*SPECIAL ISSUE*

*LESSONS LEARNT FROM A PANDEMIC: COVID-19 IN PERSPECTIVE*

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DATA SURVEILLANCE AS AN IDEOLOGICAL PRIORITY?

AYA AHMAD, ZIHAN XU AND YIBING LIU

To what extent can protecting people's privacy be allowed to come at the cost of protecting public health? In several parts of East Asia, data surveillance in connection with COVID-19 was prioritized over individual privacy on the assumption that collective transparency was for the greater good. In the Western world, such as in England, individual freedom and privacy were prioritized above nearly everything else. We have coined the term 'ideological prioritizations' to describe the values and cultural predispositions that are prioritized among one people rather than another. During the COVID-19 crisis, ideological prioritizations have been situated in a complex web of ecological, historical, political and other factors, opening up spaces in which to embrace culturally meaningful ways of understanding the different policy responses to COVID-19. By juxtaposing the ideological prioritization of data transparency in the interests of collective health with the right to privacy by an individual, we hope to open up new ways of thinking about policy-making.

Beginning with mainland China, big data (digital technology) has been widely utilized in the face of COVID-19, for example, being applied in tracking disease activity in real time while screening individuals for the virus (Whitelaw et al. 2020). In mainland China, there are two widely used mobile apps: WeChat and AliPay. These applications generate Health Codes based on their system and database, in which all outgoing residents are required to fill out and update a symptom survey. Additionally, individuals are required to allow the authorities to monitor their health status and share their migration data with government platforms.

Subsequently, residents are assigned a colour code by the Health Codes system, with different colours representing 'low', 'medium' or 'high' risk. This code translates into a health-status certificate and travel pass. In practical terms, residents must scan the Health Code when entering any public place. This visual footprint keeps track of where code-holders go and notifies them if they have been in an infected or high-risk area. Thus, the two functions of the Health Codes ensure public safety by individual contact-tracing (Bao et al. 2020).

Mainland China's policies are aligned with a relational concept of the self as part of the collective. In a culture where personal well-being is deeply intertwined with social obligations,

obeying the data transparency rules is an expression of sacrificing one's temporary freedom for collective well-being.

While South Korea shares its cultural roots with Mainland China, it differed in its COVID-19 response by not enforcing a countrywide lockdown. Instead, widespread testing and tracing were utilized. The government used GPS records from smartphone data and credit cards to trace the movement of patients and identify their close contacts (Her 2020). This required enforcing a law that provided the government with the necessary authority to access data. In addition to the earlier social trauma connected with SARS, which prompted the government to take responsibility for COVID-19, it must be realized that Confucian and collectivist cultural predispositions also influence Korean notions of the self. Compared to a lockdown for everyone that brings society and the economy to a standstill, extensive use of surveillance technology on a small proportion of the population might ultimately save more lives in the collective. The surveillance is a trade-off between Confucian values concerning collective well-being, which are historically given, and the individualistic pursuit of freedom.

In Taiwan we also see the transparent utilization of data surveillance. Realizing that COVID-19 was occurring just prior to the Lunar New Year, when millions of Chinese and Taiwanese were expected to travel, Taiwan integrated its National Health Insurance database with its immigration and customs database to set up a large data centre to perform analytics (Wang et al. 2020). The Taiwanese Infectious Disease Control Act of 2007 allowed officials to access this information as a means to control and contain the virus (ibid.). Any close contacts of confirmed cases or travellers from high-risk countries were required to quarantine for two weeks, during which time they would be monitored via personal or government-dispatched phones or in-person checks (ibid.). All hospitals, clinics and pharmacies in Taiwan had access to their patients' travel histories (ibid.). Though the monitoring measures appeared draconian, the way in which they were implemented was done with respect for individuals, maintaining crucial ethical standards (Nuffield 2020). Data surveillance was prioritized over privacy, the collective cultural assumption being that transparency in this form would allow other freedoms and lead to safety and improved community health. Furthermore, by de-stigmatizing the virus and quarantining, an environment that permitted open, honest communication was established. The aim was to form a partnership between the people and the government, rather than the latter imposing a top-down approach.

