How do we care about care homes, asks Niamh Woodier

Lloyd Rees, when discussing Australian modern art, argued that 'the universal element in art, I feel, has often come from an intense localism' (Rees in Butler & Donaldson 2015, 142).

This quote has stayed with me since my Art History degree: Lloyd Rees was originally referring to the conflict between indigenous and Western symbolic vocabularies in the increasingly international trope of Australian modern art in 1930s Sydney. Although this quote is far from my life as a part-time GP receptionist, part-time Masters student in Global Health Policy in Scotland, the importance of 'the local' has been re-emphasised during the coronavirus pandemic. Working in the setting of community health has taught me that the universal element in healthcare often comes from intensely local care: care that is personalized, close to home and promotes both health and social well-being. The importance of local care has become central to the devastating impact of coronavirus in elderly populations, is an ongoing topical issue of care homes (Observer Reporters, 2020) and is changing what care will become.

The UK population is ageing, and our health policy is adapting to suit the needs of this demographic. It is predicted that in 2066, 26% of the population will be 65 or older, compared to 18% in 2016 (ONS, 2018). Much of the integrated care that allows older people to be cared for at home was only established 20 years ago. In 2000 the NHS Reform Plan (Department of Health, 2000) introduced a new tier of services called 'intermediate care' to facilitate health and social care to older adults living in the community with the understanding that 'older people have better health outcomes when they receive treatment closer to home' (British Geriatrics Society 2019). The plan for care homes is arguably

still being written. A key question being asked is; ‘Could nursing homes (NHS) transform from settings in which many residents dwell to settings in which the NH residents and those living in neighboring communities benefit from staff expertise to enhance quality of life and maintain or slow functional decline?’ (Laffon de Mazières 2017). Person-centred dementia care is an area of research that ‘is no longer seen as the ‘Cinderella’ part of the health service, but a progressive, specialist field’ (Baker 2015, 17).

In the first international study ‘that reviewed international COVID-19 guidance for a highly vulnerable population’ (Gilissen 2020, 10), the authors noted that in the guidance for nursing homes ‘several key aspects of palliative care, practical guidance, and broader structural and coordination considerations are largely absent’ (Gilissen 2020, 9). Aspects that were not addressed included: ‘holistic symptom assessment and management at the end of life… staff training (in particular for care assistants who deliver the majority of hands-on care in these settings)… comprehensive ACP communication… support for family including bereavement care, support for staff, and leadership and coordination related to palliative care’ (Gilissen 2020, 9&10).

Caring for the elderly is a complex and fragmented task. In the current pandemic politicians and health professionals should continue to work on effective strategies to prevent coronavirus in care homes, such as barrier nursing, testing of hospital patients discharged to homes, and testing of staff (Department of Health and Social Care 2020). However the difficulty of the task has been translated into public uncertainty, particularly around palliative care. Palliative care doctor Rachel Clarke writes in *The Guardian*, ‘the outrage over allegations that doctors have apparently been using the coronavirus pandemic to write off whole swathes of vulnerable patients has been painful to witness’ (Clarke 2020). As the pandemic continues the growing percentage of elderly deaths

(Observer Reporters 2020) is a worrying statistic. The difficult and often misunderstood subject of palliative care, particularly in care homes, is therefore a topical and important issue. Working on the GP reception desk I am aware of the difficulties our local care home faces, and in order to find out more I spoke to the lead GP.

‘Care homes have more experience of death than the hospitals’, the GP pragmatically stated. ‘The majority of residents die within a few years of being admitted.’ Care homes therefore have a medical role in providing adequate healthcare and nursing support to patients. However, as the GP explains, ‘our interactions with the care home have been chaotic for years.’ Many care homes are profit-run organisations which are sadly understaffed in nursing roles. In Scotland the 2018 GP Contract (Scottish Population Health Directorate 2018) introduced the new role of Care Home Liaison Nurse, which as the GP lauded, ‘is one of the most significant additions to primary care’. This role has implemented a more organised system of communication as the nurses are now able to deal with the majority of calls from care homes and treat minor problems without the GP. In recent weeks the GPs and nurses have been supporting the care homes in the difficulties of preparing for coronavirus in the homes.

‘For the care homes now we are prescribing to every resident JIC medication, in case they need palliative support,’ the GP explains. ‘Residents are unlikely to be admitted to hospital if they contract COVID-19, and so will need the support in care homes in case it is terminal.’ Palliative JIC medication eases pain and confusion in the dying process. Ensuring that residents are able to get this medication is not to say that they will die, but to provide the correct medical support if needed. ‘Patients are having more distressing deaths in homes. I heard about a patient who needed extra morphine and midazolam. That is unusual’, the GP continues.

‘Care homes can be depressing places. They don’t always have

the right mental stimulation for patients,' the GP laments. 'It is like the Dylan Thomas poem *Do not go gentle into that good night*. Your last few years of life have to be enjoyable. If you don't have a satisfactory life, it prolongs your pain in death and you will fight death. But if you have a good experience of life at the end, dying is a lot easier.'

Care homes are important places that look after a vulnerable population often in the last years of life. For relatives the cost is huge, financially given a private sector nursing home costs an average of £847 per week (Curtis 2018) and emotionally costly too. For the elderly themselves however, living in a care home can be an experience of a 'social death'. A social death is described as 'the ways in which someone is treated as if they were dead or non-existent' (Borgstrom 2017, 5). In this difficult position the elderly are vulnerable, lacking independence and voice, and in society we feel unable to talk about our elderly because 'we lack a script, in general, for our long dying' (Banner 2016, 7). People are living longer than ever and 'because degenerative, chronic conditions have replaced acute diseases as the major cause of mortality' (Abel, 2017, 1), death is now a gradual rather than sudden progress. This new chapter of life can be a complicated conclusion, with a variety of new medical, financial and social needs. It is a chapter for which 'a script is sorely needed' (Banner 2016, 7).

As Rachel Clarke notes in *The Guardian*, 'pandemic medicine, we are learning, is far from ideal' (Clarke 2020); but the flaws it exposes are the problems we need to solve. In Gilissen's study of COVID guidance, the author noted that 'non-physical (psychological, social or spiritual) needs were hardly addressed' (Gilissen 2020, 10). Non-physical needs are important to our quality of life and 'communication about the patient's care values and preferences [are important] to develop a care plan for the future' (Sebern et al. 2018, 644). However our non-physical needs are also in part our

non-medical needs, and discussions of how to care for the elderly go beyond the hospital and the care home. ‘Ideally, the patient should be at the heart of these discussions. Failing that, then their family, loved ones or advocate should, if possible, be consulted’ (Clarke 2020). The conversation about care for the elderly is a subject we all need to be part of.

‘Epidemics are “mirrors held up to society”, revealing differences of ideology and power as well as the special terrors that haunt different populations’ (Briggs 2003, 8). The impact of coronavirus on care homes will haunt the UK public, particularly the relatives of residents which many of us are. But as the British Geriatrics Society reminds us, ‘ageism remains widespread. Quality of care of elderly patients remains a core criticism in spite of numerous reports and commissions in the past 20 years’ (BGS 2016). For the future, recognizing the vulnerability of the elderly, learning from the uncertainty and lack of guidance in COVID-19 and researching how to provide care for both physical and non-physical needs will be important to ensuring quality care for the elderly. The script for care homes will not be easily written, but the final chapter of our lives needs a personal, local and socially integrated conclusion. As American care activist Ai-jen Poo argues ‘the universality of the caregiving experience is certainly the basis for the next great wave of change’ (Poo 2017).

Taken from interviews for https://www.rovingreceptionist.com/. Interview reproduced with permission.

Niamh Woodier is currently in the Masters in Science program in Global Health Policy at the University of Edinburgh and works as a part-time GP receptionist. Working as a receptionist has given her an insight into the struggles patients and relatives face in caring for elderly relatives in

a complex care system, and the anxiety everyone is facing currently about the status of their health. In order to informally document this time of change, she set herself up as a 'roving receptionist' to give a local and personal voice in the global crisis. She says: "It has been a privilege to engage with wider policy issues during my degree at Edinburgh, and in the future I hope to be able to advocate for the ethics of care."

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Community-led responses to COVID-19 are a matter of urgency in Syria, write Lisa Boden, Ann-Christin Wagner, Shaher Abdullateef and Anas Al Kaddour

People living in the Global North might argue that the coronavirus pandemic (COVID-19) is the greatest existential threat to life as we know it in the last 100 years. Yet for Syrians, the pandemic, while undeniably traumatic, is just one more event in a litany of equally-devastating hardships that have proven inescapable, difficult and necessary to endure.

Years of protracted conflict mean that Syrians have become inured to living with significant risks and uncertainties about their future lives and livelihoods. While the attention and resources of apparent former 'global health powerhouses' like the UK and USA, are fixed on solving challenges posed by disease transmission and constraints on healthcare systems in

their own countries, there is a growing danger that the impacts of disease incursion on displaced and vulnerable populations in fragile and conflict-affected states may be completely neglected. In countries everywhere, ensuring access to appropriate healthcare is the immediate priority in this outbreak. But in countries like Syria, effective solutions are also needed to support other types of life-sustaining interventions, such as local and cross-border distribution of food and agricultural inputs which facilitate labour, militate loss of income and prevent food insecurity and its attendant effects on starvation, malnutrition and mental health and well-being A successful response to this pandemic will therefore depend not just on top-down public-health interventions, but also uptake of cross-sectoral, culturally appropriate and locally-led approaches which translate high-level strategies derived not only from security, but also humanitarian and development agendas, into concrete policies and impactful activities on the ground. In Syria, where there are uncertainties about governance and weakened institutions, a community-led response to COVID-19 is a matter of increasing urgency.

Challenges of implementing effective disease mitigation efforts in Syria

There are currently more than 4.7 million reported world-wide cases of COVID-19 and more than 315,000 COVID-related deaths (as of 18 May 2020). The risks to individuals from coronavirus are great: there is currently no vaccine, no cure and there is a non-negligible likelihood that intensive hospital care may be required for a realistic chance at recovery. We are still learning about the multi-systemic consequences of the disease; for some long-term health sequelae persist long after recovery.

More than a decade of civil war and a collapsing economy have

forced 6 million or more Syrians into crowded living conditions along the Syrian border, into neighbouring countries and failed states with fragile and fragmented healthcare systems. Syria is currently ranked as one of the least prepared countries in the world for emergency disease outbreak preparedness and response. Reported cases of COVID-19 in Syria are currently small in number (n= 59) but there are fears that most remain undetected due to inadequate testing capacity and an absence of functioning health centres. On the ground, it is becoming evident that few people are attending workshops or meetings delivering information about COVID-19, with most information about COVID-19 being obtained through social media. The lack of public trust in the Syrian government, general lack of knowledge about clinical signs of disease and concurrent gaps in information campaigns, alongside fears over possible repercussions (including discrimination, detainment, disappearance), mean that people are deterred from seeking testing or treatment even if that capability were available to them.

International aid is promised to support outbreak response efforts in Syria, but challenging to operationalise. Responders need to negotiate for permission with multiple local and international authorities, state- and non-state actors in border areas. Some NGOs are responding to the crisis in Northwest and Northeast Syria under the cross-border resolution, but this vital aid may be under threat if the UN Security Council does not overcome Russian and Chinese objections to the renewal (in July).

A curfew in government-controlled areas was initially put in place to encourage people to stay in their homes to reduce their risks of disease exposure and onward transmission. It is not at all evident that this made them safer or healthier. Individuals still need to leave home to collect their incomes- “I don’t have another choice … to survive”. “At home” for many Syrians is typically an overcrowded, physically and mentally

stressful environment, without access to adequate supplies of food or other products. Conditions are far worse for those who live in north Syrian camps, where inadequate access to basic medical, water and sanitation facilities is commonplace and a single tent may shelter as many as five to 15 people. In Northeast Syria, for example, there are over 225,000 IDPs and refugees living in last resort sites without reliable or sufficient access to essential services such as health, WASH and shelter. Although face masks and disinfection liquids may be available in some markets in north Syria, most people can't buy them- "these are available, but we don't have income to purchase it. My priority is to purchase essential food items to survive". Outside Syria, the UNHCR is trying to ensure that there is full inclusion of refugees in the preparedness, prevention and response measures to the COVID-19 pandemic in the region, but it is unclear what provisions are available to Syrian refugees if the capacity of healthcare systems in host countries is overloaded.

