Introductory Points

Kavita Sivaramakrishnan: We convened this roundtable conversation in February 2021 as an informal dialogue among leading scholars, thinking about the current COVID-19 pandemic as a moment of historical convergences. This pandemic reveals persistent, historical asymmetries and inequities rooted in specific histories of mobility and immobility—migration and displacement, capitalism and globalization, colonialism and decolonization. The roundtable emerged from an editorial the CSSAAME editorial board wrote in May 2020 that reflected on the effects of COVID-19. That editorial noted that the effects of COVID were evident in “the intersecting crises of state violence and economic collapse—along with the multiplex failures of governing institutions” that were evident in all the regions that are addressed by CSSAAME’s intellectual project. The pandemic and its multiple, complex manifestations brought “into relief a moment of history characterized by both global interconnection and deep ambivalence about it” and COVID’s flattening, universal epidemiology masked and reinforced “systems of exploitation and brutalization that structure our world.”

The conversation that we have captured here reflects the nuanced and thought-provoking ideas and scholarship of the participants—Banu Subramaniam, Julie Livingston, Omar Dewachi, and Sunil Amrith—who all study the body and biopolitics. Their approaches range across global histories of medicine and science, anthropology, and feminist studies of science, environmental and transnational histories of migration, and studies of war and humanitarianism, but they share a broad interest in the shifting power of the state and in consequences of capitalism. Their discussion and lively debate affirms, questions, and speaks to new directions for research and analysis that emerge from this moment racked by deep moral dilemmas and historical reckoning. At a time when the body is at the heart of debates about controlling, containing, and reframing its viral exposures and epidemiological vulnerability, we see that debates about controlling access to therapeutics and immunity, sustaining rapid economic growth, and investing in productive populations are now more open than ever before.

To begin, we posed several broad questions to initiate a discussion among our participants, and to suggest a common perspective, viewing COVID as having specific stages and developments. Imagining it as having a “life-course” links complex biological and social phenomena, but also reveals how virality is politically perceived and linked to social and historical conditions.

Our questions were:

- How might we consider the link between epidemic and endemic crises, especially drawing from experiences of metabolic risks, embodied pain, toxicity, violence, and stigma that have long and persistent afterlives?
- Epidemics have also long been associated with moments of dramatic, transformative rupture and of social discontinuities. Yet they can also be viewed as generating impulses toward reconstitution and reorientation, as in the case of the HIV/AIDS

COVID Roundtable

Pandemic Biopolitics, Ruptures, and Risks

Sunil Amrith, Omar Dewachi, Julie Livingston, Kavita Sivaramakrishnan, and Banu Subramaniam
crisis and the moral, political, and public health debates it generated and reframed. How might we reconsider this binary between notions of rupture and of reconstitution today in the case of COVID? In other words, how do shifts in notions of a continuous historical timeline also create new possibilities for the future, or of collective forms of futurity themselves? What moral reworkings and realignments may emerge from this pandemic?

- Finally, there has been a deepening of global biopolitics, international and national surveillance mechanisms, and health-security-focused laws that have implications for mobility, migration, privacy, and safety as legal, moral, and biological justifications have often been conflated. How do we understand these shifts now, as well as past and present responses and resistance in the face of such deepening interventions?

In addition to our participants, we warmly thank our observers, Devon Cheney Golaszewski and Valentina Parisi, who joined us and engaged closely, refining, clarifying, and articulating crucial threads of this roundtable. Their support and input were indispensable.

*Banu Subramaniam: Pandemics reveal layers of racialized bodies and dichotomies of biology/culture.* I come to this discussion as a biologist and see the unfolding global life of the virus SARS CoV-2 as yet another lesson about our impoverished accounts of the natural world. Coming from feminist Science and Technology Studies (STS), I see yet another moment of a reinscription of an abstract binary of nature and culture, rather than understanding the unfolding pandemic as an instantiation of racialized nature-cultures. The pandemic reveals rich and layered sedimentations of race: racialized bodies, racial Others—virus and human alike. From the vantage point of feminist STS, the virus is not “evil,” “Chinese,” or “foreign.” It is a single strand of RNA. Planet Earth in 2020 proved fertile ground because of the world created by some human actions, including the increased colonization of the wild, opening new pathways of viruses into human worlds; globalization hubs that transmit goods and people everywhere; and an impoverished healthcare system that renders the virus lethal to some. The pandemic is a racialized nature-culture object par excellence.

In particular, xenophobia and Orientalist discourses have dominated our narratives of the virus and its origins in China. Through the language of “yellow perils” and “yellow alerts” in keeping with Orientalist rhetoric, the virus has been rendered “sneaky,” “cunning,” as “an assailant,” “shifty like a chameleon,” “an invisible enemy that is pure evil,” and called “the Chinese virus,” “the Wuhan virus,” “the kung flu,” and “the anti-Muslim virus.” In India, during the pandemic, there was an international gathering of the Tablighi Jamaat in a mosque in South Delhi. Despite similar gatherings of Hindu groups, this event generated great publicity as a “super spreader” event. It fed already rising anti-Muslim violence, and claims of a “Talibani crime” and jihad. The leader and some others were charged with manslaughter. A year later, some are still awaiting trial.

