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WHY RESPONSES TO PUBLIC HEALTH EMERGENCIES NEED TO INCORPORATE A BROADER UNDERSTANDING OF CULTURE

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ABSTRACT

Responses to epidemics have shown a lack of cultural and contextual understanding which has led to measures being ineffective and harmful. Given the scope of the current COVID-19 pandemic, lessons learned from previous epidemics need to be integrated into response measures. This paper critically reflects on the lessons learned during the HIV/AIDS and Ebola epidemics and their implementation in response to COVID-19. It argues that there is a need for an increased awareness of cultural complexity when reacting to public health emergencies. Particularly, it stresses the dangers of a one-dimensional understanding of culture. A limited conceptualization that considers culture only in terms of behaviour, can enable stigmatisation and racism and ignores interconnections of culture with inequities in power. It is concluded that awareness of cultural complexity, which comprises flexible visible negative and positive aspects as well as the underlying context, must be integrated for effective and respectful responses to epidemics.

KEYWORDS

Cultural Rights; Epidemics; HIV/AIDS; Ebola; COVID-19; Public Health Emergency; Disaster Response

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<https://www.researchgate.net/publication/328841925> *The Role of Culture in Response to Epidemics* [Last accessed 09.12.2020].

1. INTRODUCTION

Culture is a significant determinant of health. Culture can have direct effects on health and influence the social determinants of health, such as the circumstances in which people live and work.¹ Cultural effects can therefore have a positive, as well as negative, impact by acting as either a resource or as a risk factor for individuals. For example, culturally shaped gender-inequality can result in adverse health results for women.² Furthermore, culture can have a profound influence on the processes of symptom recognition, labelling, help-seeking, and the structure of health systems.³ For instance, public health measures and the response towards them are shaped by cultural factors, such as social agreements and assumptions; representations of health and sickness; or the religious value of suffering.⁴ Thus, awareness for cultural effects is crucial to reduce inequalities and inequities in health;⁵ for designing culturally competent health systems;⁶ and for effectively approaching health emergencies such as epidemics.⁷

The significance of culturally appropriate and acceptable health services is also addressed in the human rights framework.⁸ By ratifying the International Covenant on Economic, Social and Cultural Rights states recognize the right to pursue one's cultural development (Article 1) and to enjoy the highest attainable standard of physical and mental health (Article 12). More specifically, in their general comment

¹ Juliet Iwelunmor and Collins Airhihenbuwa, 'Culture, a Social Determinant of Health and Risk: Considerations for Health and Risk Messaging', *Oxford Research Encyclopedia of Communication* (2017).

² Mat Lowe, Duan-Rung Chen and Song-Lih Huang, 'Social and Cultural Factors Affecting Maternal Health in Rural Gambia: An Exploratory Qualitative Study' (2016) 11(9) PLOS ONE.

³ R. Angel and P. Thoits, 'The impact of culture on the cognitive structure of illness' (1987) 11 *Culture, Medicine and Psychiatry* 465.

⁴ A. D Napier and others, 'Culture and health' (2014) 384(9954) *The Lancet* 1607.

⁵ Iwelunmor and Airhihenbuwa (n 1).

⁶ Jennifer White and others, 'What is needed in culturally competent healthcare systems? A qualitative exploration of culturally diverse patients and professional interpreters in an Australian healthcare setting' (2019) 19(1) *BMC Public Health* 1096.

⁷ Guitelle St. Victor and Saeed Ahmed, 'The Importance of Culture in Managing Mental Health Response to Pandemics' in Damir Huremovic (ed), *Psychiatry of Pandemics: A Mental Health Response to Infection Outbreak* (1st ed. 2019. Springer International Publishing 2019).

⁸ CESCR, 'General comment No. 14: The right to the highest attainable' (2000).

no. 14 the Committee on Economic, Social and Cultural Rights (CESCR) highlights that health services and goods must respect individuals' culture.⁹ To facilitate cultural-sensitive healthcare, states are required to train their health-care staff "to recognize and respond to the specific needs of vulnerable or marginalized groups".¹⁰ In other words, the right to the highest attainable standard of health does not only imply the need for culture-sensitive healthcare. Receiving healthcare that respects one's culture is an independent human right.

Despite this legal foundation, evidence from previous epidemics suggests that within the response to public health emergencies, cultural aspects are not sufficiently considered.¹¹ This can partially be attributed to a lack of awareness and unfamiliarity with local cultures. International measures in response to HIV/AIDS and Ebola sometimes relied on assumptions and a one-dimensional understanding of culture and cultural practices.¹² This has led to programmes being ineffective or even harmful.¹³ For instance, cultural aspects in South Africa, such as sexual norms and perceived promiscuity, was regularly framed as a risk factor for diseases.¹⁴ This resulted in an increase in discrimination, stigma, and othering of affected people.¹⁵ It is argued that responses to health emergencies must include awareness of cultural effects and the principle of non-discrimination.

⁹ *ibid.*

¹⁰ *ibid* n.p.

¹¹ A. D Napier, 'Culture matters: using a cultural contexts of health approach to enhance policy-making' (2017); James Fairhead, 'Understanding Social Resistance to the Ebola Response in the Forest Region of the Republic of Guinea: An Anthropological Perspective' (2016) 59(03) *Afr stud rev* 7

¹² Barry S Hewlett and Richard P Amola, 'Cultural Contexts of Ebola in Northern Uganda' (2003) 9(10) *Emerging Infectious Diseases* 1242; Chelsea Bond and Mark K Brough, 'The Meaning of Culture within Public Health Practice Implications for the study of Aboriginal and Torres Strait Islander Health' in Ian Anderson, Fran Baum and Michael Bentley (eds), *Proceedings Social Determinants of Aboriginal Health Workshop* (2007); Zakiya Q Al-Busaidi, 'Qualitative Research and its Uses in Healthcare' (2008) 8(1) *Sultan Qaboos University Medical Journal* 11.

¹³ J. D Mull and D. S Mull, 'Mothers' concepts of childhood diarrhea in rural Pakistan: what ORT program planners should know' (1988) 27(1) *Social science & medicine* (1982) 53.

¹⁴ Bond and Brough (n 13).

¹⁵ Steven Sovran, 'Understanding culture and HIV/AIDS in sub-Saharan Africa' (2013) 10(1) *SAHARA J: journal of Social Aspects of HIV/AIDS Research Alliance* 32.

Considering the scope and the possible long-term nature of the current COVID-19 pandemic it is of significance to ensure public health responses respect and integrate cultural aspects. Thus, lessons learned from previous health emergencies need to be critically reviewed and integrated. Despite the novelty of the pandemic, there have already been attempts to discuss the impact of culture on the response to COVID-19.¹⁶ Yet, these discussions rarely take lessons learned from previous epidemics into account. This article addresses this shortcoming and aims to critically reflect on the integration of cultural considerations in responses to both, previous health emergencies and during the current COVID-19 pandemic.

Therefore, a literature review has been conducted. The major amount of relevant papers was found within anthropological and public health literature. However, given the novelty of the COVID-19 disease, the amount of scientific literature on the pandemic was limited. Hence, grey literature such as reports by expert associations (e.g. WHO, UNESCO) and newspapers have been extensively searched. When analysing and discussing current strategies and measures it must be noticed that evidence is still scarce and often limited to anecdotal reports.

While the omnipresence of culture and its effects is acknowledged (e.g. organizational culture), the focus of this discussion lies on the culture of communities affected by diseases and the responses towards them and the way cultural aspects are considered, presented, and affected by public health measures. The scope of this discussion does not allow to delve into the implications of public health measures on access to cultural heritage that has been discussed elsewhere.¹⁷

The paper is structured as follows. First, the understanding of culture which is used as a foundation for the discussion in this paper is presented. Second, the lessons learned regarding culture in outbreaks of diseases are identified and discussed using the ongoing HIV/AIDS epidemic in South Africa, and the Ebola outbreak in West Africa 2014-2016 as case studies. Third, the results are discussed by referring to the

¹⁶ Olav T Muurlink and Andrew W Taylor-Robinson, 'COVID-19: Cultural Predictors of Gender Differences in Global Prevalence Patterns' (2020) 8 *Frontiers in public health* 174; Mary B Lamb and Amy Tolbert, 'How Cultural Differences Impact Getting Global Results in the COVID-19 Pandemic' (2020).