COVID-19 impacts on humanitarian efforts and longer-term food security and livelihoods in Syria

Since mid-March, significant price increases in fuel and some shortages in basic goods, essential food items, and personal sterilization and protection items (such as face masks, hand sanitizers) have been reported across Syria. The exchange rate has weakened since mid-March to the lowest point on record. These factors, in combination with panic-buying, disrupted supply routes, reduced shop opening hours, reduced working hours, wages and household incomes and movement restrictions are likely to deepen pre-existing vulnerabilities.

Established survival mechanisms, which are traditionally relied on by displaced Syrians to cope with informality and lack of economic support (e.g. through transnational kinship support networks, early marriage, and child labour) may become distorted over the next weeks and months, leading to other unintended, negative consequences. Among the most vulnerable

in Syrian society are day labourers, who depend on daily wages to cover the basic needs for their family. For displaced Syrians with no financial safety net, staying at home immediately worsens food security for entire households. Small-scale farmers and migratory agricultural workers in neighbouring countries will be affected too. Farmers will lose access to extension services, be hindered from working or hiring workers to help with the harvest commencing in May, and many will struggle to eat due to higher food prices/limited purchasing power due to their already insecure employment, legal status, and low-wages. Moreover, the pandemic will have important subsequent impacts on livestock sector due to reduced access to animal feed, vaccination and extension services.

The longer-term costs and indirect impacts of COVID-19 on Syria's reconstruction efforts and sustainable development will not be known for the foreseeable future. However, undoubtedly, Syrians and other peoples in fragile and conflict-affected states will feel the brunt of COVID-19 impacts, only serving to widen existing inequality gaps which will endure into future generations. In the face of the uncertainty surrounding the COVID-19 outbreak, the 2030 "blueprint for shared prosperity in a sustainable world" offered by the UN Sustainable Development Goals (SDG), Syria and other places like it, is surely in jeopardy. A deep commitment for international cooperation as well as for peace-building and transitional justice will be needed. How countries decide to support Syria during and after this health crisis, will be pivotal to the future of global health security – "a disease anywhere is a disease everywhere". But what happens next will undoubtedly depend on how those countries themselves, weather this storm.

Authors: Dr Lisa Boden, Dr Ann-Christin Wagner, Dr Shaher Abdullateef and Dr Anas Al Kaddour are collaborating with

other researchers from the Universities of Edinburgh and Aberdeen, and project partners from CARA (Council for At-Risk Academics) Syria Programme, on a SFC-GCRF COVID-19 grant for research with displaced Syrians in Lebanon, Jordan, Turkey, Iraqi Kurdistan and Northwest Syria.

Their new "From the FIELD" project uses remote surveys and ethnography to assess the impact of COVID-19 on local food supply chains and displaced people's agricultural livelihoods in the Middle East. For updates, follow the team members on Twitter: @Lisa_A_Boden, @ann_wagner_ed and @ShaherAbdulla

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Social science COVID-19 research at Edinburgh supported by Scottish Funding Council-Global Challenges Research Fund, writes Aphaluck Bhatiasevi

"It is our task to resist the biologicalisation of this disease and instead to insist on a social and political critique of COVID-19. It is our task to understand what this disease means to the lives of those it has affected and to use that understanding not only to change our perspective of the world but also to change the world itself," (Richard Horton, editor-in-chief of *The Lancet*).

Referring to renowned anthropologist Didier Fassin's book '*Life: A Critical User's Manual'*, in a recent editorial of *The*

Lancet Horton alluded to the lack of science of the social in the response to this pandemic, which is a crisis about life itself. While political leaders across the world have echoed the importance of social science to inform the COVID-19 response, little has been done to support and incorporate social science in the decisions they make on the pandemic, which impacts different social groups and communities differently.

Recognising this gap, the University of Edinburgh's (UoE) social scientists were recently granted awards from the Scottish Funding Council-Global Challenges Research Fund (SFR-GCRF) to develop innovative and timely research that would support low and middle income countries (LMIC) in the COVID-19 response.

"We are delighted to see these innovative projects that are expected to advance our understanding of social and political aspects of the pandemic. Building on past experience of the investigators and the long-standing local and international partnerships, the project outputs will directly contribute to global response to the pandemic," said Dr Jeevan Sharma, Director of Research of the School of Social and Political Science.

The following is a brief summary of the awarded projects.

Epidemic preparedness and laboratory strengthening in West Africa

Did the international response to the 2014-2016 Ebola outbreak help to prepare Sierra Leone's health system for COVID-19? Dr Alice Street, principal investigator of a joint project between UOE's DiaDev and London School of Hygiene and Tropical Medicine's (LSHTM) EBOVAC-Salone argues that technology-focused responses to epidemic emergencies – such as the development of novel diagnostics, vaccines and drugs – frequently neglect the social infrastructures that underpin the success of the technological solutions. This research

draws on the team's collective experience of carrying out research on laboratory strengthening and vaccine development in Sierra Leone and collaborations with Sierra Leone scientists and scholars to examine the impact of the international response to Ebola on the country's current epidemic preparedness. The research will be led by research fellow, Shona Lee, who completed her PhD at the Centre of African Studies in 2018 and has since worked on the EBOVAC-Salone project, and Eva Vernooij, DiaDev research fellow . DiaDev is an ERC funded project to investigate the role of diagnostic devices in strengthening under-resourced health systems. EBOVAC-Salone is a collaboration between LSHTM Sierra Leone's College of Medicine and Allied Health Sciences to examine community experiences of vaccine trials.

As the COVID-19 pandemic expands into Africa, social science has an important role to play in developing a culturally appropriate and socially feasible national and regional response. Dr Street says findings from this research have the potential to inform current COVID-19 testing strategies and diagnostic infrastructure development in the region, public messaging and communications, and the design and conduct of COVID-19 related research and trials.

Dr Alice Street is a senior lecturer in the School of Social and Political Sciences, University of Edinburgh and an expert on diagnostic device in global health.

Infectious disease related stigma

Experiences have shown that stigma is a common social by-product of infectious disease outbreaks which often undermine public health measures and are targeted towards patients, their families and health care workers. Dr Sudeepa Abeysinghe leads a joint project between UoE's School of Social and Political Science (SSPS) and the University of Indonesia to look into health care associated stigma in Indonesia.

This project aims to provide policy briefings related to mitigating stigma in health care workers through the study of public narratives of risk and threat that underpin stigmatization. The goal of the project is to reduce the risks faced by personnel aiding and maintaining the health care capacity in Indonesia.

As with other LMICs of the Asia-Pacific region, COVID-19 presents a fundamental challenge to economic development and welfare in Indonesia. In highlighting and tackling stigma, this project eases the burden of stigmatisation in Indonesia and thereby impacts on the public health and wider burden of the pandemic in this context. The results from this project will also benefit other relevant actors in the region, through the sharing of insights with the SEAOHUN (South-East Asia One Health University Network) says Dr Abeysinghe.

Dr Sudeepa Abesinghe is a senior lecturer in Global Health Policy in the School of Social and Political Sciences, University of Edinburgh.

Governance and accountability

Dr Jean-Benoit Falisse is the principal investigator of the project which draws on a unique network of in-country expertise in health systems and governance to map out and analyse the governance changes that have taken place during the COVID-19 pandemic in Kenya, Somalia, South Africa and the Democratic Republic of the Congo (DRC). This is a joint project between UoE, AMREF International University in Kenya, Somali Institute of Development Research and Analysis in Somalia, Wits University in South Africa and University of Kinshasa in DRC.

The aim of this project is equip countries with better tools to understand and act on the governance of COVID-19 through cross-country exchanges and reflections between policy

influencers, says Dr Falisse. The project will produce an interactive public database that can be interoperated and cross-analysed with other mapping initiatives such as the stringency of the measures of the pandemic's spread. This database will explore the socio-political environment, the actors or institutions involved, and the nature of the governance measures. Beyond the dataset, the academic analysis will contribute to re-formulating governance in health and pandemic preparedness, says Dr Falisse.

Dr Jean-Benoit Falisse is a lecturer in Africa and International Development in the School of Social and Political Sciences, University of Edinburgh.

Lockdown diary

Dr Sarah Jane Cooper-Knock and her team are working with a team at the University of Western Cape in South Africa to continue their Lockdown Diary Project. They are interested in the politics of urban life and issues of political inclusion, which is pursued through academia, activism and policy work. When the lockdown began, this project was developed with Impact Funding from UoE and is now being run with GCRF funding.

The project involves asking people from across Cape Town to share regular WhatsApp diaries that describe their experiences of lockdown and its impact upon their communities. They currently have 70 participants from occupied buildings, informal settlements, townships and suburbs throughout Cape Town. Participants are diverse in terms of their location, age, gender, and race. The aim of the project is to share insights from lockdown with members of the public, policy makers, and responders to the crisis.

Dr Sarah Jane Cooper-Knock is a lecturer in International Development at the Centre of African Studies and Social Anthropology at the University of Edinburgh.

COVID-19 and extreme heat for poor urban population

Dr Jamie Cross of CAHSS joins with Dr Daniel Friedrich of the School of Engineering and the International Federation of the Red Cross and Red Crescent Societies (IFRC) to look at the nexus of COVID-19 and extreme heat for poor urban populations in Sub Saharan Africa, South Asia and Southeast Asia. This project will assess the impact the lockdown on existing vulnerabilities and exposure the people living in poorly ventilated housing faciliites of high density informal settlements in urban areas and prisons have as a result of heat stress and reduced access to cooling and hydration infrastructures and services during the period of lockdown and social distancing.

Dr Cross says the project involves 4000 respondents from vulnerable populations across four countries – India, Pakistan, Cameroon and Indonesia. The effects of extreme heat on poor populations is well documented and widely known to reduce labour inputs and capacity. Reducing the impact of health on health and productivity, both directly and through interactions with COVID-19 frees up capacity for the health response and for the economic activity at large, says Dr Cross.

Dr Jamie Cross is a senior lecturer in Social Anthropology and the Associate Dean (Knowledge Exchange and Impact) of the College of Arts, Humanities and Social Sciences at the University of Edinburgh.

Dr Daniel Fredrich is a lecturer at the School of Engineering, Univeristy of Edinburgh.

Information technology for COVID-19 response

Dr Larissa Pschetz leads a team at the Univeristy of Edinburgh

which is collaborating with partners to investigate the potential of digital tools to help mitigate the spread of COVID-19 in Jamaica. The project uses data modelling and prototype testing obtained from social analyisis and practical experimentation to carry out their research. The project is done in collaboration with Mona Geoinfomatics, the Sir Lewis Institute of Social and Economic Studies (SALISES) at the University of West Indies in Jamaica, and the School of Computer Sciences in Univeristy of Glasgow.

The project aims to inform people and support agencies, and to optimize resources available to treat and limt the spread of COVID-19 in developing countries. Its findings will benefit Jamaica and other developing countries with similar socio-economic limitations and socio-technical characteristics. The research will feed into current efforts to map the spead of the virus and will propose guidelines and recommendations for development of future technological applications.

Dr Larissa Pschetz is a lecturer in Design at the University of Edinburgh.

Using COVID-19 for risk ADAPTATION for climate change challenges

Vulnerable communities across the globe give insights on how to adapt to unprecedented risks of climate change through their recent changes to social and economic practices under COVID-19. Through collective action these communities minimise their COVID-19 exposure and adapt to challenges such as shortages of food and access to clean water through, for example, re-farming land and bartering goods.

