Care During Pandemic Times: Digital Ethnography with Mental Health Professionals in Equatorial Guinea

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SUMMARY   *This article discusses how the COVID-19 pandemic impacted my anthropological research inquiry of care among mental health professionals at a community shelter and a psychiatric hospital in Equatorial Guinea. The rapidly evolving changes required the methods of digital anthropology, which allowed an understanding of embodiments of care. Under volatile conditions and intersections between the personal and the public, mental health professionals carried and invested care in communities and (re)discovered new challenges and vulnerabilities. Medical agencies revealed symbolic roles, meanings, and qualities of care. This article proposes opportunities for the discipline of public anthropology to serve as a medium for the engagement of collective solutions.* [anthropology, mental health care, Equatorial Guinea, COVID-19]

Care: An Introduction

Care is important to me. I understand it means love, union, life, and hope. It is a relationship, a gift. I also understand that care conveys infinite meanings and expressions. The care I find in human medicine, for example, has always been of interest: the kind of healing exchanged with one another, other species, and our world.

Care is everywhere. "It depends on the context," wrote anthropologist Annemarie Mol (2008, 63). We can look after our bodies through spiritual communion, check in with a local wellness center, a Chinese traditional medicine doctor, or our primary provider at a clinic. We can take care of our homes and our planet. We might even perform *care as work* through formalities of employment contracts (Mol 2008, 5), as I do when I *practice care* (Albert et al. 2015) through the coordination of mental health care programs directed to racially and ethnically diverse communities at a local hospital in Boston. In collaboration with other mental health care professionals, the medical community, and

community organizations, the team at the hospital strives to learn about the care that best suits us, especially when we experience stress, anxiety, depression, and trauma.

There are many ways to look at care. I took advantage of my training and experience as a medical anthropologist to further my career through a Ph.D. In 2019, I enrolled at a distance-learning graduate school in Madrid (Spain) to attempt at least a development in the understanding of relations that may or may not offer possibilities of sustaining life (McKearney and Amrith 2021), matters of "tinkering" (Mol et al. 2010, 11), or ambivalent actions that "transform over time in ways that are often unpredictable, complicated or conflicted" (Cook and Trundle 2020, 179). I intended to analyze or "locate" actions and exchanges between actors that are supposed to be beneficial within physical and conceptual fields of interest (Offenhenden 2017).

I chose to look into the kinds of care that approach mental health illnesses in Malabo, the capital of Equatorial Guinea, my father's country. As a daughter of the African diaspora, I am drawn to my African roots and heritage. I embrace my father's history, an Equatoguinean man who left his place of birth in the late 1970s to escape hardships under the first dictatorial rule and to migrate to Spain, where I was born and raised. I have traveled to my father's country countless times to visit, learn, and meet with my paternal family. My doctorate is dedicated to Equatorial Guinea.

My study of care in Equatorial Guinea, a Spanish ex-colony that gained independence in 1968 and an officially Spanish-speaking country and a multiethnically populated one (Boleká 2003), focuses specifically on two sites located in different neighborhoods in Malabo: a community shelter and a psychiatric hospital. These two sites emerged from a preliminary investigation on health care infrastructures and biomedical services in Malabo and Bata, the second-largest city in the country (Nvé Díaz 2020). The study results situated biomedical care, a globally present medical science (Lock and Vinh-Kim 2018), within complex webs of care diversity (Sánchez 2013). This preliminary study profiled structured and institutionalized care as a commodity and privileged care (Albert et al. 2015) operating through centralized socio-economic and political systems maneuvered and controlled by a dictatorship (Muñoz 2015).

"Care of mental health" as a theme surfaced initially from ethnographic observation and interviewing (Velasco and Díaz De Rada 2009; Creswell 2016). Care embedded in mixtures of medical traditions and biomedical impacts reflect legacies inherited from a historical past invested in colonial medicine and religious, charitable, and international organizations such as the Spanish Cooperation o Agencia Española de Cooperación Internacional (de Peray Baiges 2020). As one mental health professional, psychiatrist and Guineaequatorian man told me during a phone interview in 2020, mental health care "was developed through conversion and the change of minds".

