An Epidemic Epilogue

As I was completing this book, a new epidemic arrived.

The news of a novel coronavirus in Wuhan broke in January 2020. At first, reports of its progress juddered in fits and starts, like transmissions from somewhere incalculably far away, about the sort of catastrophe that only happens in other places. Then the virus washed up in Italy, and reports took on a tone of alarm and disbelief; then it found its way to the UK, where I am writing, and the news became a steady, swelling background noise, until it came in a deluge, and the virus was as near as our doorsteps – or as near as our hands are to our faces. As I write this epilogue, the UK has been in lockdown for two months. We do not yet know what the end might look like, but for now there is no end in sight.

There is a danger in writing without the advantage of hindsight, and without the scope of information and the time for sense-making it allows. But there is clarity and potential in it too – not least as it is so often how we must live our lives.

As we have collectively groped for perspective, appropriate responses, and meaning, comparisons to HIV have bubbled to the surface. Some forget that that pandemic is still ongoing, nearly four decades after it began. Others conclude from its example that life goes on – and it should simply go on now. But the latter conclusion overlooks the extraordinary time, effort, and resources, the mistakes and innovations, the research and treatment, the political will and failures, the personal and interpersonal choices and decisions – the illness and caring and dying – that have gone into finding a way for life to go on, and that continue to this day.

When COVID-19 arrived in Botswana, it arrived very close to home. The country went into lockdown shortly after the discovery of their first case, posthumously, in a 79-year-old woman from Maropeng who had crossed to South Africa for the day. The government declared a state of emergency, shut the borders early to all except essential traffic – mostly the import of food and necessities – cancelled some foreigners' visas, called Batswana home from abroad, set up quarantine stations and border testing, and required the use of masks in public. It was a rapid

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and decisive response, if fraught with confusion, fear, and uncertainty as the measures took effect – as with responses everywhere.

Botswana's long experience with the AIDS pandemic gives it valuable technical expertise and public health experience for facing COVID-19, as well as broad public understanding of what is at stake and how to respond. But we do not yet know how COVID-19 might impact those with suppressed immune systems due to HIV. As trials are run on lopinavir and ritonavir – components of the antiretroviral medications used to treat HIV – to test their potential for suppressing COVID-19, the tantalising possibility emerges that the decades of work and the political and financial investment that went into providing ARVs have not only extended tens of thousands of lives, but may buffer the impact of this new epidemic as well.[1] Regardless of the outcomes of those trials, the fact remains that the public provision of drugs that strengthen the immune systems of Batswana living with HIV gives them, and in turn their communities, a valuable line of defence.

So far, however, it seems to be the global North that has been disproportionately affected by COVID-19. Some of the wealthiest, most well-equipped nations in the world – including the UK – are being hit the hardest, experiencing the highest rates of infection and death. While explanations are floated in terms of demographics (older populations, greater density), preparedness, political leadership, and public trust (or a lack thereof), the need for those explanations scarcely conceals an underlying shock: we in the global North have become accustomed to the trajectories of crisis, suffering, illness, and death leading elsewhere, not leading home.

The pandemic and the widespread lockdowns that have followed in its wake have demanded an unexpected reckoning. They have demanded that we rethink who we are, how we live, and how our behaviour affects one another – locally and globally. COVID-19 requires us to refigure not only our households, work, and friendships, but also the services we access, the way we move through space, and our management of time. Our understandings of risk are shifting under our feet in ways we struggle to grasp or act upon: those to whom we are closest may pose the greatest danger; children initially appear less, rather than more, vulnerable; and, perhaps hardest of all to imagine, given the apparent prevalence of asymptomatic cases, each of us may prove a greater threat to others than

[1] In late 2021, much after this epilogue was written, the reported emergence of the Omicron variant in an untreated HIV patient in southern Africa underscored just how important mass public ARV provision has been in staving off further health crises – and just how global the risks of a lack of treatment availability can become.

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they are to us. We don't yet know enough about the virus, its transmission, or its progression to be able to gauge our risks and responses. Government guidance, even when communicated well, is often insufficient to help us determine how to behave in any given circumstance. And so we have to rethink our everyday choices and behaviours, and assess those of others, against new and unclear standards of right and wrong. We find ourselves contemplating how to respond not in terms of the virus, but in terms of our relationships to ourselves, to each other, and to the earth. COVID-19, in other words, poses a collective ethical problem – not unlike the collective ethical problem posed by AIDS before it, and, indeed, by the *dikgang* that Batswana navigate on an everyday basis.

