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# Introduction. Syndemic South Asia: Health Politics and Inequalities

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- 1 “COVID-19 is not a pandemic” as Richard Horton, the editor of *The Lancet*, one of the most prestigious international medical journals, put it in September, 2020 (Horton 2020). Rather, it is a “syndemic,” a disease caused by social inequalities and by the ecological crisis understood in the broadest sense. First conceived by Merrill Singer, an American medical anthropologist, in the 1990s, this notion emphasizes the socio-economical, politico-institutional, and ecological origins of pandemics (Singer Bulled, Ostrach, and Mendenhall 2017). The most important consequence of seeing COVID-19 as a syndemic is the underlining of its social origins. For Horton, it is not only the disrupted climate, or the continuous increase in chronic diseases that are weakening the population’s state of health in the face of new health risks; COVID-19 also appears to be the umpteenth episode in a long series of economic and political choices that have amplified the dismantling of health systems. The lesson drawn by *The Lancet* is clear: if we do not change our economic, social and political model, if we continue to treat the virus as a biological event whose circulation needs only to be “blocked,” health disasters will continue to multiply.<sup>1</sup>
- 2 At the end of 2019, while Wuhan province was dealing with the onset of the COVID-19 pandemic, South Asia had other preoccupations. India was facing massive and violent uprisings against the Citizenship Act passed by parliament, which was deemed anti-Muslim. The authorities seemed unconcerned about the virus and denied any possibility of local transmission, despite the first cases identified in January 2020 in Kerala. Until March, the Indian authorities produced communiqués stating that there was no community transmission of the virus and that it was cases coming from abroad that were to blame. Finally, after this phase of denial, the Prime Minister announced on 24 March 2020, four hours before it came into effect, the complete lockdown of the country for 21 days, which was immediately followed by another two-week period. This lockdown, which was the “most wide-reaching that the world had ever seen,” had disastrous economic effects. Many other South Asian states quickly ensured that they

would also “control the governance response to the COVID-19 pandemic” and imposed top-down national lockdowns (Mistree 2022). Yet they differed in the way they implemented these lockdowns. Pakistan imposed a “comprehensive” or “smart” lockdown, lifted it early (in the first week of May 2020) and refused to follow WHO’s advice to renew it. Considering these very few preventive measures taken, but also its fragile health care system, its lack of resources and its low literacy rate, Pakistan was predicted to be, “one of the worst-hit countries”; yet, on the contrary, the country got an “optimal hold of the coronavirus outbreak” without there being as yet any scientific explanations of this positive result (Ahmad 2021). On March 23, 2020, Bangladesh also imposed a national lockdown presented as a “general holiday” that soon turned out to be more relaxed than that of India; this was later followed by localized measures and eased to accommodate the celebration of Eid-ul-Azha and the economic activities around it (Hasan 2022). Sri Lanka, supposed to be particularly vulnerable, imposed a lockdown and was able to successfully limit cases throughout (Malji 2022). Nepal, which was the first South Asian country to report a confirmed case on January 23, 2020, imposed an initial nationwide lockdown with the closing of international frontiers from March 23 onwards while no fatalities were yet recorded (Pandey et al. 2022). By the end of March 2020, all South Asian countries had closed down their international borders.

## A syndemic where strengthening health systems was not a priority

- Worldwide, this pandemic has brutally exposed the vulnerabilities of most—if not all—health systems. The COVID-19 crisis enhanced long-lasting health inequalities and dysfunctional health infrastructures collapsed under the strain of the dramatic spike in COVID-19 cases in most South Asian countries. Lockdown measures soon became a cornerstone of the response to COVID-19, replicated around the world. Such “replication” of the lockdown approach did not always produce exactly the expected results (Al Dahdah, Falisse, and Lurton 2021). For the Indian health system, one of the most burdened and least funded in the world<sup>2</sup>, it was a critical moment, as government facilities were already overstretched in a highly fractured, underfunded, and geographically uneven health system (Das 2015; Drèze and Sen 2013; Hodges and Rao 2016). Rapidly, India imposed a nationwide lockdown with a strict travel ban on March 24, 2020, even though it had 500 cumulative cases and only one death from COVID-19 (for a population of 1.352 billion) and had just begun its screening campaign. With the lockdown, large numbers of workers migrated internally from existing hotspots, such as Mumbai and Delhi, toward their home states of Uttar Pradesh and Bihar. Until then, the Indian government’s testing strategy was relying on the assumption that no community transmission was happening in India, and that there were only foreign, imported cases;<sup>3</sup> thus only people coming from infected areas abroad were being tested.<sup>4</sup> Failure to acknowledge the presence of COVID-19 infections in the community and failure to test all symptomatic cases in Mumbai or Delhi itself may have exposed these rural States to the diffusion of the virus and led to an explosion of cases in places where health infrastructures are much poorer. This tragic exodus of migrant workers, day laborers, and often the poorest of the poor (de Bercegol, Goreau-Ponceaud, Gowda, and Raj 2020; Picherit 2020) was the most visible symptom of the Indian-style lockdown, which did nothing to flatten the trajectory of the epidemic and

may even have contributed to its spread throughout the country. Six months later, India had become the second country in terms of the total number of diagnosed cases (after the United States) and the fastest-growing country in the world in absolute numbers, according to the WHO (Lancet 2020).

