



Preparing for the next pandemic

Leveraging social and human sciences for crisis response

Se préparer à la prochaine pandémie
La contribution des sciences sociales et humaines à la gestion des crises

Lessons from COVID-19 | Les leçons de la COVID-19



Published in 2024 by the United Nations Educational, Scientific and Cultural Organization,
7, place de Fontenoy, 75352 Paris 07 SP, France

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Printed in Paris, France

Short Summary

The Social Sciences Response to COVID-19

Understanding the social impact of the COVID-19 pandemic is crucial for crafting effective and inclusive recovery policies. Prior to the pandemic, growing gaps in well-being were already undermining environmental sustainability, the social fabric, and progress worldwide. Fragile and unequal systems proved to be a pre-existing aggravating condition that fuelled the pandemic on a global scale.

COVID-19 widened the gap between developed countries—which already had the financial means to respond to the crisis and had easy access to the vaccine—and the rest of humanity, resulting in devastating effects in the Global South, with more than 130 million people crossing the poverty line.

Addressed to policymakers and scholars, this publication presents a comprehensive state of knowledge of the social science perspectives on the COVID-19 pandemic, covering a wide range of topics from its impact on mental health, education, climate change, economy, governance, migration, demography, digitalization, and more.

The authors analyse the challenges faced by society during the pandemic and present actionable proposals for policymakers and practitioners.

This publication is a reminder of the importance of Social Sciences and Humanities in addressing global challenges and provides a roadmap for future research and policy action to build more resilient societies.

**More than
130
million**

People crossed the
poverty line during the
pandemic



*"Since wars begin in the minds of men and women
it is in the minds of men and women that
the defences of peace must be constructed."*

Preparing for the next pandemic leveraging social and human sciences for crisis

Se préparer à la prochaine pandémie *La contribution des sciences sociales et humaines à la gestion des crises*

Lessons from COVID-19 | Les leçons de la COVID-19

Chief editors:

Pr. Erwan Dianteill and Pr. N'Dri Thérèse Assié-Lumumba

Foreword



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Gabriela Ramos
Assistant Director-General
for Social and Human Sciences
UNESCO

Global health crises are complex challenges, as they arise at the point of intersection between natural and social forces. Their multifaceted nature is challenging for governments, typically focused on combating a specific natural threat, without a human-centred approach, as happened with COVID-19 responses.

Since early 2020, epidemiologists and financial specialists dominated the decision-making processes and disregarded data on how lockdowns might affect human behaviour and mental health. COVID-19 widened the gap between developed countries and the rest of humanity, resulting in devastating effects in the Global South, with more than 130 million people crossing the poverty line. In parallel, COVID-19 had an asymmetric cost on social groups that were already vulnerable, disproportionately affecting the elderly, women, and youth, among others.

During the colloquium on Social Sciences and COVID-19 held in October 2021, experts from various fields joined us to debate key actions for the post-crisis recovery and presented their insights that will continue to inform policy-makers in the long term. Spanning various fields such as mental health, digital technology, migration, and gender, the researchers highlighted the vulnerability of people lacking access to formal jobs, health coverage, or community support. They noted the importance of intersectional lenses on the issue and how inequalities are compounded for women, youth, migrants, and the elderly in isolation.

Our first finding indicates that COVID-19 intensified the levels of economic and social inequality. It worsened the ongoing pattern of increasing inequalities that have persisted for many decades. For instance, it took nine months for the wealthiest 1,000 billionaires to regain their wealth levels from before the pandemic, whereas it is projected to take over a decade for the world's poorest individuals to achieve a similar recovery.

Researchers also emphasized the need for a minimal implementation of restrictive measures: As lack of social interactions led to increased anxiety, fear, depression, and other negative mental health effects, leaders should rely on multidisciplinary evidence in the future to make informed decisions that consider real social needs and conditions of the population.

We also agreed that prioritizing trustworthy data and tackling misinformation is crucial during global crises. We have drawn from the pandemic that global communication channels need to be enhanced to fight discrimination against vulnerable groups, highlight the dangers of harmful coping strategies, and combat disinformation in public communications to build confidence in preventive measures.

Researchers strongly emphasized the need for health policies to encompass a comprehensive social scope, acknowledging the inherent social nature of human beings. Understanding how sociocultural factors influence the success or failure of health policies is critical in addressing global crises.

While minimizing border closures and reserving physical distancing as an emergency measure was recommended, they insisted that these measures should be accompanied by initiatives to enhance social proximity and sociability. Any confinement measures should promptly address the conditions faced by vulnerable groups and promote ways to improve professional conditions, for example, finding ways to cope with emotional burnout for individuals working from home.

Lastly, the researchers found that socio-demographic differences, such as gender and age, contributed to the spread of the infection. They highlighted the significance of analyzing these factors to formulate effective policies and emergency measures. They explained that the incidence rate of infection was higher among women and young people, suggesting complex behavioral dynamics influenced by factors related to social demographics.

This publication emphasizes the importance of social and human sciences in addressing global challenges and provides a roadmap for future research and ex-ante policy action. It advances a collective approach that incorporates sustainability and social justice components into an evidence-based policy framework, while also addressing inequalities in their environmental and social domains.

In addition, it addresses several ethical dilemmas we will continue to face in the event of future global crises, such as: should governments implement universal basic income policies in times of crisis? Should vaccines be a publicly accessible good? And how can governments balance the need to protect public health with their obligations to uphold the rights and dignity of youth, the elderly, and migrants?

I am very grateful to the almost 70 researchers who voluntarily engaged in this publication process, as well as to the French Delegation and the French National Commission to UNESCO, the French Ministry of Foreign Affairs, and the MOST Programme's Scientific Advisory Committee and Secretariat. I hope the findings and recommendations presented here will inspire policy and decision-makers worldwide to integrate social and human sciences perspectives into policy decisions. The SHS provide us with the necessary tools to emerge stronger from the pandemic, better prepare for possible future crises of this nature, and leave no one behind.

Message de S.E. Madame Véronique Roger-Lacan

Ex-Ambassadrice, Déléguée permanente de la France auprès de l'UNESCO (2019-2023)

Nous sommes très heureux d'avoir pu participer à ce colloque organisé conjointement par la Commission nationale française pour l'UNESCO et la Délégation permanente de la France. Je remercie en particulier la Commission nationale française pour l'UNESCO qui, avec le Président du Comité MOST, a œuvré pendant les 2 années de présidence du professeur Erwan Dianteill, pour faire en sorte que ce comité puisse, après une vice-présidence française pendant les 2 années précédentes, agir à la hauteur de son mandat, c'est-à-dire développer le lien entre les sciences humaines et sociales, le monde de la recherche, le monde de l'éducation et la vie politique, la vie publique, la vie de ceux qui élaborent les politiques publiques au service des objectifs de l'UNESCO qui sont l'Education, les Sciences et la Culture.

Le mandat de l'UNESCO, né sur les décombres de la Seconde guerre mondiale, est de créer dans l'esprit des hommes et des femmes les conditions de la paix, de semer les graines de la paix pour faire en sorte qu'aucun désastre comme celui de la Seconde guerre mondiale ne survienne à nouveau. L'acte constitutif de l'UNESCO prévoit de mener à bien cette tâche par la connaissance des cultures des uns des autres et pour connaître ces cultures, il faut nous éduquer les uns les autres et par le biais des sciences humaines et sociales se connaître les uns les autres.

Le professeur Erwan Dianteill a malheureusement pris la présidence du programme dans des circonstances différentes et a dû embrasser la réalité de la crise sanitaire à laquelle il était confronté, avec le confinement de la planète entière, y compris des élèves, des enseignants, et des chercheurs. Bien que la tâche n'ait pas été aisée, la continuité de la mission du comité MOST dans le domaine des sciences humaines et sociales a été assurée. La réunion de représentants des sciences humaines et sociales pour réfléchir aux conséquences de la COVID-19 a constitué un grand défi. L'étude par les sciences sociales des changements et la gestion des transformations sociales sont le cœur de l'objectif du MOST. La diversité des points de vue prend de plus en plus le pas sur les objectifs de la Charte des Nations Unies ainsi que sur les objectifs de l'acte

constitutif de l'UNESCO que sont le multilatéralisme et l'universalisme.

Notre objectif à tous, chercheurs, diplomates, politiques, professeurs en sciences sociales, est l'universalisme. Qu'est-ce que l'universalisme signifie ? Chaque individu de la planète, a droit à la protection, au respect et la promotion de ses droits et libertés fondamentaux. Ce n'est plus aussi universel que cela parce qu'un certain nombre d'Etats membres, dont certains du Comité MOST, considèrent que ces valeurs sont des valeurs du monde « occidental ». Pourtant, partout dans le monde et les Etats membres du Comité intergouvernemental, tous les citoyens réclament la protection de leurs droits universels à la liberté d'expression, à la liberté de religion, à la liberté de vivre comme ils l'entendent, à l'égalité Homme-Femme, à leur orientation sexuelle, et c'est exactement ceux à quoi se consacre le comité MOST. Les chercheurs en sciences sociales qui ont présenté les conséquences de la COVID-19 dans un grand nombre de sociétés dans le monde ont étudié aussi certainement cette question du nécessaire maintien de la valeur universelle, la seule qui puisse garantir les droits des uns et des autres.

Nous devons nous battre pour que ces droits soient assurés et je remercie l'UNESCO pour ce colloque qui a eu aussi cet objectif.

Message de Monsieur Yves Saint-Geours

Président de la Commission nationale française pour l'UNESCO

Depuis la création de l'UNESCO en 1946, la France dispose d'une Commission nationale pour l'UNESCO, qui a été la première de son genre et a été établie simultanément à l'UNESCO. Cette commission a pour mission de promouvoir les valeurs et les actions de l'UNESCO et de les faire connaître à la société française.

Elle valorise aussi les principaux programmes de l'UNESCO, dont le programme MOST qui en est l'un de ses fleurons. Ce programme analyse les transformations sociales et humaines induites par l'évolution de la société. En outre, la Commission nationale française entretient des réseaux au sein des écoles et des clubs. Grâce à cette interface avec la société et cette coopération avec la société civile, la société française est en mesure d'approprier à la fois ces actions et ces valeurs, tout en mettant en œuvre de nombreux programmes.

Le deuxième objectif de la Commission est de renforcer la participation des Français, des experts, et des institutions françaises au sein de l'UNESCO. La Commission française mobilise les universitaires, les chercheurs et les experts pour que cette interface soit particulièrement utile, efficace et qu'elle promeuve les valeurs et les actions de l'UNESCO. C'est ainsi que, pour les sciences humaines et sociales, qui sont cruciales dans notre dispositif, nous essayons de seconder les efforts de la France en général, ainsi que des experts et universitaires français en particulier. Depuis 2016, dans le cadre du programme MOST, la France est membre du conseil intergouvernemental MOST. Elle a assumé la vice-présidence en 2017 et la présidence en 2019, avec le professeur Erwan Dianteill qui a dirigé les débats et modéré le grand colloque sur la pandémie et ses effets sociaux en 2021.

C'est ainsi que le comité intergouvernemental MOST, soutenu par la Délégation française et la Commission nationale française, a estimé qu'il était nécessaire d'organiser un colloque mondial visant à synthétiser tous les efforts déployés par les universitaires, intellectuels, chercheurs et acteurs de terrain pour comprendre le déroulement des événements et ce que nous pouvons en

tirer pour l'avenir. Des chercheurs de 18 États ont participé à ce colloque mondial. Leurs communications ont été sélectionnées par le Conseil scientifique du MOST, qui est indépendant, afin d'approfondir notre compréhension de la sociologie et de l'anthropologie de cet événement majeur à l'échelle mondiale.

Nous exprimons notre profonde gratitude envers l'équipe du Conseil scientifique et toutes les personnes impliquées aux côtés d'Erwan Dianteill pour leur préparation. Nous tenons également à remercier l'équipe de la CNFU qui a travaillé ardemment pour la réussite de ce colloque et cette publication.

Message de Professeur Nicolas Chaillet

Représentant du ministère de l'enseignement supérieur, de la recherche et de l'innovation

La pandémie a mis en lumière plus particulièrement un fait : nous avons besoin de la Science et des femmes et des hommes qui la font au quotidien. Evidemment, la crise de la COVID-19 a mis à l'épreuve nos systèmes sanitaires et a eu de profondes conséquences sur nos systèmes économiques et sociaux. Effets dont nous ressentons encore les effets. Or, les moyens de la recherche et de l'innovation nous ont permis d'atténuer cette crise, mais je voudrais ici souligner le rôle primordial des Sciences humaines et sociales (SHS) pour surmonter cette crise qui a vu s'aggraver les inégalités au sein de nos sociétés et qui coïncide avec une complexification du monde. Les SHS sont des disciplines clefs pour déverrouiller cette complexité et la rendre lisible, elles aideront aussi à trouver des moyens de sortir de futures crises.

En réalité, dès le déclenchement de ce fait social total que fut la pandémie de la COVID-19, la communauté scientifique des SHS s'est lancée dans des analyses collectives et interdisciplinaires pour tenter de comprendre sa signification. Sidérant, impensable, incompréhensible, un « événement monde » comme la pandémie de la COVID-19, au moment où il se produit, prend autant de sens différents que d'acteurs chargés de le gérer et d'en parler ; responsables politiques, scientifiques, médecins, médias, réseaux sociaux, dans cette forme de cacophonie interprétative les sciences sociales sont d'une immense utilité. Il n'est pas seulement nécessaire d'éclairer les aspects éruptifs et disruptifs d'une crise mais aussi de saisir ce qu'elle révèle de nos sociétés. Il y a eu des débats sur la pandémie, sur les SHS mais ce qui ne devrait pas faire débat c'est l'importance des SHS dans la pandémie. Que la pandémie soit un fait social tout le monde en convient, mais quel fait social ? Qu'est-ce qu'il révèle et qu'est-ce qu'il change ? Pourquoi connaître ses aspects sociaux est-il nécessaire et même vital pour répondre aux risques qu'il recouvre ? De quels savoirs et de quelles expertises relèvent ces enjeux, surtout il faut sortir de ce fait total. Là aussi, les SHS sont vitales pour énoncer des diagnostics sociaux, politiques, historiques. On aurait pu dire tirer les leçons de cette « guerre ».

Le diagnostic des SHS sur la crise que nous avons traversée est vital car il nous oblige à nous déprendre de l'urgence de l'action et des remèdes immédiats pour anticiper, pour mieux prévoir, pour préserver la cohérence de notre société. La crise a également illustré la nécessité plus impérieuse que jamais de confronter toute théorie ou doctrine à l'évidence empirique la plus large possible. Sans confisquer ni cadastrer le débat en matière économique, sociale et politique, il est important de le nourrir d'une matière première empirique qui fait l'objet d'un consensus minimum. Sans accord sur un socle de faits, le débat public peut se limiter à des stratégies de saturation des espaces médiatiques. Les résultats des différentes enquêtes socio-économiques et sanitaires qui ont été engagées tout au long de la pandémie, illustrent à quel point disposer d'un tel corpus de faits est précieux et permet d'orienter la réflexion collective dans un sens plus productif.

Les initiatives SHS françaises ont été assez nombreuses durant la pandémie. Les organismes nationaux de recherches ont réagi vite et tôt pour lancer des appels à projets en réponse à la crise. Concernant l'Agence nationale de la recherche sur des projets majoritairement en France, 25 % des projets concernaient les sciences immuno-sociales et les enjeux globaux. La Task Force COVID Sud de l'ANRS MIE (maladies infectieuses émergentes) a réalisé un inventaire des projets de recherches dans les pays à revenu faible et intermédiaire impliquant des partenaires français. Les thématiques santé publique et SHS représentaient en juin 2021 environ 41 % des projets en nombre. Les enquêtes se sont multipliées également très rapidement, en un temps record, fournissant des marqueurs sur la perception, les inégalités ou abordant simultanément les enjeux sociaux et épidémiologiques. Ces enquêtes permettent de mieux guider les décisions publiques notamment sur les aspects psychologiques de la crise.

Le temps long et la pluridisciplinarité sont également des atouts des études en SHS, en plus des apports à court terme, afin de mieux comprendre a posteriori les effets de la pandémie sur les générations futures, l'éducation, la gestion de la crise, la santé mentale et le bien-être.

Une crise est également utile pour repenser les priorités ; l'empreinte des différentes disciplines sur les politiques et la manière dont elles nourrissent de façon cordonnée les décisions peuvent encore être améliorées, les modalités de financement des SHS peuvent aussi être améliorées. Les forces de recherches réunies au sein des équipes, françaises en l'occurrence, sont en France et à l'étranger nombreuses sur le sujet de la santé. Elles couvrent l'ensemble de l'arc disciplinaire SHS : l'archéologie, la philosophie, le droit, l'anthropologie, l'histoire de l'art, la littérature, les sciences des territoires, la science des politiques, la linguistique, l'économie. Bien reconnues à l'international pour la qualité de leur travaux, ces forces de recherches sont partiellement et inégalement structurées et encore trop souvent sur un mode disciplinaire, alors que les enjeux de santé exigent une approche pluridisciplinaire au sein des SHS et la collaboration des questions de recherches aux interfaces avec d'autres sciences, je pense aux sciences biologiques, aux sciences de l'environnement, aux sciences de la Terre, aux sciences des technologies et de l'information et à la santé publique.

C'est pourquoi nous saluons l'ambition et le travail exemplaire du programme pour la gestion des transformations sociales de l'UNESCO, MOST, qui contribue à renforcer la connexion entre la recherche et les politiques et à consolider le lien entre la connaissance et l'action. Là aussi, la pandémie a souligné le besoin d'une interface renforcée entre la recherche et les politiques publiques. Les décideurs peuvent et doivent davantage s'appuyer sur les connaissances en sciences sociales fondées sur les besoins humains et à travers une culture de prise de décision éclairée par les données empiriques.

En France un Comité analyse, recherche, expertise (CARE) a été installé en mars 2020 dans le contexte de la pandémie, présidé par Françoise Barré-Sinoussi, prix Nobel de médecine. Il a été chargé de donner un avis plus éclairé aux pouvoirs publics dans la prise de décisions, décisions qui peuvent avoir des conséquences majeures sur nos théories économiques et nos relations sociales. Ce lien entre la science et la décision publique doit être à l'avenir encore

plus prononcé et ne doit pas être limité à des situations particulières comme cette pandémie, fût-elle mondiale. Nous serons particulièrement heureux de connaître les recommandations sur lesquelles vous allez travailler pendant ce colloque.

Pour conclure, nous devons évoquer la coopération internationale en matière de recherche et d'innovation, ainsi que ses conditions-cadres de manière plus générale. La France est attachée au principe de la science ouverte et à ce titre nous saluons la recommandation de l'UNESCO sur une science ouverte. Elle permet de construire une vision mondiale, partagée de la science ouverte, de mener des actions convergentes et d'engager des coopérations internationales fructueuses. C'est sur la base de ce type de principes partagés par la communauté internationale que nous souhaitons consolider les coopérations. Cela nécessite l'ouverture d'un dialogue multilatéral sur les principes fondamentaux d'une collaboration équilibrée, tels que la réciprocité, l'intégrité scientifique et la liberté de la recherche scientifique.

Acknowledgements

This publication was made possible thanks to the partnership between UNESCO, the Delegation of France, the French National Commission to UNESCO and The French Ministry of Foreign Affairs, within the framework of the French Presidency of the Intergovernmental Council of the Management of the Social Transformations (MOST) Programme of the Social and Human Sciences Sector of UNESCO. It was developed under the supervision of Gabriela Ramos, UNESCO Assistant Director-General for Social and Human Sciences.

UNESCO acknowledges the leadership and guidance provided by Dr. Erwan Dianteill, professor at Université Paris Cité and former President of the MOST UNESCO Intergovernmental Council (2019-2021). UNESCO also extends its appreciation to Dr. N'Dri Assié-Lumumba, professor at Cornell University in New York and former President of the MOST UNESCO Scientific Advisory Council (2018-2022), for her valuable support and intellectual guidance.

Gratitude is also extended to all members of the MOST Scientific Advisory Committee: Dr. Hania Sholkamy (Egypt), Professor at the Social Research Center of the American University of Cairo (AUC); Dr. Michelle Mycoo (Trinidad and Tobago), Professor of Urban and Regional Planning at the Faculty of Engineering, University of the West Indies; Dr. Ebrima Sall (Senegal), Executive Director of Trust Africa, Dakar, Senegal, and former Executive Secretary of CODESRIA; Dr. Rodrigo Liendo Stuardo (Mexico), Researcher at the Institute of Anthropological Research of the National Autonomous University of Mexico (UNAM); Dr. Rossarin Gray (Thailand), Director and Professor at the Institute for Population and Social Research (IPSR), Mahidol University, and Executive Secretary of the Asian Population Association (APA); Dr. Maja Gerovska Mitev (North Macedonia), Professor at the Institute of Social Work and Social Policy, Faculty of Philosophy, Ss. Cyril and Methodius University, Skopje; Dr. Jomo Kwame Sundaram (Malaysia), Member of the Academy of Sciences of Malaysia and Senior Advisor at the Khazanah Research Institute.

Special thanks go to UNESCO colleagues, Dr. Mariagrazia Squicciarini, Chief of the Executive Office, Dr Gustavo Merino, Director for Social Policies, Dr. Pedro Manuel Monreal González, Secretary of the MOST Programme, for their contributions to the development of the colloquium, Camille Guinet, Associate Programme Specialist and Juan Diego Sastre, Consultant, for steering the final phase of the publication. Editing was run by David McDonald, Hortense Arany and Camille Guinet.



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Introduction : la pandémie comme phénomène social global

Dr. E. Dianteill, professeur à l'Université Paris Cité : Président du Conseil intergouvernemental MOST UNESCO (2019-2021)

Dr. N'Dri Assié-Lumumba, Professeure à l'Université de Cornell à New York : Présidente du Conseil scientifique MOST UNESCO (2018-2022)

Le 12 mars 2020, l'Organisation mondiale de la santé a déclaré officiellement que la propagation de la COVID-19 pouvait être considérée comme une « pandémie », c'est-à-dire comme une épidémie étendue à l'échelle mondiale. En effet, si les premiers cas connus sont apparus dans la province de Wuhan, en Chine, en décembre 2019, le monde entier a été atteint au cours de l'année 2020. Une première vague épidémique a touché l'Europe et l'Amérique du Nord au printemps 2020, puis une deuxième vague, deux fois plus longue, a débuté en novembre 2020 et décliné en juin 2021. La découverte de plusieurs vaccins et leur diffusion progressive a fait chuter la mortalité dans les pays les plus riches, mais la vaccination a progressé difficilement dans les pays les plus pauvres.

Si les sciences du vivant ont été évidemment mobilisées au niveau mondial pour comprendre et lutter contre le virus, de nombreuses

recherches en sciences sociales sont aussi menées dans beaucoup de pays du monde depuis 2019. En tant que professeurs en sciences humaines et sociales et en tant que responsables du programme Management of Social Transformations UNESCO, nous avons proposé au courant de l'année 2021 d'en faire un vaste tour d'horizon. Ainsi, suite à un processus de sélections de proposition de communication, en octobre 2021, soit deux ans après le début de la pandémie, des chercheurs de dix-huit pays ont présenté le résultat de leur recherche dans des domaines très variés de la vie sociale. Ce sont les actes révisés, évalués et sélectionnés sur la base de critères dont la pertinence, la rigueur méthodologique et la représentativité régionale, à l'issue de ce grand colloque international qui s'est tenu à Paris, issu du programme MOST de l'UNESCO et de son conseil intergouvernemental présidé par la France, que nous présentons aujourd'hui.

Cet ouvrage est organisé en quatre parties qui balaient un grand nombre de situations exceptionnelles produites par la pandémie dans le monde entier :

- la première partie concerne les institutions en charge de la médecine, de l'éducation et de la religion ;
- les contributions de la deuxième partie portent sur les politiques menées contre la pandémie ;
- celles de la troisième examinent la qualité de vie et en particulier la santé mentale,
- et enfin, la dernière partie est centrée sur l'étude des frontières et des migrations.

Toutes ces contributions abordent de nombreux aspects de la vie sociale en temps de pandémie, de la vie du corps, des interactions personnelles jusqu'aux institutions d'Etat et à la globalisation. Elles considèrent les différents paliers de la réalité sociale de façon dialectique et non déterministe, en privilégiant les observations directes et les données de première main. Elles ont en commun de toujours considérer la pandémie comme un phénomène social total, au sens donné par Marcel Mauss à cette expression dans l'Essai sur le Don (1924) :

« Dans ces phénomènes sociaux « totaux », comme nous proposons de les appeler, s'expriment à la fois et d'un coup toutes sortes d'institutions :



religieuses, juridiques et morales - et celles-ci politiques et familiales en même temps ; économiques - et celles-ci supposent des formes particulières de la production et de la consommation, ou plutôt de la prestation et de la distribution ; sans compter les phénomènes esthétiques auxquels aboutissent ces faits et les phénomènes morphologiques que manifestent ces institutions. » (Introduction, « Programme »).

En effet, si la pandémie a évidemment une base biologique, ses conditions de propagation sont essentiellement sociales, tout comme les réponses qui lui sont apportées. Les résultats d'enquête présentés ici montrent très bien comment se combinent dans le phénomène pandémique les dimensions politiques, morales, juridiques, éducatives, religieuses, économiques et bien sûr organiques de l'existence humaine en société. De plus les caractéristiques individuelles telles que le genre, l'âge, la classe sociale, jouent un rôle déterminant dans la nature des effets de la convergence de ces facteurs. Toutes les sciences humaines et sociales sont donc nécessaires pour la comprendre mais aussi pour y répondre, s'assurer que les mesures préconisées sont les bonnes, et éviter les effets pervers de décisions politiques pouvant conduire

à la marginalisation, la pauvreté et à l'isolement.

Si la pandémie est un phénomène social total, c'est aussi un phénomène global : aucune région du globe n'a été épargnée. C'est bien le sens du mot « pandémie » défini plus haut. Il faut donc compléter la perspective maussienne par une attention accrue à tous les phénomènes de circulation des gens, des informations et des marchandises qui caractérisent la modernité avancée. Certes, la pandémie affecte tous les aspects de l'existence humaine, c'est donc un « phénomène social total », mais c'est aussi un fait ayant des effets massifs sur les relations internationales, sur les migrations, sur les frontières, sur les transports, sur toutes les mobilités humaines y compris à l'intérieur des états et des communautés locales influencées par les réalités au niveau global. Etant par définition international, le programme MOST de l'UNESCO est précisément le programme permettant la présentation publique de recherches en sciences humaines et sociales sur la pandémie au niveau le plus global.

1. En Inde, l'étude de Biju montre que la pandémie a eu un impact considérable sur le bien-être physique (santé gynécologique) et mental des travailleuses. Outre

les médecins et les spécialistes, les travailleurs de la santé de première ligne pendant la pandémie de la COVID-19 étaient principalement des femmes. Il s'agit notamment des infirmières, des travailleurs d'Asha, des travailleurs d'Anganwadi, des travailleurs de Kudumbashree, des travailleurs de l'assainissement et des membres des organes locaux. Le stress mental du confinement, la perte de travail, le lourd fardeau des travaux ménagers et le stress physique d'avoir souffert de l'infection ont provoqué des insomnies, de l'anxiété, des dépressions, des déséquilibres hormonaux et des problèmes de santé reproductive chez les travailleuses.

2. La deuxième contribution porte sur l'effet de la pandémie sur les malades du SIDA à Madagascar. Les auteurs (Pourette, Rakotomanana, Louault et alii) montrent que la peur d'attraper la COVID-19, les difficultés de déplacement liées à la suspension des transports en commun pendant le confinement et la crainte de la stigmatisation ont entraîné une baisse de la fréquentation des structures de santé par les porteurs du VIH. Certains ont pu maintenir leur



traitement antirétroviral grâce à leur ténacité pour se rendre dans leur centre de prise en charge ou grâce à la mobilisation des associations et des professionnels de santé pour délivrer des ARV près de leur domicile et en plus grande quantité. Les porteurs du VIH se sentent particulièrement vulnérables face à la COVID-19, d'où un renforcement de la confiance envers les soignants et envers les ARV, perçus comme un moyen d'être plus forts en cas de contamination par la COVID-19.

3. La communication suivante étudie la pandémie à un niveau social plus général dans le cas de Cuba. Les auteurs (Molina Cintra, Aja Díaz, Vázquez Padilla) proposent de solides résultats démographiques. La structure par âge et par sexe des cas positifs dans le pays reproduit la structure de la population cubaine, mais des différences sont appréciées lorsqu'on effectue cette analyse au niveau des provinces ou

des municipalités. Les taux d'incidence les plus élevés par groupe d'âge sont concentrés dans les groupes des 20-24 ans et des 25-29 ans. Les taux basés sur le sexe de l'individu montrent une incidence plus élevée pour les femmes dans le total cumulé jusqu'en mai 2021, bien que des oscillations aient été observées pendant la période dans le groupe des jeunes entre hommes et femmes. La source d'infection chez les jeunes a lieu "à l'extérieur". À mesure que l'âge augmente, la source intradomiciliaire d'infection diminue et la source extradomiciliaire augmente, établissant une relation statistiquement significative entre ces variables.

4. La contribution suivante s'intéresse à l'institution éducative. L'objectif de la contribution qui suit est ainsi d'identifier les caractéristiques de l'épuisement émotionnel et les

traits de personnalité parmi les enseignants au Kazakhstan. Les auteurs (Bauyrzhan Magazuly, Bauyrzhankyzy) utilisent la méthodologie de la "Mesure de l'épuisement émotionnel", conçue pour mesurer les aspects du syndrome dit du « burnout ». Cette méthode (adaptée au contexte Kazakh) peut être utilisée pour calculer et tester l'état émotionnel des enseignants dans le contexte de situations exceptionnelles comme celle de la pandémie. La méthode est basée sur un questionnaire, et les données recueillies sont évaluées selon des échelles établies. La recherche évalue aussi les stratégies de réponse (coping) au stress chez les enseignants concernés.

5. En France, les personnes âgées immigrées non-européennes figurent parmi les populations les plus durement touchées par la COVID-19. Tant du point de vue biomédical

que socio-économique et psychosocial, la crise liée à cette pandémie engendre des effets disproportionnés dans cette population, déjà grandement marginalisés et fragilisés par la précarité de leurs conditions de vie. Dans un tel contexte, elles peuvent être amenées à recevoir ou à solliciter le soutien de travailleurs sociaux. Or, face à cette crise d'ampleur inédite, la plupart de ces derniers se trouvent dépourvus d'outils d'intervention spécifiques tandis que d'autres mettent en œuvre des pratiques innovantes prometteuses. Dans un chapitre bien documenté, une équipe de chercheurs français (Belhadj-ziane, Jovelin, Galloro) présente une partie des résultats préliminaires de leur recherche sur les récits de personnes âgées immigrées dans six régions françaises.

6. C'est l'institution religieuse en Inde qui fait l'objet du texte suivant. Les auteurs (Thonbamliu, Devi) étudient le rôle social d'une Eglise chrétienne dans la communauté tribale Liangmai à Manipur, et sa coopération avec le pouvoir politique local dans la lutte contre la pandémie de la COVID-19. Ils se penchent sur la manière dont l'église a renforcé la capacité d'action des croyants et travaillé avec le conseil local qui comptait des membres de tous les clans de la communauté, pour faire fructifier les modes indigènes de contrôle des épidémies et élaborer de nouvelles techniques pour répondre à la crise économique provoquée par la pandémie.

Il apparaît clairement que les communications de cette première partie nous enseignent que le comportement humain est le principal promoteur et régulateur de l'évolution de la COVID-19 et, par conséquent, le principal outil dans le processus de contrôle de l'épidémie dans le pays.

Loin d'être trivial, cet enseignement va contre l'idée fort répandue que la pandémie serait un phénomène purement "naturel".

La deuxième partie est consacrée à l'étude des politiques mises en œuvre et de leurs effets sur les interactions entre les individus.

7. La guerre en Syrie, qui dure depuis plus de 10 ans a fait payer un lourd tribut à l'infrastructure sanitaire de ce pays. La situation est encore aggravée par la pandémie de la COVID-19. Pour éclairer les politiques sanitaires, une équipe de chercheurs syriens et allemands (Razouk, Abidin, Yeboah et alii) a conduit une étude par questionnaires dans quatre villes différentes de la République arabe syrienne sur la connaissance de la pandémie et les mesures préventives adoptées par la population. Il apparaît que si la connaissance du virus et les pratiques préventives sont bien corrélées, la réticence à se faire vacciner n'en reste pas moins importante.
8. Quel a été l'effet de la pandémie sur les minorités sexuelles ? Kasnik étudie les transformations du militantisme homosexuel dans la ville du Mexique avec la digitalisation progressive des relations interpersonnelles pendant la pandémie. Le chercheur a développé sur ce sujet une forme d'anthropologie digitale, à travers des observations ethnographiques en ligne. L'accent est mis sur la stratégie méthodologique, reposant sur des entretiens semi-directifs, des « visites guidées », des observations ethnographiques et des interactions en ligne.
9. Fedotov propose pour sa part une comparaison internationale entre la Norvège et le Canada. La recherche se concentre sur la compréhension des relations entre le gouvernement central et les gouvernements locaux

au début de la pandémie de la crise de la COVID-19. Le rôle de l'Etat reste essentiel dans le soutien et la régulation des systèmes de gouvernance de la santé, de l'économie et de la vie sociale. Cependant, les défis auxquels sont confrontés les gouvernements exigent des réponses au niveau local, prenant en compte les spécificités territoriales, ce qui nécessitent une coordination entre l'Etat et les collectivités locales.

10. L'action de l'Etat suppose l'élaboration de statistiques sociales. Sur la base d'entretiens, d'observations directes et de recherches documentaires, le texte de Daniel Enama et Koissé Mahamat Imar II prend pour objet d'analyse les pratiques discursives (logiques et dynamiques) relatives aux statistiques du ministère de la Santé publique au Cameroun. Ils cherchent à démontrer qu'au Cameroun, l'exercice journalier du nombre de malades et de décès a permis de construire socialement la crise sanitaire en renforçant d'une part l'autorité de l'Etat et, d'autre part, l'éligibilité du Cameroun à l'aide internationale des fonds de solidarité en lien avec la COVID-19.
11. Prenant comme point de départ le fait que les restrictions liées à la pandémie ont fondamentalement modifié l'interaction sociale, Horgan, Liinamaa, Dakin, Hunter, Meligrana, Wilson et Xu présentent l'étude " COVID-19 et espace public " entreprise au Canada entre mai 2020 et mars 2021. Cette étude qualitative recueille des récits de rencontres quotidiennes entre inconnus dans les espaces publics canadiens pendant la pandémie.
12. Quel a été le rôle de l'aide internationale dans la lutte contre la pandémie ? Telle est la question abordée au niveau global par l'équipe de chercheurs d'Irak, du Ghana et de Hongrie (Ahmad,

Akosa, Chopra) dans un huitième texte. Le rôle des donateurs, qu'il s'agisse d'individus ou d'organisations, a permis d'aider des millions de personnes dans différents pays. Pour les chercheurs, le soutien apporté au niveau mondial pour combattre la COVID-19 et ne laisser personne de côté a été bien réel.

La thématique de la troisième partie porte sur la qualité de vie et la santé mentale en temps de pandémie.

13. En France et en Belgique, la pandémie et le confinement ont eu des effets néfastes sur les soins psychiatriques. Tel est le résultat de l'enquête conduite par une équipe belge et française (Kane, Baumgart, Fond-Harmant et alii) présentée dans sa contribution. Beaucoup des professionnels de la santé mentale ressentent un sentiment de dégradation de la qualité des soins. Ils ont dû utiliser la visioconférence face à l'impossibilité de poursuivre certains soins en présence, ce qui a heurté leurs conceptions du soin qui accordent une place importante à la rencontre. Confrontés à des situations leur évoquant l'enfermement asilaire, les soignants ont mis en œuvre des stratégies d'innovation et de résistance pour préserver la dignité et la santé mentale de leurs patients.
14. Comment les personnes âgées ont-elles vécu la pandémie au Maroc ? Abdelkarim Belhadj dresse un état des lieux sur cette question. Les personnes âgées au Maroc sont vulnérables sur le plan de la santé psychologique. Plus précisément, l'enquête du haut-commissariat au plan rapporte que le confinement a entraîné des conséquences sérieuses pour les personnes âgées à savoir l'anxiété, la peur, les comportements obsessionnels et le trouble du sommeil. L'auteur plaide pour que la puissance publique accorde plus de considération

aux personnes âgées, compte tenu de leur vulnérabilité face à la maladie, à la dépendance, au handicap et à la précarité des conditions de vie (logement, moyens de subsistances, couvertures sociales).

15. La contribution de Kiehl Lucci et Otta porte sur le Brésil. Lorsque la COVID-19 s'est répandu, les niveaux de satisfaction de vie et de bien-être ont diminué de manière significative. Un niveau d'éducation plus élevé, un revenu familial plus important et le fait d'être marié ou de vivre ensemble sont des indicateurs d'une plus grande satisfaction dans la vie. En ce qui concerne les stratégies d'adaptation, la consommation d'alcool est négativement associée à une existence satisfaisante. En revanche, l'étude montre que les activités positivement liées à une plus grande satisfaction étaient la danse, les activités physiques et les conversations téléphoniques avec la famille et les amis.
16. Dans une perspective comparative entre les Etats-Unis et l'Inde, une équipe de chercheurs internationaux (Uttrani, Siddique, Sreekumar, et alii) a conduit une enquête d'opinion en ligne en avril 2021. Les résultats montrent que les Indiens sont principalement préoccupés par leurs pertes économiques en cas de maladie et ont stocké des articles essentiels pendant la pandémie. Ils sont plus anxieux et plus stressés que leurs homologues américains en raison des informations alarmantes concernant la COVID-19 circulant dans les médias et les réseaux sociaux. D'un autre côté, les Américains ont rapporté un nombre élevé de cas de violence domestique pendant le confinement, ce qui augmente les niveaux de stress et d'anxiété.

En outre, ils sont plus enclins à se faire vacciner que les Indiens.

La quatrième partie porte enfin sur les effets de la pandémie sur les migrations et les mouvements transfrontaliers. La COVID-19 a en effet provoqué un brutal arrêt du transport des personnes et la fermeture des frontières. Comment les personnes concernées ont-elles fait face à cette situation ?

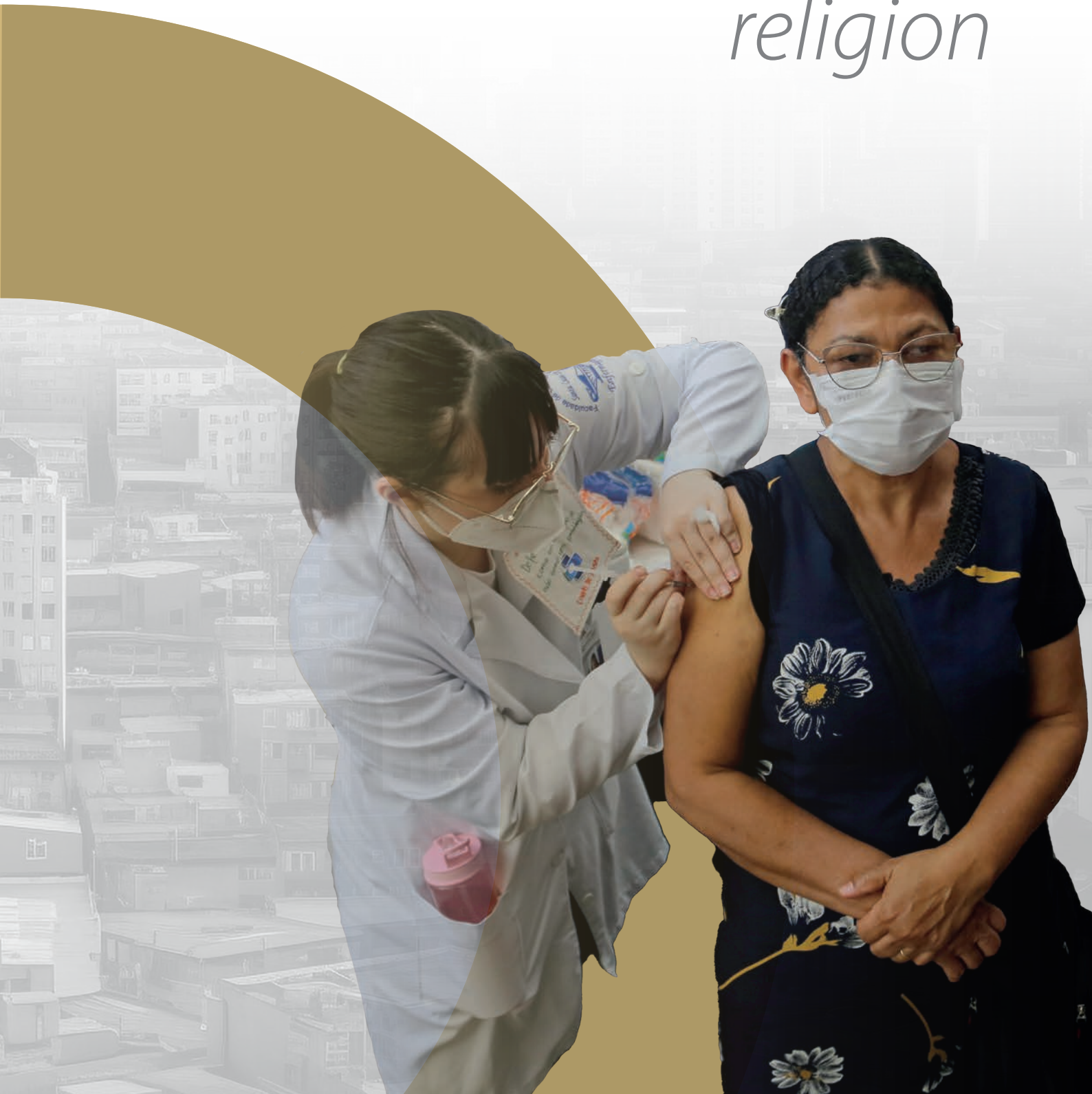
17. La contribution de Cole, Van de Ven, Ayikoru et alii propose un nouveau cadre théorique pour comprendre les crises sanitaires au niveau mondial. Il s'agit de la Géopolitique critique de la santé. Pour comprendre les effets sociaux de la pandémie, il faut prendre en compte les héritages géopolitiques et les inégalités structurelles, en particulier celles qui restreignent les mouvements des plus pauvres et des plus marginalisés à travers et à l'intérieur des frontières, et qui peuvent conduire à une résistance aux messages de santé publique. Il faut aussi considérer le type de gouvernement, nationaliste ou non, qui a fait face à la pandémie. Les auteurs présentent trois exemples analysés dans le cadre de la Géopolitique critique de la santé.
18. Dans le cadre de la riposte contre la pandémie de la COVID-19, plusieurs mesures ont été prises au Bénin dont la fermeture des frontières. Mais, très tôt, on a assisté à l'émergence de pratiques non conformes aux recommandations sanitaires, en termes de circulation des individus et des marchandises. Au moyen d'entretiens et d'observations à la frontière togolaise, une équipe de chercheurs béninois (Houngnihin, Amoussou, Montcho) montre que la pandémie a induit une reconfiguration des espaces frontaliers, faisant émerger une forme de stigmatisation de certains migrants associée à un

contrôle sélectif des usagers. En outre, la grande porosité des frontières terrestres permet de questionner l'efficacité de la fermeture des frontières comme moyen de prévention de la COVID-19 au Bénin.

19. La contribution suivante, dont l'auteur est Abdullah Khoso, prend pour objet les conditions de vie des travailleurs pakistanais en Malaisie. L'étude révèle que les travailleurs migrants sont plus attentifs à l'égard des règles sociales imposées par le gouvernement que le reste de la population. En effet, ils sont souvent dans une situation légale problématique et ils sont aussi les victimes d'une rhétorique anti-migrants les accusant d'être des vecteurs de contamination. Leur vie sociale s'est donc réduite au minimum. Ils ont renoncé à consulter des professionnels de la santé et à faire part des symptômes (fièvre et maux de tête, par exemple) à leurs collègues et à leurs employeurs. Ils dépendaient entièrement des traitements locaux à base de plantes et des médicaments facilement disponibles dans les pharmacies du quartier. Cet article conclut que les pratiques sociales des travailleurs migrants pakistanais ont été façonnées et formées non seulement par la pandémie de COVID-19 mais aussi par leur position légale (en tant que sans-papiers) et leur image stéréotypée dans les médias.
20. La dernière contribution traite des migrations internes en Inde. L'imposition d'un confinement national en Inde a été considérée comme une réponse préventive efficace à la pandémie de COVID-19. Malheureusement, les auteurs (Saklani, Mandal, Kumar et alii) montrent que le confinement a provoqué une crise migratoire pour échapper à la pauvreté et à la famine en ville. Leur recherche explore l'impact

de la pandémie à deux niveaux. Tout d'abord, pendant la période initiale de verrouillage, avec le phénomène de l'exode urbain, c'est-à-dire du retour dans les campagnes. Ensuite, pendant la période de blocage ou de post-blocage, ceux qui sont rentrés chez eux ont été confrontés à la crise économique puisqu'ils n'avaient plus de revenus.

Part 1—
*Medicine,
education, and
religion*



1.1. Countering the regressive for progressiveness: COVID-19 and women

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Abstract

The concept of economic development encompasses the social, political, economic and other spheres of human life. Human resources play a central role in economic growth, contributing enormously to development processes, irrespective of gender, age and the nature of the job. By engaging in economic activities to ensure their livelihood, both men and women contribute to the nation's development. Around 90 per cent of the workforce in India is employed in the informal sector, which like the formal sector, represents an important source of income, employment and social status. Women working in the informal sector in the country often face gender discrimination to a much greater extent than in the formal sector. As the most vulnerable group deployed in the informal sector, women entrepreneurs and workers were also disproportionately affected by the recent COVID-19 pandemic, which heavily disrupted the economy and led to significant loss of human life. Almost all sectors were adversely affected in terms of income, employment and basic necessities, irrespective of region or their nature and role.

Introduction

The informal and formal sectors play an inseparable role in the

development of a nation. In India, an enterprise owned by individual or self-employed workers engaged in the production or sale or provision of service of any kind is considered to form part of the informal sector if the number of employed workers is less than ten (Sengupta, 2008: 177). Characteristics of this sector include ease of entry, smaller-scale operations, local ownership, uncertain legal status, labour-intensive operations utilizing lower technology-based methods, and lower employee benefit schemes.

In India, the female population plays a vital role in every sphere of the economy, just like their male counterparts. Still, their participation in many spheres of the economy remains very low, with women restricted predominantly to the agricultural and informal sectors. Accordingly, women working in the informal sector are often excluded from official employment records, receive low wages and are not eligible for any benefits. Despite the many advances women have made in society, they continue to face discrimination and marginalization.

The COVID-19 pandemic severely impacted all spheres of the economy, irrespective of gender, caste, location and nature of work. The consequences are still affecting the majority of the population, placing many jobs at risk. In many countries worldwide, people

experienced loss of business due to lockdowns and movement and other restrictions. The primary segment impacted by COVID-19-related restrictions was women, a significant number of whom are employed in the informal sector and were disproportionately affected. Loss of jobs and closure of small production units depleted their main source of income. It is worth noting that women play a crucial role in supporting and providing for their families.

Objectives of the study

The main goals of this study are: (i) to analyse the impact of the pandemic on the living standards of female workers in the informal sector; (ii) to identify the problems faced by women in the informal sector, especially during the lockdown period due to the pandemic; and (iii) to examine the effect of the pandemic on women's entrepreneurship.

Methodology and sample source

The analysis of the impact of the pandemic on women in the informal sector is based on both primary and secondary data. As the study focuses on women working in the informal sector, the required information was collected from women in various fields within this sector. A total of 400 samples were collected as primary data through a well-structured survey questionnaire, employing a random sampling technique. Simple statistical tools, such as pie diagrams, charts, tables and graphs, have been used to analyse and present the data. Additionally, secondary data were gathered from various sources such as online articles and reports. Microsoft Excel was utilized to tabulate and graphically present the primary data.

Literature review

While gender discrimination existed prior to the pandemic (Chakraborty, 2020), the COVID-19 induced lockdowns exacerbated this situation. Mukherjee, Ray and Bag (2020)

reveal that 40 million jobs were lost in the country during the first year of the pandemic, predominantly affecting semi-skilled women in the informal sector. According to Mansoor and Khan (2021), the lockdown has disrupted every aspect of social and economic life, including the working environment, remuneration and necessities. Its impact has been particularly severe for the approximately 90 per cent of informal workers who rely on daily work and wages, without enjoying employment protection. Sahu and Singh (2020) studied the situation of weavers in Manipur and found that the COVID-19 pandemic introduced uncertainty into the lives of women workers. Meanwhile, Sharma (2021) found that social distancing measures, which prevented informal labourers from engaging in economic activities, had a serious impact on consumption demand, leading to a decline in their purchasing power.

Diptirekha (2015) showed that despite advancements in women's status today, they continue to grapple with the harsh realities of discrimination, exploitation and violence in organizations. They also face societal and family pressures and bear the burdens of balancing workplace and household responsibilities. Hunt and Samman (2016) observed that discriminatory social norms within various social groups restrict women's access to property, assets, financial services, education, skills development opportunities and social protection. Nayak (2020) suggests that strong cultural norms can limit women's mobility outside the home in certain regions, confining them to low-paid home-based jobs. Empowerment strategies for women in the informal economy aim to challenge these entrenched norms, structural barriers and power imbalances while promoting women's agency.

Women in the informal sector

According to the 2011 census, women account for 48.46 per cent of the population, 25.67 per cent of whom are designated as workers. Most of them work in informal sectors under socio-economic conditions significantly below those of their male counterparts. Economists like Lewis (1954) made the case for a change in the working situation of women labours, arguing that a radical shift from domestic to commercial activities was needed to advance economic development. Considerable changes have already taken place in women's engagement in the labour market, driven either by necessity or increasing educational status, changing social scenarios and increased job opportunities. But the female participation ratio in India is still much higher in the informal sector compared to the formal sector. Furthermore, women in the informal sector lack dignity in work, social security, decent and timely wages and in some cases, the right to live comfortably. The negligible importance attached to women's labour is the result of patriarchal and religious norms, with little value attached to their work regardless of whether it is domestic or informal in nature.

Data from the National Sample Survey Office (NSSO) indicate that most of the women in informal sectors are engaged in primary sector activities, such as agriculture and animal husbandry. While some were employed in the manufacturing sector, they were relegated to low paying, casual, home-based work. Women also work in jobs in the retail trade, education and paid domestic household labour, all of which receive lower wages.

In rural areas, women usually manage family expenses related to the education of children, family maintenance and medical expenses. Their own personal earnings contribute to covering



these expenses in addition to the earnings of their male counterpart in the family. As the burden of the family falls on them, women often engage in income-generating activities in addition to their regular household work. However, such women are consistently allocated to lower paid, less-skilled work and face a higher risk of job insecurity. They are also underrepresented in decision-making in various realms of social life. This gender-based discrimination manifested in sectoral and occupational segregation results in poverty, inflexible working hours, lack of childcare and poor parental leave, among other outcomes.

COVID-19: a disruptive pandemic

COVID-19 is a dangerous virus that is contagious by its very nature. Initially reported in Wuhan, China, in December 2019, it spread to other nations worldwide. The main symptoms found in patients include fever, cough, fatigue, breathing difficulties, and loss of smell and taste. These generally persist for

between one and 14 days. For some patients, recovery can take months and include damage to organs. As the virus spreads through proximity to an infected person, governments introduced numerous measures to prevent contagion and prevent spread of infection in workplace settings.

The pandemic adversely affected multiple aspects of life and also experienced different sectors of the economy, industries, the healthcare sector and tourism. The combined economic impact is estimated to be of the order of INR 7–8 trillion. The informal sector was worst affected due to the imposition of measures such as physical distancing, lockdowns, the closure of companies and industrial units, and restrictions on transportation, among others. Underprivileged members of society, particularly women, are highly dependent on this sector and were left in severe crisis during the lockdown period.

The pandemic has also shed a light on the reality of workers, the majority of whom are forced to survive in

miserable and insecure conditions. The female workforce, which is self-employed, and casual workers, are most severely and immediately affected by the loss of earnings or wages caused by lockdowns and other restrictions. Empirical analysis

Empirical analysis

Governments in India implemented lockdowns on two occasions to control the growing cases of coronavirus in the country. In the process, transport services, factories, and all kinds of public and private offices were shut, and mobility came to a standstill. These restrictive measures affected people who had vulnerable jobs, such as salespersons, menial labourers, domestic workers, those employed in housekeeping and other unskilled service workers. As many of these jobs are performed mainly by female workers, they have been worse affected throughout the last eighteen months, especially during the lockdown period, along with their families.

In addition to employment, COVID-19 acutely affected poverty alleviation activities, welfare schemes, and so on. Per-capita income and GDP growth declined drastically. The pandemic caused 135 million job losses, which in turn provoked severe poverty in India. The critical unemployment situation, especially in informal sectors, resulted in the death of large numbers of workers, many of whom subsisted on daily wages, while others struggled to survive. The impact of the pandemic and the precautionary lockdown measures also had multiple impacts on people in rural areas, especially women and their families. In order to study the impact of COVID-19 on women entrepreneurs and informal women workers, data were collected from representative samples of major informal sectors in India.

Table 1. Monthly average income of women in the informal sector during the COVID-19 pandemic

Work	Income prior to COVID-19	Income after COVID-19	Decline in average income (%)
Agriculture	4 364	4 100	6
Sales girls	8 250	6 300	23
Small shops owners	6 534	1 575	75
Small-scale industrial units	13 451	4 540	66
Daily labourers	12 270	6 548	47
Contract and casual labourers	10 500	5 050	52
Animal husbandry	6 945	5 923	15
Domestic workers	7 550	2 592	65

Source: Primary survey.

Table 2. Employment opportunities during the COVID-19 pandemic

Workers	Working days before COVID-19	Working days after COVID-19	Decline in working days (%)
Sales girls	26	12	54
Daily labours	22	18	28
Contract and casual labourers	27	8	70
Domestic workers	30	14	53

Source: Primary survey conducted among sample of informal female workers.

Gender and income

Women in the informal sector, the majority of whom are engaged in subsistence farming and self-employment activities, experienced a fall in income due to job losses and cuts in wages caused by COVID-19 related restrictions. These impacts are presented in Table 1.

Table 1 shows a decline in income across all categories of women labourers working in the informal sector. COVID-19 severely affected the level of income of small shop owners (75 per cent), small-scale industrial units (66 per cent), daily labourers (47 per cent), contract and casual labourers (5 per cent) and domestic workers (65 per cent). This decline is the result of government policies to limit human interactions to reduce virus transmission, which negatively impacted market mechanisms of demand and supply as people remained at home. Some products, notably agricultural products, showed price shocks. Furthermore, poor farmers faced heavy losses as demand dropped for many harvested products due to COVID-19-related restrictions.

Employment

During the pandemic many women working in informal sectors experienced job losses, cuts in their wages or a decline in working days. These included informal women labourers in agriculture, petty shops owners, owners of small-scale industrial units and women engaged in animal husbandry, all of whom are considered as self-employed. The study considered the employment situations of salesgirls, daily labourers, contract and casual labourers, and domestic workers when analysing the changes in employment opportunities. Table 2 shows the decline in working days due to the COVID-19 pandemic.

Most survey questionnaire respondents, both women entrepreneurs and daily labourers, stated that they had lost their jobs due to the pandemic. Both contract and casual women labourers experienced a 70 per cent decline in the average number of working days per month, while the drop was 54 per cent for salesgirls, 53 per cent for women domestic workers and 28 per cent for

daily labourers. Many responded that they had remained in the same job despite the decline in the number of working days per month. Obtaining a job with good a salary was not possible during this period. Many female entrepreneurs were affected by the restrictions imposed by the government and the overall decline in general business conditions.

Agriculture and rural economic activities

Agriculture is the main informal activity in the country and plays an important role in India, as a significant portion of the country's population is dependent on this sector. With the advent of COVID-19, the situation in rural India is likely to worsen significantly. Lockdown and associated disruptions affected agricultural activities and necessary supply chain mechanisms including input distribution, harvesting, procurement, transport, marketing and processing. Continued restrictions on movement and labour scarcity may block farming and related activities in the sector. The months of March and April are the peak harvesting season

Table 3. Source and purpose of borrowing by rural people

Purpose	No.	%	Source	No.	Percentage (%)
Household expenditure	78	39	Formal	32	16
			Informal	46	23
Education of children	134	67	Formal	56	28
			Informal	78	39
Medical expenses	92	46	Formal	36	18
			Informal	56	28
Household appliances	30	15	Formal	12	6
			Informal	18	9
Agricultural expenses	108	54	Formal	46	23
			Informal	62	31

Source: Primary survey.

for most agricultural products, but this process has been disrupted by the government restrictions and labour scarcity.

The marketing of agricultural products was also affected by the lockdowns and other restrictions on transportation and interstate movements, while restrictions on markets and transport, and bottleneck demand for fresh products, poultry and fisheries products, has impacted producers and suppliers.

Sources and purpose of borrowing

A major source of money for women labourers to meet the difference in income expenditure has been borrowing from both formal and informal sources. Uncertainty regarding repayment and the lower repayment capacity of these labourers, whose income is uneven and unstable, in conjunction with increasing expenditure, is a major concern for lending financial agencies.

Informal financial institutions contributed a major share of loan finance to rural women labourers to meet their living expenses. The major reasons for this trend were the lower repayment capacity of these women, the longer transaction times of formal institutions due to procedures and formalities, and stringent government policies related to public lending, especially in rural areas. Table 3 shows the major sources and purpose of borrowing by rural people.

Banks, cooperatives, self-help groups (SHGs), private financial institutions and local money lenders are the major sources of borrowing for women labourers. The main reasons for borrowing are to meet the education expenses of children (67 per cent) and meeting agriculture expenses (54 per cent). Other reasons included maintaining household activities (39 per cent), meeting medical expenses (46 per cent) and purchasing household appliances (15 per cent).

Medical expense and health insurance coverage

Even prior to the pandemic, informal workers had only limited access to quality and affordable healthcare. Being economically weaker, women labourers usually have little choice but to use public healthcare facilities and services, which are often overcrowded, inefficient and in most cases distant from workplaces. The private health care system is seldom accessible due to the higher cost. During the pandemic, informal workers had little access to reliable information on COVID-19 and the procedure to access health services. The majority were not registered with health insurance schemes, and in some cases were not even aware of their existence. As insurance coverage is not available, the huge COVID-19-related medical expenses represent a significant burden.

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Table 4. Health issues of respondents

Health issues	No. of samples	Percentage (%)
Diabetes	76	38
Anaemia	28	14
Gynaecological problems	133	67
High/low blood pressure	120	60
Asthma	32	16
Back/joint pains	112	56
COVID-19-related	14	7
Allergy/skin diseases	32	16
Cancer	10	5
Kidney/heart problems	6	3

Source: Primary survey.

Distribution of health issues and concerns

Women in rural areas face many health challenges, as they are subjected to a lack of medical facilities, proper knowledge about timely medication, financial problems and social stigma, shame or fear of revealing their illness. Women in rural areas are also affected by lack of accessibility to primary and specialty care facilities. Chronic health issues, including heart disease, diabetes and cancer, are also an important concern in rural areas. Table 4 presents the distribution of respondents who face health issues.

The majority of respondents (67 per cent) have gynaecological problems, 60 per cent have either high or low blood pressure, 56 per cent experience back and joint pain, 16 per cent have asthma, and 38 per cent and 14 per cent have diabetes and anaemia, respectively.

Decline in wages and salaries

Aside from loss of employment, almost all segments of the informal sector experienced wage cuts during the pandemic period, especially women labourers in the informal sector. The strict lockdown measures and restrictions on entire economic activities triggered a slowdown in business activity, which led to the closure of many unprofitable units and a reduction in salaries in others.

The impact [of COVID-19] was higher on women and on people involved and employed in informal or unemployed sectors, as they could not cope up with the unexpected shock.

Findings of the study

The impact of COVID-19 and the precautionary lockdown on employment was much greater than predicted or expected. The entire economy was considerably affected. The impact was higher on women and on people involved and employed in informal or unemployed sectors, as they could not cope up with the unexpected shock. The outbreak of the pandemic and the implementation of lockdown measures across India also impacted women workers, due to their high vulnerability to the negative effects of the pandemic as well as other shocks beyond the current crisis. Additionally, COVID-19 increased this vulnerability due to the existing social construction of gender. This section addresses the impact of lockdown measures on women workers in terms of livelihoods, wages and workloads, through a gender lens.

- Women's unpaid work burdens were amplified during the lockdown.

The majority of respondents (67 per cent) have gynaecological problems, 60 per cent have either high or low blood pressure, 56 per cent experience back and joint pain, 16 per cent have asthma, and 38 per cent and 14 per cent have diabetes and anaemia, respectively.

This is due mainly to two main reasons: (i) family members spent more time at home and (ii) children remained at home. Women had to look after their children who would otherwise have been in school or day care centres. Many stated that they were unable to work due to their increased household domestic responsibilities. This led to women facing a high risk of losing their jobs and income. The majority of the sample respondents experienced a severe decline in their family income and the number of working days per month. The situation was worse among domestic daily wage earners. Existing gender norms and wage inequalities aggravated this situation. The majority of women working in the informal sector became jobless.

- During the personal interviews, many women entrepreneurs in the informal sector shared that repayment of borrowed money had become a huge issue for them, due to the lockdown measures. Most of them started their business activities with financial support from formal and informal financial institutions, including local money lenders. In the case of small production units, due to the strictness of the lockdown measures, producers found it difficult to sell their commodities. In addition, as the majority of people lost their jobs, their purchasing

power declined, which in turn triggered stagnation in the field of production.

- Pandemic induced lockdowns brought about an economic crisis in the economy, particularly affecting the livelihoods of daily wage workers. The restrictions on movement imposed by the government and the complete lockdown resulted in a reduction in employment opportunities. *Kudumbasree*¹ workers also experienced difficulties during the pandemic. In cities they collect, segregate and sell waste to different business units who use it as raw materials. The lockdown restrictions impeded this process and small business units run by *Kudumbasree* workers also closed due to lockdown restrictions. In addition, many domestic workers lost their job as the families who employed them became reluctant to admit them to their houses due to fear of the virus.
- The study also identified restrictions on movement, fear of contracting the disease and unavailability of sufficient preventive equipment as the major reasons for loss of working days and drop in the income among daily labourers.
- Female workers tended to be concentrated in lower grade jobs such as cleaning and care services in private households, and were more vulnerable and affected by job loss caused by pandemic. There were three main reasons for this vulnerability:
 - Firstly, loss of livelihoods. While both women and men lost their jobs in sectors such as manufacturing, construction, trade, restaurants and household services, including domestic work and tourism, women workers are

overrepresented in the lower segments of the informal employment pyramid in the form of part-time workers, contract workers, unregistered workers and industrial out-workers (i.e. employment without a secure contract). As a result, they were the first to be dismissed with little hope of being re-employed.

- Secondly, the pandemic intensified women's work. The workload of women employed as frontline workers or essential service providers increased exponentially, including care services in their own household.
- Thirdly, most women entrepreneurs were found to be involved in small-scale trading, domestic service and informal traditional manufacturing activities, which are lower paid. The majority of women working in the informal sectors for low wages experienced the repercussions of lockdown in a variety of ways. An immediate but deliberate reduction in their social life increased their social and economic insecurity. In addition, women-led initiatives were badly hit due to lack of social protection. Key features of women's informal employment include informal contracts, irregular labour, and exploitative and undefined wage and working conditions.
- During the pandemic, about 70 per cent of survey respondents borrowed money from banks and other informal agencies to meet household expenses (education, medical, household appliances, etc.). Employment gaps during lockdowns left women more vulnerable than men to job loss. But credit penetration increased in favour of women providing them with higher incentives for loans, such as lower interest rates, lower stamp duties, expansion of collateral-free loans and the

opportunity to apply as co-borrowers. For instance, most women involved in informal employment took out SHG-micro finance loans, which now need to be repaid. During the crisis, the Kerala state government provided interest-free loans to women's self-help groups through the '*Sahayahastham*' scheme², which is worth Rs 2,000 crore. Similarly, the Kerala Startup Mission (KSUM)³ provided working capital to women startups through a soft loan scheme, providing amounts up to Rs.15 Lakhs.

- Borrowing increased during the pandemic from informal financial institutions and local money lenders, which increased the debt burden considerably.
- The majority of sample households (90 per cent) revealed that they lacked any kind of health insurance coverage. Loss of jobs and income during the pandemic resulted in increased vulnerability among informal women workers, who had to choose between health and money. *Kudumbasree* provided a micro-insurance scheme that extended help to working women in informal sectors with irregular cash flows. The absence of mandatory provisions are a major reason why women fail to subscribe to insurance plans.
- The study found that most respondents (80 per cent) suffered from gynaecological problems which are most common among women daily labourers. The pandemic significantly impacted both the physical (gynaecological) health and mental well-being of women workers. The majority of

1 Community organization of Neighbourhood Groups (NHGs) of women in Kerala, India.

2 The **Sahayahastham Scheme** is a loan scheme by the Kerala (India) government to provide loan facilities to all women self-help groups situated in the Kerala state.

3 The Kerala Startup Mission is the central agency of the Government of Kerala for entrepreneurship development and incubation activities in Kerala, India.

frontline health workers besides doctors and specialists during the pandemic were women. These included nurses, ASHA workers⁴, Anganwadi workers⁵, Kudumbashree workers, sanitation workers and members of local bodies. The mental stress of the lockdown and loss of work, alongside the heavy burden of household care duties and the physical stress of the virus itself, for those infected, resulted in insomnia, anxiety, depression, hormonal imbalances and reproductive health issues among women labourers. The pandemic also had devastating effects on mortality and morbidity, including in pregnant women.

Recommendations

Generating more employment opportunities through government intervention in the form of investment or provision of public services is essential to overcoming the crisis situation.

Providing basic work conditions is a fundamental need for women to enjoy self-esteem in the society. Enforcing labour laws and ensuring the payment of minimum wages will help reduce gender disparity.

Improving access for women to social protection, with a focus on pension schemes, occupational health concerns and skills development to enable higher earnings, will help enhance their social standing and standard of living.

Providing capital at a reduced rate to female entrepreneurs and creating initiatives that generate more jobs will promote employment and income-generating opportunities for women.

Conclusion

In India, one-third of the work force in the informal sector consists of women and constitutes the main source of livelihood for their dependents. Article 16 of the Indian Constitution ensures equality of opportunity in all spheres of human life irrespective of caste, creed and gender. However, the condition of women, especially those working in the informal sector, is unacceptable. Although the pandemic affected all people, the impacts were much greater on socially vulnerable segments of society, who already faced earnings and income-related difficulties. Social identities such as caste and gender determine various dimensions of economic life, regulating access to education, good health facilities, decent housing, sanitation and other basic amenities.

Domestic women workers were the worst affected during the pandemic period. The COVID-19 pandemic and the precautionary lockdown slowed economic activity, especially in cities. Many female daily wage earners and domestic workers lost their jobs and consequently their income. Conversely, employees in the formal sector retained their jobs and continued to receive their salaries. The informal sector depends on daily demand. Restrictions on movement during the lockdown period meant that potential customers of the informal sector remained at home and refrained from non-essential expenditures.

Numerous attempts were made to overcome these gender-based difficulties in the aftermath of the pandemic. Initiatives undertaken by non-governmental organizations (NGOs) and government agencies guaranteed minimum employment, even during the COVID period. Many of the issues that women face in workplace should also be addressed, and their access to social and financial infrastructure should be ensured. Moreover, efforts should be made to ensure a safe environment for

women in the workplace and in social interactions, more generally, especially during crises.

Various employment and income-generating initiatives must be introduced to support women who have lost their employment or source of income due to issues related to the pandemic. As this category of people does not have access to any kind of employment security, support in the form of government employment guarantee schemes is essential to sustain their lives as well as those of their families

Various employment and income-generating initiatives must be introduced to support women who have lost their employment or source of income due to issues related to the pandemic. As this category of people does not have access to any kind of employment security, support in the form of government employment guarantee schemes is essential to sustain their lives as well as those of their families. Women employers in the informal sector should be protected by ensuring minimum wages, job security and basic facilities in the workplace. Such basic amenities are essential to uphold the dignity and status of women in current society. By implementing a variety of schemes and programmes, the government has the ability to raise the social and economic standard of workers, and especially women workers, in the informal sector.

4 ASHA (Accredited Social Health Activist) workers are health activists in Kerala that promote awareness about health and its social determinants.

5 Anganwadi is a type of rural childcare centre in India. It was started in 1975 as part of the Integrated Child Development Services programme to combat child hunger and malnutrition.

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1.2. COVID-19 et prise en charge des personnes vivant avec le VIH à Antananarivo : se mobiliser pour le maintien du traitement antirétroviral en contexte de pandémie

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Résumé

La crise sanitaire liée à la pandémie de COVID-19 a eu un impact important sur le dépistage, l'accès aux soins et le suivi des personnes vivant avec le VIH (PvVIH). L'étude ANRS CoVIH-OI étudie les effets de la pandémie sur la prise en charge des PvVIH à Antananarivo, Madagascar. Soixante entretiens semi-directifs ont été menés entre février et juillet 2021 auprès de PvVIH, d'acteurs de prise en charge médicale, associative et de coordination. La période investiguée s'étend de mars 2020 à juillet 2021.

Les résultats montrent que la peur d'attraper la COVID-19, les difficultés de déplacement liées à la suspension des transports en commun pendant le confinement et la crainte de la stigmatisation ont entraîné une baisse de la fréquentation des structures de santé par les PvVIH. Certaines ont pu maintenir leur traitement antirétroviral (ARV) grâce à la mobilisation de

compétences individuelles ou sociales pour se rendre dans leur centre de prise en charge. La mobilisation des professionnels de santé et des médiateurs associatifs pour délivrer des ARV près de leur domicile et en plus grande quantité a également facilité ce maintien. Les PvVIH se sentent particulièrement vulnérables face à la COVID-19, d'où un renforcement de la confiance envers les soignant.es et envers les ARV, perçus comme un moyen de se prémunir de la COVID-19. La COVID-19 fait émerger des problématiques déjà présentes à Madagascar avant la pandémie, comme le poids de la stigmatisation des PvVIH sur le recours aux soins.

Des pistes d'action concrètes émergent des résultats : prendre en compte les savoirs et compétences des PvVIH et des acteurs communautaires ; créer un guide pratique de gestion de la distribution des ARV en contexte

épidémique ; maintenir les liens entre les PvVIH et les structures de prise en charge ; formuler des messages rassurants pour faciliter leur recours aux structures de santé en contexte épidémique et éviter ainsi les patients perdus de vue ; favoriser la démocratisation de la connaissance sur le VIH et sur l'efficacité des ARV. Ces recommandations serviront de base aux activités de transfert de connaissances qui seront construites dans une démarche participative avec les acteurs et institutions impliqués dans le suivi des PvVIH à Madagascar.

Introduction

La pandémie de COVID-19 a amené les Etats à prendre des mesures exceptionnelles, notamment la mobilisation des professionnels et des services de santé pour prendre en charge les personnes atteintes, et l'adoption de mesures visant à limiter la propagation du virus : confinement, suspension des transports en commun, couvre-feu, distanciation sociale, etc. Ces mesures ont entraîné des conséquences sur la continuité des soins des personnes souffrant de maladies chroniques, ainsi que sur l'organisation des soins et des activités des équipes chargées de leur prise en charge sociale et médicale. Dans le domaine du VIH, la crise sanitaire a eu un impact négatif sur le recours au dépistage, sur l'accès aux soins et sur le suivi des personnes vivant avec le VIH (PvVIH) (Chenneville *et al.*, 2020 ; Golin *et al.*, 2020 ; Hogan *et al.*, 2020 ; Le Fonds Mondial, 2021).

A Madagascar, le premier cas de COVID-19 a été confirmé le 20 mars 2020. La fermeture totale des frontières a été suivie par l'annonce des premiers cas. L'état d'urgence sanitaire a été déclaré immédiatement. Des mesures sanitaires ont alors été mises en place : fermeture des lieux de rassemblements (bar, restaurants, night clubs...), interdiction de rassemblements, distanciation sociale, port du masque, fermeture des écoles et des églises, confinement partiel, interdiction de circulation

des transports publics (bus, taxi), couvre-feu. Le 22 mars 2020, les villes d'Antananarivo et Tamatave ont été mises en confinement partiel. L'explosion du nombre de cas en juin 2020 a conduit les autorités à décider le retour à un confinement total début juillet. Un déconfinement progressif a été annoncé début août 2020, suite à la diminution du nombre de cas recensés. La fin de l'état d'urgence a été déclarée mi-octobre 2020. La deuxième vague de COVID-19 a débuté en mars 2021 avec l'arrivée du variant Sud-Africain. De nouvelles mesures sanitaires ont été mises en place : réouverture des Centres de Traitement COVID-19 (CTC), mise en place d'« hôtels médicalisés », confinement les week-ends dans les régions à risque, dont Antananarivo. La campagne de vaccination a débuté le 12 mai 2021⁶. La fin de l'état d'urgence sanitaire a été annoncée le 3 septembre 2021. C'est au cours de cette seconde vague que les entretiens ont été conduits. Au moment de la finalisation de ce papier (février 2022), Madagascar connaît une quatrième vague.

A Madagascar, la crise sanitaire intervient dans un contexte particulier. Le pays connaît en effet des crises politiques, économiques et sanitaires successives depuis plusieurs décennies, qui ont considérablement appauvri la population et extrêmement fragilisé le système de santé (Fremigacci, 2015 ; Razafindrakoto, Roubaud et Wachsberger, 2018). Dans le domaine du VIH, alors que l'ONUSIDA estimait en 2019 à 39000 le nombre de personnes vivant avec le VIH à Madagascar, seulement 5700 connaissaient leur statut sérologique et 5200 bénéficiaient d'un traitement antirétroviral – ce traitement étant accessible gratuitement (Raberahona *et al.*, 2020). Les rares recherches en sciences sociales sur le VIH/sida à Madagascar ont montré la faible connaissance du VIH dans la

population générale et les difficultés des PvVIH pour maintenir leur suivi médical et leur traitement antirétroviral, en raison notamment de la stigmatisation persistante à leur égard (Andrianasolo *et al.*, 2011 ; Njatosa *et al.*, 2019).

L'étude socio-anthropologique *CoVIH-OI – COVID-19 et VIH : Mobilisation, reconfiguration des soins et affects des acteurs du VIH face à la COVID-19 à Madagascar*⁷ porte sur les effets de la pandémie quant à la prise en charge des PvVIH à Antananarivo, Madagascar. L'étude s'intéresse particulièrement aux personnes vivant avec le VIH, aux professionnels de santé, aux acteurs des associations communautaires et de la coordination du VIH au niveau gouvernemental. Du côté des PvVIH, il s'agit de comprendre les effets des mesures prises lors de l'épidémie de COVID-19 sur le rapport à la maladie, aux soins et aux intervenants sociaux et de santé, de documenter les parcours de soins, en tenant compte des ressources mobilisées pour réorganiser ou maintenir le suivi médical, d'étudier les perceptions de la COVID-19 et les pratiques de prévention. Du côté des professionnels de santé et des acteurs associatifs, il s'agit de documenter la manière dont ils ont été mobilisés lors de la crise sanitaire de la COVID-19, d'étudier l'impact de cette crise sur leurs pratiques professionnelles et communautaires et sur leurs affects. La période investiguée s'étend de mars 2020 à juillet 2021.

Plus particulièrement, cet article se concentre sur les contraintes occasionnées par la crise sanitaire telles qu'elles ont été perçues par les personnes concernées – PvVIH, professionnels de santé, acteurs associatifs – et sur les ressources qu'elles ont mobilisées face à ces

6 En janvier 2022, moins de 3% de la population malgache est vaccinée.

7 Le projet CoVIH-OI est financé par l'ANRS Maladies infectieuses émergentes. Le projet couvre également Maurice où l'étude démarrera en 2022. Le projet a reçu l'approbation du Comité d'Ethique de la Recherche Biomédicale du Ministère de la santé publique de Madagascar.



contraintes, lors de la première vague de l'épidémie.

Méthodologie et population d'étude

La collecte des données a eu lieu entre février et juillet 2021, soit un an après le début de l'épidémie de COVID-19 à Madagascar et pendant la deuxième vague de l'épidémie. Un total de 60 entretiens a été menés auprès de 19 femmes et 11 hommes vivant avec le VIH, 10 professionnels de santé intervenant dans un service médical de prise en charge du VIH, 15 membres d'associations communautaires intervenant dans la prise en charge de PvVIH (associations membres du réseau Mad'Aids) et 5 acteurs de coordination VIH. Les professionnels de santé et la majorité des PvVIH ont été recrutés dans trois services médicaux : un service de maladies infectieuses de l'un des 8 hôpitaux publics d'Antananarivo, un autre situé en périphérie d'Antananarivo, et un service de maladies infectieuses situé dans un centre de santé publique de la capitale. Les services médicaux

ont été choisis du fait de leurs profils différents. Le premier est un service de maladies infectieuses de l'un des huit hôpitaux publics d'Antananarivo, qui prenait en charge environ 1200 PvVIH avant la crise sanitaire. Le second est situé en périphérie d'Antananarivo, qui prenait en charge une centaine de PvVIH, principalement des femmes et des enfants. Enfin, un service de maladies infectieuses situé dans un centre de santé publique de la capitale, qui suivait environ 120 PvVIH avant la crise sanitaire et 200 en mars 2021⁸. Le choix des associations enquêtées s'est fait avec la collaboration du réseau Mad'Aids, le plus important réseau associatif du pays, qui regroupe 35 associations de soutien aux PvVIH à Madagascar. Les PvVIH ont été recrutées au sein de ces services médicaux de prise en charge du VIH (8 dans chaque service) ou au sein d'une association de PvVIH (6 enquêtées), de manière

8 Du fait de l'absence d'informatisation des dossiers médicaux des PvVIH suivis dans les structures de santé malgaches, ces données sont des estimations faites par les médecins référents.

à avoir des profils diversifiés de personnes enquêtées, en termes de sexe, catégories d'âge, catégories socio-économiques, lieu de résidence (Antananarivo ville ou alentours).⁹

La majorité des entretiens ont été réalisés en malgache, au sein des services de soins ou des associations. Compte-tenu du contexte épidémique, la moitié des entretiens ont été réalisés en face à face ; les autres entretiens ont été conduits à distance, à travers un service de visioconférence. Les entretiens ont été enregistrés, transcrits et traduits en français s'agissant des entretiens en malgache. Ils ont fait l'objet d'une analyse thématique transversale consistant à relever dans les entretiens les principales tendances relatives aux différents thèmes étudiés : perceptions, attitudes et expériences en lien avec la COVID-19 ; suivi médical, rapport aux soins et au traitement du VIH (avant et pendant la crise sanitaire) ; effets de la crise sanitaire sur les activités professionnelles ou la mobilisation communautaire ; COVID-19 et ressenti personnel (pour les professionnels de santé et les acteurs associatifs) ; COVID-19 et application des directives internationales (pour les acteurs de la coordination du VIH).

Parmi les PvVIH enquêtées, les 19 femmes ont entre 24 et 47 ans. Leurs activités génératrices de revenus sont variées : six sont lavandières ou femmes de ménage, cinq sont salariées (réceptionniste dans un hôtel, employée en zone franche, employée d'un call center, vendeuse...), trois sont travailleuses du sexe, deux sont fonctionnaires, une est sage-femme, une est commerçante, une n'a pas d'activité professionnelle. Les 11 hommes enquêtés ont entre 24 et 42 ans. Parmi

9 Les limites de cette étude sont liées au fait qu'elle concerne uniquement la capitale, les résultats n'étant pas généralisables à l'ensemble du pays. Par ailleurs, les résultats portent sur le début de l'épidémie et ne rendent pas compte des évolutions ayant pu advenir après juillet 2021.

les professions représentées, nous avons rencontré deux employés en zone franche, deux commerçants, un chauffeur, un infirmier, un commercial, un employé dans un projet VIH, un chef de chantier, un bibliothécaire et le dernier était sans emploi au moment de l'enquête. Les PvVIH enquêtées ont été diversement affectées par la crise de COVID-19, en fonction de leur situation professionnelle notamment. Si une grande partie d'entre elles, travaillant dans le secteur informel, a connu une perte conséquente de revenus, d'autres ont pu maintenir leurs activités ou développer de nouvelles activités (par exemple, une travailleuse du sexe vend des beignets, la personne qui travaillait pour un projet VIH s'est reconvertie en pâtissier).



Parmi les professionnels de santé enquêtés, nous avons interviewé six médecins référents¹⁰, un major (cadre de santé), deux assistantes sociales et une sage-femme (dédiée au suivi psychosocial des PvVIH).

S'agissant des acteurs et actrices associatifs, nous avons interviewé 15 membres d'associations de PvVIH ou de lutte contre le sida (responsables, médiateurs, pairs éducateurs). Les cinq acteurs de coordination interviewés sont des responsables de services gouvernementaux ou institutionnels en charge du VIH-sida et des maladies transmissibles.

Réorganisation de la prise en charge du VIH du fait de la crise sanitaire

Les services dans lesquels nous avons mené l'enquête ont été diversement impliqués dans la prise en charge de patient.es atteint.es de COVID-19 et donc diversement impactés par la crise sanitaire. Le service de maladies infectieuses d'un grand hôpital de la capitale¹¹ a totalement réorganisé ses activités car il a été affecté à la prise en charge des personnes atteintes de COVID-19 dès le début de la pandémie. Au moment des entretiens dans ce service (mars-juin 2021) et depuis mars 2020, toutes les réunions d'équipe étaient consacrées aux patient.es touché.es par la COVID-19, plus aucune réunion ne concernait les PvVIH. Avant même l'annonce des premiers cas de COVID-19, en mars 2020, une centaine de lits a été préparée pour accueillir les personnes atteintes dans le service. Les PvVIH hospitalisées ont été transférées dans le service de maladies métaboliques (diabétologie et endocrinologie). La distribution des médicaments antirétroviraux (ARV), attribuée d'ordinaire à l'« infirmier major » du service, a été déléguée d'abord aux deux assistantes sociales du service,

puis à un autre personnel recruté en février 2021. La récupération des médicaments a été organisée, dans un premier temps, à l'extérieur du bâtiment. La réalisation des examens (prise de sang en vue d'évaluer le taux de CD4 et la charge virale pour vérifier l'efficacité du traitement ARV) a été suspendue pour la majorité des patient.es et maintenue uniquement pour celles et ceux présentant des infections opportunistes ou autres problèmes de santé. L'infirmier major maintenait tout de même la prise en charge des nouveaux cas ainsi que l'initiation au traitement ARV.

Cette réorganisation a largement affecté la fréquentation du service par les PvVIH. D'une part elles évitaient de venir à l'hôpital, en particulier dans le service de maladies infectieuses, par crainte d'une trop grande exposition à la COVID-19. D'autre part, elles ne souhaitaient pas avoir affaire à des soignants qu'elles ne connaissaient pas afin d'éviter que leur maladie soit connue par de nouvelles personnes. Une soignante décrit le refus de certains de ses patient.es de consulter un autre personnel soignant, et la confiance à son égard dont cela témoigne. Le fait de devoir récupérer les médicaments à l'extérieur du bâtiment, à la vue de tous, a également freiné leur venue à l'hôpital. Dans ce service, les médecins référents interrogés déplorent un grand nombre de patient.es perdus de vue parmi les PvVIH, notamment au cours de la première vague de l'épidémie. Une partie d'entre elles sont revenues vers les soins après avoir interrompu leur traitement pendant plusieurs semaines ou plusieurs mois et au moment de la dégradation de leur état de santé. D'autres patient.es ne sont pas revenu.es. Les médecins interviewés émettent différentes hypothèses concernant leur « disparition » du parcours de soins : déménagement hors de la capitale pour éviter l'exposition à la COVID-19, peur de quitter leur domicile, ils émettent également la possibilité que leurs patient.es aient pu être atteint.es de formes graves de COVID-19.

10 A Madagascar, les médecins référents sont des médecins formés sur le VIH et chargés du suivi des PvVIH.

11 Ce service prenait en charge environ 1200 PvVIH en 2020 avant la crise sanitaire.

En l'absence de directives gouvernementales, quelques initiatives ont été prises par le personnel soignant pour maintenir les patient.es dans le soin et assurer leur ravitaillement en médicaments.

En l'absence de directives gouvernementales, quelques initiatives ont été prises par le personnel soignant pour maintenir les patient.es dans le soin et assurer leur ravitaillement en médicaments. Pour les PvVIH habituellement suivies dans ce service mais résidant en province, des envois de médicaments par la poste ont été faits, les frais étaient pris en charge par les patient.es. Les patient.es suivi.es en province, coïncé.es dans la capitale durant le confinement de la région d'Analamanga, ont pu récupérer leur traitement au sein du service. Enfin, afin de limiter la venue des patient.es à l'hôpital, ils pouvaient recevoir deux ou trois boîtes de médicaments (pour deux ou trois mois de traitement) à chaque visite.

Concernant le suivi, un des médecins référents enquêtés indique avoir maintenu le contact avec ses patient.es par téléphone grâce à l'appui du Programme national de lutte contre les IST/Sida (PNLIS) pour l'achat de crédit téléphonique. Il s'enquière de leur état de santé et s'assure qu'ils n'ont pas de problème particulier. Ce moyen de communication était déjà utilisé par un autre médecin référent, bien avant la pandémie de COVID-19. Ses patient.es l'appellent régulièrement pour demander des conseils en cas de symptômes inhabituels et en lien avec les interactions médicamenteuses. Si ces échanges ont pu être maintenus, les visites médicales et examens sanguins pour la mesure de la charge virale ont été interrompus.

Le deuxième service¹², situé dans un hôpital en périphérie d'Antananarivo, n'a pas été impliqué dans la gestion des patient.es atteint.es de COVID-19. Les activités de prise en charge et de suivi des PvVIH n'ont quasiment pas été affectées par la crise sanitaire. Les patient.es ont continué à venir à leur rendez-vous, mensuel pour les femmes enceintes et les personnes en début de prise en charge, trimestriel ou semestriel pour les patient.es dont l'état de santé est stabilisé, en prenant compte des horaires de couvre-feu pendant le confinement partiel. Cependant, quelques patient.es ne viennent plus. Il s'agit soit de personnes résidant en province, soit de personnes qui avaient déjà des difficultés d'observance avant la crise sanitaire. Pendant la période du confinement total, durant la suspension des transports en commun (du 6 Juillet 2020 au 26 Août 2020), le médecin référent du service a pris l'initiative d'apporter des boîtes d'ARV à certain.es patient.es dont le domicile était éloigné de l'hôpital en leur donnant rendez-vous sur un axe routier important.

Le troisième service¹³, situé dans un centre de santé public au cœur d'Antananarivo, se compose d'un médecin référent et de trois sage-femmes dédiées au suivi psychosocial, à la distribution des ARV et à la recherche des patient.es perdu.es de vue. Le service n'a pas été impliqué dans la prise en charge de malades atteints de COVID-19. Mais les sage-femmes ont été appelées à intervenir dans d'autres formations sanitaires prenant en charge des cas de COVID-19. L'équipe s'est rapidement organisée et mobilisée pour rassurer les patient.es VIH et pour maintenir un lien avec eux. Dès mars 2020, elle a organisé une réunion d'information sur la COVID-19 à laquelle toutes les PvVIH suivies ont été conviées. Une

soixantaine de personnes y ont assisté, en deux groupes. Les patient.es qui n'ont pas pu assister à la réunion ont bénéficié d'une information individuelle lors de la récupération du traitement. Puis d'avril à juillet 2020, l'équipe a distribué des ARV dans les quartiers de résidence des patient.es à Antananarivo et jusqu'à 100 kilomètres autour de la capitale. Cette distribution a d'abord été réalisée par les sage-femmes, en transports en commun. Le service a reçu par la suite l'appui d'un service gouvernemental (pour le prêt d'une voiture et le coût du carburant) et d'un médiateur associatif (pour l'achat de crédit téléphonique en vue d'appeler les patient.es et leur donner rendez-vous). Les examens de charge virale ont pu être maintenus en étant réalisés à bord du véhicule. Contrairement à ce qui a été observé dans d'autres services, seulement une boîte de médicaments était donnée à chaque patient car l'équipe craignait une rupture de stock de médicaments, du fait notamment des nouveaux cas. Comme dans les autres services enquêtés, l'équipe a constaté le fait que certains patient.es étaient perdus de vue et injoignables. Quelques patient.es partis en province ont informé l'équipe, qui les a mis en relation avec d'autres médecins référents pour qu'ils prennent le relai de leur prise en charge.

Pour les personnes vivant avec le VIH : entre éloignement des soins et renforcement de la confiance envers les traitements et les professionnels de santé

Vulnérabilité ressentie face à la COVID-19 et mesures de protection

Les PvVIH enquêtées considèrent que le virus responsable de la COVID-19 est un virus qui se transmet facilement : par l'air, le vent, la salive, les postillons, les frottements, les contacts, la saleté. D'après elles, il s'agit d'un virus invisible, qui se dépose sur les objets, les vêtements, l'argent. Il s'introduit dans le corps par les orifices, y compris les yeux et les oreilles. Les enquêtées évoquent

12 Au moment de l'étude, ce service prend en charge une centaine de PvVIH, dont 17 enfants et 52 femmes.

13 Le service suivait environ 120 personnes en 2020 avant l'épidémie de COVID-19 et environ 200 en mars 2021.

des symptômes variés (mal de tête, diarrhée, fatigue, maux de gorge, perte du goût et d'odorat), mais nombreux sont ceux qui mentionnent les difficultés à respirer, l'atteinte des poumons et la fièvre. Il est à noter que ces symptômes décrivent ceux des variants en circulation lors de notre enquête.

Toutes les personnes enquêtées ont mentionné la peur d'attraper la COVID-19, perçue comme une maladie grave et dangereuse, qu'on ne peut pas soigner à domicile et qui nécessite la consultation d'un médecin. Quelques PvVIH enquêtées ont évoqué des doutes sur la réelle existence de la COVID-19. D'autres affirment avoir cru en l'existence de la maladie lorsqu'ils ont vu circuler les nombreux cortèges funéraires.

En tant que personnes vivant avec le VIH, les femmes et les hommes enquêtés se sentent particulièrement vulnérables face à la COVID-19, plus vulnérables que les personnes non infectées par le VIH.

En tant que personnes vivant avec le VIH, les femmes et les hommes enquêtés se sentent particulièrement vulnérables face à la COVID-19, plus vulnérables que les personnes non infectées par le VIH. De ce fait, tous ont mis en place de mesures de protection et de prévention drastiques. Ces mesures visent d'une part à éviter le contact avec le virus, elles visent d'autre part à renforcer le corps et lui permettre de se défendre contre le virus. L'évitement du contact avec le virus passe notamment par la limitation des contacts avec l'extérieur, l'évitement des lieux de soins, le lavage ou la désinfection de tous les accessoires, vêtements et objets amenés à être en contact avec l'extérieur, leur séchage au soleil, le fait de ne pas manger à l'extérieur du domicile, de se laver

au retour à la maison, de respecter les « gestes barrières » (port du « cache-bouche », désinfection des mains...), et éventuellement de se protéger les yeux et les oreilles lors des sorties. Les mesures visant à rendre le corps plus fort pour le protéger de la COVID-19 consistent à inhaler quotidiennement des infusions à base de plantes ou d'huiles essentielles (eucalyptus, laurier, mandravasarotra, feuilles d'oranger et de papayer...) et de boire des thés, au citron notamment, à ingérer de la vitamine C, du gingembre, des sirops produits par des firmes malgaches. Quelques personnes ont mentionné avoir pris du Covid Organics ou CVO, le traitement préventif et curatif à base d'Artémisinine promu par le gouvernement malgache et élaboré par l'Institut Malgache de Recherches Appliquées (IMRA). Quelques personnes affirment cependant ne pas prendre de CVO du fait de leur infection par le VIH car elles craignent les interactions médicamenteuses et les effets que pourraient avoir le CVO sur leur état de santé. De ce fait, elles refusent de prendre des médicaments autres que ceux prescrits par le médecin qui les suit pour le VIH. La prière est également citée par plusieurs enquêtés en guise de demande de protection contre la COVID-19.

Se sentant particulièrement vulnérables face à la COVID-19 du fait de leur infection par le VIH, toutes les PvVIH enquêtées ont souligné l'importance de maintenir le traitement antirétroviral pour le VIH. Quatre enquêtés se sentent même protégés de la COVID-19 par leur traitement ARV. Par exemple, un homme affirme que les ARV l'ont protégé de la COVID-19 car « il n'a pas eu la maladie alors que quatre personnes de son foyer l'ont eue ».

Entre le risque d'interrompre son traitement et la peur d'attraper la COVID-19

Maintenir le traitement ARV, habituellement délivré mensuellement, dans un contexte

de crainte de la COVID-19, de confinement total ou partiel, de stigmatisation des PvVIH, de perte de revenus ou de diminution du pouvoir d'achat (pour une grande partie des enquêtés) constitue un véritable défi. Pour les PvVIH, se rendre à l'hôpital ou dans un centre de santé est problématique, à un moment où les lieux de soins sont considérés comme des espaces à éviter du fait de leur fréquentation par des patient.es atteint.es de COVID-19. Ainsi, en raison de cette perception accrue d'exposition au risque d'être atteint par la Covid 19, toutes les PvVIH enquêtées ont affirmé s'être rendues le moins souvent possible à l'hôpital durant cette période ou dans le centre de santé où elles sont prises en charge pour le VIH. La majorité ont interrompu les examens de suivi de la charge virale. Les professionnels enquêtés ont ainsi constaté une diminution de la fréquentation des centres de santé.

Cependant, en dépit des difficultés rencontrées et des contraintes liées à l'évitement des contacts potentiels avec le virus de la COVID-19, toutes les PvVIH enquêtées se sont organisées pour récupérer leur traitement ARV et ne pas interrompre leur prise médicamenteuse. Si quelques-unes ont pu bénéficier d'un approvisionnement des médicaments par l'intermédiaire de médiateurs associatifs, la majorité des PvVIH enquêtées se sont cependant rendues dans leur centre de prise en charge du VIH, ou y ont envoyé un proche (conjoint, sœur), pour récupérer leur traitement : la plupart se sont déplacées à pied, même lorsque le centre de santé était situé à plus de 20 kilomètres du domicile, d'autres ont pu prendre un taxi, un taxi-moto, un vélo. Plusieurs personnes ont mentionné l'étonnement de leurs proches de les voir sortir en plein confinement, auprès desquels elles ont dû prétexter devoir sortir pour une raison ou une autre (récupérer des documents ou aller chez un ami par exemple). D'autres ont évoqué avoir dû franchir des barrages mis en

place par les autorités, elles ont alors mentionné devoir aller à l'hôpital pour récupérer un traitement médical. D'autres ont emprunté des ruelles afin d'éviter les barrages. A ce sujet, certaines PvVIH ont déploré l'absence de mise en place d'autorisation spéciales destinées aux personnes vivant avec une maladie chronique, permettant leur circulation vers les centres de santé. Plusieurs personnes ne se sont pas déplacées, par peur du risque encouru. Elles ont demandé à un proche informé de leur pathologie de récupérer, de manière exceptionnelle, leur traitement pour elles. Plusieurs personnes ont mentionné la peur de se rendre dans le service de maladies infectieuses de l'hôpital où elles étaient suivies car ce service était désormais dédié aux cas de COVID-19. Elles ont été rassurées de pouvoir récupérer leurs traitements dans le bureau des assistantes sociales du service, ce qui leur épargnait de se rendre dans le bâtiment où elles se seraient mêlées à des patient.es atteint.es de COVID-19 (ou de récupérer leur traitement à l'extérieur du bâtiment, comme cela a été proposé dans un premier temps). En dépit des ressources mobilisées, de l'arrangement avec les contraintes, de l'adaptation des pratiques professionnelles, quelques « ratés » ont été mentionnés. Notamment cet homme qui a parcouru 20 km à pied pour se rendre au centre de prise en charge du VIH pour récupérer son traitement et qui a trouvé porte close. Il n'avait pas été informé que ce centre était fermé et a dû revenir pour récupérer son traitement.

