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– ARTICLE –

BORDERED AND BORDERLESS MATERIALITIES OF COVID-19: A NARRATIVE EXPLORATION

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ABSTRACT

The emergence of COVID-19 as a distinct biomedical bordered and borderless site for anthropological exploration has sparked change in the biomedical imagination. Recent work in biocultural anthropology has offered important insights regarding the materiality and multiplicities, the realities and generalities, and the possibilities and police-abilities of COVID-19 related social and political concerns (Briggs 2020; Manderson and Levine 2020). This article, however, calls for the consideration of the important contributions of narrative to medical anthropology. Can narrative as a reflexive practice shed new light on medical interpretation? Reflexive and critical autoethnographic medical anthropology challenges anthropologists to de-naturalize the dichotomy between wellness and illness, and to instead think of biomedical assemblages as reconfigurations, reimaginations, and reworkings of reflexive and radical processes. This article originates from explorations of the borderlands of health and illness. I combine participant-observation, discourse analysis, and reflexivity with illness as material culture analysis, to address the interrelatedness of biomedical materiality.

Keywords: reflexive anthropology; borderlands; covid; structural violence; experimental ethnography

INTRODUCTION

In March of 2020, a deadly outbreak gravely impacted the United States. This outbreak was first identified in Wuhan, China in December of 2019. By mid-March of 2020, it was ravaging mid-America. The infectious novel coronavirus disease (COVID-19) would prove itself to have differential impacts on diverse communities in diverse geographies (Singer and Rylko-Bauer 2021). The emergence of COVID-19 as a distinct biomedical bordered and borderless site for broad multidisciplinary exploration has sparked change in the biomedical and

anthropological reflexive imagination. Recent work in bio-cultural anthropology has offered important insights regarding the materiality and multiplicities, the realities and generalities, and the possibilities and police-abilities of COVID-19 related social and political concerns (Briggs *et al*. 2020; Manderson and Levine 2020).

Rates of infection and the increasing number of deaths point to the importance of developing an understanding of the grave impacts of the disease and the need to find inclusive health spaces for communities that disproportionately experience health inequities – the Othered communities who often live and exist in the borderlands of liminality and temporality. A substantial decline of life expectancy has exponentially increased within these porous racialized, gendered, and sexualized communities. This experimental intimate ethnographic case study addresses the interrelatedness of a gendered, biomedical materiality in the time of COVID-19 in a neighbourhood in a rural Midwest town in Oklahoma.

Women in this neighbourhood (I will call it Renel) compared with the statistical data of women residing in other communities within the state experience higher rates of adverse health outcomes that are often linked to systemic and structural violence. The biopsychosocial harm done to the group of women discussed in this article is underpinned by historical sociopolitical structures framed by discriminatory practices present in the community. The term 'biopsychosocial' is a model often found and used in contemporary psychiatry that delineates understandings of illness and wellness affected by multiple domains, such as life experiences, genetic inheritance, and historical impacts. The pandemic has polarised the limited access to equitable healthcare services faced by women in this community. The article provides a lens through which to deeply reflect on the medicalization and governmentality that women living in resource-poor neighbourhoods are subjected to. In the neighbourhood discussed in this article, women outnumber men four to one; henceforth, their narratives are privileged in this article.

The pandemic related challenges and issues faced by Black, Indigenous, Women of Color (BIWOC) in Oklahoma are intimately intertwined with intersections of race, class, sexuality, ability, and religion. The women who share their pandemic narratives in this article locate themselves within and outside pandemic borders and borderlands. Using Anzaldúa's (1999) constructions of borderlands as a departure point, I frame borders and borderlands as spaces of health narration. In addition, the women mentioned centered in this article contribute narratives that foreground the need to decenter the concept of pandemic wellness while

illustrating the importance of constructing borderless health environments in rural communities.

