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Editorial

COVID-19, Risk, Fear, and Fall-out

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We, like others worldwide, have spent much of the last week tracking the exponential spread and toll of COVID-19, and the consequent retraction of social engagement, shifting from the joking “Are we still kissing?” to maintaining “social distance” without remark. And we are beginning to witness unanticipated harsh measures to enforce lockdown. As we wrote this (March 15), Australia, like many other countries, introduced self-isolation of two weeks for travelers returning from overseas, enforceable by fines of up to 20,000 AUD or detention. This assumes that all travelers are in excellent health, and have a stockpile of essential medicines, and sufficient food, bathroom supplies, and toilet paper. This is not necessarily so.

We are beginning to take stock of the social, economic, and political fallout that will follow as the virus surely spreads, with colder weather, to the global and geographic south. We are witness to: mediatization of the pandemic; closing of schools and

universities, libraries and museums; cancellation of conferences and smaller meetings; and loss of income for people who run stalls and street-side services and work in the informal economy. Political leaders and managers are under enormous pressure as they must decide what to keep open, what to close, what workers to keep, and who and when to retrench. The fear and panic come less from the risk of infection and more from the growing reality of its fall out.

Medical anthropologists have contributed substantially to understanding the impact of epidemics and pandemics, their effects on social and economic life, and their toll on health services and health workers. In recent decades, in monographs and articles, we have attended to HIV, including on how people drew on historical imagery of the plague, and how fear of infection fed social exclusion and discrimination (for reviews, see Briggs 2005; Parker 2001; Schoepf 2001). More recently, we have analyzed the spread, global efforts, and impact of SARS (Mason 2012), H1N1 influenza (swine flu) (Atlani-Duault and Kendall 2009; Leach and Tadros 2014), H5N1 (avian flu) (Høg et al. 2019), Ebola (Benton 2017; Moran 2017) and zika (Gray and Mishtal 2019; Stellmach et al. 2018); and attended to local outbreaks of diseases, many assumed to have been historic – cholera, measles, mumps, hepatitis, and more. What is unprecedented with this current pandemic of COVID-19 is not its scale, but the reaction of nation-states to contain viral spread.

In their article on anthropologists' engagement in policy settings with Ebola, Martineau et al. (2017) describe the attraction of anthropological expertise on funerary practices, and the perception of the significance of "culture" in this regard, but the dismissal of anthropological insight on home care. While anthropologists were considered to contribute uniquely to understanding the care of dead bodies, the care for sick people was not seen as subject to "cultural" norms and sensitivities.

"Culture" was always included in popular discourse and media accounts of Ebola. This is not so for coronavirus disease 2019, named COVID-19 to disassociate the disease from Wuhan, China, where viral infection was first identified. COVID-19 appears to be outside of culture. Yet the institution of quarantine practices, lockdowns, and border controls, and the insistence on adherence to hygiene practices (handwashing) highlight how human practices and behaviors are implicated, and foreshadow a global humanitarian crisis as community transmission takes hold in global south communities. Here, manifold risks are tied to the poverty of infrastructures and resources (Satterthwaite et al. 2019). Consider the potential rapid spread of the virus with co-

sleeping in cramped living quarters, poor ventilation, poor or absent hygiene and sanitation, water shortages and broken taps, and the lack of capacity for householders but also institutions (including local health centers) to provide soap and hand sanitizers. Consider the impact on community health workers, and the challenges that they face, in trying to manage pneumonia in older villagers when transport and district level services are miles away. Or consider the wildfire spread if (when) COVID-19 takes hold in informal settlements and slums in South Africa, Kenya, and Nigeria, cities like Rio de Janeiro and Mexico City, and cramped refugee camps in east Africa, Turkey, Jordan, Bangladesh, and Pakistan. In such settings, COVID-19 will capitalize on structural violence (Farmer 2006) and vulnerability (Quesada et al. 2011), in which context people are at high risk of infection, vilification, and social exclusion.

It is tempting to ask what the world would feel like had governments responded to other global health disasters – gender-based violence, climate change, war, poverty, HIV/AIDS, or hunger – with such vigor. The burden on public health care systems globally would arguably have been ameliorated, to some extent, had world leaders and celebrities tweeted their infections like many have done with COVID-19. But in South Africa, the first cases of the virus were diagnosed in urban townships, the possible result of residents having been exposed to the virus in more affluent households where they are employed as domestic workers, gardeners, and nannies. The likely transmission from privileged to underprivileged bodies is the nightmare scenario we must all attend to. The extent to which this mode of transmission has not tarnished the affluent with stigma is striking.

China has led the way in demonstrating the value of dictatorship in containing viral spread. The first wave of viral infections that spread from China to Europe and North America fueled the news making industry without leaning into the logic of stigma, discrimination, or blame. The closing of ports of entry in South Africa cannot, for instance, be conflated with the rise of xenophobic violence in the country. The same cannot be said for the US where the closing of borders and emerging policies of developing a vaccine only for US citizens plays into Trump's eugenicist tendencies. Had the virus first been detected in a context of what James Quesada calls "structural vulnerability" (2011), our hunch is that renewed metaphorical punishments and iatrogenic discourse might have held sway. Thus, global efforts to identify a vaccine, promote "social" distancing, shut down ports, and stem wide assemblages of economic activities and public life are happening in a new context of a new restraint away from blame (cf. Farmer 2006).