The idea of the virus as enemy has sanctioned militaristic models of immunity: to fight, battle, combat, attack, tackle, defeat, and defend. Coming from a long history of an antagonistic model, the immune system has been considered military central, commanding a hierarchical organizational structure with weapons of offense (e.g., PPE as “armor,” hospitals as “war zones”), medicines as “ammunition ready for deployment,” and “frontline” workers. These concepts represent a racially stratified militarized force of health workers that is “ready for anything.” These metaphors frame our conception of infection and immunity. Responses have also built on these militarized models, though lockdown, quarantine, and armies of scientists. This is based on a self-other model of immunity that renders the virus as the enemy and humans as victims. In fact, in severe cases of COVID, the immune system overreacts and kills, rather than the virus itself. Something more complex is afoot. I feel like we have taken a step back from the flexible bodies discussed by the anthropologist Emily Martin during the HIV/AIDS pandemic to an older model of conceptions of antagonistic immunity/immune systems.

I also want to talk about how zoonotic diseases are not only ubiquitous, but transformative too.

I am struck by how zoonosis—when a disease moves from animals to human—has been represented as an unusual, dangerous event caused by primitive people living too close to nature and eating weird food. In fact, zoonotics are ubiquitous, and three-quarters of infectious diseases are zoonotic spillovers. Zoonotic vectors, like viruses and bacteria, carry genes across species allowing for lateral gene transfer. Evolutionary biologists have long shown that such events have profoundly shaped the evolution of life on earth, including transferring novel and beneficial adaptations across species.

The same biological populations do not present the same mortality/morbidity in the West (e.g.,
Black and Indigenous populations). Black and Indigenous populations in the West have been hardest hit. The same biological populations in other parts of the world have not shown the same mortality (for example individuals from South Asia and countries in Africa during the first wave have been said to show lower mortality in their home countries than in diasporic populations in the West). Social and national contexts, rather than population or biology, seem to be the key factor.

Further, race emerges as a biopolitical strategy of obfuscation. Some deaths are seen as inevitable and medical languages naturalize and biologize the deaths of marginalized populations in abstract language of “comorbidities,” “biological propensity,” and “genetic predisposition.” This is the repetition of a racialized script during yet another health crisis, while we see little change to health infrastructures between crises.

The language we have used during the pandemic is neither obvious nor inevitable. There are other ways to represent this point: The terminology of physical distancing/cocooning/social distancing have been offered as alternate vocabularies for “pandemic safety.” The continued insistence of alienating language of “social distance,” “lockdown,” and other vocabularies of the pandemic represents an impoverished political leadership, where “physical distancing” became “social distancing.” A robust body politic could have promoted sociality without physicality. This aligns with policy (e.g., bars are open, but schools are closed).

Our focus should not be on the virus, but on systemic issues and oppressive systems that enable pandemics of various kinds. We cannot blame the virus—this misunderstands the role of viruses and bacteria on Earth. Rather, humanity creates a way of life that can render epidemic- and pandemic-prone diseases effective or can help avoid them in the future.

Julie Livingston: I want to address the introductory questions that were a starting point that Kavita posed for us and want to begin by exploring the link between epidemic and endemic crisis in three different ways.

First, the virus helps surface the burden of endemic disease, that is the extant burden of debility and suffering that we accept as the normal “cost of doing business” from the scarred lungs of factory workers and miners to diabetes, heart disease, and hypertension. We know that these underlying burdens of disease map onto political and economic fault lines. This pandemic crisis event shows us an acceleration of “business as usual” in a way that suddenly can’t be ignored. That potentially opens political possibility as well as shuts it down, depending on how it’s framed.

Second, we observe how epidemics produce effects across a wider field of disease in ways both predictable and not. I believe strongly that we need to move beyond “case” and “mortality” metrics with which we are obsessed. The AIDS epidemic is my model—the one I’ve seen up close in southern Africa. What I saw in Botswana was that the AIDS epidemic rebirthed the TB epidemic (although TB had never gone away, but it took on a whole new life as it attached to the AIDS epidemic). The afterlife of the AIDS epidemic helped birth the cancer epidemic. It’s true that some of that cancer epidemic would have happened anyway, but it was given new life through its attachment to the AIDS epidemic. While this is shorthand for complex epidemiological and biological processes, what I want to emphasize is that beyond the surfacing of an extant burden of disease, we also see engines of combination/proliferation of disease, even if we do not know exactly where they are leading.

Third, we can already see this through the rhetoric surrounding “Long COVID.” People have survived COVID with brand-new cases of diabetes, damage to heart muscle, loss of hearing, with many other forms of cascading and prolonged symptomatology. This reveals the impoverishment of our health systems. They are simply not designed around the forms of care and mutuality that are required for well-being by people who are grappling with long-term debility. It also helps reframe the relationship between the economic and the biological. For example, our current systems are predicated on the “worthy” versus “unworthy” in relation to labor, and we find this problem being faced very squarely. We have a long future to come even once infection and hospitalization rates subside.

