Negotiating the Role of Anthropological Evidence in Medical Research during Health Emergencies

Towards a Critically Embedded Approach

Luisa Enria and Shelley Lees

Abstract: The 2014–2016 West African Ebola outbreak is often cited as a watershed moment for the social science of epidemics. Anthropologists played a key role in clarifying the social, economic and political dimensions of the epidemic, highlighting both how outbreak control measures were disrupting social practices and how they could be adapted to reflect local realities and experiences. Whilst undoubtedly significant, this narrative of anthropology's successful integration risks obscuring the fraught position of the anthropologist within the Ebola response. Taking debates about public anthropology and the balance of action and critique as a starting point, we offer reflexive considerations from our work in the Ebola vaccine trials in Sierra Leone. We look at the involvement of social scientists in HIV clinical trials, which led to the inclusion of a social science component in the Ebola trials, through to the everyday discussions on how to integrate ethnographic insights into the running of operations. In so doing, we highlight the importance of foregrounding participants' and communities' voices, and confront what gets lost in translation. Keeping this tension in focus, we consider the consequences of this complex position for the possibility of a 'critically embedded' anthropology of clinical research in health emergencies.

Keywords: Ebola, ethnography, medical research, public anthropology, Sierra Leone

The significant mobilisation of 'social science intelligence' in general (Abramowitz et al. 2015a) and anthropological expertise in particular during the 2014–2016 Ebola outbreak in West Africa were frequently invoked in the aftermath of the epidemic in emboldened calls for effective integration of social science research and contextual knowledge in epidemic response mechanisms (Bardosh et al. 2019). Lessons learnt and ad hoc reflections, including from bodies such as the UK Department of International Development (DFID, now FCDO), the Wellcome Trust and the World Health Organisation (WHO) acknowledged how the experience of the West African epidemic encouraged urgent consideration of the social dimensions of epidemics and the need to adapt epidemic response measures to the experiences of affected communities. In their appeal in *Nature* for a 'new twenty-first century science for effective epidemic response', Bedford and colleagues (2019: 130) list social science expertise as an essential discipline for outbreak response and note how the role of social scientists, in their ability to humanise response efforts, have become more visible in recent years.

These contributions did not stand alone; they were rather a culmination of a decades-long trajectory starting with the emergence of the HIV epidemic in the 1980s, which sparked wide-ranging activism and social scientific engagements that cast the disease as a socio-political problem (Parker 2001). Similarly, pioneering work by social scientists during Ebola outbreaks in Uganda had already expanded insights

in the anthropology of epidemics through a focus on haemorrhagic fevers (Hewlett and Hewlett 2007).

During the West African outbreak, 'the body of anthropological work produced was far greater than in any of the previous, smaller [Ebola] outbreaks' and anthropologists concentrated in one region filled a wide range of different roles, some simultaneously (Venables and Pellecchia 2017). These ranged from providing briefings 'from a distance' (Benton 2017a) to rapid research on the ground or directly supporting community engagement activities. Some were affiliated with academic institutions, others were embedded within international agencies and non-governmental organisations, and many produced knowledge some=where in between.

Anthropological insights undoubtedly impacted epidemic control operations, providing contextual analysis to support interventions that reflected diverse experiences in affected communities, offering alternative accounts to dominant framings of 'culture' as a problem for humanitarian responders and turning the lens on the response infrastructure (Abramowitz et al. 2015b; Batty 2014; McGovern 2014). Pragmatically, anthropologists encouraged the creation of spaces for two-way dialogue and proposed that response measures take into account local practices, religious rituals and the nature of decision-making in times of suffering (Anoko and Henry 2019; Laverack and Manoncourt 2016; Lipton 2017). They contextualised rumours to make visible patterns of mistrust rooted in histories of structural violence and pointed to existing local knowledge and community mobilisation to protect themselves (Abdullah and Rashid 2017; Benton and Dionne 2015; Parker et al. 2019b; Richards 2016; Wilkinson and Leach 2015). These engagements also generated new theoretical insights. As Hannah Brown and Ann Kelly (2014) argued, anthropological analyses of haemorrhagic fevers can singularly spotlight 'material proximities – between animals, humans and objects'.

