

Engaging the Pandemic

HOW ONE MEDICAL ANTHROPOLOGIST IS BOOSTING OUR CAPACITY TO UNDERSTAND AND CONTEND WITH COVID-19.

By Mark Nichter

In late February 2020, I traveled back to the United States from India and Indonesia where I had been conducting fieldwork. Having researched emerging and neglected diseases for years, I recognized the potential for COVID-19 to become the pandemic that my global health colleagues and I had long dreaded. During layovers in Thailand and Japan—countries on high alert for COVID-19 and experiencing a growing number of cases—I watched nervous Asian passengers, many of whom had no doubt lived through SARS COVID 1 and H5N1 (avian influenza), don masks in the airport. In stark contrast, European and North Americans passengers went about their business, occasionally looking up at a TV monitor to watch a broadcast about a mysterious Chinese disease that had infected passengers on a Carnival cruise ship.

COVID-19 is a near worst-case scenario. By now, we are all aware that COVID-19 is caused by airborne novel coronavirus that, unlike the coronavirus causing SARS, enters the body and reproduces in the upper (not the lower as in the case of SARS) respiratory tract, causes symptoms mimicking common health problems, and is transmitted by pre-symptomatic, symptomatic, and asymptomatic carriers. The disease spreads rapidly and has a significant mortality rate; there is no magic-bullet cure and no promise of a vaccine anytime soon. Notably, we have no idea of the [minimal infectious dose](#) (MID) for COVID-19 (the number of viral

particles required [to start a pathogenesis cascade leading to clinical disease](#)), no idea if and how long one is immune after recovering from the disease, and no clear idea of whether apparent immunity is due to cell-mediated immunity or antibody production post disease. Not only that, but the disease is evolving with over 30 strains of COVID-19 identified to date, some possibly more dangerous than others.

RECALLING PANDEMICS PAST

During the 32-hour journey home, my mind turned to practical issues. I recalled how important it had been during previous epidemics and pandemics to work with

community leaders to change social norms necessary for breaking routes of disease transmission, be this the culling of sick chickens in the case of H5N1, the reduction of mosquito breeding site control in the case of dengue fever, postponing funerals and deferring memorial arrangements in the case of Ebola, or physical distancing in the case of airborne diseases like COVID-19. Kin networks and community provision of basic resources such as food and water also proved essential when families needed to quarantine or shelter in place during Kyasanur forest disease outbreaks in South India or Ebola outbreaks in West Africa. I also recalled how necessary it had been to move beyond naïve representations of “community” to more nuanced engagement of communal factions taking into account power relations ([see Wilkinson et al. 2017](#)). Next, I thought about regions of Asia and Africa where I had recently worked, and imagined the challenges posed by seemingly simple prevention measures such as hand washing and physical distancing in urban slums, water insecure communities, and packed refugee camps sheltering the displaced. Based on past experiences, I also envisioned migrant workers hailing from rural areas fleeing cities seen as environments of heightened risk and food insecurity.

As in the case of all pandemics I have witnessed, I also anticipated an increase in the politics of othering and victim blaming, of ethnic minorities being cast as unhygienic citizens, and foreigners blamed for the origin of the disease. And I worried about the toll that COVID-19 might take on health care systems, collateral damage in the form of falling vaccination rates and rising rates of tuberculosis (TB), and people afraid to come to hospital for safe deliveries and chronic health problems demanding medical attention.

Medical anthropologists working in global health have seen this all before. And

here we were again—only this time there were some glaring differences. The world was not mounting a unified and concerted effort to control the spread of this disease as was the case for SARS in 2002. Due in large part to SARS, the World Health Organization regained its leadership status eroded by the World Bank during the 1990s and became the go-to source for pandemic preparedness guidelines and response (Fidler 2004; Heymann 2006). Yet in the case of COVID-19, it appeared that each nation was left to fend for itself, come up with its own plan for dealing with the spread of the disease, and find essential medical resources in a competitive global market.

US RESPONSE TO COVID-19

On my return to the United States, I was quickly brought up to speed by exasperated clinician colleagues who felt woefully ill-equipped to handle a surge of COVID-19 cases and increasingly vulnerable given dwindling supplies of personal protective equipment (PPE). To buy time and not swamp the system, public health officials were calling for “flattening the curve” through “social distancing,” but it was apparent that effective leadership and a clear chain of command was lacking in our politically polarized country. Moreover, anti-science and fake news rhetoric challenged basic public health guidelines for epidemic control. I recalled the US response to H1N1 (swine flu), well-documented by Katherine Mason (2010). China abided by our Centers for Disease Control and Prevention (CDC) recommendations to lock down the country, while the United States refused to follow the same guidelines because it would threaten core American values related to liberty and personal freedom. I also remembered the anti-mask demonstrations that occurred in the United States during the 1918 flu pandemic (Canales 2020). I wondered how social distancing, the mandatory wearing of masks, and quarantine might play out this time around given the effectiveness of this strategy in Asian countries for mitigating COVID-19.