Preliminary research on spaces and actions of mental health care uncovered data related to mental health, for example, an unfinished draft of an official protocol for mental health care born out of an international mental health policy process initiated by the Spanish Cooperation in 2010 to help sustain mental health care facilities (Muñoz 2015). The Faculty of Psychology and Moral Sciences is located in the Basilica of Mongomo, in the country's eastern region.

In March 2018, the government convened the First Mental Health Congress: Mental Health on the Front Line (Primer Congreso de Salud Mental: La Salud Mental en Primera Línea). The gathering, organized in Malabo and in coalition with the Ministry of Health and Social Welfare, the Ministry of Social Affairs and Gender Equality, biomedical institutions, and international organizations, concluded with statements that corroborated that mental health in Equatorial Guinea is a serious issue on the rise and related to alcoholism, schizophrenia, and homelessness (World Health Organization [WHO] 2018)

During my preliminary research, I also encountered a few initiatives dedicated to eradicating homelessness and supporting communities that motivated, independently but almost simultaneously, the start of a community shelter in 2014 and the inauguration of the first and only psychiatric hospital in the country in 2016. In addition, my initial inquiries about approaches to mental illness in Equatorial Guinea suggested that only limited studies discussed obstacles and barriers that curtailed practice, delivery, and access to mental health care (Reuter et al. 2014). One study focused on perceptions and meanings of mental illnesses based on ethnic identities (Jimenez Fernandez et al. 2018), and another on public health professionals' perceptions of mental health services, and descriptions of their challenges to care for others (Reuter et al. 2016).

The anthropology of care emphasizes ethnographic studies of care practices and inquiries about where caring happens, who engages, and what counts (or does not) as deserving of care (Garre and Sánchez 2020). My doctoral research focuses on the phenomenological perspectives of mental health care professionals (Jackson et al. 2015) and their embodiment as actors that culturally perform the so-called *care as work* or professional care. What do these professionals, experts in mental health care, know about their bodies, selves, and identities? What do they know about other bodies and minds, and how do they express it? As generators and replicators of patterns of relationality and visions, who else is involved alongside them? Does it all work? What are the outcomes of the exchange processes and movements of giving and receiving?

I was about to find out as I was preparing for fieldwork in early 2020 when suddenly, the COVID-19 pandemic surged all around the globe. Suddenly, a virus endangered our lives. Sadly, cases of infections and death were on the rise. Immediate responses and preventative measures to keep the safety of us humans took place nearly everywhere, in our communities and our places of work.

In this article, I address how the COVID-19 pandemic impacted my research. My research halted with the rapidly evolving changes resulting from the biological threat of COVID-19 to infect and kill bodies intertwined with social complexities (Higgins et al. 2020). My anthropological gaze turned toward my body, family, and community. I was stressed out at work. I tried to maintain a balance. It took me a while until I felt I could look back to Equatorial Guinea. As I think of it, I believe anthropology came to my aid to handle the possibilities of digital research methods. And when I used them, I noticed mobility. The mental health professionals carried care with them while moving across spaces. I followed them. I perceived investment toward life. At the intersections of forms of care dedicated to bodies and kinship, the mental health professionals I spoke with navigated volatile conditions and under "the unexpected" (Mol 2008, 9), only to (re)discover vulnerabilities and further challenging implications.

Care during Pandemic Times

On the afternoon of February 22, 2020, I received an emergency text from the hospital where I work. The COVID-19 outbreak had reached Boston. First, I was in shock. I felt fear. I was at a local library, but I rushed home while I shared anxiously and sparsely public health-related texts among people I knew. I had been following the news about the novel outbreak since December 2019, but honestly, I never imagined that the deadly virus would come so close to our city and so rapidly. I worried daily about everything: my safety and health, my economic wellbeing, my family, everyone I knew, and the whole world. My younger brother and I remained in the United States. We exchanged phone calls with our family and friends in Spain and Equatorial Guinea. I became preoccupied with my father and my younger sisters. There was chaos around me. For me, my home in Boston turned out to be the only safe place.

Eventually, my neighborhood shut down. Most businesses closed. And with the general economic downfall, the state of Massachusetts declared an emergency. The news was both overwhelming and tiring. As I grew conscious of and knowledgeable about the virus and its possible effects on our lungs and entire respiratory system, events at my hospital also changed rapidly. At our department, we resolved to move forward with our programs and partnerships in accordance with state and federal safety regulations. We re-organized quickly while, at the same time, we cared for each other. We expressed concern by asking questions about ways we can offer support to each other. We understood the importance of self-care to, in turn, take care of others more efficiently. We had meetings, organized schedules, and arranged new working settings and methodologies at the hospital and at home.

