As the coronavirus pandemic unfolds, I have watched gun rights organizations like the National Rifle Association (NRA) find a profound sense of justification. I spent a year researching and learning to shoot with gun rights activists in Southern California and was struck by the fact that their reasons for owning firearms were often framed around preparedness for the unknown. While this was often motivated by fear and an accompanying need to protect loved ones, some gun owners delighted in imagining those unknowns, whether they be a violent encounter on the street or a societal breakdown. The hours that they spend at shooting ranges and defensive firearm training courses give these Americans a sense of mastery over a predicted future full of danger.

Many of the gun rights activists who I met stockpile weapons, ammunition, and food. Some have even built protective shelters in case of a major catastrophe like the coronavirus pandemic. In anticipation of widespread food shortages as well as the violence that might result from competition for scarce resources, they believe that owning firearms will give them an advantage and protect their lives.

Mass shootings often precipitate a sudden increase in firearms sales. In this case, firearms sales soared in the United States following news in March 2020 that many European countries had implemented emergency measures in response to the spread of COVID-19. These policies encouraged people to stay at home and observe social isolation (Beckett 2020). Michael Schwartz, the founder of a gun rights activist organization called the San Diego County Gun Owners, told me during the first week of these measures:

The gun shops have been crazy! All the shops are reporting a
600% to 1000% increase in sales and at least 80% to 90% of those sales are to people who have never owned a gun before. I have been at a gun shop and heard a customer come in and ask for “a gun, any gun, doesn’t matter. What do you think I should buy?”

This phenomenon has occurred nationwide. A leading firearms industry trade group has said that background checks for gun purchases increased by 80% in March when compared to February (Beckett 2020). Schwartz went on to say that:

A crisis and fear clarifies [sic] issues quickly. When someone is in fear for their life and their safety, they instinctively and logically understand that guns are the most (and in some cases the only) effective tool for defending your life.

This pandemic has triggered unprecedented shifts in behavior, beliefs about the future, and perceptions of danger that have reinforced many key assumptions that gun rights activists make about the world. For the groups of people that I spent time with, fear is a familiar motivation that convinces them that keeping firearms close by is both instinctive and logical. Schwartz believes that the rest of the world has now begun to understand the day to day reality of living with fear and uncertainty.

In response to COVID-19, The National Rifle Association aired a promotional video filmed in the bleak interior of a shooting range. The clip features an African-American woman holding a rifle across the arms of her wheelchair. Speaking with authority over what sounds like the soundtrack to an epic fantasy film, she says that vulnerable people like her have an even greater need for the personal means of protection at a time like this. She goes on to say that “even liberals” have started queuing up to buy guns. As with all promotional material from the NRA, this video speaks to a world of human threat and asks the viewer to see gun ownership from the
perspective of an at risk individual by engaging an empathic emotional response from viewers.

This film uses vulnerability to further a political cause in what has fast become a familiar tactic of the American right wing. By using liberal language and messaging, conservative media and activist organizations have been able to suggest that they fight for equality, while defending issues that often, in fact, decrease equal access to safe, meaningful, and prosperous lives.

Despite what the NRA says, the ability to use a gun in self-defense does not apply equally to all. As countless examples show, working class men, women, and non-binary people of color are likely to encounter a less responsive and often overtly hostile justice system than others in cases where they sought to defend themselves (Carlson 2014a). By positioning firearms as equalizers for vulnerable groups, gun rights organisations challenge stereotypes about their attitudes towards women and minorities while failing to acknowledge different lived experiences of violence on the basis of race, gender, and class (Carlson 2014b).

Take the Pink Pistols, a pro-LGBTQ+ firearms activist group led by a number of transgender women. They sit in the uniquely precarious position of being gun owners within a predominantly liberal LGBTQ+ community and transgender women within a conservative gun owning community. However, gun rights activists from all demographics of my research spoke of firearms as tools of “female empowerment”, occasionally using the phrase “gun rights are women’s rights.”

Joan, a transgender gun owner in her 60s who lives in San Diego county, has found a way to stay afloat financially during the pandemic by taking a job at one of her local gun shops. Her role has been to provide security by walking up and down the large cues that started forming outside of weapons shops to enforce social distancing rules. This position allows
her to utilize the very skills she has honed over a lifetime of preparing for such an event.

Many of the LGBTQ+ gun owners that I know voted for President Donald Trump in the 2016 general election, contradicting simple assumptions about how voting behavior divides along demographic lines of gender and sexuality. As the 2020 US presidential election creeps ever closer in the shadow of a global pandemic, it is worth reflecting on this fact: in 2016, whether a household contained firearms predicted which way a person would vote more accurately than any other demographic marker (Cohn and Quealy 2017). Roughly one third of households in the United States contain a firearm and of these 63% voted for President Donald Trump, while 65% of households without guns backed Secretary of State Hillary Clinton. This translates into a more consistent geographical split than even divisions based on race, religion, or whether one lives in a rural or urban environment.

For gun rights activists, this pandemic is part of a future they have always been expecting. But the question should be: Why are many Americans prioritising buying guns to help them prepare for a microscopic virus that is too small for even the sharpest of shooters to stop? It is because guns owners are predicting and placing bets on human nature. The enemies they imagine fending off are not coronavirus, but dangerous criminals provoked into lawlessness in a society somehow reduced to chaos by a pandemic, a foreign invasion, or economic meltdown.

As lockdown measures continue however, the dangers associated with keeping a firearm continue to be overlooked by many gun owners. For instance, owning a firearm is a major risk factor for suicide (Hemenway 2006). Of the over thirty thousand gun deaths each year in the United States, two thirds result from someone turning a firearm against themselves. A steady rise in firearm suicides has, in fact, only recently driven the total number of gun deaths to the highest it has been in twenty
years (Pilkington 2018).

Owning a firearm is also a risk factor for intimate partner violence. The presence of guns in a home does not necessarily increase the likelihood of abuse, but it does raise the chances that abuse will become deadly. Despite the NRA’s messaging, it has opposed laws that would prevent suspected domestic abusers from having legal access to firearms (Carlson 2014b: 60). Reports show that domestic abuse has increased around the world as people find themselves locked at home with partners (Kelly and Morgan 2020). In other words, the fact that so many Americans own firearms could make coronavirus control measures extremely dangerous in the United States.

Gun rights activists look into the future at an imagined monster: humans driven to desperation and violence by scarce resources during a crisis. Their vision of the apocalypse is very human and very pessimistic. But whatever the future holds, one thing is certain: with gun sales on the rise, firearm ownership will find a renewed relevance in the 2020 election. Like many of the gun owners I know, Donald Trump may use this crisis as an example of why it is necessary for private citizens to own firearms for protection – even if evidence suggests that they are more likely to be used to take the lives of their owners than defend them.

Joe Anderson received his PhD in Social Anthropology from the University of Edinburgh. His research explores the intersections between the practices and ideologies of defensive gun use, nationalism, gender, race, and ethics.

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The Usher Institute organizes COVID-19 webinars to strengthen partnership, inform policy and bridge knowledge gaps, writes Aphaluck Bhatiasevi

The Usher Institute in the College of Medicine and Veterinary Medicine at the University of Edinburgh has been organising weekly webinars on COVID-19 since the early days of the pandemic. Leveraging networks of research institutions and professionals across different countries, the webinars were initiated as a tool to collaborate and exchange knowledge to inform policy and practice in Scotland. They were also aimed at the academic community in the UK and beyond.
The primary intention of the webinars was to learn from colleagues in other countries about how the pandemic was being addressed there. They would serve as a vehicle to share information with colleagues in government and public health agencies and to help with decision making, says Professor Linda Bauld, Bruce and John Usher Chair of Public Health in the Usher Institute. For example, following the first webinar, notes and slides were shared with the office of the Chief Medical Officer in Scotland regarding how Singapore deployed a multi-agency approach in their COVID-19 response.

The Usher Institute works with both policy and research communities in Scotland and internationally, with a focus on health informatics, data science and social science. They connect policy makers, practitioners, patients and publics to create, develop and share knowledge to improve health.

The webinar series was established by Professor Aziz Sheikh, Director of Usher Institute and Professor Bauld. The Webinars have proved very popular and have been attended by policy and practice colleagues from Scotland and other parts of the UK, along with researchers from a range of different countries in Asia, Africa, the Americas, Europe and the Pacific.

Experiences and evidence shared in real time during the webinars included not only new findings from researchers, but also description and analysis of how different countries and inter-governmental organisations are responding to the pandemic. Issues and concerns involving containment, mitigation and in some cases intended elimination of the virus have been covered in the Webinars. In addition, data on testing, contact tracing, treatment and public health responses were discussed.

Thirteen Webinars have been held to date. They have focused on:

- Practical lessons and insights regarding the prevention
and treatment of COVID-19 from clinicians working in China during the early days of the outbreak;
- Deployment of measures involving a whole-of-government approach since January in Singapore;
- Experiences from Vietnam using a range of systems across the country, including health services, mass media, transportation and other elements to implement emergency control measures such as surveillance, contact tracing and quarantine;
- Experiences from Hong Kong on the implementation of border restrictions, quarantine and social distancing;
- Upscaling of ‘test, track, isolate and treat’ without a lockdown in South Korea, with the support of mobile test centers, credit card information for contact tracing and strong advocacy;
- Italy’s experience at the peak of the pandemic crisis and how different regions within the country were affected and responded
- Strategies New Zealand has implemented to move towards eliminating the virus within its borders;
- Experiences from Croatia including the use of social media to inform and engage the population;
- Multi-dimensional challenges and strategies low and middle income countries can deploy to respond to the pandemic, drawing on Nigeria’s experience;
- Risk factors for Covid-19 including emerging evidence on smoking and overweight and obesity; and
- Large scale, rapid research conducted by the International Severe Acute Respiratory and Emerging Infection Consortium.

Colleagues can join the Webinars by registering to participate using Zoom, or they can watch it live or on catch up via YouTube. Those joining via Zoom have an opportunity to pose questions to speakers and each Webinar has been followed by a useful discussion. The webinar series is contributing to identifying research gaps and connect those interested in
similar topics. Some of the issues raised during the question and answer sessions have been actively followed-up, helping to build or strengthen partnerships and advance research collaboration. For example, following the webinar on ‘COVID-19 and obesity: risks, realities and research needs’ the organisers connected the speaker with the Non Communicable Diseases (NCD) Alliance, a network of more than 100 organizations globally whose priorities are to prevent and control NCDs.

“We are in a crisis, and the Webinars have further emphasized to me the urgent need for collaboration. We must work closely together and learn from one another to advance our collective knowledge in order to respond to this pandemic and beyond,” says Professor Bauld.

The next webinar is scheduled for 26th June, focusing on ‘Addressing COVID-19 in Latin America: How Brazil and Chile are responding to the pandemic’.

To access the slides and recordings please visit: https://www.ed.ac.uk/usher/news-events/covid-19-webinars

Aphaluck Bhatiasevi is a PhD student in Social Anthropology at the University of Edinburgh.

Pandemics, COVID-19, and literary studies: past and present, by Nandini Sen

What made me write this essay:
“For the past four years I have been writing a historical novel set in 1901 during what is known as the third plague pandemic, an outbreak of bubonic plague that killed millions of people in Asia but not very many in Europe. Over the last two months, friends and family, editors and journalists who know the subject of that novel, “Nights of Plague,” have been asking me a barrage of questions about pandemics."

This sentence of Orhan Pamuk[1] caught my attention to write this brief essay on the similarities between the philosophical reflections existing in the current Covid-19 and the past historical pandemics through a lens of literary studies.

**Tracing the pandemics to COVID-19:**

From plagues in medieval periods, Spanish Flu (1918), herpes and legionnaires’ disease (1970s), to AIDS (1980’s), Ebola (2013-2016), severe acute respiratory syndrome (SARS, 2002-2004), and now COVID-19, contagious diseases continue to threaten and damage human populations.[2] It has become a common observation that the contagious diseases’ outbreak makes us feel like we are living within a dystopian novel. It may seem an unwelcome new territory for us, but mankind has in fact stood here before many times and written about it. According to Pamuk[3] both fear of the germs and viruses and people’s initial responses matter. Through initial responses to the recent pandemic people became philosophical, inquisitive, and interrogatory; this can also mean “stoical” and accepting the grim situation.[4] We wonder if philosophy can bring in clarity in this ethical and moral mess.[5] In order to clear the confusion, scientists, literateurs, poets, chroniclers and historians are trying to address local situations and at the same time possess a “desire to identify universal truths about how societies respond to contagious disease”. [6]

People and media have responded to epidemics by spreading
rumor, false information, and portraying the disease as foreign and brought in with malicious intent. In Fyodor Dostoyevsky’s “Crime and Punishment”, the protagonist Raskolnikov “dreamed that the whole world was condemned to a terrible new strange plague that had come to Europe from the depths of Asia”. This statement can be evidenced by the dramatic aspect of epidemic response to stigmatise and allocate responsibility. From Jews in medieval Europe to meat mongers in Chinese markets, someone is always blamed. This story of blame exploits existing social divisions of religion, race, ethnicity, class, political or gender identity.

We feel very attracted towards the sense of mystery and darkness through the prediction of mortality and process of death after battling the invisible enemy. In the COVID-19 situation, authors may examine how far it, unlike the previous epidemics is evaluating situations where elderly people will die to retain the “lives, and futures, of the young?”. Poetess Pam Ayres’s latest ode to coronavirus contradicts this notion as she regains her strength the age of 73.

Pandemics have affected social life since the establishment of civilisation. “Hippocrates recorded the first known pandemic in 412 BC, and numerous outbreaks were reported during the Middle Ages. The most notable epidemic, that of the ‘Spanish influenza’, occurred in 1918. Although more than 88 years have passed since that time, and memories of the disaster have become blurred, the sudden emergence of SARS and avian flu has reminded people of this painful past once more”. Defoe’s Chronicle shows us that behind physical and mental suffering there also lies an anger against fate, against a divine will that witnesses and perhaps even condones all this death and human suffering. In modern times we are orchestrated by our fear and the deaths. We share our anxieties and anger via different virtual network (Source: WhatsApp groups and
Facebook groups, online fieldwork 2020). We wish we can build a kind of solidarity and resistance against fate and divinity.\[14\]

Defoe\[15\] wrote about people keeping their distance when they met each other on the streets during the plagues, but also asking each other for news and stories from their respective hometowns and neighborhoods, so that they might stitch together a broader picture of the disease. Only through that wider view could they hope to escape death and find a safe place.\[16\] Likewise, in COVID-19 people created groups, blogs, and other social media platforms to exchange and record their sadness, grief, nostalgia, difficulties related to medical processes, missing attending to loved ones’ health crises including mental distraught, missing funerals, cancellation of marriages, big events, online, virtual or home-alone religious, literary and art festivals, online shopping slots, own creativities in different media (Source: WhatsApp groups and Facebook groups, Online field work 2020).

