Changing states of science: Ethnographic and historical perspectives on medical research in contemporary Africa

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Conclusion and recommendations of the workshop

Organisers

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On the changing place of health sciences and research in Africa

The conference theme, ‘changing states of science’, framed a discussion between anthropologists, concerned with the social life of health science and scientific research in Africa, historians working on the changing contexts of health and medicine in Africa, and scientists and doctors, aware, from first-hand experience, of the challenges that social life and historical change pose to the production and use of scientific medical knowledge.

Most speakers were anthropologists, many with an interest in historical change, often arising from long-term ethnographic research. The second largest group were historians utilising anthropological perspectives and methods, including fieldwork and interviews. The conference engaged both groups in a dialogue with each other and with medical doctors, health professionals involved with medical research and interventions in Africa. The empirical papers underlined the contributions that both disciplines can make to the understanding of health research and interventions in Africa (a report is under preparation).

Specifically, the conference underlined that medical historians no longer are limited to the history of colonialism and the immediate post-independence era, but that they are occupying new territory, moving up to the present of post-post-colonial history. Their questions and methods are informed by the need to understand an increasingly opaque present. Opening up present problems to an historical reading, they gain immediate political and applied relevance. Contrary to the common understanding, historians can make an invaluable critical contribution to reflections about development and overseas health. Their access to historical memory and shifting contexts, and their ability to compare situations and processes is needed to face the challenges of the present.

Similarly, the conference showed that medical anthropology has moved on from being primarily occupied with other medical cultures and issues of cultural translation. Instead, the gaze has shifted to contemporary global themes, such as science and technology, and organisation, government and state; and thereby to questions at the centre of modern life, and to our ability to shape the world we live in. This shift opens up a new scope for applied anthropology: rather than merely facilitating the applications of health science, anthropology applies its own perspective to the problems of the present, including the problems – social, political, ethical,
and epistemological – raised by medical science and technology. This is similar to an earlier shift in anthropology as related to development issues: from ‘development anthropology’ to ‘anthropology of development’. Today, an anthropology of medical science and technology has much to contribute both in helping to locate technology in its local context and uses, enabling its fruitful application, as well as critiquing its misuses and abuses.

History and anthropology relate to the contemporary field of health science in different ways, each posing different practical challenges: For historians, the distance between their discipline and health research – imposed by own disciplinary and methodological standards and by the lack of interest from the health scientists’ and funders’ side – poses a problem for access, funding and engagement. Heads of department in history tend to see as little scope in ‘applied historiography’ as do medical scientists running medical trials in Africa. Anthropologists face the opposite problem: after decades of trying to integrate themselves into the frames of health science, ‘medical anthropology’ often not so much applies anthropology to medicine and its field, but assists in the application of the health sciences. This leads to an underutilisation of the reflexive and critical potential of anthropology. In view of these different engagements with the health sciences, the collaboration between academic historians and anthropologists in studying medical science in Africa might allow us to find a different mode of ‘application’, gaining critical perspectives, applying humanities fieldwork to medical fieldwork, and historical and anthropological questions to science, technology and their uses.

Below, we list a few areas of particular interest for the collaboration of anthropology and history in relation to health science. These are of importance to practical applications of science too; that is to the problems encountered when science is produced and applied in Africa: policy making, public engagement with science, acceptance of technology, collaboration on all levels, funding and accountability and transparency, research-policy linkages, health systems impact, etc.

**Sovereignty & nation**

The problem of sovereignty – who holds it, what does it consist in and what is it applied to? – emerged across different papers. In the context of crumbling national governments and broader doubts in the nation state, these questions gained salience:

- What is the place of supranational and international bodies (e.g. WHO) in regard to health research and intervention in Africa? How do they function? How are their global operations locally contextualised? What is their potential in shaping medical science, research and health policy?

- What new modes of ‘un-national sovereignty’ (White) are emerging (e.g. ‘big philanthropy’, so-called global public-private partnerships and large-scale corporate ‘big science’)? How do these compare with and relate to supranational public institutions and national government?

