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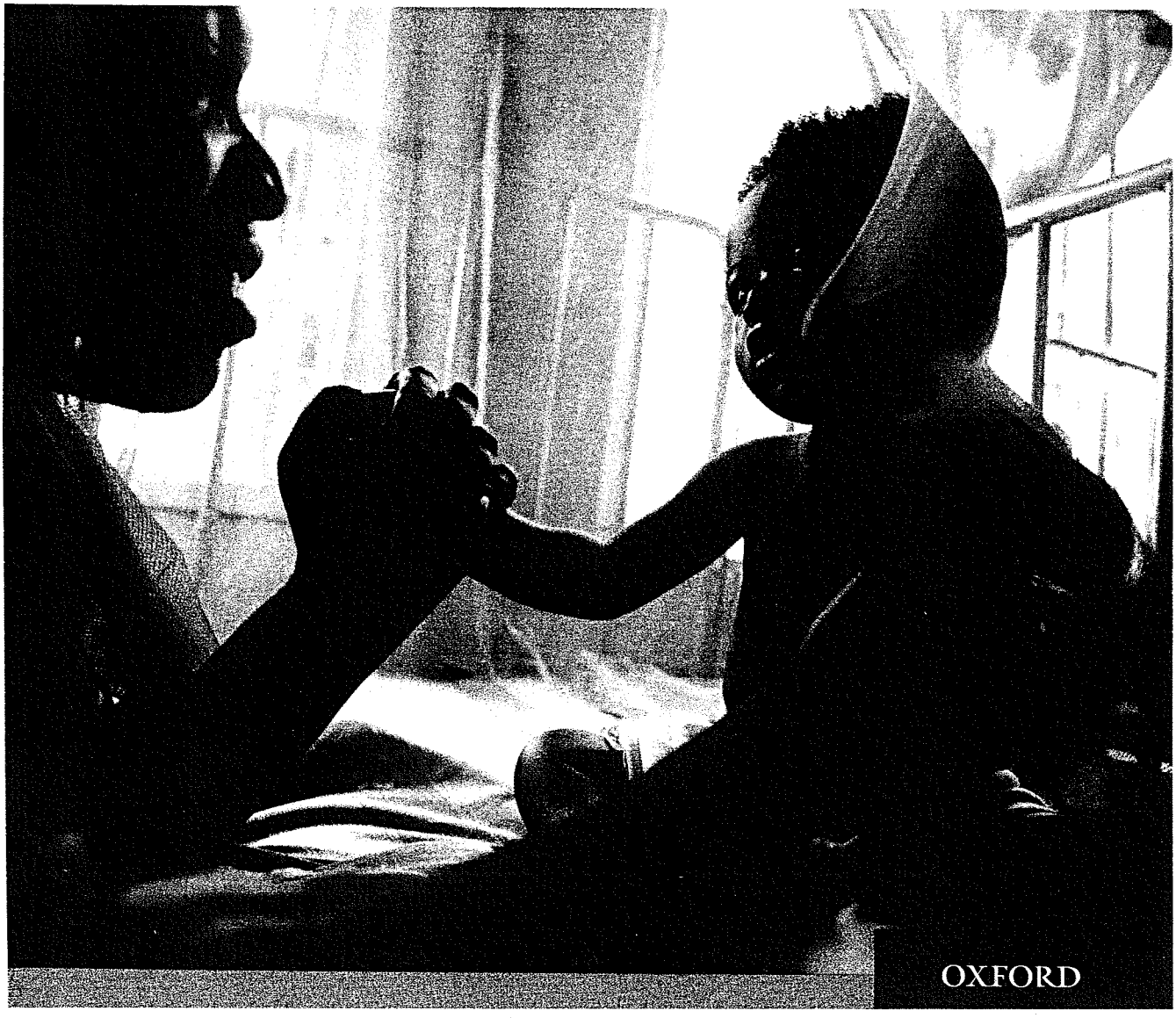
Global Justice and Bioethics



CONTENTS

CHAPTER 9

International NGO Health Programs in a Non-ideal World

Imperialism, Respect, and Procedural Justice

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In *Development as Freedom*, Amartya Sen remarks that "[t]he contemporary world is dominated by the West, and even though the imperial authority of the erstwhile rulers of the world has declined, the dominance of the West remains as strong as ever."[1] His comment captures the common intuition that the so-called "increasing globalization" of our world is actually a process of increasing Westernization. One troubling aspect of the West's global dominance is the propensity of Western beliefs, values, and practices to undermine traditional ways of life and distinctive religious and cultural belief systems. In this chapter, I propose to consider this phenomenon as it emerges in the context of development and humanitarian aid programs, particularly those delivering medical treatment, nutrition and access to clean water. (For brevity I will refer to these services simply as "health services.") I will argue that in order to avoid contributing to cultural imperialism, international nongovernmental organizations (INGOs) have a duty to ensure that they do not offer services in a way that requires their beneficiaries to choose between accessing essential health services and violating or otherwise undermining significant traditional norms and practices.[2] INGOs can accomplish this by means

of an *iterated process of reciprocal negotiation*, in which both the INGOs' and the beneficiaries' deep values and concerns play a role. In essence, my claim is that employing such a process is a requirement of procedural justice, given the non-ideal conditions in which INGOs must operate.

Many people in the developing world access essential health services either partially or primarily through programs run by INGOs. Given that such programs are typically designed and run by Westerners, and funded by Western countries and their citizens, it is not surprising that such programs are regarded by many as vehicles for Western cultural imperialism. Despite the fact that many INGOs make efforts to employ local staff and to employ a "participatory approach" to program management and implementation, they are still commonly accused of harboring a predominantly Western, liberal agenda and being insufficiently engaged with, and responsive to, the communities they serve.[3]

To set the scene for our inquiry, suppose that an INGO has chosen a population to receive aid, and a group of expatriate staff has been sent to the selected area to set up a program. Typically, before a team is sent, the INGO will have either (i) sent an exploratory mission to determine the type and extent of unmet basic needs, or (ii) reviewed reliable reports from other groups present in the area on this subject. So, a team usually will not have been sent unless staffers have some idea of the situation on the ground and some idea of what types of services their organization intends to offer. In the early stages of a program, the INGO staff will usually confer with the relevant authorities (local elders, mayors, governors, or regional or national government representatives), as well as consult local staff hired to set up and run the project.

Suppose further that during these consultations, the objectives of the project or some element of its proposed implementation meets with considerable resistance from the people consulted. What should be done if: (a) community members do not feel that the chosen activities reflect their most urgent priorities, or (b) they want to change significant elements of the way the project is implemented, or (c) many refuse the proposed services altogether—and do so on the ground that the project as envisioned by the INGO is incompatible with some belief, value, or custom widely held or practiced by the community?

The problem here is that some community members may be very badly off and so may feel that they have little choice but to compromise their values in order to obtain the material benefits they need. This is also a problem at another level, because the provision of health services (under some conditions) may have the effect of contributing to the disappearance of valued practices. Given that INGOs' main purpose is to improve the welfare of vulnerable and impoverished people, they ought not to

contribute to other types of loss and pain either for those people or for those who come after them. In addition, as a purely practical matter, many projects simply won't work efficiently—or at all—if they are designed in a way that conflicts with the dominant cultural beliefs and social conventions of the recipients. However, if INGO officials allow the religious, cultural, or value judgments of the recipient population to substantially govern project design, they might have to compromise their own deeply held convictions, and/or become involved in practices that they regard as morally wrong.

In what follows, I argue that INGOs have a duty to structure their programs such that accepting aid does not require beneficiaries to violate their central moral and religious beliefs. I also claim that in cases where conflicts about factual or scientific beliefs arise, INGOs must take steps to convince beneficiaries of their truth before implementing programs. Finally, I suggest that providing services in certain ways may undermine cultural practices, and so may contribute to their eventual disappearance. Where these practices are still valued by the community, I take this to be an objectionable instance of cultural imperialism.[4]

TWO CASES OF CULTURAL CONFLICT

In order to concretely illustrate the type of difficulty I have in mind, I will briefly sketch out two examples. I will refer to these cases throughout my analysis, and will attempt to resolve them in the concluding stages of the chapter.