- 4 During spring 2021, less than a year after its initial lockdown, India faced a terrible second wave with a very high mortality rate across its population (Bhatt, Srivastava, Schmidt-Sane, and Mehta 2021; Kar, Ransing, Arafat, and Menon 2021). The most palpable and visceral effects of this second wave in the country were the dramatic shortage of oxygen in hospitals (Bhuyan 2021), crematoriums and burial grounds running out of space (Johari 2021) and dead bodies floating down the Ganga (Sharma 2021). The incidence and scale of this second wave were exacerbated by systemic issues and especially underinvestment in the public health system.
- 5 During this deadly second wave, the world was facing another COVID-19-related scandal: the aberrant distribution of vaccine doses and the fact that 10 countries had appropriated 75% of the available vaccines in March 2021 (Quet 2021). At the heart of this international pharmaceutical system, many voices denounce the centrality of intellectual property, but suspending patents would not be enough to change the situation, as evidenced by the difficulty of obtaining doses in the very countries where the patent-holding companies operated. Even though India has been at the heart of COVID-19 vaccine production, its population did not have easy access to vaccines. Indeed, doses were first sent out to fill the orders of richer countries, notably Western ones, and Indian State governments then had to fight for doses as vaccine manufacturers were able to play off one Indian state against another (Neelakantan 2021). The situation was even worse in other South Asian countries that do not have India's pharmaceutical capacity. Richer countries got their vaccines at the cost of poorer ones.
- 6 Given the severe challenges faced by the public-health system and the dominance of unaffordable private health care<sup>5</sup> in many South Asian countries, the response to the COVID-19 crisis between 2020 and 2022 could have been to prioritize the strengthening of an affordable and accessible health-care system for all, which, however, didn't happen in most South Asian countries. Indeed, as in India, most health budgets in South Asia were far too limited to respond to the massive need for intensive care that has been necessary in all countries impacted by COVID-19 during the multiple waves that happened between 2020 and 2022. There was an urgent need to rapidly scale up oxygen capacity, ensure essential emergency and critical care, and stabilize the supply of medicines and medical equipment, none of which happened. If South Asia has a lower proportion of elderly people than European countries, government health-care facilities are limited and disproportionately burdened with patients with comorbidities—such as undernutrition, tuberculosis, diabetes, and chronic respiratory and cardiovascular diseases<sup>6</sup>—that may have aggravated the COVID-19 death toll in the region. Among all infected people worldwide, the death rate is hovering around 1 to 3 percent, but among the critically ill it climbs as high as 62 percent.<sup>7</sup>
- 7 India had officially registered only 311,000 COVID-19 deaths on May 25, 2020. This number corresponds to a rate of 223 per million inhabitants, which was twice lower than the world average. The uneven registration of deaths across the country was quickly identified as responsible for the under-reporting of COVID-19 mortality. Before the pandemic, only 22% of deaths were medically certified in India (Rao and Gupta

2020), and certification was virtually non-existent in the poorer northern states, India's most populous. And even in the states, which have better death registration, patients were not systematically tested or counted in the COVID-19 lists because of comorbidities or because they died before being formally registered at the hospital (Chatterjee 2020). Finally, the government has been accused of failing to aggregate figures reported by hospitals. For example, in April 2020, the Delhi government announced 15 times fewer COVID-19 deaths than were actually reported by Delhi hospitals.<sup>8</sup> This points to the wider issue of manipulating scientific data and information in the management of the pandemic. After the second wave, demographers estimated that India faced the largest number of COVID-19 deaths and the highest COVID-19 mortality rate in the world, above that of Brazil or the USA. According to these cautious estimates only one out of 7 COVID-19 deaths appears to be registered in India (Guilmoto 2021). The lack of data transparency in India led to under-reporting and undercounting of both cases and deaths, with severe implications for an effective and proportionate response. Failure to accurately record mortality and misleading uses of available data fueled the complacency that preceded the second wave. Beyond the death toll, this points to the weakness of the whole epidemiological surveillance system in the country (as described with regard to the lack of testing facilities) and to the wider issue of using extensively quantitative data and striking numbers in the management of the pandemic.

- 8 In fact, this pandemic revealed the extreme and appalling vulnerability to catastrophe of most people in South Asia that goes far beyond health care. Surprisingly, we have not received any paper focusing on health care services or specific public health measures to handle the epidemic. A first important reason was the difficulty if not the total impossibility of doing any fieldwork during this pandemic. It may also be that, far beyond the risk of infection and the healthcare realm, the measures taken to contain the pandemic—such as lockdowns for instance—had disastrous socio-economic consequences for a large part of the population that this special issue is thoroughly documenting.

