Necropolitics and the Impact of the COVID-19 Pandemic on the Indigenous Peoples of Tripura, Northeast India

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Abstract

This article focuses on the necropolitical effects of the COVID-19 pandemic on the lived experiences of Indigenous Peoples of Tripura, Northeast India. Our central argument is that Indigenous bodies are governed to die an untimely death. By drawing from Mbembe's (2003) theoretical framework of *necropolitics*, we uncover the consequences and experiences of necropower. Necropolitics perpetuates the exclusion of historically marginalized groups by permitting disposability during difficult times. Through technologies of control, necropolitics enables a sovereignty over mortality and construes life as the deployment and manifestation of power. In doing so, during extraordinary events, life becomes strategically subjugated to the power of death. In this study, we argue that the biopolitical effects of the COVID-19 pandemic not only affected individuals unequally but also forced hospital staff to decide who would breathe their last breath. Moreover, Indigenous Peoples' lived experiences of untimely death manifest the necropolitical technologies vested within hospitals where decisions are made over life or death.

Keywords: COVID-19, Indigenous Peoples, necropolitics, Tripura, Northeast India

Introduction

> After being tested COVID-19 positive as per the report from the hospital, my mother was later injected with an unknown drug, and I witnessed her dying just twenty-four hours later.
> —Interview with Kimi, Lalnunmwi's daughter, February 2, 2021[1]

During our conversation with Kimi, the daughter of Lalnunmwi, she sobbed as she narrated how she was present to witness her mother's death in a hospital room. She wept with grief because she was not able to conduct the last rituals for her mother. She had to unwillingly surrender her mother's dead body to the hospital authorities while she herself was forcibly locked inside a quarantine room.

Lalnunmwi was one of the victims of necropolitics during the COVID-19 period in Tripura, Northeast India.[2] Similar to Lalnunmwi's death and Kimi's lived experiences, we

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[1] All names used in this article are pseudonyms.

[2] We will further elaborate this case in the section Lived Experiences of Necropolitics.

perceive the imposition of untimely death in terms of the politics of disposability (Giroux, 2006; Misra, 2018). Life, therefore, is strategically subjugated to the power of death, particularly during unprecedented times and events (Mbembe, 2003). The COVID-19 pandemic has laid bare the value of life and the exercise of necropower (Agamben, 2020; Mbembe, 2003), especially in vulnerable communities. Moreover, the pandemic has exposed worldwide inequalities in general, and more specifically how state sovereignty rules over the power of death (Misra, 2018; Russo Lopes & Bastos Lima, 2020). Further, the influence of the pandemic has asserted itself in contrasting dimensions depending upon which social groups one belongs to. Its impacts have been shaped by varied historical backgrounds and socio-economic and political contexts where Indigenous Peoples become the most vulnerable (Russo Lopes & Bastos Lima, 2020).

A pandemic explicitly presents a situation in which biopolitical governmentality is fostered through the suggestions of government and political functionaries that some lives are more important than others (Burchell et al., 2008; Foucault, 2007). However, as with every crisis, the state alone does not always make decisions about life and death; rather, social actors within institutions also make such decisions. For example, during Hurricane Katrina in the United States, medical staff in acute situations not only made decisions to allow weak and vulnerable people to die but also, in residential-care facilities, proactively ended their lives (Giroux, 2006). In the case of COVID-19, hospital staff decide who shall continue or not continue to breathe. This is a clear example of necropolitical power, exercised using techniques of necropower, as the ultimate expression of sovereignty (Agamben, 1998; Mbembe, 2003).

India reported its first confirmed positive case of the then-novel coronavirus on January 30, 2020, in the state of Kerala (Kumar et al., 2020). On March 24, 2020, the Government of India announced a nationwide lockdown as a preventive measure against the COVID-19 pandemic, two months after this first case (Bharali et al., 2020). The sudden lockdown restricted the movement of 1.3 billion Indians. This was followed by the enforcement of a series of strict regulations in infected areas, which affected the livelihoods of many in rural and urban communities (Sengupta & Jha, 2020).

India's strategy to combat COVID-19 did not appear to be effective (Kumar et al., 2020). Under the direction and instruction of the Government of India's Ministry of Health and Family Welfare, a strategy for the prevention of COVID-19 was adopted by each state government. However, state governments failed to meet the requirements for public-health management (Kumar et al., 2020). In rural areas, health-care systems were inadequately managed, which meant that COVID-19 transmissions were not sufficiently restricted. Low testing rates and the low quality of primary-health institutions and personal protective equipment were common, particularly in areas populated by Indigenous Peoples. Kumar et al., (2020) also observed that states not only failed to focus on curative care or tackle the health emergencies that occurred during COVID-19 but also helped increase the incidence of untimely death.

