Un-healthy geopolitics? Bordering disease in the time of coronavirus

Abstract

COVID-19 is highlighting and exposing how public health and geopolitics intersect across spaces, scales, and settings. Existing literature focuses on the geopolitical determinants of health such as the allocation of foreign health-related assistance in post-colonial spaces, and the relationship between population health and the health impacts of exploiting resources for economic benefit. How populist nationalism shapes public reactions to disease has also been documented. There is a popular geopolitical dimension to how COVID-19 is portrayed—with expertise questioned, conspiracies circulated, lockdowns contested and mask-wearing ridiculed. Calls to keep 'foreign' pathogens and viruses out of national territory carry with it possibilities for exceptional measures, xenophobic politics, and heightened surveillance on the border and beyond. The place of the World Health Organization (WHO) within global health security remains complicated by the intersection of public health and geopolitical contexts. By using three themes, within and beyond the WHO, we explore how COVID-19 has been productive of three geopolitical narratives: public health as emblematic of great power rivalries, the bordering of the virus, and the (surgical) facemask as power projection. Our paper concludes with an assessment of how important it is to track and trace the relationship between health and geopolitics.

Keywords

biopolitics; COVID-19, geopolitics; health; nationalism; populism

Key insights

The article illustrates how health, COVID-19, and geopolitics intersect with one another—from great power rivalries to presidential posturing and controversies over face-masks and vaccination.

Introduction

> …the World Health Organization should lead the global response … At this crucial juncture, to support WHO is to support international cooperation and the battle for saving lives as well. China calls on the international community to increase political and financial support for WHO so as to mobilize resources worldwide to defeat the virus. (Xi, 2020)

> This is the letter sent to Dr Tedros of the World Health Organization. It is self-explanatory! (Trump, 2020)

In a space of one day, 18–19 May 2020, two global leaders issued two very different statements. President Xi of China expressed his support for the World Health Organization (WHO, established in April 1948) and its beleaguered leader, Dr Tedros (Xi, 2020). By way of contrast, US President Donald Trump released a letter he had composed to the WHO leadership via presidential tweet (Trump 2020). The US president put the WHO on notice that funding would be withdrawn from the organization if it did not engage in more direct and robust criticism of China and the initial handling of the COVID-19 pandemic. For the Trump administration, WHO stood accused of a systemic unwillingness to interrogate China's reluctance to share information about the genesis of the pandemic (which he has referred to as 'Kung Flu' (*The Guardian*, 2020a) and the 'China Virus' (*The Guardian*, 2020b)) and to frame the ensuing global public health emergency as a 'Chinese problem'.

The global response to the current COVID-19 outbreak, if it is to be successful (as the conventional public health wisdom implies), must be informed by international cooperation and mutual support (Collins, 2020). The UN Secretary-General, Antonio Guterres, noted in June 2020 that "they [countries] are creating the situation that is getting out of control" (*ITN News*, 2020). He reiterated the need for global co-ordination and was scathing—without naming any one country or political leader—of those who thought they could plan their own pandemic policies in "splendid isolation." As scholarship on serious disease outbreaks such as SARS-Cov1 (2003–4) has revealed, the control of mobility and regulation of border regimes are often thought to be integral to the pursuit of global biosecurity. Lucy Budd and colleagues (2009) have noted, for example, that the 'bio-geopolitics' of passenger aviation not only facilitated the spread of disease but also stimulated a raft of public health initiatives designed to shut-down international movement. While mass aero-mobility has been framed as a driver of infectious disease, it is lionised by neo-liberalism as integral to the globalization of economies, cultures, and societies. Economic and political nationalism was supposed to give way to footloose neo-liberal globalization (Adey, 2009; Budd et al., 2009; Elbe, 2010; Fraser, 2019; Gatrell 2011). However, as Katherine Mason's work in Shenzhen have alerted us, public health interventions can blur distinctions between liberal-democratic and authoritarian states (Mason, 2012), as nation-states of all political hues have turned to framing migrant and minority communities as contagious, dangerous, and unwelcome in order to impose sweeping restrictions on movement.

What the first SARS outbreak exposed the COVID-19 pandemic has reaffirmed. Despite appeals for global public health co-ordination and collective burden-sharing, the realities of pandemics are that they reveal socio-material terrains shot through with power plays, national security planning and unequal geographies of risk exposure and vulnerabilities (Smith and Judd, 2020). Many societies have experienced lockdowns, the introduction of mobile phone tracing apps, and rules designed to de-socialize everyday life, all giving hyper-visible form to state power. Political theorist Angela Mitropoulos (2020) has pointed to the extraordinary measures used by

states to control and contain, such as quarantine and spatial exclusion, as more often than not providing opportunities for profiteering (for example, through data collection and community monitoring) as well as reinforcing racialised framings of some communities and bodies as more high risk than others. There is a distinct biopolitical regime at play (Esposito, 2012); where appeals to 'herd immunity' and spatial containment force individuals and groups to manage their own risk, whilst ignoring of their (lack of) capabilities to do so. Recalling pioneering work by social geographer Michael Brown (1995) in his interrogation of the moral geographies of AIDS in the United States, this insight draws repeated attention to how the body was and is identified, managed, and stigmatized.

