

# Dis/Avowing Masks

Culture, race, and public health between the  
United States and Taiwan

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## Abstract

COVID-19 brought masking, a practice that was largely confined to certain technical occupational settings in the US, into the heart of a national controversy. As with prior emerging infectious diseases (such as HIV, SARS, and Ebola), US public health experts and governmental agencies positioned themselves as authoritative producers of emerging scientific knowledge, including best practices for public masking. US epidemiological outcomes, however, have sorely lagged behind many other countries. The US leads the world in confirmed cases of and deaths from COVID-19, undermining presumed hierarchies in global health authority today. In this essay, I compare US and Taiwanese masking policies, delineating how social relations of care in the US become sites of political conflict within a hierarchical global ecology of scientific knowledge and medical supplies. Drawing upon my experience as a MD/PhD in anthropology trainee studying emerging infectious diseases and as a Taiwanese American immigrant, I explore conflicts over mask acquisition and usage across borders and time, illuminating global inequities of scientific knowledge production and pandemic containment and underscoring racialised disavowals that persist in US public health. These racialised disavowals illustrate the structural limits that circumscribe possibilities of containment during an uncontained pandemic.

## Keywords

Masking, Taiwan, Race, Health policy, Pandemic response.

## Introduction

In early 2020, the world watched cautiously as a new infectious disease emerged in Wuhan, China. Still stinging from botched public health efforts to contain SARS in 2003, the Taiwanese government took immediate steps (see Su and Han 2020). A control centre was formed, flights from Wuhan were screened, the public was briefed regularly, and money was pumped into manufacturing masks. Using each citizen's national health insurance ID, the government set a quota of two masks per week. On my Taiwanese cousin's Facebook wall, people vented their frustrations: 'I went to the convenience store to get masks, but the line was too long. I guess I have to keep steaming my masks to sterilise them.' Hindsight would validate Taiwan's approach: now (late 2020), my family members go about their daily lives mask-free while US healthcare workers implore Americans to wear masks and stay home amid the third peak in COVID-19 case counts. If SARS provided potent 'lessons learned' to the global public health community (Knobler et al. 2004), including the potential benefits of public masking (Syed et al. 2003), what accounts for the difference in masking policy between Taiwan and the United States? What might tracking US COVID-19 masking policy reveal about the movement and uptake of epidemiological 'lessons'?

Taiwan, it seems, learned its own lesson from SARS. As physician and bioethicist Ezekiel Emanuel (Emanuel et al. 2020) wrote in July 2020, the United States would be wise to learn from the island. Policy experts of both conservative and liberal persuasions at the *National Review* and the Brookings Institution agree (Raleigh 2020; Daniels 2020). But would the US learn from Taiwan? Even as they praised and recognised Taiwan, these experts acknowledged vast differences between the two countries. In terms of infrastructure, Taiwan has a national healthcare system and the US does not. Public mask-wearing has been accepted practice in Taiwan (Flaskerud 2020) while it is only habitual for those in certain occupations in the US. Furthermore, even if those differences were somehow erased, questions would still remain: whose 'lessons learned' would apply to whom? Do the vectors of emerging infectious disease knowledge ever point from geopolitical peripheries to superpower metropolises?<sup>1</sup>

In this Position Piece, I reflect on projected geopolitical hierarchies from my position as a physician-anthropologist trainee and a Taiwanese American, tracing a timeline of masking in the US as an entry to examining the intersection of globalisation, recognition, and racialised power dynamics. By reading the affective voices of experts in images of the mask hoarder, mask circulation, and public health mask conservation recommendations, I highlight the role that the idea of the

1 This question is central to my dissertation, which examines American biosecurity in the wake of the 2014–2016 West African Ebola epidemic.

'Yellow Peril' (see, for example, Kawai 2006; Leong 2003; and Visco 2019) and the phenomenon of model minoritisation (see Eng and Han 2019; Wing 2007; and Wong 2015) continues to play in American pandemic containment efforts. I argue that the exceptionalism of American public health is maintained by framing non-white knowledge as 'cultural', facilitating their disavowal in the ever-emergent COVID horizon (see Petryna and Rendell 2021 elsewhere in this issue and Zhang 2021).

## January: Hoarding Hordes

In late January, a Taiwanese relative in New York anxiously asked me via text message to get some masks because she was having trouble finding them. *The New York Times* had just published a story about the dangers of mask hoarders (McNeil 2020). The story accompanied a picture of a group of masked Hong Kongers surrounding a table piled high with boxes of masks. Two other images were used in the article. One showed boxes of N-95 masks to reinforce the point that 'a study done during the 2003 SARS epidemic showed that N-95 masks [...] were especially protective for nurses'. The other depicted a pharmacy in Flushing, New York City, a predominantly Chinese and Korean community, 'emptied of face masks'. The rest of the article set the tone that would characterise the early phase of the pandemic in the United States: 'The prospect of shortages created by panic buying worries some public health experts [because] hoarding by those who are well means that hospitals [...] could run short.'

