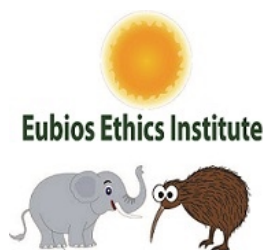


Eubios Journal of Asian and International Bioethics



EJAIB Vol. 30 (3) April 2020

www.eubios.info

ISSN 1173-2571 (Print) ISSN 2350-3106 (Online)

Official Journal of the Asian Bioethics Association (ABA)

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Editorial: COVID-19 must Push Bioethics Journals to Open Access

For the first time in the 30 year history of *Eubios Journal of Asian International Bioethics (EJAIB)* we are issuing extra issues in 2020 concurrent with the declaration of the pandemic of COVID-19 which has affected citizens in every country of the world, and the control measures that have been forcefully implemented in most countries. As a consequence we will see the entry of our world into an economic recession that may well cause even more deaths from poverty, depression and other diseases.

In this collection of the first 20 of the papers that were presented at the First International Public Health Ambassador conference organised by Eubios Ethics Institute and AUSN on 26 March 2020, we find scholars from all around the world who approach the issue as one of bioethics, social justice, discrimination, virology, philosophy, homeopathy, history, psychology, spirituality, environmental impact, resource allocation, indigenous rights, and policy. This is both a great challenge but also an opportunity. We need to pay much more attention to every ethics of infectious disease, physical distancing, quarantine, and approved diet and physical and mental health, then we have in the past century. Many papers in *EJAIB* in the past 30 years have explored these issues, but we need more scholarship on these issues.

I also continue my ongoing call for all journals of Bioethics to be open access so the scholars and policymakers all around the world, can read about how they can affect more ethical policy and review the impacts of the decisions that they make on the public. Surely one message of this pandemic, is that no more can we ethically tolerate bioethics journals that do not provide all the papers openly to effect better policymaking. Some are quick to criticize others for their ethical failures but how can they sit back and criticize when it is the barriers that they have placed on open access to ethics literature that have led to insufficient attention being paid to the ethical issues that all policy makers around the world and all governments need to pay great attention to.

There will be a further issue of this journal published with more papers on this topic in the coming weeks. I encourage more dialogue and more contributions from around the world.

- Darryl Macer

Bioethics gone viral: How to protect ourselves from any virus

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Abstract

The fast pace in modern society has obliterated a lot of our senses and “gut feelings”; However, the solution comes with time and hopefully a change in perspective from the human-centered to acknowledging that we are a part of the ecosystem, just like others including viruses. Showing some respect by restraining our liberties may lead to deeper understanding of our own needs, in conjunction with the planet. Bioethics is about choices we make. Depending on the options around us and on the values we base our decisions on. This may be a huge opportunity to reevaluate the world in and around us.

Introduction

The five sources of energy for humans are, in my opinion, communication, the Sun, air, water and lastly solid food. Research on the longest and healthiest living people on Earth have shown that some common rules apply. One of them is social interaction, community ties, family involvement. In contrast to traditional societies, the fast pace in modern society has much obliterated senses and “gut feelings”, as well as the perception of nature and seasonal changes.

This might be one of the macro-causes producing the global crisis we are traversing. The solution could come with recognition and reconnection, which might need a radical change in perspective. From the human-centered perspective to acknowledging that humans are a part of the ecosystem as much as any other, including myriads of viruses. Showing them respect by restraining our liberties may lead to deeper understanding of our own needs, in conjunction with the planet.

The dreaded disease now affects the lungs, at the same time as the lungs of the Earth are burning in rainforests or are cut for profit. This may be a chance for every individual as well as for humankind as a whole to reconsider priorities and taking a deep breath to slow down the race.

People seem to need an emergency to stop and think. Much of mainstream education is focused on imparting information more than on stimulating thinking. The foundations on which decisions are made are based less on a solid value system and more on fluctuating trends.

In my understanding, bioethics includes topics and situations which everyone will be faced with at some point in their lives. However, usually those moments of crisis offer little space of calm to confidently make a decision unless scenarios have been thought through beforehand. Therefore such opportunities are necessary and this might be a good occasion to ponder some of our choices, past, present and future.

Health is always a priority, at least in theory. In practice, the attitude is often different. “Prevention is

better than cure” is universally known, however it usually takes a severe crisis or diagnosis to eventually consider some lifestyle changes. If one is not talked into trying the latest drugs or procedures first. What if there is not a specific treatment (yet) – the panic which underscores the “new coronavirus pandemic”.

Haven't we learned in medical school decades ago that viruses mutate at least every season? How the immune system works is still not entirely understood but evidence is mounting on the interconnection between the gut, the brain, the immune and endocrine systems – “neuro-immuno-psycho-endocrinology” is the word that I scribbled on my notes as a student. Wholistic thinking is the way natural medicine works. Starting with the flow of seasons, the recognition of celestial influences in our lives, ancient wisdom reflected in Ayurveda, Traditional Chinese Medicine as well as in probably every folk system of healing.

The recent developments in life science and technology have sequenced genomes, at the same time recognizing that genes are switched on or off by environmental factors. This is tremendously empowering as “fate” takes a new form. However, it needs courage to listen to nature, especially when we are used to quick fixes. Nature is healing – others and itself.

There are modalities of healing, according to laws of nature. One of these is “like cures like”, upon which homeopathy is based. Another step in healing is removing the obstacles to cure, creating the conditions for positive change to take place. Whether it is beneficial gut flora or favorable business environment. And finally recognizing that everything is interconnected.

Every long journey starts with a few steps. It seems that this temporary halt, whether forced or deliberate, will remind our conscious minds of the forgotten lifestyle and connection. Bioethics is about choices we make. Depending on the options around us and on the values we base our decisions on. This may be a huge opportunity to reevaluate the world in and around us.

Pandemic 2020

Although the news blare about the dangers of the new coronavirus, according to WHO data

<https://apps.who.int/iris/bitstream/handle/10665/326242/WER9432-en-fr.pdf?ua=1>

and the current COVID-19 stats <https://epidemic-stats.com/> this virus seems to be at most of similar virulence to those emerging in previous years. As it is a “new” virus, the fear comes from the unknown effects. Advice on hygiene to prevent the spread is totally appropriate, however unprecedented measures – from school closures irrespective of the contamination status to deploying military of the streets for preventing “unnecessary” walks are raising question marks.

“Social distancing” has become the “in vogue” notion. While reducing redundant activities and spending more quality time with family is seen as positive, the downside of lockdowns around the globe (will) start to emerge. We need to acknowledge that healthy individuals are often asymptomatic carriers of the virus to people who are at higher risk due to advanced age or preexisting conditions. Therefore measures of protection are needed. However,

enforcing laws which allow only eight people to attend a funeral (as it happens in Romania now) are infringing on the liberty of choice, decision power and can cause lasting psychological damage.

While the weather is gearing towards spring in the Northern hemisphere, there is hope that the temperature and humidity conditions which favorize the virus will decrease as it is usual for seasonal outbreaks (*Sajadi M. Mohammad et al: Temperature, humidity and latitude analysis to predict potential spread and seasonality for COVID-19*).

Do we need to be reminded that the cold season just starts in the Southern hemisphere and that it will come again in several months in the Northern too? Isn't it clear that we need to build a strong immune system which can handle whichever new non-self-entity comes its way?

How to build an efficient immune system

Maintaining "social distance" should by no means equal deprivation from communication. While face-to-face meetings and playground interaction might decrease, making efficient use of technology can deepen relationships.

The connection between nutrition and immunity has long been established and reflected not only in scientific research over decades but also in proverbs from many cultures ("you are what you eat", "an apple a day keeps the doctor away", etc, etc). In short, whole foods, mainly plants, lots of spices, colorful produce are part of the key to vibrant health. The anti-inflammatory, immune boosting properties of innumerable compounds found in fruits and vegetables are too complex to outline here. To mention just a few: vitamin C, beta-glucan (found in mushrooms), Zinc, Selenium (whole grains, yeast, sunflower seeds, nuts), good old garlic, celery, ginger, turmeric, oregano, fermented foods... Are you already hungry?!

Changing culinary habits can be a daunting experience in "normal" times. Why not take the opportunity of challenging times to undertake some steps towards a healthier diet. We all know what it encompasses, including "sacrifices" such as staying away from sugar.

If space and time permits, working with the seasons and with earth, literally, gardening might add uncountable benefits. From getting more exercise and sunshine to connecting to nature and producing some of your nourishment, gardening is recognized as one of the most satisfying and rewarding activities.

This leads to two of the most important sources of nutrition – sunshine and air. Do everything in your power to inhale them, under any circumstances! In scientific terms this translates into improving vitamin D levels, a hormone produced in the skin, which affects EVERY cell in the body and deserves utmost consideration !

Water, as the next in my hierarchy, can be seen as the pristine liquid coming from mountain sources, as hot springs for bathing or as herbal tisanes. All of these are powerful medicines and their healing properties have been recognized in every community and time. Try to get the local knowledge on medicinal plants used in your neighborhood/region.

Phyto therapy

Some suggestions of plants useful in immunity building are Elder (*Sambucus niger*) – flowers and berries, St John's wort (*Hypericum perforatum*), Chinese skullcap (*Scutellaria baicalensis*) (NOT *Scutellaria lateriflora*) among others.

Generally, medicinal plants act through a multitude of pathways and mechanisms, unlike pharmaceuticals which have a more specific action. Therefore natural products can be used in a variety of situations, they have the ability to tune the body's self-defense mechanisms to higher gear and act non-specifically, towards any virus, new or old.

Evidence showing effects in laboratory experiments might not always be translatable in clinical efficacy. Even if an isolated herb extract has tested positively as an anti-viral *in vitro*, there are a lot of reasons that the herb might not have the desired effect *in vivo*. The required dosage of the active substance might be difficult to concentrate in the human body due to rapid metabolic processing, potential toxicity of high doses, etc. Therefore, traditional knowledge of medicinal plants plays a crucial role in prevention and treatment of respiratory infections as well as supporting the body in its recovery after illness.

To reiterate: prevention through herbs modulates and strengthens the immune system, thus shortening the duration of the illness or preventing it entirely. This should be the baseline of our health. However, if symptoms appear, we should regard them as the manifestation of the body's fight with the microscopic invaders. The body's response to the (viral) pathogen should be supported, not inhibited. Fever, as should be common knowledge by now, is the mechanisms through which the innate alarm system raises temperature in order to make the environment inhospitable to invaders. If we lower the fever artificially, we create exactly the conditions for the pathogen to thrive. Herbs which are known to reduce the duration of such illnesses, if employed adequately, support a healthy resolution of the fever process. If during the fever one feels hot and restless, some herbs help to relax, promote circulation, have sweat promoting action (diaphoretic) and diuretic effects, thus releasing heat. On the contrary, when you feel cold and chilly, you can take herbs that warm the body, resolving the discomfort.

Introduction to Homeopathy

Another law of nature, in contrast to the law of the opposites, is the law of similarity. This is one of the fundamental principles of homeopathy, a medical science founded around 220 years ago by German Dr Samuel Hahnemann (1755 – 1843). The principle of "like cures like" had been known since antiquity and practiced all over the world in various forms. Paracelsus (1493 – 1541) described the doctrine of signatures where associations between the shape of an organ and of some natural product would indicate its use (walnuts for the brain, beans for the kidneys, etc). Hahnemann, having studied medicine at the best universities of his time, was discouraged by the appalling methods of healing and stopped practicing. In order to support his family, he translated medical texts from various languages he was

master of. In one of these articles, he found the assertion that the Peruvian bark tree (*Chinchona officinalis*) was effective in treating malaria because it was bitter. Hahnemann's perceptive and inquisitive mind observed that there are many other bitter substances, some much stronger, which do not have anti-malarial properties. He undertook a self-experiment, taking *Chinchona* bark decoct, only to notice that he developed recurrent fever, headache and other malaria-like symptoms!

The first principle of homeopathy can be formulated as "the substance producing symptoms in a healthy person will cure similar symptoms in a dis-eased person". Countless provings have been and continue to be conducted worldwide to learn more about the symptoms produced by various substances. A "proving" is a carefully controlled (self)observation study of the effects produced by any substance in nature in a variety of individuals. Extremely detailed observations are done about the physical, mental, emotional symptoms that the participants in the proving experience. These symptoms are collected and compiled in themes which form the "remedy picture". The totality of these symptoms will be matched to the totality of the symptoms presented by a patient. Please note the importance of the totality of symptoms and individualization. For example, if a number of people would "prove" coffee, there will be people experiencing restlessness, insomnia, palpitations, nausea, various dreams, etc. The totality of these symptoms, described in much more details, such as time of occurrence, exact description of the symptom, eg "as if...", concomitants with other symptoms, etc, forms the remedy picture of *Coffea cruda*. Hahnemann tested around 100 substances during his lifetime. To this day there are more than 3000 proved remedies. Because some of the substances were (potentially) dangerous (depending on the dose and the susceptibility of the prover), Hahnemann devised a method of dilution and succussion (oscillatory, strong movements) through which substances become "potentized". This involves successive dilutions and succussions by which, it is now becoming evident through nano-measurements, information passes on into the solution thus explaining the stronger, more profound and longer lasting effect of higher potencies compared to lower potencies, even though chemically there isn't any more molecule of the original substance left in the solution. Initially one drop of the original substance (mother tincture) will be diluted with 99 drops of distilled water and succussed, obtaining a dilution 1 to 100 (C 1 potency). From this solution one drop is taken and mixed with 99 drops distilled water, succussed, obtaining C2, a hundredth dilution of C1, or 10^{-4} . Some of the most commonly used potencies in homeopathy are C 30 and C 200. Above C 12· due to the Avogadro number, there is (theoretically) not a single molecule left from the original solution. The infinitesimal dilution only increases the potency of the remedy, through mechanisms which are about to be revealed through modern technologies such as Transmission Electron Microscopy, electron diffraction and chemical analysis by Inductively Coupled Plasma-Atomic Emission Spectroscopy (ICP-AES).

Use of homeopathy in epidemics

Homeopathy has proven its efficacy initially during the great epidemics of the 19th century and the Spanish flu (1918 - 19). Treatment with homeopathy has achieved significantly lower mortality rates in pneumonia, diphtheria, typhoid fever, scarlet fever, yellow fever, cholera, influenza among others. Homeopathy is being used prophylactically in dengue fever also, a RCT is published in peer-reviewed literature.

Although in homeopathy the treatment addresses the person in its totality, physical, mental, emotional and social aspects, in case of epidemics where symptoms tend to be similar across the population, the patient is not one person, but "the people". By analyzing physical symptoms (what kind of fever, what kind of mucus or muscular pain, etc) the emotional state and mental reactions to the situation, several remedy pictures have come across and are being used by homeopaths in different countries (India, Italy, the Netherlands, Germany).

The Liga Medicorum Homeopatica Internationalis has compiled the genus epidemicus remedies for the COVID-19 as follows:

Early stage: *Gelsemium*, *Bryonia alba*, *Ferrum phos*, *Eupatorium perfolatum*, *Belladonna*

Later stage: *Arsenicum album*, *Phosphorus*, *Ant-tart*, *Stannum metallicum*

Each person will be given one remedy at a time, chosen by differentiating the characteristic and peculiar symptoms. As homeopathic remedies address the symptoms in their totality, mental and emotional states which are particularly prevalent during this epidemic can be effectively addressed. Anxiety, fear of contagion, fear of death, fear of poverty and other non-specific symptoms can be alleviated. Depending on the status of recognition and integration in the public health system, applicability of homeopathy varies from region to region.

Contemporary homeopaths have developed systems of looking at families of remedies. Jan Scholten has described the mineral remedies according to the periodic system of elements, Michal Yakir applies a similar way of thinking to botanical families, Drs Joshi are developing a map for remedies from the animal kingdom according to the same principle that life evolves from one stage to the next and symptoms appear when flow is impeded. When the smooth progression to the next stage in life is blocked and symptoms appear, we call it a "disease". Disease is meant to help you evolve. Sometimes an individual dies, or a species goes extinct. This pandemic might be seen as an expression of our planet's suffering. Epidemics are always acute diseases. In contrast to chronic diseases, they end in cure or death. As remedies are energy from a particular source, they regulate the energy flow of the individual (in the case of a pandemic, a group at planetary level).

Conclusion

For the suffering planet, this event might be a way to let off steam. Air travel has been reduced, pollution levels seem to decrease, overcrowded cities are having a respite. There is plenty of evidence that laughter is the best medicine. Watch comedies and get creative. And sleep. Recovery after an acute illness is as important as

prevention. The fatigued body should be supported with nutritious food and demulcent herbs to sooth irritation in the respiratory system. By listening carefully to the symptoms through which our body speaks to us, we can regain control over our health. There is a lot of research indicating that fear and worry weakens the immune system. Although the economical and societal implications of this situation may be far worse than the impact of the virus itself, the unprecedented measures taken globally might offer an opportunity to consider one's options for improved health.

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Recent interviews with Jeremy Sherr, Michal Yakir, Andre Saine, Massimo Mangialavori, Jan Scholen, Drs Joshi, Paul Herscu, etc <http://www.lmhi.org/Home/Corona>

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Ethics of care and Philippine politics during the COVID-19 outbreak

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Abstract

The outbreak of COVID-19 pandemic in the Philippines reveals three things: Firstly, it reveals the government's lack of preparation to fight a pandemic because of the ill state of the healthcare system in the country as evidenced in its lack of budget, healthcare personnel and poor healthcare facilities. Secondly, it also reveals the century-long moral antagonism that had polarized the country into the "moral we" who project themselves in good moral standing by following laws and policies and the "immoral them" who are judged to be hard headed, defiant to policies and guidelines imposed by the government and therefore, a threat to the security of the public. Thirdly, there is a movement toward agonism, a kind of space that brings the different voices and sentiments together in an atmosphere of respect and openness regardless of class standing, ideologies and morality in order to respond to the challenge of COVID-19. This paper will argue that the ethics of care as shown by President Duterte in his latest address to the nation rather than moral politics advanced by the elite members of the society can provide a solid base for social solidarity as the country struggles to fight the imminent threats of COVID-19.

Introduction

In this paper, I try to highlight the importance of strong leadership in terms of handling a crisis such as the COVID-19 Pandemic. To be able to achieve this goal, I will picture the moral conflicts in Philippine society that are rooted in colonial history as well as the social and economic divide that is gripping the country. The same moral divide results in imbalances in the allocation of resources, especially in the area of healthcare. The unfair practices in the bureaucracy requires the government to be steadfast in handling difficult issues. It is argued that President Duterte's radical approach to governance shows his commitment to social reform that is crucial in improving healthcare in the country.

Countries around the world (whether rich and poor, developed, developing and underdeveloped) are fighting in the outbreak of Corona Virus or COVID-19 pandemic which started in Wuhan, China. Its spread to other countries proved that this virus knows no boundaries. Since the mobility of people is a global phenomenon, so is the imminent threat of COVID-19. Hence, the World Health Organizations (WHO) declared it a global pandemic on March 11, 2020.

The Philippines, as a developing country, is not safe from the reach of this virus because of open policy to the entry of foreigners, including Chinese workers into its territories. Despite many calls from the "civic sphere", the elite, the professionals and the upper middle class mostly from the capital, that government should close its borders and should not accept the entry of the Chinese, our government leaders continue to accept them and other tourists because firstly, they see it as part of the daily lives of people, and therefore, mobility is a human right. Secondly, entry of Chinese and other tourists in the country can help boost the economy of the country through investments. Since the start of the presidency of Duterte, China has helped the Philippines a lot in terms of financial and other forms of aids. Thus, the government sees the need to welcome Chinese people in the country despite the many protests of those who are not necessarily racist when it comes to Europeans and Westerners, but are racist when it comes to China.

Now, COVID-19 is in the country and it appears that it is controllable because of the low number of cases. The truth of the matter, however, is that, it is low in terms of count since the country lacks enough testing kits and facilities and therefore, country has to wait for the result in a matter of days. Patients under investigations have died before the result of the test arrived.

People's initial reaction to COVID-19 onset in the Philippines

When the first case of COVID-19 in the country was recorded, a jittery public mostly in the civic sphere erupted in anger after it was revealed that the patient was a 44-year-old Chinese together with his female companion, who visited three cities in the Philippines before they were both tested positive of the virus in Manila (Santos, 2020a). During a Senate hearing following the first confirmed death linked to the virus, legislators questioned the Health Secretary Francisco Duque III over the government's system of identifying and contact

tracing who may have come in contact with the infected couple. An opposition senator, Francis Pangilinan, trying to show his moral standing lambasted the DOH secretary, saying *"I think it's not just a failure of communication. I think it's also a failure of leadership on the part of the health department"*.

But the truth of the matter is that, no matter how good your leadership and management skills are, you will face tremendous difficulties because of limited budget for human and material resources. Even among the members of the medical staff, some complained about the poor healthcare system in the Philippines. At an infectious disease hospital where the infected couple from Wuhan was admitted, what the medical staff told Al Jazeera about the lack of transparency from health authorities, understaffing, and shortage of protective medical equipment exposed the country's public health system - that it is not prepared to manage the outbreak. A lot of medical staff grew anxious and those who took care of the patient had to quarantine themselves after the Chinese man's condition turned for the worse and eventually died of the infection. This resulted in some of them breaking down in tears due to exhaustion and anxiety over the spread of the virus.

Wanting to justify their department, Alethea De Guzman from the Department of Health's Epidemiology Bureau said that their department is prepared. But they are not expecting the virus would infect people faster. Such a statement is reckless and bereft of basis. However, she said that despite the challenges, the overstretched workforce of health workers and limited resources, they have contained the infections and prevented any cases of local transmissions (Santos, 2020a). But the truth of the matter is the opposite because from day 1 March 5, 2020, there were only confirmed cases but as of this writing (March 26, 2020), there are already 707 cases distributed in Luzon, Visayas and Mindanao. This clearly suggests that there were plenty of local transmission of the virus. The mortality rate is also rather high with 48 persons who died compared with only 28 patients who have recovered (Santos, 2020b).

The Philippine healthcare system

Let us have a glimpse of the sad state of the Philippine Public Healthcare System. The level of per-person healthcare spending in the country is one of the lowest among Southeast Asia's major economies while the nation's healthcare spending is projected to increase annually (Folger, 2020). In terms of doctor-to-patient ratio, the Philippines has one doctor per 33,000 patients, and one hospital bed is available to every 1,121 Filipino patients. The question now is where to accommodate those who need to be isolated because of contagious diseases such as COVID-19 not including others who need to be quarantined. This data tells us that the Philippines is not really ready to fight a global pandemic. Our medical front liners have felt anxious, especially medical doctors, nurses and lab technicians in the last few days and weeks with the exponential increase of COVID-19 cases in the country.

Table 1 gives a glimpse of the distribution of hospitals and hospital beds throughout the country in the

year 2016. According to Lim (2020), as of 2017, there were 1,236 hospitals in the country 65% of which were privately owned. WHO recommends 20 beds per 10,000 population but the Philippines had 14.4 beds per 10,000 in 1990 and only 9.9 beds per 10,000 population in 2014. Since the virus was not contained within Manila where it started and reached to other regions, chances are there will be more people who will be admitted to the hospitals all over the country and there will be more people who should be quarantined and isolated, where will these people be accommodated?

Table 2 shows the number of health facilities by group of islands in the Philippines during the last 2016 census. There are more private hospitals than public hospitals in the country. However, the majority of the country's population is poor and cannot really afford to the higher fees of these private hospitals. If more people are affected by COVID-19 in the coming days or weeks many of whom still go out to work in order to have food on their tables, chances are many of these people will die. For most of these people, their lives have already been endangered before COVID-19 came to the country. Thus, they are not afraid to die of this virus anymore. What they are afraid of is to let their families die in hunger if they will not be allowed to go out and work. Unless the government's subsidy for their food and other basic necessities which are being channeled by President Duterte to the Local Government Units (LGUs) arrive, they will continue to work, defying government's order to stay in their houses. These measures are considered as draconian by pundits, but in the Philippines, the lack of discipline on the part of the people may need such strong kind of means in order to ensure public safety. As may be observed from news reports, similar measures are also being employed in countries such as Italy, Peru and India.

As mentioned above, medical staff have been complaining already about the sad state of the Philippine Public Healthcare System. Jocelyn Santos-Andamo, the secretary-general of Filipino Nurses United (FNU), a national union of nurses, said that the government does not treat health as a priority and the already low health budget was further cut which resulted to less medical supplies, poorly maintained medical equipment and understaffing even before COVID-19. Even before COVID-19, the public health systems was already deteriorating (Lim, 2020).

To provide a comparative picture of the number of nurses and midwives working in the country vis-à-vis the ASEAN countries, Table 3 provides a picture of the Philippine's standing. The Philippines belongs to the bottom along with Vietnam, Myanmar, Lao and Cambodia in terms of number of nurses per 10,000 population as of 2015 survey of the WHO. The public health nurses ratio in the Philippines right now is 1 to 50,000 patients. Nurses in the country prefer to work abroad because of higher salary. In spite of this scenario, the overall health budget share in the national budget decreased from 4.9% in 2019 to 4.5% in 2020 (Lim, 2020).

A study conducted by "The Borgen Project", a non-profit organization that aims to address poverty and hunger in the Philippines, reveals the following facts about the healthcare system in the Philippines:

Table 1: Distribution of Hospital Beds by Ownership and Group of Islands as of 2016

Group of Islands	Population	Government		Private		Total Hospitals	Total beds	Average beds/Island Group	Beds per 10,000 population
		Hospitals	Beds	Hospitals	Beds				
NCR	12,877,253	48	17,221	115	12502	163	29,723	182.3	23.1
The rest of Luzon	44,592,844	217	15,573	410	21,103	627	36,676	58.5	8.2
Visayas	19,373,300	80	6757	87	8,439	167	15,196	91.0	7.8
Mindanao	24,135,775	89	7,280	178	12,273	267	20,093	75.3	8.3
Philippines	100,979,172	432	47,371	790	54,317	1,224	101,688	83.1	10.1

Source: Department of Health, 2016; Department of Health-HFSRB, 201

Table 2: Number of Health Facilities by Group of Islands as of 2016

Group of Islands	Barangay Health Stations		Rural Health Units		Government Hospitals		Private Hospitals	
	N	%	N	%	N	%	N	%
NCR	20	0.10%	492	19%	48	11%	115	15%
The Rest of Luzon	9,936	49%	1,077	42%	217	50%	410	52%
Visayas	4,815	24%	471	18%	80	18%	87	11%
Mindanao	5,445	27%	547	21%	89	21%	178	23%
Philippines	20,216	100%	2,587	100%	434	100%	790	100%

Source: Department of Health, 2016; Department of Health-HFSRB, 2016

Table 3: Density of Nurses and Midwives in ASEAN Countries (Source: World Health Organization, 2015)

Countries	Midwives and Nurses per 10,000 Population
Brunei	80.5
Singapore	57.6
Malaysia	32.8
Thailand	20.8
Indonesia	13.8
Philippines	12.7
Vietnam	12.4
Myanmar	10
Lao PDR	8.8
Cambodia	7.9

1) The WHO refers to the Filipino Healthcare System as “fragmented.” There is a history of unfair and unequal access to health services that significantly affects the poor. The government spends little money on the program which causes high out of pocket spending and further widens the gap between rich and poor.

2) Out of the 90 million people living in the Philippines, many do not get access to basic care. The country has a high maternal and newborn mortality rate, and a high fertility rate. This creates problems for those who have especially limited access to this basic care or for those living in generally poor health conditions.

3) Many Filipinos face diseases such as Tuberculosis, Dengue, Malaria and HIV/AIDS. These diseases pair with protein-energy malnutrition and micronutrient deficiencies that are becoming increasingly common.

4) Healthcare in the Philippines suffers from a shortage of human medical resources, especially doctors. This makes the system run slower and less efficiently.

5) Filipino families who can afford private health facilities usually choose these as their primary option. Private facilities provide a better quality of care than the public facilities that lower income families usually go to. The public facilities tend to be in rural areas that are more run down. These facilities have less medical staff and inferior supplies.

6) Only 30 percent of health professionals employed by the government address the health needs of the majority. Healthcare in the Philippines suffers because the remaining 70 percent of health professionals work in the more expensive privately run sectors. [from <https://borgenproject.org/about-us/>]

As the number of COVID-19 cases increases day after day, the strain on health resources and personnel has revealed how weak the country's healthcare system really is (Lim, 2020). Private hospitals that have been attending to most of the COVID-19 patients appealed to the government to establish COVID-19 designated hospitals because they lack manpower since many of their staff have been put on 14-day quarantine (Lim, 2020). Indeed, such a dire situation may be traced to years of neglect on the part of previous administrations who were controlled by the oligarchy or business elite in the capital. Understandably, the lack of access of the people to quality healthcare will require a strong moral resolve on the part of the government.

Government's response to this pandemic

To respond to the call of having designated COVID-19 hospitals, the government designated the Lung Center of the Philippines and Dr. Jose N. Rodriguez Hospital as COVID-19 exclusive hospitals. The University of the Philippines (UP), Philippine General Hospital also signified its willingness to exclusively handle COVID-19 cases (Lim, 2020). However, public hospitals are also running on limited resources. The Philippine General Hospital (PGH) appealed to the public for PPEs like masks, 70% alcohol, and surgical gowns. While some public hospitals have received PPE donations and free shuttle rides for frontline responders, other hospitals are still struggling with shortages in medical supplies and personnel (Lim, 2020).

