Editorial

Covid-19 Through a Cultural Looking Glass

The Covid-19 pandemic is global in terms of its spread, restrictions on personal freedoms and economic crises.[1] However, striking differences have been observed in mortality, rates of transmission, policies, and beliefs and behavioural responses, in relation to Covid-19 in different societies and groups. The interplay between a cultural context and the experience and behaviours related to Covid-19 are thus germane to its understanding as it is a disease spread by social contact and managed at least in part through social interventions.

Friedler states that we are in many ways the architects of our own pandemics. According to her, wet markets that represent heightened risk for novel pathogen behaviours and host crossovers due to their capacity to link sociocultural and eco-biological networks act as biocultural hubs.[2] These markets exist because of their cultural value (e.g. valued social interaction, beliefs that local products are healthy, cultural value of traditional medicines derived from wild animal products). The timing of the Covid-19 outbreaks appears to have intimate cultural links, e.g. the Spring Festival in Wuhan, China and the festival season in India acted as super-spreader events.[2,3]

Societal differences in terms of individualism–collectivism, 'tight–loose' orientation and relational mobility

Individualistic cultural contexts tend to prioritize an independent construal of self, individual freedom and fulfilment of personal goals; on the other hand, collectivistic societies prioritize group ties and responsibilities. In the context of the pandemic, governments in individualistic societies might be hesitant to promulgate compulsory measures (e.g. lockdown, wearing of masks) and citizens might be less accustomed to following mandatory health advisory. In a study comparing data from 98 countries, collectivism was associated with fewer cases of Covid-19 and fewer deaths per million people, although the country's economic status played a stronger role in predicting those variables.[4] The promotion of collectivism and the action for the common good has been advocated as a strategy for public health messaging because it increases engagement with official recommendations.[5]

Individualism and collectivism also influence people's conceptualization of health and illness. Western biomedical models, based on analytical thinking, frame illnesses as intrusions into bodily systems; while holistic medical systems such as Ayurveda consider illness as an imbalance within the individual's system existing in a broader environmental context.[6] In consonance, even while supporting vaccinations, Ayurvedic physicians have proposed interventions to support global bodily functions (e.g. strengthening immune and respiratory systems) to prevent infection and manage the disease.[7]

Tightness–looseness, a measure of the strictness of societal rules, may also be related to the formal and informal enforcement of and adherence to restrictive measures. In a study on datasets from 54 countries, Cao *et al*. found that reported cases and deaths per million inhabitants were positively associated with greater looseness.[8] It should be remembered that all communities negotiate social norms to strike a balance between freedom and constraint. Tight rules regarding social distancing are critical, yet looseness within these constraints might help in the development of creative solutions to contain the pandemic and help people feel connected.[9] Thus, different strategies might be needed in different cultural contexts.

Relational mobility denotes the degree to which interpersonal relationships are fixed or voluntary in each group or society. High relational mobility (with greater propensity for making new social connections) might increase the chances of spread of Covid-19 within the sociocultural groups. Salvador *et al*. found that relational mobility was correlated with the rise in the number of Covid-19 cases and deaths across 39 countries.[10] Further, geographical mobility of relationally mobile groups could potentially spread the virus across geographical areas.

Intersection of culture and marginalization

Social amplification impacts risk perception within groups and can create grounds for social contagion of beliefs and behaviours in crisis situations. Disease threat is often associated with higher levels of ethnocentrism and greater intolerance and punitive attitudes toward outgroups. Some stigmatized groups may even face dehumanization (e.g. stereotyped as dirty and carriers of disease and pestilence) based on processes embedded in larger-scale, institutional discrimination.[11]

The Covid-19 pandemic has caused or worsened and exposed discrimination against minorities in several ways: prejudice and aggression (e.g. ethnic Asian people); over-representation in frontline and essential services; over-representation in displaced and incarcerated communities; and structural disadvantage in treatment access and vaccine distribution.[11] This, in combination with pre-existing discriminatory health inequities, has led to disproportionate detrimental impacts of Covid-19 in minority communities.[12]

In India, people from northeastern states with more phenotypically east Asian features have been discriminated against and attacked.[13] Conspiratorial rumours blaming Indian Muslims for the spread of coronavirus were propagated.[14,15] Marginalized groups (e.g. various castes and tribes) were already vulnerable because of pre-existing economic and employment disparities and health inequities. Higher levels of frontline exposure, poverty, homelessness, displacement, overcrowding, food and water insecurity, and lack of access and unaffordability of resources made their situation worse.[16] Increased rates of depression, anxiety, trauma and other mental health issues have been reported in marginalized communities compared to other groups.[14] A prominent phenomenon observed during the lockdown in India was the long march of migrant workers from cities to their native places.[17,18] The dehumanization of these migrants (e.g. they were sprayed with chemical disinfectants and denied even minimal support) and the hardships suffered by them during their journeys might have left them with worse mental and bodily scars than the threat of the virus itself.[19]