Such collective actions managing these new risks have been scare for other grand challenges such as climate change. “Collective action under COVID-19 can provide an insight on potential strategies and solutions for future climate change

challenges," Dr. Kathi Kaesehage, the principal investigator for this project explains, "It is of upmost importance to understand the new evolution of collective action and to preserve and replicate their structures and characteristics for the mitigation and adaptation other unprecedented risks such as climate change."

An interdisciplinary team of researchers at the University of Edinburgh are working to understand COVID-19 risks in ways that recognise and adapt the practices and capabilities of vulnerable communities living in the intersection of urban-rural areas. The project approaches this challenge from the standpoint of analysing COVID-19 risk mitigation strategies through a case study approach with three communities in urban areas of Mexico, Colombia and the Galapagos Islands. Building on the collaborative relationships generated by previous research the team is working with local academics and community members in each location resulting in data that be co-produced. The outcomes will generate context-specific knowledge but also provide examples of best practice for similar risks such as climate change.

Dr Katharina Kaesehage is a Lecturer in Climate Change and Business Strategy, Business School and the Director of Research at the Centre for Business, Climate Change, Sustainability at the University of Edinburgh.

COVID-19 data must highlight intersectional

marginalisation among BAME community, writes Ashlee Christoffersen

The disproportionate impacts of Covid-19 on Black, Asian and minority ethnic (BAME) people in the UK (both within and outwith the medical professions) have sparked **critical commentary**, an **evidence submission**, and an official inquiry (headed by a '**controversial**' figure largely discredited in antiracist, trade union and equality third sector circles).

While racial inequalities in England and Wales have been documented, the same for Scotland have **yet to be revealed**. Yet (with some exceptions, such as the evidence review), available analysis has often tended to homogenise 'BME/BAME' groups – either **quantitatively** or discursively. This homogenisation is, perhaps, an understandable response to a public health crisis which is exacerbating **existing racial and ethnic inequalities**, and in the form of grossly disproportionate mortality rates.

However, aggregation obscures the complexities of racism and how it is **mutually constituted** by other structural inequalities. There is thus a pressing need to disaggregate not only by **specific ethnicity**, but by intersections of other structural inequalities.

As **intersectionality theory** reveals, homogenising equality groups tends to privilege the advantaged within-groups: generalising across the category based on one particular position within it, **effacing intersectional marginalisation** in the process. Furthermore, the category BME/BAME can discursively de-gender women of colour. In the light of this, this article will reflect on the intersections of race and ethnicity with other inequalities, which we might bear in mind when reflecting on racial and ethnic inequalities and

Covid-19, and which suggest possible directions for future research into inequalities and the pandemic. These intersections include disability, gender and **gender identity, and sexual orientation**, among other salient ones: class, nationality, **migration status**, and faith.

I do this with reference to claims made by equality third sector actors (organisations which have emerged because of inequality related to markers of identity, including racial justice, feminist, disability rights, and LGBTI rights organisations) in relation to other equality communities. These organisations play a key and at times overlooked role in policymaking, and an integral role in knowledge production about inequalities. Some of these other inequalities are more recently protected in equality legislation, and as such, data collection in relation to them is patchy or virtually non-existent (as is the case with trans status). Moreover, official statistics do not consistently examine all of these together. Therefore, we cannot gain a full understanding of the complexity of race, ethnicity and intersectional privilege and marginalisation in relation to the Covid-19 pandemic with reference to official statistics or existing research alone.

The ways in which these other structural inequalities intersect with institutional racism are not made explicit in these claims, so need to be further discerned – since the equality third sector remains largely siloed into 'equality strands', a situation which **my research** on intersectionality's conceptualisation and operationalisation therein responded to. Claims from other equality sectors may also understandably employ strategic essentialism; in any case, these claims need not necessarily be understood as competing, in the knowledge that no inequalities are mutually exclusive (though of course all such claims can and should be subject to intersectional critique).

Disability

According to research by the **Glasgow Disability Alliance**, the largest disabled people's membership organisation in Europe, COVID-19 has 'supercharged' inequalities already faced by disabled people. Disabled people, with BAME disabled people among them, already faced persistent isolation, poverty and exclusion from services, while the pandemic has led to increases in these factors as well as experiences of food insecurity.

According to disabled people's organisations participating in my research, these experiences are particularly acute for BAME and other intersectionally marginalised disabled people. This intersection of race, disability and socioeconomic status is particularly significant given the correlations observed between markers of socioeconomic status, particularly **deprivation**, and vulnerability to COVID-19 in terms of both incidence and outcomes.

My research has found that UK-wide, BAME disabled people's organisations have been particularly hard hit by cuts associated with austerity, with many such organisations who specifically advocated by and for disabled BAME people now dissolved.

Gender

Early research into gender differences and COVID-19 shows that proportionally more men than women die, while women of most minority ethnic groups are more likely to do so than white women, with Black women **4.3 times more likely**. Research into **other health indicators** in the UK has found that BAME people are disproportionately diagnosed and treated at late stages, with particularly negative effects for women. One possible contributing factor to these differentials is '**medical bias**', which has been named as a likely factor in racial inequalities in deaths from COVID-19 in the US.

Increasing incidence of domestic violence is a key gendered issue in relation to the pandemic. Commentary concerning this has largely been happening in parallel to, rather than with and through, commentary about racial and ethnic inequalities, in a familiar siloing which serves to marginalise the experiences and **perspectives of women of colour**, what Kimberlé Crenshaw named as political intersectionality (1991) in her still very relevant critiques of antiracist and feminist movements.

Specialised domestic violence services led by and for BAME women **were already grossly underfunded** compared with mainstream counterparts, and **it is unclear** how much, if any, of new funding committed for domestic violence services in the light of the pandemic will reach these services.

Sexual orientation and gender identity

The gendered implications of lockdown and proximity to abusive partners, with fewer options to leave have been highlighted. Yet the framing of domestic violence as an issue exclusively manifested in (heterosexual) intimate partner relationships or towards children in those contexts, has always served to mask (gendered), hetero/cissexist domestic violence and abuse experienced by lesbian, gay, bisexual and trans people from parents and family members (LGBT people may of course also be subject to domestic violence in **intimate partner relationships**).

This is an issue pertinent to all LGBT people, not just BAME LGBT people, but research indicates that the latter are **underserved by LGBT specific services**, access to which is even more limited for all in the current circumstances, even as many LGBT organisations **report increased demand**. Many LGBT people then, who may also be more likely to have ways of organising familial relationships which diverge from the (nuclear) 'household' which the lockdown policy is structured around, will have particularly challenging experiences of

lockdown.

LGBT people experience **health inequalities** which may increase risk in relation to COVID-19. Furthermore, pre-existing health inequalities *among* LGBT people would suggest that vulnerability to COVID-19 may be particularly acute for BAME and other intersectionally marginalised LGBT people.

I have highlighted just a few issues which emerge when the intersections of race and ethnicity with disability, gender and gender identity, and sexual orientation are considered in relation to inequalities and COVID-19. The groups of BAME disabled and LGBT people, and BAME women and men, all overlap, and experiences vary further by specific ethnicity. In a context where equality claims making remains largely siloed, and attention to intersectionality is fragmentary at best, it remains to be seen whether the pandemic will exacerbate the homogenising tendency of these claims, or whether analysis might take care to highlight intersectional marginalisation among BAME people and within equality groups.

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Experiences from past animal outbreaks help University of Edinburgh veterinarians adjust to COVID-19 working conditions, by Aphaluck Bhatiasevi

Experiences of infectious disease outbreaks, such as Foot–and–Mouth disease in 2001, have prepared Edinburgh's leading veterinary hospital to develop working strategies for emergency situations.

When the COVID-19 lockdown was imposed in Scotland, the Dick Vet Hospital for Small Animals rapidly reorganised their staff and workspace to comply with health guidelines. "We prioritise the safety of our staff, our clients, and endeavour to put the welfare and care of each and every animal at the top of our agenda," says Dr Sue Murphy, the Hospital's Director, a Veterinary Oncologist with speciality in small animals.

Those who could work from home, including receptionists and the account department, and those who needed to be at home, such as staff with young children, underlying health conditions or with transportation difficulties due to lockdown, were asked to do so.

Other clinical care staff were divided into three teams, to work on a rotating shift basis. Each team is on duty at the hospital for 24 hours, four days a week, followed by four days' working from home and four days off duty. This pattern

then repeats. Team membership is not altered, which keeps the risk of cross-contamination between teams to a minimum. Social distancing is also observed where possible in a clinical environment.

Clients who want to bring their animals to the Hospital have to make appointments by telephone or email. The Hospital provides as much remote care as is possible, so that their clients do not have to bring their animals in unless urgent medical attention is needed. Non-urgent cases can be triaged and if necessary, treatment deferred to enable prioritisation of emergency cases.

Animals requiring physical examination can be assessed in the car park area, as opposed to within the Hospital, enabling clients and staff to remain at a safe distance. Clients bringing sick animals to the Hospital are asked to stay in their cars where possible. If the animals are determined to be at risk, they are treated as priority cases. These considerations are made on a case-by-case basis. “Although they may not have an acute problem today, their health condition may deteriorate in the next few weeks, so we need to judge when it’s best to see them” says Dr Murphy.

Clients bringing animals to the facility are asked to strictly adhere to National Health Service (NHS) recommendations of handwashing before interacting with staff, and to maintain a distance of at least two metres. Since lockdown began in March 2020, there has been a substantial reduction in number of clients bringing their pets to the hospital or seeking telephone consultancy, says Dr Murphy.

The Hospital regularly reviews procedures in order to provide the highest possible protection to both humans and animals, with strict adherence to social distancing guidance. The Dick Vet recently resumed the offering of vaccinations to ‘at risk’ animals. At the moment, they are not offering routine booster vaccinations.

Some animals may also develop parasite–associated infections as a result of warmer weather. These ailments are not usually serious, and if lockdown continues, may be dealt with remotely, says Dr Murphy.

The Hospital’s services are offered to a range of small animals including cats and dogs and exotic animals such as rabbits, birds, reptiles, frogs, toads, snakes, turtles, fish and invertebrates. The veterinary school also has a practice dealing with farm animals including sheep, cows, an equine practice and referral equine hospital.

The Hospital provides a range of clinical services. It has a general practice, but also referral specialist services including anaesthesia; cardiopulmonary treatment affecting the heart and the lungs; dermatology to treat all forms of skin diseases; neurology and neurosurgery to treat a range of disorders of the nervous system; ophthalmology; and orthopaedic and soft tissue surgery. They use sophisticated diagnostic imaging technology to help diagnose illness, and offer comprehensive and advanced cancer treatments including surgery, chemotherapy, radiation therapy and palliative care.

Based on an interview led by Aphaluck Bhatiasevi, curator of the Covid-19 Perspectives blog and PhD candidate in Social Anthropology at the University of Edinburgh.

Dr Sue Murphy is Director of Clinical Services and Director of the Hospital for Small Animals.

Post COVID-19 solidarity challenges the danger of returning to normal, writes

Callum McGregor

Introduction

I would like to offer a sober yet optimistic speculation on the renewal of community and civic solidarity in the face of the rapidly unfolding coronavirus pandemic. Over the last forty years, social and civic solidarity have been systematically undermined by the neoliberal project. Yet over a decade ago, a global crisis of neoliberal finance capitalism presented us with an unprecedented opportunity to break away from its orthodoxies and rebuild the solidarity necessary for democratic citizenship. Instead, we lived through an astonishing period during which the 'alchemy of austerity' reworked the crisis as one of a bloated and inefficient welfare state (Clarke and Newman, 2012). 'Zombie' neoliberalism staggered on and inequality grew, as communities across the UK organised to resist austerity and ameliorate the worst effects of brutal cuts and punitive welfare reform. Perversely, a solidaristic rhetoric of 'sharing the pain' was invoked to justify the very policies that undermined solidarity: the reduction or closure of essential public services, youth and community centres, public libraries, as well as welfare reforms that the UN Rapporteur on extreme poverty and human rights compared to Victorian Poor Laws (Alston, 2018).

