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The Politics of Contagion: States, Societies, and the Control and Consequences of Infectious Diseases

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Abstract

The study of contagion offers important but underexplored opportunities to rethink and advance our understanding of key concepts in political science. These include notably state capacity; social policy; state–society relations, especially the role of trust; nationalism and social solidarity; exclusionary dynamics, such as xenophobia, prejudice, and discrimination; and within political psychology, the role of emotions, including disgust. This article reviews studies on contagion and health within and adjacent to political science. While taking note of the surge of studies around COVID-19, this article focuses on work on infectious disease before and beyond the pandemic. It analyzes the scholarship as it sheds light on the control of infectious diseases, on the one hand, and on the consequences of that control, on the other, while also pointing to connections and feedback loops, especially as they open avenues for future research.

INTRODUCTION

COVID-19 is a grim reminder of the specter of infectious disease. Since settled agriculture and the domestication of animals, microscopic pathogens have posed one of the gravest threats to the survival of our species, killing more people than all wars, natural disasters, and noninfectious diseases combined (Inhorn & Brown 1990). Infectious diseases have altered the course of world history, derailing military expeditions from Alexander to Napoleon; precipitating the decline of prominent political entities from our past, from the city-state of Athens to the sprawling Han and Roman empires to the flourishing states of Mesoamerica; and contributing to the success of revolutions, such as the Haitian Revolution, wherein the African slaves' resistance to yellow fever contributed critically to their success. Vector-borne diseases have had profound economic consequences. Waves of bubonic plague undermined North African dominance of the Mediterranean trade (Iliffe 1995) and contributed to economic stagnation in Europe (Hirshleifer 1987). A place's pathogenic profile has also been famously linked to the nature of its state institutions, with long-run consequences for political and economic development (Acemoglu et al. 2001).

The landmark scientific advances of the bacteriological revolution in the twentieth century prompted an epidemiologic transition, feeding the conceit captured by the pronouncement usually (but apparently inaccurately) attributed to US Surgeon General (1965–1969) Dr. William H. Stewart, that "it is time to. . .declare the war against pestilence won." By the 1980s, however, the worldwide spread of the HIV/AIDS epidemic had tragically and decisively ruptured this hubris. Since then, swine flu, avian flu, Ebola, Zika, and now the global COVID-19 pandemic have laid bare our continued vulnerability to contagion. Even before COVID-19, parts of the world, including the United States, had witnessed a rise in mortality from infectious diseases. While we have unprecedented medical technologies to treat and prevent infectious diseases, they continue to claim millions of lives annually across the globe; they incur colossal economic costs (according to the International Monetary Fund, the COVID-19 pandemic will cost the global economy $12.5 trillion through 2024); and they threaten the stability and legitimacy of regimes. In recent years, the danger posed by contagious diseases has become increasingly securitized. To the fear of naturally occurring pathogens has been added, especially since the anthrax attacks after 9/11, anxiety around pathogens' deployment as agents of bioterrorism. And yet, despite this clear and urgent salience, infectious disease has remained on the margins of attention in political science, a neglect best seen as part of a broader oversight of health politics in general (Carpenter 2012, Lynch 2023).

Political science's neglect of infectious disease is lamentable not only because of the empirical importance of the topic but also because the study of contagion allows opportunities to rethink and push forward key theories of our discipline. Relevant theoretical areas include state capacity; social policy; state–society relations, especially the role of trust; nationalism and social solidarity; exclusionary dynamics, such as xenophobia, prejudice, and discrimination; and within political psychology, the role of emotions, including disgust. In this article, I cast my net widely, reviewing studies on contagion and health within and adjacent to political science, and looking before and beyond the COVID-19 pandemic as well as considering some of the burgeoning work around COVID-19. While I allude to connections and feedback loops in the conclusion, I mainly analyze works as they shed light on the control of infectious diseases, on the one hand, and on its consequences, on the other. **Figure 1** presents an analytic overview.

STATES AND SOCIETIES IN THE CONTROL OF CONTAGION

Historically, the control of disease has been a key site for encounters between states and societies. In modern times, the state, much more than the market, has been the "pivotal player" in the control of contagion and the promotion of health (Easterlin 1999, p. 261). Indeed, state attempts to

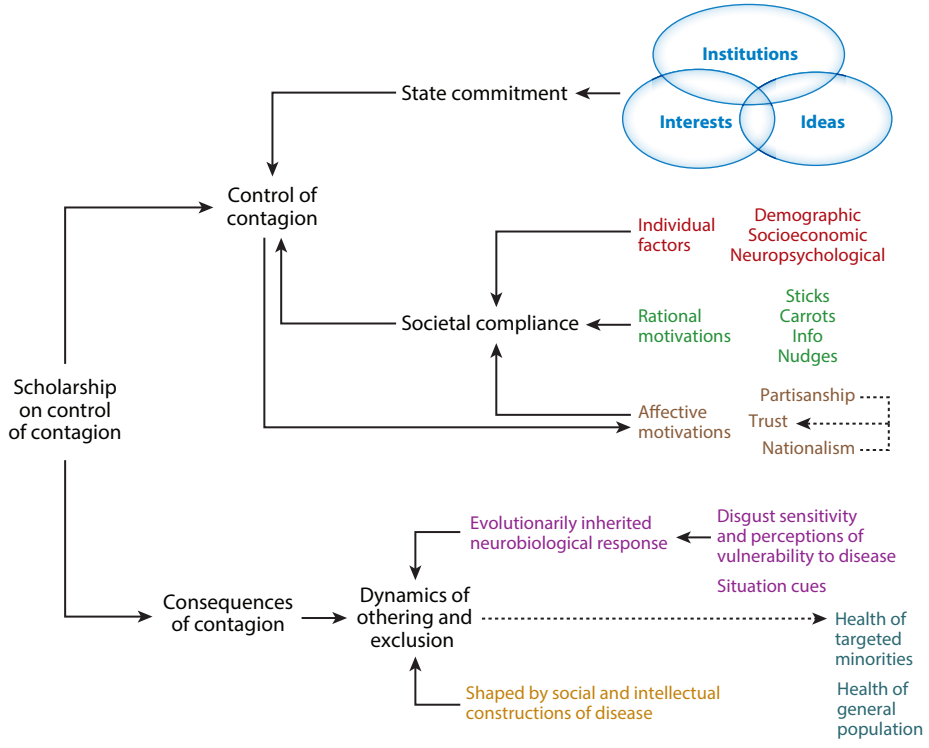

Figure 1

Analytic overview of social science scholarship on the control and consequences of contagion.

control disease have been ground zero for state building. Beginning in the late seventeenth century, infectious disease outbreaks prompted states across Europe to enact a suite of new laws (isolation, quarantines, *cordon sanitaires*) and establish bureaucratic agencies (customs, police, health boards) to enforce them. Generations of scholars have, following Foucault (1979), analyzed such interventions as states exerting "bio-power" over their people—an interpretation lent credibility by the expansion of state surveillance technologies during the COVID-19 pandemic in many parts of the world (Laruelle et al. 2020, Woods et al. 2020). Yet, while (the threat of) infectious disease led to the extension of institutions of control, it also, beginning in the nineteenth century, drove the building of unprecedented social infrastructure, notably large-scale sanitary projects and the enactment of proto-welfare policies (Ansell & Lindvall 2020, Baldwin 1999). Contagion thus drove the extension both of institutions of control and of what we may broadly term institutions of care.

