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How the Covid-19 pandemic is increasing the need for an operational approach in health anthropology

Yannick Jaffré • Anthropologist, Emeritus Research Director at the CNRS and Scientific Director of GID-Santé (Inter-Academic Group for Development) at the Académie des Sciences-Institut de France

If there is one lesson to be learned from the Covid-19 pandemic, it is that our health systems, and entire swathes of our scientific knowledge along with them, have been overwhelmed by this eruption of reality. In this article, Yannick Jaffré explains how social sciences researchers and health stakeholders would be well-advised to work together to fill the yawning gaps. In so doing, this contribution heralds our next *Focus* to be published in July 2021 on the topic of "Research and humanitarian aid: the challenges of a collaboration."

We knew that a pandemic was coming. Since the 1980s, numerous reports and articles have scientifically analysed the biological and epidemiological dimensions[1], issues relating to cross-species transmission[2], the social and scientific worlds constructed by epidemics[3], the complexity of stakeholders' practices in the technical fields of hospital hygiene[4], and the various ways in which popular cleanliness practices and infectious risks are linked[5]. Indeed, even "the ethical problems involved in the event of a flu pandemic" were contemplated[6].

So, we knew. However, this knowledge did not result in any real scientific planning, alerts or preventive action drawing on this self-same social science research in particular.

A missed opportunity

There are several explanations for this. In all likelihood, a certain cognitive dissonance meant that "we knew, but nevertheless" we didn't really believe it would happen, thus enabling a "belief to persist, despite being contradicted by reality"[7]. In addition, while from a theoretical standpoint, social science research enables "clusters of intelligibility" to be formed – robustly documented and plausible explanations –, this research work cannot claim to attain the universal generality of experimental science[8]. Consequently, how to be sure and decide to act, taking other risks, notably of an economic nature, based

[1] Gérard Orth et Philippe Sansonetti (dir.), *La Maîtrise des maladies infectieuses. Un défi de santé publique, une ambition médico-scientifique*, EDP Sciences, coll. « Académie des sciences », 2006.
[2] Yannick Jaffré, « Les professionnels de la santé face aux nouvelles infections : ce que révèlent quelques réponses hors sujet », *in* Christian Hervé, Pascal Hintermeyer, Jacques Rozenberg (dir.), *Les Maladies émergentes et le franchissement des barrières d'espèces. Implications anthropologiques et éthiques*, Bruxelles, De Boeck Université, 2011.
[3] Frédéric Keck, « Surveiller les animaux, préparer les humains : Une ethnographie de la grippe aviaire », *in* Sandrine Revet et Julien Langumier (dir.), *Le Gouvernement des catastrophes*, Karthala, 2013, p. 73-100.
[4] Yannick Jaffré, « Anthropologie et hygiène hospitalière », *in* Doris Bonnet et Yannick Jaffré (dir.), *Les Maladies de passage. Transmissions, préventions et hygiènes en Afrique de l'Ouest*, Karthala, coll. « Médecines du Monde », 2003, p. 341-375.
[5] Eugénie d'Alessandro *et al.*, « Pandémie grippale A/H5N1 et niveau de préparation du Niger : une étude sur les connaissances des soignants et l'organisation générale des soins », *Bulletin de la Société de pathologie exotique*, 105 (1), 2012, p. 68-75.
[6] Corine Pelluchon, *L'Autonomie brisée. Bioéthique et philosophie*, Puf, 2014 [2009], p. 182.
[7] Octave Mannoni thus illustrates and materialises one of the concrete modalities of the denial of knowledge that is however intellectually accepted in his book *Clefs pour l'Imaginaire ou l'Autre Scène*, Le Seuil, 1969, p. 11-19.
[8]. Jean-Claude Passeron, *Le Raisonnement sociologique*, Albin Michel, 2006.

on what initially appeared to only be a "probable scenario", or a highly possible concern? Moreover, from a practical perspective, the actual application of the recommendations of a study to real societies involves turning research into a public health issue that warrants consi-deration – *evidence-based advocacy*[9] – and needs addressing – *evidence-based policymaking*[10]. This is without taking into account the burdensome task of securing funding, and the obligation to present findings in accordance with technocratic models far-removed from the reality on the field[11], the need for agreement from the authorities and contacts in the world of politics in order to act, the impossibility of bringing together a highly competitive development market, the multiple field trips needed, and the payment of salaries. All of this means that this research, just like so many "ambitious" recommendations formulated at countless seminars held in Africa[12], never made the leap from paper to practice.

