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'Live with the Virus' Narrative and Pandemic Amnesia in the Governance of COVID-19

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Abstract: Political leaders have commonly used the phrase 'learn to live with the virus' to explain to citizens how they should respond to the COVID-19 pandemic. I consider how the 'live with the virus' narrative perpetrates pandemic amnesia by refusing what is known about pandemic-related inequities and the strategies that can be used to overcome these effects. Advice to 'live with the virus' helps to further austerity public policy and therefore individualises the social and health burdens of post pandemic life. 'Live with the virus' asks citizens to look only to their own futures, which are political strategies that might work for privileged individuals who have the capacity to protect their health, but less well for those with limited personal resources. I draw on Esposito's framing of affirmative biopolitics and scholarship on how excluded communities have built for themselves health-sustaining commons in responses to pandemic threats to health. I argue that creating opportunities for a 'COVID-19 commons' that can enlarge capacity for citizenly deliberation on how they have been governed and other pandemic related matters is vital for the development of more ethical and equitable post-pandemic politics.

Keywords: COVID-19; pandemics; media; narrative; commons

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This paper reflects on the political effects of 'live with the virus' narratives associated with the COVID-19 pandemic. Politicians, experts and media professionals have used these narratives to move publics through the pandemic, to encourage citizens to set aside uncertainty and pursue consent for how the pandemic should be managed. Consider this fragment from a news item in *The Independent*, reporting on UK prime minister Boris Johnson's advice for the British public in the run up to winter in 2021:

> "The pandemic is far from over, but thanks to our phenomenal vaccine programme, new treatments and testing, we are able to live with the virus without significant restrictions on our freedoms", said the prime minister. (Woodcock 2021)

'Live with the virus' verges on master narrative (Bamberg and Andrews 2004; McLean and Syed 2015) in the sense that it seeks to shape how individuals should think and feel about how life is to be lived. It has ideological properties since it offers itself as a reflection on the order of life, while refusing debate on how life with the pandemic will be experienced by all. 'Live with the virus' in the quotation from Johnson is used to promise freedom through the technological mitigation of the impact of the virus. It also opposes life with the virus and lack of freedom, as if they are mutually exclusive. In terms of narrative on threats to health, 'live with the virus' mandates that the disruption brought about by the advent of the virus is to be reconciled with the practical considerations of life and therefore accepted. It is also used by some to authorise the relaxation of prevention efforts because to not do so it is too harmful for economic systems. It has the significant narrative effect of supposing a particular future and foreclosing others. Commonly, the phrase is also used to signify the view that social distancing and other pandemic control methods are too damaging for economies and are unrealistically absolutist because they pretend that life without the virus is possible. It is, in part, code for taking steps towards economic activity that will continue to circulate the virus, but it is also a deeply political instruction

for how we are to be governed in an apparently permanent state of co-existence with the virus. Microbiologists, of course, know that in a technical sense the virus is here to stay in some form and that living with that situation is irresistible. Viruses travel across species and through time, evolving in response to their environments, sharing genetic material between themselves and with other viruses. Epidemiologists and clinicians also know that the virus will produce death and disease for some time to come. But to ask all to live with the virus in a political sense is an altogether different prospect and warrants interrogation.

Pandemics are profoundly political phenomena and COVID-19 is no exception. Over the course of the pandemic, nation states and regional legislatures have varied—over geographical space and across pandemic time—in how they have combined economic governance with science-based public health measures designed to moderate the impact of the infection on individual and collective health. Some governments, for example, the US and the UK (Jasanoff et al. 2021), resisted the imposition of social distancing and masks in order to inhibit the transmission of the virus, but then adopted these tactics when it became clear that the virus was air-borne and hospital systems had become overwhelmed. Governments such as in China and Taiwan (Jasanoff et al. 2021), opted for early and hard social distancing—often referred to as lockdowns—because this method was thought to lead to better outcomes for the economy in the long run. Against scientific advice, political leaders, including the US president Donald Trump (BBC News 2020a), advocated for bogus cures or disputed the effectiveness of masks and lockdowns. Some governments, for example in Italy and Austria (Jasanoff et al. 2021), mis-managed communications on threat to life in ways that energised vaccine confusion and hesitancy. Protests have been staged in major cities to re-claim freedoms supposedly under threat by public health restrictions on movement and vaccine mandates. Social media brim with stories that resist science-based responses to the pandemic. But these stories are referenced and resisted by ones that promote solidarity, encourage vaccination and how to cope with lockdowns. How these pandemic elements—space, time, science, politics—have been assembled to generate effects in the health and wealth of the body politic during COVID-19 is the focus for what follows.