I also recalled the article that Charles Briggs and I wrote during H1N1 calling for anthropologists to pay close attention to biocommunicability (2009); that is, the competing ways of framing a disease favored by stakeholders as well as factors influencing the circulation of these representations in the press and social media, inclusive of conspiracy theories that index deep-seated social divisions. I was struck by the sheer volume of disinformation circulating about COVID and the increasing influence of trolls and bots populating online platforms and serving as echo chambers fostering polarizing mistrust in scientific data about COVID-19 (see Brennen et al. 2020; Bursztyn 2020; Health in All Matters Podcast 2020; Krause et al. 2020; Perlow 2020).

Also new in the case of COVID-19 in the United States, the federal government did not step up to the plate early as the agent promoting public health guidelines, but rather flip-flopped on the necessity and reach of evidence-based recommendations directed toward saving human lives. Greater concern appeared to be focused on the health of the economy and political fortunes. Rather than being a reassuring voice of reason, messages from the White House became a major source of misinformation, disinformation, and gaslighting with politicians undermining the advice of their scientific advisors (see for example, Roston and Taylor 2020; Sarkis 2020). As a result, our CDC ceased to be seen as a global public health leader. Indeed, I received messages from members of my transdisciplinary network located all over the globe asking me why the CDC seemed to have little influence even in the state of Georgia where it was located. The answer was simple; staff were muzzled and prohibited from talking to the press (see Kuznia, Devine, and Valencia 2020).

BEING USEFUL IN A TIME OF CRISES

Given this debacle, let me briefly share where I chose to focus my attention as an engaged anthropologist (Nichter 2006), and explain my reasoning for doing so. This entailed balancing “anthropology in”

pragmatism with anticipatory “anthropology for” engagement, and seeing COVID-19 as an opportunity for systemic health care reform. As for a critical “anthropology of” perspective, I appreciated the efforts of colleagues exploring the biopolitics of COVID-19, but decided (like my colleagues had during Ebola [see Abramowitz 2017]) to wait until after the crises passed before doing so myself. For the moment I felt a sense of urgency amplified by personal circumstances. One of my sons developed a fever and acute respiratory symptoms that I feared might well be COVID-19. He was not able to be tested for COVID and tested negative for the seasonal flu. My family, like many families across the nation, experienced some degree of anticipatory anxiety as we watched and waited while he self-quarantined alone far from home. I also listened with compassion as health worker friends vented both about the distress they felt related to infecting their families and the difficulty they experienced expressing vulnerability within a public discourse that framed them as superheroes. Then, an African American community activist in Tucson, and former PhD advisee, contracted the virus and died. Her death profoundly affected our local community.

So what practical collaborations can a medical anthropologist contribute to during lockdown? With dual training in anthropology and public health, I decided my efforts were best spent on four endeavors. The first entailed translational research toward increasing public understanding of COVID-19. Given continuously evolving COVID-19 information streams muddied by misinformation coming from both high and low places, there was a need for a primer that kept abreast of the science and made it accessible to the public. The COVID-19 primer I created and update was initially designed for university professors to better enable them to confidently talk with their students about the disease, explain why public health recommendations about physical distancing need to be taken seriously, and offer advice about how to prevent the disease and respond in cases



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where mild to moderate symptoms might be indicative of COVID-19. This entails explaining public health concepts germane to an understanding of pandemic mitigation, answering questions about contagion, and highlighting lessons learned from other countries ahead of the United States in the COVID-19 trajectory.

The primer soon began circulating on several university campuses in the United States as well as overseas. I enlisted the aid of epidemiology PhD students at the University of Arizona to assist me in reviewing and fact-checking scientific articles and news summaries. Questions began pouring in, ranging from queries about the effectiveness of wearing and cleaning different types of masks to reasons for ethnic and gender differences in mortality rates, from the difference between COVID-19 tests to what is actually known about COVID-19 immunity. The primer began appearing on blogs such as [Medanthcovid-19.org](https://medanthcovid-19.org).

A second endeavor entailed highlighting what medical anthropology could bring to the COVID-19 research table. I began working with colleagues Kristin Hedges and Liz Cartwright as well as other members of the Anthropological Responses to Health Emergencies (ARHE) special interest group of the American Anthropological Association, to create working lists of high priority research issues. One list focuses on community and health care settings. Issues highlighted are largely gleaned from action-oriented ethnographic research conducted during previous epidemics and pandemics. Another highlights issues demanding critical “anthropology of” research. It draws attention to such issues as how COVID-related programs are framed by different stakeholders, and the ways such framing influences how interventions are rolled out; how prevalence and mortality data is being presented, misrepresented and suppressed; and how disparities in mortality rates are revealing underlying conditions of structural vulnerability. These lists along with the COVID-19 prim-

er are available on the [AHRE website](#), and are currently being crowdsourced.

