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# Biopolitics and public health in times of crisis

**Rokas Garliauskas**

*Vytautas Magnus University, Kaunas, Lithuania*

The COVID-19 pandemic has renewed attention to the entanglement of politics, health, and the governance of life. Measures such as lockdowns, vaccination campaigns, digital contact tracing, and quarantine protocols reveal that public health policy operates not merely as a technical or medical response, but as a form of political power acting directly upon bodies and populations. By examining how states enacted exceptional measures under conditions of crisis, this paper highlights both the potency and the fragility of sovereign control. Comparative case studies demonstrate how legal frameworks, political cultures, and ideological assumptions shape not only policy responses but also the differential valuation of life during health emergencies. Ultimately, the article argues that public health crises are not solely biomedical events, but deeply political phenomena.

**Keywords:** COVID-19, HIV/AIDS, public health governance, digital health

## INTRODUCTION

The COVID-19 pandemic has brought renewed attention to the entanglement of politics, health, and the governance of life. Measures such as lockdowns, vaccination campaigns, digital contact tracing, and quarantine protocols revealed how public health policies functions not merely as a technical or medical enterprise but as a mode of political power that acts directly upon bodies and populations. It is best understood through the concept of biopolitics, first articulated by Michel Foucault (1976/1990, 2003), who described the transition from sovereign power – the right to 'take life or let live' – to modern power structures that 'make live and let die.'

Biopolitics, in this sense, refers to the mechanisms by which states regulate, optimise, and discipline life through institutions, health systems, and norms. Foucault illustrated this historical shift with the example of plague governance, showing how the sovereign's right to kill was complemented by a new rationality rooted in population management, statistical surveillance, and the disciplinary power of the modern state (1978, 2003). Power, he argued, became entangled with the life sciences, creating a milieu in which life itself became both the object and the subject of governance (Foucault, 2007). As a result, biology became politicised, and politics became biologized, the dynamic that Esposito (2011) later described as the foundation of biopolitical modernity.

This framework has since been expanded by a range of scholars. Giorgio Agamben (1998, 2005) introduced the notion of the state of exception, arguing that emergencies enable the suspension of rights and the reduction of subjects to 'bare life.' Roberto Esposito (2011) proposed the idea of *immunitas* to describe how protective mechanisms such as vaccination or containment

* Corresponding author. Email: rokas.gar23@gmail.com

often operate through exclusion or negation of communal ties. Achille Mbembe's (2003, 2019) concept of necropolitics pushes this further by highlighting how colonial and racialised systems of governance determine who may live and who must die. This new power, emerging in the seventeenth century, seeks 'to invest life through and through', which is 'a question of constituting something like a milieu of life, existence' (Foucault, 2007). As a result, the development of life necessarily becomes the focus of inquiry, and the people (demos) become a biological population that must be governed and controlled. On the one hand, life is subjected to biological sciences, life is biologized. On the other, politics become biologized and biology is politicised (Esposito, 2011). The net result is that biopolitics emerges when life is politicised. From now on, life is considered as the biopolitical subject of biopower.

This literature review synthesises key biopolitical frameworks and applies them to the governance of public health in times of crises. It explores how vulnerability, care, and resistance are politically constructed and contested.

## THE COVID-19 PANDEMIC: A BIOPOLITICAL CRISIS

### Governance

The COVID-19 outbreak was a defining moment in the expression of biopolitical governance, revealing both its advantages and shortfalls. Biopolitical governance, particularly in the context of global health crises, is not only a matter of managing populations or securing life but also a question of ethics. The ethical implications of biopolitics are multi-faceted, touching on issues of sovereignty, justice, equity, and the distribution of care. In the context of public health crises, biopolitical interventions raise fundamental questions: who decides what counts as a life worth protecting? What ethical frameworks guide decisions about whose health is prioritised and whose is sacrificed? And, crucially, what are the broader implications for social and political structures when health responses become a tool for enforcing broader hierarchies of power?

Pandemic governance illuminated the divergent forms this power could take in different national contexts. New Zealand, often cited as a paradigmatic case of successful pandemic containment, enacted an elimination strategy grounded in early, strict lockdowns, closed borders, and centralised contact tracing infrastructure. These interventions reflect what Esposito (2011) describes as an 'immunitary paradigm', where the body politic is defended through strategic exclusion and protection mechanisms. Empirically, this strategy resulted in approximately 2500 cases and 26 deaths per million people by early 2022 – a stark contrast to global averages (Royal Commission on COVID-19 Lessons, 2023). These outcomes demonstrate the state's capacity to temporarily suspend liberal norms such as freedom of movement in favour of biopolitical rationality that prioritises population-level health outcomes.

