Care home study maps lockdown impact on families, says George Palattiyil

A new study is to gauge how lockdown restrictions have affected the families of care home residents.

Edinburgh researchers and their collaborators will assess the psychological impact – and the wider social repercussions – of distancing and other COVID-19 related constraints. The team, led by the University of Edinburgh's School of Social and Political Science, will also evaluate how physical-distancing restrictions on families have influenced the quality of care. The study will explore the creative methods used to encourage positive interaction between care home residents and their loved ones. Its findings will inform future policy and practice.

Significant effect

Restrictions such as social distancing and reduced personal contact have had a significant effect on people living in care homes. Since lockdown, residents' family members and non-essential visitors have been unable to enter care home premises. Lead researcher Dr George Palattiyil, Senior Lecturer of Social Work, said ongoing involvement is a key concern for families once a relative has been admitted to a care home. Lockdown, he added, has the potential to compound any fears and anxieties, and possibly amplify the psychological impact of having a family member in care. "An understanding of how to support the health and wellbeing of family caregivers and loved ones supporting older people is significant given the impact the pandemic is having, " says Dr Palattiyil.

Working together

Researchers will work with care homes across Scotland to recruit around 50 family carers whose relatives are residents. They will be interviewed and asked to fill out an online survey. Staff in care homes will also be invited to share innovative ways they have managed to communicate with relatives. The project involves the University's Usher Institute, the University of the West of Scotland, the University of Strathclyde and the Institute for Research & Innovation in Social Services. It has been awarded £150,000 by the Chief Scientist Office. Researchers will engage with Scottish Government policy teams throughout the project. "What we learn about the creative methods used to encourage positive interaction between residents and their loved ones can make a vital contribution to care in the long term," says Dr Dina Sidhva, Co-Investigator, University of the West of Scotland.

Dr George Palattiyil is a senior lecturer in the School of Social and Political Science at the University of Edinburgh.

A citizen science approach for supporting vulnerable populations during COVID-19 crisis, by Jessica Hafetz Mirman

There is an abundance of COVID-19 research and engagement activities happening across the Arts, Humanities and Social Sciences at the University of Edinburgh and our project team

is delighted to be part of such a dynamic group!

The overall aims of our project, based in the School of Health and Social Science, are to conduct a data-driven needs assessment utilizing citizen-science methods with people and families living in or near poverty in communities in Edinburgh. The data from the needs assessment will be used as inputs into a community organizing initiative conducted in collaboration with Faith in Community to (1) raise awareness of citizens' specific needs, (2) identify available resources and assets to meet these needs, and (3) connect citizens with the resources and assets that they need. Citizens will have an active role throughout this process as key producers and consumers of the data.

We are taking an asset- and resilience-based approach to this project, which means that we seek not to only characterize communities based on "deficits" but also to identify strengths, assets, and champions of positive change. For example, we are:

- measuring individual-level "grit" to determine how grit may be related to mental health, well-being and adaptive behaviours,
- using the selective optimization and compensation (SOC) model to understand how people of all ages and communities are strategically adapting to the crisis, and
- using the CoronaReport app (https://www.coronareport.eu/ to provide a tool for citizens to report on the impact of the virus on their lives by answering close-ended questions and completing an open text "diary". These reports can be updated as often as the citizens want, and are viewable using an interactive mapping tool, thus creating a living digital diary.

To accomplish these goals we are working with Faith in Community Scotland, a registered charity organisation that has

a vision to enable Scotland's poorest communities to flourish. They prioritise their work in communities with high levels of poverty, this includes across Edinburgh & South East Scotland. As such, they were a natural organization to collaborate with.

What makes this project unique is its grounding in Applied Developmental Science (ADS). *"ADS is scholarship that seeks to advance the integration of developmental research with actions, policies and programs that promote positive development and/or enhance the life chances of vulnerable children and families." (Lerner, Fisher & Weinberg, 2000).* I was fortunate enough to do my graduate training with the founders of Applied Developmental Science two decades ago at Fordham University and I couldn't be happier to continue to engage in ADS at The University of Edinburgh. The COVID-19 crisis is a cross-cutting public health problem with its impact reaching from neurons to neighborhoods and back again. ADS provides an established conceptual, theoretical, and practical framework to tackle the numerous challenges posed by Covid-19 and to promote a more civil society by engaging in rigorous scientific research in collaboration with community partners.

For more information about this project come find us on Twitter @Coronareportapp or send us an email at coronareportapp@ed.ac.uk. The ConronaReport App can be downloaded for free for use by citizens and scientists at https://www.coronareport.global/

The CoronaReport App was developed with seed funding from Rapid Response Impact Grant, College of Arts, Humanities and Social Sciences, University of Edinburgh.

The citizen science approach for supporting vulnerable populations during the COVID-19 crisis project, which leverages the CoronaReport App, is funded by the Data-Driven Initiative small grant program.

Dr. Jessica Hafetz Mirman is a lecturer in applied psychology and public health at the University of Edinburgh. She manages this project with Dr. Stephanie Adams

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Heat and COVID-19 in the off-grid city, by Nausheen Anwar, Sulfikar Amir, Jamie Cross, Daniel Friedrich, Aalok Khandekar, Marie Morelle, Elspeth Oppermann and Anindrya Nastiti

Amidst almost unstoppable contagion, many have hung their hopes on heat and humidity as a potential defence against contracting COVID-19. In the early months of the pandemic studies of SARS-CoV-2 suggested that the virus is transmitted less efficiently in higher temperatures or at higher rates of humidity, leading to encouraging newspaper headlines around the world, from London to Jakarta. 'Everybody hopes for seasonality,' one US epidemiologist told the New York Times in May 2020, even as comparative reviews of research concluded that summer temperatures might slow but would not halt the transmission of the coronavirus.

Against the backdrop of rising global temperatures, however, the relationship between heat and contagion demands closer scrutiny.

In much of the world heat and humidity are far from benign. Seasonal temperature highs – equated with either summertime, dry, or rainy seasons – continue to break annual records, in what are localised symptoms of global heating. The combination of this extreme heat with extreme humidity is becoming more widespread and more severe. Cities present unique heat-health risks. The combination of a high-density population and a heavily built environment, the extensive use of asphalt and concrete in construction, and the lack of green space create an urban heat island effect that can add as much as 12°C to average recorded temperatures (Dawson 2017; CIESIN 2013).

Rising temperatures in cities have led urban planners and policy makers to develop new frameworks for action on heat, with the aim of reducing the effects of heat-related illnesses (heat exhaustion, heat stroke) on public health and the economy. Yet the effects of extreme heat on cities is uneven. Modulated by both explicit and implicit politics, the particular patterning of urban growth, its relationship to topography and the building materials used, unequal financial flows, and patchy networks of transport, health, and utilities provision has created particular micro-geographies of heat-health risk. Exposure and vulnerability intersect with gender and socioeconomic difference, increasing the likelihood of negative impacts on low income or marginalised groups. In cities across the Global South these are the grounds for what – in other contexts – the medical anthropologist Alex Nading (2020) has called a thermal politics of life and death, or a 'thermal necropolitics.'

This year, heatwaves around the world will overlap with the spread of a novel coronavirus, and interventions intended to slow the pandemic will interact with interventions intended to reduce the risk of heat illness. Among those at the forefront of this nexus of heat and pandemic risk are those living in in high-density urban environments across the global tropics, from Southeast Asia to South Asia and sub-Saharan Africa; in

particular on those who find themselves confined to homes with poor thermal insulation and little ventilation, and with limited access to mains electricity, water, and cooling green-infrastructures.

As the pandemic evolves, there is mounting concern about the specific impacts on people living and working in these 'off grid' cities (e.g. SSHAP 2020). Scholars have begun to identify the COVID-19 pandemic as a uniquely urban crisis that brings to the forefront the politics of urban governance, spatial inequality and austerity in the South (e.g. Saleem and Anwar 2020; Lancione and Simone 2020a; 2020b). How do these politics intersect with rising temperatures? And how will the combined effects of heat and the COVID-19 pandemic response impact the urban poor?

Our new research project, 'Cool Infrastructures' – housed at the University of Edinburgh, with partners in Yaoundé (Cameroon), Karachi (Pakistan), Hyderabad (India), and Jakarta (Indonesia) – was conceptualized as a comparative attempt to understand how marginalised urban residents find ways to cool themselves and their homes when temperatures in their cities rise. In these cities heat disproportionately impacts the poorest residents, in particular those living in densely populated, low-income settlements. Here, levels of exposure to extreme heat intersects with vulnerabilities and capacities as a result of socially constructed norms, roles, attitudes, and gender relations, as well as with socioeconomic status and forms of labour, to produce highly specific risk profiles and risk management strategies

As we began to organize ourselves in the months leading up to the project's April 2020 start date, the novel coronavirus was also spreading rapidly across the globe. A pandemic was not something we had factored into our research and yet it had obvious implications for the project; empirically, methodologically, and conceptually. Our initial planning discussions quickly turned to thinking through collectively

what the temporal coincidence of heatwaves that were anticipated in the next few months in many of our field sites and the COVID-19 pandemic meant. In this essay, we present some preliminary reflections, hoping to elicit further feedback from the broader research community.

Biosecurity meets Climate Security

Little is yet known about how exactly the dynamics of heat and humidity interact with measures to slow infection rates of SARS-CoV-2. But we do know that people living in high-density, income-poor neighbourhoods will be highly exposed and vulnerable to both threats and their compound effects. For those people whose livelihoods depend on movement, social contracts, and the street, a heat season with COVID-19 presents a high-risk trifecta of vulnerability, exposure, and hazard.

One way of understanding and analysing the relationship between heat and contagion is to examine the different kinds of governance interventions they generate. The responses of governments and nongovernmental organisations to the outbreak of an infectious disease on the one hand and the ongoing impact of rising global temperatures on the other reflect different modalities of attempts to govern, care for and secure the health and safety of human populations. ‘Biosecurity interventions’ (Lakoff and Collier 2008) coalesce around threats to human populations from harmful biological agents. Climate security interventions (Dalby 2013, 2014; MacDonald 2013; Oels et al 2014) coalesce around threats from extreme weather events and rapid environmental or ecological change. Both biosecurity and climate security interventions are accompanied by considerable debate about what these threats look like, how they can be known or understood, what the best kind of intervention is, and who is responsible for it amongst scientific communities, policy makers and politicians.

Today, efforts to secure the health of populations from the COVID-19 pandemic, extreme weather, and climate change are shaping different kinds of intervention, across fields as diverse as public health, humanitarian aid, and urban design. When these interventions overlap, they involve trade-offs across arenas and scales of governance. These are not only negotiations about knowledge. They are also inherently political processes with decisions shaped by specific kinds of valuation and judgement. Consequently, particular populations and concerns become visible while others are rendered invisible. One inevitable outcome of this is that some types of risk are deemed more dangerous or important than others; the other is that the health of some groups of people are likely to take precedence over the health of others.