## A syndemic where religions were politically instrumentalized

- 9 COVID-19 represented a cultural cataclysm that challenged and transformed many religious rituals; it had particular effect in India where funeral rituals were sometimes significantly transformed to adjust to the high numbers of deaths and respect the new COVID-19 guidelines (Mikles 2020, 2021, 2022). Yet with the failure of the biomedical system to provide cures, South Asians resorted to the repertoire of religion to cope with the distress caused by the pandemic while different states used religion to reinforce their own political agenda. Replicating popular Hindu practice according to which an epidemic is the work of an unappeased feminine deity, in some cases the virus of Corona was attributed to a goddess associated with epidemics—such as Śītala or Sansāri (Srinivas 2020, Schlemmer in this issue)—or deified and worshipped as a new goddess (*coronā devī*, *mā* or *mātā*) in temples purposely built for her. In other cases Corona has been conceived as a “demon” (*asurā*) that needed to be destroyed: in Mumbai, its paper-made effigy replaced Holika and was burnt during the March 2020 festival of Holi, while in Bengal's 2021 Durgā-pūjā, some renamed Durgā as the slayer of

the “Coronā demon” (*coronā mardini*); different folk artists—from scroll painters to Chau dancers of North India (Bengal, Jharkhand and Odisha)—inserted the history of the Virus-demon within their existing singing, dancing or visual narratives. More innovative practices were to be found in the middle urban sphere such as chanting against the Corona or “parties” to encourage the drinking of cow urine (*gomūtra*) that the All India Hindu Mahasabha—a radical Hindu nationalist group—organized in New Delhi. While all these different ritual innovations received wide “media coverage,” they were in fact “exceptional, class-dependent, contested and, with the possible exception of scattered Coronā Devī worship, short-lived” (Frøystad 2021:6–10).

- 10 By accelerating the digital turn of religion that had started at the beginning of the 21<sup>st</sup> century, the pandemic boosted the development of religious activity in the intimacy of home spaces. Already in India, the arrival of satellite television in the 2000s had led to the exponential development of private confessional channels—Hindu, Jain, Buddhist, Christian or Muslim—that had become major instruments for broadcasting sermons, prayers and religious songs. But the shutting down of places of worship and the interdiction of gatherings forced, in unprecedented ways, many religious institutions to move their activities online with functions, holy speeches and rituals being broadcast as live streaming. While the consequences of this digital acceleration have yet to be studied, it was certainly the most prestigious places of worship it mostly benefited. On top of the mega-temples, church or mosque that already had the devices to broadcast their activities live, some selected historic temples received governmental help to initiate live streams of their worship ceremonies (Nanda 2020). This turn also benefited many individual religious entrepreneurs (priests, preachers, gurus, etc.) who had the know-how to go online on their own, using Facebook Lives, Skype, WhatsApp, or Zoom and therefore were able to maintain regular contact with their devotees who had individual connected devices. The spiritualization of the confinement with the “skyrocketing” successes of meditation apps offering breathing exercises, chanting or yoga practices aimed at appeasing secluded individuals’ anxieties linked to the COVID-19 also contributed to reinforcing this “Hindu” inspired ethos (Laurea 2020). This digital acceleration was however “uneven”: with over half of the population remaining unconnected in South Asia many small religious organizations—wayside shrines and local temples—could not afford turning online and their caretakers suffered greatly from their significantly reduced income, some without reopening again (Frøystad 2021:14).
- 11 Throughout the entire COVID-19 pandemic, religious nationalism has also been heavily “mobilized and strengthened” (Subramanian 2021). In India, this happened through scapegoating non-Hindus for the transmission of the COVID-19 and through the State intense publicization of Hindu-inspired practices cast as scientifically proven methods to fight against the virus. While the nation was asked to unite together in solidarity against the virus, as early as March 2020, came the accusation that the transnational Islamic group Tablighi Jama’at were responsible for the spread of the disease after cases amongst one of its congregations in North India. The tone was set: Muslims became targeted as virus spreaders (Yasir 2020). Extensively relayed in social media, this accusation reinforced the “political imaginary” of deviant poor urban Muslims whose intimate life and spatial organization were not fit for the nation (Rothenberg in this issue, Tyagi and Sen 2020) and acts of Islamophobia increased, notably within institutions, with in some cases Indian hospitals refusing to admit Muslims

(Wallen 2020). On the other side, election rallies in Bengal and Hindu massive gatherings for Haridwar Kumbha Mela (Sengupta 2021) were maintained in the midst of the Corona outbreak (Patel 2020). Acts of racism and discrimination also increased drastically during the pandemics, notably against North-East Indians (Colney 2020; Deori 2020; Taskin 2020). The Sri Lankan government, too, took advantage of the COVID-19 crisis to increase and institutionalize exclusionary policies, often in the name of protecting public health. Not only arrests and intimidation disproportionately targeted religious minorities, but despite the World Health Organization (WHO) guidance that allowed burials, Sri Lanka government violated Muslims' common burial practices and ritual by imposing forced cremations for almost a year in the name of a false narrative according to which the burial of COVID-19 patients could contaminate groundwater and spread the virus (Amnesty International 2021, Malji 2022).