But, in this article, we argue that the framing of health as a public good continues to pivot around a particular reading of the geopolitical (see also Grundy-Warr and Linn 2020). Repeated appeals are made for nation-states to work together to manage trans-boundary threats such as disease. In 2006, "preventing the emergence and spread of infectious disease" was one of six key Global Public Goods identified by the final report of the independent International Task Force on Global Public Goods (funded in the main by France, Sweden, the United Kingdom, Germany, and Norway). The report was clear that health is entangled with geopolitics (International Task Force on Global Public Goods, 2006, p.5) noting that "National health defences are inadequate and will not work in isolation. The actions of other countries matter to any nation seeking to defend its population." What the report was rather coy about, however, was the functionality of neo-liberal capitalism and the role of borders in discourses of harmonization and integration. While infectious disease, vectors of mobility, and international borders reveal the ongoing challenges of developing and implementing trans-national public health strategies, there is less explicit attention given to how neoliberalism has simultaneously reinforced ideas of national borders, populism and ethno-nationalism while advocating mobility, integration, and openness. The 2006 report appeared contemporaneously with an overhaul of International Health Regulations (IHR), following the 2003 SARS outbreak. The introduction into the IHR (2005) of the Public Health Emergency of International Concern (PHEIC) was an attempt to buttress further the obligations placed on states to reveal and report outbreaks of disease; but the capacity to reveal and willingness to report varies greatly. The PHEIC mechanism places a legal duty on World Health Organization (WHO) member states to inform WHO within 24 hours of conditions that have the potential to become such an event. The spectre of the pandemic is thus held to be generative of what is assumed to be shared feelings of risk, vulnerability, and responsibility. And yet in an uncannily familiar moment to the COVID-19 pandemic, the mechanism's origins came in response to China's delay in informing the WHO of early cases of SARS in 2003. In both cases, Sinophobic geopolitical narratives position the pathologized 'East' as a dire threat to the moral and bodily integrity of the liberal-democratic state in the 'West' (for example, Billé and Urbansky 2019; Huang 2004).

An interdisciplinary group of scholars including Alison Bashford, Angela Mitropoulos, and Alan Ingram have warned that the international dimension to public health is shot through with colonial, post-war, Cold War, and contemporary neo-liberal geopolitics (for example, Bashford 2008; Ingram 2005; Lane 2003; McInnes and Lee 2015; Manton and Gorsky 2018; Mitropoulos 2020; Reinhardt 2015; Slater and Bell 2002). The World Health Organization has very little power to enforce recommendations or actions on its members. Nations can be warned of impending pandemics, but what they do about those warnings is in large part shaped by the national actions of political leaderships. As Eduardo J. Gómez has written in the *Geopolitics in Health* (2017), the reactions of states to such news reveals what he terms *positive* and *negative* geopolitical positionings: some states actively seek to co-ordinate their public health policies with others and use disease prevention as an opportunity to work closely with civil society and international third parties; other political leaders pursue a negative geopolitical positioning and frame the outbreak of disease as a threat to national security and stability, warning darkly of third parties seeking extra-territorial interference (Ingram, 2005). Alternatively, they might also seek to reinforce another sort of *positioning* that seeks to invoke extraordinary techniques of control over the movement and behaviour of domestic populations and suspected interlopers. Disease and migration frequently go hand-in-hand with one another in their capacity to generate shared feelings of fear and dread, and to champion techniques of control that emphasise pre-emptive strategies and extraordinary measures.

Our framing of 'un-healthy geopolitics' is indebted to the insights of those who have interrogated the politicization of health and its implications for borders, population health and populist nationalisms (for instance, Ahuja 2016; Ingram 2005; Mitropoulos 2020; Youde 2010). The COVID-19 pandemic reveals the urgency of embracing the possible geopolitical consequences that might follow. For example, despite WHO's official policy (implemented in May 2015) that the naming of viruses should "aim to minimize unnecessary negative impact of disease names on trade, travel, tourism or animal welfare, and avoid causing offence to any cultural, social, national, regional, professional or ethnic groups" (WHO 2015), the SARS-Cov2 virus that causes COVID-19 has been repeatedly referred to as "the Chinese Virus" by President Trump in press conferences and presidential tweets (BBC, 2020a; Tanne, 2020). He has consistently suggested the virus may have escaped from the Wuhan Institute of Virology—a position universally rejected by the scientific community—and demanded a full enquiry into what he sees as a Chinese cover-up. The disease has been explicitly and repeatedly racialized and nationalized through an amplification strategy intended to be one of 'place blaming' (as noted earlier by Toal, 2009). In June 2020, President Trump tweeted that he could 'feel' the anger of the American people (Figure 1):

[Figure 1: In a presidential tweet sent on 30 June 2020, US President Donald Trump expresses anger at China for its perceived role in the pandemic's spread.]

