Clinical Field Research in a Post-conflict Setting

Marco Boggero
Department of Government, Harvard University

This article describes, from a social science perspective, some of the challenges of managing a medical research clinical trial in a post-conflict rural environment. Social science inputs have contributed much to the ongoing global fight against malaria and should continue to do so. In this sense, this article describes some of the ethical challenges of clinical research as I faced them in Liberia, revisits the fundamental variance between the 'two cultures', that is, of the sciences and the humanities, and suggests the replicability of such research on the condition that it rests on strong interdisciplinary foundations.

In 2003, 14 years of civil war in Liberia left the country devastated and around half a million displaced persons out of a population of 3.2 million. The weakened health sector’s infrastructure and personnel face a maternal mortality rate among the highest in the world at 994 per 100,000. In 2007 increasing from 578 per 100,000 in 2000. However, the public misperception rose when the tracing visits performed to follow-up patients were outside of what MSF had previously been doing in the locality, and the transportation allowance granted to patients enrolled was something new to the community. The financial aspect added to a suspicion that the collection of blood involved a payment. ‘The hospital is buying and selling blood’, the rumor spread. It required creativity from researchers and field teams to overcome superstition and ignorance. Thus, the policy on reimbursements proved successful by including effective damage-control reactivity, but the incident could have endangered the research and could have created what I referred to as ‘attitude polarization’.

From field experience, I chose two sets of problems that deal with perception and with equity. First, perception challenges have to be understood within the context of a country where practitioners and practices related to traditional medicine are present to a large degree. The explanation of what a clinical trial represents requires accurate translation in local language and symbols to avoid suspicion towards researchers. Distinctly foreign concepts, such as informed consent, are often unlikely to mean much to these populations. In such a context, the challenge of perception is inevitable, and at times intractable, especially when faced with the syncretism of beliefs from traditional medicine, religions or secret societies. The prevalence of traditional healers and soothsayers is well described by Stephen Ellis. Traditional doctors, called Nye Ke Mi, and tribal medical anthropology reveal different conceptions of the metaphysical world and diseases. Thus, perception problems are really embedded in a vast array of political, legal and sociocultural barriers to research that can be overcome by informing state and local health authorities and spreading information to the local population.

Yet the most serious incident related to the reimbursement policy to patients. A reimbursement of expenses and foregone income was considered fair and a certain amount was chosen, in line with local customs and market prices. However, the public misperception rose when the tracing visits performed to follow-up patients were outside of what MSF had previously been doing in the locality, and the transportation allowance granted to patients enrolled was something new to the community. The financial aspect added to a suspicion that the collection of blood involved a payment. ‘The hospital is buying and selling blood’, the rumor spread. It required creativity from researchers and field teams to overcome superstition and ignorance. Thus, the policy on reimbursements proved successful by including effective damage-control reactivity, but the incident could have endangered the research and could have created what I referred to as ‘attitude polarization’.

A second set of concerns is related to equity. Some research involves vulnerable people but is not immediately applied to their benefit. In order to ensure community benefit, national partners were entirely involved. Yet this research was conducted in a world of wide disparities of wealth and health, and two points epitomized this challenge: one was the above-mentioned question of monetary compensation; the second dealt with treatment. On the one hand, reimbursement posed an evident question of equity and opportunity cost, as mentioned above. On the other hand, a research team that focuses attention on a cohort of recruited patients runs the risk of applying different standards of care for all the patients, that is, those that do not meet the requirement and are not part of the study (in this case possessing two qualities: being less than...
The focus of policy should be the avoidance of divergence and polarized attitudes, and the creation of incentives towards a ‘greater mutuality of understanding’.

Notes

1. The author was previously the Head of Mission for Médecins Sans Frontières (Doctors without Borders) in Liberia.
2. For example, Williams and Jones, 2004; cf. also Mwenesi, 2005, p. 293: ‘The integration of suitable insights from the social sciences into malaria control was triggered by the realization that despite having effective methods for malaria PMC, the morbidity and mortality rates from this disease continued to rise’.
3. Liberian Demography and Health Survey (LDHS), 2007.
4. The ASAQ is a medication launched in 2007; it is a formula combining artesunate and amodiaquine for an affordable treatment of malaria. Clinical trials were conducted in Liberia in 2008–09 to allow safety and efficacy data to be collected and to allow investigators to compare the new product with the currently prescribed treatment.
5. The DNDi was initially promoted and funded by MSF itself, among others, and it focused on developing new drugs or formulations for patients suffering from the world’s neglected diseases.
6. In addition to Christian priests and preachers, Muslim imams and marabouts, and Poru and Sande zoos, modern Liberia also contains various prophets, healers and makers of medicine, often called “sooth-sayers” by Liberians (Ellis, 1999, p. 227).
7. ‘Doctors are called Nye ke mi, men who make medicine, or Yidi ka ke mi, men who do things with leaves of trees. One who knows all the customary methods of treatment will be called a zo’ (Harley, 1970, p. 38).
8. An older account of tribal medical anthropology is found in Orr, 1968.
9. A radio show and a strategy of public communication were organized. The measures were financed by MSF.
10. Health Authorities granted approval; ASAQ was declared the national protocol drug for pediatric treatment at completion of tests. ASAQ was developed with a non-proprietary public health approach in order to make it as accessible as possible.
11. I borrow the expression from Buse and Waxman (2001) who are referring to the involvement of commercial partnerships.
12. Kagan quotes a trio of problems when examining the current tensions among the disciplines within academia (2009, p. 257). Given the circulation of experts among review committees, grant-making agencies and universities that work on malaria, Kagan’s conclusions largely apply to this context.
13. Some degree of formative social science research may be required to help understand and close the cultural and communication gaps likely to exist between the researchers and the subjects (Bausch et al., 2008, p. 15). On Africa compare Bates et al., 1993.

References