is Hans Jonas. I argue that, even though some medical research activities are exploitative, participation in medical research is a moral obligation. I appeal to David Resnik’s medical efficacy thesis; John Harris’ moral obligation view; and the social responsibility stance of Schaefer et al. to defend this view. However, I conclude that obligation to participate in clinical research is only pro tanto, because it is not an absolute requirement, as other weighty requirements might outweigh it.

Jonas on the Ethics of Medical Research Participation
Hans Jonas (1903 - 1993) believed that ethical inquiry into whether human experimentation should be permissible reveals a fundamental moral conflict between the “individual good and the common good, and between the individual’s welfare and the welfare of the society” (Jonas, 1969, pp. 220-221). Human experimentation is for a purpose. In most cases, it is for the benefit of society. Society benefits from the social value of human experimentation when medical scientists develop new medical remedies.

Jonas argues that an individual may act in the interest of society because they are a member of that society. However, being a member of society does not require one to submit themselves for medical experimentation solely for the benefit of their society (Jonas 1969, p. 231). Individuals who offer themselves for clinical experiments violate their rights and dignity. The wrongness of being a research subject is not only that the society, through the medical researchers, treats the research subjects as a mere means to assuage the needs and interests of the community. Medical experimentation on the human subject is wrong because the researchers treat the research subjects as a kind of clinical research sample or mere token. And, as a research subject, they are subject to the whims of researchers and society, and risk injury or even death (Jonas 1969, p. 235). Jonas’s point, thus, is that clinical research reduces research participants to research objects for scientific use.

The clinical research cases mentioned in the preceding section exemplify Jonas’ worries. The examples also capture the primary motivation of this paper, which is that irrespective of the goal of clinical research, physicians and clinical research investigators are obligated to respect the rights and dignity of research participants and treat them as human beings rather than research ‘samples’. However, it is both scientifically and morally problematic to believe that fear of treating research subjects as research materials should prevent us from asking individuals to participate in clinical research. As Resnik aims to show, the gains of participating in the study (irrespective of the economic status or rational competence of the participants) are far-reaching even if we cannot ignore the issues of exploitation may accompany such participation. I also appeal to Schaefer et al. and Harris to show that it is morally plausible to participate in clinical research as a kind of moral reciprocation. Besides, even if one is economically impoverished or less rationally competent, they still enjoy the social benefits of clinical research. It is morally justifiable, therefore, that they also participate in research to advance scientific and social values for the interests of others (even if they may not benefit from it directly).

Resnik on Scientific Values of Medical Research
Resnik argues that the involvement of human beings in clinical research is necessary because of scientific significance, such that “some of the practical applications of research with human subjects include new drugs, biologics, surgical techniques, and other medical therapies…” (Resnik 2008, p. 2). This implies that, through human participation in clinical research, we can learn about the root cause of certain kinds of ailments, as other means may not offer valid...
scientific outcomes. For instance, it may be challenging to treat Ebola or COVID-19 by restricting tests to only animals or doing only bench science. Invoking human beings in testing helps to elucidate the nature of the pathogen and its impacts on the human body.

Resnik explains that other practical applications of research involving human subjects are in the areas of exercise and nutrition. For instance, through clinical research, we can improve human nutrition, and develop other habits that can enhance our health and well-being (Resnik, 2008). He, however, does not suggest that human involvement in clinical research should be random and arbitrary. On the contrary, Resnik argues that human participation in clinical research requires benefit estimation. In other words, to determine the kind of research that requires human participation, the investigators and the ethics committee must be able to estimate the scientific and social significance of such research. One basic question would be to determine whether the value of such research has significant treatment implications or is merely trivial. Another important question is whether particular research can advance medical knowledge and enhance professional skills. These questions are a guide to determine whether clinical research is valuable or not and whether it is reasonable to participate in such research.