The 'live with the virus' narrative also depends for some of its social potency on the notion that the pandemic is unprecedented and that it therefore was not possible to prepare for what has happened. This discourse lends force to 'live with the virus', but it is also ethically troubling and, as we will see, glosses over the demonstrable links that the COVID-19 pandemic has with previous pandemics. While it is a health threat of great impact, COVID-19 is not unprecedented in an absolute sense and has characteristics that have been addressed in previous pandemics. One distinctive feature of this particular pandemic, then, is that the lessons of the past appear to have been overlooked or forgotten. The effects of these erasures need to be evaluated.

Partly explaining this pandemic amnesia, COVID-19 has arisen in a political context comprised of resurgent, twenty-first century national populism that has sought to weaken global civil society and helped to slow and complicate the global response. Some responses to the COVID-19 pandemic framed by neo-liberalism are also inclined to resist support for collective action and deepen risk individualisation (Beck and Beck-Gernsheim 2002) and its associated inequities. At the same time, the flourishing of mathematical modelling in pandemic response planning has led to a focus on the presence and absence of infections and deaths (Davis 2021). Missing in this political and scientific framework are the social and cultural elements that make life with a virus bearable: social support, protection from prejudice, the means to take action, and the prevention of health inequity.

'Live with the virus' promises freedom from constraint but, due to the inevitable circulation of the virus, it also implies illness and death. To adopt this form of political reason makes it seem as if the death and adversity related to the pandemic is a cost naturally associated with the spread of the virus. This point of view overlooks what is known about how to prevent the transmission of the virus and protect vulnerable people. It is, therefore, a biopolitical rationality that refuses the application of reason and science to the betterment of the health and wealth of nations, a kind of anti-biopolitics in the Foucauldian sense

(Foucault 2007). As I discuss below, there is ample evidence that it is possible to manage the virus and also that without those efforts, the pandemic has worse effects for those who already face inequities in their capacity to avoid infection and, if and when they are, to cope with the infection. 'Live with the virus' narrative that resists knowledge that the pandemic can be managed encapsulates a politics that expands the privileges of some and deepens the suffering of others and is a dangerous settlement of the rights of some over others.

'Live with the virus' narrative, then, extends political reason that refuses to acknowledge how the health of one depends on the many. In his extensive analysis of the political and legal implications of the concept of immunity, Esposito (2013), shows how the assertion of immunity—in the legal sense of freedom from obligation to others—is bound into a paradoxical self-destruction. Esposito argues that the freedoms of some are tied to the consent of others, and to ignore this tie is to destroy the communal conditions that make freedom possible. He further argues that a vital politics is required to reverse these conditions:

> Now it is precisely on this terrain that the battle for an affirmative biopolitics must be braved and possibly won. It must start precisely by breaking the vise grip between public and private that threatens to crush the common, by seeking instead to expand the space of the common. The fight that has begun against the planned privatization of water, the battle over energy sources, or the one seeking to re-examine the patents granted by pharmaceutical companies that prevent the distribution of cheaper medicines in the poorer areas of the planet all go in this direction. (Esposito 2013, p. 89)

Esposito and similarly Thomas Lemke (Lemke 2010), argue for affirmative biopolitics that extend the benefits of freedom without eroding its source in the common good. An affirmative biopolitical approach could acknowledge and strengthen the social ties that make effective responses to pandemics possible. Building on this concept of interdependent life, Mbembe (2021) has noted that the COVID-19 pandemic is part of a more general depletion of life sustaining conditions. In Australia, for example, citizens facing bushfires in late 2019 and early 2020 wore masks to protect themselves from smoke. They donned masks again in 2020 to reduce the transmission of the virus, suggesting how the taken-for-grantedness of breathing freely is circumscribed in multiple ways. For Mbembe, then, the value of the common good extends to the biosphere and its vital interconnectedness. Corinne Squire (this volume) explains that affirmative biopolitics might not only be found in direct resistance of hegemonic framings of how to 'live with the virus'. Tangential and 'alter' resistance are also possible ways around hegemony, expanding the range of tactical resistances that make life with the virus more tenable. Framed in terms of affirmative biopolitics and vital interdependence, 'live with the virus' narrative could be the basis for attending to how all can make it through the ordeal of transition to post-COVID-19 existence. I reflect on how responses to COVID-19 could more effectively assist individuals and communities to imagine sustainable post-COVID-19 futures.

