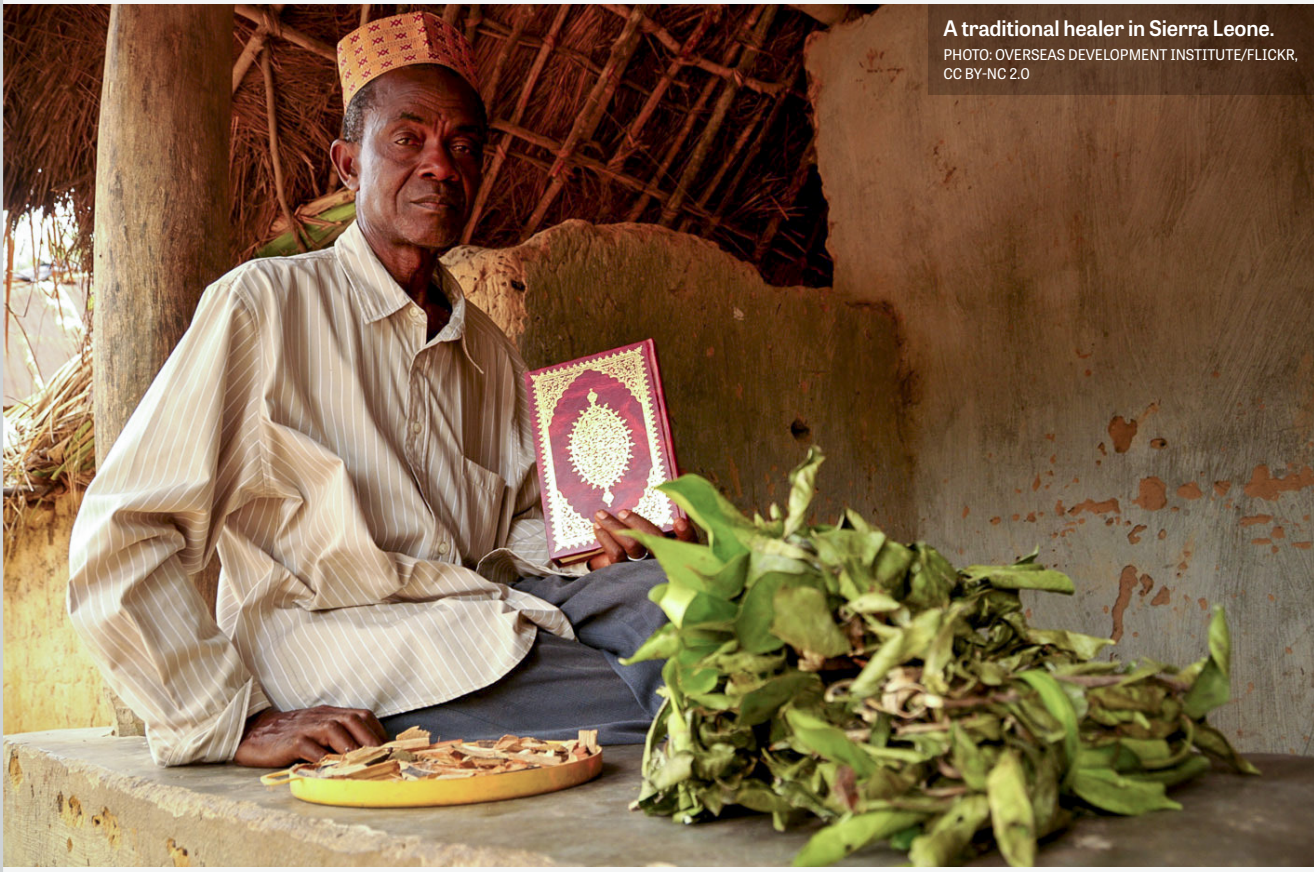
Practical Approaches

Rapid Appraisal of Key Health-Seeking Behaviours in Epidemics



A traditional healer in Sierra Leone.
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This SSHAP Practical Approaches brief highlights key considerations when appraising health-seeking behaviours in the context of an epidemic outbreak. It provides guidance on the availability of relevant social science knowledge to adapt epidemic preparedness and response to the local context. Using the guidance will result in a mapping of crucial social science knowledge on health-seeking behaviour and reveal areas for additional primary data collection.