Using experimental methodologies as a decolonising, emancipatory departure from canonical 'ways of doing' and 'ways of writing' research, the narratives included in this chapter present a challenge: to conceptualize pandemic realities, generalities, possibilities, and police-abilities. To do this, I propose an alternate configuration of reflexive medical anthropology research during times of disease related isolation. This article originates from experimental explorations of the borderlands of health and illness that have long engaged with BIWOC and Queer anthropologies praxis. I combine experimental ethnographic methods with illness as an object of material culture analysis, whether that be of objects of space and place, gendered bodies, or cultural and medical landscapes to address the interrelatedness of biomedical materiality – complex assemblages within borderlands. This article challenges the reader to reconfigure, reimagine, and rework conceptualisations of COVID-19 realities. Using intimate autoethnography, I locate myself and my own evolving relationship with COVID-19, and with the women in this neighbourhood. To this end, I incorporate experimental ethnography to show the ways in which women express their agentive capacity through radical processes of sharing personal narratives. I term the methodologies used to construct this chapter experimental in that I discuss the ways in which my own COVID-19 experiences and negotiation of categories of intersectional sameness influence my work as a female biocultural anthropologist of colour.

A HISTORY AND INTIMACY OF SELF-REFLECTION

Women who attend the Greater Good Helping Hands Church have access to supplies and services that meet their biopsychosocial needs. These supplies and services encompass free menstruation supplies, lactation support, a range of contraceptives, and perimenopause, menopause, and postmenopausal aides. In addition to the biological support, women have access to traditional healers, elders who provide counselling, and Western biomedical counsellors who provide basic services without charge. When the pandemic first surfaced in Oklahoma, women in the neighbourhood were not able to attend the weekly meetings at the local church to receive the biopsychosocial and cultural support provided within this community space. The majority of the women in the neighbourhood opted to stay home during the earliest days of the emergence of COVID-19 in the community. Staying home was short lived for many of these women because they were employed in occupations that warranted movement outside their bordered home spaces. These women were the frontline and essential workers

who did not have the option of remaining home. On many days, the women who did remain home would leave plastic bags filled with vegetables from a struggling community garden, pots of soup, or baked casseroles on the porches of the women who were required to work. On the days when it appeared that food resources were low, small Ziplock bags of peanut butter crackers (store brand saltines and a bargain peanut butter) were left on the porches of the frontline and essential worker women. Notes checking on the well-being and health of the women and their children often accompanied the food offerings.

My participation in these newly created pandemic activities led to *new* conversations regarding new pandemic protocols. Conversations shared between the women and me were not new; however, conversations about an invisible community enemy relegating us to the confines of our homes were. These conversations were shared across a fence line, or from standing on my porch while a neighbour stood outside my front gate or in the street. I would later come to understand that this form of communication and community support would become the new normal in a neighbourhood that greatly depended on daily, intimate interactions. Normal neighbourhood activities came to an immediate halt, including the weekly meetings held at the neighbourhood church. These usual shared times for exchanging knowledge, community building, bonding, and planning was replaced with a new form of exchange – exchanging recipes for homemade hand sanitiser, the community coordinating to purchase toilet tissue, bartering for needed kitchen staples, coordinating rotating shopping and drop-off times, and keeping up with family social media posts for the elderly women without internet services in the neighbourhood – bringing new knowledge into a close and closed community of women.

Beginning in the early 80s, the Helping Hands Church was built to support women in the community. Prayer services, counselling, clothing and food giveaways, tutoring, and community service opportunities were provided for the women and their families. These services have grown and expanded over the years. Today, women in the community can receive re-entry services,[2] assistance in navigating undocumented status situations, and culturally-based traditional treatment for their individual and family biopsychosocial needs. Each day women pass through the doors (figurative borderlands) at the Helping Hands Church seeking help and comfort for a variety of biopsychosocial ills and issues. I have been a member of this community for more than ten years. I moved here to perform biocultural fieldwork with a tribal community and have made this my primary home. On the days when my schedule allows, I assist with preparing and serving weekly community meals, perform intake assessments, and offer sexual and reproductive health classes. The Church is viewed

as a type of *Holy Relic* (Anzaldúa 1987, 1999, 176–181) – a counter space that pushes back against gendered, racialized, and sexualized labels often mapped on to BIWOC. They accomplish this by designating themselves as a syncretic religious 'safe place' for peoples of color, those who have diverse relationship styles such as polyamorous triads, and for gender fluid persons.

