2. Critical Health Geopolitics and the COVID-19 Pandemic: An Emerging Agenda

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Political geographers have considerable opportunities to connect with and to learn from established scholarship by health and medical geographers on diseases such as AIDS and SARS, and from work on the social geographies of (anti-) vaccination movements (Durbach, 2004, but noting Ingram 2005). During the COVID-19 pandemic, the role of four factors has taken on considerable salience: stigmatization, risk/vulnerability, international health co-operation and border infrastructure. We consider each in turn and make the case for a critical health geopolitics.

One key topic of interest to any critical health geopolitics should be systems of power that stigmatize individuals, countries, and communities as threatening, risky, or unworthy. As scholars of the AIDS epidemic noted in the 1990s, disease can and does act as a 'provisional and problematic signifier', complicating, distorting, and masking a medley of geographical, social, economic and political circumstances (Epstein, 1998; Treichler, 1999). Mindful of the dangers of geographical framings of diseases, the World Health Organization (WHO) had suggested in May 2015 that the naming of any new human infectious disease would need to recognise potential harm to cultural, national, regional and ethnic groups. Nonetheless, in President Trump's tweeting repertoire, the Sars-CoV-2 virus transmogrified into the 'Wuhan virus', 'Kung Flu' or 'China' virus, amplifying Sinophobia and encouraging anti-Asian violence. Shaming, blaming and stigmatizing is, as AIDS and critical race scholars remind us, endemic to the manufacturing of hierarchies of humanness, especially when it comes to non-white and LGBT+ communities (Epstein, 1998; Lim, 2020). The demands to 'return to normal' in many European and North American countries have carried with it a suite of ramifications for the most vulnerable communities, who never have had the luxury of protecting themselves from the virus by 'screening' and 'gating' measures.

For the Cameroonian intellectual Achille Mbembe, the unequal geographies of exposure, risk and vulnerability have laid bare who has the right to breathe and who does not (Mbembe, 2020). This point has been brought into even sharper focus in the wake of a suite of deaths of African Americans by US police officers using firearms and brutal restraint methods. Globally, COVID sufferers have discovered that access to oxygen and associated medical care can and will be rationed and or denied due to a lack of supplies. The racial and geographical implications of the pandemic continue to unfold as the privileged hoard resources, limit the capacities and rights of others, and pursue strategies designed either to amplify the dangers or, paradoxically, to dismiss the impact of the pandemic on many lives, especially racialised minorities, who are over-represented amongst 'essential workers'. Former U.S. President Donald Trump, tweeting in October 2020, shortly after leaving the Walter Reed Memorial Hospital (where he had been treated for COVID) was adamant that people should not let the pandemic 'dominate your life'. Even by his provocative standards, the tweet was incongruous at a time when the global death toll from COVID-19 was

approaching 2.5 million people (out of around 120 million confirmed cases globally) and the United States was leading mortality per 1,000,000 population (Our World in Data, 2021).

Engaging with indigenous, feminist, critical race and Global South scholarship and literatures on the biopolitical and racialised implications of disease and ill-health provides critical health geopolitics with further insights into the racialised and gendered logics of viral reproduction and transmission and the suffocating embrace of inequality and marginalisation. Established public health scholarship is relevant to the task at hand. For instance, 'blue marble health', which highlights pockets of extreme poverty in affluent societies, where diseases like tuberculosis and hookworm infections thrive but are ignored, has been used to draw attention to the disease burden of the poorest communities in the global North (Hotez, 2016). While non-communicable diseases (NCDs) such as diabetes and coronary artery disease are often cited as 'underlying conditions', this fails to acknowledge how public policies, laws, and corporate practices lead to the disproportionate distribution of ill-health and to premature death. As other scholars have warned, connecting disease and health to individual and collective characteristics fails to recognise the toxic and toxifying legacies of racism and classism, alongside the damaging effects of public healthcare austerity, environmental inequalities, housing discrimination, inaccessibility to nutritious food, and differentiated vulnerabilities to premature death due to general neglect (Davies, 2019).

COVID-19 is yet another disease that hits those made vulnerable not by their genetic background but by deep-seated structural inequalities. This includes the elderly and those with NCDs, who are more likely to be from poorer communities, in which Black and brown people are over-represented. As Laurie Garrett (1994) warned in her popular book, *The Coming Plague*, disease is enabled by structures of exploitation and domination that deepen disparities through concentrated community exposure, biodiversity loss, (im)mobility and (in)accessibility to public health. Compounding disparities is a sense of 'acceptance' rather than 'emergency' because much of the harm has been visited upon poor and marginalised communities. Wealthier groups have been better able to protect themselves from exposure to infectious diseases such as Ebola and Zika. Notably, the COVID pandemic has sparked governments and leaders to advocate urgent policy measures such as lockdowns and border closures often without addressing their impact on communities already weakened by austerity, exposure air pollution and environmental toxins, and the lack of affordable and accessible health provision, and/or in-work benefits such as sick pay.

