TWO THE COSTS OF LIVING: REFLECTIONS ON GLOBAL HEALTH CRISES

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"Goodbye, Mother," writes Clara Maass in a poignant letter penned at the Las Animas Hospital in Havana, Cuba, in August 1901. "I will send you nearly all I earn, so be good to yourself and the two little ones. You know I am the man of the family, but do pray for me."[1] A few days later, Maass, an American contract nurse, would succumb to a virulent strain of yellow fever that she contracted after volunteering as a human subject for an experimental vaccination. She was one of many volunteers for the Walter Reed Yellow Fever Commission's pursuit of the *flavivirus* that wreaked havoc on human hosts in the Cuban archipelago and the American South (figure 2.1). Finding a panacea against this viral infection is something of a scientific landmark in historical annals.[2] The life-saving vaccination was significant not only because it was an obvious public good but also because it allowed the American army to complete the construction of the Panama Canal (1904–14).[3] It assured American control of trade between the Americas. Thus, the commission's human experiments were regarded as righteous sacrifice; special mention is always made of Jesse Lazear, a young scientist whose self-experimentation proved fatal. But less is known about the deaths of contract nurses, rank and file army personnel, and local Cuban volunteers.

I begin here, in another time and another place, in order to reflect on the distributive logic inherent in articulations of health security regimes as a modern form of power over biological existence. While much has been said about biopower and its calculative rationality, in this chapter my focus is on how *crisis* as the governing epistemology of health emergencies habitually reinforces that rationality. Etymologically, the "crisis" hails from the Greek

