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History of Epidemic Response in South Asia: Challenges and Lessons for Covid-19

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Abstract

The experience of Covid-19 and the efforts made by countries in South Asia to control the number of cases is reminiscent of colonial policies toward the management of cities, epidemics and public hygiene. Although new technologies of surveillance to contact-trace populations have emerged, the dispensing of care through the use of the law enforcement shows the interrelation between medicine and violence. The lasting legacies of using cities as the locus of public health interventions during colonial times shows how closely questions of health and citizenship are linked in contemporary South Asia, with lack of adherence to health protocols resulting in the stereotyping of social groups based on religion, race and ethnicity who also increasingly experience police brutality. The management of the city historically reveals the nexus between global capitalism and international humanitarianism operating through the post-colonial state. These organizations co-opt the state in devising frameworks of disease eradication based on the idea of making economically independent individuals as the standard for health. The article considers how such histories can allow us to reflect on the short-comings of government policy in the ongoing pandemic in South Asia in order to move toward pro-poor emergency responses.

Keywords: Covid-19; Colonialism; Epidemic; South Asia; Humanitarianism

Abbreviations: DOTS: Directly Observed Treatment Short Course; AIDS: Acquired Immunodeficiency Syndrome.

Introduction

Colonial Pasts

In Colonial India, public health emerged in a very different way compared to many other countries. There was a fundamental distinction between the colonizers and the colonized, which shaped the imagination of the latter as a diseased or a healthy population. This binary logic was possible because the British had attempted to produce knowledge about social groups through classification based on race and ethnicity, which led to disease classification being inadvertently impacted by treatment based on the social characteristics of the group and the geographical location [1]. The cholera epidemic brought colonial India to global attention as the disease spread to Europe and then to North America [2]. The spread of the disease represented in some ways the failure of the British to show their responsibility toward the colony to the rest of the world. It also showed its failure to keep the disease within its own frontiers. This had led to a shift from health as a concern only for the soldier to being considered as a concern for the integrity of the empire and the wellbeing of its people. Just as there was a

move to make health truly public, there was another shift to retain earlier classifications to consider the susceptibility of the populations to illness. At the same time, there was a shift not only to secure the cantonment or the city as the site for intervention, but penetrate the domestic or the zenana which remained a entity bounded off, and thus out of colonial efforts to discipline populations through their concern for the maintenance of its people's health [1]. One example for this is that there were many social groups which provided men as soldiers and were referred to as martial races, and were thus considered less likely to develop mental illness [3]. For this we have evidence from 20th century asylums which show the differential treatment provided to patients based on class background [4]. Orientalist logic was used to understand the environment in which people lived and their indigenous treatments, but this interest in understanding local cures was put under pressure, as political rule was consolidated in the aftermath of the war of independence of 1857 [5]. Colonial cities embarked on a process of urban reform, creating spaces in a fashion such that cantonments became sites for surveillance and the monitoring of populations whereas inner cities continued to be represented as places of chaos and savagery [1]. The concern over health was inadvertently tied to the new ways of envisioning colonial space. Cities like Karachi have experienced similar moves even after partition as in the Greater Karachi Resettlement Plan through which the poor were pushed to the outskirts of the city [6]. In recent days Lahore, another major colonial city, has experienced a similar move as attempt has been made to make poor housing more attractive by painting them with murals for a consumer who is arguably foreign. In terms of agriculture, in much of Punjab the British divided agricultural lands into chaks [7]. Even in rural areas, the person who owned land and offered himself for service to the Raj was considered the archetypal colonial subject. However, those who did not have any claims to property, and did not even consider their relation to property as the British authorities deemed necessary, were referred to as criminal tribes, who were provided an opportunity to reform themselves through ownership of land and service to the state [8]. Criminality was thus a category defined biologically, but the possibility of reformation made it a social one which one could easily undo through dedication to the empire. Thus the aim was to generate aspirations and desires instead of simply turning populations into docile subjects. At the same time of course there were changes taking place in the overall hygiene such as the shift from the concern the safeguard to soldier's health to a concern about reforming the colonial city. This entailed that all sanitation works were revitalized and the logic of cleanliness was increasingly commodified [9]. The management of the city provided key components of the British policy regarding health. One could not just be subject to health interventions or discipline but needed to consider himself a colonial subject and have the desire to claim citizenship by affirming himself as a "healthy" individual. Ashis Nandy argued provocatively that to be a subject of psychoanalysis, one also had to be a colonial subject [10]. The question is: what is this history even important? How can we use this history to reflect on the situation of the ongoing pandemic? How do global disease response and the approach of post-colonial South Asian countries to mobilize public health infrastructure bear lasting colonial legacies, even when steps taken by all three countries, India, Pakistan and Bangladesh have been different? The similarity perhaps is the failure to employ a pro-poor policy.