Feeding Center

Severe malnutrition in children under 5 years old is found to be prevalent in an area where drought has decreased the annual food supply significantly. While some members of other age groups are found to be malnourished or undernourished, these cases are relatively few, and young children are found to be much worse off as a group. The INGO decides to treat this group both because INGO officials think this is the right thing to do, and because they think this approach can do the most good overall (by preventing long-term deficits in brain and behavioral development). A therapeutic feeding center with a capacity of 150 is proposed, where severely malnourished and ill children can be admitted and treated. Local community members are happy to have a feeding center in their area but suggest that, at a minimum, it should be open to

all age groups. Specifically, they suggest that heads of households and respected elders should have priority. They argue that heads of households must be able to work to provide for them and that it would be disrespectful for very young children to receive food and medical care while elderly parents and grandparents—who have done so much for their families and their community—are suffering. Some people imply that they would feel ashamed to bring their children to the proposed center for treatment if other groups were not also given the opportunity to be treated.

Traditional Healers

An INGO arrives prepared to set up an HIV/AIDS treatment center in a location easily accessible by patients from several villages. INGO staff plan to provide voluntary counseling and testing and antiretroviral therapy. They learn that local traditional healers typically prescribe herbal remedies that are known to interact negatively with antiretrovirals. Such healers are licensed by the government and are often very highly esteemed members of their communities. At the time the INGO arrives, these traditional healers are the primary source of health care for most people. Potential patients and healers alike reject the suggestion that people taking antiretrovirals should be required to cease using traditional remedies before being permitted to begin treatment. They also suggest that traditional healers should be made full treatment partners at the proposed center, since the patients already know, trust, and respect them.[5]

PRELIMINARIES: CULTURAL IMPERIALISM AND CULTURAL BELIEFS

Now that we have an idea of the type of conflicts at issue, we might do well to examine the idea of cultural imperialism in a bit more depth. While I don't want to get bogged down in a lengthy discussion of the merits of various definitions of culture, at least a working definition is necessary here. It seems reasonable to use a definition that takes in elements of several competing (although still quite standard) definitions commonly used in the social sciences. I therefore propose the following working definition: *culture* is that complex whole that includes knowledge, belief, art, law, custom, and any other institutions, habits, and signifying practices acquired by people as members of particular societies and passed on from generation to generation by means of education, the family, and tradition.[6] To avoid a similarly fraught discussion of the idea of imperialism, I will

attempt to provide some explanation and analysis of the specific notion of imperialism at work in the context of international aid projects. These remarks are not intended to be exhaustive, but should provide at least a rough idea of what it is that INGOs are accused of perpetrating.

The notion of cultural imperialism clearly has its roots in the colonial era, when Western nations set out to conquer and rule territories in North America, Asia, and Africa for the dual purpose of exploiting their natural resources and "civilizing" their inhabitants. In this context, cultural imperialism has three key features: (1) the perpetrators or "imperialists" *intend* to both dominate and reform the beliefs and practices of people from another culture, (2) they feel they are entitled to do this because they *believe* that Western culture is inherently superior to so-called "native" or "indigenous" cultures, and (3) they carry out their task *coercively*, with the aid of significant economic and military resources, as well as through political channels such as colonial judicial systems.

But these features do not appear—at first glance anyway—to apply in the context of delivering medical aid in the present day. Certainly INGO staff do not usually *aim* to dominate beneficiaries or obliterate their cultural practices. On the contrary, INGO workers typically accept what John Tomlinson calls the "sovereignty" of particular cultures—"the idea that 'how a life is lived' is a judgment to be made by the particular collectivity that possesses this culture, *and by no one else*."[7] Indeed, Tomlinson notes that criticism of cultural imperialism is often grounded on "respect for a plurality of ways of living," which is itself a central tenet of the contemporary liberalism to which most INGO workers broadly subscribe.[8] Further, INGO workers are not likely to believe that Western culture is inherently superior to others; instead, they are often vocal critics of the way in which the populations they serve have been oppressed by Western powers. Finally, INGOs have no obvious mechanisms of coercive force at their disposal, and must operate within the legal and political context of the countries where they work, rather than being able to occupy and run such institutions themselves.

While on the surface INGO medical aid does not *seem* to share in the pernicious elements of historical colonialism, some parallels are worth noting. First, the rise of INGO aid work over the last 50-odd years has occurred along with the growth of the phenomenon known as "globalization." One notable similarity between globalization and colonialism is that both appear to squeeze out particular sets of local values, beliefs, and practices and to replace them with another more homogenous set, which originated in the West. Typically, this "replacement" set of values is characterized by a strong emphasis on a few key values and practices, such as autonomy, individualism, secularism, and privacy.[9] Following Tomlinson,

we can understand this as a process of "cultural loss" for those non-Western people whose local, historical beliefs and practices are, in a sense, drowned by a flood of messages and interventions from the West.[10] Among other factors, this loss is said to be caused by the actions of the media, multinational corporations, foreign governments, INGOs, tourists, and intergovernmental organizations such as the United Nations. If INGOs are in fact contributing to cultural imperialism, then they will no doubt be doing so as part of this larger process of globalization.

A further parallel is that INGOs have the capacity to unduly influence beneficiaries into abandoning or contravening their own beliefs in their effort to secure material benefits. This influence, which I will argue can amount to coercion in certain circumstances, is not exercised by means of laws or military/police power, but rather is a function of the kinds of offers made by INGOs together with the background against which beneficiaries must consider them. In the following two sections, I will argue that while such coercion may be inadvertent and often invisible, the potential for it is nevertheless real.

Thus, there are some potentially troubling similarities between historical colonialism and the context in which INGO medical aid is currently delivered. But this is a concern only if we assume that contributing to cultural imperialism is somehow morally wrong. There are two main reasons why cultural imperialism may be morally objectionable. First, there can be no doubt that pressure to abandon, disregard, or violate valued practices and beliefs can cause distress. It can cause feelings of shame or pain or sadness in those who contravene traditional beliefs. It may also cause others in their communities to see those who abandon traditional beliefs as reprehensible or misguided, causing further suffering and difficulties due to social exclusion or criticism. Experiencing such distress makes people worse off. Second, the coercion associated with imperialism denotes a loss of choice or control over an individual's or a community's actions or way of life. Even when losing the ability to choose does not have a negative impact on people's welfare (and it often will), it is nevertheless insulting and disrespectful for choices about significant aspects of people's lives (and their society more generally) to be taken out of their hands. In these ways, contributors to cultural imperialism may wrong as well as harm others through their actions. As Sen notes, while not every way of life, belief, or practice may be judged worthy of preservation, members from all classes of the relevant society "should be able to be active in deciding what to preserve and what to let go."[11]

Finally, a preliminary word about cultural beliefs. Clearly, a variety of beliefs and views can be broadly described as "cultural" or somehow importantly influenced by culture. It is worth distinguishing some of

them here. First, we should note that there is a difference between someone's *factual* beliefs and his or her *moral and religious* beliefs. Factual beliefs are beliefs about causes and effects in the world, including beliefs about scientific and medical matters. While there may be some overlap between religious and factual beliefs in terms of specifying what is real, how the world came into existence, and so on, for the purposes of this chapter factual beliefs should be understood as those that relate to whether or not certain medicines and medical treatments are likely to make people better off by curing them, alleviating pain, or extending life.[12] The moral and religious beliefs I am concerned with are those that concern right and wrong—that is, which actions are morally prohibited (or shameful or blameworthy), and which are permissible. These will include beliefs about honor, modesty, and appropriate public and private behavior.[13] A second type of moral belief that is relevant here is someone's assessment of what would improve his or her welfare. This type of belief is basically a judgment about what would constitute a benefit for that person.

