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A Culture-centered approach to pandemic response: Voice,Universal Infrastructure, and Equality

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CENTRE FOR CULTURE-CENTRED APPROACH
TO RESEARCH AND EVALUATION

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ABOUT CARE

The Center for Culture-centered Approach to Research and Evaluation (CARE) at Massey University, Aotearoa New Zealand, is a global hub for communication research that uses participatory and culture-centered methodologies to develop community-driven communication solutions to health and wellbeing. Through experiments in methods of radical democracy anchored in community ownership and community voice, the Center collaborates with communities, community organizers, community researchers, advocates, and activists to imagine and develop sustainable practices for prevention, health care organizing, food and agriculture, worker organizing, migrant and refugee rights, indigenous rights, rights of the poor, and economic transformation.

A culture-centered approach to pandemic response: Voice, Universal Infrastructure, and Equality

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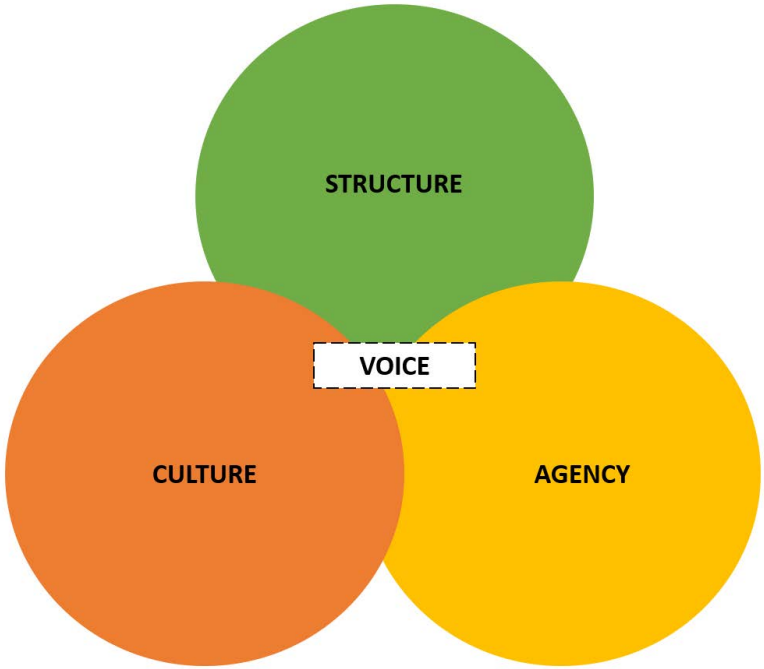
The global nodes of spread of Covid-19 highlight the significance of health communication in preventing the spread as well as in effectively responding to it. On January 30, 2020, the World Health Organization (WHO) declared the outbreak as a Public Health Emergency of International Concern. Noting the aggressive movement of the virus across countries, with eight countries reporting more than 1000 cases of COVID-19, the WHO declared COVID-19 as a pandemic. Drawing on critical analyses of the pandemic and crises response literatures as well as building on the experiences of CARE in developing culture-centered community grounded interventions,this white paper outlines the culture-centered approach to pandemic response, specifically directed at offering culture-centered guidelines for effective communication. The culture-centered approach foregrounds the interplays of culture, structure, and agency in the constructions of health meanings and the development of health solutions (see Figure 1).

Diagram 1: Culture-centered approach to voice (Dutta,2008)



Structure refers to the political and economic systems of organizing resources including health; culture reflects the everyday meanings and contexts within which health is negotiated; and agency reflects the capacity of individuals, households, and communities to actively make sense of the contexts in which they are immersed and participate in decisions that impact their health and wellbeing. Situating individual, familial, and collective community voice at the intersections of culture, structure, and agency foregrounds the role of voice infrastructures in sustaining health infrastructures and responses. Noting that structural inequalities in health mirror communicative inequalities, emphasis is placed on building communicative infrastructures for the margins that are likely to bear greater risk burdens. Communicating for health takes the form of communicating in solidarity with the global margins, to co-create local, national, and global response systems grounded in universal access and delivery.

Addressing and transforming structures

Noting that pandemic outbreaks are structurally constituted attends to the ways in which the spread of a pandemic is shaped by the distribution of political, economic, societal, cultural, and communicative resources. Recognizing that the virus spreads through contact, recommendations for self-isolation need to be placed alongside the necessities of those at the margins of contemporary neoliberal economies to make a living.

In highly unequal societies of the twenty first century, many households across the globe survive from day-to-day, on the basis of work performed daily.

The wage earned from the work of the day often feeds the family, pays the rent, keeps the electricity, and keeps the water running. Communication solutions therefore ought to take forms of advocacy and activism that ensure access to universal basic wage guaranteed within and across countries, universal paid leave, alongside access to the basic necessities of food, shelter, and preventive health. Communication solutions for advocacy ought to work on stopping mortgage payments, forced evictions, foreclosures, rental payments, and utility shut-offs. Homeless shelters ought to be equipped with the capacity for offering quarantine. Refugee camps ought to be equipped with the capacity to quarantine.

