Social Science in Humanitarian Action

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Guidance note 2. Seeking treatment for cholera in Somalia and the Somali region of Ethiopia: contextual factors

Background

As a result of depleted water resources, widespread internal displacement, malnutrition, and inadequate water and sanitation facilities, cholera outbreaks have become recurrent in Somalia and the Somali region of Ethiopia. Health-seeking is particularly challenging in this humanitarian context, with lack of health facilities, a protracted conflict and the availability of a diversity of care-providers shaping the ways Somalis seek care.

The purpose of this guidance note[1] is to support UNICEF staff in understanding the contextual factors (the practices, behaviours, social norms and wider factors) that shape risks of cholera transmission, being able to separate the social and cultural factors from those that are more structural or systemic. In this note we will explore the Somali health system and Somalis treatment- seeking behaviours in general and specifically in the case of cholera.
The guidance note is intended for use by cholera/AWD response staff, C4D staff, government counterparts and implementing partners. It aims to give an overview of the key issues and a set of recommendations that will need to be adapted to specific local situations where a cholera epidemic unfolds.

Separating social and cultural factors from structural factors of treatment-seeking behaviours

In the case of cholera the risks of transmission are determined primarily by structural factors, rather than a set of social-cultural norms, practices or beliefs that constrain people's treatment-seeking behaviour. Somalis are indeed able to identify cholera diarrhoea through its symptoms, and a majority of them would seek treatment in conventional health clinics, and swiftly use home-made or purchased oral rehydration salts.

The crucial problem to seeking treatment in health centres is poor availability and access. There are too few health centres and the conflict prevents people accessing them. In the Somali pastoral areas of Ethiopia for example, only 12 per cent of the population reported a health clinic in their community, with the nearest average distance of the clinic being 36 km away. Access to health care is much higher in urban areas than in rural areas. Lack of access is compounded by the project-based emergency-based provision: health clinics open and close continually meaning there is little continuity. Stocks are low, staff capacity and motivation is low, and the range of services that are offered are low. This results in a low level of trust by the population.

The availability of and access to good treatment will determine the outcomes of cholera infection: the case fatality rate for cholera is under 1 per cent when health care is accessible. However, limited access to proper health care services for the most vulnerable and insufficiencies within the health care systems brings a higher fatality rate.

War and violence radically alters access to health centres: close physical proximity does not mean access. Unmet need is not simply a lack of capabilities or trained personnel. Due to security concerns, trained doctors in Mogadishu could be

[1] The research was commissioned by the UNICEF Eastern and Southern Africa Office (ESARO) and Communication for Development (C4D) and undertaken by the Social Science in Humanitarian Action Platform. The Platform provides evidence synthesis and social science analysis of the social dimensions of humanitarian emergencies. To read the full report, and find out the full list of contributors, see http://www.socialscienceinaction.org/resources/contextual-factors-shaping-cholera-transmission-treatment-seeking-somalia-somali-region-ethiopia/

potentially unable to travel to cholera-struck regions. Ongoing conflict and the warring parties may hamper humanitarian access: humanitarian organisations may have difficulties accessing people in need, and people themselves are unable to travel to seek health care and water.

Costs are another limiting factor. Yet it is not only the cost of seeing a biomedical health provider, which may be very high in the case of private clinics in the cities, but the associated costs: one needs to add the cost of transport (there are very few Ministry of Health ambulances), purchase the medicines and supplies, seek accommodation or pay for a hospital bed, and provide food for the journey. On most occasions, someone needs to accompany the person travelling, who will also need to be fed and paid for, as well as forgoing several days of work.

The **capacity** to respond to health emergencies such as cholera is low. The Humanitarian Health Cluster declares that 65 per cent of Somalia's health facilities as not functioning properly. Government clinics and hospitals in cholera affected regions in Somalia do not have the medications or supplies to treat the cases who arrive there. This disrupts the trust in the clinics; if people die in a clinic due to lack of supplies, family members will not seek treatment in those facilities in the future. Health staff require training to handle cholera and other infectious diseases. Adequate triage, isolation and other relevant protocols should be follow-up strictly to prevent transmission within health facilities.

