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What comprises *fair* shared decision-making in global health research collaborations?

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Abstract: Funders (primarily located in high-income countries) and high-income country researchers have historically dominated decision-making within global health research collaborations: from setting agendas and research design to determining how data is collected and analysed and what happens with findings and outputs. The ethical principle of *shared decision-making* has been proposed as a way to help address these imbalances within collaborations and reduce semi-colonial and exploitative forms of global health research. It is important to be clear about what shared decision-making means in order to ensure it is not done in tokenistic, shallow way. Thus far, the principle's content has not been examined and articulated in detail. This paper aims to start the process of delineating a concept of *fair* shared decision-making as a minimum standard for global health research. Using two

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hypothetical case examples, the paper will demonstrate global health research practice is often inconsistent with ideal shared decision-making. In such instances, it can be difficult to decide whether shared decision-making within collaborations is fair. The paper describes how, while the two cases have potentially morally troubling features, they do not meet criteria for unfair or non-ideal shared decision-making. The nuances of these examples of research practice help generate clearer ideas about how to judge fairness in shared decision-making. The paper concludes by presenting ideas about when soft power can be fairly employed between high-income country and low and middle-income country partners and what fair compromise agreements may look like in shared decision-making.

Key Words: global health research; ethics; fairness; shared decision-making; collaboration; partnership

Introduction

Funders (primarily located in high-income countries) and high-income country (HIC) researchers have historically dominated decision-making within global health research collaborations: from setting agendas and research design to determining how data is collected and analysed and what happens with findings and outputs. Although these circumstances are changing, low and middle-income country (LMIC) researchers can still be relegated to the role of “a glorified field worker”, responsible for providing samples but excluded from “the creative, interesting and ‘scientific’ features’ of the collaboration”.¹ Hierarchies between task definers and implementers remain inherent in global health research. Current research models can thus still have less visible but nonetheless semi-colonial features.²

¹ Parker, M., and P. Kingori. 2016. “Good and Bad Research Collaborations: Researchers' Views on Science and Ethics in Global Health Research.” *PLoS One* 11, vol. 10: e0163579.

² Costello, A., and A. Zumla. 2000. “Moving to Research Partnerships in Developing Countries.” *British Medical Journal* 321, no. 7264: 827-9; Jentsch, B., and C. Pilley. 2003. “Research Relationships between the South and the North: Cinderella and the Ugly Sisters?” *Social Science & Medicine* 57: 1957–67; Tucker, T.J., and M.W. Makgoba. 2008. “Public-Private Partnerships and Scientific Imperialism.” *Science* 320: 1016-1017; Walsh, Aisling, Ruairi Brugha, and Elaine Byrne. 2016. “The Way the Country has been Carved up by

The ethical principle of *shared decision-making* has been proposed as a way to help address these imbalances within collaborations and reduce semi-colonial and exploitative forms of global health research. It has been put forward as a principle of fair global health research partnerships between HIC and LMIC researchers.³ Shared decision-making is also a way to ensure the voices and concerns of not only LMIC researchers but also collaborators from the community and policymaking sectors in LMICs are more audible and visible in agenda-setting and decision-making.⁴ This, in turn, can also help address epistemic and cognitive injustices within the health research field.⁵

It is important to be clear about what shared decision-making means in order to ensure it is not done in tokenistic, shallow way and that it promotes more equitable research partnerships, where LMIC partners' voices are raised and heard, especially in areas where they have been historically excluded (e.g. agenda-setting, financial management). We must seek clarity

Researchers": Ethics and Power in North– South Public Health Research. *International Journal for Equity in Health* 15: 204.

³ Costello and Zumla *op. cit.*, note 2; Swiss Commission for Research Partnerships with Developing Countries (KFPE). A Guide for Transboundary Research Partnerships: 11 Principles, 3rd edition. Bern: Swiss Academy of Sciences 2018.

⁴ Shared decision-making is an inherent feature of certain forms of community engagement in global health research that emphasise collaboration, partnership, and the co-construction of knowledge. For instance, Tindana et al. (2007) define engagement in global health research as 'collaborative partnership', meaning local stakeholders are involved in assessing local health problems; planning, conducting and overseeing research; and integrating research into the health care system. Similarly, co-constructing knowledge means researchers jointly design and conduct research with community organisations, policymakers, and/or other partners in ways that achieve the purposes of all collaborators (Hall et al. 2016). It entails shared decision-making in all phases of

through specificity if we are to speak usefully about a principle or term in a given context.⁶ Here, seeking clarity through specificity means defining what shared decision-making should entail in the global health research context. Thus far, the principle's content has not been examined and articulated in detail.

This paper aims to start the process of delineating a concept of *fair* shared decision-making as a minimum standard for global health research. It begins by presenting two hypothetical cases of shared decision-making in global health research practice. Next, ideas from the philosophy and ethics literature are summarised and applied to provide a picture of what ideal, non-ideal, and unfair shared decision-making look like in global health research. Theories and concepts from the philosophy and ethics literature can provide guidance on the ideal: how to undertake shared decision-making in a meaningful and respectful manner. They can also offer guidance on what not to do: namely, what comprises tokenism, unfairness, and degradation in shared decision-making.