This expression of 'anger' towards China rather than sympathy and solidarity has led to the inevitable push-back from the Chinese authorities, who have accused US military of bringing the virus to Wuhan (*The Guardian*, 2020b); with the Chinese State news agency, Xinhua, responding that "Using racist and xenophobic names to cast blame for the outbreak on other countries can only reveal politicians' irresponsibility and incompetence" (Xinhua, 2020). Whilst the field of public health has never been divorced from the intersection of politics and geography, it is now arguably more *geo*-politicized than ever before (Phonsuk et al., 2020). A marked change from the 2003 SARS epidemic has been a decade and half of further investment in national border-security-surveillance apparatuses designed to mobilise people, data, and objects in the service of discerning approved and non-approved cross-border mobility. While we might expect pandemics to generate expressions of global solidarity and collective action, this view is only sustainable if we acknowledge and investigate further the capacity of disease to be hyper-exploitable by political agents, capital and populist-nationalisms that thrive on the classification of risky and exceptional individuals and communities, some of which as noted continues to target Asian bodies and communities as infectious (on SARS and bio-Orientalism, Leong 2003).

For several decades, geographers and other scholars have warned how the border-detention-industrial complex has accumulated vast sums of money and been aided and abetted by legal and political interventions designed to racialize migration control, intensify border surveillance, and out-source unwanted peoples (for example, Mountz, 2020). Reactions to the pandemic have been informed and inflamed by ethno-populist framings that fuel exclusionist language, racist violence, and propel forward extraordinary measures of deterrence and detention. President Trump has warned repeatedly that there is an urgent need to take back control of national borders, invoking a medley of threats and dangers facing the country. Paradoxically, this involved either denying the seriousness of the COVID-19 virus and/or peddling conspiratorial narratives about its genesis and likely impact (Evanega et al., 2020). However, as Brett Bowman reminds us, "Yet, it is in the context of the COVID-19 pandemic caused by the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) in which 'struggling to breathe' is a key symptom, that the world has witnessed widespread protests against the killing of George Floyd, who like Eric Garner was suffocated to death as part of systematic violence perpetrated against African-American men by the US policing system. Protests against these violent deaths have often been accompanied by chants of 'I can't breathe' which is both a repetition of the dying words of those killed and an emphasis on the literal and metaphorical difficulties that Black men encounter as targets of systemic racism" (Bowman 2020: 312).

What follows is an investigation of some of the major narrative themes that have helped to frame vectors, actors, and material objects that compose an emerging field of pandemic geopolitics. This pandemic we argue, enables and emboldens forms of 'un-healthy' geopolitics, that highlight areas that deserve continued reflection and evidence-gathering. Un-healthy geopolitics requires the interrogation of *inter alia* 'public opinion', border regimes, intelligence-gathering, global and

national public health management, biopolitics, racialised violence, and great power politics (Bashford 2008; Bowman 2020). Fundamentally, the pandemic as organizational concept is shot through with multi-scalar and multi-layered histories and geographies of imperial, national and racial power. In the short-term, the pandemic has for some analysts nourished expressions of great power rivalries, reinforced the border security complex and techniques of control such as lockdown strategies, and enabled expressions of populist geopolitics and 'pandemic nationalism', which emphasise those people and places considered to be dangerous, diseased, and unwelcome. Populist geopolitics has inflamed scepticism about lockdown, quarantine, mask wearing, and any delays in the reopening of the 'national economy'. While anti-vaccinators and facemask critics have violently at times demanded their individual rights to be respected, they have urged more draconian action to be placed on others. Race, ethnicity, class, and geographical location have fractured and problematized appeals for communal solidarity (for example, respecting social distancing and face-mask wearing). Borders have become weaponised yet again and immigration/quarantine controls are likely to remain in place because of the ways in which foreign others are seen as trustworthy or not regarding the health of community members. In the meantime, however, populist leaders in Brazil, the United States, and Poland have expressed their continued distrust at those who seek to emphasise the public health seriousness of the pandemic. They favour instead reopening their economies even as cases rise, which should give us further pause for thought in terms of how capitalist logics are integral to the distribution of risk, the identification of business opportunity (for example, vaccine development, track and testing technologies, and laboratory analysis) and border proliferation inside and outside the nation-state.