Whilst humanitarian action cannot tackle some of these structural factors, it can incorporate an advocacy programme that pushes for a higher investment in water and sanitation infrastructure as well as health care facilities, appropriate funding and neutrality to enhance humanitarian access, investment in livelihoods and safety nets to enhance incomes and capacity building and adequate supplies to clinics. Acknowledging these structural constraints also allows us to manage expectations in terms of the impact of campaigns directed at changing behaviours: the impact will be limited, unless the structural factors change.

A diversity of healthcare providers

Health clinics, and humanitarian health outposts (including cholera treatment units) are not the only health providers available in Somalia and the Somali region of Ethiopia. Somalis seek care for their ailments not only from government or NGO clinics, but get treatment also through other health providers: home remedies and prayers, traditional healers, herbalists, pharmacy shopkeepers, Islamic healers. Somalis draw on multiple strategies simultaneously or in close succession to treat commonplace diseases. The relative weight of each is shaped by access (physical, social and economic), perceptions of quality and success, the ailment, spiritual understandings of disease, and others.

In the case of cholera, and unlike other illnesses, there is evidence that Somalis are able to identify the symptoms of cholera diarrhoea and would seek immediate treatment for the disease from biomedical services. If quality healthcare facilities were available and accessible, people would use oral rehydration salts and go to treatment facilities if needed since they understand the severity of the disease.

Somali people seek other kinds of treatments beyond the biomedical (religious, traditional, herbalists, and so on) and they are not mutually exclusive – people seek multiple options rather than one exclusively. The combination or succession of health providers and treatments chosen will be different depending on the patients' preferences and the illness (see below for examples of local understandings of disease and diarrhoea). Even within this medical pluralism, people are increasingly trusting medical facilities, particularly if they provide good service and have

appropriate facilities (e.g. laboratories) and equipment.

Herbalists (*geedole*) (who can simultaneously be healers, see below)

Herbalists have herbal remedies for the majority of disorders, using both local and imported plants. Herbalists along the rivers will use a greater diversity of medicinal plants. Remedies are often used in conjunction with prayer.

Both herbalists and *baxaar* are the only ones who traditionally can cut plants to be used as treatment. If others without the specific knowledge cut the plants, they might cause themselves harm and the plants will have no effect.

Traditional healers (*saancole* or practitioners; *dhakhtar baaddiye* or rural doctors; *Qofka sameeya dawo dhaqmeedka*, traditional medical practitioner or healer)

Relative to biomedicine (including pharmacies) and home remedies, traditional healers are less prevalent than in the past, although this depends on the illness: normal diarrhoea, gastritis, measles and gonorrhoea are commonly treated by traditional healers. Respiratory infections are also treated initially by healers, and if they are not resolved in a few days, they are referred to a clinic. Headache, stomach and chest/heart pain have also traditionally been cured by traditional healing.

Traditionally healers are an integrated part of society, practising farming or herding and assisting patients when they were needed. Healers distinguish between "treatments that focus on "natural" illnesses and pragmatic problems and treatments that focus on illnesses caused either by supernatural agents such as spirits or by problems in social relationships (e.g. evil eye). The first category includes treatments such as cupping, burning and bone-setting, and the second treatments such as recitation of the Koran and spirit possession rituals." (Tiilikainen 2014).

These traditional practices frequently include a simultaneous use of drugs and diagnostic technologies, as well as ideas of 'contagion' and 'germs'.

Religious healers (*wadaaddo*)

Religious healers have traditionally healed through a reading of the Koran and blowing on the patient. Another practice is *Tahlil* in which the suras of the Koran are either blown into water, or written in a solution of saffron or milk blackened with charcoal on a board, and then washed with water – and then the water is given to the patient to drink. Amulets consisting of a piece of paper with verses of the Koran, hung on the neck, arm, leg and hips are also used.