Yet, as the cases demonstrate, global health research practice often falls outside the ideal but isn't necessarily non-ideal or unfair. In such instances, it can be difficult to decide whether shared decision-making within collaborations is fair. The paper describes how, while the two cases have potentially morally troubling features, they do not meet criteria for unfair or non-ideal shared decision-making. The two cases are hypothetical but realistic examples of

research projects (Oswald 2016). Tindana, P. O., Singh, J. A., Tracy, C. S., Upshur, R. E. G., Daar, A. S., Singer, P. A., ...Lavery, J. V. (2007). Grand challenges in global health: Community engagement in research in developing countries. *PLoS Medicine*, 4(9), e273; Oswald, K., Gaventa, J., & Leach, M. (2016). Introduction: Interrogating engaged excellence in research. *IDS Bulletin*, 47(6), 1–18; Hall, B., Tandon, R., Lepore, W., Singh, W., Easby, A., & Tremblay, C. (2016). Theoretical pedagogical framework for community based research. In R. Tandon, B. Hall, W. Lepore & W. Singh (Eds.), *Knowledge and engagement: Building capacity for the next generation of community based researchers* (pp. 7–39). Canada: PRIA.

⁵ Pratt, B. (2019). "Engagement as "co-constructing knowledge": A moral necessity in public health research." *Bioethics* doi: 10.1111/bioe.12591

⁶ Cohen, J. & Uphoff, N. (2011). 'Participation's place in rural development: Seeking clarity through specificity'. In: Cornwall A, editor. *The Participation Reader*. New York, NY: Zed Books, p. 34-56.

decision-making in global health research collaborations. They reflect situations that have arisen in global health research collaborations but do not describe any specific collaboration. They were developed based on the author's knowledge of global health research practice, which was gained through collaborations with global health researchers and case study research on various global health research collaborations. They are employed in the paper because they are hard to classify and because they span two types of collaborations in global health research: between HIC researchers and LMIC researchers and between LMIC researchers and a LMIC community organisation. The nuances of these cases help generate clearer ideas about how to judge fairness in shared decision-making. The paper concludes by presenting ideas about what persuasive tactics can be employed and what agreements can look like in shared decision-making processes between HIC and LMIC partners that, while not ideal, are nonetheless fair.

Box 1: Cases of shared decision-making in global health research practice

Case 1

Case 1 involves a global health research collaboration between researchers from Australia, the UK, Cambodia, Kenya, and India that undertook a decision-making process to set overarching consortium research priorities. During priority-setting, a clash occurred between senior HIC researchers and senior LMIC researchers. In a first attempt, senior HIC researchers from the collaboration's managing partner proposed a priority and were surprised when senior LMIC researchers firmly said that they did not want to set it as a consortium priority. Senior LMIC researchers felt the priority added a workload that was too burdensome and questioned the added value of the priority. Senior HIC researchers still felt adopting the priority was important, so they made a second attempt to push for it. To make adopting the priority more feasible for LMIC partners, they scaled back the proposed activities related to the priority and offered LMIC partners' additional support to perform them (e.g. training and technical support). However, LMIC partners did not negotiate or persuade them to add the resources. LMIC researchers then agreed to the consortium adopting the priority. They did not feel powerless to say no or that they had no choice but to agree. It is also important to note that, in this collaboration, LMIC researchers were already in driver's seat for setting the research topics and questions of the research projects undertaken in their countries as part of the collaboration, irrespective of what overarching priorities were set for the consortium.

Case 2

Case 2 involves a global health research collaboration between South African researchers and a South African community organisation. Due to the funding awarded, the research project had to focus on nutrition but the community organisation's focus was on securing and maintaining land rights for its community. It hadn't worked on health matters before. In the end, the final research agenda for the project remained focused on nutrition but the project also collected data on other topics of interest to the community organisation at the same time. That data was owned by the community organisation and not the researchers. The researchers also agreed to perform future research projects in the community on other health topics beyond nutrition that were raised as part of discussions with the community organisation.

What makes shared decision-making ideal?

Drawing on philosophy and ethics literature about ideal decision-making can help define what makes a shared decision-making process meaningful and respectful. Relevant theories in political philosophy generally call for relying on inclusive, deliberative processes and norms to achieve ideal decision-making.⁷ This is emphasised by theories that provide accounts of *health* decision-making such as accountability for reasonableness, shared health governance, and global governance for health.⁸

The theories delineate ideal processes for deliberative decision-making, where diverse stakeholders discuss problems or claims of need and how to address them. They draw largely on the work of Jürgen Habermas, who identified two main components: the ideal speech

⁷ Young, I. M. (2000). *Inclusion and democracy*. Oxford: Oxford University Press; Gutmann and Thompson (2004); Gutmann, A., Thompson, D., 2004. *Why Deliberative Democracy?* Princeton University Press, Princeton.

⁸ Daniels, N. 2008. *Just health: Meeting health needs fairly*. Cambridge, UK: Cambridge University Press; Ruger, J. P. (2011). Shared health governance. *American Journal of Bioethics*, 11(7), 32–45; Gostin, L. O. 2014. *Global health law*. Cambridge, MA: Harvard University Press.

situation and communicative rationality.⁹ In the *ideal speech situation*, deliberation is governed by norms of equality, symmetry, and non-coercion. All participants have equal rights to initiate speech acts, to question other participants, and to respond to their questions; to question the assigned topic of conversation; and to initiate arguments about the rules of the discourse procedure and their application.¹⁰ Deliberation is coercion free, meaning participants can engage in arguments freely, without being dominated or intimidated by others to endorse or accept specific proposals.¹¹ In global health research, this means LMIC researchers and community partners have the same opportunity to raise their voice and be heard as HIC funders and researchers. It also holds true for senior and junior staff, men and women, and researchers of different disciplines.¹²

Habermas' model further proposes that *rational deliberation* produces genuine consensus. Reason prevails over power, with legitimate outcomes achieved through the force of better arguments.¹³ Legitimacy resides in that participants are convinced on the basis of those arguments that the decision is the right thing to do in a given context.¹⁴ Ideally, all stakeholders voice their ideas and the reasons behind them. They debate the pros and cons of various proposals. Participants are mutually aware of, and responsive to, one another's perspectives and needs, modifying their preferred proposals in light of other participants'

⁹ Gutmann and Thompson *op. cit.*, note 7; Kapoor, I. (2002). 'Deliberative Democracy or Agnostic Pluralism? The Relevance of the Habermas-Mouffe Debate for Third World Politics'. *Alternatives: Local, Global, Political*, 27: 459-487.

