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Contents

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Editorial: Choices and Barriers

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In this issue we start with the Barcelona Declaration of the International Society for Clinical Bioethics: Protection of children's dignity and rights in the context of new global challenges and increased vulnerabilities. Self-determination is especially a critical issue for vulnerable persons, who often find the barriers to expression of their will insurmountable. The decision making capacity of children is often ignored, despite their autonomy. Khatani and Akhtar illustrate some of the challenges faced by women in Pakistan in examples of structured bureaucracy in one of many countries where government systems do not empower citizens.

The theme of vulnerability and consent is also explored in other papers in this issue. Mohammad Mahmodur Rahman explores the process of obtaining consent in the use of cesarean sections in Bangladesh. Certain countries have higher level of cesareans, and in some cultures it has become a norm. P. Sreejith et al., explore the roles of affluence in the choices on assisted reproductive technology (ART). Affluence also affects the tendency towards control of timing of birth with cesarean delivery – and we could explore further the way that, ironically, sometimes increased wealth leads some consumers to expose themselves to technologies that may actually make them more vulnerable. However, overall access to choices such as ARTs may be a form of empowerment of people providing options. One of the risk factors for infertility is poverty, which tends to be associated with higher risks of STDs, as well as poorer public health and health, increased use of drugs, alcohol and stress.

Jan Kahambing discusses some of the ethical implications of the anthropocene, the period of human activity on the world in which we live. In the past few months we can see more examples of biodiversity loss, which seriously afflict our fellow species on the planet. There is also a paper exploring telemedicine, which can provide greater access to medical services for an increased proportion of the population than before. Youth unemployment in Nigeria further explores the rise of poverty, and the waste of a generation. Bioethical systems of government empower people to provide less barriers to their choices, stimulating innovation and life.

Barcelona Declaration of the International Society for Clinical Bioethics: Protection of children's dignity and rights in the context of new global challenges and increased vulnerabilities

XV Annual Conference of the International Society for Clinical Bioethics, Bioethics and Paediatrics: Future development and challenges, Barcelona, 20-21 September 2018

Preamble

1. The International Society for Clinical Bioethics met at her XVth Conference on September 20-21, 2018 in Barcelona and discussed future developments and challenges in pediatrics, and for children's protection rights, in an effort to make a universal appeal to ensure every child is protected for a better future.

2. Children are our common future in our Globe. They depend on us, on the families, on the states, and international and local guidelines, and regulations. Children are vulnerable and dependent; therefore, it is our duty to provide them with a happy future, healthy childhood, and protection from discrimination and violence.

3. An effort must make to ensure that the international, national and local standards to protect children's rights are strictly enforced. Global efforts must be aimed at zero tolerance to the growing vulnerability of children in the context of the scientific and technological progress, global challenges, and migration processes.

4. At the same time, threats to global peace, scientific and technological advances and a departure from the values of humanism create the conditions and prerequisites for increasing the vulnerability of children, many children still live in the risk zone.

Problems

5. Threats to the health of children remain relevant on the international agenda and at the level of national states. These include war, poverty, hunger, racial discrimination, exploitation, adult brutality and other acts of violence.

6. With increasing migration and displacement, many children are forced to leave their homes and sometimes their families. There are migrants in all countries of the world. Their number is growing faster than the world's population, and in 2015 it exceeded 244 million people. In fact, every 4.1 seconds there is a new refugee in the world, while approximately 65 million people are internally displaced, including more than 21 million refugees, 3 million asylum-seekers and more than 40 million internally displaced persons. The UN notes that 46% of the 45.2 million children and adolescents under the age of 18 are minors who become hostages of global politics and are even more vulnerable in these conditions.

7. Scientific and technological progress, designed to improve the life and health of children, promote their harmonious development and success, often creates prerequisites for threats and potential risks, including the consequences of genetic engineering, information technology and virtual reality, cybercrime, the growth of social inequality and loss of access to social benefits, social maladjustment and many others. It is a reality the 50 % of the medicines used for children have not been tested with them, 90 % in the case of premature neonates.

8. We witness the emergence of a disturbing trend of dehumanization in international and national legislation in terms of the rights of children and their parents, and the emergence of legal norms legitimizing children's euthanasia, which is a direct threat to the life and health of children, destroys the values of the traditional family.

9. All these problems lay the groundwork for dismantling the values and norms of positive results that have been achieved thanks to such basic international documents as the European Convention on Human Rights and Fundamental Freedoms (1953), the Declaration of the Rights of the Children (1959), Universal Declaration of Human Rights (1948), and the UN Convention on the rights of the child (1989).

Tasks

10. Compliance with international guidelines and regulations for the protection of children and adolescents, therefore the United Nations Convention on the Rights of the Child must be recognized at local, regional, and international levels.

11. Ensuring children equal opportunities and access to healthcare and social benefits. Advances in science and technology should be aimed to improve health and quality of life of children, reducing injuries, disabilities, and causes of child mortality.

12. Protecting children's rights of migrants, and internally displaced persons and to preventing their use for discrimination, exploitation, trafficking, and manipulation, and protecting their personal space, and cyber-space, and their personal data.

13. Children must be prepared for a responsible life in a free society and be able to adapt to uncertainty, to have the opportunity to define themselves as individuals, and realize their potential in a safe and supportive environment (e.g.,

family, education, sports, etc.) to ensure their well-being.

14. Commitment to the values of humanism in the family, social policies, including those supported by traditional religions, to strengthen the relationship between parents, family, and children.

15.Bioethical expertise and well-organized activity aimed at forecasting new emerging threats to human potential and vulnerable groups of population, especially of children, is more and more necessary.

16. The core of this kind of activity should be bioethical guidelines formulated in terms of clinical and global bioethics to minimize risks of vulnerability, to guarantee protection of children's rights in the context of global challenges and medical practice.

Ethical duties

We hereby solemnly commit ourselves to:

17. To promote active participation of the scientific and expert community, of which we are a part to protect the well-being of children.

18. To work together within the framework of international cooperation, also on local and regional levels.

19. To include in the agenda of annual international meetings topics related to risks of vulnerability, and protection of the rights of children, and to intensify research in this direction.

Barcelona, September 20-21, 2018

International Society for Clinical Bioethics

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Obtaining informed consent for Cesarean sections in Bangladesh

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Abstract

Primary and secondary level hospitals are yet to introduce an informed consent procedure before performing cesarean sections in Bangladesh. There is no standard informed consent practice in the tertiary level healthcare institutions and hospitals. This study argues that the existing informed consent practice before performing cesarean section in most of the tertiary level hospitals can be regarded *merely as consent* (and I call it mere-consent) rather than informed consent. The private hospitals and clinics usually provide so-called informed consent forms. Majority of these hospitals and clinics consider the informed consent as an institutional procedure rather than *ethical procedure*; and they use the informed consent form as a safeguard if there is any trouble concerning the safety of patient. This study concludes that informed consent in true sense needs to be practiced in cesarean sections. Obtaining informed consent may provide moral confidence to the physicians and inspire them to become *ethical physicians*. At the same time, it will create such *awareness* among them so that they realize a major surgery like cesarean section cannot be performed without the proper informed consent of the mother.

Introduction

Informed consent is one of the basic rights of patients which physician should honor for the welfare of the patients. In order to participate in the decision-making process of the treatment, a patient can rightfully ask questions related to treatment from the concerned physician. The philosophical basis of informed consent derives from the principle of respect for autonomy which strongly demands patient's involvement in the decision-making process of the treatment. However, informed consent is more of a legal and ethical procedure rather than a signature on a form. This paper focuses on the necessity and importance of obtaining informed consent concerning cesarean sections in Bangladesh. It argues that some of the standard hospitals in the country do not follow the proper procedure of informed consent; what they do can rather be called "mere-consent". This paper suggests that an informed consent in real sense

needs to be implemented for cesarean section at hospitals; and physicians should obtain informed consent before performing cesarean sections.

Mere-consent and informed consent

Giving a mere-consent is a way of allowing an action to be performed. If anyone agrees to allow something, that constitutes a consent. It seems that saying "ok" or showing particular affirmation in a certain case can be considered as giving a mere-consent. One may give a mere-consent orally or one may give a mere-consent in written. Mere-consent may involve seeking the permission to perform any task but may not always include rational decision-making process. Hence, just obtaining a mere-consent (not really informed consent) may not be enough for performing any cesarean section.

In contrast, an informed consent invokes rational decision-making process and demands a friendly and an effective relationship between two agents. It includes alternative options and a decision from the participants also. Here both agents discuss the problem to get the best solution and are informed about all the pros and cons of the issue. The solution may come from any participant. In short, informed consent must include a rational decision-making process and all information should be disclosed before coming to a final decision. On the other hand, in case of a mere-consent one participant, in fact the patient is only eligible to say "yes" or "no". She may not be allowed to say something more than "yes" or "no" and even may not offer any alternative option. Most of the time the other participant, in fact the physician plays the vital role in decision making.

Obtaining an informed consent is a legal procedure which is required for ethically sound medical practice. Physicians need to disclose each and every bit of the relevant information including risks and benefits, side effects, costs of the proposed treatment, available alternative options of the treatment and so forth. Therefore, obtaining a mere-consent is merely seeking permission whereas obtaining an informed consent is seeking permission for a treatment to be performed after explaining the positive and negative sides of the treatment. However, patients have the right to agree or disagree with the proposed treatment. One of the main requirements for obtaining an informed consent is that patients need to be competent to understand the disclosed information so that they can take decisions voluntarily which are free from any coercion or influence. A written informed consent is preferable to verbal consent.

The practice of obtaining mere-consent instead of informed consent is a medically questionable practice because it only cares about patients' autonomy whereas the other three principles of biomedical ethics are ignored. On the other hand, obtaining informed consent not only includes patient's autonomy but also cares about the welfare of the patients. Such obtaining of informed consent fulfills all the four basic principles of biomedical ethics[1]. But the medical practice in Bangladesh, especially for cesarean sections is questionable as it opens the door for obtaining mere-consent based on medical practice.

Necessity of obtaining informed consent on the basis of four principles

The philosophical foundation of informed consent rests on the principle of respect for autonomy. Respect for autonomy demands health professionals to build a sound relationship with patients so that patients can make their own decisions. "Autonomy" and "respect for autonomy" are used closely in medical practice. Kant emphasized on the autonomy concept. According to Kantian ethics, one cannot act morally unless the person is autonomous (Wood 2008, 106). These terms are thought to be consistent with informed consent procedure and are closely related with the elements of informed consent such as privacy, voluntariness, choosing freely and the freedom to choose and taking responsibility for that action. Beauchamp and Childress write, "We think that respect for autonomy does provide the primary justification of rules, policies, and practices of informed consent (Beauchamp and Childress 2013, 121)." Faden and Beauchamp (1986, 235) claim that an analysis of the nature of autonomy provides the essential foundation for their analysis of the nature of informed consent. So, we can say that informed consent is very much needed from the sense of autonomy especially from the principle of respect for autonomy.

The main purpose of the principle of beneficence is doing good to the patient in any medical practice. Informed consent suggests physician to establish an effective relation with patients for their welfare. A treatment cannot be ethically sound if benefits of the treatment do not overcome the risks of it. Moreover, an important element of informed consent is to share the possible risks/benefits of the treatment to the patient. When a physician is altruistic to his patient, he or she does not hesitate to help the patient make decisions regarding treatment. The principle of beneficence suggests the physician to be altruistic to his patients. In

[1] In biomedical ethics, the four principles are respect for autonomy, beneficence, nonmaleficence and justice. These principles are introduced by Beauchamp and Childress who are thought to be the pioneer of biomedical ethics. These principles are widely accepted by ethicists.

addition, informed consent is in legitimate interest of a patient. Thus, informed consent can be called a legal right of a patient. Some physicians are not aware of this legal right. Physicians begin their study in medicine by Hippocratic Oath.[2] Although they learn about certain laws, they may not care enough about this legal right. This right is not emphasized as a duty as mentioned in Kantian ethics. If physicians take this as their duty, they cannot deny it. The principle of beneficence obliges a physician to fulfill patient's legitimate interest. Beneficence also suggests a physician to be kind to his patient. When physicians show kindness to their patient, they become able to realize the patient's interest. Eventually physicians become aware to do the right thing to the patient. So, physicians need to care about patient's decision. They need to try their best to make every kind of help to a patient for making a proper decision about treatment. When a patient is in trouble to make a treatment decision, physician is the most reliable person to assist the patient.

The first and foremost demand for principle of nonmaleficence is doing no harm to patients by medical practice. Although informed consent is an ethical doctrine, we have seen that sometimes it can also be called as a legal right of a patient. So, if physicians do not obtain informed consent before any medical treatment, it is like ignoring a patient's legal right. The informed consent procedure demands the exposure of each and every effective information of possible treatments. If physicians do not provide so, then patients become ignorant of their treatment procedure. In that situation, they are unable to make the proper decision. So, hiding information regarding the treatment procedure sometimes may be harmful to the patient. Therefore, depriving patients from the proper information is not permissible according to the principle of nonmaleficence. In addition, informed consent may ensure the welfare of a patient. So, physicians cannot ignore obtaining informed consent; rather it is their responsibility to obtain informed consent before any medical practice.

Informed consent is also necessary from the perspective of principle of justice. The general demand of justice is fairness. One of the main purposes of obtaining informed consent is also to establish fairness in medical practice. Physicians need to be honest regarding the treatment procedure, risk-benefit analysis, and alternative options for the treatment procedure and so forth. One of the important elements of informed consent for a competent patient is the absence of coercion. Justice can ensure this condition. "Right based justice" is derived from the principle of respect for autonomy which emphasizes on proper respect to individual's right. Every patient has the right to be informed about his or her treatment. In this regard, informed consent can be called an individual right of a patient who deserves proper respect from a physician before any medical practice. Besides, "legal justice" approves various types of morally accepted laws and informed consent is one of them.

Informed consent needs to be obtained regardless of patients' position, gender, and wealth. According to Daniels (1985) "fair equality of opportunity" requires that no person irrespective of natural disadvantages (e.g. malnutrition) and social disadvantages (e.g. tribal community) should be deprived of any benefit because of a socialy disadvantageous situation. Daniels follows Rawls' theory of justice in the healthcare system with special focus on "fair equality of opportunity", and argues that healthcare needs are special as they ensure proper functioning and opportunities of a person. So, if a patient comes from a poor family, he/she deserves an equal care with a patient from a rich family. "Fair equality of opportunity" focuses on maintaining moral and legal rights of the patients regardless. As informed consent has both legal and ethical implications, it needs to be obtained from each and every patient.

We can say that a woman must have the right to take decision whether she will choose cesarean or not. Thus, performing surgeries like cesarean section needs to be approved by the patients with a prior informed consent, otherwise it may not be justified.

The present scenario of Cesarean section in Bangladesh

Cesarean sections are the most widely performed surgery for women in Bangladesh. Normally a cesarean delivery should be performed when it is not possible to deliver a baby through normal or vaginal delivery because of various complications which may endanger the life of mother or baby. The rate of cesarean section in Bangladesh has been increasing. The percentage of the Cesarean section in the country was 31.3% in 2014. The rate of cesarean section increased to 37.9% within a year in 2015 which is far away from the World Health Organization recommendation range of 10 to 15 percent (Management Information System 2016, 54). Overall, different reports show different rates of increase of Cesarean sections in Bangladesh. However, all of them agree with the increasing number of Cesarean sections.

[2] The Hippocratic Oath explains the obligations of the physician to medical students. This oath suggests physicians to consider the welfare of patient and refrain from doing harm. It encourages them to lead an imitable life.

The above-mentioned phenomenon occurs due to the fact that most of the time physicians are reluctant to wait for normal deliveries and suggest surgical ones. They do not even wait for obtaining informed consent which is required before performing a Cesarean section. The following scenario make this situation clear:

Governmental healthcare institutions

Based on facilities provided, healthcare institutions in Bangladesh can be divided into three major categories: primary, secondary and tertiary. Most of the public primary healthcare institutions are situated in ward, union and sub-district (upazilla) level which is called Upazilla Health Complex (UHC). At present the number of Upazilla Health Complex hospitals in the country is 411; 132 of them provide comprehensive emergency obstetric care where cesarean section is performed and the rest provide basic obstetric care (MIS 2016, 53). Secondary healthcare institutions are mostly government district hospitals and general hospitals. Government medical college hospitals, specialized hospitals and post-graduation health institutions in the country, Bangabandhu Sheikh Mujib Medical University (BSMMU), are the tertiary level health institutions.

According to Health Bulletin 2016, a total of 175,888 cesarean deliveries were performed in 2015 at governmental healthcare hospitals. Table 1 illustrates the country's obstetric care services (MIS 2016, 55).