This precedent of open communication was also exhibited via 'vTaiwan', a virtual democracy platform that invited open conversations in order to create unity and consensus over policy decisions (Bardi and Bollyky 2020). Through vTaiwan, a face-mask application was developed to provide information on mask stock availability. This was achieved in collaboration between

Taiwan's Digital Ministry, entrepreneurs and computer scientists (Bardi and Bollyky 2020). The Minister of Health and Welfare received approval ratings of above 80% for the handling of COVID-19, and the president and prime minister approval ratings of nearly 70% according to a poll conducted by the Taiwan Public Opinion Foundation, which interviewed 1,079 randomly selected people on 17 and 18 February 2020 (Wang et al. 2020).

Rather than reducing data surveillance measures to a lack of autonomy and privacy, countries would do better to appreciate this approach by viewing it as, in itself, a form of collective transparency for the sake of the community as a whole. As the Nuffield Council on Bioethics stresses regarding ethical considerations in responding to COVID-19, this solidarity is critical in 'recognizing what we owe each other as fellow, equal human beings' (Nuffield 2020: 5). What appears to be a crucial factor in data-use is the reciprocation of transparency and ensured consent by the people in order to maintain trust in the government.

Juxtaposing East Asian COVID-19 approaches to those of England unveils England's ideological prioritization of autonomy, privacy and 'liberal' values. As Drury et al. (2020: 6) state:

> fearing public 'panic' leads the authorities to withhold information about an emergency. But lack of information in an emergency increases public anxiety. And when the public perceives that information is being withheld from them, this damages their relationship with the authority. Consequently, when the authorities do release correct information, the public may mistrust and fail to act upon it.

The presumption of public panic and the lack of adherence by the people led the UK government to issue ambiguous, contradictory and incoherent policies.

Though individuals in Taiwan suffered a loss of privacy through intensive monitoring and data collection, they were not only told that they were being fully informed along the way but were also treated as valued contributors to the decision-making process. In England, by late April, only 12% of hospital doctors felt fully protected from the virus: 'the broken promises on testing were matched by those on PPE' (Calvert 2020: online). On 29 October Taiwan marked two hundred days without any domestically transmitted cases of COVID-19 (Graham-Harrison 2020). On 30 October, by contrast, with numbers rising again, the UK announced another month-long national lockdown. Though people in South Korea and Taiwan were denied data privacy and subjected to more monitoring, they reaped the rewards that the UK population were denied.

There are lessons here for policy-makers to learn. The above comparisons demonstrated which ideological priorities led to which types of response, and no doubt a stronger transnational dialogue can help strengthen individual nations' infectious disease strategies. In reality government and public responses are situated in a complex web of ecological, historical, political and cultural

factors. In a highly globalized world, policy decisions demand the same collaborative, dynamic thought as the context in which they inevitably exist with a virus that knows no borders.

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MASK-WEARING AS A CULTURAL PRACTICE

AYA AHMAD, ZIHAN XU and YIBING LIU

At an early stage in the COVID-19 outbreak, various and sometimes conflicting perceptions of mask-wearing among scientists, policy-makers and the wider public in different regions raised

problems regarding whether this precautionary measure should be applied. Given that initially the scientific evidence was not strong enough to support the widespread use of facemasks against COVID-19, the World Health Organization (WHO) first suggested mask-wearing only for those with symptoms suggestive of COVID-19, rather than the general public (WHO 2020; also Greenhalgh et al. 2020). However, the Chinese government introduced the compulsory wearing of face masks in public places on 23 January 2020, long before the WHO acknowledged that masks can provide protection for oneself (Pan et al. 2020). Mask-wearing was deemed a protective practice for the majority of people in East Asia, but it raised concerns regarding personal liberty and discrimination in the West. Why did East Asian policy-makers apply mask-wearing measures despite disagreement over their protective benefits? Why would people in East Asia readily adopt this practice at an early stage? And why was this not the case in the West, say, in the United Kingdom?

The previous article, 'Data surveillance as ideological prioritization?' introduced 'ideological prioritization' as a new term for explaining the prioritization of certain values and cultural ideas among some peoples rather than others. This can help us understand why, in some cultural macro-regions, such as Mainland China, South Korea, Japan and Taiwan, people readily adopted mask-wearing, while in others, like the United Kingdom, they were late in doing so.