We conclude our intervention by noting that the blaming of others for the disease's emergence and diffusion does nothing to address the immediate challenge of how to live with it, as New Zealand Prime Minister Jacinda Ardern has been quick to point out (for example, Cousins, 2020; Friedman, 2020). Ardern has championed something close to a feminist geopolitical perspective (for example, Bond et al., 2020), which is attentive to how the discourses and practices of public health need to be attentive to the alarmist, un-caring and provocative geopolitical narratives of populist leaders. She and others, such as the Scottish leader Nicola Sturgeon, have urged citizens to exercise an ethic of "care and solidarity for one another" (GovScot, 2020) which acknowledges that human bodies, animals including pets, and the virus share the same spaces. While laudable in its generation of more empathetic feelings, this argument still fails to grasp the persistent neo-liberal and authoritarian geopolitics underwriting this pandemic. Looking more closely at who actually contributes to WHO and its extremely modest base budget (US $3.9 billion in 2018–19), the economic historian Adam Tooze (2020) asks a simple but telling question:

> But how can it be legitimate or reasonable that the Bill and Melinda Gates Foundation [which donates more than the UK] is today one of the largest contributors to the budget

> of the WHO? How can it be legitimate that crucial research on life and death issues is shaped by the interests, however sincere and well-meaning, of a single immensely wealthy couple?

Complicating matters further, the Trump administration had announced that it will not be part of the UN sponsored COVAX program, which commits itself to develop and equitably distribute a vaccine to the world. Insufficient attention to un-healthy geopolitics risks not only overlooking the persistent challenges but also missing opportunities to confront deep-seated and structural injustices – this we believe is a task that a critical pandemic geopolitics should be willing to undertake going forward.

COVID-19, public health, and geopolitical rivalries

The geo-politicization of the current pandemic has been inherently multi-scalar—from the placing of blame ('China virus') and the revisiting of Cold War security alliances (for example, Taiwan and the United States; Russia as an 'enemy state') to great power competition (Russia, China, and the United States mobilising their own forms of medical diplomacy and stock-piling strategies) and to opportunities for others. India has leaned heavily on biotech diplomacy to position itself as modern, trustworthy, and neutral (Surie, 2020), and middle-powers such as Australia and New Zealand have emerged to assert public health leadership. Blurring the lines between global health policies and politics threatens to compromise global cooperation in responding to the outbreak and, in a worst-case scenario, undermine the very international instruments that it is hoped might provide the best chance to address, let alone manage, a global pandemic. But this reading of WHO and international public health co-operation is highly selective in what it seeks to highlight.

The WHO's predecessor, the Health Organisation of the League of Nations, rose from the ashes of WWI; its pre-war predecessors the International Sanitary Conferences, dominated by Europe, focused more on keeping diseases out of the 'sanitary' homelands of Empire than providing universal health coverage (for a history of the WHO, Cueto et al., 2019). The idea that the ISCs were preoccupied with an undifferentiated international is wide of the mark. Global public health management has always been shot through with geopolitical and biopolitical considerations (Esposito, 2013). From membership and recognition issues to funding priorities and intervention programmes, discussions of public health have been caught in moral geographies (for example, AIDS as a 'gay disease') and subject to repeated securitization as territorial nation-states and their expert representatives adjudicate on how far and fast to securitize disease, including imposing emergency measures (Elbe, 2010, 2011). Conspiracy theories complicate further the work of global health initiatives, with some calling into question the intentions of the philanthropic Bill and Melinda Gates Foundation (which pledged US $250 million in May 2020 for COVID-19 related work alone) to use COVID-19 as a way to 'microchip' the public and sell

more vaccines (on earlier flu conspiracies see Cohen and Carter, 2010; and on the Gates conspiracies see Georgiou, Delfabbro, and Balzan, 2020). Global public health funding, as President Trump reminded WHO recently, is dependent on major national donors and subject to disruption in moments of crisis and tension. It also worth noting that the operational budget of WHO is dwarfed by the spending of the US tobacco industry on advertising alone, as WHO's own funding quiz reveals for interested readers (WHO, 2020a).

First, the US-China relationship has revealed itself to be informed by public health schisms (Tooze, 2020). While the two presidential leaders traded thinly-veiled insults with one another, the hostility between the countries comes at a time when the nature of their economic and geopolitical relationship is being sorely tested—with China accusing the United States of war games in the South China Sea and the United States complaining about China's restrictive trading practices. This hostility has entered into exchanges regarding COVID-19. Accused of not alerting the world to the seriousness of the viral infection early enough, Chinese authorities countered that their reluctance was in part informed by a desire to better understand mechanisms (for example, transmission between humans, genome sequence of the new virus) and scale of the problem (Collins, 2020). The accusations about what China did and did not do reveal fundamental tensions about how countries respond to a crisis that proves incapable of being territorialised within national borders, and whether agencies such as WHO are granted sufficient access to assess the efficacy of public health control. During the Ebola crisis, too, WHO was criticised for holding back and waiting for national governments to invite it in—the end result being that WHO's reputation was badly eroded (McInnes, 2015). What transpired in China, external observers believe, was the Chinese authorities juggling a desire to protect national borders and reputation for domestic governance with a determination to manage their population through the imposition of stricter controls than would be possible in any other nation (for one timeline of the crisis, see WHO, 2020b).