Today, in our globalized world, health is an international concern and has been studied as such in a rich body of international relations (IR) work (see, e.g., Busby et al. 2014, Gomez et al. 2014, Kamradt-Scott et al. 2015, Kavanagh 2016, Kickbusch 2011, Shiffman 2009, Youde 2012).[1] In addition to international actors, notably the World Health Organization (see Youde 2015), domestic nonstate actors, such as religious charities, political parties, and nongovernmental organizations

[1]For a review of the sociology of public health, see Harris & White (2019); for a historical analysis of how global mechanisms have shaped responses to epidemic threats, see White (2023); for analyses of how global funding priorities structure national health priorities, often with grave implications for citizens, see Benton (2015) and Dionne (2018).

are integral to the provision of health care across many parts of the world, especially the Global South. Scholars have explored the origins and causes of the differential distribution strategies, networks, and effectiveness of such nonstate providers (Cammett 2014, Cammett & Issar 2010, Cammett & Maclean 2011, Cammett & Sasmaz 2017) and how they interact with the state. Anthropologists and sociologists, in particular, have focused on the role of civil society and social movements, especially in the context of HIV/AIDS (see, e.g., Swidler & Watkins 2017).

While global and a range of domestic nonstate actors play important roles, states remain the primary movers in public health and the control of contagion. A state's control of infectious disease, as reflected in its life expectancy and infant mortality rates, is taken as a measure of both its development (Sen 2001) and its overall capacity (Bustikova & Corduneanu-Huci 2017). And yet, this is a state capacity that is produced at the jagged edge of its encounter with society. The harsh glare of the COVID-19 pandemic exposed both how essential popular compliance is to states' abilities to control infectious disease and how elusive it can be. In the remainder of this section, I analyze state control of disease along two distinct but connected pathways corresponding broadly to the agency of states, on the one hand, and society, on the other.

States and the Control of Contagion

The COVID-19 pandemic brought out the importance of state policies for the control of disease. Even seemingly similar states can respond very differently to the same viral threat, and such variation can have potentially deadly consequences. A Lancet Commission, for example, estimated that a more proactive response by the Trump administration could have lowered US COVID-19 mortality by as much as 40% (Woolhandler et al. 2021). What explains differences in state commitment to controlling disease?

In this section, I review the scholarship on state control of infectious diseases. I refer also to writings on how states promote everyday health access, equity, and outcomes (for a comprehensive review of the latter, see Lynch 2023). Across this work, I note the shared emphasis on the mutually connected and reinforcing roles of institutions, interests, and ideas.

Institutions. Within a focus on state institutions, one strand of research has focused on their structure. For example, whether policy-making power is centralized or fragmented has been shown to influence the progressiveness of health policy, and social policy more broadly (Immergut 1990). A second, longstanding, and particularly lively scholarship centers the role of regime type. In the mid-twentieth century, Ackernecht (cited in Baldwin 1999) famously argued that authoritarian and absolutist regimes were more likely to focus on public health, especially through policies that restricted individual liberties. Baldwin (1999), however, showed this was not necessarily the case. In the context of the COVID-19 pandemic, a spate of early reporting of lower deaths in autocratic countries prompted arguments that commitment to individual rights and freedoms constrained democracies from taking the aggressively proactive measures necessary to control contagion, which their nondemocratic counterparts could more readily adopt. Others, however, countered with evidence of authoritarian countries systematically biasing their data (see Annaka 2021 for a review). Stasavage (2020) provides a nuanced historical perspective on how both forms of government have specific strengths and weaknesses in countering external emergencies. (For a review of the rich scholarship on the mostly positive effect of democracy on health policies and outcomes, see Lynch 2023.)

Drawing attention to the reverse dynamic of how contagion influences democratic institutions, works in the tradition of Foucault (1963) have analyzed how state use of surveillance, compulsion, and coercion can conflict with and erode civil rights and liberties. Other works examine how infectious disease outbreaks impact citizen engagement with democracy, noting that, unlike

other natural disasters such as floods, epidemics do not appear to increase political participation (Crisman 2020; see Lynch 2023, pp. 396–97, for a review of the relationship between health and political participation more broadly).

Institutions also figure prominently in scholarship that emphasizes the role of path dependency in public health. Robinson (2017), for example, emphasizes how family planning programs prefigured the HIV response in Africa.

Interests. One of the primary reasons that democratic leaders are more likely to commit to the control of contagion and public health is that it serves their electoral interests.[2] This interest-maximizing motive becomes more salient under conditions of political competition, prompting, as Key (1949) famously showed, greater state attention to the welfare of the population. However, in a cross-country panel study, Gottlieb & Kosec (2019) find that political competition only leads to better public goods provision, including higher immunization rates, under conditions of party system institutionalization. Kailthya & Kambhampati (2022) causally estimate that political competition prompts incumbents to trade off the provision of more visible health care provision (e.g., health center access) with less visible but critical health center capacity (e.g., doctors and medical supplies). Within a focus on electoral constraints, Dionne (2011) emphasizes executives' time horizons as a key determinant of AIDS policies across eastern and southern Africa. Lengthening an executive's time horizon increases government spending on health, but executives with shorter time horizons tend to have more comprehensive AIDS policy.

Ideas. Diseases are, as Sontag (1989) famously argued, ideational constructs. "Man-made images of [the] pestilence," especially how notions of risk and threat are framed, critically influence how political leaders and the state respond to it (Ranger & Slack 1992, p. 8). Taylor (2013) shows how the "disease identities" of HIV/AIDS and tuberculosis prompted French, British, and German policymakers to put in place very different policies to control these two contagions at their borders. Youde (2005, 2007) emphasizes how the post-Apartheid South African elites' vision of a new, African Renaissance–inspired self-identity fostered the emergence of a "counter-epistemic community" whose influence put the South African government at odds with the international AIDS control regime. Lieberman (2009) traces the starkly different state responses to AIDS in Brazil and South Africa to an interplay of ideas and institutions, arguing that formal and informal "boundary institutions," which divide societies along ethnic lines, weaken policy responses to HIV/AIDS. Lieberman (2009) posits two reasons for this. First, vulnerable groups do not lobby for action for fear of being blamed and shamed. Second, leaders, often from less affected groups, refract risk in ethnic terms; despite the intensity of the epidemic, they frame it as a problem of a stigmatized minority rather than a shared challenge facing the nation as a whole. Other studies of the AIDS crisis in Africa have foregrounded political leadership with attention to both the ideological and institutional influences that shape it (see, e.g., Bor 2007, Butler 2005, Parkhurst & Lush 2004). While they vary in their emphasis on the ideological dimension, an important set of studies emphasize how social democratic parties drive social policy, including health policy (see Barnish et al. 2018 for a review).