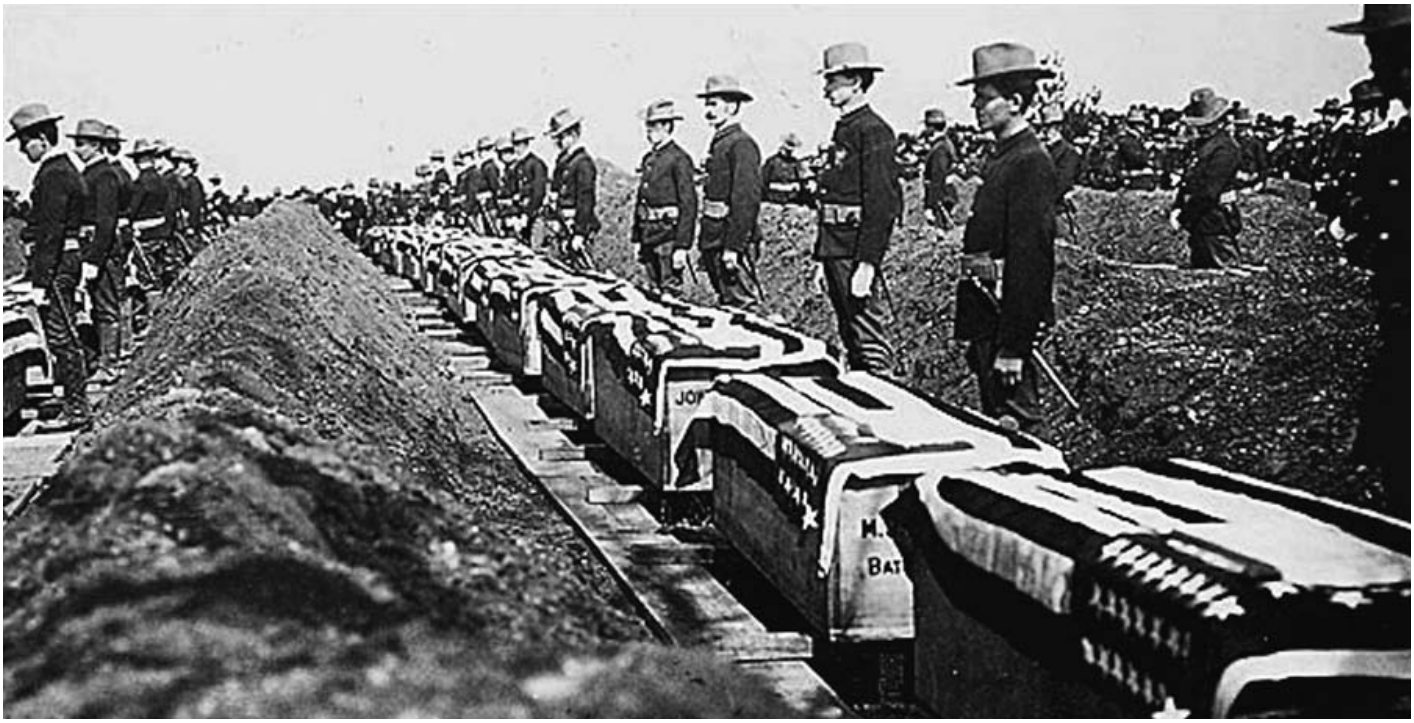

FIGURE 2.1. Military burial during the Spanish-American War, in which 2,500 American soldiers died of yellow fever. Source: Philip S. Hench/Walter Reed Collection, University of Virginia.

krinô, meaning to decide or to judge, and soon the term came to mean a turning point that called for definitive action. In its migration into the Hippocratic school and therein into medical parlance, "crisis" came to mean the turning point in a disease—a critical phase with high stakes. This chapter focuses on the "epidemic" as such a critical phase: an event that opens new pathways into the past (what went wrong?) and the future (what action is the best way forward?). The continuing "long-wave" HIV/AIDS epidemics—events with waves of spread and waves of impact that take a long time to slow down and that have long-term impacts—are my primary loci.[4] But I start with an emerging infectious disease outbreak at the start of the twentieth century to underscore recursive logics salient to HIV/AIDS epidemics, then (in the period known as "early AIDS") and now (in the post-1995 antiretroviral therapy period).

I also question the production of a unitary human subject as the antagonist to microbial hordes in a seemingly eternal species war. I do this not to undermine nonhuman agencies but to interrogate the universalizing abstraction galvanized during health crises: "the human" on whose behalf there must be needful experiments, daring innovation, and even self-sacrifice. My point

is not to undermine such efforts, and certainly not where deadly pathogens are concerned. Rather, it is to interrogate how the "public good" as a horizon of action relies on a distributive logic of security, one that divides and separates an abstract public who will reap benefits in the future from disposable congeries who will court death for those benefits to materialize: like the contract nurse who had to man up to feed a large family of German immigrants to the United States, like the recent immigrants to Cuba whom the Spanish Embassy sent as volunteers to Reed's camp, and like the ordinary privates in the US Army barracks who were inducted into heroic sacrifice.[5]

Scholars who celebrate the commission's chutzpah point out that it generated the first consent forms for such experiments. Volunteers received $100 in "American gold" for their participation, and an additional $100 was available for those who developed yellow fever. Those critical of the commission's medical ethics argue that the forms did not indicate the risk of death in adequate terms. Whichever side one chooses, the health emergency features the first materialization of the unequivocally modern power to "make live" and "let die" populational aggregates as legal-medical protocol.[6] As Reed agonized over his young colleague's death, the calculative rationality of health security found new expression as a matter of rights: by allowing volunteers to sign onto the medical experiment, the law legitimated their right to gamble on their lives for economic gain. This legalization of risk framed as individual choice held two costs of the experiment in tension: the first, the incalculable personal loss (physical, emotional, social) in which the health crisis was a protracted experiential condition; and the second, a probabilistically assessed loss (political and economic) in which the health crisis was suspended as aberration, contained in the time and space of the camp. As a state of exception, the camp ensured that the latter (well-calculated) cost would hold the former (experiential) one at bay. The most dangerous part of the experiment (the first phase in 1900) was conducted at an army camp outside the United States, a space over which the US military had sovereign jurisdiction. During the course of the century, we would see many such "camps" materialize around health crises. The US government's willed negligence of the HIV/AIDS epidemic during the Ronald Reagan years, for one, which turned vibrant neighborhoods into deathly ghettos, has been amply chronicled.[7] At global scale, the cost-benefit calculus has played out in the struggle over access to low-cost antiretroviral generics; further, there is excellent scholarship on how the global distribution of resources allocates "surplus life" to some, while others die in clinical trials.[8] Meanwhile, the huge documentation of mourning and melancholia in AIDS

media has sharpened the need to change the terms on which we narrate the histories of health crises.[9]