The recurring contempt for and violence against Indigenous Peoples in India, and the devastation of their lives engendered by the pandemic, is contrary to the arguments that exceptional measures and protocols were widely adopted during the COVID-19 crisis (Ciotti, 2020). Even though the World Health Organization suggested that the entire world was watching how effective Indian strategies were in containing COVID-19 (Gupta et al., 2020), marginalized groups or those who were already disadvantaged were unlikely to receive equal care during the pandemic (Robertson & Travagila, 2020).

This brings us to the actual life and death experiences of vulnerable groups, whose survival is decided by hospital authorities. Mbembe (2003) interpreted such phenomena as a form of necropolitics. While the virus spread to different parts of India, Northeast India confirmed its first positive case of COVID-19 on March 24, 2020, a 23-year-old woman from the state of Manipur, a student who had returned from the United Kingdom (Deori & Konwar, 2020). Gradually, COVID-19 spread to all eight states of Northeast India. Tripura confirmed its first case of COVID-19 on April 6, 2020, a 46-year-old woman who had returned from the Kamakhya Temple in Guwahati (Deori & Konwar, 2020). Robertson & Travagila (2020) argued that, as in previous crises, COVID-19 revealed many of the hidden assumptions which underpin national health-care systems. Therefore, as the current pandemic continues, necropolitical sovereignty is likely to be as dangerous as the coronavirus. The question is raised: Why, in unprecedented times like during the COVID-19 pandemic, do Indigenous Peoples, in particular, have to suffer untimely deaths?

We examine the necropolitical effects of the pandemic through the lived experiences of the *Tipra*, the Indigenous Peoples of Tripura. Tipra is a common identity for Indigenous Peoples of Tripura and is based on a shared history, language, and rich culture (Debbarma & Debbarma, 2018, p. 18). The Government of India classifies the Indigenous Peoples of Tripura under 19 Scheduled Tribes, as per Article 342 of the Indian constitution (Tripura, 2014). The central question we ask is, How are Indigenous bodies governed to die untimely deaths? This leads us to an analysis of the elements of necropolitics and of the untimely deaths aggravated by the pandemic.

The study is based on our field observations in Tripura during the lockdown and post-lockdown period between April 2020 and February 2021. We conducted interviews with members of Indigenous families who had lost family members during the pandemic and with Indigenous family members who had survived COVID-19. The 24 respondents were selected using qualitative purposive sampling. Broadly, two patterns of narratives, how Indigenous bodies were governed in the hospital and how they survived at home, were kept in mind while selecting the respondents. Using these narrative patterns, we represent the lived experiences of necropolitics by the Indigenous Peoples of Tripura during the pandemic and the politics of disposability.

We argue that those who were infected with the coronavirus and were admitted to hospital were unfortunate individuals who faced an untimely death due to decisions taken by hospital staff. We also argue that the Tipra Indigenous Peoples of Tripura, with their long history of marginalization and their disproportionate exposure to COVID-19, further exposed an illegitimate settler colonial sovereignty. Following this introduction, we structure the article into five sections: (a) the historical context of the marginalization of Indigenous Peoples in Tripura; (b) theoretical conversations on necropolitics, the COVID-19 pandemic, and Indigenous Peoples; (c) an explanation of the state's exercise of necropower through the lived experiences of the Tipra Indigenous Peoples; (d) a discussion of the consequences of necropolitics; and finally (e) our concluding remarks.

History of the Marginalization of Indigenous Peoples of Tripura

Tripura is a state in Northeast India that is home to many Indigenous communities. As an independent hill state, it was ruled by generations of Indigenous families over several

centuries until it merged with the Indian Union on September 9, 1949.[3] On November 1, 1956, Tripura became a union territory and obtained full statehood on January 21, 1972.

Tripura state shares an 856-kilometre-long international border with Bangladesh (formerly East Pakistan). During the colonial period, the British needed the hill areas for tax revenue but did not directly govern the land, and hence allowed Indigenous communities to be relatively autonomous. Fernandes (2014) asserted that soon after the British colonial intervention in Tripura, the livelihoods of Tipra Indigenous Peoples came under threat. He further asserted that, beginning in the 16th century and for primarily economic reasons, the Indigenous rulers of Tripura started to invite non-native Bengalis to Tripura. The impact of this migration of non-natives was felt mainly in the 19th and 20th centuries when the British regime intensified commercial activity in the region (Fernandes, 2014; Sandy, 1915). Between 1950 and the end of the war for Bangladesh independence in 1971, a large number of Hindu-Bengali refugees from East Pakistan were resettled by the Government of India onto Indigenous lands in Tripura (Bhattacharya, 1989; Debbarma, 2002). This destabilized the cultural and economic situation of the Tipra Peoples and impacted their identity (Fernandes, 2008, p. 29).