I have specified what counts as cultural imperialism and what types of beliefs might generate conflicts between recipients and INGOs. I now explain how INGOs can contribute to cultural imperialism through their work.

THE PROBLEM I: INFORMED CONSENT IS NOT ENOUGH

It might well be argued that the simple provision of health services by INGOs cannot be morally questionable, since this merely provides an opportunity for beneficiaries to improve their overall welfare. According to this type of view, all that is required for an INGO to work legitimately is for it to obtain informed consent from individual recipients of health services concerning the policies and procedures of the programs in which they wish to participate. After all, isn't this the ethical standard we apply in hospitals and clinics in the West? A supporter of this view might argue as follows: "It is nonsense to suggest that any beneficial services provided with the full and informed consent of the recipient can nonetheless be morally objectionable. As long as someone has the option to refuse, what could be wrong with offering someone health services?"

The plausibility of this view depends critically on what it means to have "an option to refuse." In one sense, a person who can either do X or refrain from doing X has such an option. Nevertheless, in what seems to me to be a more important sense, a person living in poverty or near poverty may not have a viable choice between accessing essential health services and,

as in *Feeding Center,* respecting the society's normative requirement that elders' needs be placed first. Thus, a mother may have both malnourished children and parents, but if an INGO offers only a program for children, then she will naturally feel that she must make use of it. However, even though her choice set was constrained on the one hand by the decisions of the INGO and on the other by her economic circumstances, she likely will still feel ashamed at having done what she did.

The first sense of "having an option to refuse" implicitly relies on what might be called the "standard" view of coercion. The standard view holds that people are coerced only when they are threatened with sanctions, and not when they are offered benefits or inducements. David Zimmerman explains this view nicely as follows:

> *P* coerces *Q* only if he changes the range of actions open to *Q and* this change makes *Q* considerably worse off than he would have been [in the normal course of events]. Thus, in the standard highwayman case, *P*'s proposal, "Your money or your life" counts as coercive (in part) because *P* changes *Q*'s range of options and because *Q* is considerably worse off in the "threat situation" in which he has to make a choice between keeping his money and keeping his life than he is in the "pre-threat situation" in which he can have both.[14]

On this view, then, potential aid recipients are free to either accept or refuse the offer of health services. Since they are not threatened with a sanction that would make them worse off than they would normally be, they are not coerced.

By contrast, the second sense of "having an option to refuse" is grounded in an alternative theory of what constitutes coercion. This view holds that offers or inducements *can* be coercive, although in a different way from threats. Joan McGregor argues that one key difference between coercive threats and coercive offers is that with threats "the coercer puts his victim in a vulnerable position," whereas "with coercive offers the proposer finds his victim in a vulnerable position."[15]

We may draw a distinction here between *offers* and *gifts*. Offers come with a price, whereas gifts do not. This means that even accepting an offer that, on balance, makes me better off will usually require me to accept some conditions and/or carry out some specific acts. An offer is coercive when it exacts an unreasonable "price" in exchange for the benefits offered.[16] The "price" of accepting an offer can be explicitly stated, or it can be the result of complying with the system by which the benefits are distributed and organized. The "price" of accepting a coercive offer is also typically something that is regarded as an evil by the person making the choice. In McGregor's words, "[i]t is true of all acts of coercion that the victim *does not want to do* the demanded action, but he does have a motive for acting in the demanded way [italics added]."[17]

So, in *Feeding Center,* the price of obtaining benefits is both the shame a mother feels when she takes her children to the center and the fact that she has violated what she regards as a normative requirement. Once we recognize that even offers come with conditions attached (a price), then we can see that these conditions can often be adjusted by the person making the offer. In particular, the terms of the offer can sometimes be made easier for the beneficiary to accept.

Onora O'Neill is another proponent of the view that offers of assistance can be coercive. She argues that offers in which someone must abandon moral or customary obligations in order to obtain basic necessities (or perhaps even survival) are effectively "unrefusable." More specifically, she identifies several key features of such coercive offers and suggests that they are not meaningfully different from coercive threats. She notes that "[u]nrefusable 'offers' work because they link the choice of any but the compliant option to residual option(s) which the particular agent cannot survive or sustain.[18] An unrefusable 'offer' is not, indeed, one where noncompliance is made logically or physically impossible for all victims; it is one that a particular victim cannot refuse without deep damage to sense of self or identity."[19] Finally, O'Neill observes that it is easier to construct such "offers" when their recipients have meager resources and capabilities at their disposal, or when they have many commitments to others that they are obliged to fulfill. It is so easy, in fact, to construct and proffer unrefusable "offers" to vulnerable people that it is possible to do this without even being aware of it. O'Neill puts forward the following words of caution:

> [A]gents who seek not to coerce have to make sure that they do not inadvertently make unrefusable "offers." Any offers they make must not link options either overtly or covertly to consequences with which those to whom they make the offer cannot live. Like coercers, they will therefore need to take account of others' strengths and weaknesses, of their *specific* vulnerabilities and of the *actual* limits of their capabilities. In particular, they will have to be alert to the ease with which the weak can be coerced.[20]

It is worth noticing that it is the *structure of the offer* that is coercive here, and once the offer has been made, then the recipient cannot escape it. Of course, some of those to whom such "offers" are made might be willing to refuse the compliant option, and so suffer the severe consequences associated with doing so. However, even resisters of this type cannot restructure the offer itself and so cannot avoid the coercion inherent in it.

O'Neill remarks, "What exceptional people refuse when coerced is compliance with the option that coercers want. They do not and cannot refuse the *'offer'*, of which that option is one disjunct. The *mark of coercion is the unrefusable 'offer', not the unrefusable option* [emphasis in original]."[21] Thus, even when people give their consent, they may still be constrained in a way that looks morally objectionable. As Zimmerman argues, the offer is objectionable because the recipient does not want to face this particular "disjunctive choice"—and by structuring the choice in this way, the offerer has undermined the recipient's freedom "to set [his or her] own ends and to consider reasons for action which go beyond" this particular choice situation.[22]

THE PROBLEM II: BACKGROUND CONDITIONS AND NON-IDEAL THEORY

It now appears that INGOs could be inadvertently coercing their potential recipients, even when they think they are merely providing services or offering benefits. By making coercive or "unrefusable" offers, INGOs can cause recipients to reject local cultural norms and practices in favor of Western practices or values. Thus, it follows that INGOs may contribute to cultural imperialism *without intending to*.[23] Note that this analysis of "inadvertent coercion" fits neatly into the earlier discussion of the unintentional cultural imperialism characteristic of globalization (as contrasted with the intentional domination of historical colonialism). It does not presuppose that the perpetrators *intend* to coerce the victims into behaving according to an alternative set of cultural norms, and yet that is what occurs. Given that INGOs control the (often life-saving) resources, they have a duty to avoid making certain types of unrefusable "offers." They cannot do this unless they first recognize the relevant background conditions against which they offer their services.

The background conditions of which INGOs must take account are: (1) the power differential between beneficiaries and INGOs; (2) the significance of a given cultural practice to (at least some of) their potential beneficiaries; and (3) the non-ideal political context in which INGOs must do their work.

Power Differential

O'Neill reminds us that it is the relative weakness of recipients vis-à-vis those making the unrefusable "offers" that makes such "offers" possible in the first place. The party in the more powerful position is the one who is

able to structure the "offer," and thereby to exert control over the choices available to the less powerful party. Indeed, McGregor sets out two advantages that those who have the power to coerce must have: (a) the weaker party must be in a relationship of "dependence" with regard to the stronger—that is, there must be few, if any, alternative sources from which the necessary benefit can be obtained, and (b) the stronger party must be able to "cause or prevent a positive evil to the weaker party."[24] INGOs frequently have both of these advantages.

