

The Pandemic, Pharmacology, and Biopower—Or My Meeting with SARS-CoV-2 and Rosa B.

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(Translated to English by Diane Whitty)

I met Rosa B. in mid-April 2020 through an app. I was in Princeton; she was somewhere in the vicinity. We exchanged a few text messages, where she always withheld her last name. It was the virus that brought us together.

Like Rosa B., the virus has a code name, but its name, unlike hers, registers its genealogy. An international committee of taxonomists christened the virus as a way of singling it out: SARS-CoV-2—like MERS-CoV and SARS-CoV, all examples of distinct individuals belonging to the same genetic family. The name informs us about kinship, host, and place and date of identification. The logic is that the better we can individualize the virus, the better we can treat it. Irony. For the virus, a designation worthy of royalty, a string of surnames indicating pedigree. For Rosa, the vague letter “B” followed by a period. Perhaps if Rosa B. had a coded name that singled her out, she, like the virus, might receive better, more individualized treatment.

[As distinct beings we can trace, isolate, hold accountable, and combat, viruses have been around for only about 120 years](#), made visible through the intersection of science, imperialist endeavors, and military campaigns. But the idea that bodies fall ill through contact with each other is an old one. “Contagion,” from the Latin *contagionem*, meaning “a touching, contact,” expresses this idea. A microscopic virus makes itself visible to us when it assails economies and human relationships. Our biological selves, built on some 23,000 genes, are estimated to harbor something like eight million microbe genes, viruses among them. We are microbial systems and any one of these many viruses only earns a distinctive name when it significantly alters our biology, habits, and modes of organization. We singularize the virus, while the virus collectivizes us by threatening us as a group. For the virus: genetic mapping and a differentiated name; for allegedly undifferentiated humanity: a global disease, Covid-19.

Thus it is disease—or the effects the virus has on our bodies in a given time and environment—that links us, evincing our interdependence and reminding us of our own finitude when we see how fragile others are. That’s how it was with Rosa B. and me. Out of eight billion indistinguishable people, Rosa B. became visible to me when the disease cast its light on her. Locked up at home, working and consuming over the internet, I learned to navigate a purchasing app—filling a virtual cart, entering my credit card data, and scheduling a delivery time. It took a while, but I figured it out. Saturday, between 9 am and 11 am, Rosa B. would do my shopping and deliver it to me.

It is hard to see the pandemic as a positive force or shift our focus from its destructive power and the negative, long-lasting consequences we can already glimpse. If Covid-19 has any potential for good, however, it might be its ability to call attention to the mechanisms of inclusion and exclusion engendered by our biopolitical systems, systems that are structured in the name of life and capital. We would do well to examine these closely, documenting and scrutinizing them analytically and politically—just as we who can identify with people

privileged by the system, as portrayed in films like Jorge Furtado's *Isle of Flowers* (1989) or Bong Joon Ho's *Parasite* (2019), have the moral obligation to register and remember the fractures in our broken humanity that are illuminated by these screenplays.

I'd like to use this light cast by Covid-19 to explore the notion of biopolitics, a concept that has been broadly cited in analyses of the pandemic. Biopolitics is often viewed monolithically, as a singular entity, and this tends to obscure the plurality both of the populations to which it applies and also of the interests served by its implementation.

Coined by Michel Foucault (1926-1984), the term inhabits the web of ideas woven by the French philosopher to describe the emergence of the State and two notions that underpin it: modern society and the "right to life." When absolutist monarchies wielded centralized power, death rituals reminded subjects—pompously, intermittently, and exemplarily—that a vassal's life belonged to the king. Once absolutism had been beheaded, another power structure emerged, rationalized around the State in terms of governmentality and called "biopower" by Foucault, precisely because it is power exercised in the name and function of life as a new structuring element. Not that people quit dying. They die a lot, but now under the rule of a regime that, even if only tacitly, and deceivingly, promises to defend their lives, a regime they can rebel against if this promise is breached.