When the pandemic emerged in this area of Oklahoma, the women who occupy the counter space decided to journal and vlog their experiences. I decided to do the same. Through a series of text messages, Facebook posts, and meetings across fences we decided to keep a diary of our COVID-19 experiences. Some kept journals while others used their cell phones to vlog. A select few used Facebook to document their COVID-19 experiences. Ten years ago, and in a separate research project, I asked the women the following: How does violence shape and impact the health of women living in this community? How do women in this area perceive health care services and organisations in this community? What are the challenges in accessing health care programs in this community? What does the lived experience of women living in an impoverished neighbourhood in this rural community look like? These are the questions I asked them to return to; however, I asked the women to place these questions into a COVID-19 context framed with the conceptualization of borders as something beyond geography – borders as women's bodies, and the generalities, multiplicities, and realities of daily lived experiences (Rothmüller 2021, 1). I asked myself the same set of questions. I was both a COVID-19 community observer and participant.

My experiences and the experiences of the women of Renel are intimately intertwined through a ten-year history of collaborative ethnographic research dependent on deep participant-observation, formal and informal interviewing, and discourse analysis. I begin by placing the writing style of this article in literary conversation with the writing style of Anzaldúa. This purposeful placement allows the reader to cross over and into narrative borders of health – a Textual Third Space (Anzaldúa 1987, 9). Drawing from the shared snapshots and vignettes, I then describe structural violence as a conceptual mechanism for evaluating COVID-19 as a community materiality and reality. Next, I position the shared snapshots and vignettes to demonstrate the effectiveness of experimental and self-reflexive ethnography. I conclude by calling for a (re) working of traditional Medical Anthropology research practices to include reflective, intimate, and experimental autoethnography in examining health and health disparities in diverse communities.

The ethnographic snapshots, vignettes, and reflexive excerpts shared here articulate the pandemic experiences of the women in this article, the processes they

use to navigate two disparate worlds of health (healthy or 'with rona') which 'form a third country – a border culture' (Anzaldúa 1987, 25). The women's voices heard in this article amplify their views of current Western health systems of care, and structured systems of justice and politics informed by COVID-19. More importantly, the ethnographic work herein articulates the ways in which border(s)/land(s) exist as a multiplicity and capacity – as "'*La facultad*" – the capacity to see in surface phenomena the meaning of deeper realities, to see the deep structure below the surface' (Anzaldúa 1987, 60).

A NOTE ON TERMINOLOGY

I use neighbourhood and community interchangeably. These terms describe the spaces where the women discussed in this article live, interact with one another, and establish networks to meet their biopsychosocial needs across time and space. I categorise this article as a self-reflexive and experimental ethnographic work. Like Lila Abu-Lughod, I use narrative to illustrate contested ideologies of COVID-19 health and wellness (Abu-Lughod 2008). This article follows the experimental ethnographic method popularised in Abu-Lughod's work. Abu-Lughod (2008) noted that she experiments with the construction of narratives to illustrate women's worlds and experiences by 'writing against culture' (Abu-Lughod 2008, 13). Similarly, Kathleen Stewart (1996) centers narrative and narration in her work.

In Stewart's work the exploration of expansion of 'othered spaces' – a type of borderland is represented through narration. These ethnographically rich spaces rearticulate events and experiences of collaborators through retelling of stories. Stewart (1996, 210) notes,

> culture as it is seen through its productive forms and means of mediation is not, then, reducible to a fixed body of social value and belief or a direct precipitant of lived experience in the world but grows into a space on the side of the road where stories weighted with sociality take on a life of their own.

This suggests that the speech economy of a community coupled with the 'emotional residue of an unnatural boundary' (Anzaldúa 1987, 25) transforms marginalised spaces into discursive areas of social life and meaning making.