Islamic clinics *(cilaaj)* are a more recent phenomenon in Somalia that has grown since the 1990s with the spread of Wahabbi Islam. They also involve recitation of suras of the Koran, sprinkling holy water, and inhaled ingredients, as well as herbal medicine and pharmaceuticals. They treat patients with jinn, evil eye or witchcraft but also natural/physical illnesses. These clinics use modern technology and elements of biomedicine to enhance their symbolic power vis-à-vis their clients. These clinics are very well respected: 'healers provide patients with meaningful cultural and religious illness explanations. Moreover, a healer may be part of the kinship network of a patient and/or live nearby, which entails easy access', and even though they can be more expensive than private clinics, people attend them (Tiilikainen 2014).

People who seek help from an Islamic healer, in the Somali pluralistic health system, would often combine it with biomedical treatment; for example a woman who struggled with infertility would ask a mullah to exorcise a jinn and simultaneously get an ultrasound in a hospital (Carruth, 2014: 4).

Shopkeepers/pharmacists

As mentioned above, shopkeepers and pharmacists are the most popular source of treatment in Somalia. They are pervasive, present in nomadic and settled rural areas, as well as in urban areas. Self-medication is common within pastoralist communities, with people self-medicating, and asking family members going to health centres to purchase particular drugs (e.g. antibiotics) for them.

Unlicensed pharmacists offer diagnosis and recommend treatment, and people seek out those pharmacists whom they trust to have some knowledge of disease, and they evaluate their success from treating previous ailments. For example, a successful drug dispenser would be someone who had worked with aid organisations and had received informal training on first aid and monitoring courses of drugs.

Biomedical treatment seeking: health clinics and health outposts

Due to the prolonged presence of the humanitarian health world there is a higher appreciation of biomedicine, particularly when the quality of care is good and the perceived necessary equipment (such as laboratory or sonogram) is available**.** People can differentiate between qualities of health provision and will travel to those clinics that provide good care.

Cholera/AWD and treatment-seeking

Within the current restrictions of availability and physical access to treatment, and living in a context where many health providers co-exist, how do people make decisions about seeking treatment? People have very clear notions of quality and technology, and will migrate significant distances to seek the best possible care and the technology they seek. People value having labs and equipment for appropriate diagnoses. People can differentiate between qualities of health provision and will travel to those clinics that provide good care. This means that people might not choose to go to the closest health facility but travel farther afield. For example, people may choose to go to a better clinic in Somaliland (and wealthier Somalis might fly out of Somalia altogether).

The establishment of trust and social connections are fundamental to encourage Somalis to attend health providers. In the case of pastoralists, whose mobile livelihoods are not adapted for conventional approaches to health provision. Mobile clinics for pastoralists partly address this, but are not the panacea. Since trust and social connection is paramount in successful patient–health provider relations, it is unlikely that this trust can be built if a mobile clinic staffed by strangers appears for a few days in the vicinity of their grazing land, they will not seem approachable.

Biomedicine is part of a system of health providers that are subsumed within a broader spiritual notion of illness. Many Somalis, regardless of whether they trust herbalists or medical doctors more, “acknowledge the divine of all illnesses, the influence of supernatural beings on the physical bodies of humans, as well as the necessity of Qur’anic healing in response”. (Carruth 2014: 162). This notion of illness as God’s will as something that is written can bring with it a sense of fatalism, in which people can think that regardless of what treatment is sought (and by whom), if it is God’s will for a particular child to die, that child will still die.

Gender is an important dimension: women are on average more neglected in health terms than men, treatment is sought less often, with significantly higher mortality and morbidity rates among Somali women. This is compounded by women’s relatively poor nutrition in adolescence and pregnancy.

Gender relations in the household may shape when treatment is sought. In more patriarchal households, women often wait for a male relative in order to seek

biomedical treatment for themselves or their children. On the other hand, plenty of women do not need men to take their children to the clinic. Perhaps accompaniment is sought if the woman is a young unmarried woman. Despite the puritanical trends of Wahhabism, less strict Somali understandings of women under Islam are still present.