History (and biopolitics 101) tells us the obvious: the economy and population health are two sides of the same coin, not opposing forces, even though they have been rendered that way in the policy and rhetoric around this pandemic. This rendering is purposeful and instrumentalized; it is a convenient political way to manage opposing forces who have different claims on the state—when you have, as we did in the US, a state that decided under the last administration that it was not going to attend to the pandemic at all. Not surprisingly, in the “not tending to it,” some people made a huge pile of money, even as so many others struggled to eat. We have to pay attention to the dramatic upward-sucking of wealth that this produces; it is not accidental. If we are going to have a large population grappling...
with the sequelae of the virus, some people will also make bank off of their needs. We need to understand those economic interests.

With COVID, we see how industrial practices are productive of this pandemic, just like they have been for many epidemics that have come before it. For example, if we look historically, we can see that gold mining in South Africa produced a massive tuberculosis (TB) epidemic, which is still plaguing the southern zone of the continent. If we look at those industrial relationships under COVID, we can see that the conditions of the possibility are ongoing. Public health needs to be more focused on the upstream causes of these pandemics, including how human action transforms and harms the environment in dramatic ways. We created the conditions of possibility for this pandemic through our industrial practices, which combined the enclosure of some of the last wild places, the evisceration of wild forests, and broad-based industrial agriculture. There are long histories of this—such as sleeping sickness in the Congo in the early twentieth century, when people were driven at the point of a gun or machete to collect wild rubber in environments that they knew were unsafe. There are many other cases. Remaining wild habitats are complex and under pressure; they house potential zoonotic pathogens, and when agribusiness cuts the forest, it allows those pathogens to move into closer proximity to humans and domestic animals. We saw that with the fruit bats associated with Ebola, where multinational corporations are undertaking a massive land grab in the Mano River region. This dispossesses the people who held customary tenure, but it is also terraforming in ways that pressure wild habitat.

Parallel to that, when pathogens enter our industrial meat industry, this also reflects transformation potential for epidemic/pandemic-prone disease because of the fact that animals are bred to be genetically similar, with an eye toward market preferences. This is dangerous to us as well as to the chickens being bred to have more breast meat for sale. In agribusiness, we manage those effects through pharmaceuticals and chemicals, which feeds back into the problem, while also creating an incentive within biotech. So, you get a market for the materials that can tend to the problem caused by agribusiness in the first place. We are encased in a profit cycle. If we look at flows of wealth, we see elements of the profit cycle. I am not saying I see someone behind a curtain directly trying to create a disaster for profit. But these systems are built with internal contradictions and great money and power, leading them to develop patterns that are hard for any one person to break.

Public health needs to move upstream and “name” this system and not allow what Banu pointed to—the obfuscation of this system by an attention to rhetoric, much of it racist models (such as exoticized attention to “wet markets”). A similar process of racialized obfuscation occurred with the “cut hunter” thesis around HIV in West Africa. These are easy to turn to because we are saturated with the racial models of causation, but public health must resist this. My own name for the system is self-devouring growth.

Finally, on the subject of rupture and continuity/possibility. It is hard to tell. I think that the National Health Service (NHS) in the UK might have been saved by this; we see with the NHS, that if you have a public health system, you can actually possibly accomplish some things, but that you cannot with the piecemeal privatized system that exists in the US. We have seen though that citizens in the US got a basic income grant—that was surprising for this country. The existence of a non-labor tied basic income grant, albeit it temporary, was a political occurrence that was quite surprising. We see all kinds of new possibilities out of the pandemic—just as we do out of the Black Lives Matter movement, or in Nigeria, the protests against the Special Anti-Robbery Squad (SARS). But we also see the hardening of borders, intensification of limits on migrants, a looming food crisis, and new forms of police brutality for the management of the pandemic in Johannesburg, Nairobi, and elsewhere, and we also see the upward sucking of wealth.

We also do not see a vaccine commons, but instead are yet again governed by a private property/secret knowledge model of the vaccine. This contributes to competition over supply, vaccine shortages, etc. It’s really bad public health. Really bad. And yet the US and Europe just doubled down and refused the TRIPS waiver to allow generic manufacture of the vaccines for distribution to low and middle-income countries.

Omar Dewachi: To address this discussion, I am going to offer more of a local and regional perspective, mainly from my work and research on medicine and public health in conflict settings in the Middle East. Over the past decade, I have been documenting the “unraveling” of biopolitics in the Eastern Mediterranean states through documenting the human experience of health care, displacement and state breakdown under protracted conflicts, and the transformations of what we could call “local biologies” of these interconnected geographies. While there has been a lot of attention to how the pandemic has reinforced forms of surveillance and biopolitical models, I see, in this region, the
unraveling of biopolitics and potentials for surveillance. Increasingly, the body politic has become more and more ungoverned.

With this perspective, one of the things I see in the region is a continuation of a “biology of history” in tandem with the breakdown of health-care infrastructure. For example, the rise of antibiotic resistance in different warzones/conflict areas in Iraq, Syria, Lebanon, Yemen, and Libya. What is really disturbing is the way that COVID-19 has sped up antimicrobial resistance processes in these areas contributing to seeing intertwined epidemics. We’ve seen in the context of war and political instability “anarchy” in terms of antibiotic use and breakdown of sanitation inside hospitals. This is accelerating under COVID, mainly because ICU units are becoming clogged with patients and there is considerable and haphazard use of antibiotics and antimicrobial agents. Thus, the clinic has become increasingly toxic.

