Transnational Scientific Projects and Racial Politics: The KEMRI Six Case Against the KEMRI-Wellcome Trust Research Programme in Contemporary Kenya

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> “In 1989 the Kenya Medical Research Institute (KEMRI), one of Africa’s leading health research institutions, formed a landmark partnership with the Wellcome Trust, one of the largest global funders of health research, and the University of Oxford, one of the world’s top research universities, to establish a research programme on the coast of Kenya.” www.kemri-wellcome.org (accessed on July 29, 2017)

In 2010, six Kenyan scientists launched a legal case against the Kenya Medical Research Institute, the Attorney General, and the Ministry of Public Health for unlawful discrimination at the KEMRI Wellcome Trust Research Program (KWTRP) in Kilifi, Kenya. In July 2014, the judge from the Industrial Court of Kenya ruled in favour of their case based on evidence that clearly indicated the Kenyans were treated “with inequality on the basis of their race”, and they were each awarded five million Kenyan shillings (about 42,000 Euros) (Republic of Kenya 2015).

The KWTRP collaboration focuses on tropical medicine and global health policy, purportedly bringing together British and Kenyan researchers, with the aim of building scientific capacity in East Africa. They portray themselves through social media and publications as an exemplar model of research collaboration between the United Kingdom (UK) and its former colony, and include partners such as the London School of Hygiene and Tropical Medicine, Open and Oxford Universities. The legal case does not name Wellcome Trust or the universities (or researchers and administrators with those agencies), due to complex transnational jurisdictional issues in bilateral agreements discussed below, but they are very much at the core of this legal case which brings together histories of medical research, constitutional law, human rights, governance of global health research, and precarious labour markets as they play out in transnational medical research projects in East Africa.

My own research on science and medicine in East Africa has focused on clinical medicine and the ways in which transnational medical research travels between Kenya and its former/current imperial/colonial powers. More specifically, I have been interested in the disjuncture between the programmatic objectives of scientific and biomedical projects (including pharmaceutical clinical trials) and the unintended consequences as they are enacted in everyday practices and interactions of North-South scientific collaborations. I see the question of scientific collaborations in resource-limited settings like Kenya as being fundamentally a question about the configuration of knowledge, one that is deeply imbricated with a history of scientific colonialism, and as such this blog post touches on both epistemological and political struggles.

The KEMRI six case is important for what it tells us about the jurisdictional domains of medical science and global health in transnational projects.[1] My aim here is threefold: First, to introduce the case, offering a partial glimpse into this continuing legal case, which is complex for the multitude of political, economic, pedagogical, and legal issues entangled within it. Second, I contextualize the case within current anthropological debates about medical research and global health governance in Sub-Saharan Africa. Lastly, I suggest that their case highlights the failure of both national and international law to protect scientists and other workers in transnational scientific collaborations. Although the paper focuses on the KEMRI-Wellcome Trust collaboration, it speaks to Global North-South scientific collaborations more generally, raising critical questions about the inherent inequities that continue to be built into transnational medical research collaborations and the failure of states to address those injustices.

Research Collaborations and Aid

As a resource-limited, or "developing," nation Kenya has relied heavily on collaborative agreements with Japan, the US, Denmark, and the UK for building its scientific infrastructure. Most medical and bioscientific research occurs under the umbrella organization of the Kenya Medical Research Institute (known as KEMRI). KEMRI formed during the years following independence (early 1980s) as a centralized national agency meant to manage and conduct research on everything from malaria to rotavirus. It was primarily funded originally by JICA – the Japanese International Cooperative Agency – and built on existing tropical medicine research projects being conducted by the British scientists and institutions, including the Wellcome Trust and Oxford University who had been working in Nairobi long before KEMRI was officially established.