Such histories inspire this chapter on the continuing impact of chilling calculations that appear during health crises every so often so as to organize common futures. The recurrence indicates those calculations are the abiding scaffolds for modern power over life. Recent scholarship on health security has drawn on Michel Foucault's writings (and especially on his lectures in *Security, Territory, Population*, delivered between 1977 and 1978) to make the case. There, Foucault analyzes what the earliest state-run inoculation campaigns reveal about modern governance: a different mode of power operating on vital circulations (blood, plasma, hormones, microbes, toxins, proteins, or lipids) whose maintenance remains unassailably necessary for the generation of goods and people.[10] Foucault distinguished this kind of power from sovereign juridical power that punishes or kills, and disciplinary power that surveys, observes, and corrects. The power to "secure" life *calculates* and *intervenes* in the vital circulations of human life; its locus is not *this* subject of law or *that* docile body but biological existence.

What is important here is Foucault's emphasis on calculation as the basis of sorting, dividing, and segregating populations. A calculative rationality mobilizes the modern technologies of measurement and assessment: consider the calculations necessary to test positive and to remain undetectable; consider the percentile goals for epidemic amelioration in national and global strategic public health plans; consider the fact that the threat of diseases to the gross national product (GNP) is one of the main motors of state intervention into epidemics. The economic modality of this health calculus and its manifold political articulations qualify the liberal fiction of the "public good." Health is not a universal human right but an economically adjudicated enfranchisement at both national and global scales. Hence states and global institutions back big pharma and insurance companies in their parsing and valuation of life in terms of risk aggregates; and state and interstate legal systems continue to protect their interests. In this regard, modern advances in self-testing, prophylaxis, and treatments are also *qualified* achievements whose benefits do not accrue to all. The uneven burdens of clinical labors are but a stark reminder of this enduring economic calculus that girds the valuation of life.[11]

Valuation is well concealed in a liberal fiction of the public good that is invoked everywhere where there is a massive state and international response to emerging infectious diseases. We have been witnessing many such responses, from SARS to Ebola to Zika. The resurgence of deadly pathogens

like Marburg, Ebola, and HIV in the 1980s proved to be the tip of the iceberg. Emerging infectious disease emergencies are particularly significant because they intensify and accelerate security regimes. Following Foucault, Stefan Elbe notes in *Virus Alert* (2009) that in these circumstances three distinct modes of power *all* come into play. National security imperatives protect soldiers, civilian populations, and sovereign territories. But since such diseases speedily lay to waste individual lives and livelihoods, human security apparatuses further discipline behaviors, habits, and lifestyles. Working alongside these two security regimes, health security regulates vital circulations, statistically quantifying populations into risk groups according to their vital states and promoting pharmacological intervention. These three security regimes constitute biosecurity interventions that calculate internal borders within populations, separating one social aggregate (high-risk cases such as the elderly) from another (low-risk groups, often prized for reproductive futures). Strong conjugations of the three enforce a rigorous biopolitics of "making live" and "letting die."[12] Where the HIV/AIDS epidemics are concerned, we are now in the fourth decade of fighting these thanatopolitics: a deluge of documentaries and biographies, oral history projects and commemorative exhibits, activist histories and public arts record how we survived the late twentieth-century plague of thirty-four million dead and counting. What better time is there to reflect on landmarks and turning points, periods and eras? In this regard, this volume is most timely in exploring a core concept for historical narration: crisis as an epistemological category that prompts a diagnosis of the past and a blueprint for the future.

In returning to such epistemological matters, one must first question the "global AIDS crisis" as a singular phenomenon as well as the emergent periodization that separates "early AIDs" as the high crisis years (when new incidences were unabated) from the post-1995 years (when the pharmacological solution changed the course of the epidemic). *Of course* the antiretroviral therapies produced a major shift in the conception of this health crisis. To the great relief of my generation, which had lost so many, in the Global North the tide turned from acute to chronic states of infection. Once a collectively lived experience, HIV infection is now a medicalized condition lived in the privacy of the doctor's office. But, as so many scholars have noted, this is hardly the case in the "Global South"—with the caveat that south is not a cartographic projection but an amoeboid geography that includes high-crisis pockets in industrialized contexts.[13] There, in those pockets, the logic of security unmasks its calculative rationality, its distributive logic sometimes in plain sight and sometimes in muted, benign forms.