The pandemic has raised the stakes for those at the sharp end of all of this. Every day it becomes increasingly obvious how our experiences of daily life under 'lockdown' are fashioned by the intersecting dynamics of social class, 'race' and gender. Domestic violence has increased as women are trapped in homes with abusive partners (Townsend, 2020). Social distancing isn't possible for those providing frontline services and those required to travel daily on crowded public transport in urban centres. As our world shrinks, the harsh reality of uneven development is starkly highlighted as issues

of work, housing, public space (especially access to safe greenspace), transport, food security and broadband internet are felt most keenly by poorer communities. Despite this depressing portrait, there are also instances of, and opportunities for, solidarity. In this period of social distancing how might we build on these opportunities to reduce social distance?

The rediscovery of social solidarity

In discussing solidarity, we ought to clarify its different meanings and inflections. Firstly, it is important to remember that solidarity isn't exclusively a leftist concept tied to expansive articulations of social justice. Solidarity can be understood in exclusive terms, including nativist, conservative and xenophobic varieties (Scholz, 2015). Secondly, we can differentiate between social solidarity and civic solidarity (Scholz, 2015). Social solidarity is a descriptive concept, whilst civic solidarity is a normative concept. Roughly understood, social solidarity refers to the objective relations of interdependence underpinning a community or society. It is in this 'social' sense that we currently seem to be re-discovering solidarity, because in our shared vulnerability we are confronted with the reality of our mutual interdependence. We are all now expressing collective gratitude for our NHS. But more than this, we are suddenly alive to the reality that without our refuse workers, our Amazon employees, our gig economy delivery drivers, our supermarket workers, our teachers, our early-years workers, our care workers, our bus drivers, our cleaners, not to mention our NHS staff, life grinds to a spectacular halt. At the same time, we (men, in particular) are forced to confront the poorly paid or unpaid social reproductive labour undergirding the capitalist economy. For some of us, this rediscovery results in a type of ennui as the social hierarchy of labour flips on its head and we're left contemplating the social value of our own jobs. Many people who ordinarily enjoy a higher degree of financial and job security are

unceremoniously plunged into precarity as we are, once again, confronted with the shortcomings of the free market as a guarantor of human wellbeing. As a consequence, it is now much more difficult to 'other' those who depend on the welfare state. It turns out, we all do. This is the rediscovery of social solidarity.

The renewal of civic solidarity

This rediscovery of social solidarity in the face of the pandemic has motivated *acts* of solidarity at every level—from the familial, to the local community, through to the national. Streets and local communities organise themselves into WhatsApp groups providing networks of support for each other and the more vulnerable; people volunteer with the NHS quite literally risking their lives to do so; people engage in quotidian but no less important acts of solidarity such as cutting the grass of elderly neighbours, buying groceries, emptying bins in local parks, and so on. Most visibly, we now stand on our doorsteps and clap every week for the NHS and keyworkers in a nation-wide collective display of symbolic solidarity. Whilst not to be underestimated, these solidarity acts aren't enough on their own.

My hope is that this acute crisis starkly highlights the more chronic crisis of care—of social reproductive labour—created by an economic system that treats it as a 'free gift' and therefore undermines the preconditions for its own reproduction (Arruza, Bhattacharya and Fraser, 2019). Tackling this demands that our rediscovery of social solidarity acts as a waystation to the renewal of civic solidarity. We can understand civic solidarity as the institutionalisation of our mutual obligations as citizens through the state. Civic solidarity is associated with the European tradition of social democracy, whereby social rights are guaranteed through an inclusive universal welfare state (Scholz, 2015; Stjernø 2005). To understand exactly what's at stake here it's useful to turn briefly to philosopher Michael Sandel's arguments

about social justice and civic virtue. Sandel recognizes that purely utilitarian justifications for democratic welfare states are lacking insofar as they fail to recognise how inequality systematically undermines the sense of community upon which democratic citizenship depends:

Public institutions such as schools, parks, playgrounds, and community centres cease to be places where citizens from different walks of life encounter one another. Institutions that once gathered people together and served as informal schools of civic virtue become few and far between. (Sandel, 2009, p. 267)

Real community requires civic solidarity and it feels as though this moment offers an opportunity to draw parallels between the current context and the post-WWII context where a shared experience of hardship reduced social distance and generated the conditions for civic solidarity. However, nothing can simply be 'read off' from the existing conjuncture—it needs to be articulated into a coherent discourse adequate to the task of challenging the desire to return to 'business as usual.'

Conclusion: 'Never let a good crisis go to waste'

Over a decade beyond the crisis of 2008, we stand at another ideological crossroad. On the one hand, we have the opportunity to build momentum for a different politics, one which identifies and protects 'non-market norms' and institutionalises a renewed sense of civic solidarity; one which recognises and acts to address the crisis of care we currently face. On the other hand, we are tempted to return to 'business as usual'. From the beginning of this pandemic, we have been confronted with the double peril of the virus and its impact on an economic model which values growth at any cost. As we navigate the media panic over recession and economic catastrophe, now is the time to emphasise the shameful disconnect between idle wealth and the dearth of

socially useful investment produced by neoliberal capitalism.

We know that GDP is a poor indicator for human wellbeing and the health of the body politic. We know that quality jobs didn't follow economic recovery after 2008. We know that economic growth doesn't 'trickle down' but rather 'up', that risk is socialised whilst profit is privatised. In a context of falling wages and job insecurity, we know that the compensatory consumerism ensured by mass credit, resource expropriation and labour exploitation is unjust and ecologically untenable.

The very real danger lies in returning to 'normal' because the implications are terrifyingly plain to see: a return to a second round of ultra-austerity following a period of 'crisis Keynesianism', where we are urged to believe once again that we are 'all in it together', tasked with a collective duty to steady the ship following an unprecedented period of state spending to tackle the pandemic. In this neoliberal discourse, symbolic solidarity is allowed, even encouraged, whilst calls for civic solidarity are branded as disruptive or unpatriotic. Good neoliberals 'never let a good crisis go to waste' and this is how we should also see the task ahead of us—as an opportunity to weave together longstanding struggles *against* the privatisation of the commons, the crisis of reproductive labour, and thus *for* an expanded conception of labour rights and a humane and inclusive welfare state.

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What is a compassionate economy post-COVID-19, ask

John Gillies, Liz Grant and Katherine Trebeck

Perhaps Adam Smith knew all along

Compassion and economy are words which you rarely, if ever, see in the same sentence.

Yet none of us would be here without the love and compassion of our families when we were born and for years afterwards. Care for each other in the home is crucial to the functioning of the economy, but it is work that is not given value in GDP-focused assessments of the success of a nation. We, as co-directors on the University of Edinburgh's Global Compassion Initiative and Katherine Trebeck, researcher on wellbeing and the economy, make a case here that the COVID-19 global emergency means that we have not just an opportunity, but an imperative to create a more compassionate *and* a more successful economy than that which was already damaging people and planet as COVID-19 descended.

Compassion

Archbishop Desmond Tutu defines compassion thus:

"Compassion is not just feeling with someone, but seeking to change the situation if they are in pain, distress or suffering. Frequently people think compassion and love are merely sentimental. No! They are very demanding. If you are going to be compassionate, be prepared for action!"

Compassion is now much in evidence around us as society organises to deal with the catastrophe of huge numbers of infections and deaths across the world. The pandemic has created huge new workloads for health and care staff, delivery drivers, shop workers and others, sometimes undertaken at great risk to themselves, as evidenced in the mounting numbers of COVID-19 deaths in these groups. Local community groups

have responded to the pandemic by helping neighbours, vulnerable and elderly. GPs have rapidly changed their working practices and now see up to 90% of patients by video or telephone to protect patients and staff from infection. Hospitals have prioritised COVID care.

The Economy

We know that the economy in the UK and globally has taken an unprecedented hit and that life for us and future generations will be affected by the virus, with mass unemployment and the incomes being partially underwritten by Governments across the world. At the same time, we know that environmental breakdown, including climate change, is the biggest problem facing the human race and has not gone away when all eyes are on COVID-19. Climate change is a direct consequence of the way in which we have designed and run our global economic system. If we return quickly to the economic status quo, climate change will continue to accelerate and threaten the survival of many species, including the human one, within a few decades. But there is huge and perhaps understandable pressure, to do just that. Already we hear many calls for a return to normal, to get economies back on the road again and open for business. But a quick return to the status quo would see us step out of one frying pan into another.

It is worth instead stepping back to the 18th century for a counter to this. Adam Smith is often said to be the originator of 'devil tak' the hindmost' market economics, but this is a misjudgement. He did say in the *Wealth of Nations*:

'*it is not from the benevolence of the butcher, the brewer, the baker that we expect our dinner, but from their regard to their own self-interest*'.

However, nowhere does Smith say that the butcher is not, or should not be, benevolent as a person. His views on how trade should function within a society are well set out in the earlier *Theory of Moral Sentiments*, in which he states '*how*

selfish soever man may be supposed, there are evidently some principles in his nature which interest him in the fortune of others, and render their happiness necessary to *him.'* As Gordon Brown said in the Hugo Young Memorial lecture in 2005, *'I have come to understand that the Wealth of Nations was underpinned by the Theory of Moral Sentiments, and that his invisible hand was dependent on the existence of a helping hand.'* And helping, we know, is often a compassionate action.

Smith's approach to the economy is thus a direct predecessor of the concept of the Wellbeing Economy, in which humanity determines economics, not the other way round. Smith did not talk of growth but of 'improvements', and this should be how we think of the goal of economic policy beyond COVID-19. It is our task to ensure that a restored post-COVID-19 economy is an *improvement* on the old, that it allows us to return to meaningful work in a system that takes into account individual and planetary health, and thus addresses the challenges of intergenerational injustice, gross inequalities and catastrophic climate change. It must also address the spectre of mass unemployment, a significant post COVID-19 threat.

Sometimes, when people realise that they have to change, they will change. In our Universities now there is a huge focus on developing antibody tests, treatments and vaccines for COVID-19. These have been very quickly incentivised by Governments, industry and research funders, working often in concert.

However, we also need a focus on how incentives can help us better build a caring environment, which supports the many individual acts of kindness and compassion. The wellbeing economy approach (as championed by the Wellbeing Economy Alliance) to is to identify economic policies for a 'great pause', and then how to build back better. These represent a sensible—and compassionate—way out of here. Scotland's membership of the Wellbeing Economy Governments(WEGo) since 2018 means that we have a head start.

We now need a strong parallel focus on economic research to identify how to create local, national and global economies for the future, both to avoid the secondary disaster of a great and long-lasting depression and to address the continuing challenges of climate change and persisting inequalities. Adam Smith would approve.

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

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

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

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

particularly robust tool of accountability.

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

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

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

As is often the case with targets, even those who disagree with the target on principle cannot resist critiquing the government for failing to achieve it. Even those sceptical of the target have found it irresistible to use it as a tool for

holding the government to account. In this way, detractors of the target have inadvertently helped shore up its validity. In this sense, targets are highly performative, recasting how we frame social problems and evaluate policy responses.

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

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

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

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Political Studies Association Mackenzie Prize for best book in political science.

This piece was originally published in Cambridge University Press blog.

As countries ramp-up COVID-19 tests, Edinburgh University researchers discuss the expectations and values of diagnostics, writes Aphaluck Bhatiasevi

"*You cannot fight a fire blindfolded. And we cannot stop this pandemic if we don't know who is infected. We have a simple message for all countries: test, test, test.*"

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

Testing for COVID-19 has been at the centre of political debate about the pandemic response, particularly in the United Kingdom and the United States. The political messaging around testing has, however, underplayed the complexity of

diagnostics, says Dr Alice Street, senior lecturer at the University of Edinburgh's School of Social and Political Science. She was speaking at the Edinburgh Infectious Diseases' webinar series on COVID-19 on 'The social life of COVID-19 testing'. Dr Street is the principal investigator of DiaDev, a partnership between the University of Edinburgh, Kings College London, Kings Health Partners and Public Health Foundation India, which is funded by the European Research Council.

