Opinion

Redefining Public Health and Life in Occupation? COVID-19 Pandemic in Kashmir

Society and Culture in South Asia
7(1) 141–147, 2021

DOI: 10.1177/2393861720977014
journals.sagepub.com/home/scs

Sarbani Sharma[1]

On 6 March 2020, as I deboarded the flight at Srinagar airport and walked towards the luggage conveyor belt, an ID carrying official kept announcing at his highest pitch, 'anybody arriving from China, Japan, Korea, Iran?' By the time I collected my luggage, I was handed over a white form that asked for my personal details, recent international travel history, complete address during my stay in Kashmir, self-declaratory confirmation of being non-symptomatic of any COVID-19 symptoms. This was followed by body temperature checks by state department paramedics and another round of checking of ID cards and luggage by the Indian Armed Forces personnel. Arrival at Srinagar airport felt like entering criss-cross lanes of biomedical and militarised-security surveillance in the same space–time continuum.

Three and half months later when I again returned to the valley, the COVID-19 cases in both India and Kashmir valley had expectedly witnessed towering spike in the cases of the viral infection. As I deboarded from the aircraft, one could see the elaborate and meticulous COVID-19 testing protocols and standard operating procedures (SOPs) being followed for every single incoming passenger by the airport ground staff and medical task force at the Sheikh-Ul-Alam Airport, Srinagar. Having ensured zero contact, negligible crowding and waiting period for over 200 incoming passengers on the given day, the health officials and paramedics

[1] Department of Social Anthropology, University of Tübingen, Germany.

Corresponding author:
Sarbani Sharma, Department of Social Anthropology, Burgsteige 11, Schloss Hohentübingen, University of Tübingen, Tübingen 72070, Germany.
E-mail: sarbani.sharma@uni-tuebingen.de

of Budgam district administration ensured extensive personal and medical history data entry. In the absence of steady Internet access, Aarogya Setu app,[1] the data entry of passengers' previous travel history and recent medical history was recorded manually by the paramedics. Systematic sample collection for COVID-19 RT-PCR at the airport was conducted free of charges round the clock. Within minutes of sample collection, the local district administration sent out SMS to individual passenger's phone number sharing the details of the swab sample collected and the address of the laboratory that was to examine the sample for the viral infection. This was followed by classification of passengers according to their forward destination to various districts in Kashmir valley for their mandatory institutional quarantine until the testing reports arrive and are verified by the Nodal Officer of every circle in a district.

Notwithstanding, the ways in which COVID-19 testing and public health emergency furthered the pervasive surveillance and emboldened coercive measures that could hinge on the excesses that any state apparatus could commit, experiences of such ordered and meticulous testing and screening protocols being followed in one of the most militarised zone in the world were indeed unique. Much like most postcolonial developing nations, Kashmir valley too struggles with languishing public health infrastructure which are overcrowded and understaffed, which additionally is struggling with massive local administrative and governance overhaul owing to a prolonged lockdown for over 11 months and a tedious process of state bifurcation that dispossessed the local administrators from the powers and authority for everyday governance. Despite this political crisis and lack of any elected government, one could witness robust public health intervention by local medical fraternity to battle the pandemic. This, however, does not imply that reflection of systematic and speedy testing procedures at Srinagar airport was mirroring this level of efficiency in the local hospitals in the valley. Everyday conversation with people were filled with anxieties about finding a bed in hospitals for those with symptoms, confusion over false-positive and false-negative test results of COVID-19 that further complicated quarantine methods and regulations, fear and suspicion about wrong treatment and expensive hospitalisation by the local private hospital systems that drains families financially.

[1] Aarogya Setu app was specifically designed and launched by Government of India to facilitate contact tracing of COVID-19 infected individuals and gathering other GIS enabled health monitoring data. The installation of the app onto the smart phones was made mandatory by the government to enter airports, railway stations and other public buildings.

Hence, most significantly, the pandemic in Kashmir is also situated within a political crisis that has now created a sustained politico-medical emergency. Almost a year ago, on 5 August 2019, the Central Government of India unanimously and arbitrarily decided to abrogate Article 370 and bifurcate the state of Jammu and Kashmir into two Union Territories of Jammu and Kashmir and Ladakh respectively. Apart from the fact that it altered the constitutional status of the state of Jammu and Kashmir, the drastic political change was accomplished by the state by enforcing a complete lockdown and e-curfew,[2] which continued until the pandemic induced further lockdown in the valley. Therefore, valley had primarily experienced the COVID-19 pandemic lockdown under the conditions of an ongoing political and economic lockdown. The prolonged lockdown had already relegated people indoors away from their livelihood and students away from schools and colleges for almost a year by the July of 2020 that culminated into a staggering economic loss since Article 370 was amended.