These demographic changes brought with them structural changes, such as the eviction of Indigenous Peoples from their ancestral land by non-natives. Non-Indigenous people, occupying positions in the state administrative apparatus, enacted legislative changes that disadvantaged Tipra Peoples (Fernandes, 2014). One such piece of legislation was the Tripura Land Revenue and Land Reforms Act 1960 (Government of Tripura, 1960), which recognized only individual land rights. This act failed to recognize the common property rights of the Indigenous Peoples of Tripura, where land had been previously managed according to customary laws. Moreover, at the time of the 1960 legislation, high levels of illiteracy among Indigenous Peoples existed and, as a result, many failed to register for individual land entitlements (Fernandes, 2014). Consequently, during the 1960s, Indigenous Peoples of Tripura lost more than 72,000 acres (30,000 hectares) of land to settlers from the then East Pakistan (Fernandes & Bharali, 2010, p. 77). Ancestral lands were also lost to state projects and to encroachment. Fernandes (2014) showed that by 1970 the Indigenous Peoples of Tripura had lost between 20%–40% of their ancestral lands. In the early 1970s, the state also expropriated Indigenous common land to construct the Gomuti hydro-electric dam project, which displaced approximately 40,000 Indigenous persons (9,000 families) from 32,000 acres (13,000 hectares) of primarily agricultural land. The previous owners of this ancestral land were evicted under the dubious authority of the Government of India (Debbarma, 2007). Tripura, therefore, is an example of where the settler state has changed laws to suit their own needs (Fernandes, 2014; see also Tripura, 2021).

The adversity of Tipra Peoples began with the influx of a non-Indigenous population who were later settled on their ancestral lands (Bhattacharya, 1989). Debbarma (2007) claimed that Indigenous Peoples in Tripura once made up more than 95% of the total population of the state; however, they now constitute only 30%. This demographic imbalance has forced them further into isolated and hilly areas (Debbarma, 2002). Demographic change and the shift in

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[3] During the initial period after 1949, Tripura state was directly governed by a chief commissioner as a Part C state.

administrative power to non-Indigenous people has (a) adversely affected the citizenship rights of Indigenous Peoples, (b) alienated them from their land, (c) contributed to the loss of their traditional languages, (d) destroyed traditional governance structures, and (e) distorted the overall Indigenous aesthetic of Tripura life and values. These experiences epitomize what Wolfe (2006) called "the logic of eliminations" (p. 387). Against this precarious backdrop, Indigenous bodies in Tripura became even more vulnerable during the COVID-19 pandemic.

Necropolitics, the COVID-19 Pandemic, and Indigenous Peoples

Mbembe (2003) defined modern governance as the ultimate expression of sovereignty. It is often expressed through power and capacity to dictate "who matters and who does not, who is disposable and who is not" (p. 27). Mbembe referred to this politics of death as *necropolitics* (p. 12). This definition underscores the state's ultimate sovereign power to control, regulate, and legitimize mortality. Some lives are regarded as disposable: an Indigenous person's death is legitimized as something nobody feels any obligation to respond to or has the slightest feelings of injustice about (Mbembe, 2019, p. 38). On the one hand, these particular expressions of state sovereignty are denoted as necropolitics, whereby an authority can favour certain lives over others' deaths or can promote circumstances in which certain bodies are more susceptible to death than others (Mbembe, 2003). On the other hand, the experiences of subjugated life show that during unprecedented events, marginalized communities become enmeshed in necropower (Misra, 2018).

Mbembe's necropolitics is a complement to Foucault's (2003, 2007, 2008) concept of *biopolitics*. Biopolitics applied through modern liberal governance looks to control populations not only via threats of death but also by controlling living populations: political rationales become the objective of population management (Darian-Smith, 2021; Wright, 2011, p. 708). Mbembe appropriated Foucault's concept of biopolitics to draw attention to how the biopower of governance in the modern state regulates who lives and who dies in a politics of death (de Jesus, 2020). Hence, necropolitics is the sovereign right to have power over death.