Much of the literature on plague and contagious diseases present the carelessness, incompetence, and selfishness of those in power as the sole instigator of the fury of masses\[17\] can be compared with the current mismanagement of so many countries’ governments.\[18\] Medieval writings, such as *The Decameron* by Giovanni Boccaccio (1313–1375) and *The Canterbury Tales* by Geoffrey Chaucer (1343–1400), emphasized human behavior: “the fear of contagion increased vices such as avarice, greed, and corruption, which paradoxically led to infection and thus to both moral and physical death”.\[19\] Under current lockdown the above mentioned vices were displayed by elite and sometimes common citizens in urban settings in the hoarding of essentials from superstores and groceries.\[20\] However, writers such as Defoe and Camus allowed their readers glimpses of didactic\[21\] and existential\[22\] philosophies
respectively beneath the waves of vulnerabilities, and fears – as something innate to human nature. *A Journal of the Plague Year,* one of the most important works of literature ever written on contagion and human behaviour, tells us how in 1664, local authorities in some London neighborhoods tried to make the number of plague deaths appear lower than it was by registering other, invented diseases as the recorded cause of death. Many commentators claim that the current UK government has likewise undermined the real figures and have not counted death figures from care homes or other informal institutes and peoples’ residences.

To write the book *The Plague*, Camus immersed himself in the history of plagues. He read about Black Death in Europe in the 14th century, the Italian plague of 1630, and the great plague of London of 1665 as well as plagues that ravaged cities on China’s eastern seaboard during the 18th and 19th centuries. However, Camus was not writing about one plague, as has sometimes been suggested, his was a metaphoric tale about the Nazi occupation of France. Like Camus’s *Plague*, *Blindness* by Jose Saramago uses its pandemic as an allegory of society, where life is reduced to a substantial fight for survival and people succumb to a contagious form of blindness which can transform your vision into a visual milky sea.

Athanasius Kircher’s investigation can be an important early step to understanding contagion, and perhaps even the very first articulation of germ theory. Kircher was possibly the first to view infected blood through a microscope. During the summer and fall of 1656, as Kircher remembered it, the “altogether horrid and unrelenting carnage” of Naples was on everyone’s mind, and “each man, out of dread for the ever-looming image of death, was anxiously and solicitously seeking an antidote that would ensure recovery from so fierce an
He predicted that the prospect of death could sometimes translate into increased inspiration, to achieve immortality. His keen observation (1658) through the Plague as reflected in *Scrutinium psetis*[^32], tells us “people scrubbed floors and walls with vinegar; burned rosemary, cypress, and juniper; and rubbed oils and essences on their skin. The wealthy left for the country if they could. Vagrants were sent to prison or conscripted to help the sick and scrub the streets of filth.”[^33]

Parallel to Defoe, Mary Shelley in *The Last Man* (1926) took her evidence from the riveting diary of plague, and created a kind of science fiction, zombie apocalypse and other apparent consequences of fate.[^34] By identifying thus with the plague in her private journal and in *The Last Man*, Shelley confronted the fact that humanity is the author of its own disasters. As scientists now remind us daily, collective human behaviour will either drive up or flatten the curve of Covid-19’s rate of infection, Shelley also saw clearly that we are both the problem behind and the potential solution to such a pandemic.[^35] COVID-19 has creepily invaded the world without prior notice, leaving many, mainly the elderly and other vulnerable people isolated at home as the only means of staying healthy and virus-free. Could they remain healthy, virus-free or avoid deaths?

People discussing COVID-19 frequently cite the famous film *Contagion* (2011) which opens with a woman coughing. It’s not just nervous throat-clearing. The cough becomes the protagonist and blends with other characters in director Steven Soderbergh’s film, creating terror. Like under COVID-19 we find in the film the policy makers, “scientists and bureaucrats who are looking, for answers, devising containment strategies, working toward a vaccine”.[^36]

Modern British authors like Benedict, Vaughan, and Lesley are
trying to create fiction under COVID-19 based on mid-life crisis, vaccines, tourists with masks in pubs, characters working in their pajamas, wildly getting on planes, journalists working from homes. They are predicting plots without excitement where characters will not interact, fight, kiss or make love, and face mental health problems. They need to explore the new norms depending on the imagination and the meaning of a multiple human calamity, across an entire overwhelmed population.[37] COVID-19 will create a void in literary pursuits. Hence, rebuilding and resolving new kinds of literary plots and ideas shouldn’t exist in oblivion.

Conclusion:

A profound cultural and ethical aspect of all major epidemics is the loss of access to personal narratives. The collective replaces the individual as protagonist, and the health of the public takes precedence over that of the individual. “There is a paradox in the multiplication of personal catastrophe throughout a society”[38]. The accounting of the past sufferings as narrated in different literary and historical texts in this context can produce thick memory with “subjective specificity”[39]. Apocalyptic traditions of pandemics including COVID-19 are deeply rooted in religious and community narratives that are turned toward the ‘end times’.[40]

Cynicism pervaded mankind in the past pandemics, but can we afford to be stoic under the current global crisis. Crucial questions remain on how storytellers in the years to come will portray COVID-19. How will the authors and artists document “the surge in community spirit, the countless heroes among us?”[41] In summary, under COVID 19 we can expect to become more articulate in our artistic creations about our individual survival, isolation, vulnerability, uncertainty, and certainly the importance of collective introspection of inequality related to pandemic deaths[42].
Dr Nandini Sen is an associate member of Centre for South Asian Studies at the University of Edinburgh.


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University of Edinburgh launches the Digital Social Science Cluster to support social science research in times of the pandemic, write cluster leads Karen Gregory, Morgan Currie and Kate Miltner

The COVID-19 pandemic is increasing our reliance on the use of technology and digital platforms for education and research. From September, universities across Scotland will begin a phased approach to incorporate a combination of digital and in-person learning, also known as Hybrid Delivery. To strengthen support for social science research in digital contexts, University of Edinburgh’s Centre for Data, Culture and Society (CDCS) has launched a new research cluster focusing on Digital Social Science.

Research around the world is pivoting toward the digital in response to some of the constraints emerging from COVID-19, and the cluster’s current focus is on helping researchers navigate this change. For researchers who are unfamiliar with “digital social science” and “digital methods”, it may seem like an entirely new – and intimidating – realm. It’s true that digital environments offer novel types of data, and sometimes at quite a different scale. However, the basic
tenets of sound research practices remain the same in digital spaces as they do in non-digital spaces. There is a lot of overlap between “digital” methods and more traditional methods. For example, online interviews, digital ethnographies and internet-based surveys rely on many of the same methodological practices and concepts as their analog counterparts. There are also a range of newer methods that allow for the exploration of digital formats.

The digital social science cluster examines the affordances and limitations of new digital methods, research ethics, data access issues, problems related to corporate relationships, and the design and use of new tools. By sharing examples of projects that illustrate the uses and challenges posed by digital methods, we highlight the wide range of tools, methodologies and techniques that are used in digital social science research. The cluster also draws on experiences from previous and ongoing research projects to identify challenges and raise questions connected to different methods, whether that is community mapping, survey research, interviews, or geo-tracking. As a “methods lab” we aim to make methods, tools, datasets, and projects accessible to students and staff.

As the Cluster evolves, we plan on hosting a speaker series featuring field-leading researchers from around the world. We also hope to host digital and in-person workshops in order to provide a better understanding on everything that goes into digital social science. We will collaborate whenever possible with other CDCS clusters on these activities.

If you are interested in giving a talk or getting involved with the Digital Social Science cluster, please reach out to any of the co-directors.

Dr Karen Gregory is a senior lecturer in Sociology and the co-director of the Master of Science programme in Digital Society at the University of Edinburgh.
Shielding and exit from lockdown: medical anthropologist Ian Harper asks why he should stay at home?

Last weekend I received a letter from the Scottish Government, dated 18 May 2020, stating: “The NHS has identified you... as someone at risk of severe illness if you catch Coronavirus... “It softens the blow by initially outlining how the government will be offering support during this period, before stating (bolded and underlined) “The safest course of action is for you to stay at home at all times and avoid face-to-face contact until at least 18 June”. This letter, to those in the highest risk group, is for our own protection and this action “will protect you from coming into contact with the virus, which could be very dangerous to you”.

In this short essay I reflect from the position of being placed by the Scottish Government in a vulnerable risk category and at risk of severe illness should I catch coronavirus. It is also informed by my background as a medical anthropologist and many years researching and writing critically on infectious diseases and their control. As a
heuristic device I pose the question as to why I should adhere to the edict to stay at home as we move towards moving out of lockdown? Why should I trust the government, and the scientific advice, upon which this decision is made? In short, infectious disease outbreaks are always social and political, and their control by necessity involves sacrifices to be made in the name of the collective good. I do not dispute this. But we do need more visibly public debate into the ethics and politics of who bears the burden of the sacrifices, and one that takes to heart questions of social and economic inequalities

The letter provided a list of things to do to stay safe:

- **DO STRICTLY AVOID** contact with anyone who is displaying symptoms of coronavirus
- **DON’T** leave your home
- **DON’T** attend any gatherings
- **DON’T** go out for shopping, leisure or travel

This was followed by a list of dos – wash hands; keep in touch with medical services; and use remote technologies. The rest of my household, in addition, is affected as I should also ‘minimise the time I spend with others in shared spaces’; aim to keep two meters away from others; use separate towels, or if possible, a separate bathroom; and avoid using the kitchen when others are present; eat alone; and “if the rest of your household are able to follow this guidance to help keep you safe, there is no need for them to wear any special medical clothing or equipment”.

This is the first time I have received such a letter, and my reaction has been mixed. I have already read extensively around the rare medical condition I have – as a responsible “sanitary citizen”, that is my understandings of the body and health are inline with modern medical ideas that allow me access to the civil and social rights of citizenship – and weighed the potential risks that I may face from being
infected from coronavirus. I am well aware of the potential drain to the NHS that I might become should I be ill. I am fortunate in being medically trained and as a social scientist I am able to read and interpret a wide range of scientific evidence. The condition I have is rare enough that the effects of coronavirus on those of us with it cannot be known yet with any statistical certainty, as the numbers required for the evidence is just not there. And from mid March, I have already had symptoms of coronavirus infection and was self-isolated, and quite ill for nearing a month, while fortunately avoiding hospital (I had considerable assistance over the phone from specialist NHS health professionals). I do not know for certain if I was infected because the policy at the time was to test for the presence of the virus only in those who were admitted to hospital.

Since recovering I have been exercising strict social distancing, exercising in the local park (this once daily trip out was keeping my anxiety levels at bay, and has become very important), but not entering into shops (unless absolutely necessary) or any other public space while out. I am fortunate in that I am able to work from home, have not been placed on furlough, and have a job that for the time being should be secure. Unlike so many others, my privilege means I do not have to physically put my body on the line and to place myself in potentially risky situations to maintain insecure income.

My reaction therefore is more ambiguous than thankfulness to a protecting and caring government. Why, then, should I adhere to these social segregation edicts that I have been on the receiving end of?

Firstly, the letter makes me feel as if I am personally responsible should I become infected (again?). The subtext is clear: It will be (partially, at least) my fault should I become ill. There seems no reflection on social determinants or inequalities, and all situations and contexts are placed on an equal footing. It also seems to make me responsible for the
distance that others in the household should maintain from me. Living as we do in a small flat, this is physically all but impossible. How did it come to pass that the vulnerable themselves have now been made responsible for maintaining their own health in a pandemic? Just beneath the surface of this letter I can sense the lines of blame opening up; that it will be my own fault if I get ill, and perhaps further, that we will be responsible for potentially infecting others should we not obey these prolonged lockdown restrictions. But context is vital: social and financial privilege allow access to greater space within which to isolate and shield. We are not all in this together in the same way.

Why, then, have I received this letter now? One interpretation is that I have been in this vulnerable risk group for months, but that the Scottish Government is so slow and bureaucratically inept that I have only just now received it. But this is, I think, ungenerous. The second interpretation, which I am more inclined towards, is that a) the category of highest risk has expanded – perhaps as understanding of the clinical effects of coronavirus have developed, and who therefore is, or is not, at risk – and that b) receiving this letter is also part of the strategy adopted by the Scottish Government for our exit to lockdown. As we now know, Scotland’s exit strategy has diverged from that of England’s and is one that is seemingly more cautious. Fears of a “second wave” and what this will mean to both the capacity of the NHS to cope, to say nothing of the rise in deaths that may entail are central to scientific and public thinking.

Responses to the pandemic have been based on modelling exercises that are only as good as the interpretative parameters and data that is entered into them (one good thing that this pandemic has facilitated is a greater debate in the public sphere on scientific logic). We are all living through an immense social experiment based on modelling – as our civil liberties, often hard fought for over years are eroded all in
the name of saving lives – and as we are subjected to a range of unprecedented social interventions by the state into the lives of us all. At the heart of the response is an immense paradox: that on the one hand the precautionary approach of science (requiring evidence before recommending something, for example around various treatments for symptoms), has been sacrificed to the one area of science for which there is little evidence, that of modelling for the future. Human sociality is not governed by the logic of mathematics. Modelling can only be really proven right in retrospect, and that I suspect only with wilful cherry picking of the post facto ‘evidence’. But again, this in itself is not enough to prevent me from not self-isolating and shielding.

It seems to me that in Scotland the government is currently implementing the recommendations of a model dubbed by the press the “Edinburgh Position”, based on an article of modelling on an idea called “segregation and shielding” or S & S.[1] [2] Basically this model looked at:

“S&S strategy using a mathematical model that segments the vulnerable population and their closest contacts, the “shielders”. We explore the effects on the epidemic curve of a gradual ramping up of protection for the vulnerable population and a gradual ramping down of restrictions on the non vulnerable population over a period of weeks after lockdown”, to quote from the abstract. They acknowledge that the model borrows from ideas of ‘cocooning’ infants with shielded adults who have been vaccinated – an odd comparator, given there is no vaccine yet – but there is no precedent for this approach in the literature. They go on:

“We show that the range of options for relaxation in the general population can be increased by maintaining restrictions on the shielder segment and by intensive routine screening of shielders.”
In short, it looks as if those of us who are vulnerable are being asked to stay indoors with restrictions to both us, and those around us, so that the rest of you – the non-vulnerable – can get back to the semblance of a normal life. Frame it however you wish, but we – those who for a variety of reasons of health have restricted movements already – are being asked to further sacrifice our freedoms for the non-vulnerable majority. Again, I don’t necessarily have a problem in doing this, but there are some further questions that I would like to have some clarity on. Is this the only option, or a compromise because of an initial response that failed to bring community transmission down?

