Insight: COVID-19 response ignores social context at our peril

Article by Rosalia Sciortino* originally published in The Jakarta Post on Monday, 6 April 2020**

While frantically reading news about COVID-19, I wonder why the voices of social scientists and even public health specialists seem so subdued. Clearly, they have a contribution to make in the fight against the coronavirus based on their disciplinary core principles and what has been learned from other epidemics, foremost HIV.

Being a medical anthropologist, I will start from what we may be most obsessed with: context, context, context. We know that the key in preventing transmission is slowing down human movement and reducing crowding. Based on experience with related viruses, especially in Asia, we have a number of tools at our disposal, from testing and identification of carriers and their contacts to washing hands and social distancing, isolation and quarantine – to name a few. These measures are meant for the entire global community, but there is no universal guideline on their right mix and no consensus on the degree of enforcement required to ensure people's adherence. This is where understanding of what is feasible and effective (or not) in particular contexts becomes strategically relevant.

What can be recommended for a slum or overcrowded area where social distancing is difficult, if not impossible, and handwashing with clean water is a challenge? What is the alternative to "work from home" for the many who work in low-wage jobs or in the informal

economy? How can prevention campaigns be framed to appeal to various population segments? Public debate and policy formulation would benefit from openly addressing such questions and the realization that a cookie cutter approach may not fit diverse realities.

We should particularly look at lockdowns as a means to achieve social distancing and isolation in order to reduce transmission. Even if the policy is not labeled as such, exhorting the population to remain home and cuts in transportation result in lockdown. To what degree is variable, but we must recognize lockdowns can never be 100 percent. In a globalized world, very few places may survive fully isolated. Even if Singapore has stopped all commercial flights, it still needs food and water to be ferried across the border. Better thus discuss what to "lock" and what is essential and should be left functioning to keep society going amid the necessary disruption – and all this weighted against epidemiological risks.

Such balance differs across locations as it is socioculturally defined. How to explain otherwise that Italy despite its stringent lockdown rules allows newsstands and tobacco shops to operate? People's habits are accommodated to make isolation more livable and therefore easier to adhere to. However, initial attempts to keep open coffee shops for the morning ritual of espresso had to be reconsidered as distance could not be guaranteed.

Risks therefore must be managed prioritizing people's sanity. Culture is to build resilience, not to be invoked to maintain dangerous practices or justify inaction. We have seen how allowing religious events in Malaysia and Indonesia (even after the experience in South Korea) and Thai boxing events in Thailand has resulted in infection clusters and spreading of the disease regionally. We do not want to see older, more vulnerable, people in Indonesia's countryside getting infected by condoning mudik (mass exodus) based on a misuse of cultural arguments divorced from scientific evidence.

We should be wary of simplistic discussions of cultural and social factors and instead promote greater public understanding of the multiple ways in which peoples' behavior and social life affect the epidemic. The low fatality rate in Germany compared to Italy may be related to the younger age of those first affected and family composition, with young Germans generally living apart from their grandparents. We know that gender has an impact: Men fall to the

coronavirus much more than women. But we do not know why. We also have yet to appreciate the role of population density, socioeconomic conditions and health systems. We need more disaggregated statistics, with risk broken down according to age, gender, occupation and other social factors to control the epidemic and avoid resurgence after this emergency stage.

Detailed knowledge is also crucial to comprehend today's many global graphics. Looking like a grim competition on which country has the highest number of cases and deaths, readers feel fear rather than compassion for those hardest hit. What do these numbers really mean? Does it make sense to compare in absolute instead of relative terms the enormous populations of China and the United States with tiny countries such as Brunei? Similarly, does it make sense to compare fatality rates without considering the number of swabs and the procedures applied in collecting them?

Beyond numbers, as the decades-long fight to contain HIV has taught us, we need to emphasize social cohesion and reject stigma to achieve results. At the time, the recognition that human behavior is embedded in specific social structures shifted the focus from blaming members of "risk groups" to intervening in the environments that put them at risk. When the low bargaining power of sex workers with their customers was understood adequately, Thailand introduced the "100 percent condom policy", making responsible the owners of the entertainment establishments for enforcing condom use.

For those who seem not to comply with isolation measures we could ask: Have they internalized (not only understood) why measures are necessary? Are they in a position to practice those measures? If not, what can be done to enable them to change their behavior, beyond financial disincentives or even "shooting" at them, as recently ordered by the leader of the Philippines. Have we forgotten that it is the virus, and not the carriers that should be battled? Our dread for "silent carriers" hampers us from seeing them as a promise of a better future since their immunity is the barrier to the continuing epidemic. Yet, we can overcome fear by taking preventing measures, so that we are protected, irrespective of what others do.

The epidemic is caused by the virus, but controlling it and reducing its human costs depends on social interventions. The fact that in the current COVID-19 discourse such interventions are called "non-

pharmaceutical” shows how little social scientists have made their voices heard, and should inspire us to do more and speak out louder -- while keeping distance!

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*Author: The writer is registered as an international election observer for the 2019 general election. She is an associate professor at the Institute for Population and Social Research, Mahidol University, director of SEA Junction, Bangkok, and emeritus regional director for Southeast Asia with the Rockefeller Foundation and the International Development Research Center.

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Shoppers wearing protective masks walk through the Historic Downtown Farmers Market during the outbreak of the coronavirus disease (COVID-19) in Los Angeles, California, U.S., April 5, 2020. (REUTERS/Kyle Grillot)