Repeatedly, we find biosecurity interventions working against or counteracting climate security interventions. We can see this, most clearly, perhaps, in the relationship between COVID-19, traffic pollution, and urban air quality. Lockdown restrictions around the world created a widely observed drop in urban traffic and dramatic improvements in air quality. However, attempts to promote sustainable public transportation as a public good (by increasing the use of buses or metros) are now complicated by guidance on physical distancing, prompting fears of a post-lockdown rise in private transportation and pollution. These fears are borne out by recent reports of rising nitrogen dioxide levels in post-lockdown European cities. In a different context, tensions between biosecurity and climate security were also evident in struggles to secure the early release of prison populations across sub-Saharan Africa. In national debates, anxieties about the epidemiological threat that newly release prisoners presented to the general public were weighed against the risks of overheating and contagion that overcrowded and poorly ventilated jails presented to prisoners themselves. Such debates offer a powerful illustration of how trade-offs between biosecurity and climate security are, fundamentally,

decisions over life itself.

These contradictions play out particularly visibly in the response to COVID-19 and heatwaves in high-density, low-income urban settlements.

Poverty, Density, Heat

Attempts to understand the health needs and health-seeking behaviour of people living in high-density urban environments reveal data gaps, urban interdependencies, specific patterns of vulnerability, as well as forms of local organisation that are all significant in understanding the impacts of COVID-19 (Wilkinson 2020). In southern cities it is not density per se that makes urban populations particularly susceptible to the spread of the virus, but density coupled with insecurity. From Karachi and Hyderabad, to Jakarta and Yaoundé, high levels of residential density are coupled with specific patterns of urban poverty. These include high levels of income insecurity, a lack of social protections, and poorly serviced infrastructures for water, sanitation, and electricity – partly as a result of cuts in public spending that followed programmes of structural adjustment or austerity policies. Put simply, there is a significant difference between *prosperous* dense places, where people have the materials and means to self-isolate or work remotely, and *income-poor* dense places, where multifamily households are crammed into living spaces of between 20 and 80 square yards, and where physical proximity is inescapable.

In October 2019, one month before the first reported case of a novel Coronavirus, The Jakarta Post reported that temperatures of 36.5 degrees was driving hundreds of people per day to visit community health centres, complaining about hot weather and dehydration. Six months later people living in cities across the Global South were confronted the twin challenge of managing a pandemic and managing the heat. Consider what we already know about the incidence of extreme heat events. In

June 2015 temperatures in Karachi – where an estimated 12.4 million people (62 per cent of the city's population) live in informal settlements – rose to 44.8 Celsius with over 1000 deaths recorded in 10 days. At the heatwave's peak on June 20th, the heat index had reached 66 Celsius. Increased demand for energy led to prolonged power outages, and the temperature placed further pressure on already limited public water supplies. The effects were particularly pronounced in high density areas where narrow lanes or congested built environments curtailed wind circulation.

Measures to slow the pandemic have made enormous dents in the incomes of millions of low-income urban residents. The well-documented impact of India's national lockdown and a collapse of informal urban economies – offers a sharp illustration of the ways that the pandemic response (a risk mitigation strategy for the coronavirus) can amplify other risks, including food insecurity and heat illness, by exacerbating social and economic inequality.

Maintaining social distance – the dominant modality of slowing the spread of the COVID-19 infection – for those who remain in high-density urban environments is challenging. So too is reducing the temperature of a body gripped by fever in a poorly ventilated, overheating room. As temperatures rose over the past two months in South Asia, for example, many people – including the healthy, the sick, and their carers – have been confined to indoor environments; from homes and wards, to dormitories and prisons. Meanwhile, those classified as essential workers and those for whom work is a precarious but essential source of income have been compelled to keep labouring in the heat. As rates of infection increase, the risks of exposure to extreme heat amongst these urban residents will be coupled with new limits on their capacity to search for cooler communal or public places, and new limits on their ability to pay for essential, and heat-managing, goods and services, including electricity, water and food.

The combined effect of heat, COVID-19 pandemic response measures, income poverty, and population density on infection and death rates remains unclear. But what seem clear is that it is creating unprecedented challenges for public health institutions, local authorities, and national governments. To date, however, the policy responses to COVID-19 and to extreme heat have contradicted each other, creating paradoxes of governance and infrastructure (e.g. Howe et al 2017).

Paradoxical Pulls

Policy responses to COVID-19 hinge on limiting social contact or subjecting both the sick and the healthy to forms of confinement. By contrast, city level heat action plans (like those drawn up by urban authorities across South Asia) prior to the pandemic hinge on contrasting principles. The measures they introduce – from the addition of extra water facilities in high-risk areas to the provision of public cooling centres – actually increase social contact.

COVID-care and heat-care thus pull the vulnerable in opposite directions. One involves social distancing and degrees of isolation, the other largely necessitates forms of public gathering. Public water taps, for example, may still be cool spots in a heatwave but they will also now be hot spots of potential community transmission. Emergency cooling centres may be important for alleviating the risk of heat stress but they now risk exposing people to infection.

These paradoxes have temporal as well as spatial dimensions. The timescales for biosecurity interventions are different than those for climate security. The outbreak of COVID-19 is an acute condition. Contagion is measured in days: in the stability or decay rates of the novel coronavirus on different surfaces or aerosols, and its incubation period (e.g. van Doremalen et al 2020). The COVID-19 pandemic response, however, is set to have a chronic impact on global incomes and inequality, with the effects on the capacity of urban

populations to withstand changes in heat and humidity potentially worsening over the coming months and years.

How will these seemingly paradoxical forms of governance be resolved? If self-isolation and quarantine increase the risk of overheating, what other kinds of interventions may be required to ensure people can keep cool in a pandemic? Some responses are already emerging. The Global Heat-Health Information Network – an international, independent group of scientists, policy makers and planners established by the World Health Organisation and World Meteorological Organisation – directly addressing the contradictions in public health protocols around heat and COVID-19 by developing specific clarifications and recommendations, including for informal settlements. Meanwhile, in cities like Mumbai, architects and designers are working in collaboration with community based organisations to develop proposals for building amidst contagion and heat; integrating recommendations for social distance, cool air flow, and ventilation into new plans for low-income housing. But how will planners and local authorities manage these overlapping pressures? What kinds of other political and economic considerations will shape their implementation? And, as policy makers and practitioners refine their interventions, what kind of measures will be people be taking themselves?

Compounding Uncertainty

Just as heatwaves are a prominent source of risk in a changing climate, so is uncertainty. The issue is not just that extreme heat is bad or dangerous but that its effects are compounded by other unexpected or unanticipated events (Zscheischler et al 2018; Phillips et al 2020).

Extreme heat coupled with water scarcity or conversely unseasonal rain can exacerbate the effects. One way of understanding the risks facing people living in high-density, low-income urban settlements is to see them as

‘multidimensional’; simultaneously about health, the environment, technology, and infrastructure (e.g. SHAAP 2020). But the contours of risk are also shaped by specific urban histories, politics, economies, materialities, and practices. The compounding effects of heat and COVID-19 on cities in the Global South are second-order effects of processes of urban development, patterns of investment, construction, and employment. Understanding the compound effects of heat and COVID-19 in cities across the Global South demands an epidemiology that can account for both for the extreme uncertainty of the pandemic, as well as the inequalities, pervasive insecurities, and uncertainties of ‘late industrialism’ (Fortun 2014).

In seeking to reduce the magnifying effects of heat governance on health governance and vice versa, we need to find ways of bringing social science insights to bear on attempts to intervene in the lives of others. If, as Jaideep Gupte (2020) hopes, the coronavirus pandemic holds out the promise of ‘course correcting’ dominant approaches to urban planning and infrastructure, perhaps leading to interventions that are more people-centred, then we need to understand the compromises and trade-offs being made between biosecurity and climate security. We need to address, more urgently than ever, how people in low-income, high-density urban contexts manage heat, and navigate multiple and converging hazards in constrained and contradictory circumstances. Over the next three years we will be examining this question. *How* we do so in a pandemic is the next challenge, demanding innovations in research methodologies and practices.

This is a repost from Somatosphere.

“Cool Infrastructures” is a three year project funded by the UK’s Economic and Social Research Council through the Global Challenges Research Fund, a £1.5 billion UK Government scheme

to support cutting edge research and global impact towards the Sustainable Development Goals. This article was written by the following project investigators:

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Bangladesh’s information entrepreneurs rally against COVID-19, writes Julia Qermezi Huang

I recently joined a COVID-19-themed Zoom session with 25 women entrepreneurs living in rural parts of Bangladesh who are trained to provide information- and technology-based services to village residents.

The session and the eSheBee program of which the women are a part are led by experienced social entrepreneur, Mosharrof Hossain, a native of Bangladesh. Over the past several weeks, these women have participated in eLearning courses via their smart phones in order to become COVID-19 first responders. Their role will be to generate awareness about health practices and disseminate the government’s advice about mitigating the spread of COVID-19 virus. They will counter social-media misinformation that advocates treatments such as shaving one’s head and rubbing saline in one’s nose to protect against COVID-19.

The crisis they will respond to is not just – and not even primarily – a public-health crisis, but also a humanitarian one.

When the nation-wide lockdown in Bangladesh began on 26 March 2020, people were advised to remain off the streets. The concepts of sheltering in place and social distancing in Bangladesh, however, are tricky ones to put into practice.

Rural families often consist of a dozen members living together in a single dwelling and who span 3-4 generations. Families live each day on the income (or products) that their members have earned that day. Their loss of mobility means the loss of income, which means the inability to purchase food. According to recent reports, 14% of families now have no food at home, and over 70% have lost their source of livelihood. This situation is less a public-health crisis, Asif Saleh, Executive Director of BRAC tells us, than "a humanitarian crisis with a public health dimension."

Alongside relief efforts promised by the government's Disaster Management and Relief Ministry and coming from large-scale NGOs such as BRAC, Bangladesh's female entrepreneurs from programs such as eSheBee are also being mobilized.

These young women are trained to provide digital-technology-based services to marginalised villagers. Until the recent shutdown, most of their work covered a vast territory. In different villages during the course of a day, rural entrepreneurs measured blood pressure, checked blood-glucose levels, and provided pregnancy tests. They topped up mobile-phone airtime, arranged digital remittances, and helped migrant workers abroad to skype with their relatives in Bangladesh. They also helped people to access government poverty-alleviation schemes. Now, in addition to key health-related information, these women will deliver medicine, essential goods, and vital information to vulnerable families so people can remain safely at home.

In 2013-14, I conducted ethnographic research among women entrepreneurs in rural areas in northwestern Bangladesh. My book, *To Be an Entrepreneur*, documents their trials and

tribulations as they attempted to mobilize their social lives and social contacts in new and entreprenruial ways, while also harnessing market opportunities to support their families and extended kinship groups. These brave women struggled against social expectations that women should stay at home, faced stigma as they rode bicycles from village to village, and experienced anxiety when they could not convince fellow villagers to pay for the services they provided.

