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Cultural Contexts of Health & Wellbeing
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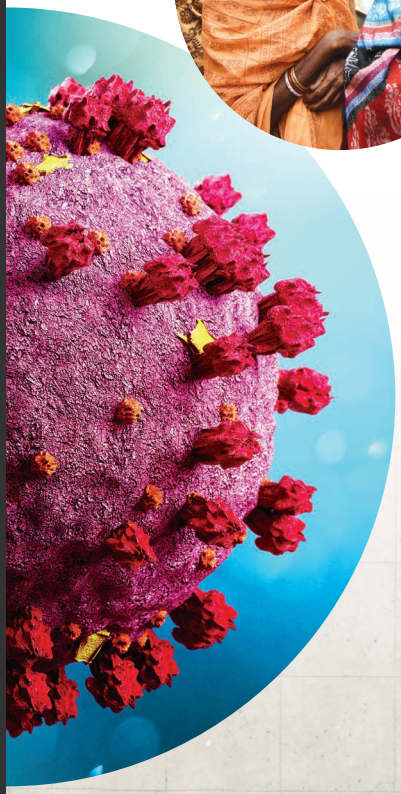

Improving **Pandemic Response:**

GLOBAL LESSONS AND CULTURAL INSIGHTS FROM COVID-19

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The Cultural Contexts of COVID-19: Policy Lessons from Global Examples.
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(Photo by Sanchit Khanna/Hindustan Times via Getty Images)

Executive Summary

The COVID-19 pandemic

has laid bare stark differences in the effectiveness of public health responses across countries and communities.[1] The United States has higher COVID-19 death rates than not only high-income peers such as Germany, Denmark, and Japan, but also lower-income countries such as Vietnam, Rwanda, and Uganda. This situation presents an opportunity to learn from global examples to improve pandemic responses, prepare for future health emergencies, and advance health equity.

By definition, pandemics are experienced collectively. Likewise, mitigation efforts are inherently social, requiring collective action. Relying on individual choice alone is insufficient. Public health requires public action: coordinated, systemic, and structural responses are needed. This brief will be useful to public health officials and policymakers at the federal, state, and local level in coping with the current pandemic and preparing for future crises.

Differences in COVID-19 death rates are correlated with key social and cultural factors, including trust, cohesion, inequities, and shared values. Cultural norms and social ties are what motivate people to act collectively or not. The virus is transmitted socially, and our collective behavioral responses to the pandemic stem from shared cultural values. Scientific skepticism, including vaccine hesitancy, results from lack of social trust as much as lack of information. These factors combine to produce vulnerabilities that cannot be fully addressed by medical interventions alone.

At the same time, the pandemic has shown how cultural assets, such as common identity, community traditions, and conceptions of hope, can be a source of creative response and resilience. To reduce transmission and mortality rates, focus on the root causes of inequities and resilience, and build trust in public health efforts, there is an urgent need to address the cultural as well as medical aspects of the pandemic.[2]

A cultural contexts of health approach:

- Acknowledges that the COVID-19 crisis is more than just a medical problem.
- Questions biases and assumptions while learning from the experiences of others.
- Recognizes social and cultural assets as sources of creative responses and resilience.
- Demonstrates a commitment to creating and extending health equity.
- Builds on common values to justify sacrifices and promote solidarity.
- Strives to rebuild social trust—and hope—among wary communities by addressing their concerns.
- Includes historically under-represented voices in public health policy and decision-making.
- Distinguishes between healthy and unhealthy cultural skepticism.
- Addresses the underlying conditions that produce resilience and vulnerabilities.
- Works actively with communities to prepare for future health challenges.

A 2014 Lancet Commission found that "systematic neglect of culture in health and healthcare" is the greatest barrier to achieving equitable health outcomes worldwide.[3]

WHO/Europe's flagship initiative on the *Cultural Contexts of Health and Wellbeing* (CCH) offers a model for applying social science and humanities research to improve policy and interventions. A cultural contexts of health approach reframes our understanding of health, recognizing that individual lives and behaviors are shaped by cultural contexts and social interactions. In this view, culture is not opposed to science. Nor is it an obstacle to health care—a source of irrational beliefs to be overcome. Rather, it refers to shared, and ever-changing, conventional understandings about how the world works and our place in it. Cultural beliefs are just as "real" as viruses in that they motivate attitudes and behaviors—in policymakers, health providers, patients, and others—and they are an underappreciated source of creative possibilities and potential.

For this report, we consulted with 23 experts from around the world and conducted an extensive literature review of cross-cultural experiences. Based on this research, we offer a series of recommendations for dealing with the acute issues associated with the current pandemic as well as the chronic underlying causes. We summarize our five recommendations below, each of which is explained in more detail in the subsequent sections.

1.

Health policy needs to account for cultural understandings of disease. How we think and talk about the virus has a direct impact on our responses.

Public health leaders should use cultural understandings to communicate in ways that enhance public health responses and reduce xenophobia.

Example: Recognizing that viruses are spread through social networks, public health officials in some countries have replaced war metaphors with language emphasizing shared responsibility.

2.

Leaders should mobilize shared values to increase support for public health efforts. Cultural norms and social ties motivate people to act collectively, or dissuade them from doing so.

Policymakers should use social science research to identify and build on pro-social values to justify personal sacrifice and coordinated public health efforts.

Example: Danish leaders revived an antiquated but familiar concept—*samfundssind*, or the virtue of sacrifice for a common good—to increase support for masking and lockdowns.

3.

Health authorities should engage communities to build trust. Trust is a two-way street, and it needs to be earned long before a crisis strikes.

Trust, especially in marginalized communities, sometimes requires reconciliation and should be built through sustained grassroots engagement and partnerships.

Example: Officials in British Columbia developed key principles to guide COVID responses. Communities were then empowered to create their own plans to achieve these goals and adapt them to local contexts.

4.

Policymakers should recognize the serious and long-term impacts of the pandemic on mental health. These mental health challenges cause suffering in their own right and affect people's capacity to follow public health recommendations.

It is important to balance the benefits of social isolation with the mental health costs explicitly, addressing not only immediate psychological effects but also underlying cultural factors.

Example: The Futbol Viral program in Brazil uses social media videos to get viewers to practice new moves and submit their own videos as part of an effort to reduce boredom and domestic conflict.

5.

Public health agencies need to identify the socio-cultural factors that shape resilience and vulnerabilities. A community's capacity to respond to a public health crisis depends in part on underlying social resources and assets.

Before a crisis starts, policymakers need to know the social and cultural as well as biological risk factors that produce health inequities.

Example: In 2017, Mexico City established a program of ongoing assessments that allowed it to quickly identify and reach homeless, transgender, and other marginalized communities when the pandemic struck.