Such pockets suggest there cannot be a global history of AIDS but a global archaeology attentive to discontinuous space-times of HIV/AIDS epidemics—in the plural. One way to approach such heterogeneous space-times is to interrogate hegemonic disease geographies organized around nation-states. Such geographies are inevitable mainly because sovereign nation-states are *the* global conduits for materializing antiretroviral therapy (ART) rollouts, public health infrastructures, and viral load testing and monitoring procedures; nation-states further govern general health parameters such as nutrition, drinking water, and sanitation. Hence, global institutions such as the World Health Organization (WHO) or the Joint United Nations Programme on HIV/AIDS (UNAIDS) routinely measure the successful epidemic interventions along national indices. And yet, what such assessments obscure are crisis situations, often locally or regionally marked, that are at odds with national ones. I characterize such situations as "high-crisis" pockets that are "discontinuous" with the scale of the national HIV/AIDS epidemic. In this chapter, I offer an illustration from India, a nation once home to the third-largest HIV-infected population but one which is currently applauded for its successful epidemic management AIDS control programs. The "case" of Manipur, a northeastern state in India that borders Myanmar, bucks the national upward swing in epidemic management, and, as we shall see, it is critically significant for what it tells us about the distributive logic of global public health.

Manipur has remained in a perpetual state of exception—under military rule within the sovereign space of the Indian nation-state—for the last sixty years. Even as the national AIDS control programs pour resources (drugs, funds, expertise) into Manipur, the Indian government's draconian emergency measures remain partly responsible for the health crisis. As the political and health emergencies feed into each other, we are confronted with a macabre articulation of the "letting die" that underlies modern health security in democracies, Western or otherwise. What, then, can conditions in this region (which is analogous to Kashmir or Palestine) tell us about the democratic fictions of public health? How do those fictions conceal an underlying logic of debility? Certainly, these extreme cases shore up the norm, but I choose a lesser-known example from the Global South as a methodological move. In part, that move constitutes a refusal to tuck away such an instance into the safe corners of area studies—as just another historical example that enriches the increasingly heterogeneous archives of global AIDS. My intent is to track the governing logic of modern health security from North America to South Asia to West Africa, and therein to provincialize every epidemic

situation. Put differently, if one followed a classic colonial account, Manipur is simply a "backward" instance of the crisis in which progressive agendas have not as yet achieved their full potential. In such an account, the Global South is still caught in the waiting rooms of history. Instead, if we think of extreme instances as sudden recursions of a continuous modern global rationality—as evident in early twentieth-century Cuba as it is in late twentieth-century Manipur and early twenty-first-century West Africa—then the task at hand is to write nonlinear discontinuous histories of HIV/AIDS epidemics attuned to global viral emergences.[14]

But before the illustration, a few remarks on crisis as an epistemological category. My reflection on the term by no means suggests that crises are not real, or that the term is not productive. If Reagan invoked the "AIDS crisis" only after the nine-year-old Ryan White died, whole populations decimated by the disease heaved a sigh of relief. It has been decades since then, time enough to reflect on what invoking crisis means for common futures of those living with HIV. Here, Janet Roitman's *Anti-Crisis* provides a strong scholarly foundation for the reflection. Roitman's focus is not on health but on the financial crisis of 2008 and its aftermath. Instead of a blame game of what was fixed and what continues, Roitman points out that, as a turning point, as a catalyst for change, crisis undertakes political work. Drawing on Reinhart Koselleck's theory of crisis, Roitman positions crisis in the second order of knowledge. For example, I may experience ill health and "know" my symptoms *before* the second level of abstracting them as a crisis or turning point in an underlying disease. My perception will spur thought about how this critical phase came to be: What had I missed? Where was I negligent?