**Harris on the Moral Significance of Medical Research**

For John Harris, participation in biomedical research is not just a social responsibility but a moral obligation, because the research itself is a very valuable venture that may not come about unless people volunteer. Since we benefit from the product of the research, we are morally obligated to also participate in the process, whose outcome we have also enjoyed. Harris lists two basic moral imperatives that underpin human participation in biomedical research, which are: ‘the principle of non-maleficence’ and ‘the principle of fairness’. The principle of non-maleficence, or the rule of rescue, which obligates a person not to harm others, is the highest form of obligation. How does the rule of rescue denote non-maleficence? The idea of rescue implies that “where our actions will or may probably prevent serious harm then if we can … (given the balance of risk and burden to ourselves and benefit to others) we clearly should act because to fail to do so is to accept responsibility for the harm that then occurs” (Harris, 2005, p. 242). A healthy participant who refuses to participate in a research protocol that would help to tackle emerging diseases, according to Harris, would be held morally accountable for the harm resulting from their refusal.

The second moral obligation is fairness. This principle holds that, since we benefit from the outcome of medical research, it is morally necessary to participate also to ensure the continuation of the beneficial outcomes of the medical research, especially for future recipients. Harris asserts that many of us would not be here in the absence of antibiotics. Since we benefit from the use of antibiotics, we have a moral obligation to contribute to the social practice that produces those medical remedies (Harris, 2005, p. 242). Even if one argues that they did not sanction the production of such medical remedies and that their parents administered those medications while they lacked both capacity and agency to consent as children, Harris, nonetheless, believes that it is morally unjustifiable to enjoy the benefits of products of research and subsequently halt their future developments (Harris, 2005, p. 243).

Individuals have benefitted from the social practice of medical research, even though some never asked for such benefits. Harris raises two points here: The first holds that if agent A autonomously decides to benefit from the products of biomedical research, it would be morally unjustifiable (given the principle of fairness) not to participate in the process of ensuring that others also benefit from the future outcome of the same research. The second holds that, even though we did not choose to enjoy the medical benefits derived from previous research, it is still morally wrong and unfair not to participate in the process that would ensure that others benefit in the future. One may argue that since agent A did not choose to receive the benefit, it would be unfair to persuade her to participate in such a process against her will. Harris’ response to this is that issues that concern public good are morally obligatory. Others contributed to this process, and that was why she was able to enjoy the product of the research, even though she did not request it. She received the benefit of the research because her parents or guardian felt that it was beneficial for her. If she refuses to participate in the same process from which she benefitted, she will deny others (both the competent and incompetent autonomous agents) the same benefits she enjoyed. Such an act, according to Harris, is unfair and morally unjustifiable. The only fair and morally justifiable course of action is to participate in the process for the benefit of others.

**Schaefer et al. and the Social Responsibility Thesis**

Participation in biomedical research is the social responsibility of all human beings because the research itself is for the common good. Participating in biomedical research is a way of contributing to the sustenance of this common good, which is the development of treatments for diseases. Therefore, any action that aims towards the common good of society ought to be obligatory (Schaefer et al., 2009, p. 68), provided the participating agents are not exploited by it, or, at least, that it costs the agents only a little. Schaefer et al. are not clear whether it is a violation of the principle of the common good for individuals not to participate in harmful trials. Their argument holds that, where biomedical research helps to tackle medical challenges in a society, the members of that society have a social responsibility to be part of the research protocol. It is pertinent to note that the principle of acting based on common good does not imply sacrificing one’s life for the common good, as Jonas rightly points out, though Schaefer et al. do not make this distinction clearly.

**Conclusion**

It is plausible to say that human beings in society must participate in the processes that facilitate the advancement of new knowledge and efficacious medicines to improve the health and well-being of everyone. This obligation is only pro tanto because it is not an absolute requirement, as other requirements might outweigh it. For instance, no one obliges an individual to participate in a research protocol in which the research shows that the risks are high, even though the research outcome would be for the benefit of all. If, for instance, there is a clinical protocol to test a trial drug for the cure of HIV, the protocol might require that one group of the participants be administered retroviral drugs while others receive a placebo. Researchers are legally and morally obligated to show evidence of quick intervention to protect participants from risks of harm from the research participation. Where such interventions are not available, it is morally obligatory not to enrol anyone in the protocol since their well-being outweighs the potential benefit from research outcomes. In other words, irrespective of the goal of medical research, the moral obligation of investigators is to conduct studies in the right way, for the right reasons, and with respect for human
participants involved. This is because the dignity and well-being of research participants ought to precede the interests of society.