A cultural contexts of health approach stresses the interconnectedness of various domains of life (social and cultural as well as biological and economic), focusing on underlying causes. Medical research and practice are not viewed as strictly scientific endeavors—they are social and cultural as well. The cultural values that a society invests in, and that political and public health leaders communicate, largely determine how it handles a pandemic.

Treating cultural contexts as secondary will only ensure that we are poorly prepared for future crises. Instead, we should learn from global examples of how to address the social and cultural dimensions of virus transmission and be better prepared for future emergencies.

1.
Health policy needs to account for cultural understandings of disease.

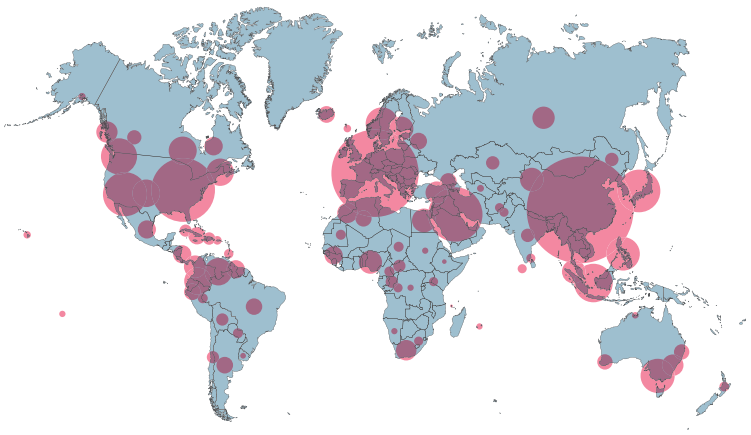
(Photo by Jeff J Mitchell/Getty Images)

Cultural conceptions of viruses and vaccines affect policy and behavior. How we think and talk about diseases and pandemics shape our responses to them just as much as our understanding of medical science does. Even our perception of risk, which motivates behavior and policy, is subjective and informed by cultural and psychological contexts as much as by scientific data.[4] In the COVID-19 pandemic, policy and behavioral choices are driven not only by the statistical danger of infection but also by cultural perceptions of risks and of how viruses work. Here we offer guidance on how to use these cultural understandings for better public health outcomes.

The virus is not a foreign enemy that can be expelled

Leaders and policymakers around the world have used war metaphors to help explain the COVID-19 pandemic. Although this may help mobilize citizens, equating the virus with a foreign invader that can be "killed" may lead to misunderstandings of viral transmission—as well as inappropriate responses. In fact, viruses do not attack us; we infect others by passing on viral information through a handshake, a hug, or other forms of social contact. This distinction is subtle, but its implications are more than semantic: Without social encounters, viruses remain dormant. The SARS-CoV-2 virus, like all viruses, is inert outside our cells. It is merely strands of genetic information that *our* cells bring to life and that we then transmit by how we live and what we do—and, crucially, how those around us live and act.

In the United States, war has long been used as a metaphor to mobilize public responses, acculturating people to look for an external enemy amid a crisis. During the present emergency, calls for military-like action to expel a foreign enemy ignore the fact that the virus is already in the community and divert attention and resources from reducing community risks and spread. In fact, a viral pandemic must be addressed from within, recognizing that we and our fellow citizens are the ones spreading the virus. Beyond COVID-19, such conceptions can result in the misuse of antibiotics and contribute to the looming global health crisis around antibiotic resistance.[5]



Researchers from Spain and the United Kingdom launched an initiative to collect alternatives to war metaphors for COVID-19.[6] The #ReframeCovid hashtag uses Twitter to crowd-source alternative metaphors that are used around the world. The collection gathers over 500 examples in 30 languages, including:

1. **a marathon** (in it for the long run)
2. **malware** (spread through networks)
3. **an ecosystem** (out of balance)

"We must answer here and now for our life on Earth with others (including viruses) and our shared fate. Such is the injunction this pathogenic period addresses to humankind ... Are we capable of rediscovering that each of us belongs to the same species, that we have an indivisible bond with all life? Perhaps that is the question—the very last—before we draw our last dying breath."

— Achille Mbembe[11]

We are familiar with what "going viral" means in common usage: some bit of information spreads widely and rapidly through social media networks. Such metaphors explain a new phenomenon in familiar terms, sometimes with unintended consequences. Today, the metaphorical sense of "viral" has become more salient than its original usage, and so it is helpful to reverse the metaphor and explain the virus as akin to a meme, shared information spread through social networks.

Recognizing that viruses do not attack us but are spread through social contact can lead to better communication and policymaking, including clear and coordinated decision-making around quarantines and vaccine distribution—not only for those most vulnerable to infection, but also those most likely to infect others through social contact.

Reframing for solidarity and social responsibility

Historically, pandemics increase racism, xenophobia and stigmatization of marginalized groups.[7] Viewing COVID-19 as a foreign invader (e.g., "the China virus") leads us to shut some categories of people out and shut others in—closing borders when viral information is already in the population. Containing people based on their national origins, ethnicity, or other group membership only marginally slows the movement of viral information.[8] During the 2020 pandemic, many governments allocated scarce resources to closing borders in order to halt what they perceived as an alien invasive agent. But once a virus is in a population—and especially one that continues to congregate socially—the greatest threat is no longer external.

At the same time, talk of a biological invasion fuels social exclusion and xenophobia, conflating fears of infection with fears of outsiders and further endangering people already marginalized.[9] Thus, a number of leaders and public health officials around the world are looking for framings that promote solidarity and civil responsibility instead of invoking war. Both German Chancellor Angela Merkel and Netherlands Prime Minister Mark Rutte have made conscious and concerted efforts to avoid war metaphors in their speeches.[10]

Promoting messaging that addresses the long term

To survive COVID-19, we must absorb the microbe (or a vaccine proxy) into our individual and collective immune systems. It is not about killing the virus before it reaches us. There is no "cure" for a virus aside from immunity built through a vaccine or illness exposure, but this crucial fact can get lost in messaging around vanquishing a foreign enemy. In the Navajo tradition, viruses are not aliens to be killed, but natural entities with which we must learn to live. The same holds true in Bali, where information is understood to be brought to life by what people do together. These cultural understandings are much closer to biological science than conventional Anglo-American conceptions and result in more realistic expectations.

Public health messaging on "flattening the curve" can lead to unrealistic timelines for reducing risk and "returning to normal." The COVID pandemic is an ongoing and long-term process—not something we will overcome in a short, defined period. Thus, along with officials in Belgium and Portugal, Sweden's Prime Minister Stefan Löfven prefers a sporting metaphor: "We are in a marathon and have to be prepared for the fact that this will be with us for a long time."[12] The public health challenge of coronaviruses will not simply disappear, in spite of talk about "defeating" and "eliminating" them. Rather, we must learn to adapt to the virus—co-existing biologically and socially, as Navajo poet and medicine man Rex Lee Jim suggests.