¹⁰ Kapoor *op. cit.*, note 9; Benhabib S. (1996). 'Towards a Deliberative Model of Democratic Legitimacy'. In: Benhabib S, editor. *Democracy and Difference: Contesting the Boundaries of the Political*. Princeton, NJ: Princeton University Press, p. 67-94; Young IM. (1996). 'Communication and the Other: Beyond Deliberative Democracy'. In: Benhabib S, editor. *Democracy and Difference: Contesting the Boundaries of the Political*. Princeton, NJ: Princeton University Press, p. 120-136.

¹¹ Kapoor *op. cit.*, note 9; Young *op. cit.*, note 10.

¹² Pratt, B., Merritt, M., & Hyder, A.A. (2016). "Towards deep inclusion for equity-oriented health research priority-setting: A working model." *Social Science & Medicine* 151: 215-224.

¹³ Kapoor *op. cit.*, note 9.

¹⁴ Benhabib *op. cit.*, note 10.

proposals.¹⁵ Their perspectives are transformed from an initial “narrow and selfregarding” baseline to a more comprehensive understanding that takes others' needs and interests into account.¹⁶ Proposals are refined or rejected and stakeholders coalesce around their preferred options.¹⁷

Deliberation thus generates *consensus as joint intentions*, which means the agreement reached is a novel proposal that at least a majority of participants can endorse.¹⁸ Since participants' preferences/positions have shifted in light of the information provided by other stakeholders and to accommodate one another's interests, the agreement does not correspond to the initial preferences or proposals of any party in the decision-making process. Achieving consensus as joint intentions means dialogue merges different ways of knowing to generate new constellations of knowledge. It enhances the social knowledge base used to identify and solve the complex problems that impede health and well-being.¹⁹ In contrast, consensus as the aggregation of preferences means that those preferences held or proposals endorsed by the greatest number of participants carry the day. Here, participants' initial preferences/proposals do not shift.

In global health research priority-setting, for example, deliberation would mean all participants are able to voice their ideas for research priorities and explain why they favour them. Other participants could then ask questions of clarification or contestation to which they would be able to respond. All participants would work together to investigate why setting certain priorities would be better or more urgent than others and to co-construct a final set of research priorities. That final set of priorities would be clearly different from those initially proposed at the outset of the process and incorporate ideas from a range of participants.

¹⁵ Richardson, H., 2002. *Democratic Autonomy: Public Reasoning about the Ends of Policy*. Oxford University Press, Oxford.

¹⁶ Young *op. cit.*, note 7, p. 112.

¹⁷ Young *op. cit.*, note 7.

¹⁸ Richardson *op. cit.*, note 15.

¹⁹ Young *op. cit.*, note 7; Santos, B. 2014. *Epistemologies of the South: Justice against epistemicide*. Boulder, CO: Paradigm.

Ideal accounts of deliberative decision-making have been criticised for their failure to take power effects seriously.²⁰ Where countries exhibit social and economic inequalities, it is likely that these ‘ideal’ processes will reinforce the status quo, giving effective voice only to stakeholders with considerable power and excluding the perspectives of those who are disadvantaged and marginalised by social norms and institutions.²¹ Ensuring that decision-making processes not only attend to the way power enters deliberative spaces but also mitigate power disparities between participants is then an important part of ideal processes.²² In global health research, the first step is to identify factors that obstruct researchers and community or policymaker partners from having an equal opportunity to participate.²³ Key (and interrelated) factors identified in the literature include: limited individual capacity for decision-making, aspects of the decision-making context, structural barriers, and discursive barriers.²⁴ Examples of specific factors that would arise in global health research are provided in the literature.²⁵ The next step is to then implement strategies to counteract the impact of all identified factors on the decision-making process.²⁶

²⁰ Cornwall, A. (2002). ‘Locating Citizen Participation’. *IDS Bulletin*, 33(2): i-x.

²¹ Young *op. cit.*, note 7.

²² Young *op. cit.*, note 7; Young *op. cit.*, note 10; Benhabib *op. cit.*, note 9; Cornwall A. (2011). ‘Whose Voices? Whose Choices? Reflections on Gender and Participatory Development’. In: Cornwall A, editor. *The Participation Reader*. New York, NY: Zed Books, p. 203-223; Gibson JL, Martin DK, Singer PA. (2005). ‘Priority-setting in Hospitals: Fairness, Inclusiveness, and the Problem of Institutional Power Differences’. *Social Science & Medicine*, 61(11): 2355-2362.

²³ Gibson et al. *op. cit.*, note 22; Pratt et al. *op. cit.*, note 12.

²⁴ Young *op. cit.*, note 6; Gibson et al. *op. cit.*, note 21; Shayo, E.H., Norheim, O.F., Mboera, L., Byskov, J., Maluka, S., Kamuzora, P., Blystad, A., 2012. Challenges to fair decision-making processes in the context of health care services: a qualitative assessment from Tanzania. *Int. J. Equity Health* 11, 30.

²⁵ Pratt et al. *op. cit.*, note 12; Pratt, B. (2018). “Constructing citizen engagement in health research priority-setting to attend to dynamics of power and difference.” *Developing World Bioethics* doi: 10.1111/dewb.12197 (see Supplemental File 2).