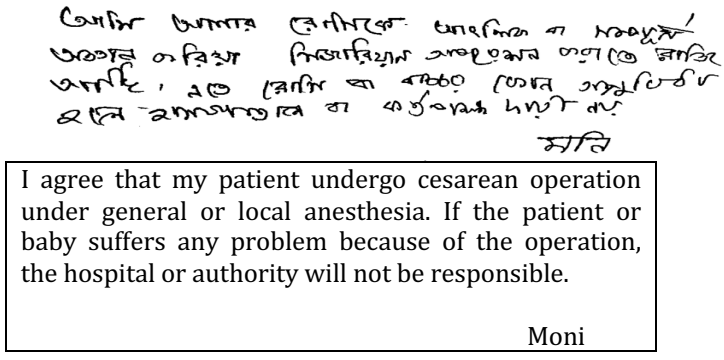
Table 1: The numbers of governmental and non-governmental emergency obstetric care facilities in Bangladesh, 2015

	N	%
Postgraduate medical institution hospital	3,403	1.9
Medical college hospital	53,137	30.2
District hospital/ general hospital	41,751	23.7
Upazilla health complex	19,561	11.1
Other govt. facilities at Upazilla level	58,036	33
Total	175,888	

A report published by the Directorate General of Health Services, shows that 44.1 percent of cesarean deliveries were performed in upazilla based government hospitals in 2015 (MIS 2016, 54). But there is no evidence that physicians at that level obtained informed consent before performing cesarean sections. Normally district hospitals and general hospitals provide better obstetric care than upazilla health complexes. But it is a matter of regret that informed consent is ignored there too.

Most of the public tertiary care hospitals which provide obstetric care are situated in the capital and divisional cities. Hospitals situated in those areas provide the highest level of public obstetric care services in the country. Some of the hospitals at that level consider informed consent insignificantly while most of them *do not* even care. Figure 1 shows a sample of so called 'informed consent' practice from one of the advanced tertiary care hospitals in Bangladesh. Most of the time hospital authorities provide this sort of form when the patient gets admitted into the hospitals.

Firstly, we notice that the permission was taken from the guardian (name: Moni) who is the husband of the patient and the permission was not taken from the patient herself without any indication of special or emergency situation. Taking consent from a patient's guardian is not justified because it requires patient's participation in the decision process. But it is a common scenario that patient's involvement is ignored in the decision-making process. Secondly, we cannot accept the procedure as an informed consent. It is a mere-*consent*. This procedure only seeks the permission to perform Cesarean but does not include rational decision-making process. Disclosing the risk-benefit of the treatment is a vital part of informed consent procedure which is clearly absent in this form. Moreover, this form only presents institutional obligation but no ethical obligation. Therefore, it can be said that hospitals or authorities use this sort of form as a safeguard when any trouble occurs.



I agree that my patient undergo cesarean operation under general or local anesthesia. If the patient or baby suffers any problem because of the operation, the hospital or authority will not be responsible.

Moni

Figure 1: Sample of so called 'informed consent' practice in a tertiary level hospital in Dhaka, with English translation

Only one institution, Bangabandhu Sheikh Mujib Medical University (BSMMU) provides a much better and relatively clear informed consent form, but the actual practice of informed consent remains uncertain and even if so only 1.9 percent of all Cesarean sections in government facilities are performed there. On the other hand, almost 60 percent of Cesarean sections are performed in other tertiary hospitals in Bangladesh.

Non-governmental hospitals and healthcare institutions

Private hospitals, clinics and NGO driven healthcare institutions provide obstetric care for women. According to Health Bulletin 2016, a total of 306,725 cesarean deliveries were performed in non-government hospitals in 2015 compared to 223,514 in 2014. Among them 93.1 percent were performed in private hospitals and clinics. The rest were performed in NGO governed healthcare institutions (MIS 2016, 55). But surprisingly the number of cesarean deliveries in the private institutions and hospitals has increased to 750,000 in 2016 (National Institute of Population Research and Training et al. 2016, 57). The practice of informed consent before performing Cesarean in private hospitals of Bangladesh is vulnerable and frightening.

A case study was recently published in one of the most popular newspapers of Bangladesh. A patient name Shazneen Begum, a public health specialist by profession, was taken to a well-known private hospital in the capital city as her water broke in the 38th week. She was told that meconium got mixed with the amniotic fluid and the baby was floating inside her womb. As her earlier delivery was normal, she wanted to wait for a normal delivery at this time too. But the doctor refused to take any responsibility for any negative outcome and justified that she go under the surgery. Shazneen Begum, on an interview mentioned that the communication process of the doctor was not supportive but threatening. She also added that there was a lack of sufficient information regarding her condition. She stated, "I was just told that it was going to be complicated. I was never explained the risks associated with stool (meconium) mixed in the amniotic fluid properly" (Karim 2017, 4). This study clearly indicates that informed consent was not obtained as informed consent procedure cannot be completed without explaining proper risk and benefit of performing Cesarean section. Although the patient wanted to know the details, she was refused. This type of scenario is very familiar in the Cesarean sections in the private sector in Bangladesh. It is quite rare to wait and try for a normal delivery in private clinics or hospitals in Bangladesh.

Like government hospitals, private clinics and hospitals provide the so-called informed consent form. But most of the times this is not given to the patient. Before the anesthesia, hospital authority takes a signature from patient's representative or legal guardian. They informe the guardian that if any complicacy arises to the patient or baby, they will not take any responsibility for that. The authority takes the sign from the guardian only as their safeguard. Most of the Cesarean deliveries recommended by physicians in private hospitals in Bangladesh are questionable. A very recent report finds that 70 percent of the cesarean deliveries in Bangladesh are unnecessarily performed ("70% of Caesarean births").

Village doctors and midwifery

Approximately 65% of people in Bangladesh live in rural areas (World Bank 2017). The majority of women living in village rely for their emergency obstetric care on village doctors and untrained midwives. There are several types of clinics in rural areas. Sometimes a rented house having few rooms with limited instruments forms a clinic. Women from poor families are their main clients. Untrained doctors are also performing Cesarean sections there. They do not care about informed consent. Some do not even know what informed consent is.

Poor ethical standard of Cesarean section in Bangladesh

A recent report suggests that 70 percent of the Cesarean section in Bangladesh is "unnecessary" which cost the patient US $315 million annually or US$552 per operation (Mannan 2017). This mammoth amount not only demonstrates the unethical business of hospitals but also indicates that the ethical standard of the hospitals is not up to the mark. Institutions like hospitals should not act like other financial institutions which focus on money making. Besides, patients being used as means for the individual welfare of the physician cannot be acceptable from a Kantian standpoint. This practice is completely immoral. Sometimes physicians provide incomplete information to the mothers and their families. This also indicates that physicians are unaware about their duties and reluctant to go by ethics and morality. Most of the time they do not feel the obligation by the principle of "do no harm", while it is an obligation to do no intentional harm to others. In medical ethics, it obliges physician to refrain from doing any harm to patients. According to many ethicists, it is the foundation of ethics in medical treatment.

According to a study the average length of primary care physician consultation time was 48 second per person in 1994, which has increased to 2 minutes per patient in 2015 in Bangladesh (Irving et al. 2017, 5). This length was the longest in Sweden at 22.5 minutes. This duration is 21.07 minutes in USA, 15 minutes in Australia and Canada, and 3.4 minutes in Pakistan. Even the consultation time is higher in our neighboring country India. Consulting a patient for 2 minutes can never be satisfactory. Even when a physician from a public hospital visits a pregnant woman in private clinics or hospitals normally he spends significantly more time than for a pregnant woman in public hospitals.

It is not unfamiliar that the same physician, who gives his or her patients only a minute or two in public hospitals, gives 10 to 12 minutes in private hospitals.

Private hospitals and clinics of Bangladesh are operated under *Medical Practice and Private Clinics and Laboratories (Regulation) Ordinance, 1982*. The ordinance does not include obtaining informed consent as a mandatory procedure before medical intervention. So, physicians in private hospitals opt for Cesarean sections which are in some cases not necessary. Besides, Bangladesh Medical and Dental Council (BMDC) which is one of the apex regulatory bodies under the Ministry of Health and Family Welfare suggests obtaining informed consent in scientifically assisted reproduction and related technologies like artificial insemination. We can say that this guideline is for special cases only and there is no general guideline for obtaining informed consent before general medical practice in the country. However, MBBS students learn about "medical jurisprudence" as well as health ethics in the forensic medicine course. The curriculum offers emphasis only on obtaining consent while informed consent is ignored (Bangladesh Medical and Dental Council 2012). Therefore, the absence of informed consent in policy and curriculum level has a negative impact on the thical aspect of medical practice like performing cesarean sections.

Implementation of informed consent in true sense in Cesarean section in Bangladesh

After the above discussion, we find that, there is no standard practice of informed consent all over the country; there are no clear rules and regulations from the governmental authority to obtain informed consent before performing Cesarean section as well. Basically, Cesarean section is a life-saving surgery. Performing any surgery without informed consent is not ethically acceptable.

The main purpose of a cesarean delivery is the welfare of mother and baby. 83 percent of the total performed Cesarean deliveries in private healthcare institutions has not been proved to be helpful for the significant reduction of maternal mortality ratio (MMR) or child mortality rate of Bangladesh. 46 percent of all performed cesarean deliveries in public healthcare institutions has not proved to be helpful in this respect either. According to Bangladesh Maternal Mortality and Health Care Survey 2016, MMR has increased to 196 maternal deaths per 100,000 child births in 2016 which was 194 in 2010 (NIPORT et al. 2016, 93). Thus, these Cesarean practices cannot be justified on the ground of MMR reduction. As most of these deliveries are performed without proper informed consent; hospitals and authorities do not take any responsibility for the harmful incident.

If physicians obtain informed consent before surgery, they would be liable for any harmful incident and that would make them perform surgery with utmost care. This type of cautious practice (not to harm patient) will give physicians moral confidence and will give positive impetus to become an ethical physician. If physicians obtain informed consent, it will also help them to become an ethical person too. After all, if physicians take responsibility to maintain proper informed consent procedure, the scenario will be different. There are some cases when women choose to go under Cesarean section without proper reason. If they are properly informed about the risk-benefit of the surgery and alternative options, they may choose a normal delivery.

In our everyday life we have to sign various types of contract. We need to sign before buying land, house, and apartment or even before getting married. Most of these cases we are clearly informed about each and every detail of those contracts. Similarly, in case of a surgical operation like Cesarean section, the practice of informed consent needs to be transparent like those so that patients will know every detail of the proposed treatment. Moreover, informed consent is an ethical procedure rather than a form. Being informed should be given priority.

Bangladesh is an over populated country having a lot of illiterate people. Therefore, expecting miraculous change in the near future will be a dream. Nevertheless, the prevailing situations in Cesarean section should not continue. Obtaining informed consent can change the existing situation. It can decrease unnecessary Cesarean operation as well as unnecessary financial expenses. If informed consent is properly obtained, then it is possible that only those women who really need Cesarean delivery and have no other option will go under this surgery. As a result, the rate of Cesarean delivery will decrease to a moderate level. As an effect, the cost for unnecessary Cesarean operation will be decreased. Therefore, it can be strongly claimed that informed consent practice is seriously needed in the Cesarean section of Bangladesh to maintain the welfare of mother and baby as well as to reduce the unnecessary physical and monetary sufferings of persons undergoing it.

Conclusion

The present scenario of Cesarean sections in Bangladesh is not in favor of welfare of concerned citizens. The vast amount of Cesarean deliveries is being performed without maintaining proper ethical norms and regulations, especially in the absence of informed consent requirement. The activities that are performed for Cesarean section in Bangladesh deprive patients from making proper

medical decision and sometimes risk their lives. Lack of proper procedure of obtaining informed consent leads to unethical practices which cannot be supported from the Kantian viewpoint. Physicians in public hospitals need to be ethically aware and should give more consultation time to the patient. They need to wait for patient's decision as long as possible. In this article I have attempted to clarify that the practice of standard informed consent instead of mere-consent is an urgent need to solve many ongoing unethical activities in the Cesarean sections. I have also explained that, informed consent must be practiced considering it as the doctrine of ethical obligation, not just as an institutional formality. Obtaining informed consent from mother before performing Cesarean delivery will help physicians to give proper allegiance to Hippocratic Oath. Their aim will be welfare of the patients.

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References

Bangladesh Medical and Dental Council. (2017). Forensic Medicine in MBBS Curriculum Update. Available at: https://docs.google.com/viewer?url=http://bmdc.org.bd/wp-content/bmdc/c2012/5-Forensic%20Medicine.pdf, accessed: 23 November, 2017.

Beauchamp, Tom L., and James F. Childress. (2013). *Principles of Biomedical Ethics*. 7th ed. New York: Oxford University Press.

Daniels, Norman. (1985). *Just Health Care.* New York: Cambridge University Press.

Faden, Ruth R., and Tom L. Beauchamp. (1986). *A History and Theory of Informed Consent*. New York: Oxford University Press.

Irving, Greg, Ana L. Neves, Hajira Dambha-Miller, Ai Oishi, Hiroko Tagashira, Anistasiya Verho and John Holden. (2017). International Variations in Primary Care Physician Consultation Time: a Systematic Review of 67 Countries. *BMJ Open* 7 (10): 1-15.

Karim, Naimul. 2017. The Curious Case of the C-section. *The Daily Star*, Star Weekend, 4-5. http://www.thedailystar.net/star-weekend/health/the-curious-case-the-c-selection-1432768, accessed: 15 July, 2017.

Management Information System. (2016). *Health Bulletin 2016*. Dhaka: MIS, Directorate General of Health Services, 2016. http://www.dghs.gov.bd/index.php/en/home/4364-health-bulletin-2016.

Mannan, Ishtiaq. 2017. Caesarean Births 'boom' is Endangering Women's Lives in Bangladesh. *Asian Correspondent*, 15 August 2017, https://asiancorrespondent.com/2017/08/caesarean-births-boom-endangering-womens-lives-bangladesh/.

National Institute of Population Research and Training (NIPORT), International Center for Diarrhoeal Disease Research, Bangladesh (icddr,b) and Measure Evaluation. (2016). *Bangladesh Maternal Mortality and Health Care Survey 2016*. Dhaka, Bangladesh: NIPORT, icddr,b and measure Evaluation, 2016. https://www.measureevaluation.org/resources/publications/tr-17-218.

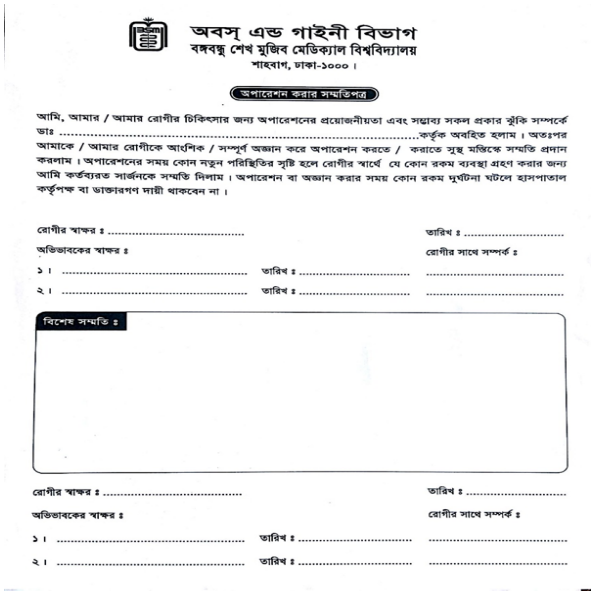
The Medical Practice and Private Clinics and Laboratories (Regulation) Ordinance, 1982. 2017. 27 May, 1982. http://bdlaws.minlaw.gov.bd/print_sections_all.php?id=620, accessed: 25 November, 2017.

The World Bank. Rural Population (% of total population). https://data.worldbank.org/indicator/SP.RUR.TOTL.ZS?locations=BD, accessed 2 September, 2017.

Wood, Allen W. (2007). *Kantian Ethics*. Cambridge: Cambridge University Press.

The Financial Express. 70pc of Caesarean Births in Bangladesh 'unnecessary'. 15 August, 2017, http://epaper.thefinancialexpress.com.bd/?archiev=yes&arch_date=15-08-2017.

Appendix 1: Informed consent form of obstetrics and gynecology department, BSMMU



অবস্ এন্ড গাইনী বিভাগ
বঙ্গবন্ধু শেখ মুজিব মেডিক্যাল বিশ্ববিদ্যালয়
শাহবাগ, ঢাকা-১০০০।

অপারেশন করার সম্মতিপত্র

আমি, আমার / আমার রোগীর চিকিৎসার জন্য অপারেশনের প্রয়োজনীয়তা এবং সম্ভাব্য সকল প্রকার ঝুঁকি সম্পর্কে ডাঃ .....কর্তৃক অবহিত হলাম। অতঃপর আমাকে / আমার রোগীকে আংশিক / সম্পূর্ণ অজ্ঞান করে অপারেশন করতে / করাতে সুস্থ মস্তিষ্কে সম্মতি প্রদান করলাম। অপারেশনের সময় কোন নতুন পরিস্থিতির সৃষ্টি হলে রোগীর স্বার্থে যে কোন রকম ব্যবস্থা গ্রহণ করার জন্য আমি কর্তব্যরত সার্জনকে সম্মতি দিলাম। অপারেশন বা অজ্ঞান করার সময় কোন রকম দুর্ঘটনা ঘটলে হাসপাতাল কর্তৃপক্ষ বা ডাক্তারগণ দায়ী থাকবেন না।

রোগীর স্বাক্ষর ঃ ..... তারিখ ঃ .....
অভিভাবকের স্বাক্ষর ঃ রোগীর সাথে সম্পর্ক ঃ
১। ..... তারিখ ঃ ....
২। ..... তারিখ ঃ ....