To intensify the state's fight against the spread of COVID-19, President Rodrigo Duterte declared a state of public health emergency in the Philippines on March 9 due to the confirmation of local transmission of the virus. Then, on March 12, 2020, the President decided to put the entire Manila on Enhanced Community Quarantine and on March 15, 2020, he expanded it to the entire country and closed its borders to foreigners. The spokesperson of the president clarified that "strict home quarantine shall be implemented in all households, transportation shall be suspended, provision of food and essential services shall be regulated, and heightened presence of uniformed personnel to enforce quarantine procedures will be implemented" (Santos, 2020c). However, as expected, not all establishments want to follow the “work from home scheme”. Some establishments (especially in the private sector) still asked their employees to report to work by imposing a ‘no work, no pay policy’. In a society where a lot of people are really in need of work, private establishments can even pride themselves of being generous to the poor by giving them work despite government's mandate not to require their employees to report to work and instead to devise a ‘work from home’ scheme. The government did not also impose sanction to the establishments for continuously requiring their employees to work by imposing a ‘no work, no pay’ policy. Thus, for the poor and those who are solely dependent on their daily work for survival, they did not have a choice but to work and brave the challenge of COVID-19 virus just to let their family have food to eat (Santos, 2020c).

Mixed reactions from citizens

Robert Mendoza, president of the Alliance of Health Workers, lambasted the government's response of putting the entire country into enhanced community quarantine and sending its military and police to penalize those who won't follow, saying “what we need is mass testing, more trained healthcare workers, and an increased health budget” (Santos, 2020c). In addition, Renato Reyes of BAYAN said that "social distancing and work from home is impossible for the poor and daily wage earners because of the “no work, no pay” policy of some establishments. Thus, they will rather risk getting COVID-19 to keep their jobs” (Santos, 2020c).

In a poor country such as the Philippines with limited budget for welfare and safety nets, the community quarantine is forced to die of hunger rather than the virus. In fact, for some of them, the virus is only an issue for the rich who most often travel to other countries and socialize with rich people (interview with street vendor in Digos City, March 17, 2020). Thus, many of them continue to sell in the streets and they just are careful not to get infected by the virus. The same sentiment is shared by tricycle drivers, a popular public transport in Digos City. Many of them asked if they are forbidden to go out and pick up passengers what will they feed to their families. They will not let their families die or see them dying out of hunger because they are not doing their job to feed them. Besides, they cannot rely on help from the government who, for them, only cares for rich people (interview with tricycle drivers, March 17, 2020). These are also the same

reactions from the agency-based janitors whom I interviewed on March 17, 2020.

Thus, in Digos City where I live, a lot of poor people and those who are daily wage earners continue to work and defy the home quarantine directives of the government. Many of them received negative criticisms and even scorn from the people in the “civic sphere” (those who are upper middle class, the rich and the professionals in the city) for being hard headed, uncivilized and a threat to the people’s safety because they might cause the spread of virus in the whole city. A lot of rich people called these people who continue to defy government’s order to stay home as “irresponsible, stupid and trouble-makers”. While some of them understand their plight – that they need to work to feed their families, some even accuse them of being lax and lacking in foresight and preparation. “They should have saved a small portion of their income to be used for emergency situation such as this so that they help in the solution of the problem rather than becoming part of the problem”. Hence, a clear divide emerges between the educated and obedient “we” among the elite and the upper middle class against the defiant, hard headed and trouble-maker “them” among the poor and the daily wage earners who need to work in order to survive, defying government’s order to just stay at home.

Morality versus poverty issues in COVID-19

For many of the rich and the elite in this country who belong to the “civic sphere”, they have a good moral standing in dictating the poor and those who belong to the “mass sphere” what to do in this time of crisis because they are knowledgeable enough as to the long term implication of following or defying government’s guidelines on community quarantine to the entire population (the rich and poor alike). While the poor, even before COVID-19, have already been facing death due to their poverty and that, they must continue to work despite government’s warning to stay at home because they need to find food for their family in order to survive. For those in the civic sphere, this behavior of the poor is somewhat selfish because they are only concerned of their own families disregarding other families. But for the poor, the rich are selfish because they are imposing something to them without really helping them. In fact, one tricycle driver said that “this COVID-19 only came to us here in the region because of the rich. They are the carriers of this disease and not the poor; so why are they telling us to stop our daily work so that we might not carry this virus and infect the whole community? They are the ones who carried it here in our region” (interview with tricycle driver, March 17, 2020).

Clearly, moral antagonism between the moral “we” in the civic sphere versus the immoral “them” in the mass sphere is becoming more evident with the coming of COVID-19 in the country. But when you trace the roots of this moral conflict, this moral antagonism has long existed in this country since the colonization period until now. This is apparent in how the elite in the country governed using the machinery of the state and subjecting local leaders to their rule (Maboloc, 2019). The elite and powerful had been imposing their notion of morality, right

and good to the poor people without really listening to their daily stories of struggle and survival. In its programs and policies, the ruling elites in collusion with rich people, are imposing a kind of morality to the poor. For example, in the implementation of their supposed “pro-poor” program, the “Conditional Cash Transfer (CCT)”, the government has strict criteria on who will receive and continue to receive the small amount of money that is granted to the families such as: they have to attain monthly meetings, they have to send their kids to school every day as their kid’s attendance will be monitored by the teacher, and etc. The CCT became an apparatus of control to discipline the poor to become “good” citizens based on their definition of what is a good citizen (Kusaka, 2017). The same finding is shared by Seki (2015) when he said that conditional cash transfers are not effective in terms of directly reducing poverty because the real purpose is to empower the poor through disciplining them to become good and responsible citizens. Thus, for Seki as well as for Kusaka, this is a form of neoliberal governance that aspired to mold people’s desires, hopes and beliefs by subjecting them to different mechanisms of control and surveillance (Maboloc, 2019; Kusaka, 2017).

What is the real reason why the previous administration and even the present administration continue to implement the CCT? If they really want to discipline the poor, they can just deploy the military (as they had been doing in the past) to threaten the poor to work hard or else they will be killed; as simple as that. But why did the government spend billions for this program and why is it the current administration of Duterte even increased the benefits of the recipients if its purpose is just to control and discipline the poor? Duterte, projected by the mainstream media to be a “killer” would have just killed all of these poor who are defiant of his orders. Kusaka (2017: 232) also said that, “conditional cash transfer may also be understood as a policy that attempts to break through the impasse imposed by moral antagonism between the civic and the mass spheres”. In short, this can be seen as an attempt by the government to satisfy the two conflicting parties without necessarily forcing them to come into unity. Kusaka (2017:232) also found that in the Philippines, handouts by politicians to the poor are desired as poverty assistance in the mass sphere but viewed as morally repugnant in the civic sphere but “it was possible to provide aid to the poor without incurring a major backlash from the civic sphere, if it were done on the condition that it would impart discipline to the poor by turning them into good, responsible citizens.”

However, Kusaka (2017) also found that the suspicion that cash transfers are a waste of money that only worsens the dependence of the poor is deeply ingrained in the “morally upright and responsible citizens in the civic sphere”. It must also be noted that discomfort and resentment as to the process of selection and implementation of the CCT also exist in the mass sphere because in exchange of a small amount of cash, they will be scrutinized and subjected to both criticism of their lifestyle as being immoral and the pressure to correct it (Seki, 2010). This is also affirmed in my own interviews with the CCT recipients of Davao del Sur. A lot of them

said that there is so much party politicking in the selection, implementation and even monitoring of the programs and activities related to CCT to the point that even if they don't want to, they will be forced to remain in the lists of those who are to receive the cash grant (interviews with CCT recipients, October 2019, Davao del Sur).

Another example of imposition of moral values by the elite and "upright" citizens to the poor citizens in the Philippines even before COVID-19 is the introduction and approval of the Responsible Parenthood and Reproductive Health Act of 2012 (RH Law) of the then Aquino Administration. The RH law is viewed as part of the broader poverty reduction effort of the government such that it targets poor women a priority in receiving healthcare services, information, contraceptives and capacity building and monitoring (Kusaka, 2017). Kusaka further said that the RH Law also calls for "values education" that will address issues such as teenage pregnancy, the rights of women and children, responsible parenthood, among others. Thus, despite the opposition from the Catholic Church, the law was enacted with the support of the elite and "upright" citizens in the civic sphere because of its "moral" and "values education" components for the poor to become "responsible" citizens. However, Kusaka (2017: 233) also points out that *"this underlying civic-sphere discourse of rescuing the poor from poverty through family planning is a tacit moral assumption that the poor are irresponsibly producing too many children."* This kind of assumption by Kusaka implies neglect over the phenomenon of structural violence and inequalities that push the poor further and further at the margins of society. Thus, it is very clear that the social policies of the Philippine government especially during the previous administration exemplify a neo-liberal governance that attempts to address poverty by educating the poor to become moral citizens with a limited welfare budget.

From moral antagonism to agonism through ethics of care

On March 23, 2020, President Duterte had an announcement to the whole nation after the house of representatives and the senate granted him additional power to fight the threats of COVID-19. As I listened to him, I feel a "caring father" in him. He reassured the public that the government will be on top of the situation. He directed all local government units (LGUs) and agencies like Department of Health (DOH), Department of Social Welfare and Development (DSWD), Department of Trade and Industry (DTI), The Armed Forces of the Philippines (AFP) and others to really see to it that all people especially those who are in dire need of help in this moment of total lockdown of the country due to COVID-19 threats receive the necessary aid from the government. Like a caring but strict father, he also gave stern warning to those who might take advantage from the situation to collect money in their own pocket that he will go after them and punish them. As a father, he wants fairness and he is firm in his directive to not let party politicking interfere with the distribution of economic aids. He ended

up his address with a call for unity and resiliency in the midst of the COVID-19 threat.

The words of the president in his address to the nation can be summed up to a call for social solidarity. He knew that there had been so much division already in the country. In fact, his coming to the presidency has further aggravated this moral division of the "upright we" citizens of the elite and rich and the "immoral and uncivilized them" of the poor and the masses. The so-called "moral" and "upright" citizens of this country did not really like him. They judged him to be "immoral" and not having moral ascendancy to govern the country. As a result of this, lots of his supporters from the mass sphere got angry with plenty of people in the civic sphere. Many times, he has projected himself as belonging to the mass sphere through his manner of speaking and misdemeanor and through his radical and populist style of politics and governance even if plenty in the mass sphere suffered and even died because of his kind of governance. For many of them, this is his way of disciplining his children as a father. This is affirmed in the study of Kusaka among the drug addicts in the slums of Metro Manila. Kusaka found that even some drug addicts supported Duterte and abandoned his vice when Duterte became president. According to Christopher Ryan Maboloc, the claim that Duterte is a father who cares for his constituents can be traced in Philippine history, from the time of Miguel Malvar to Luciano San Miguel and Makario Sakay (Maboloc, 2019). Maboloc (2019) writes: *"Solidarity is developed through meaningful communal ties. Duterte has shown the character of being a father-figure when he was a mayor. He attends to the needs of the ordinary people and by speaking their own tongue, he secures their trust. Calling him "Tatay Digong" meant that he is a leader who makes himself readily available to the people, consults them whenever he needs to, warns and issues threats to those who might mean harm to his constituents. The concept of "Tatay" or father in the context of the Filipino's communal experience is not limited to blood relations or anything biological for that matter. It is about being endeared to the wisdom of old. Someone is respected as such because one cares about the good and shows compassion to the people."*

Indeed, if we make an analysis of the present society Filipinos are amid this situation, treatment of Duterte as a caring but strict father is present even among professionals. In my interview with teachers in the Catholic schools of Davao del Sur and Davao Occidental, a lot of them considered Duterte as a caring father but very strict. I was so struck with one teacher who confessed in front of his co-teachers in a Focus Group Discussion (FGD) that he used to be a drug addict though he was employed in a Catholic school. While the sermons of the bishops and priests and the teachings of the nuns reminded him to abandon his vice and to return to God, he was not able to do it. But when Duterte became president and he listened to the man's call to the young to abandon their vices especially in taking and selling drugs, he was hit hard to the core of his heart and immediately, he abandoned his vice. When asked further why he did it or was it because he was afraid for his life, his answer also hit me to the core. He was even teary eyed when he narrated the story of his life "I changed not because I am afraid. I changed

because I can see in him the image of my father who died many years ago. He is like Tatay (Father) Digong who sacrificed a lot for his children. But we did not value his sacrifice for us until he got sick, maybe he got frustrated from us, and died..." (Interview with a male teacher in a Catholic School, October 2019, Davao Occidental).

Despite the fact that he appears to belong to the mass sphere, undoubtedly, President Duterte really belongs to the elite. He is not really poor as he said. However, he is so grounded with the realities in the ground and among the poor, he understands their feelings, he listens to them and even speaks their language. That's why for most of the Davao people, he is really their "Tatay". But since he is also an elite, he can also easily enter into their world, dine and eat with them. In fact, he is a president who can easily crisscross between these two divided moralities and can generate high level of acceptance and approval from both camps. Thus, he can use this influence to unite the people in the country by acting as a compassionate but strict father always motivated with an ethics of care. Since he can penetrate to the different but most often opposing camps in this country and receive high level of trust and acceptance from them, he really knows relationships anchored by genuine care for the other. This is the essence of the ethics of care. As Carol Gilligan writes in one of her interviews, "An ethic of care is grounded in voice and relationships, in the importance of everyone having a voice, being listened to carefully (in their own right and on their own terms) and heard with respect. An ethics of care directs our attention to the need for responsiveness in relationships (paying attention, listening, responding) and to the costs of losing connection with oneself or with others". [<https://ethicsofcare.org/carol-gilligan/>]

Psychologically speaking, when people are given due recognition and importance, they tend to cooperate and are willing to participate in collective action. We cannot give genuine care, respect and recognition if we cannot really enter in the shoes of other people. In counseling words, this is called empathy and genuine care. What the country needs now is a father- a caring and compassionate father who will listen and guide his children. In a brighter note, COVID-19 has brought a lot of good things to this country. For one, it let its ailing environment rest and recuperate. It also brought families together. This is the right time when a father of one nation, one family, Duterte should bring the Filipino people together to fight for this challenge. He has publicly shown his soft side, his ethics of care during his night's address to the nation on March 23, 2020. He just needs to be more concrete in his ethics of care through systematic and systemic programs, services and policies that will benefit all but with preferential option for the poor with the help, support and understanding of the rich. The nation this time does not need strong and moralistic leaders. What we need in this trying time is a caring father. After all, as Kusaka (2017: 234) pointed out "morality does not really rectify the unequal social distribution per se, and moral intervention carries the risk of dividing the people into "good" and "bad", thereby creating a new form of exclusion". This new form of

exclusion will be another breeding ground for rebellion that will pull our country back instead of moving forward.

However, let us accept the fact that we cannot really achieve perfect unity in society especially in a pluralistic society such as ours with its rich histories of oppression and subjugation by elite rulers even if we employ normative deliberation or deliberative democracy to give space for those at the margins of society to participate and have a voice in important public and political discourses. Deliberations are normative and deliberations based on norms and morality cannot avoid the exclusion of people for various reasons. Thus, there will always be "voices" wanting to be heard. What is imperative at this point of crisis that the country is facing is the cultivation of what Moufe (2000) calls "agonism". For me agonism is a peaceful coexistence of interdependent but opposing camps that have the capacity to respect for one another even if they continue to struggle to advance the legitimacy of their positions and this can happen if people continue to nurture "conversations" instead of debates.

Conclusion

The President's manner of leadership will be crucial in attaining social solidarity in this heavily divided country by exemplifying it in his own word and deeds. This is the time that he should engage the people, especially those who are against him, in "crucial conversations" by displaying himself as a compassionate father waiting for the comeback of his prodigal son while letting the "good", elder son understand why he needs to do such actions. He should be a model of welcoming each one and listening to the other's narratives and allowing people from the "civic" and "mass" spheres to also listen to each other's stories and narratives without the conscious desire to evaluate and judge them based on their own standard of what is good and right. He must be agent of dialogue to expand the contact zones of multiple public spheres where diverse "others" encounter one another to help suppress the moralization of politics in this country (Kusaka, 2017). After all, as in most families, a caring father or (mother) is what is most needed to unite the family.

Lastly, Duterte must act as a good shepherd to his flock this time. He must continue to engage the public in a regular basis and inform them about the situations of the country and reassure them that his government is on top of every challenge that a country is facing. He needs to be at the forefront to lead his people in this fight. While leading them, he also needs to discipline those who are not following the right path towards the green pasture like those who are not following protocols and he must do this fairly but still compassionately. As a shepherd, he should understand that a lot of people will do something to save their families but this is his time to remind them that we are a bigger family and that our lives are interrelated.

What makes a shepherd good is not his power, intelligence or techniques in shepherding (although they are important) but his heart – a heart that cares and that listens to all.

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Commentary on Bayod

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Bayod's paper about the experiences of the country in time of COVID-19 reflects on the state of the nation, from the disappointment of the Filipinos to the learnings and appreciation of the "not so familiar sector" of the society. This pandemic made me reflect and give support to the paper.

The Philippine government was caught dumbfounded on how big this pandemic would become. Though there had been lots of scenarios that should have served as a warning for the country (the likes of Wuhan, China, Italy, and Iran), still the government downplayed the situation. In pronouncements around January this year, the government claimed that we were ready—facility, healthcare, and economic-wise. The government even boasted at the early stages that the virus is just a simple flu and will never reach the archipelago; thus, banning the inbound and outbound flights from China was not an option. Further, the government ensured the public that hospitals in the country were enough to accommodate cases of COVID-19 (if the virus happened to reach the boundaries of the country), and lastly, the

executive branch even bragged on the economic standpoint and budgetary reserves of the nation that can be used to combat the said scenario.

Now, the Philippines slowly succumbs to the drastic effect of the pandemic. Thousands of Filipinos are now infected by the virus, many are dying (unfortunately mostly are senior citizens), hospitals are in full capacity and are no longer capable of accepting additional COVID-19 patients, the front liners (physicians and nurses) do not have enough PPE's to do their job effectively while keeping themselves healthy, supplies of basic necessities are gradually diminishing in the market, and stock market has reached the record bottom in the last eight years.

This incident reveals injustice and the insensitivity of some politicians and elites in the country. At the point when testing kits for COVID-19 was limited, politicians were the first who underwent testing—regardless of whether they were asymptomatic or not. Worst, even family members of these "VIP's" (as the local social media called them with sarcasm) also consumed most of the inadequate kits. Additionally, when the government issued an executive order to Enhance Community Quarantine (ECQ) and laid down the rules to be followed, it was found that the lawmakers themselves were the ones violating the laws. The president of the republic even asserted that he would not do social distancing and would continue to mingle, do handshakes and even do "beso-beso" to his friends since this is what Filipinos knew him for. Another is a senator, who is considered as PUM (person under monitoring) even accompanied his pregnant wife to one of the premier hospitals in the country without declaring that he is suspected to be a carrier of the virus. This triggered outrage from the healthcare professionals since it exposed them to the virus (at the time when they are needed the most and their numbers are dwindling). It was later found that this senator even attended a gathering hosted by another senator with the members of their political party in one of his mansions in an exclusive village of the capital at the time when social gatherings were prohibited and one of the provisions of ECQ.

Nevertheless, this paved way for the different strata of the society and the local government units to join hands in prayer and to find ways how to augment the shortcomings of the government particularly in providing the PPE's, supporting the basic needs of the society, and in providing food and support to healthcare workers. Tons of donation drives were created by different non-governmental organizations (NGO), artists, and even ordinary people of the community. This resulted in millions of pesos pouring in to support the "frontline workers" and those who are mostly in need of basic necessities like food, shelter, and water. This also serves as a wake-up call for everyone to value the works and hardships of the people who continue to work and provide services to the common good of the Filipinos.

The physicians, nurses, security guards, bank tellers, merchandisers, soldiers, policemen, farmers, media personnel, food delivery personnel to name a few are now regarded as the new and true heroes of the country.

Globalization and consumer culture: social costs and political implications of the COVID-19 pandemic

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Abstract

Using the available data and literature on pandemics, this investigation looks into the COVID-19 crisis from an economic as well as social aspect, and elaborates the political and moral implications of the outbreak. The paper argues that globalization and consumerism contribute to the impact of the pandemic to the millions of lives around the world. It counters the idea of property rights to address issues related to the affordability of future vaccines and access of the poor to modern medicine and advanced treatments. While strong leadership and draconian measures appear necessary to ensure the safety of the public, the analysis indicates that human solidarity is crucial to overcome the existential threat of this pandemic. Democracy, it will be argued, remains important as opposed to measures that violate the rights of people as societies try to contain the spread of the virus.

Introduction

This study examines the COVID-19 pandemic using available data and literature. It is an interpretative analysis that focuses on the socioeconomic ramifications of the pandemic. It attempts to explain why the coronavirus spread rapidly. Globalization and consumer culture are a part of the problem. In addition, the paper examines the reaction of governments in terms of the enforcement of strict discipline and curfews, especially in countries such as the Philippines. It is important to make distinctions and proper nuances about the value of leadership and collective efforts. In terms of purpose, the paper offers a radical critique of property rights and argues that governments around the world and global institutions should consider multilateral agreements to make future vaccines accessible and affordable in developing countries.

Pandemics: socioeconomic costs

In 1919, 40 to 50 million were killed by the Spanish Flu (Qiu et al., 4). The World Health Organization (WHO) reports that 11,299 died out of 28,581 confirmed cases during the 2016 Ebola scare (Nabarro and Wannous 2016). The Severe Acute Respiratory Syndrome (SARS) outbreak in 2003 killed 774 people out of 8,098 reported cases (Mackellar 2007, 429). Experts explain that a pandemic is a disease "occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people." (Harris 2000). In this sense, a pandemic is evaluated based on criteria such as disease movement, severity, level of infectiousness, and mortality rate (Qiu et al. 2016, 5).

Early research published by the leading scientific journal *Nature* points to bats as the source of the COVID-19 disease (Peng et al. 2020, 270-273). The US Center for Disease Control (CDC) has revealed that the first animal to human transmission happened at a wet market in the city of Wuhan in Hubei Province, China (CDC 2020).

Half of Europe's population was decimated during the 14th century pandemic known as the Black Death (Qiu et al. 2016). As of March 27, 2020, the Johns Hopkins University has reported 595,952 confirmed cases and 27,341 deaths around the world for COVID-19 (JHU 2020). The United States has overtaken China in terms of the number of cases. The US has reported 103,729 cases and 1,693 deaths. Italy has recorded the highest number of deaths with 9,134 out of 86,498 cases, followed by Spain with 5,138 deaths out of 65,719 cases. China has reported 81,394 cases with 3,295 deaths while Iran reported 32,332 cases with 2,378 deaths. In the Philippines, the Department of Health (DOH) reports 803 active cases with 54 deaths.

The COVID-19 pandemic has affected every continent, except Antarctica. In 2006, it was estimated that an influenza outbreak in the US would cost 200 hundred billion dollars (Prager 2006). A decade thereafter, that estimate appears as a miscalculation. In response to the economic impact of COVID-19, President Donald Trump signed a two-trillion dollar relief package for the American people. European states like Germany allocated 550 billion euro as an economic stimulus and Italy will inject 150 billion euro into the economy to help their citizens get back onto their feet. The United Kingdom will spend 450 billion dollars from its treasury to support British people and businesses. But it is still too early to estimate the actual costs of this pandemic. Developed economies expect a contraction of their Gross Domestic Product.

As of the moment, major stock markets around the world are down, with Wall Street losing two trillion dollars after only a week of the pandemic. Countries that rely on tourism bear the major impact. Popular tourist spots are deserted and other places of interest like museums and parks are closed. The International Olympic Committee and Japan have since agreed to postpone the 2020 Tokyo Olympics. Major sports leagues including the NBA, the Premier League, and the NFL have all suspended playing games for the current season, resulting in billions of dollars in lost or foregone revenues. But above all, it is ordinary folks who suffer the most due to lost income. Strict curfews in countries such as India, Peru, and the Philippines, and closed borders in North America and Europe prevent people from going to work.

In the Philippines, there have been major social and economic disruptions due to what the government calls an Enhanced Community Quarantine. Thousands of people are refused entry into the country's capital. Lockdowns in major cities mean very strict discipline imposed by the military and the police. The absence of safety nets is causing anxieties and great discomfort to a people majority of whom rely on a daily minimum wage in this consumption-based and service-oriented economy. At present, the Philippine president has signed into law a bill passed by Congress granting him stand-by powers that

will also send money to poor households. Around 300 billion pesos (six billion dollars) has been allocated to provide some form of relief to more than four million families living below the poverty line.

When the COVID-19 outbreak was first reported, it took a while for global leaders to react. Some governments may have underestimated the impact of the disease (RNZ 2020). The WHO did not immediately declare COVID-19 a pandemic even though the signs were clear. In fact, the outbreak happened at the height of the Chinese Lunar New Year, with millions of people traveling inside and outside of China. Italy, for instance, had three direct flights every week from Wuhan prior to the outbreak. It is also important to consider the fact that China did not immediately report the first human to human transmission (BBC 2020), which has a severe implication in terms of the spike of cases today, with countries such as Italy and Spain struggling to contain the disease. It was a Chinese doctor named Dr. Li Wenliang who revealed the outbreak on social media; the same doctor died from coronavirus (BBC 2020).

Globalization and consumer culture

In what way has globalization and consumer culture contributed to where we are right now? Globalization has brought great advantages to humankind. It has created so much wealth and comfort. But it has also, as a necessary consequence, created a hegemonic divide among and between peoples. That hegemonic divide has caused wars and hunger; in short, death for many. This pandemic is one of the consequences of a globalized world. In the past, people worried that a virus would infect computer programs and destroy or steal data. Few people saw it coming, that the bigger threat would be a virus of this geographic reach, one that threatens to ruin the lives of millions. Researchers warn that a public health emergency threatens national and regional security (Qiu et al 2016).

Consumer culture has an impact because the way people live has a direct link to the swift spread of the virus. People have lifestyles anchored on materialism. Modern technology and social media now dictate the ways people live. Most of us consume goods without regard for the environment. The environment, in this way, gets back at man for having neglected its intrinsic worth. This pandemic, as a natural disaster, is attributable to man himself. China, being at the heart of a globalized economic order, is linked to every major country, if not all countries, in terms of the goods it sells. With the wealth it is creating, comes the ill consequences of a world that is virtually interconnected.

During the 1918 Spanish Flu, air travel was not present, transport hubs did not exist, and large malls where people crowd were not around. According to Dr. Anthony Fauci, the top US public health expert battling this pandemic, the patterns and levels of infection direct us to the points of convergence of people who travel (CNN Interview 2020). Tourists coming to Europe from China and Europeans coming into the US contributed to spikes in the number of cases (CNN Interview 2020). Contact tracing is about containment but in advanced economies, we are talking of thousands of people at airports,

commercial centers, and parks, making it virtually impossible to trace every single person. It is difficult to determine when the numbers would come down, with New York still peaking, and the same fear for the UK as of the moment.

The spread of the virus is hastened by the interconnected nature of global economies. In poor countries such as the Philippines, the lack of government resources means that it is very difficult for the people to withstand the impact of COVID-19. Hospitals are overwhelmed and the DOH appears to lack the basic competency to conduct massive tests. A pandemic with the potential to kill millions is not something that a country like the Philippines is prepared for. The strong leadership of the current president might help, but overall, the situation is dire given the lack of social infrastructure and safety nets for the population. Assuming that the worst is still to come, the consequences to the lives of the people will be unquestionably unbearable. But it also matters to recognize the efforts of healthcare front-liners who are battling the disease and local officials in the community who have exerted great effort to keep the public safe. Reports say that in the Philippines nine doctors have died fighting the coronavirus (CNN Philippines 2020).

Political implications of a pandemic

The WHO has recognized that China's bold approach has radically improved the situation in Wuhan. From as high as 80,000 cases, only 13 new cases was reported in China during the middle of March. This has prompted the Chinese government to open parts of Hubei to air travel, except the city of Wuhan. Reports say that more than three thousand medical workers were infected in China as they battled the disease, with 12 fatalities. Wuhan was practically a ghost town during the lockdown, with the communist regime using every means to ensure that people do not go out to the streets, a draconian measure using state power and the police.

While some pundits in the West are blaming China's controlocracy (a term coined by Stein Ringen), the world can learn how cooperation and strong leadership can help solve this crisis. Europe as a continent is the new epicentre of the disease because of the integrated economies of landlocked states. The easy mobility of people, including their consumer culture driven way of life, caused the spread of the virus among European cities and states. To halt this spread, borders have been ordered closed, although countries such as Italy, which has since surpassed China in terms of the number of deaths, was too late to react in terms of measures to contain the spread of the virus.

One key thing to look into, as expressed by state authorities in the United States, including New York, which now has the highest number of infections in the US, is the availability of emergency supplies, protective gears, and medical equipment. New York, for instance, will need 15,000 ventilators but Governor Andrew Cuomo said that the Federal Government has only delivered 400 (CNN 2020). In Wuhan, private individuals and couriers helped in the distribution of medical supplies. Factories produced 35,000 to 300,000 masks a day. The government built two

hospitals with 1,000 and 1,600 bed capacity in just 10 days. But those were not enough so they converted stadiums and government buildings into wards as well.

A lockdown causes great discomfort and economic suffering. But this is a matter of life and death. Public safety, in this regard, is paramount. In the Philippines, ordinary folks need to but do not understand the problem. That the archipelago is a natural barrier to the contagion is not necessarily the case. While early discussions focused on the right to mobility, closing major airports was a correct decision on the part of the government. Curfews are being imposed, with violators apprehended by local authorities. The collective effort of the community is important, but some of these draconian measures also have severe implications to the lives of the people, say for instance, in terms of ensuring the food supply for the population.