In contrast, Sweden pursued a controversial strategy of minimal restrictions, relying on public trust and voluntary guidelines to mitigate the spread of the virus. Officials framed this approach as a preservation of democratic values and individual responsibility, yet it also reflected a restrained use of sovereign power – a biopolitical laissez-faire approach. By mid-2021, Sweden's death toll reached over 1400 deaths per million – significantly higher than its Nordic neighbours such as Norway (165 per million) and Finland (174 per million) (Habib et al., 2021; Pierre, 2020). While some praised the Swedish model for avoiding the social and economic costs of lockdowns, others criticised it as a failure to protect the most vulnerable and a case of necropolitical governance in which some lives were implicitly rendered more expendable (Mbembe, 2003). These divergent approaches – strict containment versus mitigative non-intervention – highlight the uneven deployment of sovereign authority and its ethical implications. The New Zealand model can be interpreted as a case where the sovereign state maximised its capacity to govern life through proactive and centralised control. In Sweden, the relative absence of such intervention arguably left the population more exposed

to viral circulation, which problematises liberal framings of autonomy when such freedoms disproportionately impact the vulnerable. Judith Butler's (2020) framework of vulnerability and collective care offers an important intervention here. Butler's assertion that 'not all resistance is liberation' calls into question the moral underpinnings of certain resistive stances during the pandemic, especially those that prioritise individual freedom over collective responsibility.

Nowhere was the tension between personal freedom and collective care more apparent than in the worldwide vaccine controversies. Countries across the globe implemented health measures like lockdowns, quarantines, and mass vaccination drives – all in the name of preserving life. However, these actions were implemented unevenly, reflecting deep-rooted structural inequalities shaped by histories of colonialism, global capitalism, and neoliberal policymaking. As the global North and the global South experienced the pandemic in starkly different ways, with disparities in access to healthcare, vaccines, and public health resources that mirrored long-standing patterns (Daston, 2021).

**Vaccination**

Just over a year after the outbreak began, research institutions and pharmaceutical companies successfully developed a wide array of COVID-19 vaccines. These included whole virus vaccines, either live attenuated or inactivated, such as BBIBP-CorV (Sinopharm, China) and CoronaVac (Sinovac, China); protein subunit vaccines like NVX-CoV2373 (Novavax, USA) and ZF2001 (Anhui Zhifei Longcom, China); viral vector vaccines such as Ad26.COV2.S (Janssen/Johnson, Johnson, USA), AZD1222 (Oxford/AstraZeneca, UK), and Ad5-nCoV (CanSino Biologics, China); as well as gene-based vaccines, including mRNA-1273 (Moderna, USA) and BNT162b1 (BioNTech | FosunPharma | Pfizer) (Forni & Mantovani, 2021).

By July 2021, there were 184 COVID-19 vaccine candidates in pre-clinical development, 105 in clinical development, and 18 vaccines approved for emergency use by at least one regulatory authority. By mid-2021, over three billion doses had been administered globally – primarily in high-income countries (Ndwandwe, Wiysonge, 2021). Nations that had vaccinated at least 50% of their populations by this point included the United Kingdom, Chile, Uruguay, Israel, Bahrain, Hungary, Italy, Spain, Germany, the United States, and France. In stark contrast, only 1% of people in low-income countries had received even a single dose by the end of June 2021 (Mathieu et al., 2021). Countries that had vaccinated at least 50% of their citizens against COVID-19 by mid-2021 include the United Kingdom, Chile, Uruguay, Israel, Bahrain, Hungary, Italy, Spain, Germany, United States of America, and France. However, only 1% of people in low-income countries had received a COVID-19 vaccine dose by end of June 2021 (Mathieu et al., 2021).

The inequitable distribution of vaccines showcased a clear example of how the pandemic reinforced geopolitical hierarchies of life and death. High-income nations stockpiled vaccines, leaving poorer nations with limited access. Duan and colleagues (2021) analysed vaccination coverage across 138 countries and found significantly lower rates in upper-middle- ($\beta = -1.44$), lower-middle- ($\beta = -2.24$), and low-income countries ($\beta = -4.05$), compared to high-income ones. Vaccination policies partially mediated these effects only in middle-income countries, they had left little effect in lower ones. Even after adjusting for demographics and health factors, the income level remained a major predictor of vaccine access. This imbalance exemplifies Achille Mbembe's (2003, 2019) concept of necropolitics, wherein certain lives, particularly in the Global South, are expendable, resulting in millions of preventable deaths (Mahase, 2021). It also reflects Foucault's (2003) concept of biopolitics, in which regulation of life and death is not an act of care but a strategic process that values some lives more than others.