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

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

Dr Street says different kinds of tests are best operated in

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

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

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

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

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

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

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

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

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

Don’t touch your face!

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

conceal their behaviour from public view, the need to satisfy their bodies through pulling and picking occupies their thoughts most of the time.

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

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

the act, these words and actions can greatly increase feelings of shame and anxiety.

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

Anxiety

Anxiety can be an enormous trigger for people living with BFRBs, with stress influencing the strength and frequency of urges. Of course, it is assumed that living through a global pandemic is anxiety inducing, even for those with lower levels of anxiety. Paradoxically, in a recent Guardian article, Farrah Jarral notes that people with anxiety disorders and obsessive-compulsive disorder in the UK have reported *lower* anxiety during lockdown. Jarral suggests this is due to the stress of normal life and the benefits of slowing down for those with comfortable living standards and safe home environments. In BFRB circles, some anxiety has also been lessening, due to reduced social pressures and more time to relax with hobbies at home. For those who normally depend on external self-care strategies to manage their BFRB (regular appointments at specialist hair salons, unrestricted exercise), anxiety can be harder to maintain. However, some people have been able to adapt their self-care routines in new ways, like a friend who finally felt able to shave an undercut on the areas of her head affected from pulling. For her, the

lockdown provided an opportunity to cut her own hair without the anxiety of anyone seeing her, and the new hairstyle has boosted her self-esteem.

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

Stay at Home

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

Home can be triggering for people with BFRBs for several reasons. The first is a matter of time. BFRBs are a massive time-suck, as their compulsive and often subconscious nature can lead to hours lost each day. This loss of time was described to me as a "zoning out", similar to what has been written on compulsive gambling (Schüll 2014). During lockdown, the change in routine and excess time can increase the chances of procrastination and makes it harder to avoid entering the zone of pulling/picking. Working from home also creates additional challenges, as people often depended on being surrounded by colleagues to limit their BFRB activity during the day, but with no one around to hide from, sitting alone at computers becomes the ultimate trigger zone. Staying home

creates new ways of being seen, and remaining hidden. As one woman with dermatillomania told me, “With no social plans, other than Zoom sessions showing me from the shoulders up, I have felt free to mutilate my skin without the usual post-picking panic of how to hide the damage before I head out to meet friends.” Similarly, a woman with trichotillomania said she had lost so much hair during lockdown that she is afraid to be seen publicly once the restrictions are lifted.

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

Isolation

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

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

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

So while scholars consider the long-lasting mental health implications of COVID-19, it is important to acknowledge the

unique ways that different mental disorders are affected by this pandemic, especially conditions that receive little attention like BFRBs. Finally, we should make sure to pay attention to the sustained efforts of people who are finding new ways to care, for themselves, and for one another during the isolation of lockdown.

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Schüll, N.D. (2014) *Addiction by Design: Machine Gambling in Las Vegas*. Princeton: University Press.

BFRB Support Links

The TLC Foundation for Body-Focused Repetitive Behaviours: www.bfrb.org

The Picking Me Foundation: www.pickingme.org

To join online BFRB support groups during COVID-19, please contact: Bridget.Bradley@ed.ac.uk

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

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

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

Political Settlements Research Programme (PSRP) research on gender-based violence and its relationship to conflict

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

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

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

The updated 2018 study found a dramatic improvement in confidence in the police by domestic violence survivors. Nevertheless, the high degree of control exerted in IPV relationships continued. Indeed, the study identified a specific perpetrator strategy of 'social isolation' of victims. For example, 54 of the 63 study participants (86%) reported that their partner had prevented them from seeing or contacting their families and friends. Forty-eight participants (of 63; 76%) reported that their partner needed to know their whereabouts at all times. More than three quarters of participants in the 2016 study (49/63; 78%) reported that IPV had disrupted their income-generating

activities such as employment and education, as well as hobbies and leisure activities. The controlling behaviour of the perpetrator and impact of abuse had serious negative effects on the physical and psychological well-being of participants.

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

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

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

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

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

Restrictions imposed by COVID-19 do not only involve formal state regulation, but also a high degree of community self-

regulation. PSRP research has found that heightened community self-policing, which is common in conflict-affected settings, manifests in gendered ways. For example, gender non-conforming behaviour can be exploited by non-state armed groups to coerce individuals – fearful of disclosure – into cooperating with them. Moreover, gender non-conforming behaviour – including IPV victims leaving violent households – can be targeted for violent reproach.

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

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

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

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

Despite growing reference to gender and gender-based violence in peace agreements, in line with the WPS agenda, the PA-X

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

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

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

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

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

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

Conclusion

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

This article was originally published on the PSRP Blog

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

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

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

Legislation in Times of Emergency

Following agreement by both Houses of Parliament, the Coronavirus Bill received Royal Assent on 25 March transposing the Bill into primary legislation in the form of The

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

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

Through emergency legislation, special and extraordinary measures are enacted to respond to certain crises, in derogation of existing standards and rules. The adoption of emergency provisions invokes differences of opinion regarding their appropriateness and necessity. On the one hand, emergency legislation is thought to enable the state to respond effectively to crises while keeping the exercise of

emergency powers within the rule of law. It reflects that, in extraordinary times, Parliament must make some allowance for the passing of laws quickly and effectively should circumstances demand it. On the other hand, emergency provisions, in granting powers to the state that circumvent 'normal' legislation, can have adverse effects on the enjoyment of rights to life, a fair trial, liberty and security, and freedom of assembly and association, as examples (see Amnesty International; Joint Committee on Human Rights; Greene). Times of emergency can, therefore, produce what Oren Gross terms a tension of 'tragic dimensions' between democratic values and responses to emergencies.

Where one sits on the potential trade-off between government intervention and individual rights and freedoms during times of emergency is a matter of personal opinion (see different contributions from Koldo Casla and Kanstantsin Dzehtsiarous). It is, however, the longer-term implications and impacts of law adopted in response to emergences that raises additional and arguably greater concerns. There is always the risk that exceptional or emergency powers, granted for temporary purposes, can become 'normalised' over time. Alan Greene has noted, for instance:

> *History shows us that emergency powers often outlive the phenomenon that triggers the introduction of emergency powers in the first instance. While the need for exceptional powers may be obvious at the outset of the emergency, assessment of the point where these powers are no longer needed is considerably more problematic.*

Elliot Bulmer also identifies that many governments have used emergency powers inappropriately – needlessly prolonging or renewing states of emergency and using emergency powers not to restore democratic normality but to bypass normal channels of democratic accountability. When examining emergency legislation, therefore, one is required to contextualise any

assessment in light of the broader realities and tensions faced, accepting as part of this analysis the need for flexibility on the part of the state to respond to the unfolding events. At the same time, it is also necessary and expedient to consider the potential ramifications of any necessary restrictions on the enjoyment of rights at a later stage. Sunset clauses, in theory, exist to bridge this chasm between immediate requirements and future fall outs, ameliorating, in turn, the tension of 'tragic dimensions' between democratic values and responses to emergencies.

The Use of Sunset Clauses in Emergency Legislation

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

Various emergency provisions adopted in response to Covid-19 have included variations or combinations of sunset clauses. In the **UK**, for instance, section 89of the Coronavirus Act provides that the majority of the provisions will expire after two years. However, this period may be extended by six months or shortened in accordance with section 90. The Government also accepted an amendment, which introduced the requirement

that the operation of the Act must be reviewed by Parliament every six months (see section 98). In **Ireland**, the powers under The Health (Preservation and Protection and other Emergency Measures in the Public Interest) Act 2020 will cease to have effect after the 9th day of November 2020, unless a resolution is passed by both houses of the Oireachtas (parliament) to approve the continuation of the measures. In **Scotland**, the Coronavirus (Scotland) Act includes a "sunset clause", according to which most of it will automatically expire six months after it comes into force. MSPs will be able to vote to extend this for another six months if necessary, and then for another six months after that, but this is the absolute limit – so the measures in the Act have a maximum duration of 18 months. In **France,** the emergency lasts for two months from the day of its adoption, although it can be extended by lawmakers.

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

The Limitations of Sunset Clauses

Nevertheless, while history teaches us to approach emergency laws with a degree of scepticism, it is equally necessary to adopt a cautious approach to sunset clauses. The addition of sunset clauses notwithstanding, pieces of emergency legislation can remain in force long after the proposed sunset. In the US, for instance, the 2001 Patriot Act adopted in the aftermath of the September 11th attacks, included sixteen sections originally meant to sunset on December 31, 2005. The Act was, however, reauthorised several times in the following years following very limited evaluation. When sunset clauses provide for further debate, the efficacy of the review

process is of central importance. However, the mere provision of future scrutiny is no guarantee for the effectiveness of that process. For instance, the Counter-Terrorism Review Project highlights that in the 2003 debate in the House of Lords on whether to renew the Part 4 powers of the Anti-Terrorism, Crime and Security Act 2001 – the controversial measures which allowed for the indefinite detention of non-national terrorist suspects – just four Lords spoke. This included the Minister who had introduced the renewal order. Only 13 MPs attended the first debate in 2006 on whether to renew the Prevention of Terrorism Act 2005 – the legislation which established the control order regime. In addition, the time allotted for debates on sunset clauses is also very short, often limited by parliamentary procedure to only an hour and a half. This has not always been a problem for Parliament. The House of Commons Third Delegated Legislation Committee, which was entrusted to consider whether the Terrorism Prevention and Investigation Measures Act 2011 should be renewed for a further five years, debated the measures for just 32 minutes (see here for discussion). In addition, there are questions regarding the most effective form of review. If parliamentary post-legislative review is the chosen approach, there may be problems associated with politicisation of the legislation in question. Should, then, the review be undertaken by an independent expert, Committees of the House of Commons or Lords, or independent group? If so, how democratic is this process?

Similarly, there are questions around the necessary period of time between adoption and review and between different review processes. Although the UK's Coronavirus Act allows for review after a period of 6 months, this may still be too infrequent. During the House of Lords review of Fast Track Legislation in 2009, for instance, The Better Government Initiative argued that "post-legislative scrutiny is all the more necessary" in cases of fast-track legislation, and that "it should perhaps be more frequent." Such is the nature of the pandemic and such

is the extent and wide-ranging nature of powers afforded under the Coronavirus Act (and similar pieces of legislation adopted globally), that more review processes might be required. But how might this be achieved in light of social distancing? Of course, many of these are issues that arise in the context of any review process, but they nevertheless demonstrate that there are a range of considerations to flow from sunset clauses, which require ongoing scrutiny themselves. In short, sunset clauses, in whatever form, are important but should also be approached with a degree of caution.

Conclusion

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

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

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

At the same time, many of these same impoverished countries are also in the throes of violent conflict. We know from experience that the relationship between armed conflict and crisis is complicated and leads to unpredictable results. If this unpredictability is, however, itself predictable – a "known unknown" – can a "smart" response be put in place? Our

ongoing research at the Political Settlements Research Programme suggests that the following 11 baseline understandings are likely to be key in designing the most effective responses to the COVID-19 pandemic in conflict-affected regions:

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

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

2. Mid-level peacebuilders have unique capacities to bridge and build trust between the state and local communities

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

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

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

4. Crisis management can have “peace dividends”

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

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

Crises can also be used as cover for military and political gains in a conflict that is continuing. For example, the same 2003 tsunami that arguably helped produce a peach agreement in Indonesia, contributed to dynamics that ultimately saw the peace process in Sri Lanka failing, producing a bloody conflict. In Nepal, the deadly 2015 earthquake pushed the main parties to agree to a permanent constitution, but at the price of narrowing the peace process’ wider promise of inclusion to

a range of ethnic and socially excluded groups, including women. In Ogaden Ethiopia, famine and delivery of food aid has often been charged as being a vehicle for the Ethiopian military to gain access to opposition-held areas, and pursue destructive policies such as “de-villagization.” Local humanitarian agreements in Syria, also stand charged with swapping “bread for surrender.” Thus, how crisis response is delivered, and how it enables other agendas, can become independent conflict accelerants, as can perceptions of bias in terms of which communities’ needs are viewed as being prioritized.