²⁶ Gibson et al. *op. cit.*, note 22; Pratt et al. *op. cit.*, note 12; Pratt *op. cit.*, note 25, (see Supplemental File 3)

In light of these concepts, features of ideal shared decision-making are summarised in Table 1.

What makes shared decision-making non-ideal or unfair?

Beyond defining the ideal, it is important to specify what makes shared decision-making non-ideal or unfair in global health research. Non-ideal shared decision-making occurs when decision-making power is not in fact shared. Literature from ethics and development studies clarifies when that happens, describing lower levels of participation: consulting and informing. Unlike shared decision-making, consulting is characterised by individuals being invited to give their input (feedback, suggestions, and critiques) on aspects of research projects but with no assurance that it will be used by those who decide.²⁷ Informing means raising awareness and understanding of what research is and of already defined research projects within host communities. Communities are told of the outputs of decision-making in research projects but do not inform the process or decisions in any way.²⁸ In global health research, where LMIC researchers are consulted or informed about research projects' topics and questions and/or other aspects of their design, that would comprise non-ideal shared decision-making.

To help define what makes a shared decision-making process unfair or degrading, philosophy and ethics literature about transactions, and the concepts of bargaining and exploitation, in particular, can be applied. Bargaining is often juxtaposed against deliberation. In contrast to deliberation, it consists of an exchange of concessions using competitive tactics to reach a compromise.²⁹ Exploitation is a central concern when conducting global health research.³⁰ It

²⁷ Marsh, V. M., Kamuya, D., Rowa, Y., Gikonyo, C., & Molyneux, S. (2008). Beginning community engagement at a busy biomedical research programme: Experiences from the KEMRI CGMRC-Wellcome Trust research programme, Kilifi, Kenya. *Social Science & Medicine*, 67(5), 721–733.

²⁸ Arnstein, S. R. (1969). A ladder of citizen participation. *Journal of the American Institute of Planners*, 35(4), 216–224.

²⁹ Albin, C. (2001). *Justice and Fairness in International Negotiation*. Cambridge: Cambridge University Press.

³⁰ Hawkins, J. & Emanuel, E.J. 2008. *Exploitation in developing countries: The ethics of clinical research*, Princeton, NJ, Princeton University Press.

means one party gains control over another party's ability or resource through some vulnerability of his/hers in order to achieve an end that is valued by the exploiter.³¹

The nature of the persuasive tactics employed and the nature of the agreement reached in bargains and exploitative transactions differ from deliberation. In such transactions, agreements that are morally problematic are accepted due to the use of *competitive persuasion tactics*. Persuasion based on reason may or may not feature. Employing competitive persuasion tactics is morally wrong when such tactics involve the *use of hard power or certain forms of soft power*. Power is about getting others to do what you want. A secures the decision-outcome s/he wants by coercing or manipulating B.³² Using coercive or hard power means changing another's behaviour by force or with threats, where A indicates that s/he will apply negative sanctions if B fails to perform the desired action.³³ In global health research collaborations, this could mean, for instance, HIC researchers based at the managing partner institution threaten to limit LMIC partners' access to project resources if they don't comply with certain terms.

Soft power attracts, co-opts, and persuades actors without the use of coercive force. A secures the decision-outcome s/he wants by shaping B's beliefs and preferences. This may include structuring a situation so that B develops preferences or defines his/her interests in ways consistent with A's own.³⁴ Manipulation is a common form of soft power and refers to "interfering with or usurping someone's free agency that does not limit or destroy free choice but, rather, influences it in certain ways that promote the outcome sought by the

³¹ Wood, A. (2014). "Coercion, Manipulation, Exploitation." In *Manipulation: Theory and Practice*, Eds. Christian Coons and Michael Weber. Oxford: Oxford University Press.

³² Siegel, A.S. 2008. Kantian ethics, exploitation and multinational clinical research. In: HAWKINS, J. & EMANUEL, E.J. (eds.) *Exploitation in developing countries: The ethics of clinical research*. Princeton, NJ:

Princeton University Press; Warren, M.E. and Mansbridge, J. (2013). "Deliberative negotiation." In *Negotiating Agreement in Politics*, Eds. Jane Mansbridge and Cathie Jo Martin. Washington DC: American Political Science Association, pp. 141-196.

³³ Nye, J.S. (1990). Soft Power. *Foreign Policy* 80: 153-171.

³⁴ Ibid.

manipulator".³⁵ According to philosopher Allen Wood, three forms of manipulation that are morally wrongful are where deception is used, pressure to acquiesce such as inducements are applied, or emotions or weaknesses of character are played upon.³⁶ In global health research collaborations, this could mean, for instance, that researchers deceive their community organisation partners by claiming to have insider knowledge of a funder's top priorities so that they are able to shape the research agenda the way they want. The nature of the moral wrong in cases of coercion and manipulation is that they circumvent individuals' freedom from domination. They are disrespectful and unfair because they undermine individuals' agency (i.e. their control over their actions and choices).³⁷

Persuasive tactics that take advantage of individuals' vulnerability are another form of soft power that is considered morally wrongful. Using such tactics fails to respect their dignity and is indifferent to their needs as human beings.³⁸ Philosopher Andrew Siegel further argues that taking advantage of another's vulnerability is *degrading and unfair* when the vulnerability results from a distribution system that does not treat individuals as equals.³⁹ When the parties taking advantage are complicit in allowing that system to persist and/or benefit from that system, their behaviour is worse from an ethical perspective compared to when the parties are not complicit or benefiting.