[2]Studies of the extent to which people's electoral decisions are responsive to the provision of health benefits (and social welfare more broadly), however, have reached mixed conclusions. Guiteras & Mobarak (2015) find that Bangladeshi citizens rewarded leaders whom they saw as responsible for a sanitation scheme. Croke (2021) shows how receipt of bed nets as part of a health program to control malaria shored up support for local politicians in Tanzania. In contrast, in the largest randomized health policy experiment to date, Imai et al. (2020) find that access to the Mexican Universal Health Insurance Program, Seguro Popular, has no measurable effect on support for incumbents.

In my own work (Singh 2016), I have shown how a sense of "we"-ness that stems from strong, shared identities, such as subnationalism, has created a sense of mutual obligations and encouraged political leaders to adopt progressive health and education policies in India. This argument builds on an older body of work that shows how the social solidarity that emerged in the wake of World War II drove the establishment of social welfare states and universal health coverage, such as the National Health Service in the United Kingdom. While most work has focused on political leaders, other scholars have also emphasized the beliefs of technocrats (Ho 2022) and physicians (Harris 2017, Starr 1982) in driving health policies.[3]

Societies and the Control of Contagion

A starting point toward understanding the factors that encourage or inhibit societal compliance with health directives is to recognize it as a "hard ask." Public health directives often infringe on individual liberties and violate established societal norms. Compliance entails costs, such as wearing a mask, social distancing, restricting social gatherings, staying at home, quarantining, testing, and getting vaccinated. There can be disagreement on the necessity or effectiveness of these measures, especially because the benefits (e.g., not transmitting the virus) are not easily visible. Further, compliance produces positive externalities (getting vaccinated, for example, contributes to herd immunity, which is beneficial to all, including those who chose not to vaccinate), thus creating incentives to free ride (Goldstein & Wiedemann 2022). [This collective action aspect of vaccination has allowed communities in Nigeria to use collective resistance, in their case to the polio vaccination, as a bargaining tool to extract the services that they desire from the state (Grossman et al. 2018).]

Why are people more or less likely to comply with state public health directives? Public health scholars have emphasized cultural, gender, socioeconomic, and other demographic factors (see Côté et al. 2021 for a review). Social and political psychologists, on the other hand, have stressed differences in neuropsychological traits, such as disgust (Kam 2019).[4] Political science scholarship, however, has focused less on such individual-level attributes and instead centered the ways in which states can gain popular cooperation.

Rational compliance. In line with hegemonic rational-actor understandings of humans as strategic interest maximizers, states and scholars alike have focused on promoting popular engagement with health policies through threats (sticks), rewards (carrots), and the provision of information. A growing recognition of the systematic cognitive biases that draw us away from rational decision making has prompted the use of so-called nudges to steer us back to it, including in the domain of health.

Sticks. Coercion has been the historic centerpiece of state public health policies. It was state incursions into the control of contagion that birthed key punitive institutions of the state. Across much of Europe, beginning in the fourteenth century, these new institutions forged popular

[3]Ho (2022) shows how Indonesian technocrats drew on their familiarity with power relations within the government to reverse years of inaction on malnutrition and push for the expansion of "benevolent" health policies, which serve low-income women and children. Harris (2017) shows how physicians in Thailand were motivated by their ethical convictions to mobilize for expansion of health policies, even though it violated their own political and economic interests.

[4]Greater sensitivity and disgust toward disease-causing pathogens have been associated, on the one hand, with more vigilant behavior and compliance with public health directives (Makhanova & Shepherd 2020), but also, on the other hand, with more negative vaccine attitudes (Clay 2017, Scott & Wendell 2016). Clifford & Jerit (2018) find that emotions of anxiety lead people to be more proactive about engaging with a viral threat, but disgust motivates avoidant behavior.

compliance with a range of draconian public health mandates by the fear of their fierce implementation (Conti 2008, Knowelden 1979). Descriptions of the time paint a vivid picture of the militaristic nature of a range of repressive policies including isolation, sanitary cordons, fumigation, disinfection, the strict regulation of the movement of goods and people, and rigid segregation of the healthy from those (suspected to be) infected (Mafart & Perret 2003, Tognotti 2013). Punishments for the violation of these policies included death (Conti 2008). A similarly harsh and brutally implemented repertoire of coercive measures were also commonplace in other parts of the world, especially in European colonies (Harrison 1992, 2020; Nethery 2021; Oluwasegun 2017). Even as new technologies to control disease, such as vaccines, emerged, the use of coercion remained consistent. Within a few decades of the introduction of the world's first vaccine at the turn of the nineteenth century, compulsory vaccination laws, often forcibly implemented, made it onto the books from Europe to North America and beyond. Compulsion remains a common public health strategy, with numerous countries mandating vaccination, banning smoking and littering in public spaces, and enacting road safety rules (e.g., wearing helmets and seat belts; car seats for infants and children). Many of these mandates, such as vaccination and wearing helmets, include explicit opt-out provisions, but they are often backed by a range of punitive measures—in certain cases imprisonment, but more frequently monetary penalties, exclusion from public services (such as state schooling and daycare), and loss of state funds. During the COVID-19 pandemic, across many parts of the world, the unvaccinated were denied access to a range of public and private spaces, barred from travel, and subject to differential lockdowns.

Carrots. In parallel, states have also offered various inducements to encourage compliance with public health directives (Higgins et al. 2012). While many countries already had incentives in place, the COVID-19 pandemic saw an explosion in the world-wide deployment of a range of fiscal and nonmonetary rewards for vaccination. Relatedly, states have sought to encourage compliance with health interventions by providing information, for example, about how the benefits of interventions such as vaccines outweigh the risks (Dupas 2011).

Nudges. More recently, an influential response associated with the discipline of behavioral economics has been to exploit the very cognitive boundaries, biases, and habits that social psychologists have shown drive our deviations from rational decision making, to instead steer us back to it (Sunstein & Thaler 2008). The influence of this paradigm is evident in the global proliferation of specialized "nudge units" within governmental bureaucracies to encourage popular compliance with state policies, especially in public health (see Hansen et al. 2016).