Loss and mental illness rocketed as the pandemic progressed in Massachusetts. The larger community struggled with mental health conditions. Vulnerability showed up in large numbers among those chronically ill. Regarding the COVID-19 infection effects on the population, I focused on Black, Latin, and immigrant communities, as these were disproportionately affected by high infection and death rates (Figueroa et al. 2020). The consequences of the pandemic on mental health had a significant and concerning impact on women. Black and African immigrant women experienced disadvantaged access to care due to socio-economic factors, barriers such as lack of time and resources, and lower rates of telehealth access that ultimately contributed to missing or incomplete care (Massachusetts Commission on the Status of Women 2021). However, there exists limited country-wide inquiry and knowledge about how the COVID-19 pandemic impacted mental health among diverse communities, especially Black immigrant women, due to the lack of focused research initiatives (Boston Public Health Commission 2021).

The pandemic situation in Equatorial Guinea was at first complex to determine from where I was in Boston. As I continued initiating contact with my father's family, acquaintances, and the mental health care professionals from the community shelter and the psychiatric hospital, I was also paying attention to the news reaching out to the diaspora. Critical voices expressed that the entire health care system in Equatorial Guinea was a failure. It seemed as if the pandemic attenuated the already existing disparities in care or the exchanges

between biomedical professionals and people needing cure and care. The pandemic unsurprisingly revealed the government's and the official health care system's incompetence. National or state news, media, and outlets supervised by the ruling party tended to report inaccurate information on the expansion of the virus across all regions. While the Ministry of Health and Social Welfare portrayed responsible action, individuals and members of the civil society complained about the quality of professional care, the lack of reliable information, public protection, and resources invested in the population. The rise of corruption or the selfish management of promised care led people to favor private care, which is less affordable.

Given the social complexities experienced since February 2020, the shifting interests in care required immediate balance. Ethnographic studies in contexts of pandemic times and lockdown exposed other examples of how ways of performing anthropology intersected with dealing with COVID-19. Anthropologists balanced research and caring for elderly family members due to their highest risk of COVID-19 mortality (Sadruddin and Inhorn 2020). Doctoral researchers experienced multiple vulnerabilities during pandemic times (Stavig 2021). Some encountered overburdened feelings when fulfilling the demands of family care, new responsibilities, and new dimensions of their psychotherapeutic work (Barata et al. 2020). One in particular felt like "abandoning the ship" when leaving the field all of a sudden after boarding one of the last flights out of their research site and relying on "privileges" at home (Higgins et al. 2020).

New Methods of Research: Digital Anthropology

Despite not knowing the next steps moving forward, I decided to continue my research in Equatorial Guinea. I planned to follow mental health care professionals and let them guide me. I started by keeping in touch with them through calls, texts, and apps from my mobile phone. I navigated the internet and social media platforms, looking at their online sites for news and updates. I kept in touch with the information about COVID-19 repercussions in Equatorial Guinea through media platforms, independent digital newspapers, and official and government webpages. I received responses. Some sent me videos, emails, texts, and photos. I conducted informal interviews and scheduled semi-structured interviews.

Without realizing it at first, from the beginning of 2020 until early 2021, I embarked on a methodological journey that was entirely new for me. I joined the movement of digital anthropology, a discipline on the rise for the last few decades, focused on culture and technology (Boellstorff 2013). It was interesting to realize the existence of online communities and how, through ethnography, it was possible to capture the roles of technologies and information technology as cultural re-productions. Related functionalities that guided me through the process of digital anthropological tools included the themes or concepts of online presence, engagement, negotiations of identity, ideologies, forms of speech and language, and images (Wilson and Peterson 2002).

The somewhat melancholic rise of digital anthropology during COVID-19, or "the anthropology from home" because we were stuck (Góralska 2020),

served me as one ethnographic tool that intermediated between my world and the world of mental health care professionals in Equatorial Guinea. The practice of digital anthropology, a discipline in ongoing constructive and reflexive critique, transformed barriers and the impediments of not being in the field due to border restrictions and imposed safety regulations into possibilities by readjusting the ethnographic method into a gentle, procedural, flexible, and open enterprise (Ghosh et al. 2020).