Farhana Sultana (2021) recently noted that the overlapping socio-ecological crises of climate change and the COVID-19 pandemic compounds these d axes of crises and injustice. Living with disease is, for many communities around the world, an everyday risk-filled reality. As with the rapid emergence of a literature on the 'war on terror', which made violence and insecurity seem new, there is a danger that a new public health threat will be treated as a novelty. Reflecting on Ghana's experience of the COVID-19 pandemic, Ama de-Graft Aikins remarks (2020, 411), 'While COVID is a new public health threat, living in complex and unpredictable health environments is not new for Ghanaians. A double burden of infectious and chronic diseases has been the epidemiological and social norm for decades'. Aikins

notes that while COVID might appear to be a 'civilizational crisis' for the Global North, it is something infinitely more familiar for a country where individual and collective memories of Ebola are ever-present (Aikins, 2020).

Reckoning with the unequal burden of disease is further complicated by a failure to acknowledge the effects of previous pandemics, such as Spanish Flu in 1918-19 and AIDS since the 1980s, and the enduring legacies of colonial medical science and past vaccination practices (e.g. Lowes, 2021). Public health crises, as Aikins notes (2020, 411) 'are shot through with complex historical legacies while everyday political cultures fail to recognize the framings of disease as indicative of relations of global domination and inequality'. There is a long history of international health collaboration that has been underpinned by the civilizational intentions of Western power, eager to protect itself from the diseases of others. The International Sanitary Conferences that emerged as a response to the 1829 Cholera Pandemic, enabled its (Western European) members to investigate the cause of diseases that were more likely to emerge in the less "civilised" East, with Turkey taking a 'gatekeeper' role on the borders between the civilized/sanitary and uncivilised/unsanitary world. Underwritten by racialised theories of disease and progress, the International Sanitary Conferences were informed by civilizational visions of world order where controls on movement would be imposed on non-European others (e.g. Bell, 2020).

The World Health Organization (WHO) was established in 1948 with a stated goal of 'the attainment by all peoples of the highest possible level of health', as noted in Article I of its Constitution (WHO 1948). The establishment of the WHO led to the closure of regional health bodies such as the Pan American Sanitary Organization as it sought to improve the co-ordination of global health. Structural inequalities, contested geopolitics, funding gaps, rival alliances and actor constellations complicated the generation of shared objectives such as the eradication of disease and universal access to vaccination. During the Cold War, countries such as Nigeria and Pakistan often found themselves on the frontline of public health interventions designed to shore-up wider geopolitical agendas. Vaccination campaigns, while integral to childhood well-being, were used cynically to enable third-party, in-country intervention under the guise of public health. This had, and continues to have, implications in terms of suspicion of foreign-funded vaccination and public health programmes.

The COVID-19 pandemic provides a fresh opportunity for political geographers to consider the socio-spatial dynamics of global co-operation and to ask whether the practices and goals of public health agencies are shared or not. Some of that work might explicitly address competing conceptions of regional and global governance. For example, the pandemic has revealed the very real limits of the WHO. Its funding is determined by UN members via the World Health Assembly, but the second biggest donor, after the United States, is the Bill and Melinda Gates Foundation. Much of the work the WHO does is to provide specialist advice: it has no legal authority to force countries to accept/implement its guidance. The radically different ways in which WHO member states have chosen to respond to the pandemic reveals stark tensions between maintaining economic interests, travel and mobility, on the one hand, and supporting public health measures such as social distancing, lockdown and

vaccination programmes, on the other. Where one might wish for greater evidence of global co-ordination in a time of pandemic, we see schisms over the desirability and necessity of even basic public health measures.

Border infrastructures have been enrolled in public health security planning. Critical scholarship on borders has focussed on the migrant crisis in and around the Mediterranean and on the US-Mexican borderlands (Delmas & Goeury, 2020), noting how EU countries and the US have used border patrols, surveillance technologies, data collection, barriers and fences, and legal mechanisms to deter and displace potential migrants. In the aftermath of the pandemic, these border strategies have become a great deal blunter and varied as EU countries, in particular, have sought not only to seal their external borders but also to dismantle internal movement within the EU itself. In other words, EU citizens and not just non-EU migrants have found themselves targeted by widespread border closures and shutdowns. The very technologies and practices used to deter and detect unregulated migration have been transformed into a public health intervention. Recognising that the scale and extent of that transference does vary from country to country and region to region, critical health geopolitics provides opportunities to consider further how border technologies and practices are used as crude health security mechanisms that threaten to undermine the international legal rights of asylum seekers and refugees.

In sum, disease is a geopolitical issue because it is shot through with social-spatial strategies and practices designed to separate out some bodies and communities from others. Disease becomes part of the realm of the geopolitical as it reveals starkly the desirability, feasibility and durability of national, regional and global governance architectures. With COVID, some Western governments have accused Russia and China of using their medical supplies and vaccines to generate strategic advantages in other parts of the world, including within the European Union. If there is a 'new geopolitics' it is underscored by an old geopolitical order, which builds on entrenched hierarchies of authority, knowledge, and resources (including, in this case, vaccines). The UN programme, COVAX, will as ever be dependent on the support given by UN member states with the most medical-pharmaceutical privilege. The implications for the geo-politicization of disease in the name of public health are multi-scalar and multi-sited. As such, they also touch upon other areas of interest to political geographers, including legitimacy – that is, who has the right to exercise authority, and who has the right to resist public authorities and (Kenworthy et al., 2021). We must continue to pose questions about how anti-vaccination and conspiracy-based movements can act as sites/actors of resistance to public health while the 'slow violence' inherent in health inequalities continues to flourish (Davies 2019). All of which should be integral to any critical health geopolitics.

Not allowing the pandemic to 'dominate your life' is a luxury that many will find hard to avoid.