La mobilisation des acteurs associatifs

Dès l'arrivée de la COVID-19 à Madagascar, les membres des associations de PvVIH se sont sentis concernés par cette nouvelle épidémie. Malgré le sentiment de vulnérabilité et la peur d'avoir la COVID-19 pour les acteurs et actrices associatifs – la grande partie étant des PvVIH – ces derniers ont continué à s'investir comme ils le pouvaient

auprès des associations et des usager.es pour poursuivre le soutien psychosocial. Toutes leurs activités ont cependant été impactées par la pandémie : sensibilisation sur le terrain, activités de prévention, groupes de partage d'expérience, aide individuelle dans le suivi médical, soutien psychosocial. Si les autorités publiques n'ont pas fait appel aux associations pour lutter contre la COVID-19 dans le cadre de leurs activités de suivi et prise en charge des PvVIH, ces dernières se sont mobilisées de leur propre initiative. Malgré le manque de moyens, surtout financiers, et les difficultés face à la situation exceptionnelle liée aux mesures de prévention contre la COVID-19, les associations se sont réorganisées pour répondre à un enjeu principal : maintenir les liens avec les usagers et usagères, assurer la continuité des services de soutien psychosocial et contribuer au maintien de l'accès au traitement ARV.

Si les associations communautaires avaient recours auparavant aux réseaux sociaux pour diffuser des informations sur leurs activités et sur le VIH, la COVID-19 a été une occasion de développer davantage cet outil pour maintenir l'accompagnement individuel et le soutien psychosocial, par exemple avec la création de groupe privé Facebook ou encore de discussions privées sur Messenger et Whatsapp. Avant l'arrivée de la COVID-19, l'utilisation des réseaux sociaux dans le cadre de la lutte contre le VIH était une stratégie utilisée par certaines organisations communautaires permettant de parler du dépistage du VIH et d'améliorer les taux de rétention dans les soins des PvVIH (Musheke *et al.*, 2013 ; Roura *et al.*, 2009). En plus de se mobiliser pour le VIH, les associations de soutien aux PvVIH ont réorienté certaines de leurs activités vers des stratégies de lutte contre la COVID-19 notamment avec la sensibilisation aux gestes barrières, la distribution de masques ou de gel hydro-alcoolique, l'aide alimentaire et la communication sur les moyens de se protéger de la COVID-19. Les

médiateurs associatifs ont joué un rôle très important en assurant la médiation entre médecins référents et certain.es patient.es qui ne pouvaient pas se déplacer et en leur apportant les médicaments ARV près de leur domicile de manière confidentielle. Cette fonction de médiation, qui existait déjà avant la pandémie pour les personnes travaillant en zone franche ou les personnes célèbres par exemple, a été renforcée lors de la crise sanitaire.



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Conclusion

La crise sanitaire révèle les tensions préexistantes autour de la prise en charge des personnes vivant avec le VIH ainsi que les opportunités et ressources développées par les acteurs et actrices du VIH pour gérer le suivi médical des patient.es. Elle met en évidence combien le poids du secret autour du VIH constitue un obstacle pour accéder aux soins et au traitement, particulièrement en contexte épidémique. L'étude met aussi en évidence les pratiques routinières développées par les PvVIH pour gérer ce secret. Les stratégies mises en œuvre par les PvVIH révèlent les compétences qu'elles ont acquises en matière de négociation avec les contraintes liées à la chronicité du VIH et aux dimensions sociales de leur maladie, notamment le poids du secret. La gestion discrète de leur médication et de leurs déplacements à l'hôpital ou dans les lieux de prise en charge du VIH, et la mobilisation des liens de confiance avec certaines personnes proches informées de leur pathologie et avec le personnel médical et associatif leur ont permis de maintenir leur traitement médical.

L'étude souligne par ailleurs l'importance et le renforcement de la confiance des patient.es envers les professionnels de santé, sans laquelle il leur est impossible de maintenir leur traitement. L'étude montre ainsi que pour une partie des patient.es, la crise sanitaire a renforcé la confiance et l'observance envers les ARV. Ce résultat est particulièrement important, dans un contexte où la honte associée au fait de prendre des ARV est particulièrement marquée (Raberahona *et al.*, 2019). Cependant, la crise sanitaire a aussi entraîné, pour d'autres patient.es, un éloignement des soins et une rupture de suivi médical, comme dans d'autres contextes (Sun *et al.*, 2021). Si la pandémie de COVID-19 a ouvert la voie à une reconfiguration des dimensions relationnelles du soin, au renforcement du rôle des associations communautaires, et

à une modification du rapport à la maladie et aux soins pour les PvVIH, se pose en creux la question des patients « perdus de vue », qui restent injoignables et ne sont plus suivis depuis le début de l'épidémie de COVID-19.

A partir de ces résultats, des pistes de recommandations émergent, elles serviront de base aux activités de transfert des connaissances résultant du projet. Ces recommandations seront construites dans une démarche participative avec les acteurs et institutions impliqués dans le suivi des PvVIH à Madagascar. De nombreux travaux ont montré les apports d'une approche communautaire pour améliorer la prévention, le dépistage et la prise en charge des malades dans le contexte des épidémies de VIH/sida, d'Ebola ou de COVID-19 (Carillon *et al.*, 2021 ; Rhodes et Sy, 2020 ; Wilkinson *et al.*, 2017). Une première piste de recommandations concerne la prise en compte des savoirs et des compétences des PvVIH et des acteurs communautaires dans la réponse aux épidémies. Une deuxième piste porte sur l'élaboration d'un guide pratique de gestion de la distribution des médicaments ARV en contexte épidémique (comment prendre contact avec les patient.es, où leur donner rendez-vous pour préserver la confidentialité, combien de boîtes de médicaments distribuer...). Une troisième piste s'oriente sur le maintien des liens entre les PvVIH et les services de prise en charge et la formulation de messages rassurants pour faciliter leur recours aux structures de santé, même en contexte épidémique, et éviter ainsi les patient.es perdus de vue. Une quatrième piste vise à favoriser la démocratisation de la connaissance du VIH dans la population générale et sur l'efficacité des ARV, dans l'objectif de diminuer les discriminations et stigmatisations envers les PvVIH et d'augmenter l'accès au dépistage dans l'ensemble de la population.

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1.3. COVID-19 in Cuba: A look into sociodemographic differentials among young people

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Abstract

The purpose of demography is to study the composition and dynamics of the population, as well as the social, environmental and economic factors that determine it. This creates a specific context, which affects the configuration of the characteristics of the pandemic. The composition of the population is an important component in the analysis of the pandemic. Three categories of elements play a fundamental role: population size, density and urbanization; sex and age distribution; and co-residence patterns and intergenerational relationships. This article addresses distribution by sex and age and behaviour in the evolution of COVID-19 in Cuba, with a particular look at young populations aged between 15 and 29 years in the period between 11 March 2020 (date of the first confirmed cases in the country) and December 2021.

Introduction

The purpose of demography is to study the composition and dynamics of the population, as well as the social, environmental, and economic factors that determine it. This creates a specific context, which affects the configuration of the characteristics of the pandemic. The composition

of the population is an important component in the analysis of the pandemic. Three of its elements play a fundamental role: population size, density and urbanization; sex and age distribution; and patterns of co-residence and intergenerational relationships. This study examines the results of the research project 'Sociodemographic Characterization of the Cuban population affected by COVID-19' conducted by the Centre for Demographic Studies of the University of Havana (CEDEM). A descriptive study is presented in which distribution by sex and age is analysed to understand its behaviour in the evolution of COVID-19 in Cuba. It also takes into consideration co-residence and source of contagion: intradomicile or out-of-home contagion, particularly among young people aged between 15 and 29 years old. The information collected covers the period from 11 March 2020 (date of the first confirmed cases in the country) to 31 December 2021. The sources of information used are officially recognized, for instance, the COVID-19 Cuba database of the Ministry of Public Health of Cuba (MINSAP) and 2020 Cuban population data from the National Office of Statistics and Information (ONEI). Descriptive statistics were used.

There are different approaches to defining age groups, for instance biological, psychological, sociological and demographic, among others. There are also different dimensions: evolutionary, epidemiological, generational, cultural, economic and so on. Establishing the limits for the periodization of human development has not been easy and criteria are usually adopted depending on the sciences of knowledge, situation, and the structural and cultural conditions of societies. However, there is a consensus on the existence of different stages, beyond the limits that define them. From here, the age of childhood or infancy is identified (COVID-19 assumes the concept of a paediatric age for infants of 0–18 years old, designated by UNICEF in the International Convention on the Rights of Children in 1989), followed by adolescence, youth, middle adulthood and old age. These distinctions raise the question of how to define the age of youth.

The use of age to define youth experiences involves some flexibility with differences between countries. Different intervals are assumed, even among the countries of Latin America. Within the framework of the Ibero-American Youth Organization (OIJ), the range of 14–30 years of age has been accepted by consensus, with three subgroups distinguished: early youth (14–17 years), middle youth (18–24 years), and mature or late youth (25–30 years) (CEDEM, 2016). The simplest criterion to identify the youth population is age (Cepal, 2000), since its measurement does not entail major reliability problems and age is a variable investigated by most of the available sources of periodic data collection. The upper limit of youth is identified with the moment when individuals reach – in different specific circumstances and at different rates in each particular sphere – the end of the formal education cycle, facing entry into the labour market and the formation of a household of their own, thus becoming adults (Cepal, 2000).

An experience important aspect that psychology contributes to the periodization of psychological development, from the cultural-historical approach, is the concept of psychological age, where it is necessary to understand development as a process that neither occurs automatically, nor is fatally determined by the maturation of the organism (Domínguez, 2003). This concept contributes to the understanding of behaviour, although there is not always a correspondence between chronological age and psychological age. The social situation of the development of young people is determined by the unique relationship between their internal conditions, biological and previous level of psychological development, and the external conditions in which they develop their communication system and in the fundamental activity they develop, study and/or work, or other tasks assumed by some young people at this stage of life, such as the formation of a family.

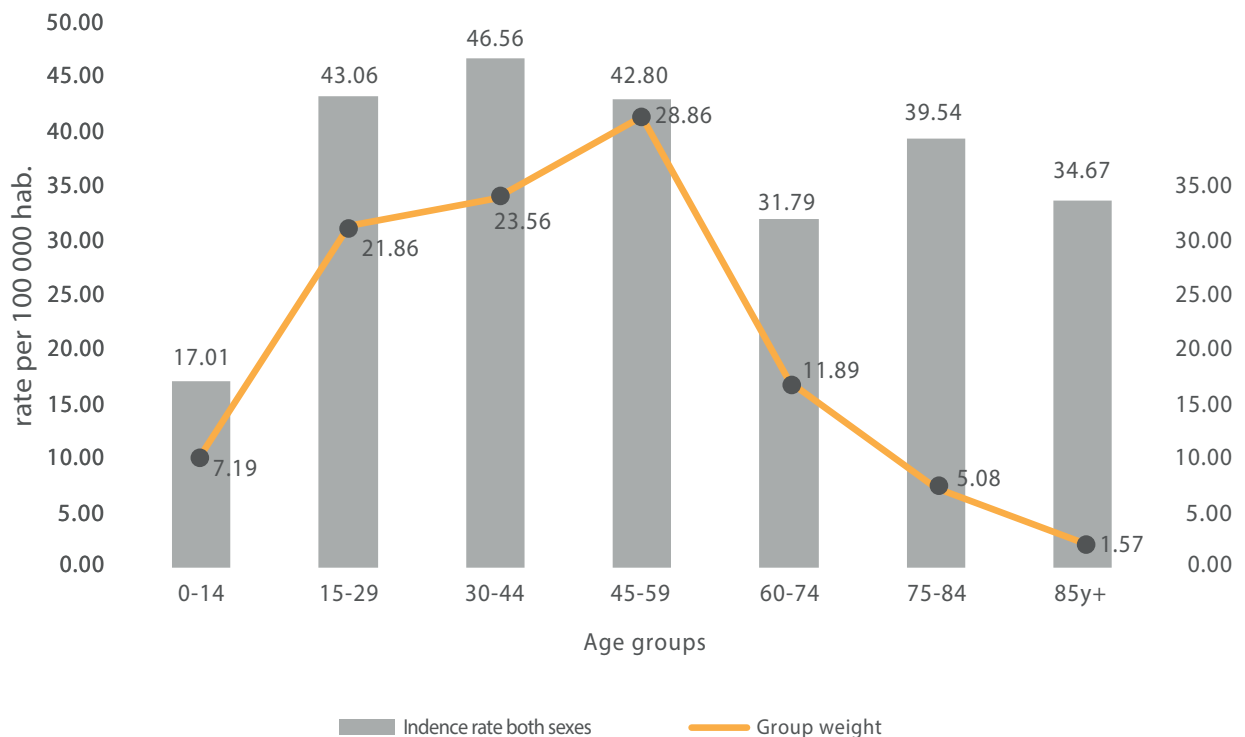
As a result of this unique relationship, new psychological components arise pertaining to each stage of their development. Self-valuation with its self-regulating function is the most important psychological formation component during the first period of youth (15–19 years). At the end of this age (20–24 years, also extended to 25–29 years), young people should have acquired a subjective conception of the world, which together with other psychological units place the young person in a new social situation.

Taking these reflections into account, the study identifies youth as a population group covering the ages 15–29 years old, with three subgroups: 15–19, 20–24 and 25–29 years old. This reflects a standard demographic division for data analysis whereby ages are subdivided into groups of five years starting from 0. However, the analysis takes into account the social heterogeneity of each group and the individual differences that may mediate individual and group behaviours in demographic contexts.

In analysis of the COVID-19 pandemic, youth as a social group has a fundamental weight due to the particularities of each young person and the tasks and behaviours assumed according to their development context.

In analysis of the COVID-19 pandemic, youth as a social group has a fundamental weight due to the particularities of each young person and the tasks and behaviours assumed according to their development context. The change in the profile of cases worldwide was confirmed by data and health authorities and disclosed in newspaper articles following the behaviour of this contagious and persistent disease. 'The pandemic is changing ... And people in their 20s, 30s and 40s are now more frequently driving the spread... Many of them without knowing they are infected', stated Takeshi Kasai, regional director for the Western Pacific of the World Health Organization (WHO) (BBC News Mundo, 2020). According to the Carlos III Health Institute since 10 May 2020, the age group with the highest number of people affected in Spain was concentrated between 15 and 29 years of age. This was followed closely by the population between 40 and 49 years of age, and between 30 and 39 years of age (Pozo, 2020). Cuba was no exception.

Figure 1. COVID-19 incidence rate and distribution of groups according to relative frequency (11 March –2 September 2020) (rate per 100,000 population age group)



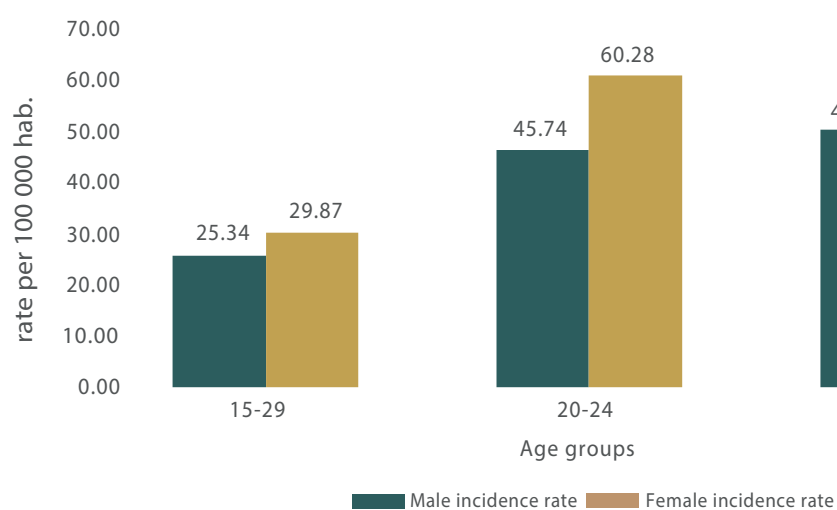
Source: Molina (2020) from COVID-19 Cuba Data and ONEI population data, 2020.

The first six months of COVID-19 in Cuba

When analysing the incidence rates of among population groups, the data show that from the onset of the disease on 11 March until 2 September 2020, the group with the highest incidence rate was aged 30–44 years old, followed by young people aged 15–29 years old and, in third place, those aged 45–59 years old (Figure 1). The incidence rate for the 15–29 age group was approximately 43 per 100,000 (i.e. 43 young people became ill per 100,000). Overall, 28.86 per cent of individuals who contracted COVID-19 belong to the 45–59 age group, 23.56 per cent belong to the 30–44 age group and a proportion close to one-fifth (21.86 per cent) to the 15–29 age group. The prevalence of infections among the younger age group was already evident at this date, with the pandemic shifting to the under-60 age group.



Figure 2. COVID-19 incidence rate by sex in the 15-to-29-year age groups (11 March – 2 September 2020) (rate per 100,000 population of the age group)



Source: Molina (2020) from COVID-19 Cuba Data and population data from ONEI, 2020.

Regarding sex, among the groups aged 15–29, 45–59 and over 85, women were the most infected. There may be several hypotheses to explain this behaviour, among them, the stereotyped and patriarchal roles assumed by women in the care of children and the elderly, and the increase in the number of female heads of household, all of which implies greater mobility in the search for food and other means and resources for care.

Regarding sex, among the groups aged 15–29, 45–59 and over 85, women were the most infected. There may be several hypotheses to explain this behaviour, among them, the stereotyped and patriarchal roles assumed by women in the care of children and the elderly, and the increase in the number of female heads of household, all of which implies greater mobility in the search for food and other means and resources for care. Another possible hypothesis relates to the high participation of women in tasks

related to essential sectors, which entails mobility and systematic contact with other people. Finally, as Cuba is a matricentric society, women are central points of contact, and thus an important vector of transmission for the virus. Only a study with a gender approach can reveal the accuracy of these hypotheses or reveal others. Such an analysis would be interesting, based on other indicators of the behaviour of women and men when facing this disease. Among the group of 15–29-year-olds, young people aged 20–24 years contributed most to the spread of this disease, followed by those aged 25–29 years and, lastly, those aged 15–19 years (Figure 2).

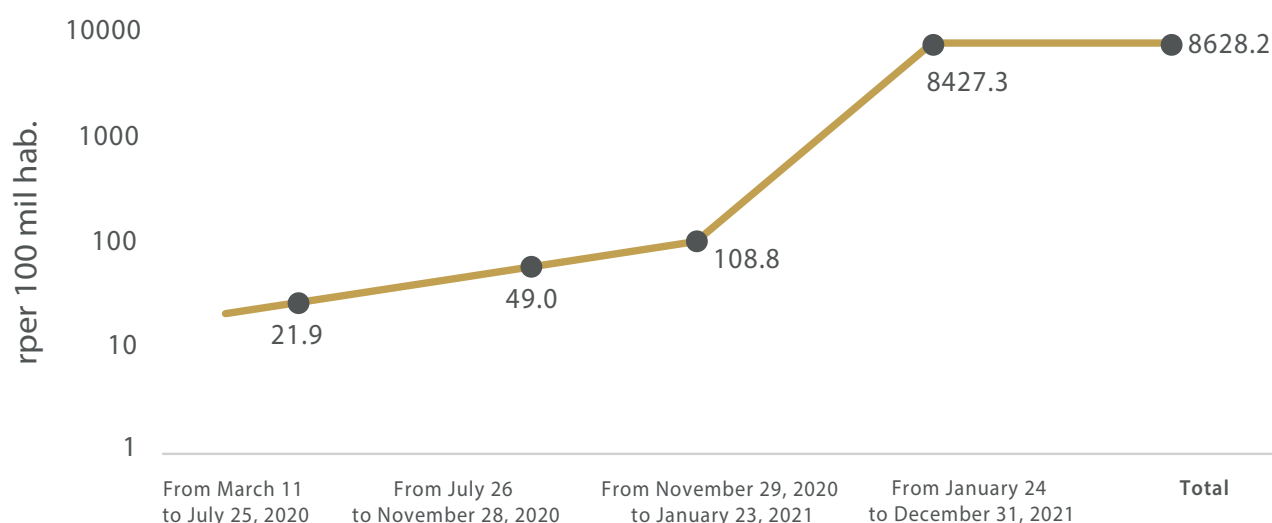
When analysing the incidence rates of among population groups, the data show that from the onset of the disease on 11 March until 2 September 2020, the group with the highest incidence rate was aged 30–44 years old

Evolution of the pandemic in Cuba and its expression in youth

Between 11 March 2020 and 31 May 2021, 135,773 patients with COVID-19 were diagnosed in Cuba, with autochthonous sources of transmission, rising to 964,772 confirmed cases by the end of 2021. There was a sustained increase in incidence rates over time, corresponding to the different stages through which COVID-19 passed in Cuba. Some 97.7 per cent of the weight of the incidence rate is concentrated in the last stage, from 24 January to 31 December 2021 (Figure 3).

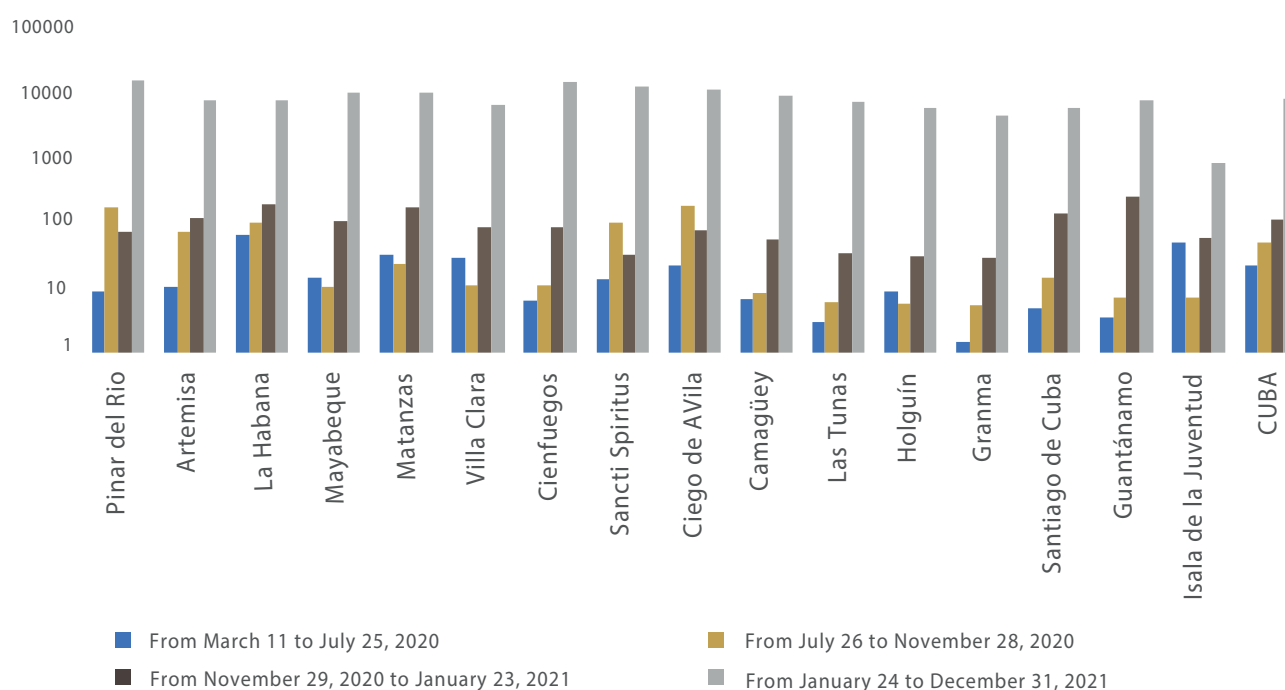
In all provinces, the highest numbers were reported in the last period of the study, with a similar trend, unlike previous periods. The provinces of Pinar del Río, Cienfuegos, Sancti Spiritus and Ciego de Avila stand out with an incidence rate above 10,000 cases per 100,000 inhabitants (Figure 4).

Figure 3. COVID-19 incidence rate by period of evolution in Cuba (per 100,000 inhabitants), 11 March 2020 to 31 December 2021

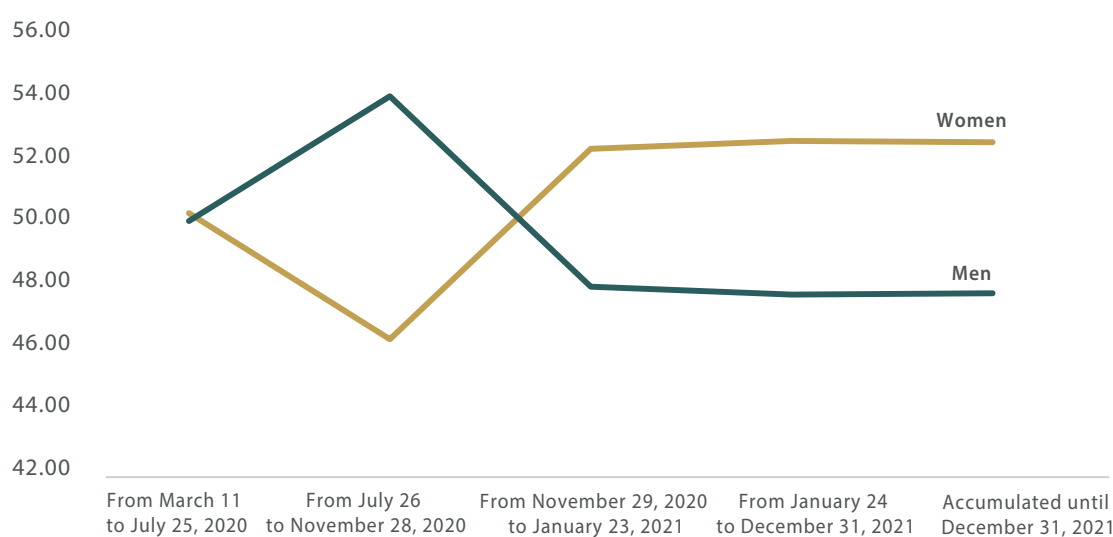


Source: Authors' own elaboration according to calculations elaborated from the COVID-19 database of the Ministry of Public Health of Cuba, updated to 31 December 2021, and from the ONEI Interface, 2020.

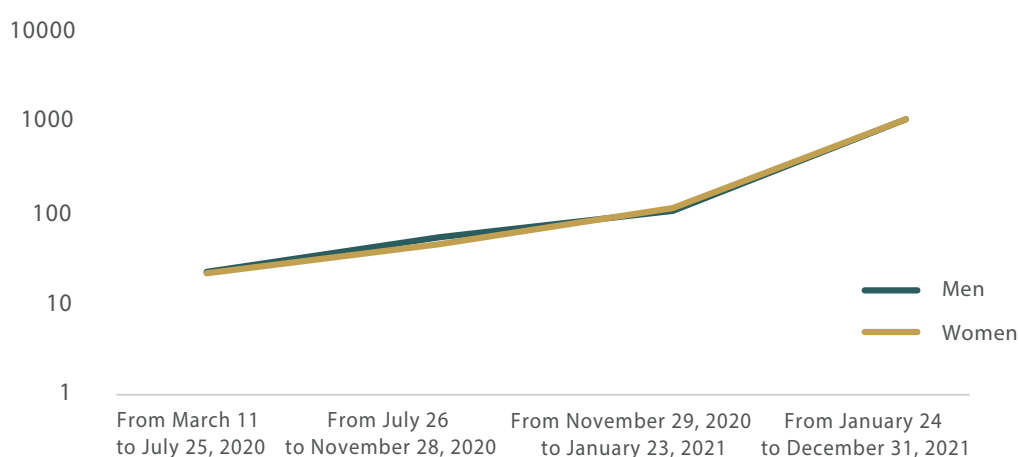
Figure 4. Incidence rates by province according to COVID-19 periods (11 March 2020 to 31 December 2021, per 100,000 inhabitants)



Source: Authors' own elaboration based on the COVID-19 database of the Ministry of Public Health of Cuba, updated to 31 December 2021, and ONEI Interface, 2020.

Figure 5. Distribution by sex according to period of COVID-19 in Cuba (%)

Source: Authors' own elaboration based on the COVID-19 database of the Ministry of Public Health of Cuba, updated to 31 December 2021, and ONEI Interface, 2020.

Figure 6. Cuba: Incidence rates of confirmed cases of COVID-19 by sex (per 100,000 population, March 2020–December 2021)

Source: Authors' own elaboration based on the COVID-19 database of the Ministry of Public Health of Cuba, updated to 31 December 2021, and ONEI Interface, 2020.

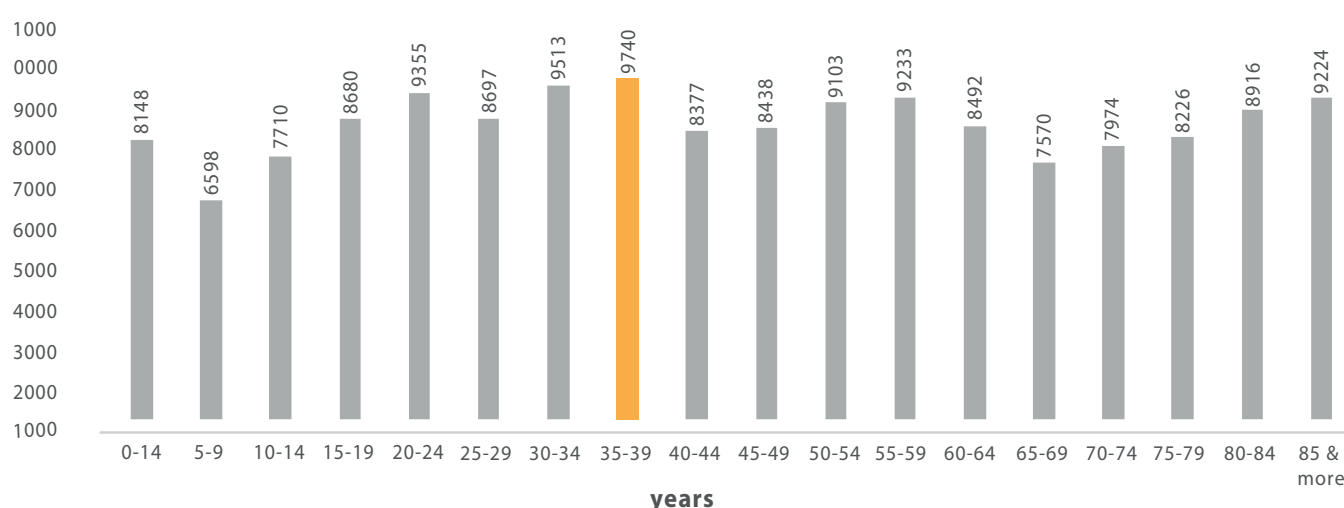
The incidence of confirmed COVID-19 cases in Cuba oscillated in terms of sex, with the final trend showing a predominance of cases among women (Figure 5). In the period from 26 July to 28 November 2020, males reported more contagions than women, while in the following period – from 29 November 2020 to 23 January 2021 – more women than men were infected. This behaviour continued until 31 December 2021 and as a general trend

in the cumulative incidence rate. This trend differs from that found in data reported at the international level, which generally report more cases of men with the disease.

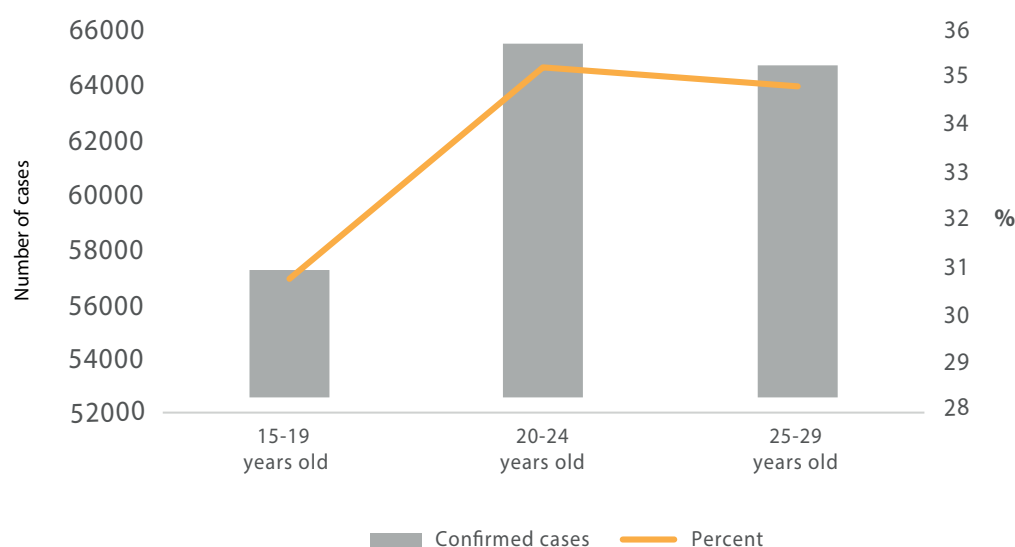
Incidence rates by sex do not report high differences between men and women, although the incidence of women is noticeable, except in the second period (Figure 6).

A high incidence rate is observed across all age groups, though the 20–24, 30–34 and 35–39 age groups stand out. The group with the lowest incidence is that of children aged 5–9 years. (Figure 7).

From 11 March 2020 through 31 December 2021, Cuba reported an incidence rate of 8,628 per 100,000 population. Some 185,960 young people between the ages of 15 and

Figure 7. Cuba: Incidence rates by age group (per 100,000 population of age group), March 2020–December 2021

Source: Authors' own elaboration based on the COVID-19 database of the Ministry of Public Health of Cuba, updated to 31 December 2021, and ONEI Interface, 2020.

Figure 8. Confirmed cases and percent of age group (11 March – 31 December 2021)

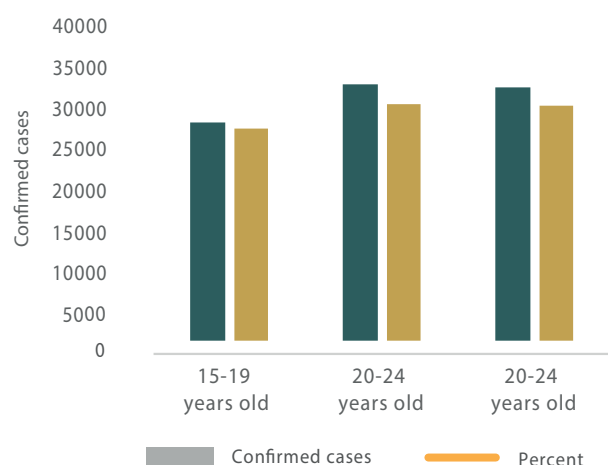
Source: Authors' own elaboration based on the COVID-19 database of the Ministry of Public Health of Cuba, updated to 31 December 2021, and ONEI Interface, 2020.

29 years were infected, equivalent to an incidence rate of 8,910 per 100,000 people. The subgroup aged 20–24 years had the highest incidence rate (9,355 per 100,000) and the highest percentage of young people infected by COVID-19 (Figure 8).

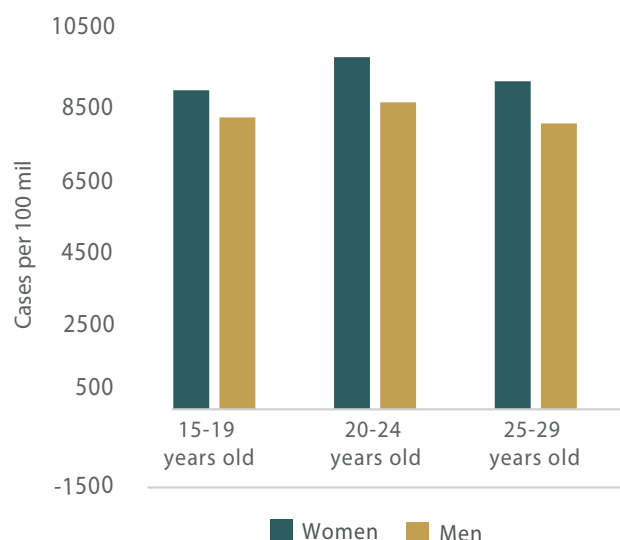
The virus does not respect age and its severity depends largely on the immune system of each person, as well other comorbidities that the

individual may present, and which in the future may compromise the favourable evolution of the disease. Thus, the high numbers of asymptomatic young people underline the importance of rigorous epidemiological and sanitary measures, since this group can inadvertently infect other people in their family while remaining unaware of the fact. The incidence rates of COVID-19 in the age groups

of young people show a relative balance between both sexes, with an increase in women. In other words, more women than men have been infected per 100,000 inhabitants in the three subgroups: 15–19 years, 20–24 years and 25–29 years (Figure 9 and Figure 10).

Figure 9. Total number of young people infected by COVID-19 according to sex

Source: Authors' own elaboration based on the COVID-19 database of the Ministry of Public Health of Cuba, updated to 31 December 2021, and ONEI Interface, 2020.

Figure 10. Incidence rate according to gender variable

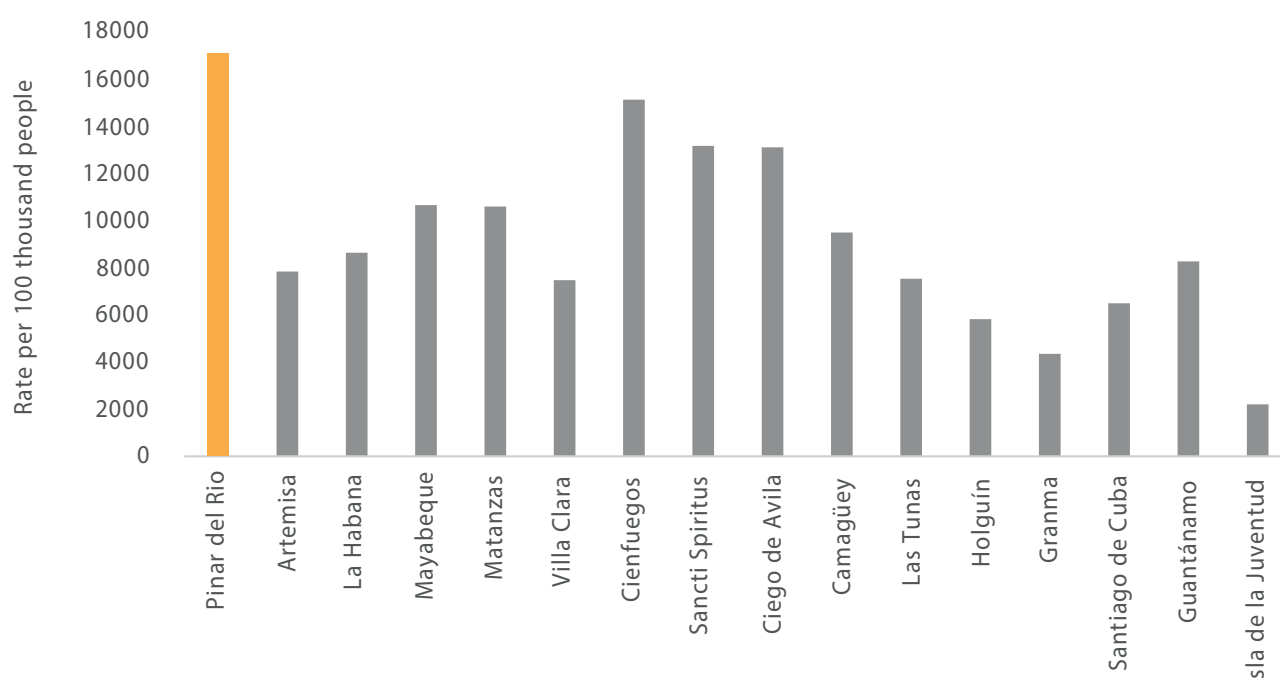
Source: Authors' own elaboration based on the COVID-19 database of the Ministry of Public Health of Cuba, updated to 31 December 2021, and ONEI Interface, 2020.



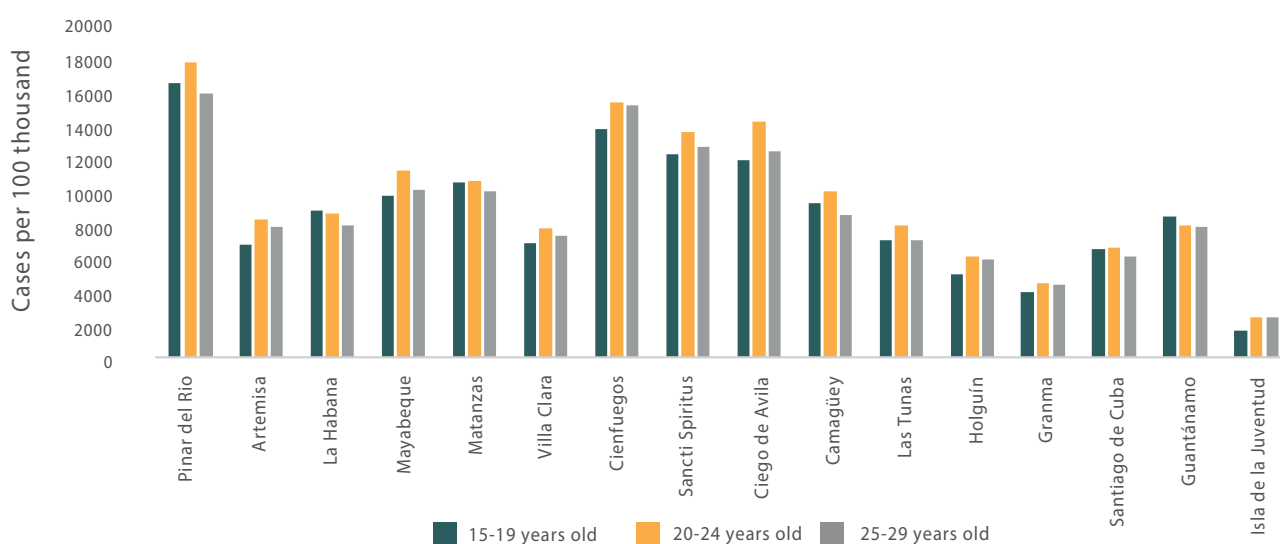
The increased presence of women infected by COVID-19 among the group of young people, and particularly in the group aged 20–24 years, is noteworthy. An in-depth study from a gender and intersectional perspective could contribute to the understanding of this phenomenon: who they are, what level of schooling they have, what their social insertion is, whether they study or work, their skin colour, marital status, socioeconomic conditions, patterns of family and work co-residence and how some characteristics intersect with others. A study¹⁴ conducted in Latin America and the Caribbean found similar results: 45 per cent of young people report an increased burden of unpaid domestic and care work. For many young people, particularly young women and those in the 20–24 age bracket, the burden of unpaid domestic and care work has increased. The province that reports the highest incidence rate in Cuba of young people infected by COVID-19 is Pinar del Río, followed by Cienfuegos, Ciego de Avila and Sancti Spiritus, where incidence rates range from 13,000 to 17,000 cases per 100,000 inhabitants aged 15–29.

When analysing provinces according to young age groups, the group aged 20–24 years has the highest incidence rate, with the exception of Havana and Guantanamo where higher rates are found among the group of adolescents (15–19 years) (Figure 12).

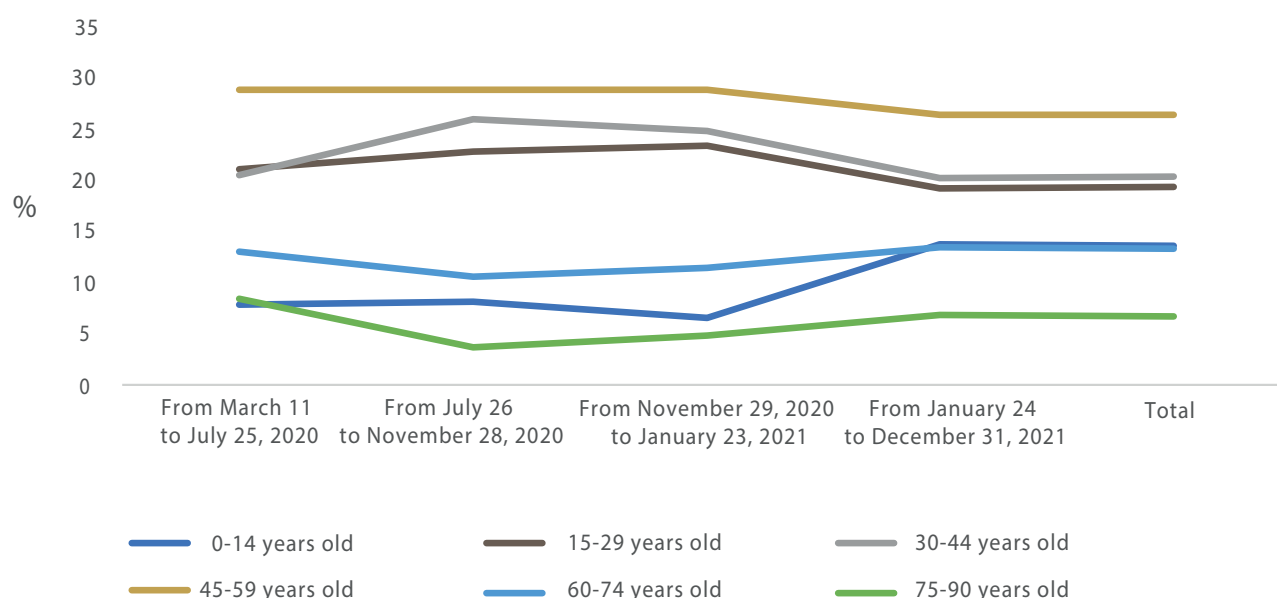
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Figure 11. Incidence rate of young people with COVID-19 according to province of diagnosis

Source: Authors' own elaboration based on the COVID-19 database of the Ministry of Public Health of Cuba, updated until 31 December 2021, and the ONEI Interface, 2020.

Figure 12. Incidence rate of young people with COVID-19 by age group and province of diagnosis

Source: Authors' own elaboration based on the COVID-19 database of the Cuban Ministry of Public Health, updated to 31 December 2021, and ONEI Interface, 2020.

Figure 13. Weight of age groups in each period of COVID-19, Cuba, 11 March 2020 to 31 December 2021

Source: Authors' own elaboration according to calculations elaborated from the COVID-19 database of the Cuban Ministry of Public Health, updated to 31 December 2021.

The prevalence of infections among the different age groups changed throughout the pandemic (Figure 13). Three groups stand out with the highest percentages across the four periods studied: 45–59 years (26.43 per cent), 30–44 years (20.37 per cent) and 15–29 years (19.32 per cent). Prevalence decreased overall during the last stage. Children up to 14 years and people older than 60

years were the groups with the lowest prevalence during the pandemic up to 31 December 2021. However, these groups showed an increase in prevalence during the final period.

Prevalence of infections among younger age groups increased until the third period, when it began to decrease in relation to the total number of confirmed cases in the country. It should be noted that between 29 November 2020 and 23 January 2021, that increase reached approximately 24 per cent of the total. In other words, almost a quarter of confirmed cases in the country belonged to the young age group (15–29 years), an amount that decreased by 5 per cent (19 per cent) during 2021.

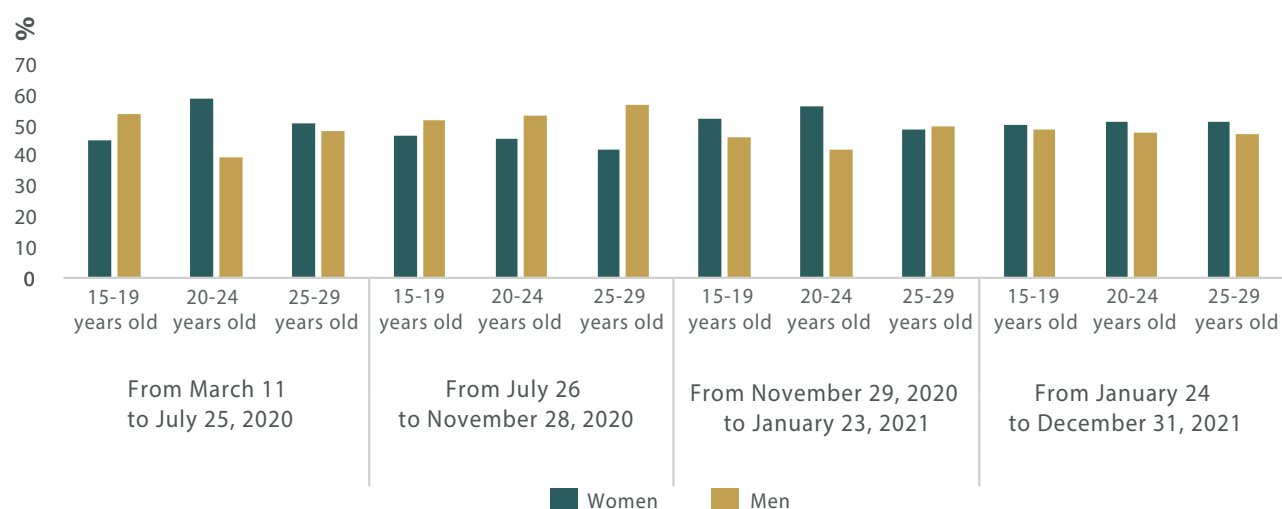
The distribution of confirmed cases in young people by sex differs according to the evolution of COVID-19 in Cuba (Figure 14). A greater distance between the sexes has been observed, except for the last period studied. Females prevail at the beginning of the pandemic and in the third and fourth period of the pandemic (from 29 November 2020 to 23 January 2021 and from 24 January to 31 December

2021), while males account for the majority of cases from 26 July to 28 November 2020.

In summary, the age and sex structure of positive cases in the country approximates the structure of the Cuban population. In the group of young people aged 20–24 years with a positive C-reactive protein (CRP), a prognostic marker in COVID-19 cases, the pyramid widens more than the population pyramid (Figure 15). Differences can be found when performing this analysis at the level of provinces or municipalities.

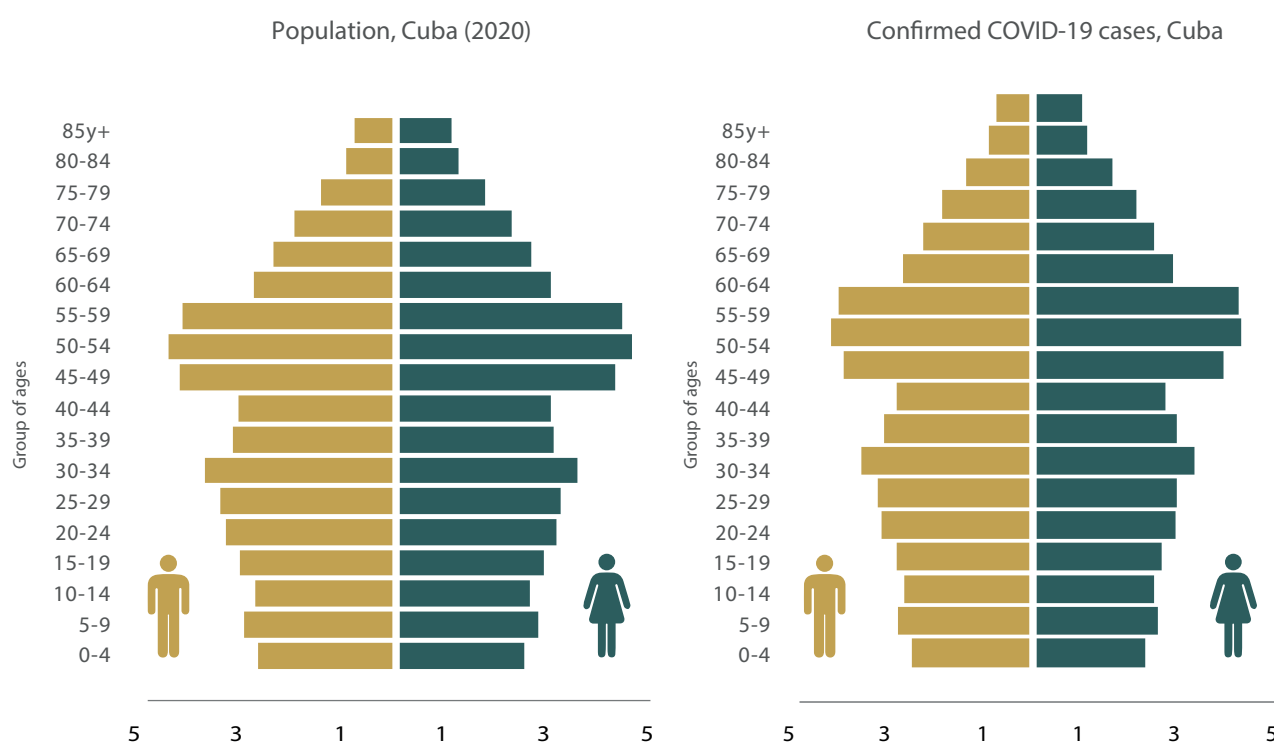


Figure 14. Distribution of cases in young age groups by sex, according to COVID-19 period, Cuba, 11 March 2020 to 31 December 2021 (%)



Source: Authors' own elaboration according to calculations elaborated from the COVID-19 database of the Ministry of Public Health of Cuba, updated until 31 December 2021.

Figure 15. Cuba 2020 population pyramid and COVID-19 confirmed cases pyramid, from 11 March 2020 to 31 December 2021



Source: Authors' own elaboration according to calculations elaborated from the COVID-19 database of the Ministry of Public Health of Cuba, updated until 31 December 2021.

It is important to generate behavioural habits in young people, since they tend to lower their guard, not being considered as a population in a vulnerable condition. In Cuba, young people were protagonists in actions to confront the pandemic. Youth brigades were organized to carry out the most necessary tasks in diverse areas, such as priority productive activities, construction, energy saving activities and health research. They also participated in scientific research related to COVID-19, including work on vaccine candidates, processing of samples for disease diagnosis, mapping, statistics, Android Package Kit (APK) applications for different uses (e.g. virtual screening, elderly care and organizing access to basic necessities), filling hypochlorite bottles to be dispensed in pharmacies and localities, making masks, arranging access to purchase necessities and organizing public transportation, among others (López, 2021). As a result, many young people did not remain at home and were exposed to a greater risk of contagion and illness.

Other research confirms the social participation of young people in addressing this health crisis:

COVID-19 has meant a rupture in the life trajectories of adolescents and young people, forcing them to redesign their practices in different spheres of their daily lives, which are undoubtedly marked by their personal experiences of this period. It has become necessary to rethink other ways of being, feeling, and acting from the youth condition; in many cases they have become protagonists of projects and diverse practices that transcend the individual, and are in function of an entire group and the social tissue. Women and men who, beyond their age, reaffirm their condition as social subjects, with a high capacity for creativity, transformation and resistance (Peñate et al., 2021).

In Latin America and the Caribbean, almost four out of ten young people have participated or led some action in response to COVID-19. The most common actions are online volunteering and making donations to support actions promoted by civil society organizations (United Nations Group for Sustainable Development, 2020).

Peñate *et al.* (2021) also found that, despite the government's call to stay at home, almost all adolescents and young people acknowledged having gone out during the isolation period. The reasons most frequently mentioned were: to buy food and basic necessities, for work, and to visit and help family members in vulnerable conditions. These reasons suggest the assumption of responsibilities that imply certain health risks, but at the same time, commitment to the family and social spheres. Less frequently cited are other reasons such as visits to the doctor for pregnancy or health problems of young children, visits to friends, carrying out various procedures and playing sports, the latter being prohibited during the confinement stage and evidently not complied with.

Another factor that increases contagion among this group of young people is inadequate use of sanitary measures [...] although they use masks and wash their hands properly, it is very difficult for them to maintain a social distance from their friends.

Another factor that increases contagion among this group of young people is inadequate use of sanitary measures. In a study conducted by researchers from Espol (Escuela Superior Politécnica del Litoral, Ecuador), around 500 young people were surveyed, and the results revealed that, although they use masks and wash their hands properly, it is very difficult for them to maintain a social distance from their friends, as this is the environment in which they feel most relaxed and safest (Pauca, 2020).

It experiences also experience important not to generalize experience to blame young people, because this group is very diverse. Instead, the intention should be to raise awareness and call for greater responsibility among those who do not comply with measures established to try to curb the spread of the disease.

An approach to youth and family co-residency

Analysis of co-residence patterns and intergenerational relationships contribute to understanding the transmission and arrest of the virus and provide possible inputs for governmental decision-making. A key nucleus for the analysis of co-residency is the family.

José Miguel Guzmán (2020) points out that the risk of infection and death may increase or decrease depending on the family co-residency arrangement. At the beginning of the pandemic, when people began taking physical distancing measures, adults stayed at home, but children became a vector of transmission of the virus. This is an important element that requires more study, in order to better understand what occurred during the epidemic, as well as the extent to which family arrangements can be a positive or a negative factor in stopping the pandemic.

The same trend was observed in South Korea, where 10,592 household

contacts showed that index patients were aged between 20 and 29 years (32.3 per cent), followed by those aged between 50 and 59 (19.3 per cent), and those aged between 40 and 49 (16.5 per cent). Other international studies have shown that the family member who does not stay at home and works outside the home has a higher risk of exposure to SARS-CoV-2, which may increase the risk of transmission to others in the household.

Research results for the first period of COVID-19 in Cuba (11 March to 25 July 2020) show that families were an important source of contagion, a trend which became noticeable as the pandemic evolved. A study¹⁵ conducted in five municipalities of Havana with 323 families found that more than 55.6 per cent of the families had an average age of less than 39 years, with the presence of adolescents and young people. Analysis of kinship relationships with the primary case indicated that transmission was strongest among children, partners and mothers. Since the beginning of COVID-19 in Cuba until 31 May 2021, more than 66 per cent of young people with a positive PCR test had been infected outside the home, while only 26 per cent had acquired the virus within their homes, but had been transmitters of the virus to other members of the families – mainly mothers, wives and children.

In 2021 (from January to December), intradomiciliary infection decreased among the group of young people (17 per cent) compared to previous periods. This behaviour has particularities by age group: 35.3 per cent of adolescents aged 15–19 were infected at home, decreasing to 33.3 per cent of young people aged 20–24, and 31.4 per cent of young people aged 25–29. As age increases, the source of infection at home decreases

and that outside the home increases, establishing a statistically significant relationship between these variables. This underscores the risk of contagion for young people if they do not comply with sanitary measures.

It is also vitally important to focus on the emotional wellbeing of young people, which includes working with adolescents. For an adolescent or young person, remaining at home in total confinement can have more severe impacts than for an adult, since it is in these stages of development that self-esteem processes are shaped or consolidated and where socialization plays a fundamental role; therefore, social isolation measures can greatly modify their lifestyles.

For some adolescents and young people, living together is perceived as complicated, challenging, difficult, stressful and overwhelming, among other adjectives. The period of confinement generated a rupture in their daily lives. Socialization time, previously shared with other areas of development, such as school, work and recreation, is now reduced to the home and family life. This situation generates high levels of discomfort and tensions, due to the persistence of intergenerational conflicts, failures in communication between the cohabitants, unequal distribution of household chores and transgression of personal spaces, among other issues. Some of these tensions may have been present prior to the beginning of the pandemic, at a lower level visibility. During these periods, relationships with friends and other family members were maintained through social networks or by telephone (Peñate *et al.*, 2021).

A study conducted experience in Argentina on the psychological impact of isolation resulting from COVID-19 (Schneiderman *et al.* 2021), featured the participation of a group of parents of young people from San Carlos Bariloche. The main objective of the study was to evaluate adults' perceptions of the emotional and behavioural impact of isolation on

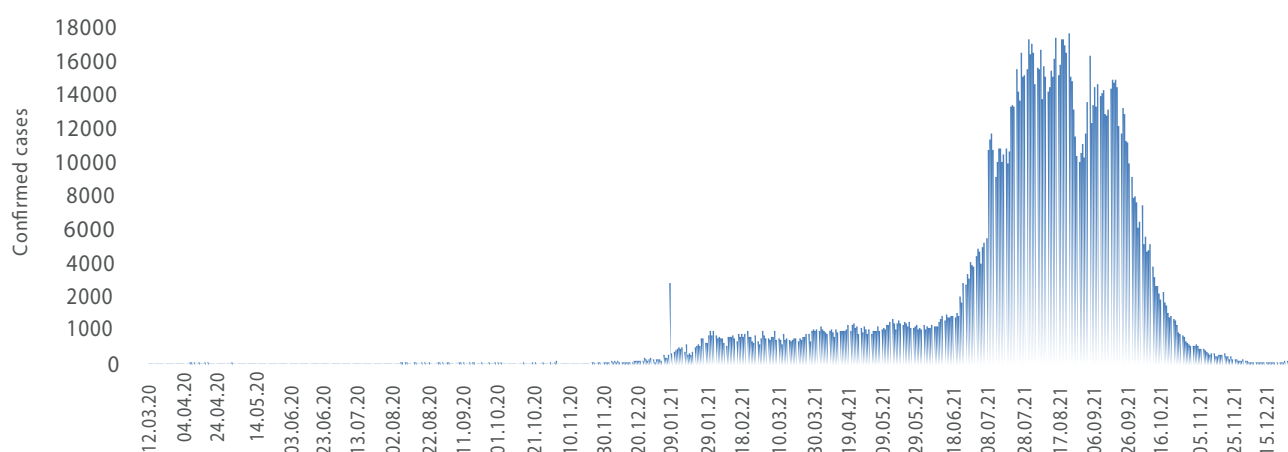
young people, changes in sleep habits, use of screens, sports activities and diet. The main results showed that 96.3 per cent observed emotional and behavioural changes such as: boredom (76.8 per cent), irritability (59.2 per cent), listlessness (56.9 per cent) and anger (54.7 per cent). Changes in sleep schedules were also observed, as the young people went to bed later and slept longer, while mobile phone usage increased.

Daily evolution of COVID-19 in Cuba from 11 March to 31 December 2021

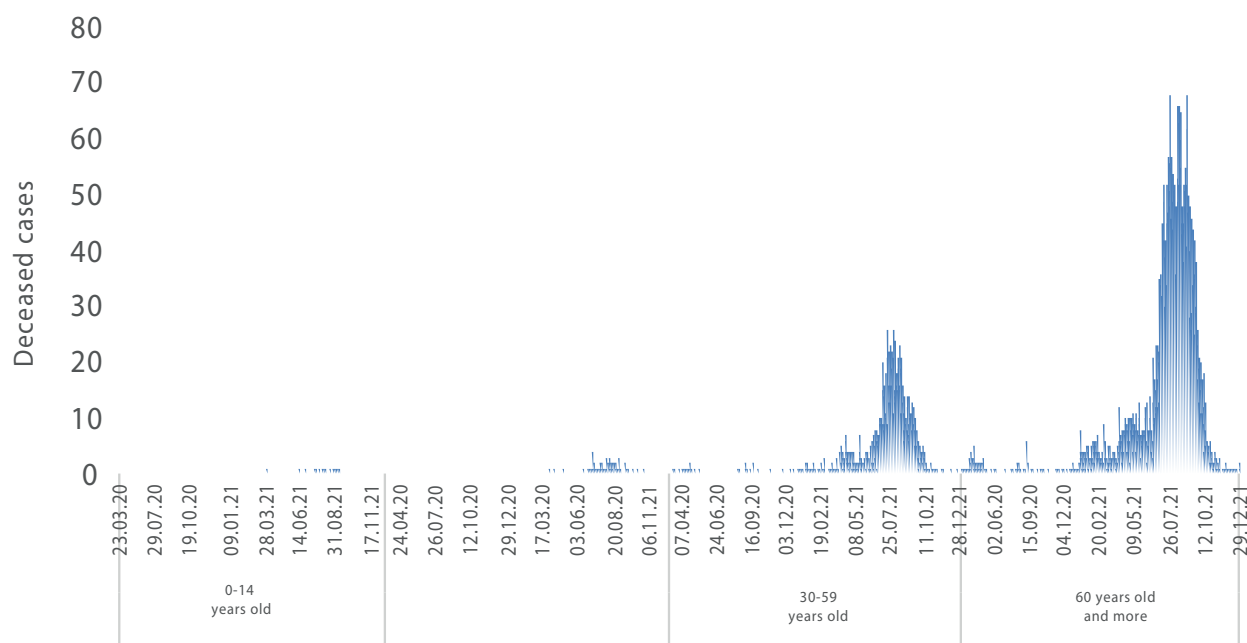
Analysis of the daily evolution of COVID-19 in Cuba shows that during the last period studied, 97 per cent of confirmed cases were identified (January to December 2021). However, this period analysis obscures the sustained decline in confirmed cases and daily deaths in Cuba over the last quarter of 2021. This decrease in cases is related – in addition to the maintenance of sanitary measures (use of masks, hand disinfection at entrance to premises, distancing in closed places, sanitary control at airports and other measures) – with the effectiveness of vaccination.

Cuban sovereignty has made it possible to achieve high coverage among the population of its first three vaccines: Abdala, Soberana 02 and Soberana Plus. The effect is noticeable in the decrease of cases at the end of the 2021 (Figure 16) and the reduction in COVID-19-related deaths (Figure 17).

¹⁵ At the time of publishing, the authors had not supplied the title and authors of this study, but the information contained within was deemed sufficiently useful to leave the text in place.

Figure 16. Confirmed COVID-19 cases in Cuba from 11 March 2021 to 31 December 2021

Source: Authors' own elaboration according to calculations elaborated from the COVID-19 database of the Ministry of Public Health of Cuba, updated to 31 December 2021.

Figure 17. Deaths from COVID-19 in Cuba from 11 March 2021 to 31 December 2021

Source: Authors' own elaboration according to calculations elaborated from the COVID-19 database of the Ministry of Public Health of Cuba, updated to 31 December 2021.



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It should be noted that deaths from COVID-19 decreased across all age groups as time progressed and the effectiveness of the vaccine on the Cuban population became clear. By the end of 2021, 9,672,464 people had been vaccinated with Soberana 02, Soberana Plus and Abdala under the Cuban scheme, a figure that represents 86.5 per cent of the country's population. In addition, MINSAP reported that 2,174,094 people had been vaccinated with booster doses (Cubaminrex-EXPERIENCE, 2022). The first stage of the vaccination scheme targeted the population aged 19 years and older; then once when the vaccine was approved for children, the second stage focused on the population aged from 2 to 18 years of age.

Compared to the global expansion of the Omicron variant, the growth of cases in Cuba has been slower and the slope has been smoother. Forecasts predict a decrease in the pandemic given the high levels of vaccination of the population over 2 years of age (Portal Cuba, 2022), as Cuba vaccinated the paediatric population prior to the entry of the Omicron

variant. A total of 96.6 per cent of the population aged 2–18 years has been vaccinated, resulting in a decrease in the number of cases. With this level of vaccination, Cuba ranks first in Latin America and second in the world in terms of immunization against the infection, surpassed only globally by the United Arab Emirates, according to the digital site Our World in Data (Granma, 2021a, 2020b; MINSAP, 2021a, 2021b).

Conclusion

It is essential to take into account current demographic dynamics and the composition and structure of the population when making decisions to confront the COVID-19 pandemic.

The sociodemographic analysis of COVID-19 in Cuba, up to 31 December 2021, shows that:

- The age and sex structure of positive cases in the country replicates the structure of the Cuban population, but differences become apparent when this analysis is performed at the level of provinces or municipalities. Among the group of young people aged 20–24 years

and 25–29 years with positive CRP, the pyramid of confirmed cases is greater than population pyramid.

- The highest incidence rates by age group are concentrated in the 20–24 and 25–29 age groups.
- Incidence rates by sex show female superiority in the cumulative total up to December 2021, although oscillations have been observed during throughout the period studied among the group of young people.
- The source of infection in young people is predominantly extradomiciliary. As age increases, the intradomiciliary source of infection decreases and the extradomiciliary source increases, establishing a statistically significant relationship between these variables.
- Human behaviour is the main enhancer and regulator of the evolution of COVID-19 and, therefore, the main tool in the process to control the epidemic in the country.

- The pandemic may have lasting consequences for the population. Although a complete picture of the repercussions of COVID-19 is not yet available, one reality has been confirmed in recent months: scientific research in general – and demographic research in particular – has much to contribute to the containment of SARS-CoV-2 transmission and to the design of policies, to address its medium and long-term effects.
- The contagiousness of COVID-19, in general medical terms, is the same for all humans, but the pandemic has shown that not all people are affected in the same way. COVID-19 constitutes a serious health problem and, as such, is also a social problem; therefore, people's behaviour influences its control. Hence, the perception of risk, compliance with hygienic health measures and other conditioning factors determine the pace – and the results – of strategies to deal with the disease. These include differentials related to age and sex, but also the mobility of populations and their morbidity, housing conditions, family dynamics, work performance, gender roles and stereotypes, care tasks, living and consumption habits, and behaviours, among others.

It is necessary to modify human behaviour in the face of the virus, both in Cuba and worldwide. The complexity of the current situation and the human component demands long-term educational and awareness-raising actions, with a local focus. Cuban vaccines have demonstrated Cuba's sovereignty and have provided coverage to the entire population from the age of 2 years upwards, reaching a high level of vaccination and effectiveness. However, control of the pandemic is only possible if epidemiological and sanitary measures to manage and eliminate the virus are also maintained. COVID-19 is a human-induced event. Therefore, studying the socio-

demographic characteristics of people is key to better modelling ways to face and overcome this health situation, promoting more protective and healthy behaviours in young people, and eradicating the pandemic.

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1.4. Gender issues in the assessment of the emotional condition of school teachers during the COVID-19 pandemic: The example of schools in Astana, Kazakhstan

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Abstract

The purpose of the study is to identify the features of emotional burnout and personality traits among school teachers in Kazakhstan. The paper draws on the empirical study-based questionnaire responses of school teachers about their emotional condition during the pandemic to contribute to an analysis of the educational environment for teachers. The interview and survey methodology employed is based on reliable and valid techniques, utilizing specifically the 'Measurement of Emotional Burnout' methodology created by Christina Maslach and Susan E. Jackson, and thereafter adapted by the Russian scholars Vodopyanova and Starchenkova. This method was designed to measure aspects of burnout syndrome. The adaptation of Vodopyanova and Starchenkova enabled application of the method to calculate and test the emotional conditions of teachers in

the context of extraordinary situations in the sphere of education. The method is based on a questionnaire (survey), with collected data evaluated according to established scales. A supplementary methodology is based on the Coping Inventory for Stressful Situations (CISS) devised by Norman S. Endler, and James D.A. Parker, and adapted by Kravkova. This method is used to determine the dominant coping strategies in a situation from among the categories: problem-oriented strategies, emotionally oriented strategies, avoidance, abstraction and social distraction (seeking social support).

Comparison of the study results revealed differences in how male and female school teachers in Astana reacted to the changing educational environment caused by the pandemic. They also reveal a need for further research to determine the reasons for the differences in scores between male and female teachers, given

that the educational environment and their professional activities offer them the same opportunities and limitations.

Introduction

Teachers bear considered responsibility for the health, education and upbringing of children in the context of the education environment. Hence, they are often subject to emotional burnout. The spread of the COVID-19 pandemic has placed an extra burden on teachers and workers in the field of education. The purpose of the study is to identify the features of emotional burnout and personality traits among school teachers during the pandemic, and thereby contribute to the study of personality traits and emotional conditions of such specialists in the sphere of education. Given the shortage of studies on the personality traits of teachers in Central Asia, and particularly in Kazakhstan, the aim of this paper is twofold: (a) to identify the features of emotional burnout among Kazakhstani teachers from the schools of Astana city, and (b) to ascertain the impact of the COVID-19 pandemic on the overall emotional condition of teachers in the case study.

The paper is based on empirical study whose factual results can serve to improve professional conditions and generate recommendations, thereby contributing to the creation of a more comfortable environment for teachers. The improvement of the mental and emotional condition of teachers will also positively affect the education process and communication with school students. The study also considers the impact of pandemic restrictions and quarantine measures as well as teachers' preferences based on their survey responses.

The context

The first case of COVID-19 in Kazakhstan was registered on 13 March 2020.¹⁶ Three days later, President Kassym-Jomart Tokayev declared a state of emergency for a period of one month, and on 5 July 2020, lockdown measures were introduced (Raushan, 2020).¹⁷ The Interdepartmental Commission on Preventing and Spreading the Coronavirus infection in the Republic of Kazakhstan (IDC) was created in January 2020 (Trochev, 2020).¹⁸ Mass events, including sports events, and forums were banned in the Republic; and all facilities were closed, except for grocery stores, pharmacies and airports.¹⁹ On 13 July 2020, the President declared a day of national mourning for all those who had died due to the COVID-19 virus.²⁰ In accordance with a Presidential Order, students were sent home from schools between 16 March and 5 April, as well as from universities, as education transitioned to online modes (Tengrinews, 2020). In total, 131 universities, 801 colleges and 7,398 schools switched to online learning during March 2020, (Raushan, 2020).

The government, institutions and ministries were tasked with the smooth implementation of online learning processes and ensuring the quality of learning and teaching at national institutions, while minimizing in-person contact. The first step was to develop and implement a system to manage the online teaching and learning process, disseminate teaching materials and ensure capacities to conduct online courses, all within a short timeframe. Kazakh government authorized flexible teaching approaches, using adapted curricula for delivery online or through other available communication technologies, such as televised lessons, study groups on social media and self-study guides (Bokayev et al., 2021). In addition to providing real-time lessons, teachers also recorded lessons for transmission on national television channels and other platforms (Kundelik.kz, Bilimal.kz, Mektep.edu.kz and TV channels such as EL ARNA and 'Balapan') (National Academy of Education named after Y. Altynsarin, 2020). Schools submitted a variety of reports to the government presenting the results of the online study process, while parents engaged in organizing appropriate education processes in the home (Bokayev et al., 2021: 2).

On 17 August 2020, the Interdepartmental Commission ordered the relaxation of the lockdown measures. Later, on 19 January 2021, the Ministry of Health of the Republic of Kazakhstan announced a mass vaccination campaign against COVID-19, due to start in February 2021. The priority was to vaccinate health care workers with a high risk of infection, followed by school and university teachers, law enforcement officials, citizens with heart, lung and diabetes diseases, and university students. The government emphasized that vaccination was voluntary and aimed to vaccinate nearly 6 million people by the end of 2021 (Trochev, 2020).

16 In accordance with subparagraph 16 of article 44 of the Constitution of the Republic of Kazakhstan (https://online.zakon.kz/Document/?doc_id=1017178) and articles 4, 5 and 6 of the Law of the Republic of Kazakhstan 'On the state of emergency' www.inform.kz/en/president-tokayev-announces-one-month-state-of-emergency_a3625158; also see <https://leap.unep.org/countries/kz/national-legislation/presidential-decree-no-285-introduction-state-emergency-republic>

17 See also the Decree at <https://adilet.zan.kz/rus/docs/P2000000489>

18 See also main sources and updates <https://coronavirus.jhu.edu/region/kazakhstan>, www.coronavirus2020.kz and <https://ourworldindata.org/coronavirus/country/kazakhstan>, <https://lexatlas-c19.org/kazakhstan>

19 www.gov.kz/memleket/entities/mfa/press/article/details/24379?lang=en

20 <https://astanatimes.com/2020/07/kazakhstan-declares-july-13-as-day-of-national-mourning-for-covid-19-victims>

In April 2021, the mobile application *Ashyq* was launched in Kazakhstan to share COVID-related updates with the public, help citizens avoid contact with sick persons and enable businesses to maintain activities during quarantine periods (Satubaldina, 2021). The application uses a QR code and reader linked to the Ministry of Health database to determine the health status of a visitor.²¹ In addition, the website www.coronavirus2020.kz was launched to inform the population about state actions implemented to prevent and minimize the spread of the pandemic.²²

In September 2021, with the start of the new school year, more than 7,000 schools in the country accepted about 3.6 million students, including about 380,000 first graders, with a 45-minute class schedule.²³ More than 13,000 video lessons for grades 1 to 11 were posted on the Kundelik system and made available online via the Ministry of Education and Science of the Republic of Kazakhstan.²⁴ The learning process in schools was organized strictly in compliance with sanitary standards. This included daily temperature measurement using non-contact thermometers, masking, disinfection via irradiation from ultraviolet quartz or bactericidal lamps, ventilation and disinfection, and 100 per cent vaccination of teachers and other school staff (except for those with medical contraindications), with a specific room assigned to each class in schools.²⁵

21 <https://egov.kz/cms/en/articles/prilozhenie-ashyq#:~:text=The%20mobile%20application%20%22Ashyq%22%20enables,of%20the%20virus%20or%20not.>

22 www.coronavirus2020.kz

23 <https://primeminister.kz/ru/news/reviews/shtatnyy-format-pri-soblyudenii-strogih-sanitarno-epidemiologicheskikh-trebovaniy-v-mon-rasskazali-o-podgotovke-k-novomu-uchebnomu-godu-277537>

24 *ibid*

25 *ibid*

In April 2022, the IDC adopted a decision to lift restrictions in the Republic following stabilization of the epidemiological situation. According to available statistics, 1,395,000 people had been infected with the COVID-19 virus and 1,380,737 had recovered between March 2020 and October 2022.²⁶

Literature review

Generally, the topic of stress in the working environment, including the education sphere, has been less explored in the Central Asian region. In particular, there are very few empirical studies on emotional burnout and the behaviour of teachers in Kazakhstan. However, as Mishina and Vorobyeva (2020) indicate, growing interest in this area among the Russian scientific community resulted in the appearance of 500 publications in 2017 on the Russian Science Citation Index (Mishina and Vorobyeva, 2020: 44). One of the few Kazakhstani studies on emotional burnout focused on middle-level company managers (Aimaganbetova et al., 2018). This study concluded that a relationship exists between the manifestation of emotional burnout and the personal characteristics of managers (*ibid*). Other studies revealed that professional burnout reduces the self-esteem of teachers, and might negatively affect teaching activities while consciously restricting teacher's capabilities (Bekmagambetova and Nurgaliyeva, 2020). Indeed, socio-psychological research shows that the teaching profession is strongly subject to emotional burnout (Mishina and Vorobyeva, 2020: 44).

The relevance of the study of emotional burnout among teachers in the context of the modern educational environment is conditioned by problems associated with inclusive education, the multiculturalism of the student population, and heterogeneity in the cognitive and

social development of children in the Kazakhstani system of education. However, as Bekmagambetova and Nurgaliyeva (2020) state, the issue of emotional and professional burnout has not been studied with any depth due to a relative lack of attention from educational organizations. Given that, the present article attempts to determine the level of emotional burnout among teachers of different ages and professional spheres.

Emotional burnout

The concept of 'burnout' was first identified by Freudenberg in the 1970s, as a state of fatigue or frustration originating from a professional working environment that has failed to provide an expected reward (Freudenberg, 1974; Freudenberg and Richelson, 1980). Later on, Maslach (1982) defined burnout as a psychological syndrome involving emotional exhaustion, depersonalization and reduced personal accomplishment that may occur in different professional spheres and affect people working in various challenging situations.

Emotional burnout has been conceptualized in different ways at different times. Pines and Aronson (2008) proposed a model based on a single component (depletion) manifested across physical, emotional and cognitive dimensions. Schaufeli, van Dierendonck and van Gorp (2007) identified two components (emotional exhaustion and depersonalization) which appeared in complaints about the physical state and emotional exhaustion. However, despite a lack of consensus on measuring burnout, one model is favoured in studies aimed at capturing the emotional condition of people in different spheres: the Maslach Burnout Inventory (Maslach and Jackson, 1981a).

The Maslach Burnout Inventory (MBI) measures three dimensions of burnout: emotional exhaustion (EE), depersonalization (DP) and personal accomplishment (PA) (*ibid*). Measurements of emotional

26 www.coronavirus2020.kz



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exhaustion captures the degree of burnout and how much the person is exhausted by the work; depersonalization assesses unsympathetic and impersonal responses toward recipients of one's instruction; and personal accomplishment evaluates a person's feelings of competence and achievement in his/her work (Maslach and Jackson, 1981a).

Coping strategies

The term 'coping' has many interpretations depending on the theoretical foundation. From a situational perspective, coping is defined as a person's behavioural and cognitive efforts to manage the internal and external demands that challenge or exceed their resources (Folkman, Lazarus, Gruen and De Longis, 1986: 572). It can also be considered from a disposition-oriented perspective, encompassing a person's preferences for certain coping styles, or domain-specific, where coping styles might differ across different domains (Brands et al., 2014: 849). The present article applies the Coping Inventory for Stressful Situations (CISS) interpretation developed by Endler and Parker (1990).

Lazarus and Folkman (1984) and, later, Endler and Parker (1994), developed instruments to measure coping models by distinguishing between task focus, emotion focus and avoidance behaviours. Task focus results indicate the degree of active effort to solve or minimize the effects of a stressful situation by focusing on the problem. Emotionally oriented coping models are strategies that involve self-preoccupation, fantasy and other activities related

to regulation. Avoidance coping models focus on forms of cognitive withdrawal, such as ignoring the situation and engaging in distracting activities (ibid).

Method

Maslach and Jackson's three-dimension model (MBI)

As noted earlier, this paper applies the methodology of Christina Maslach and Susan E. Jackson to measure aspects of burnout syndrome. Following the adaptation of Russian scholars, Vodopyanova and Starchenkova (2008: 345), this method can be used to calculate and test the emotional conditions of teachers' situations in the sphere of education. The method is based on a questionnaire (survey), with the collected data evaluated according to established scales.

The questionnaire contains 22 statements about feelings and experiences associated with work performance. It consists of three subscales: Emotional Burnout, Depersonalization and Reduced Personal Accomplishment. The answers of respondents are scored on a 7-point Likert scale and range from 'never' (0 points) to 'always' (6 points). The presence of a high level of burnout is evidenced by high scores on the 'Emotional Burnout' and 'Depersonalization' subscales and low scores on the 'Reduced Personal Accomplishment' scale (Table 1). Accordingly, the lower a person evaluates their capabilities and achievements, the less satisfied they are with self-realization in the professional sphere and the more pronounced their burnout syndrome (Vodopyanova 2009: 309).

Table 1. Results Assessment Keys

Dimensions	Low	Average	High
Emotional burnout	0–15	16–24	25 <
Depersonalization	0–5	6–10	11 <
Reduced personal accomplishment	37 <	36–31	30 >

Source: Vodopyanova and Starchenkova (2008).

Table 2. Degree of emotional burnout among school teachers in Astana

Selection	Numbers	Emotional burnout (average)*	Depersonalization (average)	Reduced personal accomplishment (average)
All respondents	N=552	20.05	9.03	36.40
High school	N=362	20.33	9.33	36.20
High school teachers, women	N=285	20.51	9.0	35.97
High school teachers, men	N=77	19.67	10.57	37.07
Primary school teachers	N=190	20.09	8.45	36.78
Primary school teachers, women	N=180	20.21	8.37	36.91
Primary school teachers, men	N=10	18.00	9.9	34.5
Women (general)	N=465	20.39	8.75	36.33
Men (general)	N=87	19.48	10.49	36.78

Note: *Answers vary on a 7-point measurement scale and range from 'never' (0 points) to 'always' (6 points).

Source: Results of the questionnaire among schoolteachers in Astana adapted to the metrics developed by Maslach and Jackson (1981), also used by Vodopyanova and Starchenkova (2008).

Coping Inventory for Stressful Situations (CISS)²⁷

Coping Inventory for Stressful Situations (CISS) is a 48-item instrument used to measure coping strategies across the following dimensions: Task Focused (T), Emotion Focused EXPERIENCE and Avoidance (A). Each scale has 16 items, except Avoidance (A), which has two subscales: Distraction (D) and Social Diversion (SD). Each of the items is scored on a 5-point Likert scale ranging from 1 (not at all) to 5 (very much). The highest score reflects the highest use of a coping strategy. The paper uses the validated Russian adaptation of Kravkova (2010) in an abbreviated form including five items for each strategy (T, E, and A), five items for Distraction and three items for Social Diversion.

The experience investigation took place among school teachers (primary and high school) in Astana. The

Kazakhstani education system consists of primary school (1–4 classes) and high school (5–11 classes). The study divided respondents into these two groups. Overall, 552 teachers (n=552) participated from around 30 schools. Each respondent participated anonymously.

Results and discussion

The results of the survey questionnaires are shown in Table 2.

The results of the study questionnaires show an average degree of 'Emotional Burnout' (20.05) across respondents (n=552, women=465, and men=87)²⁸, indicating that the burnout process is in the early stage of formation among teachers in the case study schools. This indicates that emotional burnout is not actively taking place, but finds that the requisite general loss of interest, inability to express emotions and overall dissatisfaction are all present. The same degree of

emotional burnout was found among elementary and high school teachers.

The results for the second dimension, 'Depersonalization', are higher among male respondents. The responses of male high-school teachers scored 10.57 on the scale, while the level among male respondents, in general, was 10.49 for this dimension. This result indicates that male teachers in these schools experience a higher level of depersonalization than women teachers. Such a high degree of depersonalization indicates detachment, indifference and the formal performance of duties without personal involvement.

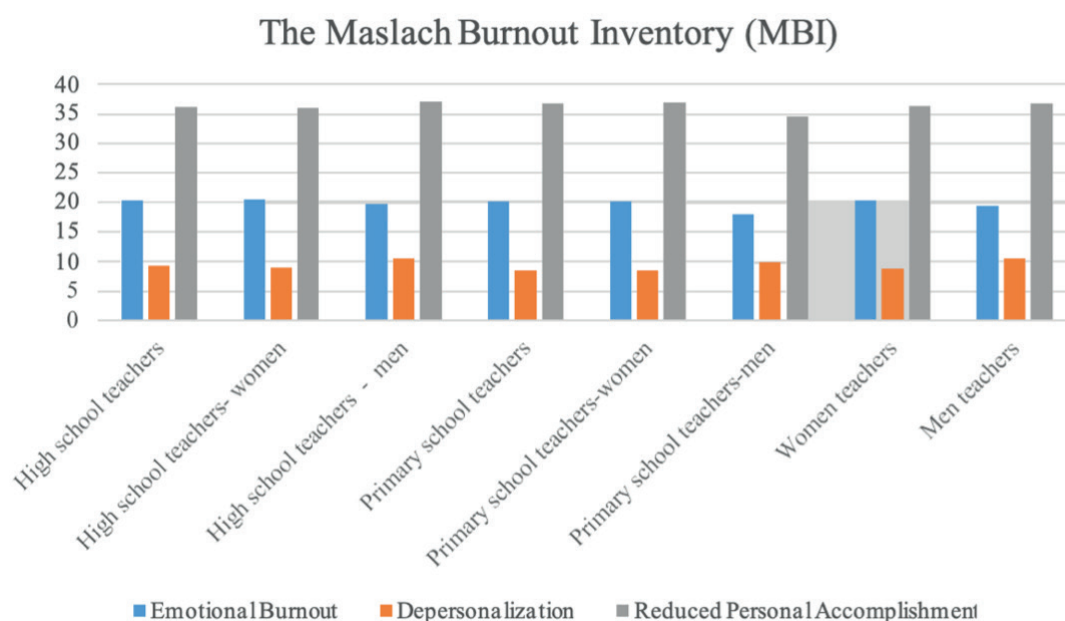
The last dimension, 'Reduced Personal Accomplishment', scores high (37.07) among male high-school teachers. In general, the average score among respondents for this dimension is slightly above the general average (36.40).²⁹ Higher scores in this dimension mean that the person or

27 This paper employed the shorter version of CISS developed by Endler and Parker (1994), adapted by Kravkova (2010).

28 Despite a preference for equal representation, the results reflect the high proportion of female teachers in Kazakhstan.

29 For this last dimension, the scale is reversed, so a score of 37 represents a low indication.

Figure 1. Results of the questionnaire among schoolteachers in Astana on the Three Dimensions of MBI: Emotional Burnout, Depersonalization and Reduced Personal Accomplishment



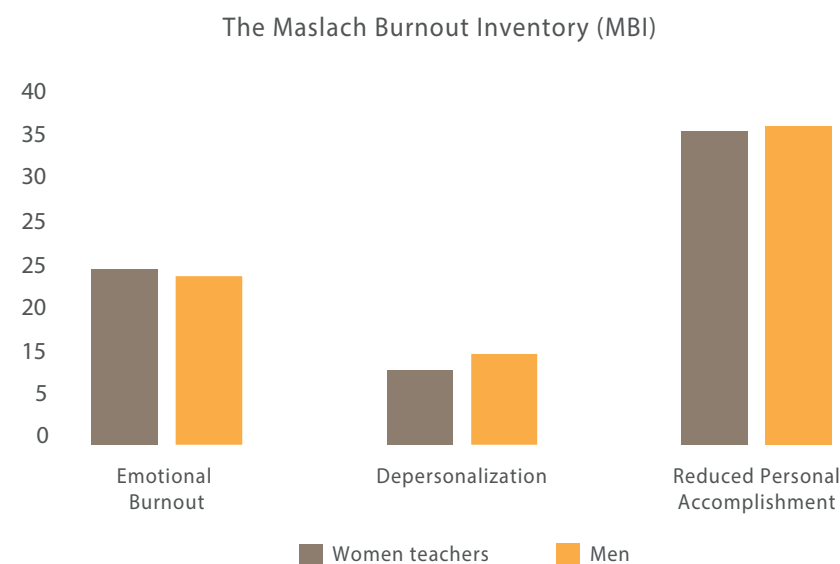
Source: Results of the questionnaire among schoolteachers in Astana.

group tends to negatively assess their own competencies, the results of their work, limits their own abilities, and finally, avoids or refrains from accepting responsibility.

As Vodopyanova and Starchenkova (2008) have indicated, the presence of a high level of burnout is evidenced by high scores on the 'Emotional Burnout' and 'Depersonalization' subscales. Analysis of the questionnaire results show an average degree of 'Emotional Burnout' and 'Depersonalization' among Kazakhstani respondents, which might indicate the presence of anxiety, disinterest and overall exhaustive behaviour (Figure 3). However, in the future, these might lead to emotional and professional burnout.

Low scores on the 'Reduced Personal Accomplishment' scale (37 is considered as a low score) mean that the person evaluates his capabilities and achievements negatively and is less satisfied with their self-realization in the professional sphere (Figures 1–5). This is one of the elements of emotional

Figure 2. Scores of all respondents on emotional burnout, depersonalization and reduced personal accomplishment dimensions by gender.

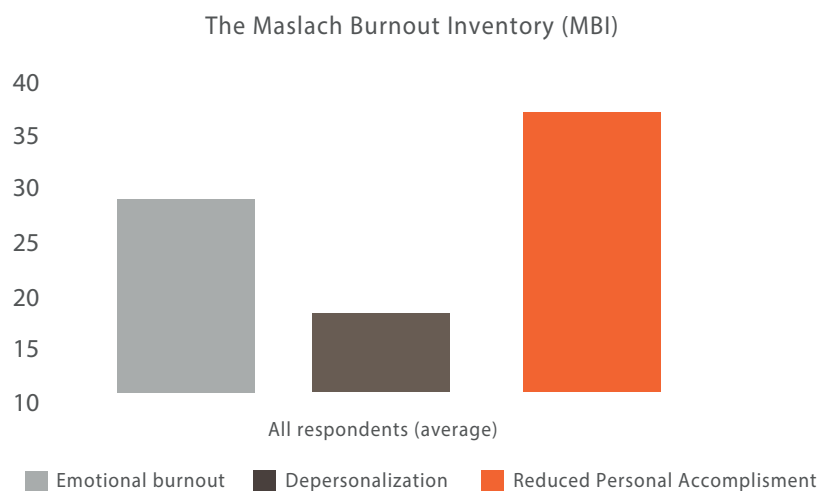


Source: Results of the questionnaire among schoolteachers in Astana.

burnout. Coupled with an average score of 'Emotional Burnout' and 'Depersonalization', this result would indicate that Kazakh teachers might be prone to emotional burnout in the near future (Figures 1–5). The results also indicate that the male teachers

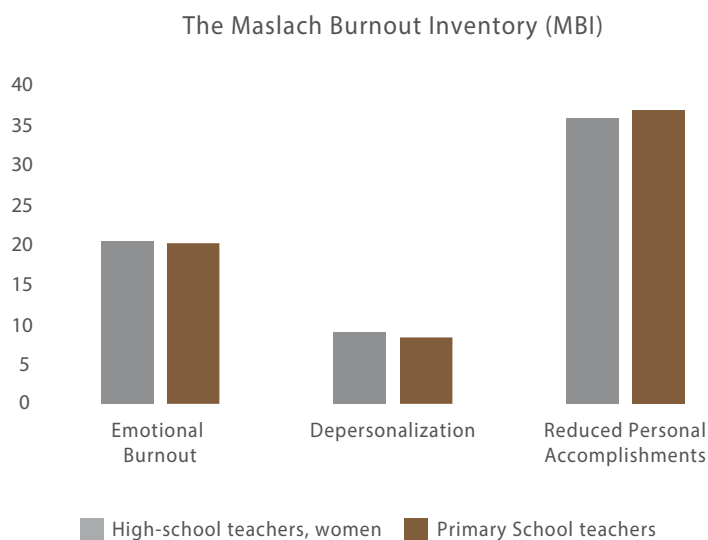
constitute the riskiest group with higher scores in 'Depersonalization' and lower scores in 'Reduced Personal Accomplishment' (Figures 2 and 5).

Figure 3. Scores of all respondents on emotional burnout, depersonalization and reduced personal accomplishment dimensions by gender.



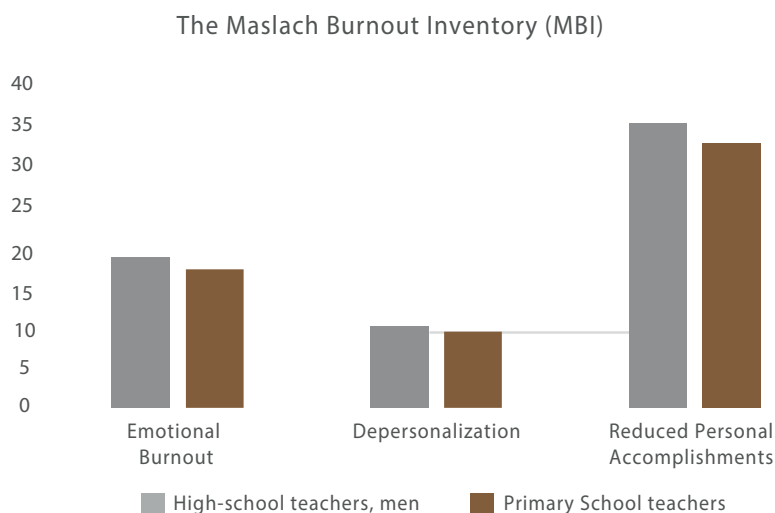
Source: Aikyz Bauyrzhankyzy, Seitbadam Bauyrzhan Magazuly.

Figure 4. Scores of women in secondary and primary schools



Source: Aikyz Bauyrzhankyzy, Seitbadam Bauyrzhan Magazuly.

Figure 5. Scores of men in secondary and primary schools



Source: Aikyz Bauyrzhankyzy, Seitbadam Bauyrzhan Magazuly.

Table 3. Coping Inventory for Stressful Situations (CISS) results among school teachers in Astana city

	Numbers	Task-focused	Emotion-focused	Avoidant coping	Avoidance subscale – distraction	Avoidance subscale – social diversion
All respondents	N=439	18.09	11.15	15.19	13.57	11.04
High-school teachers	N=295	18.01	11.23	15.10	13.47	10.94
High-school teachers (women)	N=228	18.16	11.27	15.21	13.67	10.96
High-school teachers (men)	N=67	17.50	11.10	14.74	12.80	10.88
Primary school teachers	N=114	18.25	11.00	15.38	13.76	11.22
Primary school teachers (women)	N=134	18.26	11.30	15.46	13.92	11.18
Primary school teachers (men)	N=10	18.00	6.90	10.00	11.60	11.80
Women	N=362	18.20	11.28	15.30	13.76	11.04
Men	N=77	17.57	10.55	14.70	12.64	11.00

Source: Results of the questionnaire among schoolteachers in Astana adapted to the metrics developed by Kravkova (2010).