But these women also built a strong community of fellow entrepreneurs who faced similar challenges, experienced the pride of earning their own incomes for the first time, and began to dream of futures where their families could rely on them as much as they relied on their families.

While I attended the COVID-19 eLearning session for eSheBee women entrepreneurs, I witnessed good practice in online education (a skill with which all educators across the world are also experimenting). I saw the women's dedication to continuing to contribute to the health and wellness of their communities, even at a time when their livelihoods and opportunities for earning were temporarily closing down due to the mandates of the pandemic.

Crises such as these (and Bangladesh is certainly no stranger to them) often open windows for new kinds of actors to gain social recognition, and I hope that Bangladesh's rural women entrepreneurs are recognized for the care, service, and valor they will be contributing in the coming weeks and months.

This is a repost from Cornell University Press Authors' blog.

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Responding to COVID-19: The coming of age of regionalism in Asia, asks Monalisa Adhikari

A concerted global response has been largely absent in addressing the unprecedented crisis unleashed by Covid-19. The UN Security Council, an institution at the heart of global multilateral efforts, has been condemned for failing to even bring forth a resolution on Covid-19. Similarly, the World Health Organisation, the key technical body for global health governance, hamstrung by its parochial mandate and limited regulatory authority, has come under sharp criticism from the US and other governments for failing on disease surveillance and designing a coordinated response. Likewise, Western governments who have traditionally shown leadership on global responses to pandemics have been occupied trying to address the threat inside their national borders. With the global effort largely absent and the dire need for governments to coordinate response mechanisms, space has opened for regional organisations to lead and complement national responses. This begets the question if regional organisations can fill the vacuum. Or if regional organisations can bridge the gap and provide a middle ground between parochial national responses which have competed to sustain their own health and related supply chains, and failed global multilateral responses. Drawing on the systematic analysis of statements, press releases and timeline of meetings of regional bodies, namely Association of Southeast Asian Nations (ASEAN) and the South Asian Association for Regional Cooperation (SAARC) between February and May 2020, this blog explores the uneven and

varied regional responses in Asia. In doing so, it highlights the commitments made by these regional institutions to foster coordination and support between states, and their inability to translate such pledges into concrete action.

Responses by ASEAN and SAARC

In Southeast Asia, ASEAN states[1] which weathered the storm of SARS in the 2000s, have rallied together with a flurry of diplomatic initiatives to forge a more coordinated regional response. Analysis of the timeline of meetings of ASEAN representatives and the statements issued thereafter demonstrates commitments of coordination and support across multiple sectors in the region. Starting with the meeting of senior health officials of ASEAN member states, and their counterparts in ASEAN +3 countries (the People's Republic of China, Japan and Republic of Korea) in early February, ASEAN has held multiple meetings between Heads of States, Foreign Ministers, Defence Ministers, Ministers for Finance, Ministers for Agriculture and Forestry, and Ministers for Labour. The portfolios of the meetings outline that the pandemic has impelled commitments that are far beyond the immediate domain of managing the health crisis.

On immediate health-related concerns, statements by ASEAN leaders indicates commitments to information sharing on detection, control and interventions; coordinating cross border health response, including contact tracing and outbreak investigation; capacity building interventions on public health emergency, scientific research, preparedness and response; strengthening early warning system for pandemics and other epidemic diseases; and support to ensure the adequacy of essential medicines, vaccines and medical devices both within the member countries and the region. This has been supplemented by long-term institutional commitments, including setting up a reserve of essential medical supplies that enables rapid response to emergency needs, as well as the proposed establishment of the COVID-19 ASEAN Response Fund for

public health emergencies. But owing to the lasting impact the pandemic is likely to have across sectors in a region so dependent on trade and tourism, there have been a series of pledges on economic, agricultural, labour and tourism-related issues. These have included, collective action in responding to the economic challenges, including ensuring the resilience of supply chains; coordinating for preservation, transport and distribution technologies and infrastructure to reduce food insecurity; supporting the development and implementation of a post-COVID-19 Crisis Recovery Plan to build up ASEAN tourism capabilities; and addressing the impact of COVID-19 on labour and employment. Beyond the region, there have also been meetings with Japan, US, China and the EU, where issues of collaborations on the health sector have been highlighted.

The level of institutionalisation, economic cooperation and the relative success of ASEAN cannot be compared to the South Asian Association for Regional Cooperation (SAARC).[2] However, the COVID-19 crisis brought higher hopes for a revival of SAARC where short term collaboration on the pandemic was expected to steer long term institutional coordination. SAARC, which has been hostage to the bilateral tensions between India and Pakistan, has not been able to spur greater integration, and South Asia continues to be the least integrated region in the world.[3] In this context, the pandemic brought forth a promising sign of reinvigoration. On March 15, 2020, leaders of the member states of the SAARC held a video conference to discuss measures to contain the spread of COVID-19 in the region. Led by India, the meeting was attended by all the Heads of Government, with Pakistan being represented by the Health Minister. The meeting discussed resource pooling and setting up a COVID-19 fund, with contributions from member states, to be used by SAARC member states for urgent medical supplies and equipment. The meeting also pledged to use existing institutions like the SAARC Disaster Management Centre, to share best practices and facilitate information sharing by setting up an Integrated

Disease Surveillance Portal, as well as a common Research Platform to coordinate research on pandemic control. The meeting also called for establishing SAARC Pandemic Protocols to be applied on state borders. This call between leaders was followed by a video conference between Health Ministers of member states and another conference between senior trade officials of member states to deal with the impact of COVID-19 on intra-regional trade. Even before the fund and the call, India had taken a regional approach in terms of evacuating citizens from countries of the region, including, Bangladesh, Myanmar, Sri Lanka and Nepal. India also provided medical assistance to the Maldives, under a regional framework. However, the meetings brought in the rest of the member states together and broadened the participation, raising hopes for an institutional framework for health security in South Asia.

Shortcomings in the Regional Response

The dynamism and proposed response efforts by regional bodies like ASEAN and SAARC is noteworthy. However, these regional commitments at high-level meetings have barely matched up with actions on the ground, as member states continue prioritizing effective national solutions. Rather, the crisis has reinforced the existing fault lines of both these regional groupings in varied ways. Firstly, a coordinated regional response was difficult because of the varying levels of infection, specifics of national responses, and political will. In ASEAN, the responses by Singapore and Vietnam, which have been cited as a global success, were no match to lacklustre responses by other countries. For example, Indonesia's response was a lethal mixture of an initial denial, and downplaying the nature of the crisis, including a top leader arguing that prayers had prevented the virus from spreading in the country. While not as uneven as ASEAN countries, within SAARC countries, Sri Lanka's high testing rates, with a well-established healthcare and surveillance system fared much better compared to other South Asian

neighbours.

Secondly, the very nature of the pandemic has highlighted fundamental tensions. On the one hand, it has unleashed a greater recognition that non-traditional security threats like pandemics need an interdependent approach, that needs greater coordination and cooperation within countries in a region. However, on the other, the generic responses to the crisis focused on lockdowns and border restrictions, which undermine the very idea of greater regional integration. Here, lockdowns and border closures have made migrant workers, many of them hailing from other countries within the region, more vulnerable and neglected. Images of Burmese undocumented workers being deported from Malaysia, or tens of thousands of migrant workers from Laos and Myanmar, flocking to border crossings, defying the Bangkok lockdown to return home having been rendered jobless, challenges the commitment of ASEAN leaders to supporting citizens of each other's countries. The absence of social protections for the majority of the seven million undocumented migrant workers in and from ASEAN member states poses further risks to their health and access to health services. Similarly, within SAARC, Nepal and India share an open border, but they started their border shutdowns two days apart, on 22 and 24 March respectively, without any coordination. This left many migrants from Nepal in India stranded, having to navigate through Indian lockdown to reach Nepal, only to find the borders closed.

In both SAARC and ASEAN, the crisis has reinforced the existing challenge of navigating regional cohesion in the context of unequal power dynamics and tensions amongst states. A core problem for SAARC has been the dominance of India in the region, and the reluctance of other smaller South Asian nations to acknowledge dominance, who have instead seen SAARC as a mechanism to tame the Indian hegemony.[4] Accordingly, unlike ASEAN, regional endeavours have largely relied on India's ability and interest (or disinterest) to spearhead

greater partnerships. The absence of leadership from other South Asian states, and India leading the meetings in the aftermath of the pandemic further reinforces the India-centricity of the regional grouping. Relatedly, bilateral efforts led by India in the region have been more tangible than other pan-regional commitments. For instance, India has delivered critical medical supplies to Sri Lanka, Bhutan, and the Maldives; held bilateral discussions on the crisis with heads of states from Bangladesh, Afghanistan, and the Maldives; as well as put its neighbours on a priority list for supply of critical medicines like hydroxychloroquine. Further differences between India and Pakistan continue, notably with regards to the Covid-19 Emergency Fund pooled through the contributions of individual member states. Pakistan has underlined that contributions from individual member-states should be administered by the SAARC secretariat; whereas India has stated that it is for each member state to decide on the timing, manner and implementation of their Emergency Response Fund commitments.

Yet, another fault line reinforced by the crisis in both ASEAN and SAARC has been how the 'China factor' has been critical to the shaping of responses by these regional groupings. India's leading role in South Asia during this crisis is seen to be derived out of concerns of being outbid by China, which has been offering medical teams and sending test kits and protective equipment to different South Asian countries. In ASEAN, where considerable divisions exist between individual Southeast Asian countries in their relationship with China, the crisis has made the divides more evident.[5] There was a visible geopolitical divide on how individual countries engaged with China during the crisis. While Singapore and Vietnam took a calibrated approach, imposing China travel bans, Cambodia maintained no travel restrictions with China, seeking to be on China's good books. This inhibited collective action on travel bans from China within the region, which was critical, given the extensive and relatively free movements of

people in Southeast Asia. Such developments underscore how China's engagement in these regional groupings is likely to be either *divisive*, inhibiting a pan-regional initiative or *integrative*, like in the case of SAARC- where China's greater engagement with the member states, has compelled competing regional actors like India, to take the baton of regional leadership more seriously.