- 12 In India, Prime Minister Modi played a leading role in mobilizing the nation while strengthening Hindu nationalism. Operating a radical aesthetic transformation—he grew his hair and a long unkempt beard—Modi adopted the outfit of the ascetic and ornamented his public speeches with mystic references. This use of “guru aesthetics” and semiotic language was “perfectly in tune with his already existing authoritarianism and cult-leader status” and, transformed him from a representative of Indian citizens to a leader of Hindus only, thus implicitly unifying them against all non-Hindus (Landau and Rageth, in press). His exhortations to Indian citizens to light candles for nine minutes at 9 p.m. on April 5, 2020 to “defeat the despair” was for example interpreted by many as the proof of some sort of esoteric wisdom related to numerology and/or astrology (Jha 2020). Along with the adaptations to the new COVID-19 guidelines and the many rituals innovations that followed different religious groups engaged to fight the virus through social activities. While no Hindu leaders dare to follow up the radical proposition made at the beginning of a pandemic to convert the gold stored and/or displayed in Hindu temples into bullion (Bagaria 2020), many sectarian organizations, from small ashrams to traditional *sampradāyas* and new guru-based movements, mobilized their volunteers in COVID-19 prevention or relief work: free delivery of food, vaccine camps, etc. Among them the Rashtriya Swayamsevak Sangh (RSS), a Hindu nationalist group, has registered its presence quite significantly thus reinforcing its influence.
- 13 Moreover, on top of embracing scientific epidemiology—following global protocols and administering vaccines—the Indian government, through its ministry of AYUSH (Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy), promoted alternative remedies to COVID-19 supposedly inspired by ancient Hindu practices. Yoga exercises, the ingestion of “ayurvedic” preparations made of easily accessible products and spices (cow urine, turmeric, garlic, basil, etc.) were described as immunity booster capable of warding off the disease with, in some cases, controversial randomized studies quoted to make these treatments appear “scientific” (Dore 2021, Maanna 2020). Hindu customs and lifestyle—*namaste* salutation rather than a handshake, a kiss on the cheek or a hug; cremation of the dead; burning of camphor in the home; vegetarian diet, etc.—were all rebranded as being in line with modern scientific protocols. Indian gurus, who have been associated with Hindu nationalism for a long time (McKean 1995), relayed these discourses intensely within their circles of devotees both in India and abroad.



- 14 While the narrative of an articulation between “Science” and “Hinduism” has a history that dates back to colonial India (Van der Veer 2001), the Hindutva movement brought this relation to the core of its ideology. Subrahmanian, author of the *Holy Science* (2019), qualifies it as an “archaic modernity” (2020:74) and describes it as an “imagined mytho-scientific corpus where Hindu mythology and modern science meld seamlessly into the other” (2021:2). The “grand Vedic past” praised by the 19<sup>th</sup>-century Hindu reformers as a golden age operates therefore as “the prelude to a future of India as a Hindu nation” (Subrahmanian 2021:2). COVID-19 became an opportunity to present “Vedic science”—an expression that had emerged in the 1970s among different neo-Hindu groups (King 2009)—as the very embodiment of cutting-edge contemporary science as well as a “timeless gift” from ancient Hindu civilization to the world. In the name of this supra-science that is not yet fully understood by “human” medical science, practices ranging from well-established facts to disinformation and scams—such as the multi-millionaire yoga entrepreneur Baba Ramdev’s Ayurvedic pills controversially claiming a “100% efficiency” against COVID-19—were heavily relayed by public actors and significantly participated in this “saffronisation of the public sphere” (Jaffrelot 2018). In another articulation between religion and COVID-19, Bhutan’s royal government used religious knowledge to decide on the most auspicious day for the launch of their vaccination scheme; referred to astrology to select the first person to be vaccinated and lead the country in chanting mantras believed by many as prayer powerful in warding off diseases (Rocha 2021).

## A syndemic where multiple inequalities escalated

- 15 Worldwide the pandemic was the theatre of increased discrimination and as some scholars put it an “explosion of inequalities” (Lambert, Cayouette-Remblière, and Méda 2021). Researchers worked to provide scientific evidence that the health crisis has revealed and exacerbated social inequalities that are too often invisible (Acharya and Christopher 2022). Specifically, social scientists challenge the widely held view in the media and political discourse that the health crisis affected the lives of all people equally or in a similar way and that it required an equal level of effort for all. On the contrary, they seek to show, with empirical evidence, the profoundly unequal nature of the pandemic and its various health restrictions. Some authors highlighted that the health crisis had little impact on upper-class living conditions. While wealthy households were unable to take advantage of their strong social skills during the health crisis or to make the trips abroad that they enjoy, they were, for the most part, able to cope with the confinement (Guérait 2021). On the other end of the social spectrum, in working class families, the pandemic and its various restrictive measures have had a negative, even deleterious, impact on their living conditions. The most precarious among them lost all or part of their income and were obliged to go into debt in order to cope with the crisis and pay their rent as well as the various expenses of daily life (Crépin 2021). Not only did lockdowns, compulsory residence and the variable introduction of telework highlight gender, class and age inequalities, which were largely invisible in the domestic and professional spheres, but they also contributed to “amplifying all the social inequalities that had already existed in terms of housing, employment, work, income and social relations” (Lambert et al. 2021:36).