References


Are Ethics Committee Members in the English-Speaking Caribbean Concerned about Payment Being Inducement?

By Sharmella Roopchand Martin DPT, MSc. Rehabilitation Sci., MSc. Bioethics
Head Mona Academy of Sport, Faculty of Sport,
The University of the West Indies, Mona Campus, Jamaica

“When the concept of financial compensation extends to paying research participants, it becomes a topic of heated debate amongst bioethicists, members of research ethics committees, researchers, and sponsors of research”

The offer of monetary payment for services rendered is a normal occurrence in our daily lives. We pay the barber for a haircut and the employees at a carwash to clean our cars, and we tip our waiters and waitresses for good service at restaurants. The offer of incentives to encourage someone to do something is commonplace; it is considered quite acceptable and, in some cases, is encouraged. In many workplaces, for example, it is not uncommon to offer bonuses to employees if they meet or exceed a performance target. This incentive is offered to motivate employees to work harder than they normally would. When the concept of financial compensation extends to paying research participants, it becomes a topic of heated debate amongst bioethicists, members of research ethics committees, researchers, and sponsors of research. Some are directly opposed to payment because of the belief that it may lead to persons taking unnecessary risks, especially those who are in desperate financial circumstances (McNeill 1997, London 2005). Others argue that financial incentives are acceptable because participation in research involves commitment of time and effort for which people should be paid, as well as risks (the level of which has hopefully been deemed acceptable by an ethics committee) (Emanuel 2004, 2005; Grady, 2005; Dickert and Grady, 2008). The topic becomes even more complicated for multinational trials in which variation in income level and exchange rates among countries can lead to concerns regarding exploitation (Phillips, 2011; Arnason & Van Niekerk, 2009; Emanuel, Currie, & Herman, 2005). Generally, concerns regarding payment of research participants fall into three categories: undue influence or inducement, exploitation, and biased enrolment (Resnick, 2015).

Also known as undue influence, inducement in research has been described as an incentive (financial or otherwise) that would make a person deliberately seek to conceal information or ignore personal values and preferences to be part of a study (Macklin 1981; Dickert & Grady, 2008). Emanuel (2004, 2005) suggested four key characteristics to classify an offer as being undue inducement: (1) the offer includes something desired by the induced; (2) it appears excessive or irresistible; (3) it produces bad judgement; and (4) it engenders the risk of serious adverse event for the induced. These characteristics imply that there is some monetary value at which good judgement will be “thrown out the window”. This issue, however, is not so simple. There are numerous factors that affect individual decision making, including social, cultural, and economic contexts (Klitzman, 2005). What an outsider may perceive as bad judgement may, in fact, be very sound analytical decision-making by an individual who has carefully weighed the advantages and disadvantages of research participation, the payment offer, and their current circumstances.

Much of the concern related to undue inducement is centred around risk. However, a study should not begin without ethical review and approval by an ethics committee, and one of the key considerations in this review process is risk and benefit analysis. If an ethics committee has determined that the risks of a study are commensurate with the anticipated benefits to individuals and the scientific and social value of the research, then arguments related to persons taking more risk than they normally would are not very compelling. In fact, if participants understand the risks involved, whether or not (or how much) they are paid should not matter. One could further argue that, since research participants are taking risks that may not result in any real benefit to them, they should be paid. By extension, for higher risk studies participants should be paid more than for lower risk studies. This is regularly done in other sectors. It is not uncommon, for example, for employers to pay higher salaries for jobs involving higher risk. Examples of this include airline pilots, professional athletes, offshore oil rig workers, and astronauts. These persons are aware of the higher risks of injury, disability, and death associated with their chosen profession and are willing to accept them.