Vulnerability has many layers and forms such as circumstances of poverty⁴⁰, lack of basic rights⁴¹ and unequal bargaining power.⁴² In contrast to individual study participants in global health research, it is perhaps less likely that LMIC researchers, policymakers, and community organisations will be impoverished or lacking basic rights. However, they may commonly

³⁵ Wood *op. cit.*, note 31.

³⁶ *Ibid.*

³⁷ *Ibid.*

³⁸ Siegel *op. cit.*, note 32; Carse and Little 2008; Wood *op. cit.*, note 31.

³⁹ *Ibid.*

⁴⁰ *Ibid.*

⁴¹ Zion, D., Gillam, L., and Loff, B. (2000). The Declaration of Helsinki, CIOMS and the Ethics of Research on Vulnerable Populations. *Nature Medicine* 6(6): 615-617.

⁴² Wood *op. cit.*, note 31.

experience vulnerabilities related to unequal bargaining power. In global health research collaborations, unequal bargaining power can manifest in various ways between the different parties. Some common sources of unequal bargaining power might be having differing: access to funding (where schemes require lead applicants to be from HICs⁴³), control of awarded funding (where one partner administers the grant), levels of status and seniority, institutional capacity to manage grants, access to infrastructure, ways of knowing (that are themselves valued differently by society), and/or knowledge of how research funding works.

Where disparities in bargaining power exist, they are frequently the result of an unfair research system that favours certain parties and ways of knowing over others. Structural inequities emerging (in part) from a legacy of colonialism persist and manifest in global health research.⁴⁴ As a result, research collaborations between LMIC researchers and HIC researchers are often uneven in terms of access to research funding, research resources, and involvement in decision making.⁴⁵ For example, since funders often restrict eligibility to lead applicants from HICs, LMIC partners can have little influence on how and where money for collaborative global health research projects is spent. Certain knowledge is also valued more and produced more in today's world, e.g. "Northern" epistemologies over "Southern" epistemologies; technical and quantitative measures over qualitative measures rooted in lived experiences; and expert knowledge over local and indigenous ways of knowing.⁴⁶ Thus,

⁴³ The major funding bodies of health research in LMICs are primarily located in HICs. Although the situation is slowly changing, direct access to funding from almost all of these bodies has historically been very difficult (or legally impossible) for researchers from LMICs to obtain as lead applicants (Tucker and Makgoba *op. cit.*, note 2). For instance, some funders in the United States are only legally able to give grants to 501C3 US-based institutions. Government and philanthropic funders in the UK are legally only able to award grants to institutions in the UK.

⁴⁴ Jentsch *op. cit.*, note 2.

⁴⁵ Walsh *op. cit.*, note 2; Munung, N.S., B.M. Mayosi, and J. de Vries. 2017 "Equity in International Health Research Collaborations in Africa: Perceptions and Expectations of African Researchers." *PLoS One* 12, vol. 10: e0186237.

⁴⁶ Tandon, R., W. Singh, D. Clover, and B. Hall. 2016. Knowledge democracy and excellence in engagement. *IDS Bulletin* 47(6): 19-36; Visvanathan S. 2009. The search for cognitive justice. Accessed September 4, 2017.

where HIC researchers take advantage of having greater bargaining power during shared decision-making processes, it can be unfair and degrading to their collaborators (LMIC researchers, community organizations, and/or policymakers).

In bargaining, what is agreed to—compromise—differs from what is agreed to in deliberations—consensus as joint intentions. *Compromise* involves the exchange of concessions rather than a shifting of one’s preferences in light of the preferences of others. In bargaining, especially where tactics like coercion and manipulation are used, concessions may all be one-way: one party gets everything s/he wants and the other side capitulates.⁴⁷ Where the exchange of concessions is one-sided or the distribution of compromises across several transactions always favours the same party, this is considered unfair.⁴⁸ In exploitative transactions, the distribution of benefits is used to evaluate unfairness. Exploitation occurs where certain parties receive an unfair level of benefits as part of a transaction such as where parties from HICs derive significantly greater gains from the research process relative to parties from LMICs.⁴⁹ For example, in pharmaceutical trials, HIC sponsors make lots of money from patents and HIC researchers publish first-author papers that advance their careers, while LMIC researchers aren’t always included as authors and new products are not made accessible and affordable to LMIC study participants and their communities.⁵⁰

http://www.india-seminar.com/2009/597/597_shiv_visvanathan.htm; Rowell, L.L., and E. Hong. 2017.

“Knowledge democracy and action research: Pathways for the twenty-first century.” In *The Palgrave international handbook of action research*, edited by Lonnie L. Rowell, Catherine D. Bruce, Josh M. Shosh, and Margaret M. Riel, 63-83. New York: Palgrave MacMillan; ISSC, IDS and UNESCO. 2016. *World social science report 2016, challenging inequalities: Pathways to a just world*. Paris: UNESCO Publishing.

⁴⁷ Warren and Mansbridge *op. cit.*, note 32.

⁴⁸ Warren and Mansbridge *op. cit.*, note 32; Kingori and Parker *op. cit.*, note 1.

⁴⁹ Emanuel, E., David Wendler, Jack Killen, and Christine Grady. 2004. “What Makes Clinical Research in Developing Countries Ethical? The Benchmarks of Ethical Research.” *Journal of Infectious Diseases* 189: 930–7.

⁵⁰ Petryna A. 2009. *When Experiments Travel: Clinical Trials and the Global search for Human Subjects*. Princeton, NJ: Princeton University Press.

In light of these concepts, the characteristics of non-ideal and unfair shared decision-making are summarised in Table 1.