Scotland has its own scientific advisory group on COVID-19, to “supplement” that of the UK government. The membership of this group is known to the public and is published on the government website[3]. They have clearly learnt from the fiasco that surrounded the early UK government and SAGE – and one named advisor in Scotland has been a ferocious public critic of how the UK government has responded to the pandemic. One of the authors of the “S & S” paper is also on the advisory group. There is a welcome broader range of expertise here, but noticeably absent is humanities representation. Where are the bio-ethicists? The historians? The medical sociologists? Representation from vulnerable groups? Why, in short, is the advisory group not more diverse?

Now it may be that the current strategy – and the letter I received – is not based on this proposed model (in which case I am happy to be corrected – although the principle of the concerns will remain the same). But my question to the advisory committee is this: was this paper specifically, and the approaches it suggests, discussed? If not, what approaches to coming out of lockdown were discussed? And what were the parameters for this discussion?

There is evidence to show that there is greater buy in to restrictive public health measures with serious and sustained
community involvement, as the literature around the effected communities of both HIV and Ebola show. Has this evidence from the social sciences been discussed, weighed up, and considered? Or does community involvement get jettisoned for paternalism with the need to ‘save lives’ in a crisis? Have the pitfalls historically, of segregating and shielding in all but name – both colonial and post-colonial in multiple contexts – been discussed and considered?[4] The group is well represented by public health experts, so can I assume that the broader social determinants of health, and the impact on those asked to stay in lockdown so the remainder of the healthy population can adapt to the ‘new normal’ have been considered? Has the impact of further lockdown for the vulnerable, and their mental and physical wellbeing been discussed?

It is quite possible, of course, that all this was fully thought through with the ‘deep dive’ approach on shielding that occurred at the last meeting – whatever that means (the minutes of the meetings held of the advisory group tell us next to nothing of any substance).[5] But why not show us the evidence, please, that it has been. It may be that I (and can I project into ‘we’ here?) would buy into segregation and shielding more if there was evidence to demonstrate that a broader range of positions has been considered. Personally, I need this, and assurance that we are not being placed at the mercy of an approach that is so blinkered to all but flattening curves and P values that there is little space for these other issues. The broader goals and principles of the Scottish Government’s framework for decision making suggest a “new normal” till a vaccine and potential treatments are available and in place[6]. This might be years away, and in the meantime, will this new normal involve myself, and others in my position in this high-risk category remaining segregated and shielded? What is the rationale for the June 18th cut off date? What are the thresholds that are behind this date, and what plans are in place should they not be met? I would feel better placed to trust the edicts if I was reassured that a
broad range of the ethical and social consequences had been fully deliberated upon.

*Ian Harper* is a Professor of Anthropology of Health and Development at the University of Edinburgh. He was the founding Director of the *Edinburgh Centre for Medical Anthropology* and a co-founder of *Anthropology Matters*.


[5] From the minutes of 14th May 2020: “The Advisory Group held a deep dive discussion on shielding, noting that the primary aim of the policy is to save lives but that shielding is very onerous for those being asked to isolate themselves completely for an extended period of time. The group noted the importance of making use of scientific knowledge to determine which groups are truly at highest risk. The group considered
different approaches being taken to shielding internationally, noting a wide variation in approach. The group discussed that age is the strongest general risk factor, but that rare conditions by their nature may be difficult to accurately determine a level of risk for as they won’t show up in statistics”. (See: https://www.gov.scot/publications/scottish-government-covid-19-advisory-group-minutes-14-may-2020/)

[6] “Recover to a new normal, carefully easing restrictions when safe to do so while maintaining necessary measures and ensuring that transmission remains controlled, supported by developments in medicine and technology”

“With scientists around the world working on vaccines and treatments that are still potentially many months away, we need to find a way to live with this virus and minimise its harms. We need to ensure, that as far as we can, our children are educated, that businesses can reopen, and that society can function. But we must ensure that those things happen while we continue to suppress the spread of the virus”.


Fake times and real life during the pandemic, by Angus
Bancroft

One of the effects of our arm’s length social life is that we interact with a limited range of interactional cues: our subconscious interpretation of body language, eye contact, tone of voice, is heavily truncated by the technology. There are many implications of that, not least for how we teach and engage students. They will have little sense of teachers and themselves as a classroom presence. It also has caused me to reflect on how we use these cues and others’ reactions for information verifiability. A part of my research is investigating how fake news and disinformation campaigns are produced and valued in the marketplace.

Disinformation operations are deliberate attempts to undermine trust in the public square and to create false narratives around public events. Rid (2020) outlines three key myths about them: 1. They take place in the shadows (in fact, disclosing that there is an active campaign can be useful to those running it) 2. They primarily use false information (in fact they often use real information but generate a fake context) 3. They are public (often they use ‘silent measures’ targeting people privately). Research indicates that how others respond to information is critical in deciding for us whether it is factual or not (Colliander, 2019). Social media platforms’ ability to counter the influence of fake news with verification tags and other methods are going to have a limited effect, other than enraging the US President.

Overall disinformation operations are about the intent, rather than the form, of the operation. For that reason tactical moves like disclosing an operation’s existence can be effective if the aim is to generate uncertainty. According to Rid (2020) what they do is attack the liberal epistemic order – the ground rock assumptions about shared knowledge that Western societies based public life on. That facts have their own life, independent of values and interests. Expertise
should be independent of immediate political and strategic interest. That institutions should be built around those principles – a relatively impartial media, quiescent trade unions, autonomous universities, even churches and other private institutions, are part of the epistemic matrix undergirding liberalism.

It doesn’t take a genius to work out that this order has been eroded and hollowed out from multiple angles over the past decades by processes that have nothing to do with information operations. Established national, regional, and local newspapers have become uneconomic and replaced with a click-driven, rage fuelled, tribalist media. Increasingly the old institutions mimic the new. Some established newspapers evolved from staid, slightly dull, irritatingly unengaged publications to an outrage driven, highly partial, publication model. The independence universities and the professions once enjoyed has been similarly eroded by the imposition of market driven governance on higher education, the NHS, and other bodies. On the other hand Buzzfeed evolved in the opposite direction for a time. It also doesn’t take a genius to note that the liberal epistemic order was always less than it was cracked up to be, as noted by the Glasgow University Media Group among others.

The erosion of this may be overplayed – for example, most UK citizens still get their news from the BBC. However survey data notes that there is a definite loss of trust in national media among supporters of specific political viewpoints (Brexit and Scottish Nationalism being two). The liberal epistemic order was therefore neither as robust, nor agreed, nor as liberal as it proclaimed itself to be and may have been contingent on a specific configuration of post-WW2 Bretton Woods governance. We can see plenty of examples of where this faith in the impartiality of institutions was never the case e.g. widespread support for the Communist parties in Italy and France, which had their own media, trade unions and social
Building an alternative reality was a key aim of progressive movements at one time. Labour movements often had their own newspapers, building societies, welfare clubs, shops and funeral services. Shopping at ‘the coppie’ (The Co-Op) said a lot about one’s belonging, social class and politics. That alternative reality can be the basis for social solidarity. That isn’t to compare the two. Fake news is inherently damaging to any effort to build a better society or understand the one we are living in. But real life and life organised independently does provide a defence and a basis for building a resilient post-pandemic society. Part of this is resisting and questioning what underlies fake news – the continuous attack on autonomous knowledge and Enlightenment values which have eroded the resilience of democratic societies.

References:


*Dr Angus Bancroft is a lecturer in the Department of Sociology at the University of Edinburgh.*

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The positive effects of COVID-19 and the social determinants of health: all in it together? By Sarah Hill, Sharon Friel and Jeff Collin

Policy responses to the pandemic need to take account of underlying social inequities

We welcome Bryn Nelson’s analysis of the potentially positive effects of public and policy responses to COVID-19, particularly in providing an opportunity to reassess priorities. Nelson highlights the unanticipated benefits of recent behaviour changes – but we suggest the real revolution is a re-discovery of the health potential of state intervention. Governments worldwide have taken unprecedented steps to suppress viral spread, strengthen health systems, and prioritise public health concerns over individual and market freedoms, with reductions in air pollution, road traffic accidents and sexually transmitted infections a direct (if temporary) result of the embrace of collective over individual liberty. Aside from an outbreak of alt-right protests, the usual accusations of ‘nanny state’ interference have been replaced by calls for centralised governance, funding and control on a scale unseen in peacetime.

While applauding this paradigm shift, it’s important to acknowledge both its partial nature and its extremely uneven impacts – positive or otherwise. As Nelson notes, negative impacts of the current pandemic (such as unemployment and
hunger) are ‘unquestionably troubling’, and while governments proclaim that “we’re all in this together” [viii] it’s already clear the virus disproportionately affects the poor, ethnic minorities and other socially disadvantaged groups. [ix] [xi] Even more troublingly, the very measures intended to suppress viral spread are themselves exacerbating underlying social inequities. [xii] [xiii] While a drop in traffic is very welcome, the edict to ‘work from home’ is disastrous for casually-employed service or retail workers; [xiii] and while social distancing may have reduced viral transmission in some groups, its benefits are less evident for those who are homeless, [xiv] in overcrowded housing [xv] or refugee camps. [xvi] In maximising the potential for COVID-19 to have positive effects, we must understand and address why its negative effects are so starkly mediated by class, ethnicity and (dis)ability.

Back in 2008, the WHO Commission on the Social Determinants of Health highlighted that population health and its social distribution are driven by the conditions in which people are born, grow, live, work and age, and that social injustice is the biggest killer of all. [xvii] This insight provokes serious questions about the unequal effects of this pandemic and its associated policy responses, [xviii] both positive and negative. Like Nelson, we hope the currently crisis will produce valuable lessons – most especially in understanding the need for collective action to create a healthier and more equal society.

There are three critical issues here. First, if governments are serious about “preventing every avoidable death”, [xix] COVID response strategies need to take account of their unequal impacts. While many states have acted swiftly to support businesses and wage-earners,⁴ these interventions are largely blind to class, gender and race. Unemployment and food insecurity have already increased [xx] with disproportionate
effects on women and low-income workers, and growing income inequalities are predicted. Charities report dramatic increases in domestic violence with an estimated doubling in domestic abuse killings since the start of the lockdown. While COVID-19 is already more fatal in Black and minority ethnic groups, we have yet to see the extent to which the response will exacerbate existing racial inequities in employment, income and housing. Governments must recognise – and ameliorate – inequalities in the negative effects of COVID-19.

Second, when developing strategies for transitioning out of lockdown, governments need to take account of the unequal impacts of any changes. The Scottish Government has signalled its intention to ease restrictions in ways that “promote solidarity… promote equality… [and] align with our legal duties to protect human rights”. Other governments should also consider how plans for lifting the lockdown can be tailored to minimize harm to already disadvantaged groups, and to ensure equal enjoyment of the associated benefits.

Finally, COVID-19 will produce a truly positive effect if the scale of the mobilisation to counter the pandemic can be matched by a sustained commitment to reducing social, economic and environmental inequalities in the longer term. Without such a commitment, we are perpetuating a situation in which many people live in a state of chronic vulnerability. This is bad for society, not only because it undermines social cohesion and trust, but because it places us all at increased risk. COVID-19 unmasks the illusion that health risk can be localised to the level of the individual, community, or even nation state.

If we’re serious about using this crisis to reassess our priorities, we need to recognise the urgent need for change beyond individual ‘risky behaviour’. To paraphrase Rudolf Virchow, the promotion of health is a social science, and
large-scale benefits come from political – not individual – change.\[xxix\] The genuinely positive effects of COVID-19 will come when we acknowledge the centrality of wealth redistribution, public provision and social protection to a resilient, healthy and fair society.\[xxxi\] Only then can governments begin to claim that we’re “all in it together”.

Dr Sarah Hill is a Senior Lecturer in Global Health Policy Unit, School of Social & Political Science, University of Edinburgh and of SPECTRUM Consortium (Shaping Public Health Policies to Reduce Inequalities and Harm), UK

Professor Sharon Friel is the Director of SPECTRUM Consortium, UK and the Menzies Centre for Health Governance, School of Regulation and Global Governance (RegNet), Australian National University.

Professor Jeff Collin is a Professor of Global Health Policy in the School of Social & Political Science, University of Edinburgh and SPECTRUM Consortium.

A version of this post originally appeared as a rapid response on the BMJ website in response to a feature article by Bryn Nelson entitled ‘The positive effects of covid-19’.

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COVID-19 and health systems: responding to unpredictable predictability, by Liz Grant, Yina Lizeth Gracia-Lopez and Christine Bell

Health systems across the world have been tested by this pandemic, and many have been found wanting, surprised by the pandemic’s ferocity and its unknownness, its seeming unpredictability. And yet pandemics are not new – the Black Death, cholera, yellow fever, smallpox, the Spanish Flu, HIV/AIDS. We know a lot about pandemics and can even predict them.

In an article for Just Security, Professor Christine Bell identified 11 baseline understandings likely to shape effective responses to the coronavirus pandemic in conflict-affected regions. Based on our experience with fragile and resource-limited health systems, we set out a further 11
themes that all health systems must consider in order to make effective decisions while battling the pandemic.

1. Build trust

As we have seen in past crises, the effectiveness of responses depends on the trust that people have in their clinicians, and in health systems, to protect them and have their best interests at heart. In the HIV pandemic, the move from fear and authority to a relational approach between patients and their clinicians changed outcomes. One male HIV patient captured the importance of trust when interviewed about his care: “I feel very confident [with my doctors in the infection consultations], because both he and the psychologist advise me. I thank them because they have always been extremely good, they are always aware of my mood and how I feel. Every time I come for a consultation, they take good care of me and I feel very at ease with them and with the whole team here.”

Yet, in a recent comment in The Lancet, Robert Peckham quoted a physician who led the 2003 SARS response in Hong Kong: “At that time [the SARS era] society was more united … whereas now people feel they have to rely on themselves for protection. They have less trust in the government.” If true, this will pose significant challenges in combatting the coronavirus.

2. Ensure public access to accurate information

Organizations such as Healthcare Information for All have a vision: “A world where every person will have access to the healthcare information they need to protect their own health and the health of those for whom they are responsible.” The most accessible, simple, and free “medicine” is accurate health information.

Lack of information kills. Misinformation kills.

This lesson was felt acutely during the Ebola epidemics in West Africa and more recently in the Democratic Republic of
the Congo. These saw health workers beaten to death because of false beliefs that they were bringing Ebola to the community, that injections given at health centers were full of the virus to kill communities, and that body bags for those who had died were not to protect against bodily fluids leaking and transmitting the virus but to take away body parts for sale elsewhere.