I started taking notes on my qualitative research methods' processes, which re-introduced me as an anthropologist living "far away," explaining what happened with COVID-19 in the United States. I also told people why I was not there at the sites. I shared my future travel plans. I asked for consent before interviewing; I offered them anonymity and I tried to be consistent in my online communication and presence (Boellstorff et al. 2012).

There were challenges in the process. It felt like I was starting the project all over again and asking in despair, "When will fieldwork open up again?" (Favilla and Pita 2020). I evaluated availability issues considering time differences, internet connections, and disconnections. The theme of reflexivity also made me think about my ability in digital research. I sometimes had doubts about when to call, text, or maintain short or longer conversations. On occasions, I felt unsure about deciding which digital platforms to use best to follow the news about the shortcomings of the pandemic in the country, new protocols or mandates, or emerging social issues such as the limited availability of COVID-19 testing. Traversing the infrastructure of digital worlds is a disciplinary undertaking (Geismar and Knox 2021).

Through my participation in the renewals of digital ethnography in times of crisis (Podjed 2021), I learned about personal stories, trajectories, and care management among the mental health professionals at the community shelter and the psychiatric hospital. Within social contexts on the verge of conflict, medical agents balanced their fields of care and between personal and social commitments while navigating through flows of vulnerabilities and challenging implications. This investigation inspires further research on the meanings of medical roles and care and attempts to support the advancement of anthropology as a contributing tool directed to public and community wellness.

The Mobilities and Intersections of Care

By the beginning of March 2020, the Ministry of Health and Social Welfare in Equatorial Guinea announced through an official report that the country was at high risk with more than five hundred diagnosed cases. The governmental institution developed an action protocol that included the provision of testing and treatment at selected health care sites across the country. These sites had a psychiatric hospital, where facilities were prepared to receive diagnosed individuals or "patients," a term used to characterize individuals expected to receive care service within biomedical spaces. Medical officials advised the population to remain calm and serene and recommended compliance with all preventive measures in force and the protocol established for individual and collective good (Guinea Ecuatorial Press 2020).

In October 2020, the Ministry of Health and Social Welfare, in collaboration with the Technical Committee for Surveillance and Response to the COVID-19 Pandemic, the Brigada Médica Cubana, several clinics and medical centers, and the World Health Organization (WHO), published a report that specified detailed protocols directed to the medical community, included the psychiatric hospital. The protocol advised testing, preventative measures, clinical management, and the follow-up of "patients" with COVID-19 (Guinea Ecuatorial Salud 2020).

News from social media outlets and platforms reflected shared visions and opinions. Members of the civil society expressed that the epidemic management was far from transparent. People in the country felt misinformed about the level of preparation and capacity of health centers for a large influx of patients. The numbers of infection cases were not available or efficiently reported. Health workers were not summoned or officially informed of the protocols (Progressive Alliance 2021).

Carrying Care

Under contexts characterized by divided visions and practices concerning the care against COVID-19, the mental health professionals at the community shelter, an independent initiative and a not officially recognized organization, continued the pursuit of providing care to "usuaries," a term used when referring to individuals, men, and women, of diverse ages, with medically diagnosed mental health illnesses, or in need for additional help, and integrated into the life at the shelter through a system of family referrals and internal protocols. The organization stipulates that the community shelter's goal is to promote commitment to health, wellness, and respect, as one nurse told me in 2020, "because, in this house, we are all equal, we all the same".

The mental health care professionals at the community shelter pertain to a diverse spectrum of ethnic backgrounds and nationalities, lived experiences, personal trajectories, and educational histories. Most have been educated in Equatorial Guinea, and only a few abroad. Most were Guineaequatorian; others were originally from Spain. Mental health professionals performed different roles: Some directed and coordinated resources, delivered job training, and organized mental health awareness and prevention programs. Through orderly schedules, nurses delivered daily the provision of medication while psychiatrists and psychologists conducted weekly behavioral therapy sessions. Monitors assumed responsibilities for occupational therapy workshops and routines, and cooks prepared healthy meals. The "usuaries" also had positions of responsibility. Some took turns to open the gates for visitors, and others supervised schedules and cleaning tasks. Like a family, they participated in gardening activities at the shelter. They looked after the community garden outside the city every Monday and Friday morning when they went together in the shelter's van.