In East Asia, mask-wearing reflects social identities that emphasize collective solidarity and personal responsibility in combating infectious disease (Tsang and Prost 2021). When people are sick, they wear masks to prevent onward transmission and thereby protect both others and themselves. In China, the use of face masks is associated with the idea of the self showing consideration for the collective. Despite the post-Mao era witnessing a shift in Chinese culture towards individualization, the interdependent and relational notion of the self is still dominant in China today (Fei [1947] 1992; Yan 2010). For the Chinese, personal well-being is not only concerned with the individual will, it is also deeply entangled with the social body and the more than human season- and place-sensitive 'body ecologic' (Hsu 1999: 78-83; Rittersmith 2009).

In the case of COVID-19, mask-wearing was considered to benefit both individual health and collective well-being. The high frequency of wearing masks, regardless of the presence or absence of symptoms, was found to be associated with lower levels of depression and anxiety among the Chinese (Wang et al. 2020). This might have been reinforced by the collective memory of previous pandemics. For the middle-aged and young, not to mention the elderly, experiences of wearing masks during the SARS outbreak of 2003 were still vivid. Mask-wearing became a *social habit* demonstrating the collective effort involved in combating pandemics. Thus, for the general public

in China, long-ingrained *practices reinforcing* the relational self, as well as the *living* memory of the SARS epidemic, turned mask-wearing into a source of confidence, ease and collective control.

This ideological prioritization in which the self is viewed in relation to and as protective of others was also evident in Japan. Here, mask-wearing symbolized civic responsibility and moral obligations as a rule of conduct. Individuals were also motivated to wear masks due to a collective ethical commitment to care for others. In 2007 the 'cough etiquette', which entailed covering the mouth with tissue paper or a handkerchief when coughing (PIEAC 2007), became a collective practice out of respect for others. Thus, masks could be regarded as a symbolic means whereby people communicated their sense of responsibility against a common threat to the society to which they belonged. A study by Betsch et al. (2020) showed how, during COVID-19, individuals wearing masks were perceived to be 'prosocial'. These findings demonstrated how mask-wearing could *engender a sociality* in which compliant people perceived each other more positively. Solidarity in calibrating the self in relation to others could create communal respect and unity amidst uncertainty.

The relational aspects of mask-wearing and one's relationship with inhabited space embed mask-wearing in an ecological context. Local disease patterns reside in ecosystem imbalances (McElroy 2018). Correspondingly, public health responses involve dynamic negotiation between eco-biological networks and the historical, cultural, economic and political forces in human society. To protect themselves from urban pollution or combat atmospheric haze, people in contemporary East Asia have had to get used to wearing masks. It is because of concerns over pollution haze that China has seen an increase in mask-wearing in the past decade. The dust-haze seems to be an accumulated result of both 'natural' factors in an age of rapid climate change and unhealthy economic growth against the backdrop of individualization and urbanization in China (Li and Zhang 2014). Originally designed for filtering out 'yellow dust', the certified 'Korean Filter 94' mask became popular in South Korea: those who wore masks protected themselves from the residual sand of the Mongolian steppes and China's north-western deserts that blew into South Korea. During the COVID-19 pandemic, the booming mask industry of the previous decade informed and facilitated the government's and other public responses. The Korean government actively intervened in and boosted the production and distribution of masks to deal with the shortage of supplies and the high demand during the epidemic (Her 2020). Air pollution and haze have a direct impact on the individual. This is further demonstrated by Japan's nuclear disaster of 2011, with individuals still today suffering the respiratory effects of Fukushima. After this disastrous incident, masks sold out very quickly in stores as far away as in Tokyo (Nagano 2011, cited in Horii, 2014). The city is part of a dynamic and at times hazardous, even transnational,

ecological situation. Air pollution has proved to be an educator, as its sensory perception directly affects each individual.