Experiences from West Africa therefore contributed to the field of the anthropology of epidemics (Kelly et al. 2019) but also to studies of humanitarianism and global health, exploring care infrastructures (Abdullah and Kamara 2017; Gomez-Temesio 2018; Park and Umlauf 2014), humanitarian and biomedical assemblages (Alenichev and Nguyen 2019; Benton 2017b; Hofman and Au 2017; Ryan et al. 2019; Tengbeh et al. 2018), the nuances of power, authority and citizenship in times of crisis (Enria 2020; Enria and Lees 2018; Parker et al. 2019a; Shepler 2017), and the racialised dimensions of

risk distribution (Hirsch 2021) and humanitarian structures (Benton 2014).

Anthropological involvement in the response to the Ebola epidemic in West Africa was not without its limitations and (primarily self-) critique. The need to produce knowledge quickly, either based on 'having been there' (Benton 2017a) or through rapid ethnography challenged core disciplinary values. Fred Martineau and colleagues (2016), reflecting on the significant successes of the Ebola Anthropology Platform that coordinated the dissemination of social science research during the outbreak, also highlight sizeable challenges in efforts to influence policymakers' interpretations of the crisis. They argue that whilst many pieces of advice were taken on board, lack of 'operational feasibility' meant that practitioners often took a different course, reflecting 'the tendency for humanitarians to present their work as apolitical interventions that focus on the preservation of "bare life"' (2016: 489). Anthropologists' 'contested legitimacy' showed a conditional acceptance, as operational actors saw them as firefighters negotiating access to potentially recalcitrant communities (Lees et al. 2020). The problematic framing of the anthropologist as cultural broker also comes to the fore in Adia Benton's (2017a) analysis of contributions from 'a distance', as she traces debates about the discipline's 'relevance' to the crisis. She raises crucial questions about the racialised political economies of knowledge that emerge from assumptions about who counts as an expert and where expertise is located. Similarly, Benton reports discomfort amongst some anthropologists with exhortations that, in order to be relevant, critique should be set aside.

These concerns also extend to applied anthropological contributions on the ground, as expectations of the anthropologist to interpret local knowledge and facilitate humanitarian intervention lends itself to an analysis of colonial hangovers beyond the politics of representation. In relation to recent discussions of the coloniality of global health, we may question the extent to which anthropological insights that suit operational frames may contribute to the reproduction of global structures of power. In the logics engendered by narratives of crisis, the role and value of critique that characterises anthropological investigations are often questioned or deemed secondary (Enria 2021). These tensions, between the moral and political commitment to support the development of more humane crisis responses, the complex terrains of representation and the anthropologist's position vis-à-vis powerful

global assemblages, are hardly new. Long-standing debates about the public face of anthropology have centred precisely on the role critique and the potential for either effectiveness or co-option. Discomfort with applied anthropology ranges from its tainted history as the 'handmaiden' of empire echoed in contemporary decolonial appraisals, to concerns that such endeavours are atheoretical in comparison to the '"purity" of academic pursuit", or that working within the system is either ineffective or does little more than support hegemony (Hopper 2013; Rylko-Bauer et al. 2006).

These critiques do not necessarily negate the value of engaged anthropology but require confrontation with these tensions. This includes acknowledging our normative stance regarding what kind of engagement is 'good', as Mathijs Pelkmans (2013) argues, citing the association of 'embedded anthropology' with the supporting of US military operations. A normative orientation offers the potential for critical theory to be 'at the front of engaged work' (Besteman 2013), echoing Nancy Scheper-Hughes' (2003) impassioned call for a 'militant' anthropology that is 'personally engaged and politically committed'. In her proposal for a 'critically applied medical anthropology', Scheper-Hughes (1990: 190) proposes that such a project must 'disengage and dis-identify with the interests of conventional biomedicine' and offer critique 'from the margins', questioning powerful interests.

In this article, we take these debates about the balance between critique and action, political commitment and collaboration, as a point of departure to ask: on this normative continuum, where does anthropological involvement in health emergencies sit? In this case, where do the margins lie and from what position can critique bring about change? The significant successes of anthropological engagement with the Ebola response should not obscure the fraught position of the anthropologist, and indeed offer an opportunity to revisit these important debates with a focus on the role of research in crisis. Drawing on a growing field for anthropology, we ask these questions through a reflexive discussion of our own work in HIV trials and our work as researchers embedded in the Ebola vaccine trials during and after the Sierra Leonean outbreak, situating it in the history of activist engagement with and anthropological research on clinical trials. Whilst we maintain the value of anthropological contributions *within* medical research projects, we consider the practical, political and ethical challenges involved in negotiations over the role of

anthropological evidence, and in particular how these are exacerbated during health emergencies. We trace these encounters using a historical trajectory from the involvement of social scientists in HIV clinical trials on the African continent, which led to the inclusion of a social science component in the Ebola trials, through to the everyday discussions on how to integrate ethnographic insights into the running of operations. In so doing, we simultaneously highlight the importance of foregrounding participants' and communities' voices and confront what gets lost in translation. Whilst we do not offer clear-cut answers, by keeping this tension in focus we consider the consequences of this complex position for the possibility of a 'critically embedded' anthropology of clinical research in health emergencies.

