K4D
Knowledge, evidence and learning for development

Anthropology and Health

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Question

Could you consider global evidence or examples of how anthropological evidence or behavioural insights on health-related matters have been distilled into operational pilots or innovations?
•   What are the lessons learned from what has and hasn't worked?
•   Are there any promising examples from socially-conservative settings such as Somalia, Afghanistan, etc.?

Contents

1. Overview

This report focuses on providing global examples of how anthropological evidence and insights on health-related matters have been utilised in programmes and innovations. It also considers lessons learned and has a section focusing on socially conservative settings.

Section 2 focuses on providing examples of how anthropology has been used, particularly focusing on the Ebola epidemic with a specific example of safe burials in this context. This was in effect an 'operational pilot', as the response had to be rolled out and adapted at such speed. Other examples include the use of anthropology in the Zika epidemic, medical humanitarianism, HIV prevention, childhood disability, preventable child death, gender inequality and adolescents and adolescent nutrition. There are many examples of how anthropology has been used in health-related programmes, and what contributions anthropology can and cannot make in different contexts and over time, but academics and practitioners need to get better at demonstrating how anthropological evidence is used more effectively. Anthropology also frequently produces counterpoints to existing framings, meaning the research often shows that something might be best off not being done and shows what does not work, so lessons can be learned for the future. Anthropology can also help link into country structures that are already in place and within the project seek to support and build capacity at local levels, particularly in terms of local expertise. However often anthropological evidence is not used or not utilised effectively so lessons need to be learned from this.

This is explored further in section 3 which provides evidence on lessons learned from using anthropology in health settings and how to improve future programmes. It includes case studies from mass drug administration for neglected tropical diseases (NTDs), HIV prevention, community based management of acute malnutrition, the Ebola epidemic and some lessons learned from developed countries. Different lessons can be drawn from different case studies. However, one lesson includes that it has been claimed that international and government actors largely ignore anthropological findings, unless those finding coincide with existing policy, so ways to ensure anthropology is effectively used would be an important future area of study. It can be very effective when used, for example, the importance of anthropology can be seen when looking at how understanding the social context of the country can affect whether or not people seek treatment (Oosterhoff 2008 and 2009). Additionally, it has been shown that understanding social dynamics is essential to designing robust interventions and should be a priority in public health and emergency planning. An important step is to begin with a more realistic account of local social relationships. Including anthropologists with specialist knowledge of people and contexts in policy formation and implementation can assist this process. A 'one size fits all' approach and public meetings with supposed key stakeholders is not enough. More nuanced approaches are needed which are sensitive to how social, political and economic interests interact in policy processes and local settings (Wilkinson 2016).

Lastly section 4 concentrates on examples from socially conservative settings including an example of cholera transmission in the Horn of Africa, birth registration in Angola and polio vaccination in Somalia.

This report is one of four related queries on behaviour change communication, behavioural economics, anthropology and health.

2. Global evidence on how anthropology/behavioural insights have been used in health programmes, operational pilots or innovations

Ebola response

Ebola Response Anthropology Platform (http://www.ebola-anthropology.net/)

The Ebola Response Anthropology Platform (ERAP) is co-ordinated by anthropologists at the London School of Hygiene & Tropical Medicine (LSHTM), the Institute of Development Studies (IDS) and the Universities of Sussex and Exeter, and aimed to contribute to a co-ordinated, adaptive and iterative response to the Ebola outbreak. By drawing upon existing anthropological expertise, and undertaking targeted fieldwork, the aim was to enhance efforts to contain the epidemic by providing clear, practical, real-time advice about how to engage with crucial socio-cultural and political dimensions of the outbreak and build locally appropriate interventions. In 2016, ERAP was awarded the international impact prize of the UK Economic and Social Research Council.

ERAP enabled social scientists and outbreak control teams to interact to develop a co-ordinated, adaptive and iterative response to the Ebola outbreak. They aimed to build a more locally appropriate and socially informed outbreak response by providing clear, practical, real-time advice that engaged with crucial socio-cultural and political dimensions of the outbreak.

Their core activity was providing rapid responses by e-mail, conference calls and web-based dialogues to operational questions raised by those working for Non-Governmental Organisations (NGOs), government and international agencies to contain the epidemic or care for those affected. They were able to develop policy briefings rooted in both the historical and rapidly changing contemporary context of affected communities by drawing upon existing anthropological expertise within their networks and undertaking targeted fieldwork.

Complementing their advisory role, they worked proactively with health and humanitarian organisations to design, deliver and monitor more locally responsive and socially informed interventions and research on the ground. They achieved this by identifying, connecting up and supporting in-country anthropological and other social science capacity working in African countries affected by or at risk of Ebola outbreaks.