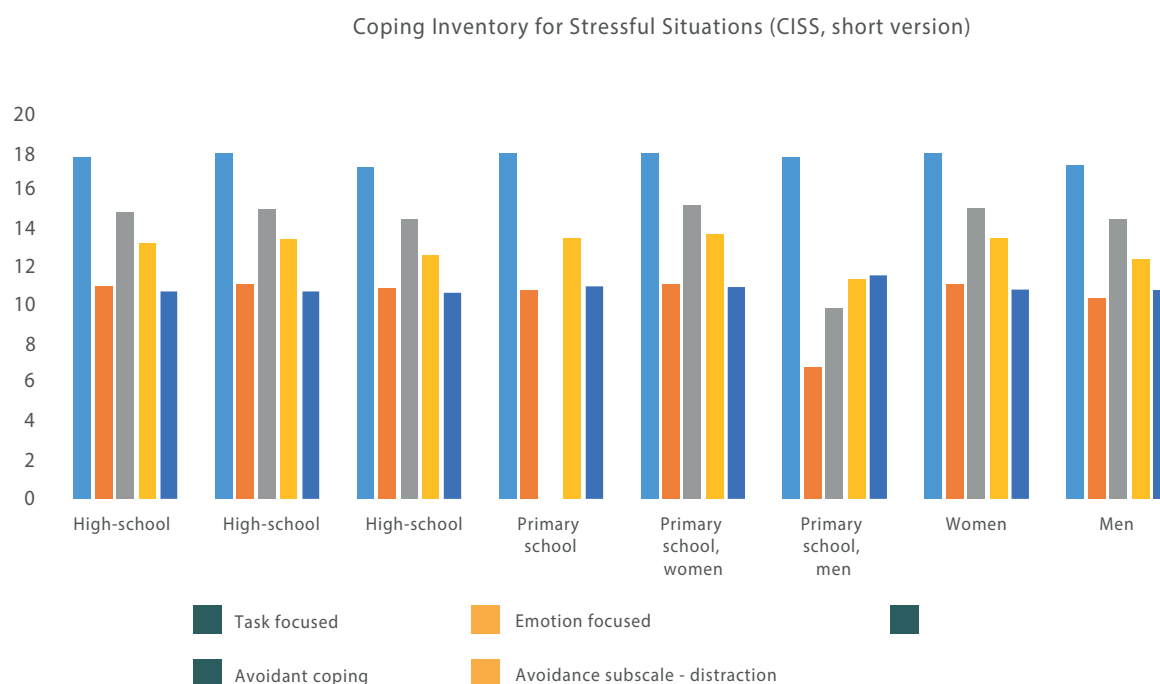
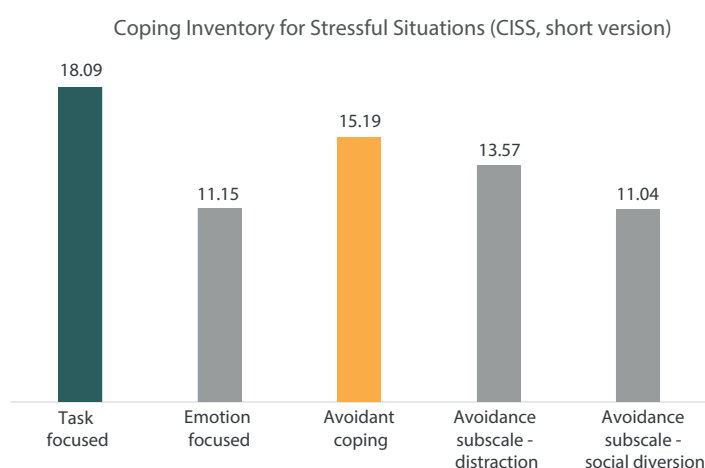
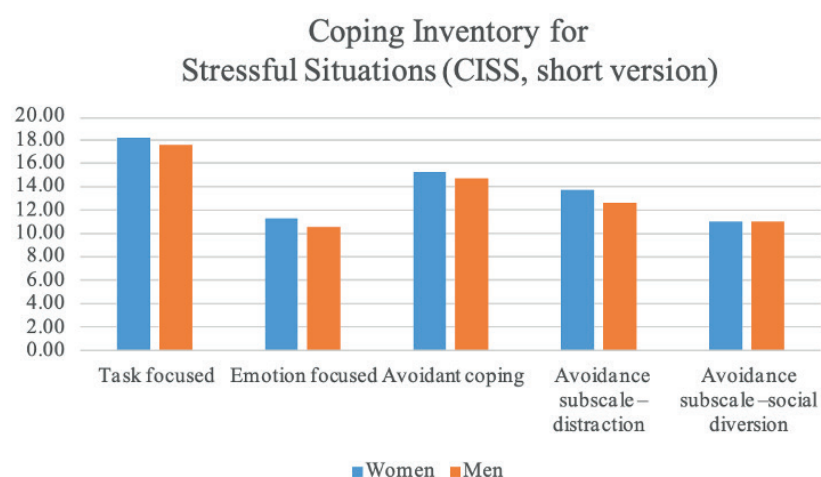
The results of the Coping Inventory show that, in general, overall respondents (n=439, women=362, men=77) show similar results (Table 3). Male teachers of primary classes score low on the Emotion-focused and Avoidance coping strategies and Distraction scales. Task-focused was the most dominant coping strategy among teachers (18.09), while the other coping strategies (Avoidance – social diversion and Emotion-focused) received the lowest scores. The other two Avoidance strategies received the next highest scores after the Task-focused strategy (Figure 6).

The average higher score for use of the task focused strategy indicates a primary control style. This involves active efforts to solve a problem or stressful situation by focusing directly on the issue. Focus is maintained and emotions are controlled. This implies that in a stressful situation, such as a global pandemic, respondent teachers focused on the problem and adapted to the situation around them (Figures 6 and 7). This coping model presumes that respondents have

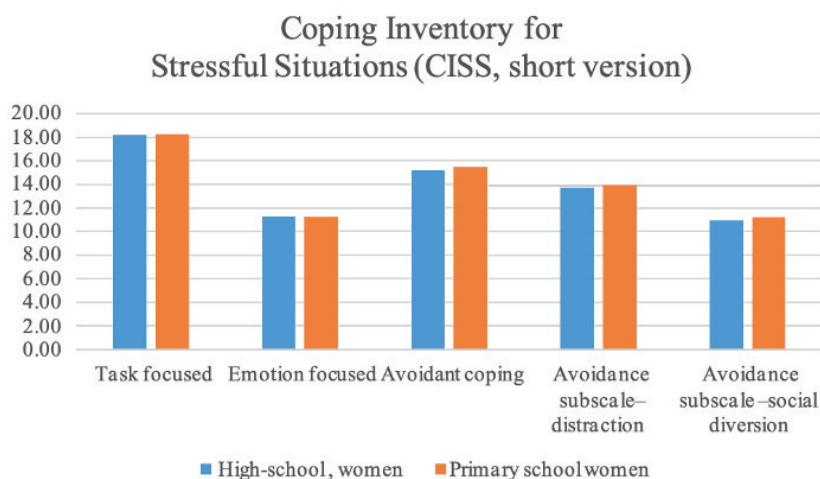
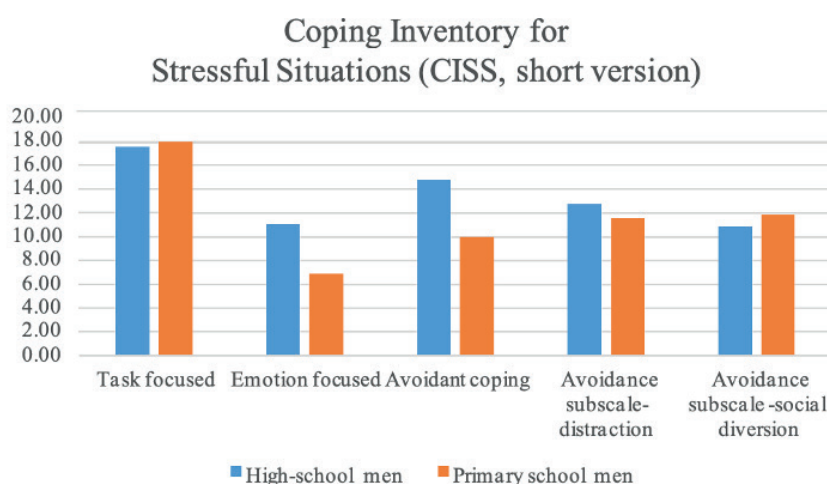
attempted to minimize the effects of stress or tried to adapt accordingly.

The lower score received by Emotion-focused strategies among Kazakhstani teachers indicates a lower level of engagement in self-preoccupation, ruminating or other fantasies and conscious activities. The comparably higher scores for Avoidance strategies show that respondents were engaged in distracting activities, including cognitive withdrawal, ignoring the surrounding situation, and so on (Figure 7 and Figure 8).

The scores of male primary school teachers were lowest for Emotion focused and Avoidant coping (Figure 10). These teachers were less engaged in self-preoccupation and were more interested in the situation happening around them.

Figure 6. Results of all respondents on the Coping Inventory for Stressful Situations (CISS)**Figure 7.** Results Coping Inventory for Stressful Situations (CISS)**Figure 8.** Results Coping Inventory for Stressful Situations by Gender (CISS)

Source: Aikyz Bauyrzhankyzy and Seitbadam Bauyrzhan Magazuly.

Figure 9. Results Coping Inventory for Stressful Situations (CISS) of women in high and primary schools**Figure 10.** Results Coping Inventory for Stressful Situations (CISS) of men in high and primary schools

Source: Aikyz Bauyrzhankyzy and Seitbadam Bauyrzhan Magazuly.

Conclusion

In summary, the Maslach Burnout Inventory results revealed a divergence in the scores of male and female respondents, reflecting differences in the way they reacted to the changing educational environment caused by the pandemic. Overall, the dimensions of 'Emotional Burnout' and 'Depersonalization' were received an average score, while 'Reduced Personal Accomplishment' received a higher score. Thus, the general emotional condition of teachers appears to be prone to emotional burnout. While this does not indicate the presence of burnout at the moment, it means that educational organizations should

take into consideration the physical and emotional state of their teachers, especially in the context of the COVID-19 pandemic.

They also reveal a need for further research to determine the reasons for the differences in scores between male and female teachers, given that the educational environment and their professional activities offer them the same opportunities and limitations.

The study also reveals a need for further research to determine the reasons for the differences in scores between male and female teachers, given that the educational environment and their professional activities offer them the same

opportunities and limitations. The results raise the question as to whether emotional burnout may be overcome or prevented by investigating different approaches based on the gender of teachers? Furthermore, are these dimensions affected by national peculiarities or cultural differences among nations? These questions might guide authors in searching for novel explanations for teachers' mental and emotional conditions.

However, the results of the Coping Inventory also revealed similarities in behaviour between male and female respondents (Figure 8). Both groups were Task focused and Avoidant, whereas male primary school teachers manifested a lower level

of Avoidance. In general, male and female teachers were less engaged in emotional and cognitive activities but reacted to the situation by focusing on the problem. It is conceivable that Kazakh hierarchical culture might have affected the stress perceptions and coping styles of respondents. Indeed, avoidant coping models can have different meanings in different cultures, as previous Asian, Indonesian and Japanese studies on CISS have shown (Imran *et al.*).

Further research can be undertaken to compare emotional burnout studies of the populations of Central Asian states. More broader investigations could affect comparisons of European, Western, Post-Soviet and/or Asian country case studies, research and data on emotional burnout, and other kinds of psychological studies. One interesting prospect would be to combine studies on gender, mentality, nationalism and state policy with research into emotional burnout among state populations, including teachers, managers and other administrative personnel.

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1.5. Impacts de la COVID-19 sur les personnes âgées immigrées non-européennes en France : difficultés, besoins et forces

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Résumé

En France, les personnes âgées immigrées non-européennes (PAI) figurent parmi les populations les plus durement touchées par la COVID-19 tant sur le plan biomédical que socio-économique et psychosocial. La crise liée à cette pandémie engendre des effets disproportionnés dans la vie de nombreux PAI, déjà grandement marginalisées et fragilisées par la précarité de leurs conditions de vie. Dans un tel contexte, elles peuvent être amenées à recevoir ou à solliciter le soutien de travailleurs sociaux (TS), qui, compte tenu de leur fonction d'accompagnement social et psychosocial, se situent en première ligne de la lutte sociale contre la COVID-19. Or, face à cette crise d'ampleur inédite, la plupart des TS se retrouvent dépourvus d'outils d'intervention sociale spécifiques aux PAI, d'où la mise en œuvre d'une

recherche-action³⁰ dont l'objectif principal est d'outiller les TS d'un guide de pratiques visant à intervenir adéquatement auprès des PAI en contexte de pandémie. À travers cet article, nous présentons un pan des résultats préliminaires émanant de récits de 79 PAI rencontrées en entretiens individuels et en *focus groups* au sujet de leurs difficultés, leurs besoins et leurs forces dans le contexte de la COVID-19.

Introduction

En France, les personnes immigrées non européennes sont plus susceptibles d'être contaminées au SARS-CoV2 que la population générale, car elles vivent plus souvent dans des communes à forte densité et dans des logements surpeuplés ou

30 Cette recherche-action est financée par l'Agence Nationale de la Recherche, dans le cadre du programme RA-COVID19 (février 2021 - mai 2022). Elle est réalisée en partenariat avec le Groupe d'intérêt scientifique (GIS) Recherche, Action, Inclusion, Formations Sociales. Vient compléter ce partenariat, le sociologue Moncef Labidi, spécialisé sur les enjeux du vieillissement des personnes immigrées. Mustapha Dehas et Quentin Moscato, doctorants en sociologie à l'Université de Lorraine - Metz, collaborent également à cette recherche.

exigus (Inserm, 2020). Entre mars et avril 2020, il a été observé une hausse des décès deux fois plus forte pour les personnes nées à l'étranger que pour celles nées en France. Quelle que soit l'origine, cette hausse des décès a été plus forte pour les personnes âgées (Papon & Robert-Bobée, 2020).

Les personnes âgées immigrées non européennes (PAI) sont directement touchées par ces facteurs de risques. La plupart vit dans des quartiers anciens dégradés ou inscrits à la Politique de la ville, des chambres d'hôtels meublés insalubres et souvent partagées, en Foyers de travailleurs migrants (FTM), ou encore dans des logements sociaux (petites chambres en milieu de vie collectif) créés dans les années 50 pour héberger temporairement les travailleurs du Maghreb et d'autres pays d'Afrique venus participer à l'effort de reconstruction d'après-guerre. Durement frappés par le chômage dans les années 80, de nombreux immigrants se sont finalement installés de manière permanente en France et ont vieilli dans ces FTM devenus vétustes, isolés de leur famille restée au pays à qui ils tentent d'apporter un soutien économique (Bachelay & Jacquat, 2013). Depuis le milieu des années 90, ces FTM sont progressivement réhabilités en « résidences sociales », où les PAI cohabitent désormais avec des publics variés en situation de précarité.

Les problématiques vécues par les PAI sont constitutives d'un processus d'invisibilisation sociale. Leurs réalités et leurs besoins spécifiques sont peu connus et rarement pris en compte par les autorités publiques. Ces populations cumulent plusieurs facteurs sociaux défavorables au niveau de la santé, des ressources financières et de l'environnement relationnel (Odas, 2018), qui les rendent plus vulnérables aux conséquences sociales, sanitaires et économiques de la pandémie de COVID-19. La plupart ont une santé physique et psychique fragile

et souffrent de pathologies lourdes dues à un vieillissement précoce lié à leurs mauvaises conditions de vie, à la pénibilité des emplois occupés, aux accidents de travail ou d'invalidité (Dury, 2019), ainsi qu'aux « expériences de discriminations et de racisme qui sont un facteur explicatif des inégalités de santé » (Brun & Simon, 2020, p. 70). La grande majorité des PAI a occupé des emplois peu qualifiés, peu rémunérés ou non déclarés, principalement dans les secteurs de l'industrie, de l'agriculture et du bâtiment, ce qui engendre de faibles niveaux de revenus à la retraite. Leur filet de sécurité économique se résume bien souvent aux allocations supplémentaires du fonds de solidarité vieillesse ou à l'allocation de solidarité aux personnes âgées. Les femmes âgées immigrées connaissent également une situation de précarité socioéconomique particulièrement difficile, en raison notamment d'un parcours professionnel inexistant, court ou ponctué de longues périodes d'inactivité. La précarité relationnelle des PAI renforce leur situation d'isolement, autant pour les hommes (Odas, 2018), que pour les femmes venues rejoindre leur conjoint suite à un regroupement familial, les femmes veuves, sans enfants ou éloignées de la famille restée au pays.

Aux côtés de ces différents facteurs, les barrières linguistiques, le manque de littératie en santé, la méconnaissance, la méfiance ou la crainte à l'égard des autorités sanitaires, des services sociaux et de santé, le non-recours aux droits sociaux ou encore l'exclusion numérique (Jaeger & Jovelín, 2016), font qu'il pourrait être difficile pour les PAI de trouver du soutien et de l'information claire relatives à la COVID-19.

Dans un tel contexte, les PAI peuvent être amenées à recevoir ou à solliciter le soutien de travailleurs sociaux (TS), qui, compte tenu de leur fonction d'accompagnement social et psychosocial, se situent en première ligne de la lutte sociale contre la

COVID-19 (Jaeger, 2020). Or, les connaissances actuelles ne suffisent pas à comprendre comment les TS pourraient soutenir et accompagner efficacement les PAI en contexte de pandémie. Les quelques leçons prises dans le domaine du travail social suite aux pandémies antérieures (H1N1), montrent que pour s'y attaquer efficacement, les pratiques doivent nécessairement tenir compte des spécificités des populations (Cassady & al., 2012). Il existe également une littérature émergente dans le domaine gériatrique en lien avec la pandémie COVID-19, mettant en lumière les conséquences néfastes des mesures de confinement et de distanciation sur la vie des personnes âgées, tels qu'une augmentation de l'anxiété, l'exacerbation de l'isolement social, du sentiment de solitude, des préjudices subis à l'égard de leur droit à l'autodétermination et à l'autonomie (Pentaris *et al.*, 2020), ainsi que des phénomènes d'âgisme (Fraser & al., 2020). Outre ces analyses, la plupart des chercheurs reconnaît, d'une part, à quel point l'hétérogénéité des populations âgées rend difficile l'appréhension de leurs difficultés vécues dans le contexte de la COVID-19, et d'autre part, l'urgence de renouveler les pratiques du travail social à la lumière de cette crise sanitaire (Swinford, Galucia & Morrow-Howell, 2020).

Face à cette crise d'ampleur inédite, la plupart des TS se retrouvent dépourvus d'outils d'intervention sociale spécifiques aux PAI. Cette situation est d'autant plus préoccupante que ces populations n'expriment que très peu leurs besoins (Dury, 2019), d'où l'émergence d'une recherche-action guidée par les questions de recherche suivantes : quels sont les difficultés, besoins et forces des PAI dans le contexte de la COVID-19 ? Comment les TS peuvent soutenir et accompagner efficacement les PAI en contexte de pandémie ? Déployée dans six régions françaises – Hauts-de-France (HDF), Grand Est (GE), Île-de-France (IDF), Auvergne-Rhône-Alpes (ARA), Occitanie (OCC)

et Provence-Alpes-Côte d'Azur (PACA) -, cette recherche a pour objectif principal d'outiller les TS d'un guide de pratiques visant à intervenir adéquatement auprès des PAI en contexte de pandémie.

Méthodologie

Cette recherche est appréhendée à partir d'un cadre d'analyse compréhensif et constructiviste (Berger & Luckmann, 1996), induisant une approche inductive permettant de mieux comprendre le vécu des PAI, tout en sollicitant les points de vue des acteurs de leur environnement.

La collecte de données a été pensée en deux phases : une première phase d'entretiens individuels et *focus groups* avec des PAI ; une deuxième phase de *focus groups* avec des travailleurs sociaux, gestionnaires et acteurs d'associations ou ressources communautaires œuvrant auprès des PAI. Dans le cadre de cet article, nous présentons la démarche méthodologique et les résultats préliminaires associés à la phase 1³¹.

Nous avons orienté l'échantillonnage des PAI vers des hommes et femmes d'origine non-européenne, né-e-s au Maghreb et dans d'autres pays d'Afrique (la hausse des décès lors de la première vague ayant été plus forte chez ces populations), de différents statuts d'immigration, ayant acquis la nationalité française ou non, vivant en foyers, en résidences sociales, en hôtels meublés ou en habitats diffus, âgé-e-s de plus de 55 ans. Cet âge a été déterminé en regard du phénomène de vieillissement précoce des PAI. Nous avons rencontré un total de 79 PAI dans les 6 régions ciblées par la recherche (N=79), 61 hommes et 18 femmes, âgé-e-s entre 55 et 86 ans, majoritairement né-e-s en Algérie, au Maroc, en Tunisie et au Sénégal. Parmi elles, 39 vivaient en foyers, résidences ou hôtels meublés, et 37 en habitats diffus. La participation des PAI s'est faite sur une base

volontaire. La majorité des entretiens et *focus groups* ont été réalisés en face-à-face, dans le respect des consignes sanitaires, dans les foyers, au domicile de la personne, dans un café, un square ou encore dans des lieux de culte. Quelques entretiens ont été réalisés par téléphone. Le guide d'entretien était composé de 2 principales thématiques liées aux parcours migratoires et aux vécus dans le contexte de la COVID-19. Les entretiens ont été analysés à l'aide d'une stratégie d'analyse thématique de contenu (Paillé & Mucchielli, 2016).

Résultats

Les résultats préliminaires présentés sont structurés en trois principales thématiques : accès aux informations sanitaires, difficultés et besoins des PAI, forces individuelles et communautaires des PAI pour faire face à la COVID-19.

Accès à l'information sanitaire

Au début de la pandémie, l'information officielle a tardé à parvenir aux PAI, notamment pour les personnes vivant en FTM et les plus isolées. Les barrières linguistiques ont constitué un frein majeur à l'accès aux informations sanitaires officielles, celles-ci étant diffusées en français seulement. Même si les PAI vivent en France depuis de nombreuses années, beaucoup ne comprennent pas le français ou très peu. En situation de crise majeure, il peut être dévalorisant et angoissant de ne pouvoir comprendre par soi-même les informations nécessaires à la prise de décisions éclairées :

Ce qui est difficile pour les gens comme moi qui ne savent pas lire et écrire et qui ne comprennent pas ce qui se dit dans le poste [radio, télévision], c'est de dépendre toujours de quelqu'un qui comprend mieux que nous et qui nous explique. On ne parle que de la maladie à longueur de journée et dans toutes les radios et les télévisions. Moi, je comprends que lorsque quelqu'un qui parle ma

langue m'explique de quoi il s'agit. PAI-13-H82-IDF³²

En France, les autorités sont intervenues tardivement auprès des personnes âgées dans les Établissements d'hébergement pour personnes âgées dépendantes (Ehpad). Or, dans ce mouvement, les PAI dans les foyers n'ont pas été prises en compte, alors que la situation y était tout autant catastrophique. Selon le témoignage de plusieurs, au début du premier confinement, des responsables de certains foyers se sont « *comme évaporés* » du jour au lendemain, laissant les résidents livrés à eux-mêmes, sans informations sur la situation pandémique ni au sujet des consignes sanitaires. Plusieurs l'ont vécu comme un véritable abandon.

Au début, il n'y avait aucune information dans le foyer. On n'a plus vu les responsables depuis longtemps. Comme évaporés. [...] Je me suis franchement inquiété. J'ai eu le sentiment que nous avons été abandonnés de tous. La maladie prenait de l'ampleur, les vieux comme moi en foyers, avons eu très peur. Il n'y avait pas de responsables dans le foyer. Ils sont tous partis. PAI-13-H82-IDF

En dehors des foyers, plusieurs associations et ressources communautaires de proximité sont intervenues rapidement en rendant disponibles les informations officielles traduites en plusieurs langues, telle que l'application *#enmodeconfine* créée lors du premier confinement par l'association *Banlieues Santé*, pour faciliter l'accès aux messages de la santé publique³³. Bien que ce type d'application soit opérante pour celles qui maîtrisent ces technologies, elles sont inefficaces pour les PAI qui n'ont pas accès à Internet. Cette exclusion numérique a également

31 Au moment de la rédaction de cet article, la phase 2 était en cours de réalisation

32 PAI - (13) 13ème participant - (H82) Homme de 82 ans - (IDF) Région Île-de-France

33 <http://banlieues-sante.fr/projets/4-en-mode-confine/>

constitué un obstacle important pour l'accès à l'information sanitaire.

Cette privation d'information les a conduits à rechercher des sources d'informations par leurs propres moyens, dans leur propre langue, par le biais des médias de leur pays d'origine ou communautaires, leurs amis/voisinages, les réseaux sociaux et les médias nationaux. Une précision est à apporter concernant l'usage des médias du pays d'origine. Bien qu'au tout début de la pandémie la plupart mobilisaient ces médiums pour y trouver de l'information personnellement utilisable, beaucoup ont continué de le faire par la suite, car pour la plupart, cette pandémie est vécue de manière transnationale ; elles sont très attentives et concernées par l'évolution de la pandémie en France et dans leur pays d'origine, inquiètes pour leurs proches et la situation sociale du pays.

Comme dans l'ensemble de la population française, cette variété de sources d'information a progressivement engendré un phénomène d'*infodémie*, induisant des doutes, des incompréhensions, de l'anxiété et une certaine forme de défiance envers les autorités de santé publique, le gouvernement et les médias :

L'information qui passe par la télé par les journaux, y a un mélange, des fois on croit, des fois on croit pas, des fois un qui t'dit ça, l'autre il dit autre chose, Raoult à Marseille il dit ça [...]. Des fois on voit les malades dans notre entourage, donc on se dit c'est vrai, et y avait l'économie, la politique, tout s'est chamboulé, on était dans le brouillard ; moi personnellement j'étais dans le brouillard. Parfois ils disaient les masques ça sert à rien du tout, parce que la France n'avait pas assez, après quand ils ont ramené des masques, alors obligatoirement si tu n'en portes pas t'as un PV. On sait pas. À midi je crois, mais à 16h je ne crois plus. Ça crée l'anxiété. PAI-4-H73-GE

Un an après le premier confinement, au moment des entretiens (avril – septembre 2021), la majorité estimait que la COVID-19 est une « *maladie grave qui touche le monde entier* ». Néanmoins plusieurs ont souligné que des décès et des hospitalisations auraient pu être évités si elles avaient pu avoir une information claire dès le début de la pandémie. Des PAI ont été porteuses du virus et ont parfois contaminé leurs proches sans le savoir, certains en sont décédés. Cela provoque chez elles une profonde détresse et un fort sentiment de culpabilité.

Difficultés et besoins

La problématique du logement, que ce soit en foyers ou en habitats diffus, est apparue de manière centrale dans les récits. Sur-occupés, vétustes et exigus, les logements sont incompatibles avec les mesures de distanciation physique et de confinement, ce qui expose les plus vulnérables à des risques élevés de contamination et à des formes graves de la maladie.

La pandémie a aggravé la précarité financière de nombreuses PAI. Certaines ont vécu des ruptures de ressources suite à l'impossibilité de joindre les services administratifs ; les communications se faisant essentiellement via Internet ou téléphone. D'autres ont perdu leur emploi suite au premier confinement ; le vieillissement ne signifiant pas toujours un arrêt de l'activité professionnelle. Plusieurs disent vivre d'importantes difficultés pour « *manger, payer les charges, le loyer, le téléphone* » (PAI-2-H66-HDF) et pour se procurer les ressources essentielles à une situation de crise sanitaire (gel hydro-alcoolique, masques et moyens de communication, cartes téléphoniques par exemple). De plus, le fait de ne plus pouvoir apporter un soutien financier à leurs proches au pays, engendre un fort sentiment d'impuissance et de culpabilité.

Ces difficultés, associées aux mesures de distanciation physique, aux

confinements et couvre-feux ont participé à exacerber l'isolement social et le sentiment de solitude. Les personnes n'ayant pas ou peu de réseau de soutien social et celles s'étant brutalement retrouvées coupées de leur famille ou de leur cercle d'amis (décès, éloignement subi ou par mesure de protection pour sa santé), sont parmi les plus touchées. Pourtant, nombreuses sont les PAI qui vivaient de l'isolement avant la pandémie, mais cette fois-ci « *ce n'est pas le même isolement* » :

Avec le confinement, je me suis senti réellement isolé, beaucoup plus qu'avant. Ce n'est pas le même isolement. Avec le confinement, on m'a pris la liberté d'aller dans les endroits où j'ai l'habitude de me rendre et où je rencontre des gens que je connais. PAI-7-H72-IDF

En foyers, la promiscuité constitue également un facteur de risque d'isolement, puisque certaines pratiquent des formes d'auto-exclusion par crainte de contracter le virus, ce qui engendre des situations anxiogènes :

Par exemple, pour la cuisine, je rentre en dernière. Comme aujourd'hui, c'était 6h30 où j'ai fait mon café. Il n'y avait personne. La bouffe, c'est bien après les autres. Quand je n'entends pas de bruit, j'y vais [...]. C'est stressant. C'est comme un poids. Ce sont ces choses qui ramènent une pression. PAI-6-F68-PACA.

Les fermetures soudaines et prolongées des espaces de sociabilité habituels tels que les cafés, les squares ou les lieux de culte ont bouleversé les repères de leur vie quotidienne en les privant d'activités et d'interactions physiques et sociales. Certaines ne sont plus du tout sorties de chez elles durant les confinements pour diverses raisons, tels que la peur de contracter la maladie, le manque ou l'incompréhension de l'information sanitaire ou encore la crainte des contrôles d'attestation

de sortie par la police (même si elles en possédaient une). Qu'elles vivent en foyer ou en habitats diffus, certaines affirment que l'isolement a engendré une dégradation de leur état de santé physique ou mentale. De nombreuses PAI disent désormais devoir quotidiennement composer avec l'angoisse, le stress, l'anxiété et la dépression. Ces problématiques de santé sont d'autant plus préoccupantes que la survenue de la COVID-19 a ralenti ou interrompu l'accès aux soins. Pour faire face à leur anxiété, certaines ont eu recours à des tranquillisants, tandis que d'autres ont plutôt opté pour des remèdes traditionnels :

Pour sortir il fallait une autorisation et je me rappelle cette situation, c'était un peu stressant, ça a augmenté mon angoisse. [...] Et en plus vous avez ce qu'on appelle la crainte, que y'ait une patrouille qui passe, même si vous avez le truc [l'attestation de sortie], qu'ils vous contrôlent. PAI-2-H70-PACA.

Cela fait plus d'un an, je ne bouge pas de chez moi et j'ai du mal à marcher [...]. Durant le confinement, je ne suis sortie que très rarement de chez moi. J'ai tout de suite senti que je n'arrivais plus à marcher comme avant (...). Des fois, je m'habille avec l'intention de sortir un peu et changer d'air et je finis par renoncer [...]. J'ai peur de tomber ou d'être bousculée dans la rue, car j'ai du mal à marcher. Je peux rester trois jours sans sortir de la maison. Je m'allonge sur le dos, je m'assois pour regarder la télévision et je finis par avoir mal au dos et aux jambes. PAI-9-F78-IDF.

Moi je me sens triste et angoissé, parce que je n'ai pas trouvé la solution. Je tourne dans un cercle fermé, autour de moi-même [...], surtout le soir, je me sens très triste, alors j'ai demandé un contact avec un psychologue ou bien un psychiatre pour discuter de mon problème [...]. La joie elle est partie dans mon cœur. La vie elle est devenue un peu triste. Moi

je suis devenu angoissé parce que j'ai vu la routine, toujours pareil. Avant je sors, avant je vais au cinéma, je vais au cirque, au stade pour voir les matchs, je prends un sandwich je vais au parc [...], je passais des journées efficaces. Et maintenant il n'y a plus rien du tout, je ne peux pas vivre comme ça, je suis angoissé. PAI-4-H64-HDF.

Ces sentiments d'angoisse et de désespoir ont été accentués par les fermetures soudaines des frontières internationales. Tel qu'expliqué, plusieurs vivent la pandémie de manière transnationale. Beaucoup s'inquiètent pour leurs proches, dans des pays où les systèmes sociaux et sanitaires sont défaillants. Par ailleurs, les restrictions de voyage et les protocoles sanitaires ont longtemps empêché les PAI de se rendre aux enterrements de leurs proches au pays ou en France. L'impossibilité de rapatrier les corps (en raison du contexte sanitaire, les personnes décédées du virus n'ont pas toujours pu être rapatriées) et leurs absences aux rites funéraires ont été vécues comme une grande souffrance psychologique, culturelle et spirituelle. De plus, une rumeur concernant l'incinération systématique des dépouilles a choqué et indigné les familles :

On écoute la radio, que des annonces qui font peur. On parle de gens qui meurent et le corps brûlés et non rendus à la famille. Chez nous, la famille est inquiète. On ne brûle pas les corps chez nous. La religion [musulmane] l'interdit. Du coup, les gens n'ont pas seulement peur de mourir, mais d'être brûlés. Il y a un autre problème aussi. On met les cadavres dans des sacs et dans le cercueil. On ne leur fait pas la toilette et ils ne sont pas propres, là aussi, c'est pas bien. Chez nous, il y a des spécialistes qui s'occupent de cela et qui donnent les soins pour que le corps soit

propres au moment où il est rendu à la terre. PAI-8-F71-IDF

Forces individuelles et communautaires des PAI dans le contexte de la COVID-19

Les liens familiaux, les solidarités citoyennes et communautaires, les croyances et pratiques religieuses et spirituelles figurent parmi les forces les plus fréquemment évoquées par les PAI. Ces forces semblent constituer d'importants leviers de résilience leur permettant de trouver des formes d'adaptation face à cette pandémie.

La famille agit comme un facteur de protection contre l'isolement. Pour celles qui maîtrisent les outils numériques, les applications de messagerie instantanée tel que *WhatsApp*, ont permis de garder un lien avec les proches et la famille en France et au pays.

Au début de la pandémie, des citoyens et associations se sont rapidement mobilisées pour soutenir les PAI dans certains quartiers (livraisons de colis alimentaires, soutien social, etc.). Les PAI se sont également organisées pour partager leurs informations et soutenir les plus vulnérables ou isolées. Les radios locales communautaires ont également joué un rôle intermédiaire, notamment pour la diffusion d'information multilingue.

Pour de nombreuses PAI, la survenue de la COVID-19 est vécue comme une épreuve divine : « *ce n'est pas la maladie qui tue, c'est le destin. C'est ton destin, Mektoub* » (PAI-10-H73-OCC), une mise à l'épreuve « *que le bon Dieu nous donne* » (PAI-3-F67-ARA), une « *maladie qui circule et qui agresse surtout les vieilles personnes [...], une volonté divine destinée à éprouver les hommes sur terre* » (PAI-8-F71-IDF). Leurs croyances et pratiques religieuses/spirituelles constituent un facteur de résilience majeur pour de nombreuses PAI. Elles les aident non seulement à trouver un sens à la survenue de cette pandémie, mais elle les aide aussi à faire face à l'isolement,

aux deuils, à la peur, au stress et à l'anxiété :

Moi, je tiens grâce à la religion, à la croyance en Dieu. C'est mon unique soutien dans cette épreuve et dans les autres épreuves de la vie. J'y trouve la force dont j'ai besoin pour endurer et patienter. Cela m'est d'une grande aide et je ne me sens pas seul dans cette épreuve. PAI-7-H72-IDF

Dès le début de la pandémie, plusieurs se sont d'ailleurs tournés vers leurs leaders spirituels ou religieux pour obtenir du soutien et de l'information. Ces leaders constituent des personnes-ressources importantes pour la plupart, car ils représentent des personnes de confiance.

Discussion

La COVID-19 a poussé le processus d'invisibilisation des PAI à son paroxysme. Nos résultats mettent en lumière le renforcement d'un système d'inégalités structurelles contribuant à surexposer les PAI aux impacts sociaux, sanitaires, économiques et psychosociaux de la COVID-19. L'inaccessibilité ou l'indisponibilité d'informations sanitaires officielles multilingues ; le traitement différencié des foyers non-perçus comme des établissements à risque pour ses résidents au même titre que les Ehpad (intervention tardive de la santé publique dans les foyers) ; la fermeture des administrations publiques et la généralisation des technologies numériques comme seul moyen de communication ; les pertes de revenus ; l'incompatibilité des mesures de distanciation et de confinement avec les logements ; les privations des espaces habituels de sociabilité ; les contrôles policiers (respect des consignes) ; la coupure brutale des liens familiaux et des réseaux de soutien social ; les fermetures des frontières internationales ou encore l'impossibilité de pratiquer leurs rites culturels, sont autant de facteurs nourrissant ce système d'inégalités.

Les impacts de l'isolement social et du sentiment de solitude sur la santé mentale des PAI sont préoccupants. L'isolement social agit comme un facteur de risque pour la santé physique et mentale des personnes âgées. Il peut notamment être à l'origine de symptomatologie dépressive, d'une détérioration cognitive, de maladies cardiovasculaires, d'une mauvaise auto-évaluation de sa santé ou d'un état général fonctionnel altéré (Yu & al., 2020). Bien que les impacts de l'isolement sur la santé mentale soient également vécus dans d'autres groupes sociaux, il importe de tenir compte des spécificités vécues par les PAI dans les programmes de rétablissement post-pandémique, car d'une part, la culture peut parfois jouer un rôle d'influence sur les perceptions autour de la santé, de la maladie et de la mort (considérant toutefois que les PAI ne sont pas un groupe homogène). D'autre part, nous savons que les gouvernements qui basent leurs réponses à une crise majeure de santé publique à partir d'hypothèses de risques égaux pour tous les groupes sociaux, sans tenir compte de leurs spécificités, risquent d'accroître les inégalités (Templeton & al., 2020).

Les associations citoyennes ancrées au sein des communautés s'avèrent efficaces en contexte de pandémie (Timmermann, 2020), car elles s'appuient sur les forces déjà présentes, entretiennent des liens de confiance avec les populations et savent comment développer des stratégies pour les soutenir efficacement en situation de crise. Pour Templeton et ses collaborateurs (2020), ces associations devraient faire partie intégrante des plans d'actions gouvernementaux en cas de crise sanitaire majeure, autant pour accroître l'adhésion aux mesures de santé publique que pour réduire le risque de défiance.

Nous avons vu comment les croyances religieuses et les pratiques spirituelles constituent un facteur de résilience

déterminant pour de nombreuses PAI. La résilience est à la fois un processus et un résultat correspondant à la capacité de rebondir après des épreuves de vie difficiles (Ramsey & Blieszner, 2013). Plus les individus vieillissent, plus la spiritualité devient une source de résilience (Manning et al., 2019). À partir du moment où elles font sens pour les individus, la spiritualité et la religion peuvent produire des impacts significatifs sur la guérison, le bien-être émotionnel, mental et sur l'adaptation (Walsh, 2019). Pour Pickard & King (2010), il est nécessaire de comprendre en quoi les croyances et pratiques religieuses et spirituelles constituent une source de résilience, car leurs impacts sur le bien-être peuvent aller jusqu'à compléter certains traitements médicaux. Nos résultats à ce sujet nécessitent d'être davantage explorés, dans la perspective d'un meilleur rétablissement post-pandémique des PAI, pour examiner comment la spiritualité peut constituer une stratégie d'adaptation et ainsi développer des méthodes d'interventions sociales spécifiques aux PAI.

Conclusion

Ces résultats préliminaires ne présentent qu'un pan des réalités vécues par les PAI dans le contexte de la COVID-19. Il demeure plusieurs analyses à affiner et des variables à croiser pour mettre en lumière et mieux comprendre les processus sociaux à l'œuvre dans les difficultés, les besoins et les forces des PAI, notamment en regard des parcours migratoires, des contextes locaux et des critères de genre. La phase 2 de notre collecte de données permettra de bonifier davantage ces analyses dans la perspective d'un renouvellement des pratiques du travail social auprès des PAI. En tant que discipline des sciences humaines et sociales, le champ du travail social est en effet appelé à se renouveler dans le contexte post-COVID-19. Les acteurs du travail social doivent nécessairement faire partie des

réponses sociales apportées à la lutte contre la COVID-19, compte tenu des savoirs dont ils disposent pour travailler dans des environnements particulièrement difficiles (International Federation of Social Worker, 2020).

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1.6. *The role of the Baptist church during the COVID-19 pandemic: A study of the Liangmai community in Manipur, India*

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Abstract

India is home to a number of religious faiths that continue to be an essential element of the modern world, evolving and taking diverse forms. These range from being used as an instrument for maintaining hierarchical structures of caste to a more liberal emphasis on contributing to the country's cultural diversity. More recently, the assertion of religious identity has been instrumental in occupying political space embedded with religious nationalism. The COVID-19 pandemic has brought to the fore yet another aspect on which religion tends to have an influence – its role in how people make meaning of epidemic diseases. This paper discusses the role of the Baptist church in the tribal Liangmai community in Manipur, India, and its work with the local polity in the struggle against the pandemic. It highlights how the local church, despite challenges related to the performative aspects of its religion, generates hope and faith within

the community and assists the local council to help the community in making meaning of the pandemic in the face of rising conspiracy theories. The paper also examines how the church worked with the local council to leverage Indigenous approaches to epidemic control and strategized new techniques to respond to the economic crisis brought about by the pandemic.

Introduction

The humanitarian crisis unleashed by the COVID-19 pandemic redirected attention to perceptions around vulnerability at the community level. People were rendered jobless, and the emergency lockdown in India implemented at the outset of the pandemic resulted in large-scale internal migration within a matter of days. As state borders closed, migrants with no other means of sustenance in cities headed back to their villages with their children, travelling on foot and carrying their belongings. Many faced immense difficulties along the

way. One account of a 15-year-old girl cycling 700 miles with her injured father on the back went viral on social media³⁴ (Gettleman and Raj, 2020). Meanwhile government restrictions were accompanied by instructions to wash hands frequently, sanitize and quarantine, directives that carried little to no meaning for migrant workers living on construction sites, slum dwellers with insufficient access to water or landless daily wage labourers living in villages. The pandemic, thus, affected all sections of society, but affected in particular marginalized people while shedding light on the profound vulnerability of their lives.

The pandemic also created fertile ground for stigmatization of and discrimination against people from Northeast India rooted in an age-old fixation with hierarchical norms. The pandemic took a communal turn when a religious gathering became the major for virus transmission during the initial phase of the pandemic. The hashtag #CoronaJihad started trending on Twitter and later became part of the national lexicon, linked to a conspiracy theory that painted Muslims as actors in a sinister plot to speed up transmission of the virus. This conflation of discrimination, marginalization and stigmatization led to the spread of wild rumours, which gravely limited understanding of the complex nature of the virus. The viral video of a daughter fighting her mother to give water to her COVID-19-positive father, who was gasping for air, was just one example of the far-reaching health consequences created by this stigma, mistrust and confusion (Sudir, 2021).

The pandemic had multifaceted consequences and severely affected the lives of all. Moreover, without a vaccine, social distancing became the only effective measure to curb the spread of the virus for many months, which had a lasting impact on the lives of the poor. In this paper, the

authors explore how the Liangmai, a rural tribal community residing in the Tamenglong district of Manipur, India, with limited medical facilities and stable means of sustenance, tackled the COVID-19 crisis during the initial months of the pandemic in 2020. The paper presents the findings of ethnographic data from the Baptist Church of Rianglong village, which, despite the challenges of performative aspects of its religion, generated hope and faith in the community and assisted the local village council to help the people make meaning of the pandemic in the face of rising conspiracy theories. The paper also highlights how organic linkages between the local church and village council, which comprised representatives of all clans in the village, proved vital in leveraging Indigenous modes of epidemic control and strategizing new techniques to respond to the predicament brought about by the pandemic.

Conceptual framework and methodology

This study is located within Marcel Mauss' framework of the exchange of gifts and Sánchez-Jankowski's social theory of local institutions in poor neighbourhoods. Mauss argued that the exchange of goods in many civilizations was made through gifts, which were voluntary in theory but repaid under obligation. His analysis of gift exchange in various Polynesian societies identified four themes: (i) a system of 'total services', (ii) the spirit of the thing given, (iii) the obligation to reciprocate any form of a gift, and (iv) the sacrificial exchange between humans and gods (Mauss, 2002: 10–20). Mauss' third theme (obligation to reciprocate) surfaced during the COVID-19 pandemic in the form of the local church's motivation to aid its members in a time of crisis. The notion of reciprocity incorporates the obligation to give, to accept and to repay, while the refusal to give or to receive constitutes a rejection of the bonds of alliance and commonality.

Furthermore, Sánchez-Jankowski (2008) demonstrates how local institutions in poor neighbourhoods of the United States, such as public housing, 'mom and pop' food stores, hair salons or barbershops, street gangs and high schools, play a vital role in sustaining local structures, providing meaning for residents in times of material scarcity. As a result, these neighbourhoods can be extraordinarily resilient in the face of both positive and negative external influences. By integrating the perspectives of Mauss and Sánchez-Jankowski, this study aims to shed light on the role of the Baptist church as a local institution within the village in the context of crises such as the COVID-19 pandemic.

The total population of Rianglong numbers around 1,000, including youth and children who have migrated to other places for education and work. As this study focuses on the role of the Baptist church as a local institution, almost all church leaders and elders were interviewed as well as village leaders, church workers, and the village COVID-19 committee and volunteers. The village has no formal statistical record on COVID-19 returnees. However, according to COVID-19 volunteers working at the village level, by April 2020, the village had received about three to five returnees each week, gradually decreasing to one person per week from July onwards.

The Liangmai Baptist Church in tribal society

The Liangmai people are a small tribe socio-culturally, politically and economically marginalized within the marginal Naga ethnicity group. They reside in peripheral areas of India, particularly in the states of Manipur and Nagaland. Their entire population as per the Census of India 2011, is 49,811. The majority are practising Baptist Christians, evangelised by the American Baptist Mission during the twentieth century. Indeed, a common feature of Liangmai villages is the ubiquitous presence of a Baptist

³⁴ The girl received the Prime Minister's Award a year later.

Figure 1. Rianglong village people walking to the field to construct quarantine huts

Church, whose role extended beyond religious worship, with education forming a significant component of the Baptist mission since the outset. The local Baptist church also contributes to the structure and life of the Liangmai village community in multiple ways. Sundays in the community weave around the vibrant gatherings of the community people in the local church. The degree of regularity in Sunday devotion is often viewed as an important trait of a person in the community. For instance, those who regularly attend church are believed to be more disciplined in abstaining from alcohol and tobacco usage. The local church is embedded in the community due to its multiplicity of roles, which includes facilitating economic mobility by providing loans to lower-income families to support managing social relations.

This paper highlights the multifaceted response of the Rianglong Baptist church to the COVID-19 pandemic. It attempts to understand the church's position while exploring intervention strategies to fight the virus and identifying and mediating socio-economic challenges during the pandemic.

Beginning of the COVID-19 pandemic: the Liangmai village context

On 24 March 2020, the first confirmed COVID-19 case in Northeast India, was reported in Imphal, the capital city of Manipur. It created panic in the city, and a few local news outlets reported hostility towards the affected person's family. The government immediately imposed a curfew to combat the virus and control the rising panic and chaos in the state (The Sangai Express, 2020). Shortly thereafter, a video of a young patient struggling for breath was widely circulated on WhatsApp. Without any clear mandate from the central government, on 25 March 2020, a nationwide lockdown was imposed.

The introduction of an emergency curfew stranded people from Liangmai villages who were working in the city of Imphal. With the help of elected members of the Autonomous District Council (ADC) of Tamenglong district, a few people from the community were able to reach the village safely. However, village people maintained a distance from them, suspecting them of carrying the COVID-19 virus. Conflicting notions about the virus circulated: some took the risk seriously and believed there was a need for immediate attention, others did not understand the complex nature of the virus,

and a few feared that their families would be stigmatized in the event of infection. The church and local council quickly realized that they had to formulate a plan to mitigate the risks of the novel virus and maintain social order in the face of rising chaos. On the night of 24 March 2020, Rianglong Village Council, along with the church, called for a General Body Meeting of all villagers to discuss precautionary measures to combat the spread of COVID-19. Their actions were based on information relayed by the government and their own Indigenous knowledge in dealing with infectious diseases.

Bringing back returnees and community quarantine

The quarantining of travellers was one of the few government mandates or guidelines issued at the outset of the pandemic. Enabling quarantine on arrival was therefore identified by the church and council as a priority. Finding an appropriate location and implementing the process required the support of the entire village. Initially, bamboo huts with banana leaves and tarpaulin roofs were built outside the village and transformed into quarantine facilities (Figure 1). However, these were not strong enough to withstand rain and wind or sufficient to protect against insects like mosquitoes, whose bites can cause fever akin to COVID-19

symptoms, which in turn might cause false alarms in the village and provoke fear among others caring for people with the virus.

Another challenge involved bringing stranded people to the village. Most families had members studying and working in major cities, so ensuring their safe transport and proper quarantine was a priority. The State Government of Manipur provided *Shramik* (Labourer) trains for stranded people from Manipur across Indian states and covered expenses related to train transportation to district quarantine centres, food for those quarantined and COVID-19 tests. Individuals who tested positive for COVID-19 were transferred to a district or government hospital at Imphal for treatment, while those who tested negative were sent home to their villages but would have to cover their own travel expenses. The majority of Liangmai returnees were students, while others worked in salons, spas and restaurants. As the national lockdowns lasted for months, most working people spent their modest savings on room rents and food in the cities. Most returnees were not in a position to pay transportation fares from the district headquarters to their respective villages. Likewise, their family members worked mainly in agriculture and could not bear these travel expenses, as they were, too, not receiving an income due to the state lockdown and travel restrictions.

At this critical junction, the Baptist Church of Rianglelong village felt it had a moral responsibility to assist families in bringing the returnees safely back to the village. Religious leaders made the claim that the essence of Christian teachings lies in helping the needy, and that extending a helping hand to people in need fulfils this Biblical mandate. The village elders, too, felt that it was the community's responsibility to bring the returnees home. Thus, Rianglelong village formed a COVID Task Force Committee, composed of deacons, village council members and a few educated

people from the village. The process of assisting returnees began in the month of April and continued till the month of August, over different days. As these trips represented a huge financial burden for the community, the village council and the Baptist church agreed to share the cost of each trip equally.

Returnees who tested COVID-19 negative would quarantine again at the village quarantine centre for 14 days. This step was taken to rule out any possibility of COVID-19 infection at the time of transportation. The village council decided that the community hall, the youth club hall, the village council office, the village student union office and a primary health centre, all of which are located in the same part of the village, would serve as the location for mass quarantine. The primary health centre has already been used as a quarantine site during the early phase of COVID-19 in 2020. Men in the village cleaned the compound of the buildings and built temporary toilets and a bamboo fence around the compound. The village council collected large pails from households to store water for use by quarantined individuals.

The village council also prepared a weekly volunteer roster and announced a list of names to the villagers. Every able-bodied man was appointed to be a volunteer, with the roster consisting of five to six volunteers per day. The idea behind the formation of the volunteer group was to minimize risks, while reinforcing the sense of mutual obligation among the members of the village. A secondary aim was to fight the stigmatization of people coming from outside the village. The main duties of volunteers were to oversee water supply and deliver firewood and food items to quarantined people, which were delivered to the volunteers by families or friends. Volunteers performed their duties from 6 AM to 9 PM. A tiny hut with a tarpaulin roof was constructed at

the gate of the quarantine centre for volunteers, who spent their time there playing carrom board and drinking black tea without milk and sugar. The village council and the church provided tea leaves, sugar and biscuits for the volunteers.

Prior to their conversion to Christianity, the Liangmai Naga had their own ancestral religion, which Niumai (2009) argues took the form of animism. The influence of Christianity and Hinduism has resulted in syncretism merging older and newer forms of religious practices (Atungbou, 2022). Traditional and customary rituals are performed by the Liangmai on ceremonial occasions but also to cope with crises. During the COVID-19 pandemic, the community increasingly resorted to traditional practices. In the past, when an epidemic broke out in the village, fresh leaves and stones were placed at the village gate and road. This symbolic measure restricted entry or exit from the village and acted as a warning for neighbouring villages while quarantining oneself (see Figure 2). The Liangmai used the term *chararet* to refer to epidemics. According to Rianglelong village elders, the last outbreak to severely affect villagers occurred in 1954–55, but was not identified by name. A sizeable number of people were infected and exhibited symptoms such as vomiting, dysentery and high fever. One of the village elders, Adinbou, aged 79, who lost his mother during the outbreak, had vague memories about the epidemic which he experienced as a young boy. Due to this and other outbreaks, the community remained fearful of epidemics, linking them to metaphysical explanations, which led to numerous (sacrificial) rituals to appease the spirits they believed responsible, and a traditional belief in quarantining.

There is a Liangmai saying, *chararet ra bai de bai lu ye*, which translates as 'cloistering can control/prevent epidemics'. While age-old traditional beliefs around epidemics contributed

Figure 2. Blocked entrance with stones to Rianglong village during the initial phase of the pandemic, March 2020

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to mitigating the risks of the COVID-19 pandemic, as historian Frank Snowden notes, each new epidemic has its own personality: some affect particular groups disproportionately, while others are more democratic (Gonzalez, 2020). Thus, each epidemic requires a new and innovative set of responses. The Liangmais, who have localised knowledge and experience in dealing with an epidemic, were not familiar with coronaviruses that can also be asymptomatic. Furthermore, there were looming uncertainties about livelihoods. This led to people questioning the need for prolonged obedience to lockdown mandates. Here, it is essential to study the Rianglong Baptist church's role in generating hope and making people understand its commitment to the community and maintaining economic and social order.

Lens of faith: meaning-making amid the COVID-19 pandemic

The COVID-19 pandemic has brought about multifaceted challenges, from generating fear among people, including those who have not had symptoms, to concerns about livelihoods. Thus, the COVID Task Force Committee engaged in constant dialogues on the need to

protect people of all age groups from the coronavirus. They argued that while healthy and younger age groups could travel to towns, if a person became infected, they might unknowingly spread the coronavirus to more vulnerable age groups (ageing population), as COVID-19 can be asymptomatic. Such behaviour, they argued, would be unethical on the part of responsible fellow villagers. Furthermore, the village had no hospital or medical professionals to treat COVID-19 patients. To further explain the complex nature of the virus, the church referred to gospel narratives to stress the need to obey government mandates.

During the COVID-19 pandemic, Khon, a deacon of the Baptist Church, drew lessons about finding hope and faith in God from the Biblical story of Daniel, who believed that God protected His faithful children in all situations. Liangmai Christians considered themselves God's children. Among the Bible-believing community, Daniel is a well-known figure for his obedience to God, and his story is recounted in church and taught at Bible school on Sundays. Daniel maintained cleanness, prayed regularly and interpreted the strange dreams of King Nebuchadnezzar. On

one occasion, the King ordered all his people to worship his statue, but Daniel refused, and was thrown into the lions' den. The lions failed to hurt Daniel, who was then pardoned, and the King declared that, henceforth, his kingdom would worship Daniel's God, that is, the Jewish God.

Using the analogy of Daniel's obedience to God, despite being in the lions' den, the church called for the same kind of obedience to government mandates, arguing that like God's Laws they expect people to behave like responsible citizens. This argument enabled each community member, who was also a church congregant, to view the prolonged lockdown protocols as an act of service to the Lord. In Paul's words, 'Everyone must submit to the governing authorities, for there is no authority except that which is from God. The authority that exists has been appointed by God' (*The Bible*, Romans. 13:2). In this framework, adherence to law and order and obeying those responsible for its maintenance, such as governing authorities, is equated with obeying God's commands.

Without a vaccine or even medical help at the village level, the only way option open to the villagers was to follow the quarantine rules and the restrictions on movement. After hours of discussion on how to control the pandemic, the COVID Task Force Committee came up with certain protocols to be followed. Anyone travelling to towns and neighbouring villages must quarantine at the village quarantine centre or quarantine at home. However, returnees arriving from cities outside Manipur were not given an option to home quarantine. Villagers who travelled to town for medical emergencies, such as purchasing medicine, or vehicle owners dropping sick people off and returning to the village on the same day, were not required to quarantine.

The Rianglong COVID Task Force Experiencee also drew up boundary maps experience in order to restrict mobility and combat the COVID-19 virus, ruling that anyone who crossed a boundary line between the villages must quarantine for 14 days. The villagers could not cross the Biuky (Barak) river to the south, the Jaduiky to the west, the Agiky to the east and the Kajinky river to the north. Although the committee's decisions were based on majority opinion, few villagers disagreed with the view that people travelling to neighbouring villages or towns needed to be quarantined.

On one occasion, an incident took place that required the intervention of the Church and the village council. In the month of July, a group of men went to hunt buffalo in a forest on the western side of the village towards the Jaduiky River for a period of three days, crossing a boundary decided upon by the COVID Task Force Committee. The party consisted of 15 hunters, and their wives and children, who had accompanied them into the forest to carry the buffalo meat. Around the same time, a number of villagers were quarantining at home after travelling to nearby towns. A few among them complained about

the hunters to the COVID Task Force Committee, making the point that everyone should be treated equally. Personal telephone calls were also made to the Committee, pastor and village elders. The complainants stated that they would end their home quarantine if the hunters were not quarantined. The village council, the church and the COVID Task Force Committee decided that since the accused villagers worked as cultivators, they could not be quarantined, as July is a busy month for most villagers, who would be occupied with paddy transplantation and weeding vegetable farms. Furthermore, the hunters had not come into contact with outsiders, hence there were minimal chances of infection, although they had crossed the village boundary as marked on the COVID-19 map. It was therefore decided that the complainants' arguments did not hold up and were made simply to hasten their own quarantine. To facilitate a reconciliation between the hunters and complainants, it was decided that the hunters would ask for forgiveness for crossing the boundary. Included among them was an elderly man, Dinrongbou Kalengta, aged 64, who sought forgiveness for making a mistake while hunting. The pastor read a Bible verse and shared a short homily on love and peace and led a prayer for the hunters and the quarantined villagers. Simultaneously, the COVID Task Force Committee admitted that they had made a mistake in mapping the boundaries and slightly altered the village COVID-19 regulations, specifically on the use of the forest for hunting, fishing and the collection of forest products.

The people's dissatisfaction with quarantine norms posed a major challenge for the church, village council and the COVID Task Force Committee. In an effort to manage and control the situation, the pastors and leaders creatively invoked the story of Noah's Ark to illustrate the significance of faith and hope in God,

as well as obedience to the village's COVID-19 regulations. According to the Bible, Noah had received instructions from God to build a ship to save his family and two of every kind of animal from the flood. This was construed as a form of quarantine, similar to the conditions of the people during the pandemic. Drawing on the insights of Martín Sánchez-Jankowski's seminal work, which explores the workings of local institutions in poor neighbourhoods, the church's actions here illustrate the crucial role that such institutions play in maintaining order and resilience within marginalized communities. Like the institutions examined by Sánchez-Jankowski, the Baptist church acted as a focal point for fostering community cohesion and developing crisis-response strategies, even strategically utilising religious allegory to support the local council in effectively implementing COVID-19 protocols, and subsequently maintaining social order in the village community.

Furthermore, the church cooperated with government directives to restrict all religious gatherings. Sunday gatherings at the church were a part of village life, and, for many, the church was more than a religious space. Prior to the pandemic, Sunday Church gatherings were viewed as a social event for this agricultural community, who worked the entire week and met fellow villagers only on this day at church gatherings. However, during the pandemic, the church encouraged everyone to pray at home. No devotional or ritual performances were allowed. However, the church's door was left open for solitary praying, a decision that was essentially symbolic in nature and intended to ensure that people did not feel abandoned during the pandemic. This was crucial because, unlike the city, religious organizations in village hinterlands were unable to explore digital spaces for gatherings and devotion, and villagers without cellular phones and the elderly, for whom sacramental devotion formed an important component of their

religious life, lacked an online medium to explore their faith.

The local church also provided counselling and support to villagers whose absent family members had tested positive for COVID-19. A few of the returnees from major cities had tested positive in the district, and their parents back home had no knowledge of their well-being due to weak phone networks. The minimal knowledge that villagers had of COVID-19 was taken from circulating videos of affected people gasping for oxygen, which triggered fear and a sense of vulnerability among concerned family members. Here, the church stepped in to provide counselling and relayed prayers for the family. Their approach was designed to control any misinformation that could create panic and address any form of stigmatization, focusing on the strength of social associations in stressful situations.

Pastors and deacons also played a crucial role in convincing people of the importance of following the government mandate to wash their hands frequently, even if there were no active cases in the village. This was important as the use of sanitizers was a luxury limited to people belonging to certain status groups. In short, in the absence of a vaccine or institutionalized medical help, the church provided support to the village council to help the community understand the nature of the virus at a time when the COVID-19 pandemic had brought shame, fear, stigmatization, despair and economic hardship.

The church's role beyond the religious space

The Baptist church has a significant presence in the lives of the people of the Liangmai community, extending beyond its role as a religious institution. Indeed, the church is vital to the social structure of the village; however, its importance became even more clearly defined with the onset of COVID-19 pandemic. While religious

gatherings were temporarily halted, the church's work spilled over into other areas that required immediate attention. This section discusses some of the actions and initiatives taken by the church during the pandemic.

Donation drive

During the first phase of the nationwide lockdown, the church initiated a donation drive to support stranded students and workers in the cities. Pastors and deacons donated half of their monthly salaries, and the church sent Rs. 500 (approximately \$6.50) to members that were stranded in cities. According to the church, the idea behind sending this support, although meagre, was to remind church members that their church was there for them during this stressful time. Recipients sent grateful messages to the church for remembering them during their distress. Liangmai, as a tightly knitted tribal community continues to maintain strong social ties, which are strengthened during moments of overwhelming uncertainty.

Food

Anthropologists view food as a mechanism to develop social relationships of exchange and alliance between individuals and create solidarity among a group of people. Sharing food is a vital and integral part of tribal and social life in the Liangmai village. The practice has different meanings; for example, if families are unable to provide food during marriage ceremonies, kinsmen come forward to provide support, offering rice, vegetables and, in a few cases, meat. Meanwhile, the Feast of Merit, celebrated in the region, is a means to obtain social recognition. Most importantly, sharing food in the Liangmai community is understood as a way to cement social bonds.

During the quarantine process, the church prepared dinners for returnees at the village quarantine centre, and the deacons and pastors once again donated half of their monthly salaries

to make this possible. According to the church leaders, the significance of this simple act lies in showing love and respect for its members. It was also an act of reciprocity for the returnees acknowledging their active participation as church members. Kania, one of the deacons, explained that the returnees consisted mostly of stranded students and workers, whose return home involved crowded trains, a lack of proper meals and state-quarantined centres at the district level, among other difficulties. Having arrived they were now complying with the village's COVID-19 rules by isolating in the quarantine centre. The occasional preparation of dinners was a means to convey the church's love and care for them, while showing that the church shared their difficulties in spirit.

Medicine

One of the most difficult realities for the village during the COVID-19 pandemic was the lack of institutionalized medical support. The nearest town, Tamei, where villagers usually go in the event of medical emergencies and to procure medicines is 29 kilometres away. The village is linked to the town via a dirt road that is impassable by motor vehicles for much of the year. The difficulties involved in making this journey were exacerbated by travel restrictions and fear of the virus, notably during the early phase of the pandemic. The church recognized the gravity of this problem and responded by amassing first aid kits and build stocks of medication and syrups to treat viral fever, diarrhoea and wounds. These medicines were given away free to anyone who fell ill. As the majority of villagers work in agriculture, they are regularly exposed to the sun and rain, making them vulnerable to fever and aches. Such symptoms during the pandemic provoked panic, made worse by the travel restrictions; hence, the church focused on minimizing health risks in a situation of limited medical support from the state. Personal Protective

Equipment kits were also procured to handle suspected COVID-19 cases.

Vaccination

At the beginning of 2021, the Indian government launched its COVID-19 vaccination drive. Vulnerable populations, such as the elderly and people with comorbidities, were the first to be vaccinated. Gradually, vaccination was opened up to other age groups. The state medical team of Manipur went from village to village for the COVID-19 vaccination drive. However, many among the Liangmai community were reluctant to get a COVID-19 vaccine, as conspiracy theories on the subject were circulating widely on social media. Some believed that the vaccine would cause infertility while others thought it would shorten their lifespan. Another more extreme conspiracy theory about the COVID-19 vaccine was faith-based in origin. Many locals believed that those who received the vaccine would be marked on their body with the number 666, turn into beasts and go to hell. The church tried to address such mistaken beliefs and confusion with the help of Bible verse.

The origin of the fascination with this number experiences the Biblical verse: 'This calls for wisdom. Let the person who had insight calculate the number of the beast, for it is the number of a man; and his number is six hundred and sixty-six' (The Bible, Revelation 13:18). The church addressed this concern by emphasizing the application of wisdom. Pastors and deacons worked to help people understand that Christians around the world, including the Liangmai, had been praying to God for the development of a COVID-19 vaccine. These prayers, they explained, had been answered with the development of a vaccine by scientists and the medical community, with God's grace. Thus, it made little sense to doubt a vaccine that one had been praying for. They further pointed out that the government had approved the vaccine, and that it was the duty of every Christian to support medical

personnel and get the vaccine once the vaccination drive reached the village, in order to end the pandemic.

The Liangmai people believe that knowledge comes from reading books and life experiences but that wisdom is derived from Divine Power. A person can possess knowledge about many issues but might lack wisdom, which is essential to manage life situations. The church made the case that this Divine Power gave scientists the wisdom to develop a vaccine, which people must not be afraid to take. Such effective use of Biblical narratives convinced many among this religious community of the need for vaccination.

Livelihoods

Lastly, the majority of Liangmai are cultivators whose primary source of income is the sale of agricultural products they grow. Prior to the pandemic, villagers would usually sell their produce in nearby towns, taking agricultural products from other houses to sell. On their return, they would buy other goods for the village. Barter also occurred but on a small scale, never involving the entire village. However, due to the lockdowns and travel restrictions, villagers were unable to sell their produce in nearby towns, or bring in necessary goods from outside, effectively dismantling their market outlets. Moreover, many local agricultural products, such as bananas – the principal commercial crop grown in the village – were perishable and needed to be sold immediately. The peak season of banana production is from May to July, and growers would suffer significant losses if unable to sell their produce during this time.

To counter this problem, the village COVID Task Force Committee, composed of council members, church and educated people, arranged to exchange company-manufactured goods with the villagers' agricultural produce. The committee contacted a trader from Kanglatongpi (near Imphal, the capital of Manipur) who has interested in

bartering for agricultural products with *daal* (lentils), *Maggi* (noodles), toothpaste, toothbrushes, soap, biscuits, detergent powder, salt and sugar. The committee calculated the price of the local produce, mainly bananas, taking into account the local market rate. These amounts of money and bananas were recorded prior to the exchange, and the bananas and vegetable produce were kept at a specific site, so that the villagers did not have to come into contact with outsiders (Figure 3), who in turn were given a place to stay overnight while their own products were stored. Before leaving they collected the villager's agricultural products, and after a gap of two days, the COVID Task Force Committee delivered the bartered factory goods to the village households.

The committee had to deal with a number of risks associated with the mass-scale exchange of products. They had to ensure that the barter represented a fair exchange, and that the families involved received a fair share and were not economically exploited or forced to sell perishable items at lower rates. They also guaranteed the villagers' safety from outside contact.

Figure 3. Rianglong village people bartering bananas for factory-made products

Conclusion

The Liangmai community, with a total population of 49,811, is socio-culturally, politically and economically marginalized within the marginal tribal Naga community. Their vulnerability across different spheres became all the more acute during the pandemic. In this context, the Baptist church, which is managed by the local people, stepped up to support its members. The empirical data analysed within a framework developed by Mauss (2002) indicated that the church felt obliged to fulfil its duties by supporting both the villagers' spiritual and non-spiritual needs during the pandemic. Mauss' third theme, 'obligation to reciprocate', is of particular relevance to the case of the Baptist church, as members provide constant support to the pastoral administration, funding church's activities through donations and getting involved in voluntary labour related to church construction and administration work. Such reciprocal relationships implied a moral obligation on the part of the church to curtail the effects of the pandemic on its members. More than the act of giving the gift, Mauss emphasizes the long-term relationships that the gift system opens up and the social associations that it fosters. The church, too, in the context of the village, has become more than a religious

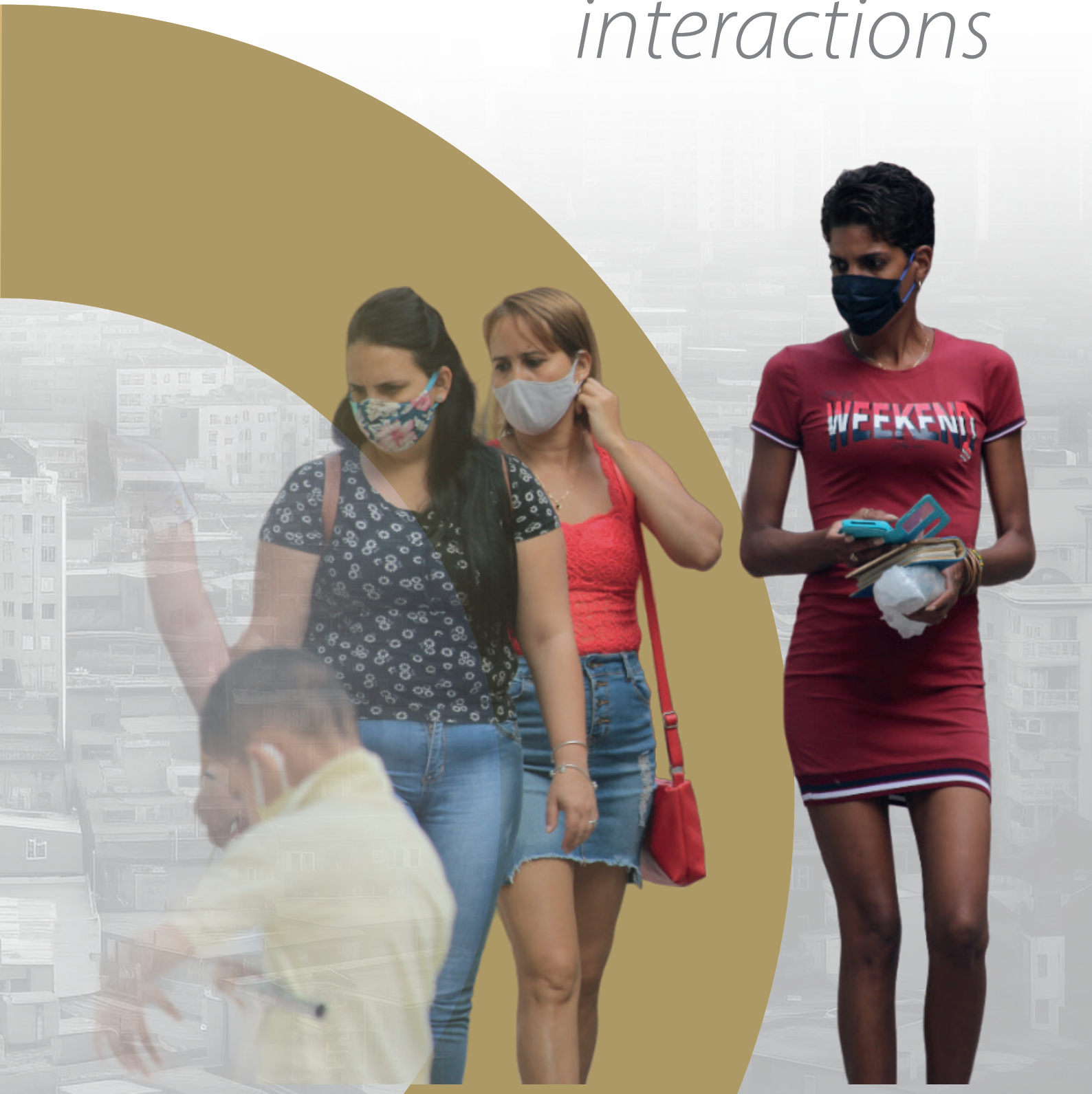
institution, extending its importance beyond the religious realm through constant interactions and associations with local people and institutions.

Furthermore, drawing on Sánchez-Jankowski's (2008) work on poor neighbourhoods, it becomes evident that local institutions function as important centres of community life, creating structure out of disorganization. In the context of Rianglong village, the local church supports the village council in maintaining the social order and helping people to navigate the COVID-19 pandemic. Nevertheless, Indigenous Liangmai Christians in India, unlike Western societies, lack a clear separation between the secular and sacred spheres. In this context, the Liangmai Baptist church has interwoven its religious obligation of worship with the central role it plays in catering to both the spiritual, psychological and physical needs of church members.

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Part 2 — Bio-politics and social interactions



2.1. Corona in the time of war: A cross-sectional study from Syria³⁵

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Abstract

In recent years, Syria has faced immense humanitarian challenges. The long and ongoing conflict has taken a massive toll on the Syrian healthcare infrastructure, a situation further compounded by the COVID-19 pandemic. In order to counteract the consequences to the fragile healthcare system, 'flatten the curve' of COVID-19 and save lives, increased attention is being paid to preventive and prophylactic public health interventions focusing on the knowledge, *attitudes* and practices of the population. In this framework, a cross-sectional study employing an interview-structured questionnaire was carried out in four different cities in the Syrian Arab Republic – Aleppo, Damascus, Dayr Ez Zawr and Hama. The Syrian population reported good knowledge of various aspects of COVID-19 (73.4 per cent), high levels of self-efficacy, low levels of social and *anticipated stigmas*, and moderate practising of preventive measures. Meanwhile, the multilevel regression analysis demonstrated a positive association between knowledge of COVID-19 and the practising of preventive measures. However, willingness to be vaccinated was low and traditional means of public health communication were limited in their reach. In conclusion, local and global stakeholders should work together to ensure immediate availability of COVID-19 vaccines, without restriction, and to organize mass-vaccination public information campaigns.

Introduction

When armed conflicts coincide with outbreaks of infectious diseases the outcomes on populations can be severe. Wars steadily deteriorate the political, economic and social structures of countries, eventually leading to an inevitable breakdown of basic life infrastructure and institutional systems (Pergolizzi et al., 2021). Weakened healthcare systems, suffering from ongoing shortages of staff and resources, are no longer able to prevent the resurgence and spread of diseases, which further complicate and amplify existing problems facing the population (Dureab, Al-Awlaqi and Jahn, 2020; Glans *et al.*, 2021; Mackowiak, 2021; Mousavi and Anjomshoa, 2020). In order to counteract the consequences of such fragile healthcare systems, 'flatten the curve' of COVID-19 and save lives, increased attention is being paid to prevention and prophylactic interventions focusing on the knowledge, *attitudes* and practices of the population.

³⁵ This article is one of many efforts of the Pharmasophy Division, Saarland University. The authors would like to express their deep appreciation to the 31 study volunteers who wish to remain anonymous. They would also like to thank Hassan Saifo and Ali Saeed from the Aga Khan Foundation, Mohammad Aukal from the Faculty of Economic, Damascus University, and the Presidency of Damascus University, represented by MHD Yassar Abdin, for their helpful discussions and advice. Gratitude is also owed to colleagues in the Pharmasophy Division and Academia International network.

The situation in Syria is highly complex. The long and ongoing war has been described as one of the worst humanitarian crisis of the twenty-first century. Politically, the country is almost isolated from the rest of the world. Several international sanctions enforced on Syria, such as the Caesar Act imposed by the United States (US) in 2019, have amplified the tragic circumstances of the population (Aita, 2020). Economically, the country's Gross Domestic Product (GDP) has shrunk by 60 per cent since 2011 (from US\$67.293 billion to US\$27.2 billion in 2021), while the inflation rate has reached around 1,300 per cent pushing 85 per cent of the population under the poverty line (Aita, 2020; Devadas, Elbadawi and Loayza, 2019; Haruna, 2021; Makki, 2021). The crisis has also displaced over half of the population: 4.8 million Syrians have sought refuge in neighbouring countries, where they live in challenging conditions, and about 7 million have migrated internally to safer cities, increasing pressure on an infrastructure already on the verge of collapse (Abdin, 2017; Doocy and Lyles, 2018).

These manifold, complex setbacks over the past decade have taken a massive toll on the Syrian healthcare system. The pharmaceutical industry, which in 2011 provided 93 per cent of local needs, can now only meet 10 per cent of requirements, resulting in a staggering increase in the prices of medication and a sharp decrease in the availability of essential drugs (Sahloul et al., 2022). Furthermore, in 2014, it was reported that at least 80,000 healthcare professionals had left the country, triggering a large gap in specialized human resources (Sharara and Kanj, 2014). The epidemiological outcomes of such scarcities and dwindling infrastructure have been rendered conspicuous by the resurgence of pre-war controlled or eradicated diseases such as cholera, hepatitis A, leishmania, meningitis, measles, polio, scabies and tuberculosis (Abbara et al., 2020; Aburas et al., 2018; Hotez, 2021;

Icardi and Tassinari, 2018; Mbaeyi et al., 2017; Miri and Alavian, 2017; Sparrow et al., 2016; Youssef et al., 2019). The World Health Organization and the United Nations Office for the Coordination of Humanitarian Affairs are preparing for the worst and require immediate additional funding (OCHA and WHO, 2021; WHO, 2021).

In 2020, the COVID-19 outbreak resulted in devastating consequences for the population and compounded existing difficulties caused by the ongoing war. The first case of COVID-19 in Syria was reported on 22 March 2020 and the first death was announced by the Syrian Ministry of Health seven days later (Ahdab, 2021). The total number of the population infected up until February 2022 was 51,341 with a death-toll of 2,968 (Ali, 2020). It should be noted that these numbers only represent confirmed cases from polymerase chain reaction (PCR) tests and that capacities to perform such tests are very limited. Moreover, an absence of reliable and substantial data from Syria on the development of the pandemic is noticeable due to the repercussions of the ongoing conflict.

The authors of this article therefore opted to carry out a knowledge, attitude and practice (KAP) study in Syria, a type of study that has gained increasing attention in public health management and policy-making (Chan et al., 2020; Ditekemena et al., 2021; Dodd et al., 2021; Dzisi and Dei, 2020; Hassan et al., 2020; Lee et al., 2020; Mousa, Saad and Abdelghafor, 2020; Ngwewondo et al., 2020a, 2020b). The results of the study would establish the level of knowledge about COVID-19 among the Syrian population, their attitude towards halting its spread and their practice of preventive measures. If found, low levels of knowledge, negative *attitudes* and a lack of preventive measures would raise serious red flags of urgency.

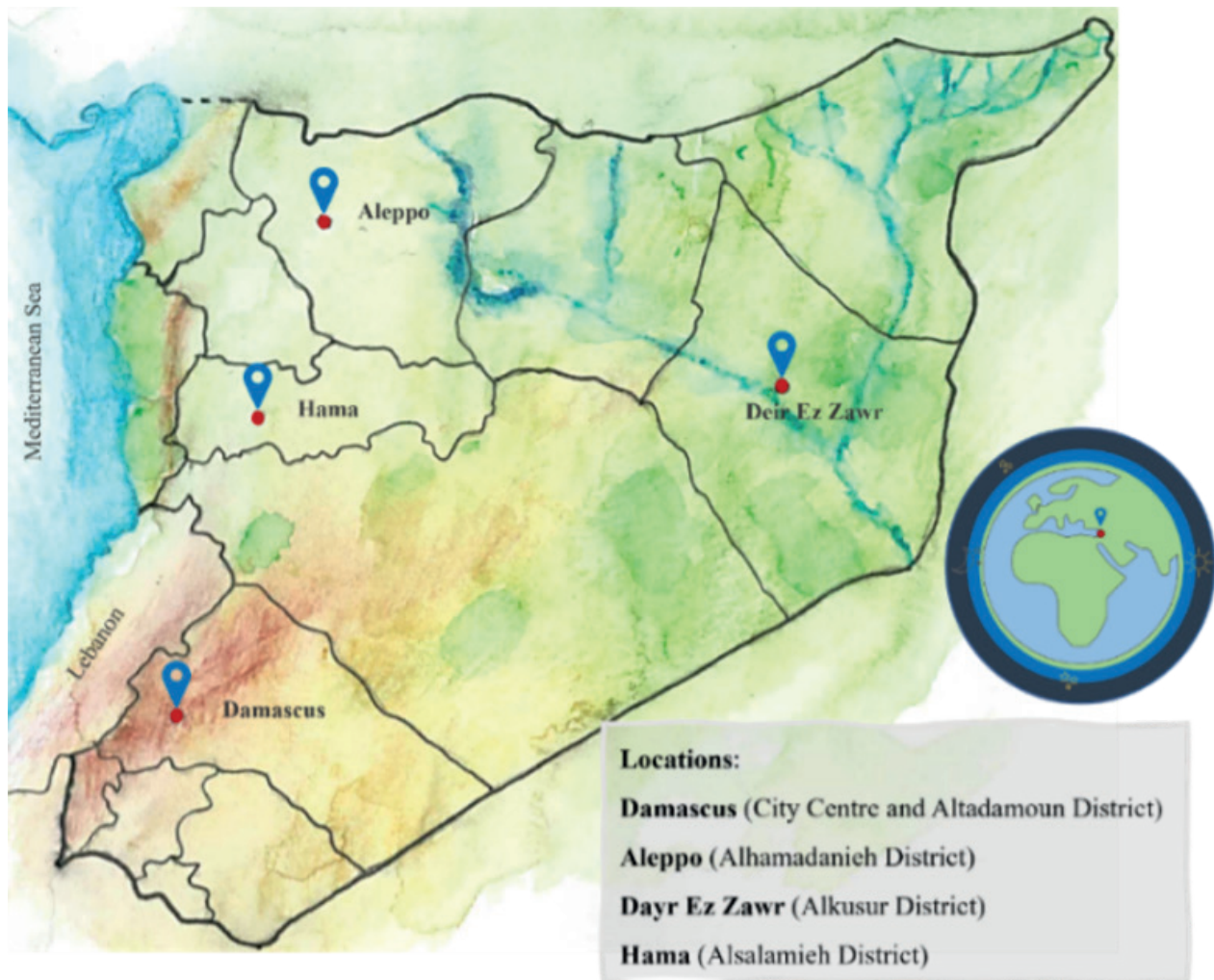
It should be noted that in the context of this study the term knowledge aimed to capture the facts, awareness or information obtained through experience or education on the questionnaire items. The term *attitudes* refers to meant self-efficacy, that is, the perceived ability to perform a specific act in a certain situation, social stigma understood as discrimination against individuals with certain characteristics diverging from the social norm, and *anticipated stigma* which denotes the belief that individuals would suffer discrimination from others for having certain characteristics in the future. The term *practices* related to whether the respondents adhered to the WHO recommendations on COVID-19, (i.e. wearing a facemask, practising social distancing, regular hand washing with soap and willingness to receive the vaccine). Further statistical analysis employed multiple linear regression to explicate the various influences of the differences among the Syrian population in terms of their socio-demographics, knowledge and *attitudes* towards practising the COVID-19 preventive measures.

Materials and methods

Design of the study

To gather these data, a cross-sectional study employing an interview-structured questionnaire was applied in four different cities in the Syrian Arab Republic: Damascus (City Centre and Tadamoun District), Aleppo (Alhamadanieh District), Dayr Ez Zawr (Alkusur District) and Hama (Salamieh District), as shown in Figure 1.

Randomizing the sampling technique was not possible due to limitations of mobility and accessibility. Instead, the research team was advised to implement convenience sampling at a safe designated locations to avoid unnecessary risk. The data collection was carried out on the spot by the principal investigator and 31 trained volunteers every day (8:00–20:00 hours) between 9 August 2021 and 20 August 2021 in the designated

Figure 1. A map of Syria showing the different locations of data collection

Source: Afraa Razouk, Ahmad Yaman Abdin, Prince Yeboah, Jawad Nasim, Claus Jacob, Werner Pitsch, Mohammad Maarouf.

locations using the KoBoCollect application on smartphones and tablets. The questionnaire was translated from English to Arabic and the responses were translated back to English by a professional linguist.

Preparation of the questionnaire

The questionnaire was designed and validated by the authors in a previous study (Yeboah et al., 2021). It was divided into four main sections: socio-demographics, knowledge, attitude and preventive practices. Excluding socio-demographics, the questionnaire had 42 items. The section on socio-demographics collected information on the age, gender, marital status, educational level, occupation sector, type of community and city of the respondents. The knowledge section consisted of four subsections

assessing the knowledge of the population about COVID-19 as well as other knowledge points of reference to allow for comparison and better understanding of the results. The first subsection covered general knowledge of infectious diseases with two categorical questions. The following two subsections addressed knowledge of two infectious diseases that have reappeared over the past decade of conflict, (polio and leishmania) and had four categorical questions each. The final subsection assessed the knowledge of the respondents of COVID-19 with nine categorical items. The attitude section consisted of three subsections which assessed the attitudes of the respondents in terms of self-efficacy, social stigma and anticipated stigma, with five continuous items for each. The last section addressed the

practice of preventative measures by the respondents with eight categorical questions.

It must be noted that the topic of the questionnaire was highly specialized and incorporated diverse points of interest ranging from knowledge of infectious diseases, symptoms and modes of transmission, to attitudes of self-efficacy and stigma, and a bundle of different preventive practices. As a result, no internal consistency was expected in the knowledge and practice sections.

Data collection

As the study was observational and had no control group, no pre-supposed sample size was calculated. After excluding faulty entries, the total sample size was (n=2,568). Only individuals aged between 18 and 54



were included in the study as they represent the majority and most active and productive section of the Syrian population, and therefore most likely to contract and transmit COVID-19. Individuals with a health-related professional background were excluded from this study as their knowledge and training might confound the results. The study was anonymous with no personal data collected from the respondents, and therefore required no ethical clearance. Nevertheless, informed consent forms were obtained from each of the participants.

Statistical analysis

The raw data was exported from the KoBoCollect application into Microsoft Excel version 16.34 (2019) spreadsheets and processed. The analysis of the data employed linear multiple regression models and was conducted using R (R core team, 2021) including car (Fox and Weisberg, 2019) and boot packages (Davison and Hinkley, 1997) at the Department for Economics and Sociology of Sports, Faculty of Economics and Empirical Human Sciences, Saarland University, Germany.

The data were tested (Chi-squared test) for representativeness of the Syrian population and were found to be non-representative in terms of age, gender, community and city. As a result, descriptive statistics were calculated as weighted means. The weights were calculated from the univariate marginal distributions, thus assuming that age, gender and city are independent. Therefore, age, gender and city were included in all the statistical models to control for error variance and confounded results from unequal cross-distributions.

In the knowledge section, the scores of the respondents were presented as weighted mean numbers and standard deviations. The scores in this section were computed via the mean number of correctly ticked answers and correctly unticked answers, hence, correcting the overall score for each question or non-response. Similarly, in the practice section, a total score representing the average weighted mean for practising of preventive measures against COVID-19 was calculated for the Syrian population. The attitude section had a normal Likert scale from 1 to 7 and the population scores were

presented as an average weighted mean within the range of 5 and 35 given that each subsection had five items.

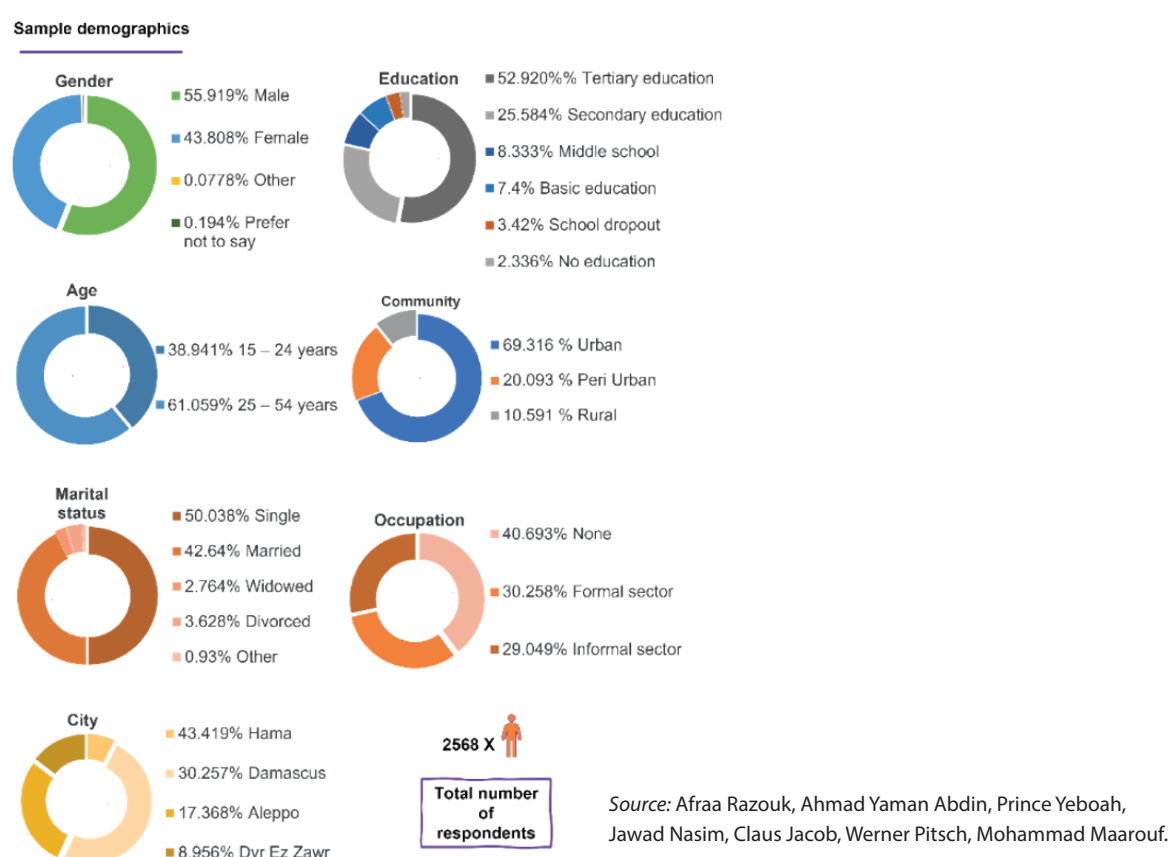
For the multiple regression analysis, gender was reduced to levels 0 and 1, excluding the seven individuals who answered other than 'male' or 'female'. The remaining factor was binary, and the sample size left for the regression analysis was ($n=2,561$). Age was entered as a continuous variable. City was dummy-coded to provide significance tests for contrasts between Hama, Aleppo and Dayr Ez Zawr, and the capital city Damascus. Multicollinearity was studied on the level of individual predictors. To this end, both the intercorrelation matrix of models and the variance inflation factor VIF were computed. Only weak multicollinearity was observed throughout, indicating weak correlations between the independent variables and hence better models and results. Normality in the distributions of variables was assessed through use of the Shapiro-Wilks test and also by skewness and kurtosis. In the case of deviation from normality, 2,000 bootstrap-replications of the designated regression coefficients were computed using the bias-corrected and accelerated bootstrap interval. *T*-values, beta coefficients and adjusted *R*-squared values were reported, as appropriate. Test results for the independence of errors (Durbin-Watson-Test), outliers and influential cases, and one-sided 5 per cent Bootstrapped Confidence intervals were reported when applicable.³⁶

Results

Descriptive statistics

This section presents the descriptive statistics of the results obtained in the study.

³⁶ The gathered, generated and analysed data and the questionnaire are available upon reasonable request.

Figure 2. Socio-demographic characteristics of the 2,568 study respondents**Socio-demographic indicators**

The socio-demographic characteristics of the (n=2,568) participants in the study are summarized in Figure 2.

Average scores in the knowledge section

The weighted mean numbers and standard deviations of respondents' knowledge scores are shown in Table 1. The average score of the population for knowledge of COVID-19 is 73.4 per cent.

Average scores in the attitude section

The weighted mean numbers and standard deviations of respondents' attitude scores are shown in Table 2. The results are interpreted on a scale from 5 to 35.

The results show that the sample has generally high self-efficacy towards practising preventive measures and low to moderate levels of social and anticipated stigma.

Table 1. Weighted mean numbers and standard deviations of respondents' knowledge scores in the knowledge section

Domain of knowledge	Mean	SD
General knowledge of infectious diseases	0.559	0.148
Polio	0.718	0.079
Leishmania	0.790	0.080
COVID-19	0.734	0.105

Table 2. Weighted mean numbers and standard deviations of respondents in the attitude section

Attitude	Mean	SD
Self-efficacy	23.368	6.733
Social stigma	9.579	5.922
Anticipated stigma	9.674	5.763

Table 3. Practices of preventive measures of respondents

Practice	Responses % (n=2,568)	
	Yes	No
Wearing a facemask	71.37	28.62
Regular hand washing with soap and water	84.71	15.2
Social distancing	38.50	61.49
Vaccinating against COVID-19	51.96	48
Testing for COVID-19	26.98	73.1
Avoiding social gathering	42.66	57.33
Avoiding unnecessary traveling	33.56	66.43
Eating a balanced diet	15.44	84.5
Using medications	20.26	79.73
Seeking spiritual protection	9.95	90.04

Average scores in the practices section

The responses of participants on the practice of preventive measures recommended by the WHO among others are summarized in Table 3. The weighted mean number and standard deviation of respondents' practice scores is 52.8 per cent (weighted SD: 0.133).

Regression analysis

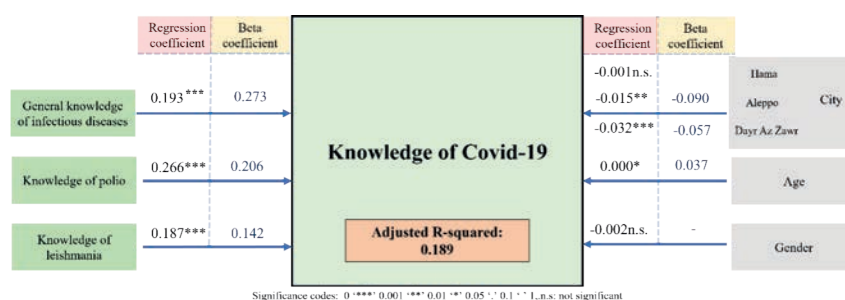
Knowledge of COVID-19

A multiple regression model was built to assess the association between knowledge of the sample on COVID-19 on the one hand, and knowledge of additional domains of knowledge on the other. Knowledge of COVID-19 was computed as a dependent variable and general knowledge of infectious diseases, knowledge of polio and knowledge of leishmania as independent variables, as demonstrated in Figure 3.

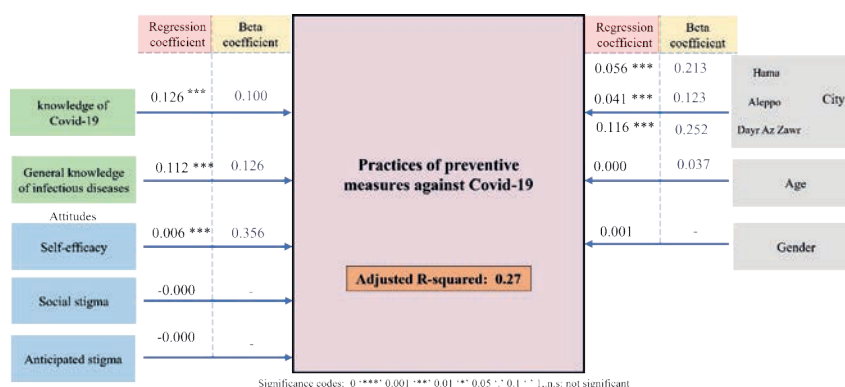
The model showed a significant positive association between the different domains of knowledge and knowledge of COVID-19.

Knowledge, attitude and practice towards COVID-19

A linear multiple regression model was built to assess the association between knowledge and attitude of the sample towards COVID-19 on the one hand, and their practice of preventive measures to halt its spread on the

Figure 3. Model employed to assess the influences of other domains of knowledge surveyed on knowledge related to COVID-19

Note: Results are shown in terms of coefficient estimates and beta coefficients. The adjusted R-squared value of the model was 0.189.

Figure 4. Model employed to assess the influences of knowledge and attitudes on the practice of preventive measures recommended by WHO

Source: Afraa Razouk, Ahmad Yaman Abdin, Prince Yeboah, Jawad Nasim, Claus Jacob, Werner Pitsch, Mohammad Maarouf.

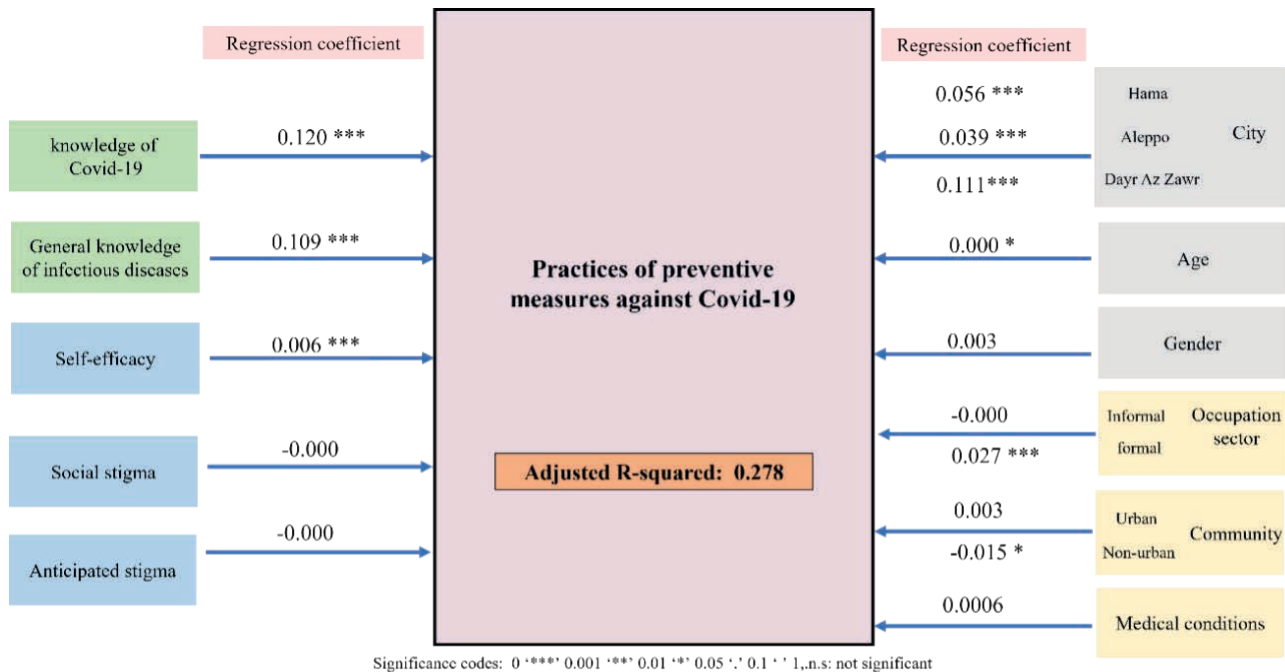
Note: The results are shown in terms of coefficient estimates and beta coefficients. The level of explained variance in the results of this model was 0.27.

other. Practice was computed as a dependent variable with general knowledge of infectious disease, knowledge of COVID-19, as well as self-efficacy, social and anticipated

stigmas as independent variables, as shown in Figure 4.