Agamben (1998) furthered the Foucauldian idea of biopolitics by examining how the sovereign state executes death in its management of populations. He made a distinction between "being killed" as opposed to passively being allowed to die, by proposing that those individuals who are considered expendable and allowed to die (excluding those who die in ritual sacrifice) be considered as *homo sacer*, those whose lives are reduced to bare life and who are stripped of their rights (Gupta, 2011; Shakhsari, 2013, p. 340). Agamben labelled homo sacer as persons both inside and outside the law, which means that a person deemed homo sacer can be killed. Such a killing does not constitute a violation in any respect either of law or the legitimacy of sovereignty and is not even related to an idea of justice (Gupta, 2011). Agamben (2020) also argued that COVID-19 anti-contagion measures and protocols approved by the government were testimony to the extent of a "state of exception."[4] Similarly, Denisenko &

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[4] Agamben's (2005) concept of a "state of exception" examined a government's increase in power during any crisis period. For example, after examining the initial outbreak of COVID-19 in Italy, he pointed out that the spread of a climate of panic, the restriction of movement, and the suspension of normal functioning brought real militarization to a municipal area, especially when at least one person was found to be COVID-19 positive and for whom the transmission source was unknown. To him, this situation allowed the authorities to extend the state of exception to other regions (Agamben, 2020).

Trikoz (2020) demonstrated that the establishment of a "walled city"[5] by the state during the pandemic could lead to the forfeit of guarantees of individual rights. Moreover, the individual bodies in spaces such as quarantine or a hospital could provide opportunities for agents of state sovereignty such as hospital staff to classify them and assign them to different hierarchical levels.

Tonel (2020) suggested that even more dangerous than the virus itself could be those people, captured by the necropolitical perspective, who dictate who breathes and who suffocates and thus put the nation's economy above human lives. He further observed how the implementation of certain health protocols, from a bioethical perspective, can be read as a death policy. Such a policy—who lives and who dies—is especially effective in regions where the state is politically, socially, and economically ineffective. Delineating the impact of the pandemic, Darian-Smith (2021, p. 61) pointed out that a lack of proper equipment and the disproportionate suffering experienced by marginalized communities had possibly been used as ways to buoy the economy. This infers a new form of economic logic that goes beyond scrutinizing or stratifying people. Referring to the experiences of Indigenous Peoples in Brazil during the pandemic, Russo Lopes and Bastos Lima (2020) observed that these groups were more vulnerable due to their history of marginalization, and that this revealed a broader ongoing political strategy. Their study also shed light on the continuation of the government's necropolitical strategies. Similarly, Nunez-Parra et al. (2020, p. 5) argued that during the pandemic the state's welfare policies favoured individual health management and thereby biopolitical control. The state's social protection services could be deployed as surveillance that intensified the violence against already marginalized people. In the Indian context, Sharma (2020) argued that during the pandemic migrant labourers were classed as expendable (in other words, defined as necropolitical), and that this granted a free hand to the sovereign state to determine "who matters and who does not" (p. 4). Also in an Indian context, Ciotti (2020) observed the humiliating experiences of migrant workers during the pandemic. The workers who belong to marginalized communities were interpreted in terms of "the production of bare life," whereby their disenfranchised socio-political status led to the suspension of all legal norms (p. 244). During the pandemic, the vulnerable migrants described by Sharma (2020) above, including others from Indigenous communities, were sprayed with a harmful disinfectant. They were punished simply because of the social space role they occupied.

So far, we have drawn on the theoretical inspiration of Mbembe's notion of necropolitics to deconstruct the state's processes of exclusion. We have shown how the behaviour of state actors went beyond regulating life to regulating death itself (Mbembe, 2019, p. 77). Understanding necropolitical sovereignty in the context of Tripura is important for understanding the relationship between the state and Tipra Peoples during the COVID-19 pandemic. In the next section, we will continue referencing Mbembe's concept of necropolitics as we analyze the contradictory state of affairs in Tripura and examine narratives of the hardship faced by Tipra Peoples in various case studies of life and death during the pandemic.

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[5] In this article, the concept of "walled city" has been used in a metaphorical sense to make clear how the pandemic has created barriers that stratify vulnerable groups. Government-funded residential-care homes, which were used as quarantine centres, could serve as an example of how a walled city can allow state administrators to classify populations and manage their life and death.