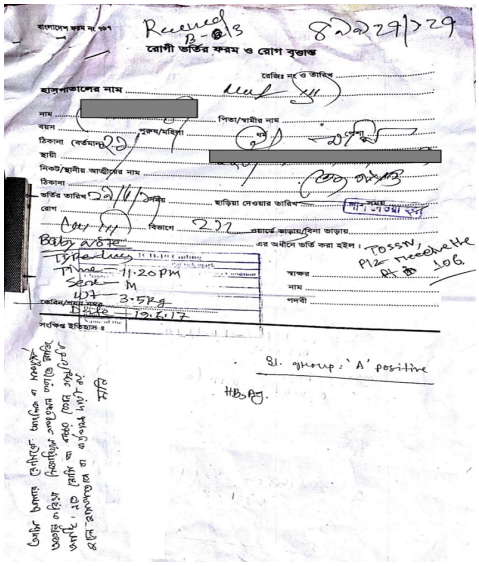
বিশেষ সম্মতি ঃ

রোগীর স্বাক্ষর ঃ ..... তারিখ ঃ .....
অভিভাবকের স্বাক্ষর ঃ রোগীর সাথে সম্পর্ক ঃ
১। ..... তারিখ ঃ ....
২। ..... তারিখ ঃ ....

Translation: Consent paper for operation:

"I, myself/my patient is informed about all the necessity and possible risks of the operation by Doctor….. After that I/my patient voluntarily and consciously approves of performing partial/full anesthesia for the operation. I consent to the on-duty surgeon to take every possible arrangement for the sake of patient's welfare in case of any emergency. Hospital authority or surgeon will not be responsible for any accident during operation/ anesthesia."

Appendix 2: Informed consent form of a tertiary level government hospital in Bangladesh


রোগী ভর্তির ফরম ও রোগ বৃত্তান্ত

Translation of the consent part
"I, on behalf of my patient agree to undergo cesarean operation by performing anesthesia. If patient or baby suffers any problem because of operation, hospital or authority will not be responsible for that."

A regulatory framework for telemedicine in Indonesia

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Abstract
Telemedicine is the use of telecommunications to provide information and medical services from a distance. There are legal issues related to implementation of telemedicine such as privacy and confidentiality of patient information, license and certification of provider, and legal liability. This technology has developed in Indonesia. However, Indonesia does not have specific regulations about it. This study aims to find out the legal aspects of telemedicine that are appropriate to be applied in Indonesia.

This research is normative research with statue approach and conceptual approach. The research material was obtained through literature review from legislation, court decisions, books, journals, and proceedings, both national and international.

The legal aspects of telemedicine in Indonesia consist of the legal definition of telemedicine, electronic medical records/electronic health record, medical device standards, data privacy and confidentiality, data protection, distance contracting and electronic signature, license and certification of healthcare and health professional, juridiction law, legal liability, and also e-prescribing.

Indonesia needs specific regulations of telemedicine, so that the implementation of telemedicine will not be not contrary with ethics and other regulations.

Introduction
The development of information technology has reached all aspects of life, including the health services area. The emerging technology in health area is telemedicine technology. Telemedicine is the use of technology to provide information and remote health services that include teleconsultation, tele-expertise, teleassistance, telemonitoring, and medical emergency call center. (Bilo et al, 2014)

Telemedicine is inside the health focus in Indonesia. It is the focus of Strategic Plan (Renstra) of the Ministry of Health 2015-2019. With this technology, communication between patients, doctors, and health facilities can occur remotely.

Implementation of telemedicine in Indonesia will provide some benefits. It's appropriate with Indonesia's geographic condition that consists of many islands. In addition, there is a maldistribution of healthworkers in Indonesia. Most doctors are centered in big cities (Anisa & Menaldi, 2015). With telemedicine technology, health services and information can be provided without limitations of distance and time. It can improve the quality of health in Indonesia and can decrease the number of referrals. It also can decrease self-diagnosis and self medication.

The impelemtation of telemedicine in Indonesia has several challenges including the guarantee of patient rights, the potential for the release of information and patient data, licensing issues and certification of service providers, and legal liability (Isabelle, 2010). The problem is very crucial, because in the health service, the patients' rights must be fulfilled. But, until now, there is no regulation for implementation of telemedicine in Indonesia.

Malaysia has had specific regulations on telemedicine called the Telemedicine Act 1997 (Laws of Malaysia, 1997). India also has a special regulation of the Telemedicine Act 2003 (Mable, 2010). Meanwhile, Indonesia has no specific regulation on telemedicine yet. Therefore, this study aims to examine the legal aspects of telemedicine in Indonesia, so that its implementation is not contraty to the patient's rights, ethics, morals, and other regulations in Indonesia.

Research Methods

This research is a normative research using a conceptual approach. The research material consists of primary legal materials (legislation relating to telemedicine in Indonesia), secondary legal materials (legal journals, law books, and legal proceedings), as well as non-legal materials (journals, books, and proceedings on telemedicine).

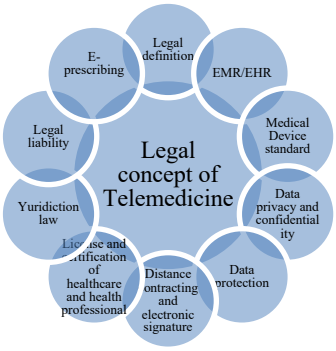

Figure 1: Legal concepts of telemedicine in Indonesia

Findings and discussion

Regulations in the implementation of telemedicine are needed to ensure the patient rights. The legal aspect of telemedicine in Indonesia includes the definition of telemedicine, electronic medical records, standard medical devices used in telemedicine, privacy and confidentiality data, data protection, remote contracts and electronic signatures, jurisdictional issues, legal responsibilities, and online prescribing.

Legal definition of telemedicine

The definition of telemedicine is a crucial matter to be agreed, because in the legal context, definitions determine whether a service is included in the context of telemedicine or not. According to the Minister of Health of the Republic of Indonesia Decree Number HK.02.02 2016 on Trial Hospital of Video-conference and Teleradiology-based Telemedicine Service Program, telemedicine is a health service that can be provided remotely through the use of communication and information technology for guidance/diagnostic consultation and management of patient care between the health care facilities of the facilitators and those who are taught. However, the regulation does not mention further the scope of telemedicine.

Telemedicine services can be done on real time basis (synchronized) such as videocall or audiocall and not realtime (asynchronized) such as chatting or sending emails. According to Blio et al, telemedicine consists of teleconsultation, tele-expertise, telemonitoring, tele-assistance, and medical emergency calls (Bilo *et al,* 2014)

Teleconsultation is consultation between patients with remote health workers. It's appropriate for use in Indonesia. In 18 provinces in Indonesia (55% of the total provinces), more than 94.1% of families are located more than 5 kilometers from health facilities (World Health Organization, 2013). Currently there are many teleconsultation services developed in Indonesia, both in the form of standalone applications and web-based. Some health services also can open remote consulting services to their patients. In teleconsultation, patients communicate with doctors or other health professionals to find solutions for the health problem. At present, teleconsultation is in great demand by patients because it is more efficient in terms of time, cost, and energy. In addition, patients can get second opinions from other health workers easily without limitation of distance and time (Gersal *et al,* 1999).

Tele-expertise is a remote consultation between one health worker and another healthworker who is more skilled. This technology can bridge the spread of health workers such as uneven doctors or specialists (Doumbouya, 2015). In some cases, health workers can consult with other experts so that they can reduce referral rates. Indonesia has developed long-distance consultations on radiology called teleradiology. This technology is used between hospitals in Indonesia.

Telemonitoring is remote monitoring of the patient's health conditions such as monitoring vital signs. In this monitoring, an alarm or emergency sign can appear if there are problems with the patient so that actions can be done immediately (Bilo *et al,* 2014). The development of telemonitoring in Indonesia has not been a focus.

Another scope of telemedicine is teleassistance. Teleassistance is the use of remote assistants in health service (Bilo *et al,* 2014). Telemedicine in this form is often used in surgical procedures (telesurgery /teleintervention). In a telesurgery procedure, the surgeon can be in another health facility, while an assistant who can be a robotic surgery assistant is in the area that is directly dealing with the patient. The surgeon can move the robotic arms remotely to perform the surgical process on the patient (Andrew *et al,* 2018). In Indonesia, telesurgery has been applied by one hospital in Jakarta since 2010 (Hospital of Bunda, 2018). Nevertheless, telesurgery has not been one of the focuses of telemedicine development in Indonesia.

Medical emergency call is a form of telemedicine in the form of a marker for long-distance emergency conditions. Patients with a history of hypertension for example will have a higher risk of stroke and heart attack. By knowing the level of risk that may occur, patients can prepare themselves for

emergency calls in the event of an emergency that threatens life, both to people around, family, and near health facilities. With this technology, it is expected that assistance services can be provided immediately to increase the patients' life expectancy (Bilo *et al,* 2014).

Apart from its scope, telemedicine is often defined based on the type of clinical services performed such as teleradiology (for long distance radiology services), telecardiology (remote cardiac services), telesurgery (remote surgery), and so on. Both consultation between patients and doctors, and consultation between health workers, monitoring, and assistance may be called telemedicine.

Electronic medical records (EMR)

In the implementation of telemedicine, the role of medical records is important. Article 46 paragraph (1) of Law Number 29, 2004 on Medical Practices states that every doctor or dentist in carrying out medical practice is obliged to make a medical record. According to Article 1 number 1 of the Regulation of the Ministry of Health in Indonesia Number 269, 2008 on Medical Records, medical records are files containing records and documents including patient identity, examination results, treatment given, and other actions and services that have been given to patient.

Medical records were conventionally stored as paper-based. However, along with the development of information technology including the development of telemedicine, electronic-based medical records (EMR) began to emerge. EMR is an electronic record or recording of a person's health information. The information is created, stored, and managed in the form of electronic data by doctors and health workers who have the right in a health service organization (Badeia, 2016). There are several advantages in using EMR including the ease of clinical decision making (decision support system) such as the patient's medical action plan, care, and treatment. Another advantage is the ease of monitoring patient data, and research data collection. Even so, the implementation of EMR has several challenges such as substantial infrastructure costs, data and network security, data confidentiality, and inexperienced resources (Bdeia, 2016).

Until now, there has been no specific regulation in Indonesia to regulate electronic medical records. However, in the implementation of telemedicine, electronic medical records are very crucial. Data on the results of long-distance health services in the form of text, images, videos, or sounds are forms of electronic medical records that must be kept in privacy and confidentiality. Therefore, special regulations are needed regarding electronic medical records to support the implementation of telemedicine in order not to conflict with the ethics, morals, and laws in Indonesia.

Medical device standards

The use of medical devices must be considered in telemedicine. In the consultation process in the case of dermatology, for example, standardization of data is needed to take or transmit images like skin disorders (Tensem, 2016). Differences in data sent and received due to compression may influence the diagnosis and therapy.

In telesurgery that uses tele-assistance with robotic surgery assistance, standard tools are very important (Andrew *et al,* 2018). Standardization of medical devices can be done with Health Technology Assessment (HTA). In Indonesia the implementation of HTA is carried out by the Appraisal Committee for Health Personnel who carry out comprehensive health technology studies including efficacy, effectiveness, safety, economic analysis, budget impact analysis, as well as social, cultural and religious values (Ministry of Health in Indonesia, 2017). However, Indonesia does not have a specific regulation regarding HTA, telemedicine technology, including regulations regarding standard devices used in telemedicine.

Device standards affect security and effectiveness that will affect the legal, ethical, and economic factors of the patient. With the standardization, the calibration can be done periodically in accordance with the standards. This can reduce the risk of errors in medical devices that cause harm to patients. This standardization is also needed to distinguish malpractice events or error in medical devices.

Data privacy and confidentiality

Protection of data and privacy of patient data needs to be considered in the implementation of telemedicine. This is because the protection of the patient's medical secrets is the patient's right. According to Article 2 paragraph (1) Regulation of the Minister of Communication and Information Number 20, 2016 on Protection of Personal Data in Electronic Systems, includes protection against acquisition, collection, processing, analyzing, storing, displaying, announcing, sending, disseminating and destruction of personal data.

In the implementation of telemedicine, the practice of sharing patient data between one health care facility and another is common (Michael, 2010). Although it can provide convenience to patients, data sharing should be done in the knowledge of the patient so as not to cause problems. This is because the contents of the medical record belong to the patient, even though the electronic file is stored by the healthcare

provider. In Article 26 paragraph (1) of Law Number 11, 2008 on Information and Electronic Transactions, it is stated that unless stipulated otherwise by law and regulation, the use of any information through electronic media concerning personal data of a person must be made with the consent of the person concerned.

To get patient approval, informed consent or general consent is needed when first getting healthcare through teleconsultation or other forms of telemedicine. At this stage, the patient needs to get a full explanation of the benefits as well as the negative impacts that can occur with the data sharing including what data and with whom the data can be shared.

Data protection

Patient data security must be considered in health services with telemedicine technology. This relates to the confidentiality of the patient's medical record. Data security and medical confidentiality of patients have been regulated in several regulations in Indonesia such as the Minister of Health Regulation Number 269, 2008 on Medical Records, Regulation of Minister of Health in Indonesia Number 36, 2012 on Secret Medicine, and Law Number 29, 2004 on Medical Practices.

Telemedicine service providers who are also providers of electronic systems must carry out procedures to secure electronic systems in avoiding interference, failure and loss. This is stated in Article 20 paragraph (1) of Government Regulation Number 82, 2012 on Electronic System Operators. Electronic system providers must also provide a security system that includes procedures and prevention systems and countermeasures against threats and attacks that cause interference, failure and loss.

Cyberattacks on patient data should be minimized by increasing cybersecurity. Improving cybersecurity can be done with periodic network security evaluation and testing and access restrictions. Access restrictions are related to healthworkers and types of data that may be accessed on a patient's medical record data.

Healthworkers that may have access patient data are doctors and other health workers, personnel related to financing health services, other personnel who have access to patient data and information, insurance, legal entities, and medical students in health facilities.

Strengthening security can be done by using a strong username and password and periodic password updates or the use of cryptographic techniques. User and service history should be stored starting from the date, time and relationship with the patient.

In addition to data security, data stability also needs to be considered. As far as possible damaged or lost data is minimized. This is because the removal of the patient's medical record has an important position in the law that can be used as evidence as stated in Article 13 paragraph (1) letter c Regulation of the Minister of Health Number 269, 2008 on Medical Records. To avoid missing data, the provider should back up data periodically.

Distance contracting & electronic signature

Therapeutic transactions are important in health services. With therapeutic transactions between patients and related health personnel, a legal relationship arises between them with the rights and obligations of each party. Typical transactions or contracts require the ability of the parties to the agreement, certain objects, and being lawful. More detailed regulations regarding the terms of the contract are listed in articles 1320, 1332 and 1333 of the Civil Code.

In the doctor-patient relationship in real practice when patients and doctors meet face to face, therapeutic contracts can occur in the form of informed consent or general consent. Informed consent can happen with implied consent or expressed consent. Implied consent is a statement of patient consent implicitly without a firm statement such as a nod or gesture when examined. On the other hand, expressed consent is a patient's approval which is stated verbally or in writing on a medical action to be taken (Ramugade, 2018)

Telemedicine requires an agreement between the doctor and patient in both implied and expressed consent forms. In the case of patients and doctors who do not meet face to face directly, implied consent is certainly more difficult to implement. In addition, in agreement with writing, electronic signatures are needed. Indonesia has recognized electronic signatures as verification and authentication tools. This is stated in Article 1 Paragraph (12) of Law Number 11, 2008 on Information and Electronic Transactions.

Although performed remotely, a therapeutic contract between the patient's doctor must be made clear. This is because patients also have the right to get quality services and legal protection in health services.

License & certification of healthcare professionals

Legality of permits and place of practice must be fulfilled in health services, as well as services using telemedicine technology. Health workers and health facilities that provide telemedicine services should have permission. According to Article 2 paragraph (2) Regulation of the Minister of Health Number 512, 2007 on Practice License and

Implementation of Medical Practices in order to obtain a license, doctors and dentists must submit applications to the Head of the District /City Health Office where the medical practice is conducted.

In addition, a place of practice or health service facility must also have a permit. This is stated in Article 36 of Law Number 29, 2004 on Medical Practice that every doctor and dentist who practices medicine in Indonesia must have a practice permit. Article 37 paragraph (2) of the law also states that the license to practice as a doctor or dentist, as referred to in paragraph (1), only is given at a maximum of 3 (three) places.

A review of permits for telemedicine implementation is needed. This is due to the existence of a doctoroid phenomenon, namely the existence of health services carried out by someone who is not a health worker and does not have a permit. The doctoroid phenomenon is contrary to Article 73 paragraph (1) of Law Number 29, 2004 on Medical Practices. The rise of this phenomenon may cause patient anxiety especially regarding health services with telemedicine technology.

Legality of license to practice is required in online doctor consultation services. The government together with professional organizations should work together to formulate regulations that govern them. Practical places and permits for online practice should be given special permission and certification with several procedures that must be fulfilled so that its implementation can minimize cybercrime that can harm both doctors and patients.

Jurisdiction issues

Jurisdiction issues must be considered in the implementation of telemedicine. This is because telemedicine is a health service not limited in distance and time. Legal problems carried out by health services or health workers in other countries can be crucial problems. To bridge this, a framework or regulation regarding telemedicine is needed internationally (McLean, 2006).

Legal liability

Legal responsibility is the responsibility of health workers or health services if legal problems happen. The problem of responsibility can become an issue if not addressed wisely. In the case of telesurgery (remote surgery) with the help of assisted robots, for example, if an error is made during surgery, who will be responsible? Is this the responsibility of the surgeon? Or is it included as a device or robot assistant error? Can the surgeon be prosecuted if there are legal problems?