¹⁷ UNESCO, 'Culture & COVID-19: Impact and Response Tracker' (2020); Elżbieta Kuzelewska and Mariusz Tomaszuk, 'European Human Rights Dimension of the Online Access to Cultural Heritage in Times of the COVID-19 Outbreak' [2020] *Int J Semiot Law* 1.

current response to COVID-19 within frame of two key lessons learned: the need for cultural awareness and the significance of community approaches to health. Finally, this article concludes by arguing that similarly to previous epidemics, the complexity of culture is not sufficiently incorporated in current responses to the COVID-19 crisis.

2. THE UNDERSTANDING OF CULTURE WITHIN THE FRAMEWORK OF THIS DISCUSSION

Culture is a complex concept that refers to overt and covert beliefs and practices and “frames our sense of reality.”¹⁸ In this sense, culture affects all people by shaping their every-day lives and the frameworks they use for making sense of the world. According to UNESCO, culture refers to a “set of distinctive spiritual, material, intellectual and emotional features” which encompasses the individual and social way of life of a group of people, value systems, traditions, and beliefs and takes diverse forms across time and space.¹⁹ For example, culture with its norms, values, and traditions can be considered as the foundation of communities and determinants of political ideologies and religious mores. Hence, the term culture commonly refers to the way of life of a group of people that is shared and learned.²⁰

However, the notion of uniformity and internal coherence within one culture has been challenged.²¹ Dynamic and highly flexible concepts have been developed that consider not only the changes over time and space but also the distinctions between individual members of one group of people. Rathje, who has a doctorate in intercultural communication, for example, highlights that individuals tend to belong to more than one collective and suggests understanding culture as a matrix rather than a single definition.²² Next to the traditional plural perspective, Rathje includes an individual perspective that illustrates the individuality and multicollectivity of people.

¹⁸ Napier (n 11) 1.

¹⁹ UNESCO, ‘Universal Declaration on Cultural Diversity’ (2002) 10.

²⁰ Bond and Brough (n 13).

²¹ Stefanie Rathje, ‘The Definition of Culture: An Application-Oriented Overhaul’ [2009] *Interculture Journal*.

²² *ibid*.

Given the complexity of the concept of culture and the variety of approaches and understandings of what culture is, it is not surprising that there is no shared understanding of what culture entails and how the concept of culture can be integrated into public health measures.²³ The omnipresence of culture increases the difficulty of identifying cultural frames and recognizing cultural effects. Napier refers to a key challenge when he underlines the difficulty of questioning assumptions and perceived truths.²⁴ For example, organizational culture or humanitarian culture can have a strong impact on responses to health needs and affected people.²⁵ However, the cultural context in which public health measures are designed and take place is often not recognised or sufficiently addressed.²⁶

Responses to public health emergencies have been criticized for being limited to assumptions about culture, using one-dimensional concepts of culture, and misinterpreting culture as coherent and stable.²⁷ In their literature review Bond and Brough found that within indigenous health research, culture is commonly conceptualized as an ideology, label, behaviour, surrogate, or cure.²⁸ Thereby, intersections with other sources of identity such as age, gender, sexuality, race and ethnicity, religion, lifestyle, and occupation are easily neglected.²⁹ Bond and Brough rightly stress the need to engage in more critical reflections on the use of concepts of culture to acknowledge not only the meaning of culture for risk-factor epidemiology but also for the people involved.

For this paper, culture is understood as a complex concept that refers to fluid and changing frames of reality that can be both, shared and individual. This understanding aims to highlight the dynamic and flexible nature of culture and takes the multicollectivity of people into account. It implies the need to assess distinct collectives in which people participate and to recognize the effects culture can have on individuals and the meaning they apply to it.

²³ Napier (n 11).

²⁴ *ibid.*

²⁵ Bond and Brough (n 13).

²⁶ Napier (n 11).

²⁷ Sovran (n 16).

²⁸ Bond and Brough (n 13).

²⁹ *ibid.*

3. LESSONS LEARNED FROM THE HIV/AIDS EPIDEMIC AND ITS APPLICATION IN THE RESPONSE TO EBOLA

To illustrate the impact of culture on public health emergencies and the responses towards them, a comparative case study approach was chosen. HIV/AIDS is considered as one of the major public health emergencies within the last decades,³⁰ with the African region being most severely affected.³¹ During the response to the Ebola outbreak between 2014 and 2016 in West Africa, the need to apply lessons learned from the HIV/AIDS epidemic had been stressed.³² Both diseases can be deadly and there is no medical cure.³³ In both epidemics, cultural effects have had a great impact on the ways people dealt with the emergencies and the public health responses towards them.³⁴ This case study aims to discuss shortcomings and lessons learned regarding culture in responses to health emergencies by comparing evidence from the HIV/AIDS epidemic in South Africa, which started in the 1960s and is ongoing,³⁵ to the response to the Ebola outbreak in Liberia, Sierra Leone, and Guinea between 2014 and 2016.

³⁰ Some authors refer to the HIV/AIDS pandemic while the WHO considers it a “global epidemic”. CDC, ‘The Global HIV/AIDS Pandemic, 2006’ (2006) WHO Europe, ‘Embracing cultural diversity unlocks key resources for more inclusive health systems’ (2020); WHO, ‘Global Health Observatory (GHO) data: HIV/AIDS’ (2020).

³¹ WHO (n 32).

³² Ishani Pathmanathan and others, ‘Insights from the Ebola response to address HIV and tuberculosis’ (2016) 16(3) *The Lancet Infectious diseases* 276.

Mariam Davtyan, Brandon Brown and Morenike O Folayan, ‘Addressing Ebola-related stigma: lessons learned from HIV/AIDS’ (2014) 7 *Global health action*.

³³ Recently the “London patient” has been cured from HIV, however up to now this remains a single case. Ravindra K Gupta and others, ‘Evidence for HIV-1 cure after CCR5Δ32/Δ32 allogeneic haemopoietic stem-cell transplantation 30 months post analytical treatment interruption: a case report’ (2020) 7(5) *The Lancet HIV* pp.340-347.

³⁴ Collins O Airhihenbuwa and J. D Webster, ‘Culture and African contexts of HIV/AIDS prevention, care and support’ (2004) 1(1) *SAHARA-J: Journal of Social Aspects of HIV/AIDS* 4; Samuel Kargbo, *How we solved the Ebola epidemic by first understanding culture* (TEDxMidAtlantic - YouTube 2016).

³⁵ Eduan Wilkinson, Susan Engelbrecht and Tulio de Oliveira, ‘History and origin of the HIV-1 subtype C epidemic in South Africa and the greater southern African region’ (2015) 5(1) *Sci Rep*.

3.1. AWARENESS OF THE SIGNIFICANCE OF CULTURE

Cultural aspects had a significant impact on the response to HIV/AIDS and Ebola, yet these effects were not considered in the initial responses to both diseases.³⁶ In 2001, UNESCO stressed that a medical approach alone is not sufficient to tackle a multifaceted issue like HIV/AIDS and called for a more culture-sensitive approach.³⁷ The motivation for this shift was not primarily driven by a rights-based approach, which underlines the right to receive culturally appropriate healthcare. Instead, the focus was on the need for more effective interventions e.g. in terms of behavioural change.³⁸ For example, it was realized that culturally embedded views of fertility or social stigma linked to purchasing condoms can affect HIV-prevention.³⁹ Therefore, it was found crucial to address social norms and consider stigma within health promotion.⁴⁰

³⁶ Sharon A Abramowitz and others, 'Community-centered responses to Ebola in urban Liberia: the view from below' (2015) 9(4) PLoS neglected tropical diseases.

³⁷ UNESCO, 'A Cultural approach to HIV/AIDS prevention and care: culturally appropriate, information, education, communication; elaboration and delivery: Methodological handbooks: special series; Vol.:1; 2001' (2001).