Given these factors, while the pandemic has reinforced the need for greater coordination within countries in South and Southeast Asia, it has also underlined the fragility and gaps in these regional institutions for coordinating effective regional responses. While meetings with commitments for greater coordination are encouraging, the tests to these commitments are already showing cracks. This is not unexpected, given that much more institutionalised regional bodies like the European Union have struggled to sustain regional momentum. Further, despite the gaps, areas of optimism persist in Asia. In the more immediate term, greater recognition of pandemics as a global and regional security threat impacting health, human and economic security is likely to compel regional institutions to draw plans for greater coordination in the future. Regional bodies are likely to institutionalise cross-border information sharing mechanisms, establish reserves on medical supplies, share best practices and shore-up scientific capacity. Likewise, the economic impact of COVID-19 is likely to be long-term. The Asian Development Bank assesses the economic losses in Asia and the Pacific to range between $1.7 trillion to $2.5 trillion, with the region accounting for about 30% of the overall decline in global output.[6] As the world itself reels from the financial crisis, countries in Asia, will need to look inwards into their regions to address this deep economic impact, and stimulate growth through greater economic collaboration.

This is a repost from the Political Settlements Research Programme.

Monalisa Adhikari is a research assistant in PSRP. She sets out the response by regional organisations in South and Southeast Asia to the COVID-19 crisis and asks what this means for Asian regionalism. This piece is part of a larger project funded by the University of Edinburgh College of Arts, Humanities, and Social Science to map and analyse the responses of regional and sub-regional organisations to COVID-19 in Asia, Africa, and Latin America. A series of blog posts detailing organisational responses is the first output, and the project will feed into other collaborative projects. It will also produce in-depth pieces to answer the more complex questions around the impact of regional and sub-regional efforts to combat this pandemic and the possibly long-term effects of the COVID-19 crisis on organisational priorities and practices.

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[1] ASEAN formed in 1967 includes 10 member states in Southeast Asia, namely, Brunei Darussalam, Cambodia, Indonesia, Laos, Malaysia, Myanmar, Philippines, Singapore, Thailand, and Vietnam.

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Responses by African intergovernmental organisations to COVID-19, by Kathryn Nash

Throughout the COVID-19 crisis there has been concern about the particular vulnerabilities of the African continent in the face of a pandemic. The Africa Joint Continental Strategy lays out these challenges in stark terms arguing that Africa’s ‘baseline vulnerability’ is high due to inadequate health and hygiene systems, increasing travel, and other ongoing health and social crises.

Despite these underlying challenges and the continually evolving nature of the pandemic, the World Health Organisation (WHO) commended the continent on 25 May for being the ‘least-affected region globally’. There has not been uniformity in how African states have responded to the COVID-19 crisis.[1] As with any region, there are examples of effective and innovative responses along with failures in leadership. However, there has been a significant mobilisation to coordinate a response at the continental level along with more

limited responses from sub-regional organisations. This blog provides a very brief overview of the responses of African intergovernmental organisations (IGOs) to the COVID-19 crisis,[2] leading into a discussion on the impact of these responses and the division of labour amongst states, sub-regional, regional and international organisations in addressing cross-border challenges. When responding to challenges from public health threats to violent conflict, coordination across governance levels is complex, and the innovative strategies and mechanisms used to manage the COVID-19 pandemic may alter responses to future crisis.

African Continental Response

The response at the continental level is led by the African Union (AU) and African Centres for Disease Control and Prevention (Africa CDC). Africa CDC was established in January 2016 by the AU Assembly of Heads of State and Government and launched one year later. There are Africa CDC Regional Collaborating Centres (RCCs) across five sub-regions, but how active the RCCs are and the extent to which Africa CDC collaborates with previously established sub-regional health bodies varies significantly. The Africa Joint Continental Strategy was produced by the AU and Africa CDC and sets out the primary objectives of ensuring a coordinated response and promoting evidence-based practices to prevent, treat, and control COVID-19.

The Joint Continental Strategy calls for two bodies to implement it – the Africa Task Force for Coronavirus (AFTCOR) and Africa CDC's Incident Management System (IMS). AFTCOR's role is to support member states by working through and building upon existing structures, notably the five RCCs. AFTCOR is comprised of a steering committee chaired by the Director of Africa CDC and a number of working groups, and it focuses on six issues – surveillance, infection prevention and control, clinical support, laboratory diagnosis, communications, and medical supply procurement. Africa CDC's

IMS and its Emergency Operations Centre for COVID-19 were activated on 27 January 2020. The first confirmed case of COVID-19 in Africa was reported by Egypt on 14 February 2020. Since then Africa CDC has been tracking cases across Africa through the Africa CDC Dashboard and in weekly briefings that present information by member state and sub-region.

The response has been guided by the six focus areas identified in the Joint Continental Strategy. For example, on surveillance Africa CDC in collaboration with the WHO ran Training of Trainers events across member states to enhance surveillance for COVID-19 at points of entry. To support laboratory diagnosis, as of 17 March 2020, over 40 member states had been trained on laboratory confirmation of SARS-CoV-2, and all laboratories received start-up kits after training. Member states with confirmed cases at the time received additional kits. More recently, Africa CDC partnered with the MasterCard Foundation to deliver one million test kits and deploy 10,000 health workers across Africa to respond to the COVID-19 crisis. On communications, Africa CDC has produced materials for the general public and healthcare workers. There have also been innovative initiatives to combat disinformation and convey risk information. Africa CDC has held numerous virtual training events for policymakers, clinicians, journalists, and other interested parties. Africa CDC is working with partners to launch communication projects in African languages to counter misinformation, and Africa CDC is in direct contact with journalists through a WhatsApp media group.

The AU has spearheaded additional initiatives to support the continental response and address the wider ramifications of the COVID-19 crisis. For example, the AU COVID-19 Response Fund was launched on 26 March 2020. The fund supports the procurement of critical medical supplies that are then distributed by Africa CDC, and it will also be used to mitigate the socio-economic and humanitarian crises brought on

by the pandemic. The AU has used it continental convening power and relationships with other IGOs to advocate on other issues that the COVID-19 pandemic has exacerbated. The communique of the recent 928th meeting of the AU Political Security Council (PSC) highlighted protectionist policies that restrict the access of developing countries to crucial medical supplies and called on the WHO to help ensure access to need supplies. The AU has also pushed for debt relief to help African states devote the necessary resources to the fight against COVID-19 and its societal-wide impacts. In addition, the AU has marshalled parts of its peace and security architecture to respond to the pandemic. The Africa CDC and Operations Divisions of the AU Peace and Security Department deployed 28 responders to several member states through the AU Strategic Lift Capacity. This was done in line with Article 6 of the AU Peace and Security Protocol that lists one of the functions of the PSC as 'humanitarian action and disaster management'.

Sub-Regional Initiatives

The continental response led by the AU and Africa CDC is one piece of a very complex puzzle with other actors across governance levels from local to international marshalling responses to a crisis that transcends governance boundaries and physical borders. Beyond the Africa CDC RCCs, sub-regional organisations have also been active in responding to the COVID-19 pandemic. Sub-regional organisations encompass the AU-recognised regional economic communities (RECs) but can also include bodies that are not recognised by the AU. One of the most established bodies, the Economic Community of West African States (ECOWAS), is tracking cases in the West African region. The sub-regional health body is the West African Health Organisation (WAHO), which was created in July 1987.

In response to the COVID-19 crisis, ECOWAS and WAHO activated the West African communication platforms, distributed supplies

to member states, finalised a Regional Strategic Plan, and raised funds for the response effort. Beyond sub-region specific initiatives, West African institutions are also collaborating with Africa CDC, particularly on support for laboratories and medical supply chains. During a 23 April videoconference, the ECOWAS Authority of Heads of State and Government recommended strengthening collaboration between WAHO and Africa CDC. The Authority also recognised the profound economic impact of COVID-19 and recommended a number of initiatives, including issuing treasury bonds and bills, deploying financial tools through Central Banks, mobilising resources from the international community, and supporting AU work to negotiate debt cancellation and raise funds.

Other sub-regional bodies have responded to the COVID-19. For example, the Southern African Development Community (SADC) is also tracking COVID-19 cases in its region. SADC has issued bulletins throughout the crisis with information on the pandemic, its economic impact, and recommendations for member states. It also adopted guidelines on 6 April to facilitate cross-border transportation of essential goods while limiting non-essential mass movements. Also in early April, the UN negotiated a humanitarian corridorin southern Africa to facilitate the distribution of food aid to countries in the region facing food shortages. This underscores the complexity of cross-border movement and the multiple organisations involved in facilitating access for essential supplies and goods. On 29 May, SADC's Council of Ministers called for increasing coordination with other regional and sub-regional bodies, specifically the AU, the Common Market for Eastern and Southern Africa (COMESA), and the East African Community (EAC), to harmonise measures and regulations. Some other sub-regional organisations have struggled to respond to both COVID-19 and other ongoing challenges, such as violent conflict. The Economic Community of Central African States (ECCAS) held a high-level meeting in early June and adopted a regional strategy to respond to the COVID-19 crisis and its

impacts. However, ECCAS in the midst of institutional reforms, and Central Africa is grappling with multiple, persistent conflicts. The UN Regional Office for Central Africa (UNOCA) is continuing operations, and there is a newly created UNOCA-ECCAS working group to support the ECCAS response. These varied responses show coordinated efforts to address both the health and economic dimensions of the pandemic and institutional cooperation with continental and international organisations. However, the resources available for responses and levels of coordination are uneven.

Responding to Cross-Border Challenges

This brief overview of African IGO responses to the COVID-19 crisis, provides a baseline of understanding but leaves many unanswered questions. First, how impactful are the continental and sub-regional initiatives? To what extent do continental and sub-regional strategic plans, support, and recommendations matter in member state responses? The impact of these organisations is an open question with ongoing academic and policy debates about the extent to which IGOs can act as norm and policy entrepreneurs and help to shape regional ideas, policies, and practices that then influence policies and practices at the national level in member states.[3] The impact of IGO responses to the COVID-19 pandemic is an open question as events are still unfolding, but there are research projects underway that aim to address these larger questions. For example, the University of Edinburgh COVID-19 response governance mapping initiative aims to understand how COVID-19 response decisions were made in several African states and what factors influenced them, which may provide additional insights into the impact of IGOs on state-level decision making.

The second pressing question is how are issues that transcend borders dealt with by the plethora of IGOs? Africa is a particularly dense space when it comes to IGOs due to an active continental organisation with strong international

partnerships and several active sub-regional organisations. The division of labour amongst continental and sub-regional organisations in peace in security is an ongoing discussion in Africa within the AU, between the AU and RECs, and amongst the various RECs.[4] Furthermore, the practices around the division of labour in peace and security vary in different sub-regions and in different arenas, from peace support missions to engagement in peace processes.[5] As this piece has shown, there are also numerous IGOs at multiple governance levels responding to this health crisis. While COVID-19 is clearly a public health crisis, it is also a human security issue because of the loss of life and livelihoods and its potential to exacerbate ongoing inequalities and conflicts. The African continental public health and security mechanisms have worked together throughout this crisis. For instance, the AU has used African Peace and Security Architecture (APSA) mechanisms to respond to the pandemic. As such, it is likely that the response to the current pandemic will have far-reaching impacts not only on how African IGOs manage health crisis but other challenges that transcend borders. Moving forward this project will examine how the responses of African IGOs may impact future policy and practice. Will this lead to an expansion of how APSA is used? Will the strong response by continental organisations lead to an expansion of their role not only in Africa but globally as other international institutions are side-lined due to rivalries between powerful states? All of these questions will be critical to understanding the state of global governance as we continue to navigate this crisis and eventually move beyond it.