Given the struggle of government officials worldwide to keep the people inside their homes, can we blame democracy for the spread of the virus? The point is that it is wrong to assume that human freedom or democracy must be sacrificed in order to protect public health. In the first place, the world is in this difficult situation because China is not a democracy. Since the Chinese regime controls all aspects of life in the state, the world was too late to react when in fact, the first case might have happened on December 1, 2020 (BBC 2020). China only reported the Wuhan outbreak to the WHO in the middle of January. Precious time was already lost in terms of putting measures to contain the virus. This scenario is symptomatic of geopolitics and ideological wars that actually endanger millions of lives around the world.

For now, it matters that people understand that democracy is about choosing the right leaders who can implement good programs to benefit and protect the well-being of the people. Instead of harsh and cruel measures such as what is happening in India that is shown on social media, compassion and care for the wellbeing of others would be preferable. We have to respect human rights and the dignity of the people even in times of crisis. Decency even in our death is not just a philosophical matter but political as well. We have to preserve our humanity and efforts to make the lives of people dignified and the basic respect for others secured as we pursue a better future for everyone after this pandemic.

Moral implications of the COVID-19 Pandemic

What is apparent in this outbreak is the effort of the scientific community to come up with a potential vaccine for the virus. Dr. Fauci fears that the viral infection might become cyclical, thus the vaccine is a necessity. For this reason, hundreds of millions of dollars will be invested by pharmaceutical companies in the race to produce one. However, since private companies will be investing a lot of money, it is expected that the motive for profit will exist. Given the lack of resources in the Third World, poor people will be at a great disadvantage considering that the vaccine will not come cheap.

The issue is rooted in the concept of patents. Poor countries cannot just manufacture any drug due to restrictions for potential violations to property rights. Any country that replicates a pill without the permission from

the owner of the patent is inviting suits in international courts. Pharmaceutical companies insist on their right to recover costs from research and development. Many of these drugs are patented in affluent societies. As a result, the poor citizens in Third World countries die, not because diseases cannot be treated, but due to the lack of money to procure medicines. From a moral end, it is high time for global institutions to look into the problem in order to make the access to lifesaving medicines fair. Multilateral and bilateral agreements remain feasible considering the humanitarian concern that is at stake.

This pandemic, in a way, reveals the unjust structures in the world in the area of healthcare. While we understand that healthcare is a right that should be prioritized by governments, access to lifesaving treatments is never a priority. With this, the impact to the lives of those who are affected will be huge and terribly disconcerting. Right now, the reported deaths in the COVID-19 pandemic are high in wealthy states. But as the outbreak threatens to reach depressed and overcrowded places, the loss of human lives might be staggering if community transmission is not controlled. In view of this, it matters that all governments must use every effort and means to prevent the spread of the virus.

Beyond state measures, rules and policies that focus on the control of the population in order to protect public health, societies can begin to look into the importance of individual moral responsibility. For instance, a top senate official in the Philippines who has been recently tested as positive for COVID-19, while on home quarantine, went to a hospital during the prenatal check-up of his wife, thus compromising the lives of the people he had contact with. This is quite revealing since poor Filipinos are suffering from the imposition of strict measures, whereas a top official has shown insensitivity to the situation of the people, notwithstanding the potential of illness or death for someone that he might have infected.

A further moral implication with regard to this pandemic is the situation of children with disability. A doctor in the Philippines died while serving as a front liner in the fight against the disease. The man left behind a son who has a cognitive disability. Such a situation should open the consciousness of people in terms of the human implications of the pandemic. While countries discuss and focus on the economic impact of COVID-19, the moral aspect of the crisis is beginning to unfold. It now becomes a question of moral concern and care for those who have no means in life. The fact of the matter is that this is not only about the wellbeing of the general population; there are people who need special care whose lives are irreparably compromised.

Conclusion

Resources are necessary in order to prepare a country when it comes to a pandemic. Dr. Fauci has revealed the potential of a second wave of the disease. Without any vaccine or drug, the suffering of people right now can only be magnified. For this reason it is important that the scientific community work on a vaccine to avert that kind of situation. However, states can look into a solid form of mutual cooperation that is considerate of the plight of the poor in the Third World who do not have an access to

lifesaving vaccines given the affordability issue and the unfair practices of pharmaceutical companies who insist on their property rights. Global institutions, in this regard, must enter into multilateral agreements with regard to the accessibility of the poor to modern medicines.

While strict discipline and police power might help in controlling a crowd, the concept of individual responsibility based on the concern for others and a sensitivity to the situation of the community as well as the wellbeing of the public in general remains important. While state measures may be necessary, these will be meaningless if the people do not embrace a responsible behavior or attitude. A collective effort on the part of the community is required in order to make rules that keep the public safe. But all measures should be pursued with the basic respect for the rights of people in mind. The world is at risk because of the lack of free speech in China in the first place. If we are to pursue a better future after this pandemic, governments must guarantee and secure the democratic rights of people.

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impact of the pandemic. The paper proposes possible moral solutions to address the emerging issues related to accessibility of lifesaving treatments, the availability of medical supplies and protective equipment and future vaccines especially in poor countries

It was mentioned in the paper that 'globalization has brought great advantages to humankind. It has created so much wealth and comfort for people. But it has also, as a necessary consequence, created a hegemonic divide among and between people. That hegemonic divide has caused wars and hunger.' I support this statement presented by the speaker. In addition, the spread of coronavirus represents the downside of globalization. At the same time, the impact of COVID-19, in such a short period of time, reminds us all of the inter-relatedness of our countries and peoples. My point here is not to promote anti-globalization sentiments; it's a call to recognize one of the downsides of an ever-globalizing world. COVID-19 is presenting the world with a unique opportunity to prove just how far we have come from the medieval practices in the past. Implementation of rational, ethical, and effective measures is the only way forward.

I totally agree with professor Maboloc that "resources are necessary to prepare any country when it comes to a pandemic". While poorer communities who are exposed to it are affected more, at the end of the day we breathe the same air, draw water from the same resource, and so on. Inequality and poverty hurts the poor the most, but in the end, it affects us all — it stunts economic growth, gives rise to crime and violence, creates unsafe and unhealthy environments, leads to a collective sense of fear and hopelessness, to name a few. I was reminded of this with the outbreak of the new coronavirus. Nothing has emphasized our connectedness – locally, nationally and globally – more than COVID-19, which continues to rage around the world. Nothing will also emphasize the link between poverty, income inequality, and health more than the spread of this incredibly contagious disease.

This period requires critical visionary and people-centered leadership at all levels of society. While recognizing our fundamental responsibility for self-protection and guaranteeing our very lives, of equal importance is the sovereign role of governments to protect our people and societies. This is the chance to help and trust our governments. They were formed to take collective actions, to undertake important jobs which need to be done for our collective survival; things which we cannot do as individuals. As pointed out by professor Maboloc "the concept of individual responsibility based on concern for others and a sensitivity to the situation of the community as well as the wellbeing of the public in general remains important". As in all public health emergencies, poor children and poor families suffer the most. An ethically defensible policy of school closures needs not just the bar of public health necessity; government agencies and community organizations in education, nutrition assistance and housing, as well as public health, must also be planning to take active measures to mitigate the disproportionate burden that will fall on our most vulnerable children. It is also appropriate and accurate for the health sector to reassure the public that most people who contract COVID-19 will

Commentary on Maboloc

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The paper is all about investigating the most recent outbreak, the COVID-19 pandemic, from an economic as well as a social point of view. The paper also argues that globalization and consumerism are contributory to the

recover fully on their own. At the same time, the public needs to be prepared for the possibility of more dire scenarios. So, while acknowledging our solo responsibilities, our governments, must do, what we elect them to do, inter alia, the protection of the people, in all forms, in this globalized world.

A brief historical review of the great pandemic of 1918: the Spanish flu

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Abstract

The coronavirus pandemic of 2019 will have a major negative impact on the world. Virtually no part of the globe will remain unaffected except in the most isolated locations. As at least one learned commentator has already recently opined that world history will now be divided into two major eras: B.C. (Before Coronavirus) and A.C. (After Coronavirus). There will unquestionably be many dramatic changes in all fields of human endeavor. None of the changes bodes well at face value, but there might be some positive aspects once the pandemic is finally over. There is also no question now that the virus is moving much faster than the human effort being frantically waged to contain it. This virus is not a new phenomenon. There have been almost annual virus outbreaks from Asia, like the Hong Kong flu, Swine flu and SARS over the decades. Also viral outbreaks have occasionally originated in Africa, like the Ebola virus. However, there is no question that mankind was not prepared for this quickly spreading, highly contagious viral infection.

Several commentators have immediately drawn similar comparisons with the last major historical virus outbreak that devastated the world over one hundred years ago: The global "Spanish Flu" pandemic. It would be helpful if a brief historical review was accomplished of the important events that led to the pandemic and what efforts were taken at the time to contain it. Although medical advances have been very impressive over the past century, the public health tools and medical procedures used to contain and control virus outbreaks has not advanced with as much modern innovation. Isolation and quarantine, face masks and ventilators, social isolation and disinfectants are being used exactly as they were back in 1918.

Introduction

Since the Black Death pandemic swept Europe in the Middle Ages, no pandemic has had a greater public health impact on humanity than the "Spanish Flu" or influenza pandemic in 1918-1920 to date. Although the Black Death lasted much longer than the "Spanish Flu", it killed a much higher percentage of people in Europe. The influenza pandemic was the worst pandemic of the

modern era. All human activities were set aside in an effort to stem the wide-ranging ravages. Millions were left as orphans. Medical scientists were desperate to find a cure, or at least find the origins of the virus to better understand it. There have been a number of scholarly attempts to explain all aspects of the pandemic since it was a multi-faceted calamity.

This particular flu outbreak that occurred over 100 years ago is one of the deadliest pandemics in human history. It remains to be seen exactly how badly the current coronavirus (COVID-19) will impact the world. The 1918-1920 pandemic was the first of two pandemics that were caused by the H1N1 virus. The other being the swine flu global outbreak in 2009.

Influenza origins and contributing factors

Exactly where the flu originated is still a matter of intense conjecture and great debate after a number of decades. Even the name "Spanish Flu" is a misnomer as the flu did not actually originate in Spain. Many more reports of the pandemic frequently appeared in Spanish news outlets as wartime censorship was not a factor there due to Spain being a neutral country during World War I. So the misconception arose that the flu virus originated in Spain. This influenza was eventually, if erroneously, called the "Spanish Flu."

Greatly accelerating the means of the virus spreading is the fact that there are more than half a million virus particles that can be passed to those nearby when an infected person coughs or sneezes. One of the major factors that contributed to the widespread transmission of the flu was global travel. Modern transportation systems made it much easier for civilians, military troops and sailors to spread the virus, especially during World War I as troops from many nations were transported to France by the Allied nations and then later repatriated.

According to some virologists and medical historians there were three waves of the influenza strain. The first strain or wave was in March 1918. The second strain or wave started in August 1918. The peak of the epidemic was in October 1918. It appeared simultaneously in Boston, Massachusetts, U.S.A., in Breast, France and Freetown, Liberia. The third strain or wave started in 1919.

Numbers of world fatalities

There have been various estimates on the total number of pandemic deaths. It has been estimated that about 500 million people, perhaps one-quarter of the earth's population, was infected over a century ago. In one 1991 study, it was estimated that between 25 and 39 million people had died. Some studies have said 30 million people died in less than six months. In a 2005 estimate, it was written that up to 50 million people died or less than three percent of the world's population at the time. Even one estimate has stated the figure could be as high as 100 million people expired or about five percent of the world's population. However, in a recent 2018 reassessment, the estimate was stated that only 17 million people died. In general, it is estimated that between one and six percent

of the world's population died if the world's population was between 1.8-1.9 billion at the time of the pandemic.

These deaths included my paternal grandmother's youngest uncle and second youngest uncle and his wife in 1918 in Maine, USA. They all died of bacterial pneumonia, the most commonly-related cause of death due to the flu virus, according to their death certificates. I only found out about their deaths during a genealogical study I did several years ago on my paternal grandmother's family members. They were all in their mid-20s, still very young. They left a young son, named Donald, who was cared for by his paternal grandparents as an orphan according to the 1920 U.S. census.

Worldwide spread

The pandemic killed many people all over the world. However, some nations were not as affected. Several South Pacific islands, namely American Samoa and the French colony of New Caledonia, prevented all ships from landing there and thus recorded no flu deaths. Japan's death rate was a minor fraction of other nation's fatalities by also greatly restricting ships from docking. It is estimated that between 12-17 million deaths occurred in India or approximately five percent of the population.

The pandemic was easily New Zealand's worst public health crisis. It was also its worst natural disaster. Over 8,500 New Zealanders succumbed to the influenza virus and the attendant pneumonia in just six weeks. It is recorded that nearly a quarter of the victims were Maori. The native New Zealand population there died at seven times the death rate of European New Zealanders.

Some epidemiologists have stated that the "Spanish Flu" originated in China. However, that is not a widely held or consensus opinion due to the lack of hard evidence. Medical records from China were not in abundance to be consulted as there was no centralized collection of records. This was due to the unrest and regional strife by competing warlords throughout the country during the whole era. The first estimate that was done in 1991 stated that between 5-9 million deaths from the virus. However, more recent studies have held a much lower mortality rate in the country. Another estimate stated that between 1 and 1.28 million died in the pandemic.

Some historical virologists believe the virus started in a UK military hospital center and receiving station in France in 1918 during World War I. The camp was close to a piggery and live poultry was frequently delivered to the camp mess halls. Also, common lore in the USA has the first influenza case being detected at Camp Funston, now a part of Fort Riley in Kansas, USA also in March, 1918. One soldier stationed at Camp Funston was from Haskell County, Kansas. He was the first identifiable case, and first known fatality, of the influenza virus in the USA. However, some scientific researchers have stated they now believe the virus actually began as early as 1915 as a low-level infection and later spread. The origins of the virus remain a contentious matter to this day.

There is no conclusive evidence to prove the virus's exact origin to any one specific location, although there have been several places of origin purported. Although the world has seen influenza epidemics in the past, this particular pandemic quickly became extremely virulent.

According to some virologists, this was due to a number of contributing factors: malnutrition, poor nutrition or undernourishment, severe wartime stress, chemical attacks that weakened the victim's immunity systems, poor hygiene in military and medical camps and hospitals caused a bacterial superinfection. In a personal letter dated 1918 to his parents from my mother's uncle, Vernon Blake, a young US Army soldier in France during World War I, he commented that the dead were piling up so fast there they were burying the corpses without coffins.

Pandemic analysis

Another analysis of the pandemic included variable such as school openings and closings, temperature span of the outbreak and human behavioral changes in response to the pandemic. All these factors were important, but the factor of human behavior was found to be paramount on its effect of the virus.

Soldiers who contracted a mild strain of the virus stayed where they were. Soldiers who contracted a severe strain of the virus were sent to hospitals in the rear areas pandemic was much deadlier than the first. The first wave had resembled typical flu epidemics. Those who were the most at risk were the sick and elderly, while younger, healthier people recovered easily. It is commonly agreed that World War I increased the severity of the pandemic. Normally, in civilian life, natural selection favors a mild strain. Those who get infected stay at home. Those who are mildly ill spread a milder version of the strain. In the trenches, the pattern is reversed. Those who got a mild strain of the virus were kept in the trenches. Those who were gravely ill were sent to the rear areas in trains or ambulances and confined to over-crowded field hospitals where many of the victims died.

As US troops began deploying to Europe during World War I the virus quickly spread among the massed troops confined at close quarters. It is believed these conditions allowed the virus to mutation and become more deadly. The flu rapidly spread through the USA after it was first detected, but there were no initial efforts to control or suppress the virus. This lack of reaction was harshly criticized later when the true extent of the medical disaster was fully known. However, nothing like the influenza pandemic had ever been seen in the USA or elsewhere where in the world. The medical personnel at the time were virtually helpless in the face of the rapidly spreading virus and could offer only palliative care, at best due to the lack of antibiotics and other modern medical treatments and devices.

Other Contributing Factors

One of the problems is health workers did not initially recognize the pandemic and its symptoms for what it actually was, having never experienced the virus before that time. Some patients were diagnosed as having contracted dengue fever, cholera or typhoid fever. The greatest majority of deaths in the USA were people who were under 65 years old and half the deaths were concentrated in people 20 to 50-years-old. Modern studies have shown that the virus to be particularly lethal. This was due to a cytokine storm being triggered (i.e.; severe overreaction of the body's immune system) and

thus killing the patients. This reaction especially ravages the stronger immune system of young adults. This very strong response by the immune system hastened young people's deaths, whereas a weaker immune system response in very young and older people resulted in far fewer deaths. It was later determined some older people had been subjected to a milder form of the flu virus and they had stronger immunity systems. In one study it showed that human behavioral responses had the greatest impact on lessening the effects of the pandemic.

Some scientists have posited that the original of the virus were avian, then it spread to humans who then infected swine. But there is still no agreement on the origin. Epidemiological research continues to try and locate then determine the genetic make-up and origin of the virus if only for historical and scientific purposes.

Conclusion

There is much that we can glean from the historical records of the "Spanish Flu" and the private and public health responses pandemic of a century ago. The major or most relevant points to control the pandemic are social distancing, isolation or quarantine of infected patients, repeated hand-washing with sanitizer or soap, wearing a face mask, sufficient respirators and medical treatment facilities including hospital beds. Undoubtedly, the most important point to combat the pandemic is especially an early recognition of the emerging threat of the flu virus, planning the correct response and the coordinated effort by all government officials, public healthcare experts and medical practitioners to take the pandemic seriously and act quickly.

All of these lessons for this current pandemic have been embraced, or not embraced, by various governments and individuals around the globe to the extent they are actually believed, or do not believe, of the actual problem existence. Some have stated the virus is a hoax. But skeptics and non-believers are quickly being persuaded of the seriousness of the problem in light of the overwhelming and rapidly mounting evidence. Eventually, over time, the virus will fade, both in reality and in memory. It is a question if the lessons from 1918-1920 and 2019-2020 will be retained to be useful for the next outbreak of another virus. That is the only certainty we can rely on. Mankind has not seen the end of flu outbreaks or more pandemics. If one had to bet, then the problem will become more severe in the future, not less.

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Ethical and social challenges of COVID-19 in Iran

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Iran

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Health is one of the most valued concepts in Iran. There are more than a million medical students in a population of 81 million people. There are 61 medical schools and 50 of them are free for the students. Students learn some basic information about the human body in the first year of high school. People get vaccinated from childhood, and they are required to have official certificates that proves they had their vaccines from health institutions to enter school and university. Students are also required to go through a health check process in a public health institution every 3 years.

Some schools teach first aid to their students and any person regardless of his or her age, can go to 'Red Crescent' organization and learn first aid for free. Still we can see from people's actions that basic knowledge of how to prevent an epidemic spreading in a population is insufficient. It is in that context that we can consider the shock that people in Iran, as in other countries, have felt to be living with a pandemic.

During the COVID-19 coronavirus pandemic, Iran reported its first confirmed case on 19 February 2020 in Qom (1). However, many people and many health organizations believe that the virus was in Iran before that reported date, and that the virus kept spreading without people being aware of it. Some said it was because some government officials wanted to only confirm the case after the election (2). A map of Iran showing the intensity of COVID-19 cases is shown in Figure 1.

One of the most important issues was people insisting to travel despite all the warnings not to travel because it may spread the virus (3). These people selfishly gave themselves the right to use their Iranian new year holidays (from 19 March) by traveling. They kept spreading the virus, and put themselves and others' life in danger. According to BBC Persian News Service, more than 2000 people with COVID-19 symptoms traveled through the New Year holidays.



Figure 2: Photograph of one holiday traffic jam at Iranian New Year (ignoring the traffic restriction)

On the other hand, there is a lot of misinformation on social media. Some fake methods to prevent the virus were suggested on the Internet, and some of them are really dangerous. Hundreds of people got extremely sick from drinking methanol, and 44 deaths were reported (4). Because drinking alcohol (ethanol) is prohibited due to religious law, some criminals sold methanol to people who falsely believed that drinking alcohol could prevent COVID-19.

Since hospitals are full of COVID-19 patients, there aren't enough beds for more people. Also, there is limited access to medical treatments for other sick people, e.g. people who need dialysis treatment, especially in this emergency situation. The focus is on COVID-19 infections so other illnesses are almost ignored; the hospitals and clinics are not safe for them, and they should just stay at home.

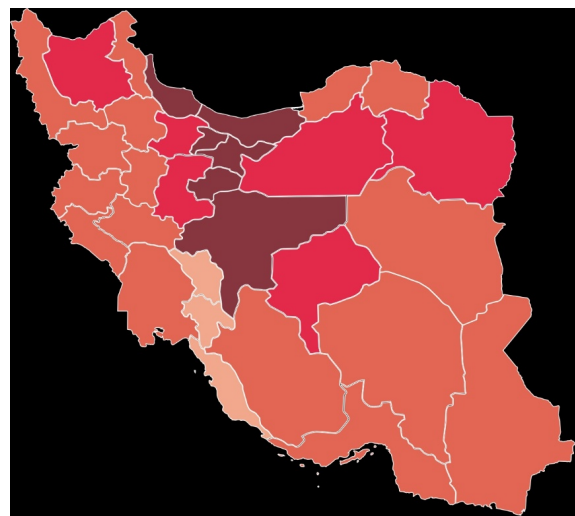


Figure 1: Relative infection rates across Iran (Source wikipedia; Date: 20 March 2020)

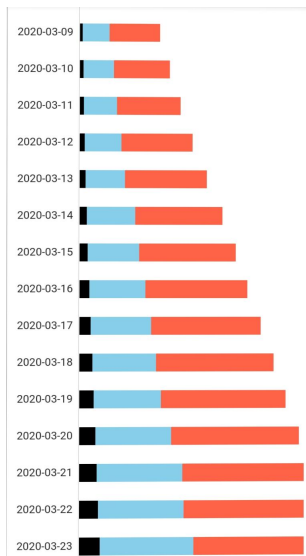
In addition, students at schools and education systems are in a bad position. Education has been supposed to be continued via social media and online methods, but a lot of schools and universities either had no capacity, or ignored their duty to continue education, so the educational system is finding it very difficult to provide even basic education. Many students are not satisfied with the materials they are receiving. Only a few professors share some pdf files. The schools immediately closed on February 23 and other public places like malls, restaurants, mosques and religious places closed a few days after schools (5). In the first few weeks people were in shock and started buying all masks and other disinfectant products but after a month all industries (even non-related ones) started producing health products rapidly to make sure most people now have access to these products (6).

The doctors and nurses have been stuck in the hospitals with sick people for months and there is a lot of volunteers who are helping the healthcare team by nursing patients. The army joined to help people; they are building open air hospitals and keep disinfecting the streets.

15 cities closed their roads by putting up physical barriers and will not let anyone in to prevent the wider

spread of the virus more than what it already has (7). Also there are some financial penalties for travelers (8).

As a student of computer sciences I am interested in the way the information has spread. There is a lot of information about the virus on social media (@dr.saeednamaki the minister of health). Lots of popular instagramers like @milad_khahhh and @erfanalirezai keep encouraging people to stay home. So they are having a positive impact, especially on young people. Though there is some misinformation going around about fake prevention methods, in general, social media had many benefits for society in this situation.



● = Deaths ● = Recoveries ● = Active Cases

Figure 3: The Reported COVID-19 cases in Iran (Source: Ministry of Health, Iran)

Popular religious leaders also tried their best to keep people safe and in their homes; they canceled all religious reunions like prayers on Friday and told people that staying safe and healthy is the most important element of Islam. Most people in Iran are Muslim, but minority religions also have done the same. Most religious leaders usually use TV and national media as their voice and most of them do not use other social media like Instagram or Twitter.

As of 23 March 2020, according to Iranian health authorities, there had been 1,812 COVID-19 deaths in Iran with more than 23,049 confirmed infections. As of 23 March 2020, Iran has the fourth highest number of COVID-19 deaths after China, Italy and Spain. It is the highest in Western Asia and the sixth-highest number of COVID-19 cases in the world (9). Figure 3 shows the increasing toll.

Overall the COVID-19 pandemic is something that has challenged people in Iran who are already living in very tough economic conditions because of the sanctions, but there are some examples where the common health threat has brought people together. Religious leaders have a big influence on people in small cities; they trust religion the most, but people in big cities trust science and doctors more.

We also have seen social criticism of persons who seem to be breaking social distancing rules for only their

short term interests and not acting in social solidarity. Some commentators from outside are also surprised that Iran has let people travel freely because they thought that the country is very authoritarian. However the balance between individual liberty and public control is more complex than it appears. The vast majority of citizens share in the common ethical goal to protect the weak and vulnerable, and to overcome the viral pandemic.

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Commentary on Baratipour

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I can relate to the following ethical and social challenges pointed out in the paper:

“Some fake methods to prevent the virus were suggested on the Internet, and some of them are really dangerous.”

In the Philippines, this is also true. Most of the Filipinos are fond of posting and reposting almost everything they see in the social media. In one instance, I asked one of my colleagues where she is getting what she is sharing in our group and she cannot tell me right away the source. It is so annoying that before flooding the page with a lot of messages, links and videos, validation of these has not been done. Fake news leads into confusion where people do not know who and what to believe anymore.

In connection to this, President Duterte was given the special power to punish people spreading fake news about the coronavirus. A last-minute amendment special powers bill contains the novel coronavirus of the section on penalties; it now includes punishment of the spread of fake and alarming information by up to 2 months in prison and up to P1 million in fines.

Section 6(6) punishes "individuals or groups creating, perpetuating, or spreading false information regarding the COVID-19 crisis on social media and other platforms, such information having no valid or beneficial effect on the population, and are clearly geared to promote chaos, panic, anarchy, fear, or confusion."

“Since the hospitals are full of COVID-19 patients, there are not enough beds for any more people.”

On a personal note, I believe that each and every one of us should do our fair share to help stop the virus. Observing the following measures below, could prevent shortage of hospital beds, equipment or doctors:

Social distancing by working from home, switching to online classes, visiting loved ones by electronic devices instead of in person and the like.

Self-quarantine by using standard hygiene and washing hands frequently, not sharing things like towels and utensils, staying at home, not having visitors, staying at least 6 feet away from other people in your household and the like.

Hospitals across Metro Manila are stretched to their limits that results into telling the coronavirus-positive patients to go home and self-quarantine. Political leader s explained that it was not a matter of national policy, but a need for hospitals to improvise given the lack of resources and manpower.

“Education has been supposed to be continued via social media and online methods, but a lot of schools and universities either had no capacity...”

In our university, we did not stop teaching our students. We reached out to them and conducted online classes using our learning management system. However, we cannot get 100% participation of both faculty members and specially the students due to Internet connectivity concerns. To address this, guidelines were formulated and implemented in favor of the faculty members and students’ concerns. Rappler Philippines’ webpage reported that in a bid to contain the spread of the virus, the whole island of Luzon is on lockdown since March 14, 2020. Classes in all levels in Metro Manila and government work were suspended until April 14, with a duration of 30-day lockdown in the capital region.

Following the Consumer on Higher Education (CHED) advisory which encourages schools to use available distance learning, e-learning, and other alternative modes of delivery in lieu of residential learning if they have the resources to do so, several schools have opted to make up for lost time with online classes. However, student governments of top Philippine schools submitted the petition to CHED and aired their concerns about transitioning to e-learning in the middle of the pandemic. In response to the students’ petition, CHED requested universities and colleges to be more lenient as classes shift online and help the students during these times.

Wherever we are in this part of the globe right now, we all have some share of the good and bad experiences of this pandemic. The best that we can do is to follow the guidelines to contain the virus to be safe and pray for each and every one.

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Commentary on Baratipour

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Iran is a textbook case of powerful social, environmental and other factors that have made Iran one of the leading 'hot-spots' of the COVID-19 pandemic. The people's immune systems have been weakened due to heavy air pollution, economic sanctions, and other societal stresses such as strict religious rules and relations that govern interpersonal relations. Overcrowding in urban areas, a lack of social distancing and a lack of medical supplies like face masks have had a negative impact on the Iranian government's efforts to control the outbreak.

Return to ourselves: Psychological reflections over compulsory physical distancing during the COVID-19 outbreak

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Abstract

COVID-19 as a potentially fatal disease has been one of the most serious global public health concerns of recent times. Extensive measures have been administered at national and international levels to control the outbreak. To reduce person to person transmission the community has engaged in a sustained and intensive hygiene campaign. Restrictions and controls were brought into social life by suspending social events; schools were closed, and people were advised to avoid international travels. Physical distancing rules were set into practice. Fewer face to face interactions and living isolated for an indefinite time can lead to psychological problems among people. In this study psychological reflections of compulsory physical distancing during COVID outbreak will be discussed. Furthermore, some recommendations will be made to overcome these problems.

Introduction

Coronavirus disease (COVID-19) is a contagious and a potentially fatal disease that is of great global public health concern. Person-to-person transmission of COVID-19 infection led to the isolation of patients who subsequently received various treatments. Comprehensive measures to diminish the transmission of COVID-19 have been applied to control the current outbreak (1).

The community has engaged in a sustained and intensive hygiene campaign. In order to prevent the spread of the epidemic around the World, countries have closed their borders, flights were suspended, many public areas like libraries, cinemas, playgrounds, cafes, pubs, and restaurants have been told to close to avoid infections. Social activities were curtailed, schools were suspended. People are being asked to keep distance from each other and to reduce face-to-face contact to minimize the spread of the virus. Many people are facing periods of enforced isolation if they are believed to have COVID-19 or have been in contact with someone who has (2).

Different contamination measures such as “social distancing”, “isolation” and “quarantine” come to the agenda in this novel COVID-19 outbreak. The meanings of these concepts are sometimes confused.