They also sought to contribute to global health policy more broadly by fostering critical debate and discussion in policy and practice circles on key anthropological priorities and concerns with the outbreak response, and advanced a comparative perspective on Ebola and other emerging infections.

Further work

The global community of anthropologists, social scientists, and area studies experts responded to the escalation of the West African Ebola outbreak through 2014-2015. They advocated for greater response resources on behalf of West African populations, and criticised the response for its insensitivity, lack of cultural sensitivity, and disconnection from local populations. Anthropologists demanded that West Africans living in Ebola-affected countries be treated with basic human decency, dignity and respect, that culturally insensitive public health responses like cremation be abolished, and that greater cultural awareness and community engagement be integrated into all aspects of the emerging global Ebola response (Frankfurter 2014). Then, coincidentally, in an unprecedented move in the brief global history of anthropology, three parallel networks – ERAP,

the Emergency Ebola Anthropology Initiative, and the Réseau Ouest Africain SHS Ebola – were formed to disseminate information, inform policy, and mobilise political activism around epidemic response. Anthropology's engagement with the Ebola epidemic spanned the gamut of possibilities for "engagement" and "relevance" in rapid policy decisions and program implementation.

Anthropology's response to the West African Ebola epidemic was one of the most rapid and expansive anthropological interventions to a global health emergency in the discipline's history. An article by Abramowitz (forthcoming) sets forth the size and scale of this anthropological response and describes the protagonists, interventions, and priorities for anthropological engagement. It takes an inclusive approach to anthropological praxis by engaging with the work of non-anthropologist "allies," including qualitative researchers, social workers, and allied experts. The article narrates how the concept of "anthropology" came to serve as a semantic marker of solidarity with local populations, respect for customary practices and local socio-political realities, and an avowed belief in the capacities of local populations to lead localised epidemic prevention and response efforts. Of particular consideration is the range of complementary and conflicting epistemological, professional, and critical engagements held by anthropologists. The article also discusses how to assess anthropological "impact" in epidemics (Abramowtiz, forthcoming).

Innovation and experiments

Against hopes that fast-tracked Ebola vaccine discovery efforts would lead to a "magic bullet," conventional epidemic containment efforts were mainly responsible for containing and ending the epidemic. However, public hysteria over Ebola supercharged the political economy of pharmaceutical development. This accelerated push gave anthropologists a rare opportunity to observe on the public stage many routinely backdoor public-private partnerships, candidate vaccine development debates, fights over trial design discussions, and economic inducements (Abramowitz, forthcoming).

Ebola anthropology's theoretical innovations (from Abramowitz, forthcoming)

Ebola anthropology generated new theoretical frameworks for conceptualising the biological and social ecologies around the Ebola epidemic that can inform future epidemic responses. Abramowitz (forthcoming) outlines the different approaches of anthropologists. 'Epistemological distance helped anthropologists reflect on the fractures in their own societies. The anthropological gaze highlighted how the world was gazing at the disaster through the lens of the media. Critical essays followed the racism, sensationalism, primitivism, and naiveté that reporters describing bushmeat—what McGovern (2014) called "a politics of disgust"—contributed to racist and primitivistic discourses' (Abramowitz, forthcoming). Anthropological critiques of the media documented the latter's panic baiting, overreactions, and hysteria (King 2015).

Early work

The Hewlett's are the first anthropologists ever invited by the World Health Organization to join a medical intervention team and assist in efforts to control an Ebola outbreak. Their account addresses political, structural, psychological, and cultural factors, along with conventional intervention protocols as problematic to achieving medical objectives. They find obvious historical and cultural answers to otherwise-puzzling questions about why village people often flee, refuse to cooperate, and sometimes physically attack members of intervention teams. They also highlight how some cultural practices of local people are helpful and should be incorporated into control

procedures (Hewlett and Hewlett 2014). There is also a section on effective behaviour change interventions for Ebola and what is acceptable and appropriate based on anthropological findings in the HEART report (Grant 2014).

Work with UNMEER

UN Mission for Ebola Emergency Response (UNMEER) in West Africa had a collaboration with a network of anthropologists and social scientists and produced a series of two-page briefs. These were focused at the senior leadership of the response. They highlighted key considerations and made direct recommendations that were used to help shape response strategies. This is a great example of how existing knowledge and information can be rapidly operationalised and used to backstop understanding of issues emerging during a response (Bedford 2014a). For example, one brief focused on key considerations about food insecurity, the migration of men and youth for work and the implication these movements may have for the Ebola response and another on the flow and control of money in relation to the Ebola response and gave recommendations to UNMEER (Bedford 2014a and Bedford 2014b).

