Understanding health behavior changes in response to outbreaks: Findings from the recent pandemics and epidemics of infectious diseases

Although greater attention has been recently given to the ecological determinants of health behaviors, we still do not know much about the behavioral changes induced by the spread of infectious diseases in modern societies, as well as the effectiveness of strategies promoting the adoption of protective behaviors in the population, such as vaccination. During the last decade, we took advantage of several large epidemics of infectious diseases in France – including French overseas regions – to examine the dynamic interaction between risk-related perceptions and behaviors that occurs in response to a disease outbreak. In particular, we tested empirically the assumption that both public risk perceptions and health behaviors were elastic with respect to incidence. Our findings suggest that people may fail to adjust their risk perceptions over time, and to a lesser extent their health protective behaviors, to the course of an epidemic because of the existence of risk habituation effects. Notably, we found that the prevalence elasticity of preventive action revealed in previous studies of behavioral response to infectious diseases differed substantially according to the type of intervention (social distancing versus hygiene improvement). Nevertheless, our experimental data suggest that the risk habituation phenomenon might be partly compensated by some brief interventions targeting health professionals.

A sociology of preventive healthcare: the case of cancer screening participation and inequalities

Social epidemiology and health sociology have increasingly paid attention to macro-level determinants of health and health inequalities. However, such approach has been lacking in the field of preventive healthcare, such as cancer screening. That is, socioeconomic inequalities have been evidenced in cancer screening participation, yet these have rarely been contextualised within macro-level institutions and social structures (e.g. healthcare systems, social policies, etc.). Hence, I argue for applying multilevel models which isolate the effect of micro and macro-level factors and examine their interactions. To support this claim, I draw on empirical studies which contextualised the effect of individual-level determinants of cancer screening participation. Results of these studies importantly revealed that individual-level associations were modified by macrolevel factors. Failing to account for such contextual effects may entail misleading interpretations of individual-level associations. Nevertheless, it should be noted that multilevel models involve strong theoretical and methodological assumptions, which need to be carefully exposed and discussed. Finally, multilevel analyses not only contribute to accounting for upstream determinants of preventive healthcare, these may also shed light on specific forms of inequalities between population (sub)groups. That is, multilevel processes shape specific conditions in subgroups, and thus their ability to access screening, which should be considered for public health interventions.