Third, I became involved with university- and state-level COVID-19 working groups examining how best to prepare for COVID-19 testing, contact tracing, and symptom monitoring when employees and students return to work. As an anthropologist, I have tried to make the case that before introducing interventions to “the community” at large, trust must first be established within vulnerable groups (see [Mason et al. 2020](#)). Reaching out to diverse community leaders in a respectful manner and training peers to do outreach is likely to prove essential in a border state such as Arizona. The same goes for working with the leaders of different industries to assess working conditions, safety needs, and challenges to public health recommendations beyond providing one-size-fits-all guidelines and checklists. As for symptom monitoring, I have stressed the importance of monitoring shifts in subjective states of well-being, not just established signs of COVID-19. Subjective states and anticipatory anxiety need to be taken into account for many reasons, from the impact they have on blood pressure, sleep patterns, appetite, and the senses to the manner in which they influence health care seeking and self-medication.

The fourth endeavor addresses a serious gap in pandemic preparedness and response: health care worker (HCW) support. During both COVID-19 surge and disease mitigation conditions, HCW face protracted periods of time during which they place their families at heightened risk

to infection. During these times, it will be necessary for many HCW to self-quarantine to keep their families safe. Little thought has been given to what kinds of support HCW will need during and after the pandemic.

Such support has to be planned for with care and compassion, bearing in mind challenges for HCW and their families that go well beyond safe housing. The needs of HCW, their partners, and children include material resource acquisition, social connectivity, attentiveness to well-being as an important factor in coping with stress, and mental health support.

Along with a group of colleagues and civic leaders, I helped launch [HCW HOSTED](#), a grassroots coalition mobilized to meet HCW needs during COVID-19 as well as future pandemic threats. It serves as a one-stop portal for all existing community and institutional support resources for HCW and their families. The health status of all HCW who sign up is monitored daily, which HCW and their families find reassuring; triage and shifts in housing are facilitated if and when necessary. HCW HOSTED is designed to be iterative and to identify emerging needs as they arise before proactively mobilizing community resources to meet these needs. It shares information about ways community members can support HCW through donations in cash and kind. And, it provides a well-documented model for community-based pandemic preparedness that may be adopted and adapted elsewhere.

In closing, let me make two points with respect to anticipatory anthropology. I view HCW HOSTED as an opportunity to do more than just support HCW during a pandemic. COVID-19 provides an opportunity to build alliances and momentum for significant health care reform. In the United States, COVID-19 has rendered transparent the fault lines of our health care system and the structural determinates of this nation's unequal health. This is clearly evident in high COVID-19 mortality rates among minority groups, the poor, and those working

in occupations with limited safeguards (see [Bailey et al. 2020](#); [Choo 2020](#); [Kendi 2020](#); [Menon 2020](#); [Rosen 2020](#)). It is also a watershed moment when HCW and the public are bonding in a way I have rarely seen happen. Doctors, nurses, and allied HCW are being hailed as heroes. They are seen as entering precarious work environments often without proper protection and risking their lives for the common good. They are also seen and see themselves as victims of a

failed health care system. Any and all ways of facilitating this bonding between HCW and the public builds critical mass needed for real-world change of our failed health care system.

COVID-19 is a health care transition tipping point. Our future is unpredictable, and it is likely we will have to learn to live with COVID-19 and its sequelae for quite some time to come. Our for-profit health care system and poorly funded community

hospitals are not well positioned to respond to a scenario of public health crises and falling revenue streams. We have already witnessed health staff furloughs, salary cuts, and hospital closures mid-crises. Rallying the public in support of HCW may embolden them to be more outspoken and proactive in pushing for systemic change in this election year. We need HCW to speak up and speak out en masse in ways they have not done in the past.

A Recipe for Polenta from Istria

By Anna Colquhoun

For my family and neighbours here in Istria, polenta has become quite an occasion during the pandemic. Together we sowed a field with maize, the first for many years, and I learned how labour-intensive it is—the harvesting, drying, shelling, grinding, and sifting. While movement was restricted here due to COVID-19 the polenta flowed through the village in the form of gift exchanges of eggs, cabbages, olive oil, and cakes. And when restrictions eased our first communal meal was a feast featuring wild boar stew with scoops of stiff golden polenta.