What has been less well understood in the reporting of the US-China flareups is the longer history of public health as a strategy for extra-territorial intervention and profiteering. European countries and the emergent United States pioneered international public health intervention: the spectre of disease was used to justify and legitimize pre-emptive action in the early 20th century, for example, when the American and German Red Cross sent doctors to Ottoman hospitals as the Ottoman Empire struggled to contain deadly outbreaks during World War I (Bulmus, 2012; Cueto et al., 2019). Monitoring populations and collecting statistical information about infection is part and parcel of the management of population: colonial powers used public health in occupied territories to control movement across national and international borders. During the Cold War, public health was used by the United States, especially polio vaccination programmes, to extend influence in geopolitically sensitive regions such as West Africa and Central Asia (Andersen 2016; Garrett 2004; Reinhardt 2015).

Second, the issue of international misrecognition has been a significant factor in the geopolitics of the COVID-19 pandemic (Aspinall, 2020). As a 'rogue province' of China, the government of Taiwan has been quick to present a counter-narrative in which its own awareness of the outbreak and its early—and very effective—instigation of containment measures, could have been shared with the world much sooner had it been able to communicate effectively through WHO. The Chinese leader, Xi Jinping, argued instead that China's efforts bought the world "precious time" to respond to the outbreak and has responded with calls to keep geopolitics out of the WHO. And as he later declared, "In [the] face of unprecedented challenges, we should focus on saving lives and not be distracted by political manipulation" (cited in Lynch, 2020).

The Republic of China—an ally of the United Kingdom and United States during WWII—was one of the founder members of the UN and WHO. What constitutes 'China' in this context, however, lies at the heart of some of the geopolitics being played out through the current crisis. When the communist People's Republic of China seized power in 1949 and banished the ROC to the island of Taiwan, disagreements arose between WHO members over whether the seat at their table belonged to the PRC and mainland China, or the ROC either as the legitimate representative of the Chinese people or as an additional seat. The recognition by the UN in 1971 as the PRC as the sole legal representative of China, effectively excluded Taiwan; initially allowed to participate in World Health Assemblies as an observer, this has been blocked by China since 2016. Taiwan has been accused by China of using COVID-19 to leverage support for overturning its exclusion from WHO and the World Health Assembly amid claims that it could have (and indeed tried to) give early warning of human-to-human transmission—(not confirmed by WHO until 14 Jan)—based on anecdotal evidence of transmission from patients to Chinese medical staff. The country began lockdown on 31 December 2019, the same day that the official WHO announcement was made to the international community.

Today, the real danger from COVID-19 may be the political vulnerabilities and tensions it lays bare and the socioeconomic and racialised inequalities it exposes further within countries as well as between them (Bowman 2020 on the 'biopolitics of breathing'). As national authorities scramble to impose border controls and raise their surveillance of movement along the borders and beyond—including internally as track and trace kicks in—within borders, the most vulnerable move not by choice but because of uneven access to resources and (in)secure environments. As climate change and political instability—and often both, hand-in-hand—compromise the capacity of some places to support communities, the imperative for many to move is heightened (on kinopolitics; see Nail, 2015). As Matt MacDonald (2020) has noted, in the Australian context, there are some difficult decisions to ponder:

> How do we balance the economic implications of movement restrictions against the public health risks of increased infections? How do we weigh individual freedoms against community protection? And if we shut down elements of our economy, do we protect

> affected people and businesses? All of them? How much support should we give them? And for how long?

As he notes, it has been a great deal easier for the Australian public to recognise the pandemic as a 'crisis' than to recognise how migration, climate change and disease are inter-related to one another.

Emergency borders

As a succession of medical geographers (for a review, Moon and Sabel 2019) have noted, the management of disease is spatial for two reasons: first, the treatment of disease is invariably socio-spatial as authorities seek to impose either quarantine measures or restrict vectors of transmission. Second, disease is made manifest by an assemblage of human and non-human actors and forces that work through space and place (Andrews, 2018; Applebaum, 2020). Disease management has often been thought to require space that then needs to be separated, quarantined, and subjected to exclusion orders as well as controlled. All of this can be deeply contested: in the United States, for example, who has the legal right to impose or lift lockdown measures has been legally challenged in semi-rural states such as Kentucky and Wisconsin (Gorman and Bernstein, 2020). In the United States, ethnic minorities and migrants were and are frequently subject to more severe mobility restrictions that their white counterparts and more likely to be enveloped by the policing-surveillance character of state power. Around the world, many citizens have been warned to avoid crowded and humid spaces such as public transport and prevented or restricted from doing so by legal decrees and active policing at levels not seen since WWII. The relevant authorities have imposed a medley of international and local travel bans, shut down airports and railway stations, and closed their international borders. But those appeals to avoid certain spaces and modes of transport are quite different to the everyday struggles of others just seeking to 'breathe' (Bowman 2020).