³⁸ UNESCO (n 40).

³⁹ C. A Varga, 'Sexual decision-making and negotiation in the midst of AIDS: youth in KwaZulu-Natal, South Africa' (1997) 7(Supplement 3) Health Transition Review 45; WHO, 'Engaging Men and Boys in Changing Gender-based Inequity in Health: Evidence from Programme Interventions' (2007); WHO, 'Condoms an important form of protection from HIV' (2009); N. N Sarkar, 'Barriers to condom use' (2008) 13(2) The European journal of contraception & reproductive healthcare : the official journal of the European Society of Contraception 114; Suzanne Leclerc-Madlala, Leickness C Simbayi and Allanise Cloete, 'The Sociocultural Aspects of HIV/AIDS in South Africa' in Poul Rohleder and others (eds), *HIV/AIDS in South Africa 25 years on: Psychosocial perspectives* (Springer 2009); Ayalew Gebre, Tekalign Ayalew and Helmut Kloos, 'Gender Inequalities, Power Relations, and HIV/AIDS: Exploring the Interface' in Getnet Tadele and Helmut Kloos (eds), *Vulnerabilities, Impacts, and Responses to HIV/AIDS in Sub-Saharan Africa* (Palgrave Macmillan UK 2013); Urther Rwafa, 'Culture and Religion as Sources of Gender Inequality: Rethinking Challenges Women Face in Contemporary Africa' (2016) 32(1) Journal of Literary Studies 43; UNAIDS, 'Country factsheets South Africa 2016: HIV and AIDS estimates' (2018).

⁴⁰ Thoovakkunon M Chandran and others, 'Predictors of condom use and refusal among the population of Free State province in South Africa' (2012) 12(1) BMC Public Health 381.

Similarly, the neglect of cultural aspects at the beginning of the response to the Ebola epidemic in West Africa led to ineffective and problematic health measures.⁴¹ For instance, people refused public health policies, such as hygienic burials of their relatives, because fundamental cultural practices of mourning were neglected.⁴² While between and within Sierra Leone, Liberia, and Guinea fundamental religious and spiritual differences exist, rituals such as washing and touching the body of the deceased are considered fundamental.⁴³ Burial rituals are thought to prevent the dead from eternal wandering and to avoid misfortune and curse on the family and community.⁴⁴ Given the importance of these rituals and the fear of being stigmatized, people in Sierra Leone hid the corpses, thereby allowing the spread of the virus.⁴⁵ Thus, the neglect of including the cultural context into the response to public health emergencies led to the measures being ineffective or even harmful.

Consequently, organisations aimed to integrate cultural aspects in their public health response to the Ebola outbreak. Three networks of anthropologists were established to inform on the design of the response to the outbreak in line with the cultural context.⁴⁶ For example, two months after Ebola was declared a public health emergency, the WHO established a new protocol for safe burials.⁴⁷ According to this protocol, the WHO aimed, in cooperation with affected communities, to take cultural concerns into account and underlined the need to gain consent for burial plans. While it remains unclear how successfully the protocol was implemented, the need to respect cultural traditions and involve local communities was recognized.⁴⁸ The right to have

⁴¹ Kargbo (n 36).

⁴² Fairhead (n 11).

⁴³ Seung H Lee-Kwan and others, 'Facilitators and Barriers to Community Acceptance of Safe, Dignified Medical Burials in the Context of an Ebola Epidemic, Sierra Leone, 2014' (2017) 22(sup1) *Journal of health communication* 24.

⁴⁴ Amy Maxmen, 'How the Fight Against Ebola Tested a Culture's Traditions' (11 August 2016).

⁴⁵ *ibid* Lee-Kwan and others (n 47).

⁴⁶ Sharon Abramowitz, 'Epidemics (Especially Ebola)' (2017) 46(1) *Annu Rev Anthropol* 421.

⁴⁷ Cordelia E M Coltart and others, 'The Ebola outbreak, 2013-2016: old lessons for new epidemics' (2017) 372(1721) *Philosophical transactions of the Royal Society of London Series B, Biological sciences*

⁴⁸ *ibid*.

access to culturally appropriate healthcare was not mentioned, yet reference was made to “religious and personal rights to show respect for the deceased”.⁴⁹

However, in many approaches that aimed to incorporate the cultural context, and the way these approaches were communicated, there lacked consideration of the complexity and significance of culture. Within some organisations culture was understood in an oversimplified way and reflected colonial heritage and westernization.⁵⁰ It has been argued that the US Center for Disease Control and Prevention (CDC) neglected fundamental cultural differences on the African continent by referring to “African culture” in the discourse of Ebola.⁵¹ For example, it was criticized that they introduced a health communications specialist who grew up in Rwanda as a cultural expert for Sierra Leone, a country almost 7 000 kilometres away from there.⁵² Indeed even in a blog entry about this specialist, no information on her knowledge of West Africa could be found, although she herself highlighted that there is no single African culture.⁵³ Unfortunately, this awareness of cultural diversity was not reflected in the social media posts of the CDC.⁵⁴ Instead, within health communication “monolithic notions of culture [have been] used as diagnostic categories onto which prepackaged solutions for Ebola can be crafted”.⁵⁵

Two shortcomings in the conceptualization of culture were particularly prevalent in both epidemics. First, culture was commonly considered in terms of detrimental behaviour only; second, the interrelatedness with socio-economic factors was neglected. Prevention programmes in South Africa and Sierra Leone aimed to change certain culturally embedded behaviour patterns such as sexual activity, hygiene practices, and death rituals.⁵⁶ Thereby, the focus was put on behaviour

⁴⁹ WHO, ‘How to conduct safe and dignified burial of a patient who has died from suspected or confirmed Ebola or Marburg virus disease: Interim Guidance’ [2017], 1.

⁵⁰ Shaunak Sastry and Mohan J Dutta, ‘Health Communication in the Time of Ebola: A Culture-Centered Interrogation’ (2017) 22(sup1) *Journal of health communication* 10.

⁵¹ Shaunak Sastry and Alessandro Lovari, ‘Communicating the Ontological Narrative of Ebola: An Emerging Disease in the Time of “Epidemic 2.0”’ (2017) 32(3) *Health communication* 329, n.p.

⁵² Sastry and Lovari (n 58).

⁵³ CDC, ‘Monique, a CDC Disease Detective, responds to the 2014 Ebola outbreak’ (2 November 2020)

⁵⁴ Sastry and Lovari (n 58).

⁵⁵ Sastry and Dutta (n 57), n.p.

⁵⁶ Abigail Harrison and others, ‘HIV prevention for South African youth: which interventions work? A systematic review of current evidence’ (2010) 10(1) *BMC Public Health* 102 Mohamed F Jalloh and

considered as risky.⁵⁷ The focus on negative behaviours within culture corresponds with the common deficit orientated understanding of culture in public health research. Bond and Brough, for example, argue that culture is typically considered as a risk factor in epidemiological inquiries and thought to negatively influence and constrain human behaviour.⁵⁸ Positive aspects, like the culture of caretaking or the flexibility of culture, were not widely acknowledged.⁵⁹ For example, community leaders in Liberia emphasized that traditional burial practices can be changed as long as the bodies of the diseased are handled respectfully.⁶⁰ This example underlines the need to be aware of underlying values and beliefs, instead of focusing on cultural behaviour only.

When culture is solely framed in negative terms it can reinforce stigmatisation and racism. Culture is sometimes still understood as a co-factor of HIV/AIDS in Sub-Saharan Africa with the “culture of sex” considered as a root of the prevalence.⁶¹ While such assumptions are not based on empirical research, they can lead to racism and discrimination. For example, societies can be blamed and stigmatized for their high prevalence rate due to assumed inherent characteristics.⁶² Similarly, it is argued that cultural explanations during the Ebola epidemic fuelled sensational news coverage that supported fears of Africa as a disease-ridden continent.⁶³ By illustrating narratives that correspond with colonial-era prejudice, such as the consumption of bushmeat as an uncivilized practice, African peoples were dehumanised.⁶⁴ As with HIV/AIDS, an

others, ‘Evidence of behaviour change during an Ebola virus disease outbreak, Sierra Leone’ (2020) 98(5) *Bulletin of the World Health Organization* 330-340B.