Health-seeking behaviours vary widely across cultures, so some questions may be more relevant than others in different contexts. Additionally, the nature of the disease itself will make some questions more relevant than others; for example, the transmission pathways (contact, airborne, vector, etc.) of the pathogens will make particular issues more salient. As such, questions will need to be tailored to a specific context and disease.

Social scientists or operational researchers embedded in an epidemic response should use this tool to gain a background understanding of the contextual aspects that shape vulnerability to a particular disease. This background can then serve to design more specific research questions and tools for primary data collection or surveys as part of the epidemic response (e.g. community feedback mechanisms; knowledge, attitude, and practice (KAP) surveys).

Methodologies for the identification of health-seeking behaviours

The following methods can be used for the rapid appraisal of key health-seeking behaviour in the context of epidemics:

- Desk review of relevant anthropological/sociological literature to provide critical evidence of knowledge gaps, as well as relevant published literature.
- Interviews with relevant local social scientists and aid or development agencies to provide up-to-date information about current or planned social science research and community engagement initiatives.
- Stakeholder interviews in affected communities, community meetings, and focus group discussions according to relevant social dimensions (age, gender, ethnicity, religion, income, etc.) to identify knowledge gaps of affected communities and assess the availability of response mechanisms.

This assessment goes hand in hand with exploring, together with stakeholders and communities, appropriate ways to adapt and react to the disease. It should be an integral part of an ethnographic context analysis (see SSHAP Practical Approaches briefs *Rapid Remote Context Analysis Tool (RR-CAT) in Epidemics* and *Rapid Anthropological Assessments in the Field*), which focuses on rapidly gathering information around an operational context (including population movement, livelihoods, and trade patterns).

Question modules

This tool comprises eight modules that provide insight into the local models of health and disease, and explanatory models that are used by communities and show how people in affected areas can care for the sick. This information can showcase how health care is sought, and what barriers exist.

The topics covered may be sensitive and asking these questions could arouse strong emotion and/or concern around intention. This means that rapport-building, honesty, mutual respect, and reinforcing trust is vital **before, during, and after** the collection of this information. Recommended steps:

- Give your name and where you are from and thank them for welcoming you to the community.
- Explain why you are there, your job, and why you want to talk with them specifically.
- Offer reassurance that you will keep their personal information private and invite them to feel comfortable with you.
- Allow them to refrain from answering certain questions if they do not feel comfortable. (However, if this happens, it provides information in itself by indicating the particular sensitivity of the topic.)
- Ask if they have any questions and be willing to answer questions about why you are there.
- Be honest – if you don't know, you don't know and that is okay.
- Inform them of the next steps and follow-up.

Identifying the proper community entry channels and going through trusted leadership is crucial. Convenient meeting times and places should be agreed with community members (e.g. not during a feast day or celebration).

Module 1: Concepts, understanding, and explanations of disease

- How is health understood? How do people speak of and explain wellbeing and disease?
- What are the common explanations for disease?
- What are the local terms used for symptoms and groups of symptoms associated with _____? And disease in general? By which different population groups?
- What are the causes attributed to these different symptoms? (Note that different symptoms associated with _____ may elicit different causal explanations (e.g. neurological signs are more likely to bring explanations of spirit possession than gastrointestinal symptoms). These causes may vary depending on the symptoms and the specific circumstances of their emergence (e.g. natural/material, mental/psychological, spiritual, or externally caused due to jealousy, witchcraft, spirits, ancestors, breaches of rules, etc.).

Module 2: Alternative narratives of epidemics and vulnerabilities

- Do some of the explanations include suspicions that the disease is not real? Or that the disease has been created and/or inoculated into the affected populations? If so, how does that map with the political histories of the affected populations?
- Are there vulnerable people or populations that can be negatively affected by ideas of what causes ____ and who carries _____? Are people or groups being, or can we predict that people or groups will be scapegoated or accused of transmitting the disease? How? Why?
- Have these biomedical and alternative causal explanations of the disease shifted in time throughout the outbreak? If so, why?
- Is there a discrepancy between the concepts and terms used in epidemic response communication and those used by different populations? Is there a difference in the connotations of urgency/relevance depending on the use of terms?

Module 3: Building on local practices of epidemic response

- Are there specific understandings of epidemic disease and mortality that could colour the current response? (Probe on past experiences in terms of epidemics, conflicts, and fears.)
- Are there previous histories and experiences with situations of high mortality and response strategies (e.g. social isolation, quarantining, changes in care of the sick or burial practices)? How do they shape current perceptions?