This reconstruction of the past, almost inevitably a critique of the past, also galvanizes a new future: I must act differently from now on. Crisis is thus not "intrinsic to the system," says Roitman, but "a distinction that produces meaning."[15] In this sense, crisis is an epistemological cut in previous understandings of how things progress in time. So far, so good: crisis can be immensely productive in establishing a moral demand for a difference between past and present. No business as usual, as we say. It opens a critique of the past laying bare normative practices that brought us to the present pass. If we think about the HIV/AIDS crisis in the United States, the activist mobilization of crisis changed the dimmed futures of the HIV affected. It shored up the social stigma that enabled an epidemic to course through a population without recourse to remedy. In all these ways, crisis as a perceived "event" is enabling critique, and it marks a new time to come.[16] Even when crisis has become an enduring condition, it can be a terrain of action.

But it is often the case that crisis does not change on what terms we narrate the past. To follow the example above: I still know my symptoms in the same way, even though I now gather them up as a crisis. In analyzing the financial crash as historical crisis, Roitman questions whether the recognition of the crash as a crisis *really* changed the terms in which we understand the past and the future. Even though home foreclosures prompted homeowners to organize into self-help groups, for instance, Roitman notes that these gatherings often came up with strategies to stem harm (moving personal funds to safer banks, for instance) but not to change the terms of harm; the question of changing the legal burden from borrower to lender came with legislative bank regulations in the aftermath of the crash, but there were almost no penalties imposed on lenders for irresponsible loans that were part and parcel of the crash.[17]

In this way, crises compel new causalities for the past and future, but that impetus might well produce blind spots around what we continue to take for granted. We may understand the financial crisis. But have we changed the terms sufficiently for it to never happen again? We might ask the same question of the HIV/AIDS epidemics. The struggle for the antiretroviral therapies was epic, and we have moved into times when the scientific-technological panacea—when and where available and accessible—seems to have abated the crisis. But that abatement has not substantially changed the valuation of population aggregates: high-risk groups continue to be targets of intervention rather than actors whose assessments of their futures shape expertise.

Now it is not the case that global institutions like UNAIDS or private foundations like the Bill and Melinda Gates Foundation simply push the antiretroviral therapies without attending to the social demands of the economically vulnerable; indeed, their scalable models strategically account for structural inequities in housing, employment, education, and migration patterns of the global AIDS crisis. Nor is there a sense the crisis is over. In fact, the *UNAIDS 2016–2021 Strategy* warns of a "fragile window of opportunity" for a fast-track to the end of AIDS; anything short of this would make possible a slide backward.[18] Here again, crisis as an enduring condition is the terrain of action. And yet the economic motor that informs population aggregation remains firmly lodged in health security regimes. Babies are always best, they are the future; newly infected drug addicts, not so great. Mothers, working people, tax-paying citizens, and property owners have the right to medical recourse, and can demand it—not so easy for those who live on the edge, migrate constantly for employment, fall off the meds, and are not versed in the protocols of demand. It is too facile to dismiss such inequities

as secondary social issues; rather, these segregations embedded in risk assessments are a problem *intrinsic* to modern power over life.

And it takes the extreme case to shore up the norm. Few cases are more extreme than the enduring health crisis in Manipur, a state that borders Myanmar and falls along the busy drug-trafficking routes of the Golden Triangle (Thailand, Laos, Vietnam) through which heroin enters Indian markets. Many Manipuri youth get their first hit as adolescent revelers at Myanmar's Moreh markets, which are as popular for acquiring cheap consumer goods (clothing, electronics, furniture) as they are for illicit trade in drugs and guns.[19] Injecting heroin (the crude No. 4) through homemade devices (a rubber stopper and a needle), a large percentage of the youth that visit Moreh for kicks are quickly addicted—and some are infected.