As Foucault (2003) theorised, biopolitical governance is not merely about protecting life but about managing populations through regulatory frameworks. The global disparity in vaccine access during the COVID-19 pandemic is

a stark example of neoliberal biopolitics at play. As Harvey (2005) notes, neoliberalism privatises public services and prioritises profit over welfare. High-income nations leveraged their economic and infrastructural advantages to monopolise vaccines (Mahase, 2021), reinforcing Foucault's (2003) idea of governmentality, where economic power determines who is protected.

The EU and US responses illustrate two faces of neoliberal crisis governance. The EU pursued a centralised vaccine procurement strategy to promote solidarity, but was hampered by opacity, fragmented implementation, and internal competition (Arroyo et al., 2024, European Commission, 2020; European Court of Auditors, 2022). In contrast, the US adopted a market-driven approach through Operation Warp Speed, emphasising speed and innovation but exacerbating domestic inequities. Digital appointment systems and private-sector prioritisation left many low-income and marginalised groups without access (Tufekci, 2020; Benjamin, 2019). These contrasting strategies reflect broader tensions between sovereignty, capitalism, and public health. While the EU aimed for equitable access, institutional opacity weakened legitimacy. The US model prioritised rapid production but struggled with fair distribution. Both reveal how neoliberal systems reinforce global and internal hierarchies, echoing Butler's (2020) reminder that not all interventions are liberatory: some entrench existing power asymmetries.

Simultaneously, vaccine diplomacy emerged as a key instrument of soft power. During the pandemic, countries such as China, Russia, and India have provided vaccines to low- and middle-income countries, thereby strengthening geopolitical ties, particularly in Africa, Asia, and Latin America. China's integration of vaccine distribution into its Belt and Road Initiative framed these efforts as acts of solidarity, offering vaccines at competitive prices and with fewer restrictions than many Western suppliers (Liu, Huang, Jin, 2022). Meanwhile, the Western countries, which initially focused on domestic needs, subsequently engaged in large-scale vaccine donations, reasserting their influence in global health governance. These parallel strategies illustrate how the pandemic was not only a health crisis but also a site of geopolitical negotiation where biopolitical tools were mobilised to achieve both humanitarian and strategic goals.

Ultimately, the pandemic exposed how biopolitical and necropolitical logics converge under neoliberalism. Global health governance, shaped by capitalist imperatives, determined whose lives could be saved and whose could be sacrificed. Vaccine access and economic fallout were dictated not by need but by wealth, underscoring how health, sovereignty, and inequality remain deeply entangled.

**Biopolitical management and the role of technology in public health crises**

The invocation of emergency powers – border closures, digital surveillance, curfews – resonates with Giorgio Agamben's (2005) notion of the state of exception, where ordinary legal protection are suspended in the name of crisis management. Emergency powers allowed states to impose lockdowns, surveillance measures, and border closures, leading to a temporary suspension of civil liberties in the name of health security. As Esposito (2011) notes, biopolitical governance, while ostensibly protective, also includes mechanisms of exclusion that render certain populations more vulnerable. For instance, while lockdowns were universally applied, marginalised groups such as the homeless, refugees, and those in precarious work often had little recourse to protection, highlighting the uneven reach of biopolitical measures (Bejan, Glynn, 2023).

At the same time, the pandemic highlighted the potential of surveillance technologies to foster greater social resilience and coordination in global crises. The experience of COVID-19 has revealed the critical role of digital infrastructures in providing timely responses to complex health threats. The widespread adoption of health-related digital tools, such as contact tracing apps, demonstrates how technology can serve as a force for good governance, providing mechanisms to maintain public order while

minimising the social and economic impact of crises (Galloway, 2020; Hall, Zeng, 2021). The accessibility of digital tools like immunity passports and contact tracing apps played an important role in ensuring that pandemic management measures were as inclusive and equitable as possible. Governments recognised the need to make these tools widely available, ensuring that everyone, regardless of socioeconomic status or access to technology, could benefit from the security and safety that these measures offered. By prioritising equitable access to digital tools, states ensured that the pandemic response was not just effective but also fair and inclusive.

Foucault's (2003) biopolitical framework also reminds us that the effective use of surveillance and biopolitical measures depends on their moral use. It is essential to ensure that such measures serve the population's well-being without causing undue harm. When implemented with equity in mind, digital solutions can empower citizens by equipping them with the resources needed to protect themselves and their communities. In this way, digital tools become essential not only for managing the pandemic but also for ensuring global solidarity in the face of a shared challenge.