SITUATING STRUCTURAL VIOLENCE

Multiple and overlapping discourses present in this work recenter women's

health as a radical concept for social change with spaces traditionally demarcated to govern women's bodies and health choices. Johan Galtung argued that violence takes shape in three ways: directly, indirectly, and culturally (Confortini 2006; Galtung 1969; Oliver 2012a). Direct violence is often defined as the direct act of violence against an individual or group. Indirect violence is any type of violence caused by a structure or system that causes harm or death. This includes but is not limited to organisations with an implicit or explicit relationship with the individual or group. Cultural violence is best described as an overarching principle that legitimises direct or indirect violence as '*normal*'. This article uses indirect or structural violence as a conceptual tool by focusing on and analysing women's narratives about ascriptions of COVID-19 health and wellness. These women have a long history of facing an unequal distribution of power and wealth and face insidious effects on personal and familial health. They are thus uniquely positioned to reflect on local and global societal inequalities, specifically those underpinned by economic power differentials directly impacting health. Galtung's (1969) definition of violence as any action or non-action that causes avoidable harm to individuals is useful when analysing the ways in which the narrators experienced and continue to experience the impacts of COVID. Many women who attend the church in Renel endure capitalistic exploitation because they are the sole providers for their families. Galtung developed the concept of structural violence to explain how social systems cause avoidable harm to human beings which I illustrate below by presenting a conversation between myself, and two of my neighbours, Miss Lucy-Gail, and Charlene.

Women who are subjected to structural violence often experience a reduced quality of life which sometimes leads to premature death. This can be attributed to inequitable life opportunities (Brock-Utne 1989; Mazurana and McKay 2001). The lack of opportunity and equal access to the most basic of resources in this community limits local employment opportunities for the women in the community. This is a food desert community with high rates of poverty, intergenerational and historical trauma which compounds the daily struggles of the women in the community.

COVID-19 exposure is not avoidable for many frontline and essential workers. Many women in Renel hold positions as frontline and essential workers. They are confined to inequitable economic systems. Economic systems that are punitive to an essential worker single mother without access to affordable emergency childcare, resulting in preventable lost wages is an example of structural violence. Structural violence is life-threatening and comes with costs (Galtung 1969; Rylko-Bauer and Farmer 2016).

A critical determinant of an individual's health status is the socio-physical environment they live in (Singer 2009). Anthropologists from various subdisciplines, including those who explore conceptions of violence, have utilised ethnographic methods to focus on health (Baer *et al*. 2003; Nguyen and Peschard 2003; Scheper-Hughes and Bourgois 2004). Paul Farmer (2009) asks, 'how might we discern the nature of structural violence and explore its contribution to human suffering? Can we devise an analytical model, one with explanatory and predictive power for understanding suffering in a global context?' Conditions of poverty and inequality, marginalisation and oppression, and inequitable access to resources all exist within the community in which the women who speak in this article live. To answer the questions of Paul Farmer, I argue for a medical anthropology that is self-reflexive and multidisciplinary, especially during times of illness related isolation, prolific false narratives, and pandemic policing.

BORDERLESS VOICES

This is a small town where 'everybody knows everybody'. Many residents often gossip in person and through social media platforms such as Facebook. They share important and not so important community information, and await the headlines in the local paper, which is distributed on Wednesday and Sunday. On the first 'lock-down' morning, I sat on my porch enjoying a cup of coffee while reading the headlines. A white van stopped in front of my house. The occupants, women from down the street, poked their heads from the window. 'You better get to Walmart, everything is almost gone', shouted the woman in the front. I thanked them for the message, and they sped off.

Miss Lucy-Gail, Charlene, and me

Just as I readied myself to go inside, I saw the curtain move at my neighbour's home across the street. A figure appeared in the window. It was my seventy-year-old neighbour, Lucy-Gail. I watched her gingerly open the door and step out onto her porch.

> *Miss Lucy-Gail*: Hey baby, what did they say?
>
> *Me*: Hi Miss Lucy-Gail, they told me to 'get to Walmart because the store is looking empty.'
>
> *Miss Lucy-Gail*: Well, let me know if you go because I am too afraid to be out in all this confusion.

Me: Yes Ma'am, I sure will.

I turned to go inside. Before I could enter my home, Charlene, another neighbour came out and called to me and Miss Lucy-Gail. I waved.

Charlene: What did those folks in the van say to you?

Miss Lucy-Gail: She [referring to me] told me Walmart is almost out of everything.

Charlene: What?

Miss Lucy-Gail: Yeah, child. Seems folks done lost they mind. Baby [to me], what else was they saying?

Me: Just that Walmart is almost out of food and other essentials. [Miss Lucy-Gail doesn't respond but in a slightly hushed tone she continues to talk with Charlene].

Miss Lucy-Gail: I'm surprised people headed to the store so fast. I mean some of us don't have a way, and if everything is gone, then what? Somebody needs to do something around here. Most of us is too old to get to the other side of town for groceries and stuff, in a moment's notice. We needed a grocery store in our area years ago. Now look what done happened.