Some empirical research has shown that, whilst payment is more likely to encourage participation in research, it does not necessarily alter participant’s perception of risk (Breitkopf et al., 2011; Bentley & Thacker, 2004; Halpern et al., 2004; Singer & Couper, 2008). For example, Bentley and Thacker found that persons were more likely to participate in research if money were offered. While there was an association between offers of money and potential research participants not disclosing personal or medical information that would jeopardize their inclusion, this was not affected by the risk level of the study. In fact, participants concealing information was associated with low- but not high-risk studies. Similarly, respondents in a study conducted by Breitkopf et al. (2011) indicated that persons should be paid more for higher risk studies. These survey respondents did not perceive payment as something that would make persons parti-
cipate in studies that were unacceptable to them. Halpern et al. (2004) also found that payment did not affect risk perception and, contrary to common concerns that poor persons are more likely to be induced to participate in research, offers of payment positively influenced the willingness of wealthier persons to participate in research (Halpern et al., 2004). Although these studies suggest that concerns regarding payment being undue inducement may be unjustified, it is important to note that findings were based on theoretical cases and may not hold true for real-world offers of payment.

I summarize below results from a recent survey in the English-Speaking Caribbean exploring concerns of ethics committee members when making decisions about payment of research participants. A total of 49 members of ethics committees (29 females and 20 males) completed all or part of the survey. A small percentage of respondents indicated that their committees often reviewed proposals offering compensation (6.3%). However, when proposals did offer compensation, the majority indicated that the amount being offered was always scrutinized (58.3%). Member places less importance on the timing of monetary offers, as only 33.3% of respondents indicated that their committee scrutinized this aspect of participant compensation.

Inducement was clearly a concern when committee members evaluated offers of money. 70.2% of participants were “very concerned” that offers of money would influence decision to participate in a study; 80% were “very concerned” that offer of money may compromise evaluation of risk; and 80% were “very concerned” that offers of money may influence persons to participate in a study that they would not normally consider (Table 1).

Table 1. Participant Responses to Questions Related to Inducement (N= 48)

<table>
<thead>
<tr>
<th>Question</th>
<th>Not concerned (%)</th>
<th>A little concerned (%)</th>
<th>Somewhat concerned (%)</th>
<th>Moderately concerned (%)</th>
<th>Very concerned (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>offers of money may influence potential research participants’ decisions to participate in a study?</td>
<td>4.3</td>
<td>4.3</td>
<td>8.5</td>
<td>12.8</td>
<td>70.2</td>
</tr>
<tr>
<td>the offer of substantial payment may compromise a subject’s ability to understand and appreciate the risks of a research study?</td>
<td>0</td>
<td>4.4</td>
<td>2.2</td>
<td>13.3</td>
<td>80</td>
</tr>
<tr>
<td>the offer of substantial payment may compromise a subject’s ability to understand and appreciate the benefits of a research study?</td>
<td>2.2</td>
<td>4.4</td>
<td>13.3</td>
<td>20</td>
<td>60</td>
</tr>
<tr>
<td>the offer of substantial payment may induce participants to enroll in a trial they would not otherwise consider?</td>
<td>0</td>
<td>4.4</td>
<td>2.2</td>
<td>13.3</td>
<td>80</td>
</tr>
<tr>
<td>the offer of substantial payment may induce participants to remain enrolled in a trial from which they would like to withdraw?</td>
<td>0</td>
<td>11.1</td>
<td>6.7</td>
<td>31.1</td>
<td>51.1</td>
</tr>
</tbody>
</table>

A few questions gauged participants’ perceptions of inducement and coercion (Table 2). Whilst 43.2% strongly agreed that there was a conceptual difference between the two, there appeared to be some confusion as to what the conceptual difference is. When given the statement “research subjects are coerced if the offer of payment makes them participate in research they would not otherwise participate in” sixty-six percent indicated some level of agreement with this statement. This was an incorrect response since this statement reflects inducement not coercion. A small percentage (6.8%) did not recognize that the statement “an offer of payment is an undue influence if it distorts a subject’s ability to perceive accurately the risks and benefits of research” represent inducement. Similarly, a small percentage did not recognize that an offer of payment is an undue influence if the payment prompts the subject to lie or engage in other forms of deceit to get into a research study.