This article does not intend, by means of an overly lenient flashback, to cheaply criticise those (including ourselves) who, often to their regret, act only on paper. Neither do we wish to focus our discussion on anything specific to Covid-19 and other emerging infectious diseases. In a broader sense, this health failing emphasises the gap between predicting, or at least intellectually analysing, a health problem, and being able to plan measures to address it.

In simple terms: how can we do better? How can research and action be better coordinated? This question is undoubtedly a little naive, but it is well-founded. In particular, it encourages us to consider a social science research stance – a practical and epistemological space – which, without sacrificing the rigour of the academic work, would be directed by a desire to have an anthropological approach focused on practically addressing health issues.

In favour of engaged social sciences

Of course, not all research can be motivated by an immediate desire to act. An accurate description of worlds in their diversity, characterisation of the tangible cornerstones (geographical, technical, climatic), emphasis of their multi-faceted nature (multiple cultures and memories, for instance), or analysis of their variations, contradictions and customs, cannot be undertaken with a "single mandatory way of thinking" or in accordance with academic procedures and topics that have been pre-defined based on an authoritarian agenda. For instance, such history-based work – apparently detached from the present – focusing on blasphemy, can sadly be seen at the heart of the debate in the wake of the January 2015 terrorist attacks in Paris. A discussion on the place of the elites and social reconfiguration in 1720 at the time of the bubonic plague in France offers specific points for considering the Ebola and Covid-19 epidemics[13]. Research undertaken to analyse links between humans and pets in France is proving useful when looking at epizootic disease in Asia[14].

Therefore, a large swathe of social science research builds up, at its own pace, a vital conceptual and documentary repository to which we can, and even "must", refer in order to look at present situations from an academic perspective – and to prevent the world from becoming submerged in ghastly prattling pitting baseless opinions against each other.

However, this subject and methodological freedom is by no means incompatible with other equally crucial but more "socially-engaged" research; research work that seeks to help address the issues of the present day, in a less delayed and random fashion. In that case, it is a question of developing a

[9] Katerini T. Storeng et Dominique P. Behague, "'Playing the Numbers Game': evidence-based advocacy and the technocratic narrowing of the Safe Motherhood Initiative", *Medical Anthropology Quarterly,* vol. 28 (2), 2014, p.260-279.
[10] Ian Sanderson, "Evaluation, Policy Learning and Evidence-Based Policy Making", *Public administration*, vol 80 (1), Spring 2002, p.1-22.
[11] François Giovalucchi et Jean-Pierre Olivier de Sardan, « Planification, gestion et politique dans l'aide au développement : le cadre logique, outil logique, outil et miroir des développeurs », *Revue Tiers Monde*, 2009/2, n° 198, p. 383-406.
[12] Yannick Jaffré, « Quand la santé fait l'article. Presse, connivences élitaires et globalisation sanitaire à Bamako, Mali », *Bulletin de la Société de pathologie exotique*, 100 (3), janvier 2007, p. 207-215.
[13] Fleur Beauvieux, « Marseille en quarantaine : la peste de 1720 », *L'Histoire*, Sophia Publications, mai 2020.
[14] Jean-Pierre Digard, « Jalons pour une anthropologie de la domestication animale », *L'Homme*, t. 28, n° 108, 1988, p. 27-58.

rigorous form of anthropology from a conceptual and methodological perspective, while also ensuring that the findings can be applied in practice, rather than concentrating on bibliographical issues and cross-disciplinary questions.

This approach to research is nothing new, and a lot of research work echoes this concern[15]. However, describing how to link academic questions to the importance of health issues, defining a method for putting forward hypotheses, while anticipating findings being put into practice, and illustrating how to enter a field by connecting one's research to that of health practitioners, seems to be a relevant way of defining a set of processes linking research to action.