Charlene [speaking to me]: Hey, you know nobody cares about this side of town. By the time we get to the store, won't be nothing left. But I guess you know that though. If you go to the store, let me know. You know we don't have a car. I am just worried that the rumours about the toilet tissue and water are true? I'll have to call my uncle to take us if you don't go, and you know that can be a pain. I don't even wanna think about having to go to the hospital. Sometimes, I feel like they don't take us [two-spirit women] seriously when we go there [referring to the hospital]. They don't understand our [American Indian] ways of understanding sickness. This 'rona thing is such a mess and I just think we need to pull together. Oh, hey … do you have a spare sanitiser?

This brief exchange is a type of the porch-yard communication that is common in this neighbourhood. Residents keep a watchful eye on the 'going-ons' in the

neighbourhood. In this exchange a glimpse at the inability to acquire needed resources is offered. The women's inability to travel to grocery stores, hospitals, and other places outside the borders of their neighbourhood coupled with their collective feelings of being disregarded speak to long-term inequities. The presence of COVID-19 as a health materiality further exacerbates the differences between the 'haves and have-nots' divide. In the narrative snapshots above, fear of scarcity of items, and access to items is expressed, and represents a type of continuous multiplicity that exists in the form of hand sanitiser, water, toilet tissue, disinfectant wipes, and a variety of disinfectant sprays serving as currency.

> *Jovita*: I have been feeling sick for a few weeks. I am the only one employed in my home. I'm underemployed if you ask me. I hesitate to go to the doctor. They see won't see me. They never have. They see me as a gay Indian woman. They see sex. They see alcoholism. They see a bunch of stuff that just show their ignorance. If I don't act a certain way, they look right past me. I have to shift back and forth in the way I act to be accepted by my friends and family, and be really seen by doctors, store clerks, my kid's teacher. Now this [referencing COVID-19]! Every sniffle, cough, headache, immediately becomes a possible COVID-19 diagnosis that could be real or false. It's a diagnosis where I must figure out and decide how to be … as a well woman, a sick woman, an Indian woman, a lesbian woman, a mother, a mother with a potential sickness. And how do I do this stoically, with dignity? I have to police myself because I know others will be policing me.

Jovita, who identifies herself as a well-educated woman, spoke at great lengths about the possible challenges that lesbian and bisexual women of color may face during the pandemic. She shares a very personal and intimate story that articulates the malleability of her identity as a form of borderland duality. Anzaldúa (1987, 25) writes, 'a borderland is a vague and undetermined place created by the emotional residue of an unnatural boundary. It is in a constant state of transition'. Jovita's snapshot reveals a pondering with the creation of a 'new identity' (Lugones 1992, 33) – a pandemic identity that lends itself to possible policing by individuals within her intimate familial circle and those operating outside the borders. In the following vignette Ericka shares another account of pluralistic modes of self-identification and operation that many women in the neighbourhood speak about.

> *Ericka*: Girl … [with tears in her eyes] … I feel like some of us are going to be triple judged. At first, I didn't give a lot of thought to the way I would be looked at, but wearing a bandana as opposed to wearing

> one of those medical masks makes some folks look at me like I am a gang member, or something … like I may rob the Dollar General. Can you imagine being looked at like that at Dollar General, of all places. And, then the folks in there really go out of the way to avoid you. Like you're automatically seen as contagious people because I am not wearing 'a proper' mask. My mouth is covered. I just don't get it. It feels like I am always viewed as something. The skin I'm in has always done that … place me in a false category. COVID seems to intensify this.

Ericka's snapshot, like many others who shared their pandemic experiences speak about the police-abilities of perceived contagion. Everyone becomes a suspect, but some people are made to feel more suspect than others. The fear of contagion exponentially impacts communities of color, specifically women. Hardy (2020) broadens the most basic understanding of masks as markers of contagion/non-contagion identities, writing (657), 'a Black interviewee connected COVID-19 to Black Lives Matter and then pointed out the ongoing racism of people who fail to understand how race and disease intersect'.