As many anthropologists and historians have documented (Geissler and Molyneux 2011; Hunt 2016; Tilley 2011; Wendland 2008), Sub-Saharan Africa has long been a site of experimentation, exploitation, and biological resource extraction for colonial scientists and contemporary medical researchers from the global North. Their work chronicles in different ways how contemporary global health projects and transnational medical research projects often start with the assumption that Africans need their capacity to "be built" or "strengthened" by non-Africans (Geissler and Tousignant 2016), influenced by the ideas of historical scientific projects conducted by German (Neill 2012) and British (Graboyes 2015) states and scientists which treated Africans largely as bodies for experiments, biological resources for extraction, or cheap labour. As Crane (2013) highlighted, in part following the global HIV pandemic, Africa became a preferred site for medical research in infectious diseases, like HIV and tuberculosis, and global health programming in the 1980s (also see Hunt 2013 on the global health industry as it has emerged and shaped stories and histories of Africa). This blog post expands these discussions by considering the intersections of jurisdictional law, medical science, and racial politics.

Before KEMRI was founded, medical research was conducted under the East African Medical Research Council, which was established in 1957 and served (after the 1960s) the former British colonies and protectorates, though the East Africa Medical Survey, the first large scale medical research project, was initiated in 1949 by researchers at the London School of Hygiene

and Tropical Medicine. Little has been written about the history of Wellcome Trust in Africa (exceptions include Bell 1999 and D'Arcy 1999).

The Wellcome Trust has an impressive international reputation for supporting health and medical research through a well-established foundation and it has supported global health research in Africa since Sir Henry Wellcome first opened laboratories in Khartoum in 1902. The Kenyan site in Kilifi was first set up in 1983 and continues today to be an important site for tropical and neglected disease research in sub-Saharan Africa. These collaborative scientific field stations are interesting spaces to examine for the ways in which "national, imperial and international infrastructures" are simultaneously, albeit unevenly, being constituted (Tilley 2011: 7), especially the relationship between law and medical science.

As others (Binka 2005; Okwaro and Geissler 2015) have pointed out, North-South collaborations remain inherently inequitable from the start since it is nation states from the *North* who set the criteria and demand for collaborative research relationships, or more specifically that researchers from the South collaborate with researchers from the North in order to access funding from developing nations. In the present case, for instance, Kenyan scientists working in paediatrics, neurology, and tropical medicine need to collaborate on research protocols from the UK, as co-investigators or non-named workers, in order to be able to access funding from the Wellcome Trust or other training opportunities offered through Oxford or Open University. Others have noted that in such scientific workspaces, Global South researchers may face language barriers, experience inequitable labour practices, and unequal access to travel, training, and publishing opportunities (Jentsch and Pilley 2003). Yet, perhaps paradoxically, one of the benefits often discussed in such collaborative research sites is capacity building, among other objectives like community empowerment, community development, and fair partnerships. The KEMRI six case highlights how in spite of decades of discussion and international guidelines regarding best practices for such ethical collaborations, there is much to be learned (Parker and Kingori 2016).

I have been working with the Kenyan scientists who launched the legal case since 2015 and this paper is the first in a series planned that consider their case as an example of the tensions inherent in the ways in which scientific research is carried out in Africa. It is based on a series of interviews with five of the six scientists and their two lawyers (approximately 25 hours of audio), the data they have collected as part of their case (over 1500 files), three of their affidavits (approximately 3000 pages in total, provided to me in electronic form by the Kenyan scientists), and the judgement from the Industrial Court on their case.

The Legal Case

The case, now known in short as 'KEMRI six', highlights on-going tensions and challenges of conducting scientific research across borders. The KEMRI six case reminds us of how important it is to continually reflect on the shifting nature of science and partnerships in global health research, and how major, influential foundations such as Wellcome Trust shape current configurations of medical research with its partners in the Global South. Like the recent work

that has focused on the histories of global health research by the Gates Foundation (McCoy and McGoey 2010; McGoey 2015) and Rockfeller Foundation (Birn 2014), the Kemri six legal case raises questions about the historical legacy of scientific research in the region as conducted or funded by agencies like the Wellcome Trust and Oxford University.