Therefore, the problem of medical device standard is important and related to legal responsibility and determination of malpractice. In addition, in teleconsultation it is also necessary to agree on legal responsibility between health workers and health facilities that provide health services.

For third party users in the development of telemedicine, agreements regarding legal responsibility are also needeed, especially regarding data security and confidentiality issues. It must be agreed whether in a data leak and data damage, the third party or health personnel is responsible or the related health facilities are responsible.

E-prescribing

Teleconsultation between doctors and patients can lead to online prescribing known as e-prescribing. E-prescribing will be written by a doctor in the form of electronic data and then forwarded to the pharmacist who will process the electronic prescription (Amber *et al,* 2014). E-prescribing plays a role in telemedicine technology, especially in teleconsultation processes that connect patients with health workers. E-prescribing has several advantages including reducing errors in prescription writing and determining drug doses, accelerating prescription acceptance, adherence to drug formularies, identification of dosage errors and drug allergic reactions, improving service quality, and reducing malpractice claims from doctors due to medication errors is prescribing online (Annie & Annesha, 2014).

Although it has many advantages, and is necessary to control the quality of e-prescribing services as needed. The Drug Enforcement Agency (DEA), an institution that controls drug distribution in the United States, issued regulations relating to the certification of e-prescribing service providers (Drug Enforcement Agency). In addition, the e-prescribing procedure is regulated in special regulations so that no drug abuse occurs through e-prescriptions. Online prescription, especially for drugs that are categorized as narcotics, must be closely monitored and there are special regulations that govern them, especially if doctors and patients have never met directly before.

Indonesia has problems with telemedicine implementation, especially teleconsultation with online prescribing. This is because Indonesia does not yet have adequate health technology to replace physical examination and provide remote support. Examinations without physical examination or supported by recommendations do not provide optimal diagnosis and therapy results. Differences in diagnosis or misdiagnosis are very likely to occur. According to a study conducted by Eedy & Wooton in 2001 regarding teledermatology, there were 33% of teledermatology cases that experienced a different diagnosis or misdiagnosis with a real

examination (Eedy & Wooton, 2001). This situation contradicts with the patient's right to obtain quality health services not harming the patient.

Online prescribing may be applied to tele-expertise models or teleconsultation models for patients who have met a doctor before and have medical record records at the healthcare facility. In tele-expertise, the doctor or expert who receives the consultation will only give advice or therapeutic recommendations while prescribing is carried out by health workers or doctors who are dealing directly with the patient. On teleconsulting patients who have received treatment at the health facility, teleconsultation can be carried out in order to obtain further information or monitoring of the patient's condition.

However, in teleconsulting online prescribing should be limited. Health services in the form of providing health information are considered safer compared to establishing a diagnosis and therapy, especially if there is no supporting technology to carry out physical examination and remote support.

Conclusion

Based on the description in the previous sections it can be concluded that telemedicine is a technology in the health sector that may be very useful if implemented in Indonesia. However, special regulations are needed to regulate the implementation of telemedicine so that it is not contradictory with ethics and laws in Indonesia. The regulations can include definitions of telemedicine, electronic medical records, data protection and privacy, legal responsibility, standard medical devices, e-prescribing, and jurisdiction issues.

References

Amber Porterfield, *et al.* 2014. Electronic Prescribing: Improving the Efficiency and Accuracy of Prescribing in the Ambulatory Care Setting. Perspect Health Inf Manag. 11; 1-21

Andrew J, *et al.* 2018. Telementoring and Telesurgery for Minimally Invasive Procedures. The Journal of Urology, 199 (2), 355-369

Anissa L, Menaldi SL. 2015. *Aplikasi Telemedicine dalam Merujuk Pasien dari Daerah Rural*. Jurnal Kedokteran Indonesia 3:220–4

Annie Hahn & Annesha Lovett. 2014. Electronic Prescribing: An Examination of Cost Effectiveness, Clinical Adoption and Limitations. Universal Journal of Clinical Medicine 2 (1): 1-24,

Badeia Jawhari *et al.* 2016. Benefits and challenges of EMR implementations in low resource settings: a state-of-the-art review. BMC Medical Informatics and Decision Making 16:116.

Bilo M, Kamsu-foguem B, Kenfack H, Foguem C. 2014. *Telematics and Informatics Telemedicine using mobile telecommunication: Towards syntactic interoperability in tele-expertise.* Telemat Informtics. Elsevier Ltd; ;31(4):648–59.

Doumbouya MB. 2015. A framework for Decision Making on Tele-expertise with Tracebility of the Reasoning. IRBM. Volume 36 Issue 1, 40-51

Drug Enforcment Administration. Available from: https://www.dea.gov/index.shtml

Eedy DJ, Wooton R. 2001. Teledermatology: a review. Br J Dermatol. 144(4): 696-707.

Gersak B, Gorjup V, Jazbec A. 1999. The telemedicine and second opinion. Stud Health Technol Inform, 68;245-6

Hospital of Bunda. Robotic Surgery. http://bunda.co.id/rsiabundajakarta/id_ID/facilities-and-services/support-facilities/robotic-surgery/. accessed: 4 July 2018

Isabelle Andoulsi. 2010. Telemedicine Legal Challenges. European Telemedicine Conference. Italy, 7-8 October.

Laws of Malaysia. Act 564; Telemedicine Act 1997.

Mable Kekana, Pitso Noe, Boyce Mkhize. 2010. The practice of telemedicine and challenges to the regulatory authorities 3, (1) SAJBL.

McLean TR. 2006. International Law, Telemedicine, and Health Insurance: China as A Case Study. Am J Law Med, 32 (1); 7-51

Michael J, *et al.* 2010. Developing Next Generation Telehealth Tools and Technologies: Patients, Systems, and Data Perspectives. Telemed J E Health,16 (1) :93-95

Minister of Health of the Republic of Indonesia Decree Number HK.02.02, 2016 on Trial Hospital of Video-conference and Teleradiology-Based Telemedicine Service Program

Minstry of Health in Indonesia. 2017. Health Technology Assessment Guidebook: Clinical and Evaluation Effectiveness. Health Technology Assessment Committee Jakarta,

Ramugade MM. 2017. Legality of Consent in Todays Dental Practice. International Journal of Current Medical and Pharmaceutical Research. Volume 3, Issue 5; pp 1681-1683

Tensem E, *et al.* 2016. Two Decades of Teledermatology: Current Status and Integration in National Healthcare Systems. Current Dermatology Reports, 5 (2), 96-104

World Health Organization. Telemedicine in Indonesia: Country Experience. Pyongyang, 30 July 2013.

Youth unemployment in Nigeria: A failed state argument

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Abstract
Youth unemployment in Nigeria is alarming. It increases annually, coupled with the increase in the number of higher institutions in Nigeria that produce many graduates yearly. The resultant effect on the Nigerian society is an increase in social vices. This situation of youth unemployment serves as an obstacle to economic, political and social development of the Nigerian state. Youth unemployment leads to high rates of poverty among the youth, and poverty in return has negative implications on the social well-being of the youth. It can lead to psychological effects, for example frustration. This study examines the causes of youth unemployment in Nigeria. The study relies solely on secondary sources data and presents its analysis in the context of the Failed states' theory. The findings reveal that the failure of the state to provide a proper school curriculum, corruption among public office holders, lack of an enabling environment for economic activities are some of the causes of youth unemployment in Nigeria. Due to the aforementioned causes of youth unemployment in Nigeria, the study recommends the state is duty bound to provide among other things more vocational and skills acquisition institutions as well as to enforce adequate governance to instill integrity. More so, priority should be given to security by the government as a way of attracting foreign investors to Nigeria.

Introduction
Youth unemployment according to International Labor Organization (ILO) is a threat to the growth and stability of different nations of the world (Kale 2012). Available records from the World Bank reveal that the unemployment rate in Nigeria was at 22% in 2012, while the youth unemployment rate was at 38% and it also reveals that not less than four million Nigerian youths go into labor market every year and that the unemployed number increases yearly (Subair 2013). As a result of unemployment, many youths developed a platform of criminal attitudes and tendency as a way of attaining to their needs through armed robbery, car snatching, pipeline vandalization, prostitution, and other criminal acts (Dabalen et al. 2000). Armed robbery, political thuggery, kidnapping, Boko Haram, and other criminal acts among youths are identified as consequences of youth unemployment. The situation of unemployment in Nigeria is more complex due to the global economic recession that has made it almost impossible for youth employment (Suleiman & Aminul Karim 2015). It is evident that the high rate of unemployment is a factor for the under-development of Nigeria. Some of the youths who are unemployed have probably turned themselves to suicide bombers due to frustration, vandals, terrorists, kidnappers, militants, armed robbers, and lots more, thereby causing Nigeria a great loss in revenue earnings, which in turn hinders her development as these problems have a negative impact on the economic, political and social aspects of the development of Nigeria directly (Kale 2012).

In addition to this set of youths, the uncountable millions who are not in employment, education and training (NEET) added to the ones that may not seek for menial employments or be involved in the informal employment have joined the evil gangs of armed robbery and kidnapping (Chiazor & Udume 2017). This great number of the unemployed youths have become mighty tools in the hands of wicked persons who use them for their selfish interest either as political thugs or use them to cause crisis in the nation (Baah-Boateng 2016). There are various reasons associated with unemployment. Besides demographic factors namely population growth and rural-urban migration generating the youth cohorts, often the strength of the economic factor namely the manufacturing economic activity (Freeman & Wise 1982) are attributed together with social dislocations associated with neoliberalism argument (Okafor 2011).

However, in developing countries the interdependence of market economy on the role of state is critical as the markets are not well developed and the penetration of capitalist economy that generates investment for job creation is still at an infancy stage. This study examines the causes of youth unemployment in Nigeria by arguing that the state has failed in its fundamental duty in playing an enabling role for the flourishing of its economy. This research adopted qualitative methodology with descriptive analysis. Its data are from secondary sources, mostly journal articles, books, reports from recognized international organizations like the ILO and NBS. Others are the Africa Bank, OECD and online resources.

Youth unemployment
Youth unemployment could be defined as a situation of young people living without an engaged job to earn a living. The International Labor Organization considers it as the entire population

of able people living in a society that were supposed to be part of the economically active people but are living without employment and are also willing and available for work (Olawoyin 2017). The implication of the above definition is that unemployment is the number of working age people between the ages of 18 and 60 years as stipulated by Nigerian constitution, who are searching and available for employment within a stipulated or given period. It is not just a workable age of people without work, but people that are interested and are actively searching and are available for a job. Such an individual is duly qualified for gainful employment and has made series of applications or attempted different recruitment opportunities but could not successfully secure any job (Okafor 2011).

Youth is being seen and defined differently by different societies of the world. The United Nations considers ages between 15 and 24 as youths, while Uganda considers ages between 12 and 30 as youths. Youth is best understood as a period of transition from dependence childhood to adulthood (Akande 2014). Youth in Nigeria is regarded between the ages of 18 and 35 years. The National Youth Policy document of Federal Republic of Nigeria stipulates the following characteristics for youths: He must be a Nigerian citizen between the ages of 18 and 35 years old, must have completed secondary school education, tertiary education, or learning a trade, he is looking for employment or already employed, he is leaving parental home because of marriage or being independent (Abdullahi et al. 2014; Osakwe 2013). In its 2017 statistics on youth unemployment, NBS (2017) reported of Nigeria having 61.6 percent youth unemployment. The same record reported of Nigeria having 97 million as the national population of the youths. Based on this report there was fear over the high rate of both the youth population and their present unemployment status as he felt youth unemployment population may constitute an army of a revolution or may stage revolution one day due to their poverty level and frustration (Ugwu 2017).

Youth unemployment as a global challenge, is more severe and challenging in developing rather than developed countries. A research conducted by UK scholars indicated Portugal had 24% as its youth unemployment rate, and UK had 12% as their youth unemployment rates. In the summary report of the study for European states, it indicated the Czech Republic has 7 percent as the lowest unemployment rate followed by Germany with 9 percent while Greece has 44 percent as the highest unemployment rate and Spain followed with 39 percent within the Euro region. The data also reveals that female unemployment was 9.2 percent and male was at 8.9 percent (Dietrich & Möller 2016; Mcguinness 2017).

In 2001, the United Nations General Assembly portrayed almost the developing states as weak and failed nations due to their inability of improving their economic, youth unemployment, security, and political stability. As a result of their deficiencies, terrorists and insurgencies activities thrive in their nations as many of the deprived citizens like the unemployed youths would choose to join unethical ways and criminal groups to earn their living. The UN concluded that with their high rate of youth unemployment, illiteracy, and poverty most of the developing states served as fermentation tanks for terrorists and other insurgencies (Azeng & Yogo 2013; Piazza 2006, 2008).

Youth unemployment in Africa has been a serious challenge as it increases yearly coupled with its related problems of criminal involvement in an attempt by the unemployed youths to meet their needs. Idris (2016) reported healthy and qualified young persons living without employment are easily lured into unethical ways of getting their needs met. Their situation is not just a threat to the leadership but the entire society of Africa. The same scholar reported that though there was global youth population explosion but the population in Africa was not commensurate with employment opportunities. The implication is that birth control was not done or was not taken seriously in Africa as regards to an expected number of children a family ought to have based on the strength of their economy (Bello & Yacim 2012; Idris 2016).

The report indicated African states had the highest youth unemployment rate among the nations of the world. North Africa in 2015 had 30 percent unemployment for male and 45 percent for female youth. The report added their situation was indeed pathetic as a great number of their youths were not in education, employment, nor training (NEET). The situation in Tunisia and Egypt was worrisome too as young persons between the ages of 15 and 29 were not in education, employment, or training (NEET).

Their NEET percentages were 32 and 40 respectively (Assaad & Roudi-Fahimi 2007) (Fenwick & Van Goethem 2017; Karimova & Manrique 2018).

Available literature shows that African states have the highest rate of youth unemployment in the world. More so that the low rate of youth unemployment among Europe and most East Asian economies emanate from their proactive strategies towards curbing youth unemployment. This study is prompted by the worrisome situation of youth unemployment in Nigeria because available literature did not critically analyze the Nigerian situation. For this reason, the study took a

departure from the previous studies to investigate the causes of youth unemployment in Nigeria.

Failed states' theory

A state or a country is a sovereign and political entity with specified and recognized boundaries or territory with its governmental institutions, and can have its democratic leadership for adequate supervision and purposive administration for development. The state therefore, is seen or regarded as a provider of services to its citizens, or the state has fundamental responsibilities to its people, for that is the purpose of its existence (Zartman 1995). The implication of the description of a state as a provider of services to its citizens according to the theorists (Rotberg and Zartman), means a state ceases to being when it fails in its fundamental responsibility of providing services to its citizens (Rotberg 2010). The theorists considered security of lives and property as the major and fundamental service a state should provide for its citizens. Others include infrastructure and social services, the rule of law, education, employment and health (Rotberg 2003).

The assumption of this theory is that a state is no longer a state when it fails in its basics and fundamental responsibilities for its existence. Its failure is not only seen in its inability to provide infrastructures, employment, or services to its citizens, but it is also seen in its deficiency to control its territorial boundary and misappropriation of the state power to the disadvantage of the citizens. A failed state, due to its deficiencies is highly threatened with terrorist groups, insurgencies and other related criminal groups within its territory. As such it hardly embarks on any economic and developmental policies as its attention has been taken by problems it created due to its deficiencies (Zartman 1995).

This theory is chosen to explain the causes of youth unemployment in Nigeria due to its peculiarities to Nigeria's present situation, where unemployment, insecurity, and criminal cases are on the increase on a daily basis as government has failed in its responsibility. The powerlessness of Nigerian leadership in providing employment for its unemployed young persons and insecurity has provided abundant atmosphere or situation for terrorism like the Boko Haram, kidnapping, and other related crimes.

The description of a failed state by the theorists is indeed a perfect glaring picture of Nigeria's present situation whereby security of lives and property is never guaranteed for the masses (Chiazor & Udume 2017). It was stated that between 2009 and 2011 more than 140 non-nationals were abducted by Nigerian youths. Their criminal actions crippled businesses and enlarged the number of youth unemployment and terrorism as the atmosphere was not safe for commercial activities and businesses, while numerous businesses crumpled and several schools shut down in the North East of the country (Adedeji[1] et al. 2018).

The incapacity of Nigerian government to provide infrastructure, facilities, and miserable nature of power supply to the people in their struggle to remain in their businesses or self-employment aggravated their situation to the extent the same self-employed individuals like the aluminum window makers, welders, furniture makers, fashion designers, and the related self-employed persons or Nigerians folded up their activities as they were not able to buy personal generators or could not afford power generators (Ruth et al. 2014). The theory is most relevant and useful in explaining the causes of youth unemployment in Nigeria and the related social problems as it is a byproduct of a failed state of Nigeria.

Table 1. Youth unemployment trends in Nigeria between 2010 and 2014

2010	21.1%
2011	23.9%
2012	24.3%
2013	28.5%
2014	30.0%

Source: Adopted from Innocent (2014)

Table 1 shows youth unemployment rate in Nigeria increases yearly. This could be due to a number of factors connected to leadership that failed in its basic responsibility of providing employment and other services for its citizens.

Causes of youth unemployment in Nigeria

Nigerian youth unemployment is the consequence of a series of factors that reflect the failure of the state to account for its responsibility namely: ccorruption, improper school curriculum, and lack of enabling environment for businesses.