In defense of life, Foucault tells us, a political space called biopolitics opens up, a field of strategies and disputes through which biopower will be exerted and that manages matters related to the vital characteristics of individuals and social bodies, that is, to their processes of birth, reproduction, maturation, morbidity, and mortality. Biopolitics encompasses negotiations over which issues will be prioritized, which areas of expertise will be relied on, and which protocols will be followed in managing life. Biopolitics is the concept of the day, as it speaks to the space of disputes and the environment where we will eventually define how to address Covid-19. This is a dynamic process that can only be narrated *a posteriori*, but surely it will be based on the reproduction of inequalities and will redefine the contours of society itself, of who, in Foucault's terms, will be made to live and let die.

In defense of my life, I stay home. In defense of hers, Rosa B. goes to the store for me. In a perverse, entrenched moral economy, the politics that protects my physical survival endangers hers, while she earns a percentage of my purchases. After delivering my order, Rosa B. rushes off in her own car, no gloves or mask, tending to the next customer on her schedule and earning a little more change. The defense of life reveals unequal existences and survival strategies and, at the level of governmentality, reflects a fragmented power, which does not emanate solely from a central government.

We find a good example of this in the implementation of AIDS policy in Brazil from the mid-1990s through the early 2000s, deftly portrayed in the ethnography of João Biehl (2007), who identified the pharmaceuticalization of public health. "Pharmaceuticalization" is the process by which health is increasingly centered on the prescription of medicine; the individualization of care (whose management, even within the public system, is increasingly relegated to the individual); the decentralization of the resources and structures that provide health; and a shift from the human right-to-health to the biological right-to-drugs.

Pharmaceuticalization reflects, at one and the same time, a shrinking welfare state and the participation of arenas that contribute to the production of pharmacological solutions on biopower's plural stage. Multinational pharmaceutical companies wield substantial weight

here, but so do biomedicine, science (which interprets and reproduces bodies in an increasingly molecularized fashion), and the government-owned drug industry, such as Fiocruz's Farmanguinhos in Rio de Janeiro, federally owned, and the Butantan Institute, a state of São Paulo facility. As Paul Rabinow and Nikolas Rose (2006: 203) remind us, one feature of the modern State, which gained firm footing in the eighteenth and nineteenth centuries, is that it developed in dialogue with "apparatuses of knowledge collection and problematization that. . .will exercise demands and constraints on central powers." Brazil's current administration might be better understood—and might better understand itself—in the light of such insights. It might get a better sense of itself, if it only realized it is not sovereign in premodern terms, but must share biopower and the political stage, engaging with the various actors indicated by Rabinow and Rose, given that the administration does not appear to be moving toward government ownership of large sectors of the economy, despite its nationalist discourse and aggressive stance toward international bodies like the WHO. In practice, the more liberal a regime, the more dependent it will be on the knowledge and power apparatuses that sustain it—and social scientists would also do well to remember this.

Biehl shows us that public policies are shaped in the voids left between interests, discourses, and the potential power of diverse forces. He ethnographs a State that responds concomitantly to a neoliberal global agenda—negotiating with international development banks and signing intellectual property agreements that benefit world powers—as well as to demands generated by civil society. This is a State that is shrinking, on the one hand privatizing, outsourcing, disinvesting in infrastructure, decentralizing its tasks by transferring (scant) funds to regional and local governments, and relegating coordination efforts and care to organized civil society, while, on the other hand, it recasts itself as sovereign, strong, and present—for example, reverse-engineering antiretrovirals and forging alliances to threaten Big Pharma patents, all in the name of defending its citizens' lives.

While Brazil's current administration makes no bones about its contempt for the human sciences, if its representatives were to read some of the research in the area, they might realize that Brazil only achieved world renown as a model for its handling of the AIDS crisis after nearly twenty years of research, which led to the development of retrovirals. Then these representatives might also recognize that the current administration has opted for a continued magic-bullet focus in medicine, where the approach is to manage illness rather than address the social determinants of disease or improve health infrastructure, accompanied by systematic disinvestment in the preventive role of public health. In the absence of some miraculous cure for Covid-19, safeguarding the "right to life" depends on the proportional distribution of community health services, hospital beds, physicians, and healthcare centers across the country, as well as on research and on funding reserves for the purposes of social welfare, testing, and healthcare infrastructure.