As we were writing this article, in the midst of the COVID-19 pandemic, these questions resurfaced vividly. Social scientists produced a wide range of illuminating analyses and contextually attuned reports on the varied experiences of and with the virus across the world, offering both recommendations and critiques of political and public health responses to the crisis (Davies and Wenham 2020; Dawson and Dennis 2020, 2021; Lees et al. 2021; Parker et al. 2020; Rhodes et al. 2020; Wilkinson et al. 2020). The pandemic has simultaneously magnified the importance of these analyses of the socio-political nature of the pandemic and highlighted the significant political and institutional challenges to efforts to integrate such insights into different elements of a response (see the articles in this special issue), raising fresh questions about the possibility of anthropological critique in this space. The experiences we outline in this article can therefore offer food for thought as we begin to evaluate the pandemic and prepare for future emergencies. Lessons across crises, as we discuss below, encourage us to assess the choices we make about how we position ourselves as social scientists in epidemic response efforts, and about the kinds of spaces that exist (or that must be created) for social analysis and active engagement, but they also encourage us to question the political conditions that make our insights more or less visible.

Embedding Anthropology in Medical Research: From HIV to Ebola

The colonial period established medical research on the African continent, which became a 'vast arena for experimentation' (Tilley 2016: 746; see also Geissler and Molyneux 2011; Graboyes 2015).

In this era, medical research was unregulated, poorly designed and rarely addressed informed consent. Instead, a coercive approach prevailed that was justified through the limited availability of treatments for tropical diseases (Graboyes 2015; Tilley 2016). During the post-colonial period, there were a limited number of (sometimes unethical) clinical trials on the African continent until there was an intensification and expansion of HIV clinical trials in the late 1990s. This rapid growth required the strengthening of institutional structures to attend to the development of research protocols, funding, ethical reviews, informed consent and data collection and management (Adams et al. 2005; Benatar and Singer 2000; Booth 2010). Questions were also raised concerning the nature of North–South research collaborations, which were potentially extractive (Benatar and Singer 2010; Molyneux and Geissler 2008; Petryna 2007).

The first HIV clinical trials in sub-Saharan Africa were controversial. In 1994, an ethical controversy erupted over a trial that tested azidothymidine (AZT) for reducing mother-to-child transmission in Africa, which involved a placebo despite the drug having been found to be highly effective in reducing transmission. The trial was stopped. Following this, in 2004 two clinical trials to test the effectiveness of the antiretroviral medication for pre-exposure prophylaxis (PrEP) were stopped in Cambodia and Cameroon following protests led by women and HIV activists who were concerned that participants would be exposed to HIV as part of the experimental process. They also argued that the research protocols did not outline an obligation to provide for ongoing care for participants who became HIV positive after the trial was complete (Forbes and Mudaliar 2009; McGrory et al. 2009; Mills et al. 2005).

Microbicide activists emerged in the late 1990s in North America, and with a feminist agenda they set the parameters for the technological development of microbicides (products containing drugs that prevent HIV transmission) and the agenda for the medical research. They focussed on 'rights' alongside engagement with science (Hardon 2010). These activists drew on the experience of AIDS treatment activism, which worked alongside scientists to steer the course of the development and fair distribution of HIV treatment (Epstein 1996; Robins 2006). In response to the ethical controversies of the first HIV trials in Africa, the activist group the Global Campaign for Microbicides called for a strengthened role for the community in the development and the conduct of microbicide trials.