The strategies to manage this coronavirus pandemic depend on individual and collective responses to a set of essential simple health messages, including wash your hands, stay two meters (or six feet) apart, avoid touching, and stay indoors. But the myths, misconceptions, and inaccurate information about coronavirus have placed thousands at risk of severe illness, and caused deaths.

Social media has amplified a tsunami of misinformation. This includes myths such as: herbal remedies or garlic can cure COVID-19; the virus is spread by 5G; it only affects older people; and spraying alcohol on your skin or gargling with salt kills the virus in your body. The health system needs to be at the forefront of the largest health information campaign in its history, while simultaneously working in tandem with Facebook, WhatsApp, Instagram, and the like, to stop rumors and myths.

3. Widen the concept of stakeholders

Everyone is a stakeholder in the health of a community and its members. What happens outside the formal health sector is as important to health and wellness as the actions of formal health workers. Cultural, religious, and traditional spaces become even more powerful in times of stress and severe illness, and behavior in those spaces may need to adapt. When rituals, rites, and beliefs such as communal worshipping services, funerals, and religious pilgrimages such as the Hajj have to be abandoned, faith leaders have powerful roles to play in reconstructing communion and recreating spiritual
space using the power of symbols and icons.

Just as “aid modalities may themselves need forms of conflict diplomacy,” health modalities may also need new forms of health diplomacy. And we are seeing a new form of health diplomacy in the public space of volunteering – informal workers offering their services. Across countries, many without formal health roles have created systems to backstop and safeguard the formal healthcare system – boda boda drivers in Uganda carrying food to hospitals, taxi drivers in Spain carrying patients to the hospital for free.

4. Be aware of the health worker gap

How are countries managing the total health worker gap? We are not aware of any country that has a sufficient number of healthcare workers. The WHO projects a “shortfall of 18 million health workers, primarily in low- and middle-income countries” by 2030, unless significant efforts are made.

This workforce shortage is across all areas of health workers, but it is particularly acute for nursing. “The State of the World’s Nursing 2020,” which the WHO published on April 6, describes a current shortage of 5.9 million nurses and estimates that there will still be a shortage of 5.7 million nurses in 2030. This shortage overwhelmingly affects Africa, Southeast Asia, and the Eastern Mediterranean.

Such shortages are further exacerbated in these fluid and uncertain times because some health workers have left their workspaces, and we need to better understand this dynamic. Which health workers have left their worksites for family, health, economic, geosocial, or geopolitical reasons? Who remains within their country, and who crossed borders before they closed? Health workers have become the social and informal political leaders of this pandemic as they, more than anyone else, know what is happening. But with lockdowns, quarantines, and, as we have seen in India, mass movement of
workers, many have moved back to their home states, provinces, and countries.

5. **Learn and implement lessons from past pandemics and epidemics**

As we mentioned at the beginning of this article, viruses with wide-ranging effects are not new. Many countries have recent experience with pandemics or epidemics, and we should learn from them.

In particular, Liberia, Sierra Leone, Guinea, Nigeria, Uganda, and the Democratic Republic of Congo developed processes to prevent the spread of and ultimately halt their Ebola epidemics. They also identified failures in resource utilization and investment made during, and in the wake of, the Ebola crises, and they used this information effectively to ensure that gaps are filled and loopholes closed. The lessons they learned include: work with communities; build on existing community leadership and coordination structures; and, from the very beginning, manage the crisis through the lens of a humanitarian emergency and build in national emergency response capacity.

6. **Understand and address inequalities in access to healthcare resources**

Public, private, not-for-profit, and faith-based health services, as well as traditional healers, all provide forms of healthcare, but each has different access to resources and different remits and commitments. It is dangerous to assume there is equality and equity of access to each service and therefore that all members of society have some form of health coverage.

In this period of pandemic there are numerous reports of hospitals turning away patients too poor to pay and patients with illnesses other than COVID-19 being unable to access care with the disruption in the delivery of essential services.
While the disease trajectory of this pandemic points to how essential intensive care units equipped with ventilators are, hospitals across the world — in New York, Madrid, and Moscow — do not have enough. Those in many low-income regions have none.

But it is not just inequalities in high-tech resources; inequalities in access to services, particularly primary healthcare, are also critical. Getting the basics of care right will change the face of the pandemic, but this is only possible when the basic primary care systems are in place. In so many countries these are missing or, if present, unaffordable to the poorest. If ever there were a rationale for Universal Health Coverage, this is it; if ever there were a time for Universal Health Coverage, it is now.

7. Understand who is being left behind

Health systems urgently must determine which communities, which groups with which illnesses, which segments of the population are being excluded from health care. As Robert Muggah, principle of The SecDev Group, has noted, “While all populations are affected by the COVID-19 pandemic, not all populations are affected equally.”

Those living in informal settings globally are particularly vulnerable as their access to health systems was already fragile before the pandemic. Among the many groups identified as likely to be outside the care system, researchers have estimated that, in the U.K. alone, between 30,000 and 40,000 homeless people are living in hostel accommodation or on the streets. Children are also particularly vulnerable, and children in fragile and conflict zones who have already experienced multiple shocks in their short lives are likely to be excluded from health care.

Groups outside the care system are not only at risk of COVID-19 but also other common illnesses, and they may refuse
to come into the health sector or find themselves excluded from it. Moreover, factors outside the health sector’s power in many countries – crowded living conditions, lack and cost of running water, and protective measures intended to curb the disease – are the very factors driving the disease. These same factors are also often responsible for hunger, malnutrition, and the exacerbation of other deadly illnesses, including untreated non-communicable diseases.

8. Address psychological dimensions as core to health

The silent psychological pandemic creeping alongside the coronavirus pandemic – fear, anxiety, isolation, and loneliness – must be studied, along with its influence on life and health. Victor Frankl’s statement, “Man is not destroyed by suffering; he is destroyed by suffering without meaning” resonates across many countries as news outlets tell of patient after patient dying alone. There is a terror of the lonely death, and the unresolved grief of families unable to say goodbye.

9. Understand disease interactivity

As with other contextual dimensions of this pandemic, the presence of diseases other than COVID-19 affects health systems’ and patients’ experience of coronavirus. For example, Clare Wenham, Gabriela Lotta, and Denise Pimenta’s powerful analysis, published in “Mosquitos and COVID-19 are a ticking time bomb for Latin America,” draws attention to the syndemic that Latin America faces. With dengue, chikungunya, yellow fever, and Zika interacting – driven by poverty, overcrowding, poor housing, lack of access to water, poor sanitation, gender inequalities, and violence – the health sponge is already saturated to capacity.

10. Maintain essential health services

While the focus of all health systems is understandably on tackling the coronavirus pandemic, failure to manage
populations’ ongoing healthcare needs could have a far longer, deeper impact on health globally. If child vaccination programs are stopped, if medication for non-communicable diseases such as cancers or heart disease and infectious diseases such as tuberculosis and AIDS are not available, if maternity services are absent, advances in maternal and child health will be reversed and the health of a country’s workforce will rapidly decline.

However, maintaining essential services is not always simple. The WHO’s maintaining essential services report explains, “a system’s ability to maintain delivery of essential health services will depend on its baseline capacity and burden of disease, and the COVID-19 transmission context.”

11. Expand valuable practices beyond COVID-19

In response to the coronavirus pandemic, numerous practices have been developed in the crisis delivery of services, such as rapid transition to telemedicine, nurse and doctor task-sharing, and guidelines enabling all clinicians to discuss anticipatory palliative care and end-of-life preferences. Some of these practices could strengthen health services in the future.

Notably, integrating palliative care into mainstream healthcare could have an unparalleled impact on the global burden of suffering, which was already acute in many low- and middle-income countries. Half of the world’s population – the 3.6 billion people who live in the poorest countries – have access to less than 1% of pain medications distributed worldwide. Indeed, the editor of The Lancet, Richard Horton, has described this great abyss of suffering as “an appalling oversight in global health.” The coronavirus pandemic has further increased demand for, and encouraged recognition of the significance of, palliative care. This provides an opportunity to integrate this essential service into mainstream healthcare outside the crisis context.
The pandemic has challenged to the core the systems that promote and protect our health. It has accentuated rather than initiated capacity failures, organizational gaps, and resource crises in almost all systems across the globe. However, the strategies for shaping effective decision-making and care to battle this pandemic could also be the strategies that will strengthen health systems in the future, making them more equitable, more responsive to needs, and more oriented towards health, rather than disease.

This article was originally published in Just Security.

Liz Grant is Director of the Global Health Academy at the University of Edinburgh, with expertise in Ebola crises.

Yina Lizeth Garcia-Lopez has a PhD in Public Health from Miguel Hernandez University, Spain. She has extensive experience in health education and health communication for disease prevention and control, centering around teenage pregnancy, dengue and HIV. She is currently based in Edinburgh.

Christine Bell is a Professor of Constitutional Law in University of Edinburgh’s Law School.

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Targets, trust and COVID-19 testing, by Christina Boswell

Political scrutiny of the UK’s management of COVID-19 has recently revolved around an ambitious target the government set for itself: the goal of carrying out 100,000 tests per day
by the end of April. The debacle around this target exemplifies many of the challenges – and paradoxes – generated by the use of quantitative targets in government.

Let’s start by considering the purpose of setting this ambitious target. The ‘100,000 tests a day’ target is a classic case of the dual function of targets: targets being used as a tool of political communication, but also as a means of galvanising action within public administration.

The first function is all about political signalling. By setting a high profile and ambitious target, the government was attempting to reassure a sceptical public by locking itself into an ambitious pledge. This type of numerical target has a particular appeal, as it can be tracked and monitored through publicly available data, thereby establishing a particularly robust tool of accountability.

But at the same time, the target also acted as a disciplining device, designed to whip the civil service into action. Political leaders have frequently expressed their frustrated at the perceived inertia of Whitehall mandarins. Setting this type of ‘stretch’ target can place huge pressure on public officials to ramp up resources to achieve ambitious goals in a short space of time. And in this case, it clearly did have a galvanising effect on public administration.

Yet combining these two functions in one target is likely to create problems. High profile targets designed to reassure publics are rarely devised in a way that aligns with operational needs. Such targets are often set with political communication in mind – rather than a consideration of the types of actions that would be most effective in achieving a particular outcome. Thus in this case, it may have been more sensible to focus on questions such as prioritisation, quality control, logistics, and the role of these tests within a broader test, trace and isolate strategy. Too much attention on just one aspect of the strategy – the number of tests
conducted – narrowed down attention in an unhelpful way.

The effects of the target were also predictable. This simple and snappy numerical goal became a lightning rod for media and political attention, the central focus for holding the government to account. In doing so, the target displaced attention from other, more pertinent questions. Thus we had several days of media headlines focused on whether or not the government had met the goal, obscuring wider issues about the relevance or importance of this numerical goal as part of the government’s overall response.

As is often the case with targets, even those who disagree with the target on principle cannot resist critiquing the government for failing to achieve it. Even those sceptical of the target have found it irresistible to use it as a tool for holding the government to account. In this way, detractors of the target have inadvertently helped shore up its validity. In this sense, targets are highly performative, recasting how we frame social problems and evaluate policy responses.

Finally, what about the political leaders who set such targets? For governments, setting this sort of ambitious, publicly monitored, goal is a big political gamble. Governments can face a severe loss of credibility when they fail to meet targets. But they also accrue very little political capital when they do meet them. Ambitious targets that end up being met tend to get very little air-time. And when they are covered, they tend to be greeted with suspicion – as we saw in sceptical media coverage at the end of April, when the government’s target appeared to be briefly met. The fact that a government meets a target it set for itself is not likely to meet criteria of newsworthiness.

So why do governments keep setting risky targets when they have so much to lose, and relatively little to gain? Despite their short-comings, targets retain a strong appeal to political leaders. They offer an especially rigorous tool for
holding government to account, in an age where governments are searching for ways of shoring up credibility. First and foremost, these tools are seen as a device for grounding political trust — even though in the longer-term, they may have precisely the opposite effect.

Given these dynamics, governments are unlikely to learn the lessons of episodes such as the 100,000 tests targets. The immediate political capital gained from signalling commitment to such an ambitious goal will continue to outweigh the potential risks further down the line.

Christina Boswell is Professor in the Department of Politics and International Relations at the University of Edinburgh. Her book ‘Manufacturing Political Trust: Targets and Performance Measurement in Public Policy’ won the 2020 Political Studies Association Mackenzie Prize for best book in political science.

This piece was originally published in Cambridge University Press blog.

As countries ramp-up COVID-19 tests, Edinburgh University researchers discuss the expectations and values of diagnostics, writes Aphaluck
“You cannot fight a fire blindfolded. And we cannot stop this pandemic if we don’t know who is infected. We have a simple message for all countries: test, test, test.”

WHO director general Dr Tedros Adhanom Ghebreyesus said at the 16th March 2020 press briefing broadcasted live on social media. He demanded governments to test every suspected case, so that they could be isolated and treated, and their contacts be quarantined. He said WHO had shipped almost 1.5 million tests to 120 countries and are working with companies to increase the availability of tests for countries most in need.

Testing for COVID-19 has been at the centre of political debate about the pandemic response, particularly in the United Kingdom and the United States. The political messaging around testing has, however, underplayed the complexity of diagnostics, says Dr Alice Street, senior lecturer at the University of Edinburgh’s School of Social and Political Science. She was speaking at the Edinburgh Infectious Diseases’ webinar series on COVID-19 on ‘The social life of COVID-19 testing’. Dr Street is the principal investigator of DiaDev, a partnership between the University of Edinburgh, Kings College London, Kings Health Partners and Public Health Foundation India, which is funded by the European Research Council.

Dr Street says the value of diagnostics has placed enormous expectations on the COVID-19 tests. They are expected to provide certainty on the pandemic situation the country. They are expected to give reassurance that the measures taken by governments and health authorities are appropriate for controlling the spread of the pandemic. They are expected to provide a guarantee for people to come out of the lockdown and get back freedom of movement. Perhaps above all they are expected to set countries back into economic production and
move towards the path of financial recovery.

While demand for more testing is expected in the UK, she acknowledges that it may not be possible in many low and middle income countries (LMIC), including in countries where investments have been made in laboratory and diagnostics capacities in recent years. Drawing on experiences from DiaDev’s (Investigating the design and use of diagnostic devices in global health) research in Sierra Leone on the West Africa Ebola response in 2014-2016, and ongoing research on COVID-19 in India and the UK, she says the social value of diagnostics and the relationships between people, technology and spaces are often overlooked. Moreover, there are multiple kinds of diagnostic technologies with varying usages and benefits, but this complexity is often underplayed in political messaging potentially generating unrealistic expectations of tests.