Indian elite in medical and political spheres first emerged in colonial Bengal. After partition and before the independence of Bangladesh, the region's relative independence from the same colonial structures in central or northern India in the form of the paramilitary had enabled it to contest the power structures of then known Western Pakistan [11]. Recently, both India and Pakistan have been going through an economic phase which I consider to be rather similar. Both have been experiencing aggressive liberalization, inflation and poverty, in addition to the plethora of health problems including but not limited to malaria and tuberculosis as the most urgent ones. Pakistan has even been among the three countries in the world to still have incidences of polio infection. The impact of rapid liberalization has seen its after-effects in the recent farmers' protests. The protest was a result of the state's attempts to bring prices to the market rates without any safety nets. Pakistani economy too has been under enormous pressure to repay debts and comply with the regulations of the global financial institutions such as the Financial Action Task Force as well as to repay its loans to countries like Saudi Arabia and UAE and organizations like the IMF. Under extreme economic instability, the experience of Covid-19 has been tied not just to the high caseloads but more often to the greater risk of hunger and extreme precarity. In both Pakistan and India, patients with chronic conditions faced acute symptoms due to the loss of income during the government-imposed lockdown especially within urban settings.

At the same time, both countries have overall experienced an intensification of disease surveillance which has often been followed by cases of police brutality. Minorities such as Christian and Shia communities in Pakistan and Muslim communities in India, most notably the Tableeghi Jamat, have been viewed with suspicions as being the cause of the rising number of cases due to their high mobility and neglect of the SOPs. These groups have been scapegoated for the countries' failed health policies. This shows the link between citizenship and the ability to be a compliant subject of the government's pandemic response. Although the government has employed many new techniques such as complex forms of data analytics to contact-trace infection,

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it has nevertheless retained the logics of colonial sanitation and hygiene. Even smart lockdowns employed by the Pakistani government have involved policing entry and exist of movement within cities through check-posts. The decision to impose a lockdown is taken by the police superintendent based on the evidence of an increasing number of cases. Both countries rely on the Epidemic Diseases Act of 1897 through which resistance to quarantine and non-cooperation with health officials was punishable by law. This was first invoked during the outbreak of bubonic plague in Calcutta and Karachi. The lasting legacies of the Act have been the exclusion of symptomatic cases but also the screening of asymptomatic cases who would be required to carry proofs of their testing, as in the case of the Maharashtra government stamping the left hand of all those who have been sent home to quarantine with "indelible ink as a means of curbing the rising trends of fleeting suspects." In 1897, plague patients in Karachi were disinfected in wooden tubs by authorities and even this surveillance was selective as in the case of the Central Provinces where the Chief Commissioner told not the detain all third-class passengers, but only those "regarded by reason of their appearance, by customs or dirty conditions of their clothes and effects" [12].

Global Disease Control & Post-Colonial States

How do we use colonial histories of public health to reflect on the Covid-19 response in each country? To answer this one must also consider the emergence of international health and how it creates its sites of intervention, which are based very frequently on frameworks of eradication, i.e. to single out one disease, which spreads through movement of people, and devote resources to eliminate it, often times neglecting much more dire health conditions. The concern of most health organizations in the past decades has been to link the question of health with economic productivity. From this perspective, health cannot be dissociated from the question of turning individuals into productive members of the society, which includes both being consumers and producers in a global market [13]. While after independence, international organizations such as the World Health Organization shaped the agenda-setting in each country, the implementation of global disease programs continues to take place through the same governance structures and the organization of hospitals and dispensaries which work in tandem with the law enforcement. The question then is: how does the South Asian post-colonial state imagine its target of medical intervention? To answer this question, we can perhaps turn to anthropological and historical literature on public health in South Asia.