The pandemic lockdown in Kashmir valley too was by no means a lockdown imagined or sustained through most parts of the world. Powered by the Epidemic Diseases Act, 1897, the state utilised the most authoritarian means (Bhan and Bose 2020) to restrict movement of even essential services for the local population and continued reduced Internet bandwidth and speed for Internet access despite multiple appeals to courts for allowing online education for students and the mandatory access to doctors for necessary updated information on treatment protocols and research on novel coronavirus. Unlike India, where emergency pandemic measures may be considered unprecedented but timely, in Kashmir they are inextricable from a long continuum of practices aimed at suppressing the movement, and the expressions and livelihoods of a dissident population (Saraf and Sehdev 2020). For most local residents of the valley, the pandemic lockdown was also an opportunity nailed by the state to execute chicaneries of power to announce much contested new domicile laws in the newly crafted Union Territory of Jammu and Kashmir that ensured speedy distribution of new domicile certificates to non-residents of the Jammu and Kashmir under the aegis of much coveted argument of minority rights protection. Legislation of new domicile laws that were abjectly opposed by the erstwhile state subjects[3]

[2] E-curfew refers to the practice of shutting down mobile and broadband Internet services imposed by the Indian state in Kashmir valley under the pretext of law and order maintenance.

[3] Since the erstwhile princely state of Jammu and Kashmir acceded to Indian Union in 1947 under conditional accession, its distinct political situation was protected through

of the state of Jammu and Kashmir were implemented in the absence of any elected representatives of the people marked a decisive moment within the Indian federal system that went against the grain of democratic governance principles. Therefore, much like the way in which everyday life in Kashmir characterises a feature of 'double interminability'—one in which it is impossible to emerge from the interminable violence that punctuates ones everyday life and simultaneous interminable need to resist and protest against the sustained injustices inflicted upon Kashmiris that calls for labouring for *Azadi* (Sharma 2020), to no exception—the pandemic with all its novelty and exceptionalism, infused a crisis within a crisis.

It is in this context, that based on my experience of visiting Kashmir twice in the midst of a pandemic do I ask the question: What does it mean to understand an unexpected efficiency in public health emergency mean in a 'Third World' militarised geography? I deliberately invoke the location of 'Third World' to reiterate the historical and structural inequalities that permeate various institutions at multiple levels that visibilise themselves through the sustained inefficiencies and corruption that choke the systems of politics and governance. Since the newly formed Union territory of Jammu and Kashmir is yet to have its democratically elected government to legislate and execute medical infrastructure decisions, the medical apparatus of the state is being operated by the Central government in New Delhi through the Governor's rule in the Union Territory. Under such circumstances, decision-making processes which are removed from awareness of ground realities have led to arbitrary changes in SOPs and confusion over misplaced prioritisation of urgent pandemic control and relief tasks. For instance, though airport testing for incoming passengers was a high priority for Sher-i-Kashmir Institute of Medical Sciences (SKIMS) Virology department, it struggled with sufficient number of data entry operators and lab staff to complete swift testing reports for the local residents in the city of Srinagar.

In his recent article on the ongoing pandemic, Arjun Appadurai (2020) underlines how despite the fact that authoritarian powers globally have seized opportunities in the pandemic to unleash racist and unscientific tenets of their political thoughts, the value of the social and local community as inevitable component and allies in management and

Article 370 of the Indian Constitution that guaranteed Article 35A to accord the native residents of the princely state the category of 'State Subject'. Provisions of Article 35A prohibited any non-local resident from buying land in Jammu and Kashmir and accessing state-driven social security measures. Abrogation of Article 370 stripped away application of Article 35A in Jammu and Kashmir too.