This is a repost from the Political Settlements Research Programme.

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About this Project

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Syria: local agreements, regional rivalry and a global pandemic, by Juline Beaujouan

and Eyas Ghreiz

As Syrian President Bashar al-Assad is moving towards his goal to recapture ‘every inch’ of the Syrian territory, Idlib governorate in northwestern Syria has been targeted by escalating military offensive from the regime, supported by Russia and Iranian-backed militias. In the last bastion of the rebel forces, an array of opposition factions, including jihadi group Tahrir al-Sham and the Free Syrian Army (FSA) are holding on their positions, backed by Turkish military forces. But the pursuit for full military victory has been (temporarily) halted in March 2020 when Russian President Vladimir Putin and his Turkish counterpart Recep Tayyip Erdogan struck the truce for Idlib province.

Since then, the outbreak of the COVID-19 pandemic coupled with the worsening economic crisis and public pressure have pushed al-Assad to engage in several local agreements with rebel groups in northern Syria. The core of these deals is to provide for the exchange of prisoners and the opening of trade routes between the ‘liberated’ zones and the areas under the control of the Syrian regime. These agreements show how ongoing practice of local conflict management are shaped by power competition at the (inter)national level. In Syria, a wider survey of local agreements reveals that they often work, less as constructive peace initiatives and more as tactical tools to grant at least one of the signing parties a strategic advantage on the battlefield.

Three secret agreements and the release of 18 prisoners

In March and April 2020, the Syrian regime brokered three top-secret agreements with rebel groups to exchange a total of 18 prisoners. The first exchange took place around the city of Darat Azaa, in the western countryside of Aleppo, on 16 May

2020. Tahrir al-Sham – who aims to establish an Islamic Caliphate inside the Syrian borders – released a Colonel and a soldier of the Syrian regime forces in exchange for three fighters.

Two days later, around the town of Tal Hiyah, three soldiers of the Legion of the Levant, a faction of the National Liberation Front, were traded for a fighter and a female intelligence officer of the Syrian regime, in addition to two bodies of Shi'a fighters (including a Lebanese one).

Given the COVID-19 pandemic, the three exchanges were subjected to particular hygiene guarantees

On 22 May, Haradh al-Mu'minin operation room – a jihadi coalition affiliated to al-Qaeda – released three "militia members" against two women and their children. One of the women was the wife of a leader of Tahrir al-Sham and had been captured two years before. She reportedly divorced her husband upon her return and left the jihadi group.

Given the COVID-19 pandemic, the three exchanges were subjected to particular hygiene guarantees. The opposition factions were reportedly anxious about the potential infection of the prisoners released by the Syrian regime. According to private sources, they had stipulated in the negotiations that they would cancel the exchange if any prisoners had been injured or if their health was not carefully checked beforehand.

The Head of the Free Doctor Union in Idlib told the authors that the prisoners released by the Syrian regime – of whom some were kept in Sednaya and Adra prisons in the north of Damascus and other intelligence military branches – were evacuated to an area under the Directorate of Health around

Ma’ara to be sterilized and quarantined for two weeks. Once their health condition was checked, they were then allowed to go back to their families.

As it is often the case in Syria, the three exchanges were logistically supported by the Syrian Arab Red Crescent. Several activists interviewed in Idlib governorate pointed to the ambiguous status of this humanitarian organization. The latter is the (only) official government partner through which all UN and international agencies must work in Syria. Formally affiliated with the ICRC, it is perceived to be affiliated with the Syrian regime and under the tight control of the air force intelligence.

Local agreements to ensure key internal and external support

These kinds of local deals are interesting because they serve a number of purposes for the Syrian president. Most importantly, Bashar al-Assad is under pressure from his ally Iran. The latter systematically insists to recover the bodies of soldiers who died on the battleground. Those soldiers belong to Iranian-backed militias and Hezbollah-affiliated groups. They are Iranian, Iraqi or Lebanese and at the centre of a propaganda strategy framed around their martyrdom and the sacrifices of the Shi’a Muslims to free the Syrian land from (Sunni) terrorism.

> ***Prisoner exchanges offer a means for the Syrian President to show his benevolence to the Syrian people***

Internal support, however, is also important to al-Assad’s power within Syria, and prisoner exchanges offer a means for the Syrian President to show his benevolence to the Syrian

people. While the deals are always top-secret, the Syrian regime depicts the practice as the exchange between heroic 'Arab sons' of the Syrian people against valueless "terrorists". In practice, the exchanges are also opportunities to retrieve precious intelligence about the other side.

Most surprisingly, the Syrian regime has been increasingly involved in local deals with jihadi groups in Idlib governorate. For instance, in February 2020, it agreed on the opening of a crossing for the exchange of goods with Tahrir al-Sham around Saraqib. These kinds of deals are likely to reinforce the role and legitimacy of Tahrir al-Sham inside the rebel-held areas. At the same time, the jihadi group remains one of the strongest opponents to the Syrian regime both ideologically and militarily.

The apparent rapprochement between the Syrian regime and the jihadi insurgents is less surprising when one considers the Syrian president's strategy to portray the conflict as the struggle of the (legitimate) regime against terrorism. In the end, this binary vision of the conflict makes al-Assad the lesser evil and would grant him the support of the international community to launch a wide-scale offensive in northwestern Syria.

Between 2011 and 2017, several observers detected clear signs of cooperation between al-Assad and jihadi factions

In the early days of the Syrian revolution, al-Assad had already given the order to release hundreds of Islamist militants from Sednaya prison. Between 2011 and 2017, several observers detected clear signs of cooperation between al-Assad and jihadi factions. On the one hand, it was believed that Syrian government forces did not engage in a military

confrontation with jihadi groups when they had the opportunity to do so. Instead, regime forces focused their military operations against the moderate elements of the opposition. On the other hand, the Syrian government has been accused of engaging in energy dealswith insurgent groups, purchasing oil and gas from territories controlled by the Islamic State (IS) organisation and Jabhat al-Nusra.

The spreading shadow of external powers

A dozen interviews conducted in Idlib with doctors, civil defence soldiers and human rights activists confirmed the upper hand of Russia and Turkey on the military and political affairs in Syria. Even the most mundane local agreements such as the exchange of a few prisoners are approved, mediated and sometimes supervised by the two powerful players. While external influence poses the question of the agency of the Syrian regime and opposition armed groups, it also jeopardizes the role of the civil society and more broadly representatives of the Syrian population in the management of the conflict.

In the words of a high-ranked officer who took part in several high-level negotiations in Syria, “When a Russian [military man] is in the room, nobody dares to open his mouth. The Russians are in control of everything in the regime-held areas and everyone listens to them”. Besides, it seems that the Russian military was able to gain the relative trust of all warring groups in Syria, including in the camp of the rebels. As the anonymous officer testified: “We know that the words of the Russians are always followed by actions, whether we like it or not”.

As COVID-19 hit Iran and Russia severely, the former is also struggling with international sanctions and a failing economy. As a result, experts expect the Islamic Republic of Iran to have a hard time recovering on the political and economic front, thereby pushing for a retreat from the Syrian battlefield but also the expensive support to several militias

across the Middle East.

Assad's reshuffling "gives Russia the upper hand to the detriment of Iran"

Last year already, accounts of the competition in the highest spheres of the Syrian regime was lending weight to Russian influence. On 8 July 2019, Bashar al-Assad announced numerous changes in the top security personnel – the most important restructuring since the 2012 bombing of the National Security headquarters in Damascus. While Russia attempted to dilute the importance of the Syrian reorganization, it was seen as the main beneficiary of the reform. The decision granted key roles to pro-Russian figures in the Syrian intelligence and security apparatus. It was interpreted as a sign of external growing influence and more precisely as "part of a larger rivalry between Russia and Iranover the control of Syria's military and security agencies and thus part of the framework of a geopolitical competition". According to former Lebanese General Elias Hanna, Assad's reshuffling "gives Russia the upper hand to the detriment of Iran". A similar analysis was offered by the Saudi Independent Arabia in a paper untitled "Will Russia overthrow Iran's influence in the Syrian security services".

In Syria, a negotiated peace is all but impossible. With the support of Russia and Iran, Bashar al-Assad is progressively retaking control of the territory. Yet, the destruction of the trust and social fabric in the country ravaged by almost a decade of atrocious conflict might well be the greatest challenge for whoever wins the final battle, and will require civic engagement.

This is a repost from the Political Settlements Research Programme.

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Scratching below the surface: what can local peace agreements tell us about

armed groups and conflict fragmentation, writes Juline Beaujouan, Tim Epple, Robert Wilson and Laura Wise

The call for an immediate global ceasefire launched by UN Secretary-General António Guterres on March 23, 2020, as a response to the COVID-19 pandemic, has been backed by some 70 states and answered by conflict parties in at least 9 countries around the world. In some of the most protracted contemporary conflicts, such as in Syria, Libya, and Yemen, the global call was briefly touted as a possible opportunity to re-energise stalled or struggling national peace talks. However, this optimism was short lived following sustained clashes in Idlib (Syria), escalated confrontations in Tripoli (Libya), and continued advances by Houthi rebels in Yemen.

Whilst the COVID-19 pandemic is the latest threat to already-struggling Track 1, national-level peace processes, locally-led attempts to mitigate or end violent conflict in contexts across MENA and sub-Saharan Africa remain ongoing, albeit under extremely difficult circumstances. The prevalence of local peace processes in the absence of sustained progress of national mediation efforts has led to more focussed attention on this phenomenon in recent years, and in this post we draw on a new collection of local peace agreements to reflect on the state of contemporary conflict management and peacemaking in an increasingly fragmented world.

The fragmentation of conflict management and peacemaking

A closer look at conflict and socio-political dynamics in MENA and sub-Saharan Africa reveals the multi-level fragmentation of conflict-affected countries: the geographical and identity

fragmentation where the state and society are divided in times of conflict and peace. The discord of those countries can be understood as where the state itself is not only fragmented but it is also only one fragment within a complex constellation of groupspositioned by geography and identity – groups who bargain for peace at the national and the local level. As such, both theatres – the national and the local – are sites of conflict and peace where groups' motivations, strategies and affiliations shift over time. The vacuum of power and legitimacy left by this fragmentation results in the multiplication of warring parties – often in the form of armed groups – which impose their rule over parts of the national territory.