The Microbicides Development Programmes established the largest ever clinical trial to test the efficacy of a microbicide gel in six sites in sub-Saharan Africa and incorporated funding for extensive social science research and community engagement at each site to understand participants' experiences of the trial and the microbicide gel. Between 2004 and 2009, Shelley Lees (SL) conducted in-depth anthropological research at the Tanzanian site (Lees 2015, 2021). An innovative approach to community engagement was developed at the Tanzanian site, which involved a participatory approach ensuring a two-way dialogue with the trial team and the participants (Shagi et al. 2008; Vallely et al. 2007; Vallely et al. 2009). Working alongside the community engagement team, SL worked to make space for a critical anthropological approach that both gave voice to the participants and turned a critical lens on the trial. This was initially challenging, especially as expectations for the role of the social science for this clinical trial was limited to understanding participants' experiences of the trial in order to improve recruitment to the trial, adherence to using the gel according to the instructions of the trial, and the acceptability of both the trial and the gel given the recent experiences with trial closures. Whilst these were important questions to ensure participant safety (protection from HIV infection), which could be answered by formal interviews, SL and the social science team sought to embed their research in the community, exploring local engagements with medical research, as well as everyday politics that affected women's sexuality and their use of the experimental gel, whilst making recommendations for the trial's operations. These difficult navigations influenced our deliberations during the Ebola vaccine trials discussed below.

With the emergence of the Ebola epidemic in West Africa, infectious disease clinical trial experts rapidly set up Ebola vaccine trials in the region. SL was invited by these colleagues to set up anthropological research in the EBOVAC-Salone trial in Sierra Leone. This invitation was cautionary: the clinical trialists had seen the value of including social science in HIV trials, and were concerned that community resistance, and sometimes anger, towards epidemic response teams might surface during the vaccine trial. Luisa Enria (LE), who had conducted research into post-conflict politics in Sierra Leone prior to the Ebola outbreak, was recruited to lead the research in country, and the methodology used in Tanzania was adapted for the trial in Sierra Leone.

Lost in Translation? Negotiating the Role of Ethnographic Evidence in the Ebola Vaccine Trials

In the late spring of 2015, as Kambia District was fighting the epidemic as one of the last hotspots and the Ebola vaccine trials were preparing to start recruiting participants, we developed a programme of social science research that would apply an ethnographic approach to study local experiences of the epidemic and encounters with biomedical research. Over the first 14 months of the project, LE recruited and worked with a team of five local researchers, and together they conducted participant observation in Kambia, situating perspectives and engagements with the trial in the town's socio-cultural and political context. Later, as the trial opened its doors, the team conducted interviews and life narratives with participants and key informants. The social science protocol was separate from the trial, assuring scientific independence. Over the course of this first year, and the transition from epidemic to recovery, we produced an analysis on a range of issues including understanding how local conceptions of power, fairness and trust shaped initial engagements with the trial during the emergency; factors influencing decisions to take the Ebola vaccine; the articulation of citizenship aspirations through encounters with biomedicine; and the role of materiality, social relations and hope in defining everyday interactions with the trial as it became embedded in Kambia (Enria et al. 2016; Enria and Lees 2018; Lees and Enria 2020; Tengbeh et al. 2018). Alongside academic outputs, or hidden beneath them, were the everyday negotiations involved in communicating ethnographic evidence for the running of the trial.

Over the years of research, whilst we aimed to maintain independence and our research was participant-facing, we were embedded within the clinical team. This involved attending meetings, reporting participant concerns and offering insights into how the trial's operations could be adapted to take into account participants' experiences. Reflecting back on this set up phase, we note the inherent tensions of this embeddedness, where our team's successes, challenges and failures all speak to the uneasy balance between critique and action at the centre of the debates introduced at the start of this article.

At the beginning, negotiating embeddedness involved trying to determine the boundaries and terms of collaboration and contending with concerns around how to communicate our 'relevance' (Benton 2017a). We set up a system for reporting our findings to the community engagement team so as to convey questions and anxieties surrounding the trials and suggest ways to create opportunities for dialogue around them. We also engaged in sustained discussions with clinical colleagues who were running the trial on the ground, communicating participants' experiences and questions around key procedures. These exchanges opened up fruitful debates about 'grounded ethics', including, for example, about how local political economies might affect perceptions of what it means to conduct ethical clinical research. This was visible, for example, in discussions about participants' frustration at being told that they would not be eligible for employment in the trial as this would be viewed to be unethical by international standards, or in mediating expectations over the parameters of free healthcare for trial participants. Key to our contribution in these debates was to render these political economies visible, to complicate notions of 'community' and to propose alternatives to the framing of participants' demands as 'misconceptions'. Our presence as ethnographers also allowed us to become mediators and advocates building meaningful relations through our participation in the town's life, making room for participants and non-participants to voice expectations and holding space for anger but also hopes and reflections over the meaning of this new vaccine and the subjectivities it gave rise to.