Shared decision-making in global health research practice often isn't ideal or unfair

While existing literature is useful to generate ideas about ideal and unfair shared decision-making, in global health research *practice*, processes often do not fall into either category. Achieving ideal shared decision-making would mean persuasion tactics based on reason alone are used by all participants and joint intentions are reached at the end of the process. Undertaking unfair shared decision-making would mean participants used coercion, manipulation, or take advantage of disparities in bargaining power to push for the outcome they want and a one-sided compromise is reached that favours the more powerful party in the decision-making process. Many shared decision-making processes conducted as part of global health research collaborations will fall in-between these two extremes and when they do it can be difficult to judge whether they are fair

Two hypothetical case examples of global health research agenda-setting are provided in Box 1. They are based on real situations that have arisen in global health research collaborations and are provided because they are not clearly cases of ideal shared decision-making or unfair shared decision-making. They were developed based on the author's knowledge of global health research practice and span two types of collaborations in global health research: between HIC researchers and LMIC researchers and between LMIC researchers and a LMIC community organisation. The two cases raise questions about what fair persuasive tactics and outcomes in shared decision-making comprise. Do they extend beyond reasoned arguments and joint intentions? If yes, what other tactics and outcomes are fairly employed and reached respectively and under what circumstances?

In Case 1, a potentially morally troubling feature is that tactics beyond reason were used. When senior HIC researchers' first attempt failed, resources were offered to help convince senior LMIC researchers to adopt the priority. Soft power was employed but it wasn't morally wrongful forms of manipulation or taking advantage of being managing partner. Providing resources did not compromise using deception, playing on emotions or weaknesses of character, or providing inducements. The resources only assisted LMIC partners to do the

proposed activities related to the priority but did not, for example, offer extra salary or the lure of supporting additional research they wanted to do but otherwise could not. Offering resources utilised HIC partners' technical expertise but was not related to their role as managing partner. As such, HIC researchers' use of soft power didn't fit the aforementioned criteria for what makes shared decision-making unfair. Yet it is not ideal to rely on competitive persuasion tactics. The example thus raises the questions: Is it unfair to use soft power to get your way if it's not morally wrongful forms of manipulation or taking advantage of unequal bargaining power? When (if ever) is it fair to use other forms of soft power in shared decision-making?

In Case 2, a potentially morally troubling feature is that a compromise, not joint intentions, was achieved. It was not a one-sided compromise where the focus on nutrition was upheld and the community organisation got nothing. Both parties benefited from the final project agenda that was set. The example thus raises the questions: Are outcomes that that involve compromise inherently unfair? If not, when are they fair?

In the next section, these questions about soft power and compromise are explored. The cases are used to help further elucidate ideas about what comprises fairness in shared decision-making in global health research.

Discussion

The conceptual literature and case examples suggest that, when judging the fairness of shared decision-making between partners in global health research collaborations, it is important to consider both the nature of persuasion used and the nature of the agreement reached. Here, it is not claimed that these are the only elements of the decision-making process to look at in order to assess fairness but they are necessary to consider (amongst other things that are beyond the scope of the paper to investigate). A spectrum of persuasion tactics exist, spanning coercion, manipulation, taking advantage of vulnerability, other types of soft power, and reason. Other forms of soft power could include using what you know about individuals' personalities, world views, likes and dislikes to get your way; providing resources (not inducements) to facilitate others doing what you want them to; and using discursive or structural (norms, rules) power to your advantage. An example of the latter could be purposefully hosting LMIC partners in a physical space that advantages HIC partners.

Physical spaces are imbued with certain norms, behaviours, and languages, and people favoured by those norms or more practiced in those behaviours and languages will dominate decision-making in those spaces.

So *when* is the use of other forms of soft power in shared decision-making fair? Two considerations will be proposed that may help make an assessment on this matter in global health research collaborations. The first consideration is: what is the context? Carse and Little argue that determinations of whether it is unfair to extract a benefit based on vulnerability are contextual.⁵¹ Similarly, I would argue that whether a party's use of soft power to extract a benefit (i.e. the decision outcome s/he wants) is unfair depends on the context. In global health research, it would be unfair under the following circumstances: HIC partners use soft power to generate a decision or agreement that reinforces semicolonial features of research projects and/or structural inequities in the research system that favour certain parties and ways of knowing over others. These include decisions that reinforce existing inequities in control of funding, HIC task definer and LMIC task implementer hierarchies, hierarchies privileging Northern over Southern epistemologies, and agenda-setting and management of projects by HIC partners.⁵²

In Case 1, the form of soft power used was not manipulation or taking advantage of vulnerability but it reinforced senior HIC researchers' control over the research agenda at the expense of LMIC researchers. This seems unfair in the global health research context because agenda-setting has historically and is still often dominated by HIC funders and researchers. Beyond agenda-setting, other key areas of decision-making in research projects where LMIC partners have often been excluded are research design, resource allocation, paper writing, and financial oversight and management. Perhaps then it is also unfair for HIC partners to use soft power in decision-making on these matters with LMIC partners in global health research collaborations. Uses of soft power (excluding morally wrongful forms of manipulation and taking advantage of vulnerabilities) by HIC partners in decision-making on aspects of global

⁵¹ Carse, A.L. & Little, M.O. 2008. Exploitation and the enterprise of medical research. *In*: EMANUEL, E. J. & HAWKINS, J. (eds.) *Exploitation and developing countries: The ethics of clinical research*. Princeton, NJ: Princeton University Press.

⁵² Costello and Zumla *op. cit.*, note 2; Kingori and Parker *op. cit.*, note 1; Munung et al. *op. cit.*, note 45.

health research where LMIC partners have not been historically excluded may be less morally wrong.