In what follows, I explore 'live with the virus' narrative and its related amnesiac effects in four parts. I consider in more details how 'live with the virus' narratives intensify risk individualization, privilege and inequity. I then critique framings of the pandemic's unprecedented character, to show that this frame is unhelpfully partial and, in combination with 'live with the virus', is exercised to weaken political resistance to governmental (in)action. Building on this analysis, I develop an argument that 'live with the virus' and the unprecedented framings of the pandemic help to further a form of pandemic amnesia that erases the basis for political resistance. In the last section of the paper, I draw on Esposito and related scholarship on the common good and political resistance, to reflect on how the 'live with the virus' narrative could be turned in meaning to imply reflection on political circumstances and the development of ethical and just responses to the COVID-19 pandemic.

1. 'Live with the Virus' Narratives and Risk Individualisation

'Live with the virus' contains within it an approach to the pandemic that has the effect of individualising risk (Beck and Beck-Gernsheim 2002). It accords with economic policy under advanced liberalism seeking to reduce the welfare state and most recently articulated as austerity (Viens 2019). In this governmental approach, state-supported public health systems are weakened, private providers expand their operation, and individuals are expected to undertake responsible management of health risks through lifestyle modification and insurance. In the UK, for example, it is estimated that public health budgets have been cut by 40% since 2013 and devolved to local authorities that have also experienced budget cuts (Lee et al. 2021), with consequences for the response to COVID-19. Risk individualisation draws attention to how the state extricates itself from involvement in assisting individuals to mitigate life risks. In these circumstances, the individual is expected to take on these risks for themselves. Risk individualisation can be distinguished from individualism, which concerns the emphasis given to the self-determining individual in liberal democracies. Risk individualisation is more specifically to do with the biographical trajectories of individuals facing the risks entailed in life choices that come to the fore under contracting welfarism and increased dependence on the resources the individual is able to command in their own right. Risk individualisation might seem like freedom for the privileged and affluent, but for those with fewer personal resources, it amounts to considerable constraint on life choices.

The assertion 'live with the virus', then, traffics into public policy a cruel individualisation of risk. For example, those whose employment allows them to easily work from home can establish social distancing to minimise the risk of viral transmission to family members. For those who have jobs that require them to be present at work—couriers, food production and delivery workers, cleaners—social distancing is less viable and therefore avoiding COVID-19 infection is more difficult to maintain. During the pandemic, some sectors of national economies have faced enormous income reduction and forced redundancies. Hospitality, entertainment and education sectors have faced these risks to income and wellbeing. Other sectors of the economy, however, have expanded and become more profitable, including corporations that deliver digital and material goods to households.

'Live with the virus' narrative also assumes that COVID-19 is the only health problem faced by individuals and communities. It is somewhat blind to the reality that some are already contending with other infectious diseases and health problems that make them more likely to be affected by the pandemic. People with immune dysfunction related chronic illness, for example diabetes, liver and kidney disease, autoimmune disease and respiratory diseases are more likely to have severe COVID-related illness, die or have long term effects (Callender et al. 2020). Cancer patients with COVID-19 and from lower economic status have been found to have higher risk of death (Ospina et al. 2021). Individuals with these conditions are already subject to economic hardship, features of their lives that are exacerbated by the pandemic. To say 'live with the virus' might suit those who are relatively privileged in economic and health terms, and therefore able to respond to the virus in ways that reduce their risks. But this approach may not make practical sense for individuals and communities already facing health challenges due to infectious diseases or health conditions that intersect with them.

There is ample evidence that the effects of the pandemic are felt unequally between and within societies. Epidemiological research of national data in the US shows that lower income and education was associated with risk of death with COVID-19 infection (Karmakar et al. 2021). UK research tracking clinical outcomes among blood donors found that age, male sex and Black ethnicity were associated with increased mortality related to COVID-19 infection (Elliott et al. 2021). Additionally, in the UK, 'live with the virus' was linked with the cessation of access to free COVID-19 testing (Limb 2022), deepening structures of inequitable access to the means to effectively manage one's risk. Narrative research with people living with HIV in the UK shows how the pandemic complicated and interrupted psychosocial supports, deepening precarities and multiplying healthcare

challenges (Squire, this volume). These patterns of illness, death and reduced capacity to take action indicate how social conditions shape risk and therefore point to the need for efforts to reduce such risks. Moreover, knowledge of long COVID and how COVID-19 infection interacts with other health problems is likely to emerge over time. Given what is already apparent and what we know of other infectious diseases, that is, the biological and social syndemics that characterise HIV, TB, Zika and malaria, among other diseases, it is likely that COVID-19 will become a significant factor in health inequity. These inequity producing impacts of COVID-19 are bracketed aside by 'live with the virus' narrative, implying that it is a policy framing blind to the deepening of inequity.