- 16 In South Asia, the pandemic deepened “the divide between people on the safe side of the social order and those at risk” (Bremner 2020). Due to the pandemic-induced national lockdown, income inequalities have been aggravated in Pakistan, especially within the urban population and the regions of Punjab and Balochistan (Ahmad, Rehman and Sarwar 2022). In India, as explained, the most visible and mediatized part of this phenomenon was incarnated by hundreds of thousands of migrant workers who got stuck and several of them died in between the home they were trying to reach and the work site they left behind because of lockdowns. Both the migrant workers as well as the houseless communities in cities<sup>9</sup> faced attacks and were ostracized by fear of infection. And it was not long before hatred discourses surfaced in this crisis with Muslim, north-eastern, tribal or Dalit Indians, all being accused of spreading the virus.<sup>10</sup> Their terrible fate highlighted multiple inequalities and discrimination reinforced by this crisis that affected millions of lives across South Asia (see for example Rothenberg, in this issue). Stigmatization as well as religious/ethnic/caste/class/gender-based polarization was indeed worsened by the crisis (see for example Siddiqui, in this issue). In other words, although the pandemic affected the entire population, not everyone saw their professional activity come to a halt, their sociability become restricted, their standard of living degraded and their mental health deteriorated. The poor and the minorities were the first to suffer from this crisis (Dang, Lanjouw, and Vrijburg 2021). For them, the consequences were dramatic.
- 17 It should be emphasized that gender disparities have been particularly exacerbated in the context of COVID-19 in South Asia, “may they be immediate effects linked with lockdowns [or] longer-term effects that are likely to emerge sequentially in time and affect recovery” (Agarwal 2022). Research in Pakistan (Shaikh 2021; Cheema, Khan Mohmand and Khan 2021), India (Agarwal 2021), Nepal (Dahal et al. 2020; Rayamajhi and Fehr 2021) and Sri Lanka (Meegaswatta 2021) show how women’s livelihoods have been massively affected due to greater economic vulnerability, increased exposure to domestic violence and higher propensity for unpaid care work.
- 18 Despite a comparatively lower level of positive cases of COVID-19 amongst women,<sup>11</sup> they were often working on the frontline in hospitals as social workers, nurses or auxiliaries with insufficient protective measures, thus facing higher chances of contracting COVID-19 in the workplace. While having less bargaining power within the family and being less inclined to be supplied with information about COVID-19 or access online platforms, they also had more limited access to protective measures or care facilities.
- 19 In addition, as women enjoy less economic independence and were seven times more likely than men to lose their work during the nationwide lockdown (Abraham, Basole and Kesar 2022),<sup>12</sup> they faced higher risks of being pushed into poverty or being asked to sell their own assets such as small animals and jewelry (Agarwal 2022). In India, where the market and the State “have failed to provide adequately for the working people,” the pandemic has also amplified women’s labor of social reproduction, that is their compliance in sustaining their families (Naidu 2021:37) and their involvement in unpaid work (Deshpande 2022). Although humorous memes that circulated during the lockdown “inaugurated a vibrant debate on men’s participation in household tasks” among the Indian middle-class (Narasimhan, Chittem and Purang 2021), lockdown restrictions and men losing their jobs have mainly resulted in an overload of domestic chores and care work for women. To cope with the crisis, women also became highly

involved in trade unions or forms of self-organization characterized by forms of female solidarity, as well as by the resurgence of old forms of patronage (Guérin, Venkatasubramanian, and Joseph 2021).

- 20 Finally, due to greater cohabitation and enhanced tension, the lockdown has increased the risk of domestic violence and reduced women's ability to seek help or escape domestic violence. Data from the Indian National Commission for Women clearly shows that the reporting of cases increased as the lockdown was being lifted gradually and women were able to leave their homes (Mukhopadhyay and Roy 2022). Domestic violence escalated with a rise estimated between 20% and 68% in India (Kapoor 2021), 50% in Nepal (Dahal et al. 2020) and more than 25% in the Pakistani province of Punjab (Shaikh 2021). Child marriages are also said to have increased during the pandemic as school dropout rates rose (Sonawane 2020) and parents pushed into poverty were more prompt in marrying their daughters (Cousins 2020).
- 21 This special issue tries to document and tackle as much as possible social, economic, political and religious based inequalities during the pandemic. By investigating instances where COVID-19 exacerbates long-standing social (low caste citizens, slum dwellers) or religious (Muslim communities) discrimination, as well as cases where loss of social status happens regardless of the economic status, the articles gathered in this special issue participate in shedding new light on the articulation between inequalities, discrimination and stigmatization in contemporary South Asia.

## A syndemic where research methods were heavily challenged

- 22 Since the beginning of this project, we have been well aware that the challenge of publishing a special issue on COVID-19 in social sciences comes with risks. Similar concerns have been raised by several social scientists and have resulted in a series of publications (Ghosh 2020; Kim, Williams, Eldridge, and Reinke 2021), Blog posts,<sup>13</sup> webinars<sup>14</sup> and videos<sup>15</sup> since the outbreak of COVID-19. How can researchers gather first-hand information at a time when it has become technically challenging to collect data and conduct fieldwork due to travel bans and state-imposed restrictions? What might be the input of academic articles that rely on secondhand data that would most likely lead to putting forward arguments already brought up in media outlets by journalists accustomed to publishing under tight deadlines? How do researchers address a rapidly changing situation where the health and political context analyzed at a given point of time often has little to do with the context in which the research is eventually published? And to what extent will logistical challenges impact both the questions social scientists are able to raise and reflect upon as well as the possibility of grasping the “context of enunciation” of a particular discourse?
- 23 If it is worth recalling that researchers have always dealt with disruption before—see for example, Malinowski during WW2—(Block 2020), social scientists' traditional methods of investigation are at first glance at odds with the challenges of writing on a highly topical and, by its essence, ever-changing subject. What's more, considering the specific time frame of research production, the papers of this special issue cannot offer a longitudinal view of the impacts of COVID-19. Rather, they provide detailed analyses of local phenomena at a particular given time as if they were snapshots. Similarly, authors were sometimes unable to engage with the literature in the way they would

have done under “normal” circumstances. While researchers commonly follow a linear timeline stemming from data collection followed by an analysis consisting of a “reading and dwelling in the world through theory” (Cerwonka and Makki 2007:4), several scholars involved in this special issue constructed their analyses as they were undertaking their fieldwork.