Critiques. This suite of "rational strategies" for encouraging popular compliance with public health, and with state policies more generally, have been criticized as normatively and ethically problematic. States' use of brute force is a clear violation of people's bodily integrity. Public health laws frequently conflict with individual liberties. Further, marginalized populations, including colonized peoples and lower classes as well as ethnic and sexual minorities, have historically borne and continue to bear the brunt of the most aggressive implementation of such mandates. Incentives and especially nudging have been censured for their paternalism and for manipulating people's choices and undermining their autonomy (Kuyer & Gordijn 2023, Sandel 2012). Moreover, these strategies are economically costly. The use of coercion necessitates massive investments in state capacity to monitor and punish. Fiscal incentives and nudging interventions involve substantial monetary outlays. Finally, all these rational strategies have been shown to be of debatable efficacy, and even potentially to backfire.

Coercive strategies, even if they induce popular compliance in the short run, have frequently fomented popular discontent, conflict, and even violence, which can threaten the legitimacy and stability of states. They can leave a long legacy of mistrust, poisoning the affective wellspring of

INCENTIVES IN PUBLIC HEALTH: DESIRABLE OR DANGEROUS?

In his classic study, *The Gift Relationship*, Titmuss (1970, p. 242) argued that paying people to donate blood was morally troubling and economically inefficient and that it reduced blood quality (because the presence of monetary incentives motivated blood donors to conceal information about their health status, especially drug use and infectious diseases). His case for voluntary blood donation kickstarted a larger, vigorous debate about motivational crowding out, that is, when fiscal incentives and disincentives have the opposite of the desired effect. In her Nobel Prize–winning work, Ostrom (1990), for example, showed how state imposition of fines and subsidies to regulate common property resources intensified their overuse.

Today, countries across the world offer fiscal and other incentives to encourage adoption of public health measures, from family planning to vaccination. While the evidence on their efficacy is mixed, critics argue that any such initiative "robs the act(s) of moral significance" (Largent & Miller 2021, p. 534), and can erode people's trust in the associated technologies by signaling that they are undesirable or even risky. Of special concern is growing evidence that incentives (and information) can boomerang, especially for at-risk population groups (for a contrary view, see Schneider et al. 2023).

Robertson et al. (2021) show how fiscal incentives, especially large ones, can dampen vaccine intent among Blacks and Latinos. A series of studies (Nyhan et al. 2014, Nyhan & Reifler 2015) found that providing corrective information about the MMR (measles, mumps, and rubella) and flu vaccines reduced intent to vaccinate for those most concerned about the vaccine.

state–society relations, and, as I will discuss shortly, undermining cooperation with public health campaigns in the (even distant) future (Dupas 2011). Some studies have found fiscal incentives to encourage vaccine uptake (Campos-Mercade et al. 2021, Commun. Prev. Serv. Task Force 2015), but others have not (Jacobson et al. 2022, Schwalbe et al. 2022). The provision of information has similarly been shown to be of limited utility in motivating the uptake of health directives and for science communication more broadly (Druckman & Bolsen 2011; Marteau et al. 2011, 2012). Some studies have found that message nudges promote vaccine uptake (Dai et al. 2021), but others have pointed to their limits, especially for vaccine-hesitant populations (Campos-Mercade et al. 2021, Rabb et al. 2022; see Jarrett et al. 2015 for a review). Of most concern are studies that find incentives and information to be counterproductive, impeding rather than improving popular engagement with health-promoting behaviors (see the sidebar titled Incentives in Public Health: Desirable or Dangerous?)

Affective compliance. Against rational actor models, several scholars have characterized public health behaviors as acts of faith (Goldstein & Wiedemann 2022), which hinge on the affective relationship between states and their people, as reflected in the roles of trust, partisanship, and national solidarity. These affective dimensions are distinct but connected. Trust, for example, works independently but is also a key mechanism through which copartisanship and national solidarity encourage popular uptake of health-protecting behaviors (see **Figure 1**). Each of these affective dimensions—trust, partisanship, and national solidarity—is also influenced by popular perceptions of state competence, including its control of contagion.

Trust. In line with political science scholarship on the role of "political trust" in encouraging popular cooperation with government policies (Levi & Stoker 2000), a legion of studies across public health and psychology, and an increasing number in political science, have found that trust in the state and leaders—and in health agencies and providers more specifically—encourages people to access health services and adopt everyday and emergency public health guidelines (see Siegrist

& Zingg 2014 for a review).[5] Trust in the state influences cooperation with vaccination campaigns (Obadare 2005), efforts to control Ebola outbreaks (Blair et al. 2017, Christensen et al. 2020, Dhillon & Kelly 2015), and the usage of health services in general. It has also emerged as arguably the most important factor explaining the uneven popular compliance with COVID-19 protocols across (Templin et al. 2021) and within countries (see, e.g., Bargain & Aminjonov 2020, Lachapelle et al. 2021, Olsen & Hjorth 2020, Sato 2022, Viskupič et al. 2022, Van Bavel et al. 2020, Weinberg 2020). Using an endorsement experiment embedded in a mobile phone survey, Blair et al. (2022) show how trust in government (more than trust in local authorities or other citizens) was a powerful driver of compliance with public health experiments in Uganda. Trust in fellow citizens (social trust), and the associated expectation that they will comply, also boosts compliance with government policies, including public health policies (Lachapelle et al. 2021, Levi 1996, Ostrom & Walker 2003). Barrios et al. (2021) analyze mobile phone and survey data to show greater voluntary social distancing in areas with higher civic capital and among individuals exhibiting a higher sense of civic duty. Further, lack of trust in experts and intellectuals undermines cooperation with health directives (Merkley et al. 2020). Relatedly, communication from a trusted source—whether government, community representatives, religious leaders, or health providers—makes scientific communication more effective (Druckman & Lupia 2017, Sunstein et al. 2020).

While trust, particularly in the state, facilitates state control of contagion by encouraging popular compliance with public health directives, there is a potential feedback loop by which trust can emerge from these dynamics. Shocks, such as an outbreak of infectious disease, can boost both political trust (the so-called rally-around-the-flag effect) and social trust. More importantly, scholars have argued that trust in the state is a product of popular perceptions of both state efficacy (Braithwaite & Levi 1998), including in the domain of health,[6] and of the fairness of state procedures[7] (Hall & Taylor 2009, Levi & Stoker 2000). As noted above, states' use of coercive techniques can leave particularly dense and lasting plumes of mistrust, which tend to be especially concentrated among formerly colonized peoples and minorities, because they have experienced the most severe and systematic exploitation in public health. For example, among African Americans, the infamous Tuskegee experiment (and a litany of other abuses) left a deep deficit of trust in, and dampened engagement with, the state, especially around public health (Callaghan et al. 2021), with grave implications for their health.[8] Coercive French colonial campaigns against sleeping sickness continue to undermine present-day trust in medicine, vaccination rates, and the success of World Bank health projects in Central Africa (Lowes & Montero 2021). Similarly, scholars

[5]For an alternative understanding that trust rooted in perceptions of government competence may lead people to underestimate risk and be less likely to take action during an infectious disease outbreak, see Wong & Jensen (2020).