Of course, we will not be looking at this vast academic and technical field in depth. However, the description of five anchor points that underpin this action-focused approach is a first step in identifying some aspects. It may also provide some guidelines for connecting up anthropological research and its implementation in specific areas. If it does not immediately achieve its goal, let's hope that it will encourage a debate for which there is a glaring need, given the current circumstances and the obligation to plan for an uncertain future.

Pinpoint the issues and make operational choices

All research topics are legitimate from an academic perspective. However, some subjects affect a large number of people. Consequently, they become issues that need addressing from a health, social and ethical point of view. In other words, even if this initial decision-making process often remains implicit, our research is always rooted in "value judgements"[16], which justify our choices.

These choices may be in keeping with the *zeitgeist* or based on debates rooted in bibliographical concerns. However, and this is the first "gear change" that we are suggesting, in our view, epidemiology seems to be a vital compass on which to base our decisions in the field of anthropology. Indeed, making use of data from quantitative disciplines, such as epidemiology, as well as demographics and bio-statistics, can help to "objectively" direct our gaze and choose topics that are connected with health priorities at times neglected by academia.

Moreover, the quantitative disciplines help identify "effective angles of attack" and target specific and pivotal issues that will improve health. For instance, from a strictly anthropological perspective, it is a legitimate exercise to describe the symbolic universes of pregnancy and birth. However, if quantitative research shows that most women give birth in healthcare facilities, rather than limiting our research work to analysing so-called "traditional" births, we should instead analyse how some popular practices interconnect with the technical fields of obstetrics and neonatology[17] and in some cases constitute "risk factors". Without taking anything away from the academic rigour of our approaches, this renewal of some disciplinary habits by medicine – a cross-disciplinary requirement in action – enables our qualitative approaches to contribute to the reduction of maternal and neonatal deaths[18].

It may also be a case of more carefully selecting the workers whose behaviour is decisive. Returning to our example, if health issues revolve more around the quality of the work done by midwives than the popular practices of traditional birth attendants, maybe it would be better, from a health perspective, to question the quality of the work done by the professionals who alone are able to address essential medical issues (transfusions and caesarean sections), rather than topics that are less technically decisive for the care of women in labour.

The same issues arise with regard to primary and secondary prevention of pandemic risks. And the

[15] Examples from the 1950s onwards include the work of Georges Balandier or Jacques Berque in political anthropology, and Jean Benoist in the field of health.
[16] Paul Ricœur, *Histoire et vérité*, Seuil, 1955, p. 26.
[17] We are notably referring to the special issue of *Santé publique* devoted to Neonatal Health in Sub-Saharan Africa (2020).
[18] Roch Houngnihin, Françoise Jabot et Alain Prual (dir.), « Santé néonatale en Afrique subsaharienne. Regards pluriels », *Santé publique*, vol. 32 (hors-série), 2020.

current situation invites us to do this more than ever. Consequently, when vaccination campaigns are being envisaged, one of social sciences' tasks is to gather information on the social constructs that underpin prevention in society (locally given names, causal interpretations, fears and rumours about the disease and its treatments, popular remedies, etc.). However, it can, and in some cases must, support the "rollout" of these vaccination campaigns, documenting the difficulties, and comparing them with similar regularly implemented campaigns (such as measles and meningitis) to study the empirical solutions applied by those involved to address the difficulties on the ground. In a more general sense, the social sciences help analyse the way in which health decisions are inevitably "deconstructed" and reconstructed by diverse institutional (staff allocation, choice of teams), resource (availability of refrigerators, vehicles, etc.), and social (popular understanding of the disease, fears, regularity and understanding of appointments, etc.)[19] factors. All of these "bottom-up" questions will be vital to the coherent rollout and evaluation of Covid-19 vaccination campaigns.

Indeed, the choice of research topics with a certain operational focus – obstetric care, rapid malaria screening[20], improving information and vaccination campaigns, and so on – in no way waters down the rigour of the research. These choices simply direct our research to discuss factors that determine the quality of health systems, and, among them, the modifiable factors involved in the various care and prevention configurations.