'Live with the virus' is an opportunity afforded to those with privileged capacity to remain disease free without government help in the form of economic support for public health measures. To ask all to 'live with the virus' may be viable for some, but for others adds considerably to the burden of illness that they face.

2. A Pandemic without Precedent?

A common theme in public discourse on the pandemic is its apparently unprecedented quality. A report published by the European regional office of the WHO was titled 'An unprecedented challenge: Italy's first response to COVID-19' (Regional Office for Europe, World Health Organization 2020). News media has also circulated 'unprecedented' to describe the pandemic. The conservative Australian prime minister, Scott Morrison, prefaced in this way an announcement of a large package of financial aid during widespread lockdowns:

> With the twin battles that we face, and that we fight, against a virus and against the economic ruin that it can threaten. This calls for unprecedented action. Governments making decisions like they never have before. And today our government has made a decision today and that I announce today that no government has made before in Australia in response to crises such as these. And I hope and pray they never have to again. (Channel 9 News 2020)

The statement revealed that a focus on economic imperatives was paramount for the government. The scale of the support—some $130 billion AUD (Office of the Prime Minister of Australia 2020)—was justified by reference to the concept of 'unprecedented crisis', though there is some ambiguity as the audience is left to wonder if the crisis is mostly viral or economic. The aid package mirrored action taken by governments across the globe and to some extent can be seen as an effort to protect citizens from the pandemic, to make it easier for them to social distance and therefore to shore up the common good. However, it is also clear in this particular statement that the support was seen to be unprecedented. It was a disruption to government as normal. For example, the turn of phrase "I hope and pray they never have to do this again" implies that in normal circumstances the government should not take these steps to protect business and therefore the livelihoods of Australian citizens. The statement can be read as making reference to a crisis for favoured public sector austerity policy. The crisis is a reputational one for the status of conservative government as the rightful stewards of austerity. The aid package, then, was the exception that proves the rule of austerity policy. It has also been suggested that the aid package benefited employers as the payments went to corporations and secondarily to their employees (Butler 2021).

These ways of framing the pandemic help to give impetus to 'live with the virus' narrative, specifically, that unprecedented conditions have to be accepted. There is no doubt that the COVID19 pandemic has features and effects that need to be reckoned with, but it is also important to understand how social and political responses to this virus have genealogies in previous socio-political configurations of infectious threats to life. That which makes the COVID-19 pandemic distinctive can be better understood if these qualities are examined in light of what we know of previous pandemic threats. It is valuable, for instance, to reflect on how previous responses to infectious diseases have articulated pandemic space and time with science and politics. This analytical project could help to temper somewhat the recourse to the language of a pandemic without precedence

and its now familiar cousin, 'live with the virus' narrative and its amnesiac and political ramifications.

The 1918–1919 influenza pandemic is often said to be the touchstone for discourse on pandemic threats. Coming at the end of the WWI, the pandemic is thought to have reached across the world within a year and eventually led to the deaths of an estimated 50 million people (Taubenberger and Morens 2006). It can also be said that accepted scientific knowledge of pandemics can be traced into the events of 1918–1919. Due to its global scale, the pandemic generated extensive mortality data, some of which has been used by epidemiologists and mathematical modellers to examine how various public health approaches to the prevention of the infection impacted on deaths (Bootsma and Ferguson 2007; Ferguson et al. 2006). Modellers considered death notifications over time in particular cities in the US to assess the effect of different approaches to social distancing on viral transmission, in particular, comparing cities that adopted wide-scale cessation of public events with cities that adopted less rigorous social distancing. This research helped to provide a scientific basis for the concept of social distancing. Pandemic preparedness and response plans generated by nation states in the 2000s have drawn on these models and can therefore be construed to connect back to the 1918–1919 pandemic (United Kingdom Department of Health 2007; Australian Department of Health and Ageing 2008). Social distancing, in part founded on data generated from attempts by cities to manage the spread of H1N1 virus in 1918–1919, have helped to shape the evidence base used to guide the management of COVID-19.

