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Neighbours, Stigma, and Covid-19

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When my university went online, in the March of 2020, I was writing an essay for David A. B. Murray's edited volume *Beyond the Endgame: Living with HIV in "Post-Crisis" Times*. The volume emerged from the panel that Murray organized which was interrogating the narrative of "Positive Living" and the framing of HIV as a crisis that was nearing its end. My essay attempted to take stock of the epidemic in India as it loomed for hijras, one of India's "third gendered," trans feminine, population. I was also listening to the interviews that I had conducted in collaboration with Veena Das and ISERDD (Institute for Socio-Economic Research on Development and Democracy) since 2014 as part of a multidisciplinary team evaluating a health intervention aiming to change provider behaviour in the private sector so as to cut the delay in diagnosis for Tuberculosis (Kwan et al. 2019). That same month, the government of India decided to go into lockdown as the COVID-19 pandemic unfolded in India. The haunting images and stories emerged of millions of migrant workers walking hundreds of miles to reach home, some dying on the way, reminded me of stories that historians had studied regarding the Indian plague epidemic of 1897 (Catanach 1983). The refusal to admit COVID-19 patients in hospitals, the way the disease spread, the keywords of contact tracing, herd immunity, viral load (McKay 2017), the pressures to keep the economy open (Watts 2001), all became uncannily familiar to me and many other scholars who have devoted their life studying various epidemics of infectious diseases across disciplines. I posed this question, "what is or would be the signature of this epidemic?" to our bi-weekly meeting of a group of scholars, named "Viral Conjunctions" run by Megha Sharma Sehdev.

To investigate this question, Veena Das and Clara Han created a new survey instrument and made it available to whoever was interested in measuring the impact of COVID-19 on household decision making. The basic premise of this survey instrument was that most survey designs on the impact of COVID-19 epidemic took the individual as the subject and ended up

Academia Letters, January 2021

Corresponding Author: Vaibhav Saria, vaibhavsaria@gmail.com
Citation: Saria, V. (2021). Neighbours, Stigma, and Covid-19. *Academia Letters*, Article 181.
https://doi.org/10.20935/AL181.

treating the household as an aggregate of individual members. However, if we take one of the insights of anthropology seriously – viz., that the basic isolate of social life was a relation and not an individual - then the household is not simply the aggregate of individuals who compose it but rather is made up of relations of solidarity, betrayal, capability, exchange, and hierarchy. One consequence of the survey design would be that it would reveal intra-household inequalities and tensions; the second, that it could capture the multiple domesticities and flux in the boundaries of the household through processes of expansion, fission, housing, and unhousing. Households would also be shown to be permeable to institutions such as the state, modes of governance, and fluctuations in the market.

Since May, every 2 weeks, my research assistant who helped me with my research on tuberculosis in Patna, conducted interviews over the phone with 16 households in order to document the effects of the fast-changing COVID-19 landscape of the city. One of the earliest and enduring question that emerged was the stigma that household members confessed regarding diagnosis. During the early stages of the pandemic many households confessed that if they got diagnosed, their houses would be sealed, and their neighbours would "stop talking to them", "the frequent visiting between households would stop", "they would stare at the infected household". These reasons at once seemed familiar and ordinary and puzzling. While stigma associated with HIV was indicative of deviant sexuality, and private providers in Patna would tell me that stigma because of TB was differentially distributed with unmarried young girls affected the most, since their prospects would be ruined if news spread, a COVID-19 diagnosis neither made visible immoral sexual practices and neither did it result in endangering the future of the young. And why did stigma seemed so intransigent that looks, stares, not visiting, not talking, became unbearable. I pushed my RA to ask whether there was such a heavy traffic of sociality between neighbours that the loss of which would explain this fear of COVID-19.

In one of our viral conjunctions meeting, a leading health economist of India, Jishnu Das reported a similar finding. At the end of August, Das and his team members conducted an experiment in rural Punjab where they interviewed 465 households and gave each household vouchers to get a free COVID-19 test done. They reported only 4 people out of 465 households came to get their vouchers redeemed and tested (Aiyar et al 2020). Apart from reluctance to test, the researchers also reported respondents concealing their symptoms. Along with stigma came the fear that people testing positive would be removed to government facilities, away from home and without arrangements for the rest of the family. A shift of policy to allow home quarantine calmed some of these fears. Perhaps, this expansive form of stigma and contagion that COVID-19 has resulted is clarified in the attacks that nurses, doctors, and other frontline workers have faced in India (Bagchi 2020). Scared that frontline workers will

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bring COVID-19 to their neighbourhoods, residential complexes, and apartment buildings, neighbours at once are celebrating frontline healthcare workers as they are attacking them. The irony of the situation doesn't end there, given the conditions of work have resulted in healthcare workers becoming a high-risk population. This conflation of two actors that have dominated the field of global health- "health worker" and "high risk" - within the same body is revealing of the status of COVID-19, as compared to HIV, and TB. The other two ongoing older epidemics have been a relentless battle between recalcitrant, noncompliant, high risk bodies and health workers that emerge from the large global health infrastructure. Underpaid, overworked, health workers can hardly stand for the ideology of health and the vehicle it provides for the state to enact draconian measures that have far reaching repercussions. Yet, one hopes that this unfamiliar position for health workers will lead to the realization that the way health and disease, living and dying, doesn't always get carnalized for the poor, the queer, and the pathologized in easily discernible ways.

This braiding of living and dying that risk entails is given differential moral recognition but the stigma and its effects are not proportionate. The weather was beautiful, in Vancouver, when we went into lockdown, and there was a collective spirit on how this was a challenge that we should and would all meet together. Yet, during that lockdown and transition to working online from home, my colleague observed that young men were running and jogging bare-chested, without masks, passing too close to the people walking about. At the same time, migrant workers were also walking back to their homes, hundreds of miles away, without masks. The difference between the two bodies is that for the jogger, the everyday was being curtailed to secure a future that seemed at risk, while for the migrant body trudging, it was the everyday that became more and more at risk. The fear of stigma that the surveyed households confessed that they would face from their neighbours was vague when materially considered; the fear was that life for these families could come unmoored in unpredictable ways the very next day.

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