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Fighting COVID-19 and forging organic solidarities: Anthropological insights and doctors working in Pulwama

Dr. Basarat Hassan

Ph.D in Cultural Anthropology from The Center for the Study of Social Systems, Jawaharlal Nehru University (JNU), New Delhi, India

Abstract---This article is based on the fact that the current pandemic has created a new global order and the institution that has faced the real test is the public health sector. The fragile health care system in most underdeveloped countries has shed light on fundamental aspects of the public health care machinery that otherwise receives scant attention. In places where health care systems were semi-paralysed, doctors and other health care providers emerged as avant-garde Covid-19 workers, risking everything to fight the highly infectious disease and save thousands of human lives. This article provides anthropological insights to illustrate how doctors work at District Hospital Pulwama, a place that remains highly militarised and censored. Through the case of District Hospital, Pulwama, it is easy to understand how doctors faced unprecedented challenges, when the public health mechanism had collapsed into chaos, and showed a group resilience and effective volunteerism to battle Covid-19 and the psychological and emotional fallout of the disease and its treatment.

Keywords---COVID-19, district hospital Pulwama, militarization, professional relationships, anthropological insights, volunteerism.

Introduction

The world is profoundly affected by the global Covid-19 pandemic. Almost, everything was shut down in the wake of the unseen, since the beginning of year 2020. To break the chain of infection, among other significant measures, a lockdown was imposed in almost all affected countries. Many human tragedies were triggered in the backdrop of unplanned restrictions and a series of strict lockdown measures. There are seminal texts that highlight both positive and negative impacts of lockdown measures (See Rossi *et al.*, 2020; Lau *et al.*, 2020). However, it is not in the scope of this article to describe the aftermaths of these government restrictions. Therefore, this paper aims to understand the people who

are at the forefront—specialists called to work in emergency wards, who are exposed to the highest risk and working day and night to respond to this “public health emergency of international concern”. (Chavez *et al.*, 2020, p.1). Before subsequent pandemic waves fully disappear from the public spaces, doctors remain significant players in fighting this fatal outbreak worldwide. To get anthropological insights into how doctors responded collectively to this extreme medical emergency, this paper chose to study District Hospital, Pulwama¹.

Pulwama is a highly tense district, which constantly attracts media attention. In recent years, it has witnessed greater military presence and recorded the highest number of military and communication crackdowns (The Citizen Bureau, 2019). It was a meticulous task to rebuild the idea of social participation among those who were otherwise severely dispersed and frightened and, at the same time, had to maintain ‘social distance’. Doctors played an exemplary role to build relationships among a diverse of social groups through mutually constitute human interactions to strengthen overall health care in District Hospital, Pulwama. Such interactions also reflect the vital connections between medical practitioners, social systems and above all material cultures. Thus, geopolitical factors and cultural systems help us to conceptualize the pandemic and its increasing visibility, and treatment. As Faas *et al.* (2020) also suggests that “pandemics are compelling space for examination of how humans confront and make sense of what they are going through” (2020:335)

For months when Kashmir was reeling under a brutal military crackdown in the wake of revocation of Article 370 in August 2019, panic and anxiety caused more mayhem in the otherwise eerie streets of Kashmir. Covid-19 had already plagued some of the most developed European countries equipped with efficient health facilities; the danger of this new disease was looming large. As Colclough *et al.* (2020) lament, “It will take months to fully estimate the future impact on all facets of the healthcare system. However, the indirect health implications may potentially outlast and outweigh the direct impact on Covid-19 patients” (unpaginated). When health facilities crumbled in the light of unbearable stress, with an increasing number of Covid-19 cases worldwide, medical professionals in Kashmir feared people in Kashmir “would die like cattle” (We’ll die like cattle. 2020, March). This fear was real and stemmed from personal experience and past history. For example, during 2010 uprisings when protesters were fired with lethal pellets, doctors had a tough time to treat pellet victims and at the same time battle political restrictions (Mohan, 2016).