⁵⁷ Abramowitz and others (n 39).

⁵⁸ Bond and Brough (n 13).

⁵⁹ Abramowitz and others (n 39); Sastry and Dutta (n 57).

⁶⁰ Sharon Abramowitz and Pat Omidian, ‘Brief on attitudes towards Ebola-related funerary practices and memorialization in urban Liberia’ (n.d.).

⁶¹ Sovran (n 16).

⁶² *ibid.*

⁶³ Fairhead (n 11).

⁶⁴ Adia Benton and Kim Y Dionne, ‘International Political Economy and the 2014 West African Ebola Outbreak’ (2015) 58(01) *Afr stud rev* 223; Sastry and Dutta (n 57).

“othering” of people affected led to stigmatization, emotional distance, and a lack of care.⁶⁵

Models that allow a more integrated approach to the cultural context of health emergencies already exist. The PEN-3 cultural model, developed in 1989 in response to HIV/AIDS, aims to centralize culture in health research and intervention.⁶⁶ It incorporates the domains of cultural identity, relationships, expectations, and cultural empowerment and emphasises the significance of cultural context in examining health behaviour.⁶⁷ For example, PEN-3 has shown to be applicable in understanding the HIV related stigma and the reluctance in condom use in a holistic way and in different cultural settings.⁶⁸ Similarly, factors associated with the spread of the Ebola virus have been examined using the PEN-3 model, stressing positive and negative practices.⁶⁹ PEN-3 focuses not only on factors that inhibit individual behaviour change or have a negative impact on health but also on factors that have a positive impact and are considered existential.⁷⁰ Being aware of the positive aspects of culture enables their support in public health measures.

Second, responses to public health emergencies often did not address cultural effects and their interrelatedness with socio-economic factors beyond considerations of disease containment. Policies sometimes led to an increased vulnerability of certain groups, which can be partially explained by cultural effects. For example, during the Ebola epidemic, the closure of schools and curfews led to an increase in gender-based

⁶⁵ Javid Abdelmoneim, *Ebola reflections: them, not us* (TEDxAthens - YouTube tr, 2016); Sarah Monson, ‘Ebola as African: American Media Discourses of Panic and Otherization’ (2017) 63(3) *Africa Today* 3.

⁶⁶ Juliet Iwelunmor, Valerie Newsome and Collins O Airhihenbuwa, ‘Framing the impact of culture on health: a systematic review of the PEN-3 cultural model and its application in public health research and interventions’ (2014) 19(1) *Ethnicity & health* 20.

⁶⁷ *ibid.*

⁶⁸ Collins Airhihenbuwa and others, ‘Stigma, Culture, and HIV and AIDS in the Western Cape, South Africa: An Application of the PEN-3 Cultural Model for Community-Based Research’ (2009) 35(4) *The Journal of black psychology* 407; Victoria Orrego Dunleavy and others, ‘Applying the PEN-3 Cultural Model to Address HIV/AIDS Prevention in Rural Guatemala’ (2018) 47(1) *Journal of Intercultural Communication Research* 1.

⁶⁹ Whembolua, G.S. Kambamba, D.K. Conserve, D. & Tshiswaka, D.I. ‘Whembolua, G.S. Kambamba, D.K. Conserve, D. & Tshiswaka, D.I. (2015). Socio-Cultural Factors Associated with Epidemics: The Case of 2014 Ebola Outbreak’ [2015].

⁷⁰ Airhihenbuwa and Webster (n 36); Iwelunmor, Newsome and Airhihenbuwa (n 77).

violence, such as rape.⁷¹ Cultural-based gender norms can support violence against girls and women by strengthening vulnerabilities and defining how gender-based violence is viewed.⁷² Thus, a restricted understanding of culture neglects underlying values and beliefs, and the potential of culture to act as both, barriers and resources in health emergencies.

The term culture needs to be used carefully and structural factors and their impact on epidemics must not be neglected.⁷³ The recognition of broader social and structural factors as determinants of disease, such as poor health infrastructure, poverty, and gender⁷⁴ and their interlinkages with culture is fundamental. Fairhead, a professor of social anthropology at the University of Sussex, argues that the Ebola outbreak, as well as the humanitarian response towards it, unsettled social accommodations. Not only did the outbreak and its response disrupt culture and customs, but also politics.⁷⁵ For example, the Guinean Red Cross was frequently under attack due to the lack of political trust in the response efforts, rather than because the healthcare worker ignored cultural aspects.⁷⁶ Similarly, public health responses, in general, to HIV/AIDS were challenged by differences in social status and gender inequality. Measures that incorporated at least one structural factor associated with HIV/AIDS, such as poverty amongst women, were found to be more successful.⁷⁷

⁷¹ Monica A Onyango and others, 'Gender-Based Violence Among Adolescent Girls and Young Women: A Neglected Consequence of the West African Ebola Outbreak' in David A Schwartz, Julienne N Anoko and Sharon A Abramowitz (eds), *Pregnant in the Time of Ebola: Women and Their Children in the 2013-2015 West African Epidemic* (Global Maternal and Child Health, Medical, Anthropological, and Public Health Perspectives. Springer International Publishing 2019).

⁷² *ibid*; Asian Pacific Institute on Gender Based Violence Website, 'Culture & Gender-Based Violence - Asian Pacific Institute on Gender Based Violence Website' (2017).

⁷³ Napier and others (n 4); Abramowitz and others (n 39); Fairhead (n 11).

⁷⁴ Eugene T Richardson and others, 'Gender inequality and HIV transmission: a global analysis' (2014) 17 *Journal of the International AIDS Society* 19035; Sastry and Dutta (n 57).

⁷⁵ Fairhead (n 11).

⁷⁶ Annie Wilkinson and James Fairhead, 'Comparison of social resistance to Ebola response in Sierra Leone and Guinea suggests explanations lie in political configurations not culture' (2017) 27(1) *Critical Public Health* 14.

⁷⁷ Harrison and others (n 65).

It can be argued that culture in terms of social assumptions and agreements,⁷⁸ shapes socio-structural factors, such as power structures and political trust. Yet, it also needs to be acknowledged that culture and its effects “are historically located,”⁷⁹ and act within a context of local and global disparities in wealth and opportunity.⁸⁰ In other words, culture is a “dynamic entity that is continually shaping—and shaped by—broader societal structures.”⁸¹ Essentially, it should also be considered that, the focus on culture must not come at the “expense of attention to socio-political and economic structures, obscuring the reality that global forces affect epidemics in Africa”.⁸²

3.2. AWARENESS ON THE IMPACT OF COMMUNITY APPROACHES

Community approaches to health and collective agency were found to be fundamental for effective and culture-sensitive responses. Research evaluating HIV/AIDS communication in South Africa has underlined that measures need to be “rooted in the culture of the people concerned”.⁸³ Strategies designed in response to Ebola, which incorporated cultural values and customs, due to their community approach were found to be more effective and integral in controlling the disease.⁸⁴ Given the familiarity with local cultures and the awareness of underlying values and beliefs, community approaches to health can support the right to culturally appropriate care and thus the acceptability of treatment.⁸⁵ However, the interrelatedness of culture with socio-structural factors, such as gender-inequity, and the multicollectivity of people may be challenging on a community-level too. For example, an educational

⁷⁸ Napier and others (n 4).

⁷⁹ ‘Genetic, Cultural or Socio-economic Vulnerability? Explaining Ethnic Inequalities in Health’ (21 September 2020) 723.

⁸⁰ Brooke G Schoepf, ‘Ethical, methodological and political issues of aids research in Central Africa’ (1991) 33(7) *Social Science & Medicine* 749.

⁸¹ Sastry and Dutta (n 57), n.p..

⁸² Jared Jones, ‘Ebola, Emerging: The Limitations of Culturalist Discourses in Epidemiology’ [2014] *The Journal of Global Health*, 1.