In addition to its effects in the science of social distancing and pandemic preparedness, the 1918–1919 pandemic was briefly echoed in an outbreak that occurred in the 1970s US and related considerations of trust in scientific authority (Neustadt and Fineberg 1983). In 1976, it was discovered that an H1N1 virus—the same virus type that led to the 1918–1919 pandemic—had led to an unusually high number of deaths in a short period of time. Authorities, worried about a resurgent H1N1 pandemic similar in scale to 1918–1919, embarked on an ambitious programme to vaccinate the entire population. Unfortunately, the vaccine chosen was found to be associated with an elevated incidence of Guillain Barre syndrome, an autoimmune disorder. The vaccine programme was ceased in the face of media outcry and the pandemic itself turned out to be less severe than first thought. These difficulties with the management of the 1976 H1N1 pandemic, the vaccine used to prevent it, and media responses have become something akin to public health lore, framing how the international community of public health experts have addressed subsequent outbreaks. Fineberg, one of the co-authors of the book about the 1976 outbreak—*The Epidemic That Never Was: Policy-making and the Swine Flu Scare*—was commissioned by the WHO to review the management of the 2009–2010 influenza pandemic (World Health Organization 2011), which also involved the H1N1 influenza virus type. The example of the 1976 H1N1 outbreak underscores the heated politics of pandemic responses and therefore how COVID-19 is not strictly without precedence.

The COVID-19 pandemic also arises in what has been said to be a period of resurgent infectious diseases (Zumla and Hui 2019). Commencing in the early 1980s, the HIV/AIDS pandemic presented as a deeply complex biomedical, scientific, social and political public health challenge (Epstein 1996). In this period, too, bovine spongiform encephalopathy (BSE) emerged as a health crisis implicated in practices of food meat production in Europe (Pattison 1998; van Zwanenberg and Millstone 2002). Multi-drug resistant tuberculosis emerged as a widespread clinical problem by the 1990s, shaded by social and regional health care inequities (Keshavjee and Farmer 2012). Methicillin-resistant Staphylococcus Aurea was detected in hospitals in the 1990s and became a high profile news story by the mid 2000s (Washer and Joffe 2006).

The outbreak of Severe Acute Respiratory Syndrome (SARS) in 2003 (Lee et al. 2005) is another important context for COVID-19, for biological and public policy reasons. SARS is a coronavirus, as is COVID-19, and led to harsh lockdowns of affected communities in Hong Kong (Baehr 2006) and Toronto (Sanford and Ali 2005). SARS generated knowledge of the

potential severity of coronaviruses and experts worried that a more easily transmissible variant could have devastating effects, akin to 1918–1919 (World Health Organization 2011). The potential danger that the SARS outbreak indicated, coming on top of the infectious diseases concerns of the previous decades, led the global health system to place an increased focus on pandemic preparedness. The WHO strengthened the International Health Regulations which required member states to create national and regional pandemic preparedness plans (World Health Organization 2011).

Pandemics and outbreaks have followed with some regularity. The 2009 swine flu (H1N1) pandemic was the first post-SARS pandemic to be addressed using international and national pandemic preparedness plans (World Health Organization 2009). The 2009 pandemic outbreak was initially the focus for intense media attention and public health responses, but like the H1N1 outbreak in 1976, proved to be of mild severity for most people in the long run. The swine flu pandemic meant that experts and governments had to once again work hard to manage public expectations, explaining how the infection was a threat to only some but that overtime it could evolve into a more serious health threat. In 2014, a serious outbreak of Ebola emerged in west Africa (World Health Organization 2014) and led to some criticism of the international response (Kamradt-Scott 2016). In 2016, Zika emerged in South America (Chan 2016; Fauci and Morens 2016) after it was first detected in Africa in 1947 (Singer 2016).

COVID-19, then, is not absolutely unprecedented. It is framed by the spectre of a lethal global pandemic that occurred in the second decade of the twentieth century. The imaginary of pandemic devastation has been coupled with the data that the 1918–1919 pandemic generated about the effectiveness of public health measures, knowledge that has persisted in public health science and pandemic preparedness and into the response to COVID-19. Experiences with previous infections have also generated knowledge about the need to manage news media and the public sphere and how infectious diseases inequities are shaped by the structures of social inequality, political power, and social abjection.

What does make COVID-19 distinctive in light of this pandemic history is how slow and variable has been the response of nations. The World Health Organization moved quite quickly to encourage the global response. They declared the outbreak a Public Health Emergency of International Concern (PHEIC) on 30 January 2020 (Global Research Collaboration for Infectious Disease Preparedness 2020), under the International Health Regulations that had been established in 2005 in response to SARS. On 11 March, the World Health Organization declared that COVID-19 was pandemic (World Health Organization 2020). For comparison, the 2009 influenza pandemic was declared a PHEIC on 25 April 2009 and a pandemic on 11 June (World Health Organization 2011), a slightly longer period of time. The World Health Organization (2022) and the United Nations (2021) also offered guidance on how to respond to the pandemic that called on knowledge and expertise garnered in experience of previous pandemics.