In conclusion, inducement is a major cause of concern among ethics committee members in the Caribbean when reviewing protocols involving payment of research participants. Whilst most appear to have a good understanding of the concept of inducement, a small percentage did not. It is important that ethics committee members are clear in their understanding of inducement, and committees to should provide education for their members regarding the distinction between inducement and coercion.
Table 2. Respondents Perceptions about Coercion and Inducement (N = 44)

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly agree</th>
<th>Somewhat agree</th>
<th>Neither agree nor disagree</th>
<th>Somewhat disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is a conceptual distinction between coercion and undue influence.</td>
<td>43.2</td>
<td>22.7</td>
<td>11.4</td>
<td>6.8</td>
<td>15.9</td>
</tr>
<tr>
<td>Research subjects are coerced if the offer of payment makes them participate in research they would not otherwise participate in.</td>
<td>50</td>
<td>16</td>
<td>2</td>
<td>14</td>
<td>18</td>
</tr>
<tr>
<td>An offer of payment is an undue influence if it distorts a subject’s ability to perceive accurately the risks and benefits of research.</td>
<td>70.2</td>
<td>15.9</td>
<td>2.3</td>
<td>2.3</td>
<td>6.8</td>
</tr>
<tr>
<td>An offer of payment is an undue influence if it prompts the subject to lie of engage in other forms of deceit to get into a research study.</td>
<td>70.5</td>
<td>15.9</td>
<td>2.3</td>
<td>4.5</td>
<td>6.8</td>
</tr>
</tbody>
</table>

References


A Review of Regulations Governing Human Participant Research in Jamaica

By Kelly-Ann Gordon-Johnson DPT, MSc. Epidemiology, MSc. Bioethics1, Sharmella Roopchand Martin DPT, MSc. Rehabilitation Sci., MSc. Bioethics 2

1. Ministry of Health and Wellness, Jamaica
2. Mona Academy of Sport, Faculty of Sport, The University of the West Indies, Mona Campus, Jamaica.

“A recent survey by the Caribbean Public Health Agency (CARPHA) revealed that ethics committees in the region varied widely in their ability to effectively evaluate research proposals”

Research ethics infrastructure in the Caribbean, though young, is steadily growing. Some Caribbean territories have established national legislative and other regulatory structures to govern various aspects of research ethics. Guyana has promulgated the Guyana Human Research Regulatory Act (2008) and the Medical Practitioners Act (Act No.16 of 1991); Saint Lucia developed, in 2016, the Clinical Trials Act of Saint Lucia; and the Bahamas passed the Stem Cell Research and Therapy Act in 2013 (U.S. Office for Human Research Protections, 2018; International Medical Travel Journal, 2015). Despite the progress being made, many Caribbean countries still have limited capacity to assess or monitor the scientific quality and ethical acceptability of biomedical research proposed or carried out in their jurisdictions. A recent survey by CARPHA revealed that ethics committees in the region varied widely in their ability to effectively evaluate research proposals. Committee members are typically volunteers who sometimes struggled to meet for committee work; some committees faced resource shortages; and all identified training needs for members (Aarons, 2015).

Many authors highlight the need for research oversight through the establishment of Research Ethics Committees (RECs), including regional bodies that may be better positioned to pool limited resources. However, formalized ethical guidelines for conduct of research on human participants are lacking in many parts of the world, including much of the Caribbean (Office for Human Research Protections, 2018). Mullings (2007) noted that the Caribbean region has few published guidelines and identified the need to strengthen research ethics frameworks in the region. The Caribbean Health Research Council (2009) developed the Health Research Policy for the Caribbean, driven by the need for a document to guide the strengthening of systems to support the production, identification, and use of health research. The policy speaks to creating an enabling environment for the ethical conduct of research through capacity building and raising awareness of the existence and functions of RECs throughout the region. CARPHA (2015) made recommendation to the Caribbean Community (CARICOM) Ministers of Health to enact legislation regulating the conduct of research with human participants, provide best practices, ensure consistency and harmonization, and protect countries from exploitative research activities (Aarons, 2015).