In countries like South Korea, for example, extensive use of contact tracing and immunity passports allowed the government to monitor and control the virus spread, while maintaining a high degree of social engagement. These systems were not used to penalise individuals but rather to empower them with the information necessary to make informed decisions about their health (Koh et al., 2020; Park, Han, 2020). By ensuring that these systems were universally available and easy to access, governments could promote social trust and ensure that pandemic measures were seen as legitimate and just.

## HIV/AIDS: historical lessons in biopolitical exclusion

The HIV/AIDS epidemic provides an earlier, and arguably foundational case study for understanding biopolitics in public health. When the epidemic emerged in the early 1980s, it predominantly affected marginalised communities, particularly gay men, drug users, and people of colour. The early governmental response to HIV/AIDS was neglectful, reflecting the moral dimensions of biopolitics, where certain lives were seen as less worthy of care. The neoliberal governance of the Reagan administration in the US exemplifies how biopolitical responses were shaped by ideologies of austerity and moral judgment. Despite early warnings from health experts, government action was delayed, and the lives of those most affected by HIV/AIDS were subjected to further marginalisation (Poon, 2016).

As Foucault (2003) argued, biopolitics does not only function through the care of life but through the regulation of populations. The response to HIV/AIDS in the 1980s illustrates how biopolitical exclusion can occur through neglect, whereby marginalised communities – those deemed 'deviant' or 'undesirable' – were left to suffer. The stigmatisation of people living with HIV, particularly in the US, reinforced racial and class divisions, as the disease disproportionately affected Black and Latino communities (Watkins-Hayes, 2014). These dynamics have persisted up until now. According to the latest estimates from the Centers for Disease Control and Prevention (CDC) (2024), approximately 31,800 people acquired HIV in the United States in 2022. While annual infections have declined by more than two-thirds since the peak of the epidemic in the mid-1980s, disparities remain stark. Black/African American individuals, who comprise roughly 12% of the US population, accounted for 37% (11,900) of new HIV infections. Hispanic/Latino individuals, representing 18% of the population, made up 33% (10,500) of new infections. In contrast, white individuals – 61% of the population – accounted for only 24% (7600) of new cases. Combined, Black and Latino communities represented 70% of new HIV infections in 2022, underscoring the enduring racialised distribution of care and risk. This pattern of exclusion mirrored the necropolitical logic that Mbembe (2003) would later describe as the active and passive denial of care, leading to unnecessary death, particularly among marginalised populations.

Butler's (2004) work on precarity is essential for understanding the politics of HIV/AIDS. The epidemic laid bare the precarity of marginalised communities whose lives were deemed expendable by broader societal structures. The refusal of governments to intervene during the early years of the epidemic is an example of how biopolitical governance functions through exclusion, leaving certain populations exposed to harm. For Butler, such exclusions are not merely tragic but deeply political, as they are the result of conscious decisions made by those in power to exclude certain populations from the protections afforded by the state.

**Further global case studies: the politics of biopolitical exclusion**

In addition to HIV/AIDS and COVID-19, other global health crises further highlight the interplay of biopolitics, exclusion, and vulnerability. For instance, Ebola outbreaks in West Africa exposed the ways in which health responses are often shaped by racialised and colonial legacies. In 2014, the delayed response of the international community to the Ebola outbreak was widely criticised. Countries like Liberia, Sierra Leone, and Guinea struggled to secure resources and international support, reflecting the historical biopolitical neglect of former colonies (Telfer, 2015). The early lack of medical assistance and containment strategies further exacerbated the crisis, particularly among the most vulnerable communities.

Similarly, the outbreaks of Zika virus in Latin America, particularly in Brazil, revealed how biopolitical governance often intersects with gender and reproductive politics. The Zika outbreak was linked to severe birth defects, including microcephaly, and led to debates about reproductive rights, abortion, and maternal health. Women, particularly in impoverished and marginalised communities, faced the brunt of the crisis as they struggled with limited access to healthcare and reproductive choices (De Figueiredo, 2016). The political dimensions of health and care are often obscured in such crises, but these case studies demonstrate that biopolitics operates through the selective distribution of care, often reinforcing gender and racial inequalities.