Conceptual Issues: social distancing, isolation and quarantine

Social distancing, which refers to creating physical space between one another and avoiding large gatherings, comes from public health and epidemiology lexicon (3). Through a variety of means, social distancing is an action taken to reduce interactions between people in a broader community, in which individuals may be infectious but have not yet been identified hence not yet isolated. As diseases transmitted by respiratory droplets require a certain proximity of people, social distancing of persons will reduce transmission and the possibility for new infections (4, 5). In this context social distancing involves using common sense by keeping a distance of 6 feet (2 meters) between people when possible (6).

According to a technical report of the European Centre for Disease Prevention and Control (ECDC), social distancing measures, as one category of non-pharmaceutical countermeasures, can be handled at individual level and at group level. Individual social distancing measures include isolation of cases, quarantine of contacts and staying at home. At group level some of social distancing measures are: closure of educational institutions and workplaces, mass gathering cancellations for cultural (theaters, cinemas, concerts, festivals and conferences) and sporting events, mandatory quarantine of a building or residential area (sanitary cordon), and measures for special populations (long-term care facilities, homeless shelters, prisons, psychiatric institution) (5).

The goal of social distancing interventions is to reduce the overall illness attack rates and the consequential excess mortality attributed to a pandemic, to delay and reduce the peak attack rate, reducing pressure on health services, and allowing time to distribute and administer antiviral drugs and possibly suitable vaccines (7). This brought up the term ‘flattening the curve’, which means to slow the rate of COVID-19 infection so hospitals have room, supplies, and doctors for all of the patients who need care. Even people who appear to be healthy are being directed to practice social distance and personal isolation, strategies designed to slow the spread of a disease and protect themselves and vulnerable groups from becoming infected (2,8).

From the perspective of psychology ‘social distance’ also refers to the sense of affinity or dissonance and is defined as ‘the extent to which people experience a sense of familiarity (nearness and intimacy) or unfamiliarity (distance and difference) between themselves and people belonging to different social, ethnic, occupational, and religious groups from their own.’ (9). Other terms used during COVID-19 outbreak are “isolation” and “quarantine”, both of which refer to “social distancing measures” (5). **Isolation** is the separation of ill persons with contagious diseases from non-infected persons to protect the non-infected. It usually occurs in a hospital setting, but can be done at home or in a special facility. Usually individuals are isolated, but the practice may be applied in larger groups (4,10). Self-isolation of individuals with symptoms of a respiratory infection is one of the most important measures for reducing disease transmission and limiting the spread of the virus in the community during an epidemic (11).

Quarantine is the restriction of movement or separation of well persons who have been exposed to a contagious disease, before it is known whether they will become ill. It may be applied at the individual, group, or community level and usually involves restriction to the home or designated facility. Quarantine may be voluntary or mandatory (10,12). Like isolation, quarantining exposed people may delay the peak of local epidemics during the early stages of an epidemic, thus helping to reduce the burden of disease and delay further spread (11).

While isolation serves the same purpose as quarantine, the main distinction between isolation and quarantine is that isolation is a control measure applied to sick people, keeping infected people away from healthy people to prevent the sickness from spreading, whereas quarantine is applied to people who might get sick—usually because they have been exposed to an infected person (6,13).

Physical distancing vs social distancing

The government, media organizations and meme creators have all embraced the term “social distancing” when discussing how to stem the novel coronavirus pandemic (3). The term ‘social distancing’ focuses on reducing physical contact as a means of interrupting transmission, but while reduction of social contact may be an outcome of that, it is not a specific aim (5). Some experts are concerned that the semantics of the term “social distancing” is misleading and its widespread usage could be counterproductive. The World Health Organization (WHO) has come to the same conclusion and decided to change the term by using “physical distancing” instead. People do not need to socially disconnect from their loved ones, ‘social connectedness with physical distance’ is expected and wished by practicing social distancing (3).

WHO epidemiologist Dr. Maria Kerkhove said in a press briefing: “We’re changing to say physical distance and that’s on purpose because we want people to still remain connected. Technology right now has advanced so greatly that we can keep connected in many ways without actually physically being in the same room or physically

being in the same space with people," (14). It is seen more convenient to use the term "physical distancing" instead of "social distancing" in this study, too.

Psychological reflections

Physical distancing is shown as the most effective way to limit the spread of COVID-19 in the community. Many governments are attempting to force everyone to self-isolate as the coronavirus continues to spread around the World (15). Physical distancing interventions such as staying at home and not leaving it, not going to work, school or public areas, reducing social and community contacts, living physically isolated during this time, have the benefit to prevent the transmission of the virus by moving and the benefit to reduce the infection rate; however, people may develop various psychological and mental health concerns over time (16,17). Going into a period of physical distancing, isolation or quarantine may feel daunting or overwhelming, and can contribute to feelings of helplessness and fear (16).

People in isolation who are affected by COVID-19 and are being treated for the infection, people in quarantine who are potentially infected, and people at home who have to comply with staying at home recommendations to protect themselves from infection, all will feel different psychological troubles depending on each protection measure. Some people fighting against the disease worry about being able to breath and survival, some fear about being infected, and some fear loneliness by staying at home.

The COVID-19 epidemic brought to people not only the risk of death after virus infection, but also unbearable psychological pressure (17). People may be feeling afraid, worried, anxious and overwhelmed by constantly changing alerts and media coverage regarding the spread of the virus (16). Because of their evolving nature and inherent scientific uncertainties, outbreaks of emerging infectious diseases can be associated with considerable fear in the general public or in specific communities, especially when illness and deaths are substantial. Fear is further fueled when infection control techniques and restrictive practices such as quarantine and isolation are employed to protect the public's health (18).

The continuous spread of the epidemic, strict isolation measures and delays in starting schools, colleges, and universities across the country are expected to influence the mental health of college students. There have been reports on the psychological impact of the epidemic on the general public, patients, medical staff, children, and older adults (19, 20, 21)

In the absence of interpersonal communication, depression and anxiety are more likely to occur and worsen (17). It is now widely recognized that in depression the immune system, which plays an important role by protecting the body against viruses and fighting against them, may be down-regulated (22, 23). Besides depression, anxiety is also inevitable. It is a general feeling of apprehension about possible danger. Anxiety can be seen as both a cause and an effect of illness. Individuals with high levels of anxiety are predisposed to a number of ailments known as "somatization". For example, anxiety may produce symptoms such as tension headaches, peptic

ulcers, and hypertension. Anxiety is also considered to be a mediator between stressful life events and ill health (24).

While it's crucial to slowing the spread of COVID-19, practicing physical distancing will result in fewer face-to-face social interactions, potentially increasing the risk of loneliness and social isolation (2). Especially for the elderly, for lonely people, without a surrounding or not successful in using communication tools, physical isolation can lead to social isolation. Social isolation is defined as the process of people losing their contacts with other social resources or their willingness to participate. Social isolation is a grave and widespread problem especially among seniors in society causing many harmful health conditions (25).

Humans are innately social. From history to the modern-day we've lived in groups - in villages, communities and family units. While we know social isolation has a negative impact on health, we don't know what the effects of compulsory (and possibly prolonged) social isolation could be. But it is expected to increase the risk of loneliness in the community. Loneliness is the feeling of being socially isolated. Recent reports have indicated that loneliness is already a significant issue for young people. Loneliness and social isolation are associated with a similar increased risk of earlier death, compared to someone not lonely or socially isolated. People who are socially vulnerable, such as older people, are likely to struggle more through this uncertain period (2). Uncertainty can be about when they might be let out again. COVID-19 is not the first outbreak humankind has faced and it won't be the last. Communication about the risk of infectious diseases and the psychological effects of microbial threats has become an important public health issue in recent years (26).

Taking lessons from history

During the 2003 outbreak, severe acute respiratory syndrome (SARS) spread to more than 30 countries. Not only did it cause severe health problems but it also imposed a great psychological impact on the public (26,27). A survey study found that individuals who had been quarantined or indirectly exposed to SARS during the epidemic, tended to experience depression symptoms possibly due to SARS impact, the economic downturn, poor health conditions, and inadequate social support. It seems that, compared to other disastrous events, those impacted had experienced alienation because of the stigma of the disease and hostility from the public in a more severe way (26).

The first lesson of SARS from a psychological perspective was that the costs of interpersonal isolation need to be borne in mind when widespread infection control procedures are implemented (28). Physical isolation should not lead to "social isolation". Even if people are distant from each other, they should continue socializing, because social isolation could often be a cause of emotional isolation. An American Psychological Association article ran the headline: "Social isolation: It could kill you." The lack of meaningful emotional relationships can be devastating for human beings (or even simply the perception that you lack them) (29).

Recommendations

Indeed, the success of physical distancing measures that are implemented over an extended period may depend on ensuring that people maintain social contact – from a distance – with friends, family and colleagues (5). While people cannot replace the value of face-to-face interactions, they need to be flexible and think creatively in these circumstances (2). Internet-based communications are therefore a key tool for ensuring a successful social distancing strategy (5). Equipping especially older and lonely people with the needed technology if they don't have access, or teaching them how to use their devices if they are unsure, are useful efforts (2).

To avoid possible psychological problems, people must change their perspectives and try to concentrate on the positive aspects of this process. Although they are isolated, this should not interrupt communication. As long as their technological possibilities allow them, they should be in contact with family, friends and those around them. If smartphones are available, video calls instead of just speaking on the phone would be more useful. This period can be an opportunity for people to connect more deeply. This may be a chance to spend more time with elderly parents and children at home. Extra attention and reassurance can be given to them.

The sense of unity has to be strengthened by helping others, and by trying to provide financial and moral support for them. Helping others will enhance the wellbeing of both the giving hand and the receiving hand. Instead of hurting their own situation, people should try to provide financial and moral aid to those who are in a worse situation. Staying at home in this process can be a luxury for those who have no economic guarantee; therefore, non-infected people shouldn't complain about staying at home, because it's a chance for protection and survival.

Every moment of life is already uncertain. It is not a time for depression or anxiety it is a time for people to return to themselves, and to deal with others. It is time for realizing plans which were postponed at an uncertain, unknown leisure time; a time that never was found until now. A long delayed book can be read now, a movie can be watched. There are many beneficial things which can be done. Being alone doesn't have to mean feeling alone, and isolation can help people to rediscover their underlying humanity, connect with what is most important to them, and deepen the compassion they need so badly in these challenging times (29).

This time should be regarded as unique and different, not necessary bad. It is a compulsory stop, a break in stressful hustle and bustle of life. It's a time to question the life one has lived. A time for thinking and planning for changes. It's a time for people to care for themselves, to take time for themselves and to look around. Being aware of every moment experienced and knowing the value of what is owned, and what is important: health, time, family, loved ones, and freedom. And the most important thing is to be aware and know-the value of each breath that can be taken!

Conclusion

During the recent COVID-19 outbreak, people in all affected areas had to comply to compulsory physical distancing rules. To avoid psychological problems among people experiencing these measures, it is of great importance that physical distancing will not lead to social distancing. Scientists who realized this, have changed the term social distancing as physical distancing. As a social being, people facing distance rules need each other more than ever and they have to stay connected. Every person needs to use this period as a chance to stop and think. People tend to postpone everything while rushing in routine life. The hustle and bustle of life causes people to forget themselves and their surroundings. Sometimes a small virus can change the course of everything and remind humans and the whole humanity what is really important in life.

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Commentary on Edisan

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This paper of Zehra Edisan is very informative and helpful at this time of the pandemic outbreak of COVID-19. When the World Health Organization declared it as a global pandemic, most of the countries implemented different policies so as not to spread the virus. In a matter of weeks, the virus that started in Wuhan China has rapidly spread from one country to another. It has been mentioned that one measure to control the spread of the virus is to prevent people from interaction with one another; some call it people distancing and in the Philippines we call it social distancing.

It is also mentioned that many countries have closed their borders, commercial establishments are also closed, flights cancelled, schools and universities canceled classes and many social events were cancelled and postponed. To flatten the curve, people were advised to practice social distancing and social isolation. These methods are considered the most effective way to stop the spread of the viruses that became a public health issue in the past like SARS and MERS.

I agree with Zehra Edisan that when we practice social distancing or social isolation, we limit ourselves interacting with other people and that can make us feel lonely, bored, or lack physical activities. To overcome these problems that might occur, one has to deal with it through a positive outlook in life. I have read about some positive effects during this community quarantine. Like for example, the earth will have time to heal itself because it minimizes air pollution, lessens the garbage, and people can reflect about life.

Here in the Philippines, there are people who took photos from the roof top of the buildings to show how the air pollution was minimized because they can now see the mountains from afar that we usually don't see because of smogs.

She also mentions that the use of technology can overcome the psychological problems that may occur in social distancing. We have now, Skype, Zoom, Messenger wherein we can see and speak to our relatives and friends. Another example of using technology is virtual conferences where we share and present different ideas. Maybe we just need to be dynamic, patient and look at the bright side of what is happening now. Let us try to make things that can benefit us and others without compromising our and others' health. Learn from one another, from one country to another on ways how we will fight this pandemic. Remember what happened in the past and let us not repeat the mistakes that occurred and get the positive side of things. Learn how to be creative.

Health care in India in the prevailing COVID-19 pandemic scenario

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Abstract

Healthcare in India is undergoing changes to meet the demands of citizens from villages to metropolitan city level. The National Health policy announced in 2017 is focused on "wellness" of patients and guarantees healthcare with suitable insurance coverage from primary to tertiary care. Ayushman Bharat Mission is a policy that promotes healthcare with a center-state cooperation. Program Indra Dhanush aims to cover immunization of children in rural and urban areas including those who were not covered in the previous program like Pulse Polio. In general healthcare is to provide and promote quality care, focus on emerging diseases and invest in promoting and preventive healthcare. The policy is patient centric and quality driven. It addresses health security and making drugs and devices free for use in India. Yet the Healthcare policy and its implementation face many hurdles in the form of funds, primary care, doctor-patient ratio, and communication. With the focus being shifted more on non-communicable diseases from infectious diseases, the centers for testing of various infectious diseases and viral diseases have taken a back seat. This is very relevant today when the world is reeling under the pandemic threat of Coronavirus disease (COVID-19). India reported its first case of COVID-19 on 30 January 2020. The Indian Council of Medical Research and Ministry of Health and Family welfare have reported nearly 640 active cases, 66 cured cases and 17 deaths in the country. The rate of infection for COVID-19 is 1.7. India has declared a lock down for the whole country for 21 days. The COVID-19 poses a great challenge to India to treat COVID-19 positive cases as it needs more ventilators and other facilities with a population of around 1.3 billion people. The present pandemic may help reduce the gap to implement its National Health Policy.

Introduction

Republic of India, a South Asian country, is the seventh largest nation by area, the second most populous country and the most populous democracy of the globe. One of the fundamental rights of Indian constitution is the 'right to life' which translates to "right to health". India is a Federal country with 29 states and 8 union territories.¹ Indian healthcare is administered by both State Governments and the Central Government. The State Government organizes and delivers healthcare and the Central Government takes the responsibility of international health treaties, medical education, prevention of food adulteration, quality control in drug manufacturing, national disease control and family planning. Indian healthcare is run by the public as well as private sectors. The public sector provides free healthcare to people who are below the poverty line. Indian public health sector

caters 18 percent of total patient care and 44 percent of total in-patient care.

The total expenditure for healthcare is around 4.2 percent of the GDP and out of pocket expenses are around 69 percent. The cost of healthcare is around 1700 Indian rupees /capita/year.²

National health policy

The national health policy was formulated on the recommendations of Bhore Committee³ in 2017, to promote the "wellness" of patients with suitable insurance cover total healthcare. To encourage center-state cooperation, Ayushman Bharat Mission was formed. Rashtriya Swasthya Bhima Yojana (RSBY) is the central government policy to provide health insurance coverage for poor families. RSBY is reported to have benefitted 57 percent of target population.

Healthcare delivery

The healthcare delivery system is a network of primary health sub centers which are the first point of contact between the village community and healthcare workers. Each sub center caters to 3000 to 5000 population. Six sub-centers clusters together form primary healthcare (PHC), the first contact point between the community and the doctor. It has a doctor, few healthcare workers with 3 to 5 beds. PHCs cater to the health needs of 20,000 to 30,000 people.

The next level of the healthcare system is the community healthcare center (CHC). It has specialists in medicine, surgery, gynecology and pediatrics. It has 30 bed strengths with paramedical and healthcare workers, a lab, X-ray unit and a pharmacy. It takes care of the health of 80,000 to 1,20,000 population. The next level is district level hospitals who work around the clock to provide emergency services for obstetric care and blood bank. There are about 6.3 hundred thousand beds in the nation with 2 hundred thousand beds in rural areas. The private sector provides extra care to wealthier patients whose services are regulated by national accreditation and certification body.

There are about 29,000 PHCs controlled by 25,000 doctors which still need 3500 more doctors. About 11 hundred thousand doctors are registered with Indian Medical Council to man the healthcare delivery. Yet the nation has not reached the WHO guidelines of 1 doctor per 1000 people. It is roughly around 0.7 per 1000 people. To support and add to the shortage of physicians India launched Ayush program (Ayurveda, Unani, Siddha and Homeopathy) in Nov, 2014. There are about 7.5 hundred thousand of such Practitioners.²

There are 529 Medical Colleges in India, 269 government medical colleges admitting 35,000 medical undergraduates and private medical colleges with another 35,000 admissions. Yet India needs more doctors. India has a population of nearly 1,30 billion with 29 states with 22 different languages in 13 different dialects. There are 6.5 hundred thousand villages and 4000 cities². Some of the megacities are thickly populated with Mumbai having the largest number of people (22 millions), Delhi (18.5 millions) Bangaluru (10.1 millions), Chennai (4.6 millions) and Kolkata (4.5 millions), respectively.¹

Healthcare delivery in India is therefore, very complex though highly organized. Children in rural areas are 1.6 times more likely die before the completion of 1 year and 1.9 times before the age of five years. Neonatal mortality rate is high and with additional incentive, funding, facilities, India is looking forward to improve its healthcare delivery in the public sector.²

Coronavirus disease (COVID-19)

Providing healthcare in a pandemic scenario has to be relied more on preventive measures. The coronavirus pandemic demands a very competent handling of the healthcare of the citizens. COVID-19 has taken all nations by surprise because of its wildfire spread. Coronavirus is one of retro viruses with RNA genome. Coronavirus 19 is the seventh virus with a structure that has spikes, helping the virus to bind to the host cells. It is a zoonotic virus which has mutated to a form that has resulted in the transmission of the virus through human contact. Wuhan the epicenter of the COVID-19 threatens the whole world with nations under-prepared to face the attack. Highly organized advanced nations like Italy, USA, and UK find it difficult to tackle the pandemic because of lack of preventive measures. Shortage of medical equipment, ventilators, face masks, sanitizers have created a grim situation for ordinary people to get the needed healthcare. The doctors, nursing staff, paramedical staff and accessory health staff have taken the huge responsibility to provide the best medical care to the needy risking their own lives, all over the world.⁴

Without proper drugs or vaccines to treat, safety measures like personal hygiene in the form of proper hand washing, social distancing and other WHO recommended methods of community care are recommended to fight the pandemic. It has led most of the nations to lock down the cities and towns demanding the citizens to stay at home.

India has declared total lock down for 21 days including the cancellation of all modes of travel, air, train and buses. Previously about 75 Districts throughout India have been locked out. The Ministry of Health and Family Welfare and Indian Council of Medical Research regulate the dissemination of information, healthcare, and other related activities with the help of state governments.⁵ The Ministry of Health and Family Welfare had reported 640 active COVID-19 cases, 66 cured cases and 17 deaths as of 26 March.

The ICMR centers help in the diagnosis of COVID-19 along with 6 private sector labs. The test kits for COVID-19, RT-PCR kit is manufactured in India by Mylab, Pune. Each test kit can test 100 cases. One can test 1000 cases per day. The company is reported to produce 1 hundred thousand kits per week.⁵

Mahindra groups of Company have converted their holiday resorts into rehabilitation centers, and have directed their production units to manufacture respiratory ventilators. Reliance Industries have opened up 100 bed hospitals totally devoted to treat COVID-19 patients in Mumbai.

Yet the challenge is enormous. Stay home, keep distance, avoid crowded places, maintain personal hygiene like personal hygiene, test if advised and follow

the instructions given by the government to follow are the dictum to be followed by citizens. Physical distancing is the most important criterion that has to be followed by every nation, taking the example of how one case like No31 COVID-19 in South Korea unknowingly by church visits and dinner in a hotel was responsible for considerable spread of the infection in the country.

Bill Gates of Microsoft in one of the Ted Talks in 2015 had warned that the world is not prepared to tackle a viral pandemic, particularly coronavirus. He had warned that every nation must prepare on a war footing for preventive measures, healthcare facilities including diagnostic centers and therapy. He said the world has to bring together world's best scientific minds to prepare a method of cure or a vaccine in place. He emphasized that every nation like military exercise must have healthcare exercise periodically to train the medical personnel and the community to face such a pandemic. Military exercise includes testing communications, planning, decision-making and thinking. By planning an exercise one gets a rough idea of what to expect. When one performs the exercise it provides a practical idea how the stakeholders play their parts to the expected levels. It is important that every nation has a machinery to fight a viral pandemic like COVID-19 like disaster management, as a priority. In future, "We need to make sure that every country in the World has the capacity to identify new diseases and treat them."

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Spiritual universal ethical values for a global health system using change theory: results of a disintegrated approach in the 2020 pandemic

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Abstract

Despite powerful strategic approaches in the health systems in many affluent countries, the pandemic that has hit us has cascaded beyond the imagination of many civil societies around the world. There is a call for a higher understanding and practice as the contents in the social

media reflected an urgency to understand more on the healing effects of the body, mind and spirit. In fact, contents in social media highlighted many coping mechanisms which were related to religious, cultural and spiritual values. The public expressed information that included remedies for the body, mind and the spiritual aspects of humanity and their interconnectedness with the environment. These narratives were equally as significant as the logistic arrangements, professional and political decision making among the healthcare professions and members of other inter-related health networks. The results of the COVID-19 outbreak has created a deeper understanding, of a higher consciousness as populations around the world recognize that the world works as one large organism trying to balance the ethical and unethical practices rampant in our societies.

This paper proposes the integration of “change theory” to explore the various existing elements in narratives of the public and research studies from healthcare practices. An exploratory analysis of contents in social media and the related literature in healthcare and nursing studies has revealed specific patterns which helped put the theory in perspective and to formulate a model for future understanding on what common universal values exist in the commonly existing patterns.

Introduction

This paper introduces the concept of *change theory* and the possibility to provide a deeper understanding of the field of bioethics through the lens of current practices and its implementation in the field of health services and sustainable development. The rise of COVID-19 pandemic and the impact it had on many people were clearly demonstrated in social media. Countries such as China, Malaysia, Thailand, Hong Kong, Macau, Thailand, Hong Kong, Macau, Japan, South Korea, Taiwan, Vietnam, Singapore, France, Australia, Nepal and the U.S. were afflicted with the virus at the beginning stages of the pandemic. Totally there were fourteen afflicted countries at the initial stages of the outbreak and the confirmed cases reported globally were 1316 with forty one deaths as of January 24th, 2020 (<https://www.buro247.my/lifestyle/news/COVID-19-virus-in-malaysia-latest-updates.html>).

The contents in social media at the end of January demonstrated the public’s lack of knowledge of the symptoms, treatment methods citizens were exploring to follow and the inability to cope. People from the public did not understand why they had to take stringent measures of control until the number of deaths increased. As a result, the coping mechanisms for the afflicted, vulnerable groups, youths and household members were not adequately addressed. At the beginning of March, governments in few countries reacted instantly with stringent measures and many people were significantly affected. Social media was an effective mode of communication during these difficult times.

Health and medical staff had to respond for the sake of the survival for many. This was the period when humanitarian efforts had to be implemented by all members so that lives can be saved. At the same time,

people had a deeper understanding of the meaning of life and the impact man had on the environment was evident. During the crisis, several people around the world had to cope with stress, ill health, fear, mental unpreparedness and emotional distress. It was only in such real life and profound experience that this catastrophe led people to go inwards, in deeper meaningful reflections to look for meaning in life and the causes and consequences of previous actions. The resulting expressions through social media indicated that many people started to realize that disease outbreaks could be a result of an imbalanced relationship between humans and animals and poor practices leading to unhealthy conditions. The local conditions in one city cascaded to a global pandemic. Thus a deeper inquiry and the interconnectedness of all living systems had to be explored. Bioethics, an umbrella which encompasses all spiritual and ethical discourses can help us have a greater understanding of the world.

Missing gap in education system

Content related to lifelong learning for wellbeing and health is missing in current school curriculum. A compelling need has come at this time of the pandemic to address the field of bioethics on a common platform, and on why a common value system is required to address these issues for life-long learning and sustainable development in all fields of life. An integrated approach to include our usage of food, water, medicines, plant life and animal life seem important for the future sustenance of the world. Several bioethical questions can be raised. Do we as human beings consider ourselves as the centre of the world (anthropocentrism); are humans a part of various living species (biocentrism); a holistic approach to the whole ecosystem which includes the environment, politics, culture and lifestyle (eco-centrism) ; or the assumption that the earth is just one part of the entire cosmos (cosmocentrism)? (UNESCO, 2010).

The different empirical data from current research studies available in healthcare case studies and tests can address the paradigm shift required for this change. The disadvantages of cognitive focused approaches in education and training in the field of health in tertiary education have shown the negative consequences for many people. If the affective processes were included in all areas of learning and training, the coping strategies maybe higher. For example, if environmental education had a core content of education and the bioethical issues were discussed along with the human-human relationship, human to environment relationship and human-man-plant-life sustenance methods, civilians would be more aware of what is required of them. If subjects are taught without an integrated approach, then learners proceed with practices that may lead to unsustainable societies. Although the pandemic comes in cycles there is a huge possibility that with affective processes integrated in curriculum and training for health and education, a paradigm shift can take place in the wellbeing of the planet.

Moreover, several research studies illustrated in Table 1 indicate the necessity to include a holistic approach when facilitators teach for wellbeing. The field of bioethics which is a field of inquiry within the contexts

of science, culture, health, environment, technology and society will be able to bring in common perspectives of people's value systems, cultural pluralism and ethical principles to a global platform related to current contexts in societies. The different critical perspectives of moral theories and various types of ethical theories which are valuable on their own may not converge to a system of universally agreeable values and a commonly agreed applied field of "ethical principles" unless there are common derivatives from major religious, cultural, traditional and spiritual practices.

The United Nations worked on common goals through analysis of empirical data which are in agreement between member states. There are possibilities of exploring and finding common values among different ethical systems and universally agreed ethics (UNESCO, 2010). These common values can be appreciated only if tried and elicited by practitioners with descriptive and critical discussions made among various cultures.

Why spiritual universal values?

The current ethical theories can only be understood in their own contexts and does not converge to a holistic understanding of how they can be used globally. With this pandemic, it is important that our philosophies merge and find a common space. The recent pandemic we are facing have also taught us that humans are only part of the environment and the natural resources. These two factors and their usage have a huge impact on the well-being of the planet. As a result there is a compelling need for exploring common spiritual universal values and a solid foundation in bioethics which is defined simply by Dr Darryl Macer as the "love of life": *"Bioethics is both a word and a concept. The word comes to us only from 1970 (Potter, 1971), yet the concept comes from human heritage thousands of years old (Macer, 1994). It is the concept of love, balancing benefits and risks of choices and decisions. This heritage can be seen in all cultures, religions, and in ancient writings from around the world. We in fact cannot trace the origin of bioethics back to their beginning, as the relationships between human beings within their society, within the biological community, and with nature and God, were formed at an earlier stage than our history would tell us"*.

Studies related to health and well being

In the field of healthcare and mental well-being, there are several studies related to consumption practices, mental stress, and disharmony in patients and learners' lives. A few of the many examples are listed in Table 1.

Table 1 indicates the new emerging field for mental well-being. Apart from medicines, there are other healing methods which patients receive from healthcare givers. Spiritual aspects encompass practices such as *mindfulness, meditation and mantra chanting*. These are few of the many ways in which we can resolve the inner conflicts. These practices also help us raise awareness of how an individual can recover and take control of situations which are not under his control.

What is spirituality?

Spirituality is about applying the principles of being mindful of who you are and what you need to do to overcome and address a particular issue/challenge in life. An individual can choose to live in joy or live in misery. They can tell themselves that they don't want to be negative about their situation (Dhall & Dhall, 2018). Spirituality, according to Dr Pal Dhall, assists the individual to realize his or her true nature and experience a balanced life between material and spiritual world. Spirituality helps with the development of individuals to increase their capacity to pacify themselves to control their impulses and emotions. Other added changes include an increase in awareness, positive self-identity, becoming socially conscious, eliciting a sense of gratitude, humility, inner freedom, intuition and self-confidence, and etc. Thus the individual has a mastery over the inner and outer world (Dhall & Dhall, 2018). Spiritual practices include different activities and actions as prayers, rituals, practicing mindfulness, getting involved in religious observance, display of feelings and emotional literacy. Such people connect with others in meaningful ways (Nita, 2019).

Spiritual wellness and spiritual universal values

This new emerging field of mindfulness and spirituality within healthcare for mental wellness and well-being is indicative that mental and physical health depend on how much one goes into reflective awareness. What faculties lie underneath the normal person? "It has been proved also by psychologists that there are many kinds of faculties lying hidden in what is called the sub-conscious and the unconscious mind of man" (Chander, n.d. p.39). There are many examples from social media where people have turned to spirituality for guidance and a few examples from studies are given below.