These dynamics of localisation and fragmentation of conflicts echo a development that can be observed not only in Syria, Yemen and Libya in the MENA region, but also in the Central African Republic (CAR), Somalia and South Sudan in sub-Saharan Africa. We suggest that these conflicts could be better described as sets of complex conflict systems that are nested within the local, regional, national, and international levels. These dynamics are also mirrored in processes of conflict management and peacemaking, which sometimes respond to this complexity by brokering and signing agreements between locally-based and other actors within a part of the wider conflict-affected area. Researchers, peacebuilders and policymakers are increasingly interested as to whether locally brokered commitments could provide a necessary complement, if not an alternative approach, when national peace initiatives have stalled, to foster an all-encompassing and more inclusive peace.

Introducing the PA-X Local Peace Agreements Database

At the Political Settlements Research Programme (PSRP) we are investigating the fragmentation and localisation of conflict management and peacemaking through a collection of almost 300 local peace agreements. PA-X Local is the first open-access

database of publicly available written local peace agreements from across a global set of conflict-affected contexts. The agreements, which span from 1990 to 2019, were signed between locally-based and other actors to address local conflict-generating grievances only within a part of the wider conflict-affected area, rather than the entire conflict zone. PA-X Local offers a glimpse into the processes and outcomes of local peacemaking, including information on how it relates to any national peace process.

This collection of local peace agreements raises the potential for analysing patterns in local peacemaking over time and across varying contexts, as well as exploring any links between local, regional and national-level peace processes. It also helps us to better understand the practices of highly localised actors, their influence on wider conflict dynamics, and their interactions with actors more embedded in the national-level process whose wider conflict agendas ultimately shape conditions at the local level. PA-X Local exposes the diversity of local peace agreements, that are highly dependent on the local settings where the conflict takes place and is managed between local parties. This includes the emphasis on categories of substantive issues addressed by local agreements: use of rituals and prayer; acknowledgement of grievances; references to cattle rustling or livestock theft; and, removal of social cover.

Here are three initial observations on dynamics of conflict and peacemaking that have emerged from our review of local peace agreements.

Observation 1: The diversity of actors in local peacemaking

The diversity of actors involved in the signing of local peace agreements echoes the plethora of contextual settings in conflict-affected countries. It also highlights how those settings shape the nature and scope of local commitments to cease hostilities. For instance, the negotiation and signature

of local peace agreements often give a prime role to representatives – such as religious leaders, community elders or civic society groups – whose credentials and legitimacy are grounded within the local community. The Resolutions of the Marsabit-Moyale District Peace Committees' Civic Dialogue in Kenya in 2006 is a good example of the diverse inclusion of local actors within a peace process that aimed to resolve issues around cattle rustling and communal insecurity in the district. This diversity also raises the question as to whether local peace processes may offer greater inclusion of women, or if women still face different and contextual barriers to participation than they do to access national negotiations.

Within this diversity of local peacemakers, there can also be a duality of role which is highly contextual. In Yemen, the title of Sheikh is often synonymous with leadership and tends to be listed alongside other prominent societal or community figureheads in agreements. Their role tends to convey a sense of civic responsibility, calling for agreements and representing the interests of the communities, tribes or specific armed actors involved, and functioning either as mediators, facilitators or witnesses. As local actors however, their true alignment continues to appear amorphous. The title can convey a sense of religious or tribal identity or community representation, however often they cannot be disentangled from the complex web of armed actors.

Nonetheless, this diverse participation of hyper-local actors does not necessarily suggest an absence of the state. In the case of intercommunal conflicts, the latter may play a key role in the mediation phase that brings all potential signing parties around the same table. Conversely, the signing of countless local agreements between armed groups in Syria has come to enshrine the quasi-absence of the state in local conflict management across different parts of the country. This diversity of actors suggests that not only does

localisation of peacemaking raise challenges for peace process designs that anticipates the state to be one of the parties, but that those wishing to support local peace processes may need to look beyond 'the usual suspects' for finding mediators and brokers with the requisite local legitimacy to engage with the process.

Observation 2: The role of religious rules, rituals, and prayer in local peacemaking

In both the MENA and sub-Saharan regions, the religious credentials of some armed groups are mirrored in the texts of local peace agreements. These religious references can include the inclusion of religious rules, including the Islamic Shariah law, to settle specific cases or provide implementation mechanisms for elements of the agreement, as in an agreement between the al-Nusra Front and the Free Syrian Army, in 2014 in Idlib. Other religious references in local peace agreements include sealing the agreement through shared Christian worship, such as the 1999 Waat Lou Nuer Covenant in South Sudan and swearing an oath on the Koran by members of a local community as part of the 2019 Proces verbal de gestion de conflit in CAR.

Religious actors, rituals, and prayers do feature in national and internationalised peace processes, such as the Papal benediction in 1998 as part of the Ecuador-Peru border dispute peace process. However, the inclusion of religious rules, rituals and prayer appears to be more prevalent and central in local peace agreements than national ones, and in some instances the inclusion of religious references may account for the importance of religious identity as an additional layer within nested conflicts.

Observation 3: The variety of purposes and functions of local agreements

Local agreements serve a variety of purposes. While some local

peace agreements may be regarded as crucial steps for the broader peace process, others pursue more limited and immediate goals, such as allowing humanitarian access or solving daily disputes over natural resources. Interestingly, some agreements challenge our notion of agreements functioning as peaceful tools for conflict management. In Syria and Yemen for instance, a number of local peace agreements were used as tactical tools to manage the conduct of warfare in order to improve outcomes for certain groups within the broader peace settlement, such as Hayat Tahrir al-Sham response to an initiative to end the conflict with Harar al-Shamin July 2017, or the 2014 agreement between the Tihami Movement and Ansar Allah. In other instances, agreements that provided for a cessation of hostilities in one locale, displaced warfare to another area, or reiterated commitments of signing parties to their struggle against a third actor. In fact, the majority of local agreements signed in Syria are assertions of the commitment of the non-state armed groups to sustain their struggle against central rule.

Yet in other contexts, local peace agreements may have positive knock-on effects. Local agreements can help contain violence in some instances, inspire peacemaking in neighbouring areas by demonstrating their effectiveness, or even improve conditions for brokering peace at the national level. For instance, the ‘people-to-people’ processes facilitated by the New Sudan Council of Churches (NSCC) in South Sudan led to the signing of a series of local peace agreements, including the Wunlit Dinka Nuer Covenant and Resolutions in 1999. While this series of agreements was not technically linked to a national process between the government in Khartoum and South Sudanese opposition forces, the ‘people-to-people’ process contributed to the creation of a peace movement in southern Sudan and fostered ‘Southern unity.’

Conclusions

In this post, and throughout our work with local peace agreements more broadly, we have argued that we cannot understand the increasing fragmentation of conflict management and peacemaking without turning our collective attention to peace processes beyond national arenas of peacemaking, and analysing the involvement of armed groups in local peace processes. Through our own efforts to research this, by compiling PA-X Local and through Joint Analysis Workshops with actors involved in local peace processes, we suggest that local peace processes are a global practice across diverse conflict settings, and the documents resulting from this practice are just one initial avenue for shedding light on the opportunities and challenges that local peace processes pose.

This is a repost from the Political Settlements Research Programme.

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Social media, blockchain, big data & co: How do we support

women mediators in peace processes in a technology-driven world, writes Fiona Knäussel

Since the introduction of UNSCR 1325 on Women, Peace and Security in 2000, women's inclusion and active participation in peace processes have been promoted and promised on multiple occasions. Within the last 20 years, we have also learned and recognized that women's involvement is important for achieving sustainable peace. Yet, the reality is that women are still excluded from many political efforts to end conflict, or have to risk their personal safety to secure a seat at the negotiating table. Enabling women mediators to participate in and lead peace talks remains an urgent goal in the 20th anniversary year of UNSCR 1325. How and when can technology help?

PeaceTech for Women

In recent days, women have been involved in online consultations and mediation in a number of conflicts around the world. Online consultations – now fast-tracked with the COVID-19 pandemic, are one part of a multi-disciplinary development of technologies aimed at supporting peacebuilding activities, or in-short 'PeaceTech'. PeaceTech offers new opportunities to support inclusion in peace processes. While many industries in the world, including warfare, have heavily benefited from the rapid emergence of new technologies, peacebuilders have only recently begun to engage with this trend. However, as the disruption of the COVID-19 pandemic demonstrates, the use of new technologies for peacebuilding has become an urgent necessity. The potential for PeaceTech is vast, and goes beyond the exchange of information on social

media, and the use of ICTs (Information and Communication Technologies) such as smartphone apps.

The Challenges

However, PeaceTech is still an emerging practice with limited sources for funding. Therefore, its application on the ground is underdeveloped, and there are additional challenges involved for women to engage with nascent PeaceTech initiatives.

Lack of infrastructure: Conflict-affected and developing countries struggle with the lack of access to digital devices, including smartphones and PCs, and to continuous, stable internet coverage and broadband connection. According to a 2019 report by the International Telecommunication Union (ITU), 53% of the global population use the internet, while only 19.1% of the people living in the least developing countries have internet access. This is despite the fact that 93% of all people live within the reach of mobile broadband. Additionally, even places with existing connections face connectivity issues, such as in Yemen, where connectivity is unstable as fallback options for damaged undersea cables are more tenuous than in many other countries. Hence, days-long internet outages, such as most recently in January 2020, take place regularly. Furthermore, the internet is now divided and controlled with different ISPs for the government-controlled and Houthi rebel controlled internets. Another problem in many countries, is lack of privacy (and therefore security), and the common occurrence of deliberate internet shutdowns and social media restrictions, as well as state-based censorship, particularly during times of unrest and crisis, which, for instances, has been the case in many countries during COVID-19. On top of this, women are prone to having insufficient or no access to a phone and the internet. On a global average, women are 26% less likely than men to have a smartphone and access to mobile internet. In the global south, this percentage is even higher, with 34% in Africa and 70% in

South Asia.

Lack of financial resources: The lack of funding for devices, access to the internetand further research into their use for peacebuilding purposes poses a great hurdle. Among conflict-affected people, and in particular, women, as well as peacebuilding and women's organisations, money for expensive technologies is scarce. For women, especially when they have been displaced, forced into dependency, or made the family's only breadwinner, such an expense is unthinkable.

Digital illiteracy: Due to the lack of access to phone and internet, and prevailing structures of gender inequality, women are less likely to own and regularly use digital tools. This makes digital illiteracy among the population, but especially among women and girls, who have less exposure to technology than their male peers, a significant problem. Despite this, in some contexts, established women peacebuilders have utilised the internet as an opportunity to expand their existing networks and promote their activities. Members of the Yemeni women's coalition, Peace Track Initiative, for example, have continued with their peacebuilding efforts throughout the COVID-19 pandemic by corresponding over digital platforms such as Whatsapp, and have even tracked ceasefire negotiations over Twitter. However, women without this existing link to a network or who lack confidence with basic online tasks may face difficulties with accessing initiatives, and risk being isolated from digital activities.