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

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

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

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

8. Diplomacy and peacekeeping may become “absent”

The pandemic has impacted on all forms of diplomacy, from Brexit to regional peace processes. Peace processes

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

9. Emergency legislation is a response with conflict-dangers

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

when the health crisis does, but continue indefinitely.

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

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

11. A lack of international legal confidence

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

Conclusion

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

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Political Settlements Research Programme (PSRP) blog.

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

The UK and other countries are using the COVID-19 coronavirus outbreak as an excuse to prevent even the most vulnerable of refugees from crossing their borders.

In recent weeks, according to the United Nations, at least 167 countries have either fully or partially closed their borders. These travel restrictions seem an important means to help contain the pandemic, but they are also proving to be a way for some countries to forfeit their asylum responsibilities.

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

Some politicians have openly signalled their intention to use the present uncertainty to ramp up anti-refugee sentiment. The

Hungarian prime minister, Viktor Orbán, for example, has told the people of Hungary that “our experience is that primarily foreigners brought in the disease, and that it is spreading among foreigners”. In Italy meanwhile, the former interior minister Matteo Salvini has claimed that his country’s outbreak was caused by a maritime refugee rescue in Sicily.

Closer to home, the legal charity Safe Passage has issued to the UK Home Office a list of unaccompanied children and vulnerable adult refugees trapped in refugee camps on the Greek islands, but who have been legally cleared for transfer to join family in the UK. The Home Secretary has refused to accept them.
What is at risk in all of this is not just viral contagion, but the very basis of the international refugee conventions that have shaped our post-war landscape. This includes the principle of “non-refoulement” which is the cornerstone of international refugee protection.

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

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

The WHO has helped establish the International Health Regulations (IHRs) designed to form an international legal

position for responding to a public health emergency of international concerns. The regulations were not conceived to undermine the 1951 Refugee Convention nor EU refugee law, where the Charter of Fundamental Rights guarantees the right to seek asylum.

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

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

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

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

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

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

Often, the news is not good.[1]

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

That said, even in countries where abortion is legal, the pandemic has shone a light on shortcomings in current abortion law and provision – and particularly the perils of assuming

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

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

borders shutting and supply chains disrupted, the revolutionary potential of abortion pills, now more than ever, is being put to the test. So: how are they faring?

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

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

Finally, even in contexts where abortion pills are available, it's important to note that, for many patients, they now exist in a context where patients have few other options – it has been reported that 25% of UK clinics are currently closed due

to staff shortages, while travel disruptions and restrictions are impacting people's ability to travel for appointments both domestically and transnationally. As Cassandra Yuill (2020) has pertinently pointed out, rights to choice in reproductive and sexual health care are "evaporating in the name of public health" – and, in so doing, revealing the ideological illusions and power imbalances that underlie many contemporary healthcare systems.

Taken together, these pandemic conditions only serve to highlight the fact that abortion pills are not, and have never been, a silver bullet solution to the issue of abortion access. Certainly, the availability of telemedicine abortion, whether through formal or informal channels, provides important opportunities for safeguarding and promoting abortion access in times of crisis. Nonetheless, times of crisis also reveal the shortcomings and limitations of these pills, which remain entangled within the wider medico-legal nexus, and shaped by infrastructures that depend on global production supply chains and technology and information systems.

While the long-term implications of the pandemic on reproductive health and rights remains to be seen, the current role of abortion pills in attempts to navigate the pandemic highlight that no one technology has the power to "change everything". If we want to ensure abortion is accessible for those who need it, then we have to address the broader political, cultural, socioeconomic, and structural factors that shape the contexts that these technologies exist within.

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

Smita Srinivas: fractured economics and considerations for the COVID-19 vaccine market, by Ritti Soncco

The Innogen Institute is a collaboration between the University of Edinburgh and the Open University to produce research and support innovation in a profitable, safe and societally useful manner. It builds, nationally and internationally, on fundamental and applied research in science, medicine, engineering and social science. In April, the Innogen Institute discussed Professor Smita Srinivas's co-authored article Economics and Public Health: a care for interdisciplinary cohesion in the time of coronavirus *and the relevance of her work on the Covid-19 pandemic. Below is a summary of the interview by our COVID-19 Perspectives team.*

Professor Srinivas's research focuses on economics, with emphasis on economic development, technological innovation, and industrial policy. One aspect is big picture economics for policy with relevant changes in the discipline, the other is microeconomics to examine empirically how technological capabilities, learning, and innovation evolve, which generate more or less useful developmental outcomes. For the last 20 years in addition to other industries, she has researched how vaccines and pharmaceuticals, with more recent work on diagnostics, come into being and are regulated. Although the perspective comes from economics, this research spans public policy and public health. Professor Srinivas explains that analysing the firms in these sectors reveals useful features of what they look like, how they perform, what they research or invest in, and how the learning and innovations that these firms generate are aligned with public benefit or are rewarded. From an industry dynamics viewpoint, public health

is an industrial organisation problem requiring greater attention; the economics underlying public health – as with much of economics – is out of date.

The economic discipline is, says Prof Srinivas, 'deeply fractured'. This is affecting how we tackle several problems, including but not limited to: COVID-19, climate change, biodiversity, energy challenges, financial crashes, etc. She argues that students of economics today are not sufficiently taught the advances in domains such as evolutionary institutional analyses nor sufficient efforts made towards teaching a pluralist economics, which includes but is not limited to, what is termed 'mainstream' economics. Economists using a single or short list of methods are holding the discipline back, states Prof Srinivas, and 'skewing public policy responses in a very alarming way'.

Currently Prof Srinivas is overseeing two projects in India one involving several Innogen members and led by the Open University: *Innovations for Cancer Care in Africa* examines how India, Tanzania, Kenya and the UK address different types of cancer to ask questions on economics methodology and a comparative policy viewpoint. The second project is a long-standing research area and recent collaboration with public health and clinical specialists examining vaccine development and its economic considerations. She is also writing on diagnostics and covid testing. In many countries, COVID-19 is a threat but so are other diseases which are vector borne or infectious, such as dengue, H1N1, and which with others, may generate inexplicable fevers. Patients may come in with several confounding symptoms, which make diagnosing COVID-19 cases difficult and sideline other disease priorities for the country. Furthermore, the Technological Change Lab (TCLab) has launched an integrative initiative of Health, Industry and Ecology (HIE) to examine the resilience of food-health systems in the current context as well as in post-COVID-19 plans; the global organisation of the health industry; and comparative

development lessons in and from India and other industrialising countries about relative successes around planning and policy.

Prof Srinivas's interest in these projects lies in the role of institutional change, including markets and their varieties, how they come to be and their regulation. Studying these factors is important in order to decide what policy responses should be and which non-market strategies to use. In the case of vaccine development, Prof Srinivas elaborates, market size and demand will determine if a private-sector led vaccine development initiative is reasonable, or which stakeholders should be involved. The seemingly infinite nature of the Covid-19 market and the frantic scrambling of companies to be the first, has left governments, donors and multilateral institutions overwhelmed and confused. Clarity on what types of markets are needed and why is essential, says Prof Srinivas, as are the instruments used. To this she points to the relevance of her 2006 publication on industrial procurement processes for vaccines that sped up learning at the level of firms, but which have reward and market design considerations for health impact. Attention to such policy instruments helps highlight the importance of a public stakeholder process built alongside industrial development: firms drawing on public resources or public data for example, might be required to create a different type of market. In any case, without taking the eye off public health outcomes, there are vital economic development considerations to be weighed, and the relevant economics that can best address this. Long-term economic strategies must be put into place for wider public benefit of technology transfer as well as private firm growth.

Summary by Ritti Soncco. Read the full interview on The Innogen Initiative website where the article was originally published:

https://www.innogen.ac.uk/news/meet-our-researchers-prof-smita-srinivas

Prof Smita Srinivas is SGSS Professorial Research Fellow (Economics, Development) and Member of the Innogen Institute at The Open University (UK). In 2015 she received the EAEPE (European Association for Evolutionary Political Economy) Myrdal Prize for her book on the health industry "Market Menagerie: Health and Development in Late Industrial States" (Stanford University Press, 2012). She is the Founder Director of the Technological Change Lab (TCLab), a research platform, Visiting Professor at the National Centre for Biological Sciences (NCBS), TIFR, in Bengaluru, India, and Honorary Professor in the STEaPP department, University College London.

Kindness has thrived during the lockdown, write the Directors of the Global Compassion Initiative

The pandemic has prompted countless acts of caring – and compassion will show the way forward after it has passed. Kindness has thrived during the coronavirus lockdown.

In Gabriel García Márquez's novel Love in the Time of Cholera, Florentino commands the captain of the river boat to raise a yellow flag signifying cholera on board. Passengers already on the boat get off, no new passengers embark, leaving Florentino and the widowed Femina together to love. The flag creates a place of separateness, allowing a deep relationship to flower.

There is a metaphorical yellow flag now flying across the UK. The lockdown triggered by the Covid-19 pandemic has echoes of that boat journey. Hemmed in, with all our movements and interactions constrained, many are experiencing rising fear, anxiety, exhaustion, frustration and anger. There is much uncertainty and confusion as to how to manage relationships altered by the pandemic. And it is within these relationships that life is lived. And lost.

It is also in the interstices of these relationships that compassion lives. Compassion can fill the space and join the separate and broken pieces. We have seen exceptional moments of compassion: the sign-up of 750,000 people to the NHS volunteer scheme; and the clapping for the NHS, care services and key workers across every city and village. And then there are countless unseen acts of compassion within communities, with neighbours checking in on neighbours, or customers purchasing the groceries of strangers who had clearly come off long NHS shifts as a signal of gratitude.

Such kindness didn’t start with Covid-19 – it was always there in people – but the pandemic has given us a space to see it and permission to be compassionate. A light is being shone on what happens every day in every town across the UK. What was hidden and unremarked upon is being noticed as an essential part of our existence, enabling us as a society to keep faith in the future and to believe that we can get through this.

There is an opportunity now to hold on to what we have, and to celebrate and grow it. Compassion can become a driver of change. Such compassionate action, the psychologist Paul Gilbert suggests, often involves individual acts of courage: to support colleagues in distress, stand up for the oppressed, or challenge authority when the wrong course has been taken. We have seen all of these during the past month.

We see daily the terrible toll the pandemic is taking on human life across the planet, particularly in low-income countries.

At the same time, interventions to contain the disease have contributed more to tackling climate change in these few weeks than the Conference of the Parties has achieved in years. Flight reductions and a cut in the use of fossil fuels have seen carbon emissions fall. It is a terrible irony that a virus, which impairs the ability of human beings to breathe, has shown compassion to the planet, providing clean air for natural ecosystems to thrive.

How do we reimagine the future and avoid merely returning to the status quo? It is acts of compassion that are transformative. By acting to alleviate suffering, we will find our way through the acute, complex challenges of this pandemic – learning lessons that build towards healthier, more balanced and happier communities globally.

This article was originally published in The Sunday Times: https://www.thetimes.co.uk/article/acts-of-compassion-ingrained-in-lockdown-can-help-us-after-covid-19-say-scots-academics-jhhll5tmq

Liz Grant is Professor of Global health and Development; John Gillies is Honorary Professor of General Practice and co-director of Edinburgh Compassion Initiative; Kirsty MacGregor is Chief of the MacGregor Leadership Consultancy; Paul Brennan is Senior Clinical Lecturer and Honorary Consultant Neurosurgeon; Wendy Ball, consultant and senior fellow, Global Health Academy; and Harriet Harris, head of Edinburgh University chaplaincy service.