Safe and dignified burials (SDB)

The importance of SDB as an integral part of reducing the transmission of Ebola and stopping the outbreak was significant, but not well understood. The Red Cross and collaborative partners therefore conducted research to determine what impact safe and dignified burials had on the epidemic. A report by Johnson and Bedford (2015) summarises the anthropological component of the research. Focusing on the work of the National Societies of Sierra Leone, Liberia and Guinea, the study used anthropological methods to assess the impact of safe and dignified burials in the West African Ebola epidemic as understood by frontline responders (e.g. burial teams and social mobilisers) and Ebola affected communities themselves (particularly 'hotspot' communities). Understanding and documenting these perceptions and experiences is key in contributing to 'good practice' (Johnson and Bedford 2015).

The greatest numbers of Ebola cases in Sierra Leone were found in villages in Mende-speaking areas. Funerals are known to be a factor in communicating Ebola. The corpse is often still highly infectious. Cases have been reported in which the virus has been transmitted to mourners at funerals and especially to those involved in preparing the body for burial (Grant, 2014). Thus, it is important to understand Mende village burial practices (Richards et al, 2014; http://www.culanth.org/fieldsights/590-village-funerals-and-the-spreadof-ebola-virus-disease), and burial practices in Sierra Leone generally. However, such practices are not standardised, are likely to change as social responses to Ebola evolve, and therefore need to be discussed on a locality by locality basis (Fairhead, 2014, briefing). The region has many religions, Christian, Muslim and ancient indigenous religious practices. Burial should be respectful of all. Fairhead's paper, '*The significance of death, funerals and the after-life in Ebola-hit Sierra Leone, Guinea and Liberia: Anthropological insights into infection and social resistance*', goes into this in more detail than is possible here.

Anthropology suggested several behaviour changes to reduce Ebola infections from burial, for example, a behaviour change which may be possible is: 'In certain regions (e.g. Sherbro) women may be conveyed to their natal homes to be buried. Importantly, however, when a death occurs away from home and the body could not be brought back, the stone (or similar) can be taken from the actual tomb and brought to the native village so the deceased can be integrated with their ancestors. Such a tradition enables one to avoid moving actual bodies home, and such a

ritual might be significant in addressing properly the burial of some Ebola victims away from home. A similar item for a deceased woman might be placed on the altar of the women's cult' (Fairhead, 2014).

'The bottom line is that even with rituals, people are more flexible than they are normally given credit for. During the war in Sierra Leone, many ordinary rituals, from initiations to funerals, were interrupted, and people either performed "place-holder" gestures promising a fuller treatment when the war made it possible, or skipped them altogether until it was safe to hold these ceremonies. I don't see why the same would not happen with Ebola. I do think there would be serious resistance to cremation in Sierra Leone, and have no idea why this solution was introduced in Liberia' (Mariane Ferme, quoted in Grant, 2014, page 8). This was later confirmed in Johnson and Bedford (2015) where they conclude that community participants were clear that the end of cremation and the corresponding opening of the Disco Hill safe burial site was a driving force in the acceptance of burial team interventions, and encouraged people to stop hiding bodies. The recommendations of this report also show how anthropology contributed to the success of this approach.

This is also confirmed by James Fairhead, in his paper. 'Ebola is not the only factor to cause deviation from "correct" burial procedure. Security concerns were a disruptive factor during the civil war, for example. A person may die in an accident or far from home and have to be buried at once. There are established procedures to compensate dereliction and to assuage guilt in such cases. Matters might be corrected by compensating rituals intended to guard against the anger of the dead' (Fairhead, 2014).

Zika

Perhaps because of learning from their role in the Ebola epidemic, anthropologists have also been involved as part of the international response to Zika. For example, anthropologists worked with the World Health Organisation (WHO) and other agencies to support the coordination of social science. There is lots of ongoing work focusing on care and support to children, their families and communities affected by Zika. For example, Hannah Kuper at the Centre for Evidence in Disability at the LSHTM is leading a Wellcome funded project applying a socio-cultural lens in their training of trainers for ongoing care of children with neurological complications from Zika (http://disabilitycentre.lshtm.ac.uk/joint-seminar-the-zika-babies-what-do-we-know-and-what-should-be-done-tuesday-july-26th-at-5-30pm-followed-by-drinks-reception/).