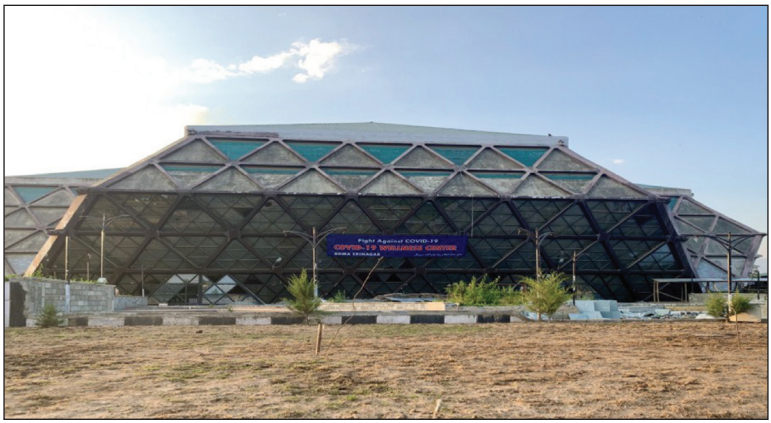

Figure 1. State-run Quarantine Centre in Indoor Stadium of Srinagar
Source: The author.

governance of life and sustenance in any society has been reified more than ever before Likewise, though the militaristic state performed itself through its governmentalities of oppression and suppression through the powers of gun and violence, yet in order to contain an invisible non-human micro-organism, it needed the social and the local of its subjects to be activated and mobilised. So, while the military state operated through the surveillance apparatuses that were now doubly enmeshed with the biological details of its subjects, and though it could potentially amplify its coercive powers of surveillance and exploitation, it nonetheless, depended on the doctors and paramedic who emerged from the same dissident population to contain a novel and mutating virus. It was common to see JK Police and Central Reserve Police Force (CRPF) personnel manning hospitals and laboratories, but the state was forced to request Masjid committees, NGOs, Anganwadi and ASHA workers[4] to inform people about the importance of social distancing and complying by quarantine rules in case of infection or proximity to an infected person. Most burials of people who succumbed to the viral infection were in fact interred with the help of local NGOs who assisted the families of the deceased with a safe and dignified funeral services.

These features of authoritarian and militaristic state powers that animated their response to an unanticipated public health emergency

[4] ASHA (Accredited Social Health Activist) workers are the first contact healthcare professionals who provide information about recommended basic nutritional, hygiene and sanitation practices to communities in villages. Anganwadi workers are the community driven child care and development professionals who work in the rural child care centers.

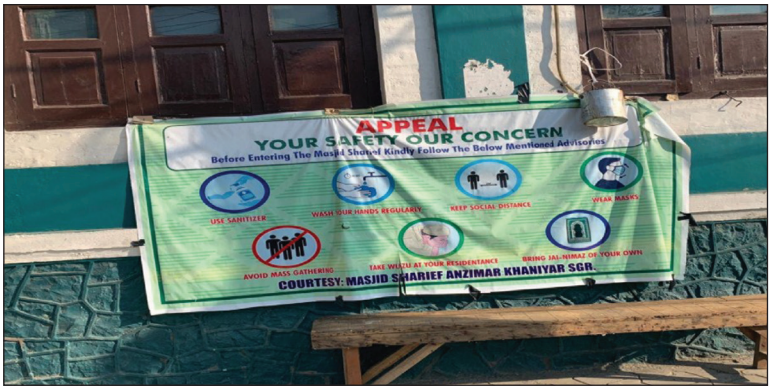

Figure 2. Banner Outside a Masjid with Guidelines for Safety and Hygiene Rules

Source: The author.

should, however, not be conflated with imaginations of weakening of authoritarian power structures. Rather, the question that I ask is that when I first experienced the rather efficient COVID-19 testing speed and procedures at Srinagar, how can we understand the means and methods through which the power structures differentiate between health and life. Could a militaristic state executing a public health intervention while politically choking and coercively imposing itself on the population, using the help of its suppressed subjects, be a vantage point to comprehend how the post-pandemic world order will redefine the definitions of life and health all over again?

Declaration of Conflicting Interests

The author declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author received no financial support for the research, authorship, and/or publication of this article.

ORCID iD

Sarbani Sharma https://orcid.org/0000-0001-8877-4286

References

Appadurai, Arjun. 2020. 'The COVID Exception'. *Social Anthropology* 28 (2): 221–222.

Bhan, Mona, and Purnima Bose. 2020. 'Authoritarianism & Lockdown Time: Coronavirus, Occupied Kashmir, and India'. *Against the Current*, 2020. https://againstthecurrent.org/atc207/pandemic-india/

Saraf, Aditi, and Megha Sharma Sehdev. 2020. 'Insurgent Frontiers and the Viral Condition'. Short Essay. *The Viral Condition: Identities Virtual Symposium*. https://www.identitiesjournal.com/the-viral-condition-virtual-symposium/insurgent-frontiers-and-the-viral-condition

Sharma, Sarbani. 2020. 'Labouring for Kashmir's Azadi: Ongoing Violence and Resistance in Maisuma, Srinagar'. *Contributions to Indian Sociology* 54 (1): 27–50.