The legal case in question involved six Kenyan medical doctors (Sam Gwer, Albert Komba, Michael Mwaniki, Moses Ndiritu, Nahashon Thuo, John Wagai) who were employed with the KWTRP in Kenya as medical researchers. Due to political and judicial bureaucratic complexities, the Wellcome Trust itself, in addition to its partners in Kilifi (including Oxford University and Open University) were able to avoid being brought into the case because of the peculiar status of the Wellcome Trust site in Kenya. Bilateral agreements between the Government of Kenya and the UK mean that Wellcome Trust and Oxford work through Kenya parastatals like KEMRI and do not exist legally as independent institutions. Thus, the case was brought against the Kenya Medical Research Institute (KEMRI), the Ministry of Public Health and Sanitation, and the Attorney General of Kenya, which may be why the case has not garnered the deserved attention it should among global health researchers worldwide.

The July 18th ruling in 2014 by Kenya's industrial court ruled in favour of the six Kenyan researchers who provided ample evidence of racial discrimination in the workplace in respect to inequitable salaries, opportunities for research awards from the Wellcome Trust, and discriminatory practices in hiring for senior scientific positions. The ruling reads in part:

> "76. It was submitted that, given the differential outcomes along racial faults as depicted in the affidavits of the Petitioners and the annexures set therein, the KEMRI Wellcome Trust Research Programme exemplifies institutional racism. That deliberate attempts by institutional leaders to inhibit calls for a re-examination of institutional policies and practices that promote racial discrimination of institutional policies, and responding with repression, indicate individual culpability by the Respondents and its senior officials in actively promoting racial discrimination and inequality." (Republic of Kenya, 2015)

The court also declared that the programme engaged in labour malpractices, deprived local researchers of appropriate scientific attribution, access to commensurate benefits of their efforts, and its general day-to-day operations supported institutional racism and an inherently exploitative research relationship. What the various affidavits from my six collaborators indicate is that Kenyan scientists working under the KEMRI-Wellcome Trust Research Programme have experienced discrimination in an intellectual environment that was deeply split along lines of race, nation and class. Kenyan nationals had different opportunities, difference pay scales, and their contributions to the science and research were ignored as if they were simply junior research assistants, or as they have stated – "as slaves." The KEMRI six scientists are highly educated and well-trained doctors and scientists. They all have medical degrees combined with graduate training at the MA level, and some have since continued with PhDs and the clinical training they had expected through KWTRP.

As explained to me, all went to KWTRP as newly graduated doctors hoping to get advanced clinical training and experience with clinical tropical medicine. They developed ambivalent

relationships with KWTRP – they relied on KWTRP for work, training, and recognition and yet they were increasingly aware of the inequities built into the research system. There were clear obstacles for African scientists in setting agendas for research priorities, strategies, and methodologies, in securing funding, and in leading their own investigators. There were obvious racial underpinnings in the management of the research centre – where Africans had fewer opportunities for advancement and were enumerated on a different scale, which the final judgement from the Industrial court confirmed (Republic of Kenya 2015). But the racism was also more overt as Samson Gwer's affidavit attests:

> "We also wish to point out the patronising and intimidating attitude that some senior white scientists have over their junior African scientists. Some scientists have used racial slurs, calling local workers 'stupid' and 'incapable of intellectual work.'"

They explained to me that space was one of the clearest markers of racial difference, both at the office and their personal spaces. In the workplace, Africans joked about needing a visa to be able to enter the British workspace, reflecting on the obvious segregation between Africans and the British. The British citizens could afford to live in high-end neighbourhoods, often on the oceanfront, with boats, whereas the salary given to the African researchers meant they had to live in more modest neighbourhoods. On one occasion, one of the KEMRI six scientists recounted a story to me how he and a British colleague had travelled to a conference together within Kenya and when they arrived at the location, they had been put up in different hotels: The British citizen in a European style beachside hotel, and he in a modest, Kenyan style hotel. When the scientist challenged KWTRP on this practice, they offered no explanation and said the policy would be changed.