Excerpts from social media

Love for the environment by Meaghan Wray (Posted March 18th, and updated on March 23rd). Her title reads "Dolphins returned to Italy's coast amid the corona virus lockdown-Nature just hit the reset button". "Venice hasn't seen clear canal water in a very long time," they wrote. "Dolphins showing up, too. "Nature just hit the reset button on us." A collage shows footage of two dolphins swimming in an Italian port, as well as Venice canal waters running clear for the first time in a long time, thanks to a decrease in water-vehicle pollution".

Source: <https://globalnews.ca/news/6697281/dolphins-italy-coronavirus/>

The Church of Jesus Christ of Latter-day Saints shared a link.(March 27). President Russell M. Nelson invites members of The Church of Jesus Christ of Latter-day Saints and friends throughout the world to unite in faith and fasting for physical, spiritual, and other healing from COVID-19 this Sunday, March 29.

Table 1: Current research trends: an emerging field in healthcare systems

Title of research areas	Interventions	Expected outcome for Health and Sustainability	Target fields
Education for sustainable consumption through mindfulness training: Development of a consumption-specific intervention (Stanzsus et. al., 2017)	"Mindfulness through reflective processes using both cognitive and affective processes (Process: reflection of individual values and actions in each given moment and therewith to potentially strengthen people's ability to deliberately focus their mind in a way that they become more sensitive for their own values, emotions and ensuing actions)".	Program to develop self-compassion and emotional resources for healthy people, loosely based on MBSR	Health
Reflective practice: Transforming education and improving outcomes (Sara Horton-Deutsch, Gwen D Sherwood, 2017)	Reflective practices through both cognitive and affective processes	Integrated knowledge with continued learning from multiple sciences and increase new awareness and insights, promoting a spirit of inquiry	Health
What and who? Mindfulness in the mental health settings (Russell, T. A., & Sigmund, G.2016).	"Use of mindfulness-based interventions to prevent relapse in major depression and for the self-management of chronic physical health conditions (e.g. pain), but the evidence in other domains of mental health work is still emerging".	Thoughtful decision making	Health practices
Mindfulness and Bodily distress (Fjorback, 2012).	"Use of mindfulness therapy to intervene in social and economic consequences of bodily distress syndrome is significant and mindfulness therapy may have a potential to significantly improve function, quality of life and symptoms, prevent a social decline, and reduce societal costs"	Mindfulness therapy appears to produce improvements within the range of those reported in the STreSS-1 trial	Healthcare practices for practitioners and patients
Nature-nurture interaction in religious and spiritual development (Granqvist, P. & Nkara, .F. (2016). Religion & spiritual development has been understood as an expression of evolved cognitive modules (nature) on the one hand, and of socialization and social learning (nurture) on the other, or in similar albeit additive terms (e.g., nature produces the brain/mind, culture fills in the details).	"However, micro and macro systems can also experience disharmony. For example, a child taught at home that God is real but immaterial can attend school in a secular rationalist education system that features secular / materialist metaphysics, and where God is rarely mentioned if ever mentioned"		Child development and education
Relationship of frequent mantram repetition to emotional and spiritual well-being in healthcare workers (Granqvist & Nkara, 2017)	"Mantram repetition incorporates spirituality, a factor that is becoming recognized as a vital component in health and well-being"	Health and well being	Health practices

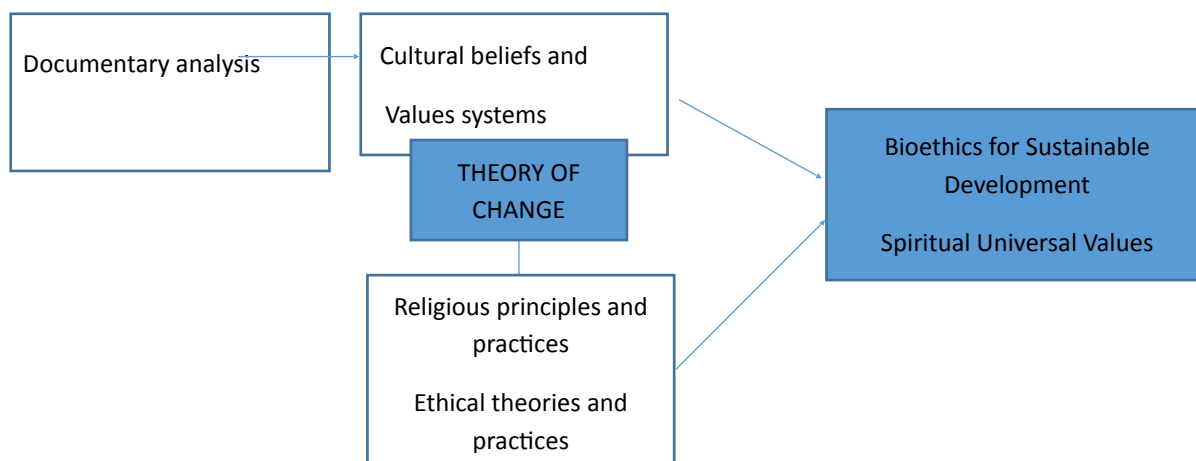


Figure 1: Adapted from Theory of Change to arrive at common goals for Bioethics

The multi-billionaire Gates, 64, who donated £85 million to combat the virus last month, believes that despite the chaos, there is 'a spiritual purpose behind everything that happens'. In an open letter, entitled 'What is the Corona/ COVID-19 Virus Really Teaching us?', he wrote: 'A Spiritual Purpose'. 'I'm a strong believer that there is a spiritual purpose behind everything that happens, whether that is what we perceive as being good or being bad. As I meditate upon this, I want to share with you what I feel the Corona/ COVID-19 virus is really doing to us.

- 1) It is reminding us that we are all equal, regardless of our culture, religion, occupation, financial situation or how famous we are. This disease treats us all equally, perhaps we should too.
- 2) It is reminding us that we are all connected and something that affects one person has an effect on another. It is reminding us that the false borders that we have put up have little value as this virus does not need a passport. It is reminding us, by oppressing us for a short time, of those in this world whose whole life is spent in oppression.
- 3) It is reminding us of how precious our health is and how we have moved to neglect it through eating nutrient poor manufactured food and drinking water that is contaminated with chemicals upon chemicals. If we don't look after our health, we will, of course, get sick.
- 4) It is reminding us of the shortness of life and of what is most important for us to do, which is to help each other, especially those who are old or sick. Our purpose is not to buy toilet roll.
- 5) It is reminding us of how materialistic our society has become and how, when in times of difficulty, we remember that it's the essentials that we need (food, water, medicine) as opposed to the luxuries that we sometimes unnecessarily give value to.
- 6) It is reminding us of how important our family and home life is and how much we have neglected this. It is forcing us back into our houses so we can rebuild them into our home and to strengthen our family unit.
- 7) 'Our true work': it is reminding us that our true work is not our job, that is what we do, not what we were created to do.

Mary Mount University (Hospice, March 27, during the COVID-19 epidemic). "The nurses, healthcare assistants, catering staff and ward managers on Marymount's St Catherine's palliative care ward recently sang their own version of Nancy Griffith's 'From a Distance' to boost morale, practicing social distancing all the while"

India

Questions by the youth to an Indian Guru: Could you share more light on building resistance using home remedies? Can we start giving preventive medicines to those on quarantine which had been established many years back? There are simple remedies which are time tested. There are enough remedies. Under Ayush Ministry there are eight lakh vaidyas and 80000 staff? Can they be allowed to do house to house survey?

Prayers

"During Chaitra Navratri Ram Nawmi we intensify our prayers. Welcome Maa Kushmanda in your home and protect you and your family. A special heartfelt prayer & dedication to All our National Health Medical warriors - the Police Force - all serving as front-liners on the terrain daring [during] COVID- 19 to save our lives.

Applying the theory of change for sustainable development in the field of bioethics

The theory of change for sustainable development can help to explore the field of bioethics and sustainable development. The different phases from the original Change theory which is integrated into this model are *Sequence of Required Events; Logical model; Context, Intermediate outcomes and Long term outcomes*. Applying the context related to COVID-19 pandemic, a documentary analysis will help provide the above details for every phase. A Conceptual framework of the Theory of Change is implemented in Figure 1.

Change theory and its application in healthcare and environment

The pandemic was sudden and the community reaction was instantaneous. News, blogs, announcement sectors were busy displaying statistics of the rise of the COVID-19 cases. Communities expressed their values, beliefs and

attitudes (affective processes) in many ways. Therefore the model derived from the literature in health care and social media was used to look at how common elements can be derived and used to list spiritual universal values. For this purpose, the evidence must include descriptive analysis of events, patterns in societies and both short term and long term outcomes of the pandemic. They also include environmental issues and issues related to education.

Various steps are involved in the Theory of Change

- *Sequence of Required Events: This area will explore the applied ethical practices in health and sustainable development*
- *Logical model: evidence based patterns in communities*
- *Context: Issues in the health field and sustainable development for lifelong learning*
- *Intermediate outcomes: A mapping of intermediate outcomes*
- *Long term outcomes: An assumption of long term outcome*

Conclusion

Narrative discourses, documentary analysis and the profound teachings of various religions and cultures will help identify common spiritual universal values. There may be impending disasters due to climate change and pollution in the future which could lead to negative consequences in the future as claimed by researchers. An approach using “spiritual universal values” in Bioethics is therefore an imperative for our common future where the global community becomes a collective community. The crisis has shown us that every single individual matters including the violence of animals.

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Bioethics at the time of coronavirus crisis; an ethical reflection on good public policies and a better future

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In the first epistemological reflections in a pandemic, an ethicist said a sentence that keeps nourishing my reflection within the last days: “Coronavirus crisis reflects on who we are, as a society.” I am realizing how quickly fear can take us, as a new disease spreads in multiple countries. As WHO declared it as a pandemic on March 11, 2020. Information can be viral, even quicker than an actual virus. Access to the Press is our daily life, but complex thinking takes time. We live in a technological society with a lot of data collected minute by minute, day by day. But real-world massive medical data is not available, and can have a crucial impact in the early stage of a pandemic. Hopefully, there is never only one way to solve a complex problem.

The quality of information we have, and above all our way to understand and select scientific information, data, guidelines and lessons learned from previous pandemic is crucial. Do we have all data we need for good decision-making and is it accurate? There was, and there is still uncertainty: What is the fatality rate? Dangerousness? What is the profile of patients? How can technology, and how can testing, help track and identify cases, so the number of persons infected can be controlled? Do we have the medical supplies (ICU units and ventilators), the protective personal equipment (PPE) to protect healthcare workers? Can each national

healthcare system provide the best care to all critical patients? If we cannot, what can be done? Is the solution implementing social distancing (physical distancing) and quarantine? How will leaders react, at a local, national, international level? Each uncertainty needs to be clarified by public health authorities and experts. We need to re-evaluate locally, frequently, rapidly, with the best means. There is also issues about sharing information transparently, even more at an international level, with the first countries affected.

It is well known, decision-makers are looking for specific data. Data they can rely on to make good decisions. Each misevaluation in a pandemic with a dangerous virus can lead to more people infected (including healthcare providers) and more deaths. On the other hand, the lack of information on the lethality of the virus on the population scale can lead to more lockdown days and other non-pharmaceutical measures imposed on populations, industries and enterprises. We should keep asking : what are our blind zones?

The words “Flattening the curve” will remain a key word in the management of the coronavirus pandemic. Epidemiologists have a strong voice in this model. Nonetheless, they are not the unique voice. What are the medical opinions? As we are submerged by the current situation, which voices should take the lead? Which ethical and moral reasoning can help to choose the best actions and the best scenario? What is relevant, and when?

It is very hard to say if we are taking the good decisions if we don't have accurate and good data. We should be very careful about it. As we know, fake news can circulate very easily, and none of us is totally immune to it, especially when a global situation like a pandemic occurs. Pandemic can be dangerous. False viral informations are harming. Blind leaders too, in different ways.

What is the crucial data in pandemic and in public policies?

We should keep asking: Do we have the real data about the virus and the damage it will effectively cause? How can we manage well the situation if crucial data is lacking? Numbers have to be interpreted carefully. What exactly is the crucial data in a pandemic? Can we have more data on the fatality rate, including asymptomatic patients? The accuracy of the fatality rate has to be interpreted carefully, since it usually implies that patients will receive care, and that the health system won't be overwhelmed. Good decision-making is based on good data. Is the public and the governments always well-informed? What is the role of emerging technologies, like AI? This crisis reveals the need for accurate information and accurate public policies in a complex society. Georgetown University has already created an open research dataset with more than 44,000 articles about COVID-19.

Ethical remarks

In bioethics, the pillar of caring for vulnerable population stands. Mistrust in healthcare systems is linked to the concrete inability to help and to fully care for people who need it. While quality of life can be a criteria in ethical decisions making, there are so many conditions that alter

population's daily quality of life. Stress, pollution, chronic diseases, mental health's vulnerability and chronic mental health's diseases, incurable diseases, etc. There is so much to be done to live a healthy life. Strongly deeply efficient caring healthcare institutions for all is an ideal we haven't reach yet.

In pandemic time, health and “saving lives” become the main issue. Caring for ourselves and the vulnerable implies prudence and low-risk actions. Still, I dare ask: Are we driven by fear of sickness, fear of losing control, fear of death? Those fears tell us something about us: our bodies are vulnerable. We have to act acknowledging our frailty. Right now, it means for most of us to listen to public health authorities, respect their knowledge and act in accordance with the best sanitary practices.

As it was raised in the medias, our current economical system can also dive into fearful areas, with adverse events. The financial burden of a recession is heavy, especially for younger generation already supporting population ageing. Can we take the time to discuss new social policies, new laws, new good public policies?

As climate change is again addressed, do we have the strength and willingness to transform deeply ways of living and a system that will provoke environmental adverses events we don't want? Knowing the consequences of our actions is the basis of all ethical and moral thinking. Can we remove our blinders? We have to make better choices to reduce pollution on an unprecedented scale. It's a matter of protecting our health and health of our communities. We don't want to be forced to make cruel or difficult choices when environmental catastrophes will occur in a future that becomes closer and closer every decade. How can we be creative in order to live in a better world, in a huge collective international effort?

Difficult choices in medical ethics are a last resort; we should act ahead if we can

In ethics and bioethics, one of the worst situation is being forced to choose between two scenarios and knowing we want neither one. The first time a student of philosophy asked me to answer to the trolley problem, I didn't want to. Who wants to choose who will survive, and who will die (at least it was a theoretical philosophical problem)? Recently, my roommate had the same reaction. This repulsive reflex (usually with a stressful or sad facial expression) can teach us something: we need to act and make efforts to live in a society, to participate in institutions and to act as citizen and in civic life, so we don't have to be forced to make difficult choices or worst, cruel choices. We should act ahead if we can. But the trolley problem remains: when unexpected and adverse events occur, will we be forced to decide who will get healthcare, especially when there is scarcity of resources? Bioethicists already had guidelines, which is now updated for COVID-19 (Ezekiel et al., 2020). The fact remains that the best scenario would be not to get there.

Three axis for public policy decision-making model in pandemic

In a time of large-scale restructuring and adjustment, we need to make the best possible decisions. As we have data on other countries' cases and pandemic management model, how accurate is this data? Are we being guided by reason?

Three main axis can be identified and can help decision-making. As mentioned above, accurate scientific and epidemiological data is crucial, prior to decision-making. This model doesn't address medical logistic and medical supply needed. It is meant for public policy decision-making, with a focus on public engagement, benefits and burden for a society seen as a whole.

Is it possible that pandemic management takes the form of preventive relentlessness, or to the opposite point, recklessness? What are the criteria and equilibrium point for each phase in a pandemic? With the aim to conduct such a reflection, I propose a three axis decision-making model.

Axis 1 - Non-Pharmaceutical Public Health Measures to be taken (or release) step by step

We have to think seriously which preventive public health measures should be imposed and when, based on risk-adjusted data. WHO described those non-pharmaceutical public health measure in a report in 2019. It was made for the global influenza programme. The evaluation of the effectiveness of those measures are now better known, with mathematical epidemiological data. Each restriction minimizes the risk of viral propagation. Precautionary principle can take the lead. It can also be evaluated proportionally to dangerousness. When lockdowns are implemented, it is unknown and uncommon to reduce so much economic, cultural, educative and social activities. Taking those preventive public health measures too quick can be seen as preventive relentlessness. But, waiting too long is recklessness. A fine line has to be trace.

Axis 2 - Evaluation of life value

This axis has also to be considered cautiously. Insurance companies are familiar with the "value of statistical life". President Donald Trump has used some of those arguments lately, he mentioned the annual number of people dying of car accidents and added: "We don't stop using cars and building cars."

Even with the best preventives measures, car accident still occurs. There is no zero risk and we still choose to drive cars. The point slowly appears: does stopping the economics worth it? Some wisdom can be find in the words of Tom Frieden, published in the *Washington Post*, on March 25 : "The choice is not between health and economics but about optimizing the public health response to save lives while minimizing economic harm."

We can also ask: Is the prior criteria to save all the lives (no fatality)? In absolute terms, we all want a good future. Nobody wants to die young of course, elderly persons wants to preserve healthy years ahead, and vulnerable populations want to be protected. A new

disease is bad news. Can we accurately evaluate the short-term and long-term impacts?

It is uncomfortable, but legitimate to compare the estimated number of COVID-19 deaths with other diseases or accidents - like cancer annual number of deaths, or tuberculosis annual number of deaths. It can even becomes a criteria to decide which measures should be taken, and when? Maybe what scandalized a lot, is that this criteria does not prevent or treat the disease. It has impact on which actions we should do. Also, as we all want to live in good societies, these statistics shouldn't be downplay. We don't want our leaders to play Russian roulette with our lives.

On 21 March 2020, David Soieghalter published an article entitled: "How much 'normal' risk does Covid represent?" I quote him: "It's always useful to remember that we're all going to die sometime, and the rate at which we do so is faithfully recorded in the life tables provided by the Office For National Statistics". Another measure, QALY, which means quality-adjusted life year, should be calculated and be publicly available. Months equivalent risk, which represents the risk in terms of months of 'normal life', has been calculated by age range.

Axis 3 - Current progress and availability of efficient medicine (anti-viral treatments, public vaccination)

For now, the scenario is the current: As the availability of more efficient medicines (anti- viral treatments, public vaccination) hopefully will happen soon, non-pharmaceutical public health measures will be released. When the threats will finally be fully known and controlled, restrictive measures will be taken off. We still need data to evaluate the risks and the impact for the population and health care workers. We can improve our capacity to identify and evaluate the threats on the health of each of us, and minimize the risks. We have to act with prudence.

Good information is still crucial in the management of the pandemic in order to decide which scenario is the best. When the entire world focuses on COVID-19, when so much research is conducted in order to find effective treatments and vaccines, good solutions may emerge.

Future ahead: hope for a better world

Beliefs are powerful and shape the world transformation and beginning of new eras, hopefully lead by collective intelligence. Will this pandemic lead to a new sense of solidarity and peace? Our economic model is based on the imperative of growth, which means roughly more activities and gaining added value. Maybe we have to change deeply our international economical system, but who can take the lead? Equity, justice, environmental issues should not be left behind in a better world. We need changes, but we don't fully know how. Stopping excessive consumption and creating simpler and happier lives is a complex problem. Sadly, yet, financial elites don't seem to be the best leaders, especially when they don't fully recognized complexity and deny the relevance of vast domains of knowledge. We need to decolonize knowledge. A switch of value is occurring: health is the imperative, and it can lead our choices. It can lead politics, public policy and daily life. Even economy has to adapt, which is

an unseen situation: a calm revolution is happening. As proverbial wisdom says: "Necessity is the mother of invention." Good leaders will emerge with a new wisdom. I hope we will re-evaluate the value of everything. Transport. Quality of food. Food security. International collaboration. Individual choices. Safety. Solidarity. Caring for others.

During lockdowns, everybody can gain knowledge and have moral reflection. It is fascinating to observe the adaptations and creativity that governments and human beings are deploying right now. In a better world, the impact of each action on others have to be taken into account. In a pandemic, there are public campaigns that raise collective awareness: protect your community, stay at home, reduce consumption to the essentials. While being at home, why don't we take the time to value what we already have (books, access to informations on Internet, public radio)? It is a good time to prioritize quality of relationship, gratefulness for what we have. Each of us can ask: what can I do to improve my health and quality of life for me and others (good nutrition, exercise, etc.)? It is a special time to learn from home (some Ivy League university course are online)... Since the pandemic has such impact on the economy, isn't the time to evaluate why we've let the previous economical system drives our lives so deeply, while alternatives are possible?

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Pandemics from the lens of former peace keeper : COVID-19 response

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Introduction

As a former peacekeeper in conflict-ridden areas of Africa and Middle East, I had the first-hand view of anxiety, hopelessness and uncertainty of people in the community at a large scale and subsequent turmoil and instability at national level. When the international community falters to respond to such tragedy in the timely manner, the tragedy gets manifested in the form of war or mega disaster or pandemic.

Moreover, as a scholar of American University of Sovereign Nations (AUSN) I have been advocating the imperatives of timely improvement of response mechanism on such precarious situation unearthing the flaws of human response in the past for it provides a prologue of past and present crisis while the guidelines can be drawn to save human and economic toll. Moreover, the lesson that we learn can provide additional insights into legal and ethical issues in response to pandemic mitigation and suppression.

Emergency in pandemics

Be it a pandemic or disasters of larger scope, they all overwhelm the resources and the providers need to prioritize as to who has a priority to these scarce resources. This is exactly what happened even in the case of most developed countries during COVID-19 pandemics. Health professionals were given implied instruction to prioritize the resources: literal meaning being "You chose who deserves to leave or die." Pandemics are devastating natural or willful events that results in damaging economic and social consequences for the people they affect, loss of life and physical and emotional hardship. When failure of civil administrative and operational systems occurs, the role of military becomes vital to keep the society running. They work in coordination with emergency managers and responders are responsible for intervening before and during such events, to minimize the harm disasters/pandemics cause and to restore order. The large scale, high complexity, profound urgency, and intense scrutiny that attend pandemics (e.g. COVID-19) provide a powerful motivation for responders to be good at response.

Peace keepers invariably work on foreign soil which is a challenge in itself but comes with a great deal of good things. They have international credibility, understanding of local situation, unbiased approach and expertise. Most importantly, peace keepers bring to doorstep the sense of belongingness, engagement and hope.

Background

Pandemics have been around the world ever since its inception. Every religion and holy books talk about the collective plights of human being and ultimate dooms day. Throughout the course of history, disease outbreaks have ravaged humanity, sometimes changing the course of history and, at times, signaling the end of entire civilizations. COVID-19 is not only the pandemics humans have faced in the annals of its history. There were many and pandemics are certain to appear in the future. Why we got alarmed this time is it caught us by surprise: not that we didn't know about it but we didn't want to learn from the past pandemics. The following pandemics were some of the brutal killers in the annals of human history:

- a. **Prehistoric epidemic:** Circa 3000 B.C. About 5,000 years ago, an epidemic wiped out a prehistoric village in China. The bodies of the dead were stuffed inside a house that was later burned down.
- b. **Plague of Athens:** 430 B.C. People in good health were all of a sudden attacked by violent heats in the head, and redness and inflammation in the eyes, the inward parts, such as the throat or tongue, becoming bloody and emitting an unnatural breath"
- c. **Great Plague of London:** 1665-1666. The Black Death's last major outbreak in Great Britain caused a mass exodus from London, led by King Charles II. By the time the plague ended about 100,000 people, including 15% of the population of London died.
- d. **Spanish Flu:** 1918-1920. An estimated 500 million people from the South Seas to the North Pole succumbed to Spanish Flu.

e. AIDS pandemic and epidemic: 1981-present day. AIDS has claimed an estimated 35 million lives since it was first identified.

f. H1N1 Swine Flu pandemic: 2009-2010. Ebola ravaged West Africa between 2014 and 2016, with 28,600 reported cases and 11,325 deaths.

g. **COVID-19.** COVID-19 is the disease caused by the new coronavirus affecting respiratory system that emerged in December 2019. More than confirmed 801,061 cases and 38,748 deaths as of 31 March 2020 (Exactly 3 months from the first formal report).

Coronavirus appears to be different from other pandemics. We know much about this virus but we also don't know so much about it but it is absolutely necessary to tell others what we do know about this pandemic. The virus has size of 50-140nm (reports still vary). It is dangerous due to its size that it can float in the air for at least 2 hours, let alone on your clothes or on other materials. Recent studies in India reported that the mutation of virus differed in different continent. It is reported that the mutation of virus is only one-time vs three times in Italy. What we can say is we have to wait for some time until scientists come up with actually what it is and what needs to be done to deal with COVID-19. Many people could be asymptomatic posing major threat to health care workers and people you associate with.

As a past peace keeper for the United Nations, my take away based on my personal experience is that while ensuring peace to vulnerable community peace keeper faces another set of challenges arising from pandemics like COVID-19. The peacekeeping radio stations like Radio Miraya in South Sudan and other parts of the world is serving as a lifeline for communities by putting out right and timely information. The main challenge is to keep yourself safe from such disease while ensuring safety and security of targeted population. The peace keepers prone to diseases are likely to spread the same to the very community they intended to protect: case in point is that of Haiti 2010.

People tend to think that the UN is an independent entity with its own mandate and scope. Partly true, but there are lots of protocols to follow given the commitments of individual nations in support of long- and short-term cause.

International response framework

Pandemics do not respect international borders. Therefore, they have the potential to weaken many societies, political systems and economies. The only international framework governing how WHO and its member States should respond to infectious disease outbreaks is the International Health Regulations (IHR). The focus of IHR is on the prevention and containment of public health emergencies of international concern. Member States commit themselves to building core capacities in the areas of national legislation, policy and financing, communications, surveillance, response, and preparedness.

Table 1: Timeline of Pandemic of Some Nations (Date format dd/mm/yy)

PARTICULARS	CHINA	S KOREA	IRAN	ITALY	SPAIN	USA	NEPAL	JAPAN
First Report	31 / 12 / 2019	20/1/20	19/2/20	31/1/20 – 2 x cases	31/1/20	1/21/20	24/2/20	16/1/20
First death	11/1/20	2/20/20	19/2/20	22/2/20	5/3/20	2/8/20- in Wuhan	NA	14/2/20
Second report	1/20/20 -139	23/1/20	21/2/20 : 13 cases	22 Feb- 60 cases	On 24 February	A few days later in Chicago	24/2/20	24/1/20
Deny Entry/ Exit	NA	4/2/20/ Int'l 24 February	5/3/20 20	1/31/20	3 / 9 / 20 different dates for cities	1/31/20	3/7/20	12/2/20
Mass quarantine/ lock down	1/23/20	NA	NA	8/3/20	3/13/20	3/12/20	3/22/20	5/2/20
Total Infection/ Death as of 3/31/20	81,518/3305	9786/162	44,605 / 2829	105,792/12,428	94,417/8,189	75,066/1,080	7/0	2124/56

The relationship between individual, national and international security is related to the introduction of concepts such as “human security” and “sovereignty as responsibility” in the post-cold war era. When this International regime boils down at the national level, different committees are created under Ministry/ secretary of health.

Being realist, states would only commit resources to human security when they derive some direct benefit from it. Thus, we see discrepancies in real time while responding to such pandemics. Some of the reasons why this happens are:

- a. Difference in understanding of the situation among countries.
- b. Individual political interest within a country.
- c. Face saving approach at the outset by nations/Stigma
- d. Lack of commitment
- e. Lack of capacity of individual nations to identify/ respond.

Best practices around the world

Countries that have flattened the curve made testing widely and freely available, using innovative approaches like mass drive-thru test centers. The United States, South Korea, India and China are investing heavily to come up with viable test kits and suppression methods. We will need to act urgently, and aggressively to adopt five key measures that helped to flatten the curve in places like Japan (initial confusion but adopted stringent policy to flatten the curve later), Hong Kong, Singapore, and South Korea.

1. Testing. Testing also allows clinics and hospitals to become better prepared, as they know how many cases to expect. And, crucially, testing helps us to know where the disease is, how it is evolving, and where to target our

efforts to control it. It identifies the hot spots of infections. South Korea has been conducting around 12,000-15,000 tests every day, and has the capacity to do 20,000 daily. While it is hard to get accurate estimates, the CDC reports that only around 25,000 tests have been conducted in total nationwide by CDC or public health labs in the U.S.

2. Communicate and coordinate. In Singapore, for example, “there are almost daily meetings between Regional Health System managers, hospital leaders, and the Ministry of Health.” Clear COVID-19 plans and protocols are in place so that all key players at all levels of the health system know what they are supposed to do. There’s also explicit, detailed information given daily to the public on the state of the outbreak.

3. Use physical distancing to protect the vulnerable. A critical tool for breaking this community transmission is “social distancing”—staying away from places where people congregate (movie theaters, bars, restaurants, shopping centers), avoiding mass gatherings (like religious services and concerts) and but renew love and passion within your own family. What we should understand is the lockdown method adopted by some countries may not be effective to other countries/ societies.

4. Protect our health workers and security personnel. Rapidly scaling up and deploying the production of protective equipment for health workers is not just a public health necessity. It’s also a moral emergency and a mental fight.

5. Expect and plan for a rise in cases. Every health care setting across the country, especially hospitals, should take steps to prepare for a rise in cases, including scaling up their supplies of equipment such as ventilators. But it should primarily come from the top policy level.