Dr Street says different kinds of tests are best operated in different places – triaging patients, for making decisions on clinical care of individual patients and for surveillance purposes. The focus on getting the tests capacitated for the purpose of emergency responses has also diverted attention from development of laboratory capacities as a whole, particularly in LMIC, where resources are limited.

Reflecting on these experiences, Dr Street says it is evident that even in a country like the UK, there are weaknesses with the supply chain and the manufacturing system for diagnostics. The focus on point of care diagnostics may be distracting concerned authorities from considering the comprehensive system, from production to marketing, distribution, maintenance and waste management.

The values diagnostics have is different for different people and social groups. Often these values are overlooked. Investigating why diagnostics matter and what benefits are expected of them are important to their development and use,
says Dr Street. Although their primary role is to inform treatment of patients, in practice this role may be least performed. Responses to Ebola outbreak and COVID-19 has shown that they have high humanitarian value and are seen to save lives. This is evident from fast tracking of regulatory procedures for its use in humanitarian responses. They have also shown to have high economic values. In the UK, increase in testing is associated with the country’s gross domestic product (GDP) and the economic recovery from the lockdown.

Testing for COVID-19 can also give the people a reassurance that the government cares. It shows that they are recognized by the state. Failure to adhere to increasing their confidence can impact their trust on the authorities. DiaDev is currently involved in a project which looks at the public perception and expectations from COVID-19 testing, to inform future testing policies. The research is carried out in Lothian, Scotland, in collaboration with the Royal Infirmary, with funding Scotland’s Chief Scientist Office.

Prof Jurgen Haas, Head of the Division of Infection Medicine at the Edinburgh Medical School says there are different kinds of tests currently available, including antibody tests which can trace past infections, but we currently do not know whether they provide information about immunity and protection. He was speaking on ‘SARS-CoV-2 in Edinburgh: Clinical situation and ongoing research’ at the Webinar.

Prof Haas is one of the six Consultant Virologists in the Royal Infirmary Edinburgh currently involved in COVID-19 response and in COVID-19 research with Scottish and international collaborators. The current testing policy in the UK is to test for COVID-19 infection only in patients and individuals living in carehomes as well as hospital and carehome staff who develop symptoms. However, previous results have shown that also completely asymptomatic individuals can be positive for COVID-19 and spread the disease. Scottish NHS Health Boards currently have a testing capacity of around
4,000 individuals per day, but in some Health Boards such as Lothian (Edinburgh) the testing capacity is not fully used since Government guidelines have not changed or not been communicated appropriately. Thus, increasing testing in elderly homes can possibly reduce death rates, he says, adding that in Edinburgh, approximately 50% of all care homes are affected.

Aphaluck Bhatiasevi is a PhD candidate in Social Anthropology at the University of Edinburgh.

Don’t touch your face! The triggers, isolation and social connections of body-focused repetitive behaviours during COVID-19, by Bridget Bradley

As an anthropologist who researches a mental health disorder that I also suffer from, I take this opportunity to reflect on the ways that COVID-19 has affected daily life with a body-focused repetitive behaviour (BFRB). In particular, this piece draws attention to the impact of lockdown in the UK including the advice on face-touching; the triggers of staying at home; the paradox of anxiety; and how isolation can lead to
increased social connections.

Don’t touch your face!

Body-focused repetitive behaviours are compulsive mental health disorders including hair pulling (trichotillomania), skin picking (dermatillomania) and nail biting (onychophagia). Clear from the name, these behaviours involve a repetitive, somewhat obsessive interaction with the body. My ongoing research with people living with BFRBs in the UK and US, as well as personal experience living with these behaviours has confirmed that BFRBs are more complex than habits that can be easily overcome. The urges that accompany BFRBs are frequently described to me in terms of addiction, where pleasure and harm are entangled with satisfaction and shame. People with BFRBs usually do not understand why they have the urge to pull out the hair from their bodies or constantly pick their skin. These urges are rarely at ease, and while people attempt to conceal their behaviour from public view, the need to satisfy their bodies through pulling and picking occupies their thoughts most of the time.

In the early advice of COVID-19, media coverage highlighting the risks of face-touching took on a new meaning for my interlocutors. For many people with compulsive skin picking, the face is a site of great obsession. Urges accompany the frequent scanning for imperfections and scabs. Some hair pullers target their eyebrows and eyelashes, others frequently touch areas of the face to search for tiny hairs to pull. For nail biters, oral stimulation of fingers and nails is a daily occurrence. Importantly, many people with BFRBs carry out their behaviours subconsciously, so may not be aware that they are doing it. The reality of these behaviours means that sudden bombardment of “don’t touch your face” messages, becomes a harsh wake-up call to the frequently with which they actually touch their faces; their lack of control over it; and the very real risks in doing so. I recently asked a friend about this message, she said, “Honestly, the ‘avoid touching
your face’ advice from the government and in the media was something I immediately dismissed. Not as unimportant, but as unimaginable. I read somewhere that the average person touches their face around 200 times a day – as a compulsive skin picker I reckon mine must be in excess of 2000”.

The “don’t touch your face” message has further connotations for people living with BFRBs, as they have likely heard this numerous times before from frustrated family members. I have written elsewhere about how trichotillomania affects and is affected by family relations (Bradley & Ecks 2018). A major challenge lies in the comments from loved ones who fail to comprehend the complexity of hair pulling and skin picking, saying things like, “stop at your hair!”; “stop chewing your nails!”, “leave your skin alone!”, or simply slapping hands away from hair and faces while pulling/picking. Due to the intensity of urges and the embarrassment of being caught in the act, these words and actions can greatly increase feelings of shame and anxiety.

With this context, the “don’t touch your face” message might surface unsettling memories for people living with BFRBs, but it also acknowledges how difficult it is for some people to avoid touching their faces, even when the risk of infection is brought to their attention. Organisations like the TLC Foundation for Body-Focused Repetitive Behaviours (TLC) have issued advice to people about how to cope with face-touching, and the Picking Me Foundation suggested to “reinterpret media bytes” warning you to ‘not touch your face’ as cheerleaders rooting you on”. Therefore, some of the impact of this message may depend on how it is framed; and a focus on compassion rather than surveillance will make it more likely for people with BFRBs to reduce their face-touching during the pandemic.

Anxiety

Anxiety can be an enormous trigger for people living with BFRBs, with stress influencing the strength and frequency of
urges. Of course, it is assumed that living through a global pandemic is anxiety inducing, even for those with lower levels of anxiety. Paradoxically, in a recent Guardian article, Farrah Jarral notes that people with anxiety disorders and obsessive-compulsive disorder in the UK have reported lower anxiety during lockdown. Jarral suggests this is due to the stress of normal life and the benefits of slowing down for those with comfortable living standards and safe home environments. In BFRB circles, some anxiety has also been lessening, due to reduced social pressures and more time to relax with hobbies at home. For those who normally depend on external self-care strategies to manage their BFRB (regular appointments at specialist hair salons, unrestricted exercise), anxiety can be harder to maintain. However, some people have been able to adapt their self-care routines in new ways, like a friend who finally felt able to shave an undercut on the areas of her head affected from pulling. For her, the lockdown provided an opportunity to cut her own hair without the anxiety of anyone seeing her, and the new hairstyle has boosted her self-esteem.

COVID-19 has the potential to highlight where the triggers to anxiety and BFRBs lie; within certain social interactions, working life, daily commutes etc. This tracking of environmental and social surroundings with BFRB urges is a key focus of the behavioural model used by BFRB therapists, but what happens during lockdown when the environment that triggers you is your home?

Stay at Home

During the interviews and observations of my PhD research, I realised that home can be a huge trigger for picking and pulling behaviours. Like in much of the world, COVID-19 has kept British people in their homes, for weeks and months (at the time of writing the UK has entered the eighth week of lockdown). The UK message to “stay at home” has different outcomes for people, and while the overall aim is to save
lives, the various challenges and risks of being restricted to the house have been acknowledged in terms of domestic abuse and suicide.

Home can be triggering for people with BFRBs for several reasons. The first is a matter of time. BFRBs are a massive time-suck, as their compulsive and often subconscious nature can lead to hours lost each day. This loss of time was described to me as a “zoning out”, similar to what has been written on compulsive gambling (Schüll 2014). During lockdown, the change in routine and excess time can increase the chances of procrastination and makes it harder to avoid entering the zone of pulling/picking. Working from home also creates additional challenges, as people often depended on being surrounded by colleagues to limit their BFRB activity during the day, but with no one around to hide from, sitting alone at computers becomes the ultimate trigger zone. Staying home creates new ways of being seen, and remaining hidden. As one woman with dermatillomania told me, “With no social plans, other than Zoom sessions showing me from the shoulders up, I have felt free to mutilate my skin without the usual post-picking panic of how to hide the damage before I head out to meet friends.” Similarly, a woman with trichotillomania said she had lost so much hair during lockdown that she is afraid to be seen publicly once the restrictions are lifted.

Staying home also affects the way we see ourselves, and for people with BFRBs, mirrors are some of the most triggering objects. This has been acknowledged in many of the BFRB COVID-19 advice blogs, suggesting that people cover mirrors, limit time in front of mirrors, or stick motivational messages on mirrors to avoid the negative effects of obsessing in them. In a recent conversation, a woman with skin picking described this situation to me, “With all this extra time at home, I have had to cover my bathroom mirror with a square of brown paper as I quickly began spending increasing amounts of time stuck in front of it. A bored/restless/isolated individual
with a BFRB and an accessible mirror is like a moth to a flame.” Finally, as mentioned earlier, the presence of family members at home can bring additional struggles for people with BFRBs, limiting privacy, and often increasing the likelihood of embarrassment and shame associated with hair pulling and skin picking.

**Isolation**

Isolation is a familiar experience for people with BFRBs who have often spent years thinking they were alone in their picking and pulling obsessions, keeping it a secret from those around them. My PhD thesis (Bradley 2019) followed the journey of women, men and children through this isolation, to finding out that their “weird habit” had a medical name, and connecting with other people who have it too. These social relations become incredibly powerful and can develop into essential support networks.

The physical distancing enforced by the UK lockdown has reinforced this isolation for many people living with BFRBs, who are unable to attend in-person support groups. This year, a major event in the BFRB calendar was affected by the pandemic, the annual conference run by the TLC Foundation which was meant to occur in April. This conference is a rare opportunity for hundreds of BFRB sufferers and their families to spend a weekend together among leading clinicians and researchers. During my PhD research, I attended 3 of these conferences and witnessed the transformative effects of connecting with this international community. These conferences really are a lifeline for many people who feel deeply isolated by their BFRB all year long. Being unable to attend the conference has been difficult for some of my BFRB contacts, including one woman who travels from the UK to America for the event each year. She told me, “My heart was broken when we knew that the conference would not go ahead. Everyone knows it’s for the best and safety comes first, but it is such a huge part of BFRB lives. It’s our annual second
COVID-19 restrictions have certainly created distance among families, and in this case, the community networks that provide care in ways that mirror familial bonds.

However, we are also reminded during this time that physical distancing does not have to mean social distancing, as technology offers us ways to stay connected. TLC are now providing weekly “hang-outs” for their conference attendees, which has greatly comforted those who join them. Similarly, monthly BFRB support groups in the UK have increased to offer people weekly virtual support. Adapting these groups online has meant that they are now accessible to more people, more frequently, and people have said that they are “the highlight of their week”.

So while scholars consider the long-lasting mental health implications of COVID-19, it is important to acknowledge the unique ways that different mental disorders are affected by this pandemic, especially conditions that receive little attention like BFRBs. Finally, we should make sure to pay attention to the sustained efforts of people who are finding new ways to care, for themselves, and for one another during the isolation of lockdown.

Bridget Bradley is a lecturer in Social Anthropology, University of Edinburgh

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COVID-19 and gender-based violence in conflict: new challenges and persistent problems, writes Catherine O’Rourke

Peace is not just the absence of war. Many women under lockdown for #COVID19 face violence where they should be safest: in their own homes. Today I appeal for peace in homes around the world. I urge all governments to put women’s safety first as they respond to the pandemic. – Antonio Guterres, April 6, 2020

This call followed swiftly on the UN Secretary General’s call for Covid-19 ceasefires. With the exhortation to states to ensure women’s security during the COVID-19 restrictions, the UN Secretary-General not just echoed his own ceasefire call, but echoed concerns from women’s rights activists globally about the potential adverse impact of COVID-19 restrictions on
women’s experiences of violence and inequality. We do not yet know the full impact of COVID-19 restrictions on victims of violence within the home and their survival strategies, for women human rights defenders, for gender rights activists and women with insecure emigration status, for women IDPs and refugees, and for women seeking inclusion in ongoing peace processes. Nevertheless, the prominence of the Secretary-General’s call is important as it indicates the ways in which the UN now sees intimate partner violence (IPV) as a matter of international and intergovernmental concern, which is itself a paradigm shift.

Political Settlements Research Programme (PSRP) research on gender-based violence and its relationship to conflict includes useful insights on the likely impacts of the COVID-19 restrictions in conflict-affected settings. The PSRP blog distils some of the most pertinent insights from PSRP research, drawing in particular on Jessica Doyle and Monica McWilliams pathbreaking longitudinal study of the impact on women’s experiences of intimate partner violence (IPV) of the formal end to conflict in Northern Ireland; Aisling Swaine’s comparative study of the evolution of conflict-related violence against women before, during and after conflict in Liberia, Northern Ireland and Timor Leste; Fidelma Ashe’s report on the qualitative impact of the end of conflict on LGB&T security in Northern Ireland; and PA-X findings on gender provisions in peace agreements.

1. In violently divided societies, alienation from police will further reduce women’s capacity and willingness to report domestic violence.

In 1993, McWilliams’ initial study on the impact of ‘The Troubles’ (as Northern Ireland’s conflict was euphemistically called) on women’s experiences of domestic violence identified a high degree of alienation from the police, in particular from women in the minority Catholic/Nationalist/Republican community. This alienation was a key factor in discouraging
their reporting of domestic violence.

The updated 2018 study found a dramatic improvement in confidence in the police by domestic violence survivors. Nevertheless, the high degree of control exerted in IPV relationships continued. Indeed, the study identified a specific perpetrator strategy of ‘social isolation’ of victims. For example, 54 of the 63 study participants (86%) reported that their partner had prevented them from seeing or contacting their families and friends. Forty-eight participants (of 63; 76%) reported that their partner needed to know their whereabouts at all times. More than three quarters of participants in the 2016 study (49/63; 78%) reported that IPV had disrupted their income-generating activities such as employment and education, as well as hobbies and leisure activities. The controlling behaviour of the perpetrator and impact of abuse had serious negative effects on the physical and psychological well-being of participants.