RECOMMENDATION:

Policymakers should use cultural understandings to communicate in ways that enhance public health responses and reduce xenophobia.

- Communicate that viruses are more like shared information than foreign invaders.
- Avoid metaphors that promote xenophobia or unrealistic expectations.
- Recognize the gap between cultural conceptions of risks and scientific understandings of viral transmission.

2.
Leaders should mobilize shared values to increase support for public health efforts.

(Photo by Angel Garcia/Bloomberg via Getty Images)

Shared values increase adherence to public health guidelines. National and local differences in COVID-19 infection rates correlate with pro-social values and how they are communicated by political and public health leaders. High levels of trust and risk perception are linked with a high level of concern for the welfare of others.[13] This is not to say that some societies have "good values" and others have "bad values," but rather that values can be framed to promote individual sacrifice for the common good. To tackle the COVID-19 pandemic, policymakers can address cultural values directly to establish solidarity and promote coordinated action.

While societal values are often viewed as uniform and fixed—e.g., some societies are individualistic while others are collectivist— every society contains a wide range of (sometimes contradictory) cultural values. In the United States, values may emphasize "pulling yourself up by your own bootstraps" or collective barn-raising, and both resonate with large swaths of the population. The role of leaders is to identify, frame, and explain salient values that will support risk-reducing behaviors to protect communities against the COVID-19 pandemic.

Policymakers can build on pro-social values to reduce COVID-19 transmission, as public health guidance works best when supported by a sense of shared purpose. The current crisis has accelerated a shift in societal priorities in and beyond health care and opened the possibility to engage populations in new ways around common experiences. Several countries provide examples of how leaders can take advantage of this opportunity, justifying new policies in terms of clearly stated shared values.

For example, in response to the COVID-19 crisis, Danish leaders invoked the idea of *samfundssind*, which means "putting the greater good above oneself." Although familiar to Danes, the term had not been commonly used for a while. In a March 2020 speech, Danish Prime Minister Mette Frederikson explained that *samfundssind* has two pillars: collective responsibility and community spirit, which she called out as key cultural values to support new public health restrictions.[15] Similarly, in Rwanda, *ubudehe* was a traditional term for communal labor that the government resurrected in 2001 to describe the cultural value of mutual assistance within a community. In response to COVID-19, the government built upon the now widespread saliency of *ubudehe*, mapping it on to the national system of community-based health care. *Ubudehe* is called upon to justify personal sacrifices for a common good, defined in terms of a local community, making the obligations to public health and the public good personal.[16]

***Atul Gawande** characterizes the U.S. response to COVID as a debate over the values of freedom and safety ("keep me safe or leave me alone"). He argues that there needs to be a focus on solidarity, the idea that we are all in this together. Gawande states that we need "to find leaders who can communicate that, and communicate it at the top level."[14]*

Coordinating behavior and adherence

Pandemic mitigation requires coordinated action and sacrifice by the vast majority of a population (e.g., wearing masks, social distancing, limiting economic activity, reducing blame and stigma). Relying on individual choice alone is insufficient when broad social cooperation is critical. In this context, weak shared values increase risks and insecurity by making people less inclined to adhere to public health guidance for the benefit of others.

Policies on social distancing and public gatherings have, in some places, been met with support and expressions of solidarity. In other places, responses have been negative, even fueling opposition to public health guidelines. These responses are rooted in different value systems. In this way, values and the behaviors they drive may matter as much as vaccines and clinical treatments in combating and limiting the impact of COVID-19.[17] Policymakers need to recognize the importance of these values, and explicitly justify the balance between them. In Argentina, the government has adopted policies explicitly grounded in the social value of solidarity to promote community culture as a vehicle of pandemic care.

Polarization and common purpose

Countries with high levels of trust and solidarity—and low levels of ideological division—tend to have lower rates of viral transmission and death. When social cohesion is low, political and cultural differences become vectors for disease transmission, inhibiting collective action. Witness the resistance to mask wearing in many communities across the United States. In the COVID-19 pandemic, social distancing may lead people to turn to virtual social networks that act as echo chambers, amplifying unhealthy and even dangerous beliefs and ideas.

Where pleas for solidarity may ring hollow, policymakers must develop strategies to manage ideological diversity —avoiding patronizing those they disagree without validating extreme positions that can jeopardize population health and wellbeing. It is not enough to say "we are all in this together" when entire segments of the population believe otherwise. Values-driven leadership from politicians and public health leaders can promote coordinated action while empowering individuals to make creative decisions consistent with overall values.

The *Millions of Conversations* program uses conflict resolution techniques developed in the Middle East to bring together people with opposing ideological perspectives to find shared values (e.g., honesty, community, freedom).[18] In the United States, the program uses these techniques to start from a point of agreement and foster productive conversations about what a shared future could look like. The goal is to reduce political polarization through millions of such conversations.

"As Danes, we usually seek community by being close together. Now, we must stand together by keeping apart. We need samfundssind*."*

— Danish Prime Minister Mette Frederiksen

(Photo by Ricardo Ceppi/Getty Images)

Vaccines and Values

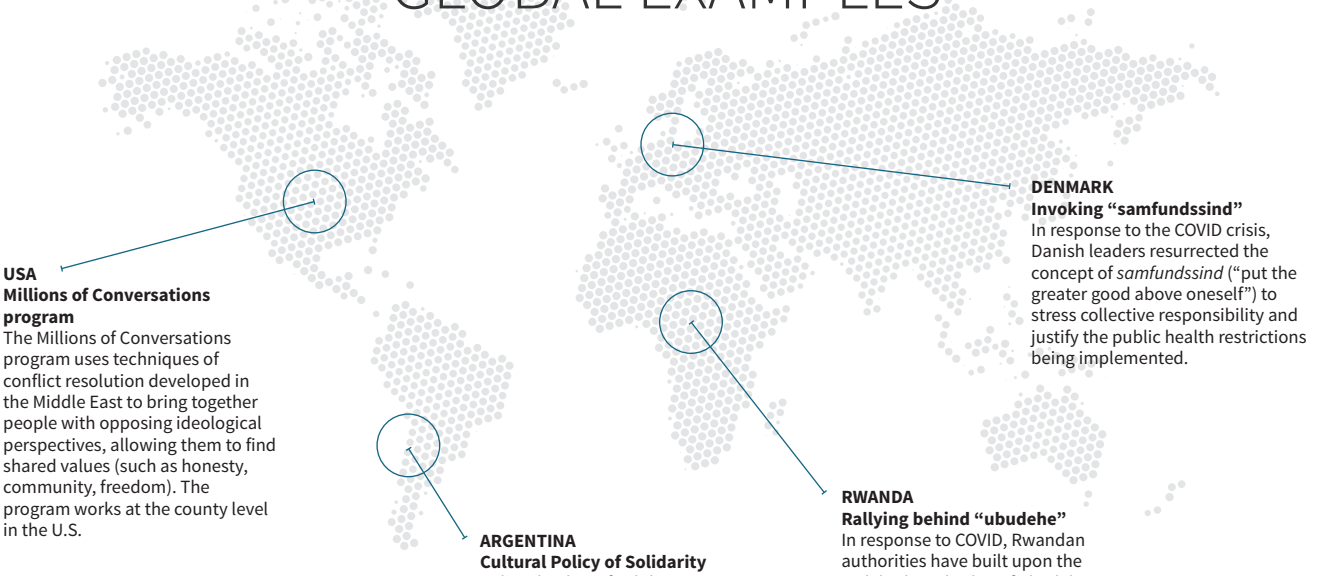
It is important to understand the cultural values that drive vaccine skepticism and hesitance. With COVID-19 vaccines at the forefront of public thought, debates over whether a vaccine should be trusted have grown increasingly contentious. For some, this may be a healthy skepticism of new technologies, but for anti-vaccine activists, it goes deeper. Their stance is based on cultural values that are linked to religion, distrust in institutions, anti-authoritarianism, skepticism of large pharmaceutical companies, and other factors.[19] It is about identity, values, and trust more than science. The cultural values and concerns driving vaccine skeptics are entrenched and morally motivated. By understanding their position as the product of cultural values instead of pushing more data on them, we can find common ground ("we all want the best for our children") and build trust to explore practical solutions.