Jamaica has no legislation governing ethical conduct of human participant research. Further, there is no documentation of international guidelines that have been adopted. The Ministry of Health is in the process of developing a Research Policy in order to achieve part of Vision 2030 Goal 1: Social, Cultural, Physical and Economic Conditions that Support the Health and Wellbeing of the Jamaican Society - Strategy 1.1.3. The strategy is to introduce a research agenda and programme to support informed decision making (The Health Task Force 2009). The goal of the proposed National Health Research Policy is to guide the strengthening of systems that facilitate the development of evidence-based policies, programmes, and practices, as well as to enhance health research culture. As it relates to ethics, the Policy is slated to align with the health values of the Pan American Health Organization (PAHO), which include ethics. The goal was adopted from the Caribbean Public CARPHA Health Research Policy for the Caribbean (Wilks, 2016).

Though legislation does not exist for the country, there are institutional policies related to human research exist. This paper sought to document and review the completeness of existing guidelines in major academic and governmental institutions in Jamaica and to make recommendations for advancing ethical standards in the country.

Methods
An online search for policies, legislation, and guidelines related to human participant research in Jamaica was conducted using a general Google engine search using the following search terms: research ethics, Jamaica, guidelines, policy, regulations. Searches were also conducted on the websites of all major academic institutions and government agencies. Fifteen governmental and eight academic institutions were contacted by phone or email to verify documents identified online and to access policies, guidelines, or legislation guiding the conduct of human research. We further requested any information setting the historical context for the establishment of relevant guidelines.

The framework for analysis was developed to assess completeness of the governmental or institutional policies and guidelines identified relative to major international guidelines and standards: World Medical Association Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Subjects; United Nations Educational, Scientific and Cultural Organization (UNESCO) Universal Declaration on Bioethics and Human Rights; The Council for Inter-
national Organizations of Medical Sciences (CIOMS) - International Ethical Guidelines for Health-Related Research Involving Humans; United States Department of Health & Human Service Office for Human Research Protections - 45CFR46 – The Common Rule. Thirteen minimum policy criteria were identified, as well as ten additional criteria the researchers deemed desirable for a comprehensive policy document. Existing policies were evaluated against these standards.

Results
A total of 6 institutions (four academic, two governmental) had existing policies available for evaluation. None of the policies included in the review addressed all thirteen minimum standards (Table 1). Only two of the thirteen minimum standards (privacy and confidentiality and RECs) were addressed in all documents. Informed consent was included in five of six documents. None of the documents addressed transnational or low resource settings for research. Only one document addressed justice, and just two mentioned autonomy and human rights. Conflict of interest was the only of the additional ten standards mentioned, in two of six documents reviewed (see Table 1).

Recommendations
Much work is required in Jamaica to ensure that all institutions involved in research have comprehensive policies. Though several policy documents reviewed contained the majority of basic standards, the additional ten elements desirable for comprehensive policy were lacking. At the time of the review (2019), no policy document addressed research in disaster and disease outbreak, though the region had already experienced several outbreaks, including, recently, Chikungunya (2013-2014) and Zika (2015-2016). Currently, Covid 19 (2020) has made the need to provide ethical oversight for research during outbreaks and pandemics a salient global concern. Considerable collaborative research with international organizations continues in the Caribbean, and, therefore, capacity building and partnerships should be adequately addressed in policy documents. Collection, storage, and use of biological materials and related data for health research need urgent consideration as well. In the absence of comprehensive legislative guidance, institutions must develop and implement comprehensive, responsive policies to guide ethical conduct of research. Institutions have further obligation to ensure their policies are up to date are continually updated to reflect the changing research landscape.