Mask-wearing has been far less ideologically prioritized in the West, especially in the UK. Data from YouGov, a market research firm, indicated that the UK had among the lowest percentage of people wearing face-masks throughout the pandemic. In early July 2020, only 38% of Britons said they wore masks in public, as opposed to 88% in Spain and 83% in Italy ('Personal measures taken to avoid COVID-19 Yougov', 2021). Eventually, an increase in newly infected cases and deaths, the policy of compulsory mask-wearing indoors, the overwhelming of hospitals and the lockdowns had the effect of increasing the 38% to about 75% in the autumn and winter months of 2020-2021. Conversely, Taiwan's mask-wearing percentage from March 2020 to February 2021 remained steady at 80-86% (ibid.). The term 'ideological prioritizations' helps analyse the UK's response better: why was the UK so hesitant in adopting mask-wearing and delayed doing so?

Analysis of the government's official statements and a survey of 1,615 adults in the UK demonstrated the ideological prioritization placed on needing scientific evidence for the efficacy of proposed measures before they could be implemented. Furthermore, British people expressed the expectation that only a unified, compulsory policy and a strong government stance would force them to wear masks. The government was sceptical about mask-wearing and did not emphasize its importance early on, scepticism that was readily mirrored in the population.

On 3 April 2020, the Deputy Chief Medical Officer stated, 'there is no evidence that general wearing of face masks by the public who are well affects the spread of the disease in our society' (Peston 2020). The UK was not alone in distrusting masks: the Western world in general was resistant at the beginning of the pandemic due to a lack of evidence regarding their efficacy. Policies based on evidence-based biomedical statistics were ideologically prioritized over following a widely affordable precautionary principle. Face masks were perceived as 'technologies containing threats to individual, national, and transnational identities and health' and were considered to have a 'connotation of danger and crime' (Greenhalgh et al. 2020). Entanglements with the prioritization of 'evidence first' and 'liberty first' gave the virus ample time to infect, spread and evolve (Tsang and Prost 2021). In the UK, a novel virus was met with a government unprepared for the manufacturing of masks and unwilling to move beyond the need for scientific evidence, creating an environment of scepticism and leaving a people unsure who or what to trust.

Our ideological prioritizations can at times act as biases that endanger us. In times of uncertainty, embodied experiences and the ordinary person's perceptions of risk serve as crucial information bites. Though not necessarily scientific, these experiences are embodied, and there is

a value in this sociocultural efficacy in itself which has been consistently underestimated in modern times. By juxtaposing mask-wearing as a cultural practice in East Asian regions to potential ideological explanations of mask hesitancy in the United Kingdom, we obtain a greater understanding of how certain ideological prioritizations are manifested in different pandemic responses.

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POLICIES AND PREDISPOSITIONS:
REFLECTIONS ON THE LIMITATIONS OF CULTURALISM


ELISABETH HSU


The previous two essays argue very compellingly for taking 'ideological prioritization' into account when formulating policies, and they do so in a nuanced way. They compare government policies and measures that affected the public and individual protective practices in different countries of East Asia with those in Western countries, in particular the UK. The essays oppose the individualistic predispositions found in the West to the collectivist ones that occur in East Asia, although they also aim to prevent a purely dualist reading by, for instance, highlighting diversity in East Asia and comparing Mainland China, Japan, South Korea and Taiwan with each other. The authors demonstrate their awareness that several issues are too subtle and complex to be raised

here, the lesson to be learned from this being that there is a great variety of different case studies, which deserve to be appreciated in their entirety.

Notwithstanding the successful implementation and effects of surveillance systems, if we look at them in more detail, we note not only variations but also limitations. Perhaps the effectiveness of data surveillance may have been overdrawn by those who implemented it? Mainland China introduced population-wide surveillance systems and lockdowns in some regions and cities, to good effect. This was followed up with a long-term monitoring system of health status and migration data to prevent future outbreaks, which has been successful, though in the beginning it was fairly slow in ringing the alarm bells. In South Korea, by contrast, a track and trace surveillance system was put in place. This also happened in Taiwan, where the government also found a legal way to access databases on immigration that it could merge with data on national health insurance. In fact, it is not socialist China but capitalist Taiwan that tends to be praised for most effectively controlling the proliferation of the virus.

Incidentally, we note that, in addition to surveillance, Taiwan imposed (1) travel restrictions and (2) quarantine rules, and that all this happened (3) very early on, in fact, before COVID-19 had been named as such, and before the epidemic became a pandemic (Wang 2020). Would these three measures alone, aimed at containing an air-borne epidemic at a very early stage, have sufficed? They require no data surveillance at all!