[6]Ellinas & Lamprianou (2014) emphasize that, especially in times of crisis, evaluations of the state's social performance—for example, of how schools and hospitals are run—are the primary driver of trust in the state. In parallel, Cammett et al. (2015) find European states with more privatized health systems to be characterized by significantly lower trust because low-income citizens perceive themselves to be more vulnerable in the absence of state-financed health care.

[7]Related to perceptions of fairness, in a survey experiment in Guinea, Arriola & Grossman (2021) show how different ethnic groups' experiences with the state—specifically, whether they have perceived themselves as historically represented within or marginalized by the state—shape both trust in and compliance with public health directives, such as HIV/AIDS advisories, issued by different authority figures.

[8]The Tuskegee disclosure reduced life expectancy at age 45 for Black men by up to 1.5 years, accounting for approximately 35% of the 1980 life expectancy gap between Black and White men (Alsan & Wanamaker 2018).

TRUST DEFICITS AND HEALTH DEFICITS: A VICIOUS CYCLE FOR MINORITIES

A long history of exploitation, including medical and research abuse, has fed a mistrust of the state, especially around health, for minorities. This dampens their inclination to access health services and is further deepened by the discrimination they face when they do. A systematic literature review (Shen et al. 2018) finds that African Americans receive less information, empathy, and attention from their physicians than White patients.

Growing research shows how generational experiences of discrimination have profound physical consequences, which layer onto the health deficits associated with poverty and inequality, making minority groups more vulnerable to chronic medical conditions such as high blood pressure and type 2 diabetes. Epidemics tend to follow the faultlines of society. During an epidemic, minorities' relatively poor health status intersects with their lower access to, and greater skepticism of, vaccines, to render them more vulnerable to infection. Black, Indigenous, and Latinx Americans had higher rates of infection and mortality from COVID-19 than White Americans through most of the pandemic. At the same time, these minorities are also more likely to suffer from scapegoating, with its attendant physical and mental health tolls. In a cruel twist, their heightened risk of infection and sickness can reinforce stigmatizing associations of minority groups with disease. Psychologists find that people negatively evaluate and avoid individuals with physical characteristics indicating illness (Kurzban & Leary 2001, Oaten et al. 2011). And in a further reinforcement of this vicious cycle, informing majority groups about such disparities does not shore up, but can instead dampen, their support of state responsiveness to contagion (Harrell and Lieberman 2021).

attribute South Africans' mistrust toward Western science, medicine, and health policies, especially regarding HIV/AIDS, to the Apartheid state's public health interventions (Fassin 2007). More recently, the Central Intelligence Agency's use of a vaccination campaign in Pakistan as a cover to capture Osama bin Laden has fed mistrust in the state and in vaccines, strengthening support for the Taliban's antivaccination campaigns in 2011 (Martinez-Bravo & Stegmann 2022).

Moreover, inasmuch as such trust deficits intersect with the well-documented health deficits of minorities, associated with systemic racism, inequality, and poverty, they exert an especially pernicious effect on minorities' well-being, particularly during epidemics (see the sidebar titled Trust Deficits and Health Deficits: A Vicious Cycle for Minorities). Yet, although the actions of states can erode trust, they can also work to construct it. Tendler (1997) famously showed how a corps of dedicated health workers built trust, with transformational consequences for social welfare, in the impoverished northeastern Brazilian state of Ceara. Tsai et al. (2020) found that door-to-door canvassing campaigns by local intermediaries in Liberia boosted trust in the government and compliance with its policies to control the 2014–2015 Ebola epidemic.

Partisanship. Partisanship shapes interpersonal behaviors ranging from perceptions of attractiveness and mate choice to economic transactions. Most relevant for our purposes, it influences how individuals perceive (*a*) the threat of infectious diseases and (*b*) state attempts and technologies to control those diseases. This scholarship has focused primarily on the United States and has paid special attention to compliance with public health directives during the COVID-19 pandemic (not surprisingly, given the polarized political climate in which it broke out).

Within this scholarship, one strand has focused on partisan alignment. Respondents in the United States are more likely to engage with an infectious disease outbreak when their preferred political party is in power, in terms of expressing concern (O'Shea & Udea 2021), obeying public health advisories such as following stay-at-home orders (Goldstein & Wiedemann 2022), and vaccinating (Ashworth et al. 2021, Krupenkin 2021). An interesting nuance is that Democratic-leaning US counties responded more strongly to stay-at-home recommendations from Republican than from Democratic governors (Grossman et al. 2020). Relatedly, affective

NATIONALISM AND SOCIETAL COOPERATION WITH THE STATE

Nationalism has historically been associated with racism, chauvinism, prejudice, xenophobia, discrimination, and conflict. Its reputation has been further sullied by the rise of a recent wave of exclusionary nationalist populists (Singh 2022). Yet, despite its destructive consequences, nationalism is also a powerful constructive force. It has powered nationalist mobilizations against foreign rule, whether colonial or Communist; facilitated the establishment and functioning of liberal democracies; and spurred social welfare policies (Singh 2016). It has the potential to improve interethnic relations (Charnysh et al. 2015, Robinson 2016). In addition, and most relevant for our purposes, the finding that nationalism boosts compliance with COVID-19 public health directives aligns with the political science scholarship that shows how it has encouraged citizen cooperation with a range of other policies that require sacrifices of money, time, effort, and even lives. National attachment and pride are linked to greater willingness to vote, volunteer for military service, and pay taxes (Gangl et al. 2016, Hur 2022, Konrad & Qari 2012, Torgler & Schneider 2005).

polarization (animosity toward noncopartisans) has been found to determine politicizations of the US COVID-19 response (Druckman et al. 2021; on affective polarization, see also Iyer et al. 2019).

A second strand of research has emphasized partisan ideologies and identities. Conservatives and Republicans express less accurate beliefs about vaccines (Joslyn & Sylvester 2019) and greater hesitation toward them (Baum 2011, Baumgaertner et al. 2018) and other public health behaviors, including during the COVID-19 pandemic (Allcott et al. 2020, Callaghan et al. 2021, Gadarian et al. 2021, Goldstein & Wiedemann 2022, Gollwitzer et al. 2020, Grossman et al. 2020, Motta et al. 2020). Scholars have traced this variation to clear partisan differences in trust in experts and intellectuals, and openness to scientific expertise. Blank & Shaw (2015) suggest that the difference owes less to Republicans' skepticism than to Democrats' greater receptivity to the advice and counsel of scientists.