1- Corruption

Corruption as a major factor responsible for youth unemployment in Nigeria. It may not be explained and measured easily; however, it is easy to be seen and identified as evil or bad behaviors (Idachaba 2014). Asian Development Bank sees corruption as wrong, bad and illegal behavior of public or private sector officers to favor and amass themselves with public resources and equally do the same to relations and friends, using their positions to influence others in illegal ways to the detriment of the general public (Oecd, 2008). It could be considered as non-violent criminal practices and

illegal manners or activities with the aim to acquire wealth or resources meant for the individuals or the public (Adedeji[1] et al. 2018).

Corruption is therefore most responsible for Nigerian youth unemployment as it is the evil or illegal actions of men and women at the management of resources that has brought Nigeria to this present level of high youth unemployment (Okorie 2014). The officers who are legally appointed for the good of the public, use their legal or authorized offices or positions for personal interest that in most cases involve stealing public fund meant for developmental purposes and creation of employment opportunities. This illegal way of such officers could involve manipulations of figures and information to favor some persons instead of being neutral in the discharge of their responsibilities as stipulated by the civil service rules that government officers should be neutral in handling their assigned duties (Samuel 2011).

Corruption as an illegal way of taking what belongs to others, especially the general public is practiced by individuals or private sector in Nigeria. Tax evasion and tax avoidance are major issues in corruption, and could be best described as deceitful manner of paying taxes to government through a series of mechanisms. The essence of this is to make money for themselves and their companies (Palan et al. 2013). The negative effect of the fraudulent activities of paying less taxes or none to the government, deprives the government of adequate resources needed for the societal development and provision of infrastructure and creation of employment opportunities (Otusanya 2011).

2- Improper school curriculum

Nigeria's educational system is seen as a major factor responsible for youth unemployment in the country. Nigeria educational system is indeed a factor responsible for youth unemployment because the curriculum planners failed to include issues that are related with the changing environment to make the Nigerian youths employable after graduation from school. One of these is computer literacy knowledge that is needed globally for effective and maximum performance in all disciplines of life. A lot of Nigerian youths are not computer literate, though most of them are graduates from different universities of the nation. This therefore makes it almost impossible for such graduates to get employment these days particularly with international organizations in Nigeria (Ajake et al. 2014).

Added to this problem is that most of the institutions are not well equipped to provide the youth in schools or under training the expected knowledge they require for employment. For example, many youths who study business in Nigerian universities and other institutions of and would be expected to be employed as secretaries or accountants and business administrative officers can hardly type or work and operate a computer due to the inability of government to equip such institutions with computers and manual type writers for the sake of skills acquisition (Collins & Halverson 2009). This is an indication that Nigeria's current educational curricula are not appropriate for the present needs and realities of life (Kareem et al. 2016).

The present curricula for Nigerian schools or educational system do not lay much emphasis and priority on entrepreneurship or entrepreneurial skills acquisition with the hope for self-employment. Instead youths are given an orientation during their trainings of seeking employment with the public or private sector after completion of trainings (Etodike et al. 2018). Vocational and technical education training as a solution to youth unemployment is not given a priority in schools' curricula in Nigeria (Edokpolor & Owenvbiugie 2017).

The major role of vocational and technical education training skills is that it equips the youths with the desired skills for self-employment and to enable them to participate in the developmental processes of their nations. Both the developed and some developing nations have identified vocational and technical education training skills as the best solution for youth unemployment and for the development of a society (Edokpolor & Owenvbiugie 2017). Added to the above reasons of youth unemployment, a scholar stated it clearer that the growing youth unemployment rate in Nigeria is an indication or expression that the huge number of youths do not have the skills to initiate and operate a business so as to become self-employed (Olajide 2015).

3- Lack of enabling environment

Nigeria's failure in providing an enabling environment for successful business and economic activities, coupled with infrastructure utility power failure is also responsible for the increasing rate of youth unemployment. The environment is not indeed safe for any reasonable economic activities; neither does it attract external investors due to the activities of Boko Haram, kidnapping, herdsmen killings, and corruption among the public office holders. It was reported that more than one hundred business organizations in Nigeria that provided employment for thousands of Nigerians closed down between 2009 and 2016 as a result of unfriendly nature of the environment as stated above and lack of adequate power supply.

The closure of some of the business organizations in Nigeria within these years eventually brought their staff to a state of unemployment. Other youths that completed their trainings in their respective institutions and trade centers had nowhere to go for employment or to apply for jobs (Chiazor & Udume 2017). The inability of the government due to corruption to provide infrastructure and facilities, and poor nature of power supply to ease the citizens in their efforts to continue with their businesses or self-employment aggravated the situation to the extent that self-employed persons wound up their activities as they were not able to buy personal generators or could not afford the power generators (Ruth et al. 2014). Apart from the artisans that closed down their self-employment, international business organizations in Nigeria like the Michelin, Dunlop Plc, Volkswagen Plc, PZ, etc also closed down their operations for the state's inability to provide them with adequate power supply needed for their operations in Nigeria. They therefore relocated to other nations with stable power supply and peaceful conditions in such nations. The multinationals departure or exit from Nigeria resulted in more than two thousand unemployed Nigerians to the already existing ones (Borjas & Van Ours 2010; George & Oseni 2012)

Conclusion & recommendations

With the available records on literature, youth unemployment is both a peril and obstruction to the development of many nations of the world. It constitutes economic, political, or social problems and also affects the unemployed youths psychologically as it renders them frustrated and powerless due to hopelessness and distress that may lead many to commit suicide and other social ills. The failure of the state to provide improper school curriculum, corruption among public office holders, and lack of enabling environment for economy activities are some of the causes of youth unemployment. The failed state argument contrasts with the neoliberalism argument which accounts for institutional constraints of developing economies like Nigeria.

Youth unemployment is a serious problem in Nigeria that needs urgent attention due to its effect that is degrading and under developing the nation. It is against this background that the following recommendations are put forward as measures for curbing the challenges of youth unemployment in Nigeria. Government should intensify efforts to create more vocational skills at acquisition institutions and centers across the country to enable young men and women to acquire skills for easy employment and to be self-employed. Skills acquisition is a strong instrument for empowerment of youths in areas like tailoring, carpentry, automobile mechanic, ICT, metal work, to mention but a few.

Educational systems should be restructured and equipped to meet the needs of the changing environment and globalization as well as equipping the youths with entrepreneurship and vocational skills for self-reliance. Agriculture should be given a priority by the government and policymakers; this would not only feed and provide income to the people but provide employment for the youths in rural areas and reduce the rural-urban migration.

Security should be made available by the government as a way of attracting foreign investors into the Nigerian society. Besides that, the state should enforce adequate governance to instill integrity and eradicate corruption. Also improving the provision of adequate power supply in major industrial and commercial centers will attract investors. Setting up business organizations and industries by foreign investors would go a long way in reducing youth unemployment, crimes, and poverty in the land as employment would be provided for citizens.

References

Abdullahi, A. A., Adekeye, D. S. & Balogun, O. S. 2014. A'nation'in Wilderness: Youth and Insurgency in Nigeria. *South African Review of Sociology* 45(2): 78-96.

Adedeji, D. B., Soyinka, K. A. & Sunday, O. M. 2018. Corruption Control in the Public Sector and the Nigerian Accountant. *International Journal of Academic Research in Accounting, Finance and Management Sciences* 8(1): 91–103.

Ajake, U. E., Oba, A. N. & Ekpo, T. E. 2014. Enriching Higher Education Curriculum to Meet the Challenges of 21st Century in Nigeria. *Journal of Educational and Social Research* 4(3): 21-30.

Akande, T. 2014. Youth Unemployment in Nigeria: A Situation Analysis. *Brookings* 23 September 2014. https://www.brookings.edu/blog/africa-in-focus/2014/09/23/youth-unemployment-in-nigeria-a-situation-analysis/

Assaad, R. & Roudi-Fahimi, F. 2007. *Youth in the Middle East and North Africa: Demographic Opportunity or Challenge?* Washington, DC: Population Reference Bureau.

Azeng, T. F. & Yogo, T. U. 2013. Youth Unemployment and Political Instability in Selected Developing Countries. *African Development Bank Group Working Paper Series* 171.Tunis Belvédère,Tunisia:African Development Bank.

Baah-Boateng, W. 2016. The Youth Unemployment Challenge in Africa: What Are the Drivers? *The Economic and Labour Relations Review* 27(4): 413-431.

Bello, A. & Yacim, A. 2012. Assessment of the Role of Private Property Developers in the Provision of Infrastructures in Karu, Keffi and Nasarawa in Nasarawa State, Nigeria. *Journal of Construction Project Management and Innovation* 2(1): 245-258.

Borjas, G. J. & Van Ours, J. C. 2010. *Labor Economics.* Boston: McGraw-Hill/Irwin .

Chiazor, I. & Udume, M. 2017. Unemployment in Nigeria: A Time Bomb Waiting to Explode: Issues, Diagnoses and the Way Forward. *Advances in Social Sciences Research Journal* 4(2): 183-194.

Collins, A. & Halverson, R. 2009. *Rethinking Education in the Age of Technology: The Digital Revolution and Schooling in America.* New York: Teachers College Press.

Dabalen, A., Oni, B. & Adekola, O. 2000. Labor Market Prospects of University Graduates in Nigeria.http://siteresources.worldbank.org/NIGERIAEXTN/Resources/labor_market_univ.pdf

Dietrich, H. & Möller, J. 2016. Youth Unemployment in Europe– Business Cycle and Institutional Effects. *International Economics & Economic Policy* 13(1): 5-25.

Edokpolor, J. E. & Owenvbiugie, R. O. 2017. Technical and Vocational Education and Training Skills: An Antidote for Job Creation and Sustainable Development of Nigerian Economy. *Problems of Education in the 21st Century* 75(6): 535-549.

Etodike, C. E., Ezeh, L. N., Ogbeide, D. E. & Ike, P. R. 2018. Typical Solution to the Unemployment Problems in Nigeria: The Convergence Utility of the Entrepreneurship Models. *European Journal of Human Resource Management Studies* 1(2):130-138.

Fenwick, C. & Van Goethem, V. 2017. *Regulating for Equitable and Job-Rich Growth.* Cheltenham: Edward Elgar Publishing.

Freeman, R. B. & Wise, D. A. 1982. The Youth Labor Market Problem: Its Nature Causes and Consequences. In Freeman, R. B. & Wise, D. A. (eds.). *The Youth Labor Market Problem: Its Nature, Causes, and Consequences,* pages 1-16. Chicago: University of Chicago Press.

George, E. & Oseni, J. 2012. The Relationship between Electricity Power and Unemployment Rates in Nigeria. *Australian Journal of Business and Management Research* 2(2): 10-19.

Idachaba, F. 2014. Government Corruption and the Underdeveloped Nigerian Agriculture. A lecture delivered at the Prof. Samson Olayide Memorial Lecture, University of Ibadan, Nigeria .

Idris, I. 2016. Youth Unemployment and Violence: Rapid Literature Review. Applied Knowledge Services, GSDRC, International Development Department, College of Social Sciences University of Birmingham. https://assets.publishing.service.gov.uk/media/58c8019640f0b67ec500018c/YouthUnemployment_Violence.pdf

Innocent, E. O. 2014. Unemployment Rate in Nigeria: Agenda for Government. *Academic Journal of Interdisciplinary Studies* 3(4): 103-114.

Kale, Y. 2012. *The Nigeria Poverty Profile 2010 Report.* Press briefing by the statistician-general of the Federation/chief executive officer, National Bureau of Statistics (NBS). The conference room, 5th floor, NBS headquarters, Central Business District, Abuja, Nigeria: NBS.

Kareem, W., Maaji, S. & Mohammed, B. 2016. Perception of Technical College Students on Woodwork Technology for Self-Empowerment in Niger State. Nigeria. *ATBU Journal of Science, Technology and Education* 4(1): 40-49.

Karimova, T. & Manrique, E. E. 2018. Regulatory Frameworks: Integration, Partnerships and Dialogue. *World Employment and Social Outlook* 2018(2): 71-101.

McGuinness, F. 2017. *Youth Unemployment Statistics*. UK: House of Commons Publications .

OECD. 2008. *Growing Unequal?: Income Distribution and Poverty in OECD Countries.* http://www.worldbank.org

Okafor, E. E. 2011. Youth Unemployment and Implications for Stability of Democracy in Nigeria. *Journal of sustainable Development in Africa* 13(1): 358-373.

Okorie, N. 2014. Corruption and the Challenges of Insecurity in Nigeria: Political Economy Implications. *Global Journal of Human-Social Science Research* ,14(5): 11-16.

Olajide, S. E. 2015. Repositioning Technical and Vocational Education toward Eradicating Unemployment in Nigeria. *International Journal of Vocational and Technical Education* 7(6): 54-63.

Olawoyin, O. 2017. Nigeria's Unemployment Worsens as 18.8% Are Jobless. *Premium Times,22 December 2017. https://www.premiumtimesng.com/news/headlines/253267-nigerias-unemployment-worsens-as-18-8-are-jobless.html*

Osakwe, C. 2013. Youth, Unemployment and National Security in Nigeria. *International Journal of humanities and social science* 3(21): 258-268.

Otusanya, O. J. 2011. The Role of Multinational Companies in Tax Evasion and Tax Avoidance: The Case of Nigeria. *Critical Perspectives on Accounting* 22(3): 316-332.

Palan, R., Murphy, R. & Chavagneux, C. 2013. *Tax Havens: How Globalization Really Works.* Ithaca: Cornell University Press.

Piazza, J. A. 2006. Rooted in Poverty?: Terrorism, Poor Economic Development, and Social Cleavages. *Terrorism and political Violence* 18(1): 159-177.

Piazza, J. A. 2008. Incubators of Terror: Do Failed and Failing States Promote Transnational Terrorism? *International Studies Quarterly* 52(3): 469-488.

Rotberg, R. I. 2003. Failed States, Collapsed States, Weak States: Causes and Indicators. In Rotberg,R.I. (ed) *State failure and state weakness in a time of terror* Washington, D.C: Brookings Institution Press, pp: 1-25. https://www.wilsoncenter.org/sites/default/files/statefailureandstateweaknessinatimeofterror.pdf

Rotberg, R. I. 2010. *When States Fail: Causes and Consequences.* Princeton, New Jersey: Princeton University Press.

Ruth, H., Emmanuel, A. Y. & Ndubuisi-Okolo, P. 2014. Understanding and Overcoming the Challenge of Youth Unemployment in Nigeria. *Review of Public Administration and Management* 400(3614): 1-9.

Samuel, A. 2011. Democratic Challenges in Nigeria and Steps Towards Achieving the Vision 20/2020. *Kubani Journal of Arts and Social Sciences* 1(1): 14-23.

Subair, G. 2013. Nigeria's Unemployment Rate Hits 22%-World Bank. *Nigerian Tribune Online.*

Suleiman, M. N. & Aminul Karim, M. 2015. Cycle of Bad Governance and Corruption: The Rise of Boko Haram in Nigeria. *Sage Open* 5(1).
Ugwu, C. 2017. Refiguring Transnational Intervention: Ethnographic Example from the Roll Back Malaria Initiative in an African Community. *Ethnography* 20(1), 108-127.
Zartman, W. 1995. Introduction: Posing the Problem of State Collapse' in Zartman, W. (ed) *Collapsed States: The Disintegration and Restoration of Legitimate Authority.* Boulder, US: Lynne Rienner.

A review of women's intellectual contribution under the bureaucracy in Pakistan

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Abstract
This paper is divided into three parts. The first part provides an overview of literature on the factors that restraint women's intellectual contribution in Pakistan's bureaucratic setup, specifically in the department of foreign affairs. The second part examines the root cause of sociocultural dilemmas that rule out the role of women in Pakistan's bureaucracy. The third part provides the argument that Pakistan's bureaucracy is not gender neutral and by consequence not Weberian (Evans and Rauch, 1999).

Women's omission from the department of foreign affairs

"No nation can rise to the height of glory unless your women are side by side with you; we are victims of evil customs. It is crime against humanity that our women are shut up within the four walls of the houses as prisoners. There is no sanction anywhere for the deplorable condition in which our women have to live. You should take your women along with you as comrades in every sphere of life."

(Muhammad Ali Jinnah, 1944)

Table 1 Women's intellectual contribution

Particular	Total	Men	Women
Foreign Minister (1947-2013)	26	25	1
Minister of State (1973-2013)	09	09	NIL
Foreign Secretaries (1947-2013)	28	28	NIL
Foreign Service Academy alumni (1983-2012)	1143	909	234

Source: official website www.mofa.gov.pk Compiled by Salman Ahmed Khatani

According to facts and figures shown in Table 1, the respective department did not follow the policy statement of Quiad-e-Azam about women's intellectual contribution. Inheriting features of a patriarchal society, this department is always headed, administrated and run by men. Though in stated policy of this department it has been clearly mentioned that the rule of equity and equality shall prevail.

Spanning from 1947 only one woman secured the position of foreign minister compared with 26 men in that period. Meanwhile, the situation under the state ministers was not in any better shape than the former; from 1973 onward, not a single woman with said portfolio was seated, never also a female foreign secretary served in the entire history of Pakistan. The negligible number of professional cadres produced by the respective academies also pictures the sorry state of representation of women in the foreign office of Pakistan.