The results of the model demonstrated a significant and positive association between the

Figure 5. Extended model employed to assess the influence of knowledge, attitudes and socio-demographic elements (type of community, previous or existing medical conditions, and occupational sector) on the practice of preventive measures recommended by WHO



Source: Afraa Razouk, Ahmad Yaman Abidin, Prince Yeboah, Jawad Nasim, Claus Jacob, Werner Pitsch, Mohammad Maarouf.

Note: The results are shown in terms of coefficient estimates and beta coefficients. The level of explained variance in the results of this model was 0.27.

practice of preventive measures and both general knowledge of infectious diseases and knowledge of COVID-19, as well as self-efficacy. The adjusted R-squared value of the model was 0.27.

Socio-demographic characteristics influencing the practice of preventive measures

The KAP multiple regression model, mentioned earlier, was extended by stepwise addition to include the occupational sector, both formal (working in an institution or organization) and informal (people not formally employed); type of community (urban or non-urban); and whether the individual suffered from a pre-existing medical condition. The extended model showed that including neither the medical history in the analysis nor the type of community added significantly to the explanation of practices to prevent COVID-19 infection, as illustrated in Figure 5.

The individuals employed in the formal occupational sector showed significantly higher practice of preventive measures against COVID-19, and the level of explained variance of the model increased by 0.8 per cent.

Discussion

Knowledge, attitude and practice among the Syrian population

The Syrian population reported adequate levels of knowledge related to infectious diseases, relatively positive attitudes toward preventive measures against COVID-19 and moderate compliance with practising preventive measures. Given the novelty of COVID-19 and the weakened healthcare system, the knowledge scores reported above are indeed high. This fact can be further refined by comparing what Syrians knew about COVID-19 and both polio and leishmania, which caused previous epidemics, resurged in recent years, and continue to be the topic of educational and awareness campaigns (European Pharmaceutical

Manufacturer, 2018; Kar-Gupta and Copley, 2021). On closer inspection, the level of knowledge among Syrians of COVID-19 correlated positively with other domains of knowledge. This means that, for instance, an increase in the population's knowledge of leishmania would lead to an increase in their knowledge of COVID-19. Differences in knowledge related to COVID-19 among individual Syrians can be predicted only at a level of 18.9 per cent from her/his knowledge of polio and leishmania, as shown in Figure 3. Hence, a Syrian with a high level of knowledge regarding leishmania and polio does not necessarily have a high level of knowledge about COVID-19. The knowledge is not transferable. Moreover, no significant differences were recorded between Syrian women and men in terms of knowledge of COVID-19. However, younger Syrians demonstrated a slightly higher knowledge of COVID-19. The level of knowledge in the capital Damascus was significantly higher than in Aleppo and Dyer Az Zawr, but not Hama.

Knowledge among concerning COVID-19 was positively associated with their practice of preventive measures. Accordingly, increasing knowledge related to COVID-19 would translate to better practice of preventive measures, thus halting the spread of disease. Yet, the results illustrate that efforts to predict the practice of preventive measures from knowledge about COVID-19 enjoy only limited success, as not every Syrian who knows about COVID-19 complies with the preventive measures. This mismatch might sound peculiar at first, although if one considers other imminent knowledge/practice related mismatches, such as knowledge about climate change and systematic lack of compliance in reducing consumption of resources or energy, this finding becomes more amenable.

Syrians scored good levels of perceived self-efficacy in terms of practising preventive measures in a variety of situations. Here, self-efficacy refers to the perceived likelihood of wearing a facemask on a hot day or maintaining social distancing despite being in a crowded place. A strong sense of self-efficacy is believed to be associated with personal well-being (Bilge, Keles and Baydili, 2022). This was indeed demonstrated above, as self-efficacy associated positively with the practising of preventive measures. The stronger the self-belief that a person will wash their hands regularly, despite scarcity of water and soap, for instance, then the more likely they will do so. Once again, the level of explained differences among Syrians in practising preventive measures in terms of their high or low self-efficacy is limited, as shown in Figure 5. For example, a Syrian with high self-efficacy might not be willing to be vaccinated.

Syrians scored moderately low in social and anticipated stigmas related to the practice of preventive measures. Most of the preventive measures recommended by WHO are visible to others, such as wearing a

facemask, and require actions, such as maintaining a distance of 1–2 metres. Such practices might imprudently diverge from cultural and social norms and hence lead to a sense of discrimination or disapproval against Syrians who practice these measures. Thus, it would be expected that the higher a Syrian scores in social and anticipated stigma, the less likely they are to practice preventive measures. Surprisingly, the results demonstrated that the influence of both stigmas on Syrians practising preventive measures was not significant.

In terms of practising preventive measures, the results are somewhat discomfiting. Syrians scored a moderate average of 52.8 per cent for practising preventive measures recommended by WHO. Regular hand washing, for instance, ranked first with 84.71 per cent. The wearing of facemasks, although this seemed to discomfort some respondents at the time of the survey, was a common preventive practice among 70 per cent of respondent, as shown in Table 3. As expected, testing for COVID-19 was not common among the respondents.

From a demographic perspective, the practice of preventive measures was influenced by city, type of community and occupation sector. Surprisingly, and despite scoring lower for knowledge about COVID-19, Syrians from Aleppo, Dyer Az Zawr and Hama had higher levels of compliance with preventive measures. Syrians from non-urban areas, such as rural and peri-urban communities, showed a slightly lower level of compliance with the preventive measures. Perhaps the most important finding here is that being employed in the formal sector significantly increased the probability of high compliance. This implies that Syrians employed in private or public institutions and organizations are more likely willing to be vaccinated than Syrians who work in black markets.

Corona in the time of war

After a decade of living under conditions of scarcity compounded by disease and war, one would expect the situation in Syria to be much worse. However, Syrians had almost identical KAP scores to other closely related populations. Their knowledge of COVID-19 was slightly lower than that found among Iraqis, Jordanians, Kuwaitis and Saudi Arabians, albeit slightly higher than for Lebanese. Similarly, Syrians' compliance with preventive measures was good when compared to neighbouring countries (Al-Hussami et al., 2022; Jadoo et al., 2020a; Naser et al., 2020; Sakr et al., 2021). In terms of self-efficacy and belief in abilities to practice preventive measures, Syrians residing in Türkiye and those surveyed for this study had similar scores (Jadoo et al., 2020b). Furthermore, the levels reported of stigmatization against the practice of preventive measures in Syria were lower than in Burkina Faso, Ethiopia, Nigeria and Saudi Arabia. Taken together, these results indicate that the ongoing public health campaign to halt the spread of COVID-19 in Syria is succeeding, in comparison with closely-tied countries with more stable living conditions (Assefa et al., 2021).

Yet on a global scale, the vaccine rollout in Syria has been somewhat slow. Syrians might not be very willing to be vaccinated either, and this could have serious consequences. The level of willingness to be vaccinated reported in this study shows Syrians lagging in comparison to other countries such as China, Germany, South Korea and the United States. As of February 2022, in such countries, over 50 per cent of the population has been fully vaccinated and discussion is shifting to providing a third dose (Chua et al., 2021; John Hopkins University & Medicine, n.d., China, Germany, Syria, United States; Lazarus et al., 2021). Meanwhile, in Syria, only 5.46 per cent of the population is fully vaccinated as of February 2022 (John Hopkins University & Medicine,

n.d., Syria). The vaccines available to Syrians are Sputnik V (Gam-COVID-Vac), CoronaVac (or Sinovac), Pfizer-BioNTech, Abdala vaccine and Oxford–AstraZeneca, Covishield (Taylor, 2022)

Syrians working in the medical field are prioritized for vaccination along with those over the age of 55 years and/or with pre-existing chronic diseases. The vaccination process requires online registration with the Syrian Ministry of Health (<http://covid19.moh.gov.sy>). Unwillingness among Syrians to receive available COVID-19 vaccines during the ongoing pandemic might lead to an outbreak of a new virus variant. If this happens, then Syria could become a hotspot for a new mutation of SARS-Cov-2 which might be resistant to the available vaccines, resulting in serious repercussions at both the local and global scale.

Conclusion

This study surveyed the knowledge, attitude and practice of Syrians amid the ongoing COVID-19 pandemic. Syrians reported high knowledge of COVID-19, positive attitudes and moderately good practice. Future public health campaigns in Syria should focus on increasing knowledge of COVID-19 in non-capital cities, especially in the countryside, and reach out to older Syrians working in the informal sector. Yet, focusing only on informing Syrians about transmission, symptoms and prevention of infectious diseases might yield low outcomes in terms of preventive practices. Public health campaigns, whether in public places, hospitals, pharmacies or even social media, should be aimed at constructing a solid and consistent body of knowledge among Syrians on infectious diseases. This can be achieved by designing campaigns which are comprehensive, transferable and link knowledge related to public health together. Public health efforts to halt the spread of COVID-19 should focus on implementing mechanisms of positive reinforcement to increase Syrians' compliance with preventive

measures – for example, a smartphone application that sends reminders and notifications to wear a facemask or to wash hands.

Global and local stakeholders should also work together on rolling out the COVID-19 vaccine in Syria, regardless of politics and sanctions. The most effective and accepted vaccines, such as those developed by BioNTech and Moderna, should be made available immediately with no restrictions and be accompanied by informed mass vaccination public campaigns. This could be achieved by implementing the concept of a vaccine passport, which limits the mobility of unvaccinated individuals. However, this approach has been called undemocratic and has resulted in a degree of social unrest, for instance in France and Germany (Tambou and Pato, 2021). Another suggestion would be to create a public media campaign in which social influencers, such as academic and religious figures, famous actors or even social media stars, use their voice and actions to promote the benefits of the COVID-19 vaccine. Other approaches should focus on utilizing the group efficacy of Syrians or other attitudinal indicators such as the perceived severity of diseases or perceived barriers to practising preventive measures.

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2.2. *De la rue à Facebook. Les possibilités méthodologiques d'une ethnographie digitale sur les différents profils de l'activisme homosexuel à Mexico*

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Résumé

La pandémie de Sars-CoV-2 a bouleversé les possibilités de la recherche en sciences sociales. L'objectif de cet article est de présenter mon mémoire de master, portant sur les transformations du militantisme homosexuel dans la ville de Mexico avec la digitalisation progressive de la vie sociale et la pandémie de la COVID-19. Je montre d'abord brièvement comment j'ai pu construire un problème de recherche sur le digital à travers des observations ethnographiques en ligne. Ensuite, l'accent est mis sur la stratégie méthodologique, reposant sur des entretiens semi-directifs, des «visites guidées», des observations ethnographiques et des interactions en ligne. Finalement, les résultats de la recherche sont présentés, pour explorer les transformations de l'activisme par la pandémie.

Introduction

«Je crois que quand on aura la possibilité d'aller dans la rue, on va le faire, pour satisfaire cette nécessité

qu'on a depuis maintenant deux ans, qu'on a dû contenir pendant trop longtemps. Mais cette fois-ci, tout va être différent. On ne sortira plus seulement dans la rue, on le fera avec un portable à la main pour tout transmettre en ligne. On fera en sorte que notre message dépasse notre cercle privé. Après deux ans de confinement, nous continuerons avec une combinaison hybride.» À l'instar de cette réflexion de Gloria, responsable associative au sein d'un collectif de prévention du VIH, l'objectif de cet article est de présenter ma recherche sur les usages militants gays de Facebook dans la ville de Mexico et la zone métropolitaine, dans un contexte pandémique particulier. Il s'agit de comprendre comment des réseaux sociaux comme Facebook peuvent être mobilisés par les activistes gays dans l'une des plus grandes villes du monde, à une époque où les activités présentielle ont été brusquement suspendues. Nous explorerons donc les configurations des interactions dans des espaces digitaux, ainsi

que les multiples significations de l'activisme en ligne.

Le deuxième objectif de cet article est de rendre compte des changements imposés par la pandémie pour les chercheurs en sciences sociales. Pour effectuer le travail de terrain, il nous a fallu (re)trouver des stratégies méthodologiques innovantes pour entrer en contact avec les informateurs sans sortir de nos foyers. Ainsi, la stratégie méthodologique de ma recherche combine des entretiens semi-directifs en ligne, des «visites guidées» des profils de certains usagers, des conversations par le chat ainsi que des observations ethnographiques de la marche des fiertés de 2021, et de certains groupes de Facebook portant sur des thèmes LGBT à Mexico.

De manière générale, les effets de la pandémie sur le corps et la notion de personne sont discutés. Il s'agit de penser les manières d'affronter les barrières imposées aux activistes par l'isolement physique forcé, la communication dans un espace digital, caractérisée par un anonymat des usagers et un rythme rapide des publications. J'explore ainsi les articulations entre le militantisme présentiel (associé aux mobilisations dans les rues) et numérique. J'analyserai l'importance des réseaux sociaux pour l'activisme gay à Mexico, reconfiguré, repensé et renouvelé par la pandémie, mais aussi engagé dans une transition de long terme vers une société toujours plus liquide (Bauman, 2003).

L'article est divisé en quatre sections. Dans la première, je reviens brièvement sur la construction du problème de recherche à travers des observations ethnographiques en ligne. Ensuite, je décris la stratégie méthodologique. Dans un troisième temps, je discute les défis liés à la réalisation d'une ethnographie digitale. Finalement, je présente et discute les principaux résultats de ma recherche.

La construction d'un problème de recherche à travers des observations ethnographiques

Pour commencer, il faut souligner que la décision de me focaliser sur les usages militants de Facebook à Mexico n'a pas été due au hasard ; elle fut le résultat de plusieurs observations ethnographiques, réalisées en ligne entre février et avril 2021. Rappelons qu'avant d'entrer sur le terrain, le chercheur ne peut pas savoir exactement quelles questions il faut poser, et ses propres idées peuvent se révéler fausses (Taylor et Bogdan, 1996, p. 32). C'est pourquoi, pour m'approcher du terrain, j'ai décidé de redécouvrir, avec le regard d'ethnologue, des réseaux numériques – Twitter et Instagram – pas trop éloignés de ma réalité quotidienne (Geertz, 1987), et pourtant assez inconnus et complexes pour moi, car je ne les utilise pas. J'ai fait des observations sur les deux réseaux en février 2021, à travers des profils explicitement créés pour cela. Ces explorations m'ont permis de me familiariser avec le fonctionnement technique des réseaux, mais aussi avec le contenu partagé par leurs usagers, en lien avec les thématiques LGBT.

Ensuite, j'ai réalisé deux entretiens exploratoires en ligne, qui m'ont montré que les usages d'un réseau social tel que Facebook étaient beaucoup plus complexes que je ne le pensais. Avant le travail de terrain, ma vision des réseaux sociaux était déterministe, car je considérais que leurs caractéristiques techniques restreindraient, ou au contraire élargiraient les possibilités d'action des usagers. Cependant, j'ai découvert que chaque usager avait une grande capacité d'agence et que le réseau social ne s'impose pas à lui unilatéralement. Il s'agit plutôt d'un espace de communication et d'interaction qui offre certaines possibilités à ses usagers, mais ces derniers conservent une autonomie pour s'en approprier comme bon leur semble.

Compte tenu de cette grande diversité d'usages et du temps limité dont je disposais pour mener à bien la recherche, j'ai décidé de me focaliser sur un seul réseau : Facebook. D'une part, car il s'agit du réseau social le plus utilisé par les Mexicains. En 2020, 97 % des utilisateurs mexicains des réseaux sociaux, soit plus de 77 millions de personnes, affirmaient avoir un compte Facebook, contre 57 % pour Twitter, en cinquième position, loin derrière Facebook, WhatsApp, Instagram et YouTube. C'est pourquoi il est plus probable qu'une publication se fasse « virale » sur Facebook à l'échelle nationale.

De plus, sur Facebook, un chercheur a un accès direct à l'information sur les usagers : leurs photos, leurs listes d'amis, les publications antérieures, ainsi que les commentaires et les réactions à celles-ci ; cela est plus difficile sur Twitter et Instagram. Dans un troisième temps, sur Facebook, il y a des groupes qui fonctionnent comme des espaces de communication et d'échanges d'informations. Ceux-ci n'existent pas comme tels sur les autres réseaux. Sur Twitter, il y a des groupes, mais il s'agit plutôt de chats privés, ce qui limite drastiquement les possibilités de communication du chercheur en comparaison avec les groupes de Facebook. Finalement, en respectant une certaine horizontalité de la relation entre le chercheur et les informateurs préconisée par Guber (2011), j'ai opté pour Facebook car les informateurs m'ont expliqué que pour eux, Facebook est lié au quotidien, à la routine.

C'est ainsi que je me suis centré sur Facebook, afin d'explorer son potentiel transformateur pour l'activisme gay à Mexico, les défis de l'action collective en ligne et les articulations entre les mobilisations presencielles et digitales dans un contexte marqué par la pandémie. Les informateurs ont deux caractéristiques communes : le fait de se considérer comme des hommes gays, et de vivre à Mexico ou dans

ses alentours. J'ai intentionnellement diversifié mon échantillon. Tout d'abord, en termes d'âge, j'ai interviewé des hommes âgés de 20 à 52 ans. Ensuite, quant au capital culturel, le niveau d'études de certains informateurs est relativement bas (des parcours professionnalisants), alors que d'autres possèdent des diplômes universitaires de licence en sociologie, en relations internationales, en communication, ou encore en arts plastiques. Ils exercent des professions variées (peintre, analyste de marchés financiers, chef gastronomique, étudiants, etc.). Ils résident dans sept arrondissements de la ville de Mexico et dans deux municipalités de la zone métropolitaine. Finalement, j'ai tenu compte du lien des informateurs avec l'activisme gay. C'est pourquoi certains se définissent comme activistes sans faire partie d'une organisation, d'autres font partie de collectifs militants, ou d'autres encore ne se perçoivent pas comme activistes mais effectuent certaines actions avec une forte dimension politique, qui permettent de les considérer comme tels.

La stratégie méthodologique

Pour m'approcher du terrain, je suis passé exclusivement par le numérique, compte tenu de la pandémie, mais aussi car je souhaitais explorer d'une manière créative les possibilités de faire l'ethnographie dans des espaces numériques. Ainsi, j'ai créé un profil de recherche sur Facebook en avril 2021. Dans un premier temps, j'ai ajouté sur mon profil quelques amis et enseignants de mon master, et j'ai élargi mon cercle d'amitiés à l'aide de la technique de boule de neige, jusqu'à arriver à 156 amis en novembre 2021.

Pour recruter les informateurs, j'ai créé un questionnaire sur Google Forms, composé de 24 questions, majoritairement fermées. Celles-ci avaient pour objectif de récolter des informations basiques sur l'informateur, conformément aux caractéristiques clés (l'âge ; le lien avec

l'activisme gay ; le lieu de naissance et de résidence ; les usages de Facebook ; Facebook comme un espace adéquat pour l'activisme gay ; les groupes de Facebook liés aux thématiques LGBT à Mexico ; la définition de l'activisme gay et le lien avec des organisations activistes).

L'objectif général du questionnaire était d'amplifier la diffusion du projet, pour recruter rapidement le maximum d'informateurs divers. C'est pourquoi je l'ai partagé sur mon profil Facebook, au travers d'une publication visible par n'importe quel utilisateur. J'ai obtenu au total 123 réponses au questionnaire. Ma recherche a été purement qualitative, donc je n'ai pas effectué une analyse statistique des données récoltées. Le questionnaire, dont les réponses ont été automatiquement enregistrées sur une feuille de calcul Excel, m'a plutôt servi à identifier les informateurs que je souhaitais interviewer, pour diversifier les caractéristiques d'intérêt que j'ai évoquées (l'âge, le capital culturel, le lieu de résidence, etc.).

Au-delà du questionnaire, le contact direct avec les informateurs s'est effectué à travers des messages sur Messenger, des commentaires, des publications dans des groupes de Facebook destinés aux hommes gays qui vivent à Mexico, etc. Le but des messages et des commentaires était d'établir une relation de confiance avec les informateurs. Les groupes ont servi surtout à diffuser le questionnaire et à récolter des opinions sur la marche en ligne des fiertés du 26 juin 2021.

La stratégie méthodologique a été clairement qualitative et assez flexible. Rappelons que « la recherche qualitative est un art. (...) L'on suit des instructions pour nous orienter, mais non pas des règles. Les méthodes servent au chercheur, et ce dernier n'est jamais un esclave d'un procédé ou d'une technique particulière » (Taylor et Bogdan, 1996, p. 23). Ma recherche s'est articulée autour de trois techniques qualitatives.

La première correspond à douze entretiens semi-directifs, d'une durée moyenne d'une heure. Les entretiens se sont basés sur un guide composé de différentes sections thématiques (le contexte socio-économique et culturel ; l'importance des usages de Facebook dans la vie quotidienne ; les usages personnels de Facebook liés à l'homosexualité ; les interactions au sein des groupes de Facebook comme des espaces d'activisme gay ; les significations de l'activisme ; l'activisme gay sur Facebook et les mobilisations présentiels ; l'importance de la localisation géographique).

Le guide d'entretien n'a pas été utilisé comme un outil rigide, mais avec beaucoup de flexibilité, pour écouter les informateurs et ne pas leur imposer mes points de vue. J'ai enregistré la totalité des entretiens, avec leur consentement préalable. Pendant seulement trois entretiens, j'ai allumé ma caméra, car dans la plupart des cas, les informateurs se sentaient plus à l'aise avec la caméra éteinte, ou des difficultés techniques ont impliqué la nécessité de passer par un appel simple, sans vidéo.

La deuxième technique correspond à l'observation – participante et non participante. J'ai fait plusieurs observations non-participantes via mon profil Facebook, pour décrire le fonctionnement basique de la plateforme et analyser le contenu des publications. De plus, j'ai observé les interactions au sein de quelques groupes Facebook. Quant à l'observation participante, celle-ci consiste en une « recherche qui implique une interaction sociale entre le chercheur et les informateurs dans le milieu de ces derniers, et pendant laquelle l'on récolte les données d'une manière systématique et non intrusive » (Taylor et Bogdan, 1996, p. 31). J'ai mobilisé cette technique pour l'étude de la marche des fiertés en ligne qui a eu lieu à Mexico, dans le contexte de la pandémie.

Je suis passé par différents groupes Facebook pour discuter avec les informateurs sur leurs perceptions de la modalité virtuelle de la marche en comparaison avec la mobilisation présentielle, et pour observer leurs publications et réactions à ce sujet. De plus, j'ai participé de manière synchronique à la transmission de la marche virtuelle sur YouTube. Pour approfondir les perceptions des informateurs sur la marche digitale, j'ai échangé avec eux à partir de leurs commentaires dans les groupes et à travers des messages privés dans le chat de Messenger.

La troisième technique correspond aux « visites guidées ». Je me suis inspiré de Pink (2019), qui l'a mise en œuvre dans une recherche sur les usages quotidiens des appareils électroniques dans les ménages britanniques, comme une alternative à l'observation. La chercheuse constate que « le spécialiste aborde les éléments de l'expérience en faisant des recherches sur les manifestations dans les routines et les activités de la vie quotidienne que l'on peut voir et desquelles l'on peut parler » (Pink et al., 2019, p. 73). Pour accéder aux impressions et motivations cachées des informateurs, Pink et Leder Mackeley (2012) ont eu recours à la technique du « video-tour ».

Il s'agit d'une technique qualitative où « l'on demande aux participants de montrer leurs maisons aux chercheurs et de parler des sentiments, de ses textures, des flux d'air, des températures, des sons, et des odeurs. Parfois, pendant le tour, le participant parle avec le chercheur également de ses expériences, et il l'invite à sentir ou à écouter des éléments de la maison qui ne sont pas évidents à observer, ou à s'imaginer de manière empathique comment est l'expérience des usages des médias » (Pink et al., 2019, p. 75). Dans le cadre de ma recherche, j'ai modifié la technique pour mieux l'adapter au sujet d'étude. J'ai fait trois visites guidées, d'une durée moyenne d'une heure, par des appels vidéo Messenger. J'ai demandé

aux informateurs de partager leur écran et de parler librement des publications dans leurs profils en lien avec des sujets de l'homosexualité et qui sont importants pour eux. Ainsi, j'ai accédé à des points de vue pluriels, de façon moins unilatérale et plus compréhensive.

Faire une ethnographie digitale : la recherche de nouvelles présences sur le terrain

Dès le début, je voulais étudier les appropriations d'un espace numérique par les hommes gays à Mexico. La pandémie, qui a commencé en France en mars 2020, a accentué encore cet intérêt pour l'exploration des possibilités et des défis d'une ethnographie numérique. La distance physique qui me séparait des informateurs m'inquiétait beaucoup pendant les premières semaines du travail de terrain. En effet, je pensais l'ethnographie comme un déplacement physique sur le terrain pour mieux connaître les contextes des informateurs. Cependant, l'isolement forcé m'a fait penser aux solutions alternatives (Geertz, 1987). J'ai donc commencé à interagir avec les informateurs par messages. Ainsi, je suis devenu plus proche d'eux, même si tous n'étaient pas très réactifs. Cependant, j'étais surpris par l'effet positif des interactions écrites sur la réduction de la distance physique initiale. Cependant, j'ai découvert que la communication par Messenger fonctionne beaucoup mieux avec les utilisateurs de moins de trente ans. Une possible explication pourrait résider dans une de mes hypothèses, à savoir que les jeunes interagiraient davantage sur les réseaux sociaux car ils ont grandi en les utilisant.

Quant aux entretiens, l'idée de les faire tous à distance ne me plaisait pas beaucoup. Dans mes recherches antérieures, j'avais seulement fait des entretiens en présentiel et la modalité en ligne m'inquiétait. Je ne savais pas comment compenser l'absence de l'immédiateté et de l'observation des gestes et des expressions faciales.

Cependant, j'ai appris à apprécier cette façon de faire. J'en ai découvert les avantages, dont une grande flexibilité quant à la programmation des entretiens en cas d'imprévu de dernière minute, ce qui serait impossible en présentiel compte tenu des distances très longues à Mexico.

De plus, avec les visites guidées, j'ai collecté suffisamment de matériel empirique auquel je n'aurais pas pu accéder à travers de seules observations. Ainsi, j'ai découvert qu'une des particularités de Facebook est que les utilisateurs basent leur comportement majoritairement sur leurs interprétations des phrases écrites par les autres. Cela peut impliquer des malentendus, moins fréquents dans des interactions en face à face. En échangeant avec les informateurs, j'ai apprécié l'importance de ne pas reproduire, depuis ma position de chercheur, ces mêmes limitations du fonctionnement de Facebook dans la stratégie méthodologique. L'intégration des visites guidées dans la stratégie méthodologique m'a permis d'avoir un point de vue plus pluriel sur les significations des publications de Facebook ; c'est ainsi que j'ai réduit la distance qui me séparait au début des informateurs.

Les observations de la marche virtuelle des fiertés de la ville de Mexico illustrent aussi comment nous continuons, en tant que chercheurs, à être présents sur le terrain en temps de pandémie. Il y a deux ans, personne n'aurait effectué sa recherche sur ce sujet depuis son canapé. Quand j'ai participé, en 2018, à ma première marche des fiertés, j'ai dû bien m'organiser pour me déplacer jusqu'à Prague, m'héberger et arriver à l'heure. La marche virtuelle a été très différente pour moi, car je l'ai suivie depuis chez moi, avec un cahier et un stylo à la main. Cet exemple illustre que les espaces numériques et physiques ne sont pas dichotomiques mais entrecroisés, pour les informateurs comme pour les chercheurs.

Les résultats de la recherche : un activisme gay hybride à la suite de la pandémie ?

Finalement, présentons les principaux résultats de la recherche. Le principal objectif de mon travail était d'analyser les transformations contemporaines de l'activisme gay à Mexico, en comparaison avec ses étapes antérieures, avec la massification des usages de réseaux sociaux comme Facebook, et dans le contexte marqué par la pandémie de la COVID-19. J'ai cherché à rendre compte de la diversité de cette « catégorie analytique confortable » (Castells, 2012, p. 29) qu'est l'activisme gay, pour rendre compte de la pluralité des situations que cette notion regroupe, et qui ne sont pas toujours bien prises en compte par les chercheurs en sciences sociales.

Le premier résultat que j'aimerais souligner est le fait que si l'activisme gay a pu survivre en temps de pandémie, c'est en grande partie parce que l'appartenance à un collectif militant – qui était rendue difficile avec le confinement – n'est aujourd'hui plus obligatoire, comme c'était encore le cas dans les années 1970-80. J'ai pu démontrer qu'avec la pandémie, on a très bien pu voir qu'une lecture de l'activisme qui passe uniquement par des collectifs militants stables et organisés semble aujourd'hui être dépassée. Ainsi, Alejandro (25 ans), étudiant de master en sciences politiques dans une université publique en Suisse, m'a expliqué que même s'il ne fait partie d'aucune organisation activiste, il se considère quand même comme activiste. Son activisme passe à travers sa page de Facebook où il partage des *friq* pour lutter contre la discrimination basée sur le surpoids, très présente au sein de la communauté LGBT. Selon lui, il « n'a pas de temps pour faire du bénévolat sur une base régulière », il a « bien trop de choses à faire dans la vie de tous les jours » pour pouvoir faire partie d'un collectif. Pour des jeunes comme Alejandro, faire de l'activisme peut passer par des actions

individuelles et ponctuelles, menées à travers un réseau social, sans qu'il y ait forcément un engagement durable vis-à-vis d'un collectif.

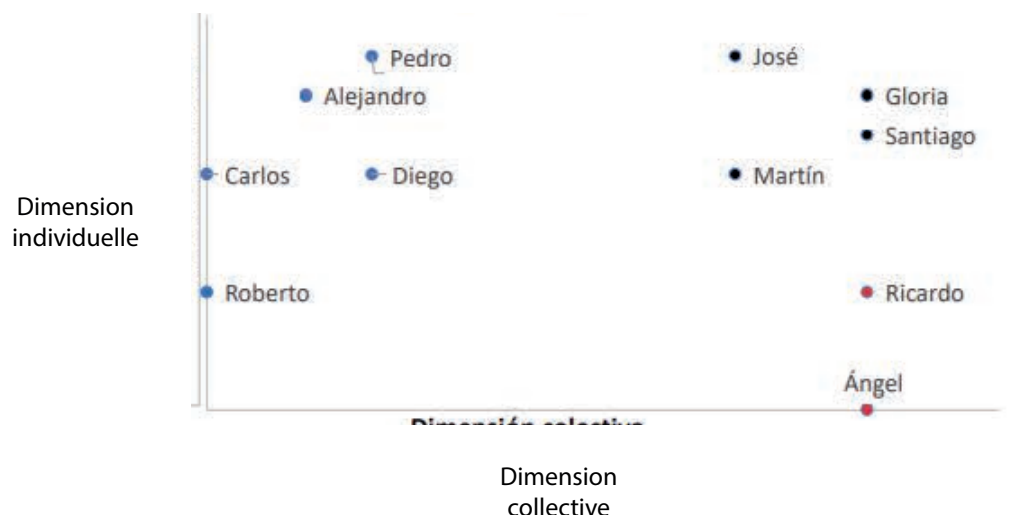
Pendant la pandémie, quand sortir de chez soi est devenu très compliqué pour beaucoup d'entre nous, Facebook s'est converti en un instrument de communication activiste de premier plan, comme l'illustre le témoignage de Carlos (45 ans) :

« Je trouve que c'est important de publier des choses de notre vie quotidienne sur Facebook, pour rappeler à tout le monde que nous, les personnes LGBT, existons. Être gay est aujourd'hui un sujet des plus banals, présent tout le temps. Ce n'est plus une grande nouvelle si un artiste fait son coming out. Mais il est important que les gens n'oublient pas qu'on reste des personnes comme tout un chacun et que l'orientation sexuelle ne doit pas occasionner des blagues ou encore des attaques. Après tout, nous restons des êtres humains et nous méritons le même respect que tout le monde. Nous montrer en train de regarder la télé, célébrant la vie quotidienne, mangeant, etc., revient à affirmer que notre orientation sexuelle ne nous fait pas être différents des autres. »

Pendant le confinement, et sûrement aussi bien au-delà, chaque personne peut faire de l'activisme en se basant sur ses routines quotidiennes, en partageant du contenu – textuel, visuel ou audiovisuel – sur ses réseaux sociaux. La dimension politique de ces activités, complètement individualisées et intermittentes, consiste à faire prendre conscience aux amitiés sur Facebook du fait qu'être gay ne signifie pas être différent des autres dans la vie de tous les jours. Avec Internet, Carlos a pu continuer à construire et reconstruire son identité de genre et faire des actions activistes, même pendant le confinement le plus dur (West et Zimmerman, 1987).

En France, la pandémie est venue s'ajouter aux autres grandes difficultés auxquelles l'activisme gay est confronté depuis une dizaine d'années. D'une part, les financements accordés aux organisations de la société civile par le gouvernement fédéral ont drastiquement diminué pendant le gouvernement actuel du président Andrés Manuel López Obrador, qui présente souvent ces organisations comme étant corrompues. Cela lui a permis de leur refuser de nombreux financements qu'elles recevaient par le passé, au nom de l'austérité républicaine (Alternativas y Capacidades A.C., 2021). D'autre part, les organisations internationales qui apportaient du financement au secteur activiste gay mexicain ont préféré délocaliser leurs soutiens financiers vers d'autres régions du monde, moins développées économiquement et politiquement que la France. Finalement, comme m'a expliqué Gloria, la pandémie de la COVID-19 a empêché de nombreuses associations de faire des interventions de sensibilisation au sein d'établissements scolaires, ce qui constituait pour nombreuses d'entre elles une source très importante de revenus. Par conséquent, plusieurs associations activistes à Mexico se sont retrouvées dans l'obligation de fermer leurs locaux et ont continué à interagir avec leurs bénéficiaires uniquement à travers leurs réseaux sociaux.

Un autre résultat important de ma recherche indique que l'émergence et la massification des réseaux sociaux sont un symptôme d'une dynamique sociale beaucoup plus large, liée à une liquéfaction progressive de nos sociétés modernes (Bauman, 2003). Depuis les années 1990, les formes institutionnelles qui façonnaient les vies individuelles ont commencé à se diluer. Depuis lors, nous assistons à une accélération toujours plus marquée des communications interpersonnelles et de nos vies de manière générale. Cette évolution a profondément modifié tous les

Graphique 1. Activisme gay dans la pandémie : une affaire individuelle ou collective ?

Source: Jan Kasnik.

domaines de nos vies, et l'activisme gay n'est pas une exception à la règle. La pandémie de Sars-CoV-2, qui a imposé un confinement obligatoire de quasiment deux ans, n'a pas été à l'origine de ces changements ; elle a plutôt été responsable de leur accélération.

Cependant, il convient d'adopter une vision nuancée de ces transformations en cours, car une certaine individualisation et diversification du répertoire d'actions activistes avec le confinement et les usages des réseaux sociaux ne signifie pas forcément que les collectifs organisés aient complètement disparu du paysage activiste, comme le montre le graphique suivant.

Pour mieux visualiser les principales conclusions de mon analyse, j'ai classé tous les informateurs dans un même repère de coordonnées relatives aux dimensions individuelle et collective de l'activisme gay contemporain dans la ville de Mexico. Je ne l'ai pas fait dans une démarche quantitative, mais plutôt pour avoir une idée globale des grandes tendances quant aux différentes formes que peut prendre le militantisme gay dans la capitale mexicaine. Dans le graphique, on peut observer trois ensembles d'activistes, chacun marqué par une couleur différente.

Le premier ensemble correspond aux activistes marqués par des points bleu clair. Ce groupe est composé de cinq informateurs, et il représente un activisme plutôt individualisé, connectif et intermittent, qui émerge en conséquence de la liquéfaction de la société (Bauman, 2003), accentuée par les réseaux sociaux et la pandémie de COVID-19. Pour ce groupe d'informateurs, faire l'activisme passe par des publications sur leurs profils de Facebook (et d'autres réseaux d'ailleurs, comme Twitter par exemple), des réactions aux publications d'autres personnes, etc., sans faire partie d'une organisation activiste clairement identifiée comme telle. Le deuxième groupe, symbolisé par la couleur rouge et intégré par deux informateurs, correspond aux activistes fortement collectifs et qui se caractérisent par un engagement durable, passant par des organisations.

Cependant, le groupe qui a le plus attiré mon attention est celui formé par les quatre points noirs dans la partie supérieure droite. Celui-ci représente des militants qui se mobilisent à travers des organisations mais qui, en même temps, se sont aussi familiarisés avec des formes plus connectives (donc plus individualisées et plus à la carte) de faire l'activisme (comme partager des publications

sur leur profil des réseaux sociaux). Ainsi, Gloria, responsable de la communication sociale d'un collectif LGBT, est aussi très active sur ses réseaux sociaux privés, à travers lesquels elle essaye de sensibiliser le public à la problématique des personnes travesties et trans. En ce sens, on peut dire que le graphique permet de visualiser assez bien la diversification du paysage activiste en termes d'acteurs et de scénarios qui en font partie.

Le deuxième objectif de ma recherche était d'explorer les possibilités et les défis que Facebook offre à l'activisme gay à Mexico. J'ai découvert que les réseaux sociaux présentent certains avantages, comme le fait de permettre une diffusion ample des messages activistes à un coût assez réduit (en termes économiques et de temps), et une facilité pour organiser des événements activistes comme des tables rondes en ligne. Santiago, l'un de mes informateurs, a ainsi pu organiser un festival des diversités sexuelles de Mexico, en invitant des intervenants qui ont participé en ligne depuis certains pays européens – comme l'Angleterre – ce qui serait très difficile (et coûteux) à faire si l'unique modalité de participation était la présence physique. Cependant, l'usage des réseaux sociaux fait que les activistes ont de nouveaux défis

à affronter, comme une présence importante des conflits entre les usagers. Comme m'a expliqué Gloria, le problème est que, sur Facebook, la communication se base majoritairement sur l'interprétation des publications écrites. Or, « les gens ne lisent pas, même quand c'est dans leur propre intérêt ». De là vient le fait qu'il y a souvent des conflits autour de certaines publications, car les gens ne prennent pas forcément le temps de bien comprendre le message que l'auteur souhaite transmettre.

Ensuite, Facebook présente un autre défi : le fait d'homogénéiser les idées activistes gays au nom de la censure. Il y a, sur Facebook, un mécanisme de censure pour éviter la propagation des discours de haine, etc. De même, des photos nues ne peuvent normalement pas être partagées par le biais de ce réseau. Cependant, comme m'a expliqué Santiago, parfois, un mot grossier et à l'origine insultant vis-à-vis des personnes LGBT peut être repris par les activistes eux-mêmes, pour l'utiliser de manière revendicative. Ainsi, il m'a raconté qu'une fois, il voulait écrire une publication qui incluait le mot « maricón », qui serait l'équivalent de « pédé » en français. L'algorithme de Facebook a tout de suite supprimé la publication, alors qu'elle avait une portée clairement revendicative. Or, d'autres publications ou commentaires, qui contiennent des insultes et un discours de haine, restent bien affichés sur le réseau, et cela malgré des dénonciations faites par certains usagers. En ce sens, Facebook continuerait donc quand même d'être un espace de communication hétéronormé, peu propice aux expressions de genre qui questionnent la norme. Ainsi, même si les réseaux sociaux comme Facebook ont permis de remplacer les scénarios en présentiel de l'activisme gay pendant la pandémie – ce qui est très pertinent aussi dans le contexte actuel mexicain, marqué par une forte austérité budgétaire –, ils ne constituent pas non plus une solution miracle à tous les problèmes.

Le troisième objectif de mon travail de recherche était de réfléchir sur les multiples articulations qui peuvent exister entre les différents profils de l'activisme gay dans la ville de Mexico. Les trajectoires de certains informateurs, à l'instar de Gloria – qui a fait partie des organisations militantes depuis les années 1990, mais qui a aussi mené des actions militantes beaucoup plus individualisées, en passant par des réseaux sociaux – ou de José – chargé de communication sociale sur les réseaux sociaux d'une autre organisation activiste à Mexico, mais qui, en même temps, partage sur Facebook et d'autres réseaux du contenu activiste varié depuis ses profils personnels – montrent clairement qu'il y a différentes manières de faire de l'activisme qui sont complémentaires, et un individu peut tout à fait les combiner à sa guise. Avec la pandémie et l'usage des réseaux sociaux comme Facebook, il est de plus en plus clair qu'être activiste ne signifie plus seulement sortir dans la rue en tant que membre d'une association pour réclamer ses droits.

Dans un quatrième temps, je souhaitais analyser les implications des transformations de notre société, chaque fois plus liquide (Bauman, 2003) et de la pandémie sur les évolutions (moins) récentes de l'activisme gay. J'ai découvert que les façons de faire de l'activisme de certains informateurs démontrent effectivement qu'on a affaire à une individualisation et une intermittence de l'activisme en général, dans une société chaque fois moins solide, au sein de laquelle la vie est devenue une course – perdue d'avance – contre le temps. Ainsi, certains informateurs comme Roberto s'impliquent très ponctuellement et avec peu d'intensité – en participant, par exemple, à certaines conversations dans un groupe de personnes LGBT à Mexico, dont le but est d'aider de jeunes entrepreneurs LGBT avec leurs démarches administratives – car ils n'ont pas le temps ou l'envie de s'intéresser de façon plus approfondie aux thèmes liés au militantisme gay.

Cependant, il faut dire que cette tendance n'est pas majoritaire au sein de mon échantillon. Pour





la majorité des informateurs, les collectifs organisés restent des acteurs très pertinents des luttes activistes, même s'ils doivent de plus en plus faire face à l'émergence des actions plus individualisées qui passent par Internet, mais dont l'existence ne remet pas en cause la légitimité de l'existence des organisations. Pour autant, la tendance vers la liquéfaction de notre société est à nuancer : nous n'assistons certainement pas à une digitalisation ou une individualisation complète de l'activisme gay à Mexico. Nous naviguons plutôt dans un espace aux frontières de plus en plus floues, entre les deux extrêmes – individuel et collectif, présentiel et en ligne – du même continuum.

Avec la pandémie, nos façons de percevoir le collectif, le fait de faire ensemble et le temps ont définitivement changé. Mais pour se pérenniser, cette évolution doit encore perdurer dans le temps. La recherche a été faite pendant le confinement, duquel on est sorti il y a maintenant plusieurs mois. Ainsi, le comité organisateur de la marche des fiertés de 2022 a décidé d'organiser

la marche des fiertés uniquement de manière présentielle. Il reste à voir si les transformations des significations du présentiel, du numérique, du collectif et de l'individuel persistent après la pandémie, ou si les solides institutionnels persistent et défient ainsi la vision de Bauman (2003) – que je partage, jusqu'à un certain point – sur ces transformations contemporaines de la société et de tous les domaines de la vie sociale, dont l'activisme.

Finalement, j'ai analysé l'importance de l'âge et de la localisation géographique pour l'activisme gay digital dans la capitale mexicaine. En ce qui concerne l'âge, j'ai trouvé que la vision selon laquelle les personnes les plus jeunes seraient plus à l'aise avec les modalités digitales de faire de l'activisme, en comparaison avec des personnes plus âgées, est à nuancer. Le cas de Pedro, photographe âgé de 52 ans qui utilise Facebook pour partager des albums photographiques des marches des fiertés à Mexico des quinze dernières années, démontre clairement que ce point de vue est à prendre avec beaucoup de

précaution. Aussi, j'ai pu confirmer que la localisation géographique est un critère très important, surtout en relation avec la présence accrue de l'homophobie dans certains quartiers de la ville de Mexico, comme Tláhuc. Des informateurs comme Pablo, un jeune étudiant de sociologie de 22 ans vivant dans cette partie de la ville, m'ont expliqué que pour lui, vivre ouvertement sa sexualité dans l'espace public dans ce quartier était très compliqué, car cela reviendrait à s'exposer ouvertement à des agressions homophobes. Ainsi, le potentiel d'Internet comme un milieu plus propice à la participation activiste dans des localités géographiques marquées par l'exclusion, l'intolérance et la violence reste encore à explorer.

Conclusions

Pour conclure, les réseaux numériques comme Facebook permettent d'explorer des thèmes aussi complexes que les façons de faire de l'activisme gay dans l'une des plus grandes villes d'Amérique latine et du monde. Les espaces digitaux offrent de nombreuses possibilités méthodologiques innovantes aux

chercheurs en sciences sociales. De plus, ils constituent des terrains de recherche qui méritent toute notre attention pour y faire de l'ethnographie, dans le contexte de la pandémie, mais également au-delà.

La recherche que j'ai présentée est un exemple concret de comment peut se construire un problème de recherche situé dans un espace numérique, et comment élaborer et mettre en œuvre une stratégie de recherche qualitative centrée sur l'ethnographie d'un espace digital particulier : Facebook.

Les résultats préliminaires indiquent que la pandémie n'a pas seulement transformé les façons de faire de la recherche en sciences sociales, mais qu'elle a également eu un fort impact sur l'activisme gay. Celui-ci est devenu plus intermittent et pluriel. De nouveaux liens se tissent entre les mobilisations présentiels et distanciels, ce qui transforme les significations de l'activisme. Cependant, d'importantes limitations sont également à prendre en compte, dont la confrontation et l'intolérance encouragées par les réseaux, ainsi qu'un impact très discutable des mobilisations digitales.

2.3. *Intergovernmental coordination and cooperation for effective policy responses: An analysis of the COVID-19 crisis in Canada and Norway*

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Abstract

The transboundary aspects of the COVID-19 crisis are becoming increasingly manifest, underscoring the need for collaborative international responses, as well as for coordination between subnational and national governments. As these challenges require a multi-level government response, public administrations in different countries have drawn on intergovernmental relations. This article analyses central-local government relations during the COVID-19 outbreak, with a view to understanding the primary role of the state in supporting and regulating health governance systems, the economy and social life. It also illustrates how the willingness and preparedness of governments to initiate joint crisis responses has varied across countries and regions, compensating for market limitations, leading to a resurgence of collective, state-based approaches to the recovery, which adopted a nuanced approach in recognition of this heterogeneity.

Introduction

On 11 March 2020 the World Health Organization (WHO) declared the recent COVID-19 outbreak as a global pandemic, and within a short period of time the mobility of populations

everywhere, including the movements of students and scholars, came to a grinding halt. The coronavirus quickly became known as ‘a transboundary mega-crisis on a global scale’ (Christensen and Lægreid, 2020: 774), an attribution justified by the serious threat it posed to basic structures and fundamental values worldwide – in part due to the complexity of the problem: little was known about the nature of the COVID-19. As a result, all major decisions were taken amid conditions of deep uncertainty. With regards to authorities, this has meant that the public measures imposed by governments have an experimental quality (Christensen and Lægreid, 2020). Given the unprecedented impact of the COVID-19 pandemic on many aspects of people’s lives, such as their health, social connections, mobility, employment and income, it rapidly became clear that the crisis required high levels of collaboration between different levels of government, while at the same time challenging existing norms of intergovernmental relations (IGR). For example, Hall and Battaglio (2020) point out that although intergovernmental strategies are operational, they show clear evidence of strained relationships since ‘neither level of government possesses the necessary capacity – alone or in

concert – to fully address the threat’ (2020: 346).

This article draws on the experience of Canada and Norway, with the aim of analysing and understanding central-local government relations during the COVID-19 outbreak. As part of this analysis, it focuses on IGR and existing differences in local and political context that can often lead to strained relationships between central and local governments. It also examines multi-level governance and issues of coordination and collaboration. In addition, the article offers a detailed review of Canadian federalism and discusses opportunities that this governance arrangement offers to provinces in terms of regulatory capacity-building in areas such as crisis management, sustainability (including dimensions such as social equity and economic development), community and partnership building, education and more.

Methods

A changing global context creates new policy and governance challenges at the national level. In response to these challenges, public administrations need to draw on their IGR systems. As the challenges posed usually require multi-level responses, there is often a need to assess the capacity of the state and political systems to manage IGR. This must be done in a way that will ensure an effective response to the COVID-19 crisis, eventually leading to recovery. The suggested framework addresses three dimensions of the policy domain (see Puppim de Oliveira et al., 2021): the political and state system, formal and informal institutions, and the political alignment between them. The different structures of the two countries – Canada is a federation and Norway is a unitary state – provide an opportunity to examine how the contrasting types of IGR have proven their viability, or not, in their response to the crisis precipitated by COVID-19.

Arguably, each country presents a distinctive configuration of administrative and political autonomy. In addition, each country may be characterized by varying degrees of organizational capacity and responsibility assigned to different levels of government. Puppim de Oliveira et al. argue in this regard that ‘organizational configurations influence the way in which states respond to the policy challenges which confront them’ (2021: 245). It has also been argued that effective IGR can combine the efforts of different tiers of government and therefore increase the capacity of a state to respond to multi-level challenges more effectively (Balme and Ye, 2014; Frug, 2014; McGuire and Silvia, 2010; Puppim de Oliveira et al. 2021). Unfortunately, efforts to understand and promote better intergovernmental coordination in practice have been often disappointing, as demonstrated in government responses to the COVID-19 crisis (Tang and An, 2020).

Central government vs. local government: similarities and differences

There are different perspectives on how to organize the central-local relationship. One approach seeks to consolidate power under a centralized government, based on the view that local government is unable to grapple with the wide range of existing problems. This view is bolstered by the consideration that local governments may be more susceptible to corruption, due to the greater frequency of possibly more intimate interactions between private individuals and officials at decentralized levels. Furthermore, the shift to a centralized government is seen by some as a way to overcome self-interested competition among localities (Frug, 2014). A second approach seeks, conversely, to empower local governments by giving them the autonomy to make their own decisions, thereby permitting local governments to adopt policies

that they deem best for their future. Finally, a third approach represents a hybrid of the previous two, dividing the functions of government into different categories. Under this arrangement, each level of government has jurisdiction over some of the categories, but not all. Some issues are managed at the regional level, some by the state and some by the federal government. Cameron argues in this regard that the degree of centralization is frequently ‘the result of evolving historical and political circumstances, rather than formal enunciation in the constitution’ (2001: 124).

Some authors have considered the possibility of managing IGR through a political process rather than as a hierarchy or fixed division of authority. Frug argues, for example, that ‘experts shouldn’t decide public policy, but neither should uninformed voters’ (2014: 5). He emphasizes that ‘democratic government has to bring the two together’ (ibid). The idea of interdependence honours both local agenda and the broader view; therefore, it is necessary to organize democratic government accordingly. Frug notes that this interdependence can work most effectively when ‘experts testify, executive officials push their agenda, [and] the private sector lobbies’ (2014: 5). Nowadays, democratizing IGR is one of the key challenges confronting governance. However, it is important to recall the context within which scholars are advised to establish IGR – the framework of democratic norms and values (Cameron, 2001).

Results: coronavirus country responses

Policy responses for Norway

The response to COVID-19 has clearly been shaped by IGR in different countries. The comparative analysis in this article helps to illustrate how different intergovernmental systems respond to COVID-19, and to identify factors that contribute to different degrees of adaptability

of intergovernmental structures and norms. While apparently successful models and experiences of governments from particular countries may be used as a benchmark, given the high human, social and economic costs of pandemic, the word 'success' should be applied to a policy response with caution. This is especially true for Norway where new COVID-19 cases accelerated in late October 2020. As of 2021, 161,809 positive COVID-19 cases have been recorded in Norway (Statista, 2021a), with the total number of deaths reaching 822 (Statista, 2021b). However, the Norwegian response to COVID-19 has worked rather well compared to some other developed countries (Christensen and Lægreid, 2020). This outcome can be attributed in part to lower the country's population density – in Norway, a total population of 5.37 million inhabit a vast territory.

The Ministry of Health and Care Services was the central crisis management ministry in Norway for handling the epidemic. The Ministry worked as the lead ministry at the outset of the pandemic, but with the expansion of the crisis into other policy areas, the Ministry of Justice and Public Security was appointed to this role. In Norway, the government response to the coronavirus included four rounds of economic compensation packages. As Christensen and Lægreid (2020) observed, the comparative success of the Norwegian government's strategy to handle the pandemic stems from a quickly adopted strategy of suppression, followed by one of control. Meanwhile, the prime minister and the cabinet, have played a central role in collaboration with parliament.

During these difficult times, the Norwegian government has relied upon a collaborative and pragmatic decision-making style and has employed best practices to communicate with the public. The authorities have also worked to avoid adverse reactions that could exacerbate the social and economic

impacts of the pandemic. This is aided by a style of government that is open and transparent, contributing to a high level of citizen trust (OECD, 2021). Moreover, mutual trust relations between Norwegian government authorities are higher than in many other countries (OECD, 2017). Christensen and Lægreid (2020) note that Norway has a strong economy and a large pension fund. The economy is based on oil and gas revenues, with mechanisms in place to ensure responsible and long-term management of these resources. Overall, the country is perceived a well-developed welfare state with a strong public sector. However, it is important to recognize that the geographic spread of the disease in Norway has been unevenly distributed due to population density, social status and vacation habits.

On 21 May 2021, Norwegian prime minister Erna Solberg announced the easing of the country's coronavirus measures, along with restrictions for United Kingdom (UK) and European Union (EU)/European Economic Area (EEA) citizens (Nikel, 2021). Unlike people coming from other parts of the world, citizens of the above regions would no longer be required to quarantine on arrival for a specific period. This was followed on 12 September 2021 by a statement by the prime minister announcing that close family members and romantic partners of Norwegian residents would be able to enter Norway from countries outside of the EU/EEA (Nikel, 2021). However, despite these announcements on easing travel restrictions, travel rules in the country have remained confusing and are changing regularly. For example, the Norwegian border remains closed to many non-residents to prevent the further spread of coronavirus variants into Norway. It is worth noting though, that Norwegian citizens and foreign citizens who live in Norway are allowed to enter the country. Additionally, there is a substantive list of entry exemptions for those who

do not have a verified digital corona certificate (UDI, 2021).

More recently, Norway has adopted the EU colour-code system for ranking coronavirus risk (NIPH, 2021). As a result, people entering Norway from 'green' countries in the EU/EEA/Schengen/UK, are no longer required to serve their quarantine period in a quarantine hotel. People coming from other parts of the world, especially areas with a high incidence of infection, must stay in a quarantine hotel for ten days. There are, however, exemptions. The mandatory COVID-19 restrictions may not apply to a person who presents a recent negative COVID-19 test with a QR code (NIPH, 2021). Upon verification, the Norwegian authorities can accept this document as a secure way to confirm vaccination or previous illness. Norway's 'vaccine passport' and the EU equivalent can be used today to bypass quarantine, as can the UK's National Health Service Covid Pass (Nikel, 2021).

In summary, Norway experienced one of Europe's lowest rates of infections and deaths during the early stages of the pandemic. However, the country was forced to tighten measures following a rapid increase in hospitalizations, triggered by more contagious variants of the coronavirus.

In summary, Norway experienced one of Europe's lowest rates of infections and deaths during the early stages of the pandemic. However, the country was forced to tighten measures following a rapid increase in hospitalizations, triggered by more contagious variants of the coronavirus. One in three adults in Norway have received their first dose of a COVID-19 vaccine, and nearly 15 per cent of adults have been fully vaccinated, according to the Norwegian Institute of Public Health (NIPH). As a result,

rates of new infections have declined steadily. On 27 May 2021, the government launched the second phase of a four-step plan to remove the lockdown (Klesty and Adomaitis, 2021).

Policy responses for Canada

Despite the introduction of COVID-19 mitigation measures, there have been over 1.4 million cases and 26,200 deaths from COVID-19 in Canada (IMF, 2021). In order to minimize the death toll and economic losses, the country introduced restrictive policies to curtail the pandemic. These were a mix of public health orders, executive orders and municipal bylaws.

Under federalism, government power and responsibility are shared between national and provincial governments. Canada is a highly decentralized federation (see Atkinson *et al.*, 2013; Bakvis, Baier and Brown, 2009; Bakvis and Skogstad, 2008; Trilokekar and Jones, 2020) that permits each province to enact policies that respond to local context. The federal government maintains jurisdiction over the entire country, while each provincial government has jurisdiction over its portion of the population and region. Education is the responsibility of provincial governments, while healthcare is largely a provincial and territorial responsibility. As such, the majority of pandemic policy restrictions have been introduced by provincial governments or provincial health officials. Accordingly, the pandemic response in each region has varied greatly.

As mentioned earlier, the pandemic is viewed as a serious challenge for all levels of government. For example, Stiglitz (2020: 40) argues that ‘there has never been an event like this in the era of modern industrialization’, noting further that there remains much ‘we don’t know about how economic agents and the economic system respond’ (2020: 40). Although the function of lockdowns is well recognized from the perspective of COVID-19 mitigation, Stiglitz

(2020) observes that lockdowns not only decrease the spread of the disease, but also induce changes in behaviour. As both information and disinformation play a noticeable role in inducing changes in behaviour among individuals, he emphasizes the crucial importance of understanding how policies affect beliefs and behaviour. In particular, Stiglitz argues that in times of extreme uncertainty, when ‘the interest elasticity of consumption and investment are likely to be very low, so that monetary policy is not likely to be very effective’ (2020: 41), fiscal policy, on the other hand, may be particularly effective.

As far as fiscal policy is concerned, key response measures in Canada represent CAD \$435.2 billion³⁷ in taxes and spending (IMF, 2021). The above amount represents 19.7 per cent of Canada’s GDP. Specifically, the federal government announced the disbursement of \$60.3 billion (2.7 per cent of GDP) to the health system, \$290 billion (13.2 per cent of GDP) in direct aid to households and firms, and around \$85 billion (3.9 per cent of GDP) in liquidity support through tax deferrals. Additionally, the government announced \$95 billion in credit facilities to firms under stress, including \$13.8 billion in forgivable loans. Meanwhile, producers, agribusinesses and food processors all expect to receive an additional \$5.2 billion in lending capacity from the federal government through Farm Credit Canada (IMF, 2021).

International travel restrictions, healthcare funding, economic stimulus, employment insurance and vaccine procurement all fall within the purview of the federal government. The federal government has also led Canada’s economic response to the pandemic. As of January 2021, the federal economic response plan had committed \$212 billion in direct support for businesses and individuals

(Cameron-Blake *et al.*, 2021). For the latter, federal support included the Canada Emergency Response Benefit (CERB), introduced on 6 April 2020. On 22 April 2020, the federal government announced investments of up to \$9 billion for students in the three areas of government benefits, job creation and targeted funding (Prime Minister of Canada, 2020). Canadian students would be eligible for \$1,250 a month from May to August 2020 under the Canada Emergency Student Benefit (CESB). The government also suspended the accumulation of interest on Canadian student loans from 1 April 2021 to 31 March 2022. During this period, payment of interest on guaranteed student loans as well as on the interest portion of the loan was waived. The government also proposed to extend this measure until 31 March 2023 (NSLSC, 2021), pending parliamentary approval. For the business sector, support included the Canada Emergency Wage Subsidy (CEWS) programme and a host of interest-free loans and targeted support. In addition, \$600 billion in liquidity was made available (Cameron-Blake *et al.* 2021).

On 14 March 2020, the Public Health Agency of Canada (PHAC) issued a statement recommending that Canadians avoid all non-essential travel outside of the country. Furthermore, the Agency advised exercising caution while traveling within the country. To curtail the spread of the virus, on 18 March 2020, Canada banned entry to foreign nationals who had travelled outside of the United States (US) or Canada within the previous 14 days. Subsequently, this rule was amended with the closure of Canada’s borders to unapproved international travellers and nationals. Beginning 21 March 2020, the Canada-US border was closed to non-essential travel. New restrictions also affected international students with a valid study permit. On 20 March 2020, exemptions were issued to travel restrictions, directly concerning international students with a valid study permit. International

³⁷ All dollar (\$) amounts given hereafter in this paper refer to Canadian dollars, unless specified otherwise.

students who had been approved or already held a valid study permit were exempted from the ban. Exemptions were also given to temporary foreign workers and those approved for permanent residence (IRCC, 2020a). All the aforementioned restrictions seem to be rooted in practical necessity, as the pandemic had already exacted a high human and social toll. Meanwhile, the Canada-US border remained closed, with extensions announced every month following the initial closure. Then, on 9 August 2021, fully vaccinated Americans were permitted to enter the country. However, the United States extend its land border restrictions with Canada until 21 September 2021 (Viera and Mackrael, 2022). As of 7 September 2021, foreign nationals who qualified for the fully vaccinated traveller exemption were able to enter Canada for non-essential travel (Government of Canada, 2021c).

In fact, hardening of the restrictions related to COVID-19 appears to have come as a natural response to the second wave of the pandemic peaked in early January 2021. Beginning 4 February 2021, direct international flights into Canada are only permitted through major airports, such as Vancouver international, Calgary International, Toronto Pearson International and Montreal Trudeau International. Importantly, all incoming travellers are required to quarantine in hotels around these four major airports. Objectively, the implications of the above decisions are significant for all travellers. The Government of Canada informs that all travellers arriving in Canada are subject to 'COVID-19 testing ... and a mandatory stay of up to 3 nights at a government-authorized accommodation' (Government of Canada, 2021a). Moreover, it is required that all 'travellers 5 years of age or older ... provide proof of a negative COVID-19 molecular test taken no more than 72 hours before the aircraft's initial scheduled departure time' (ibid., 2021). As to travellers entering Canada at land

borders, '[they] are required to provide proof of a negative COVID-19 molecular test taken in the US within 72 hours of arrival at the border' (ibid., 2021). Canada intends to introduce a 'standardized proof of vaccination' for Canadians to help with getting international travel back to normal, however this has not yet been implemented (Government of Canada, 2021d). In the meantime, COVID-19 vaccination documents in Canada are not standardized for international travel. However, the work in this direction is being continued in partnership with provinces and territories. The following sections provide examples of pronounced policy measures to limit the spread of the pandemic drawn from the provinces of Alberta, British Columbia and Ontario.

Alberta

It has been argued that the policy response in Alberta indicated a reluctance to introduce restrictions. Alberta's public health measures permitted businesses to operate with limited restrictions, and, according to Sim (2021), the Premier was slow to adopt recommendations made by public health officials. Instead, the province focused more on personal accountability and re-opening the economy. Although Alberta recommended that residents follow a stay-at-home order, this was not made a requirement. Similarly, residents were asked to limit travel between regions, but intra- or inter-provincial travel was not restricted. However, on 6 April 2021, following a rise in case numbers and new variants, Alberta reimposed restrictions in order to reduce capacity in businesses and close gyms.

Similar to other provinces in Canada, Alberta's schools were closed in mid-March 2020 and did not re-open until early September 2020. On 4 August 2020, the province announced a requirement for students in grades four and above to wear masks. Although not mandatory while seated in a classroom or playing indoor

sports, students were obliged to wear a mask in situations where physical distancing was not possible, such as high-traffic hallways and common areas. However, these belated efforts proved insufficient to control the situation, and by the end of April 2021, Alberta had the highest number of COVID-19 cases per capita in Canada (Sim, 2021).

British Columbia

On 6 March 2020, British Columbia (BC) activated its response to the COVID-19 outbreak. The fight against coronavirus in the province was led by the Provincial Health Officer (PHO) and the Health Minister. The government established a four-phase plan to tackle the spread of the coronavirus, starting with the declaration of a public health emergency on 17 March and the closure of all but essential services (phase 1). Public schools (kindergarten through to grade 12) were ordered to close indefinitely, and colleges and universities moved to online teaching to eliminate in-person instruction (Cameron-Blake et al., 2021). In mid-May 2020, many businesses reopened but their operation was conditional upon extra safety precautions and physical distancing measures (phase 2). For example, K-12 schools reopened on 10 September 2020 under strict sanitation requirements. However, some industries, such as movie theatres and cultural venues, did not re-open until June 2020 (phase 3). During this period, the restriction limiting any gathering to a maximum of 50 people remained in place. Furthermore, residents were encouraged to establish a so-called 'safe six' group normally including close friends or extended family members, within which one could feel comparatively safe while socializing. Physical distancing was not required within the group but was recommended for added safety. Cameron-Blake *et al.* (2021) report that a rapid rise in COVID-19 cases in late autumn triggered province-wide restrictions beginning on 19 November 2020, and the 'safe six'



order remained in effect indefinitely from 5 February 2021. The new measures allowed non-essential workplaces to stay open; however, gathering size and many indoor activities were limited.

Health authorities in BC have continued to develop and maintain strategies to ensure that transmission of COVID-19 is slowed or halted. To minimize disease transmission, like other provinces in Canada, BC announced that all communities must comply with government coronavirus orders. For example, the COVID-19 Public Health Guidance for K-12 School Settings (BCCDC, 2021) indicates that communities must comply with environmental and administrative measures such as lowering classroom occupancy and enhanced cleaning and disinfection, as well as personal measures to increase physical distance, hand hygiene and self-isolation. On 29 March 2021, the PHO strengthened province-wide restrictions. This implies that workplaces with a COVID-19 exposure could be ordered to close for a minimum of ten days.

Moreover, all restaurants, pubs and bars were ordered to close for indoor dining. In addition, on 7 May 2021, the PHO issued a new directive on social gatherings and events stipulating that no indoor social gatherings of any size would be permitted at a residence with anyone other than the household members. Where people lived alone, the core bubble could include, for example, a partner, relative, close friend or co-parent. With regards to outdoor gatherings, up to ten people were permitted to gather together (Government of BC, 2021).

Ontario

Ontario is Canada's most populous province, boasting a population of over 14 million people, equivalent to about two out of five Canadians, more than 85 per cent of whom live in urban centres. Not surprisingly, Ontario has the largest number of confirmed COVID-19 cases in Canada. The autumn 2020 report from the Ontario Auditor General (Cameron-Blake *et al.*, 2021) summarizes the province's pandemic response as slow and more reactive, characterized by a cumbersome command structure

that sometimes ignores public health expertise.

Regarding provincial measures, on 2 March 2020, Ontario established a command table whose function included oversight and provision of strategic direction in guiding the pandemic response across all 34 health regions in the province. Initially the risk to Ontarians was considered to be low. The command table reported to the Minister of Health and included Ontario's Chief Medical Officer of Health (CMOH). Five regional planning and implementation tables led by Ontario Health and local public health units reviewed and implemented regional plans. Ontario declared a state of emergency on 17 March 2020, and gatherings were restricted to five people on 28 March. All non-essential workplaces were closed, and although initially scheduled to re-open on 4 April 2020, schools did not resume in-person instruction until early September.

On 5 November 2020, the Ontario government released the 2020 Budget 'Ontario's Action Plan', outlining how the province was protecting people during the COVID-19 pandemic. The budget framework introduced five levels for public health unit regions (green-prevent, yellow-protect, orange-restrict, red-control and Lockdown), with corresponding health and workplace safety measures for businesses and organizations. The budget allocated \$45 billion over a three-year period (Government of Ontario, 2020) and was built on three pillars: protect, support and recover.

The first pillar, *protect*, built on the government's urgent response to COVID-19, providing \$15.2 billion in support, including \$7.5 billion in new funding. The first phase of Ontario's response to COVID-19 highlighted the following lines of expenditure: \$4 billion in 2021/22 and a further \$2 billion in 2022/23 to protect people's health; \$2.8 billion investment in a Fall Preparedness Plan to support response efforts to combat the second wave of COVID-19; and a

\$1.75 billion investment to increase long-term care capacity and access for residents, including the construction of four new long-term care homes with a targeted completion date of end-2022. Increased attention to long-term care homes aimed to address the fact that more than half of Ontario's COVID-related deaths occurred in these homes. Additionally, \$572 million was being invested in hospitals for costs incurred during the pandemic; \$270 million for public health, home and community care support and virtual care; and over \$1.5 billion pay to frontline pandemic workers for the period 24 April – 13 August 2021 (Government of Ontario, 2020).

The second pillar, *support*, provided \$13.5 billion over a three-year period in support of people and jobs, allocating \$2.4 billion in new funding, with \$380 million to be spent on students, parents and learners, following by \$378 million in March. These amounts were designated to support children, youth and students in their continued learning during the pandemic. Furthermore, \$100 million over a two-year period was to be allocated to the Community Building Fund to support communities and organizations experiencing significant financial pressures, such as organizations involved in tourism, culture and sport. A \$25 million one-time emergency payment for Ontario's arts institutions aimed to help cover operating losses incurred due to the pandemic, and over the next two years (2021/22 and 2022/23), an additional \$1.8 billion in investment was earmarked for the Support for People and Jobs Fund. This money is expected to help respond to the emerging needs of the people of Ontario (Government of Ontario, 2020). Additionally, \$1.3 billion in investment was proposed for the education sector in 2020/21 to ensure that students, teachers and staff were safe on their return to schools. Support of \$300 million was also granted to eligible businesses to help pay costs associated with property

taxes and energy bills. Lastly, a one-time investment of about \$4 billion was allocated to municipalities and transit systems. This was a result of a partnership with the federal government that strives to help local governments address budget shortfalls related to COVID-19 and to maintain critical services (Government of Ontario, 2020).

The third pillar, *recover*, focuses on building the foundation for a strong recovery fuelled by economic growth. This pillar includes \$4.8 billion in new support for efforts directed to recovery. The Government of Ontario is striving to bring more jobs to the province, and to fulfil that objective, they proposed a comprehensive plan that addressed a key concern: the high cost of electricity. This initiative is expected to save about 14 per cent and 16 per cent for medium and larger industrial and commercial employers, respectively. In addition, they took a decision to reduce property taxes on job creators and to lower high Business Education Tax (BET). Furthermore, the plan is expected to provide small businesses with municipal and provincial property tax relief over 2022/23, with the expected savings reinvested in jobs and growth (Government of Ontario, 2020).

The second wave of the pandemic peaked in early January 2021, and the third wave started in early March 2021, gradually subsiding thereafter in part due to reinstated mobility restrictions and the increased rate of vaccination. As of mid-June 2021, over 65 per cent of Canada's population had received at least one dose of a COVID-19 vaccine (IMF, 2021). During phase 3, gatherings in Ontario were permitted indoors with a maximum of 50 people and outdoors with a maximum of 100. However, in the light of the increased number of confirmed COVID-19 cases, the government re-introduced strict quarantine measures, which prohibited all indoor and outdoor dining across the province. Restaurants, bars and other food or drink establishments were permitted

to operate takeout, drive-thru and delivery only. The effort to return 'back to normal' elicited \$15.2 billion in new supports. Key investments included over \$1.4 billion to continue building up COVID-19 testing, case and contact management; \$351 million for 2,250 hospital beds; \$284 million to address the surgical backlog; and \$70 million to purchase influenza vaccines.

The Ontario government has allocated over \$1.6 billion in resources to facilitate the safe reopening and operation of schools across Ontario. The Ontario Ministry of Education (EDU) reported in 2021 that \$763 million were raised through the federal Safe Return to Class Fund. The Ontario government also offering one-time payments to support students, parents and learners by improving online learning, expanding broadband, and making a substantial investment of \$13 billion over ten years in capital grants to build and renew schools across the province. The EDU (2021) also highlighted investments totalling \$487.9 million, with a reported \$304 million to support school boards in filling staffing positions to navigate a safe school year. School boards may use this funding to facilitate smaller cohorts, physical distancing, enhanced cleaning and the delivery of remote learning. Other lines of expenditures include \$65.5 million for enhanced cleaning protocols and other health and safety measures in student transportation; \$49.0 million for special education, mental health and well-being and equity initiatives; and \$29.4 million for increased costs related to school operations, such as the need to operate ventilation systems longer and replace filters more frequently (EDU, 2021).

In summary, the Government of Canada has been working hard to ensure that all directives are working as intended to deliver the required help to Canadians. Furthermore, in response to Ontario's request for assistance to support the ongoing fight against COVID-19, additional

help has been rendered to help the province cope with the rise in new COVID-19 cases. The Royal Canadian Air Force has flown medical personnel from Newfoundland and Labrador to Toronto to assist in Ontario medical facilities (Government of Canada, 2021b), and a Government Operations Centre was established to help coordinate a federal response to the situation in Ontario.

Discussion

Making sense of the crises: the workings of regulatory capacity

The response of governments to COVID-19 underline the importance of a nuanced approach that recognizes heterogeneity. The healthcare system in Norway is controlled by the government and funded by taxes and social security contributions. In Canada, the country's healthcare is funded and administered primarily by the provinces and territories. In fact, Canadian provincial and territorial governments are responsible for functions such as financing, organizing and delivering health services as well as supervising providers (Allin, Marchildon and Peckham, 2020). At the same time, each province and territory receive additional financial assistance from the federal government on a per-capita basis. At the national level, a variety of governmental agencies oversee specific functions. In the case of the coronavirus, the PHAC is responsible for public health, emergency preparedness and response, infectious and chronic disease control and prevention, and the promotion of health (ibid., 2020). Notwithstanding differences between countries, it is important to note the crucial role of cooperative forms of IGR in formulating swift and well-coordinated responses to the pandemic.

The response of governments to COVID-19 underline the importance of a nuanced approach that recognizes heterogeneity. The healthcare system in Norway is controlled by the government and funded by taxes and social security contributions. In Canada, the country's healthcare is funded and administered primarily by the provinces and territories.

Cameron-Blake *et al.* (2021) argue that the effect of any policy intervention is contingent on local specificities, such as local political and social contexts. Christensen and Lægreid (2020) in turn claim that major crises, such as COVID-19, strike at the core of democracy and governance, and therefore, can 'constitute challenges not only for capacity but also for legitimacy and trust' (2020: 774). Maintaining or restoring trust in government arrangements that are set up to deal with such crises may represent an important obstacle. Christensen and Lægreid (2020) emphasize the dynamic character of this relationship, pointing out that each well-functioning crisis management system will present a difficult trade-off between capacity and legitimacy. Similarly, Paquet and Schertzer (2020) argue that the coronavirus pandemic should be viewed as a 'complex intergovernmental problem (CIP)' (2020: 343), a concept that can generate analytical power to understand pandemic management in federations and multi-level governance systems.

The novelty of CIPs lies in the close collaboration between agencies and governments that do not traditionally work together. The emphasis is on the need for intergovernmental coordination since mitigation measures cannot be implemented unilaterally by any one government.

Paquet and Schertzer (2020) note that in the case of pandemics or climate change, the actions of any single government to address the root causes of the above problems will not lead to resolution. By addressing only the consequences of the problem, the results of any government's action would likely be confined to their territory and their regulatory space. CIPs generate pressure to act in novel ways and thus encourage new forms of collaboration. However, CIPs are also somewhat paradoxical, since they target intergovernmental collaboration to ensure effective and legitimate policy responses, while simultaneously making the collaboration difficult to achieve by calling into question 'the existing power equilibriums and dominant narratives about how to work together and share responsibilities within intergovernmental systems' (Paquet and Schertzer, 2020: 344).

The degree of centralization or decentralization is an influential factor that shapes IGR (Cameron, 2001), in particular the balance of power between the two orders of government, namely federal and provincial. This in turn affects the behaviour of the principal players and their relations with one another. Trilokekar and Jones (2020) identify three distinct approaches to federalism in Canada: the Chrétien government's approach that might be classified as unilateral federalism; the Martin government's approach which stands more for uncoordinated federalism; and the Harper government's approach which is described as classical federalism or a form of open federalism.

Frug (2014) argues that one 'troublesome aspect of centralization is its diminishment of the possibilities of democracy' (2014: 2). At a local level, democracy enables engagement in public issues that extend beyond voting. However, in a province or city where millions of people live, popular control of public policy becomes problematic. Arguably,



the contemporary loss of faith in democratic governance is due to the gap between the rhetoric and people's sense of what is really going on in their community. Local governments can be hostile to minorities or even practise discrimination, as occurs with recent immigrants, for example. Therefore, Frug (2014) highlights the importance of ensuring that local autonomy does not present a threat to human rights. In cases when a regional unit of the federation threatens secession, it is typical for a state to resort to defensive measures which alter the normal pattern and practices of IGR. The aftermath of these events can be substantial and may be felt even after the crisis has passed. For instance, the emergence of the Parti Québécois (PQ), a political party dedicated to Quebec separatism, demonstrates that Canadian federalism should not be taken for granted. Supporters of greater provincial autonomy make a case for the diversity of all provinces' interests, arguing frequently that the distribution of powers between federal and provincial governments

needs to be more in line with socio-economic realities.

Regarding higher education, Trilokekar and Jones (2020) note that internationalization in Canada is most evident at the local institutional level and is characterized by a large number of uncoordinated processes. While universities have taken the lead, they have been hampered by the lack of a national strategy on international education (IE). In Canada, the first national strategy on IE was adopted relatively recently, in 2014, by the Harper government. At the provincial level, several Canadian provinces have IE strategies. Quebec's strategy is the oldest, having been established in the 1970s, with other provinces following a similar route later in the 1990s. Although the conflicted nature of Canada's federalism persists, it is assumed that heightened global competition will have a soothing effect on existing federal-provincial disagreements on the issue of IE. Evidence to this effect can be found in the two policy priorities of the federal IE strategy: a reliance on

international student recruitment for the purposes of funding and then retaining the graduates as immigrants to meet Canada's labour market needs (Trilokekar and Jones, 2020). These priorities seem to reconcile the federal and provincial governments on the issue that provinces nowadays should have a greater role in selecting and attracting immigrants, including international students, in accordance with the economic needs of the region. Trilokekar and Jones (2020) also emphasize that relationships between levels of government would look different had policy-makers prioritized the curriculum or study abroad component of IE instead of economic and immigration dimensions.

Bakvis and Skogstad (2008) write about collaborative federalism, the distinguishing feature of which is a partnership between two orders of government (i.e. provincial and federal) that jointly decide national policy. These orders must be equal, autonomous and interdependent. Under this arrangement, decisions

can be achieved vertically between provinces and the federal government or horizontally as a partnership between provinces. As mentioned earlier, the importance of cooperation in responding to the consequences of a crisis like a pandemic is widely accepted. While comparing the role of the provinces and the federal government in governance and policy development in Canada, Atkinson et al. (2013) also come to conclusion that the role of regions and provinces has increased. Furthermore, some authors outline the importance of planning and preparing for the unexpected and unknown. For instance, Christensen and Lægreid (2020) argue that dealing with uncertainty and ambiguity, as well as tackling urgent issues and meeting citizens' demands is a crucial but simultaneously challenging task for public authorities.

It is true that societal security and crisis management have become politically salient issues. Nevertheless, they are often subject to public criticism and debate. In fact, two major questions are of singular importance for societal security and crisis management: governance capacity and legitimacy. The former combines preparedness or 'analytical capacity', including both coordination and regulation as well as 'delivery capacity' for implementation (Lodge and Wegrich, 2014). The latter represents citizens' trust in government. Zmerli and Hooghe (2011) argue that political trust can be considered the strongest expression of diffuse support among the population. Political trust is also facilitated among other things by transparency of a government's actions. The level of political trust determines whether decisions taken by the political system are viewed by citizens as legitimate and influences strongly their compliance (Easton, 1975). Indeed, governance legitimacy relates to issues of accountability, support, expectations and reputation.

It is worth noting that analytical and delivery capacities both play a role in providing effective crisis management. However, crisis management is most successful when it combines democratic legitimacy with government capacity (Christensen and Lægreid, 2020). Furthermore, crisis management is viewed nowadays as an important policy area for political leaders and public administration in general (Boin et al., 2017). Brandsen and Honingh (2016) argue that crisis outcomes, as in the case of COVID-19, are a result of coproduction dependent on citizens' behaviour as much as on government policy, with the former affected not only by a government's capacity, but also by citizens' trust in the government. For instance, it is crucial that any measures taken to handle a crisis are readily accepted by citizens; otherwise, the government's guidelines will not be followed (see Boin and Bynander, 2014; Lægreid and Rykkja, 2019; Christensen and Lægreid, 2020). In summary, different stakeholders in society, including the private sector and civil society organizations (CSOs), play an important role in building public awareness and helping to overcome political divisions that might constrain collective responses to major policy challenges (Agranoff, 2011; Davenport and Prusak, 2000; Puppim de Oliveira et al., 2021).

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In Canada, the scope of COVID-19 is profound. The short-term consequences extend well beyond public health to mobility control, international and interprovincial

trade/supply chains and the provision of basic income security measures for Canadians. In the medium term, governments will have to deal with the economic impact of the pandemic on their revenues and budgets (Paquet and Schertzer, 2020). The pandemic response therefore encompasses multiple aspects of Canada's intergovernmental system.

Cameron (2001) argues that IGR depends on demographic and geographical factors. This means that the size of the country, the extent of the population and their distribution on the territory will have an impact on the structures and processes of IGR. As mentioned earlier, the degree of centralization or decentralization is an important factor shaping IGR (Cameron, 2001). However, another influential factor to consider when discussing the nature of IGR structures and process is whether the government is organized according to parliamentary or presidential/congressional principles. The parliamentary system tends to concentrate power in the executive branch, while the congressional system disperses power among many actors. As a result, these two systems produce quite different patterns of IGR. The former is executive dominated, and the latter is conducted by the legislative and executive branch. Cameron (2001) notes that multilingual and multicultural societies are different from socially more homogeneous federations. A common language (*lingua franca*) makes IGR communications easier and thus simplifies federal interchange. Profound socio-cultural differences within a country, on the contrary, may inhibit effective IGR due to mutual ignorance and suspicion.

During periods of external crisis such as a pandemic, increased spending on healthcare and various social support measures will be particularly in provinces and municipalities where costs rise significantly. It is crucial to understand that none of these policy

challenges can be resolved by a single order of government. Instead, the main concern is how governments will coordinate among themselves to access global capital and credit to support their strained budgets. Paquet and Schertzer (2020) argue that it is important to understand how 'the structure, norms, relationships and processes of the intergovernmental system' (2020: 345) may help or hinder the response to the crisis. Cameron (2001), in turn, argues that a great deal of the intergovernmental business of any federation is conducted informally, operating through unstructured encounters occurring between politicians and officials, as well as by telephone and email.

Different arrangements are made in Canada to facilitate interaction between the regional and the central governments. For example, 'First Ministers Conferences in Canada' bring together heads of government, ministers responsible for specific portfolios as well as various government officials. In addition, meetings between the prime minister and premiers have become more frequent. As a result, provincial governments have sought to intervene in provincial economies, challenging the right of the federal government to make economic policy and expressing the hope that the federal government will look for their collaboration or consent. This practice, where decision-making power is concentrated in government executives, such as the prime minister, premiers and the cabinet, is referred to as executive federalism (Savoie, 1999; White, 2005). To some observers, such meetings among first ministers fill a gap in the Canadian constitution, providing a forum for consultation and regulation of federal-provincial relations (The Canadian Encyclopedia, 2021).

During periods of external crisis such as a pandemic, increased spending on healthcare and various social support measures will be particularly in provinces and municipalities where costs rise significantly. It is crucial to understand that none of these policy challenges can be resolved by a single order of government.

Cameron (2001) has observed that provincial or state offices are sometimes situated in the national capital. In these circumstances, the conduct of IGR becomes more process driven, formal and institutionalized, as well as more centralized at both levels. However, IGR may also be conducted in a more informal, *ad hoc* fashion, as noted above, depending on the preferences of political actors. It is also worth noting that IGR can differ in the degree of transparency. For example, intergovernmental relations and policy decisions may occur behind closed doors with little popular knowledge or accountability or be 'embedded in processes that are open to public scrutiny and influence, and constrained by clear lines of democratic responsibility' (ibid: 125). Indeed, Trilokekar and Jones (2020) recalled that provinces came together as a group in 2011 to announce an international education (IE) marketing action plan for provinces and territories, a process that took place under the auspices of the Council of the Federation – a venue that brings together biannually the ten provincial premiers and three territorial leaders.

The contemporary challenges confronting federal and other states have Implications for IGR. Objectively, IGR is a central fact of modern political life, and one that extends beyond federations. In the 1990s, three North American federations – Canada, Mexico and the United States – jointly created the North American Free Trade Agreement (NAFTA), an international

entity that has a continuing impact on all of the constituent units of the three federal systems. It can be stressed that some of the centralist policies were no longer allowed under NAFTA (The Canadian Encyclopedia, 2021). Understanding the mechanisms through which the structure, norms, relationships and processes of the intergovernmental system are helping or, alternatively, are hindering the response to the crisis is essential to explaining the policy outcomes associated with COVID-19. Hall and Battaglio (2020) highlight resource and planning differences that have revealed gaps in capacity and performance, while Cameron (2001) refers to the emergence of 'complex multi-tiered political structures which transcend the parameters of states [e.g. NAFTA]' (2001: 126). The narratives of how governments work together to achieve their desired outcomes during these challenging times are of crucial importance; and while there have been reasons to celebrate federal-provincial-territorial (FPT) collaboration in response to COVID-19, factors such as competing interests, resource constraints, legacies from past conflicts and lack of coordination in IGR are likely to create significant tension (Paquet and Schertzer, 2020). In particular, there is agreement among scholars about difficult issues of democracy, citizenship and accountability, which often confront governments in their relations with one another (Cameron, 2001).

Conclusion

Approaches for managing the COVID-19 crisis differed between countries, while the national and provincial responses to COVID-19 pandemic arguably varied in their form and effectiveness. However, it can be concluded that the effectiveness of responses was linked directly to the effectiveness of IGR systems, since efforts at all levels of government are needed to manage such complex problems. Among the factors that impeded

IGR were competing interests, resource constraints and lack of coordination. At the subnational (provincial) level, governments had fewer resources than at the centre; they also lacked power over sectors outside their jurisdiction, and needed the assistance of the central (federal) government to ensure coordination.

In the modern world, the concept of regionalism is usually presented as a form of centralization. However, centralized decision-making without informed local input results in poor outcomes. Augmented centralization, consisting of additional levels of government staffed by people who consider themselves experts, is unlikely to fulfil the needs or expectations of voters. Frug argues in this regard that regionalism can 'become less parochial if the regional decision-making body is organized to enable localities to meet with each other and forge a common policy' (2014: 6). Nevertheless, the effort to democratize IGR remains a continuous challenge for modern types of governance, and often increases the role of informal institutions and political processes, due to their role in determining the extent of strategy implementation in more decentralized systems.

In countries where healthcare is a multi-level responsibility with overlapping jurisdictions, there should be a national strategy designed to improve coordination in central-local government relationships. Furthermore, in situations when there is little political consensus, it is essential to have well-functioning intergovernmental institutions and mechanisms in place to ensure that neither administrative systems nor their activities are hindered by ongoing struggles in the polity.

In countries where healthcare is a multi-level responsibility with overlapping jurisdictions, there should be a national strategy designed to improve coordination in central-local government relationships. Furthermore, in situations when there is little political consensus, it is essential to have well-functioning intergovernmental institutions and mechanisms in place to ensure that neither administrative systems nor their activities are hindered by ongoing struggles in the polity. It is well recognized that the state and its political systems have been instrumental in formulating an immediate response to the COVID-19 pandemic. However, at the same time, there is increased understanding of the need for empowerment, as opposed to curtailment of those in regional and local government. This approach is now acknowledged as a more effective means of dealing with the multiple challenges presented by COVID-19.

In the case of federalism, the government's power and responsibility are shared between national and provincial governments. Canada represents an example of a highly decentralized federation which permits each province to enact policies that respond to local context. Hence, each provincial government maintains jurisdiction over its portion of the population and region. However, matters relating to international travel restrictions, healthcare funding, economic stimulus, employment insurance and vaccine procurement all come within the purview of the federal government, thus it is not surprising that the federal government has also taken the lead in Canada's economic response to the pandemic.

During the inevitable uncertainties of an outbreak, public authorities play an indispensable role in assuring a population that the government can keep the situation under control. During pandemics, governments should do their best to transmit

confidence in order to prevent further reactions that could exacerbate the social and economic impact of an outbreak. It is well recognized that the behaviour of citizens is affected not only by a government's capacity, but also by the people's trust in their government. As it is critical that government measures and guidelines are readily accepted and followed, it is recommended to maintain effective communication with citizens, an approach that also helps mitigate public anxiety. These communications should send unequivocal signals about the honesty of authorities, so that the public can be confident that no disconcerting facts are being downplayed or concealed (WHO, 2005). According to Stiglitz (2020), both information and disinformation play substantive role in inducing changes in behaviour. Hence, there should be a continuing effort to boost trust and confidence in the government. Different stakeholders in society also play an important role in building public awareness, and can help in overcoming political divisions that might constrain collective responses to major policy challenges.

In the context of the pandemic, uncoordinated federalism stands no chance against CIPs. This underscores the importance of collaborative federalism, under which provincial and federal governments need to jointly decide national policy. However, the COVID-19 crisis has shown that joint interventions are not always effective, a conclusion attributable to the fact that existing mandates, agendas and processes of intergovernmental forums are not always sufficiently well-tuned to coordinate government action. Furthermore, public authorities have learned a hard and expensive lesson about dealing with uncertainty and ambiguity during the outbreak. Governments have been faced not only with the challenge of tackling urgent issues and meeting citizens' demands, but also with issues of public trust. In this regard, the experience of Norway and

Canada demonstrates how active communication can play an important role in disseminating information quickly. Authorities have even resorted to non-traditional channels of communication that enable them to reach people where they are, instead of expecting citizens to search for vital information on government portals. Furthermore, the formation of trust in multi-level governance is an outcome of a well-functioning political system. The level of political trust determines whether decisions taken by the political system are viewed by citizens as legitimate and influences strongly their compliance.

There is no doubt that discussions regarding the best system to use for confronting the pandemic will continue into the future. Based on the outcomes seen in Canada and Norway, it is possible to conclude that the government authorities of Norway enjoyed a greater level of trust from citizens compared to the response among the population in Canada. Prime Minister Justin Trudeau's decision to invoke the Emergencies Act to clear the Freedom Convoy of trucks – a reaction to government restrictions on vaccinations, especially those impeding Canadian's ability to cross national borders – clearly divided many Canadians. Some Canadians are in full agreement with the opinion of Croatian Member of European Parliament (MEP) and former judge Mislav Kolakusic, who accused Justin Trudeau on Twitter of engaging in 'a dictatorship of the worst kind' and opined that 'Canada has become a symbol of civil rights violations' (see Dzsurdza, 2022). Many Canadians have also castigated the authorities over the use of the Emergencies Act to freeze the bank accounts of convoy protesters and donors.

Conversely, many Canadians view the protesters' concept of freedom as immature and akin to anarchy (cf. McKnight, 2022). Importantly, McKnight (2022) argues that freedom and responsibility exist in a

complementary and, in fact, necessary relationship. Accordingly, people's freedom to behave as they choose (i.e. 'opt not to be vaccinated') goes hand-in-hand with responsibility for their choices and behaviour. People must therefore accept that freedom under such conditions comes with increased responsibility. At the same time, if the measures taken to handle a crisis were readily accepted by citizens, they would be more cooperative in following government guidelines. It is therefore important to design governance systems that allow for change when the defects of the system become apparent. Perhaps now is the time to start rethinking the architecture of governance and to begin working to change it.

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2.4. La gestion politique de la COVID-19 au Cameroun. Retour sur les enjeux d'une biopolitique par les chiffres

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Résumé

Que l'irruption de la COVID-19 au Cameroun se soit accompagnée d'un exercice journalier de décompte statistique sans précédent, ne conduit pas à priori au débat sur la validité ou non des statistiques -et c'est souvent bien le cas- tant les modalités de décompte sont peu connues et les agences qui en ont la charge sous équipées. Qu'il en soit même autrement que cela ne changerait rien à l'écart que la réalité en tant que grandeur garde toujours sur les instruments qui prétendent sa mesure. Seulement, si on part du postulat selon lequel la preuve statistique révèle la dynamique pandémique, il convient d'interroger dans ce cas les conditions de mise en récit des statistiques et les usages multiples auxquels elles donnent lieu. Plus qu'une simple tâche technique, les statistiques sont au cœur de l'action gouvernementale dont toute l'ingénierie est mise à rude épreuve par les défis socioéconomiques et politiques solidaires de la COVID-19. L'action publique qui en découle est à l'interstice de l'injonction de transparence et de l'appropriation. A ces conditions, l'Etat du Cameroun

peut-il au titre d'Etat hygiéniste, s'aligner sous le « régime de soins » qu'impose désormais l'urgence sanitaire ? Au final, c'est l'horizon politique camerounais, dans les rapports Etat/société et Etat/partenaires internationaux, qui s'y révèle ambiguë, les peurs et les espoirs à proportions égales.

Mots clés : action publique, biopolitique, Cameroun, COVID-19, statistiques.

Introduction

Le Cameroun face au « pire »

Dans un numéro récent de la Revue Française de Socio économie, Philippe BATIFOULIER et Nicolas DA SILVA s'accordent à dresser « un panorama international de la pandémie de la COVID-19 » (Batifoulier et Da Silva, 2021 : 151). Il en ressort que cette pandémie a davantage accentué les inégalités mettant à nu l'impréparation des politiques qui, enchâssées dans l'économie internationale recourent au privé pour défaut d'autofinancement. Ce qui pose à nouveaux frais la crise inhérente du politique. Qu'il en soit ainsi de façon générale ne dispense

en aucun cas l'inégale distribution du mal à travers le globe. En Afrique, région du monde la moins touchée par la pandémie, tout semble donner lieu à un « succès » là où les systèmes sanitaires des pays les plus développés ont échoué. Résumant l'expérience africaine de la crise sanitaire COVID-19, Fred Eboko note que « l'un des constats récurrents des analystes de la gestion de la pandémie en Afrique est la rapidité avec laquelle une grande partie des gouvernements a réagi pour contenir la propagation du virus » (Eboko, 2020 : 124). Le décompte des premiers cas de contamination et de décès a fait suite à un ensemble de mesures préventives qui ont vu se décréter l'Etat d'urgence sanitaire : fermeture des lieux publics, fermeture des frontières, adoption des gestes barrières, port obligatoire du masque, etc. Au cœur de ces mesures, le décompte statistique a été un tournant décisif dans la gestion de la crise. Il a servi tant du point de vue technique en fournissant l'information indispensable à la prise de décision que du point de vue juridique/politique en rendant légitime l'action gouvernementale. C'est donc en tant que dispositif c'est-à-dire, « un ensemble de savoirs, de mesures, d'institutions dont le but est de gérer, de gouverner, de contrôler et d'orienter, en un sens qui se veut utile, les comportements, les goûts et les pensées des hommes » (Agamben, 2006 : 29) qu'il faut comprendre la production et les usages des statistiques dans ce travail. Suivant une perspective foucauldienne, cela renvoie à une biopolitique où l'Etat se charge de gérer la vie. Pour Giorgio Agamben, le déploiement d'un dispositif suppose la formation d'un réseau, l'ordonnancement d'une fonction stratégique elle-même prise à l'étau des relations de pouvoirs et de savoirs (Agamben, 2006 : 26). C'est pourquoi l'allure triomphante que prend la gestion politique de la pandémie en Afrique en général et au Cameroun en particulier, ne devrait pas occulter les enjeux sous-jacents à la gouvernance de la crise (Heikel,

2021 : 169). Suivant une démarche essentiellement conceptuelle, cet article voudrait discuter des pratiques discursives (logiques et dynamiques) des chiffres produits par le Ministère de la santé publique au Cameroun. Il cherche à démontrer qu'au Cameroun, l'exercice journalier de décompte statistique (nombre de malades et de décès) a permis de construire socialement la crise sanitaire en renforçant d'une part, l'autorité de l'Etat et, d'autre part, l'éligibilité du Cameroun à « l'aide internationale » des « fonds de solidarité » en lien avec la COVID-19.

De la COVID-19 au retour de l'État hygiéniste

L'une des particularités de l'état d'exception qu'a laissé voir la COVID-19 est qu'il rappelait au goût du jour l'Etat hygiéniste dont la cause ultime est d'être garante du bien-être de ses populations. Michel Foucault, le premier, semblait avoir perçu ce déclin de l'Etat moderne qui exige précisément selon lui l'exercice optimal du pouvoir tant il n'était pas plus question de faire mourir mais de garantir la vie jusque dans ses intensités les plus significatives. Nous entrons alors écrit Foucault à l'ère du biopouvoir où prime la « gestion calculatrice de la vie » (Foucault, 1976 : 183) selon deux pôles : la discipline des corps et les régulations de la population. C'est l'autre événement majeur mis à nu par la crise sanitaire à savoir la dynamique comportementale de la population. En bref, l'Etat hygiéniste repousse au maximum la mort en créant les (meilleures) conditions de vie. Mais pourquoi ce « paternalisme sanitaire » s'interroge -assez rhétoriquement- Jean Marie Le Guen.