Given that INGO staff are in a position of economic and administrative power relative to those people to whom they offer their services, it is clear that the character of the offers made by the former to the latter are affected by this inequality. As the stronger party, it is the responsibility of INGOs to ensure that their offers are not structured in a manner that gives recipients no option other than to violate a norm or undermine a cultural practice that has significance for them. They can do this only by relinquishing some of their hold over the structure of the choices that are presented to individual recipients. If INGOs simply open their doors and offer services without taking account of this difference in power, then they are irresponsible.

Cultural Values

The significance of a given norm to potential recipients is crucial in determining whether an offer that requires them to violate that norm is in fact coercive. Clearly if a norm or practice has very little or no value to potential recipients, then acting against it will not count as a significant evil. However, it seems clear that any act that recipients believe they are obligated not to perform, or that would cause them to feel shame, remorse, or regret, is an act they regard as an evil. Daniel Lyons helpfully points out that the usual mark of a coercive offer is that someone is "rationally reluctant" to accept it, even if it seems to offer a benefit.[25] On this view, people are "rationally reluctant" to accept an offer when they must perform act X in order to obtain benefit Y, but regard X as morally wrong or harmful for themselves (or someone they care about or are responsible for) in some non-trivial way. This type of reluctance seems to indicate that the cultural norm is significant in the relevant sense.[26]

Political Context

Finally, it is worth pointing out that INGOs, by definition, work in political contexts that are very far from approximating ideal conditions of either

domestic or international justice.[27] Thus, the problems under consideration are problems in non-ideal theory, in both senses of "non-ideal" as outlined by Gopal Sreenivasan: (i) institutions where INGOs work "may be unjust or may not exist at all," and (ii) both domestically and internationally, individuals and states have failed to do their fair share for aid recipients within a scheme of distributive justice.[28] This is important for formulating appropriate procedures for determining how to benefit them.

Under non-ideal conditions, procedural justice will "look different" than it does under ideal conditions.[29] Under ideal conditions, where the background is a just society and a just world, recipients would have the option to refuse health services offered by INGOs on terms with which they disagree. This is because recipients would be able to access alternative sources of health care in a just world. A given INGO would not be "the only game in town." Recipients would also have various rights to religious and personal freedom that would be protected by domestic institutions, to which they could appeal in cases of conflict. In an ideal situation, then, making an offer of particular benefits under terms acceptable to the service provider would typically be ethically neutral.

By contrast, in non-ideal conditions, background institutions are often unjust or nonexistent and people are materially very badly off. This means that it is the responsibility of the party with more power and resources to avoid wronging the weaker party, even unintentionally. Therefore, procedures to protect the vulnerable from coercion and cultural loss must be put in place by INGOs themselves.

Further, it is the responsibility of an INGO, as the party in control of resources and wishing to help recipients, to make its best effort to help recipients *as they are* and not as INGOs (or other Westerners) would like them to be. George Sher notes that non-ideal theory "takes as its point of departure some problem that is raised either by the injustice of some past or present social arrangements or else *by some limitation of what people can be expected to know or do* [emphasis added]."[30]

I take it as given that people from all cultures are socialized such that certain norms and values are internalized by them. While these values can of course be altered, this is often a long and involved process, which even after much effort may result in only partial success. It does not seem appropriate to expect aid recipients to be able to shed all their ingrained socialization under desperate circumstances, just so that INGOs can organize projects in certain ways. If recipients cannot be expected to do this, then it follows that helping them requires INGOs to take seriously recipients' view of what is good for them and what they may permissibly do, rather than some view of these issues that they could or should have. It is no good offering those services that recipients *would value* if they were

living under different institutions or subscribed to a different set of norms. It is also not appropriate to offer services *in ways* that recipients find objectionable but would think were fine if they held different beliefs. Real people are non-ideal. Their beliefs are not necessarily perfectly rational or consistent or in accordance with justice. Still, regardless of the cultural norms to which vulnerable people subscribe, they ought to be helped on terms that they can live with and protected from coercion and paternalism.

Based on aspects of the analyses provided by McGregor, Lyons, and O'Neill, we can say that if INGOs wish to avoid contributing to cultural imperialism, they ought to avoid making offers in which (a) the recipients are rationally reluctant to accept the offer because accepting would violate or undermine a cultural norm or practice that they currently value, but (b) recipients also have a strong motive to accept the offer because they need life-saving or essential health services for themselves or those close to them, and (c) they cannot access equivalent services from an alternative provider, but (d) the INGO could offer these or other essential health services on easier terms—that is, terms that would not require recipients to violate or undermine a cultural norm or practice that they currently value.[31]

One important qualification needs to be noted. As in the traditional doctor–patient relationship, INGOs need not offer services that they think do not provide any medical benefit to recipients. This is only reasonable, since INGO staff must act in ways that do not violate their own deep ethical and professional commitments. However, they also should recognize that the people they are trying to help hold certain values and beliefs, and are in need of help even if these beliefs are sometimes objectionable.[32] If the mandate of an INGO is to improve the health of a given population, then it needs to do this in ways that *both* recipients and INGO staff can agree are beneficial, and without causing recipients to undergo distress, shame, or remorse in the process.[33]

OBJECTIONS

A critic might object that the foregoing analysis confuses or conflates the distinct notions of coercion and exploitation. Given that potential aid beneficiaries are already in a vulnerable position before the INGO arrives, one might well think that their situation is akin to the classic case of exploitation, in which the capitalist exploits the worker who needs a job or else will starve. In this case, the capitalist has not created the bad situation of the worker; he merely takes advantage of it in order to pay his worker lower wages and so reap more profits for himself.

It is true that INGOs *find* their beneficiaries in a vulnerable position rather than *making* them vulnerable by threatening to make them worse off. It is also true that in some cases of exploitation, as in the case of aid recipients, the more vulnerable party is made better off by the transaction. However, these resemblances are insufficient to support the claim that INGOs exploit, rather than coerce, their beneficiaries when they design projects with only their own values in mind.

While there are many and varied accounts of exploitation in the philosophical literature, it is characteristic of the great majority of them that in order to exploit someone, the exploiter must take advantage of him or her *for the exploiter's benefit.* As Robert Mayer notes, "those who exploit always extract a benefit from that which they exploit. They gain. Exploitation is thus a process of acquisition."[34] The moral wrong of exploitation is that the more powerful party takes unfair advantage of the less powerful, and so gains at the weaker party's expense. But this feature is missing from the INGO case. INGOs do not gain from offering beneficiaries access to health services, even when they cause beneficiaries to act in ways that go against the norms and practices that the beneficiaries value.

Rather, INGOs are trying to benefit their recipients. They intend to act for the good of those they wish to help, not to gain benefits for themselves. Coercion comes into the picture when they do not attend carefully enough to the background conditions, to their recipients' *own ideas* of what is good for them, and/or to those actions that are morally permissible and impermissible in their beneficiaries' eyes. In essence, either negligently or paternalistically, INGOs can end up coercing recipients for (what the INGO considers) their own good. It is true of both the standard and the alternative accounts of coercion that people can be coerced into doing something for their own good.

By contrast, it seems contradictory to say that "I exploited him for his own good." Acts of exploitation may benefit the exploited, but the object is always for the exploiter to gain. The exploited person has been harmed or cheated or treated unfairly *in order that* benefits will flow to the exploiter. Coercion does not have this feature. It is perfectly ordinary to coerce someone with only his or her interests in mind; in this case, the coercer gains nothing from the effort.[35] The wrong of exploitation is taking advantage of someone's vulnerable position to deprive that person of benefits that are rightly his or hers, in order to take the benefits for oneself. Exploitation is a species of wrongful gain, whereas coercion improperly limits the freedom of some person or group.