Before COVID, there was considerable movement of patients seeking health care across national borders and therapeutic hubs as patients dealt with collapsed health-care systems in their home countries. Iraqi patients would go to India, or Iran, or Turkey for common medical and surgical procedures and to seek medical care in a stable health-care environment. Now COVID has limited that movement of patients. At the same time, there is widespread death linked to antimicrobial resistance inside hospitals dealing with the COVID crises. When I investigate these deaths, I get the impression that the majority are dying from complications from hospitalization, mainly from sepsis, or blood infection with antimicrobial resistant bacteria. This problem varies from one place to the other and depends on the layout of the country’s health-care systems. One interesting example is the comparison between Lebanon and Jordan. Jordan has a health-care system that depends on small-clinic systems, rather than big hospitals. In the case of COVID doctors also provided medical service to patients in their homes. In Lebanon, hospitals are the main care facilities, and this is where you see more cases of death resulting from a dependence on a failed and toxic hospital-based care system. All of this is compounded by the financial crises and the environmental toxicities that have contributed to increasing rates of cancer, which are affecting younger populations more aggressively than before.

With regards to the second question, one of the things that happened before COVID was multiple social uprisings in places like Beirut and Baghdad (not to mention the fact that the Syrian conflict has been going on for nearly a decade). When the virus erupted, these protests were in full gear.

In Iraq, COVID has been dwarfed by broader political misery and violence. Since October 2019, six hundred people have been reportedly killed and between 9,000 and 25,000 injured in one year of nationwide protests. Assassinations and kidnappings are ongoing and recently there has been a return of suicide bombs. Protesters in the street through their chants and slogans equated the pandemic to the deeply seated “political corruption” under decades of post-occupation militia rule. In fact, demonstrations are articulated as biopolitical demands for the state to better regulate “life” (provide health care, clean water, electricity, and a clean environment, for example). In this context, a *laissez-faire* attitude has emerged regarding virus control/management (although the country was one of the first to close the borders). Religious events are continually happening, because the state cannot control religious militia parties that draw support from these events.

Where do we go from here? I think the Middle East in general is going to be facing a bit of an existential question over health systems that were built over decades of the solidification of the nation-state. What we’ve been witnessing since the 1980s and 1990s is the implosion and collapse of these infrastructures. I am not very optimistic of where things are going, and I am also trying not to project or speculate into the future—a phenomenon that has become accentuated in political and scientific discourses about the pandemic with all kinds of modeling exercises. But we really don’t know—there is so much unruliness and confusion as the “contagion” unfolds as a biosocial artifact. Having said that, in the Eastern Mediterranean, there needs to be a serious biopolitical reckoning through the restoration of the body politic and newfound respect for humans and the environment.

*Sunil Amrith*: On the life course of epidemics, I was struck by how this pandemic was simultaneously utterly predictable and shocking. At least in a small way it has torn a hole in the sense of insulation among the privileged in the world, who have viewed themselves as “immune” to such risks, and the rest of nature. Of course, there are many, a majority, for whom such insulation has never been an imaginable possibility. So much of the commentary in the US—but also among the privileged sections of countries across the global South—has been, “How could this happen to us?” I have been sitting with
that, and what it makes visible. What it ought to make visible is the “endemic epidemics,” or the tentacular “epidemic of environmental risk” (as Kavita and Julie have noted). What has been made visible instead is what Banu spoke about: a predictable “geography of blame” with fault lines around migration and the racialization of public life.

What is unprecedented here is maybe the response. There was an interesting intervention by Adam Tooze early on in the lockdown, arguing that this pandemic has blown up our basic expectation that the interests of the economy would always trump everything else; or the fact, as Julie mentioned, that for three months Americans had a guaranteed basic income, which would have been very hard to predict. Although it may be more complicated than that—as Julie noted, we have still seen the transfer of wealth to the very wealthy despite what appeared to be a series of health measures that struck at the heart of certainly many corporations’ business. How do we account for the nature of the responses we have seen?

On the subject of transformative rupture that Kavita posed to us, as a historian of South and Southeast Asia, the parallel for me is not to a past epidemic, but to the Great Depression in Asia. That’s the last time in Asia that you see sudden and total transformations (even reversals) in migration flows between South and East Asia. The depression ended the expected normality of circular migration to and within Southeast Asia for the next generation. After a period of fifty years (starting in the 1870s), when the number of new arrivals from India and China to Southeast Asia always exceeded the number who left, migrants were deported, or chose to go home, because the conditions on which they had built their migratory lives were no longer tenable. The long-term consequences of that were not foreseeable, but for a generation, the patterns of migration, attitudes toward migration, and the possibility of migration were transformed. I wonder if we will see any change in attitudes toward and practice of migration following this pandemic. In the 1930s, the Great Depression shifted attitudes in the countries of migrants’ origin as much as in their destinations. Until the 1970s, for example, the Indian government was very hostile toward overseas migration.