L'argument biopolitique consiste à dire que c'est parce que la santé est un des piliers du contrat social et que fondamentalement, l'Etat est garant de l'intérêt général. C'est pourquoi, l'Etat précise-t-il « a une légitimité à édicter des règles d'environnement d'une part, d'éducation au comportement de l'autre » (Le Guen,

2009 : 194). A ce sujet, Foucault fait remarquer qu'« au vieux droit de faire mourir ou de laisser vivre, s'est substitué un pouvoir de faire vivre (...) ». C'est sur la vie maintenant et tout au long de son déroulement que le pouvoir établit ses prises » (Foucault, 1976 : 182). Il faut pour cela un savoir et un pouvoir qui se transforment de façon continue. La pandémie COVID-19 dont le propre d'instaurer le mal voire un climat funeste, exige par conséquent le retour de l'Etat hygiéniste (Machikou, 2020). Dès lors, à quelles conditions et sous quelles formes de savoirs et de pouvoirs se déploie l'Etat hygiéniste au Cameroun ?

Mise en récit de la COVID-19 au Cameroun

En ce qui concerne le Cameroun, la COVID-19 ne devient un problème public que le 06 mars 2020 lorsque le ministère de la santé publique (Minsanté) déclare officiellement la présence de cas testés positifs au coronavirus sur le territoire national. Onze (11) jours plus tard, le Premier Ministre Dion Nguté à la suite d'une concertation interministérielle, communique « sous haute instruction du chef de l'Etat », la « Stratégie gouvernementale de riposte face à la pandémie de coronavirus ». Il s'agit d'un ensemble de mesures allant de la restriction des rapports sociaux entre individus (distanciation sociale) à celle des individus aux institutions (fermeture des lieux publics). En clair, c'est la mise en place de la quarantaine.

A côté de ces mesures, l'on peut aussi remarquer les sorties ponctuelles du Ministre de la santé publique Manaouda Malachie qui communique au jour le jour l'évolution du virus. De 02 cas le 06 mars 2020, on était passé à 05 cas dix jours plus tard, 27 le 20 mars et 66 cas le 24 mars. Pour Nadine Machikou, (Machikou, 2020) le « taux de propagation doublait en moyenne tous les 03 jours » si bien qu'au bout de 22 jours, le Cameroun dénombrait 1000 cas recensés (Nsebe *et al.*, 2020). Ce fut également l'occasion pour le

Encadré 1 : tableau présentant les principales mesures du gouvernement

1. Les frontières terrestres, aériennes et maritimes du Cameroun seront fermées : tous les vols passagers en provenance de l'étranger sont suspendus, à l'exception des vols cargos et des navires transportant les produits de consommation courante ainsi que les biens et matériels essentiels, dont les temps d'escale seront limités et encadrés ; les Camerounais désireux de retourner dans leur pays devront prendre l'attache de nos différentes représentations diplomatiques ;
2. La délivrance des visas d'entrée au Cameroun aux différents aéroports est suspendue ;
3. Tous les établissements publics et privés de formation relevant des différents ordres d'enseignement, de la maternelle au supérieur, y compris les centres de formation professionnelle et les grandes écoles seront fermés ;
4. Les rassemblements de plus de cinquante (50) personnes sont interdits sur toute l'étendue du territoire national ;
5. Les compétitions scolaires et universitaires sont reportées, à l'instar des jeux FENASSCO et des jeux universitaires ;
6. Les débits de boissons, les restaurants et les lieux de loisirs seront systématiquement fermés à partir de 18 heures, sous le contrôle des autorités administratives ;
7. Un système de régulation des flux des consommateurs sera instauré dans les marchés et les centres commerciaux ;
8. Les déplacements urbains et interurbains ne devront s'effectuer qu'en cas d'extrême nécessité ;
9. Les conducteurs de bus, de taxis et de mototaxis sont invités à éviter des surcharges dans les transports publics : les forces de maintien de l'ordre y veilleront particulièrement ;
10. Les formations sanitaires privées, les hôtels et autres lieux d'hébergement, les véhicules ainsi que les équipements spécifiques nécessaires à la mise en œuvre du plan de riposte contre la pandémie de la COVID-19 au Cameroun pourront être réquisitionnées en tant que de besoin, à la diligence des autorités compétentes ;
11. Les administrations publiques devront privilégier les moyens de communications électroniques et les outils numériques pour les réunions susceptibles de regrouper plus de dix (10) personnes ;
12. Les missions à l'étranger des membres du Gouvernement et des agents du secteur public et parapublic sont suspendues ;
13. Les populations sont invitées à observer strictement les mesures d'hygiène recommandées par l'Organisation Mondiale de la Santé, à savoir notamment se laver régulièrement les mains au savon, éviter des contacts rapprochés tels que se serrer les mains ou s'embrasser, se couvrir la bouche pour éternuer.

Source: Daniel Enama, Koïssé Mahamat Imar II.

Minsanté de communiquer sur son site internet le protocole sanitaire en cas de personne testée positive et une foire aux questions (FAQ) en lien avec le virus tant beaucoup de rumeurs et de soupçons circulaient à propos. Toutefois, malgré une propagation sur l'ensemble du territoire national, les régions du Centre et du Littoral sont celles qui comptabilisent le plus de cas soit 128 cas pour le Centre et 32 cas pour le Littoral à la date du 03 mai 2020. Ceci peut s'expliquer par le fait que ces deux régions constituent les deux plus grandes métropoles du pays par conséquent, leurs connexions aux réseaux globaux est plus importante (Nsebe *et al.*, 2020). A ce jour, malgré la faible médiatisation du décompte statistique – tous les regards étant désormais focalisés sur le scandale de la gestion des fonds COVID (COVID-gate) -, le Cameroun compte 61731 cas confirmés, 919 décès, 56926 remissions et 3886 cas actifs.

Encadré 2 : le protocole sanitaire du Minsanté

1- Recherche active des cas
Le premier axe est la recherche active des cas à travers notamment, un testing massif des populations.
2- La prise en charge
Le second axe est la prise en charge optimale des cas confirmés positifs, aussi bien du point de vue des protocoles, de l'offre hospitalière et de l'offre d'équipements.
3- Régulation Sociale
Le troisième axe est la régulation sociale, dont l'objectif est de limiter la contamination communautaire à travers notamment des actions de sensibilisation, de régulation des flux des personnes dans les lieux de grande affluence.
4- Gouvernance et redevabilité
Enfin le quatrième axe s'articule autour de la gouvernance et la redevabilité, afin de mieux coordonner les actions entre les secteurs, assurer une gestion efficiente de la ressource humaine et garantir la transparence dans la gestion des ressources mises à disposition.

Source: Daniel Enama, Koïssé Mahamat Imar II.

Encadré 3 : la FAQ COVID-19 du Minsanté

FAQ – COVID19
• Qu'est-ce qu'un coronavirus ? Les coronavirus forment une vaste famille de virus qui peuvent induire la maladie chez l'homme et chez l'animal. On sait que, chez l'être humain, plusieurs coronavirus peuvent entraîner des infections respiratoires dont les manifestations vont du simple rhume à des maladies plus graves comme le syndrome respiratoire du Moyen-Orient (MERS) et le syndrome respiratoire aigu sévère (SRAS). Le dernier coronavirus qui a été découvert est responsable de la maladie à coronavirus 2019 (COVID-19).
• Qu'est-ce que la COVID-19 ?
• Quels sont les symptômes de la COVID-19 ?
• Comment la COVID-19 se propage-t-elle ?
• Le virus responsable de la COVID-19 est-il transmissible par voie aérienne ?
• Peut-on contracter la COVID-19 au contact d'une personne qui ne présente aucun symptôme ?
• Puis-je contracter la COVID-19 par contact avec les matières fécales d'une personne malade ?
• Comment puis-je me protéger et éviter que la maladie ne se propage ?
• Quelle est la probabilité de contracter la COVID-19 ?
• La COVID-19 doit-elle m'inquiéter ?
• Qui risque d'être atteint d'une forme grave de la maladie ?
• Les antibiotiques sont-ils efficaces pour prévenir ou traiter la COVID-19 ?
• Existe-t-il un VACCIN, un MÉDICAMENT ou un traitement contre la COVID-19 ?
• La COVID-19 est-elle la même maladie que le SRAS ?
• Dois-je porter un masque pour me protéger ?
• Comment mettre, utiliser, enlever et éliminer un masque ?
• Combien de temps dure la période d'incubation de la COVID-19 ?
• Les êtres humains peuvent-ils contracter la COVID-19 à partir d'une source animale ?
• Mon animal domestique peut-il me transmettre la COVID-19 ?
• Combien de temps le virus peut-il survivre sur les surfaces ?
• Y a-t-il des choses à ne pas faire ?

Au-delà de révéler la dynamique pandémique et les défis structurels lui étant solidaires, F les chiffres sont intervenus à un autre moment, tout aussi important de la mise en récit de la pandémie : l'allocation d'un fonds national de solidarité constitué principalement des ressources issues du budget de l'Etat, de versements non-fiscaux de personnes morales ou physiques et des contributions des partenaires sous forme de dons ou de prêt. Au total, c'est une somme de 180 milliards dont 123 pour le fonctionnement et 48 pour l'investissement qui est mise à la disposition des autorités gouvernementales (Journal Cameroun Tribune du 27 juillet 2020). A cette allocation, s'ajoute un allègement des charges fiscales des entreprises

selon une circulaire du Ministère des finances.

Deux choses sont à relever : l'altercation entre les régimes juridiques et comptables d'une part et les trajectoires de la rigueur biopolitique mise sur pied par le gouvernement camerounais d'autre part. Sur le premier point, l'altercation des régimes montre la capacité du chiffre à construire socialement la pandémie et comment en conséquence, les mesures gouvernementales s'y appuient pour être légitimes auprès des populations. Sur le second point, on voit bien l'Etat du Cameroun assumer pleinement son rôle hygiéniste à travers le cadrage territorial, l'éducation/information et la régulation des comportements qu'ils soient sociaux ou économiques.

Ainsi, les rapports entre le savoir et le pouvoir ne se limitent pas qu'à l'instrumentation de l'un par l'autre. Le savoir comme tel se constitue comme un pouvoir. De même, le pouvoir s'entend comme un savoir. C'est ce qui fait dire à Michel Foucault qu'« aucun savoir ne se forme sans un système de communication, d'enregistrement, d'accumulation, de déplacement qui est lui-même une forme de pouvoir et qui est lié, dans son existence et son fonctionnement, aux autres formes de pouvoir. Aucun pouvoir, en revanche, ne s'exerce sans l'extraction, l'appropriation, la distribution ou la retenue d'un savoir. A ce niveau, il n'y a pas la connaissance d'un côté, et la société de l'autre, la science et l'Etat, mais les formes fondamentales du "pouvoir-savoir" (Foucault, 1982 : 20). L'interférence entre les régimes

juridique et comptable et leurs effets de disciplinarisation semble ainsi plausible (Supiot, 2015). Résumons donc.

La « pensée comptable » ou le gouvernement (par) des chiffres

Nombre de cas actifs au COVID-19, nombre de décès, de remissions, fréquence de propagation du virus, tous ces indicateurs viennent conforter l'idée communément diffusée de la place indispensable du chiffre dans la vie au quotidien. Alain Supiot, parlant justement du « gouvernement par les nombres », pense que nous sommes entrés dans une nouvelle ère sensible à la « quantophrénie » c'est-à-dire la propension absolue à tout mesurer (Supiot, 2015).

Cette sensibilité à la quantophrénie signe le passage d'une société politique administrée par le droit à celle gouvernée par les chiffres. Le nouveau management public impulsé par la logique néolibérale accélère et étant ce passage dont il constitue le référentiel. L'omniprésence des chiffres dans le gouvernement et les administrations s'aligne à cet effet aux exigences de « transparence », d'« ouverture », et de « redevabilité » (Bezes *et al.*, 2016). Selon qu'il est question de la « bureaucratisation du monde » (Hibou, 2018) impulsée par le « nouvel esprit du capitalisme » (Jany-Catrice, 2012), le maître-mot de l'Etat contemporain est la performance.

N'ayant pas les mêmes effets partout, l'horizon de performance demande aux administrations d'être productives, d'atteindre des objectifs. La gestion politique de la crise sanitaire tend à le démontrer : « les indicateurs chiffrés ont pris une importance grandissante au cœur de l'action publique. L'Etat a besoin de lois et de décrets pour agir, mais aussi de chiffres : au-delà des mots, les chiffres sont consubstantiels à l'action publique » (Fallon, 2014). C'est la raison pour laquelle, par le gouvernement des chiffres, nous voulons désigner les volontés de savoirs mais aussi de pouvoirs.

La volonté de savoir inhérente à l'usage des chiffres en vue de mieux gouverner vient du fait que le chiffre pris comme indicateur prend la mesure d'un problème public ou du fonctionnement étatique (Bezes *et al.*, 2016). Le chiffre augure ainsi des « processus de véridiction » qui à leur tour, réduisent au maximum le risque dans les prises de décision. Par le chiffre, les politiques peuvent prétendre à la justesse de leurs actions. Quantifier ou mesurer le réel (la crise sanitaire dans notre cas), est donc une « activité technico-scientifique relevant des experts et non des politiques, qui produisent des chiffres porteurs d'une autorité légitimée par leur apparente neutralité et objectivité. Ces chiffres circulent dans l'espace politico-administratif et les acteurs s'en saisissent pour l'action publique » (Fallon, 2014 : 114).

De ce qui précède, l'« argument statistique » (Desrosières, 2014), du fait de sa neutralité, produit des « effets de conviction » (Bezes *et al.*, 2016) qui dépolitise tout problème public le rendant par conséquent légitime une fois porté dans l'espace public. Partant, gouverner la crise sanitaire a consisté à mobiliser des connaissances (statistiques) afin de proposer des solutions (politiques). En ce sens, la production statistique relève d'abord de l'expertise dont le propre est de révéler les tendances ou des réalités problématiques (Cadiou, 2006). Ceci laisse visible la dépendance du champ politique à la compétence scientifique. Parallèlement donc, « ce sont bien les formes d'exercice et de légitimation du pouvoir qui sont en jeu » (Cadiou, 2006 : 122).

L'argument statistique, à moins donc d'être un pouvoir à part entière, en constitue les enjeux. Parce que produire des statistiques c'est fixer des agendas, des budgets, leurs suivis et leurs évaluations, il apparaît clairement que le pouvoir s'exerce également à travers des indicateurs chiffrés. Catherine Fallon dira à ce sujet que les « processus de quantification sont soigneusement

contrôlés par les autorités qui perçoivent l'importance de ces chiffres qui permettent d'encadrer leur action et dont ils tentent parfois également d'en infléchir voire d'en contrôler la production » (Fallon, 2014 : 114). Contrôler sinon influencer lorsque cela s'avère nécessaire, voilà un des objectifs que s'assigne le politique sous-régime de quantification.

Toutefois, il importe de noter que la technologie politique de contrôle de ces chiffres n'est jamais donnée d'avance. Elle est le fruit de l'espace social qui la voit naître et des variables y relatives. Produire des chiffres peut en fin de compte mettre en compétition des acteurs aux répertoires d'action différents, des logiques d'action également. Selon la distribution des forces, ces logiques peuvent être collusives ou collisives.

Pour Alain Desrosières, il existe une forme de circularité entre la connaissance (statistique) et l'action (politique). Contrairement à ceux qui posent la neutralité statistique comme un *a priori* du chiffre, Desrosières affirme que la « condition préalable à la production d'une statistique est la construction cognitive et politique d'un espace conventionnel d'équivalence » (Desrosières, 2005 : 6). C'est la raison pour laquelle l'existence du monde social par les statistiques est une phase secondaire celle de la mise sur pied du système de codage. Ce système est soigneusement agencé selon un projet politique. La production statistique in fine est prise à l'étau de la déontologie qui lui exige autonomie, neutralité et objectivité d'une part, et de la dynamique politique qui a tendance à imposer des circuits de production et d'usage d'autre part (Desrosières, 2005 : 7). Le savant et le politique luttent pour imposer une vision du monde. Embarqués dans la lutte, les « instruments structurés et structurants de communication et de connaissance (...) remplissent leur fonction politique d'imposition ou de légitimation de la domination » (Bourdieu, 1997 : 408). S'agissant

de la crise sanitaire au Cameroun, était-il question de légitimer un régime de soins ou de conforter un régime de domination politique et d'accumulation économique ?

Quelques (dis)continuités révélées par la crise sanitaire COVID-19

L'épreuve quelque peu réussie de la gestion politique de la COVID-19 en Afrique et partant au Cameroun, -comparativement aux prévisions catastrophiques de l'OMS- a permis de relever des permanences mais aussi des discontinuités quant à l'art de gouverner. En saisissant « au concret » (Padioleau, 1982) ou « en action » (Muller et Jobert, 1987) l'Etat du Cameroun à travers sa (bio) politique -chiffrée- de riposte à la COVID-19, deux choses essentielles ont retenu notre attention : les configurations relationnelles entre l'Etat (puissance publique) et la société d'une part, celles entre l'Etat et ses partenaires internationaux d'autre part. Bien que situés à des niveaux d'échelles différents, ces principaux acteurs de l'action publique sanitaire au Cameroun ont en commun le problème de la coordination et plus largement, celui de la construction d'un champ conventionnel de coordination. Avec la pandémie, il était également question de cela : convenir d'un cadre réflexif/cognitif relatif à la production statistique afin de coordonner les décisions qui visent le cadrage des flux divers (personnes, informations ou données sanitaires, finances, matériels, etc.). Or, la production statistique exclut tout débat et se prive de l'avis des autres acteurs pertinents de l'action publique au nom de l'expertise et du paternalisme affiché par l'Etat hygiéniste. Publier des statistiques dont la conséquence immédiate est de légitimer les décisions publiques met au corps à corps -le retour de- l'Etat et les formes -même banales- de résistance populaire. De même, cela a également donné à penser la configuration -renouvelée ? - de l'Etat partenaire.

L'Etat sous le prisme des formes d'accumulation

Le lien très fréquent entre la puissance publique et sa traduction en régimes d'accumulation au Cameroun n'est pas une nouveauté (Geshiere *et al.*, 1993). Le jeu politique et les différentes organisations socioéconomiques sur lequel il repose opposent le plus souvent un ordre contraignant à un groupe subordonné. Dans ces luttes, l'Etat désigne le lieu de cumul et de redistribution à la fois des pouvoirs et des richesses (Mbembe, 1988). Sa capture est donc imparable. Les effets de disciplinarisation et de mise en évidence du mal COVID-19 ont mis à nu cette posture de l'Etat. L'autorité sous toutes ses formes semble réhabilitée (Eboko, 2020) et par effet d'entraînement, la captation de la « manne » financière allouée à la riposte gouvernementale.

D'un point de vue politique, riposter à la crise sanitaire a donné lieu à l'exercice de la violence qu'elle soit physique ou symbolique. Les institutions policière, administratives -et bientôt- judiciaires étaient mobilisées à cet effet. Des scènes de violence entre des civils et des policiers abondent les rues de grandes villes. A l'origine, le défaut de respect des mesures alors édictées par le gouvernement pour faire face à la COVID-19. L'institution policière réprime également les mouvements protestataires issus de la campagne électorale de 2018. Comme ce fut le cas avec la « marche » avortée en Avril 2020. La conclusion étant que la COVID-19 n'a pas donné lieu à une trêve politique au Cameroun (Nsebe *et al.*, 2021). La volonté de contester, bute ainsi sur la mesure qui interdit les « rassemblements de plus de cinquante personnes » au risque de constituer des foyers de propagation du virus.

D'autres scènes de violences beaucoup sublimées font écho dans les différents services publics à l'exemple des établissements scolaires. Ce sont leurs fermetures en cours d'année scolaire et surtout

les conditions de leurs réouvertures qui causent problème. A l'inédit, on y adopte pour boucler l'année interrompue, les cours en ligne afin de limiter les contacts physiques. L'inégale distribution du réseau internet sur le territoire, ajoutée à cela, l'inégal accès aux TIC (Technologies de l'information et de la communication) impacte qualitativement sur l'offre de formation déjà décriée depuis une vingtaine d'années. Le gouvernement a beau adopté les cours publics retransmis à la chaîne de télévision nationale (CRTV) que le problème est à peine résolu. Même la répartition « en cours du jour et du soir » dans les établissements à effectif pléthorique n'y peut rien. Tout au contraire, cela empiète sur les conditions de travail des enseignants. Le même personnel est appelé à effectuer une double tâche ; ce qui pose de facto, le problème du recrutement du personnel enseignant tant pour les niveaux primaires, secondaires qu'universitaires. Il en est de même pour les services hospitaliers durement éprouvés par la COVID-19. Plutôt que restaurer une autorité, il s'agit davantage pour la puissance publique d'être « modeste » afin de prendre acte de ses vulnérabilités (Crozier, 1982).

« Riposter » a aussi révélé la logique qui prévaut dans la gestion des fonds publics au Cameroun. Cela a fait les grands titres des médias nationaux et internationaux : le Cameroun au cœur de malversations quant à la gestion des fonds COVID-19. Le rapport rendu public par la Chambre des comptes note de graves erreurs ou approximations dans les documents comptables (Chambre des comptes de la Cours Suprême du Cameroun, 2021) déclenchant l'affaire du COVIDgate (Radio France Internationale [RFI], 03 juillet 2021). Entre autres, le rapport révèle la gestion erratique des médicaments, la simulation d'une fabrication locale de ces derniers, leur non-distribution, le recours aux marchés spéciaux, la surfacturation par deux fois le prix du concessionnaire de seize (16)

ambulances, la surfacturation des tests de dépistage, etc. En bref, la crise sanitaire a donné lieu à un « marché » où viennent se ravitailler en permanence les classes dominantes dont le pouvoir d'achat est désormais revu à la hausse. Juridiquement, c'est du détournement de fonds publics. Parce que l'Etat regorge d'immenses ressources à redistribuer à sa population, les forces dominantes, à partir de leurs positions de pouvoirs, les captent au détriment du plus grand nombre. En amont, la riposte a nécessité d'importantes ressources financières mais en aval, elle s'est traduite en distribution des sceaux d'eau, de morceaux de savon, etc. Le pouvoir de capture ou de prise exercé par l'élite dominante crée une scission entre l'Etat et la société ou comme le dit Jean-François Bayart l'« Etat contre les sociétés » (Bayart, 1998 : 34).

La revanche de la société

La docilité ou l'effet de disciplinarisation qu'entraînerait une biopolitique chiffrée n'est pas totale. Là où l'Etat pense réhabiliter son autorité, les faits montrent combien le quotidien s'y invente avec « mille manières de braconner » (De Certeau, 1987 : 10). L'invention du quotidien sur fond de « créativité sociale » (Bayart, 1998 : 37) désigne les arts de faire qui contrecarrent l'idée d'une domination absolue. Face à l'autorité, se dresse tacitement, un régime d'indocilité qui trouve fondamentalement ses sources dans le précarier produit et entretenu par l'élite dominante si ce n'est l'Etat. C'est d'ailleurs l'idée que défend Loïc Wacquant lorsqu'il estime le précarier est sous-déterminé économiquement et surdéterminé politiquement. Au cœur de ce mécanisme, l'« Etat joue un rôle pivot dans la distribution tant sociale que spatiale de la marginalité » (Wacquant, 2013 : 22). L'inégale distribution des pouvoirs symboliques et matériels concourt à façonner les structures de classes, le creusement des inégalités et le remodelage de la pauvreté. Analysant la précarité dans les villes américaines, Wacquant pense que c'est aux institutions sociale et

pénale qu'il revient d'ordonner cette mise en évidence de la précarité. Leur action combinée consiste à punir doublement le pauvre qui, livré aux difficiles conditions de vie entretenues par la politique sociale, recourt au peu d'activités le plus souvent illicites laissées à eux par les « nobles ». Ils s'exposent ainsi à la pénalité. Dans le cas du Cameroun, ce sont respectivement les institutions policière et administrative qui assurent cette tâche. Le sujet qui en ressort est matériellement et symboliquement épuisé. Dans un système de précarier, il n'est donc pas rare de distinguer les « protégés », les « précarisables » et les « précarisés » (Pierret, 2013). La première catégorie correspond à ceux disposent de positions de pouvoirs au sein de l'appareil étatique, les deux autres catégories, à ceux qui en subissent les effets négatifs à quelques différences près cependant.

Avec un salaire minimum de croissance (SMIC) situé à 36279 FCFA soit 60 £ à peine, un revenu par habitant en deçà d'un dollar par jour, une offre d'hospitalisation d'1,3 lits pour 1000 habitants, un faible taux d'employabilité, un secteur privé qui tarde à décoller, plus de 80% de l'organisation économique et sociopolitique qui se meut dans l'informel, quel peut-être le poids d'une quelconque prohibition lorsque la cause du sujet n'est pas la priorité du pouvoir ? Avec la pandémie, l'indocilité se comprend comme un art de contourner dont les formes ou trajectoires sont l'indifférence, le déni voire la banalité du mal. C'est entre autres le port du masque pendant un contrôle policier et son retrait le contrôle passé ou encore le fonctionnement clandestin des débits de boisson alors même qu'il est indiqué qu'ils sont fermés.

Au-delà des approches monistes, il faut noter la crise sanitaire, bien que mettant en évidence le rapport complexe entre Etat et accumulation, permet également de lire manière combinatoire deux approches apriori

contradictoires. Aux processus de « totalisation » des pouvoirs, il convient désormais de croiser les processus de « détotalisation » portés par les acteurs subordonnés (Bayart, 1985). Seulement, cette combinaison n'est ni donnée d'avance, ni systématique. L'agencement des rapports de pouvoirs n'étant pas univoque, il reflète la situation d'action qui en abrite l'effectuation avec ses effets de structure et sa part de contingence. Peut-on en dire autant des rapports entre l'Etat et ses partenaires ?

Le (nouvel) Etat partenaire et ses controverses

L'avènement de l'Etat partenaire perçu comme nouveau référentiel politique n'a pas une trajectoire uniforme selon qu'on l'applique aux Etats du Nord ou que l'on se tourne vers ceux du Sud (Lavigne, 2017). Toutefois, les raisons de la contestation de la précédente forme de gouvernement (Etat-providence) sont presque partout les mêmes : refus de la sujétion, montée de l'individualisme, inefficacité de l'Etat (Herzog, 1997). La COVID-19 au Cameroun vient s'inscrire dans le prolongement de la crise de l'Etat providence en Afrique et à la genèse de l'Etat partenaire. L'Etat partenaire est un « Etat modeste » qui co-construit ses politiques publiques (action publique) en collaboration avec d'autres acteurs dont les bailleurs de fonds, les ONG et la société civile. Le scénario que donne à voir la gestion politique de la crise sanitaire peut nous situer dans une bifurcation comprenant d'une part l'internationalisation couplée à l'extraversion et d'autre part, la réactivation de l'action publique.

L'idée que la gestion politique de la COVID-19 reflète l'internationalisation et l'extraversion débouche des malversations issues de la gestion des fonds COVID-19. Le bilan provisoire de cet exercice jugé inconséquent du point de vue des moyens mobilisés et des actions réalisées, confirme l'hypothèse des statistiques comme conditionnalité au financement.

Prouver -par les chiffres- que la pandémie sévit au Cameroun est un argument suffisant pour décréter l'Etat d'urgence sanitaire et prétendre aux fonds spéciaux y relatifs. Pour le cas du Cameroun, le premier décaissement s'est fait auprès du FMI le 04 mai 2020 dans le cadre de la facilité de crédit rapide (FCR). Le second décaissement en cours, a eu l'approbation du conseil exécutif du FMI malgré les remous liés à la gestion des premiers fonds. C'est au total près de 276 millions que bénéficiera le Cameroun pour stabiliser son économie sévèrement frappée par la crise à condition que la gestion de ces fonds soit transparente. En l'état, rien n'augure cette volonté de transparence qui, paradoxalement donne lieu à un nouveau prêt du Fonds Monétaire International à l'Etat du Cameroun.

Vers un renouveau de l'action publique post-COVID-19

Un mode d'agencement inédit de l'action publique a pris corps à l'orée de la crise sanitaire au Cameroun et en Afrique en général. Des initiatives appuyées par le gouvernement ont ainsi été implémentées. Lorsqu'on compare les périodes auxquelles les gouvernements africains ont réagi en puisant dans leurs propres revenus et celles où ils ont sollicité l'aide internationale, on conclut sur la proactivité africaine et surtout sa prise en main. La capacité à anticiper, à prendre par soi-même des mesures, amène à relativiser l'idée communément diffuse des politiques africaines sous régime d'internationalisation (Eboko, 2020 : 133). Cela suffit-il pour prétendre à une nouvelle ère de l'action publique ?

Il serait imprudent d'y répondre hâtivement. Surtout, lorsqu'on sait tous les soupçons de malversations liés à la gestion des fonds dédiées à la riposte (Foute, 30 avril 2021). Difficile également d'affirmer qu'il n'y a eu aucune évolution dans l'élaboration et la mise en œuvre des politiques publiques en Afrique. N'étant pas exclusivement l'une ou l'autre hypothèse, l'action publique telle

que révélée par la COVID-19 oscille entre les logiques de l'« ancien » et du « nouveau ». Cette situation est liée à la reconfiguration du champ politique saisi d'une part de nouveaux acteurs et d'autre part aux résistances/réticences du pouvoir. La refonte du champ politique a donc lieu à deux niveaux. Le premier porté par les acteurs de la société civile qui tente par maintes « tactiques » d'assainir l'arène politique ; le second niveau quant à lui a lieu est porté par les pouvoirs dominants qui multiplient des tentatives d'instrumentalisation des contre-pouvoirs.

Conclusion

Aux chiffres qui enchainent, des chiffres qui libèrent et réparent

Pour conclure nos propos sur les enjeux liés à la production statistique au Cameroun en période de crise sanitaire COVID-19, il convient de noter que différentes logiques situées à différentes échelles d'action concourent à la configuration de l'action publique qui en découle. La production statistique combine simultanément une logique technique au sens où les statistiques sont des outils qui renseignent la décision publique et une logique politique dans la mesure où ces mêmes statistiques créent un cadre de véridiction (la pandémie est réelle et appelle à l'urgence) et permet par le même fait des effets de légitimation (la décision publique exclue tout débat) et de discipline (la population doit se plier aux mesures gouvernementales). La logique comptable assure ce double rôle technique et politique. Gouverner la crise sanitaire au Cameroun est solidaire de cette perspective. Les statistiques auraient ainsi une intériorité (volonté de savoir) et une extériorité (savoir-pouvoir) qui appellent aux interactions entre un Etat comptable, sa société et ses partenaires internationaux. Le premier couple relationnel traduit la nature ambiguë des rapports de pouvoirs entre l'Etat et la société. L'ambiguïté est due à l'interférence

entre les lignes de domination et de contre-dominance. Plus encore, cela traduit la scission profonde entre l'Etat pris à l'étau d'agents prédateurs et la société poussée à l'indocilité par la précarité. Une meilleure manière de combler cet écart reviendrait à élaborer une « politique de réparation » qui ne suppose pas seulement selon Achille Mbembe une « redistribution des places qu'occupent les uns et les autres (...) ». Elle invite également à d'autres façons de négocier et résoudre des conflits que suscitent différentes manières antagonistes d'habiter le monde, à un vaste ré-ordonnement des relations » (Mbembe, 2020 : 136-137). Plutôt que cette statistique qui discipline la population et légitime la décision publique, il en faut également une autre, critique, qui soulève les défaillances de l'Etat et permet d'harmoniser les statistiques sectorielles avant de conclure un décret. De la sorte, les mesures relatives à la COVID-19 n'auraient pas fragilisé davantage les couches défavorisées s'il avait été également mis à contribution les statistiques sur les revenus par habitant, sur la couverture hospitalière, les conditions de logement, de travail etc. Le second couple de relations (Etat/partenaires internationaux) permet de relativiser sur la persistance des politiques d'assistance au Cameroun. A travers l'action publique de la COVID-19, il y a eu érection d'un nouveau cadre pour penser et faire localement l'action publique, l'aide internationale n'étant qu'un additif et non le socle comme ce fut le cas autrefois. Que cela continue donc.

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2.5. *Pandemic-facilitated interaction and new affordances of sociability: How strangers improvise around masks and physical distancing in Canadian urban public spaces*⁴¹

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Abstract

Drawing on data from the 'COVID-19 and Public Space' project, this article gathers accounts of people's everyday encounters with strangers in Canadian public spaces during the pandemic. Interview data was collected in two waves between May 2020 and March 2021. This article provides a context for studying public spaces during a pandemic, outlines the study methods and reports the main findings, with a special focus on understanding how pandemic restrictions – masking and physical distancing in particular – impacted project participants' experiences in public spaces. Analysis of the interview data posits a variety of ways that the pandemic facilitated interactions between strangers in Canadian public spaces. Relevant themes identified in the interviews are discussed, including perils and pleasures of pandemic public spaces; new affordances of sociability; and soft solidarities and magnified meanings of the mundane. The

chapter concludes with suggestions for those charged with the planning and management of public spaces in the post-pandemic world.

Introduction

'Solidarity. Solidarity. Solidarity'
Tweet from @DrTedros, 27 April 2020.

At a March 2020 press conference launching international clinical trials to find effective treatments for COVID-19, Doctor Tedros Adhanom Ghebreyesus, Director-General of the World Health Organization, called the pandemic 'the defining crisis of our age (...) a test of global solidarity', noting that the 'virus thrives on division, but is thwarted when we

38 The authors gratefully acknowledge support from Canada's Social Sciences and Humanities Research Council Insight Grant (#435-2018-0730) funding for the Sociable Cities Project (www.sociablecities.uoguelph.ca) and COVID-19 Supplement Fund. Special thanks to our research participants for their time.

unite'. He decried not the strength and transmissibility of the virus itself, but the greater threat posed by a lack of global solidarity. This framing by the planet's most important medical professional was remarkable as it expanded the narrative from the specific science of spread and the particulars of the virus's causes, transmission and effects, to one that invited all people to work collectively and collaboratively to defeat the virus. 'Together', he said, 'is the solution'

As the pandemic swept the globe, videos circulated of harrowing scenes, desperate pleas and impassioned warnings from overwhelmed emergency medical professionals forced to make unthinkable triaging decisions. These videos circulated alongside touching scenes of quarantined neighbours singing to one another from balconies, children displaying drawings bearing messages of strength and support for healthcare workers and passing strangers, and eerie images of normally busy urban public spaces emptied of people. Globally, there was a palpable sense of both collective fear and collective effort.

The external constraints that tackling the virus placed on people and their immediate environments forced people everywhere to improvise in their everyday lives. In countries with low supplies of personal protective equipment, people took to making their own improvised masks, gowns and face shields from whatever materials were close at hand. Those who could work from home set up makeshift workstations. Toddlers wandered into caregivers' Zoom calls and household pets became part of business meetings. For many children, the pandemic transformed schooling, with homes becoming miniature classrooms for several hours a day. Those whose workplaces remained open navigated their way to work through barren streets, and many found their work to be more tense and stress-filled. Boundaries of public and private life became increasingly

blurred. People altered their immediate physical environments to meet distancing requirements and to abide by lockdown restrictions. In short, the pandemic profoundly transformed everyday life for billions of people.

While the pandemic is, by definition, global in scale, its everyday effects are experienced locally and interpersonally. As governments declared national emergencies and imposed restrictions on movement and physical contact between people, their everyday lifeworlds³⁹ were rapidly and radically transformed. For most, the everyday orbits in which they moved shrank considerably, with many staying in their homes or venturing no further than their immediate neighbourhood, whether or not this was mandated by public health officials. Being present in public spaces with unknown others became especially fraught. Nonetheless, people used public spaces – streets, sidewalks, green spaces – for everyday provisioning, exercise, socializing and for work. They found themselves relating to those ordinary spaces and to unknown others – strangers – in new and different ways.

This article presents data on everyday interactions between strangers in Canadian public spaces during the pandemic. Looking at mundane social interaction may seem somewhat frivolous considering how the pandemic has both produced and exacerbated wide-ranging health and material inequalities. Nonetheless, the pandemic's effects on everyday social experience are both profound and consequential.

The qualitative study, 'COVID-19 and Public Space', on which this article is based, gathers accounts of people's everyday encounters with strangers in Canadian public spaces during the

pandemic. It was conducted between May 2020 and March 2021 under the auspices of the Sociable Cities Project, a federally funded research initiative studying interactions between strangers in public space. This article outlines the study methods and reports the main findings, with a special focus on understanding how pandemic restrictions – masking and physical distancing in particular – impacted project participants' experiences in public spaces. We conclude by reviewing our findings and discussing potential policy implications, particularly for those charged with the planning and management of public spaces in the post-pandemic world.

Everyday lifeworlds: physical and social distance

Public health officials around the world quickly took up Director-General Ghebreyesus' call for physical distancing to mitigate virus transmission. In the English-speaking world, the term social distancing quickly became equally pervasive, a mixing of terms that likely grated on social scientists who research interaction. Here's why. As a basic spatial fact physical distance refers simply to objectively measurable space in two dimensions – 6 feet, 2 metres, or in Canada, popularized as the length of an ice hockey stick. Social distancing is qualitatively different. It is multidimensional and irreducible to physical space. In sociology, the term originates with Georg Simmel (1971) who defined 'the stranger', for example, as one who is physically proximate but socially distant. In other words, strangers are persons who are physically close to one another in space but know little about one another and may treat others with indifference or as a potential threat. Simmel's ideas were taken up in the United States (US) to develop the 'social distance scale' (Bogardus, 1926), which is used measure people's willingness to engage in social contact with members of different racial and ethnic

39 In the social sciences, the term 'lifeworld' refers to what is sensorily available to, and experienced by individuals in the immediate context in which they are physically located.

groups. Today, social scientists the term social distance, alongside the adjacent concept, symbolic boundary, to understand group boundedness and how solidarity expands and contracts within and across various group formations and locations (Alexander, 2006; Lamont and Molnár, 2002).

These two distinct concepts of distancing – physical and social – mixed freely in public discourse, and while the resulting conceptual confusion may be comparatively minor in the context of pandemic urgency, the distinction is of both normative and analytic consequence. Specifically, it is possible to maximize physical distance to mitigate virus spread, while simultaneously minimizing social distance to enhance the solidarity necessary to tackle the virus. Put another way, solidarity is possible among people who are physically distant from one another, but creating and sustaining solidarity between those who perceive themselves as socially distant is much more difficult (Tyler, 2013).

The pandemic and public spaces: shifting interaction rituals

Decades of social research show that most strangers in pre-pandemic urban public spaces did not explicitly interact with one another. In sociology, this basic ‘urban interaction ritual’ (Horgan 2020) where co-present strangers implicitly agree to not engage in explicit interaction is known as ‘civil inattention’ (Goffman, 1963: 83–88). At the same time, research finds that casual fleeting interaction with strangers in public spaces contributes to well-being and a sense of joy (Sandstrom and Dunn, 2014; Zeeb and Joffe, 2021). Pre-pandemic research on the Sociable Cities Project combined the above work with contemporary research on conviviality (Gilroy, 2004; Neal et al., 2019; Wessendorf, 2016), everyday cosmopolitanism (Anderson, 2011; Aptekar, 2019), geographies of encounter (Valentine and Harris, 2016) and strangership (Horgan,

2012; Jackson, Harris and Valentine, 2017), to analyse interactions and accounts of interactions between strangers in public settings. The goal is to enhance understanding of the social organization of public spaces shared by strangers. We find that masking and distancing requirements qualitatively alter interactions between strangers in public space, in particular by necessitating the renegotiation of interactional norms.

As the first waves of the pandemic spread around the globe, urban public spaces emptied out, radically altering our shared public realm. Despite the pandemic’s devastating health impacts, and even if public spaces appear potentially perilous, people still need to engage in daily provisioning, to go outside for fresh air and exercise, to say nothing of work and physically distanced socializing. To maintain physical distancing, the pandemic requires people to navigate public spaces in novel ways, placing a ‘new emphasis on etiquette and civility’ (O’Brien, 2020: 115) in shared spaces, both within and beyond the private sphere. For example, work conducted early in the pandemic demonstrated profound transformations in greeting rituals (Mondada et al., 2020). Where norms of interaction between strangers in public were previously relatively stable, a new context of uncertainty meant that strangers now needed to improvise to collaboratively negotiate and develop new interactional norms around masking, physical distancing and the pandemic more generally. The result is a heightened awareness of ‘our own uniquely complex form of sociality’ (Enfield and Levinson, 2006: 31).

Masks and distancing: public health requirements impacting social interaction

Without doubt, masking and physical distancing impacted social interactions in everyday life. In a March/April 2020 international survey (n=2013), 90 per cent of respondents reported avoiding crowds (Coroiu

et al., 2020). Using a representative sample of almost 4,000 adults in Canada, Jehn, Stackhouse and Zajacova (2021: 262) found a ‘nearly universal increase in precautionary behaviours from June to July [2020] in mask wearing (67.3 per cent to 83.6 per cent), social [sic] distancing (82.4 per cent to 89.2 per cent) and avoiding crowds (84.1 per cent to 88.9 per cent)’. This suggests that in June and July 2020 (contemporary with the Wave 1 interviews, below) more and more people in Canada altered social behaviours, for example by avoiding crowds, wearing masks and distancing. Jehn et al. also found that ‘female, older, immigrant, urban, and highly educated adults were significantly more likely to adhere to precautionary behaviours than male, younger, Canadian-born, rural, and low-educated adults’ (2021: 262). In keeping with this, Canadian public health messaging addressed to young people emphasized masking and distancing, not as practices that would protect young people, but rather as acts of intergenerational solidarity to protect elders.

In a May 2020 nationally representative survey, Brankston et al., (2021) found broad confidence in Canadian public health measures: 93.8 per cent of respondents agreed that reducing social contacts was an effective strategy; and 94 per cent agreed that avoiding crowds was effective, with women (95.9 per cent) slightly more likely than men (92.1 per cent), and over 70s (98.1 per cent) more likely than adults under 30 (89.8 per cent) to agree. In the previous 24 hours, three-fifths of respondents masked while shopping, over two-fifths while on public transit, over one-third ‘everywhere outside the home’ and almost one-quarter reported masking on sidewalks.

These studies focus explicitly on public health and so concentrate on individual behaviour and the psychology of compliance to mitigate virus transmission. While behavioural compliance is of course important,

as interpretive sociologists, the authors' interest is in assessing how the pandemic impacted social interaction and the meanings of social life in public spaces, and in particular, how participants understood and experienced changes in their public interactions with strangers during the pandemic.

The 'COVID-19 and Public Space' study

The core concern of the 'COVID-19 and Public Space' study is to understand how the pandemic impacted the 'endogenous interactional organization of collective life among copresent strangers in public spaces' (Horgan, 2020: 116); that is, how people using Canadian urban public spaces during the pandemic managed their interactions with strangers in the context of public health restrictions. From this central concern, we develop four objectives:

1. To examine how strangers negotiate and develop new norms in public spaces in light of pandemic restrictions on the use of those public spaces.
2. To understand how people perceive the impacts of face masks and physical distancing on everyday interactions between strangers in public spaces.
3. To assess if and how expressive and instrumental uses of shared spaces differentially impact interactions between strangers during the pandemic.
4. To discern the meanings that people attach to their interactions with strangers during the pandemic.

Methods

To achieve these objectives, we conducted 72 interviews with a sample of people in Canada. Interviews took place virtually in two waves: Wave 1 lasted from May to July 2020 (n=48), and Wave 2, which consisted of follow-up interviews with

50 per cent of the Wave 1 participants (n=24), occurred during January/February 2021. Interview recruitment materials were circulated on multiple websites and social media, seeking adult participants located in Canada. Nonetheless, the study encountered persistent recruitment difficulties, and so we turned to convenience and snowball sampling, focusing especially on urban and suburban dwellers, reasoning that residing in more densely populated areas increases the likelihood of encountering strangers in public spaces. In April and early May 2020, we developed and piloted a draft interview guide, with the Wave 1 interview question guide modified and standardized on the basis of pilot participant and interviewer feedback. Additional Wave 2 interview questions were developed iteratively in light of initial analysis of Wave 1 data. Due to restrictions on face-to-face research, interviews were conducted remotely in compliance with public health and institutional research ethics board requirements.

Interviews began with survey-style questions to gather standardized demographic data based on Statistics Canada census categories; these were followed by a mix of open and closed interview questions. Drawing on a basic distinction between types of public spaces where strangers encounter one another, developed by analysts of everyday interaction (Smith, Phillips and King, 2010; see also Bellah et al., 1985), each interview solicited data on participants' two most recent encounters with a stranger – one in instrumental spaces (i.e. spaces where people need to go, such as a food stores or public transit) and one in expressive spaces (i.e. spaces where people go for leisure, such as public parks or recreation areas). Questions sought detailed accounts of positive encounters with strangers in public spaces during the pandemic and the meanings of these interactions for the participants.

Upon completion of each wave, interviews were transcribed verbatim. Researchers met bi-weekly (virtually) throughout the study to collectively review and discuss interviews. Interview transcripts were coded individually, then open codes were developed jointly, cross-checking for inter-coder reliability. Out of this we collaboratively developed themes shared across multiple interviews.

Before reporting the main themes emerging from these interviews, the following provides a brief snapshot of the demographic characteristics of the sample. All 48 participants were aged between 18 and 65, with 56 per cent aged 25 and under. Women made up 67 per cent of the sample, 31 per cent were men and 2 per cent identified as non-binary; 44 per cent identified as members of visible minorities, while 56 per cent identified as white; and 33 per cent were immigrants to Canada. All participants had completed at least high school education, and 20 per cent had attained a higher degree beyond undergraduate level. In terms of household composition, 90 per cent had no dependents, 60 per cent were single, with 12 per cent living alone, 34 per cent lived in two-person households and 54 per cent in households of three or more persons. Most participants (90 per cent) resided in urban or suburban settings, largely in the Greater Golden Horseshoe, the most densely populated part of Canada, with one-quarter of the national population inhabited a 30,000 km² area constituting just 3 per cent of Canada's land mass.

While not representative of Canada's population – for example, women, visible minorities and younger single people are overrepresented in the sample – the findings are instructive for understanding how the pandemic generated significant shifts in the social life of public spaces, specifically, in terms of public health recommendations around masking and physical distancing.

Pandemic-facilitated interaction: the social life of pandemic public spaces

Dozens of themes were identified across the 72 interviews. To gather these themes, and inspired, in part, by Robins, Sanders and Cahill (1991), we develop one central concept – pandemic-facilitated interaction – to refer to the range of ways that the pandemic produced possibilities for encounters between strangers, encounters that might not otherwise have occurred. This concept collects an array of observations that we specifically connect to (a) the fact that the pandemic places everyone in a common predicament, providing common ground for interaction; and (b) specific requirements around masking and physical distancing necessitating interaction between strangers to negotiate use of shared spaces. The following section outlines three core interview themes – *perils and pleasures of pandemic public spaces*, *new affordances of sociability*, and *soft solidarities and magnified meanings of the mundane* – each of which is illustrated with direct quotes from the interviews.

Perils and pleasures of pandemic public spaces

Participants expressed both delight and apprehension when asked about being in public spaces during the pandemic. Fear and anxiety were more evident in Wave 1 interviews.

For example, one participant noted:

nobody wants to talk right now, everyone's kind of afraid of breathing on each other. There's a lot of fear.

Another said:

Public spaces are kind of difficult right now because some people ... aren't respecting ... boundaries and ... keeping distance ... But outdoors it seems like all the people are very understanding about it.

Grocery stores, in particular, featured prominently:

I'm experiencing less-friendly interactions in the public ... especially in grocery stores ... because you just feel so rushed and stressed out when you're in there. And maybe people just ... they're nervous to talk to people in the grocery store just because of everything that's going on.

Some participants saw a shift over time as people normalized the changes wrought by the pandemic. A recent immigrant noted:

I was going to the grocery store and people were just on top of each other, panicking, panic buying, grabbing everything, pushing, not waiting in line ... I was very surprised ... that's not how Canada is at all ... As a few weeks passed and people got used to the lockdowns, I feel like this kind of shift ... from these selfish acts to ... being like, 'Okay, how can we help, how can you care'; so, people kind of stabilized and ... started helping each other out more.

Another participant said:

I get very anxious in the grocery store because people don't abide by the six-foot rule ... When we went to the grocery store [early in the pandemic], everyone was like really nervous, people either just weren't going to the grocery store or ... there'd only be a handful of people there ... and everyone was really paying attention to keeping their distance ... Now I feel like that's just gone.

While recognizing that public settings were somewhat fraught, many were excited to encounter others. Two examples:

In this time of pandemic, it's so nice to meet anybody ... interaction with anybody.

We have to stay at home to be safe, and I just stayed at my house for one month. It's very exciting for me to just go outside to see what the world is like.

Several participants noted changes in the ethos of interaction between strangers:

If someone was walking towards you and you purposely went 10ft away ... if it wasn't a pandemic that'd be very rude.

I've come to a point where if someone's very close to me I actually move away ... Pre-COVID times it would be considered rude or mean, but now ... I think everyone does it ... I wouldn't go close to a person.

...and the people there [at the ice rink] are all really great about staying socially distanced and ... spreading out if they're on the bleachers.

I feel like ... in the last month [June 2020] ... people are getting a lot more chatty on walks ... and at the grocery store, cashiers have been more chatty.

Overall, while participants reported feeling some trepidation in public spaces, initial fear and anxiety seemed to wane over time. As one participant explained: 'everyone had this more underlying anxiety ... but now I think people are more used to ... managing their own comfort and ... space restrictions.'

New affordances of sociability

Affordances refer to elements of the environment that suggest, make available or 'afford' specific kinds of uses. For psychologists, affordances are not properties of specific objects or persons, but refer instead to interactions between them. Thus, a range of affordances characterize human interaction with material and social environments (see Gibson, 2011; Horgan, 2019). Across most interviews, examples emerged

of the pandemic generating new 'affordances of sociability' (Horgan *et al.*, 2020: 147–150); that is, the pandemic in general, and masking and distancing in particular, became resources for generating positive interaction between strangers. For instance, many participants reported greater willingness to both initiate interaction with strangers and to respond positively if strangers initiated interaction:

I find that in the city people don't always greet people that they don't know when you pass in the street. And I notice increasingly we've got more of a small-town feel ... people are craving interaction, so most people that I pass that I don't know I'll greet them, or they'll greet me. You know like wave, or a nod or a smile or saying hello ... I think that's a change.

It's nice ... to like just say something to someone that ... you'll probably never interact with again ... it's a nice exchange.

Distancing affords interaction. For many, being in public spaces means uncertainty around norms of civility, with concerns about etiquette and the renegotiation of norms especially pronounced in transitional spaces where strangers are forced into close physical proximity, for example, in elevators and when going through doorways:

I got on the elevator, and I held the door for her [an older woman] and said, 'I'm OK if you're OK' ... so she got on the elevator and I said ... 'it's so difficult to know what the rules are now and how comfortable others are'. She said, 'thank you very much for asking me ... that was so considerate' ... I've had that exact same scenario twice where there was an elderly person already on, and then I said, 'are you comfortable with me getting on the elevator?' ... and they're like 'Oh, thank you

for asking!' ... It's just those small moments.

I was leaving the store and a woman was coming into the store.... I'm not always sure if I should hold the door open for someone because I don't know if they think ... 'you're too close for comfort'.... I purposely try to locate my body behind the glass door so that I can hold the door for them so they are not close to me.

I've been in a couple instances where I've stopped myself from ... holding a door or something, 'cause now that's kind of the opposite of what we should be doing. But it kind of feels wrong to ... let the door close ... when you know there's someone behind you.

Essential businesses like grocery stores adapted their spaces to facilitate compliance with distancing requirements. As these regulations changed rapidly, the systems in place for lining up and checking out grocery purchases were often haphazard and ambiguous. This ambiguity generated increased interaction between persons in grocery store line ups. For example:

[There was] a whole mess of people trying to line up because lines were getting really long. So, we [her and a stranger] were ... joking about how we needed to get a better organizational way ... everyone was just going every which way and nobody knew what line led to what cash [North American term for cashier].

Outdoors, maintaining distance meant renegotiating sidewalk etiquette as pedestrians found themselves interacting in ways that participants connected directly to the pandemic. Pre-pandemic, someone walking at a faster pace would simply overtake those walking more slowly. Instead, opportunities for brief friendly exchanges arose. For example:

I was out for a walk with my girlfriend near my house and there was this woman who was walking her very tiny dog ... maybe 10 feet in front of us on the sidewalk. And her dog kept stopping to pee ... whenever she would stop we would also stop cause we didn't want to get too close ... we would all just stop ... watching her dog pee – and at one point she looked at us and was like, 'I don't know how such a small creature can hold so much pee'. So we all laughed and ... she ended up turning one way and we went straight.

Further evidence of new affordances of sociability centred on masking. For example, the prevalence and novelty of masks became an interactional resource for humour:

Standing in line [at the pharmacy], and everyone was making fun of the fact that we were still wearing masks, guys were pretending it was Halloween ... the pharmacist said, 'hey I didn't recognize you there with your masks!'... I said ... 'Yeah, these lovely COVID masks, every day is Halloween'

Participants noted an increased awareness of how and how much they communicated with others while wearing masks, with masks requiring more overt communication:

I think we haven't realized how much body, non-verbal communication, body language, specifically ... facial expression, helps us interact with people on an everyday basis. Even in the winter, right, if someone has a hat and mask on ... all you can see is their eyes ... I think it does change the way that we interact. The number one thing that came to mind is that body language, facial expression. It's ... hard to hear people, understand people.

When you have your mask on you think you're smiling and they can

see it but they can't.... Usually ... you can get away with a smile or a wave but ... in the pandemic you have to make sure you verbalize.

I feel like I have to show kindness and show care in other ways ... you have to verbalize what maybe you would just not verbalize in the past ... if you almost ran into someone with your [shopping] cart, for example ... at one point, you just gave a little smile, now you have to be like, 'Oh, I am so sorry.'

Soft solidarities and magnified meanings of the mundane

At a general level, participants consistently reported greater appreciation for interactions with strangers in public spaces, imbuing small sociable moments with greater meaning than they did pre-pandemic:

Interactions that I do have, I feel like have become more meaningful. In terms of ... dealing with workers, I have sort of an understanding of why they might be frustrated given the pandemic, and yet they're still being very helpful and pleasant, so I think I have a greater respect for them.

Small moments of interaction that would otherwise pass without comment took on more magnified meanings for many. One participant's glasses fogged up on entering a store due to her mask, and a stranger who saw this said, 'oh my gosh the same thing happens to me every time I enter the building'. This participant said that she 'felt better' just from this small interaction recognizing the shared day-to-day awkwardness of the pandemic.

For many participants, masking and distancing were ways of demonstrating care for unknown others, providing an opportunity to show 'soft solidarity' (Horgan, 2012) – a form of implicit mutual recognition – with others:

I am not saying that you have to wear your mask 100 per cent all the time, especially when there's nobody close to you, but if you go to a public space, I think you should.

It's even less about perhaps the actual masks and arrows [directional markings on the ground] that caused the change in interaction... It's... just the mindfulness that times have changed. There are changing restrictions and modifications to how we live ... We have to assume the best in people ... we have to expect that people are going to react and behave differently.

In public spaces, strangers consistently found ways to demonstrate through speech, gesture or other physical movement, that they were looking out for one another. For example, a recent arrival to Canada from Asia notes:

Every time I went out for a jog ... out for a walk or something ... everyone here is very conscious, so they would move to the side or you would move to the side just to ensure physical distancing was maintained.... There was no one who didn't do it.

Many participants observed how such demonstrations of care became automatic and normalized:

If you're walking on the sidewalk and someone else is coming, they'll either move to the other side of the sidewalk or ... go onto the road. It kind of signals that people are looking out for one another.

If I see someone else in a mask and I have a mask... my first thought is not necessarily 'oh this is weird, this is kinda draconian and strange'. My thought now is: 'Oh! Cool, we both kind of wanna look out for one another'... it showcases the sort of friendly reciprocity... like I'm gonna look

out for you, my fellow human being.

Throughout almost all the interviews participants viewed mask wearing and communication around physical distancing as part of a generalized ethic of care for co-present strangers in public. Such responses were far more prevalent than concerns around individual self-interest and self-preservation. This was not the same for everybody; most notably, and in line with the survey research cited earlier, those who identified as immigrants were especially cautious, making special efforts to wear masks in public, and to explicitly communicate with strangers about physical distancing.

Overall, the interviews yielded rich data on the impact of the pandemic on participants' experience of public space, and in particular their encounters with strangers. Participants reported many positive interactions with strangers – interactions that they felt were a direct result of the pandemic. In Wave 1 interviews, many participants reported fear and anxiety about using functional spaces such as grocery stores. This apprehension appears to be mitigated by engaging in explicit interaction with strangers to navigate masking and physical distancing.

Conclusion

Compared to the scale of medical trials and epidemiological studies, the present study is relatively small-scale conducted in one small corner of the world. However, it helps to understand the pandemic's diverse social impacts. While it focuses on issues that may at first glance appear trivial, the research suggests that the constraints imposed by the pandemic on social life appear to have facilitated more interaction between strangers, termed here *pandemic-facilitated interaction*. This is especially significant as interactions occurred between those who may otherwise have little in common beyond the shared business of being in a particular public space at the

same time. The generalized diffusion of acts of care and kindness are not generally associated with urban life (Hall and Smith, 2015), so, in this respect, as in many others, the pandemic has been transformative. In an increasingly urbanized planet, these small interactions are of consequence in expressing and enhancing solidarity between strangers. Whether such changes will become ingrained is an open question. Future research building on this study will assess if and how the lifting of restrictions in public space shapes interactions.

Based on the findings, in the short term we recommend that public health messaging capitalize on the meanings that people attach to mask wearing and distancing to promote greater compliance to mitigate spread for the virus. Over the longer term, urban planners, designers and municipal policy-makers and programmers must consider the intrinsic value of social encounters across various forms of difference for social cohesion, not only when placing restrictions on the use of public spaces, but as a general principle. This aligns well with UN Sustainable Development Goal 11: 'make cities and human settlements inclusive, safe, resilient and sustainable'.

At the first interim Meeting of the Intergovernmental Council of the Management of Social Transformations Programme in Paris in 1994, social theorist Alain Touraine spoke of research conducted by sociologists in the wake of Chile's emergence from almost two decades of military dictatorship. He noted that Chileans wanted 'the reconstruction of a feeling of citizenship that would reduce social distances, cultural distances and political distances so that there would be a sense of belonging to the same whole, of co-responsibility for the world' (1994). The pandemic has fundamentally changed interactions between strangers in public space. Yet, the question remains as to how to maintain these

collective efforts to deal with future pandemics and to overcome social distance, as society and individuals emerge from this pandemic with 'co-responsibility for the world'.

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2.6. *The role of donors in supporting poor countries in the developing world during the COVID-19 pandemic*

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Abstract

The COVID-19 pandemic has generated financial and social disruptions worldwide. The outbreak and subsequent lockdown restrictions resulted in loss of employment on a massive scale, pushing millions of people back into poverty. The length and severity of the pandemic also reshaped economies with the world witnessing a reversal in recent development progress. Poor and low-income communities in the developing world and conflict-affected countries were hit particularly hard by COVID-19. Governments were ill-prepared and unable to combat the virus effectively or provide support to vulnerable communities. A concerted community effort, backed by support from global agencies and international governments, was therefore essential to reduce the effects of the virus. Donors, both individuals and organizations, including the World Health Organization, the World Bank and the International Monetary Fund, played an effective role during the pandemic, helping millions of people in different countries by enacting support at the global level to combat COVID-19 and leave no one behind, as outlined in the 2030 Agenda. This paper aims to understand the spirit behind COVID-19 donations in response to the pandemic by examining: (i) the extent to which COVID-19 changed

how donors think about donations and aid support; (ii) the way(s) in which COVID-19 affected donor contributions; and (iii) the impact of donors during the COVID-19 outbreak. The study focuses on six Middle East and North Africa (MENA) countries: Djibouti, Egypt, Iraq, Lebanon, Syria and Yemen.

Introduction

The challenges of the twenty-first century are different and require rigorous preparedness on the part of government as well as people. The novel Coronavirus outbreak reaffirmed the importance of government intervention during crises and the fundamental role of donors, firmly positioning the state on the side of the public, based on its duty to protect citizens from harm regardless of the cost. The core dilemma of the pandemic was how to survive the COVID-19 outbreak while minimizing human and economic costs. This approach includes addressing the reversal in recent development progress caused by the length and severity of the pandemic, which pushed millions of people back into poverty. Poverty, in its multiple dimensions and manifestations, tends to increase the risk of acquiring infectious diseases such as COVID-19 and, at the same time, contributes to their increased severity. The World Bank's commitment to eradicating global poverty is evident from the

prominence given to this objective in both the Millennium Development Goals (MDGs) and the Sustainable Development Goals (SDGs). The World Bank (2018) has further emphasized that educated societies are more prosperous than those suffering from poverty and with poor health conditions.

During the COVID-19 outbreak, aid support was given in various forms. In the initial phase, medical aid packages and essentials were the priority for donor countries and even non-governmental organizations (NGOs). The international contribution in terms of donations, foreign aid and even debt drastically improved global conditions in different regions, in particular by addressing extreme poverty conditions, providing access to education, combating transmitted diseases such as HIV/AIDS, and targeting gender equality and environmental concerns. Meanwhile, the Millennium Challenge Account (MCA) process – a mechanism through which countries can secure funding for specific development projects, and which is expected to harmonize with and complement broader poverty reduction and development strategies outlined in their poverty-reduction strategy papers (PRSP) – has functioned as a channel for donor coordination. The five key principles of the PRSP focus on country content with the broad-based participation of civil society, and are characterized by a results-oriented, long-term perspective. Importantly, the process entails partnerships with all stakeholders and donors such as the International Monetary Fund (IMF) and the World Bank (Graham *et al.*, 2003: 14).

Since February 2020, there has been a strong response in terms of small funds and donations to support vulnerable segments of communities, the main goal being to 'leave no one behind'. Crucially, the World Bank and the International Monetary Fund urged G20 countries to establish the Debt Service Suspension Initiative

(DSSI). The DSSI works to help countries concentrate their resources on combating COVID-19 and saving lives. Since May 2020, the DSSI has delivered more than US\$5 billion in relief to more than 40 eligible countries (World Bank, 2021). Unlike other crises, the COVID-19 pandemic has required financial recovery contributions and has necessitated the reprogramming of budgets in many countries, particularly in advanced economies. In addition, financial action has targeted spending on lifelines for people and firms that had to curtail activity during lockdowns to limit the risk of viral transmission (Khasiani *et al.*, 2020).

The challenge was greater in poorer nations and regions of the world, as well as in poorer regions within countries. Theoretically speaking, the rich and the poor are equally vulnerable to infections, given that pathogens are non-discriminatory. However, it is common knowledge that the poor are impacted more widely and to a greater extent by infectious diseases. Thus, while biologically all humans are at risk, that risk is not even. People already living in social and economic deprivation have a greater exposure to risk factors for disease, and the economic consequences of living with chronic infectious conditions are often more serious (WHO, 2012: 13).

The effect of this confluence of poverty and infectious diseases extends beyond individuals to society more broadly. It is estimated that proper medical care would lead to a reduction in fatalities from infectious diseases and maternal deaths of 8 million, resulting in an annual monetary gain of up to US\$500 billion to the global economy (UN Chronicle, 2000; WHO, 2001 cited in WHO, 2012: 15). In response to regional and global fears, the Humanitarian Buffer was established during 2021 within the COVAX Facility as a crucial 'last resort' measure. This has enabled vulnerable populations who are not covered under any national development or

vaccination plans to gain possible access to vaccines and health facilities (OCHA, 2020).

The role of the state in crisis management, wars, conflicts and disaster management has been consistently highlighted in the literature about state and government. The challenges presented by the convergence of poverty and disease are equally if not more potent. However, these challenges differ across time and from one continent to another. In some cases, a state or a region can achieve success with limited resources due to their competitiveness and preparedness for the situation. According to Kuban (1996), 'the nature of crises and disasters demands cooperation and coordination among various agencies and jurisdictions. Crucially, the management of these events needs the adaption of day-to-day management practices to the unique needs of these situations.

While aid has been considered as an economic means to support poor countries, there are still challenges associated with aid as an obligation to help poorer countries and people. The aid transfer may not have the intended results or it could undermine development in the receiving countries. Aid may also be considered as a waste of resources and a constraint on development, especially in the absence of a clear impact (Glennie and Sumner, 2016: 11).

Meanwhile, research on the nature of global poverty from a geographical viewpoint reveals that during the 1990s over 90 per cent of the world's extreme poor lived in low-income countries (LICs), while in 2009 three-quarters of the world's extreme poor lived in middle-income countries (MICs) (Sumner and Mallett, 2013: 2). Likewise, extreme poverty declined from 47 per cent to 40 per cent in 2008 (Awortwi and Musahara, 2015). Moreover, in the 25 years from 1990 to 2015, the extreme poverty rate dropped an average of a percentage point per year – from

nearly 36 per cent to 10 per cent (World Bank, 2018). However, 119–124 million people were pushed back into poverty and chronic hunger as a result of the COVID-19 pandemic (Fleming, 2021). For poor people, obtaining basic essentials represented a serious challenge, with ‘between 720 and 811 million people in the world faced hunger in 2020, an increase of as many as 161 million from 2019’. Indeed, ‘nearly 2.37 billion people did not have access to adequate food in 2020 – an increase of 320 million people in just one year.’⁴⁰ In addition, 239 million people required life-saving humanitarian action and protection in 2020 (OCHA, 2021).

An important issue associated with poverty in many poor countries is tropical diseases. These represent a consistent challenge for poor people, as infection affects their ability to work and earn a decent income. This situation was magnified during the COVID-19 pandemic (Evans and Davies, 2015: 26), which also resulted in the worldwide closure of businesses, markets and industries. However, global contributions to aid and donations continued. During a crisis of such huge proportions, the biggest challenge in terms of aid is the timing of the assistance, and the means of delivering it to countries in need.

While COVID-19 represents a public health concern for every state, the effects of the outbreak can be particularly severe for developing and poor countries. One measure of the worldwide concern generated by the COVID-19 pandemic generated is the request from the World Health Organization (WHO) to vaccine manufacturers to donate at least 10 per cent of their production to poor countries, or to make it available at a reduced price for those countries, a request not made during previous outbreaks such as the 2009 H1N1 epidemic. However, despite the

availability of vaccines, the full benefit of vaccination can only be obtained through extensive campaigns to overcome vaccine hesitancy. In Iraq, for example, many people are yet to be vaccinated due to concerns about the vaccine.

State responsibility to combat the spread of COVID-19 is an obligation not an option, as the state is responsible for protecting its citizens and providing them with security and well-being, including by looking after their health and survival needs. As Kuban (1996) explains, ‘crises require public officials to make rapid, timely, effective and appropriate decisions on a scale rarely experienced during day-to-day operations’. The same acts of responsiveness were required for donors to support states and communities at risk of COVID-19 globally, either as a shared responsibility or as an individual contribution to mitigate the effects of the pandemic.

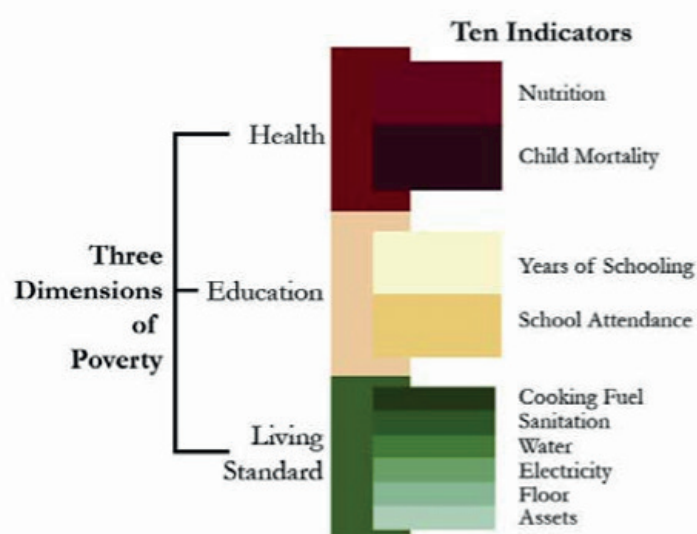
Literature review

Poverty and the enhanced risk of the COVID-19 pandemic

The concept of poverty is dynamic and complex. Poverty is not a

single identifiable condition, but a fluctuating set of circumstances (Spicker, 1998). The word poverty invokes an image of a resource-starved family or an individual, struggling to keep body and soul together. It is unsurprising, therefore, that the literature is replete with allusions to poverty from a monetary standpoint. Initial attempts to measure poverty were thus based solely on computation of the ability to access resources. Such measures have not completely lost their relevance. However, with the growing realization of the inadequacy of such a limited concept to explain the different ways in which poverty manifests itself, newer approaches to define and measure poverty have been developed, which in addition to other things, recognized its multi-dimensional nature. In this context, Alkire and Santos (2010) are credited with pioneering work to compile the different dimensions of poverty into a Multidimensional Poverty Index. The MPI measures a range of deprivation factors, grouping ten indicators into three main dimensions of poverty (i.e. health, education and standard of living). These are depicted in Figure 1.

Figure 1. Diagrammatical representation of MPI



Source: Alkire and Santos, 2010.

40 <https://unstats.un.org/sdgs/report/2021/goal-02>

It may be logical to presume that poverty exacerbates the risk of acquiring and succumbing to disease, owing to the lack of distancing, cleanliness and adequate knowledge with which it is almost universally associated. However, this association has been inadequately researched. Several factors likely contributed to this oversight. First, the medical fraternity believes that the socio-economic status of the patient falls far outside their domain and that they are not qualified to alter this aspect of a patient's suffering. Second, there is a paucity of funds, which are considered better utilized in basic research aimed at developing scientific knowledge of diseases and their cures rather than studying the socio-economic conditions of patients. Third, even though the pivotal role that poverty plays in determining disease vulnerability and outcomes has been acknowledged, the resultant solutions aimed at redressing the issue are often wrongheaded (Alsan *et al.*, 2011).

It has been emphasized, however, that notwithstanding the lack of academic and medical interest, the 'twin afflictions of poverty and disease cannot be treated in isolation and require a biosocial understanding to achieve lasting health gains' (Ibid.). The latest report from the Overseas Development Institute suggests a strong link between poverty levels and capacities to cope with humanitarian crises and disasters (Diwakar, 2020). Limited access to healthcare and weak governance means that the pace of transmission of COVID-19 in high-risk countries will easily surpass their ability to cope. South Sudan, Chad, Somalia, the Central African Republic (CAR) and the Democratic Republic of Congo (DRC) – all located in sub-Saharan Africa – have the weakest coping capacities.

Furthermore, the spread of COVID-19 adversely influences, in a disproportionate manner, those already furthest behind. Social distancing, being the main preventive measure against the

spread of COVID-19, has led not only to the closure of borders but also to lockdowns worldwide, resulting in a lack of employment for those among the most vulnerable in society, namely casual laborers (Diwakar, 2020). This can lead to a vicious circle of poverty and disease, whereby the poorest and most vulnerable are the worst affected and fall deeper into deprivation as a result.

In addition, a general paucity of resources among the poor affects their dietary intake and reduces their access to a healthy diet and lifestyle. This often results in a higher incidence of conditions like high blood pressure, diabetes, and respiratory and other chronic ailments. People with such pre-existing conditions are not only at a greater risk of contracting COVID-19, but also suffer from increased danger of mortality as a result. Infectious diseases, like tuberculosis or COVID-19, can thrive among populations that are living in low-income communities because of both increased exposure to infectious pathogens and the reduced ability of individuals to fight infections (Noppert, 2020). The state therefore needs to adopt a two-pronged strategy: (i) halt the spread of the disease and (ii) address the long-term risk of the vicious cycle of disease, destitution and death.

The role of the state during the COVID-19 pandemic

During the COVID-19 outbreak the state's importance re-emerged as a means to manage emergencies. The spread of the virus demonstrated clearly that no countries are immune from pandemics, and that all nations share the same planet and the same climate. In many states, COVID-19 is entwined with lack of security and stability, poverty, poor governance, poor economic conditions, environmental degradation and, importantly, civil wars and state failure. However, in order to combat COVID-19 effectively, all governments must focus on several priority areas:

- prioritizing the health sector and focusing on urgent challenges;
- providing adequate personal protective equipment (PPE) to health service providers;
- ensuring adequate supplies of medicines and testing kits at all designated locations;
- training health workers to prepare adequately for the pandemic;
- implementing lockdowns, social-distancing, quarantine and test measures; and
- ensuring that all necessities like food supplies, water, power and security needs are fulfilled for every person and families during periods of lockdown, to ensure total implementation.

Communities and enterprises should focus on the following items:

- keeping the supply chain of essential items including food and medicines running;
- supporting frontline health workers by ensuring adequate supplies of essentials including PPE;
- funding activities via campaigns in cities and towns in collaboration with civil society bodies and individuals; and
- ensuring that pandemic planning is incorporated into government preparedness for influenza pandemics.

In short, the role of the government can be summarized in terms of four main functions: Test, Treat, Train and build Trust in people. People then need to be provided with Service, Supplies and Security. The community and enterprises are expected to support these initiatives by collaborating with the government and through lending support to the less fortunate in society, including

those with which they are in direct contact and others.

Examples from the experiences of Middle East countries during the COVID-19 pandemic

Many countries in the Middle East suffer from limited state capacities. One notable example is Syria where millions of people have been marginalized due to the ongoing civil war and widespread poverty and unemployment. Likewise, Iraq has been in a state of war and ongoing tension since 2003, with millions suffering from poverty and lack of security. In Iran, international sanctions have led to a scarcity of health facilities and government capacity to combat COVID-19. Such socio-political factors in these countries have exacerbated the effects of COVID-19 and increased panic and uncertainty among people.

As with wars, natural disasters and recessions, COVID-19 has hit the poorer countries and particularly, the poorest people in those countries, the hardest. Páramo (2020) notes that the 'COVID-19 pandemic pushed about 49 million people into extreme poverty in 2020'. The vast majority of economic losses affected people in the form of job loss or reduced incomes, which could lead to an increased risk of poverty. Based on poverty projections from the *Global Economic Prospects Report* (World Bank, 2020), the social and economic impacts of COVID-19 could push 71 million people into extreme poverty in 2020 according to a baseline scenario, and 100 million according to a downside scenario. As a result, the global extreme poverty rate would increase from 8.23 per cent in 2019 to 8.82 per cent under the baseline scenario or 9.18 per cent under the downside scenario. This represents the first increase in global extreme poverty since 1998, effectively wiping out progress made since 2017. In this context, mitigating strategies for tackling poverty are of great importance.

Sluggish global economic activity and the projected downslide severely restricts the ability of the world as a whole to effectively respond to current and future challenges unleashed by the pandemic. To cite a specific case, UNICEF and the World Bank (2020) have highlighted Iraq as a post-conflict country suffering disproportionately from the effects of COVID-19. In addition to the need to treat those who are sick from COVID-19, the decline in economic activities will reduce labour earnings, while the economic slowdown reduces domestic and international remittances, impacting households' non-labour incomes. At the state level, oil price shock has drastically restricted government capacities to respond to COVID-19.

Donor contributions in response to the COVID-19 pandemic

During the COVID-19 pandemic, charities, social media campaigns and enterprises worldwide generated donations to support the poor and vulnerable, to help them obtain access to basic essentials during lockdown periods. Although priorities differ based on country conditions, the donations ensured an adequate supply chain of essentials in affected communities. The data show a high volume of donations and support to combat COVID-19. This flow of aid and donations has continued overcoming hurdles in the process. While the burden of COVID-19 in terms of economics, social and health has been felt regardless of geographical location, as Bermeo (2017) argues, in an interconnected world, donor countries use foreign aid to mitigate negative effects resulting from problems associated with underdevelopment, such as the spread of infectious diseases. In the same spirit, Steele (2017) argues that donors give health-related aid funds to countries combating diseases that could also threaten the donor country.

The financial support provided by donors to mitigate the effects of COVID-19 on vulnerable communities has played a fundamental role in lifting millions of people out of poverty. Although the donations are short-term in nature, they have contributed to addressing income losses, lack of access to daily essentials and food security in developing countries. This is vital as a large percentage of the workforce in this country is employed in the informal sector of the economy, where social safety networks are either missing or grossly inadequate. The shared responsibility of donations has been influential in bringing governments, organizations and individuals together in support of the response to the COVID-19 outbreak. Among the leading organizations is WHO, which has dedicated US\$1.96 billion to fulfil the requirements of its 2021 Strategic Preparedness and Response Plan (SPRP2021). This funding supports countries' efforts to suppress transmission, reduce exposure, counter misinformation and disinformation, protect the vulnerable, reduce mortality and morbidity rates, and increase equitable access to diagnostics and vaccines for all.⁴¹ In addition, the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) has provided immediate funding of up to US\$1 billion to help countries fight COVID-19 and prevent fragile health systems from being overwhelmed. The World Bank, through its various schemes and programmes, including the COVID-19 Fast-Track Facility (also called the COVID-19 Strategic Preparedness and Response Programme (SPRP)), has assisted 25 countries with grants amounting to US\$19 billion, and has contributed another US\$20 billion to support developing countries in financing the purchase and distribution of COVID-19 vaccines,

41 See www.who.int/emergencies/diseases/novel-coronavirus-2019/donate.

tests and treatments for their citizens (World Bank, 2021).⁴²

Funding from donors is directed at financing vaccines in beneficiary countries and thereby containing COVID-19, reducing the economic and social cost of COVID-19, and alleviating the health impacts of COVID-19 typically in low and middle-income countries. However, donor countries face a number of serious challenges in responding to the pandemic. International calls to support vulnerable communities focus on the developing world and conflict-affected countries, where governments are ill-resourced, under-prepared and have a lack of capacity to finance healthcare, while the general population is in a state of panic. Such communities at risk depend significantly on emergency aid, humanitarian support and donations. Furthermore, the pandemic is not yet over, with foreign aid and donations playing a supportive role worldwide in combating the effects of COVID-19.

The degree of responsiveness from donor countries and stakeholders has played a huge role in mitigating the costs of COVID-19 pandemic. Global concerns regarding foreign aid, donations and relief during and in post-disaster periods notwithstanding, the medical relief package deliveries during COVID-19 have been quick. According to Graham *et al.* (2003: 18), the situation required an urgent response to deliver essentials to the people. Thus, leadership in donor coordination was a core strategy for desired outcomes. Indeed, in many countries, government coordination during COVID-19 has been visible alongside civil society contributions. However, the existing literature provides evidence of corruption, misuse and poor management of such aid and donations in the past. For instance,

Devarajan *et al.* (2001: 21) citing a case from Tanzania, refer to challenges facing bilateral donors and their reluctance to shift responsibilities to the recipient government, explaining that while the state was implementing policy reforms, administrative capacity and competence to handle the task at hand was low. There are more instances from other African countries such as Ghana and Uganda, where local donors have played an active role alongside the respective national governments in improving aid coordination since the 1990s.

There is a global dimension to the effects of aid and poverty during COVID-19 over both the long and short term. Goldin and Reinert discuss the correlation between globalization and poverty in terms of five primary economic dimensions: trade, finance, aid, migration and ideas. They argue that if globalization is well managed, it can help alleviate global poverty under certain conditions (2007: 10). At present, it is unclear whether the received aid, donations and debt reliefs to assist counties in combating COVID-19 are being managed and distributed well. However, the data show that total humanitarian funding reached US\$24.5 billion, up from US\$22 billion, at the end of 2013, in line with standard increases in humanitarian aid and interventions during crises.⁴³

Data and methodology

Data

To ascertain the extent to which donors have contributed to reducing the effects of COVID-19 on poverty and vulnerable community members, having identifying COVID-19 as a disrupter to economies, food systems and employment everywhere (Swinnen and McDermott, 2020), the authors drew on data from open access databases, a common practice

(secondary data were taken from indices including those of WHO, UNICEF and the World Bank). The relevant variables analysed for the study were donors that contributed to efforts to combat COVID-19 and the ways in which donors helped poor communities.

To support the data, an intensive desk search was undertaken to gather information from government websites and electronic scientific databases such as: Web of Knowledge, Google Scholar Search Engine, Science Direct and Scopus. In addition, intensive research was conducted to find more about conditions prevalent in the countries included in this study and the responses of the governments in those countries.⁴⁴

Countries selected for the study

The researchers focused on six lower-income countries in the Middle East and North Africa (MENA) regions – Djibouti, Egypt, Iraq, Lebanon, Syria and Yemen – where UNICEF along with its partners has been delivering lifesaving vaccines (via the COVAX Facility), therapeutics and diagnostics, and is rolling out risk communication and community engagement activities, building on country preparedness efforts for the vaccine roll out, while strengthening health systems across the globe. These countries were selected based on their World Bank poverty ratios (World Bank, 2021). Data gathered from the World Bank revealed that every country had their unique poverty line and faced acute challenges prior to the pandemic.

National poverty lines

National poverty lines are the principal benchmark for estimating poverty indicators consistent with the country's specific economic and social circumstances, including the cost of living. They reflect local perceptions of the level and composition of consumption or income needed to

42 www.worldbank.org/en/about/what-we-do/brief/world-bank-group-operational-response-covid-19-coronavirus-projects-list

43 www.worldbank.org/en/about/what-we-do/brief/world-bank-group-operational-response-covid-19-coronavirus-projects-list

44 Ibid

Table 1. Summary of contributions to WHO for COVID

Countries	Agreement (in millions)		% of total contribution		Utilization (in millions)		Balance of agreement (in millions)	
	2021	2020	2021	2020	2021	2020	2021	2020
Germany	372.30	485.36	14.6	19.1	196.51	424.29	175.79	61.07
European Commission	170.99	111.84	6.7	4.4	69.77	74.16	101.22	37.68
UK (Great Britain and Northern Ireland)		124.32		4.9		123.08		1.24
Canada	102.60		4.0		34.14		68.46	
Miscellaneous (other sources)	91.83		3.6		40.60		51.23	
GAVI Alliance	47.22		1.9		27.76		19.66	
World Bank		68.73		2.7		66.27%		2.46
Iran		51.97		2.0		51.97		0.00
China		50.10		2.0		33.15		16.95
United States	30.87		1.2		2.01		28.86	
Japan		48.79		1.9		48.13		0.66
France	27.72		1.1		1.60		26.13	
Saudi Arabia		44.40		1.7		3491		9.49
UNDP	19.40		0.8		6.01		13.39	
Kuwait	15.00	60.00	0.6	2.4	12.89	55.38	2.11	4.62
Philippines	14.09		0.6		0.00		14.09	
COVID-19 Solidarity Response Fund		52.60		2.1		42.30		10.30
Total	1.06 bn	1.49 bn	44.2%	87.8%	467.21 bn	1.31 bn		

Source: WHO, 2021.

be non-poor. The perceived boundary between poor and non-poor typically rises with the average income of a country and thus does not provide a uniform measure for comparing poverty rates across countries. While poverty rates at national poverty lines should not be used for comparing poverty rates across countries, they are appropriate for guiding and monitoring the results of country-specific national poverty reduction strategies. Almost all national poverty lines in developing economies are anchored to the cost of a food bundle – based on the prevailing national diet of the poor – that provides adequate nutrition for good health and normal activity, plus an allowance for non-food spending. National poverty lines must be adjusted for

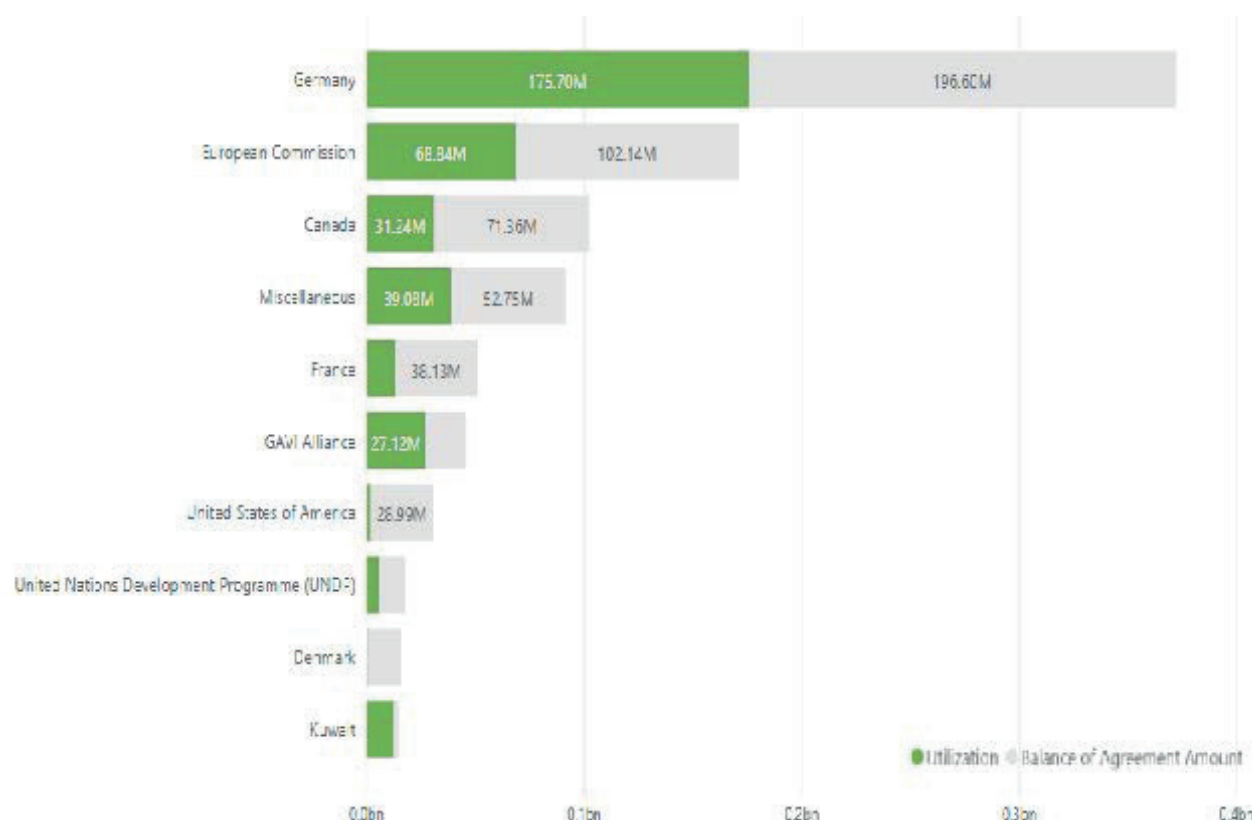
inflation between survey years to remain constant in real terms and thus allow for meaningful comparisons of poverty over time.

Challenges with data analysis

The first stage in the analysis was to ascertain the poverty ratio of the population for the selected countries and then compare data across countries. Limitations and challenges included difficulties in accessing current and multiple data and language barriers with regard to countries in the MENA regions. Another serious challenge that emerged during this study was that a lot of individual donations and mixed data were available but scattered across different sources, leading to difficulties around data unification.

Which donors contributed to the COVID-19 Poverty Scheme?

Data from the World Bank (2021), WHO (2021) and UNICEF and the World Bank (2021) indicate that contributors to COVID-19 poverty schemes consisted of government sector and private sector donors. Some international governmental organizations (IGOs) such as WHO and UNICEF have provided support in the form of donations to countries and organizations during the pandemic. WHO in particular has played a critical role. In addition to medical advice, technical guidance, vaccines, treatments and tests, strategy and planning, the organization has provided financial support in the form of donations to numerous countries. It should also be noted that some

Figure 2. Top 10 utilization and balance of agreement amounts to WHO for COVID-19

Source: WHO, 2021.

donors have collaborated with WHO, UNICEF and other organizations to contribute to COVID-19 response. Table 1 presents a list of countries and organizations who have contributed to these efforts to combat COVID-19 via WHO, the amounts contributed and utilized, and the balance remaining. The top ten donors are shown in Figure 2.

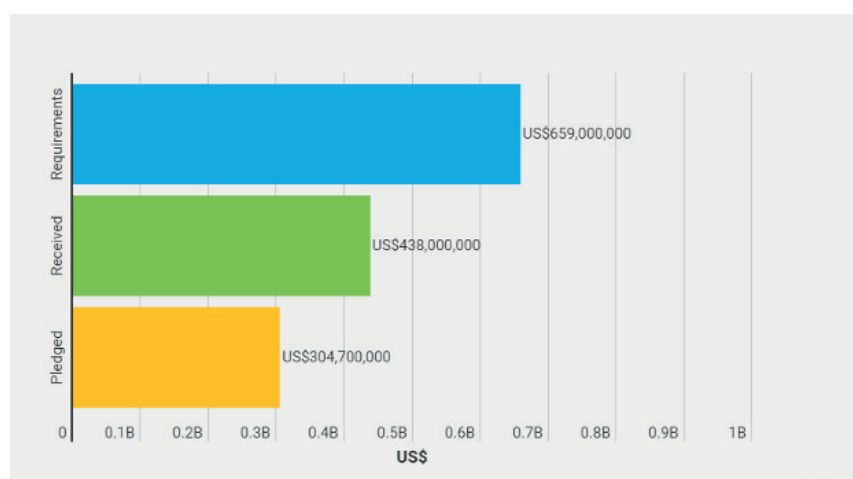
A quick analysis of Table 1 reveals that there were more contributions in the year 2020 (US\$1.49 billion, 87.8 per cent of total donations), than in 2021 as of 6 October (US\$1.06 billion, 44.2 per cent). Table 1 and Figure 2 show clearly that Germany is the highest contributor to WHO, with donations amounting to US\$485.36 million in 2020, (19 per cent) and US\$372.30 million as of 6 October 2021 (14.6 per cent). The European Commission accounted for 6.7 per cent as of 6 October 2021 and 4.4 per cent in 2020. The UK (Great Britain and Northern Ireland) contributed 4.9 per cent in 2020. Canada contributed 4.0 per cent as

of 6 October 2021, while the GAVI Alliance contributed 1.9 per cent of the total. In 2020, the World Bank accounted for 2.7 per cent of total contributions to WHO to combat COVID-19. In 2020, Iran contributed 2.0 per cent, the United States 1.2 per cent, China 2.0 per cent, Kuwait 2.4 per cent, the Solidarity Fund 2.1 per cent and Japan 1.9 per cent towards WHO's total aid package. As of 6 October 2021, France had contributed 1.1 per cent, Saudi Arabia 1.7 per cent, UNDP 0.8 per cent, Kuwait 0.6 per cent and the Philippines 0.6 per cent 2021. According to UNICEF, as of 13 September 2021, the organization had received US\$438 million from donors around the world, with the private sector contributing the highest amount (see Table 2 and Figure 3). The overall amount needed by countries and organizations is US\$659 million.

Table 2. Donors who contributed to UNICEF's COVID relief campaign

Donor	Donation (US\$)
Private sector	143 million
Japan	121.5 million
GAVI	120.2 million
United States	17.5 million
Australia	13.7 million
New Zealand	7.1 million
Switzerland	6.5 million
Denmark	3.3 million
European Commission/ECHO	1.8 million
UN Joint Programme	1.7 million
UN Multi Partner Trust Fund	333 000
Norway	233 563
WHO	200 000
Total	438 million

Source: UNICEF and the World Bank, 2021.

Figure 3. Contributions through UNICEF

As shown in Table 2, the private sector contributed US\$143 million towards UNICEF's COVID-19 campaign. Important private donors include Abertis, American Express, the BD Foundation, the Bill & Melinda Gate Foundation, Jotun, and Johnson and Johnson among others (see Table 3). Moreover, the Japanese Government contributed US\$121.5 million, GAVI US\$120.5 million, the United States US\$17.5 million, Australia US\$13.7 million, New Zealand US\$7.1 million, Switzerland US\$6.5 million, Denmark US\$3.3 million, the European Commission/ECHO US\$1.8 million, the UN Joint Programme US\$1.7 million, the UN Multi Partner Trust Fund US\$333,000, Norway US\$233,000 and WHO US\$200,000. Data from WHO and UNICEF show that some countries and organizations, such as Japan, GAVI, the United States, and the European Commission, contributed to both WHO and UNICEF.

Table 3. Sample of private donors to UNICEF in 2020

Abertis	GitHub
Aaron Levie	Gloria Principe and John O'Farrell
Accenture	Google.org
Adolf Würth GmbH & Co. KG	Gucci
Alvotech	IAMGOLD Corporation
American Express Foundation	IMC Financial Markets
Anonymous Fund of BOSF	Impetus Foundation
AVEVA	Intel
AXA	Interfaith Movement to End the Pandemic
Baker Hughes Foundation	Islamic Food and Nutrition Council of America (IFANCA)
Bank of Nova Scotia – (The) Scotiabank	Jen Rubio and Stewart Butterfield
Barbara and Edward Shapiro	Johnson & Johnson
BD Foundation	Jong-Wook Lee
Bill & Melinda Gates Foundation	Jotun
Binance (Blockchain Foundation)	Juliana Ruecker and Nicolas Poitevin
Brenda and Stéphane Bancel	Kaia Miller Goldstein and Jonathan Goldstein
Bruce and Lori Laitman Rosenblum	Keller Group Plc
Burberry	Latter-day Saint Charities
Capgemini	LinkedIn
Clarios Foundation	Lisa & Douglas Goldman Fund
Cognizant Foundation	London Stock Exchange Group PLC
Cotton On Group and Foundation	Mark Allyn
Danaher Corporation	Mikkel Svane
Deloitte	Nancy and Jason Rosenthal
Deutsche Bank Stiftung	New Gold Inc.
Discovery Communications, Inc.	Northern Trust
DP World	Novacyt
Expedia, Inc	Novo Nordisk Foundation
G. Barrie Landry	OLYMPUS
George and Danielle Boutros	Pan American Silver Corporation

Table 4. Distribution of funds to regions

Country	National poverty ratio	Funds available	Fund utilized	Areas of Funding							
				Vaccination	Risk communication & community engagement	Surveillance, outbreak investigation & public health	Case management	Operational support & logistics	Strengthening essential health services	Laboratories and diagnostic	Coordination, planning & financing
Iraq	18.9	11.97m	4.34m (36.2%)	1.38	0.41	0.01	0.09	1.34	0		1.1
Yemen	48.6	30.92	15.44 (50.0%)	3.32	0.05	0.53	0.4	3.59	1.11	1.29	1.21
Djibouti	21.1	3.09	1.10 (35.6%)		0.01	0.5	0.1	0.08		0.5	
Egypt	32.5	4.14	3.64 (88.0%)	2.13	0.05	0.11	0.33	0.91			0.11
Lebanon	27.4	13.07	9.72 (74.4%)	0.06		0.5		0.19	8.97		
Syria	35.2	5.09	2.24 (44.1%)	0.95	0.2	0.07	0.03	0.18	0.31	0.33	0.16

Source: WHO, 2021; World Bank, 2021.

To what extent have donors helped poor people/communities in the COVID era?

Based on the data from WHO (2021), various funds have been distributed to some lower middle-income countries, which have mainly helped poor people/communities during the COVID pandemic. Table 4 shows funds in the form of donations that have been given to some lower middle-income countries in the MENA region.

Funds have been distributed to poor countries in areas such as: coordination, planning, financing and monitoring, vaccination, research, innovation and evidence, risk communication, community engagement and infodemic management. Funds have also been used in other areas including surveillance, outbreak investigation and public health, points of entry, international travel, transport and mass gathering, laboratories and diagnostics, infection prevention and control, protection of the health workforce, case management, clinical operation and therapeutics, operational support and logistics, and strengthening essential health services and systems.

Djibouti

The World Bank (2021) indicates that Djibouti has a national poverty ratio of 21.1. The country has received US\$3.09 million as of October 2021.

Of these funds, 35.6 per cent have been used in surveillance, outbreak investigation and public health (US\$0.5 million), laboratories and diagnostics (US\$0.5 million).

Egypt

According to the World Bank, the national poverty ratio for Egypt as of October 2021 was 32.5. A total of US\$4.14 million has been given to Egypt. Of this amount, 88 per cent has been spent on vaccination (US\$2.13 million), operational support and logistics (US\$0.91 million), case management (US\$0.33 million), and coordination, planning and financing (US\$0.11 million).

Iraq

The Iraqi national poverty ratio is 18.9. WHO has donated US\$11.97 million to Iraq. Of this amount, US\$4.34 million has been utilized (36.2 per cent) in areas such as vaccination (US\$1.38 million), risk communication and community engagement (US\$0.41 million), surveillance, outbreak investigation and public health (US\$0.41 million), case management (US\$0.09 million), operational support and logistics (US\$1.34 million), and coordination, planning and financing (US\$1.1 million). A larger proportion of donations through WHO went to COVID-19 vaccination, operational support and logistics.