Despite this pre-existing knowledge and contemporary guidance, national responses to COVID-19 appeared to depart from the apparently coordinated action taken in 2009 and 2010, perhaps for political reasons. The 2009 influenza pandemic coincided with the centre left governments of Barak Obama in the US, Gordon Brown in the UK and Kevin Rudd in Australia. COVID-19 coincided with conservative governments in the UK and Australia and Trump in the US. Particularly in relation to Trump but also in other nations, the pandemic was met with the populist turn in politics and a related weakening of commitments to global civil society organisations like the World Health Organization. For example, in 2020 in the midst of the pandemic the US president Donald Trump sought to withdraw the US government from funding the World Health Organization (BBC News 2020b). In some nations, notably the US, The Philippines and Brazil, leaders articulated 'medical populism' (Lasco 2020, p. 1417) eschewing science, promoting unproven cures and fomenting mistrust of expert knowledge systems. Donald Trump, for example, famously advocated that citizens might inject bleach to cure their COVID-19 infection (BBC News 2020a). The absence of leadership in Brazil is said to have galvanised a civil society

response comprised of NGOs, local health services, and universities (Ortega and Behague 2022). In the UK, a senior government advisor, Dominic Cummings, travelled across the country during lockdown, therefore flouting public health requirements (Fancourt et al. 2020). Exposed by news media to public outcry, Cummings's action and later the 'partygate' scandal underlined the UK government's somewhat faltering commitment to the containment of the pandemic.

The confluence of pandemic amnesia with the deconstruction of global civil society institutions, populism and communities left to their own devices has given COVID-19 some of its specific character. To say that the pandemic is unprecedented and that we have to learn to live with it is a kind of laziness in the sense that it ignores what is known, the evidence that exists and the richly nuanced expertise of infectious diseases that is at hand. 'Live with the virus' narrative in this view signals not having really addressed the pandemic in the ways we could have done. The amnesiac response to COVID-19 points to the political landscape in which the pandemic emerged, one that endorses a refusal of pandemic pasts.

3. Pandemic Amnesia and the Erasure of Political Resistance

The pandemic amnesia entailed in 'live with the virus' narrative might also have the effect of weakening the basis by which it is possible to reflect on what has happened, both in terms of lived experience and for governance. One of narratives' richest properties is that they provide symbolic structures for accounting for the relationship between the past and present and therefore how the future might be entered into political reason. Narratives provide cultural means by which individuals can evaluate what has happened and on that basis embark on reparation and restitution, or if that is not possible, settle on acceptable new ways of life (Frank 1995). By marking shared history, narratives can also provide the basis for collective memory and political action (McAuley 2021). 'Live with the virus' narrative in most of its expressions appears to foreclose these political possibilities.

Pandemics vary, of course, but they frequently accord with the general narrative structure of setting, event and aftermath. An outbreak of some kind emerges in a community or population, wreaks effects, and then subsides. A pandemic is axiomatically an event in time where ways of life and social norms are suspended until it is possible to return to life as it more or less once was. This pandemic structure has been inscribed and reworked to the point that it is understood as a narrative genre that links diverse media, including, novels, online games, television series and films (Davis 2017; Wald 2008). The close alignment of pandemics with generic narrative structure may be one reason why stories about pandemics and pandemic-like threats are extensively inscribed and circulated in literature and popular culture.

The pandemic narrative structure of an infection that comes and goes offers the opportunity for deliberation and healing. Considering a pandemic past from the standpoint of the present makes it possible to reflect on what happened and evaluate the practical and ethical values of courses of action, and to pursue the healing of lives, relationships and collective existence (Frank 1995; Hyden and Brockmeier 2008; Davis and Lohm 2020). The capacity to look back is also a valuable tool for deliberative and democratic engagement with the modes of governance citizens are encouraged to accept, particularly if these methods of administration are implicated in the inequitable distribution of pandemic harms and the resources that may moderate them. A pandemic that does not accord with this pattern—one that is a more or less permanent state of affairs—requires different methods for reflection, evaluation, collective memory and political engagement. In this light, to say we all have to learn to 'live with the virus' without critical reflection places COVID-19 beyond reparation or restitution. It is vital that 'live with the virus' narratives are opened up to possibilities for healing.