Becoming a target: For anyone in a conflict-affected setting, participating in peacebuilding may turn them into a target of displeased authorities. Authoritarian governments have long opted to using surveillance methods, such as trackers, to monitor and disrupt activists' and peacebuilders' online activity, which, in some instances, may lead to them being threatened, harassed, arbitrarily detained, tortured, vanished, or killed. In Vietnam, for example, a repressive new

Cybersecurity law from 2019 has intensified the use of surveillance to target human rights activists operating online and increased the number of prisoners of conscience in the country's detention facilities. In other contexts, women are specifically targeted if they stand up for their rights or are politically active, such as in Houthi governed regions in Yemen, where for some women this has meant being captured, detained and sexually abused.

Online gender-based violence (GBV): Besides general challenges that women face in, use of technology can carry gender-specific risks. These include the spread of online gender-based violence (GBV), which can manifest itself as bullying, hate speech, blackmailing, cyberstalking, sex trafficking and more. Twitter, for example, has been named the most toxic social media platform for women to interact on. Its open and public nature has created a space in which harassment of women is immediate and widespread, when at the same time, it is one of the most important platforms for them to be vocal on. In May 2020, this was the case for Nobel Peace Prize Laureate Tawakkol Karman, who became the target of a smear campaign led by Saudi Arabian media. The stress and anxiety women experience as a result of online GBV often has real-life implications, such as a fear for physical harm, and can cause them to self-censor, leave a platform, or become tech-averse altogether. Many female journalists, for example, as a survey by the International Women's Media Foundation has revealed, feel the need to withdraw news stories or avoid certain topics in their work as a consequence of encountering online attacks and harassment. Additionally, some forms of online GBV can also have severe implications for the involved in real-life, notably when harmful threats are realised in person.

Too few women in tech: Within 'Big Tech'—the five largest tech companies in the US (Amazon, Apple, Facebook, Google and Microsoft)—less than 25% of tech jobs are held by women. This figure is not an abnormality in other tech-savvy countries

either. As a result, devices, applications and content are mostly created by men, and are more likely to be tailored to men's interests than aimed at benefitting everyone regardless of gender roles. For the above challenges to be addressed more effectively, gendered perspectives in technological development are needed, and ideally, women will be at the forefront to lead on them.

What does a PeaceTech solution need to do to be useful for women mediators?

Participating in peacebuilding activities can put individuals, and especially women, at a risk. Increased online activity and the use of digital devices may reinforce this risk if insufficient protective measures are put in place. This, in turn, creates an adverse effect on women's inclusion. To ask ourselves if a technological solution for women does more harm than good, we should consider if it tackles the challenges described above. This means thinking of what kind of technology women mediators on the ground find practicable and user-friendly, and how to utilise and adapt these technologies to provide adequate peacebuilding tools. The following are some important aspects to consider:

Does it inform? An aim of PeaceTech is often to provide better information, for example, to make sense of 'Big Data'—the abundance of information in the world—in a concise way to, then, better inform peacebuilding efforts. If done right, this can contribute towards equipping women with the necessary knowledge and skills to enter the peacebuilding arena, or to be offered greater support if they are already experienced.

Does it support? A PeaceTech solution can build on existing knowledge, motivations and goals, and support women with further tools. This can be by creating platforms to build networks, by providing resource hubs that makes it easier for mediators to access certain data, by facilitating decision-making through scientific methods and algorithms, by offering

applications to collect data (e.g. survey apps), by enabling knowledge-exchange on dedicated dialogue platforms, and by simplifying the presentation of information (e.g. with data visualisation tools).

Does it enable? Women who previously were not able to effectively participate in peacebuilding should find themselves empowered and enabled through PeaceTech solutions, rather than further disempowered. If a tool provides the right skeleton, female users will be able to use it to acquire vital competences, for example, by: bridging important gaps in knowledge; providing data-supported arguments for negotiations; raising international awareness and support; founding and expanding networks; finding common ground and building coalitions; running own projects on their platform; or by learning about their rights and what tools might help to realize them.

Does it aim to mitigate the associated risks? Women face greater societal, mental and physical risks when accessing technologies. The design of safeguards and protective measures for existing and new tools is needed to guarantee that online spaces are safe for women to use and do not further replicate or reinforce offline gender inequalities and exclusion. Secondly, offline availability of PeaceTech tools can be a critical asset to its practicability. It tackles the issue of low or unstable network connectivity, as well as the fact that women are less likely to own their own devices.Thirdly, the easy navigation and straightforward use of an application can be beneficial in circumventing digital illiteracy. There are many innovative and promising applications out there that are too complicated to be used by the average user without tech background, and even less so by people without the necessary infrastructure. If peacebuilders with limited access to technological infrastructure and digital literacy cannot apply PeaceTech solutions in practice, we are wasting important opportunities. Finally, a PeaceTech tool should be universally

accessible and eliminate cultural and language barriers. In practice, this means that the application designs need to appeal to women from different ethnic, cultural and religious backgrounds, and ensure availability in multiple languages, which raises key development requirements, such as user interfaces which function as well in Arabic as they do in English.

Challenges going forward

As informed and well-intentioned any new PeaceTech tool might be, its practicability and impact will only reveal themselves in the hands of its end-users. In the case of PeaceTech tools for women's inclusion in peace procceses, women mediators' user experiences will be critical to its development. The focus should be what benefit the tool gives to a peacebuilder that they otherwise would not have, and if it does so in a safe matter. Technologies have only come this far because they are continuously scrutinised, adapted and improved, and women mediators and their supporters need to have the same honest conversation about what works and what does not, where problems and risks lie, and how we can address these most effectively. This might mean taking a closer look at the circumstances of end users, what options are needed to provide the necessary knowledge and infrastructure, and in the longer-term, to vehemently advocate for women's education, digital literacy and access to technology. PeaceTech as a field is just as much about the exchanging of knowledge and sharing good (and bad) practice as it is about delivering a technological solution. And any PeaceTech solution is only useful if it effectively supports a peacebuilder on the ground.

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Fiona Knäussel is a graduate fellow from PSRP. She was part of a women-led team developing 'PeaceFem' *which works to develop*

a PeaceTech platform to support women mediators, is through a new mobile app. This is the result of a collaboration between UN Women and three leading research programmes on women's mediation. PeaceFem is a mobile app that provides a full picture to selected peace processes by combining women's strategies for mobilisation, the factors enabling and constraining their engagement and the gender provisions incorporated in peace agreements as a result of those engagements.

Changing consumption practices, by Lisa Howard

Much has been written in the media about changes in consumer spending over the lockdown period. More food and alcohol, fewer non-essential goods such as clothing and footwear, furniture and recreational goods. The patterns of our spending have reflected constraints on our mobility and perceived risks of contracting the virus in public spaces, as well as parts of the economy shutting down, such as the travel and leisure industry. The question is, now that restarting of the economy is on the government's horizon, will we revert back to old consumption habits once lockdown is over? From the evidence in my photos, I believe the marketers of these goods and services think perhaps not.

I took the photos on 9th June, at the Phase 1 stage in the Scottish Government's strategy to exit from lockdown. The photos show a series of advertisements from a rotating billboard near Murrayfield. I thought the products were particularly emblematic of the times: Wine delivered to your door; A virtual livestreamed rave; A high-spec indoor fitness

bike; and learning to write packs for children. Despite lockdown easing, the investment in advertising these products and services suggests that marketers predict our consumption habits will remain home-oriented in the near future. How might a sociologist analyse such shifts in consumption practices?

The sociology of consumption is a vast field, having seen numerous 'turns' over years, but can commonly be understood as the 'social organization of activities through which items are incorporated, deployed, and disposed of' (Warde, 2015, p. 118). The 'practice turn' in the sociology of consumption is informed by social practice theory. This seam of thought de-centres the human actor in consumption, but without prioritising structure or agency. A social practice is seen by Shove et al (2012) as integrated elements of **materials** (objects, tools and infrastructures)**, competencies** (knowledge and embodied skills) and **meanings** (cultural conventions, expectations and socially shared meanings). Social practices interlock, for example the practices of mobility, shopping and eating. They are dynamic, emerging or disappearing when links between their defining elements are made or broken.

Within this framework, the rupturing of links due to COVID-19 (for example, access to **materials** brought about by lockdown measures and economic shutdown) has resulted in new practices emerging, in part due to **competencies** to perform these having been developed during this period. For example, school closures and the need for home schooling have demanded parents learn skills of teaching, and the enforcement of spending leisure time at home has developed **competencies** in using technology for socialising. The **meanings** element of some practices may have changed due to narratives of risk, so that having wine delivered to your door could mean feeling safer (than going to the supermarket) or greater convenience. The **meaning** of taking exercise on a static bike may be related to expectations of continued gym closure, efforts towards preventative healthcare, or the need to spend more time at

home due to caring responsibilities.

I wonder whether – in the coming months and years as we start to feel the financial pinch of the economic downturn, we will see social practices shift again, with products advertised on these billboards reflecting a shift towards constrained household budgets and frugality?

This piece is reproduced from Edinburgh Decameron: Lockdown Sociology at Work.

Lisa Howard is a PhD researcher researching climate change and personal life.

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Next: The possible second wave, by Liz Stanley

A consortium of the leaders of the UK's medical, nursing and public health professions on 24 June published a joint letter in the British Medical Journal, sent to the leaders of all UK political parties. It argues for procedures to plan for what happens next, now that strict lockdown has been lifted, because in their view the possibility of a second wave of coronavirus is actually likely rather than just possible. Succinctly, it proposes a cross-party all-interest group or

inquiry but which would have planning for what happens next as its aim, rather than enquiring into what went wrong with the first wave of the coronavirus pandemic. It proposes that the focus for this inquiry should be:

- "Governance including parliamentary scrutiny and involvement of regional and local structures and leaders
- Procurement of goods and services
- Coordination of existing structures, in a way designed to optimise the establishment of effective public health and communicable disease control infrastructure, the resilience of the NHS as a whole, and the shielding of vulnerable individuals and communities
- The disproportionate burden on black, Asian, and minority ethnic individuals and communities
- International collaboration, especially to mitigate any new difficulties in pandemic management due to Brexit"

Important in its own right, there are a number of aspects worth thinking about in a bit more detail.

First, there is the fact that these professions are working together and doing so through the highly regarded vehicle of the *BMJ*. The medical, nursing and public health professions are all important, but in worldly and political terms the most powerful of these is the medical profession. The *BMJ* is a kind of lodestar, with social scientists as much as others working within medical areas aspiring to publication even as one of a very large team in its pages.

Second, the letter is addressed to the leaders of all political parties, not the government specifically or at least not in a public way in this letter. This is itself a sign of the changing times, for even just a few weeks earlier it would have been addressed to the government or some part of it. It is a return to political life that is being signalled in who the letter is addressed to, in which political debate and manoeuvering will resume publicly, for one assumes it had not

entirely gone away out of the public eye.