National solidarity. Infectious diseases do not respect national borders, but their outbreaks tend to be cast as imperiling nation-states. They are described this way both statistically, in the collation and broadcasting of key metrics of prevalence and control, and rhetorically, by leaders and the media. Sinardet & Pieters (2021) noted a "surprisingly unified" national response to COVID-19 even in the divided, federal country of Belgium. Perceptions of national threat (are used to) invoke national solidarity, a powerful if underemphasized driver of popular cooperation with state policies, including public health policies (see the sidebar titled Nationalism and Societal Cooperation with the State).[9]

Across the world, political elites, public health agencies, the media, and community leaders and organizations sought to marshal solidarity and a sense of "we"-ness to secure compliance with COVID-19 protocols (Haslam 2020, Steffens 2020). An analysis of 122 speeches made by 20 heads of government around the world during the COVID-19 pandemic (Dada et al. 2021) found that invoking "patriotic duty to encourage sacrifice" (p. 7) was a commonly deployed "rhetorical tool" (p. 1; see also Montiel et al. 2021). Prime Minister Ardern used nationalism to mobilize New Zealanders for arguably one of the most successful national responses to COVID-19 (see, for example Vignoles et al. 2021). Across East Asia, COVID-19 only reinforced the historic

[9]State leaders and the media frequently analogize their nations' fights against infectious diseases, most recently COVID-19, to waging a war. Scholars warn that such military metaphors normalize the "sacrifices" and "martyrdom" of medical personnel and other essential workers, who are depicted as "national heroes" "fighting" on the frontlines of an epidemic.

pattern of states successfully eliciting popular cooperation with health directives by framing acts of compliance as acts of patriotism (Goode et al. 2022, Singh 2022).

A large, collaborative, international project involving surveys of nearly 50,000 participants across 67 countries (Van Bavel et al. 2022) found that individuals who reported greater national identification were likelier to adopt public health behaviors (e.g., limiting travel, spatial distancing, hand washing) and endorsed public policy interventions (e.g., closing bars and restaurants) to control COVID-19. Surveys in China and the United States show how national identification mobilized and motivated people to adopt COVID-19-preventive behaviors in both countries (Chan et al. 2021). Ethnographic work highlights nationalism as an important factor in people's "willing compliance" with the Chinese state's extended COVID-19 control measures (Cai & Mason 2022). Federico et al. (2021) find higher valuation of the nation and national membership to predict greater COVID-19 solidarity in a representative panel of Polish adults.[10] Other studies link a sense of social identification (Cárdenas et al. 2021, Vignoles et al. 2021), civic duty (Barrios et al. 2021, Bourgeois et al. 2020), inducements of altruism (Rieger 2020) and empathy (Pfattheicher et al. 2020), and appeals to collective identity and health (der Linden & Svoie 2020, Hallsworth et al. 2021, Jordan et al. 2021, Motta et al. 2021) with greater uptake of public health protocols.

In addition to encouraging compliance with public health directives, nationalism functions as a "social cure" (Jetten et al. 2012) helping people cope with the psychological strains of a pandemic. In a Durkheimian vein, Goode et al. (2022, p. 63) argue that the collective effervescence produced by "performing the nation," for example, the communal singing of patriotic songs on balconies and porches as well as Clap for Carers events, provided "ontological security," especially during the long lockdowns in the early waves of the COVID-19 pandemic [Durkheim 1995 (1915), Goode 2016, Skey 2011]. Across 67 countries, Bonetto et al. (2022) found national identification to be significantly associated with wellbeing during the pandemic. As with the affective dimension of trust, it is useful to note a potential feedback loop here: Insofar as national solidarity encourages compliance, and consequently increases state effectiveness in countering contagion, the efficacy of states' responses can boost national pride (see Lim & Prakash 2021 on COVID-19 in South Korea).

THE EXCLUSIONARY IMPLICATIONS OF INFECTION

In line with our discipline's commitment to the study of boundary politics and intergroup relations, a substantial if scattered literature across political science has focused on how contagion shapes processes of othering and exclusion. These works have been siloed across traditional subfield divisions of political psychology, comparative politics, and American politics. But bringing them into conversation with each other enables a powerful understanding of the connections between contagion and dynamics of stereotyping, prejudice, xenophobia, and discrimination.

Within the overall stigma associated with infectious disease (Best & Arseniev-Koehler 2023), writings across history, sociology, anthropology, and public health, as well as popular media, have documented how historically those perceived as outsiders have been stigmatized, described as

[10]Pointing to the need to separate out different aspects of nationalism, national narcissism (defined broadly as a belief in the greatness of one's nation that requires privileged treatment) is associated with reduced solidarity (Federico et al. 2021) and greater propensity to believe in and disseminate COVID-19 conspiracy theories, which in turn leads to less engagement with health behaviors and support for policies to combat COVID-19 (Sternisko et al. 2023). Van Bavel et al. (2020) also suggest that collective narcissism is associated with perceiving out-groups as a threat and blaming them for in-group misfortunes, including scapegoating during pandemics, which is discussed further in the next section.

vectors of disease, and linked to ill health. COVID-19 was a brutal reminder of how epidemics frequently unleash a parallel plague of the targeting of minorities and foreigners. Most social scientists and popular commentators look upon infection as a fertile site for breeding outgroup antipathy. A rich tradition in social and political psychology, however, goes so far as to zero in on the ancestral threat of pathogens as the very source of outgroup antipathy. Xenophobia, by such accounts, is an ancestrally inherited psychobehavioral safeguard against the risk of infection.

But comparative political and sociological research pushes back against this psychological account by pointing to substantial spatial and temporal unevenness in the patterns of exclusion that are active within, and activated by, the forcefield of infectious disease. Why have certain epidemics been accompanied by more blaming and shaming of outsiders than others? Why have specific groups been more stigmatized and scapegoated than others? Constructivist theorizing within comparative and American politics highlights the key role of the framing of epidemics by political leaders and the media, which is in turn a product of, and embedded within the broader sociopolitical climate. Understanding how constructions of disease can magnify or moderate our neurobiologically hardwired xenophobic responses is a task laden not only with normative importance but, inasmuch as epidemic-induced exclusions undermine the well-being of both the scapegoated groups and the population as a whole, also with urgent empirical significance.

Infection and Exclusion: A Sociopsychological Evolutionary Perspective

The past couple of decades have witnessed the growth of an influential, if occasionally controversial, movement to incorporate neurobiology into political science models of human behavior (Petersen 2015). Political psychologists working within this tradition have drawn on an extensive, thriving scholarship in psychology to identify the threat of infectious disease as a critical though underappreciated determinant of human attitudes and behavior. By such accounts, the dread of contagion is the evolutionary starting point of exclusionary attitudes toward minorities and immigrants, as well as other related political predispositions.

The logic is broadly as follows. Infectious diseases posed a serious existential threat to our ancestors. In response, we evolved not only immunological defenses but also a complementary suite of psychological safeguards against disease-causing pathogens and their carriers. The invisibility and associated difficulty of detecting pathogens, combined with the high, potentially deadly, cost of missing them, made this "behavioral immune system" (Schaller 2011) hypervigilant. Unfamiliar populations might harbor pathogens to which we would have no immunity. Consequently, we developed and retained, through natural selection, a predisposition against unfamiliar stimuli, including people seen as outsiders.