RECOMMENDATION:

Policymakers should build on pro-social values to drive personal sacrifice and mobilize populations in coordinated public health efforts.

- Build on existing value narratives that stress common sense of purpose.
- Explicitly justify tradeoffs between priorities (such as health and economy) with respect for differing values.
- Create spaces for dialogue between those with opposing values to find common ground.

GLOBAL EXAMPLES



USA
Millions of Conversations program
The Millions of Conversations program uses techniques of conflict resolution developed in the Middle East to bring together people with opposing ideological perspectives, allowing them to find shared values (such as honesty, community, freedom). The program works at the county level in the U.S.

DENMARK
Invoking "samfundssind"
In response to the COVID crisis, Danish leaders resurrected the concept of *samfundssind* ("put the greater good above oneself") to stress collective responsibility and justify the public health restrictions being implemented.

ARGENTINA
Cultural Policy of Solidarity
Cultural policy of solidarity
In Argentina, an "ethos of care" has been integrated into policy and played a significant role in addressing the COVID-19 pandemic. This involves stressing solidarity, caring for vulnerable workers, and funding community cultural events as a vehicle of social care.

RWANDA
Rallying behind "ubudehe"
In response to COVID, Rwandan authorities have built upon the widely shared value of ubudehe (mutual assistance within a community) to justify personal sacrifices for a common good and frame public health in terms of community obligations.

3.
Health authorities should engage communities to build trust.

(AP Photo by Alessandra Tarantino)

Building trust is especially important in marginalized communities, where there is a need to increase acceptance of and adherence to public health guidelines. Examining the effectiveness of COVID responses across countries, we see a correlation between low levels of trust in institutions and viral transmission.[20] In particular, low levels of trust in government make people less likely to believe public health information and follow advice from governmental bodies.[21] Historian John Barry concludes that trust in public health institutions is the most important element for effectively combatting viral transmission. But trust is a social relationship built over time, easily broken, and hard to regain once lost.

Cultural factors contribute to the decline in trust in the United States and around the world, including the rise of conspiracy theories and social networks that amplify extremist views. Further, when scientists disagree, confusion can turn to mistrust, as many people fail to understand that viruses are constantly changing, as are the ways that scientists understand them. Global health experiences show that trust can be earned through sustained community engagement—and this is true domestically as well. That said, the source of information, context, and medium of communication often dictate how or even if a community will be receptive to a certain message.[22]

Histories of mistrust

Populations with histories of mistreatment are less likely to trust scientific or political institutions of power. The COVID-19 pandemic highlights that trust is hard-earned and histories of deception have enduring effects. In the United States, a Pew research study finds that, despite seeing high rates of COVID-19, some Black communities are less likely to trust medical scientists and public health officials.[23] Trust does not come naturally to traumatized communities, nor does it take the same shape across communities.

Mistrust in government and science means that strong social cohesion is, for many, only found outside formalized sectors—in religious, community, and household settings. Trust requires transparency and, most importantly, sustained community engagement.[25] Trust between parties in highly unequal social contexts is especially fragile, which makes structurally competent[26] public health messaging more challenging. Thus the Australian Department of Health tailored an intervention plan specifically for Aboriginal and Torres Strait populations. Recognizing the long history of structural racism against these communities, they based public health messaging on identified common values (e.g., "culture," "family," "country," "community").[27]

The messenger and the medium matter

Trust is specific: It is a process that takes place in particular social contexts and is built up over time by people showing that their behaviour matches their words. As such, *the messenger matters*, and information will be received differently by certain, especially minority, populations. In many communities, vaccines may be more trusted if sanctioned by a pastor or religious leader. In Bangladesh, Imams were enlisted to serve as "expert

When people say, "we have made it through worse before"

all I hear is the wind slapping against the gravestones of those who did not make it, those who did not survive to see the confetti fall from the sky . . .

We are not all left standing after the war has ended. Some of us have become ghosts by the time the dust has settled.

— Clint Smith [24]

communicators," using their mosque microphones to reach large and receptive audiences before and after traditional prayers. Imams shared public health information on handwashing, social distancing, and other pandemic measures.[28]