⁸³ Chijioke Uwah, ‘The role of culture in effective HIV/AIDS communication by theatre in South Africa’ (2013) 10(3-4) *Sahara J* 140, n.p.

⁸⁴ Coltart and others (n 53).

⁸⁵ OHCHR, ‘Handbook on HIV and human rights for national human rights institutions’ (2007).

play on HIV/AIDS was criticized for neglecting the reality of poverty by communicating that young girls should not accept gifts from men in exchange for sex.⁸⁶ While communities have the potential to design more cultural-sensitive messages, it is important to note that they must not emphasise discrimination and inequities.

The significance of approaching communities instead of individuals became evident in both the HIV/AIDS and the Ebola epidemic when addressing cultural aspects related to social stigma. When addressing the HIV/AIDS epidemic, it was recognized that there is a need to focus not exclusively on groups considered to be at high-risk for transmission, such as men having sex with men and people injecting drugs.⁸⁷ Instead, peer pressure and low perceived vulnerability⁸⁸ lead to an awareness of the significance of community approaches and collective agency.⁸⁹ These lessons learned were based on acknowledging the impact of social stigma.⁹⁰ Similar to HIV/AIDS patients, survivors of an Ebola infection can experience stigma and discrimination related to the disease and become socially isolated due to fear of contagion.⁹¹ Thus, measures aimed at communicating that everybody is vulnerable to the diseases; and challenged the misinformation that HIV/AIDS is a “gay epidemic”,⁹² and Ebola infection is linked to low economic status.⁹³

⁸⁶ Uwah (n 104).

⁸⁷ Susan Kippax and others, ‘Between individual agency and structure in HIV prevention: understanding the middle ground of social practice’ (2013) 103(8) *American journal of public health* 1367.

⁸⁸ Catherine MacPhail and Catherine Campbell, “I think condoms are good but, aai, I hate those things” (2001) 52(11) *Social Science & Medicine* 1613.

⁸⁹ Airhihenbuwa and Webster (n 36); Airhihenbuwa and others (n 79); Kippax and others (n 108)

⁹⁰ Asad L Asad and Tamara Kay, ‘Toward a multidimensional understanding of culture for health interventions’ (2015) 144 *Social science & medicine* (1982) 79.

⁹¹ Davtyan, Brown and Folayan (n 35).

⁹² J. Chan, ‘Scaling up the Ebola Response: What we Learned from AIDS Activism’ (2015) 1(1) *Journal of AIDS and HIV infections*, 2.

⁹³ Peter B James and others, ‘An assessment of Ebola-related stigma and its association with informal healthcare utilisation among Ebola survivors in Sierra Leone: a cross-sectional study’ (2020) 20(1) *BMC Public Health* 182.

Recognizing shared vulnerability allowed collective agency, decreased peer pressure, and increased the effectiveness of interventions.⁹⁴ For example, HIV testing was integrated into primary healthcare to avoid separate testing centres. Separate testing centres increased social stigma and thereby hampered accessibility and acceptability of receiving health services.⁹⁵ Similar strategies were found to be effective in reducing othering and victim-blaming and increased the acceptability of measures in response to Ebola. For example, the director of Health Systems, Policy, Planning and Information in the Ministry of Health & Sanitation of Sierra Leone decided to bury all people hygienically regardless of the cause of death.⁹⁶ By involving community leaders in this approach and trying to not disturb important traditions, he effectively aimed for a reduction of stigma with respect to Ebola.

However, while community approaches were key for successful interventions, grassroots initiatives were often narrated as inferior to international measures. During the HIV/AIDS epidemic, the focus on community approaches was implemented through increased use of community health workers, peer support systems, and grassroots initiatives.⁹⁷ Similarly, there were various successful grassroots movements to stop the Ebola epidemic.⁹⁸ Yet, the possibility of local communities to share their voice in decision-making was limited and it is argued that ideological moves within global health governance hindered community agency.⁹⁹ Sastry and Dutta, for example, stress that everyday agency in responding to diseases and outbreaks at the local level was not part of mediated narratives.¹⁰⁰ Instead, an analysis of WHO and

⁹⁴ MacPhail and Campbell (n 110); Marije Versteeg and Montagu Murray, 'Condom use as part of the wider HIV prevention strategy: experiences from communities in the North West Province, South Africa' (2008) 5(2) SAHARA J : journal of Social Aspects of HIV/AIDS Research Alliance 83; Kippax and others (n 108).

⁹⁵ Asad and Kay (n 113).

⁹⁶ Kargbo (n 36).

⁹⁷ Asad and Kay (n 113).

⁹⁸ Thomas Hird, Samara Linton and Polygeia and the Africa All-Party Parliamentary Group, 'Lessons from Ebola affected communities: Being prepared for future health crises' [2016] For example medical students in Sierra Leone and Guinea founded the awareness campaign "KickEbolaOut": <https://www.indiegogo.com/projects/kick-ebola-out-by-medical-students#/> [Last accessed 09.12.2020]

⁹⁹ Sastry and Lovari (n 58).

¹⁰⁰ Sastry and Dutta (n 57).

CDC posts on Facebook shows that international medics were considered heroes and local initiatives were hardly mentioned.¹⁰¹ Such narratives support colonial-era prejudice by comparing a modern, scientific West to primitive local practices.¹⁰²

Overall, the significance of culture and its effects became evident in the response to HIV/AIDS and the Ebola epidemic in 2014. Cultural aspects were integrated into the design of public health measures and there was a shift towards community-based approaches. However, the understanding of culture and its effects were commonly one-sided with a strong emphasis on “risky” behaviour. This interpretation of culture narrated a superficial picture of “African” culture that supported othering, stigmatization, and racism, and neglected socio-economic factors. The rights to cultural development and cultural-sensitive healthcare seemed to play a minor role, undermining the effectiveness of public health measures, and missing the complexity of culture and its effects. Whilst cultural effects were frequently integrated into response designs in a one-dimensional and biased way, lessons have been learned regarding the significance of integrating the cultural context, for example through the support of community approaches.

4. INTEGRATION OF CULTURAL CONSIDERATIONS IN RESPONSE TO COVID-19

Given the scale of the current COVID-19 pandemic, it seems crucial to consider and integrate lessons learned from previous public health emergencies. On January 30 2020, COVID-19 was declared a “public health emergency of international concern” by the WHO.¹⁰³ Since then the novel virus and its response have affected the global community in various ways.¹⁰⁴ For example, policies aiming to prevent and mitigate the spread of COVID-19 such as lockdowns and quarantine measures, have had a

¹⁰¹ Sastry and Lovari (n 58).

¹⁰² Sastry and Dutta (n 57).

¹⁰³ WHO, ‘WHO Director-General’s statement on IHR Emergency Committee on Novel Coronavirus (2019-nCoV)’ (2020).

¹⁰⁴ Cindy Cheng and others, ‘COVID-19 Government Response Event Dataset (CoronaNet v.1.0)’ (2020) 4(7) *Nature human behaviour* 756.

massive impact not only on economies but also on socio-cultural life.¹⁰⁵ This section aims to provide an overview of the implementation of the previously discussed lessons learned in the response to COVID-19. Unlike the previous sections, it does not refer to a single country nor region but draws on global reports, given its worldwide spread and the limitations of current evidence.

4.1. AWARENESS OF THE SIGNIFICANCE OF CULTURE

Public health measures in response to COVID-19 were not only affected by culture but also had a significant impact on cultural aspects. Some international variances in the response to the novel coronavirus can be understood through a cultural lens. The differences in national responses to COVID-19 can partially be explained by distinctions in cultural dimensions, as proposed by Hofstede.¹⁰⁶ The dimension “individualism” refers to the degree to which “people in a society are integrated into groups.”¹⁰⁷ People belonging to highly individualized cultures primarily look after themselves and their close family, while collectivist cultures rather act in the interest of the group.¹⁰⁸ For example, in response to COVID-19 collective societies such as China or South Korea, used tracking tools and nation-wide testing.¹⁰⁹ Contrastingly, individualised countries like Germany and the US emphasized personal responsibility.¹¹⁰ Furthermore, personal responses to the pandemic were influenced by cultural effects. For instance, it has been argued that evidence of individualism can be observed in panic buying behaviour.¹¹¹ It has been claimed that panic buying became one of the symbols of the pandemic lockdown in Germany.¹¹² Thus, cultural

¹⁰⁵ Olaniyi Evans, ‘Socioeconomic impacts of novel coronavirus: The policy solutions’ [2020] BizEcons Quarterly 3.