Liberalism is fiction and

privilege depends on disadvantage, writes Rebecca Hewer

If, like me, you find a measure of solace in comprehension, today's global pandemic will likely represent a particular kind of intellectual discomfort. Though incisive perspectives are available, the geopolitical, sociological, economic and public health implications of Covid-19 are so vast and various as to frequently defy useful ad hoc analysis. The potentially cataclysmic consequences of this health emergency are intimidatingly numerous: transnational and localised, embodied and sociological, changing day by day. This coronavirus outbreak is ripples on ripples. It will take us years, if not decades, to fully come to terms with its implications on our social reality (if such a thing were even possible).

It would, however, be irresponsible to suggest that the impact of this virus was entirely unforeseeable. Prior to this outbreak, epidemics had not been assigned to the archives of history, or the mythology of Hollywood. Indeed, in recent years, SARS, Ebola and Zika all exposed the very real possibility and consequence of contagion. Better state preparedness was possible – warnings were issued and ignored. Western exceptionalism and colonial arrogance – long critiqued by any number of voices – likely prevented the UK government from learning more quickly, or more effectively, from South Korea and China. The policy of austerity wrought havoc on our national health system: its vulnerability to crisis was anticipated. There is a difference, after all, between struggling to comprehend the granularities of a specific social occurrence and knowing where the cracks are.

This is true for more than human health and infrastructure. Our social worlds are not random and arbitrarily structured,

they adhere to regularities and to rules which shape individual chances and collective outcomes. As French sociologist Pierre Bourdieu observed ‘the games of life… [are] something other than simple games of chance offering at every moment the possibility of a miracle’. [1, p. 46] And of course, it is the task of sociologists and social theorists to explain these rules and regularities, as well as how they come to be, how they come to change and how they respond to pressure.

For a long time, critical social theorists, particularly feminist theorists, have argued that the logic of liberalism – a prevailing ideology within the western world – is premised on a political fiction. Put plainly, liberalism instructs that we, as human beings, are independent and unencumbered – relatively *invulnerable* to the vagaries of the social world, and our position in it. In turn, proponents of liberalism posit that – through ambition and endeavour – we can all sculpt out lives into whatever we desire them to be. No matter our backgrounds, or the resources immediately at our disposal, we can pull ourselves up by our bootstraps and strive. Black, white, gay, straight, woman or man – you can do it! The only thing that stands in your way, is you! If we flounder, are unsuccessful – poor and socially marginal – it is because we have failed or failed to try. If we are staggeringly affluent, it is because we have worked. We are neither victims of circumstance, nor the beneficiaries of privilege: we are masters of our fate and captains of our soul. This was the organising logic for Thatcher’s famous claim that there is ‘no such thing as society. There are individual men and women, and there are families.’

In the liberal imagination, then, dependency is abhorred: a condition of the very young, the very old, and the chronically, unforgivably lazy. Those who require income from the state are labelled morally reprehensible scroungers – maligned and blamed for their poverty. Parents who struggle to

clothe and feed their children, are condemned for the irresponsibility of ever having children at all. Structural injustices are denied, and resistance to those injustices is framed as a politics of envy and unearned grievance. This is the logic we've built worlds around: businesses, schools, legal systems and social security provision, are all predicated on these assumptions. Individual responsibility, meritocracy and social mobility are celebrated, permeating our public discourse, guiding our behaviour and shaping our perspectives.

But liberalism is a fiction; we know it's a fiction. What is more, we know that it is, always has been, and always will be, ill-equipped to understand or (in its instantiations) address the realities of the social world – whether quotidian in its violence, or unusually cataclysmic. We are not independent and unencumbered but, rather, heavily embedded in a network of relationships – with each other, the market, civic society, the state and so on. What's more, the number, nature and quality of our relationships has a significant and enduring impact on our lives – supportive and lucrative relationships are asymmetrically distributed, as are the denigrating and impoverishing ones. In sum, the idea of a person invulnerable to the various (positive and negative) influences of the social world is absurd – a fiction sustained by the privileged, who would rather the formative nature of their dependencies be hidden, and their advantages read as the achievements of the meritorious. [2]

Covid-19 exposes the political fiction of liberalism, in both straightforward and complex ways. It demonstrates our inherent embodied vulnerability to others and to a world we cannot control: we are all, without exception, susceptible to the influence of each other and disease. And whilst reducing that susceptibility has been cast as an individual task, it nonetheless remains the case that its performance is heavily predicated on our relationships – to each other, to the

market, to civic society, to the state. Our dependencies shape not only our ability to avoid disease, but the conditions within which we are able to do so. If our job is secure, our house safe, our communities supportive – we can relax in relative safety. If we live hand to mouth, in fear for our wellbeing, marginalised and excluded – a pandemic might not even register as an imminent threat. As Sarah Ahmed opined, 'Privilege is a buffer zone, how much you have to fall back on when you lose something. Privilege does not mean we are invulnerable: things happen, shit happens. Privilege can however reduce the costs of vulnerability, so if things break down, if you break down, you are more likely to be looked after.' [3]

But more than this, Covid-19 exposes the falsity of our social hierarchies, revealing the degree to which privilege *depends* on disadvantage – how privilege functions through extraction. We are only able to remain at home, fed and warm, because of relationships which were already very much in place before this pandemic occurred. We have not recently become – in the face of unprecedented crisis – dependent on factory workers, supermarket staff, delivery drivers, hospital cleaners, childcare providers and so on. We were *always already* dependent on groups of people routinely condemned for their relative lack of affluence. People who – despite massive endeavour – struggle to generate sufficient income but sometimes dare – nonetheless – to have children. Our dependencies have not only just materialised; their character has merely changed. And in this change, in this great unsettling, they have become visible. Coronavirus did not make society, it merely showed us it was there.

In a recent address to the nation, and in an obvious repudiation of Thatcher, the Prime Minister opined that 'there *was* such a thing as a society'. Nice of him to notice. But his invocation of the term demonstrated a stunted and partial comprehension of its meaning. For him, society is a

coming together, a collective endeavour, a performance of that mythological wartime spirit the British public always seem so excited about. But society is not necessarily a benign or benevolent force: it is a normatively ambivalent phenomena which can both support and stymie human flourishing. And at the moment, it is a system whose lifeblood depends on the sacrifices of the less advantaged. As I remarked in a recent publication, 'Mainstream society makes itself tall by standing on the bodies of the marginalised.' [4] How long do we imagine we can prevail upon such bodies to carry the weight?

It will be years, if not decades, until we fully understand the profound psychosocial, economic, political and cultural ramifications of Covid-19. The loss will be significant, the trauma profound, the ripples on ripples intricate in their manifestations. But we do know, have known, will know where the cracks are. And the lies of independence, meritocracy, the deserving rich and the undeserving poor, are some of the biggest cracks of all.

This article was originally published on the Justice in Global Health Emergencies & Humanitarian Crises *webpage: https://www.ghe.law.ed.ac.uk/the-illumination-of-a-pandemic-by-rebecca-hewer/*

Rebecca Hewer is a postdoctoral fellow with the Centre for Biomedicine, Self and Society at the University of Edinburgh. She is an interdisciplinary researcher, with an interest in critical social theory, whose work explores the socio-legal regulation of (women's) bodies.

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Edinburgh students share personal concerns, threats and possibilities in American Ethnologist

Jonathan Spencer: Introduction

The following texts were written by students with whom I have worked this year in a course on the anthropology of the political. The pieces were written in a few days between March 23-30; they are necessarily immediate and unpolished. Two authors (Elizabeth Fraser and Pelagie Couroyer) are final-year undergraduates, two (Anna Brooke and Juan Mejía) are MSc students. Elizabeth is Scottish, Anna is English, Pelagie is French, and Juan is from Honduras. The title is taken from Pelagie’s piece and brings out the tricks the pandemic has already played with our sense of time, and in some cases, space. Written as she packs her bags to make a dash back to France, she worries about the apparent suspension of certain kinds of critique in the face of emergency. Elizabeth tracks

the virus as it moves from remote to close to immediate, and asks what anthropology has given her by way of resources with which to respond. Juan tacks between his presence in Edinburgh, awaiting the next round of instructions for the “online scramble,” and his mother’s movements past military checkpoints in Honduras, but he also moves back and forth in time, invoking earlier experiences of curfew in Honduras, and the political imperatives that seemed to accompany them. The incongruity between the University’s institutional response, and the immediacies of the moment, is a recurring theme. Anna’s final piece details an absurd gift that magically generates new forms of sociality in a previously anomic housing block.

Pelagie Couroyer: The End of Time, not Time

Deserted seafront, Le Havre, Normandy. Pelagie Couroyer.

My timeline has abruptly stopped. After a week of emails dominated by words like “Covid-19,” “Cancelled” or “Temporarily Closed,” and “Stay safe,” I lost my grip on future plans. My thorough planning became as ephemeral as the timeline I drew with chalk on my blackboard. I am upset because I have lost control over time and never quite understood the privilege this implied. My university schedule has collapsed, graduation ceremonies are cancelled, my work hours are on hold, my routine in isolation is one constant interrogation. News stories and politicians, university emails and refund offers, have shifted my motivation to the present realm, and I do not move any more. How does one take decisions without knowing what the future holds?

I did not expect to leave Scotland a week ago, but now I write at the same time as I pack. Macron said, “I want to let all our fellow citizens abroad know that… we will organise repatriation.”[1] I have called my mother’s insurers, and the French Embassy in London who both told me, “Coronavirus is a state responsibility . . We don’t organise transport . . We don’t cover repatriation costs.” Sadly, I could not find a number for “The State.” My national feeling was short lived. So why am I leaving?

My role has forcibly changed: I am not primarily an Edinburgh student working part-time any more, I am the daughter of a “front-line nurse,” the granddaughter of an elderly woman “at risk,” in a time of an epidemic “war.” In his address (16 March) “to his fellow citizens (*concitoyens*),” the French President said seven times, “We are at war (*nous sommes en guerre*).” The obligation of kinship had rarely felt so salient to me. But in this frozen and unproductive time, my identity became relational – daughter *of,* citizen *of*. All our identities, I believe, are being amalgamated into “families,” “fellow citizens,” friendly “neighbours,” urged to #savelives by #stayingathome. We are individually responsibilized, *en masse*; I do not question the necessity to enact social distancing and other precautionary measures to contain the virus, but I do wonder why we receive the orders so uncritically. Look at Italy, listen to China. Was the motive social or economic in this slow-paced lock-down?

Do we forget about our critical thinking in times of viral war? Anthropology has always taught me that times of crisis

are decisive. So what will happen when the clock starts moving again? Will this breach in our schedules, conventions, and expectations, be a productive thinking exercise to build a better future, or a case for burying our heads in the ground? Will we continue to let governments take all the decisions in the reconstruction efforts, or will we remember a long-forgotten duty of states to protect the most vulnerable? Edinburgh might have become a ghost town, the university a digital promise, but anthropology is as important and relevant, as always.

Juan Mejía: Discourses of Contagion, Dreams of Anthropology

As the morning wears off, I have come to the eerie realization that for the last weeks there have been competing demands for me to exist in two worlds that seem to share their blindness, as well as their determination, with sleepwalkers. As 1 pm in Edinburgh gets closer, for the first time in a week I start checking my official university email to find the specific adjustments every course has made for the online scramble, just in time for my alarm to start. Away from the glories of British higher education, in 7 am Tegucigalpa, the absolute military-run curfew imposed on all major Honduran cities will be lightened, but not lifted. I follow my mother's trail, with her fake "essential" industry identification, and enough money to get out of a checkpoint or two, to reach the supermarket and later leave basic supplies at my grandmother's house.

The irresistible charm of a good text on the co-production of state and kinship at noon, with its redeeming promise of high marks and knowledge, exists in a different place from my mother and a disinterested soldier. In Honduras, my home country, we have had curfews every few years, crisis since the dawn of written history, and an unspoken intimacy with discourses of contagion. Hence, an official message with the president surrounded by military men, regardless of where you are, becomes an object of intense scrutiny. It might be the need to stop gang violence 15 years ago, the dangers of "chavismo" ten years ago, domestic terrorism, youth vandalism,

or coronavirus, but the announcement of an absolute curfew is received with a rush towards a week of supplies and towards the alleged safety of home.