"What can we do right now in this situation?" is undoubtedly the most widely heard phrase in times of crisis. This is a crucial question. Of course, this desire to be pragmatic varies in accordance with the fields and can be combined in different ways depending on the topics in question. Therefore, logistics and cold chain problems can be anticipated by using tools from anthropology of techniques: analysis of usage, maintenance longevity[21]. Even if it is impossible to prevent "unplanned pregnancies", we can at least improve the service delivered to young single girls in obstetrics departments, and in this way reduce the impact of social censure on the obstetrical risks already involved. In the field of chronic pathologies – sickle-cell anaemia, cancer, cardiac complaints, etc. – we could optimise care by reducing condition and treatment-related pain. We could better coordinate in-patient stays and everyday settings (economy, work, education). Or we could help to consider palliative care and "care for the carers" who have to cope with the tragic nature of life[22]. Whatever the health field, this interdisciplinary analysis enables our research to be linked with quantitative and/or technical approaches, and initiatives that fit local contexts to be launched.

However, none of these initiatives are possible unless they engage with the staff who will be heading these programmes. What are their demands and their experiences? Listening to them involves recognising them. Recognising their empirical knowledge and drawing on their experiences of delivering care also enables researchers to work "horizontally" in collaboration with them. Therefore, studying children's experiences of disease or socio-technical constructs of pain in conjunction with a clinic, teams of paediatricians and nursing staff obviously enables these topics, which are key for our discipline, to be anthropologically researched. However, by bringing children to the fore, this approach also helps improve the quality of paediatric care[23]. Likewise, returning to the field of pandemics, how can we hope to improve care without first understanding the behaviour and emotions felt by healthcare staff when faced with uncertainty and risk[24]?

From a methodological perspective, this "bottom-up" approach focusing on issues experienced by staff

[19] Henintsoa J. V. Ramaroson et Dolorès Pourette, « Perception des vaccinations de routine et de masse par les mères. Cas du fokontany de Namahora, région Menabe », *in* Dolorès Pourette *et al.* (dir.), *Femmes, enfants et santé à Madagascar. Approches anthropologiques comparées,* L'Harmattan, coll. « Anthropologies & Médecines », 2018, p. 173-184.
[20] S. Faye, « Améliorer la prise en charge du paludisme par les tests de diagnostic rapide (TDR) : appropriation par les prestataires et bénéficiaires de soins au Sénégal », *Bulletin de la Société de pathologie exotique*, 105, 2012, p. 237-244.
[21] Myriem Naji and Laurence Douny, "Editorial", *Journal of Material Culture*, 14/4, 9 December 2009, p.411-432.
[22] Yannick Jaffré (dir.), *Enfants et soins en pédiatrie en Afrique de l'Ouest*, Karthala, 2019.
[23] Hélène Kane, *Anthropologie de la santé infantile en Mauritanie*, L'Harmattan, 2018 ; Abdoulaye Guindo, « D'un service à un autre », *Émulations – Revue de sciences sociales*, n° 27, 2019, p. 79-96 ; Yannick Jaffré (dir.), *Enfants et soins…, op. cit.*
[24] Lise Rosendal Østergaard, « Ebola vu de loin : les agents de la santé face au risque et à l'incertitude dans les campagnes du Burkina Faso », *Anthropologie & Santé*, n° 11, 2015, http://journals.openedition.org/anthropologiesante/1833

helps to give a "socio-emotional depth" to health professionals and to highlight their "tricks of the trade": the ways in which they problem-solve without waiting for external help. For example, some staff club together to buy medicines for the needy, while others use their mobile phones to distract children undergoing treatment and use nicknames to joke around and consequently reassure their young patients. All of this may seem purely anecdotal. However, identifying these instances in which the human being takes over from the professional, enables researchers not to base their work on figures on organisational charts, sort of handy fictional public healthcare characters, but instead, by fleshing out and highlighting health staff's sensibilities, analyse their behaviour in light of their plural identities and behaviours.