Lebanon

As of October 2021, the national poverty ratio in Lebanon is 27.4. US\$13.07 million was made available to the country, the majority of which (US\$8.97 million) was utilized to strengthen essential health services.

Syria

The poverty ratio recorded in Syria according to the World Bank is 35.2. An amount of US\$5.09 million was made available to the country with the majority (US\$0.95 million) allocated to vaccination and laboratories and diagnostics (US\$0.31 million).

Yemen

Yemen has the highest national poverty ratio among the countries studied (48.6). Yemen also received more funding (US\$30.92 million) than any other country in this study, with most of these funds allocated to operational support, vaccination, and laboratories and diagnostics.

According to the 2021 Strategic Preparedness and Response plan (SPRP2021), the financial support that donors have provided to mitigate the effects of COVID-19 on vulnerable communities has been fundamental in lifting millions of people from poverty. Table 5 provides details of the amounts received and the varied locations, highlighting the global nature of the response which has

Table 5. List of private sector support

COVID-19 response	Amount	Beneficiary	Date
Zain Iraq	IQD 750 million	Iraq, health sector	March 2020
Asia cell	IQD 750 million	Iraqi government	2 April 2020
Asia cell	US\$500 000	Kurdistan Regional Government to combat COVID-19	2 April 2020
Spirit of America	US\$18 000 +	Kurdistan Regional Government	March 2020
No Kid Hungry	US\$5 million	Free meals for children in need	March 2020
Bill & Melinda Gates Foundation	US\$125 million	Seed funding to speed-up the response to COVID-19.	March 2020
GE Appliances	100 000 masks	Kentucky, US	3 April 2020
Apple	10 million masks	Health works, US	26 March 2020
Pornhub	50 000 masks	New York City workers.	24 March 2020
Airbnb hosts	100 000 housing	Health workers around the world	26 March 2020
Pope Francis	30 respirators	Vatican City, hospitals	27 March 2020
Apple	US\$7 million	China	1 April 2020
Alibaba Foundation	Medical supplies: 1.7 million masks, 165 000 test kits and other supplies	Azerbaijan, Bhutan, India, Kazakhstan, Kyrgyzstan, Uzbekistan and Viet Nam.	26 March 2020
Indonesia	US\$1.4 million (513 campaigns)	To combat COVID-19	29 March 2020
Global Fund	US\$500 million	To help protect and treat vulnerable communities	3 April 2020
Chan Zuckerberg Initiative	US\$30 million	US\$25 million to COVID-19 Therapeutics Accelerator US\$5 million to relief in San Francisco area	30 March 2020
Bill & Melinda Gates Foundation	US\$125 million.	COVID-19 Therapeutics Accelerator	10 March 2020
Amazon and Microsoft	US\$2.5 million relief fund	Seattle Communities affected by COVID-19	9 March 2020
Facebook	US\$100 million	Helping small businesses	17 March 2020
GoFundMe	US\$60 million	Organized campaigns	30 March 2020
Gates Foundation	US\$3.7 millions	Seattle area COVID-19 response	25 March 2020
George Soros	€1.1 million	COVID-19 aid to the city of Budapest	30 March 2020
We are strong together	US\$18 million	Kurdistan Regional Government	Ongoing
Belfrit	Large amount	Food support to Szent László Hospital	31 March 2020
MBA	US\$100 000	National COVID-19 Convalescent Plasma	1 April 2020
Tesla Inc	Hundreds of ventilators	New York City/Los Angeles	2 April 2020
Nestle	CHF 10 million/food and medical products	Switzerland	26 March 2020
Amazon	TL 3.5 million	Türkiye to fight COVID-19	29 March 2020
Turkish CB	US\$15 million	Türkiye, National solidarity campaign	2 April 2020
Kuwait Banks	£32 million	Combat Coronavirus	9 March 2020
Qatar	US\$150 million	Gaza/Palestine	23 March 2020
Azim Premji	US\$134 million	India	2 April 2020
Disney	100 000 N95 masks	New York/California/Florida	3 April 2020
Real Madrid Captain Sergio Ramos	264 000 masks	Spain	23 March 2020
Motsepe & friends	R1 billion	South Africa	28 March 2020
Mary Oppenheimer	R1 billion	South Africa	31 March 2020
Nigerian Senators	50% of salaries	Nigeria	2 April 2020
Aliko Dangote Foundation (ADF)	N124 million	Nigeria	28 March 2020
Oprah Winfrey	US\$10 million	US Coronavirus relief	3 April 2020
Masons Liberia	US\$6 000	Liberia to fight COVID-19	2 April 2020

COVID-19 response	Amount	Beneficiary	Date
Honda Motor Co & Honda Motor China	US\$1 431 209	COVID-19 Response	March 2020
Toyota	US\$500 000	United way for COVID-19 Relief	25 March 2020
Mercedes-Benz	Temporary hospital support	Pune, India	1 April 2020
Ralph Lauren Cooperation	US\$10 million	United States	3 April 2020
African Rainbow Minerals	US\$57 million	To help combat pandemic	3 April 2020
Sergio Armatti, USB	US\$1 million	Canton of Ticino, Switzerland	3 April 2020
Minderoo Foundation	US\$160 million	Medical Supplies Australia	3 April 2020
Michael Bloomberg	US\$40 million	Africa and low-income countries	3 April 2020
Giorgio Armani	€1.25 million	Italian hospitals and institutions	3 April 2020
Remo Ruffini Moncler brand	€10 million	Lombardy, Italy for new hospital	3 April 2020
Li Ka Shing	US\$13 million	Wuhan Frontline medical workers	3 April 2020
Said Latif	US\$10 000	Iraq-Raparin Area COVID Centre	March 2020
Samsung	US\$29 million	South Korea	2 April 2020
Google	US\$800 million	WHO	27 March 2020
Sony	US\$100 million	WHO, UNICEF and UNHCR	2 April 2020
Starbucks	US\$3 million	Global COVID-19 relief efforts	1 April 2020
AbbVie	US\$35 million	COVID-19 relief and health care support	31 March 2020
Tencent	US\$100 million	Global Anti-Pandemic Fund	25 March 2020
Tencent	US\$211 million	China Anti-Pandemic Fund	25 March 2020
Novartis	30 million hydroxychloroquine tablets, etc	United States	20 March 2020
Novartis	30 million hydroxychloroquine tablets	Global COVID-19 pandemic response	20 March 2020
BBC	US\$600 000	Coronavirus Relief Fund	27 March 2020
Netflix	£1 million	COVID-19 emergency relief fund	25 March 2020
Iraq and KRG	Mass donations	Temporal hospital constructions in all cities	Feb/Mar2020
Global	Blood donations	COVID-19 relief, various countries	Feb/Mar2020
Global	Food and hygienic supplies	COVID-19 relief, various countries	Feb/Mar2020
Global	Wage/housing relief	COVID-19 relief, various countries	Feb/Mar2020
Jinko Solar	1 million masks	Worldwide COVID-19 relief effort	30 March 2020
Rihanna and Jay-Z	US\$2 million	COVID-19 relief effort	30 March 2020
Western Union	US\$500 000	Coronavirus relief	12 March 2020
NFL Family	US\$35 million	COVID-19 relief	26 March 2020

Source: Paiman Ahmad, Franklin Akosa, Sanjay Chopra.

contributed massively to mitigating the effects of COVID-19.

Conclusion

A few key processes have shaped the effects of COVID-19. Among those, poverty has had a major impact on this pandemic. Donors facilitate the role of the state and individuals in fighting COVID-19 via contributions in the form of aid. This allows social interventions to be combined with government capacities in addressing the current challenges. These combined efforts at an international level, based on humanitarian

considerations and aimed at survival of all together, are in line with what Collier (2007) terms as 'building a unity of purpose'.

Prior to COVID-19, millions of people in the developing world, typically in the Middle East and sub-Saharan Africa, were faced with acute food insecurity due to conflict, climate and economic conditions. In addition, COVID-19 further devastated numerous areas of food security and human well-being. According to the Global Report on Food Crises 2020, an estimated 135 million people in 55 countries currently face acute

hunger and are in urgent need of humanitarian assistance (Global Network Against Food Crises and Food Security Information Network, 2020). Largely as a consequence of COVID-19, large numbers of people in several countries, particularly in Africa, Asia and the Middle East, are exposed to severe food deprivation or hunger. *The State of Food Security and Nutrition in the World* (FAO, 2021) found that 9.9 per cent of the global population is undernourished and as many as 811 million people are hungry, up from 690 million people in 2019. Job losses and loss of income have further worsened the situation.

In light of the above facts, this study has sought to gauge the importance of humanitarian aid granted by international agencies, nation states private organizations and private individuals. These donors lightened the heavy economic costs of COVID-19 to a significant extent. At the same time, questions have been raised as to whether economic aid is the most effective strategy to deal with the present crisis, given the fear of corruption and the inherent distribution inefficiencies in the worst-affected countries. Donors have explored different strategies, including their direct as well as indirect involvement in the disbursal of aid to end beneficiaries, to achieve more efficient usage of donations by the recipient countries.

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Part 3 —
*Quality of life
and mental
health*



3.1. L'expérience professionnelle de soins entravés par les mesures de distanciation physique en psychiatrie

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Résumé

L'épidémie de la COVID-19 a poussé les services de psychiatrie et de santé mentale à adopter des mesures sanitaires visant à limiter le risque de contamination. Ces mesures ont entravé la poursuite de certaines activités thérapeutiques, limité les possibilités de communication et interdit les contacts physiques, empêchant des gestes d'accueil et de réassurance.

S'appuyant sur 31 entretiens individuels et 5 entretiens de groupe réalisés auprès de professionnels de santé exerçant dans des services de Psychiatrie en France et en Belgique, notre étude examine comment ces professionnels ont vécu cette expérience de soins entravés par des mesures sanitaires, en particulier de distanciation physique.

Nombre d'entre eux ont décrit un sentiment de dégradation de la qualité des soins. Ils ont expliqué avoir été confrontés à une transformation de leur rôle habituel. Ils ont investi la visioconférence face à l'impossibilité de poursuivre certains soins en présentiel, ce qui a heurté leurs conceptions du soin accordant une place importante à la rencontre. Le confinement a réactivé l'imaginaire d'une hospitalisation en psychiatrie conçue sur le mode de l'isolement, contredisant les efforts pour coconstruire des parcours de

réadaptation, de réinsertion sociale et de rétablissement.

Mots-clés : corps, COVID-19, professionnel, psychiatrie, téléconsultation

Introduction

L'épidémie de la COVID-19 a poussé les services de psychiatrie et de santé mentale à adopter un ensemble de mesures sanitaires visant à limiter le risque de transmission de la COVID-19. En effet, du fait des modalités de vie en groupe et de la vulnérabilité des patients qui les fréquentent, ces services sont particulièrement à risque de devenir des foyers de contamination comme l'ont montré d'autres épidémies par le passé (Kelly 2020). Parmi les nombreuses mesures adoptées figurent le port du masque, le respect d'une distance physique minimale, la désinfection répétée des surfaces, l'aération récurrente des espaces, la réalisation de tests de dépistage, l'arrêt des activités de groupe, la fermeture d'unités, la suspension des sorties et des visites des proches, l'interdiction de circuler entre les unités, ainsi que l'adaptation de certaines activités en distanciel.

Dans ce contexte de crise sanitaire, les professionnels de santé mentale ont ainsi été confrontés à un double défi : prévenir le risque de contamination (Kreuzer, Baghai *et al.* 2020, Li and Zhang 2020) et assurer la bonne continuité des soins. La dimension relationnelle des soins

étant centrale en psychiatrie, les mesures prises pour prévenir la transmission de la COVID-19 ont largement entravé la poursuite des pratiques thérapeutiques habituelles ; qu'il s'agisse de consultations, de thérapies de groupe ou d'activités sociales. Les mesures de distanciation physique ont limité les possibilités de communication, en particulier non verbale (Robin-Poupard 2020), ou la perception des odeurs (Hanon 2019). Elles ont banni les contacts physiques, empêchant les gestes d'accueil, d'affection et de réassurance (Paul, Crommelinck *et al.* 2020). Par ailleurs, les activités nouvelles et répétées d'hygiène, de tests et de surveillance de lutte contre la COVID-19 ont mobilisé une large part de la disponibilité des professionnels, en particulier des infirmiers, rognant le temps à consacrer à leurs patients.

Dans cet article, nous proposons d'examiner l'expérience des professionnels de santé mentale contraints d'adapter leurs pratiques de soins en conséquence des mesures coercitives adoptées dans les services hospitaliers en France et en Belgique. Notre attention se focalise notamment sur leurs perceptions des relations de soins, considérant les soins comme un travail relationnel (Bautzer 2016). Les modalités de soins, définies comme un « ensemble des gestes et de parole répondant à des valeurs et visant le soutien, l'aide, l'accompagnement de personnes fragilisées dans leur corps et leur esprit » (Saillant and Gagnon 1999), ont en effet été fortement impactées par les mesures de distanciation physique. De plus, la réorganisation des services face aux nouvelles contraintes a recomposé les contours des rôles professionnels et la manière dont ils se construisent selon des interactions intra-, inter- et trans-professionnelles (Abbott 1993). Ainsi, nous proposons d'analyser la manière dont les pratiques de soins ont été impactées par les mesures sanitaires et en quoi les adaptations réalisées requestionnent les valeurs attribuées aux soins en santé mentale et associées aux rôles professionnels.

Méthode

Une méthodologie qualitative

Ce travail relève d'une méthodologie de recherche qualitative reposant sur des entretiens approfondis, individuels et de groupe. Ces entretiens ont été réalisés dans le cadre du projet de recherche PsyGipo2C, financé par l'ANR et la Région Centre Val de Loire. Il s'intéresse à l'impact de la COVID-19 sur les professionnels de la psychiatrie et de la santé mentale en Europe. Notre protocole de recherche a reçu l'approbation du comité d'éthique dans chacun des pays partenaires de l'étude. Pour ce travail, les entretiens ont été réalisés dans deux pays francophones partenaires du projet, la France et la Belgique. Ils visaient à documenter et comprendre les vécus des professionnels face à la crise sanitaire liée à la pandémie de COVID-19, l'expérience qu'ils en retirent pour leurs pratiques thérapeutiques, ainsi que leurs questionnements sur la situation de la psychiatrie dans leur pays respectif. Les entretiens individuels ont permis de situer cette expérience dans des parcours singuliers et des réflexions individuelles. Les entretiens de groupe, stimulant une réflexion collective, ont permis une confrontation de points de vue visant à faire ressortir les points de divergence et de consensus autour d'expériences partagées. Les groupes étaient constitués de quatre à dix participants de différentes professions et issus d'un même service. Outre la production de données, ils ont pour seconde finalité de contribuer à l'enrichissement mutuel des professionnels ainsi qu'à la construction d'une réflexivité interprofessionnelle.

Les grilles d'entretien ont été construites sur la base d'une revue systématique de la littérature internationale (Gourret Baumgart, Kane *et al.* 2021) et de l'expérience des membres du comité scientifique (Thome, Deloyer *et al.* 2020). Ils ont

été structurés autour de trois thèmes : les adaptations organisationnelles, le recours à des modalités de suivi intégrant les outils numériques et le vécu professionnel et personnel de la crise. Jade Gourret Baumgart, ingénieure d'étude, et Hélène Kane, ingénieure de recherche, se sont réparties la conduite des entretiens de manière à rencontrer chacune différents profils de professionnels dans les deux pays. L'ordre des questions était interchangeable afin de s'appuyer sur la dynamique propre à chaque entretien, et les questions ont elles-mêmes été adaptées aux profils et aux parcours singuliers des participants. Nous avons par ailleurs veillé à ancrer le questionnement dans la réalité des situations vécues, tout en amenant à une réflexivité sur les expériences, dans le but d'éviter l'écueil de propos génériques et préconçus sur la crise sanitaire.

Les entretiens ont été réalisés entre mars et mai 2021, c'est-à-dire environ une année après le début de la pandémie de COVID-19 et l'entrée en vigueur de nombreuses mesures sanitaires qui ont fluctué au fil des mois. Au moment des entretiens, les taux de vaccination étaient alors très faibles en France et en Belgique, la plupart des mesures sanitaires étaient encore maintenues dans les services de psychiatrie et en population générale.

Profil des participants

Les participants ont été recrutés sur le mode du volontariat, principalement au sein de deux services de psychiatrie en France, l'un public et un autre privé, et d'un hôpital privé en Belgique. Nous avons veillé à obtenir une diversité de participants s'agissant des professions et des durées d'expérience professionnelle, afin de pouvoir documenter comment l'impact des mesures sanitaires pouvait se différencier selon ces caractéristiques socioprofessionnelles.

Tableau 1. Répartition des participants aux entretiens selon les professions.

Profession	Belgique		France		Total
	Entretiens individuels	Entretiens de groupe	Entretiens individuels	Entretiens de groupe	
Infirmiers en psychiatrie	2	6	4	3	15
Travailleurs sociaux (assistants sociaux, éducateurs)	4	1	2	2	9
Psychologues	2	1	2	2	7
Psychiatres	1	1	4	-	6
Aides-soignants	-	2	1	3	6
Autres (secrétaires, assistants logistiques)	2	1	1	2	6
Ergothérapeutes, kinésithérapeutes	2	2	-	-	4
Pairs aidants	-	-	4	-	4
Total	13	14	18	12	57

Source: Hélène Kane, Jade Gourret Baumgart, Laurence Fond-Harmant, Gaëtan Absil, Jocelyn Deloyer, Wissam El-Hage, Catherine Maes, Frédéric Denis.

Au total, 31 entretiens individuels et 5 entretiens de groupe réunissant 26 professionnels ont été réalisés auprès de professionnels qui exercent dans des services de psychiatrie situés en France et en Belgique, pour un total de 57 participants (Tableau 1). La majorité des entretiens individuels (24 sur 31) ont été réalisés en présentiel afin de favoriser des conditions optimales de communication. En revanche, compte-tenu du contexte sanitaire, nous avons été contraints de réaliser les entretiens de groupe en visioconférence. Parmi les participants, 40 sont des femmes et 17 des hommes, ce qui est lié à une forte représentation des femmes dans certaines professions, notamment les assistantes sociales et les infirmières.

Analyse des entretiens

Les entretiens individuels et de groupe ont été intégralement retranscrits puis importés dans le logiciel d'analyse NVivo®. Un arbre d'analyse thématique (Bardin 2013) a été construit par les deux premières autrices dans un processus itératif, c'est-à-dire par ajustements progressifs liés aux allers-retours entre la question de recherche et les données des entretiens (Olivier de Sardan 2001). Dans un premier temps, cinq entretiens individuels ont été codés afin de vérifier la concordance du codage entre les deux chercheuses, puis l'arbre d'analyse a été ajusté

en reprécisant le contenu de certaines catégories avant que les deux chercheuses codent chacune l'intégralité des entretiens.

Résultats

Nous proposons d'analyser l'expérience des professionnels concernant les soins entravés par les mesures sanitaires autour de quatre axes qui en articulent les aspects les plus saillants : les activités thérapeutiques empêchées, l'adoption de nouveaux rôles, la mise en réflexion de la pertinence des mesures sanitaires et le recours à des outils numériques pour des soins en distanciel.

Activités thérapeutiques empêchées

La survenue de la pandémie et la mise en œuvre de mesures strictes en particulier lors des périodes de confinement, en France et en Belgique, ont considérablement impacté la poursuite des activités thérapeutiques dans les services de psychiatrie. Afin de limiter le risque de contamination, un ensemble de mesures a été mis en place au sein de ces services : réduction du nombre de patients hospitalisés et fermeture de certains services, arrêt des consultations externes, interruption des activités extérieures, des sorties et des visites, mise en place de « bulles », c'est-à-dire division des

services en petites unités en évitant toute circulation entre ces unités. Les professionnels ont décrit alors une impression de services « figés », « au ralenti », en attente comme « un mois d'août qui se serait prolongé » ; voire pour certains des services « fantômes », totalement à l'arrêt. Certaines activités interrompues étaient importantes dans le processus thérapeutique, et les activités suppléatives ne présentaient pas la même pertinence thérapeutique.

« Au mois d'octobre, nous avons dû supprimer les weekends, supprimer toutes les activités extérieures, qui sont vraiment des axes centraux du projet thérapeutique [...]. Il a fallu repenser d'autres activités, ce qui était relativement compliqué. On a mis quelques activités en place... Mais des activités qui étaient somme toute, finalement, relativement répétitives et plutôt sur un axe ludique ou occupationnel. » (Homme, infirmier, Belgique)

La suppression des activités habituelles a forcé les professionnels à proposer d'autres activités pour ne pas laisser les patients « sans rien faire ». Bien souvent, il n'était plus possible de s'appuyer sur des formes structurantes de participation aux activités quotidiennes : les patients hospitalisés n'étaient plus autorisés à

faire la vaisselle, à mettre la table ou lancer une lessive ; toutes ces activités requérant de nouvelles normes d'hygiènes qu'ils sont présumés ne pas savoir appliquer. Plus largement, les activités de groupe – souvent investies dans les démarches thérapeutiques en psychiatrie – étaient fréquemment proscrites, limitant drastiquement le champ des modalités thérapeutiques.

« C'est vrai qu'on a des patients où pour beaucoup on vise une resocialisation, une réadaptation par le groupe, notamment. Donc tout cela était empêché. [...] C'est vrai que notre offre de soins a été amputée de sa dynamique de groupe... alors que dans les services de psychiatrie, c'est un aspect important. » (Homme, psychologue, entretien de groupe 2, Belgique)

Une autre difficulté était la fermeture de services sociaux, administratifs ou de santé travaillant en articulation avec la psychiatrie. Les démarches sociales et les projets d'insertion étaient en suspens ; les professionnels pouvaient difficilement travailler sur les sorties. Ils avaient l'impression que leurs patients étaient bloqués dans un « entre deux », « une voie de garage » ; ils ne pouvaient pas non plus rencontrer les familles et proches afin de préparer les sorties. L'impossibilité de poursuivre des activités hors de la structure de soins tendait à « déconnecter » les patients du monde extérieur alors que les professionnels cherchaient à maintenir et entretenir ces ancrages.

Outre la suppression d'activités, l'obligation des gestes barrières que sont la distanciation physique et le port du masque brouillait la communication des professionnels avec les patients. Ils évoquaient la perte d'une partie de la communication non verbale et d'une part de l'expressivité.

« Oui, ça change, parce qu'il y a toute la communication non verbale qui se modifie.

Donc on ne peut s'appuyer que sur les yeux ou la gestuelle... Mais c'est vrai que l'ensemble du visage moi me manque ; je travaille beaucoup avec la communication non verbale et donc les silences s'entendent de manière un peu différente. [...] Je peux moins rebondir sur des visages qui expriment des fois ce qu'ils n'arrivent pas ou ne veulent pas mettre en mots. » (Femme, assistante sociale, France)

Le port du masque obligeait ainsi à recomposer les manières de communiquer, en particulier pour transmettre les émotions et les affects, dans des relations où cette communication est au cœur de l'acte thérapeutique.

« Je dirais que le fait de travailler avec un masque, dans les soins quotidiens, c'est très compliqué, parce que les patients ne voient pas nos émotions. Ce qu'on peut leur renvoyer, du coup on est presque obligés entre guillemets de le « surjouer » [...] surjouer au niveau des yeux pour transmettre l'émotion qu'on peut avoir avec un sourire, ou avec cette bienveillance. C'est vrai que c'est compliqué de trouver les traducteurs de lecture [il rit] oculaire. [...] Et puis nous travaillons aussi beaucoup forcément avec notre corps, avec notre présence [...] On travaille avec notre physique, je dirais, et ce qu'on incarne, et du coup, on a été forcés de mettre cette distance. » (Homme, psychologue, focus group 2, France)

Ce sont aussi les contacts physiques qui étaient interdits, empêchant les gestes de réconfort ou la manifestation de l'empathie.

« Cela a quand même été une barrière, parce qu'effectivement, il y a des choses qu'on ne pouvait plus se permettre. Il y a des patients qui réagissent très bien au toucher ; là, c'était terminé. Le fait de contenir, de tenir une main,

de laisser quelqu'un appuyer sa tête sur votre épaule parce qu'il avait envie de s'épancher à ce moment-là, c'était fini. Pour les personnes âgées, ça a été très préjudiciable notamment. On a eu quelques patients qui venaient d'Ehpad, justement, qui ne voyaient déjà plus leur famille [...] c'était compliqué de leur dire : « Non, on ne peut pas vous toucher. » (Femme, Infirmière, focus group, France)

La distanciation physique, qui tend à rendre les interactions moins spontanées, impliquait d'adapter la manière d'interagir avec l'autre afin de préserver l'empathie et la sincérité dans les interactions. Dans certains cas, les espaces étaient aménagés pour tenir à distance les patients, notamment lors des entretiens. Cet éloignement entravait les échanges formels, mais aussi les petites interactions du quotidien. La distanciation concernait aussi les patients entre eux, avec pour effet d'entraver leur communication et les relations qu'ils pouvaient construire.

Adoption de nouveaux rôles

Outre le fait que les mesures sanitaires empêchaient directement la poursuite d'activités thérapeutiques, les réorganisations liées à l'adoption de mesures visant à minimiser les risques de transmission de la COVID-19 ont beaucoup mobilisé les soignants, les rendant moins disponibles pour les soins de psychiatrie et de santé mentale. Les infirmiers, aides-soignants, mais aussi ergothérapeutes, éducateurs ou assistants sociaux ont notamment été mobilisés par la réalisation de tâches d'hygiène, de tests PCR, ainsi que par l'application et la surveillance des gestes barrières. La poursuite de ces nouvelles activités a engagé les professionnels dans de nouveaux rôles les éloignant de leurs pratiques habituelles. De ce fait, beaucoup ont exprimé le sentiment d'une perte de sens.

« Mais on n'avait pas le droit aux activités. [...] Les patients avaient des demandes et puis, de toute façon, on ne pouvait répondre à rien, à part postposer ou dire non. [...] Voilà, on n'en pouvait plus, le boulot n'avait plus de sens, on venait pour faire du gardiennage, pour empêcher que ça pète entre les patients. Ce n'est pas notre vocation première. [Elle rit] Les patients ne vivant rien, n'avaient rien à raconter non plus. On ne va pas ressasser le passé tout le temps non plus. » (Femme, éducatrice, Belgique)

L'exigence de faire respecter les gestes barrières a notamment absorbé l'énergie des professionnels. Beaucoup ont eu le sentiment de devoir jouer un rôle de contrôle, voire de « police », qu'ils ne reconnaissaient pas comme relevant de leurs prérogatives. La nécessité de surveiller en permanence le maintien des gestes barrières, de devoir constamment les rappeler à des patients qui rencontraient des difficultés à les intégrer du fait de leurs troubles psychiques apparaît épuisant.

« Ce cadre, il est usant à poser, il est usant à maintenir, et donc énergivore, chronophage, tout ce qu'on veut, par rapport à nos ambitions thérapeutiques vis-à-vis du patient... Oui, quand je dis que ça parasite nos prises en charge, vraiment, c'est le cas. On a parfois l'impression d'être plus des gardiens de prison que d'être des soignants. » (Infirmière, entretien de groupe 2, Belgique)

Outre le fait qu'elle mobilise beaucoup d'efforts, l'attention portée au respect des gestes barrières tendait à s'opposer aux démarches de soins en psychiatrie. En effet, la logique des mesures d'hygiène – leur application avec intransigeance pour éviter tout risque de contamination – entrainait contradiction avec les démarches de soins misant sur la souplesse, les négociations et les ajustements.

« On a quand même beaucoup de patients intolérants à la

frustration. Donc c'est vrai que les obliger à porter un masque, leur répéter vingt fois par jour qu'il faut qu'ils remettent le masque, c'est, à chaque fois, les acculer plus en fait. [...] Forcément qu'éthiquement, il y a quelque chose qui fait que le soin psychiatrique, il n'est plus tourné de la même façon. Là où, parfois, on mettait de la tolérance pour pouvoir créer l'alliance, on est obligés de continuer à frustrer... plus sévèrement. Ce n'est pas comme ça qu'on aurait procédé en psychiatrie : on aurait pu passer par des moyens détournés, pris plus de temps pour obtenir le même résultat. » (Infirmière, France)

Aussi, certains professionnels avaient le sentiment que la logique sanitaire de contrôle de l'épidémie a pris le dessus sur les démarches de soins propres à la psychiatrie, et que le sens des prises en charge s'en trouvait remis en cause.

« C'est vrai qu'il y a eu vraiment cette tension entre une logique plus sanitaire, et la logique de notre philosophie de soins, où en fait nos pratiques ont été très cadenassées par justement le fait qu'on a agi en fonction de l'évolution épidémiologique. [...] Donc ça a été une politique qui était dictée par le service d'hygiène des hôpitaux. » (Homme, psychologue, entretien de groupe 2, Belgique)

Si la majorité des professionnels estimait avoir « assuré » au niveau de l'application des règles d'hygiène, certains craignaient perdre le côté « humain » des prises en charge. De plus, la communication avec leurs collègues a aussi été entravée par des mesures sanitaires, d'autres regrettaient une moindre coordination des prises en charge ou une perte de cohérence. D'autres encore ont exprimé le sentiment de ne plus pouvoir travailler sur le plan de la santé mentale et de la psychiatrie, ou de rester en surface,

avec l'impression d'effectuer un travail relevant davantage de l'animation ou de l'occupation. Non seulement ils ont été très mobilisés par des aspects logistiques relatifs à la gestion du risque de contamination, mais face à l'épreuve de la crise sanitaire, ils ont aussi revu à la baisse leurs ambitions thérapeutiques, préférant reporter les activités les plus coûteuses psychologiquement.

« Les activités thérapeutiques, pour les patients, on sentait que ce n'était plus au centre : il fallait plus se détendre, il fallait un peu contenir les angoisses... mais je crois que du côté soignant, c'était pareil. [...] Les soins psychiques, ils sont peut-être passés au second plan, mais aussi, ça demandait une énergie qu'on n'avait plus à ce moment-là [...] moi aussi, des fois, ça m'a fait plaisir de faire plutôt un karaoké ou une balade en pleine conscience dehors, que de faire mon groupe d'affirmation de soi, qui mobilise beaucoup, qui fait bosser les patients sur leurs problématiques, parce que nous aussi, on avait cette fatigue. » (Femme, psychologue, entretien de groupe 3, France)

Eux-mêmes affectés par de nouvelles contraintes professionnelles liées aux réorganisations, ainsi parfois qu'à des difficultés pour se ressourcer dans leur vie personnelle, les professionnels partageaient avec leurs patients une « fatigue » de la situation les poussant à diminuer l'intensité du travail thérapeutique. De plus, dans des situations de huis clos où la plupart des activités extérieures étaient proscrites, des relations particulières – moins axées sur la thérapeutique – pouvaient paradoxalement se construire. La coprésence sur une longue durée et l'expérience commune d'une situation de crise inédite était propice à un sentiment de confusion avec les relations amicales ou familiales. Cette impression est exacerbée par le fait que les professionnels étaient eux-mêmes affectés par des restrictions

qui impactaient leur quotidien et restreignaient leur vie sociale. Certains éprouvaient le sentiment de mieux comprendre ce que vivaient leurs patients en faisant eux-mêmes l'expérience des restrictions et des confinements.

« Finalement, on a été un peu plus proches de nos patients. Parce que... Pendant le premier confinement, mes patients me demandaient comment j'allais... Tout le temps. D'habitude, ils me posent moins la question, et puis d'habitude, quand ils me posent la question je l'évite. [...] Donc il y a quelque chose de l'échange ordinaire qui rentre dans le cadre de la thérapie, alors que d'habitude on fait une coupure beaucoup plus nette entre notre vie sociale et notre vie avec nos patients. » (Femme, Psychiatre, France)

Ainsi, bien que les relations avec les patients étaient entravées par les mesures de distanciation physique, la pénurie de relations sociales éprouvées lors des confinements ainsi que l'expérience commune de ces restrictions ont donné de l'importance à ces relations de soins en tant que relations humaines. Pour les patients comme pour les professionnels, les rendez-vous médicaux faisant partie des rares rencontres autorisées pouvaient davantage être investies comme relations sociales ordinaires.

Mise en réflexion de la pertinence des mesures sanitaires

Bien que craignant le risque de foyers de contamination au sein de leurs services, beaucoup de professionnels se sont interrogé sur la pertinence de certaines mesures mises en place dans les services hospitaliers, compte tenu de leur impact sur les soins délivrés et la santé mentale de leurs patients. Beaucoup partageaient le sentiment que ces mesures altéraient la qualité des soins délivrés, et faisaient l'amer constat de l'aggravation des troubles psychiques de certains patients, qu'il s'agisse de patients hospitalisés subissant des restrictions d'activités

ou de patients ambulatoires confrontés aux mesures sanitaires appliquées en population générale.

« On avait tous nos psychotiques qui étaient en ambulatoire et qui étaient plus ou moins stabilisés, mais qui n'avaient plus leurs points de repère ! [...] Et on les a vus revenir en hospitalisation sous contrainte, parce que ce qui faisait équilibre à l'extérieur, ce qui faisait point d'ancrage, ce qui faisait point de repère n'était plus là. [...] Donc on a eu, je dirais, entre mars et début juin, 30 % d'hospitalisations sous contrainte en plus que les autres années [...] Chez les personnes âgées, on parle du « syndrome de glissement ». C'est comme si, pour nos patients en psychiatrie, il y avait quelque chose de cet ordre-là aussi. [...] Ils se laissent aller ; psychiquement, ça ne va plus... » (Homme, psychiatre, Belgique)

De nombreux professionnels jugeaient certaines mesures trop strictes et allant à l'encontre de la santé psychique. Leur isolement était jugé délétère, parfois décrit comme une « prison », une « prise d'otage ». Dans l'un des hôpitaux enquêtés en Belgique, les professionnels se sont indignés de l'impossibilité pour les patients de rencontrer leurs proches. En effet, pendant une année, les patients n'ont pu recevoir que quelques courtes visites dans des sas extérieurs – séparés d'eux par une vitre en plexiglas. Certains avaient également le sentiment que les mesures, plus strictes pour les patients hospitalisés en psychiatrie qu'en population générale, s'avéraient discriminatoires à l'égard des personnes souffrant de troubles psychiques. Aussi, des professionnels s'interrogeaient sur la légitimité de ces mesures au regard de leur impact sur la santé des patients.

« Il n'y avait pas moyen de se ressourcer, en fait, pour les patients. [...] Ici, on ne pouvait même pas faire d'activité « cuisine ». Vraiment tout était

à l'arrêt... En plus, on leur demandait de se lever pour aller tourner en rond dans une salle... Ça perdait du sens aussi pour eux. On sentait vraiment une déprime qui s'installait chez les patients. [...] J'ai quand même essayé de joindre la personne qui est responsable du droit des patients, pour lui demander : « Jusqu'où on peut aller dans cette restriction ? [Elle rit] Parce qu'on est en train de les tuer autrement... » (Femme, éducatrice, Belgique)

Comme cette éducatrice, plusieurs professionnels ont évoqué l'excessivité dans l'application de mesures qui mettent en danger la santé mentale des patients. Face à ce risque, certains professionnels ont tenté de négocier des marges d'action et de liberté pour leurs patients, d'autres ont transgressé les règles lorsque la « survie psychique » de leurs patients leur semblait être menacée. Certes, quelques professionnels ont jugé qu'il faudrait appliquer plus strictement les mesures sanitaires, notamment sensibles à la question car étant eux-mêmes à risque de faire une forme grave de COVID-19. D'autres au contraire les ont désapprouvés, estimant que leur impact sur la santé mentale était trop important en balance du bénéfice en termes de contrôle de l'épidémie de la COVID-19.

« Je me dis que c'est trop, parce que je trouve que psychiquement, pour eux, ce n'est pas juste. Et donc je crois que ça vient toucher mes valeurs personnelles de droits et de libertés... Donc moi, j'en suis un peu à me dire que ce n'est pas juste pour eux, que ça ne va pas, que c'est trop, et qu'il faut que ça bouge. » (Femme, assistante sociale, Belgique)

Certaines règles sont d'autant moins consenties que leur intérêt du point de vue du contrôle du risque infectieux n'est pas évident du point de vue des professionnels ; ils se sont alors retrouvés en position de devoir expliquer et faire respecter des mesures dont ils ne comprenaient pas

l'intérêt. Bien qu'ayant des missions différentes, les différentes catégories de professionnels partageaient l'impression que les conditions posées ne leur permettaient pas d'assurer la qualité des soins délivrés : les éducateurs regrettaient de ne pas pouvoir réaliser les activités prévues, les assistants sociaux d'être bloqués par rapport aux démarches entreprises, les infirmiers de ne plus avoir le temps pour les entretiens et la communication avec leurs patients, les psychiatres de ne plus pouvoir travailler certaines dimensions thérapeutiques. Le sentiment d'une dégradation de la qualité des soins et d'altération de la santé des patients a généré une fatigue associée à des formes de souffrance des professionnels mêlant inquiétude, indignation et découragement.

« Les patients s'ennuient... On fait moins d'entretiens, aussi... donc du coup, les personnes décompensent plus facilement ; donc nous génèrent aussi, plus de stress... [...] On a un patient, notamment, qui fugue régulièrement lorsqu'il sort seul ; et qu'on n'a pratiquement pas fait sortir pendant plus d'un mois, parce qu'on ne pouvait pas l'accompagner à l'extérieur. Même en prison, on a le droit à une balade par jour. » (Femme, infirmière, France)

Ces professionnels ont souligné également combien les restrictions de déplacement imposées à leurs patients s'opposaient à leur autonomie. Isolés du monde extérieur, ils étaient de plus en plus déconnectés du monde extérieur et dans certains cas dépendants des structures de soin. La fluctuation des mesures sanitaires a été également préjudiciable aux personnes souffrant de troubles psychiques.

« C'est inhérent à la situation, des règles qui changent presque de jour en jour [...] donc les patients qui sont des patients avec des difficultés psychologiques, qui ont besoin justement d'un

message univoque, enfin, d'un message clair, parfois ils se voyaient recevoir des messages contradictoires [...] ça a créé beaucoup de tensions, de frustration, et parfois des passages à l'acte, ou en tous les cas des choses qu'il fallait recadrer. [...] Nos patients, dont certains sont quand même assez vulnérables, ont besoin, voilà, d'une cohérence dans la prise en charge... Cohérence qu'ils n'ont pas pu toujours avoir, en lien justement avec ces incertitudes. » (Homme, psychologue, entretien de groupe 2, Belgique)

Enfin, eux-mêmes fatigués psychiquement, certains professionnels avaient le sentiment de ne plus être toujours en mesure de prendre en charge correctement les patients, il leur était particulièrement difficile de construire de la cohérence face à la fluctuation des règles sanitaires. Certains évoquaient une saturation et une moindre disponibilité psychique pour les patients.

Prendre soin à distance via des outils numériques

Ces contraintes ont poussé les professionnels à innover, notamment en investissant des activités sans « contact » ni transmission d'objet. Certains ont notamment eu recours aux outils numériques afin de pallier l'impossibilité de poursuivre certaines activités. La créativité de certains professionnels dans le domaine a ainsi été révélée par la crise. Certains ont réalisé des vidéos, d'autres ont organisé des forums ou des jeux via les réseaux sociaux, d'autres encore ont initié des rencontres en visioconférence. Plusieurs ont exprimé que la crise a été l'occasion de « se réinventer » afin d'assurer les soins malgré les restrictions et parfois après un passage à vide.

« À un moment donné, j'ai dû m'arrêter parce que j'avais envie de pleurer tout le temps, moi. [...] Le deuxième confinement, on a pris un peu plus les choses en

main, parce qu'on était un peu riches de l'expérience précédente et on ne voulait pas revivre la même chose. [...] On a mis en place des trucs en digital, on s'est réinventé une autre façon de travailler pour pouvoir pallier cet état de dépression et ne pas subir la deuxième vague. [...] C'était une bouffée d'oxygène pour moi et ma collègue qui animions ce groupe [En visioconférence], parce que finalement, on avait un contact et on se sentait utiles pour faire quelque chose. » (Femme, éducatrice, Belgique)

Les outils numériques ont ainsi permis de proposer à nouveau des activités, notamment des groupes de discussion en visioconférence, des forums ou des vidéos présentant des exercices de relaxation. Cependant, ce sont surtout les jeunes professionnels qui ont innové en la matière, plus à l'aise avec ces technologies. Pour une majorité, le recours aux outils numériques s'est limité à la réalisation de consultations ou de réunions en visioconférence, permettant d'assurer une certaine continuité des soins nonobstant des changements de modalités relationnelles. Les expériences de ces consultations sans présence corporelle, inédite pour beaucoup de professionnels, apparaissent contrastées. Certains professionnels, a priori réticents à la possibilité de réaliser des téléconsultations, étaient surpris de découvrir qu'il leur était possible de poursuivre des interactions thérapeutiques malgré la distance physique et une perte d'informations, notamment liées à la communication non verbale.

« Je n'ai pas l'impression que ça ait modifié les relations avec les patients. [Silence] En tout cas, ça n'a pas été délétaire. Même si... Disons que, dans l'entretien, on sent un peu qu'il manque une proximité physique. [...] Mais dans les faits, ça a quand même créé quelque chose... C'était une expérience particulière qu'on a partagée avec les patients. » (Homme, psychologue, France)

Des psychiatres et psychologues expliquaient ainsi que cette expérience nouvelle les a poussés à considérer l'intérêt de la téléconsultation dans certaines situations. Les professionnels dont les missions exigeaient davantage de contact et de proximité physique avec les patients, notamment les infirmiers, se sont montrés cependant moins favorables aux outils numériques. Ils s'inquiétaient notamment d'une certaine « déshumanisation » qui serait liée au développement des outils numériques.

« Je trouve qu'on a déjà tellement perdu en qualité de relations humaines. Les patients, ils ont tellement été isolés, à ne plus pouvoir sortir, à ne plus pouvoir aller faire des courses, à ne plus pouvoir aller voir leurs proches, à ne plus se sentir citoyens... J'aurais envie de dire que la première chose à envisager, c'est plutôt de réactiver l'humanisation et pas la technologie. » (Femme, assistante sociale, Belgique)

Par ailleurs, selon un paradigme considérant les troubles psychiatriques sous l'angle d'une défaillance des liens sociaux, quelques participants arguaient que le numérique distendait les liens sociaux. En ce sens, ajouter de nouveaux usages du numérique serait défavorable au bien-être mental.

« Les addictions, c'est avant tout une maladie du lien social. Donc [elle souffle] supprimer du lien social en plus, je ne vois strictement pas l'intérêt. [...] Aujourd'hui, où on est de plus en plus dans une individualité, dans des sociétés et des familles éclatées. [...] On voit de plus en plus l'émergence de ces maladies psychiatriques, donc supprimer encore plus de lien, ce n'est pas pertinent. » (Médiatrice de santé pair, France)

Tous les professionnels ne considéraient pas que la distance physique était la métonymie de

la distance sociale. En revanche, tous appréhendaient peu ou prou comment la digitalisation de la rencontre impactait les modalités de la relation thérapeutique. L'inscription des corps dans des espaces et temps de la rencontre physique déterminait un contexte formel et une exigence de présentation de soi (Goffman 1973) qui s'estompaient en visioconférence. Une psychiatre nous a notamment relaté avoir été confrontée à des patients qui restaient en pyjama dans leur lit lors des téléconsultations, situation qu'elle a décrit comme « régressive ». D'autres professionnels ont évoqué des oublis de rendez-vous plus fréquents, faute de leur inscription spatio-temporelle et de leur matérialisation par le « carton » de rendez-vous. Sans l'engagement « physique » de la rencontre en face à face, l'implication dans le soin ne bénéficiait pas du même cadrage (Goffman 1974), pour les patients comme pour les professionnels. Plus largement, de nombreux professionnels ont eu le sentiment que la visioconférence ne permettait pas de travailler avec la même intensité.

« On sait bien en thérapie, qu'il y a tout l'infra-verbal... Toutes les des modalités empathiques qui passent par le corps, qui passent par le regard, une odeur et qui renvoient à des choses très archaïques. [...] Quand je dis archaïques, c'est en termes de revenir un peu au bébé, et le bébé, c'est un être sensoriel... [...] Il y a quelque chose comme ça, de l'intersubjectivité qui passe par le regard, et il faut que ça s'incarne. » (Femme, psychiatre, France)

D'autres professionnels ont évoqué l'impression d'avoir travaillé de manière superficielle en l'absence de rencontre physique. Ils ont constaté que leurs consultations « en distanciel » étaient plus courtes, qu'elles se limitaient parfois à prendre des nouvelles ou à renouveler une ordonnance. Leur réticence à aborder certaines questions sensibles, ou

à travailler sur des expériences traumatiques, était également fondée sur la crainte de provoquer un malaise de leur patient face auquel ils pourraient se trouver impuissants faute d'être physiquement présents.

Discussion

S'appuyant sur des entretiens approfondis, notre étude documente l'expérience de divers professionnels de la psychiatrie et de la santé mentale qui ont dû s'adapter face à l'épidémie de la COVID-19. Au moment des entretiens, de nombreuses mesures sanitaires étaient encore en vigueur en France et en Belgique, suscitant chez la plupart de nos interlocuteurs des sentiments de fatigue, de lassitude et parfois de découragement. Teintés par la morosité de cette période, leurs propos sont donc à considérer dans ce contexte particulier marqué par l'imposition de couvre-feux, de fermetures de lieux de convivialité, de limitations des déplacements ainsi que de mesures contraignantes dans les services. Ce travail fournit en ce sens un premier retour réflexif sur une année d'exercice en psychiatrie au temps de la COVID-19, une narration nécessairement située dans ce contexte particulier d'énonciation (Olivier de Sardan 2008).

Ce travail ne prétend pas mener une comparaison entre la France et la Belgique, qui supposerait de considérer systématiquement les spécificités de ces deux pays en termes de politiques de santé, d'organisations des soins en psychiatrie et de droit des patients hospitalisés. Il permet en revanche d'analyser l'expérience des professionnels dans ces contextes singuliers, révélant notamment l'importance des organisations professionnelles et des moyens dont disposaient les services pour faire face à la situation de crise sanitaire.

Expériences différenciées selon les contextes d'exercice et professions

En France, les professionnels exerçant au sein du service public de psychiatrie ont particulièrement été éprouvés par une surcharge de travail liée aux réorganisations et à la réalisation de tâches d'hygiène, ainsi qu'une carence de ressources humaines aggravée par des arrêts maladie liés directement ou indirectement à la COVID-19. Dans la structure privée de Belgique, compte tenu des ressources humaines plus importantes et plus diversifiées, avec notamment des éducateurs et ergothérapeutes dans les équipes, une redistribution de certaines tâches a pu s'opérer plus facilement, bien que les professionnels concernés aient eu le sentiment de ne plus exercer leurs missions habituelles. En revanche, l'application plus stricte des mesures sanitaires et l'impossibilité de les ajuster en fonction des situations ont exacerbé la souffrance des professionnels face aux contraintes subies par les patients hospitalisés.

Bien que les professionnels rencontrés eussent conscience de l'importance des mesures sanitaires pour protéger leurs patients de la COVID-19, leur attention et leur sensibilité à la santé mentale font qu'ils ont développé des réflexions sur ces mesures, manifestant parfois des désaccords ou actes de désobéissance. Notre propos n'est pas de remettre en cause la pertinence des mesures ou la manière dont les professionnels les ont mis en œuvre, mais plutôt de révéler combien elles ont mis ces professionnels face à des exigences contradictoires et des dilemmes éthiques, les exposant à de fortes tensions au travail. Face à cette épreuve commune, certains se sont trouvés plus affectés que d'autres, selon leurs missions et les ressources dont ils disposaient pour les assurer, mais aussi selon leur sensibilité. Les aides-soignants et les infirmiers, qui ont subi une surcharge de travail importante, semblent avoir particulièrement souffert de la tension imposée par

la poursuite de soins quotidiens supposés devoir respecter les distances sociales. Ces professionnels étaient particulièrement empêchés dans le maintien de relations de soins fragmentées qui sont au cœur de leur métier (Rothier Bautzer, 2016) et plus exposés, aussi, aux difficultés des patients au quotidien. En comparaison, l'espace-temps de la consultation en psychologie ou en psychiatrie se prête plus facilement à la distanciation physique et au distanciel.

La souffrance de mesures s'opposant à des valeurs professionnelles

Au-delà de ces variations contextuelles majeures, les mesures sanitaires ont peu ou prou entravé pour tous la poursuite des soins en psychiatrie. Les professionnels ont notamment fait l'expérience d'interruption de prises en charge et de possibilités de communication amoindries par la distanciation physique et les masques (Robin-Poupard 2020). De ce fait, ils ont été heurtés dans leurs conceptions du soin qui ont en commun de donner une place centrale à la rencontre et à la communication. Par ailleurs, faute de pouvoir poursuivre leur rôle habituel, certains ont été contrariés dans leurs perceptions du sens de leur travail. Cette situation où ils étaient dans l'impossibilité de pratiquer leur métier selon ses règles et attendus a engendré une « souffrance identitaire de métier » (Viviers 2016).

Les restrictions de visites et de sorties ont largement contredit les efforts des professionnels pour stimuler des parcours de rétablissement. En effet, le paradigme du rétablissement suppose d'envisager les usagers de la psychiatrie comme moteurs de leur propre vie, citoyens à part entière, les services devant être configurés de manière à soutenir leur autonomie plutôt que de perpétuer leur rôle traditionnel de patient (Jouet and Greacen 2012). Les situations d'isolement et de confinement représentent en ce sens un retour en arrière déconstruisant les démarches

d'inclusion sociale et de renforcement des capacités d'agir, d'*empowerment*. Les restrictions de sortie des services ont même activé l'imaginaire d'une histoire de l'enfermement sur le mode de l'asile (Foucault 1976), alors que les professionnels tendent à favoriser l'ouverture des services, la désinstitutionnalisation et la déhospitalisation (Klein, Guillemain et al. 2018).

Place du corps dans les relations de soins et distanciel

L'expérience des mesures de distanciation a mené les professionnels à reconsidérer l'importance accordée au corps dans les relations de soins. Cette « place » donnée au corps se décline selon les professions. Les cultures de métier participent ainsi à construire différentes formes de « corporéisation » des affects, d'*embodiment* (Csordas and Harwood 1994). Si tous considèrent que rien ne peut remplacer une rencontre en présentiel – considérée comme « vraie » rencontre – les paramédicaux, travailleurs sociaux et pairs aidants professionnels se sont montrés plus inquiets du développement des outils numériques dans les soins en psychiatrie, craignant une « déshumanisation » des soins. La manière dont ces différents professionnels appréhendent le distanciel fait ainsi échos à une répartition des tâches de travail impliquant plus ou moins de proximité corporelle avec les patients (Peneff 1992).

Cependant, ce contexte inédit a incité chacun à revisiter « le soin psychique relationnel », dans un monde médical qui demeurait souvent hostile au numérique, afin de prévenir les rechutes des patients (Bocher, Jansen et al. 2020). Le recours au numérique et notamment à la visioconférence a été accueilli de manière paradoxale, en tant que forme d'échange possible lorsque la rencontre physique était proscrite, mais aussi forme de communication appauvrie. Psychologues et

psychiatres se sont plus facilement laissé convaincre par les possibilités offertes par la visioconférence. Expérimentant les limites de la téléconsultation, essayant quelques déconvenues, ils ont appréhendé la nécessité de reconstruire la bonne distance relationnelle en instaurant un nouveau cadre de soins (Ingram and Best 2020). L'expérience de la visioconférence a permis à de nombreux professionnels de dépasser certaines de leurs réticences initiales (Cowan, Johnson *et al.* 2020). En revanche, contrairement à ce qui est mentionné dans certains travaux, ils n'ont pas considéré que l'espace virtuel de la téléconsultation pouvait construire de nouvelles formes d'intimité dans la relation thérapeutique (Kocsis and Yellowlees 2018). La crise de la COVID-19 a néanmoins ouvert la voie au développement de prises en charge hybrides intégrant les atouts des téléconsultations en complément des rencontres en présentiel (Mishkind, Shore *et al.* 2020).

Conclusion

L'épidémie de la COVID-19 a obligé les services de psychiatrie et de santé mentale à se réorganiser et les professionnels de santé à s'adapter à de nouveaux contextes d'exercices entravant la poursuite de leur travail thérapeutique. Confrontés au double défi de gérer l'épidémie et d'assurer la continuité des soins et l'accompagnement des patients, les professionnels de santé ont adopté des postures de renoncement, de résistance et d'adaptation. Les mesures de distanciation les ont amenés à vivre des situations relationnelles et organisationnelles à travers lesquelles ils ont reconsidéré l'importance de la coprésence corporelle dans le soin, mais aussi de l'ouverture des services sur le monde extérieur. Cette expérience les a interrogés sur leurs rôles et missions en tant que soignants et aidants, touchant aux limites de leurs valeurs et de leur éthique. En conséquence d'une expérience partagée des

contraintes de la pandémie, ils ont appréhendé avec une sensibilité particulière ce que vivaient leurs patients. Confrontés à des situations leur évoquant l'enferment asilaire, ils ont mis en œuvre des stratégies d'innovation et de résistance pour préserver la dignité et la santé mentale de leurs patients.

Documenter l'expérience de ces professionnels face à la crise sanitaire de la COVID-19 et les souffrances qu'elle a engendrées nous permet de formuler des préconisations en faveur de la santé au travail de ces professionnels. Il importe de promouvoir le bien-être au travail et de prévenir l'épuisement professionnel et la détresse psychique de ces professionnels. La dimension relationnelle étant centrale dans les soins des personnes concernées par les troubles psychiques, il est primordial de préserver la disponibilité psychique de ces professionnels, qui peut se trouver altérée lorsque leur propre santé mentale est affectée dans le contexte de crise. Il serait opportun de développer, en complément des dispositifs de soutien psychologique qui leur sont d'ores et déjà accessibles, des dispositifs leur permettant de décompresser et de se ressourcer. Cela pourrait passer par l'implantation d'espaces aménagés et équipés ayant vocation à ce que chaque professionnel qui en ressent le besoin puisse prendre du temps pour soi. Du fait de l'importance des sociabilités entre collègues, soulignée par notre étude, nous pouvons également imaginer la mise en place d'espaces dédiés au partage de temps de convivialité, favorisant le partage d'expérience et l'entraide entre collègues. Il importe que les professionnels concernés soient associés à la conception et à la mise en place de ces dispositifs. Par ailleurs, il semble également pertinent d'accompagner les professionnels de la psychiatrie dans leur processus d'appropriation des outils numériques à des fins professionnelles. Des programmes de sensibilisation aux usages éthiques

des dispositifs numériques utilisables dans la pratique professionnelle en psychiatrie et santé mentale pourraient être mis en place, favorisant la réflexivité sur les pratiques et la recherche de solutions locales optimales. Il semble aussi approprié d'ajouter aux contenus de formations initiales un module à propos des usages éthiques des dispositifs numériques dans le cadre des soins et des suivis en distanciel en psychiatrie.

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3.2. Santé et qualité de vie des personnes âgées à l'épreuve de la pandémie COVID-19. Etat de la question au Maroc

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Introduction

Depuis l'apparition et la propagation de la pandémie de coronavirus en 2020, les personnes âgées, en tant que population caractérisée de vulnérable, se sont retrouvées sur le devant de la scène des risques et des victimes. Ainsi, bien que la vie sociale se soit retrouvée suspendue et sujette à une organisation drastique, préconisant la protection et la prévention, cette population a été reconsidérée eu égard aux conditions (sociales, sanitaires...) ayant trait à l'aménagement de son existence. Les constats rapportés par différents intervenants font état de ce que des effets de la COVID-19 ont marqué la vie de cette population, bien qu'une priorité de l'acte vaccinal leur ait été consacrée. Ainsi, demeurent des problématiques de santé liées à la vieillesse, l'isolement, la précarité et un bien-être avec impacts chargés psychologiquement et socialement. La variété des situations sociales (en famille, en maison de retraite, centre d'accueil...) a mis en évidence des réalités de vie disparates qui ont suscité des réactions en termes de résilience et des actions de soutien et de prise en charge. Ces réalités de vie des personnes âgées ont généré diverses réactions dans le contexte de la pandémie avec des enjeux engagés pour y faire face dans le cadre de l'état d'urgence sanitaire.

Lors du confinement et de l'après-confinement, ayant connus des variants de la COVID-19, même si distincts quant à leur virulence, l'alerte est donnée pour prévenir la menace et les personnes âgées représentaient une cible de premier ordre. Ainsi, la société s'est retrouvée face aux risques de ses « vieux », car figurant parmi les premières victimes et étant les plus exposés avec des pathologies chroniques (Conseil économique, social et environnemental [CESE], 2020).

La présente étude, se veut une approche de ces réalités compte tenu de l'impact potentiel de cette crise sanitaire sur la vie quotidienne des personnes âgées.

Personnes âgées et modes de protection

S'il y a une observation à soulever dans la vie sociale marocaine à l'époque actuelle et qui n'est pas retenue qu'à titre occasionnel dans la configuration de la société, elle concerne la question de la vieillesse et du vieillissement, voire, plus particulièrement la catégorie des personnes âgées, dits « vieux », voire les "Chibani" selon une appellation en langage commun local⁴⁵. Certes, c'est une question de préoccupation au regard des conditions de leur vie en société, du rôle que leur réserve celle-

45 Le terme "Chibani" a été intégré dans la langue française pour désigner les "vieux migrants" ou "immigrés âgés"/ retraités.

ci et les lieux dans lesquels elles sont appelées à vivre (Ferry et Le Gouès, 2008). Les personnes âgées (60 ans et plus)⁴⁶ représentent actuellement 12% (4,3 M) de la population totale (estimée à 37 M), une proportion qui connaît une croissance considérable (Haut-Commissariat au Plan [HCP], 2021). A noter que dans l'ensemble de la population des personnes âgées, seulement environ 1/5 est bénéficiaire d'un système de retraite, alors que les 4/5 ne jouissent d'aucune pension et ne font partie d'aucun régime de retraite.

Différents rapports (CESE, 2016 ; Observatoire National du Développement Humain [ONDH], 2018 ; Observatoire National des Personnes Âgées [ONPA], 2019) ont été élaborés ces dernières années pour rendre compte de la situation des personnes âgées telle qu'elle prévaut dans la société. Bien des actions leurs sont consacrées dans le cadre des expériences d'accompagnement, en association avec différents regards (institutionnels, associatifs, scientifiques) dans un esprit d'échange et de sensibilisation et dans une perspective d'amorce vers des questionnements scientifiques prometteurs. Ces rapports susmentionnés soulignent qu'une grande partie de cette population vivant dans des conditions précaires et difficiles (logement, revenu précaire, santé fragile) est exposée à de nombreux problèmes d'ordre psychologique et social (exclusion, maltraitance, violence, anxiété, manifestations dépressives) (Belhaj, 2021). Il s'agit donc d'une population dont le vécu psychosocial se caractérise par la fragilité et la vulnérabilité. Les mesures de protection sociale qui leur sont réservées, au niveau individuel ou institutionnel, paraissent ne pas répondre adéquatement à des besoins et des attentes qui leurs sont utiles, soit en termes d'accompagnement,

de soins et de prise en charge (Belhaj, 2018-b). Des insuffisances qui sont encore visibles et continuent de traverser la vie des personnes âgées, notamment eu égard à la santé qui est marquée par la fragilité et dans certains cas par de lourdes pathologies. Quant à l'intégration dans la société, elle reste très variable chez cette population, avec des questionnements sur la place qui leur revient et qui déstabilise leur adaptabilité sociale.

Au Maroc, bien que les structures d'accueil de type « Ehpad »⁴⁷ n'existent pas en tant qu'institutions spécialisées, des centres sociaux associatifs assurent la mission de prise en charge des personnes âgées en situation de perte d'autonomie et de précarité. D'ailleurs, l'appellation de certains de ces centres comporte ce sens désignant la dépendance et la perte d'autonomie « Dar El âajaza »⁴⁸ (Maison des vieux avec incapacité), bien que les résidents ne le soient pas dans leur ensemble. Bien que leur statut de résidents ne reflète pas leur rôle en tant que bénéficiaires, ils sont plutôt considérés comme des pensionnaires.

Ces centres dits " Établissements de Protection sociale (EPS)" constituent un réseau composé de 62 établissements accueillant environ 5029 bénéficiaires parmi les personnes âgées dont 2419 H et 2610 F (ONPA, 2019). Dans l'ensemble, 54 de ces établissements assurent des fonctions permanentes en tant que structures de vie (hébergement, prise en charge sociale et médicale, actions socio-éducatives), Alors que 8 établissements assurent un

accueil de jour (avec différents services). Ces établissements relèvent de l'action et de la gestion d'associations de la société civile avec un accompagnement de l'organisme public " Entraide Nationale" et du Ministère de tutelle⁴⁹.

Ainsi, dans le contexte pandémique, ces établissements s'étaient engagés activement afin de veiller à la préservation de la vie des pensionnaires. La mobilisation et les restrictions réglementaires ont constitué une rude épreuve pour les intervenants et le personnel de ces établissements dans l'exercice de leurs missions.

Un cadre de vie ébranlé dans un contexte d'incertitudes

Selon l'Organisation Mondiale de la Santé ([OMS]1996), la qualité de vie est une combinaison des facteurs psychologique, physique, social et matériel pour évaluer le bien-être de l'individu. Dans cette optique, la qualité de vie des personnes âgées se pose actuellement plus que de tout temps, comme exigence qui s'impose à tous (état, société civile, familles...) et tend à se projeter au centre de préoccupations multiples aussi bien sociétales que scientifiques (Belhaj, 2018-a). Ainsi, depuis l'avènement de la pandémie COVID-19, c'est bien la qualité de vie propre à cette catégorie qui est interrogée, que ce soit dans le cadre social et familial ou dans les centres d'accueil. Une telle interrogation est soulevée compte tenu de l'aspiration de se joindre aux efforts cherchant à combler le fossé entre les apports en termes de connaissances scientifiques et les modes d'intervention auprès des personnes âgées.

Cependant, le contexte pandémique a contribué à un rafraîchissement des préoccupations à l'égard des personnes âgées, notamment par

46 C'est l'âge retenu actuellement au Maroc en accord avec les patterns internationaux (ONU, OMS.)

47 Etablissement d'hébergement pour personnes âgées dépendantes, structures qui existent en Europe. Toutefois, dans ce paysage il y a le cas de la « Maison de Retraite » de Rabat (la capitale) qui est une structure destinée à la communauté française au Maroc et qui est identifiée au modèle de l'Ehpad.

48 Au sens pluriel en arabe, le singulier « âajouz » avec pour source le mot « âaj'z » qui renvoie à l'idée de l'incapacité.

49 Le Ministère de la Solidarité, de la Famille et du Développement Social : le département gouvernementale qui prend en charge les questions des personnes âgées.

rapport aux risques auxquels elles sont exposées et l'approche vaccinale qui leur est destinée.

En outre, les constats relevés dans le contexte de cette pandémie de la COVID-19, nous apprennent que les effets psychologiques et sociaux de l'état d'urgence sanitaire et du confinement sur la population entière, notamment les personnes âgées sont considérables à plus d'un titre (HCP, 2021). Ces conséquences se traduisent par la menace éminente qu'encourt cette population compte tenu de la fragilité, la vulnérabilité et les maladies qui caractérisent la santé d'une proportion importante. Le vécu de bon nombre est marqué par un fort sentiment d'isolement et de détresse psychologique, et par conséquent ce malaise ou souffrance tendent à mettre en péril non seulement la santé et la qualité de vie de ces personnes, mais aussi toute la vie collective. En outre, il y a lieu de souligner que cette pandémie et les nouveaux modes de vie qui y sont associés constituent un véritable défi auxquels les personnes âgées tentent de s'adapter au quotidien. À cet égard, les observations révèlent que ces personnes ne restent pas passives face à cette pandémie en tant qu'événement incertain, déstabilisant et perturbateur au niveau psychosocial, mais ils mobilisent des ressources personnelles et des stratégies d'ajustement en vue d'y faire face et rester en contrôle. Ainsi, c'est tout un capital psychologique (e.g., sentiment d'auto-efficacité, optimisme) dont il y a lieu de tenir compte dans la mesure où il exerce un rôle prépondérant dans la confrontation et l'adaptation aux dangers et menaces, notamment en termes de résilience, de gestion du stress et des émotions négatives (Belhaj & Azouaghe, 2020). Cela étant, la population des personnes âgées a manifesté et continue de manifester à des degrés variables, des comportements animés par un sens du risque et ne tient pas compte des mesures sécuritaires prescrites. À cet égard, la tendance à une prise



de risque de front avec le danger était perceptible dans les usages quotidiens de cette population. Les modes d'adhésion par rapport aux comportements et aux mesures de prévention pour contrer les effets de la pandémie sont restés avec la marque d'une transgression et d'un manque d'ajustement adéquat aux nouvelles normes.

Les personnes âgées face aux épreuves de la pandémie

Dans ce contexte pandémique, la situation des personnes âgées s'est posée comme une préoccupation requérant une certaine attention, tant au niveau des politiques qu'au niveau de la santé publique (Rapport Chef du Gouvernement [RCG], 2021, 47). Ainsi, bien que la société accueille cette population âgée avec de nouvelles problématiques de santé (Alzheimer...) et sociales (précarité, isolement...), les mesures pouvant leur être ajustées ont été envisagées dans un premier temps selon une option de priorisation. Les actions de prévention, de dépistage et de vaccination témoignent de cette option.

A noter que, depuis l'annonce des premiers cas confirmés d'infection par le virus responsable de la COVID-19 en date du 02 mars 2020, l'alerte est prise au sérieux avec le 2ème cas qui est celui d'une femme âgée (89 ans) présentant un état critique. C'est ainsi que, la situation pandémique a connu une progression inquiétante qui a interpellé aussi bien les politiques que les scientifiques, afin de joindre les efforts pour une réaction adaptée (Ministère de la Santé, 2021). Ainsi, cette recrudescence des contaminations, de cas critiques et de décès a imposé plusieurs aménagements et mesures préventives et coercitives (e.g., état d'urgence sanitaire, confinement, restriction de déplacement, port de masque, distanciation sociale)⁵⁰ :

⁵⁰ Décrets-lois n° 2-20-292 (23 mars 2020) et n°2-20-293 (24 mars 2020).

Aperçu sur la chronologie 2020 relative à la situation de crise sanitaire de la COVID-19⁵⁴

13- 21/03	Déclaration de l'état d'urgence sanitaire ; fermeture des écoles des cafés, restaurants et hammams, ainsi que des mosquées. Restrictions des rassemblements publics. Suspension des liaisons aériennes et maritimes. Application de l'enseignement à distance et mise en place du télétravail...
07/ 04	Obligation du port du masque et respect des gestes barrières
23/ 04	Instauration du couvre-feu nocturne durant le mois de Ramadan
10/ 06	Mesures d'allègement du confinement et des autorisations de déplacements
14- 15/ 07	Réouverture sous restrictions des mosquées. Réouverture partielle des frontières.
27/07	Restriction des déplacements à l'intérieur du pays
16/10	Ouverture des mosquées
09/11	Lancement d'une opération massive de vaccination

Source: Abdelkarim Belhaj.

Ce tableau récapitulatif de quelques mesures mises en place qui donnent des indications sur le contexte de la gestion de la pandémie. Bien évidemment, que ce sont des mesures conjuguées à l'effort consenti au niveau international, notamment par l'ONU et par le biais de l'OMS, du fait que la crise sanitaire générée par la COVID-19 est mondiale (OMS, 2020).⁵¹

Il conviendrait de noter qu'outre les mesures prises dans ce contexte, les autorités publiques ont déployé un effort médiatique inédit avec une communication tous azimuts. S'agissant de la gestion du risque sanitaire, la démarche a vu la mise en œuvre de quelques actions (Centre de Genève pour la gouvernance du secteur de la sécurité [DCAF], 2020), dans lesquelles une attention particulière à l'égard des personnes âgées a été observée, à savoir :

- Une application dénommée "wiqaytna (notre protection)"⁵² pour le traçage des contacts des malades ;
- Des missions de veille sanitaire et d'alerte précoce, avec une

démarche opérant des examens biologiques (tests PCR...) ;

- Des plateformes à distance (cellules d'écoutes) sont initiées pour fournir un soutien et un accompagnement psychologique lors du confinement. Une priorité a été accordée au personnel de santé, aux cas confirmés et les personnes isolées.

Il s'ensuit que cette pandémie a permis de dévoiler dans le tableau épidémiologique une prévalence des maladies chroniques de près de 65% de personnes âgées, sans compter les conséquences dues au coronavirus et les "effets secondaires des vaccins"⁵³. Dans une étude, à l'occasion, Dr Maamar et ses collaborateurs (2020) rapportent qu'au début de la propagation de la pandémie l'infection par la COVID-19 se caractérise par un taux de mortalité élevé chez la personne âgée, puisqu'il est de 3 % à 5 % entre 65 et 74 ans, de 4 % à 11 % entre 75 et 84 ans, et de 10 % à 27 % au-delà de 85 ans. Quant à l'hospitalisation, 45 % sont âgés de plus de 65 ans et 53 % des patients admis en unités de soins intensifs sont âgés de plus de 65 ans avec un taux de létalité en réanimation de 80 %. A cet effet, ils soulignent que cette infection est à haut risque de morbi-mortalité chez les personnes âgées,

mais les mesures de confinement qui étaient appliquées pour limiter la propagation du virus pouvaient, elles aussi, entraîner des complications potentiellement graves chez les sujets âgés. Trois complications ont été signalées : la sarcopénie, la dépression et le retard de prise en soins des pathologies chroniques, telles que les maladies cardiovasculaires ou néoplasiques. A ce tableau indicatif, il y a lieu de rappeler qu'il s'agit d'une population, dont une grande partie, se caractérise par diverses fragilités (pauvreté, immunité réduite, présence de maladies chroniques, perte d'autonomie, isolement...), par conséquent elle est considérée parmi les populations les plus à risque à la COVID-19 (OMS, 2020). Dans cette veine et comme le signale le HCP (2020-1), à la suite d'une enquête sur l'impact du coronavirus sur la situation économique, sociale et psychologique des ménages, que les personnes âgées sont très vulnérables sur le plan de la santé (physique et mentale) représentant un groupe à risque et sont les plus susceptibles à ses effets. Par ailleurs, et s'agissant de la santé psychologique, le HCP rapporte dans une note (HCP, 2020-2) que le confinement a entraîné des conséquences non négligeables pour les personnes âgées à savoir l'anxiété (43,4%), la peur (37,6%), les comportements obsessionnels (23,8%), et le trouble du sommeil (20,1%). Une telle situation relative à la santé psychologique a été actée

51 Cf. Rapport DCAF (2020). Gestion de l'état d'urgence sanitaire au Maroc. Gouvernance sécuritaire et droits humains. <https://www.dcaf.ch/sites/default/files/imce/Rapport%20COvid%2019%20version%20FR.pdf>

52 Application digitale mise en œuvre le 01/06/20 et téléchargeable sur un Site dédié à cet effet : www.wiqaytna.ma.

53 En l'état actuel de la situation pandémique, les données ne sont pas encore disponibles pour une évaluation.

par des visites de professionnels aux établissements pour les personnes âgées et au niveau des plateformes initiées par des spécialistes (Psychologues et Psychiatres) (DCAF, 2020, 92).

Des actions d'accompagnement, permanence et conjoncture

Dans ce contexte de lutte contre la propagation de la pandémie, différentes actions ont été engagées en faveur des personnes âgées, non en distinction de l'ensemble de la population, mais comme catégorie prioritaire, compte tenu de la vulnérabilité sanitaire et sociale qui les caractérise. Il va sans dire que parmi les indicateurs catégorisant les personnes âgées, la pauvreté l'isolement, et la vulnérabilité sur le plan de la santé, ont été très manifestes. De ce fait, c'est une population qui est apparue fragilisée dans ce contexte pandémique, car considérée « à risque », étant susceptible de développer une forme grave d'infection à la COVID-19. Dès lors, les différentes mesures sanitaires instaurées, dont le confinement, ont eu un impact sur l'accès aux services de santé pour les personnes âgées souffrant de maladies chroniques ou autres maux et nécessitant des examens ou des soins. Cependant, un tel accès pour les pensionnaires dans les centres d'accueil, a continué à fonctionner, non sans difficultés à la suite des aménagements dictés en la circonstance (mesures : gestes barrières, distanciation sociale...). A remarquer que ces « lieux de vie » ont subi une transformation les transformant de fait en « lieux de soins », vu qu'un confinement aux mesures drastiques a été imposé aux pensionnaires. En outre, des cellules d'écoute psychologique ont été mises en place afin de répondre aux appels de la population, des personnes âgées et de leurs familles sollicitant un soutien psychologique pour faire face aux épreuves générées par la COVID-19. En outre, il y a eu l'opération « Salama » lancée par le Fond des Nations Unies pour la Population (FNUAP, 2020) en étroite collaboration avec les départements

ministériels (Santé, Solidarité et Famille, etc.) des partenaires institutionnels et de la société civile, pour agir auprès des populations les plus vulnérables. Cette opération a accompli des interventions sur divers fronts : diffusion d'informations fiables sur la prévention de la maladie, protection des professionnels de santé, minimisation des effets économiques de la pandémie sur les plus vulnérables dont les personnes âgées. Dans ce cadre, des « Salama Kits »⁵⁴ contenant des articles d'hygiène et des informations de prévention ont été mises à disposition de ces populations. Cette action participait à l'amélioration de l'autonomie des populations les plus vulnérables et contribuer à leur bien-être. Par ailleurs, diverses actions d'information et de sensibilisation ont été conduites à travers différents médias de communication à l'adresse de la population (spots télévisés, capsules pour radio et réseaux sociaux) et dans les langues en usage (Arabe, Berbères et français). L'objectif défini à ces actions consistait en la conscientisation sur les risques, menaces et dangers que présentait le Coronavirus tout en visant particulièrement les personnes âgées.

Toutefois, force est de constater que les effets de cette crise sanitaire sur le vécu (santé, qualité de vie, relations sociales) et les comportements des personnes âgées n'a pas encore fait l'objet d'étude ou systématique au Maroc en vue d'évaluer non seulement les conséquences psychosociales de cette crise, mais aussi et surtout l'identification des facteurs de risque et de protection contre la COVID-19 chez cette catégorie sociale.

A remarquer que les différents aspects de la problématique sanitaire et sociétale suscitée par cette pandémie, depuis son apparition et sa propagation, a été traitée par la mise en œuvre méthodique d'une gestion

de crise actée par les mesures d'état d'urgence sanitaire avec une prise en charge préventive et un traitement vaccinal, dont l'objectif est d'asseoir une immunité collective. Dans cette optique, les personnes âgées ont été une catégorie retenue comme objet de grandes inquiétudes face aux effets de la pandémie, compte tenu de la vulnérabilité et la précarité qui caractérisent leur situation sociale. Le taux de personnes vaccinées au mois 09/21 a atteint 75% de la population des établissements de la protection sociale⁵⁵. Mais, il y a lieu de remarquer que la logique de la gestion des risques dans une optique préventive et spécifique aux personnes âgées s'est avérée insuffisante dans les stratégies d'action et de réaction, non seulement en guise de sécurisation et d'anticipation, mais également dans les dispositions de riposte. Il en est de même dans les usages sociaux, au niveau individuel et collectif, où l'on constate une timide culture de conscientisation du risque, au vu d'une prévalence de comportements de type hasardeux, ainsi que des modes de pensée irrationnels, si ce n'est une tendance fataliste, face à la pandémie. D'ailleurs, nombreuses scènes et infractions ont été enregistrées eu égard aux mesures de précaution et de prévention préconisées en la circonstance. Un tel état de fait traduit une propension au déni, des résistances aux changements ainsi qu'une tendance à sous-estimer les risques, et par conséquent l'indifférence vis-à-vis de ces mesures.

Pour ce qui est de la perception et de l'agir chez la population, beaucoup plus chez les personnes âgées que chez les adultes et les jeunes, la vision manifestée avait trait à une causalité externe aux modalités non contrôlables (Châtiment divin, Volonté d'Allah, Destin, Fatalisme). C'est une logique sociale de la causalité qui n'est pas tributaire à

⁵⁴ Cf. note UNFPA : <https://www.unfpa.org/fr/news/lop%C3%A9ration-salama-aide-des-millions-de-marocain%C2%B7e%C2%B7s-informations-sur-la-pand%C3%A9mie-fournitures>

⁵⁵ Note du Ministère de la Solidarité du Développement Social, de l'Egalité et de la Famille à l'occasion de la Journée internationale des Personnes Agées 01/10/21.

la situation pandémique, mais qui traduit une pensée sociale fréquente du sens commun (Belhaj, 2010). Il s'agit, donc, d'un état d'esprit cherchant à expliquer l'origine du virus, autre que celui officiellement affiché et rationnellement attesté (OMS) ou ayant circulé en termes de complotisme (Miller, 2020). Une telle vision s'est accompagnée de comportements à risques tout en manifestant des attitudes d'insouciance quant aux effets immédiats et différés de la pandémie au niveau individuel et social. Les drames et dommages de la pandémie sont vécus avec angoisse et ajustements en temps réel et restent davantage ressentis avec des effets variables sur la vie de cette population de personnes âgées (Belhaj, 2020). Dans les milieux défavorisés, cette population s'était retrouvée exposée en tant que victimes réelles et potentiels, étant nombreuses sont les complications associées à leur condition physique, psychologique et sociale. Ainsi, la conjoncture actuelle rend compte du fait que les personnes âgées constituent une population dont le parcours de vie est indéniablement marqué par des diverses expériences allant de la résilience (Ploton & Cyrulnik, 2014) à la déprise (Meidani & Cavali, 2019) suscitant des réaménagements psychologiques et sociaux, que les institutions tentent d'assurer par des options d'accompagnement et de prise en charge spécialisées (Personne & Vercauteren, 2009).

Quant à la population résidant dans les centres d'accueil, des adaptations selon des modes de protection et prévention ont été assurées compte tenu des mesures instaurées par l'état d'urgence sanitaire. En somme, cette pandémie est apparue comme un révélateur des solidarités et des capacités de mobilisation et de réactivité dont les différents acteurs (professionnels du soin, paramédicaux, bénévoles...) ont su faire preuve à l'égard des pensionnaires. Pour ce qui est de l'intervention de l'état, elle a été méthodique avec une assurance notable dans la gestion de la

crise pandémique et des actions entreprises pour la contrer. La population des personnes âgées a été placée aux premiers rangs, bénéficiant d'une exclusivité lors des opérations de dépistage et de vaccination.

Avec le contexte généré par la pandémie Covid 19, une révision s'impose dans différents secteurs en relation avec les personnes âgées (Santé, formation, accompagnement professionnel, travail social, protection sociale...), car la vie d'une génération est à l'épreuve de son existence. Les problèmes posés actuellement aux personnes âgées le seront continuellement pour la génération qui la représente, tant qu'une visibilité n'est pas développée scientifiquement afin de permettre une connaissance adéquate et servir une existence sociale intégrée et stable.

A cet effet, un ensemble de recommandations est à signaler en vue de l'amélioration de la condition des personnes âgées, dont certaines sont évoquées par différents rapports

Accorder la place qui se doit aux personnes âgées au cœur du « nouveau modèle du développement »⁵⁶, notamment en matière de protection sociale (Commission Spéciale sur le Modèle de Développement [CSMD] 2021);

- Mise en œuvre d'une politique publique en faveur des personnes âgées ;
- Inciter à la recherche scientifique autour des questions de la vieillesse et de la condition des personnes âgées ;
- Renforcer les capacités des centres d'accueil des personnes âgées dépendantes et vulnérables ;
- Encourager la formation de spécialistes (gériatrie, gérontologie) et

⁵⁶ Un projet de société élaboré par une commission spéciale mise en place par le Roi. C'est un projet qui a suscité l'adhésion des différentes composantes de la société et qui a été au cœur du programme gouvernemental actuel.

de professionnels d'accompagnement ;

- Asseoir une culture du vivre ensemble dans la sphère communautaire et l'espace public;
- Inscrire des actions sur la base des perspectives présentées par l'OMS en vue d'une « Décennie pour le vieillissement en bonne santé (2020-2030) » (OMS, 2020).

Certes, ces recommandations et bien d'autres, invitent à des réponses adéquates, en considération aux efforts déployés par les personnes âgées en tant que génération actuelle, qui a largement contribué à la construction du Maroc contemporain.

Conclusion

Bien que les personnes âgées suscitent une certaine attention, il n'en demeure pas moins qu'elles méritent davantage de considération, compte tenu de leurs statuts et rôles sociaux dans la société. Un intérêt en termes de conception et d'application a été adoptée à leur égard et à leur condition de santé qui est marquée par la fragilité, notamment leur vulnérabilité face à la maladie, à la dépendance, au handicap et à la précarité des conditions de vie (logement, moyens de subsistances, couvertures sociales).

Ainsi, les questions relatives à la santé et la qualité de vie des personnes âgées au Maroc se posent avec force, et ce, indifféremment de la situation sanitaire générale. Toutefois, avec le contexte pandémique ce sont des questions qui ont apparues pressantes, car elles interpellent le fondement des politiques et des systèmes en vigueur dans la société. Ainsi, bien qu'elles soient des questions nouvelles, les réalités qu'elles convoquent demeurent d'actualité et de tous temps. Dès lors, les groupes les plus sensibles parmi la population des personnes âgées, sont les pensionnaires des établissements de protection sociale.

La crise pandémique actuelle représente une épreuve pour repenser la place des personnes âgées dans

la société. Plusieurs enseignements sont à retenir pour agir et rejoindre le rendez-vous du plan d'action de la Stratégie mondiale de l'OMS (2020_2) sur le vieillissement et la santé « Décennie de vieillissement en bonne santé 2020- 2030 ».

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3.3. *Satisfaction with life and well-being during the COVID-19 pandemic in Brazil: 2020 and 2021*

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Abstract

Brazil was one of the countries most impacted by the pandemic in terms of number of COVID-related deaths and major political and economic consequences. This study aims to assess satisfaction with life, subjective well-being and coping strategies during the COVID-19 pandemic in Brazil. An online study was conducted in Brazil with the participation of 1,224 Brazilian adults between the ages of 18 and 50 years: 379 in 2020 and 845 in 2021. The participants answered socio-demographic questions and questions about the spread of COVID-19 in their social network including about coping strategies and completed the Brazilian versions of the Satisfaction with Life Scale (SWLS) and the Multidimensional Subjective Well-Being Scale (MSWS). The study found that spread of COVID-19 among the respondents' social network increased significantly from 2020 to 2021. The greater the number of people in the respondents' network who contracted the virus, the lower the evaluated satisfaction with life. Being unemployed was also predictive of lower satisfaction with life. Conversely, higher family income, being married (or living together) and having a greater educational level were predictive of higher levels of satisfaction with life. Regarding coping strategies, physical activity, dancing and talking to friends and family members were positively related to satisfaction with life, while drinking

alcohol was negatively related to satisfaction with life. This exploratory study contributes to understanding how the pandemic has affected the well-being, satisfaction with life and coping strategies of Brazilians during the outbreak and peak of the COVID-19 pandemic, as well as to knowledge about behavioural coping strategies used by people hoping to increase their well-being.

Introduction

In March 2020, the World Health Organization declared the COVID-19 outbreak a global pandemic, an unprecedented situation that led to the introduction of restrictions worldwide. As of September 2021, Brazil had 21 million confirmed cases and over 590,000 deaths – one of the highest COVID-related deaths tolls in the world. For every ten deaths due to COVID, eight occurred in Brazil. The death rate among pregnant women was also the highest worldwide at 12.7 per cent, accounting for 77.5 per cent of all maternal deaths reported in the literature (Nakamura-Pereira et al., 2020). The pandemic also triggered popular dissatisfaction against the government, which denied the severity of the pandemic and discouraged public safety measures such as wearing masks and practising social and physical distancing.

While the threat of virus transmission led to fear of illness and death, confinement and other constraints

linked to social distancing and economic, social and psychological stress also triggered distress (Anglim and Horwood, 2020). The economic consequences of the pandemic had an even greater impact on the population resulting in widespread discontent. It is projected that job losses globally due to COVID-19 will be between 5.3 million and 24.7 million (Kawohl and Nordt, 2020). In Brazil, the economic crisis has seen an increase in the number of families living in extreme poverty (defined as a monthly income of up to R\$89.00 per person), reaching about 20 per cent of all Brazilian families. Data from the Ministry of Economy show that in May 2020 requests unemployment claims rose by 53 per cent compared to May 2019 (Neves, et al., 2021). The pandemic also presented particular challenges for those already at risk (e.g. depression), with the scenario of growing unemployment corresponding to an increase in suicides estimated at 9 570 deaths (Kawohl and Nordt, 2020; Klomek, 2020).

Humans, like other primates, are social beings to whom personal relationships are essential to well-being. In the 1950s, studies conducted with rhesus monkey infants showed the disastrous impact of social isolation on development (Harlow and Zimmerman, 1959; Suomi, 1997). These studies formed the basis for understanding the importance of bonds for socio-emotional development. While such studies were not performed with humans for obvious ethical reasons, the unprecedented threat of the COVID-19 virus, and subsequent confinement measures, resulted in widespread social isolation, the impacts of which on well-being and happiness are today being assessed.

The psychological and emotional repercussions of a pandemic can be enormous, with common, frequent responses including fear and anger. Fear is an important defence mechanism for living beings and

involves a series of physical and behavioural responses to a potentially threatening event. However, a continuous state of alertness can become harmful and even trigger various psychiatric disorders. During a pandemic, fear increases anxiety and stress levels in healthy people and intensifies the symptoms of those who already have psychiatric disorders (Ornell, et al., 2020).

Prior to the pandemic, research on social isolation and loneliness already pointed to detrimental impacts on health, such as premature mortality, depression, cardiovascular disease and cognitive decline as well as an increase in diseases associated with unhealthy behaviours (e.g., smoking and physical inactivity) (Smith and Lim, 2020). Studies conducted during other epidemics and pandemics, such as SARS, Ebola, H1N1 and Equine Flu, demonstrated clearly that individuals' psychological impacts are not limited to the fear of contracting the virus (Barbisch et al., 2015); other consequences such as separation from loved ones, loss of freedom, uncertainty about the progression of the disease and feelings of helplessness are of equal importance (Saladino, Algeri and Auriemma, 2020). Taking into consideration the importance of social networks for health and well-being, the negative impacts of physical isolation on children, youth and adults during the pandemic give cause for concern.

The literature on subjective well-being investigates how and why people evaluate their lives positively, including cognitive evaluations and affective reactions. Various terms such as happiness, satisfaction with life and positive affect have been used to this end (Diener, 2009). Diener has grouped well-being and happiness definitions into three categories. The first of these is an external criterion or a desirable state judged from a particular culture of values. A second category refers to satisfaction with life, and relies on the respondent's criteria of what they consider a good

life. Satisfaction with life is a measure that refers to a cognitive, judgmental process of the global assessment of a person's quality of life according to his/her own criteria (Shin and Johnson, 1978). A third category refers to subjective well-being emphasizing the predominance of positive over negative emotions.

A study conducted by Zacher and Rudolph (2021) in Germany showed that, on average, satisfaction did not change significantly between December 2019 and March 2020, but decreased between March and May 2020. Research at the beginning of the first wave of the pandemic in the United Kingdom found increases in suicidal ideation and anxiety symptoms, while levels of depressive symptoms did not change significantly and positive affect increased. Women, young people (18–29 years), the socially disadvantaged and people with pre-existing mental health problems were the most affected in terms of mental health (O'Connor et al., 2021). Another study in Germany, this time by Möhring et al. (2021), investigated family satisfaction and job satisfaction during the isolation period and found an overall decrease in family satisfaction and a decline in job satisfaction. Negative effects were more pronounced among mothers compared to fathers, and the effects of lockdown measures and social distancing likely varied over time and as a function of environmental conditions, with increasing economic and psychological stress. A well-being survey conducted by Anglim and Horwood (2020) in Australia showed that positive and negative affect were impacted more by the pandemic than satisfaction with life, which as a broader assessment is less affected by negative events of a relatively fixed duration. In particular, people reported much lower levels of interest, enthusiasm and excitement. Many studies (e.g. Foa, Gilbert and Fabian, 2020) highlighted the harm of restriction policies implemented to



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contain the spread of the COVID-19 pandemic on mental health.

Brazil was one of the countries most impacted by the pandemic in terms of number of COVID-related deaths and major political and economic consequences. The goal of this research therefore was to understand the impact on subjective *well-being* and *satisfaction with life*, as related to the number of people in the respondent's social network known to have contracted the COVID-19 virus. The study investigated whether professional status, family income, age, gender, marital status and education – variables shown to be important to understanding the effects of the pandemic – are significantly associated with well-being and satisfaction with life. Accordingly, data on these two criteria were collected and evaluated over two months: June 2020 and April 2021. As of June 2020, Brazil had reached 29,937 deaths; by April 2021, that figure had risen to 325,284 deaths.

Aims

The study has two principle aims:

- to verify whether the number of acquaintances (social network) who experienced symptoms, were hospitalized or died from COVID 19, was predictive of satisfaction with life and subjective well-being, in addition to gender, age, professional status, family income, marital state and education, among Brazilian respondents to a self-reported survey conducted in 2020 and 2021; and
- to examine coping strategies that predict satisfaction with life during the peak of the pandemic in 2021, in addition to socio-demographic variables such as gender, age, professional status, family income, marital state and education.

Method

Study participants

A total of 1,224 Brazilian adults in the age range 18–50 years participated in the study: 379 (mean (M) = 33.86 years, standard deviation (SD) = 8.19) in 2020 and 845 (M = 35.73 years, SD = 8.30) in 2021. The participants came from the five macro-regions of Brazil (see Table 1 for details). The inclusion criteria were: Brazilian, over 18 years old and access/familiarity with a computer/tablet for internet use. The survey was conducted by a Research Institute using quota sampling defined by sex, age and social class. The study was approved (CAAE 80833817.6.0000.5561) by the National Council of Ethics in Research (CONEP) of Brazil.

Table 1. Sociodemographic characteristics of participants in 2020 and 2021

		2020		2021	
		N	%	N	%
Sex	Male	218	57.5	398	47.1
	Female	161	42.5	447	52.9
Professional status	1: employed	278	73.4	614	72.7
	2: not working*	44	11.6	105	12.4
	3: unemployed	57	15.0	126	14.9
Geographic regions	North	29	7.7	184	21.8
	Northeast	107	28.2	161	19.1
	Southeast	144	38.0	148	17.5
	South	63	16.6	168	19.9
	Central-West	36	9.5	184	21.8
Education level	Elementary school	2	0.6	12	1.4
	Middle school	137	36.0	207	24.5
	Some college, no degree	93	24.5	152	18.0
	College or above	147	39.0	474	56.0
House income month (1 BRL = 0.20 USD)	<2 000	115	35.8	157	21.2
	2 000–4 000	105	32.7	211	28.4
	4 000–8 000	71	22.1	186	25.1
	>8 000	30	9.3	188	25.3
Children living at home	None	14	8.2	30	6.9
	One	95	55.9	193	44.7
	Two	45	26.5	150	34.7
	Three or more	16	9.4	59	13.7
Marital status	Without partner**	187	49.3	378	44.7%
	Married or living together	192	50.7	467	55.3%
Age [years, mean ($\pm$ SD)]		34 (8)		36 (8)	
Network COVID-19		3.23 (2.5)		5.56 (3)	
Total		379		845	

source : Tania Kiehl Lucci, Emma Otta.

Note: * Students, retired, household work** Separated, widowed, single.

Instruments

Exposure of respondents to COVID-19: Participants were asked if someone in their social network (family members, friends, acquaintances) had experienced symptoms, been diagnosed, been hospitalized or died from COVID-19. They also provided information about themselves. Each of the items received one point if answered positively (see Table 2 below).

Satisfaction with Life Scale (SWLS): The study employed a five-item scale developed by Diener *et al.* (1985) designed to measure global cognitive judgments of one's satisfaction with life against a 7-point scale and validated in Brazil (Zanon, Bardagi *et al.*, 2013). The available responses were:

1. In most ways my life is close to my ideal.
2. The conditions of my life are excellent.
3. I am satisfied with my life.
4. So far, I have gotten the important things I want in life.
5. If I could live my life over, I would change almost nothing.

Table 2. Exposure of respondents to COVID-19 in 2020 and 2021

	2020		2021	
	N	%	N	%
I have been diagnosed	17	4.5	169	20
One or more family member(s) has/have been diagnosed	72	19	421	49.8
One or more close friend(s) was/were diagnosed	112	29.6	376	44.5
I have acquaintances who have been diagnosed	179	47.2	410	48.5
I do not know anyone who has been diagnosed	88	23.2	39	4.6
I have experienced symptoms	51	13.5	225	26.6
One or more family member(s) experienced symptoms	89	23.5	426	50.4
One or more close friend(s) experienced symptoms	118	31.1	396	46.9
I have acquaintance(s) who have had symptoms	162	42.7	430	50.9
I don't know anyone who has had symptoms	93	24.5	60	7.1
I have been hospitalized	1	0.3	24	2.8
One or more member(s) of my family has/have been hospitalized	38	10	224	26.5
One or more close friend(s) was/were hospitalized	63	16.6	269	31.8
I have acquaintance(s) who have been hospitalized	144	38	471	55.7
I do not know anyone who has been hospitalized	169	44.6	136	16.1
One or more member(s) of my family has/have died	15	4	132	15.6
One or more close friend(s) died	32	8.4	216	25.6
I have acquaintance(s) who died	130	34.3	513	60.7
I don't know anyone who died	215	56.7	163	19.3

source : Tania Kiehl Lucci, Emma Otta.

Multidimensional Subjective Well-Being Scale (MSWS): Respondents also answered 29 questions regarding their emotional states, both positive and negative (e.g. good mood, stress), their purpose in life (e.g. goals to achieve, self-confidence), satisfaction with the environment (e.g. residence, district) and appearance linked to self-esteem (e.g. looking in the mirror and feeling good). Each item had an 11-point response scale (0–10), anchored by verbal opposites as endpoints (see MSWS as supplementary material in Lucci *et al.*, 2022). Items that were negatively worded were reverse coded prior to data analysis, so that high values expressed the same type of response on every item. Analysis was conducted on aggregate scores.

Socio-demographic information: A self-reported sociodemographic questionnaire was used to gather information about gender, age, education, marital status, employment

status, household monthly income, children at home and region of residence.

Coping strategies: Respondents were asked to specify whether they were using physical activities, reading, writing, watching TV, playing, drinking alcohol, taking illicit drugs, browsing social networks, playing or listening to music, dancing, talking to people they lived with, talking to friends or family members on the phone or video calls, working or doing housework in order to increase their well-being during the peak of the pandemic in 2021.

Data analysis

Data analysis was conducted using SPSS Statistics for Windows, Version 27.0 (IBM Corp, Armonk, NY). Three Regression Analyses using the forward method were performed. In the first model, satisfaction with life was analysed (Dependent Variable – DV) as a function of COVID

spread in the social network and sociodemographic variables (gender, age, professional status, family income, marital state and education), comparing respondents in 2020 and 2021. In the second model, Well-Being was analysed as a function of the same independent variables used in the previous model. The third model was applied to measure satisfaction with life as a function of coping strategies during the peak of the pandemic in 2021, considering the same sociodemographic variables included in the previous models.

Results

The study found that the spread of COVID-19 among the respondents' social network increased significantly from 2020 to 2021. The data in Table 2 show that 12.4 per cent of respondents reported having lost a family member or close friend to COVID-19 in 2020 versus 41.2 per cent in 2021.

Table 3. Regression results for satisfaction with life (SWLS) during the COVID-19 pandemic in 2020 and 2021

Year	Model	R	R ²	Adjusted R ²	SE	Change statistics				
						R ² Change	F Change	df1	df2	Sig. F Change
2020	1	.183a	0.034	0.031	699.813	0.034	11.087	1	319	.001
	2	.215b	0.046	0.040	69.624	0.013	4.283	1	318	.039
2021	1	.311c	0.097	0.096	72.049	0.097	79.254	1	740	.000
	2	.341d	0.116	0.114	71.311	0.02	16.396	1	739	.000
	3	.357e	0.128	0.124	708.986	0.011	9.623	1	738	.002
	4	.370f	0.137	0.132	70.565	0.009	7.995	1	737	.005
	5	.377g	0.142	0.136	704.132	0.005	4.179	1	736	.041

Source: Tania Kiehl Lucci, Emma Otta.

Note: **a** Predictors: (Constant), family income; **b** Predictors: (Constant), family income, age; **c** Predictors: (Constant), professional status; **d** Predictors: (Constant), professional status, family income; **e** Predictors: (Constant), professional status, family income, network COVID-19; **f** Predictors: (Constant), professional status, family income, network COVID-19, marital status; **g** Predictors: (Constant), professional status, family income, network COVID-19, marital status, education.