Way forward

We should learn from the past and gear ourselves to take up the challenges of future. Vision, preparation and robust mechanism to swiftly spring into action with international engagement. People got exposed because policymakers failed to stop the spread. Some recommendations are:

- there should be a global cooperative entity working at local level to ring alarm bell to international community
- once the pandemics is positively identified the world should act to stop the spread.
- associate health policy commitments with global economic and human security to elevate the level of priority and produce results. The country itself must ensure that high end production houses retain its versatility to switch to the production of desired health equipment in time of crisis.
- Create a global and a national pandemic influenza preparedness plan. It is now widely recognized that effective prevention and response to a pandemic requires national health systems to fit into international systems. Universal health-care coverage is not the only answer in strengthening health systems but many states, such as China, need it desperately.
- IHR compliance needs to be understood through a regional lens and supported by global institutions. The preparedness plan vis a vis National law enforcement agencies and national supply chain link must be revised to meet the global challenges by its core ability to switch to international mode from the national one.

Evaluation of public health and clinical care ethical practices during the COVID-19 outbreak days from media reports in Turkey

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Abstract

Objective: This main aim of the study is to explore COVID-19 pandemic problems from the perspective of public health-clinical care ethics through online media-reports in Turkey.

Method: This research was designed as a descriptive and qualitative study that assesses COVID-19 through online media reports on critics between the periods of March 11, 2020 and April 2 2020 as a quantitative as number of reports and qualitative (headline analysis) study, across Turkey. Reports were from Turkish Medical Association websites which included newspaper reports. Study data were presented as statistically and qualitative data case and headlines. No ethical or official permission was sought as the study was conducted through open access internet news sites.

Results: This online reports analysis retrieved about 6723 articles about the COVID-19. According to study

data, information about COVID-19 were themed as follows: general deficiencies in taking action and isolation (1,800), lack of isolation (160), passengers and transport vehicles not quarantined (247); insufficient diagnostic tests (361), decision to test after healthcare professionals become infected (361), lack of equipment (560), lack of evaluation outbreak countries (389) [Table 2].

Conclusion and Suggestions: COVID-19 is a pandemic and is a global public health problem that concerns every individual and needs to be handled carefully. This requires a multi-faceted preparation and education. In this context, healthcare professionals should be well trained in this aspect and have all the necessary equipment throughout the process. Additionally, it should work systematically with the cooperation of all health organizations, the Ministry of Health, local governments and of course the media, in order to inform society, fairly distribute the resources and to implement the safety measures effectively. Briefly, lack of transparency, insufficient information, limited resources, lack of public health protection measures such as partial quarantine decision, partial implementation of the scientific board's recommendations for economic reasons, and contradiction of the explanations are revealed as serious ethical problems.

Key words: COVID-19, public health ethics, clinical ethics, pandemic

Introduction

Public health is a science that aims to protect humanity from diseases by improving environmental health conditions with organized community studies, preventing infectious diseases, providing early diagnosis and treatment of diseases, and developing a life level that will maintain the health of each individual (Binns & Low, 2015). While public health aims to protect the health of society by making a long-term plan with the data it collects in order to protect the health of society, it also plans and practices to protect the whole society against natural and human disasters. Therefore, public health preparedness and practices are important as well as clinical treatments during disaster. A pandemic is a public health and public health ethics problem due to its multidisciplinary features and its' worldwide health threat (HUBAM, 2020; Zohny, 2020). The current pandemic that the world is facing is COVID-19.

COVID-19 was first publicized on January 13, 2020 when it was discovered in Wuhan Province, China. The World Health Organization (WHO) declared COVID-19 as a pandemic due to the epidemic spreading to more than 114 countries by 11 March 2020 (WHO, 2020a). It has spread to all continents except Antarctica. Meanwhile, since this is a novel virus, there is no vaccine to counter it and the presented vaccines have not been able to prevent the serious health problems it has developed in different ways or to even minimize its spreading speed. People have only taken some preventive measures to control COVID-19 such as hygienic measures, physical distance adjustment, isolations and self-quarantine as their own decision or as a government order.

Table 1: Differences between natural/man-made disasters and the COVID-19 Pandemic.

COVID-19 Pandemic	Natural or man-made disaster
The enemy is invisible and “Patient Zero” is important.	The enemy has some visible points and there is no first victim term.
The pandemic risk group or risk is not limited to a geographical location.	It has geographical boundaries and it is effective within these boundaries.
Healthcare professionals are the primary risk group.	Victims/survivors in that specific location constitute the risk group.
Insufficient health resources.	Usually sufficient health resources
Forced physical distance among people	Not applicable
Authorities cannot create a control area during pandemic	Authorities can create control areas
Patients are stigmatized as an enemy; ageism discrimination became more visible	Victims are innocent
The time of the pandemic is much longer than other disasters, it is almost impossible to determine a clear time frame.	Disaster times are usually limited; mostly disaster contains its own duration.
It can only be terminated when scientists find drugs or vaccines	Precautions to be taken against others are clear, losses can be mitigated by these measures
It ignites scientific discussions	Scientific data are already available
It does not only pose a health problem, it causes to question all socio-economic, political and all existing institutions and organizations and attitudes	Only the possibilities of existing geography or victims, policies and people’s attitudes are criticized.
Fear/anxiety/hopelessness spreads to almost the entire planet	Fear/anxiety/ hopelessness exists in the affected area
It provokes conspiracy theories.	No conspiracy theories.

Source: channel 24 KSA (29 March 2020, 20:00: Hrs)

Correspondingly, COVID-19 has led to the emergence of new and extraordinary demands for both public health resources and the clinical care process. Moreover, it has begun to render the existing health system as well as hospitals to be inadequate and ineffective. For this reason, it has caused panic and fear to spread and continue much more strongly around the world. For example, in the case of a pandemic, it showed that there are insufficient hospitals that will provide healthcare services in the affected areas, as well as shortage of equipment such as intensive care beds and ventilators, and high filtration N-95 masks for health care workers (WHO, 2020c). Moreover it has revealed that there are also now shortages of hospitals and healthcare facilities for diabetes, oncology, hypertension or any other emergency health problems patients. In other words, almost all the deficiencies and faculties of the current system have hit everyone’s faces just like a bioterrorist attack. On the other side, it has revealed that some persons (including journalists, scientists, physicians, for example) who criticize the present health system, health practices, and other socio-economic policies may be either heard or punished (Haber, 2020; Hegarty, 2020).

Differences between COVID-19 and natural/man-made disasters:

As these differences can be seen in (Table 1), pandemic COVID-19 contains different risks and thus indicates new measures. We should take consideration of these differences (Table 1). Because, there is a need for new development of an appropriate package of public health preparedness and practices by assessing the serious differences between natural and human-made disasters (e.g. earthquake, nuclear issues, mass accidents, tsunami) and pandemic (COVID-19). To distinguish these differences is important, because, if we put all the disasters in the same basket then we cannot evaluate their deficiencies and inadequacies, so that the measures will not be as effective as desired.

To distinguish these differences is highly important. Because, if we put all the disasters in the same basket then we cannot evaluate their deficiencies and inadequacies, so that the measures will not be as effective as desired.

Public Health ethics and Clinical care ethics

All infectious diseases require higher accountability as they utilize both public health and clinical ethical practices. Because infectious diseases are twofold, either

they require soft paternalistic applications of public health ethics; or they require treatment of patients within the framework of human rights in patient care (Mann, 1997). COVID-19 covers the clinical ethical practices of the clinical treatment process of the patients, as well as the application of preventive measures taking into consideration the public health ethical values during the control of the pandemic process.

Therefore, during pandemic period, the government should follow public and clinical care and their ethical protocols related to sharing up to date information to the public and ensuring that the shared information is accurate and reliable (Ives et al., 2009). Second, is to share the available information from a comprehensive website and to provide it to both healthcare professionals and to civilians instantly. Third, information given should provide how, to whom and where to seek help from healthcare system and healthcare professionals (e.g., especially for the clarification of the preliminary diagnosis, the tools and equipment related to the tests should be supplied quickly). Fourth, providing the medical, social and economic needs of healthcare professionals; in this case, the healthcare worker provides a better service by overcoming his / her concerns other than healthcare. And the fifth is to ensure that the society is easily adaptable to the quarantine and isolation process by eliminating health and social-economic concerns by the state.

Moreover, in the clinical care service, the values and principles of medical ethics should be applied as far as possible in the context of human right in patient care. Persons under monitoring (PUMs) and persons under investigations (PUIs) should have the right to get information about their COVID-19 tests as soon as possible. Of course, the suspected individual does not have the right to refuse treatment or to quit the quarantine period because of the possibility of infecting the greater community. However, the suspected individual has the right to obtain accurate and sufficient information about his/her current condition and the planned action for treatment. This right does not disappear in any way. Beyond this, face-to-face visitor meetings may be restricted due to possibility of infection, but communication can be provided with suspected individuals and their relatives in appropriate situations through technology. Some media reports in Turkey have indicated that there have been serious violations to both public health ethics and clinical care ethics. These violations have created trust problems between the community, healthcare professionals, and authorities who take COVID-19 pre-cautionary measures such as in this case; where some suspicious persons are not quarantined because of their socio-economic status; nepotism (Hrsimple, 2018) and making this practice unethical, dangerous and criminal. That is why such public health ethics violations should be evaluated by criminal law. In fact, success in such extraordinary situations depends on the strength of mutual trust. Another problem is test process which is taken a long time, and test results can be false negative. Therefore, it is important to evaluate in clinical findings.

How to maximize the delivery of benefits of patient care ethics during COVID-19 pandemic?

Here, the main goal is to increase the effectiveness and efficiency of healthcare both at the social and individual level, and to ensure that human rights in human care are realized. Correspondingly, treatment process provided is in a manner that is in accordance with human dignity without ignoring bioethics and its sub-branches, public health ethics and clinical ethical values and principles.

Healthcare professional had of course received ethical training, and before starting their duty they signed a social contract with the Hippocratic Oath (Güven & Ersoy, 2000; Kavay et al., 2015) and patient rights regulation that determines their limitation and obligation. Where they indicated that both on their behalf their professions and on themselves, they will not hesitate to perform their duties under all kinds of difficulties and dangerous conditions. However, they should protect themselves not only for their job but also for their lives. But, the COVID-19 pandemic creates special conditions and the first line of health professionals risk group has increased. That is why the researcher has proposed some suggestions for the COVID-19 Guidelines:

1. Maximizing the benefit and reducing harm of medical ethics principles needs a guide for practice. The first section of this guide should be about healthcare professionals; where they should be protected first, diagnostic tests should be repeated, equipment, training, appropriate environment and their families should be given the necessary support (Emanuel et al., 2020)
2. Risk assessment tools of the infectious disease (like COVID-19) should be considered in the identification and ranking of risk groups, protection measures, treatment and vaccination. This tool contributes to the prevention of all forms of abuse, discrimination [(e.g., ageism, social status etc.(Stall & Sinha, 2020)] and also ethical problems.
3. Maximizing the benefits; using limited resources needs some rules to provide medical-humanistic priorities; so that people can have equal treatment possibilities and to arrange treatment models of humans based on medical reasons provided that it is intended to maximizing the benefits (Emanuel et al., 2020). This also prevents wealth, social status, and other gender-social-cultural-age-religious discrimination and social injustice. If the extraordinary conditions caused by the lack of medical resources force the healthcare professional to choose, then the choice can be made taking into account the possible life span after treatment. Thus, besides maximizing the benefits involves both more people and more life-years are also taken into consideration.
4. Prioritizing the treatment of healthcare professionals is a must, because the healthcare worker who survives the treatment themselves can resume the treatment of other patients. This contributes significantly to more people getting health care. In the event of an outbreak, the priority should be to test health professionals (Emanuel et al., 2020). Because by evaluating the health status of healthcare workers, it prevents them from getting infected, including other healthcare workers, to suspicious or uninfected people, and also increases the benefit by ensuring that healthcare professionals start

their treatment in a shorter time and return to their duties.

5. Vaccination should be administered considering the risk groups (Emanuel et al., 2020). This method contributes to maximizing benefit when the vaccine is limited. If a vaccine is developed for COVID-19, the vaccine should be given primarily to healthcare professionals, other hospital staff, the group at risk of spreading the infection (market workers, drivers, etc.), and the community.

6. Application of triage in the pandemic process is vital. Because the triage will help physicians prioritize emergency cases as well as maximize the benefits involved (Centers for Disease Control and Prevention, 2020; Petrini, 2010; Sztajnkrzyca, Madsen, & Alejandro Baez, 2006), and the effective use of time in the ongoing pandemic. After the first triage is performed, patients who are considered to be prioritized in the first triage can be re-evaluated if their current treatment opportunities are limited and by that time the necessity to make a new compulsory choice (Klitzman, 2020) may arise between two patients with the same disease level. It is useful to determine the criteria related to this kind of situation in guidelines (doctors of other countries have encountered such conditions in the pandemic process).

7. In this process, it is vital to find the suitable treatment in a short time and it should be supported with intensive research (Bioethics, 2020; Emanuel et al., 2020; WHO, 2020b). In order to apply the guideline models suggested above, voluntary patients with severe symptoms should be preferred first, and then volunteers with mild symptoms should be next.

Public health and clinical care ethical practices play a key role in solving the current COVID-19 pandemic dilemma and not just the application of its philosophical values.

Research question

This study has two main research questions related to Turkey directly facing COVID-19 after March 11 2020.

1. Did the country took the necessary measures taking into account the problems faced from previously affected countries like China, Italy, Iran and Spain?
2. Did the critics in the media news take into account the terms of limiting the pandemic?

Method

This research was designed to assess the COVID-19 pandemic in online media reports on critics between 11 March 2020 and 2 April 2020 as a quantitative study using the number of reports and a qualitative study (headline analysis), across Turkey. Reports were from Turkish Medical Association websites which included newspaper reports. For this study, the chosen Google search engine has entered the word COVID-19 and found more than 182,000 articles. These consisted of websites, newspapers, magazines and other online sources, therefore collected online newspaper news and Turkish Medical Association declarations present some suggestions, reporting current shortcomings and informing healthcare professionals. **Study criteria:** After collecting the data, we organized the online reports by

study criteria's. Second, separated articles according to headlines and excluded irrelevant articles by using key words such as COVID-19, public health ethics, clinical ethics, pandemic 6723 online reports were taken into consideration.

Data analysis: Standard descriptive statistics were used to describe the data.

Table 2: Headline Classifications

Information about COVID-19 (sufficient, insufficient or wrong information)	1800
General deficiencies in taking action [e.g., preventing trips to Saudi Arabia/ Umrah area and not controlling Iran and Syria borders (irregular refugees), Istanbul airport, Izmir port]	512
Autonomy and informed consent	5
Lack of isolation control for many of those traveling abroad	160
No forced quarantine for ships, aircraft crew and passengers	213
Nepotism, some persons returning from travel do not engage in isolation due to their status or are removed from the isolation before the period is completed	247
Insufficient diagnostic tests, and decision to test after 610 healthcare professionals become infected (decision criticism negative and positive)	361
Insufficient number of healthcare professionals and intensive care units, protective and therapeutic equipment (N-95 mask, ventilator, etc.) in case of the spread of COVID-19	560
The outbreak in Italy, Spain and Iran has not been sufficiently evaluated and Turkey was not prepared	389
Deficiencies in providing socio-economic support to the society in case of quarantine emergency in the country	780
Turkey has launched donation campaigns like Iraq, Lebanon, Sri Lanka, Senegal and South Africa (criticism and support articles)	89
Applause campaign for health professionals launched, but violence continues	34
News about those who fled from quarantine	13
News on how to perform Friday prayers (Mosques are not closed)	35
International news about the COVID-19 pandemic and World Health Organization's explanations	1018
Statements by professional organizations (Turkish Medical Association, Turkish Pharmacists Association etc.) on COVID-19	512
Statements by the President, the Ministry of Health and the Science Committee	95

Results and Discussion

The number of COVID-19 cases exceeded 1 million worldwide and was detected in 204 countries and regions. The data of 4 April 2020 reported that COVID-19 cases totaled 1,210,422 with recoveries summing up to 251,822 and deaths recorded were 65,449. On the same day, the numbers of cases in Turkey were 23,934 recoveries were 786 and the death toll being 501 on 5 April 2020 (Sabah-Newspaper, 2020; Worldometer, 2020). This study used Google search engine and used the keywords COVID-19, COVID-19, public health ethics, and clinical ethics,

pandemic and found more than 65,000 articles. However, in accordance with the criteria and limits of the study, we only evaluated the news including public health and clinical ethical problems, these related reports also appeared in more than one press organs, and they were evaluated by eliminating repetitions. General findings are shown in Table 2.

The newspaper headlines in (Table 2) also revealed the reasons for the emergence of public health ethics and clinical care ethics that arose during the pandemic timeframe. Because this situation did not only reveal the problem of treatment, but also the necessity to isolate COVID-19 with serious social reorganization and hospital needs reorganization.

These articles provide information on the deficiencies in the necessary infrastructure to face the pandemic, both in the community and in the health organization. This is actually the case for many countries that face the COVID-19 pandemic after China. Authorities of states couldn't not imagine the COVID-19 pandemic would harshly hit the current advanced health system. Because they thought that scientists would develop the vaccine in a short time and find the treatment model. Due to this negligence, states did not fully understand the danger posed by the outbreak and did not take it seriously enough. Correspondingly, they have not taken into account the report published by the World Health Organization stems and doctors, scientists, journalists and other thinkers who tried to explain the magnitude of the danger this pandemic poses. Briefly, some of states have avoided taking aggressive measures with economic-political concerns. Therefore newspaper headlines are of special importance for understanding this process and reasons of "Pandemic Ethics" problem.

Some details and examples about the problems stated in the table above are as follows: When the contents of the articles in Table 2 are analyzed, it is seen that there are generally criticisms and warnings also related each other topics. Therefore, chosen some themes and given explanations and examples like below.

1. Headlines on general deficiencies in taking necessary action: There are warnings and criticisms about articles not taking serious measures: Because Turkey did not want to stop people travels and did not isolate passengers despite the emergence of the epidemic. This situation caused COVID-19 to spread all over the country in a short time. "Moved from Istanbul and Izmir from Europe, Anatolia from Saudi Arabia-Umrah, those from East and Southeast from metropolitan cities and contact with Iran and Iraq, Mediterranean from Europe and other cities, Black Sea from Europe and metropolitan areas. Late measures taken for travels, which play a major role in the spread of the pandemic, played an important role in the rapid spread of COVID-19 (ABC-Newspaper, 2020)". Because, in serious health problems with a potential pandemic, the country's health committee should be competent, due to politicians are with high political concerns. It reveals that negligence in this matter should adopt new transparency rules in post-corona (Juliet Williams, 2020; Köylü, 2020).

2. Headlines on lack of information: The second important criticism is on COVID-19 cases declared only by

numbers (Köylü, 2020). For example, how many patients are there in which cities, what their age and gender have these patients, these patients brought the virus from which countries abroad, did these patients get in their own neighborhoods, and when started local cases; cases information is belong to which neighborhood or city. This kind of information could play an important role in the creation of isolation or quarantines.

3. Headlines on lack of isolation/quarantine precautions: The third criticism and warnings are; COVID-19 cases number started to increase, some of precautions started, however, while education was interrupted, shopping centers, mosques, cafeterias, etc. were still open, so people continued to go to these places in groups. However, after the spreading rate rose to a certain extent, the places in question were closed completely except mosques. Some of the reasons for this issue have been included in the press as follows. If we give two examples of this; football matches were not delayed, matches without spectators were held. This caused COVID-19 to spread among many coaches (Fatih Terim, Albayrak etc.) and sportsmen. Due to these criticisms like this, some television programs were punished by the state board that issued the programs (Fanatik, 2020). Moreover, workers/laborers, civil servants in freelance, private company and government sector are not giving paid vacation. Critics related to this situation are made as in similar countries.

3. Headlines on lack of diagnosis tests: The third important online reports were about not having enough diagnostic tests are done. Also, there is a margin of error in the tests used for the detection of the virus, and that the lung tomography of the suspect should be taken. (Öztürk, 2020). Some of online reports criticized that a limited number of tests have been prevent understanding the extent of the outbreak; they warned authorities it causes lack of outbreak related measures.

Professor Dr. Necmettin Ünal from Ankara University Intensive Care Department said that "At this stage, the dissemination of the tests will determine the scenario we will encounter as well as preventing the number of patients coming to intensive care." (Yüce, 2020)

Some of the articles in this context have drawn attention to the emergency and intensive care units and warned that "the number of intensive care beds, the number of doctors who can work in intensive care, the number of healthcare professionals who can work in intensive care, and the capacity to increase the number of intensive care beds" will not be sufficient when cases increased (Gündoğdu, 2020; Yüce, 2020).

4. Headlines on lack of healthcare professionals' protective equipment and booked hotels: The articles on this issue are generally about our health system being ready for the coronavirus outbreak, both the staff and the number of intensive care beds, ventilator as well as protective equipment. In addition, healthcare professionals carry the greatest risk of contamination due to COVID-19 patients, so not only themselves but their families are at risk. Therefore, some hotels may be booked to health professionals during this epidemic process. In this way, another precaution can be also taken against the risk of spreading.

"We can easily say that no health system in the world is fully prepared for such a pandemic. Turkey's health system is also unfortunately not in better condition than many other examples. The fact that we do not have enough intensive care beds, doctors, medical staff and that we cannot increase them quickly gives us a very clear message." (Sözcü-Newspaper, 2020)

"It is clear that the number of hospitals, intensive care beds and personnel capacities will start to be filled in a short time, the palms opened to applaud yesterday will be tightened and turned into fists. Everyone should be aware of the fact that the policies, media attitude and inadequate and complex legislation implemented so far in our country will result in this result. It was time to enact a law protecting health care workers" (Istanbul Family Medicine Association Chairman of the Board. Dr. Kutbettin Demir) (Sözcü-Newspaper, 2020)

The statements of health professionals show that we have started to experience serious problems and losses at the beginning of the pandemic.

"The nurse was under quarantine; hospital manager is called for a seizure and is on duty at the clinic right now. Nurse stated that the same clinic has health professionals who are both quarantined and working " (Gerçek-Gündem, 2020).

"Adana state hospital is opened a corridor for COVID-19 patients in the intensive care unit, but healthcare professionals do not have dressing rooms and healthcare professionals cannot connection with hospital managers."

"The nurse stated that they did not have protective materials, so they paid for them personally and received protective materials." (Atam, 2020)

"Corona virus was detected in a total of 610 healthcare professionals working in different cities of Turkey." (Independent, 2020)

While some hospitals consider the contact abroad for the COVID-19 test, some hospitals take into account whether there is fever, cough, and lung involvement outside this criterion, considering that it has started in the local case. There is no consensus yet. Doctor Doğaç Ergezen is 29 years old said that *"there is still a lot more to say but now I am both exhausted and very angry. I don't want to talk angrily. Please take this virus seriously"* (Tele1, 2020).

Professor Dr. Necmettin Ünal, said that *"The most important factor for intensive care is protective equipment. It is not a different approach to bring any of the intensive care team (doctor- nurse- caregiver- cleaning staff) without protective equipment into the patient's room than to send them with a knife on the machine gun. If you lose the intensive care staff, there is no staff to replace them"* (Yüce, 2020) "

The above examples reveal that health professionals should be given priority. Many research and state hospitals have healthcare professionals who are under treatment as COVID-19 patients across Turkey. This situation is doubled risks here because healthcare professionals are facing serious life risk and at the same time the sick doctors cannot treat their patients.

5.Headlines on autonomy and informed consent: Medical ethics principles and concepts must be applied intelligently, kindly and thoughtfully in difficult

circumstances (Aydın & Ersoy, 1995; Civaner, 2015; Ersoy, 1994). In the early days of the pandemic, some people announced via social media that they were isolated and tested, but were not informed about the results of the test. After their videos were published on social media, they had learned that they were COVID-19 positive. Stating that 61-year-old father-in-law died after a heart attack and visited 4 h hospitals, the citizen said,

"The corona test was done in the hospital, but the result was not disclosed. But all the procedures were done like coronavirus. It doesn't state anything in the report. The officials of the Ministry of Health came to the neighborhood and asked their neighbors before the death of his father-in-law, the citizen said, "Now everyone is looking at us abnormally." (Akdemir, 2020).

In the video he published on Twitter, the server Burak Akkul, stated that he had been tested with coronavirus in a hospital in Istanbul with his wife, but that the test result was not told to him right after, but later to be explained that the test results came back positive (T24, 2020)

"Details about the death of the former Land Forces Commander Aytaç Yalman, who died after Aytaç Yalman's diagnosis of COPD, became clear. On the 11th of March, Aytaç Yalman's wife and brother died in quarantine, and Fenerbahçe Orduevi, where he played sports, went to an alarm. " This late information also caused A.Yalman's relatives and also other victims to be diagnosed late and not to be infected during this period (Sözcü, 2020).

No explanation was made from the health institutions or doctors about the situation in question, and it was probably to avoid announcing the bad news to the patient, patient relatives and the society. However, this contributed not only to unethical behavior, to violation of patient rights, but also to increased infection..

6. Headlines on commercialization of hospitals and nepotism: Some articles were concerned that private hospitals, which have increased in recent years, will not be functional in handling the pandemic. So, the other reason is related to the health system main aim whether to save profit and populist practices. If a health system is being commercialized that time this system has neither the capacity, neither equipment nor personnel to be sufficient in such extraordinary cases. In this process, we can see how disadvantaged countries in which the health system is specialized have faced such a disaster (e.g., Spain, Italy, US, France etc.)

These articles stated that without reducing the risk that healthcare professionals face COVID-19, without completing all the health needs of hospitals, without making diagnostic tests widespread, most of private hospitals not conducting COVID-19 diagnostic testing and therefore they don't received COVID-19 patients, namely temporary or permanent expropriation and without taking serious precautions regarding quarantine (e.g., nepotism practices: some people are not taken under quarantine like celebrities, high status people or religious place visitors etc.); public health and public health ethics does not apply, if public health ethics is not implemented it means opening the road to death for its public.

The evaluation results of these online articles are supported by the report published by the consulting firm

of Le Beck "Turkey's crisis with the transfer method will reduce the effectiveness of the measures to be taken against the virus, "a false sense of security" was recorded it was created" (Le-Beck, 2020).

Limitations

The present study data were collected from online newspapers by Google research engine (e.g., Yeniçağ, Sözcü, Cushuriyet, Evrensel, Gazete Duvar, Birgün, Fanatik, Sabah, Hürriyet, T24 and ABC newspapers) and also from websites that take official data into consideration and compare them. However, the pandemic has just begun in Turkey, so the articles in question are limited to the timeframe specified. Furthermore there was a possibility of some unreachable/unnoticed articles or resources. Of course, the synthesis of COVID-19 pandemic data may involve more than the data's context but also in different contexts or interpretation.

Acknowledgements

I would like to thank all healthcare professionals, and express my condolences to the families of the deceased and I offer my wishes for a recovery of health to the current and recovering patients.

Conclusion

The online newspaper news provides a map of the pandemic measures and deficiencies. This map also shows the factors that contribute to ethical problems and violence against healthcare professionals (Sevimli, 2020). In this context, first, this study reveals these critical reports, the differences between the pandemic and other disasters. This approach is important for public health preparations after post-corona. Second, this study also indicated that public health ethics and clinical care ethical problems are not only reasoned by medical/healthcare professional's attitude but also from socio-economic-politic system. Moreover, this study shown the need for a detailed ethical guideline that covers the decision making process in the context of medical ethics and public health ethics. This guide will save the individual doctor from acting on his own conscience and from the great psychological burden that may occur later. Because, casuistry/heart-searching is relative and may vary depending on the situation (García Gómez & Monlezun, 2015). The decision of the individual doctor with reasoning may involve a heavy burden for him/her. The healthcare professional should be freed from this heavy burden. Therefore, in order to remove or expand/detailed theoretical rules from a particular situation, we should avoid future ethical problems by reorganizing and applying these rules with detailed examples, taking into account the problems in the pandemic process. Of course, this is possible with the participation, solidarity and support of competent ethicists, scientists as well as legal authorities. So, we can create a better life by human rights in patient care, social justice, love, and dignity.

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Impacts of COVID19 Pandemic on Care of the Patients with Cancer

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Abstract

COVID-19 was declared as a pandemic by WHO on 11 March 2020. Three days later, the U.S. Surgeon General recommended stopping elective surgeries. The healthcare capacity that is either required now or soon expected, for the treatment of COVID-19 is limited all over the world. Hence, we need to flatten the curve of hospital admissions. We need to ethically examine under which ethical criteria canceling or postponing so-called non-urgent surgeries to an unpredictable date is a reasonable, although difficult decision during the pandemic. The major impacts of COVID-19 pandemic on patients with cancer could be listed as i) age as a common risk factor for cancer and COVID-19 caused mortality; ii) patients are considered to be immunocompromised that means they have a higher risk of getting the infection; iii) the mainstream treatment of various cancers involves surgeries, after which patients might need ventilators; iv) the postponed treatments will likely advance their cancer stages by time; v) the cancer survivors have regular follow-ups requiring hospital visits; vi) COVID-19 causes anxiety which could be predicted to be detrimental for the mental health of patients with cancer and may potentially impair their immune system. These issues collectively might be expected to cause an increase in cancer-related mortality rates. Therefore, immediate action plans are needed to provide the best care for patients with cancer during the pandemic.

Keywords: Cancer, COVID-19, pandemic, ethics, oncology, surgery, chemotherapy, radiotherapy, mortality, healthcare system

Introduction

Coronavirus disease 2019 (COVID-19) is caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). COVID-19 is not simply an airborne disease. The SARS-CoV-2 causing the disease can transmit mainly via respiratory droplets but also via touching the surfaces contaminated with the virus and then the face. Hence, keeping physical distance, wearing masks, and frequent hand washing are the mainstream precautions for controlling the further spread of the virus. The number of ventilators, intensive care units (ICU), healthcare professionals, and many other crucial parts involved in the treatment of the COVID-19 that are either required

now or soon expected, for the treatment of COVID-19 is limited all over the world. Hence, we need to flatten the curve, which means that with protective measures, we aim not to exceed healthcare system capacity (Figure 1).