The experts cited in the article drew on their experiences with other emerging infectious diseases like Ebola and H1N1. But the article's subtext—that Asians were responsible for the shortage—was clear. The article ended with a discussion of how the wearing of masks is uncommon in the United States except for 'some Asian communities', where 'it is common for people to wear masks to protect themselves against germs and pollution, or because it is considered impolite to not wear a mask if one is coughing or sneezing'.

I was caught in a double bind. The anthropologist in me was telling me to take my relative's concern seriously as a source of 'cultural', if not epidemiological, wisdom. The medical trainee in me, however, parroted the company line: 'They said it's not a big risk in the US,' I assured her. 'We should save the masks for people who need them.' With *Bloomberg News* reporting a global run on face masks (Chen 2020) and *The Gothamist* reporting that 'Chinese New Yorkers Worried About the Coronavirus are Wearing Masks' (Kim 2020)—both featuring photos of ethnic Chinese people wearing masks and buying boxes of them—my mind turned to San Francisco Chinatowns at the turn of the 20th century (see, for example, Risse 2012 and Shah 2001). Then, as now, racialised fears of epidemics found various

expressive avenues. For some, the masked Asian represented a disease threat (Caspani and Hay 2020). For others, the masked Asian was recognised as selfish, putting her personal fears above the healthcare workers of the multicultural society that so graciously included her as a model minority (Hsu 2015). As one exasperated physician wrote in the *Los Angeles Times* under the headline ‘Your Hoarding Could Cost Me My Life’: ‘Every day we see photos in the newspaper of people going about their ordinary lives wearing professional-quality masks to protect themselves instead of simply staying home. It’s frustrating to see those covered faces when I know that doctors and nurses on the front line already desperately need the masks’ (Patel 2020).

Similarly, the physician journalist Elisabeth Rosenthal (2020) wrote to a *New York Times* readership that hand washing and staying at home were more important than wearing masks: ‘By all indication SARS [...] was a deadlier virus than the new coronavirus circulating now, so keep things in perspective.’ The associate chief medical officer for Emory University Hospital, Colleen Kraft, who helped treat the first US Ebola cases in 2014, ‘cautioned that [our] understanding of the novel virus is still evolving [...] As we learn those things, we can gauge what our panic mode needs to be’ (Abutaleb 2020). I echoed such messages when communicating with my relative: ‘Improperly worn masks can actually be more dangerous if the virus is transmitted via surfaces, so just wash your hands,’ I told her, hoping to dissuade her from her mask search.

Yet afterwards, with the benefit of hindsight, I grew uncomfortable with the racialised power imbalance inherent to this wait-and-see approach, especially as it applied to known public health practices like masking. Rosenthal (2020), who covered the 2003 SARS outbreak in China, wrote, ‘Those photos of people walking down streets in China wearing masks are dramatic but uninformed.’ Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases and the face of the American COVID-19 response, said in a March *60 Minutes* interview, ‘The people who, when you look at the films of foreign countries and you see 85% of the people who are wearing masks—that’s fine, that’s fine. I’m not against it [...] but it could lead to a shortage of masks for the people who really need it.’ In an emerging epidemic, the dearth of formal peer-reviewed scientific knowledge could have at least enabled and encouraged consideration of other forms of knowledge. This disavowal—or casual brushing aside—by experts prioritised the *ignorance* of formal science over the embodied practical knowledge of the Asian communities that I belong to. To the experts, the Yellow hoarders signified threat, selfishness, and exotic customs that would never be accepted in the US (Gover, Harper, and Langton 2020).

## April: From no masks to cloth coverings, and #TaiwanCanHelp

The fear of hoarders reached its zenith right before the March shutdown of many American cities when Surgeon General Jerome Adams tweeted, ‘Seriously people – STOP BUYING MASKS! They are NOT effective in preventing general public from catching #Coronavirus, but if healthcare providers can’t get them to care for sick patients, it puts them and our communities at risk!’ (tweet since deleted; see Asmelash 2020). Guidelines posted by the US Centers for Disease Control and Prevention (CDC) reinforced the idea that masks should not be worn by members of the general public: ‘You do not need to wear a facemask unless you are caring for someone who is sick (and they are not able to wear a face mask). Facemasks may be in short supply and they should be saved for caregivers’ (CDC 2020).