Social Science in Humanitarian Action
http://www.socialscienceinaction.org/

The Social Science in Humanitarian Action: A Communication for Development Platform 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 the social and communication dimensions of emergency responses. It focuses on:

- Building on a long and successful history of anthropological engagement in health emergencies – within and beyond WHO

- Mobilising long-term knowledge in real-time, through highly-accessible briefings, syntheses, helpdesk, backstopping

- Expanding and connecting networks (European, US and IRD/West African Ebola networks; professional associations)

- Working with locally-based anthropologists (some)

- Engaging with field-based operations and agencies – enhancing 'community' respect and dialogue, interaction

- Informing high-level policy and strategy (UK SAGE Anthropology and Social Science sub-committee, WHO Science Committee; Community Care Centres, Burial protocols)

- Creating a quality, authoritative, anthropological community of theory and practice, engaged interactively with health emergency policy and operations

Medical humanitarianism

Recently, anthropologists have become more involved in medical humanitarian situations as scholars, consultants and humanitarian practitioners. In 2012 a poll on anthropology, health, and humanitarian practice in which 75 anthropologists discussed their experiences was conducted. The aim was to move beyond the existing anarchy of individual voices in anthropological writing and gain an aggregate view of the perspective of anthropologists working in medical humanitarian contexts. Responses lead to six inductively derived thematic priorities. The findings illustrate how anthropologists perceive medical humanitarian practice; which aspects of medical humanitarianism should be seen as priorities for anthropological research; and how anthropologists use ethnography in humanitarian contexts (Abramowitz. S. and C. Panter-Brick, Eds. 2015).

Anthropology was essential in HIV prevention, support and care in many countries.

Pauline Oosterhoff used medical anthropology and action research to develop a mother centred prevention of mother to child HIV transmission (PMTCT) program in Vietnam; starting with 4 HIV positive women it grew out to a national network, changed policy and won many awards (Oosterhoff 2008, 2009). Core anthropological insights were that loss of face prevented women who felt at risk from asking for a HIV test, and providers from asking or proposing it as they did not want to embarrass women (Oosterhoff, 2008, 2009). They proposed opt-out testing when that was still seen as a Vietnamese state sanctioned human rights violation. Another idea was that motherhood is culturally a double edged sword – while it is a burden with many obligations women can also claim political rights by motherhood. NGO and group meeting were illegal and needed a lot of permissions in Vietnam, so they said this was a mothers group. In Vietnam – a socialist place – all mothers have the right to raise their children into productive, healthy Vietnamese citizens, they argued that therefore these mothers need to live and access care. They mobilised nationalist and Confucian views of motherhood to change organisations, families and care arrangements (Oosterhoff 2008, 2009).

There is more about this project in the 'Lessons Learned' section. There are other examples from the HIV world as well (for example see Ginny Bond and Shelley Lees at LSHTM). One project focuses on the key to the success of a HIV combination prevention strategy, including

galvanising the current push to roll out universal test and treat (UTT), being the involvement and buy-in of the populations that the strategy aims to reach. Drawing on the experiences of engaging with 21 communities in Zambia and South Africa in the design and implementation of a community-randomised study of combination HIV prevention including UTT, this research reflects on the commitment to, approaches for and benefits of involving communities. Key lessons learnt include that all communities require continuous community engagement (CE) and engagement needs to be adapted to diverse local contexts. Intrinsic goals of CE, such as building trusting relationships between study stakeholders, are necessary precursors to instrumental goals which strengthen the research quality. Engaging the community for combination prevention requires that CE successfully bridges science and real life, paying attention to influences in the wider social landscape (Simwinga et al, 2016). Another study focused on women involved in transactional sex (Lees et al, 2014).

Childhood disability in Malaysia

A mixed-methods study was conducted to explore the knowledge, attitudes and perceptions associated with childhood disability in Malaysia (Moore and Bedford, date unknown). This is an example of the use of formative research in a stable environment for broader development work. Key to this project was the inclusion of children and youth with and without disabilities, using creative and participatory methods. The project was able to capture the voices of children with and without disabilities and include examples of their lived realities in the reporting. The research is being used by the UNICEF country office in the development of their new country strategy.

UNICEF Malaysia commissioned the study to expand national understanding of community perceptions of disability, and provide an evidence base to inform communication for behaviour and social change that addresses the root causes of stigma and discrimination as experienced by children with disabilities and their families. The study had four core objectives: i) to assess the knowledge, attitudes and practices of society towards children with disabilities, children with disabilities themselves, and their peers without disabilities; ii) to assess the life satisfaction and perception of children with disabilities towards their own impairment and that of their peers with disabilities; iii) to analyse the root causes of stigma and discrimination faced by children with disabilities, and the drivers of the current attitudes; iv) to establish a baseline to inform future interventions and strategies in communication for behaviour and social change. In focusing on knowledge, attitudes and practices, this study has provided new empirical evidence about children with disabilities in contemporary Malaysian society. Findings should be used by UNICEF and other partners to inform programme design and communication strategies to support the Malaysian government to systematically address issues of inclusion, and to promote the rights of children with disabilities as part of Vision 2020 (Moore and Bedford, date unknown).

Preventable child death in Mongolia

In Mongolia, formative research was undertaken by Anthrologica on preventable child death and was tasked to provide key evidence to help shape UNICEF's Communication 4 Development (C4D) strategies in-country. For this project, Anthrologica was awarded the 'Best of UNICEF Research 2014' (Johnson and Bedford 2013). The research identified barriers that prevented communities adopting healthy behaviours and identified best practices to support communities to seek care. This research should be operationalised and used to inform programme design and

communication strategies and will also be used in an in-country workshop to develop C4D strategy.