The compounding effects of social isolation as a perpetrator strategy, aligned to alienation from the police in many conflict-affected settings, need to be factored into any response to COVID-19’s gendered impact.

2. The further empowerment of security forces in conflict settings can exacerbate gendered and sexual harassment.

The further empowerment of state actors to enforce COVID-19 restrictions can heighten the forcible regulation of gender norms. Research conducted during the Troubles in Northern Ireland found gay and lesbian young people frequently reporting gendered forms of harassment. For example, in instances of police harassment, sexuality was often focused on as a ‘vulnerability’, and in particular with regard to people from Catholic/Nationalist/Republican communities, to be used to push people to become ‘informers’. Informing was in itself a lethal activity given that informers were routinely killed
by the IRA.

Fidelma Ashe’s study of LGBT security in postconflict Northern Ireland reveals a situation where LGBT communities still feel insecure. Even new generations are affected by some of the historic distrust of institutions such as police, with respect to past actions.

3. In violently divided societies, community ‘self-policing’ heightens scrutiny of gender non-conforming behaviour. Also, additional surveillance creates new opportunities for ‘entrepreneurial' harassers.

Restrictions imposed by COVID-19 do not only involve formal state regulation, but also a high degree of community self-regulation. PSRP research has found that heightened community self-policing, which is common in conflict-affected settings, manifests in gendered ways. For example, gender non-conforming behaviour can be exploited by non-state armed groups to coerce individuals – fearful of disclosure – into cooperating with them. Moreover, gender non-conforming behaviour – including IPV victims leaving violent households – can be targeted for violent reproach.

Swaine’s comparative research found that conflict can present increased opportunity for state and non-state actors to enact violence on a personal motivational basis, in the absence of or alongside ordered militarised violence. For example, in Northern Ireland and Timor-Leste there is evidence of armed and civilian actors enacting sexual abuse on children and women for personal motivations, enabled by increased contact opportunities resulting from increased surveillance, such as checkpoints.

4. ‘Don’t you know there’s a war going on?’ Crises typically redirect police attention and resources from gender-based violence to ostensibly more urgent matters.

In the context of ongoing ethnic violence, McWilliams’ initial
study on IPV in Northern Ireland in 1993 found several domestic violence victims and survivors reporting police disinterest and deprioritisation of their experiences. There is potential for the policing priority of COVID-19 restrictions, coupled with ongoing conflict issues, to risk the further deprioritisation of IPV, unless pro-actively addressed.

5. Crafters of peace agreements typically view issues such as IPV as outside their purview, resulting in a missed opportunity to improve institutional responses.

Despite growing reference to gender and gender-based violence in peace agreements, in line with the WPS agenda, the PA-X database reveal very few references to IPV in peace agreement texts (the only clear examples of inclusion are found in Colombia, Yemen, Zimbabwe). PSRP gender work on peace agreements identifies how the peace agreement texts establish certain path dependencies as to how the issues and institutional reforms that are prioritised in the postconflict setting. With the UN’s COVID-19 ceasefire initiative, it would be important to both understand how forms of violence against women are included in the terms of the ceasefire, and to understand how addressing IPV can be made a priority for any post-agreement period.

6. Generalised restrictions can be used to target gender non-conforming behaviour.

Outside of conflict contexts, we see evidence of undemocratic leaders using ‘crisis’ to sharpen and toughen measures against perceived ‘deviance’ from gender norms. For example, Hungarian lawmakers have commenced an effort to end legal recognition of gender reassignment amid the COVID-19 crisis.

Such dynamics are often very much shaped by conflict divisions in conflict-affected or post-conflict contexts. Northern Ireland witnessed efforts by some political leaders to subvert
long-awaited and hard won liberalisation of abortion provision due to COVID-19 restrictions. Liberalisation of access to abortion in Northern Ireland was finally secured through Westminster legislation last year and was due to commence at the beginning of April. Some Executive members, including the Minister for Health, sought to postpone provision until the end of the COVID-19 restrictions. These efforts were only reversed by determined action by campaigners compelling health authorities in Northern Ireland to make formal provision for abortion by telemedicine in line with provision with the rest of the UK and Ireland.

7. Generalised feelings of insecurity can further fuel militarism, with gendered consequences.

PSRP research in Northern Ireland found that the increased availability of guns due to the conflict – both legally and illegally held guns – resulted in more fatal incidents of domestic violence in the jurisdiction as compared to the rest of the UK and Ireland. Similarly, the broader demilitarisation of society associated with the peace process positively correlated with a reduction in the use of firearms in domestic violence. Dramatic increase in gun sales in places like the United States, for which we have data, point to further worrying trends in responses to the insecurity engendered by the COVID-19 pandemic. There is also evidence that organised crime is flourishing as organised criminals seek to step into COVID-19 service provision voids, in countries as diverse as Italy, and Guatemala. These moves are often closely associated with these groups exerting forms of local community control, which are underwritten by increased arms that bring threat of violence into communities and even homes.

Conclusion

Women’s rights activists are rightly calling attention to the uneven gendered consequences of the COVID-19 pandemic and efforts to halt its spread. Whilst the COVID-19 pandemic
presents a new and unprecedented global challenge, the gendered effects of crises and complex emergencies are not new. We have a robust evidence base from which to anticipate gendered inequities and to be vigilant against them.

This article was originally published on the PSRP Blog

Dr Catherine O’Rourke coordinates PSRP Gender Research and is Director of the Transitional Justice Institute at Ulster University, a partner in the PSRP Consortium. PSRP Consortium is a partnership with University of Edinburgh’s Law School.

COVID-19, emergency legislation and sunset clauses, by Sean Molloy

The UK’s Coronavirus Act 2020 affords the UK government new powers in attempt to mitigate the effects of the COVID-19 pandemic, as with similar legislation enacted by governments around the world. But how important are sunset clauses as part of these measures? And what checks and balances are needed?

On 25 March, the UK passed the Coronavirus Act 2020 as part of its attempt to manage the coronavirus outbreak. The Act introduces a wave of temporary measures designed to either amend existing legislative provisions or introduce new statutory powers in order to mitigate the effects of COVID-19
As countries around the world enact similar laws, there are notable concerns regarding not only the impact of emergency provisions on human rights, but also the potential of emergency powers to become normalised. One response is to utilise sunset clauses. This piece argues that while sunset clauses are both welcome and necessary, they should nevertheless be approached with a degree of caution.

**Legislation in Times of Emergency**

Following agreement by both Houses of Parliament, the Coronavirus Bill received Royal Assent on 25 March transposing the Bill into primary legislation in the form of The Coronavirus Act 2020 (c. 7). The Coronavirus Bill Explanatory Notes capture the Act’s existence as emergency legislation that ‘enables the Government to respond to an emergency situation and manage the effects of a COVID-19 pandemic.’ Amongst other things, the Act attempts to increase the available health and social care workforce, ease the burden on frontline staff, and contain and slow the virus. Conversely, the Act also grants police, immigration officers and public health officials new powers to detain “potentially infectious persons” and put them in isolation facilities. It will also enable the government to prohibit and restrict gatherings and public events for the purpose of curbing the spread of COVID-19.

Similar pieces of legislation have been passed across the globe, sometimes following a declared state of emergency and other times existing as emergency provisions (see Asanga Welikala on differences between states of emergence and emergency legislation). In Scotland, for instance, the Coronavirus (Scotland) Act 2020 passed through the full legislative process at Holyrood in a single day. In Ireland, The Health (Preservation and Protection and other Emergency Measures in the Public Interest) Act 2020 was passed by both
houses of the Oireachtas (the Irish Parliament) and was signed into law by the President on 20 March 2020. On Sunday 22 March, France’s two-chamber parliament adopted a bill declaring a health emergency in the country to counter the spread of the coronavirus, a move that gives the government greater powers to fight the spread of the disease.

Through emergency legislation, special and extraordinary measures are enacted to respond to certain crises, in derogation of existing standards and rules. The adoption of emergency provisions invokes differences of opinion regarding their appropriateness and necessity. On the one hand, emergency legislation is thought to enable the state to respond effectively to crises while keeping the exercise of emergency powers within the rule of law. It reflects that, in extraordinary times, Parliament must make some allowance for the passing of laws quickly and effectively should circumstances demand it. On the other hand, emergency provisions, in granting powers to the state that circumvent ‘normal’ legislation, can have adverse effects on the enjoyment of rights to life, a fair trial, liberty and security, and freedom of assembly and association, as examples (see Amnesty International; Joint Committee on Human Rights; Greene). Times of emergency can, therefore, produce what Oren Gross terms a tension of ‘tragic dimensions’ between democratic values and responses to emergencies.

Where one sits on the potential trade-off between government intervention and individual rights and freedoms during times of emergency is a matter of personal opinion (see different contributions from Koldo Casla and Kanstantsin Dzehtsiarous). It is, however, the longer-term implications and impacts of law adopted in response to emergencies that raises additional and arguably greater concerns. There is always the risk that exceptional or emergency powers, granted for temporary purposes, can become ‘normalised’ over time. Alan Greene has noted, for instance:
History shows us that emergency powers often outlive the phenomenon that triggers the introduction of emergency powers in the first instance. While the need for exceptional powers may be obvious at the outset of the emergency, assessment of the point where these powers are no longer needed is considerably more problematic.

Elliot Bulmer also identifies that many governments have used emergency powers inappropriately — needlessly prolonging or renewing states of emergency and using emergency powers not to restore democratic normality but to bypass normal channels of democratic accountability. When examining emergency legislation, therefore, one is required to contextualise any assessment in light of the broader realities and tensions faced, accepting as part of this analysis the need for flexibility on the part of the state to respond to the unfolding events. At the same time, it is also necessary and expedient to consider the potential ramifications of any necessary restrictions on the enjoyment of rights at a later stage. Sunset clauses, in theory, exist to bridge this chasm between immediate requirements and future fall outs, ameliorating, in turn, the tension of ‘tragic dimensions’ between democratic values and responses to emergencies.

The Use of Sunset Clauses in Emergency Legislation

Sunset clauses or provisions are dispositions that determine the expiry of a law or regulation within a predetermined period. Through their use, an act or provision automatically ceases in its effect after a certain time. For instance, in the UK, The Terrorist Asset-Freezing (Temporary Provisions) Act 2010 stipulates that its provisions have effect for the period beginning when this Act comes into force and ending with 31 December 2010. Sunset clauses can also make provision for future debate in order to limit the potentially
deleterious and undemocratic nature of legislation that is ‘fast-tracked’. Thus, sunset clauses can require either that parliament renew a piece of legislation or replace it with a further piece of legislation subject to the normal legislative process. Indeterminate provisions such as these blur the lines between sunset clauses and post-legislative scrutiny.

Various emergency provisions adopted in response to Covid-19 have included variations or combinations of sunset clauses. In the UK, for instance, section 89 of the Coronavirus Act provides that the majority of the provisions will expire after two years. However, this period may be extended by six months or shortened in accordance with section 90. The Government also accepted an amendment, which introduced the requirement that the operation of the Act must be reviewed by Parliament every six months (see section 98). In Ireland, the powers under The Health (Preservation and Protection and other Emergency Measures in the Public Interest) Act 2020 will cease to have effect after the 9th day of November 2020, unless a resolution is passed by both houses of the Oireachtas (parliament) to approve the continuation of the measures. In Scotland, the Coronavirus (Scotland) Act includes a “sunset clause”, according to which most of it will automatically expire six months after it comes into force. MSPs will be able to vote to extend this for another six months if necessary, and then for another six months after that, but this is the absolute limit – so the measures in the Act have a maximum duration of 18 months. In France, the emergency lasts for two months from the day of its adoption, although it can be extended by lawmakers.

Sunset clauses when included in emergency legislation can be seen as a mechanism by which democracies devise ways to accommodate governmental powers within a pre-established legal framework, rather than leave it to governments to use raw power and untrammelled discretion to deal with emergencies in an unregulated way.
The Limitations of Sunset Clauses

Nevertheless, while history teaches us to approach emergency laws with a degree of scepticism, it is equally necessary to adopt a cautious approach to sunset clauses. The addition of sunset clauses notwithstanding, pieces of emergency legislation can remain in force long after the proposed sunset. In the US, for instance, the 2001 Patriot Act adopted in the aftermath of the September 11th attacks, included sixteen sections originally meant to sunset on December 31, 2005. The Act was, however, reauthorised several times in the following years following very limited evaluation. When sunset clauses provide for further debate, the efficacy of the review process is of central importance. However, the mere provision of future scrutiny is no guarantee for the effectiveness of that process. For instance, the Counter-Terrorism Review Project highlights that in the 2003 debate in the House of Lords on whether to renew the Part 4 powers of the Anti-Terrorism, Crime and Security Act 2001 – the controversial measures which allowed for the indefinite detention of non-national terrorist suspects – just four Lords spoke. This included the Minister who had introduced the renewal order. Only 13 MPs attended the first debate in 2006 on whether to renew the Prevention of Terrorism Act 2005 – the legislation which established the control order regime. In addition, the time allotted for debates on sunset clauses is also very short, often limited by parliamentary procedure to only an hour and a half. This has not always been a problem for Parliament. The House of Commons Third Delegated Legislation Committee, which was entrusted to consider whether the Terrorism Prevention and Investigation Measures Act 2011 should be renewed for a further five years, debated the measures for just 32 minutes (see here for discussion). In addition, there are questions regarding the most effective form of review. If parliamentary post-legislative review is the chosen approach, there may be problems associated with
politicisation of the legislation in question. Should, then, the review be undertaken by an independent expert, Committees of the House of Commons or Lords, or independent group? If so, how democratic is this process?

Similarly, there are questions around the necessary period of time between adoption and review and between different review processes. Although the UK’s Coronavirus Act allows for review after a period of 6 months, this may still be too infrequent. During the House of Lords review of Fast Track Legislation in 2009, for instance, The Better Government Initiative argued that “post-legislative scrutiny is all the more necessary” in cases of fast-track legislation, and that “it should perhaps be more frequent.” Such is the nature of the pandemic and such is the extent and wide-ranging nature of powers afforded under the Coronavirus Act (and similar pieces of legislation adopted globally), that more review processes might be required. But how might this be achieved in light of social distancing? Of course, many of these are issues that arise in the context of any review process, but they nevertheless demonstrate that there are a range of considerations to flow from sunset clauses, which require ongoing scrutiny themselves. In short, sunset clauses, in whatever form, are important but should also be approached with a degree of caution.