During curfew, life is supposed to be interrupted, two or three months of political frenzy with vast periods of staying at home. Reacting to a crisis in any other manner has always seemed like a kind of betrayal. During a long university strike, when the possibility of students accepting the implementation of distance learning emerged, a classmate screamed: “Normal lectures? With so many arrested and dead, that is impossible!” Context aside, the demands of being a student in a prestigious private university, away from home and funded with difficulty from a feeble public budget, now create a parallel sense of guilt. What was I pursuing in this university? Was it a degree like those that often adorn Honduran living rooms which would open a gate or two? Or was it the dream of learning new and different ways of working with ideas in anthropology?

Vanity becomes at times indistinguishable from genuine intellectual curiosity, but for the sake of argument let’s put my vanity aside and consider the dream of anthropology. It is a dream that sends shivers down my spine and that seems distorted, not by the contingencies of a crisis, but by the imperative to transform higher education into a degree-printing machine. The higher education system can seem gilded. The scramble into distance learning is a demand that cannot be ignored. A demand for a double betrayal and double existence in two times, 1 pm in glory and 7 am at home.

Elizabeth Fraser: Contagion: From the Classroom to the “Real” World

On Monday March 23, Boris Johnson appeared on our television screens and interrupted normal programming to announce the lockdown. I had an interview earlier in the day for a graduate programme. My self-isolating interviewer, who was alone rather

than heading a panel, and on Skype rather than in person, remarked as she looked over my transcript how ironic it was that I was taking an anthropology course called Contagion in the middle of a pandemic.

And yes, a silver lining of Covid-19 is that it has proven to my hard science-subscribing family that medical anthropology is a valuable discipline to pursue. Every time I phone her, my mother now talks about the virus "revealing so much about what's wrong with society." The posts spilling one by one onto our social media feeds like a pot of bad news boiling over are all in some way about structural violence:

• People we know on zero-hour contracts admitting they have lost their jobs overnight with no compensation.

• Lists of tweets from American food servers who think they might be infected but can't afford to take unpaid sick leave, so go into work anyway.

• Desperate pleas from NHS Lothian asking for volunteers to come to hospitals and feed patients because there are not enough employees to keep up after years of under-funding and under-staffing in the name of austerity.

• Caroline Criado Perez, author of *Invisible Women* (2019), pointing out that "small" size medical face masks are a *men's* small, so on smaller women are often ill-fitting and loose, leaving them more susceptible to infection.

Glancing at Facebook may now not be much different from scanning the reading list of a medical anthropology class.

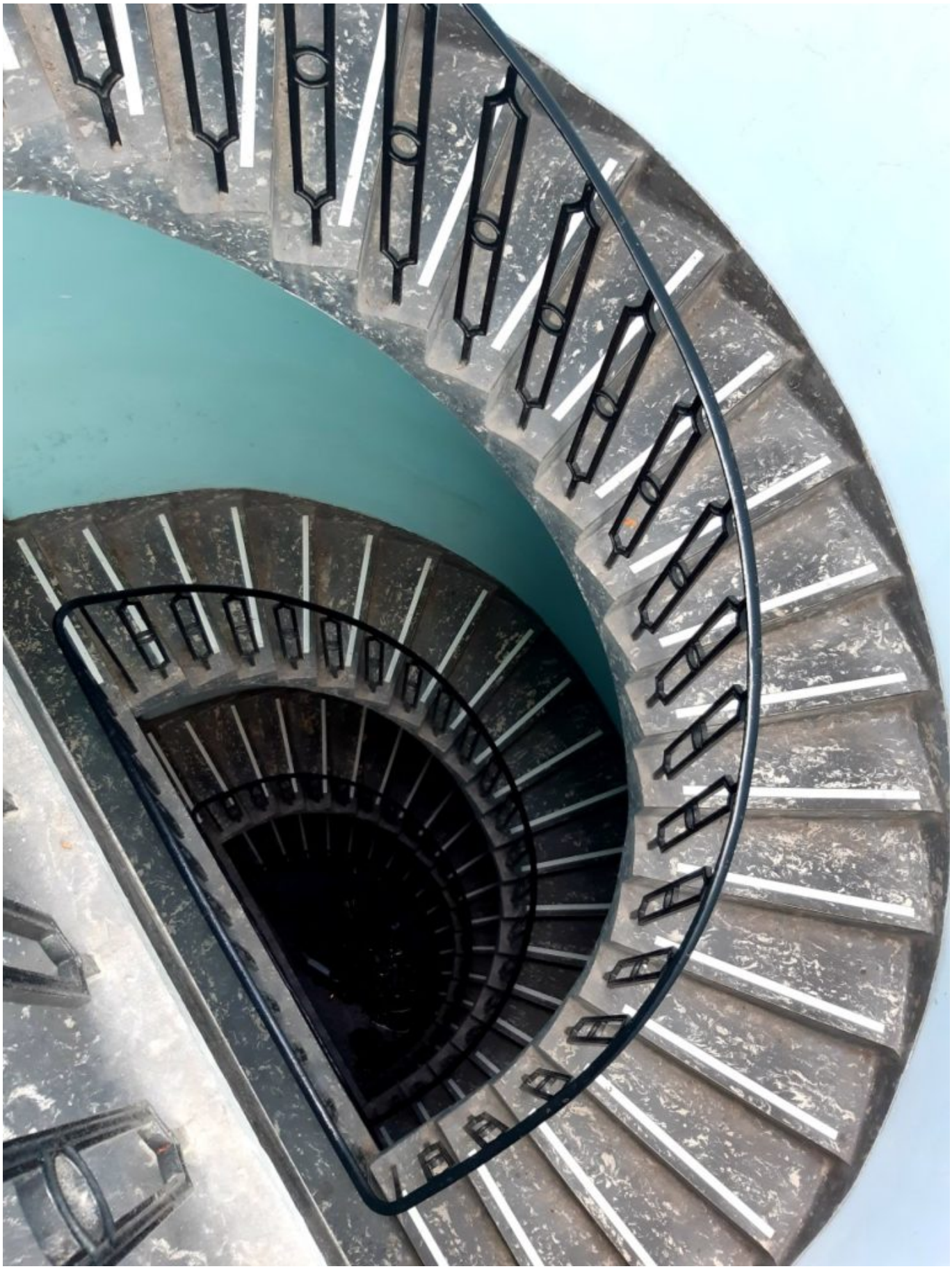
Yet, did my Contagion course prepare me for lockdown any better than anyone else? Despite talking about little else in class, Covid-19 was easy to brush away. It was terrible, of course, but so far off. Even when it reached Europe for the first time, and then reached England for the first time, I stupidly felt safe tucked away in Scotland. My first encounter

with it was in early February, when I went into an independent pharmacy on a main street in Edinburgh with a friend, and the woman behind the till sighed with relief at the sight of us. “I’m just glad you didn’t ask for a face mask,” she said, pointing to a scrawled sign behind her saying there were none left, “All the Chinese are taking them.”

My “freak out” moment did not arrive till March 12, when I was travelling by train from my parents’ house back to Edinburgh. I felt like I could not move an inch lest I touch a surface and be contaminated. I sat stock still, staring at a news alert reporting that 200 people had died in Italy the previous day, and actually *properly* thought of how many bodies that is. *200 a day*. A crushing weight of bodies. I entertained the possibility that my grandparents might be gone in a fortnight. And as I did so I was consciously disappointed in myself that I only bothered to take the time to have this realization when they were European bodies – close bodies, apparently to my mind more attention-worthy, bodies? Contagion may have made me a bit more informed than the average Briton, but it did not *really* drag me out of apathy (or Eurocentrism).

Elizabeth Fraser:
I took this picture of my flatmate the other day when we were going out to buy food. She is a healthcare student and was very worried about infection control so she cut up an old tshirt and some flannels and sewed us make-do masks following a YouTube video guide. This is her trying to get it fastened tight enough.

Anna Brooke: An Early Birthday Present



I live in a student bedsit, in a block of flats where, until recently, I had rarely ever seen anyone. It is one of those places that has the air of people who keep themselves to

themselves and like to keep it that way. There is a dark stairwell with a broken light and a gently wafting smell of weed. Last week, the thought of staying here alone and embracing the Government's recently announced "lockdown" measures had started to fill me with dread – surely this wasn't how life should be? But that was before a rather peculiar moment happened last week.A knock at my door and my neighbor from the flat below appeared, looking anxious. She held out a note, somewhat formally, and explained that her mother in Sweden had decided to give her an early birthday present. It was an online delivery of toilet rolls, given the shortages. The only problem was that her mother had accidentally ordered "industrial jumbo-sized" toilet paper and the equivalent of 960 toilet rolls – 19 kilometers' worth of toilet paper! What should she do? Would I like some?I thought it must be a joke at first. My first reaction was to laugh. Looking at her face, I soon realized it was not. But the delightful and surreal absurdity of the situation was also dawning, together with my overactive imagination, and not having seen anyone for a while. Together, we descended into fits of laughter and soon had tears rolling down our cheeks. It was contagious and unstoppable. The whole madness of the world we found ourselves in seemed to be encapsulated in that moment. Of all the things that could happen right now, who would ever imagine we were about to be deluged in 19 kilometres of toilet paper?

As the impending delivery loomed closer that day, the giant gift of toilet roll metaphorically seemed to unravel through the stairwell. We posted notes through each door, and there were conversations reacting to the somewhat surprising offer (a highly prized commodity!). Endearingly, my neighbor's pink-cheeked embarrassment broke the ice each time. Over the next few days, it unleashed a back and forth of activity between neighbors, including creating a WhatsApp group, sharing chocolate cake and wine in the stairwell, agreeing to stamp loudly on the floor if ever in need, and an attempt at cat-sharing to try and catch an errant mouse (although the puss involved, Peggy, was more categorical in sticking to working from home).

Fortunately, in the end, my neighbor was able to send back the whole delivery. But the imaginary presence of the gift had been felt and it had opened up a palpable sense that there was a human, living presence and connection behind each of the front doors. In this moment, the compelling and humorous power of the gift was able to transgress what “social distancing” and “lockdown” might otherwise suggest, in a seemingly paradoxical move of unlocking social relations and creating solidarity.

Only time will tell if and how this extraordinary and deeply uncertain point in history might help us imagine different ways of relating in the world more generally, but it seems like now is the time to be asking the question.

Jonathan Spencer: Building on Social Relations

Anna’s final piece concerns a gift so absurd it engenders new

social relations. If we can reflect on these relations, it is just possible we can also build on them for a better future. The central episode, the threatened arrival of a mountain of toilet paper, is a helpful reminder that this is a crisis that has been marked by a great deal of shared humor, as well as terrible tragedy. The metaphoric overload in the story could keep most anthropologists happily distracted for years, but let me add one, rather obvious point. The obvious referent for Anna's story is, of course, Marcel Mauss's *Essay on the Gift*, a short text every anthropology student knows they have to pretend to have read, and which quite a few actually do read. In recent years, though, anglophone readers of Mauss have been reminded – most persistently and effectively by Keith Hart – of the political circumstances in which Mauss composed the essay, and which he quite explicitly intended to address in it. Mauss was writing as a politically highly engaged author, a socialist as much as a sociologist, addressing an audience that had been devastated by the calamity of the First World War. *The Gift* concludes with a utopian call for a science of "civility" or "civics" – the very stuff that links these different student reflections. Mauss's final sentence is as good a reminder as any of what we, as students and teachers, can at once gain and give at moments like this: "Through studies of this sort we can find, measure and assess the various determinants . . whose sum is the basis of society and constitutes the common life, and whose conscious direction is the supreme art—politics in the Socratic sense of the word."

Notes:

[1] *Je veux dire à tous nos compatriotes qui vivent à l'étranger que … nous organiserons le rappatriement.*

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