World Food Programme (WFP)

A four-country project focusing on adolescents and adolescent nutrition is currently being conducted with the WFP. This examines different definitions of adolescence (biological, socio-cultural markers), with a specific focus on nutrition for adolescent girls in relation to the Sustainable Development Goals (SDGs). This is a good example of how an agency that has not done much formative research before is starting to engage with social scientists and anthropologists at both policy and programmatic levels. The data is being widely shared with other international and national stakeholders, and particularly in two of the countries, Kenya and Uganda, is being absorbed by the government (anthrologica.com).

Gender inequality

The report, '*An Equal Start*', presents evidence on the impact of gender discrimination on child mortality and maternal health (Save the Children 2011). It adds an important dimension to the global debate on how to reduce child and maternal mortality. Unless the unequal status of women is tackled, further efforts to reduce maternal and child mortality are likely to be undermined. Failing to tackle gender discrimination is already resulting in lives being lost unnecessarily, economic potential wasted and progress held up. Research presented in this report suggests that, although child mortality is on the decline, gender disparities are increasing. More girls than boys are dying during childhood, and the gap is widening. This report demonstrates that gender inequality affects child survival through discriminatory practices like foeticide and infanticide. Gender inequality also perpetuates systematic discrimination against women and girls in a number of other ways that contribute to child and maternal mortality. It limits their livelihood options, leads to greater social exclusion and poverty, and denies them a voice and marginalises them in national governance and the global political economy. These symptoms of gender inequality limit women's power in society and in the home, and can lead to discriminatory practices, such as son preference, and child and maternal malnutrition. They also compromise women's and girls' bargaining power and physical integrity, and their equitable access to available, appropriate and good-quality healthcare services. An Equal Start challenges organisations to place women and girls at the centre of their work, and to break the cycle of discrimination.

3. Lessons learned

Mass drug administration for neglected tropical diseases

It has been claimed that international and governmental actors largely ignore anthropological findings, unless those findings coincide with existing policy. One striking example of this is that work by anthropologists on mass drug administration for neglected tropical diseases (NTDs), has revealed that the strategies adopted over the past ten years are failing in many places and for several diseases (notably schistosomiasis and STHs) (Allen and Parker, 2016; Parker and Allen 2014). The Cochrane review process of randomized control trials (RCTs) has confirmed the anthropological findings, but often the evidence is still ignored in programming.

Large amounts of funding have been assigned to the control of NTDs. Strategies primarily rely on the mass distribution of drugs to adults and children living in endemic areas. The approach is presented as morally appropriate, technically effective, and context-free (Parker and Allen 2014). Drawing on research undertaken in East Africa, a recent journal article discusses ways in which normative ideas about global health programs are used to set aside social and biological evidence (Parker and Allen, 2014). In particular, there is a tendency to ignore local details, including information about actual drug take up. Ferguson's 'anti-politics' thesis is a useful starting point for analysing why this happens, but is overly deterministic. Anti-politics discourse about healing the suffering poor may shape thinking and help explain cognitive dissonance. However, use of such discourse is also a means of strategically promoting vested interests and securing funding. Whatever the underlying motivations, rhetoric and realities are conflated, with potentially counterproductive consequences (Parker and Allen, 2014).

Another study by the same authors drew on field research in Uganda and Tanzania, and engaged with both biological and social evidence to show that assertions about the effects of school-based deworming are over-optimistic (Allen and Parker, 2016). The results of a much-cited study on deworming Kenyan school children, which has been used to promote the intervention, are flawed, and a systematic review of randomised controlled trials demonstrates that deworming is unlikely to improve overall public health. The article also shows that 'confusions arise by applying the term deworming to a variety of very different helminth infections and to different treatment regimes, while local-level research in schools reveals that drug coverage usually falls below target levels. In most places where data exist, infection levels remain disappointingly high. Without indefinite free deworming, any declines in endemicity are likely to be reversed. Moreover, there are social problems arising from mass drug administration that have generally been ignored. Notably, there are serious ethical and practical issues arising from the widespread practice of giving tablets to children without actively consulting parents. There is no doubt that curative therapy for children infected with debilitating parasitic infections is appropriate, but overly positive evaluations of indiscriminate deworming are counter-productive' (Allen and Parker 2016, page 1).

In 2004, Miguel and Kremer were more moderate in their claims about deworming on schooling than has sometimes been suggested. They mentioned potential problems arising from school-based deworming in the discussion of their results. Drawing on insights from anthropologists and other social scientists, as well as biomedical researchers, they emphasised the importance of social learning and other behavioural factors influencing the uptake of medications (Miguel and Kremer 2004).