During emergency rule in India from 1975-77, American foundations such as Ford and the Rockefeller foundation supported population control programs. According to Emma Tarlo, the ability of men to sponsor other men to get sterilized was necessary to retain their places in government bureaucracies. Within this context, there were also men selling their certificates, which created a framework of co-victimization for both the sponsorer and sponsored: the former to secure their jobs and the latter were under the pressure to get sterilized so that they could be resettled to the outskirts of Delhi [14]. Thus we can see from the emergency rule that international organizations have often co-opted governments. Similar population control programs have been implemented particularly during military dictatorships in Pakistan, which have attempted to create an imaginary of a nuclear family that is divorced from the extended kinship networks. Similarly, one of the biggest failures of any disease control programs in the South Asia is to truly appreciate the social structure of the society, its patterns of exchange and the interdependencies of people. As much as the movement of social medicine has been hailed by international organizations, the use of "social" remains necessarily limited, and based on longstanding histories, is even used to stereotype populations in deciding whether they can be healthy citizens or not [15]. As mentioned above, subjecting oneself to a medical intervention continues to be a prerequisite to access state services, property, etc [16].

Kinship has been an integral subject for anthropology. When anthropologists study kinship, they try to understand marriage rules, exchange of goods and tensions and intimacies within a wider kin network beyond the nuclear family. We live in and through kinship in sorrow and happiness. But why should any of this matter for a global disease response? We have entered a stage in which Pfizer-BioNTech, Moderna and Oxford/AstraZeneca vaccines have completed their clinical trials are ready for distribution. While China has been a major contributor of the Sinopharm vaccine to Pakistan, India is also a major producer of the Oxford-Astra Zeneca vaccine. The reason why developing countries have opted for the Oxford/AstraZeneca vaccine is due to its low price which could make it accessible to the poorest segments of the society. One of the biggest problems faced by any disease response in the third world has been that of compliance. While the two countries have been rushing to vaccinate their vulnerable populations, the decision to vaccinate in reality is shaped by a range of factors, the most notable of which is whether the family structure enables or disables members to seek care. In the government's attempts to vaccinate the maximum number of people, it is necessary to take examples from previous epidemics in the two countries and the way health systems responded to them. The polio epidemic in South Asia has shown how structural problems including the pay gaps between the vaccinators and program managers reduce the effectiveness of the program on the ground [17]. Kinship was central to the team of vaccinators whose negligence in

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vaccinating children in each house could cost them their jobs leading to the loss of income for their families. It was also central for households in which vaccinations were being administered. Households were imagined as a bounded units with children's presence at a relative – living in the same or a different neighbourhood– was ignored by the vaccinators. At the same time, internally displaced people who could not be designated created problems in authenticating whether members had been vaccinated at all in the past. Additionally, we know, for example, that Directly Observed Treatment, Short Course (DOTS) centers play a central role in the developing world in the attempt to ensure surveillance of populations for tuberculosis medication to prevent resistant strains of mycobacterium. But even those DOTS centres may triage patients based on their ability to improve in the case of tuberculosis where the development of a drug-resistant and the burden of care is entangled in concrete domestic relations and their finiteness [18]. Training of local healthcare workers to administer medication on timely basis both in the clinic and at the doorsteps to those infected has been shown to have a positive impact in decreasing mortality due to tuberculosis and AIDS. But is access to medication or vaccination in the case of the ongoing pandemic the only answer?

Why Kinship is Important

One the one hand, there is a medical reality of the virus, and we know that the emergence of new strains in the context of the Covid-19 have created new restrictions on movement and new anxieties about the efficacy of the vaccines. But one might ask how does the changing reality of the virus shape social relations at home, and raise questions about which individual should be prioritized by families for vaccination? What happens when the vulnerable individuals given the tensions in kinship in low-resource settings, do not receive the care they deserve? As developing countries begin to roll out their own vaccination programs, it is necessary to understand beyond cultural differences and the lack of trust, why kinship formations can be central to the success or failure of any vaccination efforts. I remember teaching Roberta Bivins to my undergraduate class on immigration, kinship and health – again an experiment in finding the relevance of kinship for health outcomes – where I highlighted the example of the smallpox epidemic in Karachi and its outbreak in the UK. I showed that a major anxiety experienced by the NHS in contact-tracing was that the Pakistani immigrants were not easy to track as they were accustomed to living with several of their existing relatives and friends in the UK before they established independent households [19]. In the context of tuberculosis eradication in the United States, it has been shown that question of admitting oneself to a sanitorium and the rumors about infection created anxieties about the threat of eviction and repatriation for illegal migrants [20]. Thus there is a long history of interventions which have acted upon the family and have shaped the success or failures of the eradication efforts. The ever-changing reality of Covid-19 thus has to be considered alongside the changing patterns of kinship. For instance, while in most parts of the world on average two doses of the polio vaccines are required, in places like India, Pakistan or Afghanistan, successful prevention may take up to five doses [21]. Of course, one major problem faced is regarding the lack of efficiency of local programs, government corruption, etc. But a much more important one is: How do you account for questions like differential attitudes toward vaccinations or the pandemic existing within the family? How do tensions or hostilities particularly within kinship make care burdensome? Consequently, how is access to vaccination shaped by uneven networks of care based on how much a person can stake a claim to being a part of the family in the context of patrilocal or, say, matrilocal marriage?