Third, the leaders of the medical, nursing and public health professions have used a letter, a public open letter, to make their intervention. In academic terms, much has been pronounced (wrongly) about the so-called death of the letter. Against this, not only is there a massive upsurge in forms of communication premised on 'letterness' aspects, text and email amongst them, but in formal circumstances it is notable that only a written letter directed to a known person and physically signed by the letter-writer will do for legal, official and other public purposes. Using a public letter as the device of communication is a strong signal of intent on the part of identified persons, with their names and positions specified as part of 'the letter' overall, which includes its address and sign off as well as its specific content.

And fourth, in the *BMJ* letter the way that what happens 'next' appears is that this might well be rather like previously, unless problem areas are tackled and better forward thinking mechanisms put in place. 'The future' is described as 'the future state of the pandemic' and the letter is concerned with planning for this. It is notable that there is no sign of an 'after', in the sense of the pandemic coming to an end, of this being a possible state that UK society will be in. Instead there is next, a haunting by a possible future that could be as terrible as what has happened already.

This piece is reproduced from Edinburgh Decameron: Lockdown Sociology at Work

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Rethinking the house as a public health technology of preparedness, writes Imogen Bevan

The main public critique levelled at the UK government's "Stay Home" campaign was its failure to be implemented fast enough, and the abandonment of community contact tracing in its wake. Beyond all expectations, the UK public proved "highly compliant" in staying home (even too much so) according to a recent report. A powerful new "spatial and moral logic" (Fitzgerald, 2020) had seemingly engulfed the UK. But what happens to houses now, as lockdown measures are gradually lifted? And more importantly, what did we learn from the "Stay Home" policy?

As a national strategy, home confinement provoked little controversy. As restrictions are eased, a new order not to leave one's home for fourteen days (if approached by a contact tracer) is seen as normal. The contact tracing technologies themselves on the other hand (such as those proven effective in South Korea, and currently being developed in the UK) provoke deep moral discomfort, understood to be the ultimate intrusion into our lives. Why is this? Isn't the house also a technology of sorts? What is being masked by discussions around data privacy? What might houses, in times of COVID-19, reveal about social relationships and values in contemporary Britain?

Anthropology has a long history of studying houses, and the many layers that compose them. From structuralism to feminist anthropology, to new kinship and material culture studies, we learn that houses participate in the production of power relations, gender, kinship and relatedness, as well as ideas

about individualism and capitalism. The theme of the house features heavily in my own research on sugar consumption, and what sugar might teach us about contemporary forms of kinship in urban Scotland. In my research, I am interested in the way that houses themselves, from the storage of (sugary) foods and objects to the configuration of rooms and furniture, embody and reflect the texture of social relationships.

In 2018-2019, I did fieldwork with families whose houses slowly warped over time, to accommodate changing relationships between kin. In 2020, their living spaces now compressed and strained to become the workplace, the school, the nursery, the clinic, and even the hospital. The policy of "Stay Home" largely relies on the (imagined) flexibility of the house, its capacities of absorption, and the magical powers of kinship to transform parents into nurses, school teachers, and early years practitioners behind closed doors. Houses are regularly depicted as spaces over which we have heightened agency and control, where we can express our individualities, our intimacy, and secrets. But when the home becomes a "clinical and epidemiological trope," as Fitzgerald writes, houses themselves disappear.

The 'Stay Home, Stay Safe' slogan recycles an oft-told story about the house – that it is a cocoon, a space of nurturance, the ultimate metaphor of kinship itself. Literary analysts reveal the long history of this trope in Britain, whereby houses emerge as "a symbolic substitute for the security and union of the womb," as they do in Dickens's work, for example (Armstrong 1990). In these romantic imaginaries, the house is made to work as an enclosure, a domain of life carved out, a safe haven constructed in opposition to the state. A black box of private life. A protective bubble. Yet houses and kinship are not starkly distinct from the realm of politics and the state. Nor are they inherently safe and protective places, as Sophie Lewis points out:

> *"How can a zone defined by the power asymmetries of housework*

> *(reproductive labor being so gendered), of renting and mortgage debt, land and deed ownership, of patriarchal parenting and (often) the institution of marriage, benefit health?"*

The imaginary segregation of the house from the outside world, and the dichotomies that accompany it (inside/outside, pure/polluted, privacy/surveillance, domestic/political), are attractive from a national and global policy perspective. As a technology of preparedness in times of pandemic, houses are readily available as a policy at no additional cost to the State. These imaginaries of houses – as hermetic borders, sites of personal freedom and mutual obligation – make them a prime tool for acting upon the virus. However, the language of "home" brushes aside a longstanding academic tradition in public health research, where home (as housing) has been readily conceptualised as a space of *exposure,* rather than one of safety.

Public health interventions have a long history of intervening upon, *or through*, the house. During the course of Dickens's lifetime, health authorities had come to establish the role of houses themselves in the onset and spread of diseases such as cholera, typhoid, and tuberculosis. In North Edinburgh, as late as the 1950s, a wave of cases of tuberculosis was traced back to the nature and conditions of low-quality urban housing. Public health research into houses' negative effects on health – temperature, dampness, leaks, indoor pollution, numbers of inhabitants – have led to some of public health's most important reforms. The long term effects of lead exposure, residual tobacco smoke, asthma, and allergies are just the latest chapter in the morbidities and inequalities houses produce.

While the UK government heavily invests in a new furlough scheme to shift people from workplaces into houses, responsibility is waivered concerning the glaringly unequal

ways this pandemic will be experienced, according to the kind of housing people can access. Meanwhile, forms of work that can be pushed inside the physical walls of the house – home-schooling, or nursing elderly relatives – are broadly exempt from any additional state assistance. Stay Home, Stay Self-Reliant.

Bourdieu (1970) famously argued during his early structural period, that the house represents a microcosm of society. In Britain 2020, the house bears witness to the reshuffling of priorities. It lays certain values bare. Within the logic of COVID-19, we are to seal (and conceal) ourselves within the home, regardless the type of housing. Any person in another household, however close the connection, must be distanced. Death of a grandparent? Stay home. A romantic relationship? Invalid unless it involves cohabitation. The house of COVID-19 feels a little like a Noah's Ark, each of us steering a floating household reduced only to the most necessary relationships – supposedly those of cohabitation, most often framed as the nuclear family.

I feel wary of the version of the house that "Stay Home" ushers in, with its celebration of nuclear family at the expense of other relationships. I also feel wary of current celebrations of homeliness and (gendered) ideals of domesticity, which are so often enmeshed with ideals of home ownership and fantasies of World War II austerity. The re-summoning of our so-called Blitz spirit – including memories of collectively producing a national blackout from our homes by boarding up the windows every night. World War II Blackout windows and home confinement are two sides of the same coin, I would argue. They both rely on the same notion: The British house as a sealed black box, whose outside boundaries can be thickened to better conceal and preserve the nation and the individual lives within.

In my Edinburgh research, the house cannot be theorised as a safe black box. People I met fought against threats of

eviction, or felt insecure in temporary housing with little to no cooking facilities, finding uncomfortable reflections of their positions in society. Anthropologists show that houses are metaphor, symbol, idiom, but also process, substance, structure. If the State expects and relies on the house to become the workplace, the school, or the clinic in times of crisis, this pandemic reveals more than ever the State's moral obligation to ensure good living conditions within our cities. And if the (nuclear family) house is also to be a technology of preparedness in case of future pandemics, we need to think of those who are excluded from its imagined and physical walls.

Imogen Bevan is a PhD student in social anthropology at the University of Edinburgh. Her research explores sugar consumption and the meaning of sugar for families in Edinburgh. What role does sugar play in social relationships? Imogen has published ethnographic research on tobacco and emerging e-cigarette practices among young people in urban France as a member of the Chemical Youth team, University of Amsterdam. Imogen's research interests include anthropology of the body, health and well-being, kinship, morality, sensory anthropology and visual methods.

This piece was originally published in Somatosphere. It is based on a presentation at the University of Edinburgh medical anthropology symposium "Uncertain Futures, Uncanny Presents".

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A gun for the end of the world, by Joe Anderson

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.*

This piece was originally published in Medical Anthropology Quarterly

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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

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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*".[7] 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.[8]

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.[9] 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?*".[10] Poetess Pam Ayres's latest ode to coronavirus contradicts this notion as she regains her strength the age of 73.[11]

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*".[12] Defoe's

Chronicle[13] 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*,[23] 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.[24] 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.[25]

To write the book *The Plague*,[26] 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.[27] Like Camus's Plague[28], *Blindness*[29] 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.[30]

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 evil*".[31] 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].

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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.

Dr Morgan Currie is a lecturer in Data and Society at the University of Edinburgh.

Dr Kate Miltner is a TRAIN@ED Postdoctoral Fellow 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 Coronovirus…. “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 coronovirus. 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.

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[2] For a fuller and critical engagement with this proposal see: Ganguli-Mitra A, Young I, Engelmann L *et al.* Segmenting communities as public health strategy: a view from the social sciences and humanities [version 1; peer review: awaiting peer review]. *Wellcome Open Res* 2020, **5**:104 (https://doi.org/10.12688/wellcomeopenres.15975.1

[3] https://www.gov.scot/groups/scottish-government-covid-19-advisory-group/

[4] For more on these critical points see: Ganguli-Mitra A, Young I, Engelmann L *et al.* Segmenting communities as public health strategy: a view from the social sciences and humanities [version 1; peer review: awaiting peer review]. *Wellcome Open Res* 2020, **5**:104 (https://doi.org/10.12688/wellcomeopenres.15975.1

[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".

https://www.gov.scot/publications/coronavirus-covid-19-framework-decision-making/pages/2/

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 life.

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.

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This article was first published in the Edinburgh Decameron: Lockdown Sociology at Work

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,[i] 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,[ii],[iii] 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.[iv] Aside from an outbreak of alt-right protests,[v] the usual accusations of 'nanny state' interference[vi] have been replaced by calls for centralised governance, funding and control on a scale unseen in peacetime.[vii]

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],[x] Even more troublingly, the very measures intended to suppress viral spread are themselves exacerbating underlying social inequities.[xi],[xii] 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,[13] and growing income inequalities are predicted.[xxi] Charities report dramatic increases in domestic violence[xxii] with an estimated doubling in domestic abuse killings since the start of the lockdown.[xxiii] While COVID-19 is already more fatal in Black and minority ethnic groups,[xxiv] we have yet to see the extent to which the response will exacerbate existing racial inequities in employment, income and housing.[xxv] 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".[23] 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,[xxvi] but because it places us all at increased risk.[xxvii] COVID-19 unmasks the illusion that health risk can be localised to the level of the individual, community, or even nation state.[xxviii]

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.[12,[xxx]] Only then can governments begin to claim that we're "all in it together".

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A verion 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 unknowness, 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 people 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.

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