The ambiguity of our role, between clinic and community, balancing embeddedness and our position on the margins of both, made mediation and advocacy possible but also practically, ethically and politically challenging. We saw this firstly in debates within our social science team about our level of involvement in the trial and the balance and nature of both critique and action. Different members of the social science team articulated visions of the role of the team vis-à-vis the trial based on our different positionalities. Despite a shared commitment to amplifying participant voices and community perspectives, we disagreed on the best place to do this from – LE as a foreign researcher was initially concerned about the need to maintain scientific distance from the trial, whilst the Kambia-born research assistants challenged this stance in various instances, feeling a strong responsibility to personally intervene to mediate disputes and resolve issues arising between participants and clinicians. These discussions challenged the notion that critique must rely on detachment, and raised

questions about who gets to define the normative boundaries of anthropological action. Indeed, our internal discussions often hinged on the question of whether it would be unethical *not* to be more involved and embedded.

Our embedded position was also fraught with interdisciplinary encounters. Firstly, negotiating action on ethnographic evidence in the everyday running of the trial was testing, partly because of long-standing disciplinary differences around the value of quantification versus qualitative insights that tend to be seen as anecdotal or non-representative. Secondly, our search for relevance, especially in the early months during the emergency period, occurred within a limited space for critical engagement and co-production. To begin with, despite a genuine commitment to thinking through ethical conduct in a way that was locally meaningful, the parameters of clinical protocols had been set in stone rapidly in high-level emergency meetings, leaving little space for adaptation and challenge. Secondly, our value was defined primarily in relation to our ability to make findings 'operational'. This often meant producing findings that could be seen to have operational value, expressed in expectations that anthropological insights would support recruitment, increase vaccine 'acceptability' and identify the causes of potential 'resistance' so that they could be addressed. This was especially the case against the backdrop of crisis, where slow reflection, demands for moral hesitation or reminders of complexity can be deemed to be distracting.

The Operational versus the Political

Determining the value of these contributions requires, as Pelkmans (2013) cautions, being explicit about our normative judgements. We shared our clinical colleagues' firm resolution that achieving a licensed Ebola vaccine was a 'good outcome', not least having witnessed the human cost that the epidemic had wrought in Sierra Leone. However, our experience raised the question of whether the operationalisation of anthropological insights is always possible or desirable. This is visible particularly if we consider what to do with resistance or refusal. Our work endeavoured not only to challenge expectations of hesitancy but also, drawing on long-standing anthropological work, to contextualise mistrust of medical research, situating it in legacies of extractive colonisation and post-imperial global political and economic regimes. Shifting the lens from resistance

to mistrust had some practical implications, encouraging for example two-way dialogue that took anxieties and rumours seriously, but it also had significant limits as these deeper interpretations negate quick fixes. We should, however, also ask: *should* these analyses always result in fixes? The problem of representation is arguably, then, not only about the rightful place of the anthropologist, and particularly white Western anthropologists, in acting as a filter for the voices of participants (though that is an important problem too) but it is also about the *act* of representation and translation itself. As LE has argued elsewhere, there is a danger that translation into operational insights, boiling down insights to actionable interventions, 'flattens the emotional and political significance' of engagements like resistance or hesitancy (Enria 2021). In other words, to what extent do recommendations for community engagement based on ethnographic insights depoliticise popular critiques of international interventions or questions around pharmaceutical companies' profit motives that we identify in our research?

We found no simple answers in our efforts to reconcile our complex ethical and political commitments and our entanglement in different kinds of social relations with clinical colleagues, with other anthropologists, with communities and with trial participants. However, our experiences led us to some imperfect efforts to inhabit the discomfort of this position in between. Building collaborative relationships through everyday negotiations with clinical researchers and by producing sometimes operationally relevant insights, we were able to start cementing a place for independent qualitative research aimed at humanising and grounding clinical research. We engaged in processes of learning from critical anthropological and activist engagements with clinical research to consider avenues for applying their lessons and pushing forward debates on the ground, for example around grounded ethics, taking advantage of the openings created by the landscape of the Ebola response, albeit limited. From this position, we sought to expand channels for expression of participant voices both in the Kambian clinics and in broader international discussions, where we try to advocate for research practices and standards during health emergencies that consider meaningful co-production from the start. On the other hand, we want to make visible the practical difficulties of translation and the double challenge of representation that can blunt critical engagements. Reflecting on our own role leads us to question whether in an endeavour to be operationally relevant we missed

opportunities to foreground the political import of participant voices. Based on these experiences, then, we conclude not by suggesting a revaluation of anthropological collaborations in clinical research during health emergencies but propose the need for future reimaginations that take inspiration from past social movements towards a critically embedded approach.