Like many of the interviewees in Hardy's (2020) work, the women sharing their narratives in this chapter view their nodes of intersectionality as a border intimately intertwined with COVID-19. According to Anzaldúa (1987, 25), 'borders are set up to define the places that are safe and unsafe, to distinguish us from them. A border is a dividing line, a narrow strip along a steep edge'. The real and imagined construction of borders is born out of an objectifying gaze of self and other. It is othering and otherness that creates the management of (re)configured, (re)imagined, and (re)worked bodies. In the snapshot below, Sarita discusses the ways in which she disrupts the COVID-19 social imaginary.

> *Sarita*: I know what's being reported. Women like me are most likely to get sick … to die. Yes, it's true, my size gives me the appearance of being unhealthy but, I'm not. I get movement every day. I make good food choices. I'm just a big lady. People judge bigger bodied people. We get labeled lazy, unclean, unhealthy, unmotivated, Now, with all the different news information family and friends think I am going to be the first to die of the 'rona because I am bigger bodied. I am taking all the proper precautions when I come home from work. I am wiping down all the groceries before they come in, and everything. I'm giving back to the neighbourhood too. I know folks are afraid to get tested because of their citizenship status. When I order my groceries, I order extra items for traditional holistic remedies, and

> I educate them on proper mask wearing and regular handwashing. I translate the latest COVID information from the news to the older Doñas[3]. I'm proving that big folks can be examples of a healthy lifestyle. I am going to stay true to me, stay true to my culture. COVID can't change that.

Sarita is a young woman who operates from a dual consciousness, a mestiza consciousness and a COVID-19 consciousness. Sarita's snapshot illustrates the ways in which discourses dismantle the disciplinary entanglements of racism and compulsory able-bodied aesthetics. Anzaldúa (1987, 83) posits, 'there are more subtle ways that we internalize identification, especially in the forms of images and emotions'. Anzaldúa (1987, 83) goes on to note 'food and certain smells' are intimately connected to her identity. Sarita's account of utilising grocery store items to create traditional folk remedies speaks to her conceptualisation of her identity, specifically, her health identity.

In Anzaldúa's (1987, 1999) work there is an intentional reframing and reimagining of consciousness, using the mestiza way of knowing and being as a (re)construction of personhood within the borderlands. As in Ramlow (2006, 181) expanding Wong's (1981, 178) notion of subjectivity, Sarita is demonstrating a 'desire for a pluralistic' way of being and experiencing through a shared, hypervisible imaginary. Her COVID-19 assemblages of personhood rupture ideal-bodied and wellness categories.

> *Myself*: I have worked and lived among the women in this community for ten years. We have survived ice-storm related, weeklong power outages in the dead of winter. We have survived tornadoes. Will we survive COVID? I wish I could tell the women in the neighbourhood we will survive this too, but the truth of the matter is, we may not.[4] An elder parent who has preexisting health conditions is sheltering in place with me. We are two multiethnic women – mother and daughter living in a rural community with limited local access to health care. My identities as participant-observer, as a biocultural anthropologist, as the daughter of an elder parent has taken on new meaning during this current health crisis. It is an identity in constant flux depending on the needs of the community, the needs of my profession, the needs of an elder parent, and my own need to exercise self-care.

Embodied in a communicative practice, the borderless voices in this article articulate experiences within a gendered pandemic action schema. In the

snapshots above, we see the location of the pandemic self and the possibilities and multiplicities of codes of conduct in ordered and order-less places – in borderlands. Their shared narratives assist in developing an understanding of the economic and social forces that give rise to COVID-19 experiences.

THINK GLOBALLY, ACT LOCALLY: LOCAL IMAGINATIONS

The discussion of these narratives functions as a framework to (1) broadly expand scholarly and discipline-based approaches to healthcare research in rural communities with a specific application in communities in the United States; while (2) focusing on the ways in which a reflexive practice impacts the sharing of health-related discourse; and (3) illustrates borders and borderlands as tangible; through (4) exploration that facilitates an understanding of the lived experiences of women in a rural community in Oklahoma. This chapter articulates the ways in which pandemic experiences, specifically COVID-19, impacted the biopsychosocial health of women in this rural community.