**The ethics of resistance: reimagining biopolitics**

As biopolitical crises, such as the COVID-19 pandemic, continue to unfold, the question of resistance becomes a central concern. Judith Butler (2020) insists that not all resistance is liberatory. In the context of public health, resistance can take many forms: from defying lockdown orders and anti-vaccine protests to advocating for the rights of marginalised groups. However, not all forms of resistance are aimed at promoting collective care or solidarity. In fact, some forms of resistance, particularly in the form of individualistic resistance to state intervention, can undermine public health efforts and exacerbate inequalities (Brown, 2019).

For Butler, resistance is not inherently liberatory unless it recognises the interdependence of individuals within the collective social body. In health crises, this means that resistance must be oriented toward solidarity, prioritising the collective welfare over individual freedoms. Resistance that fails to acknowledge the shared vulnerability of all individuals, especially during a pandemic, can lead to fragmentation and further biopolitical exclusion.

This perspective aligns with Esposito's (2011) work on immunisation, which reframes immunity not merely as individual protection but as a paradigm for collective responsibility. In a time of crisis, true resistance would advocate for the dismantling of systems that perpetuate inequality in public health and for the creation of a global infrastructure that ensures equitable access to healthcare and protection for all populations.

The use of biopolitical measures in times of crises is inherently political as it involves decisions about how to balance the needs of the collective with the rights of individuals. Yet the ethical foundation for these decisions is rooted in the common good and the shared responsibility to protect vulnerable populations. Framing these interventions as ethical biopolitical responses – as opposed to authoritarian

overreach – requires acknowledgement of their foundation in the common good. Effective pandemic governance, therefore, is not incompatible with resistance. Rather, it invites a reimagining of resistance as an ethical demand for justice, inclusivity, and care. The work of scholars like Torfing et al. (2020) and Müller (2020) further reinforces the idea that effective governance during health crises requires collaboration between state authorities, public health experts, and citizens.

## CONCLUSIONS

The COVID-19 pandemic has underscored the pivotal role of biopolitics in shaping contemporary governance, particularly in times of global crises. From state-mandated health measures to the implementation of surveillance technologies, biopolitical practices have demonstrated their capacity to control, regulate, and protect populations in ways that were previously unimaginable. However, as this article has explored, these biopolitical measures must be carefully balanced with respect for individual freedoms, democratic values, and social justice.

The ethical implications of biopolitical governance are profound and far-reaching. Health crises like COVID-19 and HIV/AIDS force us to confront the ethical dimensions of governance, sovereignty, vulnerability, and care. As we have seen, biopolitical interventions can be tools of exclusion, exacerbating social inequalities and leaving certain populations vulnerable to harm. However, they also offer opportunities for reimagining public health governance in ways that prioritize collective care, justice, and equity.

The future of biopolitics, particularly as it pertains to public health and pandemic governance, must navigate the tension between state authority and personal freedoms. For biopolitics to be truly liberatory, it must be reimagined through the lens of social justice, focusing on solidarity and collective responsibility rather than coercive power. As we face future crises – whether related to climate change, migration, or global health – the lessons learned from the COVID-19 pandemic will be invaluable in shaping how states respond to emerging threats. Rather than resorting to authoritarian measures, governments must focus on inclusive governance, ensuring that biopolitical practices are used to protect human rights and equality for all citizens.

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**Rokas Garliauskas**

## BIOPOLITIKA IR VISUOMENĖS SVEIKATA KRIZĖS LAIKAIS

*Santrauka*

COVID-19 pandemija išryškino glaudų politikos, sveikatos ir gyvenimo valdymo ryšį. Tokios priemonės kaip karantinas, vakcinacijos kampanijos, skaitmeninis sekimas ir izoliacija atskleidė, kad visuomenės sveikatos politika nėra vien techninis ar medicininis atsakas – tai ir politinės galios forma, tiesiogiai veikianti gyventojus. Analizuojant, kaip valstybės taikė išimtines priemones krizės sąlygomis, straipsnyje pabrėžiamas tiek suverenumo galios veiksmingumas, tiek jos trapumas. Lyginamosios atvejų analizės atskleidžia, kaip teisinės struktūros, politinė kultūra ir ideologija ne tik priima sprendimus, bet ir skirtingai vertina gyvybę globalių krizių metu. Straipsnyje pabrėžiama, kad visuomenės sveikatos krizės nėra vien biomedicininiai reiškiniai – jos ir politiniai įvykiai, atskleidžiantys biopolitinio valdymo įtampas ir kviečiantys permąstyti atsakomybės, rūpesčio ir etikos vaidmenį pažeidžiamumo akivaizdoje.

**Raktažodžiai:** COVID-19, ŽIV/AIDS, visuomenės sveikatos valdymas, skaitmeninė sveikata