Additionally, it may be fair for LMIC partners to use such forms of soft power in shared decision-making about matters that they have historically been excluded from in global health research. It may also be fair for LMIC partners to use soft power in relation to other decisions when their rational arguments are discounted due to epistemic injustices (e.g. unjust credibility deficits). Where their legitimate use of rational persuasive tactics is unfairly discounted, such circumstances might legitimise their use of non-rational persuasive tactics.

The second consideration is: what is the intent behind the use of soft power? I would argue that the reason for using soft power also matters in determinations of fairness in shared decision-making. This raises the question of what comprises a good intention versus a bad intention to use soft power. Reasons for the use of soft power by HIC partners likely fall on a spectrum from total self-interest, on the one end, to promoting the interests of LMIC partners and populations (i.e. putting others' interests ahead of their own) on the other end. In global health research agenda-setting, the use of soft power for reasons of self-interest could mean it is employed to push for research priorities that are consistent with HIC partners' areas of expertise and research interests or that further their career development. At the other end of the spectrum, it could be used by HIC partners to push for the research priorities that are in the best interests of LMIC partners and populations—namely, priorities that address LMIC partners' research interests and/or the health needs and concerns affecting their countries. In the middle of the spectrum, soft power could be used to support research priorities that are in the best interest of the collaboration as a whole. Priorities that are likely to secure funding, have a big impact globally, and/or generate prestige for the entire research team. Perhaps fairness in the use of soft power corresponds to the extent that LMIC partners' and populations' interests are factored into the outcomes its use furthers. In other words, its use in global health research is the fairest where it promotes LMIC partners' and populations' interests, somewhat fair when it is used to advance the interests of the entire collaboration, and unfair where its purpose is to further HIC partners' self-interest.

Even so, where soft power is used by HIC partners to push for the interests of LMIC partners, it is possible that this can be done in a way that is paternalistic and thus disrespectful. In such cases, HIC partners might assume they know what LMIC partners want and what's best for

them, without asking them. It is important not to use soft power in a way that is paternalistic even if the intent is to help advance LMIC partners' interests.

To assess the fairness of persuasion tactics used, the following considerations are suggested: Where forms of soft power other than manipulation and taking advantage of vulnerability are used by HIC researchers, does their use of soft power reinforce structural inequities between them and LMIC partners? Does its use further HIC funders' and/or their own self-interest at the expense of LMIC populations' and partners' interests? Where forms of soft power are used by LMIC researchers, is it during decision-making with HIC researchers about matters that they have historically been excluded from or where their rational arguments have been unfairly discounted? Do they use soft power to advance their population's or the collaboration's interests?

Turning now to the nature of agreements in shared decision-making, the case examples suggest that forms of agreement beyond joint intentions and one-way compromise favouring HIC partners arise in global health research. This raises the question: Are agreements that are not joint intentions inherently unfair in global health research collaborations? If not, when are compromises fair? Perhaps one-sided compromises favouring HIC partners are unfair but several other forms of compromise have been described. *Intersection compromises* occur when there is some overlap between the positions of the parties involved in the decision-making process. The parties agree to compromise on that area of overlap and to forsake aspects of their positions that do not overlap. For instance, if each party has a list of research priorities, they agree to move forward on those priorities found on both lists and to leave behind any priorities that are only on one party's list. Neither party thinks that the area of overlap is actually better than his or her own full original position, but each thinks that achieving a subset of that original position is better than what may occur in the absence of an agreement.⁵³ *Conjunction compromise* means the parties' positions do not share any elements whatsoever in common; their positions are completely in conflict. Nonetheless, the parties agree to a conjunction compromise consisting of some elements of each of the conflicting positions. Each believes that the compromise solution is worse than his/her own initial position, but agrees to the compromise because implementing it is better than what would

⁵³ Leopora, C. and Goodin, R. 2013. *On Complicity and Compromise*. Oxford: Oxford University Press.

occur in the absence of any agreement.⁵⁴ As an example, where parties do not share any research priorities in common, a conjunction compromise occurs where they decide to move forward with five priorities from party A's list and five priorities from party B's list.

In Case 2, the agreement reached was a conjunction compromise. Both LMIC researchers and the community organisation got things that they wanted on the final research agenda. The project's focus remained on nutrition, as the researchers had initially proposed. Yet the community organisation was able to collect data on other health issues, take the lead on data collection and analysis, and employ community members as field investigators. It was also assured that future collaborative projects would focus on priorities within the community such as alcoholism.

In Case 1, the agreement reached was closer to a conjunction compromise than a one-sided compromise. The decision-making process did result in an overarching research priority that reflected the ideas of senior HIC researchers, which is consistent with a one-sided compromise. Yet, LMIC researchers were able to set the research topics and questions for the research projects undertaken in their countries as part of the collaboration. They had agenda-setting ownership at the project level and thus may have been less concerned about influencing the consortium's overarching priorities. Additionally, the case suggests that it is important to consider compromises across levels of priority-setting within global health research collaborations in order to make an accurate assessment of what types of compromise have been reached. If only the consortium level were considered, this example might be seen to have resulted in a one-sided compromise.

The decisions reached in both cases were classified as conjunction compromises, rather than the ideal outcome of joint intentions, but this does not necessarily mean such outcomes were unfair. Fair compromises occur when the value or size of the concessions made by parties to the compromise are balanced.⁵⁵ Either the parties all make small concessions or all make large concessions to reach an agreement. For example, in an intersection compromise, the positions that are given up are of similar value for both parties to the compromise. I would

⁵⁴ Ibid.