They emphasised the hazards of generalising findings from one social group to another (Kremer & Miguel, 2007). They found that families outside of the trial group, but friendly with families in the trial group, were less likely to deworm their children than families who were not friendly with those who had been part of the initial control group. Thus, contrary to external expectations, adults did not necessarily perceive treatment as beneficial for their children's health and well-being, and they were not necessarily willing to let their children participate in school-based treatment programmes. They also found that a school-based health education intervention had no discernible impact on worm prevention behaviours and that requesting a small payment for drugs (in 2001) led to an 80% reduction in treatment rates. This, in turn, suggested that school-based treatment had not created a demand for treatment. The purported benefits of deworming were not locally appreciated, and commitment to de-worming in the population was low. They

concluded that reading too much into their earlier results gave an 'illusion of sustainability' (Allen and Parker 2016).

Lessons learned from anthropology and HIV project

Oosterhoof (2009) examines some of the challenges and opportunities of combining the roles of a health professional and a medical anthropological researcher, based on the author's experiences combining PhD action research with management of interventions on prevention of mother-to-child transmission of HIV in Vietnam.

She examines the opportunities and the challenges of these dual roles to resolve three distinct anthropological dilemmas: 1) the friction between insider and outsider perspectives; 2) maintaining distance as opposed to being involved; and 3) non-intervention versus intervention. In this case, a combination of roles was efficient. Using existing rules, procedures and structures of the program had various important practical, methodological and ethical advantages. The dual role allowed for efficient integration of research findings into improving program performance and for developing realistic and evidence-based policy recommendations that resulted in a new national policy that acknowledged the rights of HIV-positive mothers to receive treatment and support (Oosterhoff 2009).

The importance of anthropology can be seen when looking at how understanding the social context of the country can affect whether or not people seek treatment. In 2003 when Oosterhoff started to assess the needs and gaps in HIV/AIDS programs in Vietnam, she learned that most women were infected by injecting drug users (IDUs). Both drug use and HIV infection are socially stigmatised. Health workers often could not contact HIV+ women after a positive test result because they had given a false address. Doctors mentioned that women with severe AIDS just refused to stay in a hospital bed for fear of being seen; in the matrilineal and patrilocal structure of the Vietnamese family these women seemed to sacrifice themselves to save the face of their families, and died alone (Oosterhoff 2009).

She conducted a collective participatory action research way of using and constructing medical anthropological knowledge in a well-funded program and a national context where free antiretrovirals (ARVs) became available. It is important to mention this because these ARV must be available in order for a medical anthropologist to figure out how to get universal access, you need both the medicines and the insights (Oosterhoof 2008, 2009).

Together they did change a policy in which women were seen as vessels with no rights to ARV themselves (they were given a shot of ARV before and after delivery) into one where they kept women alive in order for them to enjoy the right to raise their children and kids to be raised by their own mother (Oosterhoff 2008,2009).

Community based management of acute malnutrition (CMAM)

Despite significant changes in operational context over recent years, there remains great potential for CMAM to exert huge impact on the health and wellbeing of children worldwide, particularly through its integration into national health systems as part of routine child health services. A key theme behind current challenges and critical in effectively moving forwards is a renewed focus on community engagement as the foundation of CMAM. Engagement with the community should be participatory, inclusive, equitable, reciprocal, creative, continuous, accountable and transparent. It must be adapted to a local context in a way that inspires ownership, empowerment and shared responsibility. At the same time, strong commitment at local, subnational, national and international levels needs to be structured through relevant policy and broader community health system strengthening strategies that are informed by health

systems analysis, including root cause analysis. These measures combined with ongoing analysis and sharing of promising practices, will help to ensure the feasibility and sustainability of CMAM (Grey et al, 2014).

Lessons from the Ebola epidemic

At the height of the crisis, the global anthropology community was essentially watching events unfold and concerns continued to rise as reports from the field documented patients "getting lost" in the chaotic health systems, disregard for local burial practices, human rights violations in quarantine, repeated "lock-downs," and increased securitisation and military interventions (Abramowitz and Bedford, 2016). A recent report writes that '*the representation of African populations was frequently dehumanising, and global debates about 'closing' the region aroused xenophobic reactions in the United States. Many anthropologists received phone calls from both national and international journalists, and were asked to talk about "traditional" funerary practices and customary attitudes towards burials, as well as security issues, the involvement of US troops, and border closures. In what may be an indication of anthropology's challenges in communicating with the media and the public, enquiries were frequently unaware of the research on African national health systems, humanitarianism, and security issues that anthropologists had been engaged in for decades*' (Abramowitz and Bedford 2016, page 3).