Lived Experiences of Necropolitics

In this section, we focus on lived experiences of necropower among the Tipra Peoples during the COVID-19 pandemic. Our data are based on our interactions with the family members of COVID-19 patients. To simplify the representation of experiences, we have divided this section into different case studies. Firstly, we provide narratives of Indigenous persons who were reported as COVID-19 positive and who later died after seeking treatment at a government hospital. Secondly, we provide narratives of Indigenous persons who were reported as COVID-19 positive and survived after refusing to be treated in a government hospital. Using these narratives, we unravel the various experiences of Indigenous persons who encountered necropolitics.

Dying in the Hospital

Case 1: Kwthang

On June 9, 2020, the chief minister of Tripura tweeted:

Unfortunate to share that Kwthang Debbarma,[6] a COVID-19 patient from West Tripura, is no more. Our doctors gave their best but failed to save his precious life. On the 1st of May, he suffered a stroke and was a patient of hypertension. (Asian News International, 2020)

With this official tweet from the chief minister, Mr. Debbarma became the first official COVID-19 death in the state of Tripura. He belonged to the Indigenous community and hailed from Chachu Bazaar, a remote village. On June 1, 2020, the 42-year-old Mr. Debbarma was admitted to the only government-recognized COVID-19 hospital, located in the capital city of Agartala, after a stroke and with symptoms of hypertension. He was later confirmed as COVID-19 positive on June 3, 2020. After being treated as a COVID-19 patient in the government hospital, he passed away. After his death, questions were raised as to how Mr. Debbarma came in contact with the coronavirus as he did not have any history of travel and his ancestral village was 65 kilometres away from Agartala.[7] As his family recounted, he was ill for several days before suffering the stroke. It was suspected that he might have contracted the virus from his migrant son, who had recently returned from the city of Bengaluru. His son, however, did not show any symptoms and later tested negative for COVID-19. In such situation, Mr. Debbarma's life could have been saved if adequate treatment had been provided for his immediate medical condition. His life was considered to be disposable and, unfortunately, after being governed by the state's necropolitical technologies, he died an untimely death.

Case 2: Lalnunmwi

This is the case of a 55-year-old woman who was admitted to a government hospital after testing positive for COVID-19 and who later died there. In a conversation during our fieldwork, Kimi, her 25-year-old daughter, sobbingly narrated, "After my mother was declared COVID-19

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[6] The name in the original tweet has been changed in order to maintain the confidentiality of the identity of the person.
[7] Before this date, there had been no reports of positive COVID-19 cases in the rural areas of Tripura, areas inhabited primarily by Indigenous Peoples.

positive, the hospital treated us like animals. I was all alone, and no hospital staff members came to provide any treatment to my mother." Before the pandemic, Lalnunmwi was suffering from unknown health issues. She was admitted to the district hospital at Khowai and was informed by the doctor that she was suffering from Stout disease (a disease characterized by progressive bone loss). They spent 11 days in the district hospital, and Lalnunmwi was later discharged as the hospital failed to provide treatment. Her discharge was the ultimate statement of her inadequate treatment.

With no hope for further treatment from the hospital, her daughter took her to visit a local prayer centre almost 65 kilometres from their village—where they hoped Lalnunmwi would receive better treatment. They stayed 10 days in the prayer centre. After the sudden announcement of an India-wide lockdown, they returned to their village. A week later, the family observed a sudden deterioration in her condition. She was immediately rushed by government health officials to the hospital in the capital city of Agartala on July 4, 2020. As per hospital requirements, she underwent various health tests. On July 16, 2020, 12 days after her admission to the hospital, a health report revealed that she was suffering from a brain tumour. After assessing her case, the attending doctor suggested she be admitted to the cancer ward of the hospital to ensure proper treatment. After consulting with the administration of the cancer ward, she was informed that she must first be tested for COVID-19. The doctor confidently communicated to Lalnunmwi's daughter that her mother would test negative as she was not showing any symptoms.

On the same night at 8:00 p.m., a COVID-19 rapid-antigen test was conducted, and family members were assured that they would receive Lalnunmwi's test result within the hour. They were not informed of the result that night, and subsequently the daughter experienced a sudden change in the behaviour of the nurses, doctors, and other hospital staff members: they were avoiding her. The daughter was later informed by a member of the medical staff that her mother had been confirmed as COVID-19 positive, and she was told to keep her distance from her. As all the hospital staff members avoided her, she took her mother to the COVID-19 care ward. The daughter told us about her experiences there:

> After we reached the COVID care ward, many doctors came to visit my mother and injected unknown drugs from different drug bottles. I tried to investigate what sort of drugs were injected into her, but the doctor told me that it was a COVID-19 drug. After the injection, she immediately stopped moving her body and became completely unconscious, and I saw her breathing her last breath in front of me on July 21, 2020, at 4:00 a.m. After witnessing my mother dying, I implored the hospital staff members to come and see my mum, but they refused to see her. Only at 5:00 a.m., one of the doctors came to confirm that my mother had passed away.

