

Reflections on Borders in the Time of COVID-19

The Doubly Stigmatized

BY DANILO MANDIĆ,
HARVARD UNIVERSITY

The current pandemic has inspired stirring calls for solidarity with “the most vulnerable among us.” This tends to encompass only citizens, in-group nationals, or co-ethnics (typically elderly). As governments increasingly shut and militarize borders, it is worthwhile to remember a category that notoriously falls between the cracks of nation-state boundaries: those in limbo; those in perpetual emergency; those whose very humanity, as Hannah Arendt famously argued, is questionable; those who have no “home” to designate them as “among us” to begin with.

Forced migrants—refugees, internally displaced persons, asylum seekers, stateless people—number over 70 million worldwide. Most are women. Most are children. Of the (un)lucky few who crossed an international border, 80% reside in a country neighboring the one they fled. Germany recently became the first-ever Western country to join the top-ten refugee host nations; otherwise, they are all impoverished

societies, often with dismal health infrastructures. The rate of successful refugee resettlement globally is less than 1%. Meanwhile, 3.7 million school-aged refugee children have no education (nor access to Zoom).

Just as the UNHCR froze refugee resettlements due to the pandemic, fears of “refugee corona” seem to have embarked on an infectious trajectory of their own. The notion that refugees spread sickness—perhaps by design, it is insinuated—is a cornerstone of the xenophobic repertoire. During and after World War II, Jewish refugees were universally slandered as infectious. For Nazi propaganda, they were rodents (what do rats do, the thought went, other than spread disease?). But the sentiment was not restricted to Axis territories. The American War Refugee Board waged a Sisyphean campaign to persuade wartime elites and public opinion that Jewish refugees were not contagious. A common objection to Fort Ontario, the sole Jewish refugee camp on U.S. soil, was that its 900 brutalized inhabitants were a health risk to the native New York population. “Refu-Jews,” the slur had it, were sick.

Decades later, such defamations persist. Across the Middle East, encampment and non-encampment policies alike are justified in reference to forced migrants as public health hazards. Kenyan officials accused Somali and Ugandan refugees in Nairobi of spreading disease. The Rohingya were denounced as transmitters of STDs. Poland's largest opposition party crowed that Syrian refugees spread "cholera" and "dysentery." In the Czech Republic, television managers at Prima TV instructed their producers to fabricate reportages on refugees as health risks for Europe. In Scandinavia, Austria, Greece, and Serbia, right-wing vigilantes and hooligans assault refugees as self-appointed health inspectors. In the U.S., the president aggravated his cruel and dysfunctional "Remain in Mexico" policy by insinuating that all the migrants at the southern border (tens of thousands of whom are undoubtedly asylum seekers) are coronavirus carriers. The view that refugees bring sickness—indeed, are a sickness—is very seductive.

Yet study after study has demonstrated that refugees do no such thing. The World Health Organization (WHO) published a recent report, based on a synthesis of 13,000 documents, showing no increased transmission of illnesses from refugees to the native populations of host societies. Refugees, furthermore, are "more vulnerable than the host population to the risk of developing both

noncommunicable and communicable diseases." As it happens, the ghettoized spaces that forced migrants inhabit are precisely the most at-risk sites for the worst infectious illness outcomes. Due to collapsing health care systems, overcrowding, and neglect, Syrian refugees recently suffered a re-emergence of tuberculosis, polio, measles, and cholera. Millions of other forced migrants are compelled to reside in poor living conditions that drastically increase their risk for mental illness and disease, including respiratory infections. The average length of stay in refugee camps is ten years. The average duration of exile for refugees is over two decades. Sociologists have rightly called it "refugee warehousing" (a concept that captures some realities of U.S. detention facilities on the southern border as well).

Consider Moria, a Greek refugee camp on Lesbos island. The site is on the frontline of a cynical and deadly European-Turkish policy on the Mediterranean. When I visited the camp years ago, volunteers and administrators dreaded overcrowding. "What the hell will we do when it's 1,000 people? 2,000?" The despair and trauma were breathtaking. Even the prospect of the common cold spreading seemed unbearable.

Meanwhile, the camp—equipped to handle a maximum of 3,000

refugees—has swollen to 20,000 residents today. Food, water, sanitation and clothing are disappearing. Six people per single tent; one water tap per 1,300 people; one toilet per 250 people. Not only is social distancing physically impossible, so is hygiene. Last month, the first COVID-19 case was confirmed inside the camp. These residents are now “trapped in an overcrowded, dangerous, and unsanitary camp”; a fertile ground, experts note, for “catastrophic morbidity and mortality in a population that is unable to deal with the pandemic effectively.”

When it comes to disease among refugees, there is a twofold stigma. First, refugees are regularly demonized: as agents of economic destruction, as organized criminals, and as potential terrorist threats. This is perverse enough, given that refugees are victims of these very forces. Second, however, there is another, disease-specific stigmatization: they are spreading ill-health to the community that magnanimously accepted these outsiders. A healthy refugee is threatening enough; an infectious one is hopelessly unattractive.

Refugee-ness in the time of COVID-19 is, in the words of sociologist Erving Goffman, a doubly spoiled identity. During pandemics, refugees deserve double our attention.

Borders and Economics of Worth During COVID-19

BY IOANA SENDROIU AND
RON LEVI, UNIVERSITY OF
TORONTO

How have political leaders justified decisions to close or restrict national borders in response to COVID-19? We coded early political statements to close or constrain border crossings by President Trump in the United States, Prime Minister Trudeau in Canada, and the European Commission President Ursula von der Leyen.

We coded these statements sentence by sentence to analyze the common moral registers being invoked, drawing on Boltanski and Thévenot (2006) to code for justifications in the name of the market, equality, community and custom, passion, creativity and the divine, reputation, or efficiency and reliability. Given the substantive goals of these statements, and our focus on social collectivities, we did not code for the “connectionist” order of worth, in which projects and networks are justificatory ends (Boltanski and Chiapello 2006). In so doing, we find that restricting borders can be underwritten by different moral justifications across political cultures (Dromi and Stabler 2019; Lamont et al. 2017).