Of course, the wider issues are not forgotten (salaries, outdated equipment, social and status inequalities, State failings, etc.). But pragmatically the question being asked is not so much the influence of social factors on action, but what it is possible to do locally despite these conditions. In these contexts, it is important to analyse the leeway enjoyed by workers faced with these issues: "If we perceive actions […] as choices made in light of the constraints, the core question is no longer that of the application of standards defined in the abstract, but that of the leeway enjoyed by the subjects within a social sphere with vague contours", in the highly accurate words of Alban Bensa[25].

In practical terms, some care professionals or care facilities devotedly do what others refuse to do. For want of a "regular" and homogenous expert system, the local level is vital, and in many cases the anthropologist observes discrepancies between the standards adhered to in some departments, and a failure to adhere to them in others faced with the same socioeconomic issues. Consequently, and in many ways, the anthropological approach based on "actor perspectives"[26] echoes health concerns, emphasising the importance of local initiatives.

Determine circumstances and develop effective interdisciplinarity

Each pathology – notably emerging infectious diseases – develops specific interfaces between medical advice and the social dimensions. In fact, health topics are always specifically linked to wider social issues: fertility, sexuality and religion; paediatrics and the status of children; chronic illnesses and intergenerational links, viruses and contact with animals. A health initiative always involves issues that are differently defined depending on the context.

It falls to anthropology to map these social and medical ramifications, by using differences of scale. Anthropology helps health initiatives to link their aims with precise configurations and to determine the socio-technical circumstances which enable pathologies to develop locally, or, on the other hand, enable them to be eradicated.

Therefore, combatting fevers and malaria involves at once research focusing on entomological data, comparative epidemiology on variable prevalence depending on the location and practices, on mosquito net usage techniques, and of course qualitative research on rapid detection tests methods, and semantics research on attitudes towards fevers. Likewise, combatting emerging diseases[27], such as some diarrhoeas and cholera epide-mics, involves undertaking investigations with hydraulic engineers on water usage, working with vets on contact with animals[28], and architects and town planners on healthy urban areas. In other areas, the focus will be on the role of technical equipment and its maintenance in hospital settings: incubators, ultrasound scanners, X-rays, drugs[29], or health programme infrastructure

[25] Alban Bensa, *La Fin de l'exotisme. Essais d'anthropologie critique*, Anacharsis, 2006, p. 188.
[26] Norman Long, *Development Sociology. Actor Perspectives*, London and New York, Routledge, 2001.
[27] Serge Morand et Muriel Figuié, *Émergence de maladies infectieuses. Risques et enjeux de société*, Éditions Quæ, 2016 ; Frédéric Keck, « Surveiller les animaux, préparer les humains : Une ethnographie de la grippe aviaire », art. cit.
[28] Muriel Figuié, « L'action collective face au défi des zoonoses émergentes », *in* Serge Morand et Muriel Figuié, *Émergence de maladies infectieuses…*, *op. cit.*, p. 79-104.
[29] Alice Desclaux et Marc Egrot (dir.), *Anthropologie du médicament au Sud. La pharmaceuticalisation à ses marges*, L'Harmattan, coll. « Anthropologies & Médecines », 2015.

(vehicles, repairs, tyres, petrol coupons)[30].

From a methodological perspective, meeting these specific health needs requires us to undertake rigorous social anthropology with the aim of developing, by the very fact of the accuracy of the empirical indexation of the hypotheses, "a methodologically manageable micro-system of links between data"[31].

In a practical sense, each of these socio-pathological circumstances requires our research to scour and gather information from interdisciplinarities far-removed from our usual academic relations. From this operational perspective, there is always a need to tackle each of the research topics based on the polysemy of its usages: its technical characteristics (mechanical operation, cognitive understanding, ergonomic and physical constraints, economic availability, etc.), just as much as social semantics, moral practices and affects that influence use (choice of healthcare beneficiaries, selective professional and ethical conduct, social interpretations of effectiveness, practical standards, etc.). In the simplest possible terms: it is not enough to list equipment (ventilators, syringes or drugs), instead, we must analyse how this equipment is actually used, based on practical rationale and ethical choices.