After her mother's death, the daughter wished to conduct a sacred ceremony according to her Indigenous beliefs, whereupon the body of the deceased should be returned to the family home. Initially, the hospital administration approved the transport of the dead body; however, after receiving an order from the local government administration, permission was revoked. As per instructions from the sub-divisional magistrate,[8] the daughter was informed that she would face a penalty if these government orders were violated. With sorrow heavy within her,

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[8] The sub-divisional magistrate is a middle-level local administrator as per the Indian local governance system (for details see Tripura [2020]).

she surrendered her deceased mother's body to the state authorities and she herself was forcibly sent to a quarantine centre. During our conversation with her, the daughter told us that she was currently preparing to conduct her mother's death ceremony and fulfill the wishes of her ancestor's spirits as per Indigenous beliefs.

Case 3: Khapang

This is the case of a 55-year-old man who lost his life in a hospital due to a minor heart issue. As his wife narrated,

> My husband was fit and fine and had no record of health issues until he succumbed to a light cough on September 25, 2020, at 12:20 a.m. and experienced a minor heart attack. We therefore visited the nearby rural hospital for an emergency check-up.

After the check-up, Khapang was declared to be suffering from a heart attack and moving him to the hospital in Agartala was discussed. The family were also informed that Khapang had to undergo a compulsory COVID-19 test.[9] As hospital rooms are not equipped with basic necessities, Khapang's wife returned to their house to bring him clothes and other essentials. Upon returning to the hospital, she was shocked to discover that her husband had been declared COVID-19 positive. Moreover, as the local hospital was not equipped to treat COVID-19 patients, they recommended Khapang be shifted to the hospital in Agartala.

The following day, they were transported to the hospital in Agartala by a government hospital ambulance. As his wife told us,

> Even after reaching the capital city hospital, my husband was fine and could still walk. However, after a week, he experienced another heart attack as there was no treatment. No doctors came to treat him. As a result, his health deteriorated, and he became worse. He was kept in observation for forty-eight hours in the ICU ward. However, on account of repeated [heart] failures eventually he fell into a coma.

Due to the failure of the doctors at the Agartala hospital, the hospital administration recommended transferring him to a better-equipped hospital in Kolkata for further treatment. His wife then tried to arrange a flight to Kolkata. The airport authority rejected her request for tickets as her husband had tested positive for COVID-19. After she informed the hospital authorities, they subsequently provided her with a negative test result (both wife and husband). On October 9, 2020, because of his critical condition, Khapang passed away in a Kolkata hospital. His wife told us, "My husband would have survived if the hospital had provided him with adequate treatment for the correct disease."

Case 4: Lalnunfeli

This is the case of a 56-year-old woman who also lost her life after being admitted to Agartala hospital as a suspected COVID-19 positive patient. A family member told us,

> Her health was normal. Even though she was experiencing breathing problems, we were initially afraid to take her to the hospital because we wanted to avoid the COVID-19 test. However, realizing the deterioration in her health, after a few days

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[9] During this period, every patient had to undergo a compulsory COVID-19 test before getting treatment in any hospital in Tripura. However, this requirement did not apply to the person who accompanied the patient.

we admitted her to a nearby rural hospital. The doctor initially suspected it to be coronavirus but, after a routine check-up, we were informed that it was an issue with blood pressure.

Later, the rural hospital administrator recommended that the family shift Lalnunfeli to the hospital in Agartala for better treatment. On reaching Agartala hospital, her COVID-19 test was confirmed as positive. The hospital also informed family members that her health conditions had become critical as the virus had infected her lungs. Lalnunfeli's daughter told us,

My mother was given only … antibiotic drugs, and that led to a worsening of her health. No specialist doctor came to visit her to deal with her health issues after she tested COVID-19 positive. We lost her three days after being admitted to hospital as COVID-19 positive.

Case 5: Rachil

This is the case of a 65-year-old man, a retired state-government employee who also tested positive for COVID-19. Doctors from the local hospital suspected that he came in contact with the virus via his local shopkeepers. After a rapid-antigen test, he was declared COVID-19 positive. He was taken to the hospital where the authorities gave him the option of going home and being treated there or continuing to get treatment at the hospital. Rachil's house was close by, so he decided to stay at home and be treated. His family members were instructed to keep distance from the neighbours. A family member stated: "The drugs that were provided by the hospitals [were] only antibiotics, which further worsened his health. That is why he died. He would have survived if proper treatment had been given to him."