The capacity for reflective deliberation on how a threat to health—most keenly one that is shaded by deep inequity and disinterested leadership—is vital for the survival of affected individuals and communities. Grattan (2019) has made an argument that ACT-UP

was an early form of HIV activism that helped to constitute a 'queer commons' in the face of governmental inaction (Butt and Millner-Larsen 2018). By this he meant the making visible of dissenting politics about HIV's inequities, the grassroots responses of affected communities building alliances with agencies of civil society to provide education, care and support, and lobbying for treatments research and access. The political action of ACT-UP in the late 1980s and 1990s (Crimp 2002; Treichler 1999) comprised an important means of defending the health of populations in political circumstances where the rights of sexual and drug using minorities were under attack. As Douglas Crimp (2002) noted, the shame and stigma attached to AIDS made it difficult to mourn the loss of life. ACT-UP and simlar community acitivism made it more possible to grieve and memorialise the loss of loved ones in ways not otherwise possible. In this light, it is important to ask if imperatives to live with the coronavirus make it possible or difficult to mourn in ways that provide the basis for healing, particularly for those individuals and groups more deeply affected by the pandemic.

Like Esposito, previously discussed, Grattan argues that the queer commons has been erased in public policy through a gradual process of revisionism by the medical establishment typified by biomedical discourse on the passing of HIV exceptionalism (Bayer and Fairchild 2006; De Cock and Johnson 1998) and the increasing intensity of austerity and risk individualisation in public policy. Grattan argues that being unable to reflect on this activist past has significant political effects:

> I am beginning from the premise that remembrances of AIDS and AIDS activism in the United States have been willfully occluded through a series of narrative tactics of forgetting, reimagining, and denying. Like many ideological structures, the sinister recedes into the natural, and forgetting occurs not on the level of an active engagement but from the grounds that there was never anything to remember in the first place. I see revisiting ACT-UP as the beginning of a project of archival recovery, but also an affective provocation. Crucially, the elision of AIDS activism, and the pressures of the AIDS epidemic more broadly, from popular social memory is an act of enforced forgetting that functions symptomatically to illustrate the ways a commons is often forcibly enclosed. (Grattan 2019, pp. 127–28)

Grattan invites us, then, to consider how the erasure of the history of AIDS activism is not simply a matter of moving on, but also a profoundly political erasure of the foundation upon which the quest for equity and justice is made possible. This is also Esposito's point (2011) in relation to his political philosophy of *immunitas*, understood as the suspension of obligations to collective life and, therefore, a privileged release of the self to self-interest. Taken to its logical extension, however, immunity takes on a paradoxical quality as to forget that the source of one's freedom is a privilege that is bestowed by collective existence is to trouble the conditions of one's freedom. 'Live with the virus' offers citizens freedom, but also asks them to forget how it is possible to take that course of action and ignore how the privilege of self-determination comes with the devaluing of the conditions that make effective social responses to pandemics possible.

HIV provides additional lessons for how it might be possible to 'live with the virus.' HIV does not fit with the idealised pandemic narrative of before and after, but it does draw attention to the vital politics of ethical and just social responses. For individuals affected by HIV, diagnosis and its aftermath can be an important focus for experiential narrative on recollection and futures (Squire 2007; Barraso 1997; Roth and Nelson 1997). The example of ACT-UP and similar grassroots responses to this health threat showed how to address some of the inequities that the infection produced. The 'HIV commons' built by this action in different parts of the world have made it possible to advocate for treatment access and to roll it out when it became available (Davis and Squire 2010). In South Africa, shared narratives on living with HIV became the way of sustaining individuals and communities in face of stigma and discrimination (Mbali 2013; Robins 2006; Squire 2007). Squire's analysis of post COVID-19 narratives amongst people with HIV (this volume) underlines

how living with HIV is undermined by the COVID-19 pandemic but also a source for resisting the hegemonic framing of how to live with the coronavirus.

Expectations that citizens ought to 'live with COVID-19', then, raise questions with regard to when and how it will be possible to take up the vantage point of critical reflection or, as in the case of HIV, how individuals and communities will be able to assert and protect their rights to health. This negation of critical reflection on life's circumstances has significant political resonances. Reflecting on the severity of the Omicron variant in late 2021, the Australian prime minister was quoted as saying:

> "Our plan is to keep moving forward, not to go back. We're not looking in the rear vision mirror. We're not going back to what Australians have had to go through. We're going to go forward and we're going to live with this virus." (Piovesan 2021)

This advice links the expectation that citizens should 'live with the virus' and a metaphorical cessation of hindsight. It asks citizens to not consider the merits and harms of how the pandemic has previously been managed and therefore endorse a particular way of 'living with the virus', effectively erasing the possibility for political debate and the basis for political resistance.