¹⁰⁶ Geert Hofstede, ‘Dimensionalizing Cultures: The Hofstede Model in Context’ [2011] Online Readings in Psychology and Culture.

¹⁰⁷ *ibid* 11.

¹⁰⁸ Hofstede Insights, ‘Country Comparison - Hofstede Insights’ (2020).

¹⁰⁹ Lamb and Tolbert (n 17); Hofstede Insights (n 132).

¹¹⁰ Lamb and Tolbert (n 17); Hofstede Insights (n 132).

¹¹¹ Shanaya Rathod, ‘A European roadmap out of the covid-19 pandemic’ (2020) 369 BMJ (Clinical research ed) m1556.

¹¹² Deutsche Welle, ‘Coronavirus: German minister warns against new wave of panic-buying’ (2020).

concepts, beliefs, and values impact the response to both the pandemic and public health efforts to curb its spread.¹¹³

Yet, while broader cultural concepts shaped responses, cultural effects were not sufficiently considered within many public health measures. The initial focus of national policies was on the prevention and mitigation of the spread of COVID-19 without addressing their long-term impacts on people's lives. The pandemic was primarily seen as a biomedical crisis and was only later acknowledged as an economic and political one.¹¹⁴ Protestors around the globe and statements by UN agencies highlighted the need to consider the impact of public health measures on human rights and particular aspects of life, such as employment and food security.¹¹⁵ However, cultural factors that can increase vulnerability, as well as resilience in times of public health emergencies, were commonly neglected. The need to design cultural-sensitive measures was rarely voiced by officials. When culture was incorporated as a concept it relied on one-dimensional understandings that sometimes supported othering and racism.¹¹⁶

The two shortcomings in the conceptualization discussed above are prevalent during the COVID-19 pandemic. First, culture was regularly reduced to (risky) behaviour in the public health discourse. Secondly, interconnections of culture with inequities in power have been ignored. As seen within the discourse around HIV/AIDS and Ebola, culture was regularly reduced to certain behaviours, which supported stigmatization and neglected socio-economic factors.

This time, "Asian culture", particularly Chinese culture has been framed as a risk factor in Western narratives. Persons of Asian 'appearance' were othered and even faced xenophobic attacks in several Western countries.¹¹⁷ Within political and media discourses colonial narratives have been reinforced and China, as a country,

¹¹³ Rathod (n 135).

¹¹⁴ Jan D van der Ploeg, 'From biomedical to politico-economic crisis: the food system in times of Covid-19' (2020) 47(5) *The Journal of Peasant Studies* 944.

¹¹⁵ Kerstin Schweizer, 'COVID-19 protests mounting as restrictions are eased' (2020); UN Women, 'Press release: COVID-19 will widen poverty gap between women and men, new UN Women and UNDP data shows' (2020); United Nations, 'Preventing a pandemic-induced food emergency' (2020).

¹¹⁶ Andrew Liu, 'Blaming China for coronavirus isn't just dangerous. It misses the point' *The Guardian* (10 April 2020).

¹¹⁷ Liu (n 140).

and the Chinese were othered as authoritarian and backward.¹¹⁸ For example, the virus was called the “Chinese” virus, and China was blamed for its culture by US-American and European politicians.¹¹⁹ Potential positive effects of prevalent philosophies and cultures (e.g. Confucianism), on how some Asian peoples coped during lockdowns and quarantine have hardly been acknowledged.¹²⁰ This is in line with the history of perceiving and treating Chinese and Asian peoples generally as public health threats due to their cultural behaviours, particularly in the US.¹²¹ Next to fuelling racism, this “otherization” led to a “false sense of security among Americans”.¹²² Due to the frequent attribution of COVID-19 to Chinese and Asian peoples, some people in the US perceived a very low vulnerability towards the virus. In this regard, the one-dimensional understanding of culture may have negatively influenced the on-set of the pandemic in the US.

Public health responses regularly disregarded the protective potential of cultural components to act as resources, such as rituals and traditions, in the initial response to the pandemic. Everyday routines, for example going to school or work, have been highly interrupted by policies in response to COVID-19. This might have a severe impact on wellbeing, as routines are a common way to show resilience in times of disasters.¹²³ For example, Orbann explained why students participated in spring break parties despite COVID-19, by emphasising the need for cultural rituals particularly in chaotic times like this.¹²⁴

In addition, it can be argued that the omnipresent use of the term “social distancing” exemplifies the limited awareness of socio-cultural determinants of health. Zaki, a psychologist from Stanford suggested using the terms “physical distancing” and encouraged people to practice “distant socialising”.¹²⁵ For instance,

¹¹⁸ M. Meinhof, ‘Othering the Virus’ (2020).

¹¹⁹ K. Shepherd, ‘John Cornyn criticized Chinese for eating snakes. He forgot about the rattlesnake roundups back in Texas’ *The Washington Post* (19 March 2020); Liu (n 140).

¹²⁰ Pepe Escobar, ‘Confucius is winning the Covid-19 war’ (2020).

¹²¹ Tyler T Reny and Matt A Barreto, ‘Xenophobia in the time of pandemic: othering, anti-Asian attitudes, and COVID-19’ [2020] *Politics, Groups, and Identities* 1.

¹²² Ann Mongoven, ‘“Othering,” Bad and Good, the Coronavirus’ (2020).

¹²³ Mongoven (n 156).

¹²⁴ E. Stann, ‘An important history lesson: Why historical events can help us understand how cultural behaviors can influence the spread of COVID-19’ (2020).

¹²⁵ Melissa de Witte, ‘Try “distant socializing” instead’ (2020).

public health experts highlighted that social isolation bears high mental and physical health risks particularly, for the elderly and children.¹²⁶ While some authors and institutions pointed to the drawbacks of physical distancing early on,¹²⁷ middle- and long-term outcomes of quarantine and lockdown measures are yet to be evaluated. However, some governments in Europe have acknowledged the risks of social isolation and the need for rituals and social contact during “the second wave.” For instance, a “soft lockdown” was announced in Germany for November 2020, emphasising the need to avoid complete social isolation of risk groups; and with the aim to lift restrictions during Christmas.¹²⁸ Consequently, state measures in response to COVID-19 which had ignored the need for social contact and traditions, without providing alternatives, arguably proved ineffective and sometimes even harmful.

Alternatively, anecdotal evidence suggests that cultural effects have been understood as a resource or a protective factor. There are some instances where cultural traditions have been positively used to support public health measures against the pandemic. For example, in Chad, traditional storytellers are travelling to remote areas to distribute public health information.¹²⁹ Also, the resources and challenges of subcultures have been integrated into some public health responses. The writer Bailey emphasizes the power of cultural competence in healthcare and describes how health services in the US adjusted their messages and services to homeless people and people using drugs.¹³⁰ Public health policies regarding social distancing were in direct conflict with previous public health messages for homeless people using drugs, which emphasised the need to stay in groups to prevent overdose.¹³¹ Thus, it was important that context-specific behaviour was not only

¹²⁶ M. Schrappe and others, ‘Thesenpapier 2.0 Die Pandemie durch SARS-CoV-2/Covid-19: Datenbasis verbessern Prävention gezielt weiterentwickeln Bürgerrechte wahren’ (2020); Regional Risk Communication and Community Engagement Working Group, ‘COVID-19: How to include marginalized and vulnerable people in risk communication and community engagement’ (2020).

¹²⁷ European Centre for Disease Prevention and Control, ‘Rapid risk assessment: Coronavirus disease 2019 (COVID-19) pandemic: increased transmission in the EU/EEA and the UK – eighth update’ (2020).