Surviving at Home

Case 6: Jakopa

This is the case of a 70-year-old man, who often suffered from a light cough and heavy breathing, attributed to tiredness as he cultivated his fields. After witnessing him suffering from a light disturbance in his breathing, his family members suggested he go for a COVID-19 test. When he visited the local government hospital, staff, on seeing his symptoms, declared him to be infected with the coronavirus. The family members did not believe a subsequent report, including the purported test result, as it was handwritten. After two days, they moved him to another nearby hospital for a second COVID-19 test to confirm their doubts. These test results indicated that Jakopa was COVID-19 negative. Jakopa was healthy at the time this study was conducted.

We questioned family members to understand why they had decided to undertake a second test. Jakopa's family members informed us that

medical staff are blindly confident in the prescribing of drugs for us without even having a proper test and, therefore, we did not believe in their testing kits. Our grandfather tested positive in the first hospital but, two days later, he tested negative.

Case 7: Lallunmoya

This is another tragic case of a 45-year-old man who almost lost his life in a hospital after being declared COVID-19 positive. Initially, after he complained of a breathing problem, his

family members advised him to go for a COVID-19 test, whereupon he was confirmed COVID-19 positive. Without much further testing or observation, the hospital authorities prescribed him antibiotic drugs. After consuming them, his health worsened. As his treatment was taking place in his house, the hospital authorities suggested he be treated in the hospital. The family members we spoke to were suspicious of the rapid-antigen-test result conducted by the government hospital, and therefore they admitted him to a nearby private hospital, and he underwent another COVID-19 test, a RT-PCR test. This test result was negative. Moreover, the symptoms of COVID-19 were waning. Still, to remove his doubts Lallunmoya repeated the test several times in different test centres and was declared negative every time. Now Lallunmoya is alive and healthy.

Case 8: Ningham

This is a case of a 35-year-old man who survived after visiting a hospital and being declared COVID-19 positive. He was treated well in the hospital with proper food and the best medical treatment. He shared with us his experiences with COVID-19 and also how the hospital saved his life:

> The virus had reached my lungs, and I completely lost my strength. I was so helpless that I did not even have the strength to carry my cell phone … but I owe the hospital for the best treatment for bringing me back to normal life.

After conversing with Ningham about his social background, we learned that his wife was a faculty member at a nearby medical college. This suggested to us that an individual's social position matters in an unprecedented crisis like the COVID-19 pandemic.

Reflecting on the above cases, most sufferers were identified as members of Indigenous Peoples who inhabit the rural areas of Tripura. As Indigenous persons infected with COVID-19, their lives were not considered worthy of saving by state authorities and hospitals (Mbembe, 2019). They were treated as disposable on account of their vulnerability and their lack of knowledge of treatment drugs (Ciotti, 2020). The inaccuracy of different COVID-19 test procedures and results is also clear. The role of the state government and state hospitals in deciding who must live and who should die is also depicted (Mbembe, 2003). Furthermore, despite the state government's promises of compensation of up to Rs.10 lakhs (approximately USD 13,500) to family members of the deceased (NDTV, 2020), to date, no evidence of such compensation has been found.

The lived experiences of Tipra persons, therefore, portray the necropolitical sovereignty of the state in terms of decision-making with respect to death during the COVID-19 pandemic (Mbembe, 2003). In the words of Misra (2018), the lived experiences of Tipra persons are instances of necropower. The deployment of necropower was easily exposed during a time of wide-scale medical crises and the consequent fear of, and preoccupation with, COVID-19. Necropolitics was exercised via technologies of control: the prescribing of inappropriate drugs, the consequences of inaccurate test results, and the failure of hospital staff to properly diagnose and treat the correct disease. It is simply not the case that even in a pandemic those who visit hospitals would be only COVID-19 patients. However, the hospital authorities responded to patients only as sufferers of COVID-19, overlooking the possibility that patients could also be experiencing other (non-COVID-related) diseases. These assumptions by hospital, while trying to carry out their humane responsibilities resulted in the untimely deaths of unfortunate rural Indigenous persons.

Consequences of Necropolitics

During the COVID-19 crisis, the hospitals and COVID care centres were the only facilities to which infected rural Indigenous bodies could turn to save their lives. The lived experiences of rural Indigenous persons like Kwthang, Lalnunmwi, Khapang, Lalnunfeli, and Rachil indicate to us that the hospital care facilities that were meant to save their lives turned out to be an apparatus that led them to untimely deaths. These are instances of where a state, through its residential hospital care centres, decided who would live and who would die. Mbembe (2003) coined these experiences of untimely deaths among Indigenous Peoples as the *politics of disposability*.