'Live with the virus' portends fewer options for democratic engagement with the conditions of our existence. In time of excessive austerity and the hyper risk individualisation that have contributed to the pandemic, it is important to create the capacity to assess these circumstances. This is particularly the case since some turnings of 'live with the virus' narrative instruct citizens to not look back on what has happened and not question the circumstances that are upon them.

4. Affirmative Biopolitics for the COVID-19 Commons

Exhortations to 'live with the virus' bracket aside the complexities and uncertainties of efforts to prevent the transmission of the virus through public health measures, as if those have proven impractical or impossible to implement. It is a turn of phrase that simplifies and reduces, and so incanted casts a paralysing spell on its alterities and perhaps even over those who might seek to question or resist it. It is a phrase that turns away from efforts to resist the virus and implies acceptance of the view that it is possible to only mitigate the pandemic. Tacit also in 'live with the virus' is an acceptance of mortality, since to weaken or even forgo prevention—until such time as vaccines and antiviral treatments are able to prevent it—death of some is expected. It appears to admit that deaths related to COVID-19 have to be accepted despite evidence that social and political conditions shape risk for infection and mortality. In some uses, 'live with the virus' narrative is retrograde, anti-biopolitics in that it pretends that life is shaped by fate and not by science and politics. There is little promise in 'live with the virus' other than a reduction in the economic costs of public health and a tacit neo-liberalised individualisation of risk. 'Live with the virus' is the favoured clarion call for those seeking to exercise their privileged wealth and health over the needs of the less advantaged. In this sense, 'live with the virus' is optimistic/tragic master narrative since it proposes a method of pandemic life that assures privileges and disadvantages measured in life and death.

'Live with the virus' is made possible, too, by its close alignment with forms of pandemic amnesia. The common use of 'unprecedented' and other modes of COVID-19 exceptionalism, underline this willful forgetting. Pandemic amnesia has the effect of ignoring the inconvenient evidence, knowledge and understanding that has been accumulated over the decades, at least, since the 1918/1919 influenza pandemic. It borrows from the 'medical populism' that has emerged in the public discourse on COVID-19 (Lasco 2020). 'Live with the virus' combined with pandemic amnesia denudes public life of opportunities for the reflective appraisal of how citizens have been governed, the collective basis for political resistance, and how life with the virus could be made more just and equitable.

It might be possible, however, to turn what it means to 'live with the virus'. Digesting and creatively adapting this particular narrative could be a way of exploring, debating

and imagining how post-COVID-19 lives can be shaped to advantage. Remembering what is known about pandemics and, in particular, how they exaggerate social and health inequity could radically alter the meaning of 'live with the virus'. Calls to live with the virus could be cause to reflect on how this might be possible and, therefore, the ethics of policy settings and messaging and how to strengthen efforts to reduce health economic and related syndemic inequities (Singer 2016). Precisely in the face of failed leadership during the pandemic, formations of 'COVID-19 commons' have arisen through the building of alliances across civil society and local, community organizing (Ortega and Behague 2022). These experiments with how to live with the virus provide ways of resisting the foreclosure of deliberative reflection on political conditions post-pandemic.

'Live with the virus' narrative also needs to be interrogated for the politics of health and wealth it traffics at the expense of community life. Esposito's (2011) political philosophy suggests that to refuse the collective conditions that make self-determination possible—that is, the freedom to live with the virus in the body politic—ultimately makes life unlivable. There is urgent need to reflect on the conditions of our political existence, share stories of 'how to live with the virus' in acceptable ways and acknowledge the multiplicity of privilege and disadvantage. Action like this could help to strengthen ways and means of building lives post-COVID-19. 'Live with the virus' could become—not an instruction to forget—but a source of healing and political action, as it has been for infections like HIV. This kind of retrospective narrating of pandemics would comprise investment in the material and symbolic means of social public health and the amelioration of inequity.

Pandemics test societies in many ways and COVID-19 tests nations, communities and individuals greatly. Amongst these challenges is ensuring that the pandemic is not used by some to erase affirmative biopolitics and creating a 'COVID-19 commons' through which it might be possible to live with the virus, justly and equitably.

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