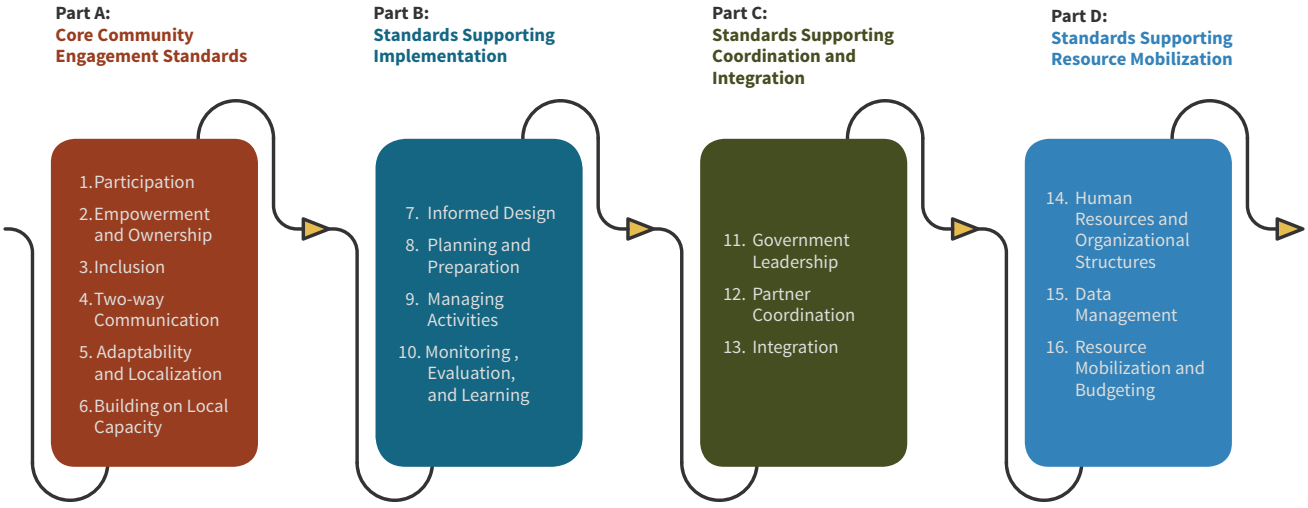
The medium that conveys information also matters. The best way to reach people opposed to public health measures is to convey information through their trusted social networks. Public health officials should be open and clear about what is known and what is unknown to help the public deal with pandemic uncertainty and fatigue. Although trust in government is usually low in Vietnam, authorities gained credibility through their communications during the COVID crisis. Authorities sent regular text messages to all cell phones in the country. They also used popular platforms like TikTok, Facebook, and Zano to post messages that were widely shared. Commentator Hồn Du Mục writes that "unlike what has been happening elsewhere, it has truly felt like we've all been in it together here [in Vietnam]. This trust was earned, and it wasn't easy." [29]

Partnering with communities

Some communities with the poorest health outcomes have the strongest levels of social cohesion. Public health policy needs to build on that strength and collaborate with communities to identify pressing needs. This may involve non-traditional partners. For example, in Rio de Janeiro's *favelas*, local gangs imposed curfews, banned gatherings, and mandated the use of face masks. Community organizations also converted schools into isolation wards, installed public sinks for hand washing, and disseminated information via loudspeakers and Whatsapp. The Oswaldo Cruz Foundation (FIOCRUZ) worked with a local *favela* organization to create a public information campaign "*Se Liga No Corona*" (Beware of Corona). The effort disseminates information from WHO and FIOCRUZ—and crucially adapts it to the realities of life in the *favela*.[30]

Positive results come from building on the internal capacity of communities to address emerging health needs through the pre-crisis, crisis, and post-crisis phases of a pandemic. It is unfair to expect challenged communities to innovate on their own. But when they do innovate successfully, such innovations should be supported concretely. To bridge ideological gaps, start by identifying shared problems, common ground and adopting minimum standards (such as UNICEF's) that support community engagement, planning and implementation, coordination and integration, and resource mobilization.[32]

UNICEF Standards for Community Engagement[31]



Empowering communities

Trust is reciprocal: It has to be given to be received. Policymakers should emulate models that support communities in making their own adjustments based on information provided by health authorities.

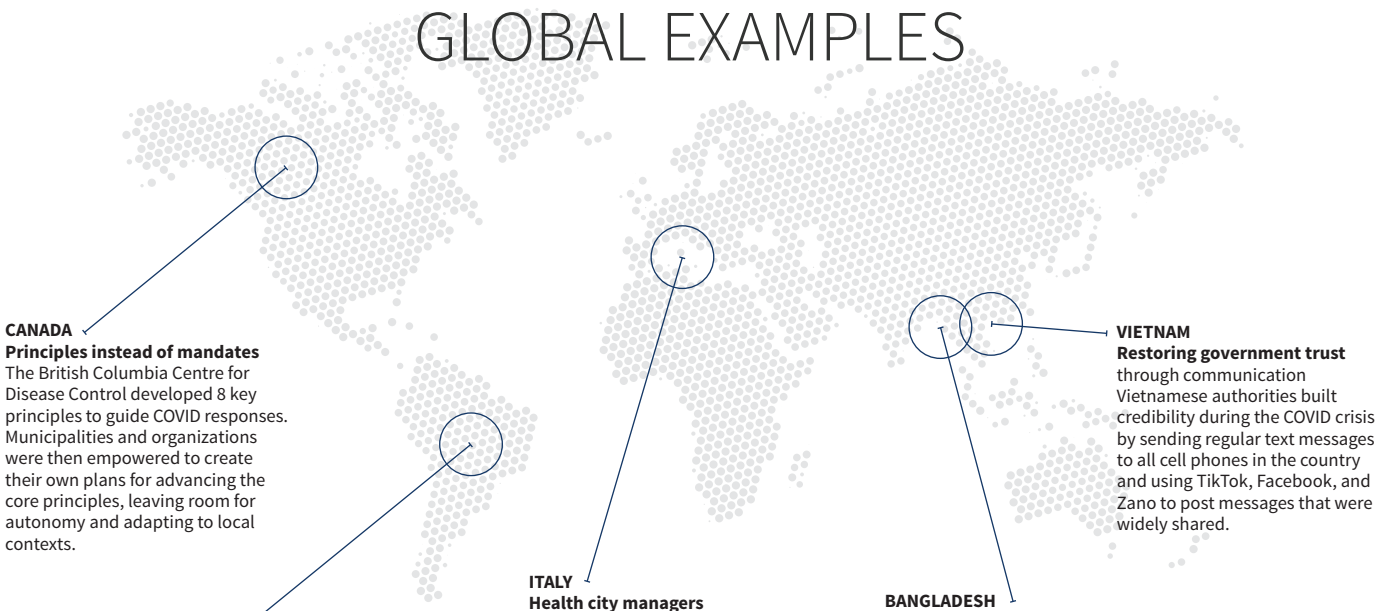
For example, the British Columbia Centre for Disease Control developed a set of key principles rather than strict guidelines. Municipalities and organizations were then empowered to create their own plans for advancing these core principles.[33] This approach leaves room for autonomy, emphasizes trust in the population, and avoids shaming people. It also produces better outcomes, as with contact tracing that is based on locally defined categories of risk.

RECOMMENDATION:

Trust, especially in marginalized communities, should be built and rebuilt through sustained local engagement.

- Acknowledge and support communities' ability to address their own needs, supporting them in developing their own plans of action.
- Work through community and religious leaders to facilitate uptake of public health guidance.
- Be transparent in communications, acknowledge what is known and unknown, and convey information through social media as well as traditional outlets.

GLOBAL EXAMPLES



CANADA
Principles instead of mandates
The British Columbia Centre for Disease Control developed 8 key principles to guide COVID responses. Municipalities and organizations were then empowered to create their own plans for advancing the core principles, leaving room for autonomy and adapting to local contexts.

BRAZIL
Community engagement in favelas
In Rio de Janeiro's favelas, local gangs and community organizations worked together to impose curfews, ban gatherings, and mandate the use of facemasks. They also converted schools into isolation wards, installed public sinks for hand washing, and disseminated information via loudspeakers.