¹²⁸ The Local, ‘Germany’s lockdown proposal to ‘save Christmas’: What you need to know’ *The local* (28 October 2020).

¹²⁹ UNESCO, ‘Culture & COVID-19: Impact & Response Tracker’ (2020).

¹³⁰ Meryl Bailey, ‘Culturally Competent Healthcare: Lessons from COVID-19’ (2020).

¹³¹ *ibid.*

understood as a risk factor, but also as a personal resource, and safety practice and messages were tailored to the specific situations people were living in.

Regarding the second shortcoming in responses to COVID-19, public health measures did not sufficiently consider the underlying cultural and socio-economic effects. Vulnerabilities, which were caused or exacerbated by policies on social distancing and shaped by the cultural context were not always addressed. This was because the initial approach to COVID-19 was often exclusively focused on clinical medicine. The implications of measurements on people's lives were only partially considered. Thereby, vulnerability and risk were primarily understood in terms of risk of infection of COVID-19 and the severity of the disease for certain people, such as the chronically ill.¹³²

Vulnerability and risk regarding public health measures have been largely neglected. Women, for example, have been disproportionately exposed to the effects of the pandemic and the response towards it due to culturally-shaped gendered norms and sexual stereotypes.¹³³ Women were at higher risk of infection as they form the majority of the healthcare workforce in many regions.¹³⁴ Similar to the Ebola epidemic, lockdowns and curfews increased the vulnerability of women and girls, and there were rises in gender-based violence in African, European, Asian, and American countries.¹³⁵ Thus, policies in response to health emergencies need to consider and address (culturally-shaped) vulnerabilities beyond the risk of infection.¹³⁶

There have been instances when cultural behaviour has been declared a protective factor, yet these instances still neglected the underlying power structures, inequities, and their detrimental effects. For example, it is argued that in Japan cultural tendency towards obedience was used by the government and led to peer pressure

¹³² Schrappe and others (n 161).

¹³³ Miguel Lorente Acosta, 'Gender-based violence during the pandemic and lockdown' (2020) 46(3) Spanish Journal of Legal Medicine 139.

¹³⁴ United Nations, 'Policy Brief: The Impact of COVID-19 on Women' (2020).

¹³⁵ Monica A Onyango, 'Sexual and gender-based violence during COVID-19: lessons from Ebola' (2020); Lorente Acosta (n 168); Silja Fröhlich, 'Violence against women: Africa's shadow pandemic' *Deutsche Welle* (6 October 2020); Phumzile Mlambo-Ngcuka, 'Violence against women and girls: the shadow pandemic' (2020).

¹³⁶ WHO, 'Q&A: Violence against women during COVID-19' (2020); Regional Risk Communication and Community Engagement Working Group (n 161).

and public shaming.¹³⁷ While this might have helped to contain the spread of COVID-19, it also supported an atmosphere of mistrust and anxiety.¹³⁸ By acknowledging the significance of mental health and social wellbeing, it can be questioned whether this reinforcement of a cultural tendency, to curb the spread of COVID-19 was justified.

Furthermore, Muurlink and Tylor-Robinson have suggested that women are at lower risk of infection in “cultures that place greater restrictions on the movement and dress of women”.¹³⁹ This conclusion seems reasonable given the known ways of transmission of COVID-19.¹⁴⁰ Yet, it can be argued that when gender roles and culture-based behaviours represent gender inequalities and power imbalances, they must not be supported to tackle the spread of COVID-19. Existing vulnerabilities of women and girls are already increased in times of crisis and disease and need to be addressed in public health responses, instead of being strengthened.¹⁴¹ Gender inequality has detrimental effects on the health and wellbeing of women and girls,¹⁴² which has manifested in an increase in gender-based violence during the pandemic.¹⁴³ Therefore, it is important to consider culture as a complex concept that can incorporate resources as well as barriers to health on various levels.

4.2. AWARENESS FOR THE NEED FOR A COLLECTIVE AGENCY

Despite the differences in scope and location of HIV/AIDS, Ebola, and COVID-19, collective agency and community approaches have again been considered

¹³⁷ Tomoya Saito, ‘Contact-tracing and peer pressure: how Japan has controlled coronavirus | Tomoya Saito’ *The Guardian* (8 June 2020); n.a. ‘For better or worse, Japan’s COVID-19 success may be the result of peer pressure | The Japan Times’ *The Japan Times* (7 June 2020).

¹³⁸ Saito (n 172); n.a. ‘For better or worse, Japan’s COVID-19 success may be the result of peer pressure | The Japan Times’ (n 172).

¹³⁹ Muurlink and Taylor-Robinson (n 17).

¹⁴⁰ World Health Organization, ‘Modes of transmission of virus causing COVID-19: implications for IPC precaution recommendations: scientific brief, 29 March 2020’ (2020).

¹⁴¹ Neetu John and others, ‘Lessons Never Learned: Crisis and gender-based violence’ (2020) 20(2) *Developing world bioethics* 65.

¹⁴² G. Sen and P. Ostlin, ‘Gender inequity in health: why it exists and how we can change it’ (2008) 3 *Suppl 1 Global public health* 1.

¹⁴³ John and others (n 176).

fundamental to tackle the pandemic. HIV/AIDS and Ebola are epidemics within specific regions and their response involved major international involvement.¹⁴⁴ COVID-19 affects communities on a global scale, with national governments being the main actors. Yet, in April 2020, the WHO called for collective agency, referring to the need for joint action of individuals, communities, governments, and businesses.¹⁴⁵ The global spread of the pandemic and its impact on economic and social life leads to a shared vulnerability across countries and to a certain degree, across socio-economic status.¹⁴⁶ This shared vulnerability was recognized and was used by the UN Secretary-General António Guterres to call for solidarity and collaboration.¹⁴⁷ Thus, similar to previous epidemics, shared vulnerability requires recognition and application of collective agency during the COVID-19 pandemic.

Collective agency has been found to not only be vital in reducing the spread but also in tackling stigmatization. At the beginning of the COVID-19 pandemic, some countries placed the focus of policies on high-risk groups, due to the anticipated severity of infection and people returning from affected countries. This sometimes supported stigmatisation. For example, a subnational public health policy in Germany stated that all people who have returned from high-risk areas in Italy were supposed to stay at home and were not allowed to go to school or kindergarten.¹⁴⁸ This occasionally led to institutional measures including the removal of children during class, thereby increasing fear and stigmatization of people who had been abroad.¹⁴⁹

Yet, as the incidence of COVID-19 increased, countries adapted measures that targeted whole populations¹⁵⁰ and acknowledged the need to focus not exclusively on

¹⁴⁴ World Health Organization, 'The role of WHO within the United Nations Mission for Ebola Emergency Response' (2015).

¹⁴⁵ WHO, 'COVID-Strategy Update' (2020).

¹⁴⁶ n.a. 'Redefining vulnerability in the era of COVID-19' (2020) 395(10230) *The Lancet* 1089

¹⁴⁷ Antonio Guterres, 'Shared Vulnerability to COVID-19 Reveals Common Humanity, Secretary-General Tells Faith Leaders, Stressing Their Key Role in Fighting Intolerance, Disinformation | Meetings Coverage and Press Releases' (2020).

¹⁴⁸ Kultusministerium, 'Zusätzliche Risikogebiete: Regelungen für Schulen und Kindergärten' (2020)

¹⁴⁹ n.a. 'Coronavirus und die Folgen in Stuttgart: Schulen schicken Südtirol-Rückkehrer heim' *Stuttgarter Nachrichten* (6 March 2020).

¹⁵⁰ Cheng and others (n 128).

high-risk groups but to foster collective agency.¹⁵¹ The significance of shared awareness and collaboration beyond communities and countries has been highlighted by European politicians and international associations and sometimes led to collective action.¹⁵² For example, it is argued that the Norwegian call to join the effort in fighting COVID-19 led to a strong team-spirit.¹⁵³ Also, mandatory mask-wearing was found to reduce stigmatization in Germany.¹⁵⁴ Thus, similarly to previous epidemics, there was a shift away from stigmatisation and towards collective action.