Surveillance instantly brings to mind apprehensions regarding the destruction of the juridical and moral person, and ultimately also of the individuality of the person. It conjures up Hannah Arendt's *The origins of totalitarianism* (1951), and with it the threats of the Third Reich. Furthermore, it re-instantiates the Orientalist trope of despotic rulers in the East, against which the polis in classical Greece defined itself as democratic. However, if anyone ever thought that surveillance systems were only advocated in East Asia, Shoshana Zuboff's (2019) *An age of surveillance capitalism* provides a sobering antidote. The automated information flows about everyone that tech giants like Google and Facebook have generated are being used today in ways that enable social engineering far beyond any dreams of the behaviourist B.F. Skinner. In surveillance capitalism, commercially driven data analytics, business strategies and Skinnerian experimentation with human behaviour, algorithmically adapted and multiplied by Artificial Intelligence, are combined, ultimately being geared towards a 'rendition of all aspects of human experience into behavioural data … [that] guarantee behavioural outcomes' (ibid.: 339, cited in Williamson 2019). Globally, governments are making use of this commercialized e-industry. Computation and statistics have long been the basis of governance. There is nothing new about that, yet coupled with surveillance capitalism, they are geared towards undermining public debate,

as well as social and political life. So, even though data surveillance policies have been implemented more systematically by governments in East Asia, with evident success and general acceptance by the collectivities affected, Zuboff reminds us that 'data surveillance' is not specific to that region.

In a similar vein, 'individual privacy' may not be specific to the supposedly individualistic West. Although one reason against wearing face-masks was that they had a de-individualizing effect, the above essay on face masks makes clear that there were many other reasons too. The ecology of 'yellow dust' being blown from the Inner Asian steppes into South Korea not only engendered mask-wearing as a protective practice, it also curbed the economy of industrial mask production. People had been habituated into wearing 'designer masks' as status markers. Air pollution, due to its smell and often tangible stickiness, tends to have instantly sensed effects. Mask-wearing can accordingly be optimized by the individual, directly, immediately, autonomously. Mask-wearing is thus easy to appropriate into one's individualistic repertoire of health-preserving body techniques, in East Asia as in the Western world.

Every epidemic instigates make-believe, and white-coated professionals combatted fear by saying 'We are well-prepared', 'Do not wear masks' or 'Masks cause fear in people', reminding people unduly of the epidemic's presence or of hooded robbers and criminals; masks could also cause a false sense of security and claustrophobia in their wearers. Then, a month later, the same spokesman for the Swiss Ministry of Health declared the opposite: wear face masks, they do protect you, they reduce the infection rate to 30% and protect others, pro-socially. So, when two people meet, they are likely to have reduced the infection rate to 60% (this was before vaccines were available, cf. Hung 2021). When the spokesman said this on Swiss TV, it transpired through the newspapers and on the ever more active grapevine that there had not been sufficient masks in stock! Meanwhile, some companies had been quick to produce face masks; within weeks they had flexibly adapted their production line to the acute demand, as did a family-owned firm in a little township in central Switzerland. Government regulators thereupon appeared standardizing materials and supply chains, and imposing newly invented control procedures, which sometimes stifled individual initiatives. Money-making was exclusively reserved for the giants, the supermarkets, Amazon or DPD, requiring masses of unskilled, temporary and poorly paid labour. Meanwhile, the artisan, the resourceful petty entrepreneur and members of the hospitality and well-being sectors, many of them individualists working in a fragile social ecology, were sent into lockdown or put on furlough schemes. These policies did nothing to cultivate the ideal of the autonomous individual. Conversely, when Ohnuki-Tierney (1984: 21-50) speaks of Japanese germs, she points to public–private distinctions in the Western world comparable to the Japanese

opposition between *mi-uchi* (within my body) and *ta-nin* (other persons). Social intimacy happens in the *uchiwa*, the inner circle: for instance, when one is invited to eat food with the family's chopsticks and not those reserved for guests. She highlights how the spatial boundary between the outside world, which is by definition dirty and full of germs, and the inside of the house is maintained by a long list of body techniques, such as changing from street shoes into house shoes, washing one's hands, sometimes even gargling, or sprinkling some cleansing salt on to oneself after a funeral. In this context, we learn about the face mask: 'The Japanese use it to prevent themselves from inhaling someone else's germs, whereas American surgeons and patients use it to avoid transmitting their own germs to others' (ibid.: 26). Ohnuki-Tierney thereby treats the biomedical regime of mask-wearing as on a par with another cultural belief system, no less real, the Japanese belief in germs. Yet this is precisely a relativizing stance that more recent medical anthropological research directed at policy-makers has queried.

