

Clinical Field Research in a Post-conflict Setting

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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.¹ Social science inputs have contributed much to the ongoing global fight against malaria² 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 2007³ increasing from 578 per 100,000 in 2000. In this context, malaria is among the deadliest killers. The malaria research carried out in Nimba County, Liberia, tested a new drug called ASAQ.⁴ The implementing agency, Médecins Sans Frontières (MSF), was supported by Epicentre and funded by the Drugs for Neglected Diseases Initiative (DNDi).⁵ Such research in rural conditions presents an extreme contrast to the highly controlled, resource-rich environment of medical research sponsored by pharmaceutical firms in industrialized countries. A post-conflict and *African* setting presents greater challenges for policy; that is, I argue, the avoidance of attitude polarization between the disciplines. In this article, I first exemplify the risk of attitude polarization, and then tackle the epistemological question.

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.⁶ Traditional doctors, called *Nye Ke Mi*,⁷ and tribal medical anthropology reveal different conceptions of the metaphysical world and diseases.⁸ 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.⁹ 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.¹⁰ 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 *other* 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

five years old and positive to malaria laboratory examination). The danger is one of creating two classes of patients, or, in other words, 'islands of excellence in a sea of under provision'.¹¹ It may also create two classes of staff, that is, on the one hand the research team and, on the other those who run the health services and are not part of the research agenda. The danger for divergent and polarized attitudes is here again noticeable.

C. P. Snow's basic thesis was that the breakdown of communication between the sciences and the humanities, the *two cultures* (Snow, 1993), was a major hindrance to solving the world's problems. The same is true today when faced with some of the most pressing problems of public health. The experience of the research trials in Nimba shows that wherever research is performed, there is an urgent need to link science and social science. First of all, better communication means an awareness of epistemology that can prevent incidents of incompatible and incoherent responses to adverse events. Secondly, in the practice of research, it must be shown that science can be partially detached from, rather than collapsed into, the immediate priorities of research. Research at the micro level reminds us of the limitations of current global health policies: 'it is salutary to consider that we have not yet wisely applied already proven drugs and vaccines, or our accumulated impressive knowledge, to improve the health of people across the world' (Benatar et al., 2003, p. 109).

Thus, the focus of policy should be the avoidance of divergence and polarized attitudes, and the creation of incentives towards a 'greater mutuality of understanding' (Kagan, 2009, p. 266). Since Snow wrote his 1959 essay, the social functions of intellectual communities have developed a broader gulf. Kagan warns: 'each culture ... represents a potential source of restraint when one, in a move to dominate the others, advocates ideological excesses that stray too far from evidence or violates the communities' ethical sense' (Kagan, 2009, p. 265). In contemporary public health problems, the pursuit of celebrity and the extreme degree of specialization can be the most problematic.¹² Different paradigms, outlooks and approaches between social science and medicine risk producing profound variance. Further, with regard to the problem-specific public health agenda that crucially occurs in Africa, awareness of the social sciences – and of Africa itself – is indispensable, a theme often touched on by scientists.¹³

Global health policy makers should help this process of convergence at the micro and macro levels. Field research, whatever its focus, must constantly be shown to address the immediate priorities of the context. Policy makers should continuously reconnect research to the health agendas of the individual country, the potential threats, the ecological weaknesses and, most importantly, the

development agenda and political situation of a fragile state.

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 Poro and Sande *zoes*, 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 la 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

- Bates, R. H., Mudimbe, V. Y. and O'Barr, J. F. (1993) *Africa and the Disciplines: The Contributions of Research in Africa to the Social Sciences and Humanities*. Chicago, IL: University of Chicago Press.
- Bausch, D. G., Sprecher, A. G., Jeffs, B. and Boumandouki, P. (2008) 'Treatment of Marburg and Ebola Hemorrhagic Fevers: A Strategy

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- for Testing New Drugs and Vaccines under Outbreak Conditions', *Antiviral Research*, 78 (1), pp. 150–161.
- Benatar, S. R., Daar, A. S. and Singer, P. A. (2003) 'Global Health Ethics: The Rationale for Mutual Caring', *International Affairs*, 79, pp. 107–138.
- Buse, K. and Waxman, A. (2001) 'Public–Private Health Partnerships: A Strategy for WHO', *Bulletin for the World Health Organization*, 79 (8), pp. 748–754.
- Ellis, S. (1999) *The Mask of Anarchy*. London: C. Hurst.
- Harley, G. W. (1970) *Native African with Special Reference to its Practice in the Mano Tribe of Liberia*. London: Frank Cass.
- Kagan, J. (2009) *The Three Cultures*. Cambridge: Cambridge University Press.
- Mwenesi, H. A. (2005) 'Social Science Research in Malaria Prevention, Management and Control in the Last Two Decades: An Overview', *Acta Tropica*, 95 (3), pp. 292–297.
- Orr, K. G. (1968) 'Field Notes on Tribal Medical Practices in Central Liberia', *Liberian Studies Journal*, 1 (1), p. 20.
- Snow, C. P. (1993) *The Two Cultures*. Cambridge: Cambridge University Press.
- Williams, H. A. and Jones, C. O. H. (2004) 'Critical Review of Behavioral Issues Related to Malaria Control in sub-Saharan Africa: What Contributions have Social Scientists Made?', *Social Science & Medicine*, 59 (3), pp. 501–523.