Interestingly, this pervasive production of fear strongly relates to Beck’s (1998) phenomenal work that explores how risk or anxieties are conceptualised in the light of unprecedented historical understandings, cultural underpinnings and personal engagement with a catastrophe. Beck (1998) illustrates how societies have become laboratories where no one has control over the risks that emanate out of modern cultures and political convictions. Cottle (1998) also suggests that “[t]he nature of contemporary ‘risks’ for Beck are historically unprecedented in terms of spatial and temporal reach, their potential catastrophic effects and importantly, their invisibility” (p. 8). In normal circumstances, hospitals in Kashmir remain overloaded and understaffed. When the pandemic hit Kashmir in March 2020, the local administration had no idea how to prepare. In many cases,

patients had to run from one hospital to another to get treated, which eventually turned hospitals into Covid-19 hotspots (Ahmad, 2020). The situation was further compounded because of persistent internet censorship, military crackdowns and uninhibited spread of misinformation. Changoiwala (2020) also avers that because of communication blackouts, the situation in the region was doubly dangerous and perplexing. As Team and Manderson (2020) also reiterate that Covid accentuated the already existing structural problems in a more explicit way. “[E]xacerbating mental health problems and nurturing the transmission of parasitic, viral and bacterial diseases. COVID-19 fed on this. It thrived on the structural vulnerabilities that worldwide shape access to, quality and security of housing.”(Team and Manderson: 2020, 671)

One distinct aspect is that doctors faced the maximum threat of contracting the virus. The mortality rate for doctors was around 8% higher than that of the general population (Siddiqui and Pal, 2020). Likewise, since the Covid-19 spread its deadly footprint across Jammu and Kashmir, doctors at District Hospital, Pulwama, showcase a story of resilience and group solidarity. This volunteerism was ‘resilient’ in nature because most of the doctors were involved in the feeling of low-self-esteem and other negative factors that are sufficient to demotivate volunteerism. Initially, when the doctors at District Hospital Pulwama were gathering the information from Covid suspects, it was an uncanny feeling for them. On one hand, they were duty bound to look after such frightened people who had no symptoms of the disease yet and on the other hand, they were themselves frightened that they might contract the disease. Therefore, it needed enormous empathy to pull the strands and recruit more voluntary work. As Wilson also reiterates in his work “it is intuitively plausible that empathic people, those who are adept at putting themselves in the shoes of others, are more likely to become volunteers (Wilson 2016:4). Also, District Hospital, Pulwama remains burdened by providing medical care to a large population because of its strategic geographical location, which means that people from both Central and South Kashmir throng to it for treatment. Also, given that the district of Pulwama continues to be one of the most affected areas by the military violence, attending to Covid-19 patients was a colossal challenge.

At present, the hospital is designated as a Covid-19 treatment center with 200 beds. Doctors here have gone out of their way to help the general public fight this pandemic. The group dynamics and volunteerism forged between the doctors were centrifugal forces that not only debunked conspiracy theories but also strongly countered widely prevalent misinformation, rumors and hoaxes constructed around the pandemic. At a time when the social fabric was unraveling, doctors found new ways to encourage social cohesion and integration. As Markovsky and Lawler (1992) points out, those group solidarities are facilitated through proper communication and influence within the group members. Emotional attachment among the group members increases “voluntary compliance to group norms and decrease free-riding” (p. 34). Lewandowsky *et al.* (2017) argues that to deal with the ‘post-truth’ era and abundance of misinformation, it is crucial that sound scientific research and knowledge is brought back into the larger social structure that is overtly dominated by waning trust in science, technological and political supremacy.

In a way, scientific knowledge must be set free from military and political hegemony. Therefore, by constantly conscientising suspected Covid-19 patients against the possible ramifications of ignoring necessary measures to fight the disease, doctors at District Hospital Pulwama found ways to creatively respond to and tide the various levels of misinformation. Doctors adopted various methods to ensure that vulnerable groups utilise community resources to reclaim their right to participate in community initiatives while remaining healthy and safe. As Airhihenbuwa et al. (2020) informs that structural inequalities increases vulnerability of ethnic and racial communities or further burdened by the Covid-19 restrictions and containment measures Thus, socio-spatial inequalities, in a particular context, limit the 'global' and uniform response to the Covid-19 pandemic. For example, not all the people have access to computers and technology; therefore, had limited options to avail telehealth benefits and support.