Foreign policy objectives of Pakistan

According to the stated policy of Foreign Service Department under the Vision of Father of Nation and per constitution of Pakistan, The Muslim Family Laws Ordinance, 1961:[3]"Equality of status, equality of opportunity, equal pay for equal work and guarantee of rights for Muslim women under the Muslim Personal Law of Shariah" were a part of the Charter of Women's Rights, prepared by Begum Jahan Ara Shahnawaz.[4] The Charter was passed by the Constituent Assembly with an overwhelming majority. One key focus of foreign policy is, "ensuring optimal utilization of national resources for regional and international cooperation[5]."

But unfortunately, in the first decade (1947-1958) of independence, this newly born country had faced a discriminatory behavior and pattern in policy. This was contrary to the basic policy statement that was laid down. The reason behind this pattern was that during the first eleven years of independence, six Prime Ministers came to power

[3] See the text of the Ordinance in the Gazette of Pakistan (Extraordinary), March, 2. 1961
[4] Anis Mirza, "Women's Role in the Pakistan Movement and the Formative Years", paper read in the Soroptomist Club Seminar "Women in Public Life, October, 1972 Lahore" p.4. This Front was particularly active in Karachi, which was then the Capital of Pakistan.
[5] official website www.mofa.gov.pk

one after another with eight cabinets whose members were all male. Never ever any female was selected or nominated in any Cabinet with any portfolio or designation during this era. Naturally this pattern expedited its repercussions on the subsequent offices that came under different ministries and portfolios; the foreign affairs department inherited this pattern where the supremacy and advocacy of men prevailed as gender bias.

These brief historical facts are opposite to the stated policy objectives of Pakistan. But the question is why the stated policy could not be followed, and what were the reasons that restrain women's intellectual contribution to the concerned departments. In the second part of this paper we will look in detail at the sociocultural norms and taboos that are the root cause of these unjust and discriminatory roles. This part will examine the root cause of sociocultural dilemmas that rule out the role of women in Pakistan's bureaucracy.

The missing piece of jigsaw, the identity…

Societies have been governed by unwritten social codes, which were highly respected and expected to be followed by every member of society. These unwritten rules have greatly contributed to preserving the romantic image of marriage and motherhood, an ideological device functioning to entrap women into accepting an unfulfilling and limited role in every walk of life.

Women are always depicted as "mothers-women". She gives birth to many valuable offspring. One who always gives herself up completely, without hesitation, both spiritually and physically to her family; such a character, a woman who is aware of and accepts her role as a sacred mother/wife figure imposed on her by society. She can only see herself within the frames of the traditional mother role, or a devoted daughter or a woman who is a sister to a brother. Even behaviorists used romantic and fairytale imagery to give her a romantic aura that instantly separates her from being a natural human being more than any other role. She is confined to many other roles, suppressing her emotions, leading her own soul torn apart with these roles quarrelling with each other. The misunderstanding between the two souls is an example of the conflict between individuality and culturally based perceptions. Through women's roles as mothers or wives, they become "symbolic bearers" of the collectivity's "identity and honor" and are often required to carry this "burden" of representation which restrains women's intellect at every walk of life. Since she could never give up herself - the true essence of her, a woman would give her life for her children, but couldn't give herself more and that's why she lacks professionalism. It's something which may only be comprehended as a *severe identity crisis*, which is in fact the total absentia of her one true identity that is *humaneship*.

The prejudices & oppressions in bureaucracy

In order to understand the historical oppression of women in bureaucracy, we have to understand not only the physical dimension such as extortion and man handling but also the shameful practices especially those concerned with constructions of identity that have questioned the roles affixed to the male and female identity. We have also sought to show how these roles interplay with the total bureaucratic setup; the dichotomies apparent in identity-construction can also be found in the division of bureau realms, where men's "natural" or "determined" role is found within the public sphere, and that for women is found within the private sphere**.** The subject area of reproduction rights and responsibilities has historically not been given high priority within the political realm and in bureaucracy which can thus be explained through the idea that "women's issues" are private issues and thus do not belong in the official political public sphere.

The first theme explored relates to the notion of women's identity within the bureaucratic context, where the focus is on how women's identities come to serve particular interests in relation to the interest of the nation. Women's roles within the private sphere are then seen to be constantly reinforced as they legitimize their position in the national collective. The second theme deals with the dichotomy of Law versus Victimization. Here, the focus should be on how this dichotomy is fitted within the construction of women's and men's identities; where women often need to be constructed as "victims" in order for her actions or rather non-actions to become comprehensible. The third theme questions the context of choice that women are offered within the abortion discourse. Here the analysis is discussed and thus a specific context is produced in which the issue can be handled.

Responsibility or confinement …

Women's "natural" position within the family is also important to highlight since the role stands in an opposed relation to the roles assigned to men. Many argue this matter by showing how women's identities are often constructed so that they contrast with values associated with men: it is reflected in our values by the way of assigning women's roles within the bureaucracy. This leaves the impression that the role of a mother or wife is in fact her given role in society. The responsibilities

that this role entails can thus be "best" handled by her since she has "always" handled these issues and thus cannot contribute to anything professionally because she is not able to. This leads to a very deterministic understanding of women's and men's roles in society. By ignoring these oppositional relations and the significance of values attached specifically to women and men, the delegation indirectly decides who has the greatest power within bureaucracy.

An honor, a shame…

Some women live in constant fear in bureaucracy. They live in constant fear because they could have their spying brother as their worst enemy, their mother as a tyrant and their father's honor depending on how they behave socially. A woman ought to obey the norms that exist in bureaucracy otherwise she could be forced to marriage with someone, abused or murdered. Hence, within this environment it is not uncommon that crimes of honor could be seen as heroic deeds and carried out in a predetermined sense. Therefore, there has always been strong ambition to give a theoretical perspective that these violations are created by different social attributes of honor vs. dishonor, control, shame, gender and religious interpretations that also could be based on aspects of tradition and heritage. Even though women have lived in a multicultural society as in developed countries, they have been murdered in the name of honor by their relatives. According to United Nation estimations around 5,000 women are killed annually worldwide in the name of honor, out of which 600 were killed in Pakistan in 2003 (Ghanim).

The exact number of women that have been exposed, affected or victimized by crimes of honor is not known, neither internationaly nor in Pakistan. It is evident within crimes of honor that strong elements of ethnicity, heritage, tradition and religious interpretations do oppress females thus reflecting on discrimination within bureaucracy. The victims of these crimes ought to be given support and aid, but there is no specific law or convention that actually gives its support; hence the legal remedy comes from relevant regulations. Consequently, the support and punishment that is given could be limited; in a sense where it is misdirected and wrongly carried out. Thus, it is unfavorable for those women who need a good support. Still, it is not only legislation and some aspects of the support that need to be extended; people's mind needs to change too.

Gender blindness in bureaucracy of Pakistan

One can conclude that bureaucracy in general and foreign affair offices in specific are patriarchal and least gender sensitive. This part of paper explains the gender blindness in Pakistani bureaucratic recruitment process and on the basis of this, neglecting the argument made by Evans and Rauch (1999) that Pakistan bureaucracy is gender neutral (Weberian).

The secondary function of women as depicted on the canvas by the colors of social and cultural dilemmas show gender inequity in the bureaucracy of Pakistan, with a substantial report by World Economic Forum's Global Gap Report 2014 that ranked Pakistan the second lowest country on overall measures of gender-based bias (World Economic Forum, 2013).

Weberian framework and gender neutrality

Weberian parameters are considered to form the basis for professional conduct in Pakistan's bureaucratic setup as it has been inherited by the British Empire in 1947, in which Weber emphasized on equity in promotion, efficiency, and reward among candidates of an organization.

Weber (1968) theorized that a rational, efficient and achievement–oriented bureaucracy must emphasize objective standards and impersonal rules which would ensure organizational reliability and predictability. This entails objective, independent and impersonal decision-making, without the influence of bias, prejudice, self-interest, or external pressure that would ensure the most optimum decisions. These would ultimately produce an organization that is optimally efficient and technically superior.

Evans and Rauch (1999) collected a data set from 35 countries, constructed a Weberian scale and tested the data with respect to economic growth. According to their findings, state bureaucracies characterized by meritocratic recruitment and predictable rewarding career ladders are associated with higher growth rates; they conclude that meritocratic recruitment is the element of bureaucratic structure that is the most important for improving bureaucratic performance. In their research paper Pakistan ranks high on the Weberian scale.

Meritocratic recruitment & Pakistani women

In Pakistan, a woman's position in life, her education, her ability to make independent choices and whom she is to marry are connected through her living situation, tradition and culture. Ideally, a woman's living situation, class or caste should not

have an impact on whether she is treated as equal to men in the society, or not. But, during different stages in life, a woman has to fight to obtain a level of independence, may be agitated over the subordinated position of women and especially face those women who don't fight for themselves. The middle class is growing and more women are getting educated. As a result, in so far as education is correlated with higher degree of personal independence, equal rights put into practice are also improving. Basic education and higher education seem to be non-optional for women in the third group. According to their views, they have to get higher education to ensure that they will not be subordinate or dependent upon anyone. Having their own career is very important to them.

Three faces of women in Pakistan …

There are women in top political positions and women running grassroots organizations in Pakistan. But there are also women who have no or little knowledge about their legal rights. No one can say that all women are discontent with their situation of living and are obliged to involve themselves in political organizations or self-help groups or in civil service examinations. But it seems evident that they ought to be aware of their rights and to be able to speak their mind without fear of consequences. There are substantial differences in how women recognize and exercise freedom in their daily lives. By *dividing* women into three different groups their actions can be analyzed as representative of these *three groups*.

For the first group of women, the ones living with less privileges having a few or even no years in school, education is of vital importance but sill remains very difficult. Access to necessary and enough information to make independent choices is what we expect to find in our society. Being illiterate restricts the life of a woman in many ways, for example in her ability to gather information, or to be aware of the bureaucratic system.

Women in the second group are literate and have entered the public sphere through politics where they think of themselves as representing the voices of women. Women need other women in political positions to plead their cause. It is today possible for a woman to be leader of a slum area and after some time to reach a political position where she can have an even greater influence. The presumption that only a woman knows the needs of women is shared by many of the women. But the needs women have, differ depending on their position in society. The women in the second group fight for issues such as those concerning clean water, sanitation, work possibilities, and education for everyone. In the election campaigns, they turn to voters who would fit into the first group of women, those living in slum areas, by promising to improve their situation and to meet their needs of, for example, clean water. But still to take part in civil service exam and get through it and get a position in the apex of policy makers in not an agenda for them.

Women in the third group, those with higher education, are the ones who seem not to be bound to home. In contrast, women in the first and second group, with lower or no education, have full responsibility for the household chores. Some of them expressed interest in bringing about a change, for example by being able to work or to get involved in the decision making at home. But to take part in decision making at policy level is even not their piece of cake. Many things in the daily life of women are connected through the cultural context they live in. The traditions still live strong in many areas of society. The spheres of women and men are clearly separated although they are becoming more and more questioned and challenged. Those who challenge the spheres are women from the second and third group, women who are politically and cognizably active or have a higher education, that is, those with the ability to do so. The division of public and private sphere has to be explored in every case; there have been manychanges in women's position among certain groups of the society, and no change at all in others.

The analysis of the ground realties and cultural norms rationales shows that meritocratic recruitment in Pakistan bureaucratic process is not possible. As mentioned in code of conduct only 7% of positions are offered on merit basis while the rest of all on the basis of quotas and allocation as per constitution. After criteria are fulfilled by the candidates they all go through a training process and after that the patriarchal phenomenon comes in act and the deputation process gets generalized by the institution.

Women, as Kanter (1977) suggests, stay out of the power loop. They never get the chance to secure relatively important and substantial portfolios like secretary interior, secretary of establishment, secetry of commerce, secretary of foreign affairs and chief secretary. To this date never ever any female got the chance to become the chief secretary of any province. Women are only offered a deputy position on relatively less important portfolios like women's welfare, etc.

Conclusion

In conclusion, though the literacy rate all over the country is low and specifically among women still some get the chance to appear in CSS exams and then to go through the process of selection and interview. Their count has been fewer and after all of these hindrances when they reach to the

bureaucratic setup they face discrimination based on sociocultural dilemmas, religious advocacy, and male treatment as they want to take all power and authoritative posts.

To understand the pattern in Pakistan bureaucratic system, we have to consider the social, cultural and religious conventional norms that prevail in the society generally and in bureaucracy specifically. In Pakistan from the birth of a child the first authoritative voice heard by the newly born baby is always from a male cleric and the final funeral of human also is headed and governed by men. This shows an eve of power, craving for authority and thirst to cater and control all affairs by Men. Women fall under the umbrella of patriarchal sky.

This is a far cry from the Weberian bureaucracy espoused by Max Weber, who initially designed the bureaucracy in opposition to the the traditional practices in operation at that time. At that time traditional, monarchic, hereditary and feudal methods were used to hold on to power and authority (Tanwir, 2014).

Max Weber failed to understand and accommodate the difference in social and cultural norms prevalent in societies of different countries for implementing rules and regulations formulated and designed by men. Weberian system tries to swap the traditional feudal and patriarchal oriented system of authority and power by a fair, free, competent and gender-blind meritocratic system. It can be concluded that Weber "ideal" system of bureaucratic practices could not and per continuation of the rationales, would not be, fit for Pakistan bureaucratic setup. How one can claim that Pakistan has gender blind bureaucratic setup with no discrimination against women? Rather than that they have been restrained as shown by facts and figures; there are so many barriers that restrain women's intellectual contribution in Pakistan bureaucracy.

References

David Ghanim, Gender and Violence in the Middle East, Chapter 3 Crime and honor.

Evans, P. & Rauch, E. (1999). "Bureaucracy and Growth: A cross-national analysis of the effects of Weberian state structures on Economic growth". American Sociological Review; Oct (1999) 748-765

Kanter, R. M (1977). Men and women of the corporation. New York.: Basic.

Tanwir, Maryam (2014). Gender Neutrality and the Pakistani Bureaucracy. *Journal of International Women's Studies*, 15(2), 143-164.

Weber, M. (1968). Economy and society, an outline of interpretive sociology, edited by Roth, G and Wittich, Bedminster press, New York.

World Economic Forum, (2013). The Global Gender Gap Report 2013, © 2013 World Economic Forum.

Influence of affluence in the choice of assisted reproductive technology and why it warrants a policy change

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Abstract

Presently we have a research project on azoospermia and Y chromosome microdeletion in infertile males of Kerala funded by the Department of Health Research, Government of India. During the study in Sree Avittom Thirunal Hospital of Government Medical College (SATH), Thiruvananthapuram, it was observed that the economic status of couples influence the decision-making process of choosing Assisted Reproductive Technology (ARTs), hence the study. The study was started on March 2017 and selected 202 azoospermic males from the semen analysis registry of SATH. Personal interview method was adopted for collecting demographic data. The principal investigator detailed the ethical, financial and scientific basis of the study to each participant and consent was taken. In the present study, it was observed that the financial status, education and nature of job have a bearing on pursuing infertility treatment, the choice of selection and attitudes towards the treatment. Money is a limiting factor for a majority while moving to advanced treatment options. The government must include infertility under the public or private insurance schemes since the cost of ART treatments are not covered under health insurance. Finance is a major limiting factor for pursuing expensive ART methods for the economically marginalized patients.

Introduction

Infertility is "a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse" (WHO, 2013). Studies show that among all infertility cases, more than 30% are due to male factors, >35% are due to female factors, and >40% are due to problems in both. In 10-20% of cases, no cause is found, defined as idiopathic (ART fact sheet 2014).

Infertility affects 15% of the reproductive aged couples worldwide (Sharlip *et al*, 2002). The inability to conceive a child is the source of significant personal suffering to millions of couples around the globe. Assisted Reproductive Technologies (ARTs) are established treatment options for male and female infertility. As the name implies, ART will assist or support the patient to become pregnant or to become parent of a child. The commonly available ARTs are depicted below (Figure 1).

The number of patients seeking infertility treatment is escalating worldwide and the cost of treatment is also on rise making it unaffordable to a large number of couples. Even after the World Health Organization (WHO) and I*nternational Committee Monitoring Assisted Reproductive Technologies (*ICMART) have defined infertility as a "disease" of the reproductive system, the insurer's and patients view regarding insurance for ARTs still holds ethical and policy apprehensions. Since the birth of the first *in vitro* fertilized (IVF) baby 40 years ago, ARTs are not covered fully by the insurance companies**.** Like most of the countries, in India also ARTs are not covered under any of the insurance schemes of the government or private agencies. In general, the direct costs for ARTs and the laws and regulations pertaining to insurance coverage vary widely in different countries, but ubiquitously it has certain pindowns.

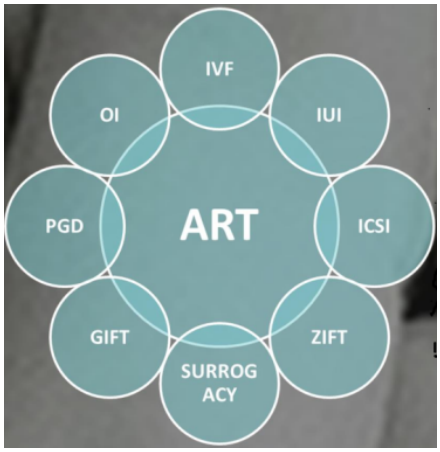

Figure 1: Various Assisted Reproductive Technologies (GIFT: Gamete Intrafallopian Transfer, ICSI: Intra Cytoplasmic Sperm Injection, IUI: Intra Uterine Insemination, IVF: *In vitro* Fertilization, OI: Ovarian Induction, PGD: Pre-implantation Genetic Diagnosis, ZIFT: Zygote Intrafallopian Transfer.)