Anthropologists struggled to share their insights with the public, the media, their governments, and humanitarian organisations. Individually, anthropologists found their way to the table in various capacities. However, there was also a sense that the collective contributions of past and present anthropologists were not being fully utilised. The Emergency Ebola Anthropology Initiative and related networks created 'an agile, virtual think-tank that had the short-term capacity to rapidly respond to the Ebola outbreak' (Abramowitz and Bedford 2016, page 2). Their ability to identify, assess, aggregate and translate local information into strategically relevant data, provided governments, agencies and national and international NGOs with the tools to forecast how culture, context and local capacity were likely to impact their policies and humanitarian assistance at specific points in the response and over time. Its role was to negotiate and mediate between different types of knowledge and different types of stakeholders, but their activities benefited from the scholarly independence that surrounded the network and gave credibility to anthropologists' engagement in the response. In the tradition of public anthropology, the formation of the network also encouraged American anthropologists to be public intellectuals (Abramowitz and Bedford, 2016).

Abramowitz and Bedford's report documents anthropologists' global engagement with the Ebola response, and locate roles and experiences within these efforts. They provide a personal narrative account detailing how the Ebola Emergency Anthropology Initiative was established, and document the achievements, limitations and lessons learned in creating an agile anthropology network to respond to the West Africa Ebola outbreak.

Wilkinson et al (2017) wrote that the lesson from the Ebola epidemic is that understanding social dynamics is essential to designing robust interventions and should be a priority in public health and emergency planning. A critical step is to begin with a more realistic account of local social relationships. Including anthropologists with specialist knowledge of people and contexts in policy formation and implementation can assist this process. A 'one size fits all' approach and public meetings with supposed key stakeholders is not enough. To achieve the post-Ebola aims of a trusting public and strong resilient health systems, more nuanced approaches are needed which

are sensitive to how social, political and economic interests interact in policy processes and local settings.

Other authors have focused on the issue that given the available anthropological knowledge of a previous outbreak in Northern Uganda, it is surprising that so little serious effort was made this time round to take local sensibilities and culture into account. The "first mile" problem is not only a question of using local resources for early detection, but also of making use of the contextual cultural knowledge that has already been collected and is readily available. Despite remarkable technological innovations, outbreak control remains contingent upon human interaction and openness to cultural difference (DeVries, 2016).

Further comments include:

Networks and platforms of applied anthropologists are key and several of those were made available in the 2014 – 16 West Africa Ebola outbreak…. this approach was appreciated by Governments, the UN system, civil society and donors. It contributed to the social and emotional intelligence of the response, helping with the establishment of interventions perceived, by people at risk, as both rational and acceptable; and perceived by the responders as meaningful and achievable. The approach has helped the identification of priorities for the building of more resilient health systems, governance and society. It is inevitable that applied and adapted anthropological capabilities will be in greater demand in infectious disease outbreaks and many other situations to come (Open letter January 24th 2016 from David Nabarro: United Nations Special Envoy on Ebola August 2014 to December 2015).

Many of our witnesses emphasised that establishing the Ebola Anthropology and Social Science sub-Group of SAGE was "extremely important in controlling [the] outbreak". Professor Chris Whitty described social science as "important in almost every aspect of what we did" in West Africa. This included understanding the "history of inequalities and economic policies that left people distrustful of foreigners and the state in many areas" as well as the "social routes", such as burial practices, through which Ebola was transmitted (Report of the UK Parliamentary Science and Technology Committee 'Science in emergencies: UK lessons from Ebola' Inquiry, https://publications.parliament.uk/pa/cm201516/cmselect/cmsctech/469/469.pdf).

UK Government Chief Scientist cited ERAP in calling for mechanisms to integrate social science and interdisciplinary evidence into a wide range of global challenges, from health and economy to climate change (https://www.timeshighereducation.com/opinion/policy-needs-social-science-and-humanities-input).

Lessons learned from developed countries

Systems change is necessary for improving health care in the United States, especially for populations suffering from health disparities. Theoretical and methodological contributions of anthropology to health care design and delivery can inform systems change by providing a window into provider and patient perceptions and practices. Community-engaged research teams conduct in-depth investigations of provider perceptions of patients, often uncovering gaps between patient and provider perceptions resulting in the degradation of health equity. They present examples of projects where collaborations between anthropologists and health professionals resulted in actionable data on functioning and malfunctioning systemic momentum toward efforts to eliminate disparities and support wellness (Hardy and Hulen 2016).

Among necessary changes to address barriers are the needs for providers to obtain information on how patients understand their messaging, how to more effectively connect with patients in short visits, and how to recognise patient bodies as entities inhabited by agents who have the ability and desire to make changes in their lives. In searching for the positive changes in behaviour that patients may choose to make, and finding out what it is they do already know about health, providers can increase trust and the "leg work" they need to be advocates for closing vast inequities in health. It may also be the case that physicians themselves, who are suffering from displeasure with their jobs, may benefit from exploring their own resilience practices and knowledge to understand the ways that their patients may be unable to change, or successes in how they can change to obtain a healthier life. It is in this area of learning that anthropologists and healthcare scholars and providers may choose to work together to develop and provide collaboration and training for closing the gaps in between (Hardy and Hulen 2016).