Again, community approaches have been considered fundamental in some countries, yet compared to the previous epidemics, grassroots initiatives have occasionally been narrated as heroic acts. The key functions of community approaches during COVID-19 have been stressed and their potential to increase health equity highlighted.¹⁵⁵ For example, it has been argued that community engagement is needed to understand individual circumstances and to increase the effectiveness of public health measures.¹⁵⁶ In many situations, community approaches have been fundamental to limit the spread of COVID-19 and to support vulnerable populations during lockdown measures. For instance, in some European countries, networks were initiated to assist with shopping duties and reduce the risk of infection of high-risk people.¹⁵⁷ Such grassroots initiators have been considered heroes and have been

¹⁵¹ Hans H P Kluge, 'Statement – Older people are at highest risk from COVID-19, but all must act to prevent community spread' (2020).

¹⁵² Emeline Han and others, 'Lessons learnt from easing COVID-19 restrictions: an analysis of countries and regions in Asia Pacific and Europe' (2020) 396(10261) *The Lancet* 1525; 'International regulators pledge collective support to combat COVID-19 pandemic | European Medicines Agency' (7 November 2020); International Coalition of Medicines Regulatory Authorities, 'ICMRA statement on COVID-19' (2020); Fabian Hattke and Helge Martin, 'Collective action during the Covid-19 pandemic: The case of Germany's fragmented authority' [2020] *Administrative Theory & Praxis* 1.

¹⁵³ Han and others (n 192).

¹⁵⁴ Cornelia Betsch and others, 'Social and behavioral consequences of mask policies during the COVID-19 pandemic' (2020) 117(36) *Proceedings of the National Academy of Sciences of the United States of America* 21851.

¹⁵⁵ Katharina Thomas and Dennis, Angie, T. 'Opinion: COVID-19 – The anatomy of community-centered response' (2020).

¹⁵⁶ Rathod (n 135).

¹⁵⁷ OECD, 'OECD Policy Responses to Coronavirus (COVID-19): The territorial impact of COVID-19: Managing the crisis across levels of government' (2020).

awarded with honours in the UK.¹⁵⁸ Community approaches have in some circumstances been actively supported by national response measures¹⁵⁹ and international development projects.¹⁶⁰

5. CONCLUSION

This discussion has illustrated the significance of culture and its effects in response to public health emergencies. It has also underlined the need for an increased awareness of cultural aspects. The shift towards a cultural approach can be considered as a major lesson learned within the HIV/AIDS response.¹⁶¹ This change stressed the need to engage anthropologists and local communities in public health responses around the world to “produce comparative understanding”¹⁶², and investigate how culture matters for the people concerned and how diseases affect these cultures. Yet, while positive changes have taken place, the response to the Ebola epidemic and the current COVID-19 pandemic highlight persistent challenges in integrating cultural aspects.¹⁶³ Particularly, there are three shortcomings in the considerations of culture that have been evident in the public health emergencies discussed: 1) reducing culture to behaviour that is considered negative, 2) enabling stigmatisation and a language of racism, and 3) ignoring interconnections of culture with inequities in power. These drawbacks not only decrease the effectiveness of public health measures but may pose a threat to health and wellbeing in themselves.

One-dimensional understandings of culture neglect underlying beliefs and values. The response to the Ebola crisis has highlighted that cultural practices cannot

¹⁵⁸ BBC, ‘Birthday Honours 2020: The drivers, volunteers, and the quizmaster’ *BBC News* (10 October 2020).

¹⁵⁹ Jude Stansfield, Tom Mapplethorpe and Jane South, ‘The community response to coronavirus (COVID-19) - Public health matters’ (2020).

¹⁶⁰ World Bank, ‘Community Responses to COVID-19: From the Horn of Africa to the Solomon Islands’ (2020).

¹⁶¹ Leclerc-Madlala, Simbayi and Cloete (n 43).

¹⁶² Fadwa El Guindi, ‘What the Coronavirus Crisis Needs From Anthropology’ (2020) n.p.

¹⁶³ Hewlett and Amola (n 13); C. Jenkins, ‘HIV/AIDS and Culture: Implications for Policy’ in V. Rao and M. Walton (eds), *Culture and Public Action* (Stanford University Press 2004); Matthew W Kreuter and Stephanie M McClure, ‘The Role of Culture in Health Communication’ (2004) 25(1) *Annu Rev Public Health* 439.

be changed without considering their underlying meanings, traditions, and beliefs. Rather, approaches which failed to respect local cultures increased violence and harm.¹⁶⁴ Furthermore, by framing culture or cultural effects as a risk factor, the integral significance of cultural aspects and their potential to act as a resource, particularly in times of disasters, are ignored. The WHO Europe rightly states that “allowing for careful considerations of cultural differences in health-care interventions means recognizing culture as an enabling factor for sustainable development and health-care systems that leave no one behind”.¹⁶⁵ Yet, during the initial response to COVID-19, cultural factors were merely acknowledged and even less supported as a resource for individual and social well-being. Given the potential of the pandemic to last for another few months or even years, it is of importance to acknowledge the role of culture and strengthen its positive effects.

Public health measures and media discourses on public health emergencies have in some instances enabled othering, stigmatization, and racism. In response to the Ebola and HIV/AIDS epidemics, colonial prejudice and superficial narratives about the “African culture” led to an othering of affected people and a loss of empathy. COVID-19 affected the global community, however again stigma and discrimination were prevalent and sometimes supported within public health measures. As discussed above, particularly racism against people of Asian descent and ‘appearance’ had increased.¹⁶⁶ While it has been argued that a universal approach to culture can lead to the “neglect of the radical differences (in experience and interpretation) that accommodations conceal”,¹⁶⁷ culture must not be considered as the foundation for othering and discrimination. Therefore, this article argued that public health responses need to be sensitive to discriminatory and racist language and avoid measures that can support stigmatization.

Furthermore, there needs to be an awareness of socio-structural interlinkages with culture in the design and implementation of responses to public health emergencies. Socioeconomic factors can be highly interrelated with cultural effects, such as gender norms. Public health measures might lead to negative implications by

¹⁶⁴ Maxmen (n 48).

¹⁶⁵ WHO Europe (n 32).

¹⁶⁶ Human Rights Watch, ‘Covid-19 Fueling Anti-Asian Racism and Xenophobia Worldwide’ (2020).

¹⁶⁷ Fairhead (n 11).

supporting cultural practices that present inequities in power. For example, women might be particularly vulnerable not only regarding infection but also due to public health policies such as lockdowns, that have been shown to exacerbate the risk of domestic violence globally.¹⁶⁸ Hence, the complexity of culture needs to be considered, which comprises negative and positive visible aspects as well as the underlying context and the dynamics in between.¹⁶⁹

In conclusion, this paper argues that there is a need to integrate a more complex understanding of culture into responses to public health emergencies. The COVID-19 pandemic shows that lessons learned decades ago are still not being sufficiently implemented in public health measures.¹⁷⁰ A culture of listening and community approaches must be developed to connect response efforts to the lived experiences of affected people.¹⁷¹ Such a cultural-sensitive approach would tackle the danger of interpreting culture as stable and coherent, leading to more effective measures, by respecting the human right to receive culturally appropriate healthcare.¹⁷²

¹⁶⁸ Mlambo-Ngcuka (n 170); BBC News, 'Coronavirus: Domestic violence 'increases globally during lockdown' - BBC News' (2020).

¹⁶⁹ Schoepf (n 101); Airhihenbuwa and others (n 79).

¹⁷⁰ Bond and Brough (n 13); Paul Komesaroff and Ian Kerridge, 'Ebola, ethics, and the question of culture' (2014) 11(4) *Journal of bioethical inquiry* 413.

¹⁷¹ B. T Shaikh and J. Hatcher, 'Health seeking behaviour and health service utilization in Pakistan: challenging the policy makers' (2005) 27(1) *Journal of Public Health* 49.

¹⁷² Sovran (n 16).