

Review of: "Expanding Participatory Epidemiology to Explore Community Perceptions of Human and Livestock Diseases among Pastoralists in Turkana County, Kenya"

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Epidemiologists like to think they can control epidemics. They cannot. In the first place, epidemics are driven by the actions of infectious agents. If agents of infection understand their own role in the spread of infectious disease, behavioural modification becomes a potentially powerful agent for disease prevention. For this reason, all epidemiology should be 'participatory', in the sense of allocating a major role to building a broad base of human understanding of infection processes. This was a lesson well learnt in African Ebola epidemics, and promptly forgotten or ignored by (so-called) 'advanced' countries in the pandemic of Covid-19, in a breakneck search for high-tech solutions. As a result, many populations never really learnt how the Sars Cov-2 virus moved and what they might do to reduce infection risks. So, three cheers for this paper, which offers further examples of the potential for behavioural mobilization in handling both animal and human diseases through local participation. It is a One Health study, paying equal attention to animal and human diseases, and this is in fact, the place to start, given that African rural communities often pay as much attention to the health of their animals as to their own health, as a key to their economic survival. The field team I led in Sierra Leone during the 2014-15 Ebola outbreak found it could explain human infection risks from Ebola (a new disease in West Africa) by referring to experience of PPR in goats. Rural people knew that if an animal brought into the village showed symptoms of PPR all goats would die. Some communities passed byelaws on quarantining all newly imported goats. It was no great stretch to apply this to Ebola, and cases began to decline, even before the arrival of the much vaunted 'international Ebola response'. [1] There is, however, a key problem with the social classification of disease in this paper. To develop PE we need to agree what we are all talking about. In Table 3, the authors (rather airily) note that disease/syndrome names were 'given in English' and 'the local name was [also] provided', adding only a need to clarify 'local ambiguity'. This, I fear, greatly understates the problem. This is not simply an issue of correct translation, but relates to larger schemes of conceptualization, which in turn refers to divergent processes of institutionalization. Take the category 'country disease' widely used in rural Sierra Leone. A 'country disease' is one a pharmacist or doctor is powerless to treat, because it reflects deeply disordered mental and social relations. Valuable though this study is in drawing attention to the potential of participatory epidemiology (PE) I would urge the authors to pay serious attention to what social science teaches about the complex logic of local schemes for disease classification, and the ways anomalies are handled (e.g. Mary Douglas, 1986, *How Institutions Think*). It will then become clear that local institutionalization of science is a much bigger challenge than the authors imagine, but ultimately a more rewarding one.

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[1] Paul Richards 2016, *Ebola: how a people's science helped end an epidemic* London: Zed Books