Exceptional lessons from the “panic” response to COVID-19 are in motion. The first is that people can change behavior quickly when presented with institutional mandates to do so. The empty shelves in shops provide evidence that worldwide, people are washing their hands on a regular basis, that is, among people who can afford disinfectants. People are bumping elbows instead of hugging, kissing, or shaking hands. Embodied knowledge seems to be more flexible than often theorized in medical anthropology. People are slowing down and moving to virtual classrooms and conferences. People are stockpiling toilet paper and tinned foods. And in some circles, people are starting to question the sustainability of global capitalism. University systems, museums, and theaters everywhere are shutting down; increasingly, it seems, entire cities are doing so. Even so, we are seeing that some people who may be infected are going about their daily routines, either because their jobs do not provide paid time off or because of systemic failures in our privatized and public health care systems. The capacity to respond is thus uneven along the predictable fault lines of class, race, and gender.

Indeed, while COVID-19 has proven that people can care for one another through “social” distancing, people ensnared by structural violence face limited access to water, modern sanitation systems, or safe homes with ventilation. The crisis in refugee camps across Europe testifies to this.

An ethnographic anecdote pointing to privilege can be seen in a COVID-19 Daily Schedule sent to families in Cape Town. It includes morning dog walks with the family for an hour, academic time, creative time, lunchtime, chore time, afternoon fresh air-time, dinner time, and free TV time. The geography of poverty in the Western Cape means that this schedule reeks of white privilege.

Closely linked with white privilege is the neoliberal urge to move on with life as usual regardless of risk. As Divine Fuh cleverly shored up in an anthropology WhatsApp conversation, “The virus’ DNA is coded to directly attack our deepest neoliberal urges and logics, especially our strongest egos” (March 15, 2020). The social urge to host gatherings, celebrations, academic conferences and meetings, or attend places of worship is under attack. Anthropologist Nikiwe Solomon clarified that “this virus is forcing us to act counterintuitively” (March 15, 2020). Importantly, the need for counter-intuitive action is not only for self-protection but more so for the protection of those whose immune systems and social support systems are compromised by inequality.

Additional information

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References

1. Atlani-Duault, L., and C. Kendall 2009 Influenza, anthropology, and global uncertainties. Medical Anthropology 28(3):207–11. doi:10.1080/01459740903070519.

PubMed | Web of Science ® | Google Scholar

2. Benton, A. 2017 Ebola at a distance: A pathographic account of anthropology's relevance. Anthropological Quarterly 90(2):495–524. doi:10.1353/anq.2017.0028.

Web of Science ® | Google Scholar

3. Briggs, C. L. 2005 Communicability, racial discourse, and disease. Annual Review of Anthropology 34:269–91. doi:10.1146/annurev.anthro.34.081804.120618.

Web of Science ® | Google Scholar

4. Farmer, P 2006 AIDS and Accusation: Haiti and the Geography of Blame. Berkeley, CA: University of California Press.

Google Scholar

5. Gray, D., and J. Mishtal 2019 Managing an epidemic: Zika interventions and community responses in Belize. Global Public Health 14(1):9–22. doi:10.1080/17441692.2018.1471146.

PubMed | Web of Science ® | Google Scholar

6. Høg, E., G. Fournie, M. A. Hoque, R. Mahmud, D. U. Pfeiffer, and T. Barnett 2019 Competing biosecurity and risk rationalities in the Chittagong poultry commodity chain. Bangladesh. Biosocieties 14(3):368–92. doi:10.1057/s41292-018-0131-2.

Web of Science ® | Google Scholar

7. Leach, M., and M. Tadros 2014 Epidemics and the politics of knowledge: Contested narratives in Egypt's H1N1 response. Medical Anthropology 33(3):240–54. doi:10.1080/01459740.2013.842565.

PubMed | Web of Science ® | Google Scholar

8. Martineau, F., A. Wilkinson, and M. Parker 2017 Epistemologies of Ebola: Reflections on the experience of the Ebola response anthropology platform. Anthropological Quarterly 90(2):475–94. doi:10.1353/anq.2017.0027.

Web of Science ® | Google Scholar

9. Mason, K. A. 2012 Mobile migrants, mobile germs: Migration, contagion, and boundary-building in Shenzhen, China after SARS. Medical Anthropology 31(2):113–31. doi:10.1080/01459740.2011.610845.

PubMed | Web of Science ® | Google Scholar

10. Moran, M. H. 2017 Missing bodies and secret funerals: The production of “safe and dignified burials” in the Liberian Ebola Crisis. Anthropological Quarterly 90(2):399–421. doi:10.1353/anq.2017.0024.

Web of Science ® | Google Scholar

11. Parker, R. 2001 Sexuality, culture, and power in HIV/AIDS research. Annual Review of Anthropology 30:163–79. doi:10.1146/annurev.anthro.30.1.163.

Web of Science ® | Google Scholar

12. Quesada, J., L. K. Hart, and P. Bourgois 2011 Structural vulnerability and health: Latino migrant laborers in the United States. Medical Anthropology 30(4):339–62. doi:10.1080/01459740.2011.576725.

PubMed | Web of Science ® | Google Scholar

13. Satterthwaite, D., A. Sverdlik, and D. Brown 2019 Revealing and responding to multiple health risks in informal settlements in Sub-Saharan African Cities. Journal of Urban Health-Bulletin of the New York Academy of Medicine 96(1):112–22. doi:10.1007/s11524-018-0264-4.

PubMed | Web of Science ® | Google Scholar

14. Schoepf, B. G. 2001 International AIDS research in anthropology: Taking a critical perspective on the crisis. Annual Review of Anthropology 30:335–61. doi:10.1146/annurev.anthro.30.1.335.

Web of Science ® | Google Scholar

15. Stellmach, D., I. Beshar, J. Bedford, P. Du Cros, and B. Stringer 2018 Anthropology in public health emergencies: What is anthropology good for? BMJ Global Health 3(2). doi:10.1136/bmjgh-2017-000534.