And yet, abundant research has shown considerable variations within this shared human inheritance of preemptive behavioral responses to infection threats, driven on the one hand by individual differences in sensitivity to disgust and perceived vulnerability to disease (PVD), and on the other by varying situational cues and contexts.

Individual differences in disgust sensitivity and perceived vulnerability to disease. Since the 1990s, emotions have occupied an increasingly prominent place in political psychological models of human decision making. Yet, even as this scholarship has expanded, it has tended to focus on certain emotions, mainly anxiety and fear (Albertson & Gadarian 2015, Banks & Valentino 2012, Lodge & Taber 2013). In contrast, the study of contagion brings into focus "the most primitive and central" (Smith et al. 2011, p. 1), yet relatively underexplored, human emotion: disgust (Hatemi & McDermott 2012). Pathogen-based disgust has been shown to shape human personality, emotions, sexual behavior, and values; Fournier et al. (2021, p. 1) term it a "foundational political difference that colors a very large range of social and political attitudes and behaviors,"

including, most relevant for our purposes, political orientations and ideologies that are closely associated with outgroup exclusion. People who have higher disgust sensitivities have been shown to be more right-leaning, politically and socially conservative, and conformist (Curtis et al. 2011, Fournier et al. 2021, Inbar et al. 2009, Smith et al. 2011, Terrizzi et al. 2010, Tybur et al. 2016). [Interestingly, Navarrete et al. (2007) find that in the first trimester of pregnancy, when the body is naturally immunosuppressed and functionally adapts with "morning sickness" and greater disgust sensitivity, women also exhibit higher levels of xenophobia and ethnocentrism.]

Aarøe and colleagues have linked individuals' differences in pathogen disgust sensitivity to variations in levels of social trust, voting for socially conservative parties (Aarøe et al. 2020), and, critically, greater opposition to immigration (Aarøe et al. 2017). Aarøe et al.'s (2017) review finds that, across well-powered studies using representative and convenience samples from the United States and Denmark and controlling for a comprehensive set of variables, physiological and self-reported measures of disgust sensitivity and pathogen aversion increase opposition to immigration. Importantly, Aarøe and colleagues find that the effect of "contamination disgust" is larger than income, equivalent to education, and persistent when they control for political ideology, all key determinants of opposition to immigration as per the established research. Variations in disgust sensitivity have been shown to underlie differences in how people respond to disease outbreaks [Kam (2019) focuses on Ebola and Zika outbreaks in the United States] and to policies to protect against physical, moral, or imaginary contamination more broadly (Kam & Estes 2016).

A second, closely associated subtrack has shown how differences in PVD, more generally, can increase xenophobia and ethnocentrism (Green et al. 2010a,b; Navarrete & Fessler 2006; Navarrete et al. 2007) and prompt people to perceive greater dissimilarity and distance from outgroups (Parsons et al. 2012). Faulkner et al.'s (2004) research suggests that these effects vary by the ethnicity of the immigrant group. Increased PVD triggers negative reactions to immigrants from ethnic groups seen as subjectively foreign but not those seen as subjectively familiar. Increased salience of disease has also been shown to prompt social and political conservatism (Beall et al. 2016, Karwowski et al. 2020).

Varying situational cues and contexts. Within a second set of works that emphasize how variations in our immune system sensitivities and PVD are differentially activated by situational cues, one strand focuses on the individual level. Specifically, this literature documents how cues that generate feelings of protection against pathogens, such as hand washing and being vaccinated, can blunt our disgust sensitivities and, in association, our opposition to immigration (Aarøe et al. 2017, Éberhardt 2019). A twin track, popularly termed the parasite stress theory, focuses on subnational, national, and cultural units, showing how higher environmental prevalence of pathogens is associated with more exclusionary attitudes. Places with higher infectious disease burdens report higher xenophobia and ethnocentrism, with aligned traditionalist, collectivist (versus individualist), conservative (for a review on the link to conservatism see Terrizzi et al. 2013), and authoritarian (Zmigrod et al. 2020) attitudes and partisan preferences. US states with a greater exposure to human transmissible infectious diseases reported significantly stronger affective preference for, and identification with, the Republican Party (O'Shea & Ueda 2021). Relatedly, places with higher infectious disease burdens are more likely to be ruled by authoritarian regimes (Fincher & Thornhill 2012, Murray et al. 2019, Zmigrod et al. 2020) and have higher rates of conflict, including civil war (Cervellati et al. 2019, Letendre et al. 2010).

Infection and Exclusion: A Comparative Constructivist Perspective

This understanding of the exclusionary implications of contagion as rooted in an evolutionarily inherited neurobiological adaptation to ancestral pathogenic threats can be seen as the theoretical

foundation for the well-documented historic association of ethnic and sexual minorities with disease and ill health (Aarøe et al. 2020). Historians have traced how, as far back as ancient Rome, those perceived as outsiders have been vilified as disease vectors (equated with vermin, rats, lice, cockroaches, and plagues; see Banks & Valentino 2012). They were called detritus, scum, unclean, filthy, or dirty; their unfamiliar lifestyle and habits were described as unhygienic and morally deviant.[11] Morone (1997) observes that the discourse of public health, in general, has been framed in terms of a virtuous "us" and a delinquent, even dangerous "them." The link between infection and outsiders has led to the "othering" of entire public health issues such as liquor, drugs, and sexually transmitted diseases, especially HIV (Morone 1997).

In line with psychological research that yokes greater exposure, and perceived vulnerability, to contagion with heightened prejudice against outgroups, these exclusionary dynamics have been heightened during disease outbreaks. Scholars have noted the scapegoating of outgroups ranging from Jews during the bubonic plague in mid-fourteenth-century Europe (Cohn 2012) to the waves of immigrants in the United States during cholera and polio outbreaks in the nineteenth and early twentieth centuries (Kraut 2010), and more recently, "Africans" in Western countries for HIV/AIDS and Ebola, followed by "Asians" for H1N1, SARS (severe acute respiratory syndrome), and COVID-19 (Dionne & Seay 2016, Ingram 2008). Braithwaite et al. (2022) draw upon a global data set of countries for 1996–2015 to show how epidemic outbreaks increase the likelihood and scale of government repression targeting refugee populations.

Yet, the vilification and victimization of minorities are not a necessary feature of infectious disease outbreaks but a dimension across which they vary. Why does an outbreak of the same disease provoke the scapegoating of a minority in one country but not others? Why is a particular group singled out for blame versus another? These are questions ripe for future research. A promising line of argumentation builds on the influential and longstanding tradition of constructivist theorizing (Lieberman & Singh 2012), emphasizing the ways in which epidemics are social and intellectual constructs (Ranger & Slack 1992). Such constructions can be influenced by the disease's severity, newness, and mode of transmission (sexually transmitted diseases have tended to be especially vulnerable to scapegoating), and, as reflected in disease names, by the geographic location or population group perceived (sometimes mistakenly) as its origin or as being at high risk.[12] Recognizing naming as a powerful and potentially dangerous disease-framing strategy, the World Health Organization published best practices that advocated more generic, descriptive terminology. Regardless, political leaders and media frequently choose to broadcast stigmatized monikers, with potentially devastating consequences for the associated minorities. [For an analysis of how criminalized and marginalized groups reinvented their "at-risk" categorization during the HIV/AIDS crisis in India to renegotiate citizenship and to make demands on the state, see Vijayakumar (2021).]