A second objection to my analysis might be that the main problem I raise is not specific to instances of cultural imperialism, but rather is widely applicable to circumstances in which the more powerful try to help

the less powerful. It is surely true that unrefusable "offers" can be made in a variety of contexts and by a variety of agents. As such, we might simply note that some kinds of offers made by INGOs constitute a subset of this larger group.[36] However, it is also true that this type of practice has implications for cultural imperialism that it might not have in situations where both parties are from the same culture, broadly speaking.[37]

One implication is best explained if we envision the consequences of offering the kinds of coercive choices just sketched out to very many vulnerable people in a given community at once. The result, I would argue, is a particular kind of collective action problem. It may be beneficial for an individual to accept badly needed medical services even at the cost of failing to fulfill societal obligations, or feeling shame, or going against tradition. In an individual case, we might even say that the good done for the aid recipient outweighs the harm of being coerced. However, if many people make the same choice, over a substantial period of time, some customary ways of doing things could begin to disappear because they have no current practitioners. And the *reason* these practices will have disappeared is that INGOs encouraged their practitioners to defect from them on an individual basis by making unrefusable "offers."

Consider *Traditional Healers.* Given that the healers need a minimum number of patients to sustain a viable practice, if they were to lose sufficient support, then they would have to seek other ways of making a living, and might not endeavor to teach anyone else how to carry out their practices in future. (I assume that the healers had something to offer the community other than the treatment for HIV/AIDS. This does not seem far-fetched, since they were the only health care practitioners in the village before the INGO arrived.) Each individual who chose not to go back to his or her traditional healer for further HIV treatments might have thought that he or she was merely choosing between two services. All individuals, in a sense, expect to "free-ride"—they expect that the practice they have stopped supporting will still be there for them if they want to access it again. But in cases of widespread defection, the traditional healer may be gone.

THE SOLUTION I: NEGOTIATION, RECIPROCITY, AND PROCEDURAL JUSTICE

Having established that INGOs should guard against making coercive offers of the type identified above, I now address the question of how that might be accomplished. Cultural imperialism both can and should be avoided by INGOs, even in situations where difficult conflicts arise. It is

my contention that INGOs can avoid contributing to cultural imperialism in instances of conflict by adopting an *iterated process of reciprocal negotiation*. Even against a background of injustice, INGOs can design and implement projects justly by making decisions within a particular procedural framework. The framework is intended to allow agreement to be reached concerning *who* should receive health services, and *how* they should be provided.

However, before any process of negotiated decision-making can succeed, it would seem that INGOs and recipients need—or need to work out—at least some shared beliefs and values, in order both to communicate effectively and to arrive at mutually acceptable projects. After all, if the worldviews of the two groups are completely at odds, it seems implausible that there could be any jointly satisfactory project designs.[38] Henry Shue rightly notes that this shared background need not exist *prior* to the actual discussions that lead to agreement. He argues, "[e]ven the shared 'premise' on which new-found agreement rests need not have existed *ex ante*, before the conversation occurred."[39] Jeremy Waldron suggests that, in the course of a conversation, the evaluations of various proposals by all parties involved can "themselves . . . constitute the background practice that gives them sense and substance."[40] This insight is at the heart of the decision-making procedure I am recommending here.

This process would work as follows: INGO staff and various representatives of the community (including potential beneficiaries) would sit down and discuss the plans for a new project. They would each present their own reasons for supporting or condemning the project.[41] Then, as negotiations proceed—as comments and suggestions are put forward and considered—it will become clear which commitments each side has that it is unwilling to compromise, and which ones are not as deeply held and so admit of some "wiggle room." Indeed, it might happen that some concerns are shared by both parties and so can constitute a shared end for the project, which then needs to be spelled out in terms of concrete implementation mechanisms, which are then also subject to deliberation and negotiation.

Waldron's point is that after several iterations, the line between the reflective evaluations of one group and the other will blur, such that it will not be not entirely accurate to assign each belief or principle to one group rather than the other. Even if no deep or ultimate shared concern is uncovered, they will have a mutual interest in reaching agreement. In addition, they will have some idea of the parameters within which they must work once the non-negotiable commitments are on the table. This framework of deep commitments can act as their background in the way Waldron suggests.

To be clear, I am *not* suggesting that INGOs and the communities in which they work should somehow "just compromise and get on with it." The danger of a forced settlement is that one or more parties may feel morally compromised by the resulting agreement. Michele Carter and Craig Klugman note that in cases of cultural conflict, the requirement that each side compromise "can have a negative connotation, implying situations where an individual [or group] may be asked to forfeit a cherished belief or practice."[42]

It should not be necessary for either INGOs or their recipients to violate cherished or central beliefs or values in order to agree upon the ends and implementation mechanisms for aid projects. INGO projects are necessarily limited in scope, and so do not affect every aspect of recipients' lives. Disagreement, and the accompanying need for mutual concessions, need only affect a few elements of the cultural and moral framework within which each party operates. Only partial overlap is actually needed here. In addition, we should recognize that such overlap does not always have to occur at the level of fundamental moral principle (although of course it may). As Shue (following Rawls) points out, "ultimate premises [may] differ but certain intermediate premises [can] work equally well."[43]

In contrast to mere compromise, the model I am suggesting here calls for *reciprocal negotiation* or engagement. According to Lawrence Becker, one central element of reciprocity is that the parties are disposed "to return good for good."[44] This does not mean that recipients must make a return in kind, but rather that responses (to proposals, to benefits offered, or to concessions made) should be both "fitting and proportional."[45] For a response to be fitting, it must be in line with the special purpose of the institution, practice, or relationship of which it is a part.[46] For it to be proportional, responses must not demand much more, or give much less, than is reasonable relative to what has been offered or conceded by the other. The reciprocal negotiation must also be characterized by equal respect and standing, in the sense that each participant must have the right to respond to proposals and make suggestions, and each party's point of view must be considered seriously and responded to without hostility or intimidation. The requirement that each participant negotiate on equal footing reflects the validity and relevance of each autonomous person's view of what is good for him or her and for the community. As such, reciprocal negotiation under conditions of equality is an expression of respect, and is demanded by the equal dignity of all persons.[47] It is precisely by affording recipients this respect that INGOs can avoid coercive offers.

I argue that a process of this type must be used by INGOs if they wish to avoid becoming agents of cultural imperialism. In effect, I am

suggesting that an iterated process of reciprocal negotiation under conditions of equality is a requirement of procedural justice for INGOs.[48]

However, given the importance of negotiation and reciprocity, what should be done when a community and an INGO come to a genuine impasse? In my view, it is better to agree not to proceed than to carry out projects that violate the deep commitments of either those who participate in them or those who are responsible for running them on a day-to-day basis.[49] I recognize that certain benefits will necessarily be foregone as a result, and some money will inevitably be wasted. But I regard this as acceptable given the alternatives: (1) the INGO designs and runs the project with its own values in mind and does not alter it in the ways requested by the community, or (2) the INGO contravenes its own principles and gives in to requests that it views as ethically unacceptable.

I have already argued at length for why option (1) is objectionable. But it is also objectionable to use the good will of INGOs against them, as in option (2), by suggesting that the delivery of medical treatment is inherently oppressive so long as *any* consideration of INGOs' (Western) values has informed decisions about which services to offer and how to offer them. Aid agencies and individual practitioners have to justify themselves to the wider world and must be able to "live with themselves." They should not have to participate in projects or activities that they regard as unethical. It is not reasonable to accuse INGO officials of participating in cultural imperialism simply because they will not give over total control to the community or its representatives—again, because this approach is entirely one-sided and does not demonstrate a concern for reciprocity. Reciprocity is required because it is a concrete demonstration of respect for those with whom one is engaged. It is the recognition that one is negotiating with self-determining individuals who possess the capacity for both ethical reflection and reasoned judgment; and so it cuts both ways.