Conclusion

The 2014–2016 Ebola outbreak generated new opportunities to foreground 'the social' in responses to health emergencies, but also to debate the nature of anthropological engagement with different components of an epidemic response.

In this article, we have focussed specifically on the question of balance between critique and action, revisiting questions about 'engaged' or 'embedded' anthropology through the lens of interdisciplinary collaborations in clinical trials. By situating our discussion in a historical trajectory of medical research from HIV to Ebola, we have traced the range of engagements with the socio-political dimensions of epidemics and clinical studies over the course of the last four decades, from activism to community engagement. We have considered the fraught role of the anthropologist mediating within and between these spaces. In telling the story of the trials from this historical perspective, we argue for the importance of revisiting debates about engaged anthropology and articulating both challenges and possibilities for placing critical theory and practice 'at the forefront' (Besteman 2013). During epidemics in particular, it is important to make space for the whole continuum of anthropological engagement in, and with, medical humanitarian emergencies – from critique that renders visible the global workings of power to operational deployments for 'people-centred response' (Bardosh et al. 2019). Our experiences suggest that there are opportunities for ethnographic research that deliberately inhabits a space 'in between': a 'critically embedded' anthropology that does the work of both positions.

This 'in between' work requires making normative judgements about what kind of action is valuable, sitting with the discomfort of grey areas and facing the significant challenges that remain in maintaining a critical stance in crisis. It is, for example, difficult to negotiate space for ethnographic evidence beyond studies of 'acceptability' or to convey the voice of trial participants through existing channels without diluting its political significance. The lessons from HIV and Ebola trials, both our successes and failures, and broader learning from anthropological engagements with medical humanitarianism suggest how we might start reimagining what critical collaboration might look like.

Firstly, a position 'in between' can be leveraged to advocate for interdisciplinary collaborations with clinical trialists and humanitarian responders that more firmly embrace social complexity and centre participants' lived experience. This requires the redefinition of co-production between disciplines and with communities, and this redefinition must happen during 'peace time' so that it can be applied effectively during emergencies. Co-production should include bringing anthropologists, clinical trialists and community activists to the same table in deliberations about clinical protocols.

Secondly, such a shift requires reconsidering what community engagement is and what role anthropologists play in relation to these efforts. Here, there is much to be learnt from activism in transnational HIV research. Over the years, ideas of engagement with medical research moved from 'an activist-led movement where individuals "pushed" for inclusion, to a research-led effort, where study staff worked to encourage participation and "pull" untrained, overburdened, and often marginalized individuals into relationships with Western educated researchers' (Slevin et al. 2008: 6). An alternative vision would be to push beyond conceptions of community engagement that emphasise how it can serve to ensure effective recruitment, adherence or compliance, to consider how prospective participants can 'seek not only to reform science by exerting pressure from the outside but also to perform science by locating themselves on the inside' (Epstein 2006: 13). Within this vision, the role of critically engaged anthropology should be to support a repoliticisation of community engagement in clinical research during emergencies, centring subjective engagements and political critique that emerge from our research rather than smoothing their edges for effective operationalisation. Emergency landscapes can work to side-line the significance of movement-building and to reduce 'the social' to efforts to increase the uptake of interventions. Yet, by building coalitions with clinical researchers and negotiating space for a wider range of anthropological critique, engaged researchers can advocate for longer-term commitment to political deliberation about the parameters of clinical research and the possibilities for citizen advocacy around it during emergencies.

The contours of these reimaginations are not for us to define. Indeed, a repoliticisation of community and anthropological engagement in clinical trials also necessitates a rejection of the (particularly Western) anthropologist's role as cultural broker or translator and at times resisting measurements of value based on how 'actionable' findings are. Instead, we can explore different iterations of an 'in between space', acting as allies of local organising through research and as an active and critical partner in interdisciplinary collaborations that make space for more transformative citizen engagement with science, even, or especially, in times of crisis.

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