- 24 That being said, this special issue’s contribution is threefold. Firstly, at a time when few social scientists could travel, it includes papers of researchers that were able to access their field sites, either directly (as in the case of Grégoire Schlemmer who got “stuck” at his usual fieldwork site) or indirectly through the help of long-term research assistants (as in the case of Isabelle Guérin, Jalil Nordman and Cécile Mouchel).
- 25 **Isabelle Guérin, Christophe Jalil Nordman and Cécile Mouchel’s** contribution explores how rural populations in India have mobilized their social networks in times of forced “social distancing.” Mixing Social Network Analysis, descriptive statistics and qualitative interviews conducted before, during and in the aftermath of the lockdown, the authors analyze the effects of the first Indian lockdown from March to November 2020 on the use of interpersonal social networks in rural areas of Tamil Nadu, with a focus on caste. This paper shows that kinship ties and caste-based relationships are still used as inescapable economic resources, especially when it comes to surviving in this unprecedented worldwide economic and social crisis. The region under study has undergone profound changes in recent decades, combining the disappearance of agrarian forms of dependency and the strengthening of intra-caste interdependence among the lower caste group (measured in this paper in terms of homophily and homogeneity) with a focus on access to credit and self-help to access employment. The crisis has been putting these social networks to the test. This contribution shows that if subsidized food prevented famine, it did not prevent severe malnutrition and if kin and caste solidarity played a key role in helping households to survive, it did not prevent the resurgence of old forms of patronage.
- 26 **Grégoire Schlemmer’s** contribution is, in a sense, a successful outcome of an adverse event. In March 2020, whereas he intended to conduct fieldwork in India, the sudden enforcement of the Nepali lockdown confined him for weeks to the village of eastern Nepal where he had been doing fieldwork for the last 25 years. Although he had no interest in carrying out research on the pandemic and no experience in making ethnographic documentaries, he ended up producing an 18-minute film on a ritual aimed at warding off COVID-19 among the Kulung. Grégoire Schlemmer’s short documentary narrates villagers’ conception of the epidemic and their participation in a ritual intended to chase the virus away, with a particular focus on how the COVID-19 outbreak led to the creation of a new ritual to Sansāri, the goddess of diseases. In addition to this film, Grégoire Schlemmer’s paper provides a fine-tuned analysis on broader themes of the anthropology of religion as well as on ethnographic research methods. He discusses the relationships with invisible entities and the ways old rituals integrate new elements as well as the embeddedness of the religious, medical and environmental spheres among the Kulung. By engaging in reflexivity and by confronting his understanding of the virus with villagers’ local interpretations, he ultimately raises the question on how one makes sense of the unknown.
- 27 Secondly, this special issue shows researchers’ inventiveness in devising new methodological resources, whether by relying on the movement flows of a large panel of users through Facebook (Samuel Benkimoun), by conducting interviews through

phone calls (Bulbul Siddiqi and Nur Newaz Khan) and video-call platforms (Christine Ithurbide and Khetrinmayum Monish Singh) or by processing online information such as stories or postings that circulated on social media (Rachel Rothenberg) but also data provided by E-commerce platforms (Christine Ithurbide and Khetrinmayum Monish Singh).

- 28 To explore the socio-economic difficulties faced by the craft industry in India's North-East region during the pandemic, **Christine Ithurbide and Khetrinmayum Monish Singh** rely on qualitative methodology associating document analysis and fieldwork conducted before the lockdown in February 2020 in Assam, and followed by online interviews conducted after several months of lockdown. Their contribution looks at the ways in which the pandemic has strengthened the use of digital platforms and accelerated reconfigurations within the craft industry. While this sector remained largely unorganized and was for some time dominated by cash, a transition toward online businesses mediated by digital platforms—either social media platforms (WhatsApp, Facebook, Instagram) or e-commerce platforms—has started and was reinforced during the months following the COVID-19 lockdown. This qualitative research, articulating offline and online fieldwork, examines the adaptation of work dynamics in a largely informal and precarious sector, the changes in terms of platform strategies, and the way in which the pandemic may have reinforced processes of dependency toward certain digital players.
- 29 **Bulbul Siddiqi and Nur Newaz Khan's** contribution on social stigma and sufferings in Bangladesh employs a qualitative approach based on telephonic interviews with different individuals affected by COVID-19 at the beginning of the pandemic. Focusing on cultural perceptions and experiences of social stigma, the paper argues that socio-cultural and religious practices and various new metaphors in day-to-day linguistic usage around COVID-19 created and shaped social stigma for suspected, infected, associated, and even recovered individuals and groups. Additionally, lack of knowledge and education, superstitious belief, and long held socio-cultural understanding and prejudice about infectious disease further aggravated the process of stigmatization. The lack of awareness material and the preparedness of the Government also contributed to stigmatization. The findings show that stigmatization around COVID-19 took place due to fear of infection, perceived loss of social status, multiple forms of discrimination, and exclusion from standard health services that need to be addressed in health and related policies for future.
- 30 Disabled from going to Jaipur (Rajasthan, India) where she had been doing fieldwork among different households over the last two years, **Rachel Rothenberg** analyzed social media accounts followed by her young Hindu interlocutors. She shows that although these “rank-and-file” Hindus—as she calls them—are not members of a specific Hindu nationalist organization and would describe themselves as “apolitical or uninterested in politics,” they engaged in intense online discussion on the pandemic which contributed to “reify Hindu nationalist imaginings of the nation and its people.” In these discussions, Muslims are consistently described as the main culprits of the transmission of the disease either because of their alleged lifestyle made of uncontrolled everyday promiscuity or because of their unreasoned regular gatherings, such as that of the Friday prayer in the mosque or the grouping of Tablighi Jama'at. The radicalness of the exchange went to the point where some suggested that “mass killing” was the only way forward, therefore not advocating the extermination of the