[11] Anti-immigrant attitudes in England have been linked to beliefs that foreigners eat "disturbingly unclean foods" such as roots, frogs, haggis, and other foods "fit only for dogs" (Faulkner et al. 2004, p. 4). At the turn of the century in the United States, various immigrant groups were stereotyped in terms of their (ill) health—Asians as feeble and infested with hookworm, Mexicans as lousy, and Eastern European Jews as vulnerable to trachoma, tuberculosis, and a favorite "wastebasket" diagnosis of nativists in the early 1900s—"poor physique" (Markel & Stern 2002). In a particularly egregious instantiation, Nazi discourse described Jews as a disease afflicting the German nation.

[12] Examples of diseases being named for their geographic location include the West Nile virus; Nipah virus for Nipah, Indonesia; Middle East respiratory syndrome; African sleeping sickness; Japanese encephalitis; Ebola, for the Ebola River in the Democratic Republic of Congo; and Zika, for Zika, Uganda. It is also relevant to recall the initial clinical labeling of HIV/AIDS as GRID (gay-related immune deficiency).

Bieber (2022, p. 18) describes the "iconic image of the global pandemic" as a close-up of the daily press briefing of US president Donald Trump, which showed the word "Corona" crossed out and replaced with "Chinese" (Cillizza 2020). On the one hand, this racist description, propagated by Republicans and the right-leaning media (for example, through references to the "Wuhan virus" and "kung flu"), is best understood by temporally locating the outbreak of COVID-19 against the global ascendance of a wave of (far) right populist parties and leaders espousing exclusionary nationalisms that championed dominant ethnic groups against minorities and immigrants (Bieber 2022, Singh 2022).[13] On the other hand, the anti-Asian framings of COVID-19 in the United States built on a long history of the country's medical scapegoating of Chinese immigrants (Dionne & Turkmen 2020).[14]

Such scapegoating is of deep normative and ethical concern. It also poses real risks to the physical and mental health of targeted minorities. One risk is that vilified minorities may be threatened or attacked. In a large survey, Reny & Barreto (2022) found Asian Americans and Asian immigrants to be about twice as likely as Whites to report having encountered instances of COVID-19-related acute discrimination. Another risk is that members of victimized groups may fail to adopt protective behaviors, deny early symptoms, and delay seeking care for fear of further stigmatization. [Early in the COVID-19 pandemic, Asian Americans debated whether to wear masks, as they might provoke attention or even physical attacks (Dionne & Turkmen 2020).] Scholars have also documented the mental health impacts of scapegoating, noting that during the COVID-19 pandemic, a majority of Asian Americans worried about being threatened or attacked, with one-third saying they had changed their daily routine because of these concerns (Lee & Howard 2023).

Further, Dionne & Turkmen (2020) point out how the scapegoating of a minority for a pandemic can impact the health of the public, as a whole, because of denial and complacency by majorities who perceive themselves as less vulnerable. A stark example of this is the AIDS pandemic. Dionne and Turkmen's survey data also showed that White Americans believed themselves to be at lower risk from COVID-19 and were less proactive about protective behaviors compared to Americans from marginalized groups.

CONCLUSION

In contrast to many of the topics that have been reviewed in the *Annual Review of Political Science*, such as state capacity, bureaucracy, and nationalism, there is very little by way of a dedicated scholarship on infectious disease. Instead, we encounter political science research on contagion much as we encounter contagion in the real world—unexpectedly. To a much greater degree than other topics, social science scholarship on infectious diseases is dispersed across subdisciplines, notably comparative politics, political economy, American politics, and political psychology. We stumble

[13] In many of these countries, fingerpointing for COVID-19 furrowed established prejudices. Exclusionary nationalist leaders across Eastern Europe blamed and even violently targeted the Roma, long at the margins of (especially right-leaning) understandings of who belongs to the nation. In India, the BJP (Bharatiya Janata Party) regime disingenuously vilified their arch "other," Muslims, condemning them as "superspreaders" engaging in a "Corona Jihad" (Perrigo 2020, Turaga et al. 2020). In Brazil, President Bolsonaro scapegoated the LGBTQ+ community.

[14] The US Surgeon General's labeling of the 1900s plague epidemic, which was thought to have originated in San Francisco's Chinatown, as an "Oriental disease, peculiar to rice eaters" provoked widespread racism, including the arbitrary detention, for months, of almost a quarter of a million Asian immigrants (Elias et al. 2021). Eichelberger's (2007) ethnographic study of the 2003 SARS epidemic in New York City's Chinatown showed how stigmatizing discourses from the late nineteenth century resurfaced and were repurposed to blame Chinese culture and people for disease.

upon it intersecting with themes of state capacity, regime type, ideas, institutions, and interests, and with state–society relations. We see it quietly but powerfully shaping phenomena as weighty and varied as state building, the nature of colonial institutions (with associated implications for contemporary socioeconomic outcomes), and our emotions, values, and solidarities with and prejudices against groups. Seeking comprehensive coverage of the political science scholarship on contagion would be a Sisyphean task, even more so because of the explosion of work analyzing the COVID-19 pandemic, much of which tends not to engage with or build on the preexisting theories. Instead I have drawn an analytical arc through the scholarship, cleaving it, albeit on occasion with some violence, by whether it approaches contagion as an outcome or an explanation.

In conclusion, however, it is worth noting how smudging this distinction, and taking scholarship on both sides of the equation together, brings into view both fault lines and feedback loops that represent fertile avenues for future research. As an example of a potential tension, higher disgust sensitivity and greater PVD have been shown, on the one hand, to prompt greater compliance with disease-controlling behaviors such as hand washing (Porzig-Drummond et al. 2009). But also on the other hand, to be associated with more conservative attitudes and partisan identities (Beall et al. 2016, Karwowski et al. 2020, O'Shea & Ueda 2021), and, in the United States, with voting for the Republican Party—characteristics that have in turn been linked to less expressed concern about disease outbreaks and greater skepticism of scientific expertise and technologies to protect against disease such as masking and vaccination (Baumgaertner et al. 2018). Feedback loops can be both virtuous and vicious. This is exemplified by how (low) trust and nationalism can (dampen) boost compliance with public health directives, leading to the (in)effectiveness of the state response, and thus, perceptions of government (in)competence, which in turn feed political (mis)trust and (low) national pride. While the politics of infection, as a whole, calls out for more dedicated scholarship, such tensions and contradictions, and mutually reinforcing cycles, represent especially promising and urgent avenues for future research.

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