Conclusion

Sunset clauses will continue to be included in emergency legislation adopted in response to the COVID-19 pandemic. They are unquestionably a useful mechanism by which to ensure that emergency provisions do not normalise, thereby entrenching powers that can adversely affect the enjoyment of individual rights and freedoms. At times, they merge with post-legislative scrutiny, conditioning the continuation of legislation on the basis of ongoing and periodic review processes. They can, as noted, ease the tension of ‘tragic dimensions’ between democratic values and responses to
emergencies. However, there are limitations associated with sunset clauses. They can exist on paper but have little impact in practice. They can be renewed on an ongoing basis, often with little or insufficient scrutiny. Thus, adherence to sunset clauses must itself be scrutinised. On the whole, emergency legislation adopted in response to COVID-19, will require, as Stephen Tierney and Jeff King note, not only sunset clauses, but also ‘robust parliamentary scrutiny of the powers, and adequate provision for administrative and judicial oversight are imperative for the granting of such significant powers to ministers.’ To this one might also add the important role that the media, civil society, international community and human rights monitoring mechanisms will play in assessing the use of powers granted under emergency legislation.

This article was originally published by the UK Constitutional Law Association and the PSRP Blog

Dr Sean Molloy is a PSRP associate and researcher at Newcastle University Law School. PSRP is a consortium in partnership with the University of Edinburgh’s Law School.

COVID-19 and violent conflict: responding to predictable unpredictability, by Christine Bell

The World Health Organization is working on the basis that death rates rise when COVID-19 casualties exceed domestic health service capacity. The response is to require “social isolation” and shutdowns of large swathes of society and the
economy. So far, media focus has been on the crisis in China, Europe, and the United States. However, the world’s poorest countries have little public health care capacity, and often also lack effective central governments with any geographic reach or legitimacy to order – let alone enforce and manage – shutdowns. Unless there are mitigating disease dynamics in other places that are not yet understood, the consequences of the ongoing pandemic on poorer countries will be grim.

At the same time, many of these same impoverished countries are also in the throes of violent conflict. We know from experience that the relationship between armed conflict and crisis is complicated and leads to unpredictable results. If this unpredictability is, however, itself predictable – a “known unknown” – can a “smart” response be put in place? Our ongoing research at the Political Settlements Research Programme suggests that the following 11 baseline understandings are likely to be key in designing the most effective responses to the COVID-19 pandemic in conflict-affected regions:

1. Implementing technical solutions is always political, and “conflict lenses” are needed to anticipate the effectiveness of any response

Violent conflict takes place in deeply divided societies, where “the State” is often seen as owned by and serving “one side” of these division(s). Any disease response needs to factor in that any “technical response” will be understood through local conflict sensibilities. Local populations will appraise and measure any response in terms of wider conflict divisions and lack of trust, which will determine how “help” is received. For example, even in relatively peaceful Northern Ireland, disagreement over when the power-sharing government should implement COVID-19 school closures, took on a conflict hue, as Irish nationalist parties pushed for similar timing to the Republic of Ireland, while Unionist parties awaited the response of the British government.
2. Mid-level peacebuilders have unique capacities to bridge and build trust between the state and local communities

Where and whenever possible, combined messaging by local and international “ethical brokers” who are trusted in local communities can be important for navigating lack of trust. During and after the Ebola crisis in Sierra Leone, networks of local “mid-level” peacebuilders played an important role in building trust for interventions in borderland communities whose experience of the conflict had left them with no trust in the State or its health interventions.

3. Flexible aid may be needed that can bypass the State in contentious areas

Donors may need to provide creative “direct-funding” for local communities, particularly where they are autonomous and oppositional to the state. However, states subject to such bypassing, will likely view this process as a threat to their sovereignty, particularly if the sub-state region has aspirations of becoming an independent state. Hence, aid modalities may themselves need forms of conflict-diplomacy.

4. Crisis management can have “peace dividends”

Moments of crisis can also provide turning points in a conflict, depending on how the parties and international actors behave. COVID-19 itself has already contributed to renewed calls for a ceasefire, and implementation of prisoner releases in Afghanistan. Both were provided for in the recent U.S.-Taliban Agreement, but until COVID-19 evolved into a full blown global pandemic, these provisions were proving difficult to implement. Similarly, President Rodrigo Duterte of the Philippines recently declared a unilateral ceasefire with the National Democratic Front (NDF) to better fight the spread of the coronavirus, although the NDF greeted the call with some suspicion rather than reciprocity. The December 2003 tsunami that devastated
Indonesia reinvigorated a settlement process, which was all but dead between the Free Aceh Movement and Indonesian government, resulting in a peace agreement.

5. Conflict parties often seek to make military and political gains, under cover of crisis response

Crises can also be used as cover for military and political gains in a conflict that is continuing. For example, the same 2003 tsunami that arguably helped produce a peach agreement in Indonesia, contributed to dynamics that ultimately saw the peace process in Sri Lanka failing, producing a bloody conflict. In Nepal, the deadly 2015 earthquake pushed the main parties to agree to a permanent constitution, but at the price of narrowing the peace process’ wider promise of inclusion to a range of ethnic and socially excluded groups, including women. In Ogaden Ethiopia, famine and delivery of food aid has often been charged as being a vehicle for the Ethiopian military to gain access to opposition-held areas, and pursue destructive policies such as “de-villagization.” Local humanitarian agreements in Syria, also stand charged with swapping “bread for surrender.” Thus, how crisis response is delivered, and how it enables other agendas, can become independent conflict accelerants, as can perceptions of bias in terms of which communities’ needs are viewed as being prioritized.

6. State and non-State armed actor capacities for mobilization, and their political and military calculations, will be different

During conflict, efforts by international agencies to implement something like a “shut down” will impact very differently on State forces as opposed to non-State forces such as al-Qaeda or the Taliban. In a conflict like Afghanistan, where policing border crossings are key to inserting break points in disease spread, if these are also conflict or rebel-held hotspots, then this will pose added
challenges. Local geographies will be affected differently, because crises will affect them differently and because they will have different local political settlements between State, non-State and civic actors, which affect their capacity for coordinated responses.

7. COVID-19 may pose unique logistical challenges to current peace processes

There are challenges that may be unique to COVID-19 because of its global scale, and the nature of the crisis.

8. Diplomacy and peacekeeping may become “absent”

The pandemic has impacted on all forms of diplomacy, from Brexit to regional peace processes. Peace processes depend on diplomacy and third party guarantees. In peacekeeping forces and donor country missions, States are withdrawing personnel. The COVID-19 pandemic has already seen a travel ban and ban on social gathering implemented in South Sudan, where the last transition agreement is but three weeks old, effectively bringing its process of implementation and diplomacy to a standstill. The COVID-19 pandemic differs from the Ebola crisis in that with Ebola diplomacy and internationalized responses could continue beyond shutdowns and immediately affected zones. Whereas with COVID-19, diplomats falling ill, sometimes perhaps as a result of their diplomatic contact, has been a feature of transmission this far. There are innovative ways to use technologies – the two week old Spanish-Catalan dialogue is moving online for example. But, face-to-face contact often has a distinctive trust-building role to play in conflict settings (e.g. Anwar el-Sadat’s visit to Jerusalem, which paved the way to the Camp David Accords).

9. Emergency legislation is a response with conflict-dangers

Western states such as the United Kingdom and France seem to be moving toward forms of emergency law that have little
democratic or judicial oversight. Where democratic states go, more autocratic, conflicted states will quickly follow. In divided societies, states of emergency have a long history of uneven application to national minorities and political opponents. They are often “synonyms of sustained and extensive human rights violations.” There are reasons to work within the confines of human rights law, especially during health crises where use of law really matters. In any country, the risk is that while some urgent powers will be needed for health care provision, the police and executive powers will have wider application. In conflict contexts, crisis often provides a pretext for a long-term executive power-grab of dubious constitutionality or other abuses of exercises of emergency powers. A clear danger is that these emergencies do not end when the health crisis does, but continue indefinitely.

10. Elections are also peculiarly at threat, with specific conflict consequences

The social isolation element of containment also means that the holding of elections is particularly at threat in a context where democratic decay is already a global phenomenon and poses a particular risk for conflicted states. Post-conflict contexts depend on elections to resolve power tussles peacefully and avoid governmental breakdown, such is now threatened in Kosovo.

11. A lack of international legal confidence

Finally, the COVID-19 pandemic provides wider challenges because of the moment in which it arises. We are living in a period during which the currency of international norms, international organizations, and globalized responses, are less popular than even a decade ago. For a crisis that is inherently, cross-border – indeed global – in nature, such increased skepticism of multilateralism render necessary cross border global responses harder to put in place.
Conclusion

In conclusion, the COVID-19 threat is unusual in that it is imminent, and globally existential. Countries in conflict have populations who have been facing existential threat for a long time. At time of writing, the U.N. Secretary General has called for a world-wide ceasefire. If illness takes hold in conflicted states, it is possible that this call will be heeded. But even ceasefires require agreements and diplomacy. Creative thinking on how to address coronavirus and conflict together could play a game-changing role in ending unnecessary deaths by disease and warfare in of some of the world’s most troubled places.

This article was originally published in Just Security and on Political Settlements Research Programme (PSRP) blog.

Dr Christine Bell is the director of PSRP and a professor of Constitutional Law at the University of Edinburgh.

How COVID-19 is used to stop lone child refugees from joining families in the UK, writes Nasar Meer

The UK and other countries are using the COVID-19 coronavirus outbreak as an excuse to prevent even the most vulnerable of refugees from crossing
In recent weeks, according to the United Nations, at least 167 countries have either fully or partially closed their borders. These travel restrictions seem an important means to help contain the pandemic, but they are also proving to be a way for some countries to forfeit their asylum responsibilities.

Presently, at least 57 states are citing COVID-19 to ignore international conventions by making no exception for refugees seeking asylum, even though the World Health Organisation (WHO) offers clear guidance on the use of quarantines and health screening measures at points of entry for those fleeing persecution.

Some politicians have openly signalled their intention to use the present uncertainty to ramp up anti-refugee sentiment. The Hungarian prime minister, Viktor Orbán, for example, has told the people of Hungary that “our experience is that primarily foreigners brought in the disease, and that it is spreading among foreigners”. In Italy meanwhile, the former interior minister Matteo Salvini has claimed that his country’s outbreak was caused by a maritime refugee rescue in Sicily.

Closer to home, the legal charity Safe Passage has issued to the UK Home Office a list of unaccompanied children and vulnerable adult refugees trapped in refugee camps on the Greek islands, but who have been legally cleared for transfer to join family in the UK. The Home Secretary has refused to accept them.

What is at risk in all of this is not just viral contagion, but the very basis of the international refugee conventions that have shaped our post-war landscape. This includes the principle of “non-refoulement” which is the cornerstone of international refugee protection.

Enshrined in Article 33 of the 1951 Refugee Convention, this principle insists that “No Contracting State shall expel or return (‘refouler’) a refugee in any manner whatsoever to the
frontiers of territories where his [or her] life or freedom would be threatened on account of his [or her] race, religion, nationality, membership of a particular social group or political opinion.” This principle is in serious jeopardy and Filippo Grandi, the UN High Commissioner for Refugees, has said he fears “the core principles of refugee protection are being put to test”. It is a test we cannot fail.

Even Germany, a country that has in recent years shown the rest of Europe (if not the world) how to successfully take in refugees, has seen the suspension of its humanitarian refugee admission programmes. In the case of Germany, this is expected to be a temporary measure but there is no guarantee this will be the case for other countries.

The WHO has helped establish the International Health Regulations (IHRs) designed to form an international legal position for responding to a public health emergency of international concerns. The regulations were not conceived to undermine the 1951 Refugee Convention nor EU refugee law, where the Charter of Fundamental Rights guarantees the right to seek asylum.

Temporary travel restrictions, therefore, should not apply to people in need of international protection or for other humanitarian reasons.

Indeed, on April 2, the European Court of Justice ruled that Hungary, the Czech Republic, and Poland were not legally entitled to opt-out of EU treaties that required them to take their allotted share of asylum seekers from Greece and Italy in 2015.

There is, of course, a long history of associating diseases with migration, but COVID-19 will not be tackled in the long-term by closing borders to the most vulnerable, and the cost of doing so is profoundly undermining our post-war refugee settlement. Forced returns and refoulement are not justified
by suspicion of COVID-19 transmission.

There are ways to manage border restrictions in a manner which respect international human rights and refugee protection standards. It is imperative that in all the uncertainty accompanying this virus these approaches and standards are upheld.

This article was originally published in The Scotsman

Nasar Meer is professor of race, identity and citizenship at the University of Edinburgh. He is the principal investigator of the research project: the Governance and Local Integration of Migrants and Europe’s Refugees (Glimer)

What do abortion pills mean in a pandemic, asks Leah Eades

Like many doctoral students, my research is currently in limbo. I was meant to be moving to Ireland in September to conduct anthropological research on the politics of abortion — but now, I’m waiting to see whether that will be possible. In the meantime, I do the only thing I can: sit in my Edinburgh flat and watch my social media newsfeed fill up with stories of how COVID-19 is impacting reproductive rights and healthcare across the world.

Often, the news is not good.¹

Researchers, campaigners, and journalists alike have been
quick to note that the pandemic is having a devastating effect on abortion. In some places, COVID-19 has given anti-abortion politicians a thinly veiled excuse to further restrict access to legal abortion – take, for example, Poland, whose government attempted to push through an abortion ban while protestors were on lockdown, or the conservative US states that rushed to categorise abortion as a non-essential “elective” medical procedure, rendering it inaccessible for the duration of the crisis. In other places, such as Gibraltar and Argentina, progress towards legalising abortion has also ground to a halt, with referendums postponed and parliaments closed for the foreseeable future.

That said, even in countries where abortion is legal, the pandemic has shone a light on shortcomings in current abortion law and provision – and particularly the perils of assuming that abortion rights necessarily translate into abortion access. The UK is a good case in point. In England, Scotland, and Wales, legal restrictions have now (after some kerfuffle) been temporarily lifted in order to permit telemedicine abortion, allowing people to receive abortion pills in the post following a telephone consultation. In Northern Ireland, however, abortion only became legal on 31st March. The government, citing the pressures of the pandemic, refused to launch domestic services on that day as initially planned, and instead advised abortion-seekers to travel to England for procedures, in spite of the nationwide lockdown. In response to this inaction, both Alliance for Choice and the British Pregnancy Advisory Service (BPAS) publicly announced plans to provide abortion pills to residents of Northern Ireland – a move that finally prompted the government to change its position and begin allowing abortion on 9th April. Even now, telemedicine abortion remains unavailable in Northern Ireland, unlike in the rest of the UK.