Exceptional measures become justified either in the name of homeland security and biosecurity and/or public health-informed border strategies. Viruses, in effect, expose the 'sovereignty myth' but this has nonetheless stimulated extraordinary bordering practices (Agnew, 2020a; Liu and Bennett, 2020). As Wendy Brown (2010) warned over a decade ago, when the state no longer enjoys any sort of exclusive authority over its national territory, this can and does encourage nativist and populist politics to re-engage with the 'territorial container' and double-down on filtering out undesirable bodies and infections. As a consequence, viruses might be framed explicitly as 'foreign', with migrants, refugees and minority communities facing vitriol and xenophobia. In the early days of the pandemic, the media was rife with stories of Chinese nationals, or those of Chinese descent, being abused on the streets of London and Sydney, and elsewhere in the world; more recently Chinese students were warned they may face abuse when universities resumed (Caiyu and Keyue, 2020).

The everyday environment for minority communities becomes in effect ‘hostile’ as their movements and behaviours are subjected to censorious scrutiny. Citizens are encouraged to ‘keep the virus’ out of the homeland and to ‘stay alert’ in case others violate and make insecure that space. They are encouraged to agree to more surveillance, monitoring and restrictions on their own movements, at a more intimate level, lest they themselves present a threat. All the time, however, they are encouraged to go to work, attend school and support local shops and business interests. In the United Kingdom, for example, the supermarket delivery driver was initially lionised as a reassuring figure of cross-space mobility and connectivity.

Emergency measures re-define who is legal and not legal and who can move and not move at a time of pandemic (Nail, 2015). Borders open and close depending on circumstances. National airlines stopped carrying civilian passengers but were then re-purposed for the collection of personal protection equipment (PPE) held at airports they might never normally fly to, while simultaneously scrambling to bring back their own citizens stranded overseas—and, potentially, the viruses they might carry with them. Italy welcomed medical supplies from Russia but at the same time announced that it would be closing its ports to migrants rescued in the Mediterranean. European states were able to restrict the internal movement of fellow Europeans and in effect suspended the removal of borders in the Schengen bloc.

In other parts of the world, however, the border is felt a great deal closer to home. Migrant workers have found themselves trapped in their dormitories unable to leave due to visa restrictions and financial considerations; they have subsequently been blamed for flare-ups of disease after cases have dropped. Singapore has highlighted foreign labourers and dormitory settlements as a case in point (Yea, 2020). In India, a sudden prime ministerial decree about lockdown effectively gave internal migrants to cities little to no chance to return to their home villages. Poorly ventilated, overcrowded accommodation often designed to house migrant communities (Chew et al., 2020) creates vulnerable pockets of $R>1$ in the midst of regions where otherwise, epidemic containment would have been achieved. (An R number of 1 means that on average every person who is infected will infect 1 other person, and the total number of infections will remain stable; anything greater than 1 implies cases will increase.)

International borders can and do act as potential flashpoints for neighbouring countries wishing to impose their own restrictions, lockdowns, and social distancing measures. Like WHO, NGOs cannot enter a country without the express permission of its national authorities, which may be delayed due to failure of resource-poor governments to recognise the seriousness of the problem, highlighting the risks inherent in poverty as well as disease ecology (Farmer, 2014).

COVID-19 is a reminder that borders, local, national, and global are porous and fragile between socioeconomic groups as well as between nations. But borders are also hard-wired and capable

of being re-imposed with vigour—tougher border controls could erode further the scope and potential for refugees, asylum seekers and even cross-border traders and communities to continue their everyday lives. Domestic citizens in host countries have been encouraged to be vigilant border-managers, with direct appeals for universities, private sector landlords and employers to check and double-check the papers of immigrants. In public health terms, the cultivation of a 'hostile environment' to illegal migrants inadvertently might discourage those same people from seeking out professional medical services during a pandemic (on the antecedents of the United Kingdom's 'hostile environment', see Yuval-Davis et al., 2018). At the same, however, governments have expressed concerns about how public health data crosses administrative and international borders. In the United Kingdom, we have had controversies involving Public Health England and its sharing of infection data with local government authorities.

The current COVID-19 outbreak is thus exacerbating and highlighting both the politicised nature of health and the geopolitical tensions that intersect with it. While some countries such as Iceland, South Korea, New Zealand, and Germany have been lauded for their strong leadership and public health measures, which have not only provided clear health plans for their own countries but have provided lessons that might be adopted at a global scale, others—most notably Brazil, Mexico, and the United States—have seen the pandemic create severe schisms in public life, between opposing parties and between its own citizens.