A Multiple Linear Regression analysis was conducted to predict satisfaction with life (SWLS) from the spread of COVID-19 in the respondents' social network and sociodemographic variables (gender, age, professional status, family income, marital state and education) at two time points: 2020 and 2021. As shown in Table 3 and Table 4, the final model predicting satisfaction with life in 2020 included two significant predictors: ($R^2=0.046$, $F(2,318)=7.742$, $p=0.001$). SWLS scores were positively associated with family income and age. The final model predicting satisfaction with life in 2021 included five significant predictors: ($R^2=0.142$; $F(4,737)=24.352$; $p<0.001$). The greater the number of people in the respondents' network who contracted the virus, the lower the evaluated satisfaction with life. Being unemployed was also predictive of lower satisfaction with life. Conversely, higher family income, being married (or living together) and having a greater educational level were predictive of higher levels of satisfaction with life.

Table 4. Coefficients of Multiple Linear Regression of satisfaction with life (SWLS)

Year	Model		Coefficients			t	p-value	95% CI for B	
			B	SE	Beta			Lower	Upper
2020	1	(Constant)	19.22	0.574		33.486	.000	18.09	20.349
		Family income	1.334	0.401	0.183	3.33	.001	0.546	2.122
	2	(Constant)	15.911	1.698		9.373	.000	12.571	19.251
		Family income	1.292	0.399	0.178	3.238	.001	0.507	2.077
		Age (years)	0.099	0.048	0.113	2.07	.039	0.005	0.194
2021	1	(Constant)	26.376	0.581		45.418	.000	25.236	27.516
		Professional status	-3.316	0.372	-0.311	-8.902	.000	-4.047	-2.585
	2	(Constant)	24.164	0.793		30.47	.000	22.607	25.721
		Family income	1.021	0.252	0.146	4.049	.000	0.526	1.517
		Professional status	-2.859	0.385	-0.268	-7.418	.000	-3.616	-2.103
	3	(Constant)	25.633	0.92		27.869	.000	23.827	27.439
		Family income	1.15	0.254	0.165	4.526	.000	0.651	1.65
		Professional status	-2.931	0.384	-0.275	-7.635	.000	-3.685	-2.178
		Network COVID-19	-0.278	0.089	-0.109	-3.102	.002	-0.453	-0.102
	4	(Constant)	23.19	1.259		18.422	.000	20.719	25.661
		Family income	1.114	0.253	0.16	4.398	.000	0.617	1.612
		Professional status	-2.786	0.386	-0.261	-7.226	.000	-3.543	-2.029
		Network COVID-19	-0.287	0.089	-0.113	-3.224	.001	-0.462	-0.112
		Marital status	1.501	0.531	0.098	2.828	.005	0.459	2.543
	5	(Constant)	20.449	1.837		11.129	.000	16.841	24.056
		Family income	0.893	0.275	0.128	3.245	.001	0.353	1.433
		Professional status	-2.696	0.387	-0.253	-6.96	.000	-3.456	-1.935
		Network COVID-19	-0.299	0.089	-0.117	-3.359	.001	-0.474	-0.124
		Marital status	1.557	0.53	0.102	2.935	.003	0.515	2.598
		Education	0.682	0.334	0.079	2.044	.041	0.027	1.337

Source : Tania Kiehl Lucci, Emma Otta.

Table 5. Regression results for well-being (MSWS) during the COVID-19 pandemic in 2020 and 2021

Year	Model	R	R ²	Adjusted R ²	SE	Change statistics				
						R ²	F	df1	df2	Sig. F
2020	1	.159a	.025	.022	41.08	.025	8.30	1	319	.004
	2	.196b	.039	.032	40.87	.013	4.36	1	318	.038
2021	1	.231c	.053	.052	40.37	.053	41.53	1	740	.000
	2	.267d	.071	.069	40.00	.018	14.52	1	739	.000
	3	.276e	.076	.073	39.92	.005	3.98	1	738	.046

Source : Tania Kiehl Lucci, Emma Otta.

Note: **a** Predictors: (Constant), age; **b** Predictors: (Constant), age, professional status; **c** Predictors: (Constant), professional status; **d** Predictors: (Constant), professional status, age; **e** Predictors: (Constant), professional status, age, network COVID-19.

Table 6. Coefficients of Multiple Linear Regression of Well-Being (MSWS)

Coefficients									
Year	Model	B	SE	β	t	p-value	95% CI for B		
							Lower	Upper	
2020	1	(Constant)	143.354	9.283		15.443	.000	125.101	161.606
		Age	0.936	0.266	0.178	3.513	.000	0.412	1.46
	2	(Constant)	150.944	9.839		15.342	.000	131.599	170.29
		Age	0.927	0.265	0.176	3.496	.001	0.406	1.448
		Professional status	-3.629	1.624	-0.113	-2.235	.026	-6.821	-0.437
2021	1	(Constant)	192.679	2.53		76.158	.000	187.713	197.645
		Professional status	-6.254	1.023	-0.206	-6.116	.000	-8.261	-4.247
	2	(Constant)	166.236	6.694		24.832	.000	153.096	179.376
		Age (years)	0.721	0.169	0.143	4.259	.000	0.389	1.054
		Professional status	-5.924	1.015	-0.195	-5.835	.000	-7.917	-3.931
	3	(Constant)	170.839	6.967		24.52	.000	157.163	184.514
		Age (years)	0.78	0.171	0.154	4.568	.000	0.445	1.116
		Professional status	-6.201	1.02	-0.204	-6.081	.000	-8.202	-4.199
		Network COVID-19	-1.105	0.477	-0.079	-2.314	.021	-2.042	-0.168

Source : Tania Kiehl Lucci, Emma Otta.

Note: **a** Dependent Variable: Multidimensional Well-Being Scale (MSWS).

A Multiple Linear Regression analysis was also conducted to assess subjective well-being with the same independent variables – spread of COVID-19 in the respondents' network and sociodemographic information (gender, age, professional status, family income, marital state and education) – for both time points: 2020 and 2021. As shown in Table 5 and Table 6, the final model predicting the Multidimensional Subjective Well-Being Scale (MSWS) scores in 2020 included two significant predictors: ($R^2=0.039$ $F(2,318)=6.371$, $p<.002$). MSWS scores were positively

associated with employment and age. The final model predicting MSWS in 2021 included three significant predictors: ($R^2=0.076$, $F(3,738) = 20.340$, $p<0.001$). MSWS scores were positively associated with age. In addition, the number of people the participant knew who had been affected by the COVID-19 virus became a relevant factor that contributed to lower reported well-being. Unemployed respondents had lower MSWS scores.



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Coping strategies during the peak of the COVID-19 pandemic

Respondents to the 2021 survey reported the coping strategies they had used to increase their well-being during the pandemic. As can be seen from Table 7, a large proportion of respondents reported activities such as watching television (59 per cent) and browsing social networks (51 per cent). Other frequently mentioned coping strategies were physical activities (45 per cent), talking to people they live with (42 per cent), play (41 per cent) and work (40 per cent).

Table 7. Coping strategies used to increase well-being during the pandemic (2021 survey)

	N	%
Physical activities	377	45
Reading and writing	324	38
Watching TV	496	59
Playing	342	41
Drinking alcohol	183	22
Taking illicit drugs	34	4
Browsing social networks	431	51
Playing or listening to music	138	16
Dancing	108	13
Talking with people they live with	354	42
Talking with friends or family on phone	311	37
Working	335	40
Doing housework	286	34

Source : Tania Kiehl Lucci, Emma Otta.



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Table 8. Regression results for coping strategies in 2021

Model	R	R ²	Adjusted R Square	SE	Change statistics				
					R ² Change	F Change	df1	df2	Sig. F Change
1	.311a	0.097	0.096	72.049	0.097	79.254	1	740	.000
2	.341b	0.116	0.114	71.311	0.02	16.396	1	739	.000
3	.360c	0.13	0.126	708.205	0.013	11.271	1	738	.001
4	.375d	0.141	0.136	704.183	0.011	9.455	1	737	.002
5	.387e	0.15	0.144	700.955	0.009	7.804	1	736	.005
6	.395f	0.156	0.149	698.884	0.006	5.369	1	735	.021
7	.401g	0.161	0.153	697.353	0.005	4.230	1	734	.040

Source : Tania Kiehl Lucci, Emma Otta.

Note: a professional status; b professional status, family income; c professional status, family income, alcohol consumption; d professional status, family income, alcohol consumption, dancing; e professional status, family income, alcohol consumption, dancing, marital status; f professional status, family income, alcohol consumption, dancing, marital status, talking; g professional status, family income, alcohol consumption, dancing, marital status, talking, physical activity.

A Multiple Regression analysis performed to predict satisfaction with life during the peak of the COVID-19 pandemic in 2021 considered activities that respondents used to increase their well-being (Table 7) and five sociodemographic variables (marital status, professional status, sex, age and family income). As shown in Table 8 and Table 9, the final model predicting satisfaction with life in 2021 included seven significant predictors: ($R^2=0.174$, $F(8;734)=19.325$; $p<0.001$). Regarding coping strategies, physical activity, dancing, and talking to friends and family members were positively related to satisfaction with life, while

drinking alcohol was negatively related to satisfaction with life. Regarding sociodemographic variables, professional status negatively predicted satisfaction with life (unemployed individuals reported lower levels of satisfaction), while family income and marital status positively predicted the dependent variable (those with higher household incomes and those who were married reported higher satisfaction).

Regarding sociodemographic variables, professional status negatively predicted satisfaction with life (unemployed individuals reported lower levels of satisfaction), while family income and marital status positively predicted the dependent variable (those with higher household incomes and those who were married reported higher satisfaction).

Table 9. Coping strategies during the 2021 pandemic and sociodemographic variables

2021	Model	Coefficients						
		Unstandardized	Std. Error	Standardized	t	p-value	95% CI for B	
		B		β			Lower	Upper
1	(Constant)	26.376	0.581		45.418	.000	25.236	27.516
	Professional status	-3.316	0.372	-0.311	-8.902	.000	-4.047	-2.585
2	(Constant)	24.164	0.793		30.47	.000	22.607	25.721
	Professional status	-2.859	0.385	-0.268	-7.418	.000	-3.616	-2.103
	Family income	1.021	0.252	0.146	4.049	.000	0.526	1.517
3	(Constant)	24.508	0.794		30.858	.000	22.949	26.067
	Professional status	-2.882	0.383	-0.27	-7.527	.000	-3.634	-2.13
	Family income	1.124	0.252	0.161	4.452	.000	0.628	1.619
	Alcohol consumption	-2.118	0.631	-0.116	-3.357	.001	-3.356	-0.879
4	(Constant)	24.183	0.797		30.351	.000	22.618	25.747
	Professional status	-2.876	0.381	-0.27	-7.554	.000	-3.623	-2.129
	Family income	1.146	0.251	0.164	4.564	.000	0.653	1.638
	Alcohol assumption	-2.215	0.628	-0.122	-3.527	.000	-3.448	-0.982
	Dancing	2.383	0.775	0.105	3.075	.002	0.861	3.904
5	(Constant)	21.687	1.195		18.152	.000	19.341	24.032
	Professional status	-2.729	0.383	-0.256	-7.132	.000	-3.48	-1.978
	Family income	1.102	0.25	0.158	4.404	.000	0.611	1.594
	Alcohol consumption	-2.128	0.626	-0.117	-3.4	.001	-3.357	-0.9
	Dancing	2.551	0.774	0.113	3.297	.001	1.032	4.07
	Marital status	1.479	0.529	0.097	2.794	.005	0.44	2.518
6	(Constant)	21.435	1.196		17.921	.000	19.087	23.784
	Professional status	-2.712	0.382	-0.254	-7.108	.000	-3.461	-1.963
	Family income	1.036	0.251	0.149	4.124	.000	0.543	1.529
	Alcohol consumption	-2.179	0.624	-0.12	-3.489	.001	-3.405	-0.953
	Dancing	2.289	0.78	0.101	2.936	.003	0.758	3.819
	Marital status	1.378	0.53	0.09	2.602	.009	0.339	2.418
	Talking with friends and family	1.228	0.53	0.08	2.317	.021	0.188	2.268
7	(Constant)	20.981	1.214		17.287	.000	18.598	23.364
	Professional status	-2.688	0.381	-0.252	-7.056	.000	-3.435	-1.94
	Family income	0.978	0.252	0.14	3.875	.000	0.482	1.473
	Alcohol consumption	-2.234	0.624	-0.123	-3.583	.000	-3.459	-1.01
	Dancing	2.101	0.783	0.093	2.683	.007	0.564	3.639
	Marital status	1.43	0.529	0.094	2.704	.007	0.392	2.469
	Talking with friends and family	1.166	0.53	0.076	2.202	.028	0.126	2.206
	Physical activities	1.08	0.525	0.071	2.057	.040	0.049	2.112

Source : Tania Kiehl Lucci, Emma Otta.

Discussion

The results of the study revealed differences in the predictors of both satisfaction with life and well-being for 2020 and 2021. At the outbreak of the pandemic, in 2020, higher family income and being older were predictive of higher satisfaction with life, assessed by an instrument designed to measure global cognitive judgments of satisfaction with one's life (Diener *et al.*, 1985). However, at the peak of the pandemic, in 2021, the spread of COVID-19 in the respondent's network as well as being unemployed, were significant predictors of lower levels of satisfaction with life. Conversely, higher family income, higher educational level and being married (or living together) were predictors of higher satisfaction with life.

Analysis of subjective well-being, which measures whether a person is experiencing preponderantly positive emotions over negative emotions, showed that at the outbreak of the pandemic, in 2020, age and professional status were important predictors: specifically, being older and employed were predictive of higher well-being scores. However, at the peak of the pandemic, in 2021, the spread of COVID-19 in the respondent's social network became an important predictor, along with age and employment status: lower number of infected acquaintances, being employed and being older correlated with higher levels of well-being.

Due to the fact that pandemic did not affect everyone in a similar manner, the number of 'known people' infected by the virus can be used as a variable to consider the extent to which a person was affected by the outbreak. In the current study, affirmative answers to various items referring to the level of severity of personal exposure and exposure of members of the respondent's social network to COVID-19 – from acquaintances to friends and family members – give an idea of the impact of the pandemic

on respondents to the 2020 survey and the 2021 survey. To the authors' knowledge, this is the first study to use this measure of the impact of the pandemic on subjective well-being and satisfaction with life, taking into account individual differences in the degree to which participants have been affected by the pandemic. The results showed that the effects of the pandemic became increasingly stressful both from a psychological, social and likely economic point of view. The spread of COVID-19 infection among the respondents' social network was a significant predictor both of reduced satisfaction with life and reduced well-being in 2021, at the peak of the pandemic, but not in 2020 at the beginning of the COVID-19 pandemic.

The results of the current study corroborate the findings of research conducted in Germany comparing satisfaction with life across three periods: December 2019, March 2020 and May 2020. In that study, lower satisfaction with life ratings were found for the last of these three periods (Zacher and Rudolph, 2021). However, in the present study the mean levels of satisfaction with life and well-being remained similar for the two periods studied. The study endeavoured to measure the spread of the COVID-19 virus in the social network of participants in order to better understand the impact of the pandemic on well-being and satisfaction with life. Crucially, it considered the proximity of the participants to the virus and its consequences. The outcomes confirmed that the greater the proximity to people who have been infected, the greater the impact on their subjective well-being.

The outbreak of the pandemic also accentuated unemployment, with an estimated loss of 5–4 million jobs worldwide, evoking existential experience of loss and fear, and underscoring the centrality of work in human life (Blustein and Guarino, 2020). In Brazil, the unemployment

rate was already high even before the pandemic (2012–2018), especially for young people and Black women (da Silva and da Silva, 2020) due to economic and political crises, but this situation has since worsened. The present study highlights the concern of Brazilians with unemployment, particularly in 2021, with having a job being an important prerequisite for higher levels of satisfaction with life. Regarding well-being measures, employment status was an important variable for both the 2020 and 2021 samples.

The present study, as well as others conducted previously (Blanchflower, 2021), show that older age is related to higher satisfaction with life and happiness. While it was believed that the onset of the pandemic might change this result, given the increased risk of complications from the virus in older people, age was positively correlated with higher satisfaction with life in 2020, in agreement with previous studies, but was no longer a significant predictor in 2021. However, the same trend was not found for the measure of subjective well-being, where being older was an important factor for higher well-being in both 2020 and 2021.

A previous study showed lower rates of depression and anxiety in older people during the COVID-19 pandemic (Palgi *et al.*, 2020). While this result might seem counter-intuitive, it could be explained by the fact that older people had more effective emotional regulation (Knepple Carney, 2021; Losada-Baltar *et al.*, 2020). In the present study, people who were married or living together with a partner reported higher satisfaction with life. This finding is in line with previous studies (Smith and Lim, 2020) which show that the main risk factor for depression and anxiety is loneliness (Smith and Lim, 2020). Italian researchers have shown that although concerns about the pandemic significantly threaten psychological well-being, they also increase the chance of more explicit

communication about stress between couples, increasing dyadic coping via supportive behaviour, which is ultimately positively associated with psychological well-being (Donato *et al.*, 2021). Therefore, promoting couples' dyadic coping skills enhances their ability to manage stress and to deal with concerns. Other studies however show that the pandemic may have damaged marital and family relationships, increasing the number of divorces and even domestic violence (Global Times, 2020; Kofman and Garfin, 2020). Contrary to expectations, however, gender was not an important predictor of well-being or satisfaction with life in the samples, contradicting a hypothesis that women rated their lives worse than men, as previous studies have shown, and that this measure would be further impaired in the context of the pandemic (Möhring *et al.*, 2021; O'Connor *et al.*, 2021).

The most frequent activities employed to cope with the pandemic, according to the survey results, were watching television, browsing social networks, physical activities and talking to the people they live with. The results showed that drinking alcohol was negatively associated with satisfaction with life, while dancing, physical activities, and talking with family and friends by phone were positively related. Among sociodemographic variables, it is notable that respondents who were unemployed or not working (students, retired and household keeping) reported lower levels of satisfaction, while those with higher household incomes and those who were married reported higher levels of satisfaction.

The findings of this study are interpreted as an indication that loss of contact with friends and family due to COVID-19 and even the fear of losing loved ones had a profound impact on psychological well-being, as well as satisfaction with life in general. Unemployment caused by the pandemic will remain an unfavourable condition and likely

one that will continue to negatively impact the psychological well-being of the population. Physical activities should be encouraged and promoted as public health interventions to encourage a better quality of life as a way of coping with challenges, as well as encouraging social contact especially with friends and family via phone, video calls or the internet.

The present study, despite its preliminary nature, contributes to understanding how the pandemic has affected the well-being and satisfaction with life of Brazilians during the outbreak and peak of the COVID-19 pandemic, in 2020 and 2021, as well as to knowledge about behavioural coping strategies used by people hoping to increase their well-being. Although the analysis based on two different samples elicits important information, future studies should analyse longitudinal data in order to better understand this phenomenon.

Conclusion

This study, both in its design and its main findings, is in line with UNESCO's underlying ethos that 'since wars begin in the minds of men and women, it is in the minds of men and women that the defences of peace must be constructed'. Brazil is one of the countries worst affected by the global COVID-19 pandemic, and concerns have been raised about the psychological impact on the population. Brazil began administering COVID-19 vaccines on 17 January 2021, when the number of deaths had reached 210,000. On 13 April 2021, the Brazilian Senate opened the COVID Parliamentary Commission of Inquiry (CPI) to investigate the authorities' alleged failures in dealing with the pandemic, including a lack of central coordination, which has been associated with reduced success in limiting cases and deaths. The pandemic is also believed to have produced psychological and societal changes, with changes in one area spreading to others, potentially triggering widespread cultural change.

In this study, the spread of COVID-19 infection among the respondents' social network, reaching acquaintances and family members in addition to the individual himself/herself, brought about a significant decrease in levels of satisfaction with life and well-being. A higher educational level, higher family income, and being married or living together, were all predictors of higher satisfaction with life. The 2019 coronavirus disease also has many facets that challenge understanding. Besides the biological and epidemiological components, social, economic and psychological factors also influence the extent of the disease spread and the lethality pattern in a population. In Brazil, COVID-19 lethality was associated with worse socio-economic and health conditions, indicating the existence of a relationship between social inequalities and health outcomes in times of pandemic (Sanhueza-Sanzana *et al.*, 2021). Such socio-economic factors were of greater importance than individual comorbidities in determining the outcome of COVID-19 (Baqui *et al.* 2021). For example, people with low education and a low socio-economic status were more likely to erroneously believe that chloroquine prevented infection (Nunes *et al.*, 2023). Deconstructing and understanding the different facets of COVID-19 also has important consequences for policy-making (Srivastava, 2020). According to Tedros Adhanom Ghebreyesus, Director-General of WHO, 'All countries should take an all-of-government and all-of-society approach. Together, we are powerful. Our greatest enemy right now is not the virus itself. It's fear, rumours and stigma. And our greatest assets are facts, reason and solidarity'.

Regarding coping strategies reported by the respondents in this study, drinking alcohol was negatively associated with satisfaction with life. Furthermore, ongoing substance use may increase the risk of infection with COVID-19 (Kumar *et al.*, 2021; Melamed *et al.*, 2020). Activities found

to be positively related with higher satisfaction with life were dancing, physical activities, and talking to family and friends by phone. These activities are also recommended behavioural strategies, taking into consideration the available evidence that exercise is a protective factor against viral infections and the positive association identified between social capital and health (Clemente-Suárez *et al.*, 2022; Marconcin *et al.*, 2022). Moving forward, proper psychosocial support programmes are needed to reinforce adaptive coping strategies and to reduce maladaptive ones, in order to help change people into active survivors of the coronavirus crisis rather than passive victims.

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3.4. Social distancing, mask wearing, treatment preferences, and fear and risk perceptions related to COVID-19 in India and the United States of America

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Abstract

Prior research has investigated people's risk perception, knowledge, concern, awareness, decisions and actions related to rare pandemic events. However, little is known about the effects of mask-wearing and social distancing on the people of India, their perceptions of risk and fear related to COVID-19, or how these variables compare between two nations with different COVID-19 outcomes. The primary objective of this research was to fill this gap in the literature. To this end, the authors recruited a total of 405 participants from India and the United States (US) to participate in an online survey. The participants were asked questions about their perceptions of risk and virus-related fears, measures such as mask-wearing and social distancing, and their knowledge, concern, awareness and treatment preferences related to COVID-19. A 5-point Likert scale was employed to quantitatively analyse the participants' responses, followed by a descriptive analysis. A correlation analysis was then performed to visualize the relationship between different factors. The results revealed a higher level of risk perception and fear among Indians than Americans during the COVID-19 pandemic. However, people in the United States reported a high number of domestic violence cases during the lockdown, provoking

an increase in stress and anxiety levels. In addition, a significant negative correlation was observed between people who had taken at least one dose of the vaccine and those who feared dying as a result of COVID-19 in both India and the United States. Similarly, another significant negative correlation was observed between people who had taken at least one dose of the vaccine and those that believed that the government's actions were inadequate to combat the pandemic in India. However, no such correlation was observed in the United States. The paper highlights the implications of these findings for policy-making and governance during the pandemic.

Introduction

The World Health Organization (WHO) declared the COVID-19 outbreak a global pandemic on 11 March 2020. Since then, more than 200 countries have been affected by the virus, with more than 177 million cases and close to 4 million deaths reported (WHO, 2020). The pandemic has severely impacted the health economy and restricted international trade (Kerr, 2020). Furthermore, informing and supporting authorities with knowledge and information about practical implications based on possible factors linked to COVID-19 has proved a challenge.

Literature review

In a study conducted during the pandemic in the United States, Xu and Cheng (2021) examined the attitudes of participants towards masks and social distancing behaviour, political theory, cognition, risk perception and self-control. However, their study was limited to the United States and measured only two of the five identified factors: social distancing and mask-wearing.

Oosterhoff *et al.* (2020) investigated adolescent responses to social separation during the pandemic and their relationship with social and mental health. This study assessed the motivation to participate in social distancing, the commitment to follow social distancing norms, and social and mental health. However, while the study used a representative sample of young people from across the United States, the majority were white and female, thereby limiting the generalizability of the findings. Furthermore, the data were cross-sectional, thereby preventing temporal or causal inferences. Moreover, the study would have benefitted from an examination of the personal, permanent relationships between motivation, social distancing, and social and mental health, specifically the linkages between prolonged periods of social distancing and deterioration in mental health across time.

In a review of literature on the current pandemic and violence against women, Viero *et al.* (2021) evaluated 42 publications and found that confinement measures imposed by governments to combat the pandemic exacerbated gender-based violence, resulting in a 'shadow pandemic within the epidemic'. However, the authors did not undertake a comprehensive assessment of the quality of the research in question, or systematically extract and analyse data from the studies. As a consequence, the study did not provide a systematic review of literature on this relationship.

Wise *et al.* (2020) investigated changes in perception of risk and prevention in the United States during the first week of the pandemic. They studied how risk perception and participation in preventative actions changed in 1 591 participants and the degree to which an individual's risk perception anticipates defensive activities. Over five days, individuals demonstrated a rising awareness of the virus's risk, and reported participating in preventive measures with increasing regularity. However, compared to ordinary Americans, they underestimated their risk of infection. The anticipated risk of being contaminated, instead of the possibility of transmission, was the strongest predictor of handwashing and social distancing. However, the authors only investigated one component, risk, and their experiment only lasted for one week. Furthermore, the study was limited to risk perception in the United States, not globally, or in other countries.

In another study, Mertens *et al.* (2020) investigated dread of COVID-19, polling 439 participants online to determine predictors of fear related to the novel coronavirus. Psychological sensitivity variables (e.g. anxiety related to health, worry and uncertainty intolerance), exposure to media, and personal significance (i.e. controlling the risk, risk to loved ones, and personal health and the health of others) were all found to be predictive. However, their study was constrained by the non-representative nature of the population sample, which consisted largely of highly educated Dutch females between the ages of 20 and 40, and the cross-sectional aspect of the research.

Bell *et al.* (2020) examined the opinions of parents and guardians in England on the appropriateness of a potential COVID-19 vaccination. According to their findings, most parents and guardians said they would accept a COVID-19 vaccine for their children and themselves, with their foremost concerns relating to its efficacy and safety. The authors

identified household income and ethnicity as predictors for COVID-19 vaccine refusal, while self-protection against the COVID-19 pandemic was the primary motivation for vaccine acceptance. While the sample size was sufficient to indicate income and ethnicity as drivers of vaccine acceptability, an examination of open-text replies highlighted the impossibility of investigating differences in vaccination beliefs based on these characteristics.

A study on fear and practice modifications among dentists to combat the COVID-19 outbreak was conducted by Ahmed *et al.* (2020). These authors observed that healthcare professionals, especially dentists, are more likely to become infected with the virus due to their close contact with patients, and thus assessed related anxieties and fears among practitioners working during the current pandemic. It found that despite having a high standard of knowledge and practice, dental practitioners worldwide are in a state of anxiety and fear due to the global impact of the COVID-19 pandemic on humanity.

A study conducted by Ivan-Marbaniang *et al.* (2020) examined the burden of anxiety among people living with HIV during the COVID-19 pandemic in Pune, Maharashtra. The authors found that the level of anxiety was high among the population of socioeconomically disadvantaged people living with HIV, seemingly influenced by concerns about antiretroviral therapy availability. This burden is likely to increase as the pandemic worsens in India and the sources of anxiety persist.

Much of the above research was performed mainly in the United States and United Kingdom (Ahmed *et al.*, 2020; Bell *et al.*, 2020), with researchers studying only one or two factors among the main five linked to the COVID-19 pandemic. In addition, most of the research was not generalized according to ethnicity, gender, location or age.

Aims

This paper aims to overcome the limitations cited above by conducting a more generalized survey based on gender, age, location, education and literacy across India and the United States. Thus, this study compares perceptions of mask-wearing, risk, social distancing, fear, and treatment of people residing in India and the United States. It hypothesizes that people in India will have a lower regard for mask-wearing, social distancing and treatment compared to people in the United States due to much higher population density, which makes it less feasible to maintain social distancing. Furthermore, it is hypothesized that India's low literacy rate will negatively affect perceptions and uptake of mask-wearing due to more limited knowledge of the importance of masks in combating transmission of air-borne diseases. Lower quality of healthcare facilities in India compared to the United States will also likely negatively affect perceptions around treatment. Lastly, perceptions of fear and risk will likely be higher in India than in the United States due to the population size, low feasibility of maintaining social distance and challenges related to healthcare facilities.

Prior research on risk perception and fear have shown that fear of the unknown and dread causes society to comply with situations (Fehr, Fischbacher and Gächter, 2002; Fischhoff *et al.*, 1978). However, very little is known about people's risk perception and fear or dread regarding COVID. In addition, there is little information available on the extent to which fear (Ahn *et al.*, 2001; Dawes *et al.*, 1986: 3–4) motivates the adoption of social distancing and usage of masks (Wilder-Smith and Freedman, 2020), and may drive the population to comply with COVID-19 protocols imposed by the government. The primary objective of the research is therefore to close these literature gaps and to document the impact of the

pandemic on risk perceptions, fear, social distancing, mask wearing and treatment preferences among the populations of India and the United States.

The factors evaluated by the study are risk perception, fear, social distancing, mask wearing and treatment preferences. In the case of social distancing, participants were asked whether they felt it helped mitigate the spread of COVID-19, and if it provoked anxiety and increased domestic violence. In order to analyse people's risk perception of COVID-19, participants were asked about their beliefs, the probability of themselves and their families getting infected, and the economic and health consequences if they did. The mask variable captures people's attitude towards using masks as a precaution to prevent transmission of COVID-19. Participants were asked about the probability of themselves wearing a mask, the consequences of not wearing a mask in public and the effectiveness of homemade masks. They were also asked whether they would wear masks after infection cases dropped. Regarding fear, the study evaluated the different levels of fear among people about loss of life due to COVID-19, the inadequacy of healthcare systems and loss of sleep due to fear of COVID-19. In addition, the survey included questions on the effect of being exposed to COVID-19 stories in the media and the stockpiling of household supplies. Lastly, the participants were questioned about COVID-19 vaccines to evaluate their response to treatment. They were surveyed on their likelihood of taking a first and second dose of the vaccine for themselves and their families, the consequences of not taking the second dose, following precautions after taking the vaccine, and their level of belief in alternative treatment as a cure for the virus.

This paper attempts to understand public reactions, acceptance and awareness regarding the pandemic

by evaluating the above factors. The results of this analysis of collected data can then be utilized to improve communication around health risks and risk management, and to shape country-specific policy measures accordingly. Furthermore, the perceptions about health risks discussed here can influence individual behaviours. If the public underestimates the health risks of COVID-19, they will not accept mitigation measures imposed by the government. Conversely, fear among people may cause them to overestimate the risk to their health.

The following sections describe the experimental setup, the investigative variables and the procedure followed in carrying out the research. The findings are documented in the results section and the outcomes of the study are documented at the end of the paper.

Methodology

Participants

The study collected survey responses from 405 participants in India (N=201) and the United States (N=204). The online survey was conducted via Amazon Mechanical Turk, an online crowdsourcing platform (Crump, McDonnell and Gureckis, 2013) between 17 April 2021 and 29 April 2021. Participation was voluntary, and the questions covered topics related to perception of risk, fear, mask-wearing, social distancing, knowledge, concern, awareness and treatment preferences related to COVID-19. About 57 per cent of the participants were male and about 43 per cent were female. The age range of the participants spanned 19 to 80 years old (mean = 36.6 years and standard deviation = 11.5 years). More than 60 per cent of the participants had not been vaccinated with the COVID-19 vaccine, while around 31 per cent had received their first dose and the remainder were fully vaccinated during the study.

Table 1. Demographics the participants recruited for the study from India and the United States

	India	USA
No. of participants (N)	201	204
Mean Age	34.5 (8.25) ¹	38.7 (13.08) ¹
Female participants	35%	51%
Male participants	65%	49%
Vaccination Status	Fully Vaccinated: 3% Vaccinated with first dose: 31% Not Vaccinated: 66%	Fully Vaccinated: 12% Vaccinated with first dose: 32% Not Vaccinated: 56%
Infected after vaccination	After first dose: 10% After second dose: 0.5%	After first dose: 6.3% After second dose: 0.9%

Source : Shashank Uttrani, Anam Siddique, Neena Sreekumar S., Varun Dutt, Neha Sharma.

Experimental design

The main motive of this research is to compare people's various types of perceptions, knowledge and attitudes towards COVID-19 in India and the United States. Perception covers people's risk and fear perception, whereas attitudes encompasses people's attitude towards mask wearing, social distancing and treatment. Participants participated in the study through an online survey. Previous surveys had focused separately on the perception and attitude of people. The aim of this survey was to compare both factors and draw some inferences. The survey was divided into two main parts. The first part asked demographic questions to collect general information about the participants (i.e. age, gender, employment, education status, and infection and vaccine status). The second part questioned the participants about their perception of fear and risk towards the virus and their attitudes and norms about social distancing, mask wearing and treatment.

A 5-point Likert scale was employed to analyse the different components of the survey. People were asked a set of questions regarding different topics. These questions were then used to understand people's attitudes towards the respective topics.

Procedure

The recruited participants were provided with a weblink to a google form which consisted of a consent page to participate in the survey voluntarily. Upon obtaining consent, the participants were directed to the first part of the survey, which was designed to elicit basic demographic information (see above). The survey included questions on the respondents' perceptions of risk, fear, social distancing, mask wearing and treatment preference related to COVID-19. A quantitative analysis of the enumerated responses was carried out employing a 5-point Likert scale followed by a descriptive analysis. A correlation analysis was then performed to visualize the relationship between different factors.

Measures

Risk perception

In order to evaluate the decision-making skills and risk perceptions of respondents, participants were asked to indicate their likelihood of indulging in activities such as 'drinking heavily at a social function', 'engaging in unprotected sex', 'driving a car without wearing a seatbelt', 'riding a motorcycle without a helmet' and 'walking home alone at night in an unsafe part of the town'. The survey provided a 5-point scale for responses where 0 = extremely unlikely and 4 = likely.

Fear

While the COVID-19 pandemic has triggered a variety of fears of different magnitude among the population, the study focused on a specific number of variables that have visibly engendered a fear response. These included the fear of becoming infected with the disease and the resultant economic loss, the increased fear of dying, apprehension around government actions and the state of healthcare infrastructure, and fear of the prolonged lockdown leading to the stockpiling of essential goods. A 5-point Likert scale was used again to record participants' responses and level of fear.

Social distancing

Social distancing has been one of the most commonly followed guidelines imposed to reduce the spread of the virus. Even where maintenance of social distancing differed on paper and in practice, the medical community was entirely optimistic about its effectiveness. Responses to questions about social distancing were recorded on a 5-point Likert scale.

Masks

Face masks covering the mouth and nose rapidly became part of everybody's lives. Responses regarding the effectiveness of masks in reducing the spread of the disease were recorded on a 5-point Likert scale.

Table 2. Average Likert scale points of the United States and India on COVID-19 risk perceptions

Questions	US	India
What is the likelihood that you may have already contracted COVID-19?	-0.166*	0.078*
If you contract COVID-19, how severely do you think it will affect your health?	-0.127**	0.137**
If you contract COVID-19, how severely do you think it will affect you and your family financially?	-0.180**	0.356**
How likely do you think you and your family are to contract COVID-19?	0.063*	0.141**
In your opinion, how important are your personal actions to limiting the spread of COVID-19?	0.737*	0.776**

Source : Shashank Uttrani, Anam Siddique, Neena Sreekumar S., Varun Dutt, Neha Sharma.

Note: , $p = .05$ and **, $p = .01$ where p refers to the confidence level associated with the correlation coefficient.

Treatment preferences

Given that the world is trying to adjust to the new normal created by the COVID-19 pandemic, it is essential to study the effectiveness of different modes of treatment to cure the disease. While the main focus is directed towards vaccination, it is important to understand how other popular methods might be used to achieve the desired end. The usage of Ayurveda as a mode of treatment is particular to India. Therefore, respondents were asked a few questions in order to evaluate their knowledge and ascertain the popularity of Ayurvedic products in treating COVID-19. Questions were also asked to elicit a general response to vaccination in order to perform the correlation analysis.

Results

Descriptive statistical analyses and correlational analyses were performed on the obtained responses from participants. The Pearson correlation coefficient was calculated to determine the correlation between participants' responses for risk perception, fear, social distancing, masks and treatment preferences.

Risk perception

Descriptive analysis

The findings suggest a limited range of perceptions (0.166) among respondents in the United States that they will not become infected. In India, the findings show a minimum

average perception (0.078) on the positive side of the spectrum, indicating that respondents are mildly concerned about being infected. Both Indians (0.137) and Americans (0.127) have a somewhat shaky belief that COVID-related illnesses will not affect their health, and only limited knowledge of the risk or severity of health repercussions. The Indian respondents (0.356) takes the opposite view of pandemic risk to US respondents (0.180), who believe it will significantly influence the economy (see Table 2).

Correlation analysis

The correlation analysis showed that, in India, people's perceptions of the seriousness of not receiving the second dose of vaccination and their chance of vaccinating family members are linked ($r(198) = 0.28, p = .01$). Likewise, people are worried about COVID-19 because they believe their life is in danger. This fear of loss of life and the perception of the risk to their health if they contract the virus are positively related in India ($r(198) = 0.44, p = .01$). In India, the belief that one should wear masks in enclosed places in respect of COVID-19 requirements and the opinion that contracting the virus represents a danger to one's health is also somewhat positively connected ($r(203) = 0.38, p < .01$). People's perceptions of the risk the virus poses and their poor sleep due to pandemic-related fears are also linked ($r(198) = 0.39, p < .01$).

In India, people's opinions of the severity of the virus's influence on their economic circumstances are moderately positively connected with their perceptions of the health implications of being infected by the virus ($r(198) = 0.46, p = .01$).

Table 3. Average Likert scale points of the United States and India on fear about COVID-19

Questions	US	India
Do news and media stories about the pandemic cause you nervousness or anxiety?	0.151**	0.502*
Do worries about contracting the virus affect your sleep?	-0.751*	-0.327*
Have you stockpiled supplies to prepare for potential problems due to the COVID-19 outbreak?	0.044**	0.176*
Are you afraid that the healthcare system is not adequate to deal with COVID-19?	0.141*	0.229**
Are you afraid of losing your life during the pandemic?	-0.0097	-0.170

Source : Shashank Uttrani, Anam Siddique, Neena Sreekumar S., Varun Dutt, Neha Sharma.

Note: , $p = .05$ and **, $p = .01$ where p refers to the confidence level associated with the correlation coefficient.

Table 4. Average Likert scale points of the United States and India for social distancing

Questions	US	India
To what extent to you follow social distancing norms?	0.819**	0.839*
Do you agree that social distancing has led to social distress/anxiety?	0.483*	0.327*
Do you agree that lockdown/quarantine has increased domestic violence?	0.609**	0.185*
Do you agree that your locality has been involved in religious and social gatherings despite being aware of social distancing norms due to COVID-19?	0.400**	0.551*

Source : Shashank Uttrani, Anam Siddique, Neena Sreekumar S., Varun Dutt, Neha Sharma.

Note: , $p = .05$ and **, $p = .01$ where p refers to the confidence level associated with the correlation coefficient.

Fear

Descriptive analysis

The findings show that concern among Indians regarding (0.502) after being exposed to COVID-19-related news and stories in the media (0.151) is higher than among Americans (0.715), who are substantially less likely than Indians (0.320) to suffer from COVID-19-related sleeplessness (see Table 3).

Correlation analysis

In both India ($r(198) = 0.47, p = .01$) and the United States ($r(203) = 0.39, p = .01$), a positive correlation was found between people's fear of their healthcare system not being sufficiently competent to cope with COVID-19 and people losing sleep over contracting the virus. Both in India ($r(198) = -0.14, p < .05$) and the United States ($r(203) = -0.44, p = .01$), adverse effects of vaccinations and family acceptance of the vaccine were found to be adversely linked. In India, the side effects of the COVID-19 vaccine and people's fear of a failing healthcare system were strongly correlated ($r(198) = 0.35, p = .01$). Both India ($r(198) = 0.52, p = .01$) and

the United States ($r(203) = 0.78, p < .01$) observed that after receiving the first dose of vaccine, the likelihood of receiving the second dosage and accepting the vaccination of family members was positively connected. Both in India ($r(198) = -0.18, p < .05$) and the United States ($r(203) = -0.38, p < .01$), the likelihood of receiving a second dose of vaccination and the symptoms of receiving the vaccine were found to be negatively connected after the first dosage.

Social distancing

Descriptive analysis

The findings revealed that more people in the United States (0.609) agreed that lockdown/quarantine had increased domestic violence than people in India (0.185). Perceptions among respondents about other social distancing matters, such as engaging in social distancing, stress caused by social distancing, and participating in religious and social gatherings despite being aware of social distancing restrictions, were nearly identical, disproving the hypothesis that relatively fewer people obey social distancing

guidelines in India than in the United States (see Table 4).

Correlation analysis

The analysis revealed that an increase in domestic violence during lockdown/quarantine, as well as social distress/anxiety caused by social distancing, were positively correlated in both India ($r(198) = 0.43, p = .01$) and the United States ($r(203) = 0.30, p = .01$). Individuals who were likely to wear masks in public knowing they could catch COVID-19 without one and people who engaged in social distancing were positively correlated in both India ($r(198) = 0.28, p < .01$) and the United States ($r(203) = 0.50, p < .01$). According to the correlation analysis, nervousness and anxiety caused by exposure to COVID-19-related news and stories on social media platforms were positively correlated with social distress in both India ($r(198) = 0.24, p < .01$) and the United States ($r(203) = 0.21, p < .01$). People becoming fearful and anxious after checking the news on social media platforms was positively correlated in both India ($r(198) = 0.43, p < .01$) and the United States ($r(203) = 0.45, p < .01$).

Table 5. Correlation analysis of different variables for India and the United States

Variables	US	India
Wearing a mask in public places and willingness to take a vaccine	.45**	-.18*
Stress and anxiety from news and stockpiling of items	.45**	.43**
Stress and anxiety from news and belief that government actions are inadequate during the pandemic	.43**	.43**
Fear of contracting COVID-19 and economic concerns	.51**	.77**
Fear of dying after taking at least one dose of vaccine	-.25*	-.23*
Belief that government actions are inadequate after taking at least one dose of vaccine	-	-.66**

Source : Shashank Uttrani, Anam Siddique, Neena Sreekumar S., Varun Dutt, Neha Sharma.

Note: , $p = .05$ and **, $p = .01$ where p refers to the confidence level associated with the correlation coefficient.

Table 6. Average Likert scale points of the United States and India for mask wearing

Questions	US	India
How likely are you to wear a mask in public knowing that you may easily catch COVID-19 without one?	1.278**	1.127**
How severe do you believe are the consequences of not wearing a mask in public?	0.502**	0.780*
Do you think that wearing a mask in public to protect against COVID-19 even after cases drop is a good idea?	0.961**	0.932**
Should people wear masks in open places (e.g. parks) due to COVID-19 norms?	0.707**	1.190**
Should people wear masks in enclosed spaces (e.g. cinema theatres) due to COVID-19 norms?	1.288*	1.219**
Do you think homemade masks are effective against COVID-19?	-0.297**	0.005**

Source : Shashank Uttrani, Anam Siddique, Neena Sreekumar S., Varun Dutt, Neha Sharma.

Note: , $p = .05$ and **, $p = .01$ where p refers to the confidence level associated with the correlation coefficient.

Masks

Descriptive analysis

The survey results show that Indian people (1.190) present a higher degree of willingness than the United States (0.707) to wear masks in open places for the duration of the pandemic. They also hold different opinions on whether homemade masks are effective. The American people think that homemade masks are ineffective, resulting in an average negative answer (-0.297). In contrast, Indian people are almost neutral on this question (0.005). It is also worth noting that Indians strongly believe (1.190) that people should wear masks in open spaces, while conviction among Americans on this subject is weak (0.707) (see Table 6).

Correlation analysis

Individuals who were likely to wear masks in public knowing they could catch COVID-19 without one and people who engaged in social distancing were positively correlated in both India ($r(198) = 0.28, p = .01$) and the United States ($r(203) = 0.50, p = .01$). People agreeing that alternative treatments are efficient against COVID-19 and people who believe homemade masks are effective against COVID-19 were also found to be positively correlated in India ($r(198) = 0.21, p = .01$) and the United States ($r(203) = 0.26, p = .01$). Individuals in the United States who stated they might wear masks in enclosed spaces to conform with COVID-19 norms and those who assumed that contracting the virus implied health impacts were moderately positively correlated ($r(203) = 0.38, p < .01$).

Treatment preferences

Descriptive analysis

Findings for this factor show that Americans (-0.585) have little confidence in alternative treatments. In contrast, some Indians (0.293) have confidence in alternative treatments such as Coronil, yoga and so on. Significantly more Indians (0.751) believe that society will soon return to a pre-pandemic lifestyle than people in the United States (0.361).

Table 7. Average Likert scale points of the United States and India on perceptions towards COVID-19 treatment

Questions	US	India
How likely are you to accept the COVID-19 vaccine for your family?	1.048**	0.804*
What do you believe are the side effects of taking the COVID-19 vaccine?	0.614**	0.468*
After the first dose of the COVID-19 vaccine, how likely are you to take the second dose?	1.102**	0.917*
How severe are the consequences of not taking the second dose of the vaccine after taking the first dose?	-0.351*	-0.048**
After taking the COVID-19 vaccine, how likely are you to follow COVID-19 precautions. (e.g. social distancing, masking, sanitizing)	1.049*	0.980**
Do you agree that alternative treatments are effective against COVID-19?	-0.585**	0.293**
Now that the vaccine drive has begun, do you believe it will be long before we return to the lifestyle we had before the pandemic?	0.361**	0.751*

Source : Shashank Utrani, Anam Siddique, Neena Sreekumar S., Varun Dutt, Neha Sharma.

Note: , $p = .05$ and ** $p = .01$ where p refers to the confidence level associated with the correlation coefficient.

Correlation analysis

In India, there was a moderate positive correlation between the probability that individuals will accept the vaccination of their family and their impression of how likely their family is to become infected by the virus ($r(198) = 0.35, p < .01$). A moderate positive correlation in India ($r(198) = 0.35, p < .01$) and a strong positive correlation in the United States ($r(203) = .65, p < .01$) were found for those who believe that the prevention measures they take are having an impact on minimizing the spread of COVID-19 and those that are more inclined to follow COVID-19 precautions (e.g. social distancing, mask, sanitization) after taking the vaccine. In addition, Americans are slightly more fearful of COVID-19 after receiving the vaccine. Indians who use alternative medicine are more likely to still be vaccinated ($r(198) = 0.33, p < .01$), whereas Americans are less likely to do so ($r(203) = 0.65, p < .01$). People agreeing that alternative treatments are efficient against COVID-19 and people who believe homemade masks are efficient against COVID-19 were positively correlated in India ($r(198) = 0.21, p < .01$) and the United States ($r(203) = 0.26, p < .01$). Meanwhile, people in India ($r(198) = 0.22, p < .01$) and the United States ($r(203) = -.28, p < .01$) agreed that alternative treatments are efficient

against COVID-19. Individuals who believe that alternative treatments are efficient against COVID-19 and those who are more interested in adopting the COVID-19 vaccine for themselves and their families were positively correlated in India ($r(198) = 0.15, p < .05$) and negatively correlated in the United States ($r(203) = -.28, p < .01$). In India, people's views of the severity of not taking the second dose of vaccine and their likelihood of taking the second dose of vaccine were positively correlated ($r(198) = 0.20, p < .01$).

Discussion

A COVID-19 outbreak is a global occurrence with far-reaching implications on everyone's everyday lives. The survey conducted for this study helped to better understand the perceptions of risk and fear, attitudes towards social distancing and mask-wearing, and treatment preferences among the Indian and US populations during the COVID-19 pandemic. It also enabled attitudes towards preventive measures and the use of vaccines to be understood better than hitherto. Analysis of the data received from the survey produced some interesting results, while others matched advanced hypotheses. The results of the preliminary data analysis revealed that Indians believed they were at greater physical and financial risk.

Likewise, the possibility of contracting the disease was considered by the respondents to be much higher in India than in the United States. However, compared to the United States, less people in India believed in wearing masks as a preventative measure. The factors evaluated in the research are discussed below.

Risk perception

Based on the survey, people in India view the risk of getting infected by COVID-19 as high. Most people also believe that there will be severe consequences for their health if they contract the virus. Indians also attach a high risk to the implications for their economic situation if they become ill. However, the perception of risk related to their family members contracting the virus is low. As expected, only a small proportion of Indian people believe that their actions to limit spread of the disease are making a difference. This disparity in risk perception regarding the likelihood of contracting the virus are most likely due to the vast population in India. As previously noted, views on risk levels and the severity of health repercussions differ between the two countries surveyed, as the United States and other developed countries have a more robust health infrastructure than India, despite the large population gap. The measure of

risk differs between the United States and India in relation to the impact on the respondent's economic condition if they become infected. Most family members are financially independent in the United States, whereas this is usually not the case in India, where fewer family members earn and there are more dependants. Accordingly, this difference contributes to a greater risk perception of economic impact in India. However, the people of both countries understand the importance of preventive measures to curb the spread of the disease, and believe that these are useful.

Fear

The results of the survey show that fear among Indians of being infected with COVID-19 is greater than among US citizens, and that the former also believe that contracting the virus might be a life-threatening situation. The main factors contributing to this fear are anxiety and distress due to exposure to social distancing guidelines and news received through TV channels, online public platforms and social media.

Social distancing

Based on the survey results, incidences of domestic violence increased in India as a result of social distancing norms, which in turn increased anxiety and stress. Furthermore, the number of incidents of anxiety and tension caused by lockdown has been higher in India than in the rest of the world. This could be related to India's higher unemployment rate, alcohol usage and job insecurity. Unlike the United States, where social events and religious gatherings have had a positive but modest link with anxiety and stress, social and religious gatherings have had a far smaller impact on anxiety and stress in India. This could be due to a widespread but mistaken belief that attendees would not become exposed to COVID-19 during such gatherings.

Masks

It was observed that people in India have an affinity towards wearing masks. Moreover, sensitized individuals who wear masks have continued to do so consistently even after the drop in cases.

Treatment preferences

Based on the survey, Indians who think vaccines have severe side effects are less likely to vaccinate their family and do not have much faith in the healthcare system. Those who have received one dose of the vaccine are more likely to get their family vaccinated and are less likely to worry about possible side effects, but are not confident in their healthcare system. Indians who are already obeying social distancing measures, continue to follow these rules even after getting vaccinated. The results also show that those who believe in alternative treatment are more afraid, anxious and worried about COVID-19. People in the United States are also afraid of dying from COVID-19, just as they are in India, and are afraid that their healthcare system cannot help them. Those who already practise social distancing, maintain this habit even after being vaccinated due to their fear of dying from COVID-19. Those who believe in alternative treatment are also more afraid, anxious and worried about COVID-19, and are less likely to vaccinate their family and obtain a second dose of vaccine. Accordingly, it can be inferred that Indians and Americans maintain essentially the same views on COVID-19 treatment.

Conclusion

The research surveys conducted with residents of India and the United States illuminated the risk perceptions of people and their fears related to COVID-19. They also permitted better understanding of people's attitudes towards preventive measures, such as social distancing and wearing masks, and vaccination. Looking ahead, the comparison of views

from both countries may aid in the development of protocols and policies for mitigating COVID-19-related risks.

To prevent the virus from spreading, people must practise social distancing, wear masks and vaccinate themselves and their families against the COVID-19 virus. In practice, however, people will not wear an uncomfortable mask for an extended amount of time. Even if they do, it is unlikely that they will do so properly. Similarly, Schaffer DeRoo, Pudalov and Fu (2020) emphasized the importance of understanding both acceptance and hesitancy in relation to vaccines, in order to create interventions based on evidence, as multiple levels of vaccination are necessary to attain herd immunity. This will enable healthcare professionals and officials to develop communication approaches to address concerns and inform everyone, especially vulnerable groups.

Based on the findings of this study, it is recommended that work be done to address coronavirus phobia. The observed connection between media exposure and coronavirus anxiety indicates that more media exposure can increase anxiety. People should therefore be urged to minimize their sources of information related to COVID-19, as constant exposure to multiple media-based sources of information can lead to high stress and anxiety. The results of the study also showed that people in India exhibited higher levels of social anxiety due to social isolation or lockdown and economic insecurity.

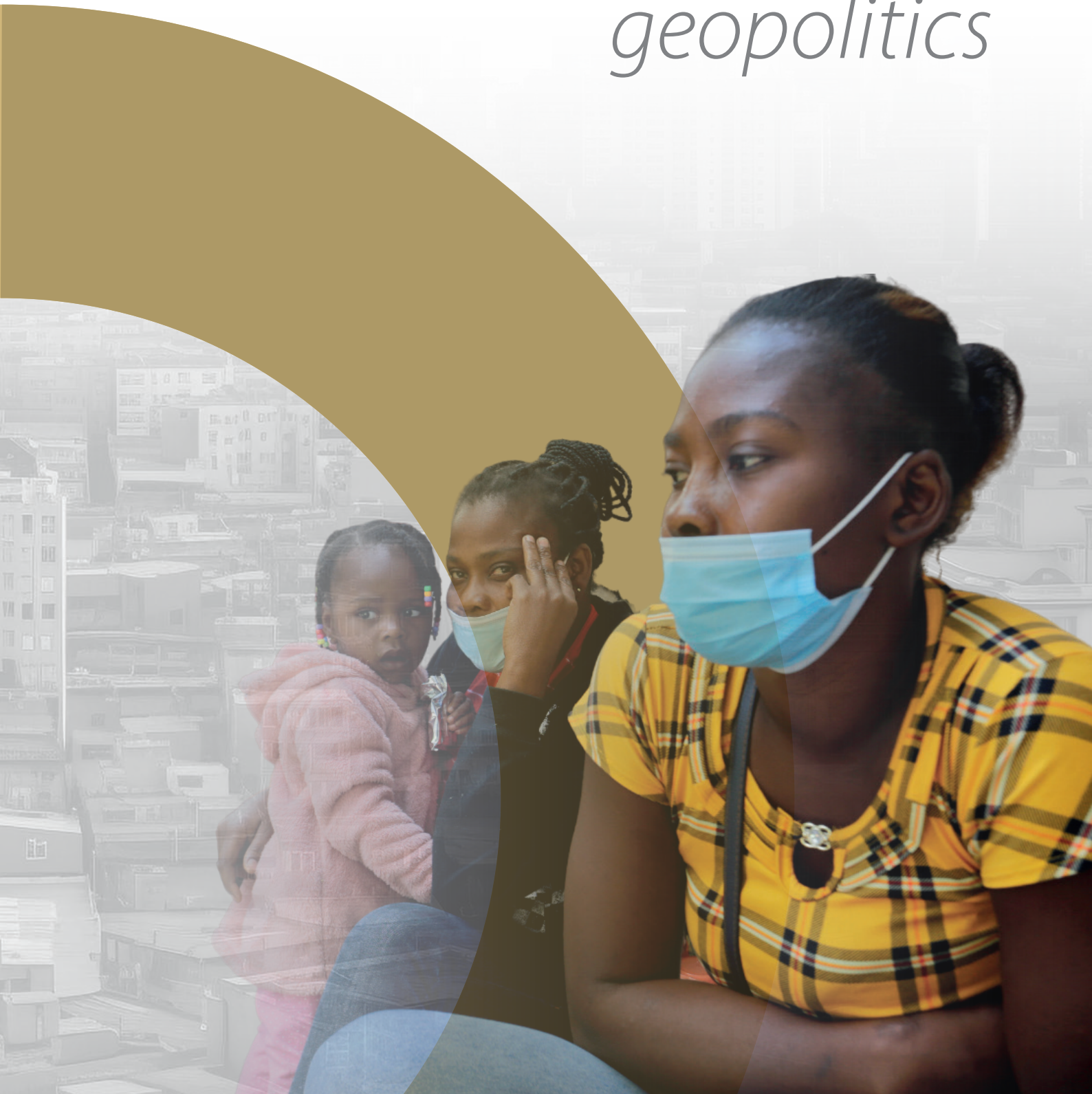
Regarding future research in this field, the utmost caution should be used when developing questionnaires, comparing outcomes from different studies and even comparing scores on different items, as even tiny changes in wording can significantly impact perceived risk. It is crucial to confirm that the stated differences are actual changes in risk perception.

Lastly, the results of the survey conducted in the two countries holds great potential for suggesting better policies and recommendations to address the COVID-19 outbreak and other future pandemics. It is hoped that this research may serve as a strong foundation for future work and improvements in handling rare global disease events such as COVID-19.

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*Part 4 —
Borders,
migration, and
geopolitics*



4.1. Critical Health Geopolitics: (Un)healthy spaces of the COVID-19 pandemic

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Abstract

Critical Health Geopolitics (CHG) is an analytical framework that offers opportunities for making sense of the COVID-19 pandemic and its aftermath. It links geopolitical research with health research, and reapplies them to the pandemic and post-pandemic world with an eye to how geopolitical power is exercised. The framework encourages researchers and policy-makers to detect and reflect upon the intersectionality of governance, political ecologies, cultural legacies, social and spatial mobilities, and biopolitics. This paper uses case studies to show how a CHG lens can: investigate the dangers of ignoring geopolitical legacies and histories of structural inequality when planning public health interventions; focus on how decisions made in response to COVID-19 exacerbated political and colonial legacies and structural inequalities; and consider how filtering COVID-19 mitigations and policies through a nationalistic framing impacts on satisfaction (or not) with national and supranational policies. CHG also has the potential to act as a multiplier and amplifier of health surveillance and intrusion, identifying why some individuals, populations and thus the areas in which they live may be more vulnerable to disease, and to resisting the control of disease, than others. Furthermore, it offers the most

appropriate lens through which to focus research, drawing component fields together to create stronger and deeper understandings of health (in) justice, pandemic preparedness and global health.

Critical Health Geopolitics: (un) healthy spaces of the COVID-19 pandemic: an introduction

Critical Health Geopolitics (CHG) is an analytical framework that offers opportunities for making sense of the COVID-19 pandemic and its aftermath. CHG considers the geopolitical underpinnings of health, healthcare systems and the socio-spatial governance of disease. Engaging with the field can help to link geopolitical research and health research, reappling them to the pandemic and post-pandemic world with an eye to how geopolitical power is exercised (Sturm et al., 2021). The framework encourages researchers and policy-makers to detect and reflect upon the intersectionality of governance, political ecologies, cultural legacies, social and spatial mobilities, and biopolitics. This paper uses case studies to show how a CHG lens can: (i) investigate the dangers of ignoring geopolitical legacies and histories of structural inequality when planning COVID-19 interventions, particularly those that restrict the movement of the poorest and most marginalized across and within borders, and which can lead to public

health messaging being resisted (Cole and Dodds, 2021a; Sturm et al., 2021); (ii) focus on how decisions made in response to COVID-19 exacerbate political and colonial legacies and structural inequalities that threaten to further challenge social mobility in the post-pandemic world (Ayikoru et al., 2023; Cole, 2020a); and (iii) consider how filtering COVID-19 mitigations and policies through a nationalistic framing impacts on satisfaction (or not) with national and supranational policies, including those of the European Union (EU) and World Health Organization (WHO) (Badalyan et al., 2021; Van de Ven, 2021). The examples used come from the authors' own research.

The production and regulation of health is intimately connected with the exercise and organization of geopolitical power. National lockdowns, tier systems, track and trace, and quarantine all speak directly to the spatial ordering of life itself. CHG interrogates how health and medical practices are incorporated into governance and how these practices might be resisted through the imaginings of political spaces and identities (Sturm et al., 2021). This can then help to explain why some individuals, communities and even countries resist pandemic containment (including vaccination) not because they resist pandemic control per se, but because they are sceptical – even hostile – to the governments, governance structures and political ecologies through which those responses are delivered and mediated.

Critical Health Geopolitics (CHG) as health surveillance and intrusion

CHG has the potential to act as a multiplier and amplifier of health surveillance and intrusion, identifying ahead of – as well as during – an outbreak why some individuals, populations and thus the areas in which they live may be more vulnerable to both disease itself, and to resisting the control of disease,

than others. Epidemiology and health surveillance can identify where case counts are highest, or where cases are rising. CHG explains why and how the situation may be improved, as well as with whom and where work may be needed to improve it. Such approaches have shown, for example, that displaced people are vulnerable to ill-health not only due to the conditions experienced along their migration journey but also because they continue to face barriers to accessing public health services, and thus are more vulnerable to experiencing chronic ill-health than more established populations, in the places where they settle (Cole, 2020b; Mladovsky, 2007).

CHG expands the quantification of poverty, inequality and precarity. The areas of highest deprivation in the UK often have above average rates of ethnic minorities and immigrant communities, and also the highest rates of 'essential workers' such as healthcare assistants, bus drivers and delivery couriers. During the COVID-19 pandemic, these were the areas and communities in which the highest numbers of cases were recorded (Cole and Dodds, 2021a). High rates of COVID-19 cases, hospitalizations and deaths were the consequence of an inability to remain enclosed in the 'locked down' home, not a genuine choice to move and resist restrictions (Cole, 2021b). The spaces the marginalized move into and around, and where they had little choice to continue to do so throughout the pandemic, are not the healthiest, so it should be no surprise that their (ill) health reflects this. They are victims of the disease situation and not, as they are often painted, its cause.

Case study 1: Vulnerable pockets and vaccine 'resistance' in Slough, UK

The first case study presented here exposes the role of inequality and the legacies of structural racism in vaccine 'resistance'. This is highlighted using the example of Slough, a town in south-east England with a highly

diverse population of around 165,000 people. In January 2021, the authors were commissioned by Slough Borough Council to investigate the reasons for above average numbers of COVID-19 cases in the town, low vaccine take-up and low levels of testing, and to suggest possible health interventions (Cole, 2021a).

Throughout 2020, cases of COVID-19 in Slough had been consistently higher than for the UK as a whole, reaching a peak of 1:100 population in January 2021. Communities characterized by Slough Borough Council as 'ethnic minorities' – all those who did not meet the only alternate categorization of 'British Caucasian' – accounted for 75 per cent of these cases, compared with 64 per cent in the local community overall. Such statistics painted the 'ethnic minority' communities as problematic, even resistant. Towns such as Slough were in danger of being framed as risky, ungovernable and in need of further containment and quarantine. In the UK, the short-lived tier system in 2020 over-identified such communities as Tier 4 – those at highest risk.

Hidden within these statistics, however, are challenges posed by structural inequalities that CHG can help to expose. For example, cultural misunderstandings between those responsible for drafting public health messages and those who received them created confusion over the meaning of a 'household'. To the majority 'British Caucasian' vocabulary, a 'household' is a single building – the house in which one resides, but to some Asian communities in Slough, 'household' was understood as the extended family, who may reside in more than one building. Those moving around the city to visit relatives were not, based on their own understandings, breaking any rules. Lack of inclusion of the target audience in the generation and testing of messages prior to dissemination perpetuated 'white privilege', which favours white, more affluent social groups in health

messaging (see e.g. Rouse, 2021; Vargas, Mora and Gleeson, 2021), and has also been observed to favour language that is more easily understood by those whose education more closely matches that of the message writers than of the target audience (Weiss and Paasche-Orlow, 2020). Such messaging can equally disadvantage poorer, less educated individuals and communities from majority groups, such as those of the white working class in the UK (Nakanishi and Kobayashi, 2020).

The Slough population contains individuals of many nationalities, ethnicities and religions including but not limited to Pakistani, Indian, Bangladeshi, Afro-Caribbean, Somali, Arab, Chinese and Roma, each of which is far from heterogeneous itself. Designations such as 'ethnic minority' or 'BAME' (Black, Asian and minority ethnic) amplified resistance to authorities who were seen as out of touch. They also amplified existing tensions between members of the Afro-Caribbean and Asian communities and East Europeans who were often perceived as being more than averagely vaccine hesitant but not problematized within a 'Not White' designation (although this was a misconception, as the Council's designation placed 'white not British' within 'ethnic minority' regardless of colour, as the alternative was 'British Caucasian'). The designation also ignored the plight of the white working class, who were often as marginalized and disadvantaged as other ethnic groups during the pandemic (see e.g. Halfon, 2021).

Legacies of racism created particular resistance to authority among older individuals from Afro-Caribbean backgrounds, who found it difficult to trust the UK Government after being subjected to years of institutionalized prejudice. As part of the 'Windrush Generation' they had been encouraged to come to the UK in the post-Second World War era only to find that promised opportunities

were increasingly constrained, leaving them further marginalized over time (Wardle and Obermuller, 2019). Resistance to the UK public healthcare authorities among these individuals cannot be separated from the legacy of colonial and post-colonial structural violence that first enslaved Africans, relocated them to the Caribbean and then attempted to relocate their descendants again to supply cheap labour to the UK while simultaneously eroding their rights as British Citizens. By the decade directly before the COVID-19 pandemic, the Windrush Generation was finding it difficult to access routine health treatments as easily as other British Citizens, which in turn problematizes claims made by national leaders to 'protect the NHS [the National Health Service]' (Khan, 2021: 149). People who have been systematically shut out of society in general and public health systems specifically (or have suffered, compared with White Britons, comparatively poor healthcare outcomes when they have engaged), cannot be expected to immediately lean back in when those responsible for closing the door want them to. This raises important issues linked to the self-understanding of the UK, with the NHS held up as a beacon of inclusive Britishness (as choreographed during the opening ceremony of the 2012 London Olympics). This example exposes the challenges faced by just one group within the Slough population; however, addressing reasons for higher infections, low testing and vaccine take-up across the city requires a similar critique of the geopolitical lived experiences of all, each of which presents unique forms of resistance.

Slough is an area of considerable deprivation (Slough Borough Council, 2023: 9) with high levels of employment precarity. During the pandemic, Slough residents who were still working had little incentive to undergo testing for COVID-19, as a positive test, when one's employer does not provide sick pay, is not an attractive prospect. Enduring

structural violence suffered by immigrant communities to the UK has trapped them in poor-quality, often overcrowded housing, low-paid jobs and educational under-achievement, pooling them in areas and occupations in to which the virus also moves most easily (Keys et al., 2021). This structural violence also helps to shed light on why such communities appear to be resisting behaviours those in positions of privilege would prefer to see. This should signal to society the need to improve conditions in these areas rather than blame the residents for their risky behaviour and vulnerability (Chwalek et al., 2021). Furthermore, the power geometries of health demand an approach that does not reinforce white-majority lived experiences that depend on privileged access to public services and private transport.

Case study 2: Colonial legacies and social mobility in the post-pandemic world

The second case study highlights how the statistics linking poverty with high numbers of cases and deaths signpost enduring threats to social mobility in the post-pandemic world. In Uganda, the authors documented the experiences of healthcare professionals (HCPs) in the formal healthcare system, the government and civil society and among religious groups (Ayikoru et al., 2023). In 2020, Uganda adopted a formal national plan for the pandemic (Amonya, 2020), assembling a task force from government, civil society and major religious organizations. In theory, this body covered all key areas of concern ranging from clinical (case management) and epidemiology to risk communication, and psychological and social protection for the most vulnerable. In practice, the experiences of HCPs and other key stakeholders, including some who were members of the taskforce, highlight significant challenges caused by structural inequalities, some of which are colonial in origin but persist to this day.

For example, HCPs designated as 'key workers' experienced wide variations in the availability of personal protective equipment (PPE), depending on whether they worked in public, private for profit (P4P) or private not-for-profit (Pn4P) facilities. In metropolitan areas, HCPs were more likely to have PPE provided to them and were able to share private transport services through social pooling if friends had an approved car or other vehicle. In rural parts of the country, healthcare workers often worked without PPE, shared the little that was available or purchased equipment at their own cost. A much-debated 'risk allowance' for those called to work in the designated COVID-19 treatment centres was available only to HCPs in public hospitals. It excluded those providing routine care to patients in the same settings. Decisions regarding whether or not to pay similar allowances were left up to P4P and Pn4P managers and directors.

The national task force had equity and fairness as a key criteria for patient care, but in practice there were wide variations in the experiences of HCPs delivering care and the facilities in which they worked, with evident implications for the most vulnerable. Notably, shortages of oxygen and ICU beds highlighted major inequalities between hospitals based on their locations and the socioeconomic standing of the patients they were likely to receive. The planning process aimed to establish a limited number of designated COVID-19 treatment centres where all resources would be concentrated, ostensibly to ensure cases were isolated from general healthcare facilities as a way of minimizing the rate of community infections. Many centres had only one or two oxygen tanks, with the question of who would be prioritized often depending on status and ability to pay. Several nurses and a few doctors interviewed for this study expressed their frustration at watching poorer patients being overlooked, or even having their oxygen removed to

serve those that could afford beds in the private wings of public hospitals. Health inequality based on ability to pay has been documented many times before (e.g. Falkingham, 2004; Roy and Howard, 2007; Molla and Chi, 2017).

The research in Uganda – as in Slough, UK – highlighted the point that vaccine 'hesitancy' may be due more to lack of access and appropriate messaging than lack of will. The official stance of the government and national taskforce is to ensure that the majority of the population is vaccinated to protect against COVID-19, but this position is undermined by limited access to vaccines. Uganda, like many low-income countries, depends on the COVAX (COVID-19 Vaccines Global Access) instrument to source vaccines (Burkti, 2021), given the ongoing inequity in distribution and sale of those available. The country aspired to vaccinate at least 20 per cent of the population by the end of 2021; at the time of the conference at which this paper was presented, a little over 12.5 million doses of vaccines had been administered in a country with population of more than 42 million people. This international structural inequality has arisen not due to a lack of funds – as pooled resources, including donor funds had been set aside to buy the vaccines – but as a result of constraints imposed by a vaccine supply chain that excludes the majority of the Global South, which has limited capacity to manufacture COVID-19 vaccines for its own populations.

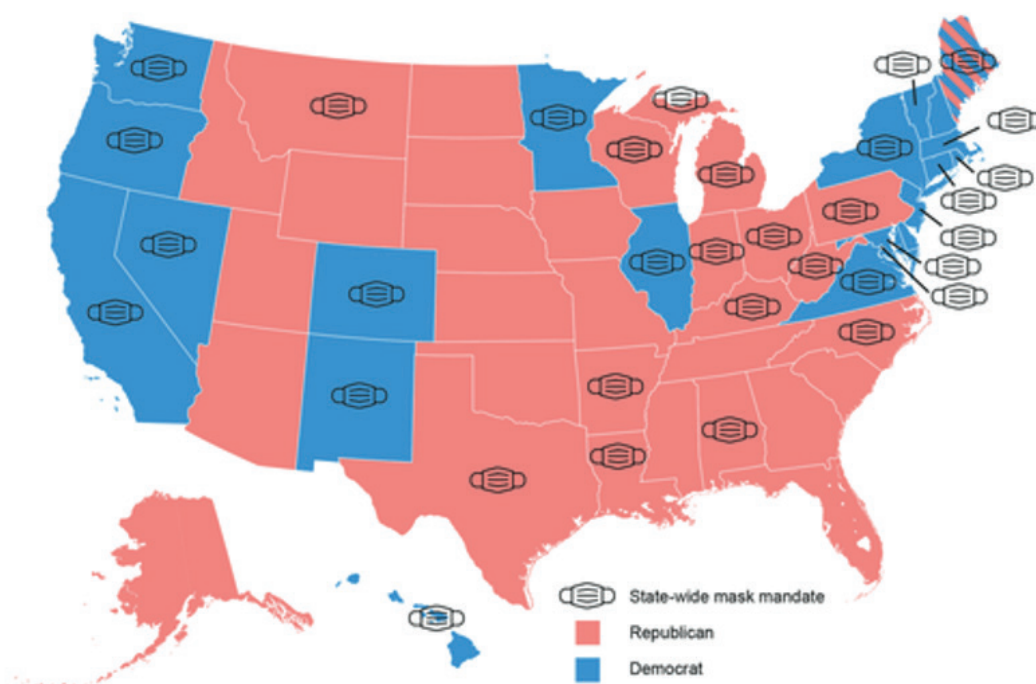
Concerns about geopolitical decisions were also noted. Most vaccines available in Uganda did not qualify for the EU's vaccine passports, required for international travel to the EU until mid-2022. While this seems like a political decision rather than a clinical one, it has been used by some within the anti-vaccination lobby to imply that the vaccines sent to Uganda and similar countries must be unsafe – otherwise why would

Ugandans be excluded? (Unless, as some argued, public health measures were being used as a proxy for control of movement from the Global South to Europe and North America). At the beginning of the pandemic, Yoweri Museveni, the President of Uganda, was himself cautious of the vaccines (Reuters, 2021). Even though he was eventually vaccinated, many of the HCPs interviewed for this study were sceptical as to whether he had received the same vaccine as that commonly available to the Ugandan public, or whether in fact he had been vaccinated at all, given his prior resistance. When the government does not trust international agencies to treat them fairly, and the public does not trust the government to treat them equitably, it is hardly surprising that vaccine confidence can be hard to embed. This example represents a cautionary note for all those of the opinion that hesitancy must be rooted in more sinister contexts and sentiments.

Case study 3: Nationalism and pandemic mitigation: (lack of) support for supranational agencies and regulation

The production and reproduction of 'healthy' and 'unhealthy' spaces is integral to CHG. The origin and easy mobility of COVID-19 triggered a series of unhealthy geo- and bio-political framings, ranging from blaming China and the accompanying Sinophobia, to framing the disease and associated vectors as threatening to the metaphorical 'healthy body' of the state. In the past, such linkages have often been the basis for justifying and legitimizing exceptional measures and authoritarian expressions of state power, and have driven more nationalistic framings. Understanding the impact of political ecologies on populations affected by COVID-19 is essential for determining how best to introduce pandemic management and control measures that are likely to be observed and accepted by all, at regional, national and international levels. The research

Figure 1. Map of the US showing states that had already introduced mask mandates on the day President Trump was hospitalized with COVID-19 in November 2019, and the political lines along which those states were governed



Source: Cole and Dodds, 2020a.

for this study shows that nationalism brings specific challenges during a pandemic in that it creates in-group and out-group identities (Van de Ven, 2020) at a time when the world needs to work collaboratively in order to limit cases and facilitate global vaccination roll-out.

Lockdowns, although necessary for disease control, are freighted with considerable social, economic and psychological costs that draw stark fault lines between the most privileged and the disadvantaged. Elgar, Stefaniak and Wohl (2020) mapped social inequality and COVID-19 vulnerability across 84 separate countries worldwide, and Barrera-Algarín et al. (2020) across 30 in Europe alone. Poverty and inequality are driven by, and in turn drive, nationalist political ecologies that encourage populations to turn

inwards when there is an urgent need to work collaboratively in areas such as climate change and public health, a process described as 'looking near without looking up' (Robbins, 2002).

While one can point fingers of blame at nationalist political leaders and their followers, it is important to know not only where nationalism affects behaviour towards COVID-19 (see Figure 1, which shows a clear relationship between the local political ecology and US mask mandates), but also why and in precisely what ways. The research for this study evidences links between nationalist governments and distrust of international agencies: COVID-19 was seen by nationalist Europeans as both a threat from 'out there' and the trigger for unwelcome impositions that threatened their national sovereignty and body politic (Van de

Ven, 2021). Also, and perhaps more valuably, the research shows that in countries with nationalist leaders, the strength of an individual's nationalism influences feelings of dissatisfaction with regulations that come from supranational agencies such as the EU and the WHO more than it does towards measures introduced at the national level.

Focusing on four EU member states – France, Germany, Poland and Hungary – it is possible to draw a comparison between the level of nationalism observed within government and the level of acceptance of national, EU and WHO lockdown policies by more nationalist individuals (see Table 1).

Table 1. Measures of lockdown and level of government nationalism

	Moderate government	Nationalist government
Strict lockdown	France	Poland
Moderate lockdown	Germany	Hungary

Source: Van de Ven, 2021.

Analysis of data collected by the Eurobarometer survey (European Commission, 2021), which polled 33,000 Europeans just after the first rounds of national lockdowns in spring of 2020, showed that nationalist individuals living under more moderate governments (France, Germany) objected to COVID-19 restrictions coming from the EU and WHO more than they objected to restrictions they saw as coming from their national government, even though, it can be assumed, they may not have voted for the politicians in power. Nationalist individuals living under highly nationalist governments (Hungary, Poland), demonstrated no significant difference in their opinion of national, EU or WHO restrictions, perhaps because they trusted their government more and saw them as less likely to accept restrictions imposed on them by the out-group. Ironically, nationalist governments appear to buffer nationalist individuals from dissatisfaction with international policy, suggesting that nationalism could have a mediating effect on satisfaction with COVID-19 measures at the international level. Additionally, when comparing the countries with a stronger lockdown (France, Poland) to those with a weaker lockdown (Germany, Hungary), the data show that where nationalists were in power, a weaker lockdown was preferred, but in the countries with a more moderate government, a stronger lockdown was more accepted.

These findings could have profound implications for how national governments – nationalist or not – think about how restrictive measures are presented to their population, as individuals may not so much ‘look near without looking up’ as ‘look up

and reject’ if they are nationalistic. Decisions may need to be framed as coming from, or at the very least being accepted and welcomed by, local politicians if people are to be expected to comply with them. Furthermore, it is notable that nationalism seems to have more influence on dissatisfaction with COVID-19 measures from the EU than the WHO, perhaps because fewer people have a clear view of what the WHO does, or perhaps because the EU is seen as much more of a threat than the WHO, as the latter has little official power or sovereignty (Gostin, Sridhar and Hougendobler, 2015).

This distinction indicates an important difference in attitude between two different modes of nationalism: civic nationalism, which is purely political and focused primarily on citizenship, which outsiders can attain, and ethnic nationalism, which is focused more on ethnicity and is thus less accessible to outsiders (Reeskens and Hooghe, 2010). Civic nationalism can help to unify people, whereas ethnic nationalism focuses on protecting the national in-group from external threats (Woods et al., 2020) and frames supranational organizations as risky, as well as COVID-19 itself, making international policies more difficult to implement.

Nationalist politics and in/out group identities shaped by political legacies frame governments, authorities, nations and foreign citizens as untrustworthy, and thus can undermine confidence in vaccines. In Armenia, for example, quantitative research (de Figueiredo, 2020; Howard et al., 2018; Kluge and McKee, 2021) has shown that national confidence in vaccines is lower than in most other

European and surrounding countries. Qualitative research (e.g. the authors’ work with Badalyan et al., 2021) shows that this hesitancy is shot through with bio- and geopolitical legacies – particularly of ethnic cleansing in the early twentieth century and the Cold War – that threaten to derail the path out of the COVID-19 pandemic. These legacies create not only vaccine ‘hesitancy’ but a whole spectrum of vaccine attitudes from apathy to outright conspiracy (Cole et al., 2021; Ayikoru et al., 2023) which bed in easily in post-Cold War as well as and post-colonial spaces.

Conclusion

The COVID-19 pandemic revealed some ugly truths. Or perhaps it only re-packaged and re-animated issues that need to be addressed with greater urgency. Policy-makers need to act more collaboratively. ‘Super-wicked’ problems are made even harder by an inability to communicate with one another in a climate of trust. Risks and vulnerabilities need to be discussed in a way that acknowledges access, capacity and inequality. Reconciling the desire to return to the old normal of free markets and unfettered mobility for the globally privileged sits awkwardly with a global majority that is poorly served by vaccine-sharing and burdened by restrictions. Around 400 million people still lack access to basic health services. These numbers are not likely to reduce in the post-COVID-19 era.

The three case studies above show how CHG can expose, amplify and even overcome some of the challenges that more quantitative epidemiological and health surveillance methods may miss. CHG offers opportunities to bring

Figure 2. Component fields of Critical Health Geopolitics

Source : Jennifer Cole, Maureen Ayikoru, Cas Van de Ven, Hermine Mkrtchyan, Klaus Dodds.

together, under a critical framework, understandings of behaviour and culture; history and legacies; narrative discourses; mobilities and lack of mobility; political ecologies and behaviours; and distributive (in) justice that can be applied not only to COVID-19 but also to other super-wicked problems, ranging from climate change (Cole and Dodds, 2021b) to antimicrobial resistance (e.g the authors' work with Abimbola, Otieno and Cole, 2020). It is crucial to ask *how*, *why*, *where* and by what some lives are made more precarious and vulnerable than others. Geography's deep commitment to enabling inclusion of all voices (e.g. Byron, 2020; Solís et al., 2014) provides a strong base for exploring the lived

experiences of diverse communities. The broad methodologies the discipline applies will help to bridge contributions from disparate fields.

The research that has been brought together for this paper has underscored the need for a new agenda based on Critical Health Geopolitics (Cole and Dodds, 2021a). Engaging with Indigenous, feminist, critical race and Global South scholarship and literature on the biopolitical and racialized implications of disease and ill-health provides CHG with further insights into the classist, racialized and gendered logics of viral reproduction and transmission, as well as the fault lines of inequality and marginalization that trap people

(and communities and countries) in vulnerable and infectious networks of poverty (see Figure 2).

Clear parallels can be drawn with AIDS/HIV, particularly now that COVID-19 has become endemic, controlled by pharmaceutical measures in countries that can afford to do so, while poorer nations bear the larger burden of disease. Established public health scholarship is both relevant to the task at hand and in need of greater engagement with social science and the humanities to fully understand the issues and challenges. Public policies, laws and corporate practices lead to the disproportionate distribution of ill-health and to premature death.

Social science needs to unpack the toxic and toxifying legacies of racism and classism, alongside the damaging effects of public healthcare austerity, environmental inequalities, housing discrimination, inaccessibility to nutritious food and differentiated vulnerabilities to premature death caused by general neglect (Davies, 2019). Doing so will enable humanity, together, to manoeuvre through the pandemic and into, it is hoped, a more just, equal and healthier post-pandemic world. Critical Health Geopolitics offers the most appropriate lens through which to focus these efforts, drawing these component fields together to create stronger and deeper understandings of health (in)justice, pandemic preparedness and global health today and in the future.

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4.2. *Les frontières en contexte pandémique de COVID-19 au Bénin : construction sociale des discours et des pratiques*

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Résumé

L'une des mesures essentielles prises par le gouvernement dans le cadre de la riposte contre la pandémie de COVID-19 au Bénin, concerne la fermeture des frontières. Mais, très tôt, on a assisté à l'émergence de pratiques non conformes aux recommandations sanitaires, en termes de circulation des individus et des marchandises, renforçant les risques de contamination. C'est dans ce contexte que la présente étude a été menée aux fins de comprendre la « vie sociale » des frontières en contexte pandémique de COVID-19. L'approche méthodologique repose sur des entretiens semi-directifs et des observations réalisées au cours du premier semestre 2021, auprès d'individus de différents profils : acteurs institutionnels, forces de l'ordre, soignants et populations. De façon générale, les modalités d'appropriation des mesures sanitaires sont divergentes. Elles sont révélatrices d'un climat à la fois d'anxiété, de défiance et de résignation. La pandémie a induit une reconfiguration des espaces frontaliers, faisant émerger une forme de stigmatisation sociale marquée par un contrôle sélectif des usagers. La grande porosité des frontières terrestres et les logiques en jeu fondent la faible efficacité de la mesure de fermeture des frontières comme moyen de prévention contre la COVID-19 au Bénin.

Mots clés : frontière - vie sociale - mobilité - COVID-19 - Bénin

Introduction

Le premier cas du nouveau coronavirus, la COVID-19, est apparu dans la ville de Wuhan (en Chine) en décembre 2019. Dès le 12 mars 2020, cette maladie s'est répandue dans toutes les régions du monde ; elle a été requalifiée de pandémie par l'Organisation mondiale de la santé (OMS, 2020). En effet, à la date du 26 mars 2020, plus de 472 790 personnes étaient déjà infectées avec plus de 21 313 décès. L'Afrique n'a pas été épargnée ; environ 11 979 735 cas d'infection dont 254 661 décès ont été déclarés sur le continent, contre environ 586 578 918 cas et 6 424 271 décès au total sur la planète, à la date du 10 août 2022 (Centre Africain de Contrôle et de Prévention des Maladies [CDC Afrique], 2022). Le Bénin a enregistré 27 316 cas dont 163 décès (Center for Systems Science and Engineering [CSSE] at Johns Hopkins University [JHU], 2022).

À l'échelle internationale, de nombreux pays ont suivi l'exemple de la Chine et ont pris des mesures fortes : réglementation des sorties, confinement, couvre-feu, fermeture des frontières et des établissements scolaires, suspension des compétitions sportives et autres grands rassemblements, etc. C'est le cas par exemple de la France, de l'Italie,

de la Belgique, de l'Espagne ou encore des États-Unis.

Très tôt, l'OMS a exprimé « *sa plus grande préoccupation* » envers l'Afrique dont « *la plupart des pays ont des systèmes de santé plus faibles* ». Le continent était perçu comme le plus grand foyer à risque de propagation de la COVID-19. Dans la perspective de « *se préparer au pire* », plusieurs pays africains ont pris une cascade de dispositions : état d'urgence sanitaire, couvre-feu, fermeture des frontières, des établissements scolaires, des marchés et bars, restriction des événements sociaux, etc. (Burkina Faso, Côte d'Ivoire, Ghana, Mali, Niger, Sénégal, Togo, etc.).

Au Bénin, un plan de contingence a été adopté et un comité national de crise a été créé pour organiser la surveillance, le dépistage et la prise en charge des cas. Dès le 30 mars 2020, les premières mesures prises par le Gouvernement ont consisté en la mise en place d'un cordon sanitaire (constitué de douze communes supposées à risques élevés et situées au sud du pays), la fermeture des frontières et des établissements scolaires et universitaires, la mise en quarantaine systématique et obligatoire de toute personne venant au Bénin et la fermeture des lieux de culte.

Partout, le contrôle des mobilités entre les pays a été le souci majeur des autorités nationales. Il a été l'une des premières réponses déployées contre la propagation de la COVID-19. Comme nous allons le voir, au Bénin, la fermeture des frontières a manqué d'efficacité, en raison de nombreuses pratiques émergentes non conformes aux recommandations sanitaires. Dans cette perspective, la pandémie de COVID-19 a constitué une opportunité pour comprendre le rôle ambivalent des frontières nationales et les logiques des différents acteurs sociaux impliqués, tant du côté des institutions publiques que des populations. La nature des facteurs explicatifs est hétérogène :

organisation du travail, perceptions populaires, pratiques des acteurs, etc.

Une telle problématique soulève un certain nombre de questions d'ordre anthropologique que nous examinerons à travers le cas spécifique de la frontière terrestre avec le Togo à Hilacondji et à Hounsahoué. Elle implique le refus de considérer les frontières comme un tout cohérent, intégré, et non-contradictoire dont la fermeture contribuerait efficacement à la prévention des épidémies en général et de la COVID-19 en particulier.

Depuis environ trois décennies, les sciences sociales ont examiné les barrières sociales, culturelles, politiques et économiques entravant la fermeture des frontières. Surtout en Afrique où ces frontières sont généralement considérées comme fabriquées de toutes pièces par le colonialisme, les anthropologues ont mis en évidence le fait que ces délimitations politiques séparent des groupes homogènes du point de vue linguistique et culturel. Les travaux de Barth (1969) sur *Ethnic groups and boundaries* sont toujours d'actualité ; ils soulignent la construction sociale des frontières par des acteurs individuels avec l'idée que la frontière est « le lieu où se lit le mieux la variabilité des identités, sans cesse construites, reconstruites ou déconstruites ». Pour Barth, ces *boundaries* (frontières administratives *stricto sensu*) ne sont pas des barrières ; elles peuvent se maintenir, s'effacer ou disparaître ; elles peuvent aussi devenir plus flexibles ou plus rigides.

Le présent article est donc une contribution à l'analyse des enjeux liés à la fermeture des frontières dans un contexte épidémique. Il est abordé en référence aux approches et concepts de l'anthropologie, faisant de l'espace frontalier, un objet social et culturel chargé de sens, support de représentations culturelles, de discours et des pratiques sociales. De nombreux auteurs sont revenus sur cette dimension sociale et

culturelle des objets, en particulier en construisant des cadres d'analyse autour des notions de « biographie » ou de « vie sociale » (*the social life of things*) (Nichter et Vuckovic, 1994 ; Whyte, Van Der Geest et Hardon, 2002 ; Desclaux et Egrot, 2015).

Dans un contexte plus spécifique de gestion épidémique, Bourdelais (2008) soulignait que l'épidémie contribue à la création, la reprécision, la matérialisation et à l'étanchement des frontières, parfois au-delà des limites d'une région, empêchant tout échange, engendrant autant d'espaces spécifiques mais aussi de stigmatisation sociale. Dès lors, les épidémies influencent l'organisation et la gestion des frontières. En se référant à la notion de biopolitique de Foucault, Bourdelais estimait que « la protection de la vie des sujets est devenue un objectif plus important que la protection des activités économiques » (Bourdelais, 2008 : 3). Ainsi, l'option consistant en la fermeture des frontières entrave le développement des activités économiques.

Les impacts sociaux des épidémies ont été bien analysés pour d'autres pathologies au cours de l'histoire (Corbin, 1988 ; Fabre, 1998 ; Bourdelais, 2001 ; Moulin, 2014). Ces publications ont clairement démontré que la fermeture des frontières n'est pas un moyen efficace de lutte contre la propagation des épidémies. Elles confortent les critiques de certaines organisations médicales qui avaient estimé qu'une telle mesure risquait d'aggraver l'épidémie de COVID-19, tout en fragilisant, un peu plus, l'économie des pays concernés. Ce postulat fonde le présent travail qui vise à décrire l'hétérogénéité des dispositifs promus dans les espaces frontaliers, à analyser les pratiques et les stratégies de contournement développées et les sociabilités induites et à proposer une relecture des certitudes sur la fermeture des frontières en lien avec les épidémies.

Tableau I : Répartition des acteurs par catégories d'acteurs

N°	Catégories socioprofessionnelles	Effectifs
1	Population (revendeuses, conducteurs de taxi, importateurs/exportateurs, ...)	50
2	Professionnels de la santé et guérisseurs traditionnels	6
3	Responsables administratifs et politiques (autorités sanitaires, élus locaux, ...)	16
Total		72

Dispositif méthodologique

De nature qualitative, analytique et inductive, l'étude s'est intéressée à la vie sociale des frontières et aux changements induits dans leur organisation en situation épidémique. La population étudiée comprend des personnes de différents profils (acteurs institutionnels, forces de l'ordre, soignants et populations) sélectionnées à partir des méthodes de choix raisonné et de la boule de neige. Au total, soixante-douze acteurs ont été interviewés.

Des entretiens semi-structurés et des observations ont été effectués au niveau de la frontière togolaise de Hilacondji et de de Hounsahoué et des localités environnantes (Agoué, Grand-Popo, Aplahoué et Azové notamment). La collecte des données a été réalisée au cours du premier semestre de l'année 2021. Elle a permis d'explorer divers aspects de la pandémie au niveau des frontières tels que : les contenus, les sources et les circuits des informations diffusées, les perceptions de la COVID-19, du risque de contagion et des mesures de prévention, avec une attention sur les expériences personnelles et sur les écarts qui pourraient exister entre les pratiques et les normes.

Les entretiens réalisés ont été transcrits et regroupés par thématique. Les méthodes classiques d'analyse de données (triangulation et recoupement des informations) ont été mobilisées. Du corpus produit, des verbatim ont été sélectionnés pour illustrer les faits décrits.

Description de la population d'étude

Sur les soixante-douze personnes ayant participé aux entretiens, les individus en population en composent le groupe principal ; ils représentent 69,4 % des enquêtés. Dans la plupart des cas, ces enquêtés partagent le même profil sociodémographique : conducteurs de taxi, artisans locaux, commerçants, fonctionnaires, importateurs/exportateurs, ... L'échantillon comprend également des professionnels de la santé rencontrés dans la sphère administrative et qui représentent 8,3% de la population d'enquête. La troisième catégorie d'acteurs est représentée par les responsables administratifs et politiques au rang desquels figurent les autorités sanitaires et les élus locaux ; cette catégorie représente 22,3% des personnes enquêtées. L'âge moyen des enquêtés est 38 ans, pour un minimum 28 ans et un maximum de 63 ans. L'échantillon comprend 63% d'hommes contre 37% de femmes. Par ailleurs, 73 % des enquêtés relèvent du secteur primaire, contre 27 % des secteurs secondaire et tertiaire. Enfin, 29 % des enquêtés n'ont jamais fréquenté l'école, et 71 % d'entre eux ont affirmé pratiquer les religions chrétiennes.

La fermeture des frontières, une mesure primordiale de la riposte contre la COVID-19

L'épidémie de COVID-19 a donné lieu à la frontiérisation rapide du monde (Ndong Beka Il, 2022). Cette mesure a été adoptée sur le continent africain où les pays ont très rapidement opté pour le contrôle des mouvements

internationaux, en raison de la provenance extérieure de la maladie. La gestion de l'espace par la réduction des mobilités a été l'une des premières réponses apportées. Il était question « d'enfermer les populations qui doivent être protégées du danger ». La logique de protection du « nous » face à « eux » a orienté la prise de décision. Ainsi, les pays les plus touchés par l'épidémie au moment de la fermeture de leurs frontières comptaient moins de 100 cas ; seule l'Égypte approchait les 200 cas. L'Ouganda et le Rwanda ont fermé leurs frontières avant même la détection du premier cas de COVID-19 sur leur territoire.

Les pays limitrophes au Bénin ont adopté cette mesure, et en ont fait un dispositif primordial de la riposte. L'accent est beaucoup plus mis sur la restriction des mobilités et la fermeture des frontières terrestres d'une part et la mise en œuvre d'un contrôle sanitaire surtout au niveau des frontières aériennes. À cet effet, le Nigéria, pays partageant plus d'espaces frontaliers avec le Bénin, a décidé de suspendre la plupart des vols commerciaux et de fermer ses frontières terrestres, entre le 20 et 23 mars 2020. Le pays était sous la barre des 100 cas ; il a enregistré son premier cas de décès le 23 mars 2020. Au Niger, la prise de ces mesures a été effective le 20 mars 2020 alors que le premier cas confirmé a été confirmé le 19 mars 2020. Le Burkina-Faso a décidé de la fermeture des aéroports de Ouagadougou et de Bobo-Dioulasso aux vols commerciaux à l'international et des frontières terrestres et ferroviaires à compter

du 21 mars 2020 pendant que 40 cas sont enregistrés avec le premier cas de décès (France24, 2020). Quant au Togo, la fermeture des frontières et la suspension de vols commerciaux ont été mises en vigueur entre le 20 et le 21 mars 2020, avec moins de 100 cas détectés (*Premier décès lié au coronavirus*, 2020). Les autorités ont renforcé les mesures le 21 mars 2020 en fermant toutes les frontières terrestres. De fait, tous les pays limitrophes du Bénin ont décidé de la fermeture ou des restrictions au niveau des frontières, presque dans la même période, avec très peu de cas détectés et/ou de morts enregistrés.

Au Bénin, le 17 mars 2020, le gouvernement, lors d'un conseil extraordinaire des ministres, a adopté onze mesures « pour éviter la propagation de l'épidémie de COVID-19 dans le pays », alors que le deuxième cas positif n'a été confirmé que le 19 mars 2020. Le premier point de ces mesures a concerné « la limitation à l'extrême nécessité des entrées et sorties aux frontières terrestres de notre pays. Seules les traversées indispensables seront autorisées en liaison avec les autorités des pays voisins ». Les points 2 et 3 faisaient référence respectivement à « la restriction de la délivrance des visas d'entrée au Bénin » et à « la mise en quarantaine systématique et obligatoire de toute personne venant au Bénin par voie aérienne ». La restriction des entrées et sorties s'est étendue aux membres du Gouvernement. Le point 4 des mesures portait sur « la suspension de toutes les missions à l'extérieur du pays pour les membres du Gouvernement et pour les cadres de l'administration publique ».

Au total, la gestion des frontières et des mobilités a été une mesure essentielle des politiques publiques face à la propagation de la COVID-19. La restriction des entrées et des sorties du territoire national a essentiellement ciblé les frontières terrestres, alors que l'accent était mis sur le contrôle sanitaire des voyageurs au niveau des frontières aériennes. À l'évidence,

« la pandémie de COVID-19 a eu de graves répercussions sur la mobilité mondiale, bloquant à l'étranger des millions de personnes, travailleurs migrants et membres de leur famille ou étudiants internationaux », a déclaré le Directeur général de l'Organisation internationale pour les migrations, António Vitorino.

Une appréciation controversée de la mesure de fermeture des frontières

Bien qu'elle réponde à une logique de protection des populations, la fermeture des frontières a été diversement appréciée.

Pour une minorité de répondants, la régulation des espaces frontaliers est une mesure nécessaire pour limiter la propagation de la COVID-19 au Bénin. Les mouvements migratoires sont perçus comme le canal de diffusion du virus SARS-CoV-2 entre les pays. Les populations sont en accord avec les autorités sanitaires, en ce qui concerne la prise de ces mesures.

« C'est par le flux migratoire que les gens sont affectés, parce que quand quelqu'un est affecté et il voyage dans un pays, il peut facilement contaminer les gens sur son chemin et propager la COVID dans le pays. La fermeture des frontières est une solution à la taille du risque » (Justin, policier, Aplahoué).