Care at the community shelter involved the welcoming residence for the "usuaries," recipients of expert care. The management and possible resolution of severe and persistent mental disorders alternated psychosocial rehabilitation and multiple mechanisms of social re-engagement and inclusion (Glynn

et al. 2009), as well as community care, companionship, and family contact. Mental health care providers strived to solve problems related to mental illness also through comprehensive and effective responses, encouraging, at the same time, internal collaboration and the strengthening of mental health care networks between communities, families, public entities, and non-governmental organizations (NGOs). The maintenance of the foundational belief of La Rueda de la Vida or the Wheel of Life, as one coordinator expressed during an interview in2021, a philosophy encrypted in the daily life at the shelter, promotes and enhances self-knowledge, self-esteem, personal care, routines and self-discipline, positive relations, emotional and spiritual health, and transcendence as valuable keys to mental health.

But, by the beginning of 2020, while the mental health professionals I knew maneuvered care practices, and some still were sending me pictures about the progress "usuaries" had made at gardening and tapestry workshops, they also started mobilizing. While discussing ideas and plans related to financial proposals to receive support, they slowly turned their attention toward a different kind of care focused on themselves. During our reconnections, some spoke of self-care or self-medication with natural products to fight the virus. Some extended care to kinship; others stepped out of the community shelter and traveled across the country and abroad.

The mental health care professionals I met through my research also showed care for me. When I reached out, I heard: "¿Cómo estás?" "How are you?" "¿Cómo está tu familia?" "How is your family?" "¿Cómo van las cosas en Boston?" "How are things going in Boston?" We inquired about each other's bodies, emotional states, and kinship with evident care. Our conversations became intimate. We displayed acts of care toward each other. We reciprocated as never before. During those moments of interaction, we were no longer "professionals" or "experts." Our exchanges did not integrate me as the anthropologist asking questions and them as the participants in my research showing me how they practice care. Instead, we exchanged concerns and learned more about each other's lives.

At the psychiatric hospital, care ran slightly differently. The approximately one- hundred-and-fifty-bed hospital is a public institution and a governmental initiative that employed, on rotational vias, at the start of the pandemic, two Guineaequatorian psychiatrists, several Cuban psychiatrists from the Cuban medical cooperation, two psychologists, all of them mainly educated abroad, and nurses and nursing assistants who underwent mental health care training. These mental health care professionals practiced biomedical care based primarily on medication and hospitalization directed to "patients," term for individuals referred and medically diagnosed with mental illnesses. The care involved ambulatory care or an extended stay in parallel with rehabilitation services for in-patients with chronic diseases, such as addiction or severe mental conditions. Non-ambulatory care, or the short visit, allowed out-patients needing care services access to consultation, treatment, medication, or follow-up services to help diagnose, treat, and monitor, for example, stress and anxiety. In 2019, staff at the hospital proposed efforts to integrate psychosocial rehabilitation and community psychiatry, initiatives that planned to engage mental health care outside the hospital (Olga et al. 2019).

The psychiatric hospital was in transition. A new and vital protocol placed the hospital at the front in the fight against COVID-19. According to reports, specialists from the Cuban Medical Brigade and national specialists treated patients with COVID-19 there (Guinea Info Market 2020). As soon as cases of COVID-19 rose and the operational administration started admitting cases of infection, the psychiatric hospital closed down much of its communication with me. I had difficulties reaching out. The forms of care practiced at the hospital moved inward to internal spaces. Under those contexts, "professional" identities were strengthened. There were no personal interactions. Although the mental health care professionals inquired about my well-being, the matters of care about the self, family, or kinship seemed non-existent. We remained professional with each other. The emphasis was on monetarily remunerated care, or care as work.

Management changes also took place at the hospital. A new psychiatric doctor took the position of Director. Some mental health professionals moved around the hospital, assuming different places; some were transferred to the Psychiatric Unit Ward at the regional hospital in Malabo. The transferred mental health professionals focused on continuing the outreach to homeless individuals in urban and rural areas. Some cases were severe. Many people considered ill were brought into the hospitals by the police. Often, individuals showed signs of having been tied up. The mental health professionals contacted family members and conducted medical consultations and assessments to proceed with psychotics and admission to the psychiatric hospital. But these professionals had additional plans, such as the planning of community psychiatry, a form of care that would treat a "patient" from home and reduce admissions. The professionals were also in the middle of creating programs directed at youth and pediatric mental health care.