Similarly, the recommendations for social isolation need to be located within the broader structures constituting the distribution of work and employment. Recommendations for staying at home need to be located amidst considerations of the employment and work needs of the working and precarious classes. Universal paid leave ensures that workers who go on quarantine when experiencing symptoms have their jobs assured when they return.

Similarly, recommendations such as studying online from home need to be situated amidst consideration of digital access and costs of internet connection, especially among children and youth at the margins of highly unequal societies.

Noting that online access is not universal, communities need to be equipped to deliver educational resources that can be used at home. Community infrastructures for educational support are integral to sustaining and supporting the educational needs of children and youth at the margins.

Close attention needs to be paid to the nature of high-contact work performed by precarious workers such as delivery workers, cleaners, porters, and service workers. These forms of high-contact work are particularly at risk at nodes of movement of the virus, such as hospitals, airports, and open public spaces.

Recommendations for cleaning up surfaces for instance need to be situated in relationship to the question of who is doing the cleaning work, and the workplace protections available to cleaners. The challenges of workplace exposure for workers are also sites for communication advocacy for structural transformations, advocating for local national-global policies that protect the health of workers that are likely to be exposed to the virus, and develop appropriate mechanisms for worker compensation. These workplace advocacy efforts are particularly salient.

Health resources for pandemic prevention such as masks, soaps, water, and personal protective equipment need to be accessible universally, with the work of health communication focusing on advocacy to ensure access to these resources and the equal distribution of these resources to those in need. Similarly, access to testing for the virus needs to be made universal, anchored in transparent and publicly accessible criteria for decision-making.

Communication advocacy should seek to make corona virus testing free, and communicate this free testing resource publicly, especially to those at the margins, using communication channels that are embedded in the practices of community life.

Strengthening public health systems for testing and response is critical to preparedness, with the rapid development of infrastructures for

responsive healthcare. A public health infrastructure that has the basic health resources and operates on the principle of universal access is strongly equipped to address the pandemic, creating infrastructures of prevention, infrastructures for testing, and infrastructures for response. Placing accessible sites of rapid testing within communities is a vital step in ensuring rapid treatment and preventing the spread. Investing public resources into developing treatments and then ensuring that treatments are publicly available is key to developing socially just responses.

Also salient is the consideration of the margins of society that are likely to fall through the cracks of the health care system because of the absence of infrastructures of claims-making. With large numbers of people that have been rendered stateless and without access to mechanisms for laying claims on health resources, foregrounding the ethic of universal care holds states to account in creating universally accessible resources for prevention, testing, treatment, and care for migrants and refugees.

The global spread of pandemics renders salient the role of global advocacy that works through transnational networks of health advocacy, connecting activists across spaces to create a framework for universal global health. Culture-centered health communication in the context of the COVID-19 pandemic is communication advocacy that works in the immediate and long terms contexts to build universal infrastructures for public health.

Recognizing that protecting the health needs of all, and especially those at the margins, is integral to preventing the spread of the virus builds an anchor for health communication as communication for social justice.

Engaging cultural constructions

Culture as a site of meaning making forms the communicative infrastructure around the pandemic. Simultaneously, interrogating hegemonic meanings and narratives that reify and reproduce racism is critical in the climate of fear and anxiety created by the pandemic. Even as racist images circulate xenophobia and catalyse panic on digital platforms, health communication that is culturally-centered dismantles these images and narratives by foregrounding the voices of the margins that are the targets of these racist attacks. Through the foregrounding of voices of those that are targets of xenophobic attacks, alternative anchors for meanings are created. Spaces of advocacy and health activism are foregrounded that actively address and dismantle racism in COVID-19 discourse. Meanings of COVID-19, meanings of what it means to be healthy, and meanings of what it means to negotiate health offer anchors to developing responses.

Political and media discourses of hate are held to account through anti-racist strategies. Disinformation disseminated on digital platforms is countered through the presence of the voices of the cultural margins, disrupting hegemonic narratives of hate.

Simultaneously, the processes for cultural centering foreground the locally situated, contextually embedded solutions to the pandemic. For instance, norms of community care and familial ties in cultures offer vital lessons distribution of care in societies and communities. Neighbourhoods where members draw on culturally situated practices to care for each other offer vital resources for social cohesion, creating narratives of care that challenge the neoliberal ideology of self-help. Communities and neighbourhoods of care create alternative rationalities for organizing response to the pandemic. With neighbours helping each other, sharing childcare, sharing food, carrying out care tasks, and taking community ownership for care, alternative rationalities for organizing healthcare are foregrounded.

Communities emerge as vital anchors to delivering care as the pandemic increases in size and severity within nation states, with general practitioners, nurses, and peer leaders within communities offering vital roles in community care.