Their affidavit highlighted the low representation of African scientific leadership in KWTRP, which contravened the national Policy on Kenyanisation, which allocates a percentage of leadership roles in medicine and science to Kenyan nationals. For instance, in the core programme funding application period between 2010-2015 there was only one African co-applicant and as of July 2017, the Tropical Medicine department at Oxford University website lists 14 principal investigators for KWTRP, but only one of those is Kenyan (see https://www.tropicalmedicine.ox.ac.uk/kwtrp-researchers, accessed on July 29, 2017).[2]

Furthermore, the KEMRI six clearly identified in their own research, submitted as part of the affidavit, the agency's failure to engage African scientists in granting for the more than two decades that the KWT Research programme has been in operation (see table 1). British citizens, often junior in age, education and experience, would come as temporary researchers to the site and be offered advanced clinical training while the Kenyan scientists continued to be denied the very same kind of training. From Michael Mwaniki's affidavit:

> "The employees have over the years taken on enormous responsibilities and executed them diligently — in many cases working well beyond 40 hours a week without any compensation. Most are subjugated by poor contractual arrangements that leave them with no room for economic and personal growth. Importantly, many are further aggrieved when they see jobs that can easily be locally or regionally recruited, taken up by

> expatriates who go on to earn several fold more."

All of this occurs in a context where the KEMRI-Wellcome Trust Research Program had been given a strategic awards grant by the Wellcome Trust whose mandate was explicitly to offer advanced clinical training (a Master's in medicine) to African doctors.

The Kenyan six scientists have argued that by refusing graduate medical training for the African doctors, KWTRP created a two-tiered system that provided relatively cheap African labour to British clinical researchers. As explained in Moses' affidavit:

> "Employment at KWTRP is discriminative along nationality and racial lines. There are local African salaries and international expatriate salaries. The latter are provided through Wellcome Trust and the University of Oxford. Only a tiny group of Africans are able to access these international contracts. What is most obvious is that some of the jobs advertised internationally and given to favoured expatriates from the UK can be done by Africans."

They went to KWTRP expecting the training and educational opportunities promised but they all left discouraged and rather scarred from the experience. Although it has been almost seven years since they left the research collaboration, and three years since the Kenyan High Court ruled in their favour, the effect weighs on each of them. The ruling has been appealed by KEMRI and due to the overburdened court system, it has been stalled now in the courts for three years.

Their experience, however, is not unusual or limited to the KWTRP. In the ten years that I have worked in Kenya on questions related to scientific and medical research, I have heard similar stories from young Kenyan researchers who have worked with the University of British Columbia, the US Center for Disease Control, and others. (This is not to say that there are not transnational scientific collaborations that work well, nor am I suggesting that *all* Kenyans working with the KWTRP had the same experiences as the KEMRI six.) What is unusual about the KWTRP is that the six Kenyan scientists were willing to risk all to challenge the inherent system of inequity and racial discrimination they faced daily in the workplace. Their resistance was organic. They talked among each other; the frustration grew more intensely for some more than others. Eventually they requested meetings with the senior British management but when their concerns were disregarded, when their supervisors (all British) either didn't acknowledge their claims or ignored them, they composed a letter to the institution that was circulated publicly on email. There they carefully identified their concerns and observations, demanding some fair and equitable solution be developed. Yet, both the KWTRP and KEMRI discouraged them from pursuing the issue. After sending an anonymous email (because of the fear of dismissal), they were called to the office of the chief operating officer. One of the scientists recounted that meeting to me:

> "[T]he next day in the morning we are called to the chief operating officer, we are frisked

> and told that we are aware that you sent this. I actually felt surprised. They said, ‘I am afraid we will let you go home and if there is any issue then we will call you back’.”

As they recounted to me, they were harassed, intimidated, and threatened to drop the case by senior colleagues (both British and Kenyan). When they didn’t, they lost their jobs, to be reinstated within days when administration realized they could not legally dismiss the scientists. In the end, a case was mounted, and the judge ruled in their favour highlighting the clear evidence of racially discriminatory labour practices in this scientific collaboration. Justice Nderi ruled (Republic of Kenya 2015):

> “The systemic discrimination and violation of the fundamental rights has had significant detrimental effect on the researchers, they have not only lost a chance to renew their employment contracts and connected scholarships to complete their studies but have lost significant research outcomes as a result of the discriminative practices.”