ITALY
Health city managers
Italian cities have health city managers, professionals who work alongside mayors and local administrators to coordinate public health strategy. This arrangement responds to local needs and facilitates coordination across administrative units.

BANGLADESH
Imams as public health allies
In Bangladesh, imams were enlisted to serve as "expert communicators" in public health messaging around COVID. Imams share public health information on handwashing, social distancing, praying at home, and other COVID measures.

VIETNAM
Restoring government trust through communication
Vietnamese authorities built credibility during the COVID crisis by sending regular text messages to all cell phones in the country and using TikTok, Facebook, and Zano to post messages that were widely shared.

4.
Policymakers should recognize the long-term impacts of the pandemic on mental health.

(Photo by ADEK BERRY/AFP via Getty Images)

During the COVID-19 crisis, interventions such as isolation, social distancing, and mask-wearing have been recommended to slow the spread of the virus. These measures have also unintentionally disrupted traditional patterns of social interaction that support mental health. Combined with uncertainty about the future, such disruptions may exacerbate conditions ranging from depression and anxiety to post-traumatic stress and substance abuse. A CDC study found a tripling of anxiety symptoms and a quadrupling of depression since the pandemic's onset.[34] Research by the Brookings Institution has shown a doubling of overdose and suicide-related mental health calls between 2019 and 2020.[35]

Protecting mental health should be part of the virus response strategy. Again, factoring in social and cultural contexts is key here. For example, discrimination and xenophobia heighten isolation and anxiety. A Canadian study found that ethnic minorities who experienced COVID-related discrimination had worse mental health outcomes. Furthermore, cultural stigmas associated with mental health challenges in some communities make dealing with these issues difficult.[36]

Acknowledging tradeoffs caused by social isolation

For many people—whether they're college students longing to socialize or mothers giving birth alone—the physical threat of contracting COVID-19 does not outweigh the mental health sacrifices of following social distancing guidelines. COVID-19 has increased instability in lifestyles, adversely affecting those already in precarious situations, such as people with preexisting mental health conditions, abusive home environments, or struggles with addiction. Many "essential workers," such as grocery store cashiers and fast-food workers, are feeling more stress due to their heightened risk of exposure, and medical professionals have reported drastically increased levels of trauma, burnout, and even PTSD.[37]

COVID response can backfire if policymakers are not honest about mental health impacts. Social distancing is critical to slow infection rates and protect health services, but the mental health impacts of prolonged isolation can be extensive. For many, this means sacrificing in-person cultural gatherings (including funerals and church services), which takes a toll on mental health. Public health guidelines should explicitly address the balance between slowing viral transmission and minimizing the damage to mental health.

In October 2020, Swedish officials encouraged elderly people to come out of isolation because of mental health concerns. Before that, elderly individuals were encouraged to stay inside, avoid physical contact, and avoid public transport and public

(Photo by David Dee Delgado/Getty Images)

(Photo by China Daily CDIC)

places.[38] Although Sweden's approach has been controversial, authorities explicitly acknowledged the toll that social isolation can take on mental wellbeing and the tradeoff required between public health safety and mental health.

Pandemic fatigue and demotivation to follow guidelines

Many people are becoming increasingly stressed and weary with the social sacrifices required to follow pandemic regulations. Pandemic fatigue, as defined by WHO/Europe, is "demotivation to follow recommended protective behaviors, emerging gradually over time and affected by a number of emotions, experiences and perceptions." [39] Recent studies show that, as stress levels over COVID-19 rise, compliance with public health regulations tends to decline.[40] Although many people were able to cope in the early weeks and months of the pandemic, as time has worn on, anxiety has grown, motivation to follow restrictive measures has declined, and desire for personal freedom has increased.[41] As methods of coping change, so too should the messaging and support offered by government and public health officials.

In the Arctic region, suicide was a pandemic long before COVID-19, especially among Inuit and other Indigenous youth. Local2Global is a culturally sensitive and community-driven program focused on addressing and preventing high rates of suicide by connecting international Arctic communities through digital storytelling and sharing experiences with suicide prevention.

But, while frustration with COVID guidelines has grown, the messaging has largely stayed the same. At this stage, most people have received basic data about COVID-19.[42] In fact, a study of African responses to COVID found that, although most people had a solid understanding of COVID-19, *emotions* and *context* influenced their behavior more than knowledge. Public health messaging should offer positive suggestions on how to make the most of time spent away from others and provide resources (stressing what people *can* do, not just what they should not do). This may include virtual socialization, organized outdoors excercise, or internet hotspots for people who may not have WiFi access.

A pilot program in Brazil addresses two potential effects of lockdowns—increased boredom and domestic violence—by providing a purpose-driven activity to bolster motivation and maintain adherence. The FUTBOL VIRAL program in Brazil enlists soccer players to demonstrate their moves on Facebook Live and YouTube videos, encouraging viewers to practice the moves and send in their own videos of themselves.[43]

Taking advantage of opportunities to reduce mental health stigma

In many communities around the world, including in the United States, seeking mental health treatment carries a stigma. With the impacts of COVID so widespread, many people are becoming more comfortable speaking about their mental health problems. The COVID-19 pandemic has provided a unique

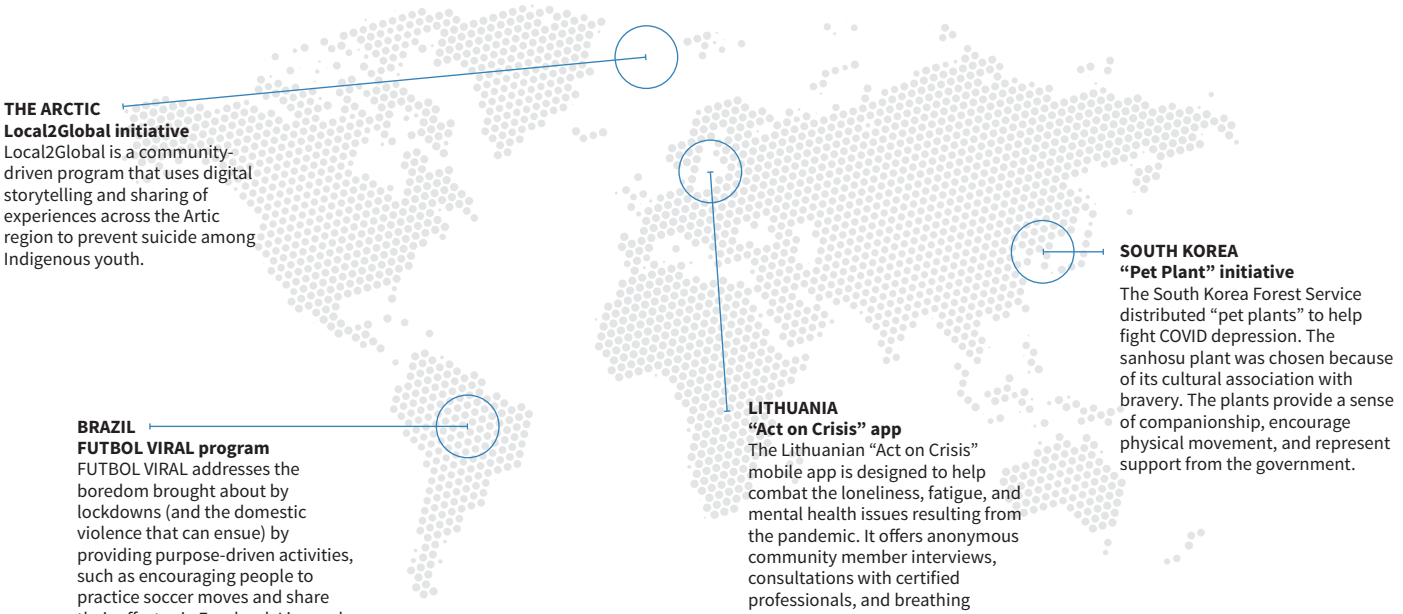
opportunity to open the discussion surrounding mental health as well as to understand the importance of social engagement as a health-enhancing activity.