Manipur has been one of the main targets for the Indian government's rollout of antiretroviral therapies because it has always been and remains one of the states with the highest incidence of HIV/AIDS infections. These include new infections; in this regard, the epidemic is still emergent, and the crisis unabated. In contrast, India is celebrated for the state's successful eradication of new HIV infections: a 57 percent reduction between 2000 (274,000) and 2011 (116,000) from HIV Sentinel Surveillance data. With an estimated 2.1 million living with AIDS, new infections declined from 150,000 in 2005 to 80,000 in 2016. The Indian National AIDS Control Programme (NACP) was launched in 1987, a point at which India had the third-largest population of people living with HIV/AIDS (after South Africa and Nigeria). In the 2017 survey, Manipur recorded the second-highest estimated adult prevalence in India despite state efforts to provide access to testing and antiretroviral therapies (in accordance with the 2010 Indian Supreme Court directive[20]). The state wing of the NACP had set up twelve Anti-Retro Viral treatment centers, eleven linked ART centers, and ten community care centers since the 2000 report.[21] Yet Manipur remained at crisis.

Just as these 2011 reports were appearing, I found myself in Manipur conducting research for a book on HIV/AIDS epidemics. My research was on grassroots organizations that had long provided health care amid acute health crises of these epidemics. The national NACP often drew on the enduring social credit of these outfits to implement its programs among the socially vulnerable. In Manipur, the most vulnerable were the addicted, and a few went on to organize informal networks that still remain foundational to HIV/AIDS healthcare. The success stories among the four or five fledging organizations that tackled the raging epidemic in the mid-1980s are CARE and MNP+ (Manipur Network of Positive People), which distributed generics

from Cipla and Ranbaxi, and followed up testing viral loads without formally registering patients. Since there are scant resources for archiving the intervention of such groups in the Global South—no oral histories, no papers, no documentaries—a part of my research agenda was to collect and circulate their achievements at a point when the Indian state garnered the lion's share of credit for handling the HIV/AIDS crisis. This is particularly ironic, if not offensive in this context, because it is the Indian state that is partly responsible for the exacerbation of Manipur's health crisis.

Manipur has remained in a perpetual state of exception since 1958, when India imposed the Armed Forces Special Powers Act (generally known as AFSPA) to eliminate radical secessionist tendencies in the provinces bordering China and Myanmar. On grounds of national security, the Indian Army was granted legal immunity to restore order in the state; much like in Kashmir, the army's abuses are legendary.[22] Within the discourse of national security, Manipur is positioned as a "backward region" of Indigenous "hill tribes"; the cultural corollary makes appearance in the national bourgeoisie anthropological curiosity about Manipuri "folk" ethnicity. Thus, it is small wonder that the many Manipuris see themselves as stranded on an island; on my visit, I was extremely aware of my own status as a mainlander (although the state is topographically contiguous with India). And why not, since the roads into the state are heavily guarded against twenty-some insurgent groups who battle the army for a "free Manipur."

The low-intensity warfare reorganizes every aspect of life, from petroleum shortages to interrupted antiretroviral medicine shipments. In the midst of this ongoing emergency came the HIV/AIDS epidemic. Unlike other Indian states with high infection rates, Manipur's infected communities were and are primarily injectable-drug users (IDU): among 2.38 million, if 8 percent are HIV positive, 72 percent of the infected are drug users.[23] Unable to contain insurgencies in Manipur, military personnel often regard anyone who makes frequent trips to the border with suspicion. Drug users are widely regarded as irresponsible citizens who are potential threats to national security, for they can be economically persuaded to run guns for the insurgents. In the earliest phase of the epidemic in Manipur, the army began to run random checks on Manipuri youth under the AFSPA provisions for arrest without trial on "reasonable suspicion" (figure 2.2). Anyone with needle marks on their arm was unceremoniously thrown in jail *before* testing and housed in the HIV cells. National security measures amped up disciplinary and calculative interventions, so much so that the HIV/AIDS crisis presented an opportunity for cleaning up the border state's drug problem.

FIGURE 2.2. News photo of army roundup, Manipur, February 20, 2012. Sinlung North East India. Source: www.sinlung.com.