THE SOLUTION II: TWO CASES REVISITED

To sum up the foregoing analysis, INGOs have a negative duty to avoid making unrefusable offers, as well as a positive duty to create the conditions under which is possible to engage in reciprocal negotiation with recipients, because this process constitutes a concrete expression of respect for recipients as self-determining beings. I now return to the examples I introduced at the beginning of the chapter. While the kind of model I have been advocating here does not really admit of application in the absence of the actual affected parties, I will nevertheless allow myself to speculate about some possible resolutions to the various conflicts.[50]

Feeding Center

In this case, the INGO has two main value concerns at stake: efficiency and distributive justice. It chose to target children under 5 years old because that strategy would produce the most medical benefits per patient treated and would help remedy the effects of a cultural bias within the community that works to distribute a disproportionate amount of essential resources to (usually male) heads of households and elders. But INGO officials are also committed to the equal value of each individual, and presumably they would not think that serving malnourished members of any group was a waste of money. The community also has two main concerns: community members think elders should have priority (on the basis of desert or respect), and that, practically speaking, everyone will be better off if those who are working are well fed and able to perform their duties. Thus, both groups are concerned with efficiency, but they are calculating benefits at different levels. To accommodate their other concerns, each group could agree to sacrifice some amount of efficiency. The outcome of this would be that the INGO would make the feeding center open to all on an equal basis.

This arrangement would not be a violation of the INGO's main commitments, and it would avoid making a coercive offer. The INGO could agree to see family groups rather than individual patients and to treat any family member who meets the criteria for malnutrition. This would be mainly children in any case, and so this policy would lower the level of good outcomes that the program is able to generate—or raise the cost—by only a relatively small amount. However, even if the efficiency lost in terms of health outcomes was more significant, it is the responsibility of health practitioners to help their patients in ways that do not wrong or harm them, even under resource constraints. If fewer people are helped as a result, then at least the help has been provided in a morally defensible way.

The INGO might also decide to engage in supplementary feeding for undernourished family members, thus preventing them from becoming worse and acknowledging the need for heads of households to remain well for the sake of the whole family. Certainly an INGO would agree that it is better for the community generally for its working people to be healthy.

By treating everyone equally, the INGO risks giving more resources to privileged community members who already have an unequally large share within the family and community. Thus, it could be reinforcing existing inequalities. But if the INGO merely agrees to evaluate everyone and to provide lesser food supplements to those who are not technically malnourished, then it would still be concentrating its efforts on those who need help the most. Granted, this approach would widen the recipient group to include all of the sickest (rather than just those who are under 5 years old), but this arrangement would preserve the INGO's concern for treating the most vulnerable while at the same time accommodating the community's priorities to some extent.

Traditional Healers

In the *Traditional Healers* case, the INGO's concern is to provide the best-quality medical care for its patients; the community's concerns are to treat these trusted members of the community with due respect and to maintain access to traditional healers in the face of new "competition." Community members are also concerned, of course, to get the benefits that the INGO is offering, such as antiretroviral therapy for people with HIV/AIDS. Both sides agree on who should be helped and the benefits to be provided, but they disagree on the conditions attached to accessing that help. This conflict admits of three potential resolutions:

1. The INGO could hire the traditional healers as center staff and have them work directly with the INGO doctor(s). In this way they could collaborate on a case-by-case basis in determining the best treatment for each patient.
2. As above, but in addition INGO physicians and staff members could ask the traditional healers what it would take to convince them that the remedy they have been prescribing is not beneficial in combination with antiretroviral therapies. The INGO staff members could then try to demonstrate this to the satisfaction of the traditional healers, which might induce the traditional healers to abandon treatments that interact negatively with Western medications. Since this is a disagreement about facts, the INGO only has to provide evidence to the relevant parties that its view is true.
3. To avoid contributing to cultural imperialism, the INGO could move on to another community of people who need HIV/AIDS treatment just as badly but do not have sets of beliefs and practices that conflict with the project as originally envisioned.

Option (1) is objectionable from the INGO point of view because it does not ensure that the traditional healers will forgo prescribing the remedies to which the INGO objects, thereby lowering the standard of patient care. It does not address the INGO's concerns, but simply ensures that the disagreement will be out in the open. It does, however, respect the value commitments of the community and avoids making coercive offers.

To my mind, option (2) is the best resolution, but it is not entirely without drawbacks. It will cost time and money to attempt to persuade the traditional healers that the remedies at issue actually interact negatively with antiretrovirals. While there is no way to say hypothetically what would ultimately prove persuasive, nevertheless we might imagine that both sides could appeal to people they trust in the Ministry of Health, or in respected nearby hospitals, to conduct experiments or review literature and then report back their opinions. It might be difficult to find people trusted by both "camps" who also have the scientific expertise required to assess the evidence, but this doesn't seem clearly impossible.

Option (2) also promises to deliver the best scenario for patient care. Provided that the traditional healers could be persuaded of the truth of the INGO's claim, then patients would cease taking the relevant traditional remedies. They would also benefit from being treated both by someone they trust and who knows them intimately, as well as by someone who has specialized knowledge of HIV/AIDS. Close cooperation between the INGO and local healers also might significantly improve patient compliance. Further, by collaborating with the traditional healers, the INGO would avoid making patients choose between the two services, and would ensure that it is not contributing to the demise of a local practice that is valued by some members of the community.

Alternatively, option (3) looks like an acceptable resolution under the reciprocal negotiation model, because at least it would not impose unacceptable choices on community members, possibly undercutting their traditional practices. It also would not "waste" money demonstrating scientific facts that are not disputed in the Western medical community.

From another perspective, however, option (3) seems *very* imperialistic, and so looks like the least attractive resolution. This type of decision-making would no doubt send the message to communities in the developing world that those populations that are most similar to INGOs in terms of values are more likely to receive aid. Once this becomes known, it would create an incentive for communities to alter practices in advance in order to appear more compatible with the work of certain organizations. This would then become simply a large-scale version of the unacceptable choice situation discussed earlier, and so would also be

an objectionable course of action for an INGO to take, especially as a matter of ongoing policy.

OBJECTION

No doubt my (admittedly tentative) resolutions of these cases will be quite unsatisfying to many people who might be described as holding broadly liberal values or convictions. Some proponents of universal human rights and some liberal feminists would certainly object that these resolutions either reinforce existing injustices or at least do nothing to rectify them. Such critics also might suggest that when those with more power—such as elders, heads of households, and traditional healers—support a policy choice, it is highly likely that the policy will work to the detriment of the less powerful, such as women, children, young people, and the very poorest. According to this view, INGOs should set an example by insisting on human rights and equal treatment, rather than accommodating cultural practices and beliefs; if their insistence contributes to the elimination of certain unjust practices, then so much the better.

There can be no question that if INGOs consult only the people in power, any agreement reached will merely reinforce existing social inequalities. This difficulty can be rectified by seeking out those who have less power in the community and including their views in the discussion, as well as by paying special attention to whether certain individuals are intimidated into supporting certain views, and whether certain individuals are not genuinely trying to reach agreement based on shared principles but are, say, pressing for a resolution that personally benefits them (for instance, financially). By assessing these aspects of the claims made within negotiation, INGOs can choose to build an agreement that does not merely reflect the interests of the powerful, but that reflects the legitimate concerns of all participants—including INGOs' own staff and likely patients from different parts of the community.

To some, this initial response will seem to take an overly rosy view of the possibilities that the model allows for. In particular, Susan Moller Okin suggests that "interactive" approaches based around dialogue and agreement (such as the one I have proposed) have limited value in contexts where "oppressed people have internalized their oppression."[51] She claims that "we are not always enlightened about what is just by asking persons who seem to be suffering injustice what they want."[52] This is because oppressed people's view of what they want or what is good for them is often distorted by "adaptive preferences." This phenomenon occurs when oppressed people learn to desire things that are in fact

harmful to them, or at least to accept their inferior social position. They may also adjust their hopes and expectations such that they desire only small improvements in their overall condition, rather than demanding more robust fulfillment of their human rights.[53] Therefore, according to Okin, engaging in reciprocal negotiation—even with a varied group of community members, and even taking into account possible intimidation and conflict of interest—will inevitably favor the (unjust) status quo. This means that the only just way for INGOs to determine project designs and goals is to make sure they are in line with the demands of human rights and equality.