Policymakers should use this opportunity to expand access to mental health services. Research suggests that simple "psychological first aid"—promoting good mental health practices and making mental health services more widely accessible—has a beneficial effect. A team of Lithuanian psychologists and information technology experts developed "Act on Crisis," a mobile app designed to combat loneliness, fatigue, and mental health challenges from the pandemic.[44] The app includes access to community member interviews, one-on-one meetings with certified professionals, and breathing exercises. It serves as a "mental gym" where people can focus on their mental health as they do their physical health.[45]

RECOMMENDATION:
Policymakers should balance benefits of social isolation with the mental health costs, addressing not only immediate psychological effects but also underlying cultural factors.

- Explicitly acknowledge and legitimate the mental health costs of social distancing guidelines.
- Offer guidance and suggestions about what people can do (not just what they should not do) in ways that support the mental health benefits of social interaction.
- Meet communities where they are by providing increased access to mental health services via telehealth methods, applications, or other means.

GLOBAL EXAMPLES



THE ARCTIC
Local2Global initiative
Local2Global is a community-driven program that uses digital storytelling and sharing of experiences across the Artic region to prevent suicide among Indigenous youth.

BRAZIL
FUTBOL VIRAL program
FUTBOL VIRAL addresses the boredom brought about by lockdowns (and the domestic violence that can ensue) by providing purpose-driven activities, such as encouraging people to practice soccer moves and share their efforts via Facebook Live and YouTube videos.

LITHUANIA
"Act on Crisis" app
The Lithuanian "Act on Crisis" mobile app is designed to help combat the loneliness, fatigue, and mental health issues resulting from the pandemic. It offers anonymous community member interviews, consultations with certified professionals, and breathing exercises.

SOUTH KOREA
"Pet Plant" initiative
The South Korea Forest Service distributed "pet plants" to help fight COVID depression. The sanhosu plant was chosen because of its cultural association with bravery. The plants provide a sense of companionship, encourage physical movement, and represent support from the government.

5.
Public health agencies need to identify the socio-cultural factors that shape resilience and vulnerabilities.

(Photo by Nicolò Campo/Sipa USA)(Sipa via AP Images)

Amid the COVID-19 pandemic, some communities have shown remarkable resilience—the capacity to effectively adapt and cope with a crisis—while others have experienced heightened risk and vulnerabilities. To understand how certain variables can produce resilience among some communities while pushing others into conditions of extreme vulnerability, we need to look at how socio-cultural factors intersect with biological factors, such as preexisting conditions, to affect health outcomes. The COVID pandemic has shown that anyone can become vulnerable. We see the heightened precariousness of jobs deemed "essential," from physicians to delivery drivers, and new vulnerabilities created by lockdown measures, as with schoolchildren. To help those most in need, it is critical to understand the dynamics of resilience and vulnerability and not simply revert to stereotypes about who is at risk.

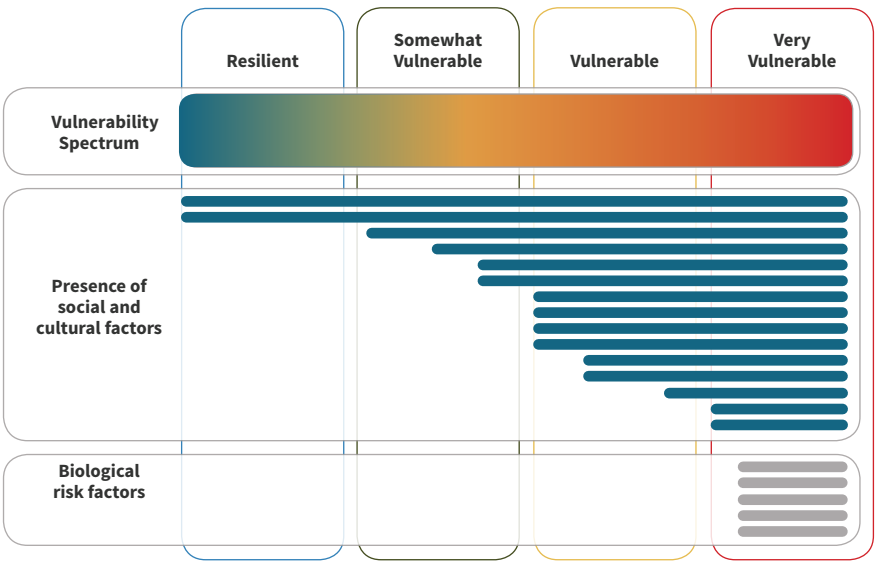
Resilience and vulnerability are not innate traits. They are social conditions produced by changes in circumstances. Social and cultural factors such as trust, stigma, dietary habits, gender roles, and cultural conceptions of illness interact with biology to produce resilience and vulnerability. Lockdowns and participation in social media and other online communities have impacts of their own. Coordinating an effective response requires new approaches to assessing social, cultural, and biological risk factors and how they interact.[46] One key challenge is breaking down the "silos" of health and other policy domains.[47]

Resilience and vulnerability as social and cultural processes

Biological factors such as age, obesity, and diabetes render certain groups of people more vulnerable to sickness and death from COVID-19. From a public health perspective, these factors can come to define—and sometimes stigmatize—people labelled as "vulnerable." But, vulnerabilities and resilience result from more than biological and economic factors. By rethinking vulnerability as a dynamic interaction, we understand how social and cultural capital can form the basis for resilience and productive innovations.