From this operational perspective, namely real life, the aim is not to incorporate it into a few wide-ranging categories that supposedly explain the diverse range of situations observed. Instead, it is a question of highlighting the complex factors that constrain situations and how healthcare staff act, whether from a technical, logistics or medical ethics standpoint.

Target "what can be changed" and the low-key deciding factors

Health anthropology is a holistic discipline with an extremely broad scope in order to understand the reasons behind a health phenomenon or explain what underpins disease-related behaviour. However, if this largely exploratory aspect is vital for understanding the health of a population or the behaviour of individuals affected by a disease, it does not necessarily result in initiatives that would improve the observed situation. Sadly, understanding does not actually mean being able to take action.

Indeed, "taking action" involves analysing how the problems develop in practice and shifting our attention from the direct medical causes of mortality and morbidity to the principles underpinning the behaviour of those who develop these risks. Finally, it becomes possible to identify how action can be taken to address some of the behaviours. For example, asphyxia and infections are some of the leading causes of neonatal mortality, and analysis of deaths shows that they are mainly caused by mistakes made by medical staff. However, the errors are in turn explained by a certain relationship with their profession and the status of the child. Therefore, taking action will involve following these threads of "low-key" causalities and tackling these issues with healthcare staff[32].

Not everything is feasible, but certain points are crucial because of their health importance and low financial cost. Explaining treatment, questioning and reassuring a patient, calming a woman in labour and helping her to breathe so that her contractions are more regular and effective, explaining a prescription to help improve treatment compliance: these are all factors that can be changed and can significantly improve healthcare without requiring any additional inputs.

Moreover, broadening the scope of anthropology can, for example, by following patient pathways, help unearth dimensions that are neglected because they are "modest" and seem too banal to be included in studies and programmes. Yet how reception desks operate in some hospitals is crucial for those wishing to access care[33]. The state of the toilets in maternity wards and hospitals, the dilapidated nature of the

[30] Thierry Berche, *Anthropologie et santé publique en pays dogon*, Karthala, 1998.
[31] Jean-Claude Passeron, *Le Raisonnement sociologique*, *op. cit.*, p. 116 ; Dominique Schnapper, « Un "tableau de pensée" », *in* Dominique Schnapper, *La Compréhension sociologique. Démarche de l'analyse typologique*, Puf, 2012, p. 9-34.
[32] Roch Houngnihin, Françoise Jabot et Alain Prual (dir.), « Santé néonatale en Afrique subsaharienne. Regards pluriels », art. cit.
[33] Abdoulaye Guindo, « D'un enfant à un autre : variation dans l'accès aux soins dans un service de pédiatrie à Bamako

accommodation offered to midwives when posted to the bush or the distance to be travelled at night between their home and the health centre are all factors that determine the choices made and behaviours of healthcare staff and users[34].

An integral approach to stakeholder experiences helps to include dimensions that seem "marginal", yet in fact are essential component parts, into health system improvements.

Determine initiatives based on contexts and stakeholder capacity

In 1932, on his return from Germany, Raymond Aron gave a brilliant exposé to a secretary of state for foreign affairs, which led to the following short exchange: "all of that is very interesting, but what would you do if you were in my shoes?" And Aron admitted, "my response to that question was a lot less brilliant"[35]. This is a well-known anecdote. And it also raises questions and offers lessons. We will be focusing on two of them, located at two different levels of intervention.

Firstly, this humorous and practical parable encourages researchers to be somewhat modest. The parable invites researchers not to content themselves, often after the event and locating themselves in a peaceful spot providing an "overview", with producing research that takes the form of a critical catalogue: "should have" or "those involved failed to do this or that". How many researchers, "experts" and heads of international institutions are exponents of this history based on "what ifs"[36] when they put forward "recommendations" and set the world to rights, without being confronted, on the frontline, with the chaos of statutes, relations, skills, political contingencies, and the dissipation of power, and decisions that always have to be negotiated.

On the other hand, "putting oneself in someone else's shoes" is all about having to contextualise all the proposals against locally available skills, the inevitable indecision, and decision-makers' scope for action. This method improves the understanding of how, in many ways, what is actually possible constrains what is conceivable and desirable.