But more than that – these subtle, insidious practices cut much deeper. After mediation and negotiations clearly failed and the group moved forward with the case, they were ostracized, friends shunned them, senior colleagues and respected mentors tried to coerce them into dropping the case, and they suffered financially, professionally, and in a deeply personal way, which no lawsuit, or remuneration, could ever make up for. One of the scientists talked to me about the pressures of mounting the case:

> “There were ups and downs, there were pressures that had to do with the new situation that we found ourselves in, new situations where we had no jobs. Careers sort of cut off in a way that you didn’t know how you would fit into the normal system. It had to do with no money. It was really difficult by the fact that you are also isolated by the other people and so there is also the pressure, not necessarily from Wellcome Trust, but from other guys who remained in KEMRI, essentially seeing you as stupid and the one who should never have protested.”

And speaking about how hard it was to keep faith among the six of them during the entire process, one of the scientists said:

> “He [one of the six] was really scared, he said that he was going to lose everything, and I told him I am also losing everything.”

Conclusion

This case reminds us how difficult it is to disentangle contemporary medical research projects between the Global North and Africa from historical colonial projects. As I have suggested

elsewhere (Elliott 2016) the unequal economic and political relations between states like the UK and Kenya mean that bilateral negotiations over agreements for anything from military to bioscience limit the Government of Kenya's authority to demand equitable relations or resources in such collaborations. Racial discrimination as manifested in granting practices, authorship, and international travel opportunities are widespread and 'public secrets' in Kenya and yet such practices continue.

For me, one of the most interesting questions emerging from the KEMRI six case is how institutions from the Global North, including the Wellcome Trust and Oxford University, are able to avoid any direct responsibility and accountability for the research and labour practices of their citizens working long-term in Kenya. The question of the global governance of international scientific research collaborations is of increasing importance as concerns about biosecurity threats and transborder health risks grow (Taylor 2004). But if international law does not apply in such cases, maybe it is time to reconsider such scientific core-periphery collaborations? As Okwaro and Geissler (2015) suggested, and similarly Noelle Sullivan (2016) has illustrated in the case with medical volunteers, the continual pattern of sending Northerners to Africa for training and experience is deeply problematic and troubling, especially given the same opportunities rarely exist for Africans in the Global North.

As mentioned, the case has been stuck in the court of appeals, but three years after the judgement was made in the Industrial Court of Kenya they are returning to court this August. The case has, surprisingly, generated very little international attention (exceptions include Nordling 2014 and 2012). I write this blog post hoping that knowledge of the judgment in favour of the KEMRI six plaintiffs will generate increased awareness regarding racial and institutional discrimination in contemporary transnational scientific projects and pressure influential global health funding agencies, like the Wellcome-Trust, to seriously consider how they are perhaps unintentionally reifying scientific colonialism. The KEMRI six have reported interest in taking the case to the UK with the expectation of getting the responsible entities to take up responsibility and with the hope of impacting on the way entities like the Wellcome Trust and others relate with Global South scientists and affect the global health agenda. Such an undertaking would require great legal support and interested persons should contact the lead author at dae@yorku.ca for more information.

Note from KEMRI Six collaborators: Although Dr. Elliott offered us the opportunity to be co-authors on this paper, we declined given that she both developed the idea for the paper and wrote it in its entirety. This reflects the principles of the memorandum of understanding (MOU) that we collectively agreed to and which outlines shared practices for authorship and addresses issues surrounding ownership of intellectual property for this project.

Bio statement

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[1] Similarly, see Noelle Sullivan's recent post that speaks to thefailure of international guidelines to regulate international medical volunteers in the global south. See http://rolereboot.org/culture-and-politics/details/2017-04-international-medical-volunteering-harm-good/ (accessed on July 27, 2017)

[2] There appear to be two websites for KWTRP: that based at the Department of Tropical Medicine at Oxford University and that specifically for KEMRI-Wellcome Trust. Though some of the information is repetitive, there are clear differences. The KEMRI-Wellcome Trust site, http://kemri-wellcome.org (accessed on July 29, 2017), highlights more Kenyans in senior leadership roles and as leading scientists (but still does not list them as principal investigators).

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