During an ongoing research project funded by the Department Health Research, Ministry of Health and Family Welfare, Government of India, New Delhi on azoospermia and pattern of Y chromosome microdeletion in infertile males of Kerala in Sree Avittom Thirunal Hospital (SATH), Government Medical College, Thiruvananthapuram, India it was noted that the economic status of couples was a determining factor for the choice of ART treatment, prompting us to investigate the influence of affluence in the choice of Assisted Reproductive Technologies.

Methodology

The present study was started in March 2017 after obtaining approval from the Institutional Ethics Committee of Government Medical College, Thiruvananthapuram, India, vide approval No. 06/06/2016/MCT dt.17/11/2016. A total of 202 males with azoospermia were selected from the semen analysis registry of SATH for a period from January 2015 to December 2017 (Table 1).

Out of the selected cases, 164 patients were included in the study (81%). Others could not be contacted with the given telephone number and/or address. After contact, the participants were met personally during their visits at SATH. The couples were informed about the study and consent to participate was taken. Non-structured interview method was adopted for collecting demographic data from each patient. The principal investigator detailed the ethical, financial and scientific basis of the study to each participant. Case sheets were also utilized to acquire patient history and demographic data. The collected data were compiled and analyzed. During the face to face interaction with the couples, we came across certain ethical issues related to economic status of patients and choice of ARTs.

Table 1: Year wise azoospermia cases

Year	Total Azoospermia cases
2015	82
2016	51
2017	69
Totak	202

Findings

Analysis of data revealed that the majority of the patients approaching for ARTs at SATH were economically weak. 75% of the participants had a monthly income of less than 1,000 rupees (USD 15) per month and were unskilled/skilled laborors (Figures 2, 3).

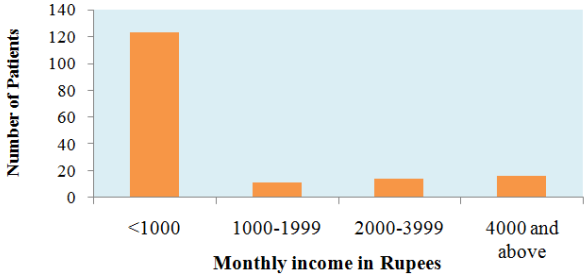

Figure 2: Average monthly income of the study participants

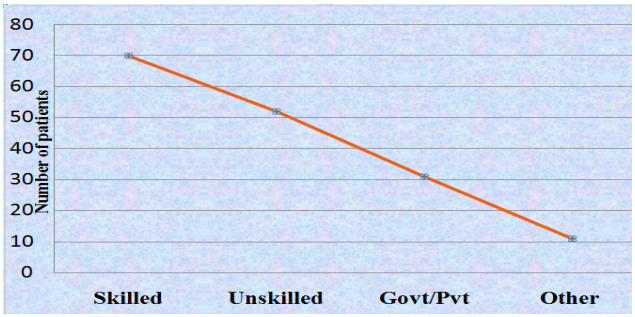

Figure 3: Job status of the study participants (Govt- Government, Pvt-Private)

Most of the study subjects completed basic education (Figure 4) and had knowledge about the treatment methods, its success rate and uncertainties of ARTs. During the direct interview it was noticed that financial status and education have a bearing on pursuing infertility treatment, the choice of its selection and attitude towards treatment. The high cost as well as the uncertainties of ARTs together put more stress on patients choosing the costly treatment options.

The patient case records showed that all the participants completed initial investigations like blood tests, hormone analysis and scanning. But solvency was a limiting factor when moving for advanced treatment options like IVF, ICSI etc. Presently, in India no private or public insurance and/ or other agencies provides financial support for male /female infertility treatment. Hence the cost of ART has turned into a limiting factor. The majority of participants suggested an urgent need of policy change by the government to support the less fortunate.

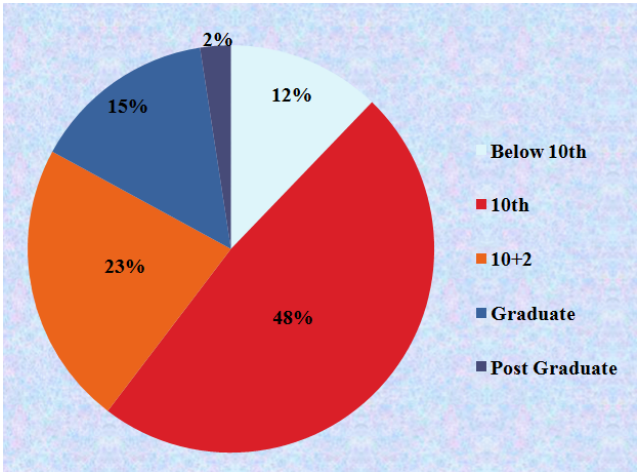

Figure 4: Educational status of the study participants

Discussion

ARTs are well established treatments for many types of sub-fertility, thus representing a considerable economic and healthcare implication for patients, healthcare providers and society as a whole. The financial support and guidelines of ART treatment share few common characteristics among countries, ranging from generous, relatively unrestricted public funding in Australia to negligible public funding in US and most developing countries (Mark *et al*, 2010). The Center for Disease Control and Prevention (CDC) defined infertility as a "public health priority" similar to food safety, heart disease and stroke (CDC, 2010). Household income can be considered as a strong predictor of the choice of infertility treatments. Several reports indicated a correlation between low socioeconomic status and higher rates of infertility (Greil *et al,* 2010). The economically marginalized groups have a lower opportunity to utilize advanced treatment methods and for a majority, financial status will be a dead end for their dream to become a parent.

In the present study we observed that the majority of the patients registered for infertility treatment at SAT Hospital had high school level education and were unskilled laborors. Educational status is a determining factor related to infertility and ART treatment. Previous data showed that the rate of infertility is higher in patients with low education (Fane *et al*, 2017). This may be because of a lower socioeconomic status along with low education levels. Populations with higher educational attainment often have higher income and may choose options of treatment from advanced hospitals/laboratories. In order to accomplish reproductive justice, these obstacles must be surmounted.

We found that some of the patients discontinued treatment once the preliminary investigations were initiated. About 56% of the couples with infertility seek medical assistance (Boivin *et al,* 2007). The chances of success can be as high as 72% for couples undergoing treatment as compared to untreated. But many choose to discontinue treatment before attaining success. Discontinuation is a primary determinant of the effectiveness of treatment because it attenuates optimum clinical benefit. Inability to bear the costs of treatment is one of the prominent factors responsible for the discontinuation of infertility treatment (Gameiro *et al*, 2012).

Unlike other developing and developed countries, the cost of infertility treatment in India is less. But parallel to many other countries, in India also the financial burden of ART is not covered under any public or private insurance companies. In the present study we observed that the majority of patients attending SATH were from financially lower class. For the majority the initial laboratory tests were feasible but the burden came into

picture when they were sent for advanced treatment options.

Our investigation infers previous findings of other researchers that socioeconomic and educational status have a profound impact on the choice of ARTs and subsequently the chance to have a child (James *et al,* 2012). The government has to take necessary measures to support/subsidize the financial burden of the patients. In August 2018 the Insurance Regulatory and Development Authority of India (IRDAI) removed infertility treatment from the list of "optional cover", and made it part of "Standard Insurance Policies" thereby making it more affordable to millions of infertile couples. Moreover, if we make our own consumables under the "Make in India" program, instead of importing all of them which increase the cost of treatment, we may be able provide ARTs much more affordable than it is today.

The existing policies in different countries face some common issues that need to be addressed by the policy makers and insurers while planning for a policy change. The most significant dilemmas associated with infertility treatment are intricate medical, economic, gender and ethical uncertainties related to the cause, duration, cost and result of treatment and this should also be considered. But unlike other health issues the infertility and its socioeconomic elements are less studied and addressed by healthcare providers and policy makers of our country. Further detailed scientific understanding related to the rate of patients' participation, treatment success and dropout incidence in our population are needed.

Conclusion

The study concludes that the economic status of couples influences the decision-making process of choosing ARTs. Since no financial support is available for ARTs in India, the government has to take necessary initiatives for policy change to help the less fortunate and ensure that money should not be a limiting factor for those who wish to become parents of a child. In addition, policymakers should consider providing equal coverage for male and female infertility care in future health insurance laws.

Acknowledgment

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References

Boivin, J., Bunting, L., Collins, J.A., Nygren, K.G. (2007). International estimates of infertility prevalence and treatment-seeking: potential need and demand for infertility medical care. Human Reproduction. 22(6):1506-12.

Centers for Disease Control and Prevention. (2010). Outline of the National Action Plan on the Prevention, Detection, and Management of Infertility.

European Society of Human Reproduction and Embryology (2016). "ART fact sheet".

Fane, G., Daniela, I., Man, Y. L., Raül, S.L. (2017). Educational Disparities in the Battle Against Infertility: Evidence from IVF Success. EUI Working papers. ECO 2017/05.

Gameiro, S., Boivin, J., Peronace, L., Verhaak, C.M. (2012). Why do patients discontinue fertility treatment? A systematic review of reasons and predictors of discontinuation in fertility treatment. Human Reproduction Update. 18: 652–669.

Greil, A.L., Slauson-Blevins, K.S., McQuillan, J. (2010). The experience of infertility: A review of recent literature. Sociology of Health and Illness. 32, 140–162.

James, F., Smith, M.D., Michael, L., Eisenberg, M.D., David, G., Susan, G., Millstein, Marcelle, C., Thomas, J., Walsh, Jonathan, S., Lauri, A., Pasch, Nancy, A., and Patricia, P., Katz. (2012) Socioeconomic Disparities in the Utilization and Success of Fertility Treatments: Analysis of Data from a Prospective Cohort in the United States. Fertility and Sterility. 96(1): 95–101.

Mark, P., Connolly, S.H., Georgina, M.C. (2010). The cost and consequences of assisted reproductive technology: an economic perspective. Human Reproduction Update. 16: 06:603-613.

Sharlip, I.D., Jarow, J., Belker, A.M., Lishultuz, L.I., Sigman, M., Thomas, A.J., Schlegel, P.N., Howards, S.S., Nehra, A., Damewood, M.D., Overstreet, J.W., Sadovsky, R. (2002). Best practice policies for male factor infertility. Fertility Sterility. 77: 873-882.

WHO 2013, available at: https://www.who.int/reproductivehealth/topics/infertility/definitions/en/

Living the anthropocene from 'the end of nature' to ethical prospects

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Abstract

This article explores the viability of life after 'the end of nature' – as Žižek reports – in the Anthropocene. Humans can no longer consistently rely on their persistent interventions to nature as its source. The end of nature, however, does not only mean that the problem is solely ecological. Instead, it points to the original chaos of catastrophes that disturb the link of man's relationship to nature. In short, the current predicament of the times not only exposes problems of ecology per se but also of economy, biology, and society. So, what comes next? Taking off from Heidegger and Leibniz, ethical prospects

after this four-fold end should reopen the task of thinking the Anthropocene in various independent but coalescing fronts.

From 'the end of nature' (disturbance)…

In 2010, Slavoj Žižek enumerated four catastrophic events summing up his report of the end times as the 'four horsemen of the apocalypse' in allusion to the last book of the Bible, *Revelation* (Greek: ἀποκάλυψις; *apokálypsis*). Žižek discusses in *Living in End Times* (2010a) the four horsemen: Impending ecological catastrophes (as ecology), the global financial meltdown (as economy), the biogenetic revolution and its impact on human identity (as biology), and the social divisions leading to the explosion of protests and revolutions worldwide (as society). Is it not precisely the popularity of the academic buzzword 'Anthropocene' – man (*anthropos*- 'ἄνθρωπος') + new (-*cene* 'καινός') – already an indication of how the current geological epoch is heavily influenced by man's constant intervention, especially the side-effect of technological innovations leading to plant and animal mass extinctions, ocean pollution, atmospheric alterations (Stromberg, 2013), and loss of biodiversity (cf. Pope Francis' *Laudato Si'*, Zimmerer et. al., 2019)? Žižek (2015) delves further into the current crisis and raises the task of thinking the Anthropocene, first by exposing that it disrupts the sustainability of nature and second by going into the extreme that 'Mother Nature no longer exists' – that it is already unstable (she is, in his words, a 'crazy bitch': see Žižek 2010b) – using McKenzie Wark's *Molecular Red: Theory for the Anthropocene*:

1. The Anthropocene is a series of metabolic rifts, where one molecule after another is extracted by labor and technique to make things for humans, but the waste products don't return so that the cycle can renew itself (Wark, 2015, p. xiv)
2. We still tend to think that if we stop certain actions, the ecology will right itself and return to homeostasis. But perhaps that is not the case… What if there is only an unstable nature. (Wark, p. 200 as cited from Žižek, 2015)

In what other case can one make sense out of this? The failure of the modern project allows for the understanding that any sort of metaphysics of nature can no longer work, following from Schelling's report (Schindler, 2007). Science and religion in this sense may have overtaken a philosophy of nature but these two as representatives of man's enlightenment project failed in keeping at bay the supposed homeostasis – the by-product prospect of modernity's reification methods to control nature (cf. Minteer, 2012). Nature becomes disturbed when the fundamental link that tries to objectify nature as its specimen is cut off. What is 'nature' in this regard? Nature is 'to be understood here in the traditional sense of a regular rhythm of seasons, the reliable background of human history, something on which we can count on to always be there (Žižek, 2017b).' In this sense, the life that is overviewed as a context of human intervention is one that is a 'constant struggle against apparently unpredictable elements (Žižek, 2017b).' And this signifies a paradox in the Anthropocene: 'humanity became aware of its self-limitation as a species precisely when it became so strong that it influenced the balance of all life on earth (Žižek, 2015).'

Žižek (2017a, 2017b) then caps ecological disturbance, particularly when hurricane Irma occurred, as an affirmation of the '*end of nature*'. The implication would be that nature in its end would no longer serve its purpose in the Anthropocene:

> *"When we can no longer depend on it [nature], we enter what we call "anthropocene": a new epoch in the life of our planet in which we, humans, can no longer trust the Earth as a reservoir willing to absorb the consequences of our productive activity."*

This period being that 'humans have noticeably impacted the patterns of geological erosion and atmospheric chemistry' (Crutzen and Stoermer as cited by Waller, 2019). Nature – the m(other) that figures the balance of things – in this sense, dies. Moreover, the prospect of this end is reflective of a consequentialist follow-up of God's death, a Nietzschean killing of a feminine other: "after the death of the God-Father, the masculine reason, we should also endorse the death of the Goddess-Nature" (Žižek, 2015). But there is no balance that can withstand the destructive force that already characterizes the figure of nature at the moment. The end of nature signifies the breaking away from traditionalist conceptions of modern progress and even the sustaining pantheistic essentialism that underlies it. As Wark puts it:

> *"the God who still hid in the worldview of an ecology that was self-correcting, self-balancing and self-healing—is dead … The human is no longer that figure in the foreground which pursues its self-interest against the background of a wholistic, organicist cycle that the human might perturb but with which it can remain in balance and harmony, in the end, by simply withdrawing from certain excesses."* (Wark, 2015, p. xii)

How does one consider this 'end'? The idea is that all the four horsemen cannot be taken individually: all four are crucially connected that in the end man bears the destruction altogether. Asserts Žižek (2010a):

> *"the common-sense reasoning which tells us that, independently of our class position or of our political orientation, we all will have to tackle the ecological crisis if we are to survive, is deeply misleading: the key to the ecological crisis does not reside in ecology as such."* (pp. 333-334).

Alongside ecology, the complex interweaving of societal, economical, and biological concerns also affect life in the Anthropocene. In the case of biology – the common denominator of technology inserting itself into the fabric of human society – organizations, for instance, captivate studies that center the terminology on the posthuman such as a 'Posthumanized Future Workplace' (Gladden, 2018) where there is a posthumanizing process in the growing number of adoptions of 'social robotics, advanced AI, virtual reality, neurocybernetics, and ubiquitous computing.' And this virulent intrusion of bioengineering has consequences not only to the society and economy, but also to ecological resources for sustenance.

If there is a crucial lesson of confronting this ecological disturbance, it is that the ethical prospects to address this would have to be in multifaceted fronts, which means that they would have to be independently orchestrated. What this further means is a concoction of Heideggerian and Leibnizian train of thought. Heidegger's 'end of metaphysics' is often a look at the manifestation of his criticism against the onto-theological tradition of scholasticism, the critique of the remaining Nietzschean 'metaphysical' pronouncements, and a transition to nihilistic times (cf. Heidegger, 1973). But isn't it also telling of the fact that since this end of philosophy debunks the underlying presuppositions of essentialist precedence, this 'end' also means a further *independence* of the sciences and their various tractions to thinking, namely, the opening (or unveiling) of thought? Anent to this, Leibniz's *Monadology* (cf. Rescher, 2014) comes to mind as a juxtaposition to the independent courses of thought. The Leibnizian view of this world as 'the best of all possible' ones, allows for sufficient reason to suppose that the harmony of things is not found in an explicit manner of connection (man and nature, in this case), but of a bigger picture of synchronization upon seeing the independent courses of events. Which is to say that, like an orchestra, the independent musical pieces of various instruments would coalesce in the end towards a grander melody. In these tasks, one might see an opening for fitting diagnoses.