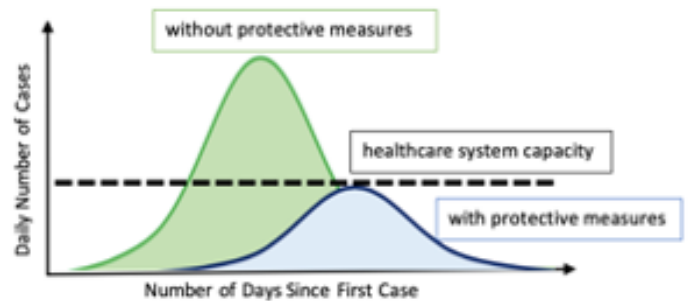


Figure 1: Flattening the Curve. Adapted from: CDC, 2007

COVID-19 was declared as a pandemic by the World Health Organization (WHO) on 11 March 2020 (WHO, 2020). Three days later, the United States (U.S.) Surgeon General Jerome Adams M.D. recommended stopping so-called elective surgeries (Ambulatory Surgery Center Association, 2020). Although canceling or postponing surgeries to currently unpredictable dates are both reasonable and difficult decision against the COVID-19 pandemic to flatten the curve, this decision would affect patients with different diseases in different levels. We need to ethically examine under which ethical criteria canceling or postponing so-called non-urgent surgeries to an unpredictable date is a reasonable, although difficult decision during the pandemic. This mini-review aims to provide the potential impacts of the COVID-19 pandemic on patients with cancer. Since our knowledge regarding COVID-19 has been changing very rapidly since the beginning, it is valuable to state that this mini-review contains the literature until 5 April 2020.

COVID-19 General Clinical Considerations

The Centers for Disease Control and Prevention (CDC), the national public health institute of the U.S., suggests obtaining the specimen from the nasopharynx to test for SARS-CoV-2 (CDC, 2020). SARS-CoV-2 causes severe pneumonia which might require a ventilator usage for an extended period during which the patients stay in the intensive care unit (ICU). During hospitalization, patients might need to have a chest x-ray (CXR) and computed radiography (CT). The two most important risk factors for COVID-19 caused mortality are age and comorbidities including diabetes mellitus, hypertension, coronary heart disease, chronic respiratory disease, and cancer (Wu et al., 2020; Zhou et al., 2020). The current treatment involves supportive care and many other experimental options, such as remdesivir and hydroxychloroquine (McIntosh, 2020). On April 4, 2020, WHO shared that globally there are 1,051,635 confirmed cases and 56,985 deaths where the mortality rate is 5.4% (WHO, 2020). However, the COVID-19 mortality rates have been changing very rapidly, depending on the country's existing health care system capacity and their national precautions.

Advancements in Treatment of Cancer

The U.S. cancer-related mortality rate decreased by almost 30% since 1991 (Miller et al., 2019). Moreover, the most considerable annual decline in the U.S. was from 2016 to 2017, according to the study published in 2019 (Miller et al., 2019). The recent advancements in treatment and screening programs should have played crucial roles in this achievement. It is widely accepted that age is the single most important risk factor for developing cancer (National Cancer Institute, 2015).

The COVID-19 pandemic also endangers the cancer research that might be either basic science research or clinical research. The concerns about animal research mainly can be stemmed from the risk of animal infection with SARS-CoV-2, the risk of shutting down the research facilities, and the grant-related issues such as deadlines. Clinical research, including phase I, II, and III trials, plays a crucial role in cancer treatment. Clinical trials involve regular visits, including administration of the medications, blood tests, and imaging studies. Currently, people are discouraged from visiting the hospitals unless it is an emergency. The major question that requires immediate attention is that how we should assess outcomes of the clinical trials, primarily the survival if the patients are passing away due to the COVID-19. The institutions should develop action plans in order to be able to maintain our progress in cancer research.

The Impacts of COVID-19 on Care of Patients with Cancer

The definition of patients with cancer should include four populations: i) people with known cancer and currently receiving treatment, ii) people with a known cancer history also referred to a cancer survivor, iii) people who have not diagnosed with cancer but currently has it, and iv) people with known cancer and living at a hospice. Given the fact that SARS-CoV-2 affects lungs, patients with lung cancer can be considered to be at higher risk for the infection and mortality compared to patients with other cancer types. A recent study from China, including 18 COVID-19 patients with a history of cancer, revealed lung cancer as the most common cancer type (Liang et al., 2020). A meta-analysis revealed that 2.1% of patients diagnosed with COVID-19 had a history of cancer or have cancer (Desai et al., 2020). Italian data demonstrate that 20% of the COVID-19 patients with comorbidities who died also had cancer diagnosis (West, 2020).

Firstly, age is the common risk factor for cancer, and COVID-19 caused mortality (National Cancer Institute, 2015; Wu et al., 2020). Given this information, it is almost inevitable not to observe a higher mortality rate due to COVID-19 among patients with cancer than the healthy population. Secondly, patients with cancer are considered to be immunocompromised. It means that theoretically, these patients are more prone to infections than healthy individuals. Hence, they have a higher risk of getting SARS-CoV-2. A recent study from a hospital in Wuhan showed that the incidence of SARS-CoV-2 found to have higher in patients with cancer than people without cancer (Yu et al., 2020). Thirdly, the mainstream treatment of various cancers involves surgeries such as endometrium cancer and ovarian cancer. Following the surgeries, some

patients might need ventilators for several days. Due to the pandemic and delaying the elective surgeries, the priority to use ventilators would most likely be given to the people with the COVID-19. Fourthly, the postponed treatments, including chemotherapy, radiotherapy, and surgery, will likely advance their cancer stages by time. Similarly, due to the healthcare access restrictions and stay home policies, people will get diagnosed at later cancer states.

Delaying surgeries based on the U.S. Surgeon General's recommendation creates three essential questions: i) how long the delay will last, ii) how to prioritize the patients for surgery when surgeries can be performed, and iii) how long delay safe is. During cancer treatments, patients might require transfusion of blood and blood products. The U.S. Surgeon General was also declared his concerns regarding the potential risk of a shortage of blood during the pandemic (American Red Cross, 2020). He also encouraged people to donate blood (American Red Cross, 2020). Fifthly, the cancer survivors have regular follow-ups when they need blood tests and imaging studies to rule out the recurrence, mainly. This would delay the detection of the recurrence; hence, the chance of early intervention. Overall, it would be leading to disease progression. Additionally, imaging instruments the patients receiving treatments due to COVID-19 might be infected with the virus and further increasing the infection risk for patients with cancer during the follow-up visits. The pandemic leads people in a healthy population to the anxiety of having/getting the virus, fear of death, and various other mental health problems. Additionally, keeping the physical distance aiming to flatten to curve might further impact on mental health. Sixthly, these risks might be seen even more prominent in patients with cancer and also may potentially impair their immune system.

Triage during the Pandemic

In medicine, triage is defined as the quick assessment of the patients and making decisions based on their severity to determine the order of the treatments. This strategy has been well adopted by emergency departments worldwide. The triage ethics follow the four principles of biomedical ethics: i) respect for autonomy, ii) beneficence, iii) nonmaleficence, and iv) justice (Aacharya et al., 2011). A triage protocol, including the ventilation, was developed during influenza (H5N1) pandemic (Christian et al., 2006). Their triage protocol included the Sequential Organ Failure Assessment (SOFA) Score together with four components: i) inclusion criteria, ii) exclusion criteria, iii) minimum qualifications for survival, and iv) a prioritization tool (Christian et al., 2006). WHO recommended using standardized triage tools for patients who came to the hospital with a severe acute respiratory infection (SARI) with suspicion of COVID-19 (WHO, 2020). During the COVID-19 pandemic, in Italy, the healthcare system capacity was exceeded that led to the triage of the patients (Rosenbaum, 2020). They suggested three principles for the triage i) the healthcare providers who treat patients and make triage decision should be classified, ii) the triage parameters should be periodically reviewed by a central system, and iii) the triage algorithm

should be frequently updated according to the novel data (Rosenbaum, 2020). The triage protocols developed during the pandemics may not be the ideal because of insufficient healthcare system capacity; however, they adhere to utilitarianism where the healthcare providers target to benefit the majority of the patients (Melnychuk et al., 2006).

Conclusion

Overall, all of the issues (i) age as a common risk factor for cancer and COVID-19 caused mortality; ii) patients with cancer are immunocompromised meaning a higher risk for the infection; iii) after cancer surgeries patients might need ventilators; iv) the postponed treatments will likely advance their cancer stages by time; v) delaying the cancer survivors' follow-ups would advance their cancer and delay the early intervention; vi) the burden of COVID-19 on mental health might be felt more in patients with cancer and potentially impair their immune system) collectively will have a negative impact on the cancer-related mortality rate. Patients with cancer diagnosed with COVID-19 were found to have poorer outcomes than patients without cancer (Liang et al., 2020). Delaying the surgeries, chemotherapy, or radiotherapy should be very carefully considered. Furthermore, considering the limited healthcare capacity and the risk factors for COVID-19 mortality, it seems likely that patients with cancer would not be at the top of the triage list. It is expected, in particular, for admissions for ICU. The shared decision making between the physicians and the patients should take place during the discussions. The international, national, and institutional guidelines regarding the management of the patients with cancer during the pandemic should be closely followed. To be able to minimize the mortality rate in patients with cancer during the pandemic, the institutions should immediately develop action plans for the best interest of their patients, given their institutional capacity. Most importantly, during preparing the guidelines the fundamentals of ethics must be followed.

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Equality, Positive Health and Global Inequality in the midst of the COVID-19 pandemic.

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Abstract

Thomas Pogge presents a historical picture in terms of the unjust distribution of wealth around the world. Unjust structures contribute to the suffering and misery of people, especially in Third World countries, whose citizens do not have an easy access to quality but expensive medical treatment, thus putting them at a disadvantage. This paper looks into the problem of unequal resource distribution around the world, using the Capability Approach as lens, and proposes the notion of positive health as a right that will secure the welfare of people in the midst of the COVID-19 pandemic.

Keywords: Global Inequality, Positive Health, Global Justice, Global Resources Dividend, Thomas Pogge

Global Inequality and Poverty

Poverty and inequality have become a global pathology that providing aid and the need to finally end them is a global project and a moral imperative. While majority of the world's population is living in dire poverty, the world's affluent nations and citizens are indifferent towards the suffering of the global poor. Over three billion people, that is, almost half of the world, live below the poverty threshold of 2.50 USD per day. And Eighty percent of the world's population lives in developing countries where income differentials are huge and dire poverty exists (Anup, 1998). Moreover, the world is producing annually 18 million deaths; with 22, 000 poor children, usually below five years old, dying every day due to poverty related causes (Anup, 1998). Such severe and extensive poverty exist while the world's rich nations are getting richer. The north is accumulating massive economic wealth, more often at the expense of the developing country's resources, while the number of the global poor remains to be increasing. In 1990, there were about 1.9 billion people living in extreme poverty; the majority of these lived in sub-Saharan Africa and South Asia. This troubling fact of severe global inequality warrants a serious moral consideration.

However, it cannot also be denied that over the past two decades the global economy has grown in an astonishing rate; in less than 10 years the value of the annual global economic production has doubled (Roser and Ortiz-Ospina, 2019). What this practically means is that with the rise of the overall global affluence there likewise is the rise of the middle-class societies. The increase of the global economic productivity has led many to leave their most destitute states of existence. Many of the poorest of the poor has improved their state of abject poverty. Accordingly, more than a third of the world's population, that is, 900 million people, live on more than 10 USD per day (Roser and Ortiz-Ospina, 2019). In 2015

the World Bank Organization in reformulating its proposed "International Poverty Line" lowered the poverty line index from 2.50 USD in 1990 to 1.90 USD per day. So that in 2015 those who are living below 1.90 USD per day are considered poorest of the poor. The proposed index is designed to measure the monetary value of a person's consumption (Roser and Ortiz-Ospina, 2019). The result was an astonishing rise of the global middle class and the diminution of the poorest of the poor. Accordingly, "the number of people living in extreme poverty has fallen from 1.9 billion in 1990 to 650 million in 2018." (Roser and Ortiz-Ospina, 2019).

Nonetheless, it is important to emphasize that the international poverty line of 1.90 USD per day is extremely low, so that those who are living below this poverty line index are extremely poor. And to focus simply our attention to those people who met the standard set by the international organization is to deny the most disadvantaged people of their right to development. More so, it does not necessarily mean that those who are living on or above the poverty line are not considered poor, nor do they not experience the hardships that the poorest of the poor person suffers owing to her absolute state of capability deficit. Notwithstanding the relative development caused by the world bank's lowering of the international poverty line, the world's poorest of the poor societies remained to be the same and had not experience any sort of amelioration of their state of absolute deprivation. This stagnation of the development of the worst-off societies globally, if no alternative measures that the global community will take to improve the situation, will eventually lead to an increase of the number of people who are extremely poor at about 500 million in 2030 (Roser and Ortiz-Ospina, 2019).

Deaths from Poverty and COVID-19

According to the World Health Organization most of the diseases of poorer societies that constitute 46 percent of their disease burden are consequences of poverty, such as poor nutrition, lack of access to proper sanitation and health education, and lack of access to effective but expensive health care services (Stevens, 2004). What this means is that human poverty and infectious diseases are inseparable social phenomena that necessarily determine the fate of the poor in developing countries. The world is constantly battling against deadly diseases, such as tuberculosis, malaria, HIV/AIDS, hepatitis B and dengue. These infectious diseases are prevalent in most low-income societies, but thanks to the development of genetic engineering the world was able to create potent vaccines that can fight these diseases, which have led to the dramatic decline of the number of deaths of poor people over the last 25 years.

During the first fifteen years of development, from 1990 to 2005, every year the world was producing 18 million deaths from infections and poverty-related causes. Among these deaths were 50,000 adults and 34,000 children below the age of five, and half of these children were infants in their first month of life. Nonetheless, in the proceeding years of development a remarkable decline of the number of deaths of poor people was recorded. In 2005 there were only 8.9 million poverty and infectious

diseases related deaths and in 2015, 8 million, with 96 percent of these occurring in poorer societies (Alkire et al., 2018). Despite the decline of the number of avoidable deaths worldwide the fact remains that vast inequality among the world's richest and the poorest exist and millions of poor people dies each year. The rate of poor children dying of vaccine-preventable diseases in comparison to children of high-income societies remains scandalously high. Accordingly, children from low-income societies are 60 times more likely to die of preventable diseases during their fifth year of life than children from high-income societies. In 2017, an estimated 6.3 million children died of infections and amenable diseases, some 5.4 million of whom were children under the age of five. One child under 15 years old dies every five seconds, with half of these deaths in Sub-Saharan Africa and 30 percent in Southern Asia (World Health Organization, 2018). The disparities of the ratio of children dying per population in Sub-Saharan Africa and in high-income societies is depressingly high; in the former, one in 13 children dies before their 15th birthday, while in the latter that number is one in 185 (World Health Organization, 2018). Moreover, babies in low-income societies are nine times more likely to die of infections and diseases during their first month of infancy. In total, in 2017, 2.5 million children died in their first month. And if no feasible alternative is taken to stop these deaths in 2030 an estimated 56 million more children under age five will die.

The persistent existence of inequality of opportunity for quality health care between the rich and the poor raises problems of social justice. More often than not, the rich with their financial capabilities are more likely to refer themselves to the most sophisticated medical care and facilities. They can afford to buy the most expensive medicine and be admitted to the most expensive private hospitals. While for the rich longevity and positive health are possibilities that are readily available, the majority of the poorest population can only wish for the same possibilities. It cannot be denied that those capable of obtaining the best health care services are in a superior position compared to those who are not (Kotze, 2016). People who can afford it are assured of their positive health.

Notwithstanding, these deaths are caused by diseases that humanity had long been battling; common diseases that medical science and advance genetic therapy can instantly cure if opportunity for positive health is open and affordable to all. However, the world is currently facing a global health crisis that is caused by a novel corona virus which already took thousands of lives all over the world and has posed an imminent threat to the overall global economy. In March 12, 2020 the World Health Organization announced the COVID-19 as a global pandemic inasmuch as it has already infected 199 countries all over the world, and took the lives of some 25,042 people and has affected more than 552, 589 worldwide (at the time this paper is written), inscribing its global fatality rate at around 4.4 percent and which is projected to further increase as the pandemic continues to ravage the world. The rise of COVID-19 and its devastating effects to the world and to the socio-economic well-being and to the overall health of the people has prompted

insights of the need to embrace a more universal conception of social justice. A universal principle of justice that seek to appease and compensate the unnecessary sufferings the global poor are forced to suffer due to the entrenchment of unjust global institutional orders. The proliferation of these unjust global structures is rooted by the design of geopolitics, as a rule, unjust global politics and structures are aimed at benefitting the rich nations while leaving behind the welfare and well-being of the developing states (Maboloc, 2019: 1192). If the first world countries with their developed and advanced healthcare systems and medical technologies remained victims to the dreadful effects brought about by this pandemic, how much more the poor countries which, in their lack of resources and knowledge, are left blindly to battle against a formidable enemy that is new to the world.

World Poverty and Cosmopolitan Justice

In his attempt of extending the liberal principles of justice to the global arena, Pogge proposed his theory of cosmopolitan justice. Such idea of justice is grounded in the presupposition that the affluent countries from the north owe to the global poor claims of justice. This is because the rich countries, having actively participated in the design of unjust global institutional orders, have unavoidably harmed and worsen the state of deprivation of the global poor. And that the mere insistence of a positive duty of assistance is inefficient to give justice to the atrocities and injustices the rich countries, with their global institutions, have caused the global poor to unnecessarily suffer. Pogge insist that the first world must embrace the more stringent duty not to harm the global poor in order to appease the negative effects the past actions of the affluent institutions have proliferated. Global aids or charities must be transformed into just compensations for the injustices the affluent countries have caused the poorer societies to suffer.

The necessity of extending the liberal principles of justice to the international realm is brought about by the persistent existence of global poverty and inequality. It is ironic that while some of the world's affluent nations are expanding their wealth and technological developments, others are left to die on their own being miserably poor and absolutely deprived. The rich are getting richer while the poor are getting poorer. And yet it seems like the rich countries from the north have done less if not nothing to help alleviate the poorer societies from their miserable state of existence. Pogge argues that extensive global inequality and poverty will persist to continue inasmuch as the affluent nations do not find its eradication morally compelling and worthy of serious moral reflection (Pogge, 2002). This acquiescence towards global poverty and to the global poor's cry for help is caused primarily by the beliefs that eradication of global poverty is not worthy of serious moral reflection and that the affluent countries in fulfilling their minimum duty of assistance to the global poor are actually doing fine, that there is nothing wrong with their being acquiescent. To this Maboloc explains that "The discriminatory concept of nationhood is protective of the country's citizens. Non-citizens are judged as outsiders. In this respect, the sense of justice in

the world is limited to a mere duty of assistance" (Maboloc, 2019).

Radical Inequality and Global Resources Dividend

The moral urgency to eradicate global poverty is brought about by the fact that hundreds of millions of poor people are unnecessarily suffering and are dying each day. And the sheer domestication of the problem, by putting all blames on the political culture and structure of a particular poor society, is to deny the real culprits of their moral obligations to appease the negative effects their actions in the past have caused some people to unnecessarily suffer. Pogge argues that the poor societies are poor not entirely because their social and political structures are corrupt and nonfunctioning. They are poor because the rich countries are doing nothing to eradicate, if not, to mitigate the effects of their state of absolute deprivation and poverty. Such indifference on the part of the world's affluent states is caused primarily by their persistent denial that they have something to do with the sufferings of the global poor; that they have not caused the unimaginable sufferings the poor peoples in the world are suffering from. Pogge explains that such resistance is caused by the conventional understanding that global poverty is solely traceable to the local-domestic structure of a polity, thereby justifying the acquiescence of most rich countries of the world towards eradicating global inequality and poverty. To this Pogge asserts that "[such] illusion conceals how profoundly local factors and their effects are influenced by the existing global order" (Pogge, 2002: 200).

Although it is true that most developing societies are corrupt and are often suffering from weak and incoherent bureaucracy; caused primarily by the entrenchment of dictatorial rulers and faulty social structures. However, one cannot simply set aside the significant role the present global institutional arrangements contribute in determining the future lives of the poor. The constant possibility of civil strife, the entrenchment of dictator rulers and the rise of deprivation among poor societies, are driven by international factors such as: foreign monetary bribes from huge companies abroad who help in winning the elections of corrupt leaders who in turn will allow their illegal trades to flourish in their specific districts; the two international privileges of resources and borrowing, being indifferent to how rulers attain power over their constituents, both necessarily provide incentives for the proliferation of civil war and the entrenchment of political warlords. Pogge emphasizes that "The reason is that the citizens and the governments of the affluent countries whether intentionally or not are imposing a global institutional order that foreseeably and avoidably reproduces severe and widespread poverty. The worse-off are not merely poor and often starving, but are being impoverished and starved under our shared institutional arrangements, which inescapably shape their lives" (Pogge, 2002: 201). It cannot be denied, therefore, that the new global orders have contributed to the proliferation of global inequality and has indirectly caused the deaths of poor peoples in poorer societies.

A positive duty of assistance, for that matter, may not sound morally compelling, for it reduces the moral

obligation of the affluent societies towards alleviating the poor states to sheer duties of beneficence. And the need to help the worst-off societies is dependent on the arbitrary wills of the affluent states. But looking at the extent of global deprivation, the deaths and the injustices the new global orders have unjustly imposed to the global poor, the more stringent duty not to harm the worst-off must be given serious considerations. This is so because, "The affluent countries have been using their power to shape the rules of the world economy according to their own interests and thereby have deprived the poorer populations of their fair share of global economic growth" (Pogge, 2002: 201). What is needed therefore is to conceive a feasible new global arrangement that will secure the just compensation of the poor who were made to suffer the negative consequences of the past global arrangement. To this Pogge proposes his Global Resources Dividend or GRD. What is being presupposed in the said global economic arrangement is the idea that governments will not have absolute libertarian rights over their owned resources. And that they are required to give a "dividend" of the values of the resources they use or sell to the global poor (Pogge, 2002). The GRD, in principle, requires the rich countries to give a small portion of the value of the resources they use. This is because "the global poor own an inalienable stake in all limited natural resources" (Pogge, 2002: 196). These payments will then be used to help alleviate the state of existence of the global poor and to capacitate them to self-development later in their lives.

Moreover, Pogge explains further that the requirement of giving a portion of the value of the used national resources of the rich countries does not presuppose that the poor countries can interfere with the deliberation of the usage and selling of the resources, neither can they (the worst off societies) insist on large amount of payments. For as specified by Pogge, the amount needed to totally eradicate global poverty is only 1.2 percent, roughly around \$300 Billion, of the annual gross income of the high economy countries in the world. For Pogge the GRD posits a necessary moral constraint over the distributive pattern of the global resources, in as much as most of the poor societies in the world were products of past colonization and state lootings by the colonizing societies, who are now the world's affluent states.

The incorporation of the moral claims of the impoverished and suffering humanity worldwide in the global institutional orders, their rights and entitlements over the shared planetary resources is what makes the GRD morally compelling. It presupposes that "the rich countries owe to the poor payments for the atrocities and the horrendous crimes the rich societies have inflicted to the poor communities. "The GRD proposal is meant to show that there are feasible alternative ways of organizing our global economic order that the choice among these alternatives makes a substantial difference to how much severe poverty there is worldwide, and that there are weighty moral reasons to make this choice so as to minimize such poverty" (Pogge, 2002: 197).

Human Rights and Global Institution

Pogge is critical to the conventional understanding of human rights that presupposes a necessary interrelation between human rights and legal rights. This interactional idea of rights presupposes that moral claims of individual rights, in order for them to be truly realized, need to be incorporated in a country's legal and judicial system. Pogge writes that "Each society's government and citizens ought to insure that all human rights are incorporated into its fundamental legal texts and are within its jurisdiction, observed and enforced through an effective judicial system" (Pogge, 2002: 45). The necessity of incorporating ideas of human rights to the country's effective and functioning judicial system is grounded in the faulty logic that through the legalization of these moral constraints their realization is secured. Such legal conception of human rights for Pogge may come as too strong and too weak. Too strong, for a society maybe so well ordered that every individual's human rights are fulfilled even their access is not legally guaranteed. That the human right to nutrition is considered fulfilled even if its achievement is not inscribed in the judicial system of a polity; so that a society cannot be said to be unjust if a certain human right is fulfilled despite of it not having any legal prescriptions. Too weak, for even if a polity profess to have lists of human rights but if its system of governance is not well functioning, the fulfillment of these rights may not necessarily be secured (Pogge, 2002).

To this, Pogge offers his alternative conception of human rights that is "primarily as claims on coercive social institutions and secondarily as claims against those who uphold such institutions" (Pogge, 2002: 44-45). Such, a conception of human rights bears moral claims on the way citizens and the government of a society design the social institution that ensure everyone's rights are upheld. This idea of human right is detached from any legal and juridical conceptions. The need to separate human rights from concepts of legal rights is caused by the fact that adding legal terms to concepts of rights are, for Pogge, of less importance. He argues that in a society whose citizens fully embrace religious freedom, thereby allowing everyone to fulfill their human right to freedom of religion cannot be referred as unjust simply because there was no legal specification that guarantees such freedom to be fulfilled (Pogge, 2002: 47).

Pogge further explains that, "Human rights are not supposed to regulate what government officials must do or refrain from doing, but are to govern how all of us together ought to design the basic rules of our common life" (Pogge, 2002: 47). Such conception of institutional moral rights is not addressed to the government neither of the citizens of the same polity, but to the actual design of the basic institutions of a society. That is, a feasible conception of human rights must move the citizens and the government of a polity to design its social and political institutions that rights of everyone one is proliferated. The need for an institutional understanding of human rights is vital for the realization of a global institutional reordering. This is so because the world is undeniably and closely interconnected, in terms of, political values, market trades, and international relations. And that the unjust ordering of a certain society may have direct effects to

some; as was noted in the previous sections, the international global orders worsen the state of deprivation of the global poor. Pogge believes that with this institutional conception of human rights the poor will be compensated of the injustices they suffered from the unjust global institutional orders. Pogge adds that, "Such an understanding would lead us to take the under-fulfillment of human rights abroad more seriously – provided we accept that persons involved in upholding coercive social institutions have a shared moral responsibility to ensure that these institutions satisfy at least the universal core criterion of basic justice by fulfilling, insofar as reasonably possible, the human rights of the persons whose conduct they regulate" (Pogge, 2002:49).

Positive Health and the Global Pandemic

It was mentioned in the above sections that human poverty and infectious diseases are two interrelated phenomena that define the fate of poor people all over the world. And that efforts in reformulating the global orders must be directed towards irradiating both instances of global social injustices. Poverty breeds infectious diseases. The root cause of the deaths and the unnecessary sufferings of the global poor is absolute poverty; so that the complete irradiation of it presupposes the assurance of positive health. It is when an individual is capacitated to choose freely from among life's best alternatives without any constraints that one can say that she is truly developed and that the totality of her positive health is secured. Positive health consists in the actual state of development of the person, physical, emotional, intellectual and social wellbeing. It is when one is capable of achieving different life's functionings, being well nourished, being healthy, easy access to medical services, education, and the like. Human development is based on the positive freedom of the individual to freely choose the life she finds reasonable to live. And that justice demands that social institutions are so designed that everyone is given equal opportunity to achieve their goals in life. Contrary to what is the case globally, while the wealthy nations are busy in accumulating massive amount of wealth, the global poor are getting poorer. And the inevitable effect of such unjust distribution of the global wealth is the persistently high number of deaths suffered by the poor worldwide caused by curable diseases. With the rise of the global pandemic, the urgent need to answer the problem of global inequality has taken moral ascendancy. Poorer societies are of high risk to the devastating effects of the virus compare to countries from the north. What is needed at this moment of global health crisis is that nations, particularly poorer states, must not be left alone to battle against the pandemic but other nations must embrace the moral responsibility to channel compensatory aids to the suffering states.

Conclusions

With the world's current state of health crisis brought about by the rise of the global pandemic COVID-19, the more stringent duty of formulating a global institutional order that will secure the lives and well-being of the global poor has taken a strong moral ascendancy compare

to rather simply providing aid. The lack of resources and effective social institutional orders that most developing countries are suffering posit the moral imperative to channel additional resources that serve not as charitable aids but as just compensations of the past atrocities the rich countries have caused to these global poor. COVID-19 posit more threat to the global poor than to the first world countries, for reasons that poor societies often lack resources and technologies necessary to battle against the imminent threat that the virus brings. Insuring health, being a fundamental object of human right, to everyone must be one of the vital objectives that every institutional scheme has to secure. The capability to choose from among life's best alternatives can only be made possible if people are in constant good health and the opportunity to avail for the best possible health care relative to every state is open to all. Now, inasmuch as the current global institutional order does affect the structures and systems of national institutional schemes all over the world, most especially that of the poorer societies, the more a universal idea of justice is necessitated. Understanding the underlying global danger that the pandemic brings to everyone will lead one to assert that efforts in dealing with this crisis must not be limited solely to local national states but must be extended further to the global arena. The pandemic does not only posit an immediate threat to the national welfare of a national state but to everyone in the world. The need to embrace an all encompassing sense of moral responsibility that does not limit itself to caring only for citizens of a particular state but transcends to all nations is what is truly needed in order to win the battle against COVID-19.