- What roles are played by existing and emerging extra-national organisations such as watchdog organisations (BUKO, Amnesty…) and activist groups (e.g. DNDI, Treatment Action Campaign)? What are their possibilities and constraints? What interactions do they have with other levels of organisation?
• What new forms of citizenship arise in relation to new and old forms of sovereignty, and which are closing down? These might include the ‘communitarian’ citizenship of village life, civic republican notions in which citizenship is realised through participation in a public sphere of debate, emergent forms of solidarity that might be thought of as bio-citizenship or therapeutic citizenship, or emergent forms of global citizenship that unite people from diverse locations. How do these relate to conventional, liberal understandings of the term as ‘public’ citizenship vis-à-vis government? What are the uses and limitations of the term as analytic category?

• Across concerns with sovereignty and citizenship, what are the real conflicts of interest that lie behind these concepts and their application?

Philanthropy & Donors

Health research and interventions in Africa have long been dominated by outside donors, in shifting forms of collaboration with national governments and non-governmental health bodies. In recent years new actors have entered the field in the form of philanthropic initiatives of a new scale (‘big philanthropy’), long-term donor-led health research sites (‘big research’) and corporate initiatives. These actors are not anchored in the nation state and often act bypassing its structures, reaching out to communities and people. These new forms of resource transfer raise new questions:

• What new bodies are there, how do they relate to nation states and government and to each other? How do the new initiatives work?

• How is ‘big philanthropy’ related to earlier private initiative and to corporate and political interests?

• Specifically: what is the impact – on health, economy and politics – of the new main players such as Gates Foundation and Global Fund?

• How is the particular notion of efficacy that inheres to big philanthropy and big research played out in Africa? What impact does this efficiency and competitiveness have on science, on government, and on health?

• What is the impact of big philanthropy and big science on the nature of medical knowledge in Africa, e.g. on institutional memory, learning and expertise and commitment?

Private interest & corporate science

The wide-spread notion of ‘public-private’ partnerships was interrogated by various speakers suggesting that both the ‘public’ side needs to be defined and historicised, and the ‘private’ side examined and critiqued, asking questions about interest and power:

• What is the role of the pharmaceutical industry and how can it be monitored and controlled by public national and supranational institutions?
• What existing and emergent forms of public negotiation are there regarding medical science in Africa?

• What can historical continuities and changes in private and philanthropic engagements in health funding, teach us for the present?

• How do new private and economic interests shape health research and public health campaigns (e.g. ART and PEPFAR)?

State (dys)functioning & (re)construction

While many papers spoke of ‘state weakness’, there was agreement that the simple description of states as weak or strong was insufficient to characterise their transformations and their effects on health. Indeed, the notion of ‘failed states’ is often conveniently mobilised as a narrative to justify international intervention, in ways that obscure actual, ongoing modes of state operation on the ground. A more disaggregated, historicised analysis of how states are actually operating is needed. Attention was drawn to states that seem to function, in that their institutions exist, polls are held etc. but that fail to fulfil their aims due to corruption and dysfunction. The many examples of dysfunctional states raise questions:

• What are the relations between the government health system and donor led interventions in care and disease control, and in medical research?

• Specifically, what are the relations between global campaigns and local systems (e.g. polio eradication, VCT)?

• What are the effects of big research and big philanthropy on weak and dysfunctional states? What impacts and what opportunities?

• What role can medical research and health interventions play in the strengthening rebuilding of states and health systems (e.g. S.Sudan, Congo, Angola)?

Interests & political economy

Throughout the discussion, the importance of political and economic relations, inequalities, and of political and economic interest was noted. In scientific work, as well as in related ethics debates, this aspect is often neglected as being ‘outside’ the brief of science, but the papers showed instead that interests and problems of inequality pervade all scientific relations in Africa, from international collaborations to intra-family relations. Specific questions arose:

• What are the effects of political economic inequality on research agendas and collaboration, especially with ‘big’ actors?

• How do the economic interests of particular actors and agencies shape research and its implementation (e.g. pharmaceutical industry, philanthropic foundations)?

• How do political-economic facts limit or affect the application of ethics procedures?
What is the role of economic class and poverty in relation to the implementation of research ethics, and in the context of trial implementation, e.g. the recruitment of study subjects?

**Ethics & law**

The ethical and legal regulation and control of medical research and interventions was touched upon by various papers. From this emerged the impression that existing bodies of ethical rules and semi-legal instruments need to be historically situated, politically examined, and located in the context of economic disparities. Only if their taken-for-grantedness is questioned will they be able to fulfil the work they were intended for: to protect subjects, facilitate good science, and improve health:

- How has the relationship between medical science and legal tools and ethics guidelines changed over past decades? What factors shaped the ‘legalisation’ of science (e.g. ethics, GCP)? What are the intended benefits and the unintended side-effects of this evolution?