Module 4: General health-care behaviour

- When someone falls ill, who is responsible for them? Within the household/family, who decides if it is necessary to seek treatment and which health-care provider to approach?
- If treatment requires transport, money, medicines or contact with doctors, who provides for these? What is the role of the extended family, in-laws, and the community in arranging these?
- Who cares for the sick (according to age, gender, or kinship role, e.g. mothers, mother-in-law, sister)? Who decides if the person needs to be taken to a hospital or treatment unit?
- What is the physical access, affordability, and quality of biomedical services? What does the biomedical health system look like and how is it decentralised/organised (e.g. including community health workers)?

Module 5: Alternative healthcare provision

- In the affected area, what is the relative importance of alternative health-care providers (e.g. home care, herbalists, traditional healing, faith healing, drug vendors, pharmacists, private health-care providers, etc.)?
- What ailments do alternative health-care providers treat? What diagnostic techniques do they normally rely on? What treatments do they generally offer?
- Are alternative healthcare providers in this context organised into professional associations (e.g. associations of traditional healers)?
- Are there differences between social groups (according to urban/rural, income, ethnicity, gender, etc.) and their reliance on these different providers?

Module 6: Health-seeking pathways

- Which healthcare providers are sought for what ailments or symptomatologies?
- Do people seek advice simultaneously or in succession from different healthcare providers? What are the typical health-seeking pathways? Are there specific pathways that people follow for _____?
- What is the typical geographical movement of people in each of these health-seeking pathways (e.g. sometimes people cross international boundaries to seek care)?
- How is failure to find a cure interpreted? Does this change the understandings of the cause of the ailment?
- How does successful treatment shape people's views of the effectiveness of a healthcare provider?

Are particular groups of people (e.g. ethnic groups, minorities, etc.) discriminated against in the provision of healthcare?

Module 7: Response mechanisms

- How do communities perceive treatment units? When mortality occurs within those units, what are the common and diverse explanations of what happens in them?
- How do people perceive the response? Do people trust it? If not, why not? How do people interpret the influx of resources in response to _____?
- What are the perceived interests of current elites in the framing of the disease? Is it believed that the emergency is being highlighted/downplayed/ignored for political reasons?
- Are people adequately informed of treatment options and gaps? Are visits to patients in treatment units permitted, an if so, and are people informed that these visits are allowed?
- Who are regarded as the most trusted first aid providers in the epidemic? Is this the same in each social group (e.g. minorities, young people, etc.)?
- Are there particular professions or groups of people that are especially trusted by the population and that can effectively communicate relevant information?

Module 8: WASH, livelihoods, and nutrition

- What are the disparities in the provision of safe water, sanitation, and hygiene (WASH) services across different social groups? How do these disparities overlap with conflict/trust in the national government and the response?
- Are people's movement patterns (e.g. internally displaced people in conflict contexts) driving people towards areas with inadequate water and sanitation provision?
- What are the local ideas of pollution and contamination? What concepts are used to define these? How do these overlap with WASH messaging?
- What are the diverse WASH needs for different social groups (e.g. gender, age, religion, etc.)?
- If the disease is zoonotic, are risk prevention mechanisms putting people's livelihoods at risk? Who is most vulnerable (e.g. slaughterhouse workers, hunters, etc.)?

About

The Social Science in Humanitarian Action Platform (SSHAP) aims to establish networks of social scientists with regional and subject expertise to rapidly provide insight, analysis and advice, tailored to demand and in accessible forms, to better design and implement emergency responses. SSHAP is a partnership between the Institute of Development Studies (IDS), the London School of Hygiene and Tropical Medicine (LSHTM), Anthrologica and UNICEF Communication for Development (C4D).

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This Practical Approaches brief is part of a portfolio on Social Science Lessons Learned in Epidemics and was supported by the Office of U.S. Foreign Disaster Assistance (OFDA) and UNICEF.

Credits

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Citation: Ripoll, S.; Gercama, I. and Jones, T. (2020) *Rapid Appraisal of Key Health-Seeking Behaviours in Epidemics*, SSHAP Practical Approaches brief 5, UNICEF, IDS & Anthrologica.

This document has been funded by UNICEF and the U.S. Agency for International Development (USAID) Office of U.S. Foreign Disaster Assistance (OFDA). However, the views expressed herein are those of the author(s) and do not necessarily reflect those of USAID or OFDA, or the partners in the Social Science for Humanitarian Action Platform (SSHAP).

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