Investing Care

The mental health care professionals at the community shelter announced that confinement was declared. It was essential to understand that protective measures included reducing the number of visitors. As one of the coordinators told me in 2021, they needed to control "who comes and goes because those inside are protected here; if someone is going outside, you cannot enter, which is the problem [in community shelters] in Spain. The entity that entered and left the residences are the ones that brought COVID and infected."

Doors closed, and "usuaries" stopped going to the vegetable garden. By the pandemic's start, I was told that the shelter was at its maximum capacity with sixteen "usuaries." Although, on occasion, someone requested their relative to be admitted, users who had already finished their rehabilitation (after approximately three months) were discharged and sent home, while others entered through the admission protocol that required prior testing, blood analysis, and vitals taking at the regional hospital. With the closing of the community shelter to new usuaries, management reduced staff. Some workers were at risk, others not. Shifts turned around along with stipulated strict hygienic conditions.

Mental health professionals at the community shelter were invited to participate in a Ministry of Social Affairs meeting. The issue was regarding COVID-19

topics and needs so that they could tell the deputy minister and representatives what they needed for the shelter and the "usuaries." They compiled a list of disinfectants, masks, and gloves, but the mental health professionals I spoke with reported they received nothing. As I learned later, organizations often do not expect much; they know how things are and are self-sufficient. The best strategy to remain afloat was to continue the agreements on support with the relatives of the "usuaries" and the community. However, as the professionals specified, these meant heavy economic burdens.

Meanwhile, at the psychiatric hospital, cases of COVID-19 among mental health "patients" were low or inexistent. No deaths were reported among mental health professionals or workers, except in the case of a nurse I was told was in "a serious state." The hospital took suitable precautions by restricting the environment and applying the Chinese vaccine to all workers. The news online announced that the hospital continued receiving assistance and support from the government. By May 2020, the institution had the innovative update of hospital-wide internet connection at the start of treating the first cases of COVID-19. A total of 273 patients were diagnosed, among which three died (Equatorial Guinea Press 2020).

Transferred mental health professionals extended their care as work, especially during weekend trips to rural areas. They also focused on implementing mental health care support programs directed to pediatric and youth mental health care. There was a new need to focus on outreach and assessment, the following-up of primary care that entailed cycles of infant vaccinations, and the checkup of common comorbidities that affect underage patients, such as tuberculosis, malaria, malnutrition, and respiratory problems. Among the youth, the programs delivered from the regional and psychiatric hospitals planned to promote education and awareness about preventative care against HIV/AIDS, alcohol, and substance use and lessen the high-risk social determinants of isolation, lack of family support, and unemployment.

Vulnerabilities of Care

The rapidly evolving changes resulting from the pandemic uncovered social complexities, paradoxes, contradictions, inequalities, uncertainties about responses and possible future directions, adequate governmental and medical infrastructures, and considerations of ethnicity, gender, and socioeconomics (Higgins et al. 2020). The mental health professionals in Malabo delivered more care. Individuals requested more care. There was a precipitated and simultaneous dread over uncertainty, loss, or vulnerabilities in the exchange and demand for care and safe spaces (Adam and Nadin 2020). Some mental health professionals felt an immediate demand for care had come their way. Services delivery proved inadequate due to structural health vulnerabilities and medical emergency failures. Other mental health care professionals received support in their care, yet accessibility to that care among those in need was difficult.

The "usuaries" experienced isolation due to reduced visits to the shelter. To them, the visits from their family members were appreciated. The mental health care providers mentioned that they did realize the positive effect family visits had on the "usuaries." Connection, contact, and communication elevated

levels of well-being. Although family members and relatives often called the shelter, this time was different, and the change was felt. The "usuaries" noticed their relatives passed by less often.

Although the mental health professionals at the shelter often conducted outreach to promote awareness of their services among individuals of all ages in the community, the number of women requesting their services rose to unprecedented numbers. Women reached out asking for help and support due to cases of stress and depression experiences. They specifically requested the assistance of Guinean-born mental health care professionals. Due to the alarming lack of social support provided by the state, these women sought the help of the community shelter. Some were unhappy in their relationships; others wanted to leave home, felt economic pressures, found themselves pregnant, or were about to give birth.