This requirement to take into consideration stakeholders' constraints and "capacity", link words and deeds, and envisage research with a connection to its consequences and potential usage, characterises an "ethic of responsibility" largely based on using facts in dialectics[37].

Once again, reducing the scale of analysis and "putting oneself in the shoes" of stakeholders, understanding the motives behind their actions, feelings, obligations and often conflictual norms that govern their behaviour, helps to identify the amount of leeway that they have and tailor our proposals to it. Therefore, how can researchers take into account the constraints of midwives to enable them to undertake their role in rural settings? How can a sort of "cost of corruption" be incorporated in order to – at least provisionally – put in place an obstetrical risk insurance scheme? How to deliver medical care to a newborn baby without coming into conflict with those representing authority and a certain brand of "tradition", at times sadly detrimental to children's very survival?

A modest "ground-level" description of the practices and rationale underpinning behaviour enables a sort of scope to be sketched out for each of the actors (health professional, patient, or population), emphasising the part that they play in the development of the health issue.

(Mali) », *in* Yannick Jaffré (dir.), *Enfants et soins…*, *op. cit.*, p. 83-104.

[34] Yannick Jaffré, « Ce que les sages-femmes disent de leurs vies, de leur métier et de leurs pratiques de soin », *Santé publique*, n° HS, 2018, p. 151-166, https://www.cairn.info/revue-sante-publique-2018-HS-page-151.htm

[35] Paul Thibaud, « L'œil du cyclone Raymond Aron », *in* Revue Esprit éd., *Traversées du XXe siècle*, La Découverte, 1988, p. 179-199.

[36] Quentin Deluermoz et Pierre Singaravélou, *Pour une histoire des possibles*, Seuil, 2016, p. 19.

[37] Jean-Pierre Grossein, « Leçon de méthode wéberienne », *in* Max Weber, *Concepts fondamentaux de sociologie*, Gallimard, 2016, p. 31.

Building reflexivities

Therefore, it is not a question of analysing worlds to comment on them "from afar" in a learned and potentially academic fashion, or worse to use the multiple gadgets offered by "ex post facto research". And neither is it a question of saying what should be done in the name of a health "truth", as is broadly the case by "top-down" programmes seeking to order the world based on their decisions.

The aim of our work is to open up "enlightened" forums for debate, enabling everyone to take a stance based on the acquired knowledge and what the individual understands about the choices and constraints of the other stakeholders involved in the same health and social setting. Consequently, the intention is not to solely build "knowledge about" but "knowledge with" the stakeholders. This "bottom-up" approach makes extensive use of feedback to the populations in question.

"Field feedback" is standard practice in anthropological research [38]. The feedback will differ depending on whether the researchers are addressing health professionals who performed certain tasks so that they can describe their behaviour (mirror-meetings), or if researchers are cross-checking and comparing the different views of stakeholders in an in-person meeting. In the latter case, this enables midwives to explain to women who were recently in labour the reasons for their actions, and for women who have just given birth to express their fears and criticisms to obstetrics staff, making for a process of reciprocal explanation.

Although these practices are diverse, they all involve getting stakeholders to confront their behaviour and the many ways in which it is linked with the behaviour of the other stakeholders. The intention is neither to judge nor find fault. These uncovering and deployment practices enable each of the "professional links in the chain" – and visual anthropology has a big part to play here[39] – to contextualise their actions in a bigger picture (following up a medical prescription, the pathway taken by a prescription from the prescribing physician to its purchase and usage, understanding of prevention messages, etc.). These practices also help to analyse the consequences of their behaviour in accordance with their own moral standards and social obligations (consequences of technical negligence, perception of violence in the workplace, and so forth).

Research should foster debate and help develop enlightened dialogue leading to a health democracy reflected in deeds, rather than opposing social conducts that always result from negotiations between several systems of constraints, or wanting to impose standards, all in the name of a health rationale.