Intersectionalities between cultural and other sociodemographic categories such as gender, age and social class affect the rates of transmission and morbidity due to a disease. Unexpectedly, the levels of stress reported by younger people in several countries were consistently higher than those reported by older adults despite higher social isolation implemented on the latter.[20] Globally, more men than women have died of Covid-19 disease. While this may be related to biological differences (e.g. immune responses and smoking patterns), behavioural factors may also play a role. Use of niqabs or burkas by Muslim women might work as a protective factor against contamination, while preferences for facial hair in men might act as a risk factor for contamination. Gender segregation and differing levels of involvement in various societal spheres (e.g. almost 70% of frontline health and social care providers globally are women) might also influence the likelihood of exposure.[21] In addition, quarantine measures pose more risks for women, children, elderly and people with disabilities to experience abuse.[2,9] Chronological patterns of transmission of the virus (greater spread in richer sections initially and in poorer sections later) and case fatality due to Covid-19 (often due to comorbid conditions) were related to social class.[22]

The disparities in access to healthcare and treatment are reflected in the distribution of the Covid-19 vaccines. Many rich countries negotiated private deals with pharmaceutical companies for early access to several vaccines outside the WHO's Covid-19 Vaccine Global Access Facility (COVAX); hence, the equitable distribution of vaccines between countries and within a given nation to disadvantaged marginalized groups continues to be a matter of concern.[23]

Common threats can create opportunities to reduce sectarian prejudices. Coordinated efforts across individuals, communities and governments to fight the spread of disease can send signals of cooperation and shared values. Since communities may differ in levels of trust in social institutions (including the healthcare system), there is a need

for targeted (culturally sensitive) public health information and for partnerships between public health authorities and organizations trusted by minority/marginalized communities.[9] Airhihenbuwa *et al*. have proposed a cultural model of public health messaging that has three domains: cultural identity, relationships and expectations, and cultural empowerment.[24]

Political polarization and conspiracy theories

Affective polarization can privilege partisan beliefs (e.g. through self-selection of polarized news sources or partisan 'echo chambers') and decrease trust in public health information, so different segments of the population may arrive at different conclusions about threat perception and appropriate actions.[9] In the USA, certain news channels recommended precautionary measures against the transmission of Covid-19, while others downplayed the severity of the pandemic in 2020. This impacted their viewers' risk perception, adoption of preventive behaviours, and infection and fatality rates.[25] By highlighting an overarching identity, politicians, the media and opinion leaders can help reduce political division around various issues. Since misperceptions underlie polarization, combating misinformation that could generate partisan reasoning and inaccurate beliefs could help.[9]

People are likely to accept conspiracy theories about events that have serious consequences. Regarding the Covid-19 pandemic, some conspiracy theories concerned the origins of the SARS-CoV-2 virus (e.g. it is a bioweapon created to wage wars), while others focused on prevention and cure (e.g. medical treatment should not be trusted and alternative remedies should be used).[9] Belief in conspiracy theories is associated with vaccine hesitancy, prejudice and hostility towards outgroups. The emergence of Covid-19 added to the pre-existing trend of propagation of anti-vaccination rumours through social media. Propagators manipulated information and fabricated facts to promote incredulity toward experts and polarization against purported common enemies (e.g. government or scientific community) depending on local, shared beliefs.[26] Giving people factual information through trusted voices can combat belief in conspiracy theories and fake news.[9]

The individual in the cultural context

Individual attitudes and beliefs are influenced by cultural factors and motivate behaviours that affect the risks of contagion and impact of the disease. Collective narcissism is an individual trait that is grounded in broader political polarization and nationalist ideology. It involves a strong sense of identification with one's own perceived group, feelings of collective entitlement, unrealistic beliefs about the ingroup, and outgroup hostility in reaction to perceived threat.[27] Collective narcissism was positively associated with dissemination of conspiracy theories related to Covid-19; and negatively correlated with preventive behaviours such as washing hands and staying home.[28,29]

The cultural context also plays a role in individual adjustment and well-being. Collective optimism (a shared optimism about a group) was found to favour the espousal of effective coping strategies such as positive reappraisal during the Covid-19 crisis.[30]

Conclusions

The impact of every disease is contingent on how individuals, groups and societies understand it, experience it and respond to it. It is evident that dynamics of privilege and marginalization interact with cultural beliefs to influence subjective experiences of diseases and their outcomes. Understanding these dynamics can help in better communication and promotion of protective measures, help people cope with their current realities, and promote inequity repair and solidarity with marginalized communities.

Finally, the Covid-19 pandemic marks the beginning of a major cultural–historical change. Lusardi and Tomelleri have called the pandemic a cultural break point—a watershed between the relatively unreflective social configuration that was in place earlier and the one to come—with the consciousness that complexity of knowledge and global interdependency require collective awareness, political participation and shared responsibility.[1]

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PRATAP SHARAN
Department of Psychiatry
All India Institute of Medical Sciences
New Delhi
India
pratapsharan@gmail.com

[**To cite:** Sharan P. Covid-19 through a cultural looking glass. *Natl Med J India* 2021;**34:**193–6.]