Accounting for cultural variables is critical to understanding how vulnerability and resilience are created or heightened during a crisis. It also sheds light on the drivers and priorities that motivate people. In the United States, cultural norms also shape vulnerability and resilience to COVID-19 in a variety of ways. For

The Vulnerability Spectrum (from Anna-Maria Volkmann, Cities Changing Diabetes)



example, gender norms have played a major role throughout the pandemic, with women continuing to shoulder primary childcare responsibility and filling the vast majority of frontline caregiving jobs.

In the United States, certain populations, such as Black, Latino, and Native American communities, have suffered more from the pandemic not because of innate biological predispositions but because of social and structural factors stemming from histories of disenfranchisement. At the same time, these communities demonstrate capacities to deploy agency in the face of adversity, building on grassroots cultural resources to produce unexpected levels of resilience and hope.[48] These communities offer invaluable lessons about adaptive strategies undertaken to navigate crises. [49]

The social norms and culture that drive a society can render certain populations vulnerable, resilient, or a mix of both. In the COVID-19 pandemic, certain cultural norms have suddenly become risk factors for transmission and infection, disrupting the way of life for millions and forcing people to rethink their social practices. For example, in Italy, multigenerational family gatherings and meals are normally a source of comfort and support, especially during holidays. However, during the COVID-19 pandemic, these meaningful social occasions became dangerous, increasing the chances of infection and rendering older people especially vulnerable.

The siloed operation of policy sectors is a significant barrier to understanding the dynamics of resilience and vulnerability. The practice of treating policy sectors as separate areas of concern hinders opportunities to collaborate on comprehensive and integrated interventions. In response, health organizations across the globe have called for "health in all policies" approaches.[50]

Vulnerabilities must be understood and reduced before a crisis

To be prepared for future health emergencies, policymakers should assess social, cultural, and biological risk factors that produce both resilience and vulnerability. These factors are compounding, and assessments should identify when and how capabilities start reversing.[51] Examining risk factors independently hides how they interact and build on each other. A more comprehensive assessment plan should account for the legacy of past experiences, knowledge of existing resources, understanding of community networks, and the local cultural perspectives.

Many communities were in crisis well before the pandemic started. For them, COVID-19 was another crisis—and not as pressing as others they confronted. Dealing with multiple crises at once may force otherwise resilient populations to focus solely on their needs for survival, such as food and shelter. At the height of a crisis, vulnerable communities may be so isolated—lacking access to computers, email, or cell phones—as to be "invisible."

Vulnerability and resilience assessment should be an ongoing process—not a short-term, reactive one. In Mexico, the COVID-19 pandemic has occurred alongside an epidemic of non-communicable diseases (especially obesity) amid pronounced social inequality.[52] Starting in 2017, Mexico City established a program of vulnerability assessment focused on the city's most marginalized populations. This effort allows officials to target communication and intervention toward specific groups, such as the elderly, sex workers, and immigrants.[53] Because this program was introduced prior to the COVID crisis, the government has been able to distribute food and medicines to vulnerable citizens, reaching them in their homes. Jaime Morales, Mexico City's Undersecretary of Human Rights, states that "having implemented it in advance has allowed the city to not be taken by surprise by the emergency." [54]

RECOMMENDATION:

Policymakers need to know what's going on in a community across populations and across areas of life—housing, food security, employment, and more—to respond effectively to pandemics and address health inequities.

- Understand that vulnerabilities and resilience operate along a spectrum, produced by social and cultural factors as well as biological risk.
- Involve various public health and social sectors in a health-in-all-policies approach to addressing the compounding risk factors that lead to vulnerability.
- Assesses the factors that produce resilience and vulnerability before a crisis to prepare for future emergencies.

GLOBAL EXAMPLES

LATVIA
General practitioners emerging as vulnerable group
During the COVID pandemic, Latvian general practitioners emerged as a vulnerable group due to the stress and mental burden added to their jobs, resulting in burnout. The Latvian Ministry of Health tried to lessen the burdens by waiving certain bureaucratic requirements and granting additional funding.

UGANDA
Learning from past epidemic experience
Uganda used its experience with past epidemics (Ebola, yellow fever, measles) to inform its COVID response policies. This includes utilizing infrastructure that had already been put in place following the Ebola epidemic, such as testing sites, information dissemination methods, and public health regulations.

AUSTRALIA
Aboriginal-tailored public health messaging
The Aboriginal and Torres Strait Islander Advisory Group on COVID-19 developed a culturally competent intervention plan based on vulnerabilities unique to their communities. The plan identifies social and cultural factors that make them particularly vulnerable to infection including high mobility.

ALBANIA
Proactively assessing vulnerability
Albania's socioeconomic recovery plan rests on five pillars: health first, protecting people, economic recovery, macroeconomic response, and social cohesion/community engagement. Part of this strategy includes conducting field assessments of vulnerabilities and collecting data for targeted responses.

Conclusion

Viral pandemics are more than biological phenomena—

they are also social and cultural. We cannot fully understand how a virus works—or treat its effects—by looking through a microscope or sequencing the genome. Virus transmission occurs through social networks and cultural pathways. The virus itself is inert, and its most consequential impacts result from how it intersects with cultural values, social vulnerabilities, and political-economic decisions. Global examples provide insight into the role that culture plays in a pandemic response, allowing us to see how varying norms can produce varied outcomes. This allows policymakers to draw on practical insights from other cultures who are handling the pandemic in a variety of ways. Treating the social and cultural dimensions that drive a pandemic as secondary will ensure that we are poorly prepared for the next one.

The factors discussed here are all interrelated. Trust is built and based on shared values, common purpose, and community engagement. Perceptions of risk are produced by cultural understandings of viral biology and concern for the welfare of others. Social and cultural factors contribute to both vulnerability and resilience. Lockdowns save lives, but they also cause human suffering. Health, vulnerability, and virology are linked to structures of racism and cultural ways of thinking about and understanding the world. Addressing any one aspect in isolation misses the systemic and processual nature of the problem.

Policymakers should explicitly acknowledge the tradeoffs of lockdowns and vaccine response, including the impacts on social interaction and the economy. Rather than retreating to absolute and polarized values, we need to negotiate a just balance and agree on the tradeoffs.

The COVID-19 pandemic is an acute problem, but the issues underlying much of its devastation are chronic. The current crisis requires an immediate response, but a key lesson from this study is that governments and communities need to be better prepared for future emergencies. Solutions must be long-term, adaptive, and integrated. Thus, the need for sustained crisis preparation is crucial, including investments in public health as broadly conceived.

A cultural contexts of health approach offers guidance on sustainable and cost-effective measures. Keeping people healthy and reducing infection rates require more than rolling out recommendations and blaming those who are not on board. Instead, we should learn from global examples of how to work with communities to address the social and cultural dimensions of virus transmission and be better prepared for future emergencies.

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VANDERBILT
Cultural Contexts of Health & Wellbeing
INITIATIVE

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