The reform of a health system is very similar to building a Lego model by using investigation and by finding in existing practices the pieces needed to develop the best measures for a specific context. In other words, rather than devising wide-ranging programmes based on diverse "theoretical" objectives, the idea is to create circles of quality made up by working groups in set socio-professional units (a department[40], a clinic, etc.). The perspectives need to be reversed. We should not think that a project will transform a given context, but rather that each department, and often in an informal fashion, houses a group of "reformers" and dynamics that research-action must identify and support.

The strong connections between research and practice in anthropology

Everywhere, health is extending beyond the purely medical sector, and the World Health

[38] Patricia Vasseur et Laurent Vidal, « Le soignant en son miroir : Accompagnement anthropologique d'une intervention en santé maternelle au Sénégal », *Autrepart*, 3, n° 55, 2010, p. 107-124 ; Laurent Vidal, « Rendre compte. La restitution comme lieu de refondation des sciences sociales en contexte de développement », *Cahiers d'études africaines*, n° 202-203, 2011, p. 591-607.

[39] See various films on paediatrics, unplanned pregnancy, and the quality of paediatric care produced under the framework of the ENSPEDIA network (Children, Health Care, and Paediatrics in West Africa Research-Action Project) that can be viewed on GID's website: https://g-i-d.org/fr/gid-sante/programmes-de-recherches-en-cours

[40] See, for instance, the film *L'enfant au cœur des soins*, which illustrates this development of quality practices in paediatrics: http://g-i-d.org/fr/gid-sante/programmes-de-recherches-en-cours/item/401-l-enfant-au-coeur-des-soins

Organization's guidelines seeking to include "Health in All Policies" apply in diverse areas this sort of "evidence-based" empirical approach that we have endeavoured to illustrate.

Once again, if we confine ourselves to a handful of examples in Africa, public health, in conjunction with multiple non-profit sector stakeholders, inevitably goes beyond its strict health prerogatives. For instance, it goes beyond the health sector by leading most of the campaign for safe medical abortions[41], the legal marriage age, or the rights of sick people, pitting itself against "fundamentalist" political-religious authorities, or against financial interests, or enshrined gender inequality. Public health also makes a contribution by addressing the stigma which, from HIV to Ebola, and now Covid-19, adds social censure to the health difficulties experienced by those with the disease. In no way is it a case of pitting public health against anthropology, but rather the intention is to foster a technical and epistemological space in which social sciences' contribution involves bringing to the table a practical reference framework for the terms used by the developers: "what is a health professional?", "what does going to hospital mean?", "what is a complaint?", "what is a nurse's day like?", "how does one administer vaccinations in a clinic on market day?"…

The development of health systems everywhere involves this focus on real life. The links between social practices and medical causalities need to be researched, the burning social issues that hamper prevention for both patients and health staff need to be analysed, and the human issues involved in epidemiological transitions need to be described. For all of those reasons, sustainable health systems tailored to local contexts cannot be developed without linking together globalised technical-scientific approaches, local versions of modernity, and ethics that are often constrained by the available resources. This will only be achieved if we analyse the many conflicting norms that govern most behaviour by both health staff and patients, and also if we give the floor back to the stakeholders so that they can identify worlds that fit with their choices. In Africa and elsewhere, this concrete concern for communal assets should encourage social sciences and health stakeholders to continue and deepen their collaboration. If they manage to do so to the extent of getting science and health requirements to fit with real-life constraints, at least the Covid-19 pandemic will have had a major benefit.

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Translated from the French by Gillian Eaton

Biography • Yannick Jaffré

Anthropologist, emeritus research director at France's National Centre of Scientific Research (CNRS – UMI 3189 Environment, Health and Society) and scientific director of GID-Santé (Inter-academic Group for Development-Health) at the Académie des Sciences-Institut de France. Yannick Jaffré lived in the Sahel for twenty years where he taught at several faculties of medicine and conducted various studies on the anthropology of the body, health and sensitivities. His research focuses mainly on maternal, child and neonatal health.

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[41] Siri Suh, "Rewriting abortion: deploying medical records in jurisdictional negotiation over a forbidden practice in Senegal", *Social Science & Medicine*, 108, 2014, p.20-33.