Then there is biopolitics and surveillance, and I think Singapore provides a good instance of some of the dilemmas at work. Singapore appears exemplary at first glance in terms of pandemic control—and in many ways, it has been. But in Singapore, probably more than any other place I know, the concentration of the suffering in the lives of migrant workers has been so extreme. There have been very few cases outside the migrant labor community, but within it has been hit very, very hard. In April 2020, 40 percent of migrant workers were testing positive, at a moment in which there were very few cases overall. In Singapore, the very rhetoric of “community cases” excludes migrant workers. They are not considered part of the “community” despite the fact that there are close to a million of them resident in Singapore. Additionally, these migrants continue to live in isolation, while for others, things are opening up. Migrant workers can leave state-sanctioned dormitories only under strict conditions—they must get permission to leave their dorms for just a matter of hours to undertake errands. While Singapore did not deport these workers like other countries did, the state increased its surveillance of this population. There has been a big debate about this: it has also led to a powerful critique from civil society groups in Singapore of how migrants have been treated, and—at best—has created new spaces of solidarity and empathy.

I am also struck by the geography of the pandemic. The countries that “did well” are almost entirely in East and Southeast Asia (with New Zealand as rather an exception). This is not about democracy vs. authoritarianism—as it has often been portrayed in the Western media—but rather about different relationships between states and citizens (Julia Adeney Thomas has made this point well), and higher levels of trust in both the state and expertise. This is where what Omar said struck me, perhaps it explains it. I think we are looking at the contrast between those countries where biopolitics is unraveling—including the US—and those where biopolitics is inscribed in everything. This is not about democracy versus authoritarianism, but different historical trajectories. Countries that have done very well, like Taiwan or Korea, all had their moments of economic growth at the moment of the birth of neoliberalism, but they are also shaped by longer historical trajectories, such as histories of Japanese colonization and forms of colonial medicine and health surveillance (compared with say the British in India).

Open Discussion

On the Unraveling of Biopolitics

OD: It is interesting that there is a current shift in global health discourse around health-care systems with an emphasis on universal health care as opposed to decentralization. This has become tied to conversations about
which states are succeeding and which are failing in response to the pandemic. These questions have critical histories and genealogies. Health care became a central problem for state building in Iraq during the twentieth century under the British mandate. At first, the British goal to create a unified health system was resisted by a call for decentralization, but then the Health Directorate, under Iraqi-British doctors, used the cholera epidemic of 1923 as a political opportunity to argue for a more centralized universal health system and a platform for state building. Even during moments of crisis, such as the 1980s Iran-Iraq war, state biopolitics became consolidated, with decreases in infant and maternal mortality during the longest conventional war of the twentieth century. However, since the 1990s, during the Gulf War and international sanctions, we saw the unraveling of this biopolitical state. This continued after the 2003 US occupation—as both doctors and patients were leaving Iraq. We see various processes of deregulation and various processes of the “undoing” of biopolitics through violence and war (Syria is another example—it used to produce all of its pharmaceuticals, and now they are being imported). Thus, we witness a different trajectory of this health care “ungovernability” with war and international interventions (sanctions) contributing to the dissolution of the biopolitical state, as opposed to neoliberal processes in other locations in the global South.

COVID is a shock to neoliberalism, to the emphasis on deregulation, privatization. This of course has been going on in the US—you can register anywhere to get a vaccine, and no one will follow up! For me, a lot of concepts, including surveillance, become problematic when things don’t really work as we would imagine in the abstract. There is much more chaos on the ground than we think. I think these different processes of undoing biopolitics are important to trace and follow. The local and regional become very important for thinking about how places are connected and disconnected, how history unfolds in the realm of biology, not merely in the realm of politics and economics.

JL: What Omar says is really interesting. I want to think about this lumpy space between the “retreat” and “intensification” of biopolitics. The US carceral system is very adept at tracking/tracing and capturing people, but can’t decide how and when to harness that to public health. Or, based on my limited knowledge about China, we see a biopolitical system that can be remade for all manner of different ends—within reeducation camps to which Uighurs are subject to and counter that, the ability to test all of Beijing for COVID within two days or the response in Wuhan. (Sunil’s link to Singapore is interesting here, too, and we also see this in Israel, which has been getting attention for a good response, despite the giant “donut hole” in the vaccination policy, which ignores the existence of the Palestinian population.) The withdrawal of the biopolitical is about more than neglect; it is part of a larger, more complex system of management that takes into account the “lumpiness” of the population, which is composed of various subpopulations, and reacts to them differently. How is the economy constituted in relation to this? Africa did not present many cases, but faced horrible effects in relation to economics/lockdowns and the enforcement of these by security apparatuses. Some of these measures took place in places without a single case at that time. If you look at the epidemiology in Africa, it is very uneven. South Africa is devastated, which is awful for people there. And it’s not that there is no COVID in Eswatini or Botswana but they have had very different experiences and places like Senegal have been managing COVID extremely well. Yet, there are also similarities in biopolitical management between these places because much of their biopolitical management has already been captured by the global health apparatus.

KS: I think what everyone is bringing out is a new form of biopolitics that is malleable and quickly reconstituted. Is it receding, or is it reconstitution and is it even to be imagined and associated only through the state and its bureaucracies that are in crisis? Simultaneously, what are its more flexible and malleable forms: the pervasive power of global health bodies and the medical-industrial conglomerations? We can see the state and big capitalistic networks easily adapt to these changing situations. That’s the real “immunity”—the political and economic immunity they have had to any of these shocks that the rest of the world has been facing. In some cases, like in India as Banu’s work has shown, it has reinforced the kind of fascist work of the state. There is a malleability to these biopolitics. It is not just the crude visibility of various forces, but what is also not visible.