Financial needs were on the rise. Economic and resource sustainability at the shelter was somewhat limited. The burden felt upon the most vulnerable. The mental health professionals in charge of the financial coordination had to subsidize the shelter's personnel and general maintenance. They started projects on designs of international and national grants and subventions. They did not receive governmental support.

Another vulnerability experienced by the mental health professionals at the shelter related not only to the lack of economic support from the government or public institutions but also to network deficiencies. The mental health care professionals believed in inclusion and the importance of having frames of collaborative reference. All institutions and community agencies dedicated to health can join forces derived from the common community and public wellness frameworks. The decentralization of vital resources existing within the extensive health care system and an optimum design of referrals could maximize care efforts. In that regard, the shelter was relatively isolated.

The mental health professionals suggested ways to defy the effects of marginalized care. One suggestion was the finalization and conclusion of the mental health care policy document or protocol. During an interview in 2020, one coordinator urged the provision of psychiatry care referrals to community shelters because "the hospital also has benefits, because the health system needs to have a psychiatrist". The coordinator also added that rotational services could be of benefit too, because "at the psychiatric hospital, people are not rehabilitated, (…) [they] may recover abilities, (…) but at home, at the shelter, with the community, they can be reintegrated [socially, hopefully economically as well] again." Another coordinator mentioned feeling worried about the larger community: "We are not doing enough."

Meanwhile, the psychiatric hospital also closed down visits from the outside. At the hospital, visitors were not typical. There was the case of one "patient" who did not have anyone coming to visit for over two years. After May 2020, or since the establishment of the psychiatric hospital as one site for COVID-19 treatment among other sites, mental health care professionals received about 285 patients; 95 percent of them were discharged, and sixteen passed away. Although it is unknown how the initiative of care toward "COVID-19 patients" worked out for "mental health patients," the decrease in cases of infection began in June 2020. The hospital did not have a single seriously ill patient for

more than a month. The director said they would keep the hospital ready to receive "patients" because "the disease has been controlled, but it has not disappeared. We will keep the staff active in case of an avalanche of cases surge" (Guinea Ecuatorial Press 2020).

The outreach efforts conducted by the transferred mental health providers continued. Although more data and assessment are needed, these efforts revealed insights into the prevalence of mental illnesses in Equatorial Guinea. Private institutions, community organizations, NGOs, and mental health clinics, such as those funded by religious philanthropy and offered in Bata, Ebibeyin, and Malabo, dealt with barriers to outreach, promoting awareness, and improving accessibility. Homelessness, social marginalization, and abandonment represented severe issues across the country (Universal Periodic Review (UPR) 2019). According to Reuter and their colleagues (2016), public health professionals employed by the government expressed dissatisfaction due to the current medical system not meeting care workers' and community's needs. Respondents' specific suggestions included additional or improved infrastructure and additional governmental assistance.

The vulnerabilities in care found in Equatorial Guinea coincide with the results of a wide array of literature based on empirical studies that report how the pandemic increased the burden of care multi-dimensionally. Within contexts of poverty in Sub-Saharan Africa (Alkire et al. 2020) and specific cases in South Africa where health professionals assumed tasks of lockdowns advisory, individuals with chronic conditions could not reach the clinics (Levine and Manderson 2021). Other examples described localities of the impacts on delivering care due to changes in needs and availability of services (George et al. 2020; Palinkas et al. 2020), while other cases tell stories of movements of frontline health care workers that attempt to raise awareness of new dimensions of care labor at home and workplaces (Neely and Lopez 2020).

Care in Public Anthropology

I felt the burden. In my spaces, I found vulnerabilities in care delivery and accessibility. The following quote resonated: "The structures of social life, government and governance, economics and politics, space and place, shape people's health and well-being" (Team and Manderson 2020, 671). Within my localities, the amplified-due-to-COVID-19 stressors of racism, social determinants of health, language limitations, migration status, isolation, poverty, and underlying conditions affected prevalent depression, bipolar disorders, anxiety, post-traumatic stress disorders, phobias, and obsessive-compulsive disorders among diverse communities, and in particular, Black, African, Latin, and immigrant communities. The emotional consequences of the pandemic and related policies had a significant and concerning impact on women of color in Massachusetts. One of the biggest challenges was the lack of access to mental health care (Massachusetts Commission on the Status of Women 2021).