Many Doctors walked on foot to reach such vulnerable groups and use Masjid loud speakers to make announcements to general public about such urgent health initiatives. The role of local masjid committees was effective because it could establish the lines of communication, organic network and, more significantly, collating data at local level to provide mortuary services. Such little efforts upheld the core values of social justice at a time when there is growing 'digital divide'. Also, Farakas and Romaniuk (2020) argue that "[T]he pandemic has sharpened this digital divide into a social justice issue and accentuates the need for enhanced advocacy efforts" (p. 71). Doctors worked relentlessly to disseminate accurate information about the etiology of the virus and to affirm community spirit with compassion, caring and vigilance. In sum, doctors attempted to rebuild trust between medical practitioners and potential covid-19 patients who otherwise viewed scientific research and medical intervention as faulty and political appropriations. Dr. Asif, 45, narrated how medical practitioners are facing a multitude of challenges and how camaraderie has become a potent tool to fight the outbreak of Covid-19:

In the beginning, it was merely a knee-jerk response from the administration. A scientific outlook was ignored in favour of bureaucratic supremacy. There was a strange anxiety and fear all around prior to when the pandemic hit our Valley. Once it hit, everything transformed. We started feeling the virus for real. Not much was known about the disease then, as it was still evolving and we were ourselves frightened that we might contract the virus even while wearing proper PPE. Things got worse; myself and my wife, who is also a doctor, had to leave our three-year-old daughter at my in-laws' house. On top of that, it was hard to rent a room near the hospital, as people started looking at doctors with more suspicious eyes and as possible carriers of disease. There was no end to our ordeal. We would work day and night and in return we faced one of the worst social boycotts. It is painful and nightmarish. Yet, there are always some positive things to count on. One such example is how youth groups came together to show support to vulnerable groups and even at times cooperated with the frontline workers. These youth groups are always on their toes. They make sure people take proper precautions and motivate them to stay indoors. Elderly people, who are most at the risk, directly receive medicines from these youth groups. In other places, people voluntarily give their neighbors kits containing masks, sanitizers and hand wash. Above all, when in some cases patients feel lost and get violent, such youth

groups are quite effective to help people to reconcile with this pandemic and stay composed. (Personal interview, 24 January 2021)

Voydanoff (2004) argues that in a work-to-family conflict, there is always more strain in channelling community resources to facilitate an environment that could positively alter the working environment and fulfill community demands. Therefore, marshalling every possible resource to treat Covid-19 patients, doctors emerged as linchpins not only in District Hospital, Pulwama, but also in other parts of Kashmir. To deal with the coronavirus onslaught in the initial period, doctors decided to fight against disinformation. A strong discourse regarding the disease had already progressed even before the disease entered into the geographical confines of Kashmir. This early establishment of discourse underlines Hall *et al.* (1992) significant theoretical contribution that discourse is always “a crucial medium between the production of knowledge and subsequent representation of reality” (p. 85). Given how health systems bore tremendous pressure in advanced countries like Spain and Italy to managing the spike in Covid-19 cases, people in the Valley were scared knowing their inadequate infrastructure and shortage of manpower would not be sufficient to deal with the pandemic. In the words of Bunton and Peterson (2002), it was originally the Foucaultian idea of ‘governmentality’ that was at work in such health systems, evidenced by the fact that people were treated as self-regulating subjects who only saw fear, as there was no mechanism to dispel their immediate fear.

Palsson while commenting on Foucault’s work writes that in the light of modern medical clinic “[T]he body was dissected and subjected to the scientific gaze and manipulation of supposedly detached observers” (Palsson: 2006,73) In a similar vein, doctors at District Hospital, Pulwama, constantly recalled how patient’s experience are powerful enough to construct the knowledge around the disease and its therapeutic treatment. In most of the cases, these experiences are embedded in the quotidian socio-cultural posture of the patient. Likewise, when crises pushed government facilities to a breaking point and the culture of volunteerism, both shared and patterned social norm of Kashmiri society, mediated way for a concerted mechanism to prevent the widespread transmission of the disease. Faas *et al.* (2020) observes, “[P]athogens, capital and commodities, enduring colonial and neo-colonial forms of exploitation and domination risk communication enactments of measures to prevent the rates of transmission; and politics of knowledge refracted through positionalities that coproduce forms of compliance and resistance (pp 34-5). People look for cultural engagements to counter illness and misfortune. Thus, It was essential to break the traditional notion that looks at patients as merely as consumers of health care and education, especially given the dire conditions of the pandemic. As Lub (2019) also states, it is pertinent to untangle the complexities of the structure to attain the objectives of the target group. Therefore, it is equally necessary that effective ways of social participation are designed to build a paradigm that leads to an emancipatory environment and encourages social cohesion for such target groups.