Finally, the bordering geopolitics of COVID-19 is being played out through the language used and the posturing political leaders are taking at the level of the body, the nation, and the international stage. Scholars have long warned that using military rhetoric against the microorganisms that cause disease does not help to frame the best approaches to them (Liu and Bennett 2020), and a number of world leaders including New Zealand's Jacinda Arden have spoken out about the dangers of seeing the virus as an enemy, stigmatising it and those seen as responsible for it. In contrast, President Trump and his supporters used the virus to deepen divisions opened up in his presidential campaign, playing Americans he sees as loyal to him against those he does not (Agnew, 2020b) whilst doing little to protect those least able to protect themselves. The announcement of his diagnosis with COVID-19 in early October 2020 encouraged some of his supporters to denounce further the virus as 'hoax' while generating further conspiracies about who might have infected him in the run-up to the 2020 presidential campaign. As Agnew (2020b) also warns, many of those same Trump supporters are likely to be suspicious of expertise, hostile to state and federal-level impositions and prone to conspiracy theorising about the genesis of the virus. Trump's apparent willingness to support anti-science stances has seen leading academics (Frumkin and Myers, 2020) and entire academic journals (Scientific American, 2020) take a political stance against him.

Face masks and pandemic populism

Socio-ecological contexts inform the intimate geopolitics of health and vice versa. As scholars of 'blue-marble health' (a term coined by epidemiologist Peter Hotez to refer to the prevalence of poverty-related illnesses in otherwise wealthy countries such as the United States) remind us, the very poorest individuals in the global North bear the brunt of this ecological vulnerability and economic precarity just as much as the least developed communities of the Global South (Hotez 2020). Disease not only permeates human-imposed borders but also highlights often less visible divisions within them, between for example digitally literate, technology enabled white collar workers who can operate from home during lockdown with minimal impact on their daily lives and their blue collar and service sector colleagues. The latter have no choice to go outside and mingle with the disease and its carriers as they travel on crowded public transport to places of work where multiple interactions with others like them are unavoidable. While it may seem easy to demonise the lockdown protestors of the US, isolation, lockdown, and social distancing takes on radically different possibilities depending on individual and community dynamics and experiences. Medical geographers have long warned that poverty, inequality and precarity are powerful markers of health and welfare geographies (as noted by Moon and Sabel, 2019).

An early high profile coronavirus patient in the United Kingdom, Prime Minister Boris Johnson expressed his sincere appreciation to the NHS workers who treated him (two nurses from New Zealand and Portugal were identified as integral to his care). At the same time, it was becoming apparent that the distribution of risk and health care throughout the United Kingdom was highly unequal. For frontline workers, including care workers, delivery drivers, and supermarket employees, their (involuntary) commitment to work was held up as indicative of the national spirit—not buckling under the exhaustion and pressure brought on by the pandemic. Their bodies and associated endurance become integral to expressions of intimate geopolitics, where essential work is complicit with public health nationalisms and nostalgic attempts to link the pandemic to past disruption such as World War II. Wider publics in the United Kingdom were encouraged to show their support for key workers as a way of building attachment, recognition, and solidarity with those on the 'front line,' conveniently ignoring that these essential workers have had little choice in the decision to leave them in risky situations. Borders divide the affluent from the less affluent, condemning the latter to circulate in unhealthy spaces from which the former can more easily isolate and protect themselves (Gatrell, 2011).

These intimate biopolitics are also seen in the ways in which the different world leaders choose to don masks (or not), how they answer questions about their national responses, reveal whether they are taking medical treatments, and/or socially distance when out and about, and how they approach those infected individuals and households within their borders and legal domains. The body is integral to geopolitical performance, as is the manner in which presidential leaders and prime ministers do or do not follow the national public health guidance they attempt to impose (or not) on others (for a review, see Mountz, 2018). While Prime Minister Boris Johnson

appeared relaxed about the scale and nature of his contact with others in the early days of the pandemic, another (Jacinda Ardern) was at pains to explain why reducing such contact was an imperative. The former contracted COVID-19 and the latter (so far) has not.

There has been a marked reluctance on the part of populist leaders such as President Trump and Brazil's Jair Bolsanaro to wear a facemask. As the Dutch political scientist Cas Mudde warned, there are multiple populist responses to this pandemic and populism is capable of mutating to adjust to changing political and public health circumstances (Mudde, 2020). In May, Trump shared a tweet suggesting that the mandated use of face masks was complicit with a "culture of silence, slavery, and social death" and routinely criticised those who advocated masking as a public health strategy. He eventually wore a White House embossed facemask in July 2020, while walking through the Walter Mead Hospital in Washington DC, a well-known centre for the treatment of veterans. As he noted to reporters before the visit, "I love masks in the appropriate locations … I've never been against masks, but I do believe they have a time and a place" (NPR, 2020). The president did not elaborate on this idea of what were 'appropriate' and 'inappropriate' locations but going forward students of populist geopolitics might wish to investigate further when and where leaders do and do not wear their masks as one point of evidence-gathering. He did offer a cryptic clue, however; "If I'm with soldiers, people that — you know, I don't want to spread anything." In October 2020, he entered the Walter Mead hospital for treatment for COVID and treatment carried out by military medical staff.