BS: I also wonder about what narratives are being told? Who tells the narrative? Which epidemiological/economic models are championed, picked, and transmitted? In India, many people living in gated communities don’t step outside of their homes; the food comes to the gate. But of course, there are people outside of the community doing the shopping, delivering
the food. This is also true in the United States. In many places there was one narrative about how we should solve the pandemic—via lockdown and quarantine—but as Julie just noted, this model presented a choice between economics and health. In wealthy countries, the government was able to economically support the population. But in countries like India, where this was not done, such responses severely affected the poor. In fact, India doubled down on a more stringent model of the lockdown than many wealthier countries. I am surprised that few countries had a different model, even though epidemiologists in India, for example, suggested other models. People dying of starvation is not any worse than dying of COVID, and political leaders should think more expansively about the health of the population.

JL: One example is Sweden, which became a cause célèbre because it did not lockdown. But, at least in the US, the question is, Why is “lockdown” not linked to the redistribution of wealth? There is so much money in this country. The idea that the choice was between lockdown or no lockdown—is this a false option. Why wasn’t money automatically attached to lockdowns and restrictions and then directed to impacted businesses, like restaurants? Why wasn’t lockdown undertaken through necessary redistribution of wealth, especially as people are making money off of this pandemic, Amazon being one example? Why not give this money to people who need to pay their rent? Instead there were loans.

KS: A diverse and linked global middle class is also complicit in this, not just characters like Jeff Bezos/Amazon. It’s amazing that across the world, people have decided that some bodies will take the risk—we’ll apportion it to them—and there are others who will not take the risk. This of course has a long history in studies of medicine in industrial settings (e.g., mines where for the sake of “development” some people can shoulder this risk). In Delhi, for example, those employed in daily wage labor know that COVID is a threat, but will say things like “my child is coughing every day due to pollution around us”; these enduring, lived risks are deadly, and are compounded by COVID. But we have decided there is one disease we want to focus on, and this is a choice that is made through decisions to shut down (and ignoring chronic diseases). There is also a hierarchy of risk. For the keeping of a “global order,” the middle class is willing to forgo structural changes (like shifts in apportioning welfare) and sacrifice others. People might post things to social media, but they are not mobilizing—allocations in budgets for education and health remain the same.

SA: I wonder how the very language of “social distancing” shapes our capacity for solidarity and action. Even those of us who don’t live in gated communities have in some ways created a sense of isolation around ourselves, so that the delivery workers come “to the gate.”

KS: It is also ironic to see in places like Africa and Asia the advertisements of “no-contact delivery” where contact is often integral to daily life and to the range of services people are used to receiving.

JL: I do want to push back a little bit and say that this summer, what I saw in the US and beyond [in the BLM movements, in Nigeria in anti-SARS protests] was that many people poured out into the streets, putting their bodies on the line and saying, “No, I don’t accept the status quo; I want this changed, and I am willing to at least show up.” When we put this alongside what you are noting about the global middle class, we can ask, what would the mechanism be for the global middle class to intervene in effective ways? If you are called to the street, will you go? What would the demand be? What is the mechanism? The strategy? In addition, the systems we have been describing are totally corrosive to the political process.19

On the Role of the University

BS: Can I bring that question “back home” to ask what is happening at the level of the university? In the case of the university, we have seen widespread job cuts, budget reductions, and other issues. Administrators seem to be using the pandemic to enact policies they have long wanted to make—for example, it is widely speculated that faculty and staff who decided to take generous packages for early retirement likely will not be replaced. Post-pandemic many departments find themselves with fewer faculty, and staff do even more work given the additional needs emerging from the pandemic. It is unfortunate that this moment did not become a rallying cry to get more money into higher education. What could and should universities do? How might we use this moment to strengthen rather than decimate higher education?

OD: We have the same problem at my state university. However, our union has been pushing back. I observe new attention to racial justice and language of solidarity, but in a way in which the administration says, “We will only fund talks on racial justice and COVID, and all the better if your talk can do both.” This “competition” of sensitivity has created a weird environ-
ment that has limited some dialogue (i.e., reactionary posturing; everything needs to be “decolonized”). Discussions around diversity are rooted in American concepts and experiences of race, and it is surprising that international students are not fit into these categories, from the perspective of someone who is from the US. I agree with Banu that the university has used this crisis to do what they always wanted to do (including an overload on faculty and cutting of staff, and an extraction of labor); where are the indicators of “financial crisis”? What can we do as academics? We will have to give up our jobs, perhaps.

SA: I also see this as a turn inward. Many discussions in the university are related to US issues (and US history and issues of racial justice), and this is clear in hiring and student recruitment. This to some extent mirrors the accentuation of borders across the globe.