Dr Altaf, 47, talked about the communication blockade and initial escalation of fear: In the beginning, there was more distress in Kashmir because of the severe communication blockade. Everything was blanketed in secrecy. While the world

didn't know much about the disease, doctors at Pulwama hospital were unable to even download the guidelines. It further escalated fear among the local population. Doctors at Pulwama hospital had to face layers of difficulty. They were instrumental in not only educating reluctant patients to minimise the spread of Covid-19 but also helping patients to dispel the wrong information that otherwise could have resulted in more cases of Coronavirus. In the context of Kashmir, and bearing in mind the high sensitivity of Pulwama district; conspiracy theories rocketed to a new level. Doctors were concurrently blamed for instigating suspicion and medical 'machinations'. The misinformation spread among the general masses and patients visiting the hospital wards reached to an unprecedented scale. (Personal interview, 17 January 2020)

Kamali (2015) underpins that modern projects like militarisation and neoliberalism actually curb 'practising solidarities' and create new structures that reproduce social inequalities and destroy socio-economic systems; doing group work or social work in such paradigms is inconsiderable. Furthermore, Kashmir is always a different terrain, a land of multitude emergencies stretched beyond 'history and time'. In military complexes and ecosystems, civilians are constantly assured that there is no public health risk. For most of the time, civilians have no or reduced access to information. "[In] the name of national security, civilian workers and their families have been systematically denied information that would permit them to make informed decisions as to what level of health risk they are ready to accept" (Gould: 2007, p. 332). Many respondents recalled how during the initial lockdown, a strict, militarised approach was followed throughout the entire Valley. Pervasive surveillance, enforced crackdowns and internet censorship were legitimised in the name of 'precautionary measures' and, therefore, spurred militarisation under the banner of a war against Covid-19. Marebello (2020) writes, "Surveillance-oriented models of state are bolstered, performed and interpreted during epidemics and ethnographic privileges, everyday experiences to grasp specific practices and state's surveillance and control of citizens" (p252).

Many residents remember it as dystopian nightmare, how during a curfew or lockdown, police had created a 'culture of mass incarceration' in the garb of growing pandemic threat. Health workers were routinely frisked, halted for hours or even beaten up if they intend to drive when there was a military convoy moving in another lane, even if they were travelling in the opposite direction, as the procedure requires all civilian vehicles to be stopped for the duration of the passage of the convoy. Such 'security' halts could also result in fatalities among patients in need of immediate medical attention. The military discourse used by the media and political leaders justified increased militarisation as the only way to tackle such a crisis situation. "Healthcare workers are on the frontlines, scientists are the new generals, economists draw up battle plans, politicians call for mobilization" (Kalkman: 2020, p.100) Price (2014) while commenting on bring humantraian relief in militirzed terrians notes, " [H]umantraian relief is rarely a neutral enterprise and is embedded with political economies of warfare and how the contingencies of biopower impacting the distribution of aid can blur the lines separating humantraism, soft power and hard power"(Price:2014,95). Kashmiri doctors had to simultaneously negate with medical contingencies on one hand

and on other, they had to deal with the military-industrial complex on daily basis. Dr Shagfuta summarised the situation ardently:

In our place we have more military and less society. Paranoia, fear, suspicious, death; everything is here. The paranoia grew so fast because people have less faith in civil institutions. A militarised response furthered the existing polarisation between the political elite and commoners. There is always a huge fund allocation for military hospitals to deal with emergencies, whereas our civil hospitals are inadequately equipped to work even during normal times. Moreover, doctors themselves were doubly discriminated against, both at the workplace and home, because people were very suspicious that they were carriers of the disease. The whole scenario was appalling. My parents continuously pleaded with me to leave this job immediately after one of my close colleagues, who was overexposed to the virus, eventually contracted it and succumbed to the disease (Personal interview, 13 November 2020)

In addition, Venkatesh and Edripulla (2020) argue that social distancing as a measure to curb virus transmission has its own serious implications on mental health. In fact, measures like social distancing or even quarantine precipitate boredom, frustration and depression. Likewise, when residents were asked to stay at home to slow down the spread of virus, community solidarity become central to maintain relationships in a world where social distancing has had become a norm. Most people actually adhered to their religious faith, as they were confined to their private spaces. People were motivated not only by their respective religious beliefs to fight this pandemic but also by the commitment to ensure vulnerable people would not go hungry. Thus, many helped those in need receive meals when the economic downturn grew increasingly severe. Koenig (2020) states that psychological systems are adversely affected by unbounded anxiety and fear and further illustrates that religious meditation can develop positive emotions that could benefit the immune system. This study also suggests sacred scriptures validate how “religious faith is an important source for health and well-being, one whose effects should not be underestimated” (p. 2206). Likewise, the majority of the people living in the Valley find their daily prayers as central to building their spiritual health in the absence of congregations and religious gatherings. Eller comments “[Religion] works in some ways by transforming personalities. Through doing religion man become different. They become strong more courageous and more certain” (Durkheim 1965, as cited in Eller 2014, 141)