⁵⁵ Warren and Mansbridge *op. cit.*, note 32.

argue that the value or size of the gains achieved by the parties are also balanced in a fair compromise. This is what eventuated in Case 2 between LMIC researchers and the LMIC community organisation. I would further argue this definition of fairness primarily applies in contexts where parties in decision-making are both from the same country or countries between which there have not been historical or current power imbalances.

Given the inherent structural inequities between HICs and LMICs, a fair compromise would look different between HIC and LMIC partners. Fairness occurs, not where balance is achieved, but where parties from LMICs achieve *greater* gains and/or make *smaller* concessions than parties from HICs. Compromises where LMIC partners' gains are bigger is one way to combat an agenda-setting environment that favours HIC funders and researchers.

To assess fairness in a compromise decisions of a global health research collaboration, the following considerations are then suggested: 1) what did each party get? Are LMIC partners' gains higher in value than HIC partners? Are LMIC partners' gains of similar value to other LMIC partners? 2) what did each party lose? Are LMIC partners' losses smaller in value than HIC partners? Are LMIC partners' losses of similar value to other LMIC partners? A fair outcome is achieved where the gains and losses favour LMIC partners over HIC partners and where the gains and losses for LMIC partners are similar. For example, in global health research priority setting, the following would comprise fair types of compromise:

- Conjunction: Two research questions come from LMIC partners and one research question comes from HIC partners; Each is a high priority research question for the partner proposing it
- Intersection: Two research questions are selected in the overlap zone between LMIC researchers and LMIC policymakers. Each is the highest priority research question in the overlap zone for the respective partner
- One-sided: LMIC research partners' research questions are adopted; HIC research partners' research questions are not

Conclusion

The principle of shared decision-making has been proposed as a feature of ethical global health research partnerships. It is important to be specific about what is meant by the principle if we are to speak usefully about it. So far, its content has not been described in

detail. Towards developing an account of fair shared decision-making as a minimum standard for global health research collaborations, this paper has shown that part of assessing fairness entails considering the nature of the persuasion tactics used and the nature of the agreement that is reached.

Ideas were presented about when soft power (other than morally wrongful forms of manipulation or taking advantage of vulnerability) can be fairly employed between HIC and LMIC partners and what fair compromise agreements may look like in shared decision-making. Where forms of soft power are used by HIC partners, they should not reinforce structural inequities in the research system or privilege HIC partners' interests over LMIC partners' interests. Where forms of soft power are used by LMICs partners, they should be employed in decision-making related to matters where they have historically been excluded and to further their population's or the collaborations' interests. Where the agreement reached is a compromise, the gains and losses should favour LMIC partners over HIC partners. While these are not the *only* considerations to take into account to assess the fairness of shared decision-making in global health research collaborations, they are necessary considerations to help make such determinations.

This paper has primarily proposed ideas for what comprises fair decision-making between *HIC and LMIC* partners in global health research collaborations. An important topic to explore in future research is, thus, what comprises fair shared decision-making between LMIC researchers from different countries or between academic partners and community partners. What constitutes fair persuasive tactics and agreements in such partnerships? When (if ever) is it fair for LMIC researchers to use soft power when making decisions with other LMIC researchers or community partners? While context and intent considerations may still apply, they will likely differ from the ones introduced in this paper for shared decision-making between HIC and LMIC researchers.

Future research should also further define and clarify what constitutes fair use of soft power and fair agreements between HIC and LMIC partners in global health research collaborations. Such research could usefully continue to explore when it is fair or unfair for LMIC partners to use soft power when decision-making with HIC partners. Two scenarios are identified as fair uses of soft power in this paper (i.e. when decision-making is about matters that LMIC partners have historically been excluded from and when their rational arguments are unfairly

discounted), but there may be more fair scenarios along with a range of scenarios when it is unfair.

To continue developing the proposed account, it would be useful to gather HIC and LMIC researchers, community organisations, and policymakers’ views on what comprises good and bad intentions in shared decision-making in global health research. Applying additional conceptual literature on compromise, fair benefits, and consensus and conducting empirical work could help further define what gains and losses favouring LMIC partners look like in global health research. Future research could explore whether and/or when compromises favouring LMIC partners are ethically better or equivalent to joint intentions that blend the ideas of HIC and LMIC partners. Finally, further development of the account requires research to explore features of fair shared decision-making beyond persuasive tactics and resultant agreements such as whose voices are fairly raised and heard. A question to consider here is whether and/or when it is fair for some voices to dominate and to have unequal voice.

Ultimately, this paper has sought to interrogate the principle of shared decision-making, which is increasingly promoted in global health research. It is hoped the ideas presented will prompt more consideration of what the ethical standards of shared decision-making should be in global health research.

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Table 1: Types of shared decision-making

Ideal shared decision-making	Fair shared decision-making
Rational persuasion tactics used Equal opportunity to raise voice and be heard Mitigate power disparities in deliberative spaces Consensus as joint intentions	Competitive persuasion tactics used <ul style="list-style-type: none"> - Forms of soft power other than manipulation and taking advantage of vulnerability Intersection, conjunction, or one-sided compromises that favour LMIC partners Other yet to be identified features

Unfair shared decision-making	Non-ideal 'shared' decision-making
<p>Competitive persuasion tactics used</p> <ul style="list-style-type: none">- Hard power- coercion <p>Soft power- manipulation and taking advantage of vulnerability</p> <p>Some voices dominate; others are silent</p> <p>Power disparities are used to advantage</p> <p>One-sided compromise that favours HIC partners or an agreement with unfair level of benefits for LMIC partners</p>	<p>Failure to share decision-making power: consulting or informing</p>

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