Such forms of community care can be integral to minimizing the load on hospitals as well as in developing a system of care where those in the greatest need are placed at the hospital, and multiple layers of care are put into place, generating out into the community.

Community diversity itself emerges as a cultural resource, where plural communities that are built on the principles of diversity are key resources in addressing racism, stigma, and the fears that are planted and disseminated through digital networks of disinformation. Such forms of community pluralism offer the bases for social cohesion by challenging racist stereotypes and stigmas that are circulated by the politics of hate.

Co-creating infrastructures for collective agency

Culture-centered processes of health communication center the agentic capacities of the margins, individuals, households, and communities as active participants in decision-making. Recognizing the communicative inequalities that constitute health and healthcare, culture-centered interventions address these communicative

inequalities by building infrastructures for voice democracies, ever attentive to the ownership and presence of the voices of the "margins of the margins" in discursive spaces.

In pandemic response, building voice democracies among the margins turns toward creating communication infrastructures where individuals, families, and communities can articulate their voices, present their understandings of the problems they are experiencing, and put forth solutions that they envision to the challenges being experienced.

Community-anchored knowledge plays a key role in working alongside the emergent evidence base, while simultaneously ensuring that the evidence base is democratically distributed across communities. This is especially critical within the context of the inequalities that are reproduced by pandemics. Community-based democratic infrastructures at the margins play key roles in addressing stigmas, racist ideologies, fears and anxieties around the pandemic that are often planted by powerful interests.

In contrast to traditional approaches to pandemic communication that frame the work of health communication as creating effective messages to disseminate the information (washing hands, covering mouth while coughing and/or sneezing, self-isolating if symptoms develop etc.), the CCA positions the work of communication as building voice democracies. In addition to creating messages that are culturally meaningful and sensitive, the CCA recognizes that the work of building spaces for voices is integral to creating cognitive equality, creating opportunities for communities to participate as knowledge generators by drawing on lived experiences, in creating solutions that are meaningful to community life and embedded in cultural contexts.

Creating voice democracies and ensuring that democratic spaces of participation are available to those at the margins ensure that problems during a pandemic experienced at the margins are placed as issues to be addressed, resources are mobilized., and communities at the margins democratically participate in working through the solutions.

Community voice is also integral to sustaining democratic processes, holding accountable technologies of surveillance, monitoring, and disease mapping. Whereas on one hand, technologies such as geolocation tracking can offer critical resources in managing pandemic response, on the other hand, these technologies consolidate tremendous power in the hands of the state. Ensuring accountability and community participation foregrounds the ways in which the uses of such technologies can be embedded within democratic processes, and community-anchored policies can be created for guiding the uses. The rapid pace at which pandemics spread makes it critical that infrastructures for voice democracy are built through communication work, and that health communication advocacy pushes for building these infrastructures. Recognizing the cultural norms and narratives as key resources for health and wellbeing, communicative infrastructures at the margins bring forth solutions that are systematically absent or erased from the dominant spaces of solution development. For instance, community-based social capital anchored in concepts of care and mutual support offers a vital framework for organizing response to COVID-19.

The co-constructive process of knowledge generation that places community collective agency in dialogue with the emerging scientific evidence base creates a dialogic framework for developing rapid solutions, monitoring which solutions work, and innovating on solutions as the pandemic emerges and evolves. Communication advocacy in this instance works upward, from the grassroots to the top, ensuring that political leadership and the state are accountable to communities, creating pathways of democratic access to science. Simultaneously, the science underlying the pandemic and responses to it is democratized, working through communicative processes to render the explanatory pathways and evidence base accessible to communities.

Health information is not only information on best practices for prevention, but reconfigured as information on policies, programs, and resources, decision-making underlying the distribution of resources, and processes for holding decision-makers accountable.

Discussion

In summary, culture-centered processes for responding to pandemics address communicative inequalities as anchors to building democratic infrastructures for community voice. Noting that health is constituted amidst structural inqualities shapes the development of health communication as advocacy that attends to the creation of preventive and care solutions anchored in the principle of universal health. Attending to structures calls for advocacy solutions guiding policy that build universal access to food, housing, and financial resources to address the needs of individuals, households, and communities at the margins. Work-based advocacy turns to safeguarding the health and wellbeing of workers who are most likely to be exposed to the virus through work.

Appropriate strategies for responding to the health and wellbeing of workers are salient. The process of cultural-centering turns to culture as a site for foregrounding solutions as well as for addressing the racist and xenophobic

narratives that are circulated through digital platforms. Finally, creating democratic avenues for access to science information (explanatory information as well as the evidence base) as well as sustaining voice democracies builds the dialogic infrastructures for co-creating solutions to the pandemic, embedded in contexts and connected globally in building and sustaining practices. Co-creating infrastructures for community collective agency on one hand, recognizes community capacity for developing solutions, and on the other hand, supports community and individual needs through universal access to prevention and care.