Dr Nazir, 53, shared his personal story: My father is a devout Muslim. He never misses his prayers. In the beginning of the pandemic, he would not follow the guidelines and offered his prayers at a local mosque. It was very unusual and hard for him to accept the fact that mosques and other religious places were shut down completely in the wake of pandemic. He thought it is mandatory to offers prayers at the mosque. I consistently advised him not to go into the mosque. Despite himself being an educated person and a well-known, retired government officer, he would not heed my words. Later after listening to many influential local religious scholars and reading a bit more about the religion, he was convinced there are no such rulings that stop people in pandemics and other tough times from praying at home. In fact, he was surprised to know Prophet Muhammad (Pbuh) had suggested the idea of quarantine for the first time in human history

some 1,440 years back. He could relate to Islamic history and found resilience in religious beliefs to fight the deadly virus. It was interesting to see how people followed religious beliefs to fight isolation, social distancing, anxiety and the pandemic *per se*. (Personal interview, 17 February 2021)

Doctors are not only the gatekeepers who protect their communities from such dangerous diseases but also the ones who must deal with the aftermath of such contingencies (Li, 2020). Doctors are doubly pressurised: On one hand, there are huge public expectations from doctors to look after patients during such medical emergencies. On the other hand, their families remain worried that they might bring the virus home. Although doctors deal with chronic diseases and death, dealing with such a dilemma was a new experience altogether. They find themselves at the crossroads of a new medical reality. Similarly, doctors at District Hospital, Pulwama, had to overcome emotional crises and mental exhaustion to take care of Covid-19 patients; that in itself was a challenge for them. The most valuable organic support garnered at this hospital was through peer support. Wu (2020) affirms that peer support is an effective mechanism to mitigate contingencies situation and also fight determinants to foster a culture of resilience. For example, when junior doctors roped in to deal with the increased number of Covid-19 patients faced intense pressure, they forged organic solidarities based on common goals.

According to Durkheim (1893), collective consciousness forms a certain kind of social action that results in greater social cohesion and solidarity. For these young doctors in Pulwama, the network of peer support not only encouraged them to feel motivated but also reduced their physical burnout. Such organic solidarities create immense space for proper medical interventions as well as counter-narratives that otherwise distort the role and responsibilities of medical doctors during such critical junctures. Similarly, Agarwal et al. (2019) observed how peer support built resilience among health workers to rationally manage occupational stress and also ensured investment in programs that aim to improve overall organisational resilience. Likewise, Leventhal and Cnaan (2009) argue that people who have connected to cohesive social networks encourage volunteerism in one or the other way. “Social capital can also explain the impact of human capital (income and education) on volunteering, given that individuals with higher positions at work and those who attend colleges have more social contact” (Leventhal & Cnaan, 2009,66). Behrman et al. (2020) also point out, in order to counter the pandemic crises efficiently, there is a need for identifying new ways to “minimize the transmission of the virus, existential problems related to the disparity between individual experiences and the ‘hero’ narratives portrayed in the media” (p. e64). In truth, lived realities are always harsh and remarkably diverse from the one discussed in the mainstream media.

Dr. Shafat, 47, recollected: Doctors in Kashmir had to face a new challenge. The fear of being exposed to an unknown threat was greater among not only the general public but also doctors. The stress level had reached to an unfathomable level. Initially, people who contracted the virus found it hard to believe that they tested positive because the disease did not result in any symptoms that made people hold irrational beliefs and myths to further a grand conspiracy. Many argued that Covid-19 is a cover up for major political issues in Kashmir that

include the revocation of Article 370 and systematic settlement of outsiders, arbitrary military actions and growing unemployment. People who contracted the virus, and were reluctant to move to hospitals, had to face police violence. But overwhelmingly, doctors faced the real brunt. A dire shortage of PPEs and other essential medical equipment, required to perform invasive procedures, resulted in doctors being overly exposed to high viral loads and the deaths of many senior specialists; the alarming doctor–patient ratio of 1:3866 against the WHO norm of 1:1000 further imperils the work of doctors. (Personal interview, 23 January 2021)