These strong assertions about mask efficacy, themselves built upon the lack of scientific evidence suggesting masking by the general public works to contain an epidemic, made it difficult for public health messaging to remain nimble when information changed daily. Indeed, many Americans were caught by surprise when the CDC reversed course and changed its recommendations overnight to read ‘everyone should wear a cloth face cover when they have to go out in public’ (CDC 2020). When National Public Radio (NPR) reached out to the Office of the Surgeon General for clarification, it issued a statement saying that the Surgeon General was following CDC and World Health Organization (WHO) recommendations about how best to protect individual members of the public (Huo 2020). Guidelines, this statement suggested, will always change because they simply follow ‘the science’, and science changes.

It is difficult to make concrete and actionable guidelines during a pandemic, especially when policymakers feel like they cannot trust the public (Wallace-Wells 2020). The Surgeon General’s recommendations prioritised providing masks for a finite number of hospitals and frontline providers, and this allowed for concrete action when both the pandemic and the racialised hoarding public seemed out of control. Yet this about-face from *masks don’t work* to *masks do work* makes me wonder about the kinds of knowledge that are included and excluded when considering which policies to enact. Whose knowledge counts? Whose science?

While the Surgeon General and many members of the well-read public keenly observed CDC and WHO guidelines, some public health experts began to look elsewhere for model behaviour. Jeremy Lim, adjunct associate professor of public health from the National University of Singapore, described how ‘East Asia’s threshold for taking action on face masks and more potentially preventive measures was sparked by SARS. [...] For East Asian countries, the attitude was

“better to be safe than to be sorry” (Huo 2020). Masking, or at least ‘cloth covering’, had long been in the public health toolkit, but, in the context of COVID-19, it was treated by American public health experts and journalists as a ‘cultural practice’ instead of scientific knowledge.

As journalist Huo Jingnan (2020) wrote:

The existing culture of mask-wearing helped Asian societies [to contain the pandemic]. After surviving the outbreak 17 years ago, many people in this part of the world began wearing masks even if they just had a cold—to protect others but also for a sense of being protected from others, even if there isn’t scientific data to back that up.

Margaret Harris of the WHO coronavirus response team concurred: ‘The mask is almost like a talisman,’ she is quoted as saying. ‘People feel more secure and protected’ (Ibid.). European and American cultures are different from East Asian cultures, she adds, in that mask-wearers in the former are perceived as trying solely to protect themselves from everyone else.

These expert voices acknowledge the merits of public masking for coronavirus pandemics and yet persisted in framing it as an ‘oriental’ practice. In doing so, they reduce the masking policies of many East Asian public health authorities in January to cultural particularities, restricting their applicability to East Asia. Taiwan has ‘societalized’ (Lo and Hsieh 2020) pandemic preparedness, but ‘it would be a complete shock to the American public to see widespread face mask use’ according to Lawrence Gostin, a professor of global health law at Georgetown University and the director of the O’Neill Institute for National and Global Health Law, a WHO collaborating centre (Huo 2020).

Further, the supremacy of Euro-American public health prevents the recognition of emerging pandemic knowledge that originate in global peripheries. The failure of Taiwan to gain international recognition is instructive. Following United Nations guidelines, the WHO continues to restrict Taiwan’s participation in its activities despite the country having successfully prevented new COVID-19 cases since April 2020 (Deng 2020). This, by design, cuts Taiwanese input—‘lessons learned’—from the main hub of global public health. Even as Taiwanese academics publish in American medical journals to advocate for Taiwan and its success in mask usage (e.g., Su et al. 2020 and Su and Han 2020), they are rarely cited—and, when they *are* cited, it’s mostly by other Asian authors.

Where Taiwanese ‘lessons learned’ failed to gain recognition in these formal scientific channels, they found better reception in more public forums. Focusing on global mask shortages worldwide—the main concern of American policy—the

Taiwanese government and private sectors adopted #TaiwanCanHelp, sending millions of masks to the United States, Europe, and its diplomatic allies in April. Celebrities like Bill Gates and Barbara Streisand ‘hailed the island as exemplary’ (Hernández and Horton 2020) and praises of Taiwanese success came from policy-focused media venues,<sup>3</sup> contrasting starkly with the relative silence of American public health experts.<sup>4</sup> At stake was not just global pandemic containment but also political participation. As Taiwan’s vice president said in an interview, ‘This is a good opportunity [...] to let people know that Taiwan is a good global citizen<sup>5</sup> [...] We have to fight for our participation’ (Office of the President Republic of China [Taiwan] 2020).