(Orchestrating) Ethical Prospects

There is, then, a viability to seek ethical considerations as interventions. And these had to crucially consider, aside from ecology, the other aspects of economics, society, and biology as well. It is to be noted, moreover, that the challenges that are posed in finding perspectives for ethics must be framed in the question of responsibility and must elicit 'an ethics that comes from being human, required to bring about sustainable features' (cf. Chin et.al, 2017). Will our ethical response be framed within that of responsibility or some other perspective? What are other ways of seeing things vis-à-vis the responsibility of nature and ethics altogether?

Converging ideas to propose concrete solutions are perhaps fundamental in this case. Siegle (2016) in *the ethical guide to the Anthropocene* suggests a curtailing of negative trends by thinking differently. Under processes of climate change, humans must 'transition away from a fossil-fuel world economy in the next 25-30 years.' She takes the proposal of the UN's Global Climate Change Summit in Marrakech: from four outdoor gym machines that generate electricity while exercising to fashion ideas turned into production through ethical means.

It is significant in this regard that a responsible agency within the epoch is connected to some form of character reshaping. On the religious side, Pope (2018) proposes a *cruciform ethics* which is born out of the kenotic ethic of Christianity. This position entails, via population, a 'self-emptying of our endless desires to reproduce ourselves' to address the large carbon footprint of the planet. It also means less consumption in human societies defined by a gluttony of 'excessive or wasteful eating, or energy profligacy.' This follows from what he calls *Sabbath economics,* where the earth consumption must rest every seven years. A specific route that it takes is vegetarianism, which lessens the treatment of 'animals as commodities and not creatures.' It also prevents the high consumption of animal proteins that enables methane emissions and the global collapse of fisheries. Vegetarianism in this sense reduces greenhouse gas emissions and the future impacts of climate change (Pope, 2018). Under this proposal, one becomes responsible for curtailing one's desires.

Taking the necessary cue of asking the reason behind the sudden crisis of Anthropocene despite preceding decades of environmental ethics, Paul (2018) takes a different theorizing on understanding the responsible relationship between human and the environment. There is a sense in which the urgency of the environmental ethics in the Anthropocene is no longer a matter of moral debate but already a 'question of the very survival of life on Earth, including ourselves (p. 2896).' She contextualizes, following from Latour's argument of the 'paradox of modernity,' that there is a 'hyperseparation between nature and society'

and this is processed either through purification (is the phenomenon purely natural or social?) or through translation (the environment is a social and political construct). Paul thinks that there should be a 'hybridize notion of environment' against the purification process. Like Žižek, Paul highlights the realization that environmental problems are 'neither in human nor in nature, rather it lies in the relationship': in the height of the Anthropocene era, 'the environment we encounter is no longer "natural," and we as humans are no longer just cultural or social.' So there is a need for a phenomenological perspective in analyzing the situation, which is to say that one must view the situation as an experiential knowledge of the interconnectivity of humans and nature. Both must be given equal priority.

Following from a phenomenological standpoint, Zylinska's *Minimal Ethics* sees the Anthropocene 'as a phenomenon and a discourse' that elicits an ethical response coupled with human responsibility. Humans can no longer be regarded as the aggrandized figure to take care of the earth. Instead one must tone down this hubris into what she calls a 'narrative of humility' or a 'minimal narrative.' This is reminiscent of the Lyotard's report of dispelling grand narratives (cf. Lyotard, 1984) as well as Jenning's proposal of cultivating humility in civic governances that are centers of decision-making (2016). In this sense, the need for better stories is part of a phenomenological lens. For Zylinska, a 'better story would be a story that makes such power distinctions visible. Otherwise there is a danger of the Anthropocene becoming this kind of great leveller in which everyone is equally guilty (Valero, 2018; Zylinska, 2014, p. 46).' A non-normative story would have been a narrative of responsibility without rushing towards solutions.

Another possibility is revealed from those who slightly distance with the emerging analysis of an already-framed picture of responsibility that seems to take on a conservative 'social justice' kind of looking at things. The manner of argumentation proceeds from a revisiting or rethinking of thought while not bringing out a purely retroactive solution. Hamilton et. al (2015) think of the banality in terms of ethically addressing the situation. Moving away from Paul (2018), they point out that the task is deeper than a call for interdisciplinarity around 'hybrid "socio-logical" objects', so the era of human social contracts must be "rethought." Pacing in rationalization, one of the crucial points of not easily succumbing to the parade of proposals is the so-called "political Anthropocene" forwarded by Karera (2019) who notes that the new management of Anthropocene ethics is 'unequipped to face the racial histories of our current ecological predicament' and should not neglect 'black suffering.' It is then important to highlight the significance of political consequences in any ethical variants. Without taking amiss the racial antagonisms of society at large, current proposals must be fortified with critical potentiality. They must be ready to face the era head-on sans denying the 'geological impact of human force on nature' or uncritically assessing the promotion of capitalist values while compromising, through disavowal, social antagonisms.

With the common dismissal of modern ethical traditions predominating the discourse of the Anthropocene, Schmidt, et. al. (2016) suggest a reassessment and repositioning of traditional issues as well as identifying novel ethical problems. Trachtenberg (2017) agrees with it while emphasizing on the richness of traditional ethical conceptions and marking the important method of rereading. There are important approaches that must be revisited. For instance, with the 'large-scale uncertainties and struggles to address collective action problems,' one can hinge on a virtue ethics that molds justice, truthfulness, and hope in character development (cf. Jamieson, 2014; Williston, 2015).

One should also not easily terminate those who are affected by the complexity of moving beyond nature or ultimately proceeding to an automated response of accepting the current constellation of events. Here, one can think of Rolston (2017) who proposes entering not the Anthropocene per se, but a *Semi-Anthropocene,* a modestly wiser and more ethical course, which is not to go *beyond* nature and keep the 'natural symbiosis' with humans. This view is consistent with the paradoxical thought forwarded by Jacques Lacan who says: 'I don't much like hearing that we have *gone beyond* Hegel, the way one hears we have *gone beyond* Descartes. We go beyond everything and always end up in the same place (Lacan, 1990, p. 71).' Such is true for the most part when it comes to the nomenclature found in the academia where one simply coins a different name for a somewhat analogous concept. Many names can be called for the dimensions of looking at the new changes in the period, but one can reduce them to a main thematic condition. In one of Chan's (2019) six urban conditions ethically examined in the Anthropocene, for instance, two of which is simply precarity and fear. But one should never take these two lightly as they are patterns of thought that are analogous to other sophisticated formulations as well.

In a somewhat different coinage, therefore, Miles and Craddock (2018) propose a "Biome Ethics" (as preferable to Anthropocene ethics), which is different from bioethics, eco-ethics, and environmental ethics. This is to be understood as a global biome rather than a parochial one because it

comprehensively captures relationships 'between human activity, all life forms, and the environment.' They consider the non-neutrality of Anthropocene by calling out the 'particular histories of colonization and capitalism' which are responsible for 'various mechanisms of oppression, exploitation, and displacement.' Considering the larger context then, the principles and values for Biome Ethics are connectivity, human and nonhuman continuum, and shared suffering. The idea is that consumption is based on an environment of global connections, from production to human and nonhuman relations, so that the suffering of one redounds to the suffering on the other – a kind of shared suffering which Donna Haraway bases from the feeling of empathy rather than cognition. With the prospect of the end of nature, Biome ethics refocuses on the interconnectedness for life forms. And this even disavows an ethics of responsibility because of the imperative nature of obligation contracts, rights, and enforcement rather than what is to be desired.

Clearly, these proposals are ironically independent while promoting interconnectedness, responsibility, and so on. However, what if these ethical prospects in their own ways can in the end not only pursue the discourse of Anthropocene ethics or whatever name one has for it to explain the current epoch: what if with some paradoxical twists and turns of events, a wide tapestry of consequences will also lead into a resolved future? Going steady with concrete proposals of energy conservation, calling on for interdisciplinarity, rereading or rethinking previous ethical traditions, developing character-based movements on humility, hope, empathy, justice – these are not short-term prospects with immediately seen effects. It would be a trap for visions to quickly demand automated solutions to living in the Anthropocene. Instead, one might just well pursue independent courses of actions for an orchestrating by-product in the end. Or to quote Žižek's *Living in the End Times* (2010a, p. 182), which pursues a thought that does not rely on a carefully linked and fast-paced protocol of solutions: "one does not wait for the "ripe" objective circumstances to make a revolution, circumstances become "ripe" through the political struggle itself."

References

Chan, J. (2019). *Urban Ethics in the Anthropocene: The Moral Dimensions of Six Emerging Conditions in Contemporary Urbanism.* Palgrave Macmillan.

Chin, A., Beach, T., Luzzadder-Beach, S., Solecki, W. (2017). Challenges of the "Anthropocene". *Anthropocene, 20,* 1-3.

Gladden, M. (2018). A Phenomenological Analysis of the Posthumanized Future Workplace. *Praktyczna teoria,* 3, 31-39.

Hamilton, C. (2015). The Banality of Ethics in the Anthropocene. Speech to the GLOBALE Festival, Zentrum fur Kunst und Medientechnologie, Karlsruhe.

Heidegger, M. (1973). *The End of Philosophy* (Joan Strambaugh, Trans.). New York and London: Harper & Row Publishers.

Jamieson, D. (2014). *Reason in a Dark Time: The Co-production of Science and Social Order.* New York: Routledge.

Jennings, B. (2016). Unnatural Selection. *Minding Nature 9,* 4-11.

Karera, A. (2019). Blackness and the Pitfalls of Anthropocene Ethics. *Critical Philosophy of Race, 7*(1), 32-56.

Lacan, J. (1990). *The Seminar of Jacques Lacan, Book II: The Ego in Freud's Theory and in the Technique of Psychoanalysis, 1954-1955 (Le Séminaire #2)* (Sylvana Tomaselli, Trans., Jacques-Alain Miller, Ed.). New York: W.W. Norton.

Lyotard, J. F. (1984). *The Postmodern Condition: A Report on Knowledge* (G. Bennington, & B. Massumi, Trans.). Minneapolis: University of Minnesota Press (Original work published 1979).

Miles, S.H., and Craddock, S. (2018). Ethics for the Anthropocene Epoch. In Dominick A. DellaSala, and Michael I. Goldstein (Eds.), *The Encyclopedia of the Anthropocene*, vol. 4, (pp. 21-27). Oxford: Elsevier.

Minteer, B. (2012). Geoengineering and Ecological Ethics in the Anthropocene. *BioScience 62*(10), 857-858.

Paul, K.B. (2018). Re-conceptualizing Environmental Ethics in the Anthropocene. *Pertanika Journal of Social Sciences and Humanities, 26*(4), 2894-2907.

Pope, M. (2018). A Religious Ethic for the Anthropocene? A Response to Freya Mathews. *ABC Religion & Ethics.* Retrieved from https://www.abc.net.au/religion/a-religious-ethic-for-the-anthropocene-a-response-to-freya-mathe/10214288

Rescher, N. (2014). *G. W. Leibniz's Monadology*. Abingdon, Oxon: Routledge.

Roston, H. (2017). *The Anthropocene!: Beyond the Natural?* In S. Gardiner, and A. Thompson (Eds.), *The Oxford Handbook of Environmental Ethics.* Oxford University Press.

Schindler, D.C. (2007). Restlessness as an Image of God. *Communio: International Catholic Review 34*, 275-276.

Schmidt, J. J., Brown, P. G., & Orr, C. J. (2016). Ethics in the Anthropocene: A research agenda. *The Anthropocene Review, 3*(3), 188–200. doi:10.1177/2053019616662052

Siegle, L. (2016). The ethical guide to the Anthropocene. *The Guardian.* Retrieved from https://www.theguardian.com/environment/2016/dec/11/the-ethical-guide-to-the-anthropocene

Stromberg, J. (2013). The Age of Humans: Living in the Anthropocene. *Smithsonian.com*. Retrieved from: https://www.smithsonianmag.com/science-nature/what-is-the-anthropocene-and-are-we-in-it-164801414/

Trachtenberg, Z. (2017). "Ethics in the Anthropocene: A research agenda" Review. Retrieved from https://inhabitingtheanthropocene.com/2017/04/19/ethics-in-the-anthropocene-a-research-agenda/

Valero, L.B. (2018). Joana Zylinska: "We need a new way of seeing the Anthropocene". *CCCBLAB Cultural*

Research and Innovation. Retrieved from http://lab.cccb.org/en/joanna-zylinska-we-need-a-new-way-of-seeing-the-anthropocene/

Waller, A. (2019). Preventing the Catastrophian Age: Mechanisms to negate the need for lifeboats. *Eubios Journal of Asian and International Bioethics, 29*(1), 36-40.

Williston, B. (2015). *The Anthropocene Project: Virtue in the Age of Climate Change.* Oxford: Oxford University Press.

Wark, M. (2015). *Molecular Red: Theory for the Anthropocene*. London: Verso Books.

Zimmerer, K., Haan, S., Jones, A., Creed-Kanashiro, H., Tello, M., Carrasco, M., Meza, K., Amaya, F.P., Cruz-Garcia, G., Tubbeh, R., Olivencia, Y.L. (2019). The Biodiversity of food and agriculture (Agrobioversity) in the anthropocene: Research advances and conceptual framework. *Anthropocene,* 25

Žižek, S. (2010a). *Living in the end times*. London: Verso.

Žižek, S. (2010b). Wake up and Smell the Apocalypse. *New Scientist.* Retrieved from https://www.newscientist.com/article/mg20727751-100-slavoj-zizek-wake-up-and-smell-the-apocalypse/

Žižek, S. (2015). Ecology against Mother Nature: Slavoj Žižek on *Molecular Red.* Retrieved from https://zizek.uk/ecology-against-mother-nature-slavoj-zizek-on-molecular-red/2/

Žižek, S. (2017a). Irma o el fin de la naturaleza (Irma or the end of nature). *The World.* Retrieved from https://www.pagina12.com.ar/63769-irma-o-el-fin-de-la-naturaleza

Žižek, S. (2017b). Hurricane Irma will happen again – so we need the answers to some difficult questions about global politics. *The Independent.* Retrieved from https://www.independent.co.uk/voices/hurricane-irma-climate-change-recycling-donald-trump-rehousing-slavoj-zizek-

Zylinska, J. (2014). *Minimal Ethics for the Anthropocene.* Open Humanities Press.

Book Review of **Beyond Bioethics: Towards A New Biopolitics**

By: Obasogie, O.K. and Darnovsky, M. 2018. University of California Press. *518 pp.*
ISBN 978-0-520-27784-7

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Bioethics plays an increasingly important role debates regarding and the pathways followed in science, medicine and innovative technologies. It is a widening field that encompasses considerations from patient, medical practitioner, environmentalist, sociologist, legal, economic, religious, philosophical and scientific perspectives. Bioethics can incorporate ethical dilemmas that relate to all *biota* such as the broader *Britannica* definition or to the narrower *Merriam Webster* dictionary definition that refers to biological research and especially that involving medicine. In this book *Beyond Bioethics* the essays are written by experts within the latter field, largely focusing on reproductive technologies and genetic engineering issues related to the provision of health care. Nonetheless key insights that are pertinent to all bioethics are illustrated throughout the text, such as a perceived shift from the primacy given to adherence to the precautionary principle towards greater decision making based foremost on principles of consumer entitlement.

This collection, of over fifty essays, is divided into ten parts. The first two present some historical background and critique of bioethics including eugenics, principlism, feminist and disability rights issues. Subsequent sections delve into arguments surrounding emergent technologies and the growing influence of consumer market forces in dictating medical provision. There is a section that addresses the research ethics of medical testing. A number of essays tackle debates over fertility clinics, designer babies and race-based medicine. The final section looks to the future; one argues for more democratic citizen engagement in decision making over the use of CRSIPR technology rather than a moratorium based on assessments made by "experts". Do the rights of wealthy individuals in developed countries to have "perfect" babies infringe on the principles of human dignity, protecting future generations, the biosphere and biodiversity as called for by the UDBHR? Indeed, one of the failures, in my opinion, of this compendium is the general lack of reference to UDBHR. The guidelines of which have strengthened political arguments, supported the development of bioethics committees and helped design legal frameworks in many nations, especially those of the global south. The absence references to this widely recognised soft biolaw surely reflects the blinkered view of the rest of the world's political processes by the editors.

My further concern is the limitation of presenting bioethics as merely the field of biomedical ethical issues dealing with personal values, rights and responsibilities. These are all well and good, but they promote health and wellbeing for individuals before consideration of wider communities or populations let alone other living organisms and our interdependence with them. The obsession for the right of every person to have their own offspring, at this point in time with exponential human population growth and rising environmental problems, runs counter-current to morality based on virtues such as moderation,

prudence, justice or self-discipline. If values and moral decisions are framed in narrow medical ethics terms, or if these override environmental ethical considerations without first and foremost and remaining continually aware of our interdependence on other species and our natural world, then in the long run we are heading down a dead-end alley.

We can be given a glimmer of hope that bioethical medical issues have inspired some shifts in political action and processes such as the 1975 Asilomar agreement regarding recombinant DNA technologies. Let's hope the second edition of the text sees the necessity and wisdom of encompassing bioethics beyond the human fishbowl, recognizes what has already been achieved in some less developed countries and celebrates the potential and influence of international agreements such as the UDBHR.

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