The real problem was that drug users would have to register for regular testing to avail of the therapies. But the "high-risk" group found themselves in a bind. The health crisis had changed nothing about the value the state placed on their health; they were always subjects of benign welfare. On the other side of the aisle, the insurgent groups mirrored the same terms of calculation. Groups that saw themselves as the de facto government of Manipur (the larger groups even have a parallel tax structure) threatened to shoot addicts: in their view, an autonomous Manipur should be a drug-free one. Here, crisis as a second order of knowledge created an epistemological moment to rewrite the past and anticipate the future. For the socially vulnerable, that future became more precarious than ever before, for now they were faced with arrests, imprisonment, and death threats. At a juncture when eight of every ten families had a regular drug user in the household, drug users refused testing and went underground, while HIV infection rates among them jumped from 1–2 percent in 1990 to 50 percent in 1994 to as much as 80.7 percent in 1997.[24]

Thus the opportunity to seize the future only exacerbated existing inequities. This failure has much to do with the unchanging calculative logic of modern governance that shapes health interventions. And it is against this logic that time and again we see another kind of compensatory intervention: activist networks that contacted drug users in secrecy (in gyms, eateries, market hangouts, Narcotic Anonymous meetings); ensured regular clinic visits, compliance with drug regimens, and advice to patients on diet and exercise; and offered social support in forums, camps, screenings,

and meetings. In Manipur, CARE and MNP+ gathered social credit because they were affiliated with neither the government nor the insurgents: as self-organizing networks, they remained open-ended, contingent upon their "users," and a parallel health infrastructure in the state.[25] State-run programs secure life as it determines economic productivity and political stability; the costs are unevenly distributed and that distribution is masked through the liberal fiction of the "people of Manipur." The activist health-care networks, however, organize life around another kind of cost: personal and communal losses. The head of MNP+, for instance, started the outfit with five other HIV positive friends, one of whom did not survive the crisis. Here, too, the costs are experientially uneven, but they cannot be split, sorted, and distributed; in short, they are incalculable. When this second "calculus" of personal and communal loss overtakes the first, we witness a shift in the terms in which we narrate crises. The ground of the "health crisis" is no longer eternal microbial-human war but willful politics of making die. The call is for policies and programs that ensure such thanatopolitics has no place in the future of public health. The re-narration of the HIV/AIDS epidemics has achieved just this in all kinds of fabulous ways all over the world. Those achievements are localized, often singular, and the interventions are not always portable. Yet they signal the horizon for what is to be done for communities living with HIV/AIDS.

As we zoom out from Manipur, let me close with a recent iteration of a global health crisis in which deathly calculations once more made their mark: the Ebola outbreak in Guinea, Liberia, and Sierra Leone, from March to September 2014.[26] In the health crisis that followed, a miracle drug came into view. Only three doses stored at Kailahun, Sierra Leone, spurred hopes: Could this be *the* scientific breakthrough on the scale of the antiretroviral therapies? Would science once again save the day? Amid the anticipation, national interest dictated the distribution of the scarce doses. Mainstream media carried news of two Americans airlifted from Sierra Leone to the safety of American shores: a doctor, Kent Brantley, and a health worker, Nancy Writebol, were saved by their access to ZMapp. But legal-medical protocols prevented the same access for African scientist and doctor Sheikh Umar Khan.[27] Defenders of global governance highlighted striking differences between national health-care systems as the reason why Umar Khan was not given one of the three available doses. The administration of ZMapp required the kind of monitoring and supportive care, they maintained, that was inconceivable in the West African epidemic situations. Others decried the cost-benefit calculus foundational to the military-economic foundations

of global health security. In this replay, Umar Khan joined Clara Maass in a recursive history. As uncontainable microbial life from those hot zones on the blue planet skip into new human, plant, and animal host populations, the calculation that values some lives over others remains the real cost of crisis as epistemology.