The knowledge of diagnosis and the decision about whether or not to vaccinate do not exist in a vacuum. These decisions are shaped by social realities within the space of the domestic and beyond. If the likelihood of infection still exists even after vaccination, which has been the case for Covid-19 as well as several other diseases, we need to consider how people, who are now used to interacting through the telephone or the internet come together once vaccination programs are expanded. A related question is, how is difference of access to vaccination or pressures to vaccinate, as has been the case with testing in Covid-19 and previous health emergencies borne by different class backgrounds? As shown in the case of AIDS in Latin America, the middle-class was much more likely to get themselves tested for AIDS more than once, which was a part of the biopolitics of creating a disease-free population [22]. Sex workers in Pakistan have shown how their approaches to safety – the use of contraceptives and frequency of sex – was shaped by the need for social support and intimacy with certain partners while being away from family [20]. The fundamental question is how we make kinship a central part of the study on vaccination trials and implementation globally. In the 19th century Cuba, humanitarian logics were used when there were calls to abolish slavery, but only to use slave children to harvest yield and to vaccinate children of the plantation owners. Unfortunately, such an idea of using racial groups, particularly in the global south to expand testing has continues to persist in modern times [23]. Just as the children of white slaveowners were vaccinated with the help of slave children in 19th century Cuba, even today it is important to ask: who is scapegoated and for whom? In the biopolitics of AIDS and smallpox therefore we can see a particular imaginary of the nuclear or a slave owner family based on dominant ideologies of the time. The challenge for a social scientist is to consider the forms of familial relations

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that are ignored by global and local medical interventions.

Conclusion

Instead of simply relying on cultural differences, one must consider kinship as the process through which behaviour toward vaccination can be understood. The limitation with using culture often is that public health experts fall into the trap to think about indigenous culture as stable which is never the case. The mistrust toward vaccine implementation can more fruitfully be understood when we see the difference in the imagination of kinship between transnational health organization and indigenous communities themselves for whom kinship consists of affinal and agnatic relations, patterns of residence after marriage, exchange of presents and enduring relations between affinal and agnatic kin as a source of hostility and intimacy. In some parts of Pakistan as in India, participation and withdrawal from a clan (biraderi) are based on relations of exchange. Marriage takes place endogamously within castes while also hypergamous, i.e. when a woman marries into a higher biraderi within the same caste [24]. In areas of Punjab in Pakistan, marriage takes place outside of the village, with continuous relations of exchange between the wife and the wife's brothers. However, these relations have increasingly been put under pressure due to the emergence of Islamic rules of kinship which institute the permissibility of marriage with paternal and maternal first cousins. In both the former and latter, it is very difficult to separate the individual from the broader social group as well as the adjacent one with whom relations of exchange have been established. At the same time, it is important to be mindful of how these enduring relations have been put under pressure due to market forces, war, displacement which leads individuals to find work abroad or in other towns. Birth control programs particularly face the problem of implementation as their imagination of a productive family is at odds with the importance of kinship relations among local communities. This perception toward birth control i.e., a different way of imagining the "ideal family," can even halt vaccine implementation as shown in some areas of Nigeria, where immunizations were denied because they resembled injectable contraceptives in their administration [25]. Thus, instead of simply saying that it was a matter of cultural difference, I would argue that it was centrally an issue about the fear of jeopardizing the ability to procreate and hence the denial of one's kinship when people confused birth control programs with the immunization program.

One of the participants of my three month-long Covid-19 household survey research that I conducted in low-income areas of Lahore and Karachi died during the study. While the family knew she could have died due to Covid-19, they did not get their elderly mother tested out of the fear that this might deny her the chance to be surrounded by relatives on her death. Her health continued to deteriorate as her brothers and son-in-law fought over the settlement of debt that the latter owed to the former. The brothers transferred their sister's property to their name as a way to settle the debt, thereby denying their nieces their right to their parents' property. Their mother died over bitter conflicts, possibly even due to Covid-19 as some members shared. Family troubles made the elderly mother's health secondary. Contesting notions of kin relatedness are therefore crucial to understanding the success or failure of a disease response.

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