virus itself but that of its bearer, the contagious Muslim. Not only does this paper draw attention to the hegemonic presence of the ideology of Hindu nationalism in everyday life in contemporary India but it also underlines its consistency and alignment with the radicalness of the original narrative of its founder, V. Sarvakar, who had characterized Muslims as a foreign virus which had sapped the Hindu *rashtra* of its health and strength (Sarvakar 1923).

- 31 While classical spatial epidemiology underlined the crucial role of human movement in spreading the virus, **Samuel Benkimoun** in his paper, is using the lenses of geography and quantitative analysis to grasp the impact that lockdown measures had on urban spaces and networks during the first lockdown in the Delhi region. By processing raw movement datasets provided by Facebook through its program “Data for Good”—data that have some blind spots and do not reflect all segments of the population due to the unequal access to smart mobile devices in South Asia—Benkimoun takes into account no fewer than 48 sub-districts of Delhi (Delhi itself, its Union Territory as well as its nearby metropolitan area, the National Capital Region) as well as their specific territorial dimensions. He thus shows that privileged populations located in the urban center have shown greater adaptability to movement constraints and have, in numerous cases, been able to relocate temporarily to a more comfortable setting. In contrast, populations living in peripheral areas have been more dependent on on-site presence due to the precariousness and/or nature of their jobs. Benkimoun thus argues that the pandemic acted as a “catalyst of pre-existing spatial dynamics” whereby mobility, defined as “capacity” that goes beyond the ability to physically transfer oneself from one place and encompasses the competences needed before, during, and after the movement itself as well as the possibility of renouncing physical movement, that took on the aspect of a privilege reserved to populations with higher economic and social capital.
- 32 Within the last year, many debates have focused on the advantages and disadvantages of relying on the digital in social sciences, revivifying old debates (Pink and al 2015). At times, COVID-19 was portrayed as a wonderful opportunity to assess new methods of investigations and compensate classical ethnography’s “relative weakness in advancing in digital theories and methods” (Boellstorff 2020). Authors rightly pointed out that conducting digital research has many advantages such as maintaining relationships over distance or ensuring freedom from external intervention (Ghosh 2020). Some advocated for a “patchwork ethnography” made of short-term field visits as well as other innovations that help maintain long-term commitments and should be “a resource for a changed world after the pandemic” (Günel, Varma, and Watanabe 2020). It was sometimes explicitly—yet controversially—considered that long-term “traditional” fieldwork would now be a practice of the past (Günel, Varma, and Watanabe 2020). Other times, such inventiveness was presented “out of spite” as an ersatz, as a mere alternative offered to researchers, in particular to PhD students who were waiting months in vain to get authorizations to conduct fieldwork but yet had to hand in their thesis on time. While digital data collection might have been more easily adopted by some sociologists or economists who were already accustomed to remote research, it has been more problematic for anthropologists who consider that empirical data requires direct observation and interviews, and therefore needs to be personally collected in the field. Moreover, according to their disciplinary affiliations, researchers

might not ascribe the same status to data depending on the way it has been collected (first-hand/second-hand; in the field/digital, etc.).

- 33 No matter how researchers from different disciplines position themselves on this important and sensitive issue, the challenges triggered by the pandemic encouraged many of us to “revisit the virtues and limits of conventional fieldwork” (Fine, Johnson and Abramson 2020:8) through fruitful reflexive work. This special issue does not take any normative position with regard to the relevance of digital vs classical ethnographic research per se. Rather, it illustrates a whole range of creative approaches that researchers implemented out of necessity to document social aspects of COVID-19 despite multiple restrictions, and it prompts us to reflect on the ways researchers construct field sites and delineate samples.
- 34 Thirdly and finally, by presenting the ways the COVID-19 outbreak was experienced locally and how it has altered lives in India, Nepal and Bangladesh, this special issue intends to bear witness to an event that will probably be remembered in history, but whose individual life stories may be forgotten. It seems to us that the authors closely observed what was unfolding in order to analyze the impacts of a major and worldwide crisis, as well as to bear witness. As Pamela Block (2020) underlines, “bearing witness can take the form of communicating traumatic personal experiences or documenting for others the dislocations, institutionalized violence, and kinds of difference-making than often escape social examination.” It is not about “amorphous and abstract policy decisions,” but rather about “giving people something to become vested in” (Higgins, Martin, and Vesperi 2020:3).