Notes

1 Chaves-Carballo, "Yellow Fever and Human Experimentation," 557.
2 The extensive Philip S. Hench Walter Reed Yellow Fever Collection at the University of Virginia archives the work of the commission. For an overview, see "Yellow Fever Collection 1806–1995."
3 While the credit for the vaccine goes to Walter Reed, who wrote about the experiments in great detail, a Cuban physician, Carlos Finlay, had long argued that the mosquito was the vector for the disease; when the commission decided to test the mosquito theory, Finlay provided the infected mosquitoes.
4 Whiteside, *HIV/AIDS*, 4.
5 One of the privates, William H. Dean, was X.Y. in Reed's records; he was later honored for his sacrifice (see Kelley, "Private Dean").
6 Foucault, *"Society Must Be Defended."*
7 President Reagan did not mention AIDS as a health crisis until 1987; by that time twelve thousand Americans had died. As early as 1985, the Centers for Disease Control (CDC) had put together a $33 million preventive plan that was rejected by the White House. But things began to change in October 1987, with the death of the president's friend Rock Hudson. There are many well-known accounts of this silence and its effects. See, for instance, Jefferson, "How AIDS Changed America," and Shilts's exposé, *And the Band Played On*.
8 See Sunder Rajan's *Pharmocracy* and Cooper's *Life as Surplus*. There is also a considerable history of medical apartheid, as elaborated in Washington's *Medical Apartheid*.
9 There is a massive literature on mourning and melancholia in the AIDS epidemic: notable bookends are Crimp's early "Mourning and Militancy," which was later collected with his other writings in *Melancholia and Moralism: Essays on AIDS and Queer Politics*; and Woubshet's *Calendar of Loss*, a book that represents efforts to globalize the literature on mourning.
10 See Foucault, *Security, Territory, Population*; Lakoff, *Unprepared*; Elbe, *Virus Alert*; and Ahuja, *Bioinsecurities*.
11 Cooper and Waldby elaborate the notion of clinical labor in their coauthored *Clinical Labor*.
12 Elbe, *Virus Alert*. These concepts from Foucault, *"Society Must Be Defended,"* have become axiomatic in discussions on race, biopolitics, and globalization.
13 The "Global South" was a term that emerged as early as 1969 but gained momentum after the fall of the Berlin Wall in 1989, which threw the

cartographies of First, Second, and Third Worlds into question. Scholars prefer the geographic descriptor for a number of reasons, not the least of which is to refute the historical trajectories of economic development implicit in the terms *Third World* or *developing world*. *Global South* captures global regions often interconnected by histories of colonialism or neo-imperialism, some of which are "within" the cartographic reaches of North America or Europe, where large-scale inequities in living standards, life expectancies, and resource access persist. For a conceptual argument for the efficacy of the term, see Levander and Mignolo, "Introduction."

14 "Emergence" (from the Latin *emegere*, meaning "to appear") is a capacious term for multileveled occurrences across scales of action, human and nonhuman, that resists linear causality and is therefore difficult to predict.

15 Roitman, *Anti-Crisis*, 93.

16 Roitman, *Anti-Crisis*, 19.

17 Roitman, *Anti-Crisis*, 67–68.

18 *UNAIDS 2016–2021 Strategy*, 3.

19 Moreh is to Imphal what Tijuana is to Los Angeles—a border town with all the trappings of pleasure and danger. As India's gateway to Southeast Asia, the town has been growing in size and importance, fueling talk of beefing up security. See Bhattacharya and Daniel, "India's Wild East Unprepared."

20 The directive instructed the federal and state governments to provide therapies to patients as a "right to life" guaranteed under the Indian Constitution's Article 21. The bill against discrimination based on HIV and AIDS passed in the upper house, the Rajya Sabha, in March 2017.

21 "AIDS Situation Alarming."

22 In 1949 the princely state of Manipur was annexed to the newly independent Republic of India, and secessionist groups sprouted in the region. About a decade later, the Indian Parliament passed the draconian AFSPA—whose extreme provisions derive from a British Ordinance of 1942, designed to quash the historic Quit India Movement—ushering in a perpetual state of emergency in the region. See Tarapot, *Bleeding Manipur*.

23 Bhagat, "In a Vicious Circle."

24 Bhagat, "In a Vicious Circle."

25 I elaborate on the vital health infrastructure in the state in "Staying Alive."

26 The first case is traced to December 2013 and the last to June 2016; the World Health Organization reported 28,616 reported cases of infection.

27 There was a lot of coverage of the two infected Americans, and brief references to the controversy. Maina Kiai, a human rights activist in Kenya, reported that the seeming inequity in dose distribution was discussed on the sidelines of the summit meeting of African leaders held in Washington: "There was a sense of the same pattern," he said, that "the life of an African is less valuable." See Pollack, "Ebola Drug"; and Hayden and Reardon, "Should Experimental Drugs Be Used?"

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