Indigenous bodies were considered disposable and a burden and were strategically removed via the state's rule of exception (Agamben, 1998). In state hospitals, the Indigenous bodies suspected of being infected with the virus were segregated from those who were not infected. Indigenous bodies were treated as treatment experiments—a course of action that eventually led to their untimely deaths. Indigenous bodies were denied the opportunity to breathe their last with dignity, as shown in the lived experiences of Lalnunmwi. Therefore, from the point of view of these rural Indigenous Peoples, the state's necropolitical strategies can be considered to be more dangerous than the virus itself. Jimenez (2020, p. 2) affirmed that if we look carefully, it is not the virus that is strange and alien but the state's necropolitical strategies in how it deals with infected bodies. This is similar to Indigenous persons' experiences of death in the hospital, which had less to do with the COVID-19 pandemic and more to do with necropolitics: hospitalization and treatment appeared to be the main cause of untimely deaths.

These experiences of Indigenous bodies during the COVID-19 pandemic also relate to a pre-existing marginalization. The present situation is but a platform for the state, as an apparatus of elimination, to practise sovereignty in terms of deciding between life and death. The pandemic as a mechanism for disposal can be considered a success for the state, as it led to the untimely death of Indigenous bodies in hospitals. Yet these deaths do not violate the (state's) idea of justice. This killing of innocent Indigenous bodies is thus an expression of the state's ultimate power over death (Agamben, 1998; Mbembe, 2003). Watson (2020) asserted that untimely deaths are not simply random or accidental but are rather built upon existing exclusionary practices. Referring to Klein's *Shock Doctrine* (2007), Jimenez (2020) observed that a crisis such as the COVID-19 pandemic is an opportunity for states to make both political and economic profits. During such a crisis period, the state promotes life or death based on social position by stratifying those who should be eliminated and those who may live. In our example, the untimely death of Indigenous persons underscores their subjugation under the current political system.

The state's necropolitical sovereignty became more visible when infected Indigenous persons refused to remain in their hospital beds for treatment but rather chose to remain at home, thereby avoiding the state's necropolitical strategies. Our study shows that Indigenous bodies who were treated in hospital became the victims of untimely deaths. Those who resisted, decided not to be treated in the hospitals, and stubbornly chose to remain at home successfully avoided necropower and escaped an untimely death. These experiences of Indigenous bodies also show that they were not only recipients of hospital treatment but were also victims of state surveillance, through strategies of hospital administrators who prioritized who deserved to live and who deserved to die during the worst of the pandemic.

Despite all odds, many Indigenous Peoples in Tripura started to look for solutions within their communities to tackle the immediate harsh situations created by the pandemic, supported by various community socio-cultural organizations and village councils, in accordance with their customs. For example, the Molsom Youth Association, Tripura Chubalai Buthu, and Darlong Village Council provided basic necessities to the most vulnerable members within their community. To protect their community from the virus and also to avoid experiences of state necropolitical sovereignty, they enacted certain rules (by consensus) in their respective villages, for example, social distancing. Bamboo roadblocks were set up around many of the Indigenous villages in Tripura in order to prevent outsiders from entering. The fear of being forcibly admitted to hospitals whenever a member of their community was suspected of being infected with the coronavirus saw them take responsibility as a collective to protect themselves. There were also instances of formal, community-based associations and organizations that successfully intervened to prevent community transmission (Tripura, 2020).

Conclusion

Using qualitative case studies with purposive sampling, we explored the impact of the COVID-19 pandemic on Tipra Peoples of Tripura, Northeast India. In this article, we argued that untimely Indigenous deaths in hospital beds were a manifestation of the sovereign power over life and death of the state's governance system. Secondly, we also argued that due to the historical and ongoing marginalization of Indigenous Peoples and their victimization through necropower during the crisis, their suffering was extreme and often not reported in the mainstream media. We have tried to unravel and reveal these hidden sufferings. Thirdly, we argued that hospitals, either strategically or proactively, on account of their adherence to the state's authority, make decisions over the lives of Indigenous bodies. Through this study, we have exposed the realities of necropolitical sovereignty in Tripura during the COVID-19 pandemic. We have also examined how a transition from a state of exclusion to one of execution occurred during the pandemic through a state apparatus that made decisions about lives and deaths among Indigenous Peoples of Tripura.

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