One previous review from the UK has synthesised evidence regarding the effects of interventions to improve healthy eating, physical activity and smoking behaviours amongst low-income groups, finding a positive but small effect on all three behaviours (Bull, Dombrowski, McCleary & Johnston, 2014). This systematic review with meta-analysis of randomised controlled interventions to improve the diet, physical activity or smoking behaviour of low-income groups found small positive effects of interventions on behaviour compared with controls, which persisted over time only for diet. Despite research highlighting the urgent need for effective behaviour change support for people from low-income groups to assist in reducing health inequalities, this review suggests that current interventions for low-income groups are positive, but small, risking 'intervention-generated inequalities'. Policy makers and practitioners alike should seek improved interventions for disadvantaged populations to change health behaviours in the most vulnerable people and reduce health inequalities (Bull, Dombrowski, McCleary & Johnston, 2014).

Reframing the question

It is also important to note that anthropological data has also been useful in reframing the questions and therefore solutions under consideration. Rather than always providing an 'innovation' (which is often required for political economic reasons) anthropology often produces counterpoints to existing framings which means often research shows that something might be best off *not* done. This is frustrating to policy makers who want a solution in the form of an innovation. So, often end up finding health initiatives are 'poor investments' as they do not address the 'upstream factors' that cause particular problems that are trying to be solved, and also these initiatives/innovations may themselves contribute to existing problems – in other words the problem definition was problematic in the first place (Chandler, 2017).

4. Examples from socially-conservative settings

Horn of Africa

The drought in the Horn of Africa and the protracted conflict has created a humanitarian emergency that has led to a declaration of famine in several Somali regions. The most affected is South Central Somalia, but the south-eastern Somali region of Ethiopia is also affected as are easternmost districts of Somaliland and Puntland. As a result of depleted

water resources, widespread internal displacement, malnutrition and inadequate water and sanitation facilities, cholera outbreaks have occurred in regions South Central Somalia and in the south-eastern Somali region of Ethiopia (Ripoli, forthcoming).

Key insights into behaviours and practices related to cholera transmission include that behaviours are a product of structural vulnerabilities – lack of water and sanitation infrastructure and lack of access to health services are the main culprits. Other key insights include:

- There should be hand washing facilities close to latrines and soap should be made available; there is a need to incorporate ablutions into prevention interventions
- Washing bodies in funeral rites can spread disease
- Open defecation due to lack of latrines is practised, especially in the case of nomads and IDPs, with gender specific challenges
- Risk of drinking 'sweet' water from rivers after the rains
- Somalis use Oral Rehydration Solution (ORS), either home-made or purchased
- People see the value of human vaccination, and campaigns which adapt to livelihoods are advised, for example provision through transit points for pastoralists, linked to livestock vaccinations, and at a regional, rather than national level
- Lessons from other countries suggest including the humanitarian response into the epidemiology and acknowledging risks of cholera narratives to reproduce class, gender and ethnic divides

Investment aspects need to be addressed otherwise any successes in behaviour change will be short-lived and ineffective in controlling cholera.

Angola

Formative research was conducted in Angola on birth registration (Gray and Bedford, 2016). Angola is a complex setting, and this mixed-methods study focused on birth registration in the broader sense, as a social protection, health and education issue. This was used by the UNICEF country office to build advocacy work to increase registration and was part of a greater push towards increasing birth registration in sub-Saharan Africa. A publication that summaries the key research findings and how these were used in the programme is being drafted.

This research provides new empirical data that contributes to understanding of knowledge, attitudes and practices about birth registration in Angola, and related barriers and enabling factors. The report is structured to be of operational use to UNICEF and its partners at local, national and international levels. It outlines the methodology used in the study, presents a situational analysis of birth registration in Angola, and of the study sites and participants, and details the observations made at birth registration posts. The four subsequent chapters focus on: knowledge, attitudes and practices related to registration; barriers to birth registration; enablers leading to birth registration and solutions to barriers identified; and communication and collaboration. The final chapter presents the study's conclusions and recommendations (Gray and Bedford, 2016).

Somalia

Rapid qualitative research was conducted in Puntland, focusing on how to engage nomadic pastoralist communities regarding polio and polio vaccination. The research highlighted key issues and potential methods or modes of engagement, and the findings were used by the UNICEF country office to develop a tailored communication strategy. Anthrologica and UNICEF are co-authoring a publication to document the research and how the findings were operationalised in country.

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