Indeed, the recognition of Taiwanese ‘lessons learned’ occurred only in the context of Euro-American political parties competing for power *vis-à-vis* their stances on China. Later on, in August, the Czech Republic’s President of the Senate, Miloš Vystrčil of the conservative Civic Democratic Party, led a friendly visit to Taiwan in defiance of the Czech president Miloš Zeman, who belongs to the progressive Social Democratic Party, which is sympathetic to China (Wu 2020). In the preceding April, however, the Trump administration had set aside Taiwanese masks for staff use two weeks before the US’s masking policy change (Leonig et al. 2020). These masks appeared later at a press conference in May, where senior White House officials, including Press Secretary Kayleigh McEnany and Jared Kushner, were seen wearing these ‘Made in Taiwan’ masks to signal their stance against China (McLaughlin 2020).

In these moments, Taiwan became a kind of global model minority whose inclusion only functioned to exclude other non-conforming ‘Orientals’: both those depicted as hoarders early in the pandemic and those who refused to subscribe to the Western democratic model. Such inclusionary modes of anti-Asian sentiment in political spheres highlight racialised hierarchies in global public health and international relations, where peripheries like Taiwan only matter as pawns in political contests. From dangerous hoarders to global model minority, the changing figure of the masked Asian in US public health and politics demonstrates the limits of recognition and inclusion for places like Taiwan.

## July: No Regrets in the Euro-American Horizon

At the time of writing (winter of 2020), Taiwan has had only 935 cases of COVID-19 and 9 associated deaths (Taiwan CDC n.d.). This success cannot be attributed

3 Including the Heritage Foundation (Kim and Miller 2020) and Foreign Policy (Yip 2020).

4 In August 2020, Anthony Fauci belatedly acknowledged lessons the US learned from Asian countries. See Fottrell (2020).

5 Taiwan does not have embassies in Euro-America. It has, fittingly for my argument here, ‘Taipei Economic and Cultural Offices’ (emphasis mine), which perform functions like the issuing of visas.

solely to masks, but even the eventual implementation of similar mask mandates by increasing numbers of American states and cities serve to highlight the enduring disavowal of the knowledges and practices of global peripheries; American public health figures and medical professionals recognised the Taiwanese model only after the World Health Organization (WHO) and the US Centers for Disease Control and Prevention (CDC) issued their own mask recommendations, reinforcing the sense that emerging knowledge can only originate from within Euro-America (or, as we see below, Europe). The fragmentary nature of US public health institutions and politics challenges structural interventions including universal testing, vaccination, and broad lockdowns, which have been (or are in the process of being) implemented across Asian and European countries. My point has been less about whether or not the US will adopt practices from elsewhere and more about how the maintenance of American public health exceptionalism involves consistent efforts to racialise, culturalise, and disavow the public health knowledge of global others. Taiwanese masking policy is just one example.

In November 2020, the Philadelphia Health Commissioner Thomas Farley updated the city on the new ‘Safer at Home’ COVID-19 restrictions (PhilaGov 2020). He makes clear exactly who sets the example for America:

Maybe what’s a better model now is what’s happening in Europe now—France and Spain and Germany and Italy and the United Kingdom. All had case rates that were rapidly rising [...] They put in place a group of restrictions [...] and it appears to be working. Case rates are levelling in Germany and the United Kingdom and they are falling in France.

It would be unfair to judge the politics of the US public health effort when it is beset by pressures and attacks from all sides. But if a deadly pandemic (during which American experts have themselves acknowledged that they do not have the answers) fails to challenge existing global hierarchies of epidemiologic knowledge then what hope is there for global knowledge flows to ever reverse? Cultural humility as a model of practice (Tervalon and Murray-García 1998) has yet to appear on the emerging infectious disease horizon even as figureheads like Anthony Fauci double down on masking (Panetta 2020):

I don’t regret anything I said then because in the context of the time in which I said it, it was correct. We were told in our task force meetings that we have a serious problem with a lack of PPEs and masks for the health providers [...] When it became clear that that the infection could be spread by asymptomatic carriers [...] that made it very clear that we had to strongly recommend masks.

At the time of those task force meetings, Taiwan was already masked up.



Who stands at the forefront of infectious disease horizons, and what falls out of their field of vision? In hindsight, there were many lessons learned that were ignored by the American public health response because they were deemed ‘cultural’ rather than scientific. For me, regret signals the capacity to change and accept the knowledge of others that came before. If we did not insist upon American exceptionalism and considered public health practices from Taiwan and other global frontlines, how might public health outcomes have been different?

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