Much like *dikgang* in a time of AIDS, I suspect that the crises of Covid will generate creativity, innovation, and the possibility of unexpected change – particularly in and through families. As we seek new ways to live with and relate to each other in the presence of this novel coronavirus – in many cases, locked down at home – I anticipate that many of those innovations will emerge first in our most intimate relationships, among kin, where such experimentation is already commonplace. Whether we are stuck with them or cut off from them, our pandemic circumstances make family and intimacy a new sort of problem. But from among the extensive repertoire of problems we have already negotiated or anticipated in those contexts, new responses suggest themselves. The virus reminds us that to be family is always, in one way or another, to be a risk to one another; the perpetual issue is how best to manage that risk and how to sustain love and care for one another, not only in spite of it but as a means of addressing it and rendering it generative.

However, COVID-19 is also what Marshall Sahlins might have called a 'revelatory crisis' (Sahlins 1972: 124, 143; see also Solway 1994): a crisis that exposes structural contradictions, inequalities, and deteriorating socio-economic conditions – here, not just to the ethnographic observer but to anyone who is paying attention. Collectively, we have scrolled through reams of digital newsprint reminding us that the virus does not discriminate, and will happily infect prince or pauper. Further reams of commentary demonstrate that this is not quite true, and that the marginalised are disproportionately affected and at much higher risk of death – the poor, ill, elderly, and, especially in the global North, those from black, indigenous and minority ethnic backgrounds. What both of these analyses miss is something HIV taught us long ago: that pandemics of highly contagious viruses demonstrate above all the unexpected, intimate, and uncomfortable ways in which we are connected to one another, across every socially constructed barrier of nation, class, race, age, gender, or sexuality (Comaroff 2007). Such viruses are transgressive, in

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the literal sense of crossing and collapsing boundaries; and they demonstrate that our interconnectedness is much more tightly woven than we might like to think. While we might imagine prince and pauper in discrete, segregated worlds, it may well be that one has infected the other – and, worse, that if the prince has a better chance of survival, it is *because* the pauper has a worse chance. It is no accident that a highly contagious virus should throw all of these questions wide open; it has destroyed our containment fields and has demonstrated their frailty and inadequacy.

The risk of revelatory crises is that they can also conceal the very contradictions and injustices they reveal, by attributing them to the crisis itself – thereby reproducing or exacerbating those underlying problems (Solway 1994). Our immediate response to a pandemic – to reinforce the seemingly natural boundaries that separate us, whether as bodies, households, or nations, through different forms and practices of quarantine – has critical, unquestionably necessary public health advantages. It keeps people healthy and alive. But I suggest that quarantine, while a highly effective public health measure, casts an ideological shadow. In attempting to make meaning from illness and death, and even from the experience of quarantine itself, people caught in this interpretive shadow can conclude that it is the transgressive, 'unnatural' relationships through which a virus moves that are sick, and that it is those relationships that must be severed to stop the spread of disease. And, of course, the relationships that some may already find transgressive are those that are made suddenly threatening in this ideological revisionism: those that cross national borders or socially constructed distinctions of race and ethnicity, age or class, or those that do not conform to normative expectations of cisgendered heterosexuality, for example.

In the long term, a 'quarantine ideology' may conceal, naturalise, and reproduce the inconvenient truths and injustices that the pandemic crisis has revealed, but it will not protect us. HIV and AIDS were highly susceptible to this sort of quarantine ideology. Even now, in the popular imagination of the global North, HIV and AIDS remain afflictions of the marginalised: of gay men, drug users, sex workers, migrants, and African-Americans – or Africans. And nearly 40 years after AIDS first appeared, there are still 1.7 million new infections a year globally, statistics likely to worsen in the shadow of COVID-19 (UNAIDS 2019; 2020). Quarantines can contain and even halt pandemics; quarantine ideologies perpetuate them.

What I hope this book has shown, in part, is that the intimacies and relationships through which a contagious virus moves are not the problem; if anything, they are the signs of our humanity and the

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expansive success of our sociality. They indicate a mutuality that, when we recognise it, triggers a renewed sense of our moral responsibilities to one another and opens up a space for us to reflect on and engage them together – in ways that strengthen our selves, relationships, and societies.

The prefix *epi-* means upon, over, among, or in addition to. An epilogue casts back over a text to add a final word; an epidemic is upon and among the people. The latter in particular describes something permeating, enveloping; something that draws in and covers everyone by saturating the spaces between them. Understanding the ways in which we are similar or different – the classic preoccupation of anthropology – is of somewhat limited use in an epidemic. An epidemic requires us to see the ways in which we are *connected*. And it demonstrates to us how expansive and wide-ranging our connections are, transgressing and collapsing the boundaries and categories around which we have organised our sociality – and proving beyond a shadow of a doubt that those boundaries and categories create inequalities that kill people. The ties that connect us are not pathological; the insuperable inequalities that characterise them are. And until we find ways to redress those inequalities, COVID-19 is unlikely to be the last pandemic we have to learn to live, and die, with.

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