The ethnographic snapshots that have been presented here articulate experiences that point to ruptures in a social system designed for the health of all. However, the stories shared by these women illustrate the ways in which they perceive some populations and groups being implicitly denied equitable access to resources. The lack of transmissible health care information and knowledge, an implied segregation of community, and labeling of women in this neighbourhood as 'other', a label that is highly charged with political opinion and emotion and comes with a double set of images and standards. The linkages between gender and socioeconomic status in marginalised rural communities during times of health crisis is an area for continued exploration that will utilise community and reflexive narratives as a transformative and boundaryless approach to research, methodology, and analysis.

Understanding the factors that contribute to and perpetuate pandemic health disparities lends itself to an understanding of the ways in which disease phenomena is experienced by vulnerable populations. Despite these adversities, the women in this study have banded together to improve their situation while the pandemic lingers. There are numerous overlapping and interconnected factors that contribute to the lack of economic survival and opportunity for the women in this community, especially one terrorized by a novel disease.

The utilisation of self-reflexive and experimental ethnography provides a path forward in the development of an understanding of COVID-19 during a time when traditional models of fieldwork are put on hold. This model can be

used to frame the analysis of COVID-19 borders within two primary domains: 1) agentive realities, which refers to the activities and attitudes of individuals and how their individual and community intentions, motivations, beliefs, and cultural values shape personal COVID-19 responses, and 2) historical and sociopolitical structures, which refer to the geopolitical structures that govern and guide community action. This model provides space for anthropologists to 'do anthropology' differently during times of crisis. For me this consisted of a careful and systematic negotiation of imposed health-safety boundaries. The new COVID-19 protocols halted community gatherings where traditional participant-observation would take place.

The focus in this article has been placed on the interculturality and intertwined experiences influenced and impacted by elements of COVID-19. Shaw (2001, 103) writes, 'interculturality is a way of describing a borderland' and 'refers to the intersection of different forms of knowledge and experience, and deployments and effects of power'. My extended commitment to my research community has allowed me to impart different forms of knowledge and knowledge construction as suggested by Shaw. To many in anthropology, my time in this community classifies me as a native anthropologist. There is a bit of truth to this classification in that I have an emic understanding of community structures. It is this understanding that lends itself to my call for research addressing health disparities in similar communities across the United States, and to alter and change the current socio-political structures that continue to implicitly marginalise, colonise, and oppress women. This is an area that is ripe for anthropological research. Researchers and scholars within anthropology must begin to not only focus on health disparities globally but must begin to examine them locally – as in their own backyard and across their own fences. Fanon (1963, 35) writes, 'To tell the truth, the proof of success lies in a whole social structure being changed from the bottom up. The extraordinary importance of this change is that it is willed, called for, demanded. The need for this change exists in its crude state, impetuous and compelling, in the consciousness and in the lives of the men and women who are colonised'. As researchers, policy makers, and health care providers we must begin to address the need for structural change to insure equitable access to resources for all. Our praxis-oriented approach to illness as crises emphasises the importance of collaboration across and within borders.

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COVID-19 has birthed many personal and professional challenges for myself and the women in the communities in which I live and work. I began asking

complicated COVID questions across fencelines separating my home from the homes of my neighbors during the earlies days of isolation and quarantine. The questions, comments, and concerns shared during these beginning times of uncertainty laid the groundwork for this study. I am indebted to those who shared and connected during a time of social distancing. This article would have been impossible without the patience, guidance, grace, and support from the editors of this collection. Thank You!!! Finally, I would be remiss if I didn't acknowledge two study collaborators who lost their fights with COVID in January 2022, FDRO and CAB. You will be missed.

NOTES

1 Elisha is a biocultural anthropologist, folklorist, and visual ethnographer. Her research explores the intersections of space and place, health, and folklore in rural and urban communities of color. She is an active member of American Anthropological Association. Elisha is a professor at OSUOKC, and OCCC. She serves as a STEM mentor for a national organization and is an anthropology community liaison for a non-profit organization in Oklahoma. Elisha often is invited as a discussant on the international crime podcast where she explores the biocultural aspects of crime and the behaviors of those who commit them. Elisha earned her Ph.D. in anthropology from the University of Oklahoma.

2 Re-entry services are a grouping of services provided to previously incarcerated women.

3 Doña is a term of endearment and respect for elder women among Mexican community members. It translates to Mrs. in western vernacular.

4 At the completion of this article three women succumbed to COVID-19.

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