I highlight the UK case as a means to exploring a question that is increasingly on my mind: what do abortion pills mean
in a pandemic? In recent years, abortion pills have come to mean a lot of different things to a lot of different people. Often, they’re framed as having revolutionary potential – one that can “change everything” in terms of how abortion is conceptualised, accessed, and provided (Berer and Hoggart 2018), and can be linked to wider processes of demedicalisation and decriminalisation (Jelinska and Yanow 2018). Moreover, the rising availability of abortion pills has significantly changed the political geography of abortion – increasingly, as Sydney Calkin (2018) notes, access is determined not by state-imposed legislation and regulations but rather by fluid, dynamic, and transnational technology and information infrastructures. The COVID-19 pandemic represents, perhaps for the first time, a major reconfiguration of these infrastructures – and one that has profound implications. With borders shutting and supply chains disrupted, the revolutionary potential of abortion pills, now more than ever, is being put to the test. So: how are they faring?

As the UK case above highlights, the possibilities of abortion pills during a pandemic are significant. Through telemedicine abortion, patients are able to access safe, legal abortion without leaving lockdown and exposing themselves and health workers to unnecessary risk. In Northern Ireland, meanwhile, the informal supply of abortion pills provided people with an alternative to abortion travel at a time when such travel was, at best, inadvisable, and at worst, impossible. Moreover, pro-choice groups such as Alliance for Choice and BPAS were able to effectively use the threat of circumventing state restrictions by supplying pills as a means of forcing the government to act.

However, it is important to note that abortion pills are not a panacea – alone, they cannot ensure that abortion is always accessible when it is needed, during a pandemic or otherwise. Firstly, it’s vital to note that medication abortion is not suitable for everyone – there will always be patients who need
surgical options, for example those at a more advanced stage of pregnancy or those with pre-existing health conditions or other complications. Secondly, even for those who can have medication abortions, access continues to be shaped by infrastructures that determine who can access abortion pills, as well as where and how. The pandemic has already led to concerns about disruptions to the medication supply chain. In addition, the suspension of international mail in places such as Poland means that abortion pills can no longer be reliably imported, leaving abortion-seekers with even more limited options and in even greater uncertainty.

Finally, even in contexts where abortion pills are available, it’s important to note that, for many patients, they now exist in a context where patients have few other options – it has been reported that 25% of UK clinics are currently closed due to staff shortages, while travel disruptions and restrictions are impacting people’s ability to travel for appointments both domestically and transnationally. As Cassandra Yuill (2020) has pertinently pointed out, rights to choice in reproductive and sexual health care are “evaporating in the name of public health” – and, in so doing, revealing the ideological illusions and power imbalances that underlie many contemporary healthcare systems.

Taken together, these pandemic conditions only serve to highlight the fact that abortion pills are not, and have never been, a silver bullet solution to the issue of abortion access. Certainly, the availability of telemedicine abortion, whether through formal or informal channels, provides important opportunities for safeguarding and promoting abortion access in times of crisis. Nonetheless, times of crisis also reveal the shortcomings and limitations of these pills, which remain entangled within the wider medico-legal nexus, and shaped by infrastructures that depend on global production supply chains and technology and information systems.
While the long-term implications of the pandemic on reproductive health and rights remains to be seen, the current role of abortion pills in attempts to navigate the pandemic highlight that no one technology has the power to “change everything”. If we want to ensure abortion is accessible for those who need it, then we have to address the broader political, cultural, socioeconomic, and structural factors that shape the contexts that these technologies exist within.

Leah Eades is a PhD candidate in Social Anthropology at the University of Edinburgh. Her research looks at abortion and the politics of reproduction in Ireland following the repeal of the 8th Amendment. You can follow her on Twitter at @AnthropoLeah.

References


For up-to-date news about the impact of COVID-19 on reproductive health and rights, I recommend consulting the Centre for Reproduction Research’s COVID-19 and Reproduction Digest as well as the International Campaign for Women’s Right to Safe Abortion’s news archive.

Edinburgh based anthropologist and artist auctions her painting to raise funds for the NHS, writes Aphaluck Bhatiasevi

Inês-Hermione Mulford is a resident artist at the Royal College of Surgeons. She graduated form the University of Edinburgh in Social Anthropology in 2018. She combines the disciplines of the arts and sciences through anthropological research and uses the medium of paint to present her findings. She wanted to do something to help raise funds for National Health Services (NHS). Her mother is a midwife based in Oxford, while she lives in Edinburgh.

“We are in a health crisis and are told to stay home to help prevent the spread of COVID-19, and to protect our NHS. My sister Felicity and I wanted to do something, but during these times, we can’t go on long distance runs or organize a social activity to raise funds. We’ve been discussing over Facetime as she’s in Oxford,” said Ms Mulford. They decided to develop
a website where they could auction one of her oil paintings to help raise funds.

She has relocated her studio to her flat and developed her website during the lockdown. The oil painting she chose to put out for auction was recently created as part of her surgical art series from her flat during the COVID-19 pandemic. It displays the white gowns and hands of a surgeon and a nurse performing a surgery. She has named this painting “PPE” (personal protective equipment). The auction will be closed at 5pm on Friday the 8th of May 2020. The funds from the auction will be managed by the NHS Trust, with the contributions going to NHS Edinburgh and NHS Oxford.

To create the paintings, in normal times, she captures images of surgery in real time, while performing the surgery, through sketches and photographs. She then follows-up with discussions with surgeons and nurses. When she gets back to her studio, she reviews these materials, and then begins to work on her painting. “I try to reflect on the complexity of the surgical artform, both in the theatre and on canvas,” said Mulford.

Ms Mulford is currently working on a set of paintings on robotic surgery where she explores relationships between the surgeon, the robot and the painting. This piece of work is part of ‘The Body Voyager’ exhibition which will feature work on the future of surgery. It was scheduled to be on display at the Surgeon’s Hall Museum in October 2020, but due to the pandemic, the exhibition has been postponed to March 2021.

Aphaluck Bhatiasevi is a PhD candidate in Social Anthropology at the University of Edinburgh
In April 2020, National Health Service (NHS) England and Public Health England launched an inquiry into the disproportionate impact of COVID-19 on Black Asian and Minority Ethnic (BAME) communities. As we wait for the terms of reference to be announced, and with mounting disquiet over the lack of transparency and appropriateness of its membership, it is imperative that policy-makers, public agencies and researchers maintain a broad focus on the underlying determinants of susceptibility to the virus and not allow the physiological risks to be separated from their social exposures.

In our recent submission of evidence on COVID-19 and the disproportionate infection and mortality rates for BAME groups, we set out why the UK government response, including its emergency legislation in the Coronavirus Act 2020, overlooks the inequalities broadly experienced by ethnic minorities.

As of 24 April, data from the Intensive Care National Audit and Research Centre indicate that people from Mixed, Asian,
Black and Other ethnic groups make up a third of patients critically ill with confirmed COVID-19, whilst only constituting 14% of the general population in England and Wales. Meanwhile, the Racial Equality Foundation calculated – from data up to 21 April – that the risk of dying in hospital from COVID-19 was twice as high for people of Mixed ethnicity, nearly three times as high for British Asians, and four times as high for Black and Other ethnic groups compared with White British people.

This disproportionate burden of COVID-19 among ethnic minorities mirrors the picture emerging elsewhere, including the United States, Sweden and Spain.

Despite long-standing evidence that increased health risk in UK ethnic minorities reflects underlying inequalities in housing, employment and income, medical ‘experts’ continue to propose various biological (and even genetic) ‘explanations’ for this pattern. A recent piece in the British Medical Journal opined that “BAME individuals… lack knowledge on the importance of a balanced and healthy diet containing all essential micronutrients that are required to boost immunity and prevent infectious diseases”.

This ignores the overwhelming weight of evidence that ethnic inequalities in health are driven by social, economic and political divisions, and reinforces harmful (and flawed) conceptions of cultural essentialism which deflect responsibility onto the victims of structural discrimination (Williams and Mohammed, 2013).

It is true that the disproportionate burden of COVID-19 among BAME undoubtedly reflects greater levels of pre-existing chronic health conditions in these groups. Yet these higher levels of chronic illness are themselves the product of socioeconomic disadvantage and other manifestations of racial discrimination (Phelan and Link 2015).
From the post-war to the present, both institutional and personally-mediated racism have channelled new migrants into the lowest rungs of the UK’s segmented labour market (Meer, 2020). As in most countries, institutional racism in the UK ‘unwittingly’ allows White people to gain more from the education system, the labour market, and the health system (Hill 2015), while also affording marginal attention to the racial dimensions of policy responses in health and other sectors (Salway, 2020).

It is for these reasons that COVID-19 and the UK Government response have the potential to amplify existing socio-economic disparities and racial discrimination that undergird ethnic health inequalities. The same factors that predispose people from ethnic minorities to live and work in circumstances that engender chronic ill health are those that will make it harder for these same people to protect themselves from COVID-19 by social distancing.

**Ethnic minority households** are more likely to be overcrowded and multi-generational, minority groups are grossly overrepresented in institutional settings where social distancing is ineffective and impracticable, and they are more likely to be in keyworker occupations where they are compelled to continue at work.

Worryingly, we anticipate extremely disproportionate economic impacts from the lockdown that will compound these social inequalities even further. As noted above, ethnic minorities have been incorporated into the UK’s segmented labour market in ways that direct them predominantly towards sectors offering few job protections, including a lack of provision for sick leave and sick pay (Qureshi et al., 2014).

It is deplorable – but sadly unsurprising – that The Independent’s BMG poll found people from BAME households are almost twice as likely as White British people to have lost income and jobs.
As such, the terms of reference for the inquiry must not be narrowly focused, but reach beyond these peak months into the long-term and disproportionate impact of COVID-19 on BAME groups. We urge NHS England and Public Health England to focus on the social determinants of health, and demand action on long-standing inequalities. In order to secure sustained public health preparedness, the UK needs a long-term commitment to improving social protection and social equity for all our communities.

This post is reproduced from Discovery Society

References

Nasar Meer is Professor of Race, Identity and Citizenship at the University of Edinburgh and a Commissioner on the Post-COVID-19 Futures Commission convened by the Royal Society of Edinburgh (RSE). @NasarMeer Kaveri Qureshi is a Lecturer in Global Health Equity in the School of Social and Political
Edinburgh based sociologists document their social transformation by the COVID-19 pandemic to create new sociological knowledge, writes Aphaluck Bhatiasevi

As sociologists voice out on how the COVID-19 lockdown is impacting societies across the world by transforming the social relations and interactions, a group of sociologists at the University of Edinburgh have come together to curate a blog to document and share personal experiences on how the pandemic has transformed them socially. The objective of this virtual diary in the form of a blog, is to share experiences as a collective, and to generate new knowledge on social transformation.

I recently interviewed Prof Liz Stanley and Dr Angus Bancroft, curators of the blog Edinburgh Decameron: Lockdown Sociology
at Work. They told me about how the blog emerged from conversations they had with other members of the Sociology Department through Skype, Zoom and Teams meetings under the lockdown. Dr Bancroft is interested in maintaining the sociological community and documenting the social change which may influence the creation of new knowledge, while Prof Stanley is interested in ideas of storytelling, from the “Decameron” perspective where different people who may be in similar situations, tell different stories because of their different experiences. Both the experts wanted their blog to get away from the usual scientific discussions they have in the academia, to reflect on the COVID-19 times as sociologists and as human beings, which includes being able to express anger and upsetness with the situation.

Concerning some of the contradictory things happening, Prof Stanley spoke about one of these being the tussle between rationality and emotionality that many people, herself included, are presently experiencing. Although not a sentimental person, she commented on finding that things like the Thursday clap for care staff and reports of hundred-year birthdays touched an emotional nerve because linked to the shared sorrow or trauma of so many deaths occurring.

Dr Bancroft says the lockdown has changed their lives as academics. “How we do scholarship and teaching will be very different. Whether our students will be based in Edinburgh or not in the coming year, we don’t know.” Inspired by renowned British sociologist Sir Patrick Geddes’ observational techniques to discover and work with relationships among place, work and folk, Dr Bancroft says this form of documentation of experiences may lead to new knowledge and theories in sociology. For instance, Edinburgh as a place which houses the University is important to the discovery of how education may be transformed by COVID-19. The notion of how time is perceived and during the lockdown is very different for different people, says Prof Stanely. While some
people say they have a lot of free time at hand, others may feel their time has passed by quickly without being able to do what they had planned to.

As a collective, they want to document the different stories told by sociologists living in a real pandemic, a transformation from the imagination, only a month ago. These stories, told in forms of structured narratives through written texts, poems, images and voice or video recordings, carry momentum that moves forward accounts. Interpretations of these viewpoints in future dates will provide evidence and arguments, analysis and conclusions to inform development of social theory.

The blog is open to the university’s staff, students and alumni, to share their experiences from different parts of the world.

Prof Liz Stanley is a professor of Sociology in the School of Social and Political Science at the University of Edinburgh.

Dr Angus Bancroft is a senior lecturer of Sociology in the School of Social and Political Science at the University of Edinburgh.

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Edinburgh Infectious Diseases
COVID-19 is affecting the great majority of people on the planet in one way or another and information (fact and fiction) relating to the pandemic is circulating via social media streams at an astonishing rate.

Providing factual, accessible, and unbiased interpretations of insights emerging from COVID-19 research is critical. To help contribute to this Edinburgh Infectious Diseases published summaries of the talks at the Edinburgh Coronavirus Workshop at the end of March.

However, as with so much of the information that is available about COVID-19, these summaries are in English.

Engaging locally and globally

To make this information much more accessible for people whose first language is not English, the Edinburgh Infectious Diseases community came together to translate these summaries into twenty one different languages from around the world.

Over 50 students, postdocs and group leaders have generously contributed their scientific and linguistic knowledge to the project, which has now published translations in Arabic, Bosnian, Chinese, Croatian, Czech, Dutch, Esperanto, French, German, Hindi, Italian, Malay, Nepali, Polish, Portuguese, Romanian, Russian and Spanish, Telugu, Thai and Turkish.

“I’m delighted that so many members of our international community in Edinburgh have contributed to this initiative
allowing access for non-English speakers from around the world to learn about the cutting edge COVID-19 science being carried out in Edinburgh that is being used to inform clinical treatment and public health measures,” said Professor Ross Fitzgerald, Director of Edinburgh Infectious Diseases.

Particular thanks are due to Nat Ring at the Roslin Institute and Julie Fyffe in the School of Biological Studies, who collated and compiled the translated texts, he added.

It has been wonderful to see how many people from across Edinburgh Infectious Diseases and beyond have come together to make this project possible, and highlights the truly global diversity of our staff and students.

For the translated summaries of the talk from SARS-CoV2/COVID-19 workshop please visit Edinburgh Infectious Diseases website.

Hilary Snaith is the Manager of Edinburgh Infectious Diseases, University of Edinburgh.