It is important to remember at this point that there are dissenters in virtually every cultural context. As Ann Cudd notes, "where there is a request for information or debate from within the culture, there is an opportunity for respectful and rational dialogue."[54] Indeed, it does not seem reasonable to assume that all people with power will espouse the same views, or that (some of) those with less power will not see perfectly well that they are at a disadvantage. This takes some of the sting out of Okin's objection, since her view seems to be premised on the idea that most members of a cultural group are not themselves critical of it.

Okin does admit that sometimes oppressed people criticize the institutions and practices that oppress them. However, I agree with Alison Jaggar when she says (referring to Okin and Martha Nussbaum) that "their practice of raising questions about adaptive preferences and false consciousness only when confronted by views that oppose their own encourages dismissing the views of the poor and oppressed without considering them seriously."[55] Considering such views seriously entails understanding the significance of the beliefs and practices at issue from the point of view of the person who holds the view, and, in an empathetic manner, trying to see what violating certain beliefs or norms would mean for that person in terms of social consequences, personal distress, guilt, and shame.[56] It cannot be reasonable for INGOs to take a dismissive attitude toward recipients' important moral and religious beliefs; after all, the aim of the exercise is to benefit them. And one worthwhile way to benefit recipients is to improve their health in ways *they deem to be important*, without also imposing extra costs on them.

Granted, this may not be the most efficient way to help them; it also may not abolish those cultural practices that, from a Western perspective, are pernicious. I do not mean to make light of either the concern for wasted money and time, or the necessity to work against injustice. Nevertheless, it seems unnecessary to trade off treating people with respect (no matter what their beliefs are) in favor of maximizing efficiency, when there are many ways to improve the health and welfare of beneficiaries that

are consistent with mutual respect.[57] If an INGO is satisfied that a project designed through reciprocal negotiation can provide real health benefits at a reasonable cost, then it should choose this instead of a more efficient but coercive (and so imperialist) alternative. In effect, the duty to avoid coercive offers should act as a constraint on what INGOs view *as* viable alternatives in the first place.

Finally, when considering how to provide health care in developing countries, we would do well to keep two things in mind: (1) In the West, we do not generally think it is the province of health care providers to reform the desires and beliefs of their patients, even where this would create better health outcomes for less cost; and (2) we are not in agreement in our own societies about how to prioritize health care for different groups under resource constraints. If we are willing to admit that there is continued controversy in our own societies around what health services should be offered, to whom, and on what basis, then we should not be surprised to find that this is also an issue where INGOs may not see eye to eye with beneficiaries from other cultures. The right solution to these difficult issues—both at home and abroad—is to engage in debate and try to reach mutually acceptable arrangements, rather than to make paternalistic assumptions about the interests of others, or to make coercive offers based on only the providers' assessments of health needs.

CONCLUSION

It is the argument of this paper that it is inappropriate for INGOs to impose themselves on beneficiaries in ways that result in distress, coercion, and (perhaps) cultural loss. That said, the reciprocal negotiation model does not require INGOs to *endorse* beliefs, values, or practices that they find morally suspect, and it does not prohibit them from trying to persuade people of their views by reasoned argument. Reciprocal negotiation merely requires INGOs to take steps to ensure that their recipients are not forced to choose between upholding their values and obtaining the health services that they desperately need.

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NOTES

1. Sen A. (1999). *Development as Freedom*. Oxford: Oxford University Press, p. 240.
2. "INGOs" should be understood to refer to those organizations that originate in the West and provide health services directly to beneficiaries. I am not here referring to either those nongovernmental organizations that originate in the developing world (and so typically serve the communities in which they originate) or those concerned only with monitoring and reporting, such as Human Rights Watch or Amnesty International.
3. For a nice discussion of the various forms this type of charge can take, see Ibhawoh B. (2007). Human rights INGOs and the North–South gap. In D.A. Bell and J. Coicaud, eds. *Ethics in Action*. Cambridge: Cambridge University Press, pp. 79–97. He points out that it is no longer plausible to insist that criticisms of INGOs generally originate with opportunistic members of the ruling elite, since even those people who accept that INGOs play an important role in delivering vital services have concerns about their priorities and methods.
4. Where such practices are grossly unjust, it might seem implausible to argue that it is objectionable to contribute to their disappearance. As I will point out later, however, if the practice is valued, then it is up to the community itself and not to outside agencies to decide whether the value the local community places on it justifies sustaining the practice, or whether it ought to be abolished.
5. Both examples have their basis in real situations that have been faced by INGOs, although of course they have been considerably fictionalized. INGOs that deliver health services often run into some of the most serious issues of intercultural conflict. The reason for this (as has been discussed widely in the bioethics literature) is that matters concerning the body (especially women's bodies), birth, death, and the endurance of suffering are likely to be surrounded by a host of important customs and traditions. In addition, these are matters about which people usually have strong beliefs, and to which they may have profound emotional reactions.
6. This is my own definition. It combines the commonplace "complex whole," "semiotic," and "particular way of life" understandings of the concept. These elements are all cited by John Tomlinson in his 1991 book *Cultural Imperialism: A Critical Introduction*. London: Pinter, pp. 4–7. It also borrows heavily from a definition formulated by E. B. Tylor, a prominent 19th-century British anthropologist. This definition also includes the important notion that practices are transmitted to each new generation by the last and so can usually be expected to continue over many generations. For instance, see Fairchild HP. (1966). *Dictionary of Sociology*. Totowa, NJ: Littlefield, Adams and Co., pp. 80–81.
7. Tomlinson J. (1991). *Cultural Imperialism: A Critical Introduction*. London: Pinter, p. 6.
8. Ibid., p. 6.
9. This characterization of the dominant values of the West is largely owed to Segun Gbadegesin. (1998). Bioethics and Cultural Diversity. In Kuhse H and Singer P, eds. *A Companion to Bioethics*. Oxford: Blackwell, p. 30.
10. Tomlinson, 1991, p. 173.
11. Sen, 1999, p. 242.