Polenta was once an everyday staple here in Istria, the peninsula in the Adriatic which today comprises parts of Croatia, Slovenia, and Italy. Families grew maize, both yellow and white, and took it to one of the hundreds of small mills, now ruins in the forest. But while other so-called peasant foods associated with Istria's rural heritage have become hallmark features of "Istrian cuisine,"



polenta has not experienced this culinary revival. Unlike most of those other dishes it was not a feasting food, so perhaps its association with poverty makes it unsuitable.

It also takes time to cook, which is inconvenient. Of course, one can buy "quick-cook" polenta. But if you have the time—and perhaps you do right now—it's worth finding some coarsely ground cornmeal and an hour to cook it. The pot only needs intermittent care, it provides an alternative to pasta, and leftovers fry up beautifully. If you're used to quick-cook polenta the taste

and texture will surprise you too. You can enrich it by substituting stock or milk for water and adding butter and cheese. But good cornmeal needs just salt and a dash of olive oil, leaving the sweet maize flavor intact.

SOFT OR STIFF

This is personal preference: a soothing porridge-like consistency to eat with a spoon, or rough hunks of firm polenta to contrast with a saucy stew. The difference is achieved by varying the ratio of polenta to water, measured by volume. As a rule of thumb 1:2 results in a very firm polenta, 1:3 medium, and 1:4 or more soft. However, it depends on the grind, so follow packet instructions, or experiment until you find your sweet spot.

USING LEFTOVER POLENTA

Polenta from the fridge should slide out of its container, providing a neat block to slice into tranches. Place a skillet, preferably cast-iron, over a medium heat and wait until heated before adding enough oil to cover the surface and your slabs of polenta. Fry for a good eight or so minutes on each surface until a golden brown crust has formed and the inside

COVID-19 also marks what I hope is a swing from disenchantment with science to a greater appreciation for and public interest in science. Will COVID-19 signal the end of anti-science, fake news forms of tyranny? Despite sensational new coverage to the contrary, I am hopeful when I see massive public support for Dr. Anthony Fauci and state governors who make health decisions after conferring with scientists. Organic intellectuals (see [Susser](#)

[2011](#)) and those engaging in practical, yet value-driven phronetic social science ([Flyvbjerg 2001](#)) will have a role to play in bringing about this shift, anthropologists among them. 🌀

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is piping hot. Don't be tempted to move the pieces too often—they need time to form a crust and release from the pan.

ACCOMPANIMENTS

Pretty much anything you can imagine pairing with pasta or mashed potatoes goes with polenta. Here are a few ideas:

- *Your favourite meat stew.* Here we love it with wild boar goulash, cooked with red wine and flavoured with rosemary, sage, and juniper.
- *Your favourite greens.* Take a heap of kale, mustard greens, chard, or sprouting broccoli and blanch them in salted water. Meanwhile gently fry chopped garlic and chilli, and salted anchovy fillets too if you like, in olive oil. Drain the greens and toss with the garlicky oil.
- *Eggs.* Polenta and eggs are a fantastic combination, whether the polenta is soft or fried up for breakfast. Keep it simple with fried eggs and chilli sauce, or indulgent with poached eggs, plenty of melty cheese, and a moat of fresh or soured cream.
- *Mushrooms:* Another great pairing. Slice and simply fry with a little chopped garlic until golden, or turn into a rich ragù with the addition of rehydrated dried wild mushrooms, white wine, and cream. 🌀

BASIC RECIPE (SERVES 6–8)

2 cups (475ml) coarse ground polenta
4–8 cups (945–1,900ml) water (see note above)
3 tablespoons (45ml) olive oil
salt

Choose a medium-large tall saucepan in which the water will fit with head-room. Bring the water to a boil, season with salt, and add the polenta in a steady stream, whisking continuously to prevent lumps. Once it's all whisked in and bubbling, reduce the heat to very low and switch to a long wooden spoon or spatula to stir in the oil.

Let the polenta cook slowly, magma-like bubbles barely breaking the surface, and stir every 10 or so minutes to prevent it catching at the bottom. Inevitably it will stick a bit, but don't let it burn or the whole pot will be infused with an unpleasant scorched flavour. It can help to keep the pot covered between stirs. If the consistency feels too stiff, beat in some hot water.

After an hour, maybe less, the polenta should be ready. Taste to check no grittiness remains, and add more salt if it is bland. (You could stir in a knob of butter or handful of grated Parmesan at this point.)

If your polenta is soft, scoop it directly into shallow bowls. If it's firm, you can pour it onto a wooden board, leave to sit for a few minutes to firm up some more, then cut into wedges.

If you cannot eat it all right now, transfer the remainder to a straight-sided container while still piping hot and pourable. Once cooled transfer to the fridge where it will keep for two or three days.

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ed in social relations and place-making as the region becomes a "gastronomic" destination. She has worked in food for many years and written several cook-books.