KS: Even in classes, there is a flattening of debates and ideas at times, as in how students see the past through these experiences. Some students are tying nineteenth-century plague politics and caste to the experience of race in the US during the twentieth century; the comparisons show that they are interested, but historical experiences and realities are more complicated. With regard to Banu’s question, there have been funding crises with grad students. COVID-19 has been a big excuse for administrators to do what they want, and no one really has the full picture of the fiscal and administrative crisis. This is also a problem of access to information and knowledge. Even if you’re on a finance committee, you are told, “It’s COVID.” As social scientists we can be hesitant to propose forecasts, futures, as easily as some other disciplines like epidemiology that are confident in predicting the future. But we sort of abandon public knowledge-making to them. This also opens the reality that some see this as an opportunity for new funding sources.

JL: I agree that this will further the ongoing marginalization of the humanities, and further accelerate the turn to other disciplines as money-making and the idea of the self-funding university. There is an unevenness to how this plays out within the university. But it does not appear to be causing a rethinking of managerialism, or of running a nonprofit institution as though its tax-exempt status marks a primary responsibility to public benefit. Political possibilities may be tied to debt relief for higher education debt. But it will depend on the amount. If people have significant education debts erased, that will have a meaningful effect. I also see another political possibility, though more ephemeral, in the undercommons, which I think are bustling with activity right now. While the fortress has its eye on other things, the undercommons is a hive of activity.20

BS: Also striking is the question of university endowments; why won’t universities touch endowments? Some people describe it as a “rainy day fund” and other people say, “It’s pouring!” But those things become sacrosanct, and the narrative is that we must weather the issue on the backs of employees. Additionally, we’re asked to promote the narrative of normalcy and create the illusion of normalcy—that classes are going on “as normal” and our task somehow is to create that illusion.

JL: It’s also so infantilizing to our students, and missing the opportunity to hail them as members of a polity. To say, “Look, this is a difficult moment in which many people are going to have to work together, and we should create mutual aid or mutuality, knowing that different people will have different needs and resources,” in contrast to the idea of students as consumers, who are purchasing as close a proximity as possible to “the normal” experience, despite all that is going on around them.

The Question of Data, Science, and Public Trust

BS: One thing I have struggled with is the question of data. What countries are putting out versus what people on the ground are saying, and how to make sense of it. Are we seeing innovations in the theorization of data and inequality?

SA: Are there new practices that are emerging in this moment to address gaps in the infrastructure of epidemiological knowledge gathering?

KS: I am thinking of different kinds of virality in terms of communication across the globe. People don’t rely on what is a formal channel of surveillance or information. We see other social modes of thought that are transmitting about the virus, regarding surveillance, regulation, and control. This also shifts how we interpret and accept expertise of who has data and how they communicate it. In somewhere like India, how you look at someone who is in public health as an authority (or a scientist with data) has shifted. We have such a politicization of expertise. Whatever data is being shared by the state, people—including colleagues and scientists—do not trust it. There is a set of fractures of disbelief and believing in alternate channels of what you’re told as credible. How different is this from rumors in historical pandemics.21

JL: It is interesting that this is coexisting with the rhetoric we keep hearing surrounding “trusting” the
science. But meanwhile, it looks like science and as we know, it’s a messy process. But it is fascinating, this juxtaposition.

SA: It is interesting because in other realms, we have seen other practices—look at community mapping projects and citizen science when it comes to climate data. We are seeing these different initiatives, like measuring water flow and mapping common property rights in parts of India. But I’m not sure if there are alternative pandemic maps being generated at the community level, especially in terms of the invisible or protracted consequences that you were mentioning earlier, Julie. Are there other ways of representing this pandemic that move beyond infection and mortality statistics?

KS: There are more efforts to map loneliness and spatial disjunctures among older populations, in places like Chennai. This is moving beyond morbidity and mortality, looking to recognize other kinds of suffering/pain that hasn’t happened before, especially as mental health and trauma are more publicly acknowledged, though not necessarily treated. This includes the role of caregiver stress as the pandemic stretches on from wave to the next wave. Telemedicine also links into this, allowing more flexible access to treatment for those who have the means and portals to pay and secure this connectivity, and medical experts can now get certain kinds of medical data that they would not have had access to about patients and their care-seeking behavior and needs. You can keep tabs on peoples and numbers, but also explore new avenues of vulnerability. This also gets taken up by the private sector and is in turn compromising, because all of the data is shared through corporate structures, such as the sale of phone numbers in India.22

Creating Immunity, Immune Bodies

OD: I think the issue of vaccination is also paramount. How will vaccines be rolling out in different places? In Jordan, for example, there is the option of different vaccines, and people are opting for the Chinese vaccine, as there are many rumors about the Moderna vaccine also circulating (regarding its efficacy and its use as a tool of surveillance). We are going to see lots of rumors about vaccines.

KS: Is there a difference that people make between inherent immunity and induced immunity? I have been seeing a tropical medicine trope but reversed! The idea that these are bodies that are resistant to cholera and sleeping sickness, so let them work in the plantations. In India, this narrative is recurrent, reclaimed but reversed and exposure to heat, dust, and chronic infections was supposedly providing positive benefits like immunity to COVID.23 Claims to immunity (by those who have already survived famines and other infections) could be the only way to live in a daily life of insecurity. I find this discourse surrounding immunity is problematic in the global South and in the US, too, with rumors and racialized assumptions that African American populations are immune, or wouldn’t get COVID in the same ways.