Table 1: Summary of Standards for Institutions with Written Research Ethics Policies

<table>
<thead>
<tr>
<th>Benchmark Standard for Research Ethics Policy Documents</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum Standards Expected</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human Rights</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefits</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk or Harm</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reimbursement &amp; Compensation</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autonomy</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Informed Consent</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vulnerable Groups and Individuals</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Privacy &amp; Confidentiality</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Justice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research Ethics Committees</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Transnational / Low Resource Settings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sound Research Practices</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Dissemination &amp; Publication</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional Standards Expected in Comprehensive Policies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choice of Control for clinical trials</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caring for Participants Needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Engagement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capacity-Building and partnership for Research</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collection, Storage and Use of Biological Materials, Related Data and Health-Related Research</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research in Disaster &amp; Disease Outbreak</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cluster Randomized Trials</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Online / Digital Data Use</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Accountability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conflict of Interest</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
References


Dr Rosmond Adams, a graduate of the The Caribbean Research Ethics Education Initiative (CREEi) assumed the post of director of the Pan Caribbean Partnership Against HIV and AIDS (PANCAP) earlier this year.

PANCAP is a Caribbean regional partnership of governments, regional civil society organisations, regional institutions and organisations, bilateral and multilateral agencies, and donor partners. PANCAP provides a structured and unified approach to the Caribbean response to the HIV epidemic.

Dr. Adams was a member of the first cohort of participants when the CREEi programme started in 2015. CREEi provides three levels of training: a Certificate in Research Ethics, a Diploma in Research Ethics, and a Master of Science in Bioethics. CREEi’s mission is to train clinicians, scientists, academics, lawyers, and administrators from low- and middle-income countries in the Caribbean Basin to become research ethicists, advocates for human research protections, and institutional and national leaders in their home countries.

In 2018, Dr. Adams graduated with a Master of Science degree from Clarkson University, having received a full scholarship supporting his study.

Dr. Adams is a Vincentian national and is a physician by training. Additionally, he holds a Master of Science in Public Health. Dr. Adams brings to the PANCAP partnership a wealth of experience, having worked at both the national and regional levels in the areas of surveillance, communicable diseases, including HIV, emergency response, and health security.

Dr. Adams plans to use his training in research ethics to advocate for the development of a regional HIV research agenda to provide an evidence base to advise government, national programmes, and civil society on plans and policies, and to build strategic partnerships to effectively manage, control, and reduce the spread of infection in the region to mitigate the public health threats posed by HIV.
**INSTRUCTION TO AUTHORS**

We invite submissions to future issues of the CANREC Bulletin, published online twice yearly by the Caribbean Public Health Agency.

The Caribbean Network of Research Ethics Committees (CANREC) is a network established by the Caribbean Public Health Agency (CARPHA) with the cooperation of Research Ethics Committees (RECs/IRBs) across the CARPHA member states. CANREC promotes a sustainable infrastructure, intraregional cooperation, harmonized review processes, information sharing, and capacity development for research ethics in the Caribbean. For more information, visit http://carpha.org/What-We-Do/Research-Training-and-Policy-Development/Research-Ethics/CANREC.

The CANREC Bulletin solicits contributions on research and research ethics, as well as news and updates from member states and organizations working in the region. We invite short reviews of books that would interest our readers. Please email the editor in advance with suggestions for reviews.

We encourage a broad range of submissions from an equally broad range of contributors. Submissions from academics, researchers, ethicists, policy makers, and others are welcome. We will consider contributions from authors at all levels, from students to senior colleagues.

Articles should be about 1500 words in length; please limit news and update items to 500 words. Book reviews should be 500-700 words. All citations and references should follow APA format. Please prepare manuscripts in Microsoft Word and direct submissions via email to canrecbulletin@carpha.org.
CONFERENCES

Regional
65th Annual CAPRHA Research Conference, 16-19 June 2021, Online
Email: conference@CARPHA.ORG


International
2021 Institutional Animal Care and Use Committee Conference, 14-16 April, 2021, online: https://my.primr.org/s/community-event?id=a1Y3i000001eIfFEAU

9th International Association for Education in Ethics Conference, 16 July 2021, online: https://mdanderson.cloud-cme.com/assets/mdanderson/data/FINAL%20CALL%20FOR%20ABSTRACTS.pdf

PRIM&R Advancing Ethical Research Conference (AER21), 19-21 November, 2021, Orlando, FL: https://www.primr.org/programs/aer/2021-sber-aer