Two years before the COVID-19 pandemic, and ten years after SARS, Lynteris (2018) published most insightful medical anthropological research on mask-wearing. His publication is an exemplary anthropological-*cum*-historical overview that pulls together information that is hugely relevant for policy-makers, yet, like most anthropological research, it has simply been ignored. If policy-makers had read this article, they could have saved many lives, as it addresses head-on the claims that policy-makers expressed at the beginning of the pandemic throughout the Western world, namely that wearing masks was a 'cultural' practice, and hence impossible to value as a 'scientific' one. It would appear that simple prophylactic devices, like mask-wearing in the case of any airborne infectious disease, should always be advocated by policy-makers, even if their benefits are not always proved by randomized controlled trials (RCTs) (Greenhalgh et al. 2020).

Lynteris's historical research shows that the 'anti-epidemic face-mask', which broke through into global medical history during the 1910–11 Manchurian plague, was not just a symbol of biomedical rationality: importantly, it worked as a catalyst for the 'hygienic modernity' that followed, not only in China, but globally. Even if people made use of more than ten different makes of masks of variable quality, mask-wearing 'both stopped germs from entering the human body and … transformed the public from being "superstitious" and "ignorant" people into an enlightened hygienic-minded population: a population that accepted the contagious nature of the disease'. (ibid.: 451).

The low-tech protective devices advocated in this pandemic include physical distancing, reducing contact with human beings outside an inner circle generally called a 'bubble', frequently washing one's hands and clothes, wearing gloves, etc. However, there are many more self-protective and fortifying practices that could have been promoted on a large scale, such as

fortification through vitamins C and D in particular (vitamin D is essential for the immune system's basic functioning, regardless of its debated specific effects on combatting COVID-19), lots of sleep, and vigorous walking in the fresh air that strengthens the lungs, boosts blood circulation and brightens the mind. In East Asia, where populations have no doubt had a long history of being exposed to other coronavirus-induced epidemics, the culinary preparation of foodstuffs with garlic, onions and the like has been developed into a medical art, so-called food therapy (Hsu et al. 2020). Furthermore, the seasonality of viral diseases has long been recognized: warmth factor disorders are known to spike in the spring (Hanson 2011), as is currently the case in India and Brazil (as of April 2021). Porkert (1976: 67), discussing the 'strengths of Chinese medicine', coined a Latin word to do justice to Chinese medical expertise: *chrono-demic* disease. He explained that 'A number of diseases, which flare up simultaneously over vast territories are, according to Western medicine, probably caused by a virus. But they are explained in Chinese theory as deficiencies or redundancies of energy in certain orbs, conditioned by the momentary immunological situation.' Japanese common sense reinforces this (Ohnuki-Tierney 1984: 33): 'In particular, *konome doki* (bud time; the time when leaves are budding in early spring) is the transitional time from the cold to the warm season and the time when people are considered susceptible to sickness; sick people and old people must be particularly careful.' While there are ample prohibitions on eating specific wildlife delicacies, lest one risks succumbing to various forms of dis-ease, there is little evidence in the historical record so far of the zoonotic origins of epidemics.

Alongside individual effort, the ethnographic record highlights that, most importantly, epidemic crises require coordinated community responses. In a multiply interconnected globality, this begs the question of what makes up a community. During the Manchurian plague, as is evident from early photographs, the self-protecting white-masked 'plague fighters' visually formed a unity against the dark quarters in the background, in which lurked the 'black death'. The 'spectacle of masked unity' sufficed, says Lynteris, to instil a sense of social solidarity. The problems of a pandemic are wide-ranging, and bio-technology alone cannot solve them. Creating community involves paying attention to individualities.

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