To deal with this pandemic, doctors at District Hospital, Pulwama, had hectic work schedules including night shifts. Chan and Huak (2004) acknowledge that health professionals are at greater risk: “they are exposed to intense physical and emotional suffering and are frequently the focus of primitive transference reactions, both affectionate and hostile” (p. 208). Likewise, because of enormous physical exertion and emotional exhaustion, doctors working in Pulwama underwent subsequent traumatic stress while working for long hours in depressing isolation wards and being away from their families for months at a time. Whether living in isolation or with families, the process of sanitising themselves was new standard. Once they reached their homes, they would immediately throw away their gowns and shower. They disinfected everything they touched, changed their clothes, removed gloves and constantly sanitised their bodies, as maintaining their health was essential while being in close contact with the virus and helping thousands to recover. Dr. Rukhsana Taj, 33, a microbiologist working closely with coronavirus patients, provided fresh insights:

By the time I would disinfect myself and the space around me, my one-year-old baby had fallen asleep. In the morning, I would have to rush again; I couldn't touch or hug my baby for days. But after that, I felt it was enough; I was overwhelmed with a mother's love and shelved the fear of the virus for some time. One night, one of my colleagues had tested positive. I was completely stressed out and worried for my daughter. I literally stretched to the point of exhaustion and fell sick after that. The idea of treating your patients is altogether different, and when you get the feeling that you have contracted virus yourself, you feel numb; when the virus reaches your own body, you yourself go through that pain of testing, breathlessness—you turn into a patient yourself. This transformation is different wherein you are both the observed and an observer, both an examiner and the examined one. With low or no salaries for months and patchy measures in places, surviving itself is the biggest resilience. (Personal interview, 12 November 2020)

With the outbreak of Covid-19, a constellation of linked problems surfaced. Many vulnerable groups like children and women faced not only physical stresses but also psychological ones. Lancet (2020) also highlights that because of the spike in Covid-19 cases, vulnerable groups that consist of the elderly, homeless and people from low socio-economic backgrounds constitute a serious challenge, as these groups continue to be disproportionately affected by this contagious disease. Manderson et al (2021) admits that precautionary measures like hygiene and physical distancing are not within reach of ordinary people, as are disadvantaged and face incessant socio-economic and racial discrimination.

“These are luxuries of few in a glossing uneven world where millions live on the streets, in crowded quarters without water and sanitation.”(2021, 2) (Likewise, many patients visiting District Hospital, Pulwama, had psychological symptoms rather than having Covid-19 symptoms. Sometimes it was necessary for doctors to depart from their routine roles and shift to narrating tales of recovery to help people endure. Doctors have had to counsel Covid-19 and other patients whose mental health was affected by subsequent lockdowns and economic disparities. “Pandemic loaded onto already existing socio-economic inequalities, racial discrimination and uneven access to healthcare, exacerbating what we call stratified livability” (Manderson:2021,2). Covid-19 patients feared social stigmatisation and disruption of normal relationships in their families and neighborhood. Doctors in Pulwama provided emotional support to such patients to fight loneliness, passivity and paranoia. In service to humanity, doctors provide multiple services that evolve to include effective and appropriate responses to medical emergencies. Hugman et al. (2011) highlighted that in order to provide direct services to vulnerable groups, health professionals or social workers both use and produce efficient therapeutic tools and group-work methods to provide immediate services to such groups.

Dr Lateef, 45, recalled the formation of many support groups: When there was internet blockade, we wrote handwritten notes, photocopied them and distributed to inform the general public to take necessary measures and to generate a sane opinion. There was so much misinformation and rubbish doing rounds about the virus. In addition, many of us, after treating patients, would travel to places that had little internet connectivity to update people about the pandemic. When internet services improved, we formed WhatsApp and other groups to disseminate accurate information about the disease. There, we would discuss our cases so that we could dig deeper into the patients histories, as many Covid-19 patients were being treated at other hospitals in the Valley. Likewise, many doctors would talk to their relatives to disseminate accurate information and emphasise sharing it with other relatives and friends. It snowballed to a huge number of people, and with time, people have started believing that the virus is real and are inclined more towards scientific advice rather than getting hooked to conspiracy theories or political rhetoric. (Personal interview, 14 December 2020)