SA: Yes, I think we do see the reversal and reclaiming of tropical medicine discourse. I have seen a lot of commentary to the effect that COVID is really a disease of the global North, asking why, then, the global South has still been pressured by the global health establishment to take these drastic measures. I’m a little skeptical of this—it seems to me that the global health establishment has had very little influence on the policies adopted by specific countries in the global South, especially larger ones. Some of this contrast has been justified by a return to the idea of tropical climates, and natural immunity based on climate. Another example are discussions around the BCG tuberculosis vaccination, and its presumed protection against COVID. This has not been demonstrated in any clear way, but it has become a matter of “common sense” in places like India.24

BS: But it hasn’t helped those with BCG in the West! Indians in the US or the UK, for example.

KS: Or Asians and people of African descent in the UK, who are dying in much larger numbers than other groups. There is a persistent focus, as we discussed, on expert-generated data to identify mortality, and making COVID out to be a pandemic event that is discontinuous from the past and an exception.

JL: We can also see this in the context of Latin America—where the pandemic has been extremely intense across a number of countries, health systems, and political systems. It throws into relief the unpredictability. Why did Ecuador look the way that it did? We think we can explain Senegal, or Vietnam . . . certainly we can see the strength and intelligence of their public health systems, but I am not sure we can account for the successes yet. And then some places do well for a long while and then get slammed. There is something unpredictable that we can’t fully grasp yet.

OD: Early in the pandemic, we saw all of these different theories about certain populations being genetically more immune; there were lots of folk theories emerging. One thing in Iraq, which you might assume was one of the worst places in the beginning, actually in the early
period was not (the incidence was low). One thing we can pose is that it is a younger population, as is much of the Middle East. Another element is that Iraq is not a travel hub, unlike some of the earliest hit places. But even that eventually changed. Then we saw a folk theory about immunity, with a religious element surrounding immunity and protection. People would say, “Imam Ali can protect me at the end of the day; Imam Ali is stronger than the virus.” So, do you go for the ziyara or pilgrimage or not? Many religious leaders are telling people, “If you go for the ziyara you will be protected. Or if you die on the ziyara, that would be the most gratifying form of death.” Various theories map onto wider uncertainties; this ties to how people relate to and understand death. There are many interesting sociological questions here to explore.

KS: This comes up historically—that the cholera won’t kill you on your pilgrimage. I’m also thinking about other forms of practices. There is no perfect form of knowledge. Biomedicine emphasizes generalizability and scaling up, but that is not a priority in other forms of healing like ayurveda. Something about biomedicine makes you have to think about perfect knowledge.

JL: It is interesting to think about how this relates to the “global” and the “specific.” We imagine COVID to be a single pathogen, affecting individual bodies with a relatively straightforward set of symptoms. Bodies may vary by age, preexisting conditions, gender, and so forth, but these are minor variations of a “universal” body. Yet everything we see shows us that this is not the case. There is some kind of localization to it. You want to go back to local biology to think it through. I am not sure where it leads. I will say the turn to indigenous medicine reads differently in southern Africa due to the experience of the AIDS epidemic. With a “Northern-bred” pandemic, which is now expressing itself in the bodies of people in the global South, it may be that some of the medicines that have been developed in the South to tend to health problems that are differently conceptualized or differently experienced within a different metaphysics may not be where people can find their primary solution (and this is not a criticism of indigenous medicine).

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Notes
5. Martin, Flexible Bodies.
7. See Lyons, The Colonial Disease.
8. Livingston, Self-devouring Growth.
10. See Dewachi et al., “Changing Therapeutic Geographies.”
12. See Dewachi, Ungovernable Life.
13. See EASO, Iraq.
15. I have written about this in my Crossing the Bay of Bengal; see also Baker, “Economic Reorganisation and the Slump in South and Southeast Asia.”
16. See Beech, “Singapore Seemed to Have Coronavirus Under Control.”
17. Thomas, “The Blame Game.”
18. See Dewachi, Ungovernable Life.
19. As our participant Devon Golazewski pointed out, “Another example of this is in Brazil, where the voter participation in elections dropped, as people from the middle class feared going to vote in person. But at the same time, going back to the much earlier point, Brazil was a place that did an even more expanded version of a basic income grant.”
20. Harvey and Moten, The Undercommons.
21. Devon Golazewski: “I also think we have to take into account the relationship of the state as credible or otherwise. In the US and Brazil, it was clear that state leaders were actively not putting forth safe information about COVID, to the extent of the crowd-sourced data from Florida. In places like Mali, there were active antigovernment protests, which supported a coup d’etat last August. The crisis of expertise in COVID was connected to other skepticism of the state.”
22. DG: “In New York, mutual aid organizations which developed could provide forms of information, especially about other kinds of insecurity like food insecurity sparked by the pandemic.”
23. This was a grim and cynical assumption, leading to the neglect of induced, vaccine-based immunity and vaccination campaigns in many countries such as Brazil and India, and state authorities mostly abandoned citizens to their own personal initiative and social networks when the second wave returned with deadly consequences. Collective pain, suffering, and remembrance are still evolving in their expression, to understand and memorialize how societies ruptured and lost, in ways that are common with past pandemics such as plagues, AIDS, and SARS, but also marking a different historical conjunction.
24. This was the case at least until the devastating resurgence of the pandemic in India in April 2021.

References