- How do ethics boards function? What are the relations between local, national and international ethics institutions?

- What is the boundary between private and public ethics as applied to overseas medical research ethics?

- Can the division between private and public (or professional) concerns that underlies existing ethics guidelines be held up in the context of radical economic and political disparities?

- If political and economic inequality is the key ‘scandal’ of overseas medical research, can the transfer of ethical instruments and expertise from North to South tackle the challenge? How can ethics expertise be transferred as a critical public discourse in addition to legal tools?

- What public spheres are there to negotiate ethical concerns when state-related public fora of negotiation and democratic institutions of arbitration have broken down?

- How are research ethics played out in emergencies and situations of state breakdown? Does the private public divide apply in emergencies?

**Time - past and future**

Problems of time – how people imagine time and experience changes in time – appeared in the papers across different levels of scale. Often science and public debates about science neglect the problems posed by past and future, focusing exclusively on the present. New questions thus need to be asked:

- What is the impact of history on contemporary health initiatives in Africa? What has been the post-colonial and post-post colonial history of medical science in Africa?
• What are the memories of medical science in Africa (among scientists, subjects etc.)? How do different evaluations and changing memories affect health science?

• How do imaginations of the future shape medical science and its application? What do people (scientists, policy makers, subjects) think will happen?

• How do times past and future interact with the present? How do memories inform hopes and fears and define the horizons of the present? What futures do we want?

• How do different layers of time interrelate in health research and intervention, e.g.: trial time (ending with outcomes), project time (ending with the funds), health time (defined by illness), and the life times of individuals and groups?

Universities

Underlying discussions about medical and social sciences, the problem of the African university emerged as an important and neglected focus. Instead of taking their existence as academic centres of research and knowledge reproduction for granted, we should ask questions:

• How have African universities been historically transformed since their foundation in the last century? Which forces have transformed them? What are the results of recent neoliberal changes on the privatisation and expansion of university life?

• How do African universities function today? How does their actual functioning relate to their stated aims (teaching, research, public role…)?

• What place does public learning have in Africa today?

• How does the crisis of the African university relate to the global transformation of academic life and its public role?

• How are different disciplines affected differently? What are their possibilities and constraints?

• Can universities today be assumed to reproduce intellectual labour force in Africa? Which other initiatives are there for capacity building and training? How do universities and new, external initiatives interact?

• What new academic institutions have there been created within or alongside universities to respond to contemporary challenges?

• What are the relations between teaching, research and collaboration, as well as external consultancies in African universities today (comparing different disciplines)?

• How do universities interact with external collaborators, with government, and with business?
These questions point to the broader concern with the ‘neoliberalisation of knowledge’, and the changing role of public and private expertise on a global scale. While most of the seminar discussed the changing political-economic contexts of the natural and health sciences, these changes affect the social sciences as well. The same political-economic changes that erode health care and public natural science, undermine the production of public knowledge and the freedom of academia in the humanities and social sciences. Moreover, these changes occur on a global scale and invite global linkages and comparisons, as well as global co-operations in response to them.

**Activism**

Finally, various presentations suggested paying more attention to activism in health. Rather than dichotomising between government and state (and medical science) on one side, and citizens (and subjects and patients) on the other, it was suggested to look at the new forms of political debate and intervention between citizens and larger entities, such as national and transnational government, corporations, scientific communities etc.:

- What role can activist organisations play in negotiating health sciences in Africa?
- Can activist publics replace or reconstitute the public spaces that were lost with the dysfunctional state?
- What role can be played by scientific activism, doctors’ activism in the context of health research and intervention?

**End**

Across the different topics there was consensus that history and anthropology as critical social sciences can make an important contribution. However, they can only do so if they take their critical mandate seriously, and if this critical mandate is taken seriously, acknowledged and used by funders and health and development actors. Both disciplines have comparative possibilities to change taken-for-granted frames of looking at the world, by showing how things have evolved and how differently they can be played out. The present that appears solid and stable to us, has been different before, is different elsewhere (or looked at from elsewhere), and thus: it can be made different.