It is an incontestable fact that the pandemic has been used to reinforce the image of the State as a powerful, autonomous entity; to strengthen nationalisms; and to enforce states of exception through the adoption of policies that primarily tend to affect underprivileged citizens and populations at a biological level, as pointed out by Paul Preciado in one of the most inspiring essays about Covid-19 that I have read. The latter was the case with certain lockdown restrictions. While some people were able to work from the safety of their homes, many were forced to accept unsafe working conditions or in other ways risk their health to keep their jobs; large numbers of informal workers were simply forced off the labor market. The pandemic further served as an excuse for job cutbacks and reductions in work hours, wages, and benefits on the formal market. While I sit here writing this in April 2020, people

are shouting anti-democracy and anti-science slogans in Brasilia. But we cannot lose sight of the knowledge or power apparatuses that collaborate to shape this narrative, nor can we let them slip into invisibility. Where pharmaceuticalized logic has already been institutionalized, as suggested by the anthropologist Joseph Dumit, health will always have to fight to keep from being reduced to the size of any given market.

Health was once deemed the absence of disease, but in many places around the globe, it is now viewed as the management of chronic conditions and risk prevention through drugs. Until pharmacological treatments or prevention options have been developed for Covid-19, pharmaceuticalization will find space for itself between the cracks, as a normalizing apparatus (of fetishism, of lives). As to the government, perhaps it will be less creative in its attempts to respond to the moment, feeling like its hands are tied until saved by the pharmacochemical bell. As far as the interests and modus operandi of the pharmaceutical industry, now is the time to get rid of drugs on the shelves and maximize profits on those already on the market. Let us not forget about the rush to approve chloroquine as a Covid-19 treatment, a medication already available in generic form and therefore producible in Brazil, nor should we forget the expedited approval to test Remdesivir, produced by a U.S. company—to cite just two examples. With the economic crisis here to stay, new and old products will be tested in countries that lack sturdier structures, reinforcing—to cite another anthropologist, Adriana Petryna—[*ethical variability*](#), which relativizes protocols and exercises unequal protection of human subjects in a global world. Perhaps in the future, Rosa B. will find herself in need of treatment and, in exchange for monetary compensation, will take part in a clinical trial. In defense of her life, a government should have mechanisms in place to protect her.

With Covid-19, just as with AIDS at the outset, the Brazilian State has been slow to recognize the pandemic as a problem and has failed to coordinate initiatives to fight the disease at state and local levels or offer prevention measures. Without testing, without broad, well-coordinated monitoring, and without ongoing care, it is impossible to chart the disease and reveal its effects. Brazil was late to tackle AIDS, which moved from big cities into rural areas. It began male and urban, spread into peripheral areas, became endemic, and then became female as well, infecting increasing numbers of women and, vertically, the children they bear.

Biehl's book suggests that the ongoing management of health through drugs is now part of an essential set of practices that legitimize citizenship. This is how pharmaceuticalization develops a structure. Drug consumption becomes crucial to being a patient and thus part of the health system and medical market. People who are of no value to the prevailing system tend to be erased by mechanisms Biehl calls "technologies of invisibility." This anthropologist knows: to track the movement of power, policy, and other abstract entities, along with their effects on bodies, we must go looking for those less visible, for those on the margins, and we must consider their survival strategies. When we speak of biopolitics, we tend to talk mostly about lives engaged with technologies and systems; it is a challenge, especially under quarantine, to identify those who face even more precarious circumstances than Rosa B. and lack access to health, credit, consumption, or the internet and cell phones. Herein lies another challenge for the social sciences today: finding new ways to trace the "social" during isolation.

The pandemic evokes the need for collective action; it draws us together and universalizes us both as a species and as an endangered global society. But it also individualizes, discriminates, and excludes. "The precarious nature of our lives is intensified or protected by global precarization policies," wrote Debora Diniz (2016: 26). Rosa B., with whom I

exchanged a few texts about the expiration date on a salad, never told me her last name, but her genealogy was nonetheless evident: she was Black, perhaps Latina; poor; and had no health insurance even though she lived in the planet's largest economy—and, in early 2020, the epicenter of Covid-19.