In the early days of the pandemic at District Hospital, Pulwama, Covid-19 patients had a difficult time to come to terms with the hospital ambience and treatment procedures. They were largely scared of the latter, which included uncomfortable tests; painful isolation; intensive care units with different machines, tubes and wires and the way the deceased were buried, away from the loved ones. Doctors at Pulwama admitted that modern treatment procedures, also known as the biomedical model, have its own lacunas. Similarly, sociologist Nettleton (2006) also argues that the biomedical model is a reductionist approach and that “the body can be repaired like a machine; thus medicine adopts a mechanical metaphor presuming that doctors can act like engineers to mend that which is dysfunctional” (p. 8). In a similar vein, Iron and Gibbons (2020) inform that new social connections and intensified communications on online platforms and other social media channels have ruptured the existing medical discourse and has put the hegemony of biomedical model in critical question. Furthermore, though NGO groups and the Center Reserve Police Force (CRPF) personnel served

meals to Covid-19 patients, the patients, already distressed with their health status, found it difficult to consume, as the food was not suited to the local taste. Doctors understood the situation well and raised funds within their own circles to help Covid-19 patients access their preferred food. The pandemic hit the valley, a Muslim-majority population, during the month of Ramzan, and so many Covid-19 patients and others in quarantine centers were offered proper food to break their fasts. Such assertions illustrated in the form of cultural food practices and community feelings actually works as a determinant to the supremacy of biomedical model As, Omoto and Synder (2002) rightly pointed out that the voluntary work, both at individual or organizational level, intends to build bridges and typically helps people with whom one has no prior bond or relationship and interestingly, all different types of voluntary activities are basically situated “squarely in the community”(2002:848)

When the pandemic had literally grounded everything, doctors at District Hospital, Pulwama, and elsewhere in the Valley were forced to look for new possibilities and ways of being with one another. Many of the doctors at Pulwama narrated how they relied on technology to communicate with their parents, children and friends when physical distance became a new norm of their professional life and a substantial measure to contain the spread of virus. This crisis invoked a new solidarity to ensure the well-being of many distressed families.

Dr Nawaz, 39, described the situation: Doctors faced something very unusual, a new emergency. With every passing moment, there was an uncertainty; it all had started like a whisper, had filled every little space with that unpleasant fear. In the hospitals, we went through ‘medical isolation’, whereas at home we had to bear a choking social isolation. For the fear of contracting virus, our family members shifted to other relatives’ house. We felt the weight of loneliness to the extent that we would literally talk to the walls. We mustered all our courage to treat patients in such conditions. The biggest motivation to work in such a scenario was definitely the feeling of ‘we’-ness, the community feeling and the professional pledge to risk everything for our own brethren, community and people of whom we all are an indispensable part. A number of doctors formed morning walking groups in their own localities, which helped a great deal. And eventually the truth about the disease spread to a sizable population. Such small steps really made a huge difference. (Personal interview, 23 December 2020)

Conclusion

Doctors at District Hospital, Pulwama have showcased great resilience and how organic solidarities can be effective in times of a great public health emergency. When the state machinery was in disarray, doctors at this hospital searched for new ways of engagement to fight the layers of misinformation while putting aside their personal concerns and endangering their own life and the lives of their family members; they went above and beyond to treat patients relentlessly for several months. With a soaring death rate in the hospital and society at large, doctors held their heads high, while continuing to fight military surveillance, communication blockade and political hegemony. The paper illustrates how in professional settings a kind of volunteerism emerges to strengthen the overall

healthcare when normal social relationships and networks were severely affected by a high level medical emergency. Thus, local volunteerism as a form of social solidarity, cultural model and site of knowledge production could prove as viable mechanism to counter institutional failures and alter global perspective about the pandemic.

Note

To maintain the confidentiality, the real names of the respondents have not been used.

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ⁱ District Pulwama, a place in South Kashmir, invoked a new wave of 'military nationalism' after a suicide bomber blew himself up, killing more than 40 Center Reserve Police Force (CRPF) personnel. The attack subsequently triggered violence and backlash against Kashmiri Muslims, students, in particular, living in different parts of India. More so, both India and Pakistan engaged in a diplomatic and military standoff in the wake of the attack. Kashmir has been referred as 'Valley' multiple times in the latter text.