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## NOTES

1. We are grateful to Sanjukta Das Gupta and Alessandra Consolaro who, together with Raphaël Voix, brought up the idea of this theme while preparing a common EASAS-SAMAJ issue in August 2020.
2. India's just over 1% public health expenditure as a percentage of GDP is even lower than that of its poorer neighboring countries, such as Sri Lanka, Bhutan and Nepal.
3. See ICMR press release of March 19, [https://icmr.nic.in/sites/default/files/press\\_release\\_files/PressRelease\\_ICMR\\_19March2020.pdf](https://icmr.nic.in/sites/default/files/press_release_files/PressRelease_ICMR_19March2020.pdf)
4. Testing is crucial to gauge the extent of COVID-19 transmission in any country. India had one of the lowest rates of testing in the world in 2019, which may have masked coronavirus cases during the first wave. As of June 16, the country conducted 4.29 COVID-19 tests per one thousand people, the lowest rate among the BRICS countries. South Korea carried out 21.35 per one thousand people, the United Kingdom 70.7, the USA 73.96, and Italy 77.66.
5. Knowing that the average cost of private hospitalization in India in 2017 was 31,845 rupees (roughly 384 euros), that India's monthly per-capita income stands at 11,254 rupees (roughly 135 euros), and that most Indians do not have any health insurance, the majority of patients were not

able to afford private care once the modest public facilities were overwhelmed. Moreover, many private hospitals added very expensive COVID-19 packages to their normal fees.

6. In 2018, India accounted for a quarter of the global tuberculosis burden, with 2.15 million active cases and an estimated total of 450,000 TB-related deaths. Diabetes and chronic respiratory and cardiovascular diseases were estimated to account for 3 percent, 11 percent, and 27 percent of all deaths. Sources: WHO-India Noncommunicable Diseases (NCD) Country Profiles, 2018 and India TB report 2019 (<https://tbcindia.gov.in/WriteReadData/India%20TB%20Report%202019.pdf>) consulted on April 4, 2020.

7. Most deaths are due to hypoxia, an insufficient supply of oxygen to the body's tissues, or multi-organ collapse. Around 5 percent of infected patients will require intensive care (<https://journals.lww.com/ijmr/pages/default.aspx>), and half of those admitted to the intensive-care unit will require mechanical ventilation; up to one million ventilators at the peak of the COVID-19 epidemic may be needed (see <https://onehealthtrust.org/wp-content/uploads/2020/03/covid19.indiasim.March23-2-eK.pdf>, accessed on 20 September 2020). As per Ministry of Health estimates, as of March 24 there were 8,432 ventilators in public hospitals, a number that could reach 50,000 if we factor in private hospitals (see <https://theprint.in/health/india-has-40000-ventilators-but-could-need-many-many-more-in-worst-case-scenario/388874/> accessed 20 September 2020). Even the meager numbers quoted above hide extreme disparities in access. Intensive-care facilities, especially ones that offer mechanical ventilation, are concentrated in big urban areas and richer provinces; Mumbai alone has one thousand ventilators and Kerala five thousand, which means there is a significantly smaller number of ventilators available in some of the poorest and most rural provinces of the country. Hence, the massive oxygen crisis that happened during the second wave in India (see *The Lancet* 2021)

8. See <https://thewire.in/government/delhi-government-casualty-hospitals-data>, accessed on 15 May 2020.

9. Paroj Banerjee, Ratoola Kundu and Maggie Paul's oral presentation entitled "Unsafe bodies, hostile city: governing the houseless in India during COVID-19 induced lockdown" (CSH, CPR, March 29, 2022) highlights for instance how policies exacerbated insecurity among unhoused population. <https://cprindia.org/events/unsafe-bodies-hostile-city-governing-the-houseless-in-india-during-covid-19-induced-lockdown/>

10. See for instance:

11. This is due to both women's inherent biological advantage as well as their use of the public space.

12. As shown by the examples of wage workers in areas surrounding Delhi (Desai, Deshmukh, and Pramanik 2021) and women informal sector workers (Chakraborty 2020), broad comparisons on gendered employment patterns should not hide variations according to industries and occupations.

13. See for instances The Wenner-Gren Blog series entitled "The Future of Anthropological Research: Ethics, Questions, and Methods in the Age of COVID-19: Part I" <http://blog.wennergren.org/2020/06/the-future-of-anthropological-research-ethics-questions-and-methods-in-the-age-of-covid-19-part-i/>

14. Such as the webinar "Fieldwork in an era of pandemia: digital (and other) alternatives - Webinar of the World Council of Anthropological Associations" from the World Council of Anthropological Association (May 19, 2020) <https://www.apantropologia.org/apa/fieldwork-in-an-era-of-pandemia-digital-and-other-alternatives-webinar-of-the-world-council-of-anthropological-associations/>

15. See for instance the video series from the Centre for Global Ethnography (University of Stanford) entitled "Doing Ethnography Remotely." <https://iriss.stanford.edu/doing-ethnography-remotely>

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