12. While this is admittedly a very rough account of what constitutes factual beliefs, I think it is adequate for the purposes of my analysis.
13. I will not distinguish between those normative requirements that are said to originate from God or religious scripture, since in both the moral and religious cases, those who hold these beliefs understand them as required, and so violating them would be wrong from their point of view. Whether these beliefs rest on religious authority or something more secular is not strictly relevant to my discussion here.
14. Zimmerman D. (1981). Coercive wage offers. *Philosophy and Public Affairs* 10, p. 124. Note that in this passage, Zimmerman is merely articulating the standard view but does not himself subscribe to it; he allows that some offers can be coercive.
15. McGregor J. (1988–89). Bargaining advantages and coercion. *Philosophy Research Archives* 14, p. 45.
16. Both Virginia Held and Daniel Lyons note that offers have "prices." According to Held, gifts do not have conditions attached, but offers characteristically do. She notes that "[i]t seems fair to say that gifts are among the rarest of entities in the political and public realms." See Held V. (1972). Coercion and coercive offers. In Pennock JR and Chapman JW, eds. *NOMOS XIV: Coercion*. Chicago: Aldine, p. 57, and Lyons D. (1975). Welcome threats and coercive offers. *Philosophy* 50, p. 427.
17. McGregor, 1988–89, p. 35.
18. O'Neill O. (2000). Which are the offers **you** can't refuse? *Bounds of Justice*. Cambridge: Cambridge University Press, p. 93. The "compliant option" here refers to the one the person making the offer wants the recipient to choose. For example, in *Traditional Healers*, the INGO wants patients who could benefit from antiretrovirals to cease taking certain traditional remedies and accept the antiretrovirals, as opposed to (b) refusing the antiretrovirals and continuing with the traditional remedies. Even though the patients might be better off all things considered by opting for the compliant option, it might nevertheless be "unrefusable" on O'Neill's terms and so objectionable. O'Neill, 2000, p. 91.
19. Ibid., p. 91.
20. Ibid., p. 93.
21. Ibid., p. 91.
22. Zimmerman, 1981, pp. 128, 130.
23. Not everyone who agrees that offers can be coercive also agrees that coercive offers can be made *unintentionally*. Nevertheless, O'Neill's intuition that this is possible seems plausible to me.
24. McGregor, 1988–89, p. 35.
25. Lyons, 1975, pp. 428–429.
26. Note that it is not important whether recipients have reason to feel remorse, regret, etc. or whether they merely think (mistakenly) that they do. Either way they are coerced since they are put in the position of choosing (by their lights) the lesser of two evils.
27. At least for the purpose of this paper, I take an ideally just society to be one that approximates the requirements of Rawls' theory of justice. See Rawls J. (1971). *A Theory of Justice*. Cambridge, MA: Harvard University Press.
28. Following Rawls, Sreenivasan calls these two branches of non-ideal theory "partial-compliance theory" and "transitional theory" respectively. Sreenivasan G. (2007). Health and justice in our non-ideal world. *Politics, Philosophy & Economics* 6, p. 220.
29. For instance, it is widely recognized that college admissions procedures that favor historically disadvantaged groups are just, given the unjust circumstances in which they are applied.
30. Sher G. (1997). *Approximate Justice: Studies in Non-Ideal Theory*. New York: Rowman and Littlefield Publishers, p. 1.

31. Clearly more needs to be said both about what happens when no easier terms are available or acceptable to the INGO, and so it cannot offer easier terms, and what happens when the other essential services that can be offered do not provide equivalent benefits. The requirement to avoid coercion has the most force when either the same or other roughly equally beneficial services can be provided on terms acceptable to beneficiaries. I take it that this will usually be possible, given that aid beneficiaries tend to be very badly off.
32. To be fair, some INGOs do recognize this, at least in some cases. However, they are also sometimes criticized for treating people without regard to their beliefs. For instance, an INGO may be criticized by donors and others for helping people from the "wrong" or "undeserving" side of a conflict. This type of criticism puts pressure on INGOs to refrain from helping those who have "objectionable" beliefs or histories.
33. Where this can be avoided. Sometimes people feel shame or distress simply because they are sick, or because the treatments that can help them are invasive or debilitating in the short term. Clearly these feelings can't always be avoided by restructuring the way services are delivered or by offering different health services.
34. Mayer R. (2007). What's wrong with exploitation? *Journal of Applied Philosophy* 24(2), p. 139.
35. We do this all the time when we pass laws that require everyone to, say, wear a bicycle helmet or seatbelt.
36. I am not suggesting that intra-cultural coercion would be a trivial matter, just that cultural imperialism is distinct from this in certain ways.
37. I say "broadly speaking," because it has been suggested to me that Oxford-educated charity workers working with the urban poor in Britain might encounter similar difficulties in terms of setting project goals for recipients who have ideas about what is in their interests that differ from the charity workers' ideas. My response to this scenario is twofold. Either what is going on in this case is that the parties have differing opinions from within the same culture of what constitutes the recipients' interests, or there is an element of "class culture" in play here that is analogous to the INGO case.
38. I don't think it is very likely that any INGO staff and a group of potential beneficiaries would be so different as to have no common ground at all from which to begin discussion. However, there may well be extreme cases where the area of overlap is quite small. I am partly responding to what is essentially a worst-case scenario here.
39. Shue H. (2004). Thickening convergence: human rights and cultural diversity. In Chatterjee DK, ed. *The Ethics of Assistance: Morality and the Distant Needy*. Cambridge: Cambridge University Press, pp. 217–241.
40. Waldron J. (1987). Nonsense upon Stilts? —a reply. In Waldron J, ed. *Nonsense upon Stilts: Bentham, Burke, and Marx on the Rights of Man*. London: Methuen, pp. 151–209.
41. These conversations typically take place with the aid of translators, which of course makes the whole enterprise more difficult and time-consuming. However, this added dimension need not prevent the process of dialogue from working in the long run. Also, it might not be either appropriate or possible for all representatives to meet at the same time, which would require the INGO to go through several iterations of the proposed design *with each group* until one could be accepted by all. This again would add to the cost of the process but does not present an insurmountable challenge to obtaining agreement.
42. Carter MA and Klugman CM. (2001). Cultural engagement in clinical ethics. *Cambridge Quarterly of Healthcare Ethics* 10:20.
43. Shue, 2004, p. 232.
44. Becker L. (1986). *Reciprocity*. New York: Routledge & Kegan Paul, p. 89.
45. Ibid., p. 105.
46. Ibid., p. 106.

47. My account draws on Seyla Benhabib's characterization of both "universal moral respect" and "egalitarian reciprocity" in her 2002 book *The Claims of Culture.* Princeton, NJ: Princeton University Press, pp. 19, 107, 115–120. However, ultimately my view differs from hers substantially, since the contexts in which we are discussing cultural conflict are importantly different. She is concerned to articulate a deliberative view appropriate for members of multicultural democratic states, which presupposes a certain set of background conditions not present in the INGO case.
48. I try to spell out what this process might look like with respect to my two examples in the next section.
49. Another reason why such an impasse is unlikely is that within communities there are differing views, and usually it will be the most extreme ones that generate such intractable conflicts. However, since usually not everyone in the community holds these views, it is likely that some agreement can be reached that satisfies most people.
50. The resolutions I discuss in this section should be taken as merely speculative because the model I have proposed is predicated on the actual act of negotiating in good faith between real people with real interests, beliefs, and commitments. It is also worth noting at this point that the model does not suppose that it is enough for an INGO to consider what it would be "reasonable" for a population to accept, without engaging that population in the reciprocal negotiation process. This is because it is not sufficient justification for interfering with someone's community and his or her fundamental choices that the person doing the interfering thinks it is reasonable to do so.
51. Okin SM. (1994). Gender inequality and cultural differences. *Political Theory* 22, p. 19.
52. Ibid., p. 19.
53. As Alison Jaggar notes, this is sometimes characterized as "false consciousness" by Western feminists influenced by Marxist critique of ideology. Jaggar A. (2005). 'Saving Amina': Global justice for women and intercultural dialogue. *Ethics and International Affairs* 19, p. 58.
54. Cudd AE. (2005). Missionary positions. *Hypatia* 20, p. 171.
55. Jaggar, 2005, p. 69. Jaggar's point here seems particularly true of Okin when the view in question has its origin in religion. See Okin. (2003). Poverty, well-being and gender: what counts, who's heard? *Philosophy and Public Affairs* 31, p. 313. See also Nussbaum M. (1992). Human functioning and social justice: in defense of Aristotelian essentialism. *Political Theory* 20(2), p. 204.
56. Whether or not beneficiaries' moral and religious beliefs are true is beside the point here, as it is when treating patients in the West. What someone regards as a benefit should also be taken seriously, although some questioning is appropriate in cases where the procedure in question is life-threatening or seriously debilitating. Compare, for instance, the common practice of male circumcision in North America, which is not usually questioned and yet is also thought to have limited (if any) health benefits. I have already noted that what an INGO regards as mistaken factual beliefs should be dealt with in a different manner.
57. This is a reiteration of Lyons' point, noted earlier, that INGOs can usually offer the same or other, roughly equally beneficial health services under easier terms than those put forward in a coercive offer. Why not do this when it can no doubt be done in the vast majority of cases, and at the same time it circumvents the danger of cultural imperialism?