I wondered how we, mental health care professionals, might be contributing to those vulnerabilities. I engaged as much as possible at my local hospital and with diverse community organizations, other mental health care professionals, non-academic researchers, nonprofits and for-profits members and CEOs, and

governmental commissioners, who were also interested in understanding the quality of and barriers to mental health care. Through regular communication and online meetings, we collectively discussed plans of action involving promoting trust, reach, access, education, and strategies that can enhance effective public engagement and care network systems.

While drafting grants in collaboration with several community organizations to create and support community-based mental health care programs in Boston, I continued thinking about Equatorial Guinea. And now, while I also continue drafting my doctoral thesis given these results and preparing to return to Malabo, I am still unsure about the actions the mental health professionals would take to defy vulnerabilities. This journey of learning and experimenting with care concepts and spaces in Equatorial Guinea has been challenging. What are the ongoing process and outcomes of the mental health professional's care efforts to mitigate social vulnerabilities? How are they contributing, resisting, relating, changing, or desisting? How are they doing personally with their self-care?

My suggestions for further research include a profound description and humanization of interlocutors to clearly illustrate their positions, something I could not do here due to contexts of dictatorship and curtailed freedom of expression, further analysis of research methodologies, deeper insertion into the particularities of care at each site, and the inclusion of all mental health professionals. The analytical frames of ethnicity and gender and the field of "usuaries" and "patients" to understand care exchanges from the receiver's perspective also need attention in this inquiry. Nonetheless, the progress regarding the original focus on mental health professionals, knowledge, expression, patterns of relationality, visions, and outcomes point out diverse trajectories in community and biomedical care. The mobilities and intersections of care surfaced along with online and digital anthropological presence, sudden changes derived from the global surge of the COVID-19 pandemic, and the rotation of identities and spaces.

The mobility and intersections of care in Equatorial Guinea reflected when mental health care professionals experienced the prioritizing of self-care and kinship care, and sometimes care toward me as an anthropologist. At the intersections of bodies and kinship, mental health professionals navigated their skills between personal and work contexts. Care turned into a symbol of identity. Individuals *carried care* and *invested care* in communities. Under volatile conditions, the mental health professionals who interacted with me believed in the importance of their roles to sustain life, always in conjunction with commitment and continuous generation of patterns of relationality and visions between other engaged agents, communities, and institutions (Offenhenden 2017).

Unsure about all the outcomes of mental health care efforts, the learning of care from the mental health professionals at the community shelter and the psychiatric hospital unfolded forms of care: public, community, and institutional. At the onset of (re)discovering limitations and vulnerabilities related to equity, access, and inclusion, mental health providers referred to their ability for care as a tool. Roles and medical agencies can reveal diverse meanings and qualities of care when determined to engage in social development and activism (Murphy et al. 2015), economic-commercial partnerships (Estroff 1985), or both.

Anthropology is a medium to understand human action in our world. Anthropologists offer insights, as I intend to continue doing, about care, histories of care, management and production, and critical assessments (Smith-Morris 2018) because "we observe. We experience. We participate. We write. We find ways to critical insights into situations that seem obvious and tacit. We find ways to engage" (Adams et al. 2020, 461).

The engagement of anthropology in care during pandemic times and beyond suggests the integration of public anthropology. This methodological and theoretical tool addresses public problems in public ways or broad problems through broad audiences. This approach reviews history and identifies significant social issues to ultimately foster transformation (Borofsky and De Lauri 2019). Moving forward, research on care from inside the community shelter and the psychiatric hospital may intersect with public spheres and beyond. Using ideas from digital anthropology, public inquiries can mobilize through flows of dialogic, multicentric narratives (Borofsky 2020) to ultimately offer the possibility of extending relationships in pursuit of common goals (Sanday 2016). These multi-spatial inquiries could look into knowledge production, social entanglements, and local and global regulations about the kinds of care that fight COVID-19 and mental illnesses, definitions of shortages of care, or lack of access to care, inequality, and awareness of forms of destabilization at the institutional and national policy levels (Napier 2020), and the rise of structural vulnerabilities, or "disparities of class, culture, gender, sex and race that impact on individuals, families, and communities" (Team and Manderson 2020). While I continue my research in Equatoria Guinea, I hope to develop these suggestions further.

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