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Tribal Communities and Nations in a Time of COVID-19

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Abstract

Indigenous nations across the United States and the globe are not strangers to epidemics and germ warfare. Over multiple generations of humankind, U.S. tribal populations have experienced one of the greatest downsizing of numbers on the planet: from nearly 17 million (Thornton 1987) to their current population of approximately 5.2 million (U.S. Census 2010) in the United States alone. Biological warfare, smallpox, and government policies have been used to reduce and wipe out entire nations. This article looks at the potential impacts of COVID-19 on tribal populations in the United States today, including the potential loss of elders, knowledge keepers, and language speakers. America's indigenous communities today are aging communities, and significant portions of their populations are at risk of death due to the current health status of tribal populations, distance to medical resources, inadequate resources, and extreme poverty. Using insight from tribes in the American Southwest, this presentation will offer insight into sustainability for tribal nations, community ties, cultural capital, and resiliency as buffers to the virus.

Introduction

Since the founding of the United States, indigenous populations across the North American continent have been subjected to disease, germ warfare, and existential threats by European settlers. The colonization of North America, also referred to as the North American holocaust (Thornton 1987), led to the eradication of nearly 12 million Native Americans. Today, the population of indigenous peoples in the United States is approximately 5.2 million. According to the Bureau of Indian Affairs (BIA 2016), there are 573 federally recognized tribes in the United States, not counting tribes fighting for federal recognition (<https://www.ncsl.org>).

Historically, the indigenous peoples of the United States have been subjected to disease and illnesses brought by European settlers, including but not limited to smallpox, bubonic plague, chicken pox, cholera, diphtheria, influenzas, malaria, measles, and scarlet fever. According to Carlos and Lewis (2012), the smallpox epidemic of 1781-82 in the Hudson Bay region of Massachusetts devastated indigenous populations living there. Studies suggest that the smallpox epidemic among tribal populations had a mortality rate of between 20% and 50% (Carlos and Lewis 2012; Fenner et al. 1988). In addition, the U.S. government facilitated a massive genocide by ordering the distribution by the U.S. military of smallpox blankets to indigenous peoples (Valencia-Weber 2002). "In the old day blankets infected with smallpox were given to tribes in an effort to decimate

them" (Deloria 1970). Hopkins (1983) illustrated how colonists fostered the spread of the disease in order to break indigenous resistance and to facilitate land grabs by European settlers. An estimated 90% of the North American tribal population was reduced in the years following the European invasion (Thornton 1987).



In more recent years, Native Americans have been impacted by contemporary epidemics such as those related to diabetes, suicide, and HIV, all of which have negatively impacted tribal populations. Such contemporary epidemics illustrate the current state of health among tribal peoples and residual effects of centuries of colonization. In 1955, the Indian Health Service (IHS) was established, and clinics and hospitals were built to address the health of Native Americans. Today, a total of only 26 hospitals, 59 health centers, and 32 health stations exist in the United States to serve 573 tribes and more than 5 million people. Federal funding of the IHS is discretionary, and spending is optional and varies by administration. The program is historically underfunded, making it difficult to serve patients across the country. In 2020, the U.S. Department of Interior announced a 14% cut in funding for tribal programs. According to the IHS chief medical officer, the entire IHS system had only 625 hospital beds, only six ICU beds, and only 10 ventilators (<https://www.politico.com/news/2020/03/20/coronavirus-american-indian-health-138724>). According to the Indian Health Board, only 16% of tribal providers reported receiving any type of federal resources, and only 4% received protective

equipment since the start of the epidemic. According to the Center for Disease Control and Prevention (CDC 2020) the Coronavirus Preparedness and Response Supplemental Appropriation Act, 2020 (P.L. 116-123) \$8.3 billion in emergency funding for federal agencies to respond to the COVID19 pandemic, \$40 million which is to be allocated to tribes, tribal organizations, and health service providers. Divided across 573 tribes, this amounts to roughly \$70,000 per tribe, barely enough to make ends meet.

In the face of the COVID-19 pandemic, the IHS system is not prepared and is not funded to support the needs of everyday populations and offers little support. In this paper, I make several arguments. First, the failure of U.S. and state governments to address the social determinants of health among tribal populations and minorities has placed tribal populations at an elevated risk during this pandemic. Second, the lack of engagement and investment by national and state political leaders and policymakers have exacerbated health conditions across tribes, contributing to a shortage of investments in life-saving resources such as education, healthcare, internet access, and preventative care. Third, and most importantly, the indigenous peoples and tribal nations of North America possess community cultural wealth (Yosso 2005) that encompasses a multitude of strengths and measures that each tribe can call upon to ensure the protection of their communities.

Elevated Risk and Underlying Health Conditions

The current health profile for American Indians and Alaska Natives in the United States demonstrates deep disparities compared to other racial and ethnic groups in the United States. According to the CDC (2014), death rates among Native Americans are 50% greater than those of non-Hispanic Whites. Death records for both Native American men and women combined show that the leading cause of death in the United States is cancer, followed by heart disease (CDC 2014). Heart disease is a leading cause of death in the United States among all populations: Approximately 610,000 people die of heart disease every year (CDC 2017). Heart disease is a leading cause of death among Native Americans in the United States, with the CDC (2018) reporting 3,632 deaths among Native populations between 1999 and 2016.

While other racial and ethnic groups have seen a decrease in mortality rates due to heart disease, Native American populations have not seen a substantial decrease in heart disease-related deaths since 1993 (CDC 2016). Between 1993 and 2017, there was an average of 100.4 deaths of Native American males across the United States per 100,000 population (CDC 2016). Heart disease is the second leading cause of death among Native American women (CDC 2017). The CDC (2015) reported that 17% of all deaths among Native American women were related to heart disease (CDC 2015). According to the CDC (2014), Native American men are 20% more likely to smoke cigarettes and are 30% more likely than non-Hispanic Whites to have high blood pressure. Native Americans died from heart disease at younger ages than any other racial and ethnic groups in the United States (CDC 2004). According to the CDC (2004), 36% of heart

disease-related deaths occurred before the victims were 65. Cancer is the No. 1 cause of death among Native American women and the second leading cause of death of men (American Indian Cancer Foundation 2014). While cancer rates decreased for non-Hispanic Whites over the past 20 years, Native Americans have seen a substantial increase (AICF 2014).

Disparities in health outcomes vary across tribal nations. Some groups experienced elevated rates of diabetes, heart disease, and mortality rates compared to others. For example, Native Americans in New Mexico died at younger ages and have the highest percentage of children who will not outlive their parents. Native American toddlers between the ages of 1 and 4 have a premature death rate of 55.6 per 100,000, compared to the non-Hispanic White counterparts (-0.5 per 100,000). In South Dakota, the Pine Ridge reservation has one of the lowest life expectancies in the United States: 47 for men and 55 for women, compared to the U.S. life expectancy of 78.69 years for men and 81 for women.



Aging Populations, Knowledge Keepers, and Language Speakers

COVID-19 is attacking--and could decimate --America's Native American populations in such a violent manner, killing vast numbers of men and women over the age of 25, that the tribes could be at risk of never recovering. More than just lives lost, the virus sweeping across America could wipe out tribal cultural knowledge and heritage, tribal traditions, and tribal languages. All are at a real risk. Especially vulnerable to COVID-19 are tribes' elders. According to the American Community Survey (ACS), in 2011-2013, there were close to half a million Native American elders 65 and older. Some 35% of all Native Americans were concentrated in Arizona, Texas, New Mexico, Oklahoma, Florida, North Carolina, and New York. Elders are integral to tribal communities. Protecting the knowledge only they possess is at the forefront of tribal efforts everywhere. Ohkay Owingeh Pueblo of New Mexico, along with several other pueblos, have closed their borders and ordered tribal members to stay home. Ohkay Owingeh tribal members are actively assisting the community by distributing masks and cleaning products to the homes of elders. Ensuring their safety and the safety of the community is key. Protecting our elders is essential to sustaining traditions, language, and our cultural knowledge.

At the pueblo where I live, Ohkay Owingeh, in New Mexico, the tribal leadership has positioned over the past few days cement barricades and signs, blocking entrances onto pueblo lands. No one from outside of the pueblo is

allowed to enter. No one. Stay home, tribal members have been told. Only by self-isolation, tribal leaders believe, can COVID-19 be defeated. Other pueblos have taken the same or similar drastic and decisive measures. Michael Chavarria, governor of Santa Clara Pueblo and chair of All Pueblo Council of Governors describes "our mission is to protect the life and health and safety of all our members and employees of Santa Clara Pueblo, we had to close down our casino, golf course, restaurants, and all our entities" (KSFE, Santa Fe Public Radio 2020). He described the financial hardship that his tribe is going through and the difficulty of preparing for a threat that cannot be seen. He urged tribal members to not take anything or anyone for granted and reminded the community that no one is immune. President Nez of the Navajo Nation argued in public commentary that tribes once again have been forgotten. The Navajo Nation as of April 2, 2020, had 389 reported cases of COVID-19 (New Mexico Department of Health 2020). The Navajo Nation has since closed its borders and ordered a curfew for the nation. The Navajo Nation is one of the largest tribes in the United States with close to half a million members.

Community Cultural Wealth and Tribal Capital

If decisive action does not take place, COVID-19 has the potential to devastate communities. Yet despite pre-existing health conditions of many members of virtually every tribe, America's tribes have the potential to buffer the effects of COVID-19 and to flatten the curve for their own communities. Tribal populations in the United States are no strangers to scarcity and life-altering pandemics. Tribal peoples of North America possess community cultural wealth. Community cultural wealth focuses on cultural knowledge, skills, abilities, and networks within communities and across communities (Yosso 2005). According to Yosso (2005), many of these skills go unrecognized and unacknowledged. Yosso (2005) described community wealth, an array of capital that exists within marginalized groups, including resistance capital, linguistic capital, navigational capital, and familial capital. Resistance capital refers to knowledge and skills that challenge inequality, where linguistic capital includes the intellectual and social skills gained through communication experience. Navigational capital refers to the skills of maneuvering through social institutions entrenched in structural inequalities. Familial capital refers to the cultural knowledge that's nurtured among family or kin and community history and to social capital as networks and community resources. Tribal populations possess community cultural wealth that dates back thousands of years--since the creation of the universe and dissention of the first peoples on mother earth.

Building on Yosso's (2005) forms of capital, I add tribal capital. Tribal capital is the strengths and resources that tribal nations possess in addition to other forms of capital that are specific to tribal populations that have gained federal recognition. Tribal capital includes but is not limited to sovereignty and federal recognition. Federal

recognition signifies that the U.S. government has recognized the right of an Indian tribe to exist as a sovereign entity and that a government-to-government relationship exists (www.ncsl.org). Tribal sovereignty predates the formation of the United States and is recognized through the U.S. Constitution and numerous federal statutes and court cases. Tribal governments are on equal footing with state governments and have a government-to-government relationship with the federal government (National Conference of State Legislatures). In the case of the COVID-19 pandemic, sovereign nations could request aid from other sovereign nations, including countries such as Cuba, and from organizations such as the World Health Organization. During the American Indian Movement (AIM), members of that group received aid and support from Cuba and built a platform of solidarity around the globe. Where the federal government has failed tribes, tribal capital can be exercised to bring aid and support to the sovereign nations of the United States.



In addition to sovereignty, tribal nations have traditional forms of government. Although, many tribes have one government, many have dual forms of government. Dual governments equate to traditional forms of government that follow indigenous governing bodies, separate from governing bodies that deal with the federal government or state governments. Traditional governing bodies can provide protection for communities and have an in-depth knowledge of community members and traditions and stand to protect the well-being and survival of communities. In-depth knowledge of the community allows for the recognition of peoples that may be at higher risk, including knowledge of any preexisting health conditions that community members might have. This allows for the isolation and immediate protection of elders and members whose health may be compromised--and thus provides an added layer of protection, communication, and togetherness with nations. Since the coronavirus pandemic was declared, many tribes have closed their borders and provide food and medicine to elders.

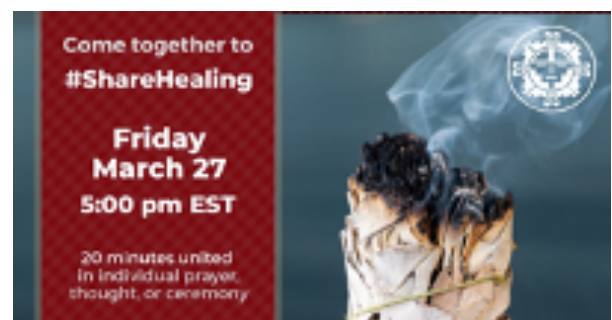
Tribal populations can close their borders to nontribal members. Many have internal resources such as hotels and casinos that could double as makeshift areas to house and protect elders. Others have access to food services that can deliver food and sustenance into tribal

areas without members leaving reservation borders. Food services that normally serve tribal education, and adult service centers, and casinos can provide food for tribal members. Eliminating the need to enter crowded towns and urban centers to shop for necessities. There are many other resources available. It is time for tribal leaders to think outside of the box, in an effort to protect their nations at all costs.

Tribal Traditions and the Power to Survive

Tribal traditions and healing practices and a knowledge of medicines are an integral component of tribal nations. Understanding the COVID-19 pandemic from a traditional perspective reduces anxiety and reinforces inner strength. Dr. Rodney Haring, a Seneca tribal community member of New York, describes COVID-19 as creating "a time when people of cultures have an opportunity to reconnect and recreate. Reconnect to identity, person-in-environment, and place and time. A micro yet global self-evaluation. It's also, perhaps, a sign to slow down, let the Earth rebalance, "take a breath" from the everyday hustle and bustle of human impression." In some communities, art is being used to promote the use of masks and safety. One nonprofit, Dukes Up of Albuquerque, N.M., placed billboards across the city to promote the use of masks and to direct people to practice social distancing. The intention was to remove the stigma of wearing masks in tribal communities in an effort to protect the health and well-being of family. Together, the indigenous of North America will continue to thrive. Many are using their artistic skills to create awareness. Many communities are using song and dance to create unification and healing.

Other communities are organizing prayer groups. Some are offering their art. As traditional people, we have the power to resist and to hold strong to elements that have provided mechanisms for survival for the past 2,000 years.



Conclusion

In summary, there is an urgent need to support and protect tribal nations across United States and globally. Indigenous people in the United States and throughout the Americas are at great risk. Centuries of tribal downsizing efforts by the U.S. government and governments across the Americas have made indigenous peoples some the most at risk populations in the world. Until structural racism and the social determinants of health are addressed among tribal peoples their existence will be challenged.

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COVID19: Social Stigma and Public Health Dilemma

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Introduction

The World Health Organization declared the outbreak a pandemic. Coronavirus disease (COVID-19) is an infectious disease caused by a newly discovered coronavirus. Most people infected with the COVID-19 virus will experience mild to moderate respiratory illness and recover without requiring special treatment. Older people, and those with underlying medical problems like cardiovascular disease, diabetes, chronic respiratory disease, and cancer are more likely to develop serious illness. ¹ The corona virus COVID-19 is affecting 196

countries and territories around the world and 1 international conveyance (the *Diamond Princess* Cruise ship harbored in Yokohama, Japan). ² Public health emergencies, such as the outbreak of coronavirus disease 2019 (COVID-19), are stressful times for people and communities.³ Social stigma in the context of health is the negative association between a person or group of people who share certain characteristics and a specific disease. In an outbreak, this may mean people are labeled, stereotyped, discriminated against, treated separately, and/or experience loss of status because of a perceived link with a disease. Such treatment can negatively affect those with the disease, as well as their caregivers, family, friends and communities. People who don't have the disease but share other characteristics with this group may also suffer from stigma. The current COVID-19 outbreak has provoked social stigma and discriminatory behaviors against people of certain ethnic backgrounds as well as anyone perceived to have been in contact with the virus.⁴

Social Stigma and COVID19

The level of stigma associated with COVID-19 is based on three main factors: 1) it is diseases that's new and for which there are still many unknowns; 2) we are often afraid of the unknown; and 3) it is easy to associate that fear with 'others'. It is understandable that there is confusion, anxiety, and fear among the public. Unfortunately, these factors are also fueling harmful stereotypes.⁴ Fear and anxiety about a disease can lead to social stigma toward people, places, or things. For example, stigma and discrimination can occur when people associate a disease, such as COVID-19, with a population or nationality, even though not everyone in that population or from that region is specifically at risk for the disease. Stigma can also occur after a person has been released from COVID-19 quarantine even though they are not considered a risk for spreading the virus to others.³

Some groups of people who may be experiencing stigma because of COVID-19 include:

- Persons of Asian descent
- People who have traveled
- Emergency responders or healthcare professionals

Social Stigma and its Impact

Stigma hurts everyone by creating fear or anger towards other people. ³ Stigma can affect people, places, or things. It occurs when people associate a risk with something specific—like a minority population group—and there is no evidence that the risk is greater in that group than in the general population. Stigmatization is especially common in disease outbreaks.

Example: A 2002 outbreak of severe acute respiratory syndrome (SARS) in China caused global concern. Unfortunately, fear also led to a great deal of stigma. Although there were no associated cases of SARS in America, many citizens began to avoid Chinatowns and other Asian-American communities—including Japanese, Korean, and Vietnamese peoples—throughout the United States because they believed those groups were at greater risk for spreading SARS.

Stigmatized groups may suffer psychologically and economically. They may be subjected to:

- Social avoidance or rejection
- Denial of healthcare, education, housing, or employment
- Physical violence ⁵
- Drive people to hide the illness to avoid discrimination
- Prevent people from seeking health care immediately
- Discourage them from adopting healthy behaviors ⁴

Stigmatizing minority groups may also distract people from focusing on the real risks in a crisis situation. When only part of a population is perceived as being affected, others may incorrectly believe they are not at risk. By assuming they are safe, majority population groups may not take important public health precautions, unintentionally compromising their own health and well-being.

Addressing Social Stigma and Public Health

Crisis communicators must work to counter stigmatization during a disaster. Messages should reinforce real risks through accurate information and awareness. Images should reflect all people who are susceptible to getting sick. Ideally, public health messages will proactively address possible stigma before it begins. However, prepared communicators should be ready to challenge any negative stigmatizing behaviors that do emerge. ⁵

Communicators and public health officials can help counter stigma during the COVID-19 response.

- Maintain privacy and confidentiality of those seeking healthcare and those who may be part of any contact investigation.
- Quickly communicate the risk or lack of risk from associations with products, people, and places.
- Raise awareness about COVID-19 without increasing fear.
- Share accurate information about how the virus spreads.
- Speak out against negative behaviors, including negative statements on social media about groups of people, or exclusion of people who pose no risk from regular activities.
- Be cautious about the images that are shared. Make sure they do not reinforce stereotypes.
- Engage with stigmatized groups in person and through media channels including news media and social media.
- Thank healthcare workers and responders. People who have traveled to areas where the COVID-19 outbreak is happening to help have performed a valuable service to everyone by helping make sure this disease does not spread further.
- Share the need for social support for people who have returned from China or are worried about friends or relatives in the affected region. ³
- Journalistic reporting which overly focuses on individual behavior and patients' responsibility for having and "spreading COVID-19" can increase stigma

of people who may have the disease. Some media outlets have, for example, focused on speculating on the source of COVID-19, trying to identify "patient zero" in each country. Emphasizing efforts to find a vaccine and treatment can increase fear and give the impression that we are powerless to halt infections now. Instead, promote content around basic infection prevention practices, symptoms of COVID-19 and when to seek health care.

- All materials should show diverse communities being impacted and working together to prevent the spread of COVID-19. Ensure that typeface, symbols and formats are neutral and don't suggest any particular group ⁴

Conclusion: Fight the COVID19, not the people

Disease related stigma could very well qualify as the most damaging form of social stigma. It poses, in some cases, insurmountable barriers to what could be lifesaving medical care. Disease related stigma has a deleterious effect on its victim's psycho emotional capacity. It effectively hinders our neighbors from seeking treatment - placing the community as a whole at greater risk of contagion, and the effects of unrelenting panic. It is powerful enough to incite violence, and malicious enough to compromise and drive a wedge between amicable nations. ⁶ People who have confirmed COVID-19 and are in isolation, and people who may have been exposed to COVID-19 and are self-monitoring, are doing the right thing and helping to protect their communities. ⁷

When talking about COVID-19 disease, certain words (i.e suspect case, isolation) and language may have a negative meaning for people and fuel stigmatizing attitudes. They can perpetuate existing negative stereotypes or assumptions, strengthen false associations between the disease and other factors, create widespread fear, or dehumanize those who have the disease. This can drive people away from getting screened, tested and quarantined. Words used in media are especially important, because these will shape the popular language and communication on the new corona virus (COVID-19). Negative reporting has the potential to influence how people suspected to have the new corona virus (COVID-19), patients and their families and affected communities are perceived and treated. ⁴ They should never be harassed and bullied, including through social media. We should offer compassion, support via phone and texts, and assistance as appropriate, but never hostility or judgment. ⁷

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Maintenance of Physical Distance to Prevent COVID-19: A Glimpse at Bangladesh

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Introduction

The world is now preoccupied with combating a formidable foe, i.e., COVID-19 (Corona Virus Disease 2019). It is “an infectious disease caused by a newly discovered coronavirus” with flu-like symptoms that does not have any vaccine or a specific treatment. Even though becoming infected with COVID-19 does not mean confirmed death, it brings fatal consequences to people with co-morbidity like “cardiovascular disease, diabetes, chronic respiratory disease, and cancer” (WHO 2020a). The disease spreads very fast through droplets discharged from coughs and sneezes of infected persons. In this short paper attempts have been made to reveal some facts on the maintenance of physical distance in Bangladesh to prevent COVID-19 using secondary sources of information.

Although coronavirus has reached Bangladesh after invading 102 countries (Al-Jazeera 2020), the UN fears that its easy transmission process and conditions in Bangladesh may lead to death of 2 million people if proper measures are not undertaken immediately (The Australian 2020, March 29). In order to resist such a situation, washing hands frequently with soap or using hand sanitizers and maintaining a physical distance of at least three feet between two people (the authors prefer to use the term ‘physical distance’ rather than ‘social distance’ as they believe the latter has a different connotation) are essential (WHO 2020b).

Measures undertaken to prevent COVID-19

To prevent spreading of the disease the government has taken various actions including closure of all primary, secondary and tertiary level schools/colleges/universities from March 18, 2020 to April 11, 2020 and declaration of a general holiday from March 26, 2020 to April 11, 2020 so that people stay home and are able to maintain physical distance. Public transports (on land/water/air) have stopped running and the army has been deployed to prevent people gathering on the streets. National programmes, e.g. Inauguration of the year-long celebration the Birth Centennial of the Father of the Nation was observed in a limited scope on the 17th of March and other national programmes to celebrate the Independence Day (26th March) and the Bangla New Year

(14th April) have been cancelled to maintain physical distance.

As COVID-19 did not originate in Bangladesh, it could enter this country only through infected people who came to this country from a country already affected by the virus. The first case of COVID-19 diagnosed in Bangladesh had its source in a Bangladeshi who returned from Italy—a country severely affected by COVID-19. All the people who came to Bangladesh from corona affected countries have been requested to remain in home-quarantine for the first 14 days since their arrival which meant that they must live in an isolated room within their houses with preferably a separate washroom, having no physical contact with anyone, even family members.

However, in a densely populated country like Bangladesh, it often becomes very difficult to maintain physical distance at home, where three or more people often sleep in one room. Sparing a room with a separate washroom for one person may become impossible for a family to manage.

Response from the people

Reports say that although 298,000 people returned to Bangladesh from other countries between January 21 and March 23 only 17,834 people ensured quarantine. To the contrary, “these returnees have been roaming around their localities, going to markets and even holding marriage ceremonies, instead of being in the 14-day quarantine” (*The Daily Star*, March 25, 2020). When asked by the media, some of them said that they did not understand what quarantine meant.

People usually do not accept uncomfortable practices like being confined in their homes until the danger arrives at their doorstep (Costa-Font, 2020). They do not believe that they, along with their loved ones may face death if they do not comply with the government appeal to stay home. Evidence of such disbelief was observed when people rush from Dhaka to their village homes in over-crowded buses, trains and ferries after a general holiday was declared from 26th March to 4th April (before the orders on closure of public transport was announced). They did not realize that they themselves and their relatives in the villages would become more vulnerable through such acts. As people are facing a situation that they did not experience before, they cannot make decisions regarding what they should believe and not believe; what they should do and not do.

During such periods, rumors spread very easily. We have seen news of people being busy collecting and *Thankuni* leaf (*Centella asiatica*) all night in Gopalganj, believing that if one eats (by chewing) three *Thankuni* leaves with salt, they will not be infected with COVID-19 (Dhaka Tribune March 18, 2020). Such rumors lead people to gather outside their houses in the middle of the night with lanterns in search of the herb. Such rumors are very much likely to aggravate the situation.

If people are convinced that their full participation in the physical distancing efforts is the key for them and for their near and dear ones to be safe from COVID-19, they are likely to go through the ordeal, albeit may be a difficult task. Celebrities who are idols to the people may play a very good role in convincing people and to place

them on the right track. We have seen Shakib Al-Hasan (a famous cricketer of Bangladesh) going into quarantine after he reached the US (Timesnownews.com 2020). Meher Afroz Shaon, Tahsan Khan and some other singers/actors have gone into quarantine after they returned home from abroad (Campuslive.com, March 17, 2020, Dhaka Tribune, March 18, 2020). These instances help people in making their choices. Video messages from other celebrities are shown in the media to inspire people to accept the unusual practice of remaining within their houses for days together.

In Kaukhali Upazila of Pirozpur District, the Upazila Nirbahi (Executive) Officer set rather an exceptional example. She went to the homes of the people who were under self-quarantine and gave them some books to help them pass their time, appreciating their sacrifice for the greater good (Prothom Alo 2020, March 24).

Realizing that it would be very difficult for humans to win against COVID-19 without divine blessings, some people have circulated in the social media, some *hadith* (sayings of the Prophet Muhammad (peace be up on him)) announcing that people who stay at home and rely on Allah during epidemics will be highly rewarded in the hereafter. Some prayers (dua) have been circulated in the social media to seek blessings of Allah. Some big companies (like Grameenphone and BRAC) are airing commercials of their goods/services with messages requesting people to wash their hands and remain at home for the greater cause of the country. A few have prepared commercials with jingles and songs sung by popular artists with appealing lyrics to attract people's attention and convince them to remain in their homes.

The most vulnerable in maintaining physical distance

According to Amnesty International (2020), daily wage earners, Rohingya refugees, health workers and prisoners are the most vulnerable to COVID-19 as they cannot maintain safe distance away from other people. Daily wage earners like rickshaw pullers and the homeless can hardly maintain the distance they are being asked to maintain between two persons. They must stay on the streets to earn their living. Prisoners also are compelled to stay in crowded rooms and hence are very vulnerable to becoming infected. The prison authorities and the government are checking out possibilities of releasing 3000 prisoners who are under trial for bailable offences on bail. However, the final decision will be made by the judiciary (*The Financial Express*, April 1, 2020).

According to Seigfried (2020), aid workers are facing a lot of difficulty in educating the Rohingyas regarding COVID-19, as there is a ban on use of mobile phones in the camps, which are "more densely populated than the most crowded cities". A TV news report on Cox's Bazar, aired on March 30 depicted that physical distancing was not maintained at all in market places and people's activities were almost as if it were a normal day. After six days of staying home, on April 1 people of Dhaka also started coming out into the streets gathering in small groups, saying that they could no longer remain locked in their houses, and many private vehicles were the main roads and highways. Observing such situation the deployed army is going to play a tougher action against those who

fail to follow instructions regarding physical distancing and quarantine from April 2, 2020. Till April 1, the army and the police tried to keep people off the streets politely.

The Prime Minister of Bangladesh, Sheikh Hasina in her address to the nation on March 25, 2020, and later on several other occasions has explained the measures that her government has taken, including efforts to provide salary to the garments workers for the period they remain at home and provide shelter to the homeless. The district level administrations have been instructed to help the disadvantaged people by providing them with the basic necessities. People belonging to different religions have been requested to pray at home, rather than gathering in mosques and other places of religious congregation. Dates for paying utility bills (like electricity and gas) have been extended, so that people do not gather in crowds in banks for such payments. Bangladesh Bank has issued a six-month moratorium so that those who have taken bank loans including microcredit holders do not have to pay installments during the lockdown periods.

The Prime Minister also urged the affluent people to come forward in helping the low-income people. The national cricket team members have declared that they will donate half of their salary. Many others have also come forward to help the needy amid this global crisis. Some organizations are distributing daily essentials and disinfecting items. It has been observed in TV news that physical distancing is often not being observed while distributing these goods. Experts are calling for coordinated efforts so that all the needy receive relief more or less in proportion to their need, maintaining physical distance.

Doctors, nurses and other health workers are the most vulnerable to COVID-19 in any part of the world. Initially, there was a shortage of personal protective equipments for doctors in different parts of Bangladesh, which hampered delivery of health services. The government is trying to make arrangements for special hospitals for treating COVID-19 patients. Till April 1, 2020, 54 patients tested positive for coronavirus and among them 6 have died, 26 have been cured and others are under treatment. Among the infected 2 were doctors and 2 were nurses.

Conclusion

In the above attempts have been made to portray a glimpse of Bangladesh regarding maintenance of physical distance to prevent COVID-19. In conclusion it may be said that maintenance of physical distance has to be ensured in this country by convincing people regarding urgency of this measure as well as by creating an environment and social conditions in which it can be practiced. Otherwise, in a densely populated country like Bangladesh, it would be very difficult to manage outbreak of the virus.

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