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## **Covid-19: asymptomatic infection and the question of face masks for how we live this pandemic.**

Unlike any other potentially deadly viral infection, Covid-19 has required a contraction of living on a scale never seen before. Amidst the demands of 'social distancing' and 'self-isolation' and the uncertainty about how the UK can come out of 'lockdown', is the question of face masks for the possibility of preventing transmission.

Early on in the pandemic, it was established that only **certified masks** are able to prevent the penetration and expulsion of the viral particles for Covid-19. To conserve the inadequate supply of certified masks for healthcare providers, those not 'on the front line' in the UK have been discouraged from not only seeking them but, also, from using other kinds of masks because their weave can be permeable. Faced with dissension amongst scientists on whether various other types of masks can prevent infection transmission (see **Greenhalgh and Howard 2020a**), the UK government has refuted their use. At the time of writing, the government's instruction is that those with 'confirmed' or 'suspected' symptoms of Covid-19 are to self-isolate or '**stay at home**' until their symptoms disappear. However, it is also likely that large numbers of people may be asymptomatic while infectious. Evidence from China suggests that **four in five Covid-19 cases in China were asymptomatic**. There is also evidence that the **highest peak of shedding viral particles** – the potential for transmission – may begin 2 to 3 days before the appearance of the first symptoms. Presumably, the presence of 'asymptomatic' persons has been the rationale for 'social distancing'. But this is curious given the stricter controls on those who become symptomatic and whom, according to existing scientific research, are considerably fewer in number.

In April, the acute shortage of certified masks for healthcare workers in the US led the Centre for Disease Control and prevention (**CDC**) to say that a scarf or a bandana may be worn in a health care situation where virus is likely to be present. With reluctance but unable to furnish crucial protective masks for 'front line workers', the UK government shifted to accede to this still confusing position. Meanwhile, some individuals within the UK and others supported by their own health authorities in countries such as the Czech Republic, Slovakia and parts of Germany, have departed from the wait that has come with what is said to be 'following' science. They have followed a practice common in South East Asia, where it is expected that a mask would be worn in the felt presence of a respiratory infection or simply to signal a care to others.

But there is another kind of infection that we might learn from in considering our response to the demands of Covid-19 and, specifically, the risk of asymptomatic infection. Early in the HIV epidemic, when it became evident to science that many people could be 'asymptomatic' and, unknowingly, could transmit the virus with near inevitable fatal consequences, gay men speculated that the simple device of the condom might replace what others advocated as 'sexual abstinence' (**Kippax and Race 2003**). There was no established scientific evidence available to say that **condoms** would prevent transmission. There could not be. The situation was new. Lay thinking was needed if a crucial dimension of sociality was to continue: could a small piece of latex, already established as safe and *relatively* effective for preventing conception address the uncertainty (and potential discrimination) of HIV status? Even now condoms are not assumed to provide a guarantee against transmission or an ideal

inclusion in sex. But they have provided a practicable response to a situation that could otherwise have required its own kind of 'lockdown'. In sum, the male condom became the most effective addition to an otherwise untenable situation that, since, has altered with the achievement of diagnostic tests and therapeutics.

If we consider the argument 'masks for all' made by **Trisha Greenhalgh and Jeremy Howard** (2020a) in response to the situation of Covid-19, we might deduce that condom use to protect against HIV was arrived at by the biomedical *principle* of weighing various modes of extrapolated evidence to enable a 'for' and 'against' in an *interim* of uncertainty (**Greenhalgh and Howard** 2020b). But we might also view the take up of condoms as a *pragmatic* response to a situation where evidence of situated effect can only come after (**Rosengarten and Murphy** 2020; **Rosengarten and Savransky** 2019). With this in mind and drawing on the pragmatism of the philosopher, **William James**, attuned to a world of uncertainties, we might consider *masks for all* as adding a difference to the current ongoing potential of asymptomatic infection. Not a finite solution but as a possible in the midst of numerous uncertainties, including those of the arrival of diagnostics, vaccines and therapeutics.

If we face, square on, that the 'lockdown' cannot be sustained as is, that we will never have absolute certainty of the *hic et nunc* and, indeed, what may come of the future – even with vaccine or efficacious therapeutics – it is clear that a difference is called for in what we are told is the UK 'science-led' approach. Rather than seek what might *return* us to 'normalcy', as if risk was not always present and won't be in the future, a pragmatic approach to *masks for all* invites us to engage *with* the specifics of risk that now call for 'social distancing'. The potential danger of an individual permeable mask collecting viral particles would be altered in the presence of another potentially reducing their emission. Coupled with social distancing where practicably possible but, also, where it is not, a host of situations could become more feasible. Sitting on a bus or train with empty seats between may work to prevent infection but only when there are few others onboard. Children can be confined but with difficult consequences for them and for those who are required to impose this prevention strategy.

Bearing in mind that many have chosen to use masks because there can be more to do than wait for more scientific evidence, we come to the most obvious of questions: What are the consequences of accepting that 'symptoms' of infection call for masks but not 'asymptomatic' infection? What kind of imaginary is at work in this distinction and the consequences that are becoming of it? If the distinction is underpinned by a shortage of certified masks, what makes *en masse* replication of certified masks so difficult? And, in their absence, what might be added to the current situation by those of scrutinised, *well-fitted* but not guaranteed fabric if, as advocated by Greenhalgh and Howard, they were donned not according to the current distinction but by all? (1). In sum, a doubling of surfaces that might, in the absence of knowing, intercept the unwanted connectedness that is being made with Covid-19. If HIV has taught us that we cannot wait for scientific evidence of efficacious interventions in order to think and, to do so in ways that might transform the *hic et nunc*, we come to the premises of the Covid-19 lockdown: is it because of the consequences of viral infection or because we are waiting, as if already apart from the possibilities of transmission, for evidence that will come too late?

Renowned for his efforts to rein in not only Covid-19 but a US President who wants to forego a lockdown for politico-economic gain, the Director of the US National Institute of Allergy and Infectious Diseases, **Anthony Fauci** has stated: 'You've got to be realistic, and you've got to understand that you don't make the timeline, the virus makes the timeline.' In part, we agree. But we should not forget that it is also made by how we and a host of 'things' – including policies of 'social distancing', futuristic evidence-making (see **Rhodes, Lancaster and Rosengarten 2020**), and, in the UK, degrees of government inertia – affect the infection. To put this another way, the virus does not act on its own. None of us do and this includes science, public health and, indeed, lay publics. Amidst the talk of a collective response to Covid-19, the call for masks would require them to be actualised for all. As such, masks may serve as both a crucial intervention and a provocation. Not for *imposing* an ethos of collectivity, indeed, a contradiction in terms (or for ceasing 'social distancing' and 'self-isolation), but because when it comes to infection we are already living its demands.

1. Our thanks to Lion Blau for his advice on mask design for aged care in Germany and for the image of a mask.

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