Families' incomes and livelihoods are being squeezed by the protracted drought and conflict, with an important psychosocial impact on mothering and childcare. Women are impacted psychologically by the conflict and the depletion of livelihoods.

Male notions of strength and stigma also shape how they access treatment: men will not seek medical health due to the idea that they must be tough, that there is social stigma in seeking health services and this may affect health-seeking.

Family networks are crucial in order to take someone to the doctor or healer. Contacts through social networks yield the knowledge of which practitioner to choose and the access to them. Particular reputed members of a family (often those more educated and linked to the humanitarian industry) will play the role of translator/mediator between the patient and the health provider. In the Somali region, real translation is required, in those health centres or treatment units that deploy Amharic speaking staff. This mediating role is a family responsibility and a source of status.

Further, kinship and clan responsibilities are central to paying for and enabling access to different kinds of medicine. Families 'frequently and informally redistributed monetary and livestock holdings within subclan, close cousins (*ilma addeero*) and restitution (*mag* – "blood money") units to pay for medicines, hospital visits, Qu'ranic healing, or more rarely, travel abroad for care'. (Carruth, 2015: 66). Close family step in to provide the logistics support and advice. Further, when seeking treatment outside one's community (the most likely scenario in rural areas), people depend on food and lodging by extended family. People who do not have extended family will be unable to pursue health care when referred to other regions.

'Health-care diplomacy' is as important as quality of provision. In the Somali region of Ethiopia, clinics and treatment centres provided by the Ethiopian Ministry of Health are often managed by *habashas* – non-Somali, Amharic-speaking Ethiopians. There is a language barrier, but there is also significant prejudice and discrimination against the Somalis. Somalis are often perceived and treated as backward or ignorant by the *habasha* doctors. Prejudice that hampers the clinic-patient relations can occur amongst the Somalis themselves, for example, traditionally there has been a tension between Somalis from the Ogaden clan and Bantu Somalis.

Somalis do not appreciate the prejudices they confront and would rather go further afield if needs be. When they do use the clinics, they do so for minor ailments and to get medication. Many Somalis would prefer to be seen by a Somali health worker, and by a woman for female patients, particularly in the case of gynaecological concerns.

Nurturing good social relationships within the clinic can help heal social and cultural differences in the Somali region of Ethiopia and Somalia. There is an example of a successful 'health diplomacy' that healed the rift between Ogaden Somali doctors and Bantu Somali patients in a UNICEF mobile clinic, when the doctors engaged socially with their clients: 'because of their affability, alacrity, their efforts to bend patters of triage to better match local assessments and their willingness to forge familiar care-giving relationships outside the walls of clinical spaces [the doctors] were interpolated into community life'. Trust was built, and the services were used.

Recommendations for action

Advocacy for humanitarian access

There is a need to ensure humanitarian access: people should be enabled to move freely to seek healthcare and water, and humanitarian organisations should have safe passage. Adequate funding and the neutrality of aid agencies in the Somali conflicts is paramount.

Working with other care providers

- Engage with pharmacists and traditional and Islamic healers to promote cholera prevention and control, getting messages through them, as well as providing health training for referral to biomedical clinics when necessary
- Communicate the type of services/quality of care that families will receive. Attendance is more likely if people are informed about the existence of laboratory and equipment facilities as well as qualified staff, to prove it meets people's standards of quality.

Building trust and social capacity of care providers

- Incorporate sensitivity to intra-community dynamics in training of health staff and build skills for inter-personal communication and socio-cultural understanding in healthcare workers to ensure people use treatment facilities. Cultural sensitivities are needed.

- Clinics should include Somali staff or if they are non-Somali they should receive training in dealing with Somali clients to reduce misconceptions. Translation services should be offered in the latter case. There should be female Somali staff for Somali women

- Understanding which health providers people trust (biomedical, herbal, traditional, pharmacists, religious healers) and how people frame their diseases experiences will help with appropriate messaging and establishing alliances

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