At the time of Trump's hospitalisation, 18 of the United States had still not mandated the wearing of facemasks in public spaces, with some of the most heavily affected states such as Florida amongst those resisting such calls. Mandates were split noticeably down party lines: nearly all 'blue' states had mandated face coverings, whilst those that had not were more likely to be 'red' (Figure 2).

[Figure 2: States requiring the use of face masks when in public as of 10 October 2020. The regions with and without State-wide mandates are visibly divided along political lines.]

The political bordering of face masks has become so pronounced that Arnold Schwarzenegger, former Republican Governor of now Democrat-controlled California, has been pushed to describe anyone making masks a political issue "a moron" (Wallis, 2020).

There is a wider point here to be made about the facemask and its extraordinary presence in contemporary expressions of popular geopolitics. From Guy Fawkes masks and the Occupy protests (for example, Gledhill, 2012) to the masks worn by Zapatistas and anti-occupation protestors around the world, the use of masks has largely been studied through the prism of social and environmental protest, and the desire to conceal oneself from the surveillance infrastructures of states and other forms of authoritative power (Ruis, 2013). During the

pandemic, however, the facemask is imbued no longer with subversive logics (as shown by face mask fashion news stories multiplying in number). As Jasmin Zine concluded, however, the intersection of race, geopolitics, and public health deserves repeated and ongoing scrutiny:

> Not having to think about how one's body is read by others when wearing a mask is a privilege of whiteness that eludes racialized groups. White mask privilege includes not having to bear the racial stigma of being seen as a foreign disease carrier, being safe whether or not you "tip your mask," having the ability to cover your face in public and not be denied social services. (Zine, 2020)

This pandemic reveals repeatedly how and where public space is occupied and policed, and everyday bordering practices. Wearing a mask or not, does not as Zine warns us, eradicate the historic and ongoing racialization of disease. And wearing a facemask or not should not obscure the intimate digitization of this disease as well—the track and trace QR codes (one element of pandemic public monitoring technologies)—that silently monitor the movement of people and their interactions with others.

Conclusion

Un-healthy geopolitics is one where the norms of social and political life are undermined and violated. In the face of great uncertainty, expert knowledge is questioned and even ridiculed by those determined to place blame somewhere – and that somewhere is one where minority and migrant communities bear the brunt of that targeting. Populist leaders pour scorn on those who warn about the public health consequences of disease and rail against professionals who favour maintaining quarantine and lockdown (without always being sufficiently attentive in turn to the social, economic and psychological costs of such measures). Concerns are routinely expressed that vaccine nationalism will overwhelm more collective efforts to promote global public health policies (Tooze, 2020). As US-based public policy scholar David Mussington (2020) concluded:

> As millions suffer under the direct threat of uncontrolled disease, governments seek to control both the impacts on their citizens, and the responses to risks of significance to national security. For China and the United States, COVID-19 creates incentives for both cooperation and competition.

The interplay between great power co-operation and competition might be one expression of COVID-19 geopolitics. But there are many other qualities to consider that intersect with the biopolitical. National governments and communities are grappling with questions such as: When to close down? How to allow one's own citizens to return home while restricting and monitoring the movement of others? How to ensure supermarkets can supply food, in store or via deliveries, to those who need it? How to manage the unequal distribution of risk and health care provision

that might be bitterly divided by everyday experiences and political voting preferences? Answering these questions inevitably requires some bodies being placed in unhealthy environments that others can and do avoid. Populist leaders call on their supporters to show resilience, absolving themselves of the responsibility of protecting those who may be less able to protect themselves. Communities are asked to take pride in the fact that their country is having a better pandemic experience than others. All the while the pandemic revealing ample opportunities for political groups to consolidate their grip on emergency powers (El Salvador being one example) while marginalising and stigmatizing vulnerable communities already bearing the brunt of structural and racial inequalities (Bowman 2020; Grundy-Warr and Lin 2020; Ravindran 2020).

Building a critical pandemic geopolitics for the future would be one that scrutinises carefully the legacy of the COVID-19 pandemic not only for the adoption of emergency powers and population controls but also the articulation of alternative geopolitical ideas and practices – transnational civic activism, public scrutiny of expertise and demands for more accountable and just forms of global public health (Kearns and Reid-Henry 2009).

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