Les enquêtés ont donc des points de vue convergents avec les politiques publiques drastiques proposées. La peur de la contagion et les échos des ravages liés à l'épidémie fondent cette perception. La fermeture des frontières est donc perçue comme un moyen de limiter la propagation de la COVID-19 entre les pays. Elle est une mesure socialement acceptée et justifiée pour une frange de la population. Ce renforcement du pouvoir protecteur de l'État contre une « menace extérieure » congrue donc à la demande sociale.

En revanche, pour beaucoup d'autres personnes, la fermeture des frontières est une mesure d'une inefficacité certaine. La non-suspension des vols commerciaux et/ou la non-fermeture de la frontière aérienne est perçue comme un risque pour le pays en termes de propagation de la COVID-19. Ainsi, tous les types de frontières devraient être concernés pour rendre compte de l'efficacité de la mesure. Les acteurs mettent en cause la capacité des acteurs institutionnels à organiser le contrôle à tous les niveaux. La fermeture de l'aéroport de Cotonou, seule frontière aérienne, est une mesure plus simple et plus rassurante pour certains répondants.

« Pour un pays comme le nôtre, laisser l'aéroport ouvert alors que des pays comme le Nigeria ou autres décident de fermer, c'est un risque, avec toutes les insuffisances de notre système sanitaire » (Honoré, importateur, Aplahoué).

Cette tendance illustre la perception du risque au niveau des différentes frontières. Une comparaison avec les pays limitrophes nourrit un doute sur la capacité du système sanitaire à juguler la crise.

Au niveau des frontières terrestres, la limitation des entrées et des sorties comprend également les mesures de renforcement du contrôle sanitaire, notamment le respect des gestes barrières, la prise de la température corporelle, la référence (en cas de suspicion) pour la réalisation des tests de COVID-19, voire la mise en quarantaine et/ou la prise en charge. Ces tâches sont assumées par les agents de santé délégués.

À l'analyse, la fermeture des frontières nationales cache un aveu d'impuissance ; elle se fonde sur une annonce stratégique se positionnant en faveur de la sécurité des populations. Il s'agit de réactiver l'identité nationale détériorée par des événements d'ordre surtout politique ou économique (pauvreté

des populations). La décision de la fermeture des frontières prise par les États, est révélatrice d'une atmosphère de fébrilité sous fonds d'effets d'entraînement au niveau régional. L'épidémie de COVID-19 a été une occasion de réaffirmation géographique, stratégique et politique des frontières (Dumont, 2019), en ce sens que les épidémies sont « créatrices de frontières » (Bourdelaïs, 2008). Comme l'ont décrit des auteurs comme Berrod et Bruyas (2020) et Dumont (2019), la frontière a une fonction de barrière de protection, de sécurité des populations. Ainsi, émerge et se consolide la frontière comme « un objet matériel et symbolique à travers la mise en place de dispositifs d'affirmation et de régulation du pouvoir » (Ndong Beka II, 2022 : 33).

Plusieurs arguments révèlent le caractère peu opérationnel de cette mesure dans le contexte caractérisant les pays africains. Ils traduisent une faiblesse des États dans la réappropriation des recommandations formulées au niveau international. Car, malgré la fermeture des frontières, le virus du SARS-CoV-2 a abondamment circulé et il s'est disséminé dans tous les territoires.

La même situation a été observée dans d'autres épidémies, telle que celle de la maladie à virus Ébola en 2014 au cours de laquelle l'Union africaine a appelé, en septembre 2014, les pays à lever toutes les restrictions aux voyages « afin que les gens puissent se déplacer entre pays et faire du commerce et afin de favoriser les activités économiques » au profit de « mécanismes de surveillance adéquats à mettre en place, aux points de départ et d'arrivée des citoyens ». Pour cette institution, l'impact social et économique de la fermeture des frontières semble supérieur à celui de la maladie elle-même. Dans la même veine, l'OMS demandait aux États d'éviter l'application de mesures de restriction « qui se sont révélées inefficaces, coûteuses et qui vont à

l'encontre du résultat recherché » (OMS, 2014 : 15).

À l'évidence, la fermeture des frontières a poussé les voyageurs vers la clandestinité, rendant inefficace l'objectif de santé publique visé.

« Avec ça, les gens passent clandestinement à travers les villages, les hameaux et les forêts pour rejoindre l'autre côté, parce que, de toutes les façons, les frontières sont très poreuses » (Paulin, policier, Hilacondji).

La fermeture des frontières n'a pas donc freiné les déplacements. La porosité des frontières terrestres constitue un défi majeur pour la mise en œuvre efficace des mesures. La tension est donc permanente entre impératifs de sécurité sanitaire et nécessité économique. Elle a induit des usages spécifiques au niveau des espaces frontaliers.

Une construction sociale des frontières en contexte épidémique

Plusieurs modalités d'appropriation sociale des mesures sanitaires face à la pandémie de COVID-19 ont émergé au niveau des frontières.

Le contrôle sélectif des usagers, une autre modalité d'appropriation des mesures sanitaires

Au niveau des frontières terrestres, le dispositif se caractérise par un contrôle sélectif des usagers, faisant émerger deux groupes d'acteurs : les catégories exemptes de COVID-19 et celles suspects de COVID-19. Les individus appartenant au premier groupe ne sont pas contrôlés au niveau des frontières ; ils bénéficient du dispositif de contrôle sélectif mis en place. Au rang de ces personnes, figurent « ceux qu'on connaît », les riverains des frontières, les autorités et officiels et les « grandes personnes ». « Ceux qu'on connaît » et les riverains sont constitués des habitués des frontières, des personnes familières aux agents, parce que résidant aux environs ou

qui traversent régulièrement les frontières, bénéficiant de ce fait, de sociabilités particulières. On y retrouve également toute personne capable de décliner une identité professionnelle semblable à celle des travailleurs en poste : agents de santé, policiers, agents des eaux et forêts, agents des douanes, vétérinaires et agents phytosanitaires, etc. Ainsi, le corps de métier reste ici déterminant.

« Quand je viens là, je dis que je travaille au ministère de la santé, et on me laisse passer » (Pascal, fonctionnaire au ministère de la santé, Hilacondji).

Ces sociabilités dérivent de la confiance et de la réciprocité liées à l'appartenance aux mêmes réseaux sociaux. Les autorités et les officiels ne sont également pas contrôlés. Ils sont identifiés à travers les plaques d'immatriculation des véhicules qui les transportent perçus comme un signe distinctif de positionnement social. Par ailleurs, les « grandes personnes » sont constituées des individus qui bénéficient d'un capital social circonstanciel, en raison souvent de leur apparence physique ou de la détention d'un passeport.

En revanche, les principales catégories perçues comme étant suspectes de COVID-19 s'observent parmi « ceux qui sont sales », « ceux qui voyagent par bus », les « étrangers qui rentrent dans le pays », « ceux qui ne disposent pas d'un passeport », ... L'obligation leur est faite de décliner leur identité et de se soumettre aux formalités de contrôle sanitaire⁵⁷.

« Non, ça ne se fait pas à tout le monde. C'est ce que nous constatons. Ce n'est pas tout le monde qui reçoit cette lampe sur le visage ; et puis si tu entends un bruit pif là, c'est souvent les étrangers qui rentrent dans le

⁵⁷ Le contrôle sanitaire aux frontières (CSF) a pour objet la prévention de la propagation par voie terrestre, maritime ou aérienne des maladies transmissibles, conformément au Règlement sanitaire international.

pays, ... » (Alain, conducteur de taxi-moto, Hilacondji).

La « lampe sur le visage » fait référence à la prise de température au moyen du *thermoflash* (thermomètre infrarouge sans contact)⁵⁸. Ce dispositif donne aussi l'occasion de poser des questions aux individus sur leur état de santé et de leur rappeler les mesures en place pour freiner la transmission de la COVID-19, comme le lavage des mains et la distanciation physique. Cette prise de température traduit un sentiment d'insécurité que véhicule l'individu contrôlé. Ainsi, dans les espaces frontaliers, tous les passants ne subissent pas cette prise de température, de même que les autres mesures qui suivent. En tant qu'instrument de police sanitaire, le contrôle sanitaire est sélectif ; il est révélateur de pratiques de stigmatisation ou de discrimination développées à l'encontre de catégories sociales spécifiques, qui, en général, ne disposent pas d'un capital social au sens de Bourdieu (1980). Ces personnes sont perçues comme ayant une part de responsabilité dans l'émergence et la diffusion de la maladie. De telles pratiques ont été observées à propos de l'épidémie du sida pour les migrants et les homosexuels désignés sous le vocable de « groupes à risques » (Taverne, 1999 ; Hardon *et al.*, 2008).

Des sociabilités induites par l'épidémie de COVID-19 au niveau des espaces frontaliers

L'analyse des acteurs et de leurs rôles dans les espaces frontaliers en contexte épidémique est révélatrice de plusieurs sociabilités. Que ce soit en période ordinaire ou en temps d'épidémie, quatre catégories de fonctionnaires gravitent autour des frontières : les agents de santé, les policiers, les agents des douanes et les agents vétérinaires et phytosanitaires.

Chacun de ces acteurs a des rôles « traditionnels » et des rôles induits par l'épidémie de COVID-19.

Au Bénin, les tâches ordinaires des agents de santé portent sur le contrôle sanitaire institué depuis 2010 par arrêté n°3460/MS/DC/SGM/CTJ/ DHAB/DNPS/SESS/SA consacrant la mise en place des postes de santé des frontières. Ces agents ont pour mission d'assurer la surveillance sanitaire et le contrôle de l'hygiène. À ce titre, ils sont chargés de veiller à l'application du règlement sanitaire international, d'assurer la disponibilité des soins médicaux d'urgence au niveau des frontières, de contrôler les carnets de vaccinations internationales chez tout voyageur entrant au Bénin (et de procéder le cas échéant à la vaccination recommandée du voyageur conformément à la réglementation), de contrôler la régularité du transfert des dépouilles mortelles, etc.

Avec l'avènement de la COVID-19, des tâches supplémentaires se sont greffées à celles traditionnellement exécutées par les agents en poste dans les frontières. Les nouvelles activités sont de plusieurs ordres : le dépistage des cas, la sensibilisation des usagers, la surveillance des dispositifs de lavage des mains (contrôle du niveau d'eau et du savon) et la prise en charge d'éventuels cas. La sensibilisation des populations porte sur les précautions de biosécurité à respecter pour éviter d'être contaminé. Elle se rapporte au respect des gestes barrières et des mesures de distanciation physique. Cette approche entre dans le cadre de la promotion d'un programme d'interventions sociales et comportementales dont l'objectif est d'informer le public et de favoriser l'adoption des pratiques qui diminuent la transmission communautaire.

« Quand l'épidémie est arrivée, on a sensibilisé les bonnes dames, celles qui vendent ici des denrées alimentaires, pour les mesures préventives ; c'est-à-

dire, on les a sensibilisées sur la maladie ; on leur a expliqué que le coronavirus existe, et comment ça se manifeste. (...) Dans les bus, si vous constatez qu'il y a des cas suspects, arrêtez et dirigez-vous vers un centre de santé » (Abel, agent de santé, Hilacondji).

Le travail effectué par l'agent de santé comporte également l'observation des passagers présentant des signes éventuels de COVID-19, leur orientation vers les dispositifs de désinfection, la prise de température, le contrôle du remplissage des formulaires d'enregistrement et la prise en charge des personnes présentant une forte fièvre. Dans maints cas, d'anciennes tâches ont disparu pour donner place aux nouvelles.

Cette situation est vécue comme une surcharge de travail ; elle n'a d'ailleurs épargné aucune catégorie professionnelle au niveau des frontières. Même les policiers se sont vus confiés des tâches relevant du secteur de la santé. En dehors de leur mission régalienne consistant à veiller à la sécurité nationale, notamment en surveillant l'entrée de tout produit prohibé (armes, drogue, ...), ils doivent assurer la sécurité du matériel installé, et veiller à ce que des « malades de COVID-19 n'entrent pas dans le pays ».

« Oui, nous avons plus de travail, parce que si notre travail, c'est de contrôler les gens qui entrent dans le pays, c'est-à-dire voir si par hasard, la personne n'est pas armée, ou bien la personne n'est pas porteuse de produits codés. En plus de tout ça, s'ajoute l'état de santé de la personne, se rassurer que la personne n'est pas porteuse de la maladie pour entrer au Bénin » (Pascal, policier, Hilacondji).

« Ce sont les policiers qui nous aident ; c'est pour ça qu'on a positionné les dispositifs non loin d'eux » (Caroline, agent de santé, Hounsahoué).

⁵⁸ L'application du *thermoflash* consiste à viser le front, côté temporal droit en plaçant le thermomètre à 5 cm de distance, et à presser la touche de mesure du thermomètre. La température s'affiche quasiment instantanément.

La présence de la police non loin du dispositif de biosécurité est censée dissuader toute personne voulant éviter le lavage des mains. Parfois même, les policiers aident à la prise de température, face à l'affluence des usagers.

La gestion du risque a fait donc émerger des responsabilités perçues comme une surcharge de travail par les acteurs. Elle a induit de nombreuses sociabilités au niveau des espaces frontaliers.

Le recours à l'informel se compte parmi les stratégies de résilience adoptées. Les effets de la fermeture des frontières sont vécus différemment selon les secteurs d'activités. Au niveau des opérateurs économiques, la COVID-19 a induit une baisse des activités en lien avec la réduction des transits et des échanges commerciaux entre le Bénin et le Togo. Dans un environnement déjà vulnérable, les agriculteurs, les petits revendeurs et les chauffeurs/transporteurs sont les catégories les plus touchées. Ces travailleurs du secteur informel ont perdu une part importante de leurs revenus en raison de la fermeture des frontières. Pour faire face à la chute de leur pouvoir d'achat, ils ont développé des nombreuses stratégies dont l'emprunt des « voies de brousse » devenu la solution pour contourner et gagner le Togo.

Dans le quotidien des usagers, la reconversion vers d'autres activités économiques par certains ou dans l'illégalité par d'autres relève d'une logique de survie. La recherche d'une source de revenus pour assumer les besoins des ménages motivent cette forme de "réinsertion professionnelle". Cette reconversion dans l'illégalité expose les usagers à plusieurs risques, celui lié à la contagion et celui en rapport à l'insécurité (vol, perte de colis, ...). Ainsi, la frontière n'est pas un fait spatial avec des conséquences sociologiques, mais un fait sociologique qui prend une forme spatiale (Schaut, 2016). Une littérature relativement abondante a d'ailleurs

traité des effets économiques induits par la crise sanitaire (Ndong Beka II, 2022).

La mesure de fermeture des frontières, entre défiance et résignation

La perception de la COVID-19 et de son étiologie est un facteur de défiance vis-à-vis des mesures de riposte préconisées par les autorités sanitaires. Maints acteurs y voient « une maladie des blancs » ou un « complot » entre le colonisateur et l'élite politique nationale », ou encore une « nouvelle invention du blanc pour mieux dominer le noir ». Cette théorie complotiste est récurrente dans d'autres contextes morbides. Jusqu'à ce jour, le vaccin contre la poliomyélite, découvert dans les années 1960, est confronté aux mêmes réalités sociales (Houngnihin et Gbébioho, 2015).

Par ailleurs, plusieurs personnes disent n'avoir jamais vu un cas de décès ni même de maladie. Malgré l'existence de vaccins, la COVID-19 demeure une maladie stigmatisante, obligeant maints sujets détectés positifs à dissimuler leur état ou carrément à ne pas se faire dépister malgré l'existence de signes évocateurs. Cette situation entretient un contexte d'« épidémie de la peur » et de déni de la maladie et du modèle virologique. La COVID-19 reste une maladie iconoclaste qui impose des interventions socialement inacceptables, sujettes à des « interprétations persécutives » (Desclaux et Sow, 2016).

L'absence de sources d'informations crédibles et univoques et l'omniprésence des réseaux sociaux face à une population hautement connectée fait le lit à l'infodémie.

« Bon, c'est avec des informations par ci par là ; à chaque fois que je suis sur les réseaux sociaux » (Théophane, déclarant en douane, Hilacondji).

Maints agents de santé qui devront servir de relais d'informations, disent n'avoir pas été formés, mais avoir

été informés par les mêmes réseaux sociaux. Il en est de même des autres acteurs concernés (policiers, douaniers et agents vétérinaires et phytosanitaires).

« Je vous ai dit maintenant que, par exemple les formations au sujet de cette maladie, je ne suis pas impliquée. C'est sur les ondes que moi j'apprends qu'il y a ci, qu'il y a ça, et c'est à base de ça que je prends des précautions » (Pauline, agent de santé, Hilacondji).

Dans un tel contexte marqué par l'absence de sources formelles d'informations, les professionnels développent différentes perceptions de leurs propres rôles. La récurrence des discours divergents et disparates est flagrante. À cette situation, s'ajoute la porosité des frontières qui accentue le sentiment de défiance et de résignation des acteurs.

« Il y a plusieurs voies ici, au niveau des frontières. Il y a des déviations un peu partout où les gens prennent pour contourner ; il y a plusieurs passages ici, mais néanmoins, nous essayons de mener des luttes pour pouvoir décourager ces genres de choses » (Philippe, agent de santé, Hilacondji).

« Les frontières disposent de nombreux débarcadères et beaucoup de gens parviennent à traverser en secret » (Jean, policier, Hilacondji).

Ces propos décrivent l'état poreux des frontières terrestres et l'existence de plusieurs voies de contournement, à travers l'existence de nombreuses pistes et débarcadères sans surveillance, bien connues de tous les usagers.

L'insuffisance de ressources humaines et matérielles conforte la difficulté pour les agents de mettre en application les mesures de restriction.

« Nous n'avons pas de voiture. Ces traversées clandestines, c'est inquiétant à cause du trafic

de drogue, d'armes et aussi de COVID-19. Quand on arrête une personne, on y pense, car on ne sait pas d'où elle vient, ni qui elle est » (Alain, policier, Hilacondji).

Le manque de logistique ne permet pas aux policiers d'assurer convenablement la surveillance au niveau des pistes de déviation. Ces conditions de travail complexifient non seulement le contrôle de l'épidémie mais aussi celui de l'importation des substances illicites. Ce caractère peu opérationnel des mesures de surveillance a été souligné par presque tous les acteurs. Il se traduit également par le non-renouvellement systématique des dispositifs de protection.

À l'évidence, les agents publics ne se sentent pas capables d'affronter l'épidémie de COVID-19, ni même de se protéger personnellement contre la maladie au niveau des espaces frontaliers. Entre autres, ils mettent en cause l'absence de formation et la détention de sources d'informations secondaires et qui véhiculent des messages dont la validité, la véracité et la pertinence sont sujettes à caution.

Cette situation traduit une vulnérabilité certaine des acteurs. Elle est perçue comme un facteur explicatif des écarts observés dans la mise en œuvre des contrôles. Les sentiments vont de la défiance à la résignation dans un contexte où le risque de contagion par le biais des voyageurs est bien évident.

« COVID-19, c'est une bombe à retardement ; dès qu'une personne attrape, si on ne fait pas vite attention là, toute la population est partie. Heureusement, en tout cas moi, j'ai prié beaucoup einh ! Et heureusement que ce n'est pas arrivé » (Régis, déclarant en douane, Hilacondji).

Ainsi, c'est « dieu qui nous sauve », a déclaré un agent de santé. Ce sentiment permanent de fragilité, de manque de confiance et de peur d'être contaminé est associé à la soumission à la volonté divine. Les soignants estiment qu'ils sont les plus vulnérables, parce qu'étant les plus exposés aux cas de maladie. Cette perception de leur propre vulnérabilité au risque infectieux justifie le sentiment d'inquiétude exprimé et qui est renforcé par le caractère poreux des frontières.

Conclusion

L'étude sur la vie sociale de la frontière terrestre de Hilacondji et de Hounsahoué a tenté de comprendre la complexité de la mesure de fermeture des frontières en contexte de COVID-19. Elle a révélé la nécessité d'une approche holistique et d'une autre façon d'appréhender les frontières, d'un point de vue à la fois social, culturel, économique et sanitaire. Pour les populations dont le quotidien transfrontalier a été soudainement bouleversé par les contrôles plus renforcés de la police, l'espace de vie commun s'est progressivement déconstruit et remis en cause par l'épidémie. À tous les niveaux, les travailleurs frontaliers ont dû faire face à des injonctions diverses décidées de part et d'autre de la frontière (Berrod, 2020).

Par ailleurs, la fermeture des frontières semble plus servir à rassurer les opinions publiques qu'à éviter la propagation du virus. Malgré les initiatives de veille sanitaire, le risque de contagion a été omniprésent. Ce risque a été bien décrit par tous les acteurs ; il se justifie par des mesures de surveillance poreuses et des pratiques préventives hors normes. Aussi, les mesures mises en place ont-elles influencé le fonctionnement des services publics et la vie des personnes ayant des activités connexes à la frontière.

Dans un tel contexte, la fermeture des frontières ne résout pas le problème de risque sanitaire. Elle répond à plusieurs usages en lien avec une volonté politique de plaire aux populations. On est en présence d'une réappropriation des espaces frontaliers qui renforce le risque épidémique au regard des stratégies de contournement induites.

Au total, la pandémie de COVID-19 a donné une nouvelle opportunité pour relire les frontières en Afrique. Dans cette logique, l'étude a révélé, s'il en était encore besoin, la nécessité de tenir compte du contexte historique des frontières. Une analyse articulée autour de l'historicité des rapports entre acteurs de différents pays reste intéressante pour approfondir la réflexion (Cherubini, 2004). Enfin, la nécessité d'articuler le rôle de l'anthropologie et celui de la santé publique a également émergé de la réflexion. Elle révèle le besoin d'une déclinaison locale des différentes mesures sanitaires. La « glocalisation » comme champ de lecture de la situation devrait répondre à la question suivante : comment les mesures internationales finissent pas être transformées par des réalités locales ?

Note : Cette étude a été réalisée par le Laboratoire d'Anthropologie Médicale Appliquée (LAMA) avec l'appui financier de « The Couffo Collaborative ». Aucun conflit d'intérêt déclaré.

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4.3. Preventive practices adopted by Pakistani migrant workers in response to COVID-19 measures imposed by the Malaysian government

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Abstract

Since March 2020, COVID-19 has become a global public health challenge. This has led to growing research on the mental health challenges of migrant workers during the pandemic. However, this research has not yet considered the perspectives and adopted practices adopted by migrant workers in response to preventive measures imposed by the government, especially personal health and hygiene practices to ensure and maintain their health. This paper seeks to remedy this deficiency, drawing on 11 informal in-depth interviews conducted with Pakistani migrant workers in Kuala Lumpur, Malaysia. This research finds that stereotypes in the media, employers' attitudes and work-related activities, and legal status have all shaped the preventive or precautionary health practices of migrant workers. It also finds that migrant workers were more conscientious in their response to the government's regular Standard Operating Procedures (SOPs) announcements because their level of anxiety had increased due to documentation-related issues and anti-migrant rhetoric in their social surroundings. The level of caution and prevention increased to the extent that many migrants ceased

to visit neighbouring co-workers, even in the absence of lockdown, due to the widespread perception that migrant workers were to blame for spreading the virus. As a consequence, migrant workers also stopped visiting health practitioners and sharing symptoms (such as fever and headache) with their co-workers and employers, instead depending on local herbal treatments and medicines readily available in neighbourhood pharmacies. This paper concludes that the practices of Pakistani migrant workers have been shaped and formed not only by the COVID-19 pandemic but also by their legal position (as undocumented), their stereotyped image in the media and the treatment they received at the hands of their employers.

Introduction

Since March 2020, the COVID-19 virus has become a global public health challenge and emergency. Countries have taken extraordinary measures to stop its spread and limit its impact on human lives, including Malaysia, which has played a prominent role in preventing the spread of the virus.

Malaysia is an important migrant destination country as well as a state heavily dependent on migrant workers to fill low-skilled positions. Manufacturing, construction, services,

Table 1. General profile of respondents

Name	Age	District	Years in Malaysia	Work
Muhammad Javed	40	Gujranwala	10	Expert in glass fixing
Waqarudding Ahmad	35	Peshawar	6	Electrician
Maqbool Ahmad	34	Chakwal	4	Expert in glass fixing
Muneeb-ur-Rehman	25	Toba Tek Singh	3	Expert in glass fixing
Bilal Ahmad	26	Sialkot	6	Electrician
Tahir Shaikh	27	Khanpur Katora	6	Electrician
Muhammad Imran	35	Lahore	7	Mechanic at auto workshop
Muhammad Naeem	27	Peshawar	4	Mail sorter; courier company
Bisharat Ali	36	Karachi	9	Salesperson at garment shop
Muhammad Amir	34	Rawalpindi	7	Restaurant cook
Muhammad Naveed	33	Lahore	12	Expert in glass fixing

plantations and agriculture are the five major labour-intensive sectors which rely upon migrant labour. In 2019, Malaysia was estimated to have 2 million documented migrant workers, and 5 million migrant workers overall, including those that are undocumented (Hwok-Aun and Leng, 2018; Loganathan, Chan and Pocock, 2020). In this regard, the country has been criticized for policies that create obstacles for migrant workers, including complicated visa regimes that leave many undocumented, as well as the disreputable practices of visa agents and employers (Khoso, Thambia and Hussin, 2020; Wahab, 2020). More recently, continuous raids by the Malaysian Immigration Department have resulted in the arrest and deportation of many illegal migrant workers, while media reports of inhumane and degrading treatment in local detention centres and successive lockdowns have pushed hundreds more to exit the country (Khoso and Noor, 2021; Lee, 2020).

Malaysia imposed three major lockdowns completely restricting all forms of movement except for certain basic and emergency-related activities, resulting in the cessation of numerous economic activities. The first lockdown was imposed on

18 March 2020 and continued until 4 May. According to the informants, during this time, migrant workers were abandoned and unable to work. In addition, extensive raids were conducted to arrest undocumented migrant labourers. The second nationwide lockdown was introduced in January 2021 (Yusof, 2021) and the third on 1 June 2021. While Malaysia was praised for containing the spread of the virus during its first and second lockdowns (Passeri, 2020), these structural conditions and restrictions brought misery to marginalized communities, including migrant workers (Khoso and Noor, 2021; Wahab, 2020), severely impacting their lives and activities.

Despite the exodus of many migrants due to deportations and lockdowns, the remaining pool of available migrant workers in Malaysia provided an opportunity to study and understand their perspectives regarding the COVID-19 pandemic. Research more generally on the knowledge, attitudes and practices of populations coping with COVID-19 has grown rapidly (Azlan *et al.*, 2020; Reuben *et al.*, 2020; Xue *et al.*, 2021), and includes studies on migrant workers examining, for example, the mental health challenges they face (Choudhari, 2020), the effects

of specific stressors on their lives (Alahmad *et al.*, 2020; Wahab, 2020) and the impacts of COVID-19 on migrant fishers (Marschke *et al.*, 2021). However, little attention has been paid to their preventive practices in academic research. This research therefore aims to investigate migrant workers' preventive practices during the COVID-19 pandemic and, more specifically during lockdowns, especially the personal health and hygiene practices they adopted to ensure and maintain their health. It also argues that stereotypes in the media and social surroundings and legal status all shaped the preventive or precautionary health practices of migrant workers.

Methods

To understand their preventive practices, this research draws on 11 qualitative informal interviews with Pakistani migrant workers in Kuala Lumpur, Malaysia. These 11 respondents (see Table 1 for more details) are among the thousands of Pakistani migrant workers living and working in Malaysia, around 70,000 of whom were recorded in Malaysia in 2015 (Khoso, Thambia and Hussin, 2020), although no data were available for Kuala Lumpur.

To aid the qualitative data collection process, an interview guide was prepared. Interviews took place from June 2021 to August 2021 and were conducted either face to face or, when lockdown restrictions hindered physical meetings, via WhatsApp messenger (audio and text messages), a tool commonly used in academic research (Khoso, Thambiah and Hussin, 2020; Khoso and Noor, 2021). Follow-up interviews were scheduled to clarify context and certain statements made by participants. All respondents lived in a minimum group of four to six workers in a house often provided by employers. They provided updates about their routine activities and challenges they faced both individually and collectively as house members. In most cases, the interviewer communicated with the participants in the presence of their housemates, who fed information to the respondent. These qualitative interviews also covered the collective practices of around 45 migrant workers who lived closely with the main participants. The names of all respondents have been changed to protect their identity.

The interviews were transcribed, condensed, coded, and themes were identified. The relevant texts/themes were placed together and analysed. The researcher also used online data to cross-check and ensure that details about migrant workers (or information provided by them) relating to lockdown measures and the stereotypes being discussed were consistent. The majority of respondents stated that they and their housemates experienced no serious medical issues during the pandemic. However, one respondent (Tahir) confirmed that he and his three housemates had tested positive for COVID-19 and had quarantined for 14 days within their house until they had tested negative. All respondents stated that the houses they inhabited were spacious, with four workers living in a house of three rooms, for example. None of the respondents had a formal employment letter from

their employer or was covered by social security. All were working on the basis of verbal agreements that favoured their employers, whom they called 'bosses'.

Findings

Stereotypes in the media and social surroundings: consequent practices

Before and after the COVID-19 pandemic, the Malaysian authorities continued to conduct raids on undocumented migrant workers. The intensity of these raids increased during lockdowns, even as the number of positive COVID-19 cases escalated. One respondent claimed that airports and immigration offices for permits were closed across the country during lockdowns, and that the unused immigration personnel were reassigned to catch undocumented migrant workers. These personnel were also responsible for ensuring migrant workers complied with standard operating procedures (SOPs).

Tenaganita, a Malaysian non-governmental organization (NGO) working with migrant workers and refugees, reported that migrant workers were either confined to their dorms or given extremely limited time to attend to their personal needs outside. The underlying rationale was to reduce the risk of COVID-19 infection. Refugees and migrant workers who were convicted of any crime, including COVID-related crimes, had to serve a prison sentence, after which their work permits were cancelled, and they were detained in immigration detention centres to await deportation (Electronics Watch, 2021).

On 30 June 2021, the immigration authorities arrested 229 migrant workers for violating SOPs, many of whom had ongoing documentation issues in Kuala Lumpur. Among them were 33 Pakistani workers (Bernama, 2021). Such stories featured regularly in social media and provoked terror among migrant workers,

especially regarding the possibility of deportation (Santhiram, 2021). One respondent, Amir, spoke about his constant fear of immigration raids. These would prompt him to leave his shop for a safer location whenever a raid occurred in the surrounding area. Another informant, Waqaruddin, confirmed that these news stories were a constant source of fear among the community and that workers took care to respect the SOPs, avoiding going out unnecessarily. Only those with valid documentation would go outside.

Most workers complained about the agent system, and the majority had visa-related issues which had been created by visa agents and blacklisted companies. For example, Javed ran into serious difficulty during the pandemic. In 2020, he learnt that the company through which he received a work permit had been blacklisted. Over a two-year period, he had borrowed RM 12,000 to pay different agents for a visa, but had lost both his money and his passport, which the company had taken. Continuous police and immigration raids compounded his stress and resulted in significant trauma. News stories about such practices filled the media, negatively impacting the vaccination drive (Fishbein and Hkawng, 2021). Javid added:

I had many sleepless nights. I was so depressed. I had family in Pakistan to provide with adequate support. In Malaysia, I had taken loans from many friends and co-workers, and everyone was demanding [repayment]. I consoled my heart by praying to Allah.

Javed also explained that his lack of documentation left him distraught and constantly fearing arrest. He was therefore careful to always follow the SOPs.

Perception of COVID-19 and vaccination

All respondents stated that, initially, they feared that the government measures were a deception. If they remained unvaccinated, they would not be allowed to work. It was also difficult and dangerous for them to obtain the COVID-19 test from dispensaries. In both cases, they feared being quarantined and then sent to jail because the majority of them had visa issues. Visa agents were not responding and had not provided any proof that their applications had been submitted to the Malaysian immigration department, which was itself closed. In May 2021, according to Bisharat, Malaysia imposed a lockdown because new daily COVID cases had reached 3,000; however, in August 2021 the lockdown was relaxed despite a new case level of around 20,000 per day. His response was:

I do not believe in this [the COVID-19 virus] but consider it politics.

Except for Naeem and Tahir, all respondents claimed that their vaccination experience was easy. However, Tahir was unable to receive the vaccine because, on the day of the appointment, he tested positive for COVID-19, along with his other three housemates, all of whom had a mild fever and a cough and had to quarantine for 14 days. In the case of Naeem, his passport was being held by the immigration department, which was closed due to the lockdown. He arrived at the vaccination centre for his appointment at the correct date and time, but was refused a vaccination because he did not have his original passport with him. While respondents such as Muneeb-ur-Rehman were vaccinated without difficulty, many took circuitous routes to reach the vaccination centre in order to avoid interactions with the police, due to documentation-related issues. All obtained appointments through the

government's online application, and were vaccinated on the given date.

Lockdown impacts and survival practices

According to Bilal and Javid, the majority of migrant workers were badly affected by the government's three successive lockdowns, not by the pandemic. Most respondents stated that during the first lockdown, they did not work for three months. In the second lockdown, they worked for no more than a month. In the third lockdown, most did not have work for two months. For Amir, the lockdown was pointless, resulting in damage to the economy, and loss of work and workers.

Moreover, the government had shut the informal economy, which was operated by migrant workers. As Waqaruddin said:

Repeated lockdowns have had a bad impact on our lives. Its main impact has been on our work. When our work is impacted, means everything is affected.

Amir added:

During the lockdown, we had no work, but when we worked after the lockdown, we were paid less than 20 per cent of our routine daily wages. There was no paid leave.

Naeem elaborated:

We are daily wage earners. Our survival is based on daily work. If we get work, we survive. During the lockdowns or other emergencies, the bosses do not give us money. For the first four months, many other workers and I had no work and no money. Those who had little money barely survived. They borrowed money and bought tickets, and returned to Pakistan. These were the most difficult days. Many workers tried to borrow money from friends, and many relied on charity

and food support from their community groups.

Waqaruddin and many others had some savings, and used these to survive through the lockdowns. They exhibited frustration at their employers who supplied no assistance, and paid their wages in bits and pieces. In addition, according to Waqaruddin, their employers did not provide facilities, and made available food on a very limited basis and living spaces to only a few. He added that prior to COVID-19, such places were extremely congested, but during the pandemic, congestion eased somewhat due to the exit of the majority of migrant workers from Malaysia out of fear of arrest and deportation.

Waqaruddin and all other respondents stated that they had reduced the frequency and amount of remittances sent to family members. Remittance sent during the lockdowns amounted to less than 30 per cent of the amount sent prior to the pandemic. Muneeb-ur-Rehman had sent a nominal amount of money to his father on two occasions since March 2020. Bilal regretted that he had been unable to send a penny to his family since March 2020. As he explained:

Migrant workers in Malaysia mean work. If the workers are working, they will get money; if they are not, they have no money. The government has not done any good for the migrant workers; instead, it raided migrant workers, mentally tortured them and stopped them from working.

Most respondents were the sole earners of their families in Pakistan. The lockdowns and the consequent reduction in remittances therefore badly affecting the rights and needs of their family members in the home country (Khosro and Noor, 2021).

The research further indicates that migrant workers often lost their temper at the (lack of) response of employers, visa agents, the police and

immigration officials, on account of being deprived of their wages and passports and their rights (Khosro, Thambia and Hussin, 2020).

Government and employers: did they help or not?

All respondents stated that the Malaysian government had done little for the migrant workers except to create misery and mental torture. However, a few respondents noted that the government had enabled migrant workers to get vaccinated without charge, as long as they could show a photocopy of their passport. Some respondents also claimed that their employer had paid half or the entire fee for COVID-19 tests, with most claiming that the test was fully covered. Beyond these examples, the migrant workers received no other assistance in any context.

According to Javed, they had no work for around seven months from March 2020 to August 2021. Amir added that when the lockdowns were removed, they received only 30 per cent of their daily wage for working 12 to 14 hours a day. He elaborated:

We [workers] had a tough life. The bosses did not help us. Instead, they helped us with our own money, and did not give us our full wages.

All respondents complained that the government had compensated local people for the loss of their work and wages, but not the migrant workers. Except for one individual, all respondents stated that their employers kept a month's wages to ensure that the workers did not leave. Throughout all three lockdowns the workers received little back pay; instead, they were paid their wages in instalments. Naeem explained:

My bosses had given us money from our wages. All bosses provided us with one hundred, or two hundred a week. During the last two months of lockdown [July and August], the boss only gave

me RM 400. It was pitiful, he had my RM 1 200, but he did not give it to me. I had been begging others to provide me with money so that I could survive here.

Naveed had been in Malaysia for ten years working with the same employer since the beginning. He complained that during the lockdowns, his employer kept his wages to stop him from leaving and paid him extremely small amounts in instalments, which were far from sufficient:

My boss owed us one-and-half month's wages, which is around MYR 3,000 for each worker. He gave us MYR 100 for one week for food. But, I knew many were without work, and they could not get help from the bosses or anyone. It was such a tough time for those workers.

Javed stated that he had no work for three months during the first lockdown, and his employer gave him MYR 400 after 15 days, which he used to buy food. His employer stopped giving him money the following month, even though he was owed MYR 1,000. Another respondent, Maqbool, confirmed the use of this tactic:

Bosses do not give us money from their pockets, but it is workers' money. It is our money.

Javed claimed that employers felt little sympathy for their workers. Maqbool added that employers knew that their workers were a cheap source of income, and that exploiting them was easy during the lockdown period.

Practice of prayer

These difficulties, challenges, uncertainties and fears generated coping strategies among migrant workers and intensified engagement in rituals, particularly the practice of prayers, rooted in a desire to avoid the police and return to work as soon as possible. Most wished to offer prayers in masjids, a Muslim practice closed to migrant workers since the

introduction of the government's lockdown measures. Imran said:

They do not allow migrant workers to offer prayers. This is bad; why do they have a closed masjid? This is Allah's house. The locals can go, but workers cannot pray.

This argument was echoed by Naveed, who added that even though he was vaccinated and took care to respect the SOPs, he was still unable to access the masjid, unlike the locals.

Precautionary measures

Two months ago, Maqbool had a fever which lasted for 11 days. Medicine from the pharmacy had no effect, so he went to the hospital because, he said, he had no other choice. Once there, he tested negative for COVID-19. Like many other migrant workers, Maqbool was scared to consult a doctor. He feared that if he tested COVID-19 positive, he would be sent to a quarantine centre, and from there, to an immigration cell and thereafter be deported. He claimed that his visa had expired, and that the agent was unable to apply for a renewal because the immigration department was closed. Naeem also stated that he knew many workers who did not visit doctors because they feared being placed in quarantine centres. Bisharat mentioned some of the alternative remedies used by migrant workers:

We have faith in Allah. But I often use kahwa [green tea] and completely avoid taking cold beverages or even water. I never felt that there was ever a need to take steam because I never got sick. However, as a precaution, I take every possible measure to protect myself from the virus, because the virus is not as dangerous as the government is dangerous to workers.

Naeem reaffirmed the point that migrant workers would never contravene the SOPs, and took great care of their hygiene, making sure to double-mask and use sanitizer. Muneeb-ur-Rehman added that most workers use Vicks but do not resort to steam if they have a cough or flu symptoms.

As soon he and his co-workers returned from work, Naveed explained that they put their clothes into the washing machine and always took a shower before dressing in clean clothes. The majority of the workers cited the same routine as a precaution to protect themselves and their housemates from the virus.

Waqaruddin emphasized that migrant workers would not be seen outside during lockdowns without a genuine purpose. They would not go to meet friends, but instead only leave the house to buy groceries.

Except for a few, most migrant workers claimed that they had reduced their intake of cold beverages as they had heard that these were less effective as means of combating the virus than hot drinks. Thus, they preferred tea over cold drinks. In addition, the pandemic had resulted in regular cooking at home, according to Muneeb-ur-Rehman, which was not previously common practice.

One exception to migrant workers' efforts to avoid going outside and visiting friends was an emergency. Waqaruddin accompanied his friend to a clinic for a COVID-19 test, which was positive. The result triggered panic as both feared being taken to a quarantine centre, where according to their social media, living conditions were far from good. He explained that workers prayed frequently for safety from the virus to avoid loss of work and money. During the pandemic, Waqaruddin and his housemates often avoided going to hospitals for any treatment because they felt that the locals might be suspect them of being COVID-19 patients. Amir added that migrant workers often avoided

sharing health issues like fever and body ache with co-workers and employers for the same reason.

Discussion

Fear of being deprived of their liberty and money, stigmatized and deported, had an intense impact on migrant workers' way of life and practices, as well on their preventive and precautionary health practices (i.e. their perceptions, feelings, knowledge and actions) during the pandemic. Clinical psychologists have recognized the social impact of this dehumanization of migrant workers in Malaysia, where they believe that migrant workers and refugees are viewed as dangerous and dirty, a portrayal echoed in the media and amplified in the statements of government officials (Zainul, 2020). The continuous and successful raids directed by migration officials and their circulation on social media had triggered intense feelings of fear and despair, exacerbated by the media statements of officials threatening to deport migrant workers found to be flouting the SOPs (Santhiram, 2021). Despite their conscientiousness in following these regulations, this anti-migrant rhetoric combined with documentation-related issues has resulted in a dramatic increase in anxiety and depression. The respondents in this research also revealed that they were often scared of being targeted for minor mistakes.

This public rhetoric against migrant workers was heard and felt by the migrant workers, resulting in the majority avoiding hospitals, as noted above, thereby depriving them of their fundamental right to health. They also stopped sharing their concerns and health problems with their co-workers, especially local people. Eventually, the news media covered the unfair treatment of migrant workers during COVID-19 tests, and the Prime Minister of Malaysia enjoined the media and public to restrain from blaming migrant workers for spreading the virus (Idrus, 2020).

Migrant workers' general practices and health-specific practices are shown in Table 2. These practices result from the circumstances, conditions and challenges in their social surroundings created by Malaysian social actors (i.e., society, employers, policies, SOPs, public and media rhetoric against migrant workers, and law enforcement agencies). Migrant workers' agency interacts with social actors in their social surroundings, enabling them to respond and adapt coping or survival strategies. Together, these shape their agency as migrants and their practices in general as well as those related to health.

Conclusion

The research finds that migrant workers were more conscientious towards the SOPs issued by the Malaysian government because their anxiety and depression had increased due to documentation-related issues and anti-migrant rhetoric in their social surroundings. The intensity of prevention and caution increased to the extent that they abandoned practices of visiting co-workers and friends next door. However, the intensity of migrant workers' connectivity with social media increased exponentially, apprising them of unfair treatment their fellow migrant workers had received during the COVID-19 pandemic. The misplaced blame attached to them for spreading the virus caused migrant workers to abandon visiting health practitioners and sharing symptoms, such as fever and headache, with co-workers (from other communities, i.e., Bangladeshi, Nepali) and employers. Some resorted to using local herbal treatments and medicines that are readily available in neighbourhood pharmacies.

This paper focuses on the practices of Pakistani migrant workers that have been shaped and formed not only by the COVID-19 pandemic but also by their legal position (as undocumented) and their stereotyped portrayal in the media. It shows that government measures and public

Table 2. Challenges facing migrant workers in Malaysia during the pandemic and common and health practices

Specific COVID-19 challenges	General mitigation practices	Preventive health practices
- Repeated lockdowns (three since March 2020) - Loss of work and money - Low wages - Restrictions on physical movements - Inability to renew work permits (visas) due to closure of immigration offices and the absconding of visa agents - Documentation issues - Little or no money for food and other basic needs - No or little remittance for family members in home country - Repeatedly asked for COVID-19 tests - Not allowed to offer prayers in masjids - Migrant-specific media stereotypes - Roadblocks and early closure of shops - Inability to understand shifts in COVID-19-related facts - Deprived of wages by employers - Police bribes to avoid jail and deportation	- Staying calm and relaxing by watching religious programmes, dramas and movies - Abiding by SOPs - Not leaving the house unnecessarily - Saving money by avoiding visiting markets and buying unnecessary items - Avoiding visiting areas that may be policed - Praying at home - Communicating often with relatives in the home country - Staying in touch with the migrant community of practices - Intensifying prayers for work to recommence - Expressing frustration for the loss of work and wages - Expressing anger at agents, employers, the officials - Reducing remittance amounts - Relying on community charity	- Avoiding cold drinks - Drinking normal water and hot beverages - Obeying SOPs while outside, and never contravening SOPs - Using double masks and sanitizers - Never going outside without a mask - When returning from work, removing clothes, taking a shower and putting on clean clothes - Intensifying prayers to avoid infection with the virus - Intensifying prayers to connect with Allah - If fearful to visit doctors, visiting a pharmacy to address fever, ache and flu symptoms - Sharing stories related to COVID-19 cases with others in the community - Avoiding going outside without a vital reason - Avoiding sharing health symptoms (fever, body ache, and headache) with co-workers, employers, etc.

reaction were least favourable to the migrant workers, and that their own responses to health policies (or SOPs) instituted in response to the COVID-19 pandemic were severe. The paper also highlights the perspectives of migrant workers in regard to these measures, offering insights into the practical challenges they faced as a result of government policy and practices. In addition, it reveals that policy achievements related to preventive measures deprived migrant workers of much-needed work and wages. This study contributes to scientific research regarding the perspectives of marginalized communities concerning preventive measures. However, in the future, more rigorous research is required to include more nationalities marginalized groups, in order to attain a broader perspective on preventive science approaches and methods.

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4.4. *The impact of push-pull factors on the socio-economic status of migrant workers in the neoliberal world economy during the COVID-19 pandemic: A case study of district Pauri Garhwal, Uttarakhand, India*

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Abstract

In 2020, a nationwide lockdown was imposed throughout India in response to the COVID-19 pandemic. One result of this pre-emptive measure was massive 'reverse migration' of migrant workers from destination centres to their places of origin, in an effort to avoid the financial crisis and starvation. In addition to highlighting the government's mishandling of the migrant crisis, the pandemic has foregrounded a more extensive debate around the exploitative nature of neoliberal economic structures in India and other parts of the world. This paper explores the impact of push-pull factors on the socio-economic condition of migrant workers in the neo-liberal world economy during the COVID-19 period. It also analyses the migration crisis during COVID-19 in India at two levels: first, during the initial lockdown period when most countries witnessed mass reverse migration; and second, during the lockdown or post-lockdown period, when migrants were faced with the financial crisis and unemployment in their places of origin. Furthermore,

the paper argues that the neoliberal economic setup has proven inadequate in its handling of the predicament of migrant workers and scrutinizes the way in which this structure limits the socioeconomic condition of migrant workers to one of meeting basic needs.

Introduction

On 23 March 2020, the Indian government declared a nationwide lockdown in response to the COVID-19 pandemic. As a result, hundreds and thousands of internal migrants left the urban centres where they worked and returned to their places of origin by whatever means were available. Many of them walked hundreds of miles and a few died on route to their destination. The underlying rationale for these journeys was the inability to survive in cities during the lockdowns. This choice also reflects a failure on the part of the private sector to act responsibly to protect their workers, as well as mismanagement on the part of the government. This situation was not limited to India either – many developing countries of Asia, Africa

and Latin America, such as Brazil, China, Indonesia, Kenya, Myanmar, Nigeria, South Africa, Thailand and Uganda, are also reliant on workers (Siddiqui, 2012) and witnessed reverse migration at a mass level.

Prior to the COVID-19 pandemic, the Planning Commission of India had made explicit provisions in the Fourth, Fifth and Sixth Five-Year Plans for the formulation and implementation of specific developmental actions for the development of the country's hilly regions. However, the development of the Uttarakhand state did not take place as expected (Joshi, 2018). The contribution of the primary sector to state GDP was 14.0 per cent in the financial year 2011/12, decreasing to 10.81 per cent in 2018/19, while the contribution of the secondary sector decreased from 52.13 per cent to 48.28 per cent. Estimates of the contribution of the tertiary sector showed an increase from 33.88 per cent to 40.91 per cent (RDMC, GoUK, 2018, 2019). Overall, the contributions of the primary and secondary sectors, which accounted for the majority of the output from the rural areas of the plains and the hill districts, have declined with time. This left the people with lower job opportunities and low per capita income, compelling them to migrate towards cities to seek work. Additionally, the hill districts remained more underdeveloped with increasing unemployment and slow growth in per capita income in comparison to the plains districts of Uttarakhand. Overall, development in Uttarakhand is heavily biased towards the plains districts while development in the hills districts continues to languish. This is evident across six economic development variables: per capita income, infrastructure, health, education, industrial employment and tourism (Gupta, 2014). A comparison of the estimated growth of the gross domestic product (GDP) of the state's hill and plain districts between 2009–10 and 2016–17 shows a 2–2.5-fold increase in the hill districts and more than three-fold increase in the plains.

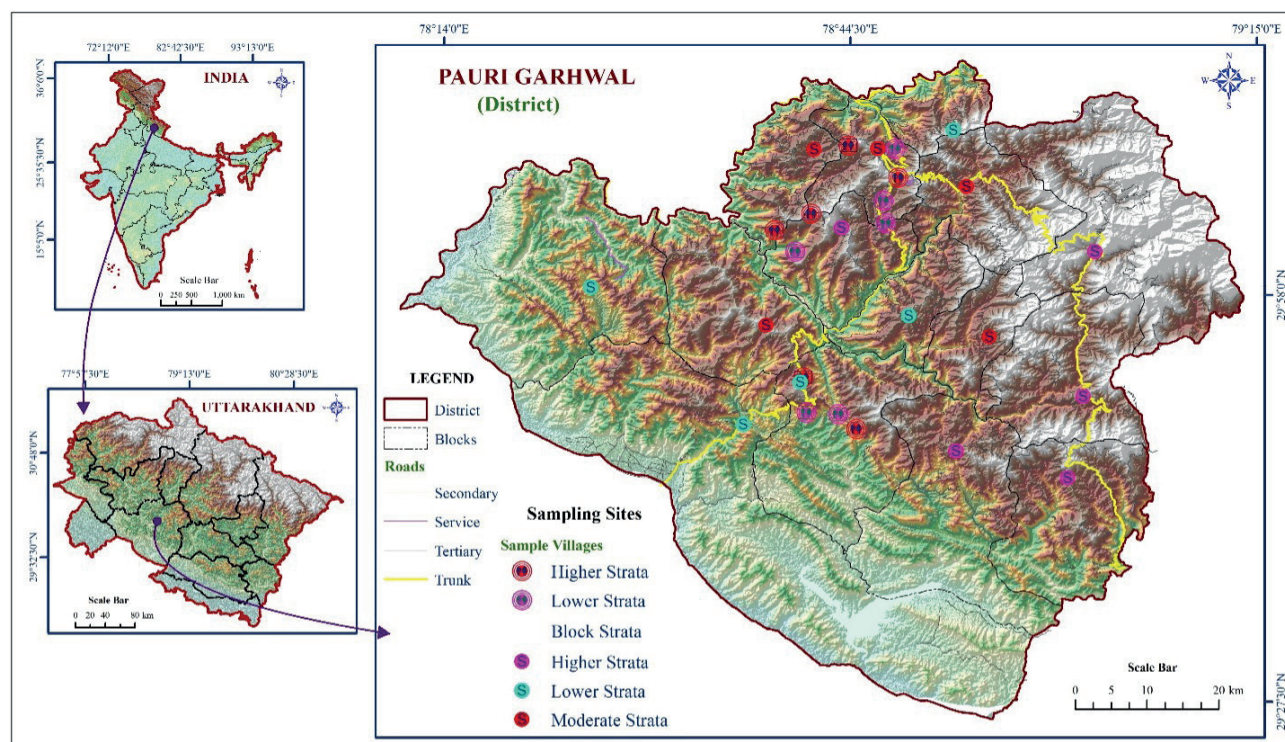
Given the above situation, migration remains the last option for the people of Pauri District, Uttarakhand to improve their living standards. In the last decade, there has been a continuous increase in the migration of people within and outside states from rural to urban areas in search of employment and better opportunities. According to the Census 2011 (migration census), approximately 455 million people in India were classified as migrants based on their birthplace. About 395 million of this group migrated within the state of enumeration⁵⁹ but outside the location of enumeration, while 54 million migrated from one part of the state to another (i.e. to other states in India outside the state of enumeration) (Office of the Registrar General and Census Commissioner, 2011). According to the Rural Development and Migration Commission (RDMC, 2019), in the last ten years a total of 383,726 people in 6,338 gram panchayats have migrated on a semi-permanent basis, visiting their home villages on an intermittent basis rather than migrating permanently. Conversely, a total of 118,981 people have become permanent migrants from 3,946 Gram panchayats. Data indicate that there are more semi-permanent migrants than permanent migrants in all districts of the state (RDMC, GoUK, 2019).

The COVID-19 lockdown also exposed the vulnerabilities of interstate migrant workers in India. Migrant

workers from different states were affected to different degrees, but workers from Uttarakhand were among the worst affected. The primary causes of significant out-migration from Uttarakhand are shortage of earning prospects, lack of access to quality education and poor medical facilities. Agriculture, once a primary source of income for mountain people, is now unprofitable due to a lack of irrigation facilities, wildlife interruptions and climate change. Meanwhile, migration remains a viable option for the people of Uttarakhand seeking to improve their living standards and gain access to better services. At the global level, migrant workers/labourers have been the driving force of development; however, they remain among the most vulnerable groups and have no access to social security assistance in any form (Parveen and Mamgain, 2020). This vulnerability was apparent during the pandemics when migrant workers had little option but to return to their native villages in the face of a sudden nationwide lockdown. According to the RDMC, almost 357,536 reverse migrants returned to their homes in Uttarakhand, including 95,079 to Pauri Garhwal District.

The government-enforced lockdown halted economic activity. Host states where migrant workers were employed provided very limited economic security, while access to existing government schemes was poor, as the majority of migrants worked in the informal labour market as manual workers. Existing laws relevant to interstate migrant workers were not effectively implemented and, as noted above, no effective policy was in place to provide them with access to social security. Both the central and state governments have launched schemes to provide financial assistance and job security to reverse migrants in their respective places of origin, but despite governmental attempts to provide jobs in their home villages and boost the regional economy, their situation continues to worsen with time. Such clear evidence

⁵⁹ State of enumeration refers to a specific administrative region or state within a country where a census or data collection process is taking place. The term is used to describe the geographical area where people are being counted or surveyed for some purpose, such as a population census. The phrase "within the state of enumeration" means that the migration or movement being discussed is occurring within the boundaries of the specific state where the enumeration (data collection) is taking place. People are moving from one location to another, but both locations are still within the same state which is the subject of the enumeration.

Figure 1. Map of the study area, sample strata and Gram panchayats sampling sites of Pauri Garhwal District

Source : Dinesh Prasad Saklani, Narendra Kumar, Hitesh Kumar Mandal, Ekta Singh, Rajesh Naithani, Akshita Bahuguna.

of policy lapses led to the double victimization of migrant workers during the pandemic both in the destination city and in their native villages. Furthermore, it affirms the argument that the nexus between the state and the market consistently avoids any mechanism that ensures bare minimum conditions for migrant workers; instead, prolonging their lack of access to social and economic security, thereby ensuring their vulnerable position during any crisis susceptible to a financial crash.

This study therefore aims to identify the causes of the migrant crisis during the COVID-19 period in India in general, and in Uttarakhand in particular. It focuses on the Pauri district of Uttarakhand, which has one of the highest numbers of reverse migrants in the state. The study has three objectives. The first is to analyse the relationship between push-pull drivers and the socio-economic conditions of reverse migrants during COVID-19. The second is to examine the role of the neoliberal economy during the migration crisis caused by the nationwide lockdown. The third is to explain the vulnerability of reverse

migrants before and during the pandemic-19.

Methodology and conceptual framework

Study area

Pauri Garhwal is a district in Uttarakhand that spans over 5,230 square kilometres and is located between the northern latitudes of 29° 26' 45" and 30° 14' 42", with eastern longitudes ranging from 78° 14' 30" to 79° 14' 20" (Rawat, Sharma and Pant, 2018). The topography of Pauri Garhwal is by and large rugged except for the narrow strip of Bhabhar. The entire region is mountainous. Its hills are inconsistent in character with the district situated within the Shiwalik range, the outermost range of the Himalayas (DEIAA, Pauri Garhwal, 2016). The district is bordered by the districts of Tehri Garhwal and Rudra Prayag in the north, Chamoli in the north-east, Bijnor and Udham Singh Nagar in the south-west, Nainital and Almora in the south-east, Dehradun in the north-west and Haridwar in the west (Figure 1).

The 13 Tehsils (sub-district) that make up Pauri Garhwal District are: Pauri, Srinagar, Lansdowne, Thalain, Kotdwar, Bironkhal, Dhumakot, Chaubatakhal, Satpuli, Jakhanikhal, Rikhnikhal, Chakisain and Yamkeshwar. In addition, there are 15 community development blocks:⁶⁰ Pauri, Kot, Kaljikhil, Khirsu, Pabo, Thalisein, Bironkhal, Nainidanda, Rikhnikhal, Dwarikhal, Jaiharikhal, Dugadda, Yamkeshwar, Pokhara and Ekeshwar (District Pauri Garhwal, GoUK, 2021; RDMC, GoUK, 2018). The District

⁶⁰ A community development block (CD block) or simply 'block' is a Tehsil sub-division in India that is administratively designated for planning and development. A Block Development Officer (BDO) oversees the area and is assisted by many technical specialists and village-level workers. A community development block covers several gram panchayats and local administrative units at the village level (Maheshwari, 1984).

comprises 1,212 Gram panchayats.⁶¹ The total population amounts to 687,271 of which rural areas account for 574,568 and urban areas 112,703 (Chandramaouli, 2011). The total number of reverse migrants in Pauri Garhwal district was (95,079 – both rural and urban) accounting for 26.59 per cent of all reverse migrants in Uttarakhand from the day the nationwide lockdown was announced until September 2020 (RDMC, GoUK, 2021).

Data

The study is cross-sectional in nature and was designed for the district of Pauri Garhwal, Uttarakhand. It includes both quantitative and qualitative approaches that offer different but complimentary perspectives, focusing on facts and perceptual exploration. This method allows for a thoughtful exploration of the various socio-economic dimensions of reverse migrants (IIPS and ORC Macro, 2000; Roy *et al.*, 2021). The entire study is based on primary and secondary sources of information, with the latter collected mainly from the District Panchayati Raj Office, Pauri Garhwal; the Rural Development and Migration Commission, Uttarakhand; and the Primary Health Centres (PHC) of community development blocks, among others.

Research design and method

This study combines a selection of primary data providing rigorous quantitative results that reinforce qualitative findings on the vulnerability of reverse migrants. Without these primary data, it would be impossible to authenticate the

experiences of reverse migrants and throw light on the push-pull factors of migration and the socio-economic vulnerability of reverse migrants. To gather these data, a survey of reverse migrants was conducted in the community development blocks (*Kaljikhla, Pauri, Jaiherikhla*) of Pauri Garhwal district during the first wave of COVID-19.

Sample size

To ensure coverage and representation of reverse migrants across the whole region, a Multi-Stage Stratified Random Sampling Technique was used (IIPS and ORC Macro, 2000; Roy *et al.*, 2021). In total, 85,613 reverse migrants returned to Pauri Garhwal District (Rural) between the announcement of the national lockdown in March 2020 and September later the same year (DPRO, 2020).

The sample size for the primary survey was given by

$$N = \frac{Q}{p} \times \frac{1}{e^2}$$

(Equation 1)... (Sridhar, Reddy and Srinath, 2010)

The proportion of reverse migrants in Pauri Garhwal District (CD Blocks, Rural) accounts for 23.95 per cent ($P=23.95$) of the total number. This percentage was used to establish the Universal Sample Size (USS). If P is the given proportion, $Q=1-P$ (here, $1-23.95=76.05$) gives the proportion of non-reverse migrants in the Pauri Garhwal District (rural). With $P=23.95$, $Q=76.05$, error (e) = 0.010. Accordingly, the sample size for the study was calculated as 321 reverse migrants (Sridhar, Reddy and Srinath, 2010). Based on these considerations and the budget, the chosen sample consisted of 234 reverse migrants from higher strata and 126 reverse migrants from lower strata, resulting in a total sample size of 360 reverse migrants for the study. Based on the above equation (Equation 1), the equal Proportion of Sample Size (PSS),

360 reverse migrants were sampled from 12 sites (see Figure 1 and Table 3) during the first COVID-19 wave. The samples consisted of 21 reverse migrants from each lower strata and 39 reverse migrants from each higher strata (Behera, Mishra and Behera, 2021; Roy *et al.*, 2021).

Sample site selection procedure

Based on the number of total reverse migrants in each community development block out of the total number of reverse migrants in the Pauri Garhwal district, all 15 blocks were categorized into three strata: *higher, moderate and lower* (Table 1). The total proportion of blocks in each stratum is 33.34 per cent. Higher strata, moderate strata and lower strata are based on the percentage of reverse migrants in a given block; higher strata include blocks with more than 8.0 per cent reverse migrants, moderate strata include blocks with 5.6 per cent to 6.7 per cent reverse migrants, and lower strata includes blocks with less than 5.5 per cent reverse migrants. Random numbers were generated for each block in the given strata and the block with the highest random number was considered as a sample block for the first stage. These included Kaljikhla block from the higher strata, Pauri from the moderate strata and Jaiherikhla from the lower strata (Table 1).

Similarly, within each selected block, all the Gram panchayats were categorized into two strata (*higher and lower*) based on the total reverse migrants in each Gram panchayat. Higher strata include Gram panchayats with more than 0.151 per cent reverse migrants and lower strata include Gram panchayats with 0.150.0 per cent to 0.056 per cent reverse migrants out of the total number of reverse migrants in Pauri Garhwal district. All the Gram panchayats in which the percentage of reverse migrants were below 0.055 per cent were not considered in the list of classified strata for sampling due to the low

61 The Gram panchayat is a basic governing institution in Indian villages. It is a political institution, acting as cabinet of the village in the defined jurisdictioned area. The Gram sabha functions as the general body of the Gram panchayat. The members of the Gram panchayat are elected directly by the people. The President of the Gram panchayat is called the Pradhan or Sarpanch. There are about 250,000 Gram panchayats in India (Chaturvedi, 2012).

Table 1. Classification of block strata for sample site selection

First stage						
Reverse migrants						
Strata	Block name	Code	Total	Percentage	Random number	Selection
Higher strata	Kaljikkhal	104216103	6 854	8.0	0.562719516	Selected
	Nainidanda	104216108	9 175	10.7	0.515774496	
	Rikhnikhal	104216109	6 898	8.1	0.450085788	
	Birokhal	104216107	12 049	14.1	0.378900873	
	Thalisain	104216106	9 595	11.2	0.310427878	
Moderate strata	Pauri	104216101	4 760	5.6	0.893416213	Selected
	Kot	104216102	5 035	5.9	0.394425174	
	Pokhra	104216114	5 252	6.1	0.118346987	
	Pabau	104216105	5 445	6.4	0.103127032	
	Dwarikkhal	104216110	5 755	6.7	0.048463294	
Lower strata	Jaiharikkhal	104216111	4 725	5.5	0.92138482	Selected
	Khirsu	104216104	1 633	1.9	0.658459329	
	Dugadda	104216112	3 355	3.9	0.480751157	
	Yamkeshwar	104216113	1 047	1.2	0.448743571	
	Ekeshwer	104216115	4 035	4.7	0.25450872	
District total			85 613	100.0		

Source: author's calculations based on DPRO, Pauri District, 2020 data.

Table 2. Percentage distribution of reverse migrants under different strata and stages of sampling

Second stage						Third stage				
Strata	Higher strata			Lower strata			Higher		Lower	
	Reverse migrants			Reverse migrants			Reverse migrants		Reverse migrants	Block
Strata name	Total	%	Total	%	Total	Total	%	Total	%	Total
Kaljikkhal	915	1.07	4 002	4.67	4 917	383	0.45	146	0.17	529
Pauri	986	1.15	3 016	3.52	4 002	285	0.33	208	0.24	493
Jaiharikkhal	1 079	1.26	2 557	2.99	3 636	276	0.32	132	0.15	408
Universe total	2 980	3.48	9 575	11.18	12 555	944	1.10	486	0.57	1 430
District total	8 5613	23.95								

Source: Authors calculation based on DPRO, Pauri District, 2020 data.

ratio in comparison to other Gram panchayats. In total, 3.34 per cent of reverse migrants come under the higher strata among which 1.07 per cent belong to Kaljikkhal Block; 1.15 per cent of reverse migrants to Pauri and 1.26 per cent to Jaiharikkhal. Conversely, 11.18 per cent of reverse migrants come under the lower strata among which 4.67 per cent belong to Kaljikkhal Block, 3.52 per cent to Pauri, and 2.99 per cent reverse to Jaiharikkhal (Table 2).

Selection of the Gram panchayats involved the categorization of all Gram panchayats from each block into two strata – higher (above 0.151) and lower (0.150-0.056). Random values

were then generated for each stratum resulting in two Gram panchayats with the highest and lowest random values in each stratum. Following this procedure, six Gram panchayats were selected from the higher strata and six from the lower strata. This gave a total of 12 Gram panchayats as final sample sites (Table 3).

In the third stage procedure, 1.10 per cent of the reverse migrant population fell under the higher strata of which 0.45 per cent belong to Kaljikkhal block, 0.33 per cent to Pauri and 0.32 per cent to Jaiharikkhal. Meanwhile, 0.57 per cent of the reverse migrant population fell under the lower strata among which

0.17 per cent belong to Kaljikkhal block, 0.24 per cent belong to Pauri and 0.15 per cent to Jaiharikkhal (see Table 2). A list of Gram panchayats in the district of Pauri Garhwal was obtained from census amenities data (Chandramaouli, 2011) for all community development blocks. In order to select a sample of Gram panchayats from blocks in Pauri Garhwal district, the Probability

Table 3. Distribution of sample sites, random numbers for strata, reverse migrants, households and populations for field survey

→ First stage strata ↓		→ Third stage strata ↓											
Block name		Gram panchayats			Reverse migrants		Households		Population		Random number		Per site samples
	Name	Code	Percentage	Name	Code	Total	Percentage	Total	Total	Total			
Higher	Kaljikhhal	104216103	Higher Above 0.151	Ashgarh	45901	129	0.151	89	407	0.86085767	39 interviews		
	Kaljikhhal	104216103		Diusa	45862	254	0.297	102	410	0.2972652			
Moderate	Pauri	104216101		Ujiyari	46136	138	0.161	199	782	0.17172828			
	Pauri	104216101		Nisni	46224	147	0.172	246	854	0.95699078			
Lower	Jaiharikhhal	104216111		Asankhet	47440	129	0.151	34	136	0.94072722			
	Jaiharikhhal	104216111		Jaiheri	47396	147	0.172	398	1666	0.19740456			
				Strata total		944	0.184	1 068	4 255				
Higher	Kaljikhhal	104216103	Lower 0.150 –0.06	Agrora	46046	55	0.064	46	173	0.98080978	21 nterviews		
	Kaljikhhal	104216103		Ghandyal	45891	91	0.106	179	580	0.02566644			
Moderate	Pauri	104216101		Shri Kot	46203	80	0.093	44	144	0.97225333			
	Pauri	104216101		Dungari	46250	128	0.150	104	387	0.00128152			
Lower	Jaiharikhhal	104216111		Guniyal	47468	52	0.061	42	142	0.98801942			
	Jaiharikhhal	104216111		Chametha	47422	80	0.093	40	109	0.02566751			
				Strata total		486	0.095	455	1 535				
Total strata						1430		1 523	5 790				

Source: Author's calculations based on DPRO, Pauri District, 2020; Census, 2011 Data.

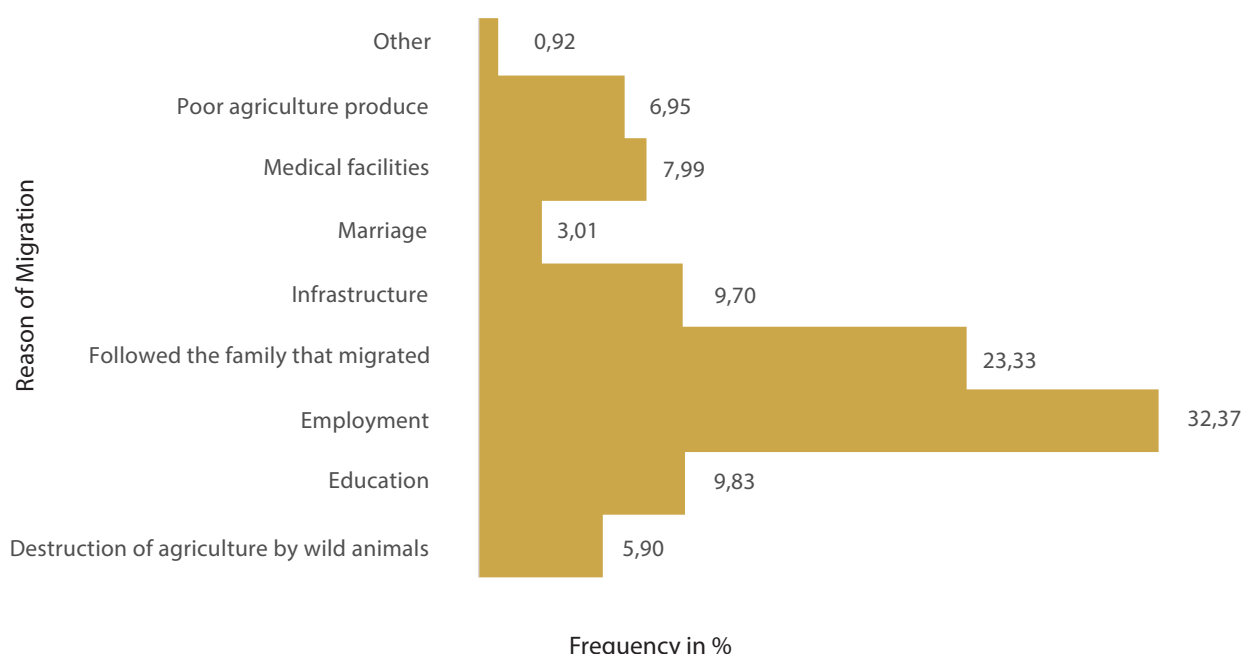
Proportional Sampling method⁶² was used. Given the study sample size of 360 reverse migrants, the sample had to be distributed equally across the Gram panchayats. Likewise, due to the minimum requirement of 21 samples of reverse migrants for each Gram panchayat under the lower strata, six Gram panchayats spread across various geographical locations (Figure 1) of Pauri Garhwal district (Kaljikhhal, Pauri, Jaiharikhhal) were chosen for the field survey.

Similarly, given the minimum requirement of 39 samples of reverse migrants from each Gram panchayat under the higher strata, six Gram panchayats spread across various geographical locations of Pauri Garhwal district (Kaljikhhal, Pauri, Jaiharikhhal) were chosen for the field survey (Table 3).

Statistical analysis

Descriptive statistics such as percentages, frequency and average value were used to enhance the study, presented in a variety of graphic forms including tables, pie charts, bar and histogram graphs, correlation matrices and heat maps. The answers to the structured questionnaire were digitized into an Excel spreadsheet. The relationship between push-pull factors and the socio-economic condition of reverse migrants during the first wave of COVID-19 was analysed using a correlation matrix, and the relationship between different income classes of reverse migrants before and during the first wave was analysed using Pearson's correlation coefficient (Hassan *et al.*, 2020; Hoffmann *et al.*, 2019; Sridhar, Reddy and Srinath, 2010).

⁶² Probability proportional sampling, usually known as probability proportional to size (PPS) sampling, is an unequal probability sampling technique, in which the probability of selection for each sampling unit in the population is proportional to an auxiliary variable (Cheung, 2014).

Figure 2. Reason for migration in pre-COVID-19 (Factors wise) with interpretation

The relationship between push-pull drivers and the socio-economic condition of reverse migrants during COVID-19

Migration is a global issue driven by economic, social, political, cultural, physical, medical, academic and infrastructural factors. It commonly arises due to the push factor of fewer socio-economic possibilities and the pull factor of more prosperous areas (Thet, 2014). It is driven by macro-level inter-and intra-regional imbalances, as well as a lack of employment possibilities, resulting in poor living conditions for diverse socio-economic groups at the micro-level (Simpson, 2017). Push factors are elements that induce people to leave one location and travel to another for various reasons. Low productivity, joblessness and lack of development, economic malaise, a lack of opportunities for advancement, natural resource degradation, and natural calamities are all common push factors. Pull elements are factors that persuade migrants to relocate to a particular location. Opportunities for career enhancement, greater salaries, facilities, good working conditions and appealing facilities are all pull factors. Additionally, unhappiness with one's current location is a common push

factor, while the attributes of distant places make them appear more appealing and function as pull factors (Dorigo and Tobler 1993).

The bulk of studies indicates that economic factors are the main motivation for migration (Haas, 2011). Among these, the desire for a higher standard of living is the first and most important factor, with the highest proportion of variance, driving people to relocate to cities. A dearth of economic opportunities and growing pressure on the local economy have been highlighted as two probable factors for migration in the state (Arya and Arya, 2020; Awasthi, 2010; Awasthi and Mehta, 2020).

In emerging nations, reduced farm income, agricultural insecurity and lack of job opportunities are major factors driving migration to more prosperous areas with greater job possibilities (Sridhar, Reddy and Srinath 2010; Teddy, 2019). According to the primary data (Figure 2), 32.37 per cent of reverse migrants cited seeking employment in destination cities as the motivation behind migration, followed by 23.33 per cent of reverse migrants who followed family members that migrated earlier. In addition,

9.83 per cent identified education the main reason for migration, and 9.70 per cent and 7.99 per cent cited better infrastructure and medical facilities in the destination cities, respectively. Other drivers of migration were poor agriculture produce and the destruction of agriculture by wild animals in native villages (6.95 per cent and 5.90 per cent, respectively), followed by marriage and other factors (3.01 per cent and 0.92 per cent, respectively).

Reverse migration is a concept in which migrants leave their respective localities and then return after a period of time to their places of origin (Mohapatra and Jha, 2019; Stark, 2019). During the COVID-19 pandemic and subsequent lockdown in India, it is estimated that at least 12 million migrants returned to their places of origin, a figure that continued to climb after the initial wave (Chisti, 2020). Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Odisha, Jharkhand, West Bengal and the hill state of Uttarakhand had the highest number of reverse migrants. The number of reverse migrants in Uttarakhand during the pandemic was estimated to be more than 215,000 (Awasthi and Mehta, 2020; de Haan, 2020).

Table 4. Socio-economic condition of reverse migrants during the COVID-19 pandemic

Factors	Sub-variables	Total	Factors	Sub-variables	Total
Section -A			Section -A		
Gender	Female	30.56	Income	Below 10 000	6.94
	Male	69.44		10 000–15 000	19.17
Education	Illiterate	2.50		15 000–25 000	24.17
	High school	39.44		25 000–40 000	10.83
	Intermediate	33.61		40 000 and above	3.61
	Graduate	20.28		Not applicable	35.28
	Postgraduate	2.78	Family size	Less than 2	0.83
	Other	1.39		2–4	57.50
Married	Married	70.28		4–6	38.06
	Unmarried	29.72		More than 6	3.61
Employed	Government sector	5.28	Ration card	Antyodya	0.56
	Multinational company	7.22		BPL	45.00
	Private sector (small-scale industry/ retail/hospitality)	47.50		APL	34.72
	Not employed	34.17		Not applicable	19.72
	Self-employed	5.28	Landholding	Small piece of land but uncultivated	14.72
	Other	0.56		Small piece of land with cultivation	33.61
				Medium-sized land but uncultivated	9.17
				Medium-sized land with cultivation	28.89
				Large amount of land but uncultivated	5.83
				Large amount of land with cultivation	3.61
				Not applicable	4.17

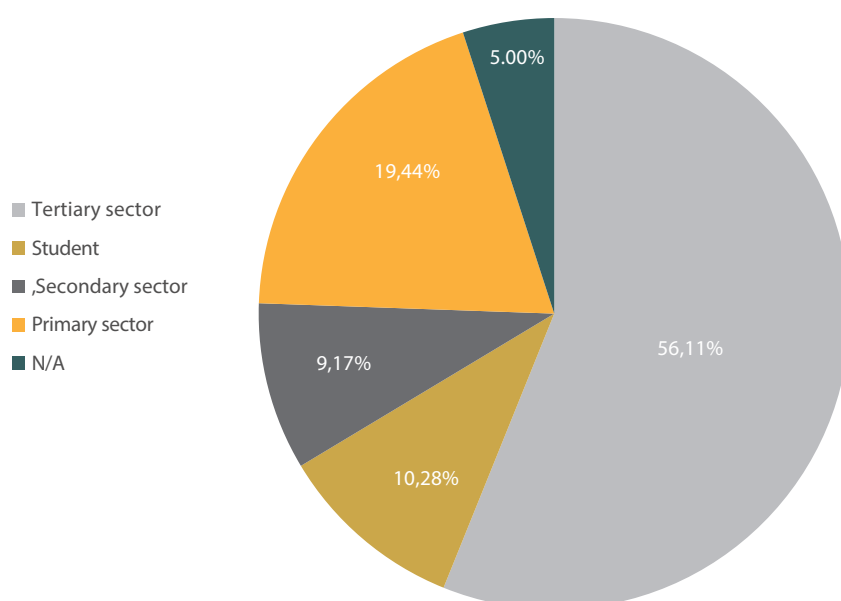
Source: Authors' calculations based on field survey, 2021.

According to data received from DPRO at Vikas Bhawan in Pauri Garhwal district, around 100,000 were from Pauri district alone, encompassing both urban and rural areas.

According to the Rural Development and Migration Commission (RDMC, GoUK, 2021), 357,536 reverse migrants arrived in Uttarakhand from other regions of the country in the months up to September 2020. Among these, 104,849 (29.0 per cent) relocated again. In Pauri Garhwal district, a total of 95,079 reverse migrants returned to their hometowns, with

15,101 relocating once more (RDMC, GoUK, 2021). These reverse migrants belong to various socio-economic backgrounds with different education levels, marital status, household size and landholding capacity, among other factors. Table 4 provides a breakdown of the socio-economic condition of reverse migrants of Pauri District of Uttarakhand during the COVID-19 pandemic, in terms of gender, marital status, education level, employment sector, household size, landholding size, type of ration card and income per month.

The statistical analysis of the socio-economic condition of reverse migrants in Table 4 shows that only 30.56 per cent were female compared to 69.44 per cent male reverse migrants. Of these, 70.28 per cent were married and 29.72 per cent were unmarried. In terms of education, 2.50 per cent were illiterate, 39.44 per cent had completed high school, 33.61 per cent had passed intermediate level and 20.28 per cent had earned a bachelor's degree. In comparison, 2.78 per cent had completed post-graduate studies and 1.39 had other educational

Figure 3. Employment of reverse migrants by sector

qualifications. Regarding employment history, 5.28 per cent of the reverse migrants in the sample were government employees; 7.22 per cent worked in multinational companies (MNC); 47.50 per cent worked in the private sector including small-scale industry, retail and hospitality. 34.17 per cent were not employed, 5.28 per cent were self-employed and 0.56 per cent were engaged in other types of employment. An analysis of the income of these reverse migrants found that 6.94 per cent earn below INR 10,000, 19.17 per cent make between INR 10,000 and 15,000, 24.17 per cent earn between INR 15,000 and 25,000, 10.83 per cent earn between INR 25,000 and INR 40,000, 3.61 per cent earn above INR 40,000 and 35.38 per cent were categorized not applicable (Table 7).

Data on the family size of reverse migrants show that 0.83 per cent have less than two members, 57.50 per cent have two to four family members, 38.06 per cent have four to six family members and 3.61 per cent have more than six family members. The

data also show that 0.56 per cent of the people held Antyodaya ration cards, 45 per cent had Below Poverty Line (BPL) ration cards, 34.72 per cent had Above Poverty Line (APL) ration cards and 19.72 per cent had none. The statistical analysis of landholdings shows that 14.72 per cent and 33.61 per cent possess a *small* piece of land that is uncultivated and cultivated, respectively; 9.71 per cent and 28.89 per cent possess a *medium* piece of land that is uncultivated and cultivated, respectively; and 5.83 per cent and 3.61 per cent possess a *large* piece of land that is uncultivated and cultivated, respectively.

The neoliberal economy and migration during the COVID-19 pandemic

In Asia, particularly in India and China, the process of globalization and concomitant structural reforms in the framework of neoliberalism have accelerated the pace of urbanization and given rural-urban migration a new character. Many globalist thinkers believed that globalization

in the neoliberal world economy would result in an influx of foreign wealth and higher local investment, resulting in more job opportunities within or around cities. According to neoliberal theorists, the socio-economic condition of people in the rural sector would improve further as they opted to migrate to work in the urban market. However, a key criticism of this theory is that migrant workers are confined to the informal economy of cities, resulting in urban poverty (Sengupta, 2013). This is borne out by the study's findings. Primary socio-economic data from the Pauri district (Table 4) show that 54.72 per cent of migrant workers work in the private sector (multinational corporation and small-scale industry/retail/hotel industry), whereas only 5.28 per cent work in the government sector. At the same time, 56.11 per cent and 9.17 per cent of total migrant workers work in the tertiary and secondary sectors of cities, respectively. In other words, many migrants work in the private component of tertiary and secondary sectors in their respective destination cities (Figure 3).

India's neoliberal economic reform triggered multiple forms of migration. Permanent long-distance migration and short-distance temporary and circular migration have both increased significantly. During the last two decades, migration between Indian states and districts has surged at an unprecedented rate (Sengupta, 2012). In most cases, migration in India is driven by a desire to find work to maintain a subsistence level of living, rather than by a desire to earn a higher wage (Deshingkar, 2010). Rural-urban migration of this kind may be purely seasonal, cyclical or permanent under this neoliberal world system. It is a routine livelihood strategy in the countryside, not just a response to shocks like droughts, floods and earthquakes (de Haan, 2000, Deshingkar and Start, 2003; Rogaly and Coppard, 2003). According to Kundu and Sarangi (2007), rural

people have been forced to relocate to cities due to slower growth and the low income-generating ability of agriculture, as well as a lack of alternative livelihood possibilities. However, the absorption of migrants caused immense stress in metropolitan areas, while doing nothing to improve the condition of the migrants. Many structuralist researchers have shown how the market intermediaries exploited migrant labourers, and emphasized their incapacity to escape poverty (Olsen and Ramanamurthy, 2000; Reddy, 1990). These conditions of urban poverty and a stressed urban informal sector contributed to mass reverse migration during the first lockdown.

The economic problems affecting migrants during India's pandemic had two specific causes: the actions of the market and the state in the neoliberal economic context during the pre-COVID-19 and COVID-19 periods. Migrant labourers in India were significantly more vulnerable compared to other categories of migrants during the pre-COVID-19 era, demand for their labour in cities being predicated upon sustained economic growth (Skeldon, 2009). This demand was driven by a neoliberal expansionist market structure with little interest in broader development.⁶³ The existing vulnerability of migrant workers was then compounded by state intervention during the COVID-19 pandemic. By imposing measures to repress economic activity, the state removed the only means of survival in

cities for migrant workers, triggering reverse migration on a nationwide scale from destination cities back to villages of origin.

At the turn of the millennium, the worldwide community agreed upon eight Millennium Development Goals (MDGs) to achieve development by eradicating poverty. These collectively constituted 'a global agreement to reduce human poverty' (UNDP, 2003), making poverty reduction and eventual elimination the most crucial aspect of development. The MDGs established precise aims to halve the number of people living on less than \$1 per day (in any country) and to halve the proportion of people suffering from hunger between 1990 and 2015. Accordingly, a key question in any discussion of migration and development is whether migration can be regulated to help reduce poverty in these ways (Skeldon, 2003, 2009). Other MDGs also seek to attain universal primary education, promote gender equality and women's empowerment, reduce infant mortality, enhance maternal health, and combat HIV/AIDS, malaria and other diseases to help accomplish the first objective of poverty reduction (UNDP, 2003). The fifth and sixth MDGs aim to ensure environmental sustainability and build a worldwide development partnership. This stands in stark contrast to the concentration of migrant workers in India's cities, the principal outcome of which is the economic growth of their destination location.

It was assumed that the process of globalization would result in the entry of foreign capital and increased local investment, providing job possibilities inside or near metropolises for migrant workers. According to the neoclassical paradigm (Harris-Todaro, 1970; Todaro, 1976), the migration window was also supposed to encourage labour in poorer regions and isolated rural areas to flourish. Urban areas and dynamic urban centres continue to welcome migrants who seek to improve their economic

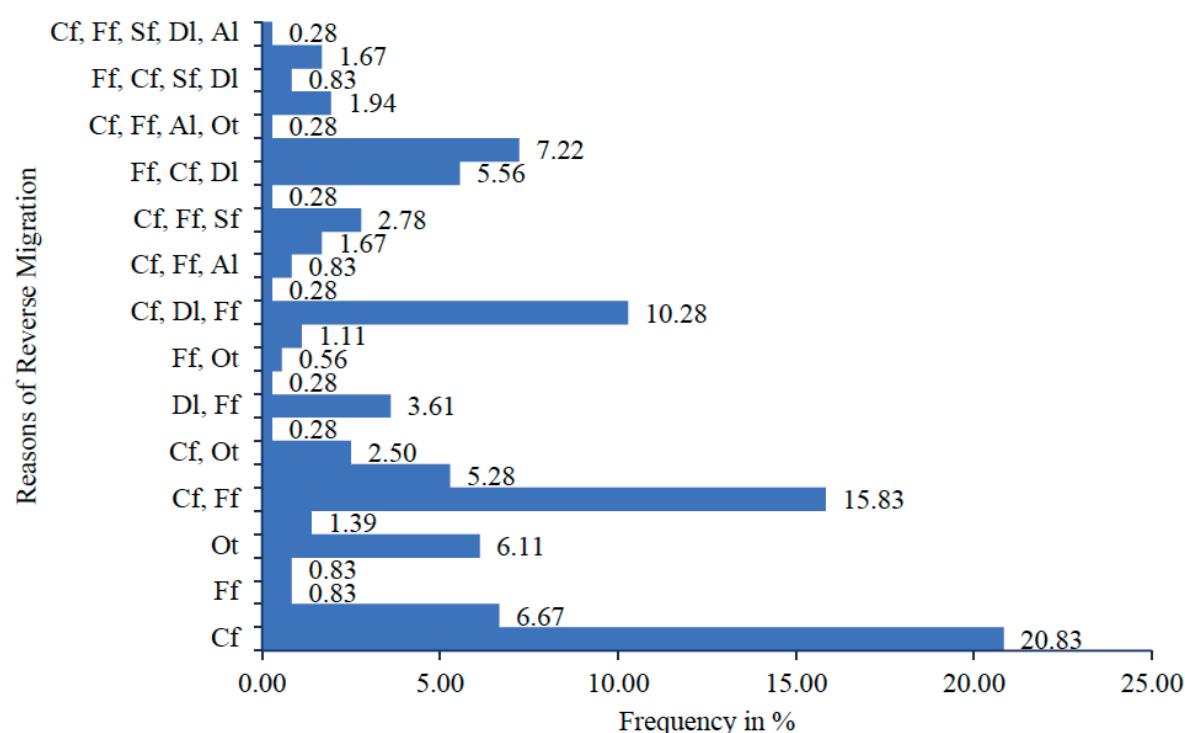
well-being. However, such a dramatic improvement has not taken place for migrants in developing countries of the Asian continent. Significant numbers of rural out-migrants have failed to succeed in modern society due to skills deficiencies or because their skills were acquired in small towns and rural areas of the countries. Migrant workers from rural areas have thus remained poor because rural-urban migration generated urban poverty (Bremar, 1978).

This feature of migration has exacerbated socio-economic inequality by amplifying antagonistic and exploitative production processes and social connections between the owning and non-owning classes. The concentration of production means (land, labour and capital) among a privileged few has resulted in opulence among a small section of the owning class and the discharge of excess labour resulting in increasing unemployment. As the accumulation of capital and wealth continued unabated, an increasing number of employees were excluded. This resulted in a significant outflow of refugee labour from impoverished villages to metropolitan slums and other comparatively developed zones, simply to survive (Mukherjee, 2013).

Neoliberal economic exploitation during the COVID-19 migration crisis

The effects of neoliberal economic structures during the pandemic were visible on two fronts: first, during the initial lockdown period when most countries witnessed mass reverse migration from urban areas; and, second, during the lockdown or post-lockdown period when reverse migrants experienced financial crises and unemployment in their home villages and towns. Regarding the former, primary data show that 20.83 per cent of reverse migrants returned to their places of origin by every possible means of transportation, due to fear of COVID-19, while only 6.67 per cent returned due to loss of work. Of the total, 5.28 per cent returned because

63 Skeldon (2009) argues that economic growth is fundamental to development, but that development is more than simply economic growth, with the proceeds of growth being distributed throughout society manifesting in improvements in health, education and gender relations. However, this intuitive notion of development as improvement in the human condition is not a good benchmark for understanding the situation in India, where migrant workers in destination cities are particularly vulnerable to crises.

Figure 4. Reasons for reverse migration during the COVID-19 pandemic

Source : Dinesh Prasad Saklani and Narendra Kumar, Hitesh Kumar Mandal, Ekta Singh, Rajesh Naithani, Akshita Bahuguna

Note: Cf: COVID-19-related fear, Al: anxiety due to loneliness, Dl: due to loss of job/work, Ff: financial fear, Sf: shortage of food, Na: not applicable, Ot: others.

of loss of work and fear of the virus; 15.83 per cent returned because of fear of both COVID-19 and financial crisis; 10.28 per cent returned due to fear of the virus, financial crisis and loss of work; 3.61 per cent lost their jobs and returned out of financial fears; 0.28 per cent returned due to fear of the virus and even faced shortage of food; and 7.22 per cent returned due to fear of the virus, loss of jobs, fear of financial crisis and also faced shortage of food (Figure 4).

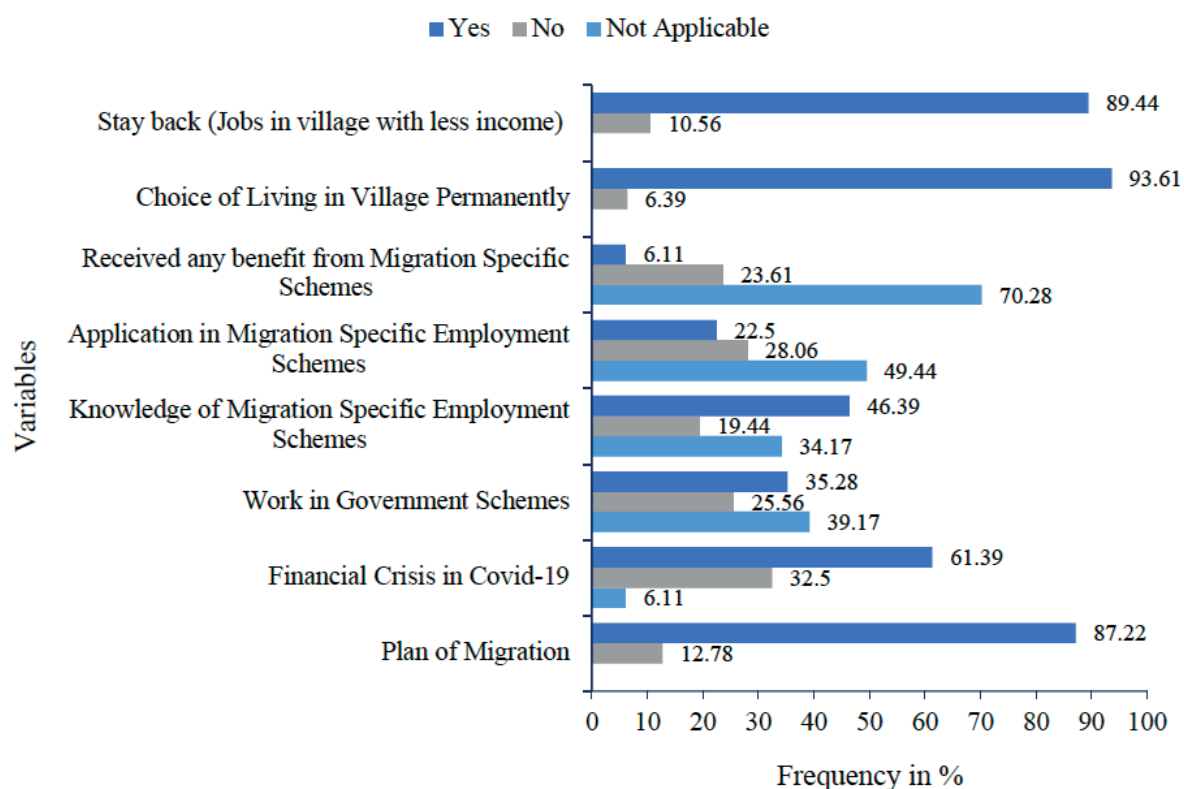
This situation is a direct consequence of a neoliberal world economy where private market players, operating in tandem with the state, exploit migrant workers. The condition of these labourers throughout their working tenure is precarious, meeting only the basic needs for their own and their family's existence. This migratory workforce is a function of globalization processes engendered

by the neoliberal economy to enable large private corporations to generate a surplus out of cheap labour. However, the chain of economic mechanisms that absorbed the large migrant population is being hampered by nationwide lockdowns of different intensities and parameters throughout Asia, Africa and Latin America, generating internal reverse migration.

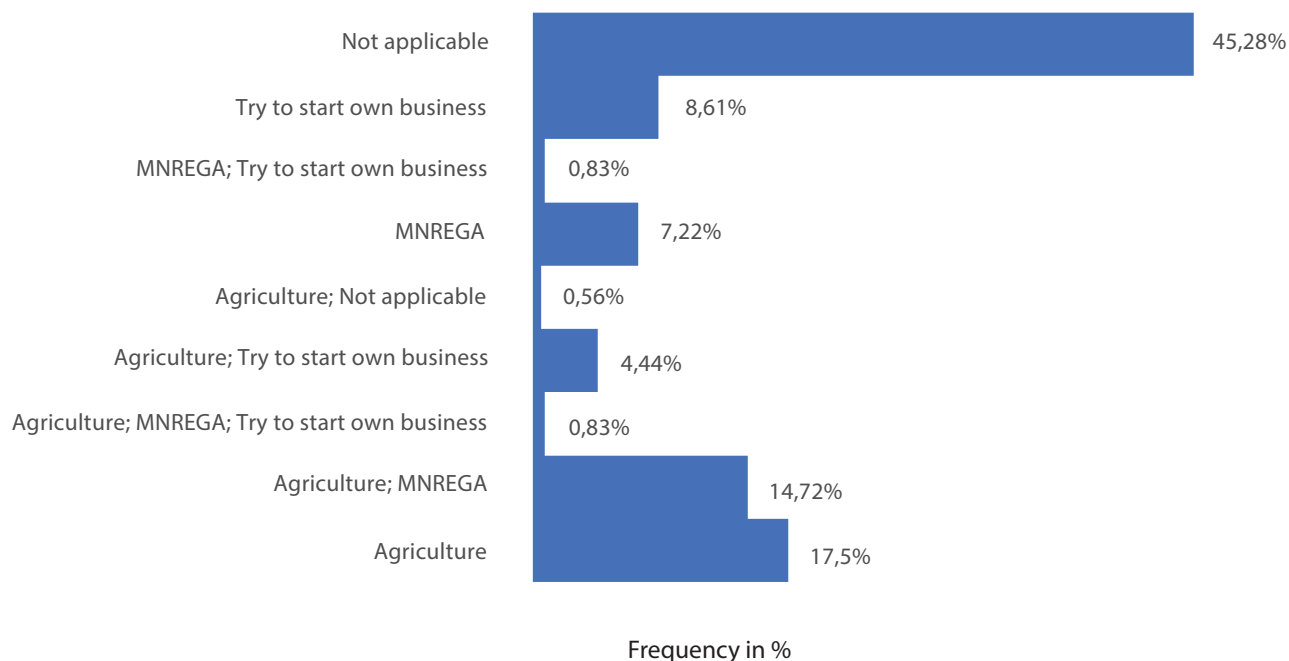
During the lockdown or post-lockdown, reverse migrants faced financial crises and unemployment in their places of origin. According to primary data collected during the survey, 61.39 per cent of reverse migrants faced a financial crisis on their return, compared to 32.5 per cent who did not (Figure 5). Migrants engaged in many types of work in their native homes to overcome financial difficulties during the pandemic. Among these,

17.5 per cent turned to agriculture; 14.72 per cent worked in agricultural alongside work provided under MNREGA⁶⁴ schemes; and a marginal proportion (0.83 per cent) engaged in agriculture, MNREGA work schemes and tried to start their own business simultaneously (Figure 6).

64 The Mahatma Gandhi National Rural Employment Guarantee Act 2005 is an Indian social welfare measure that aims to guarantee the 'right to work'.

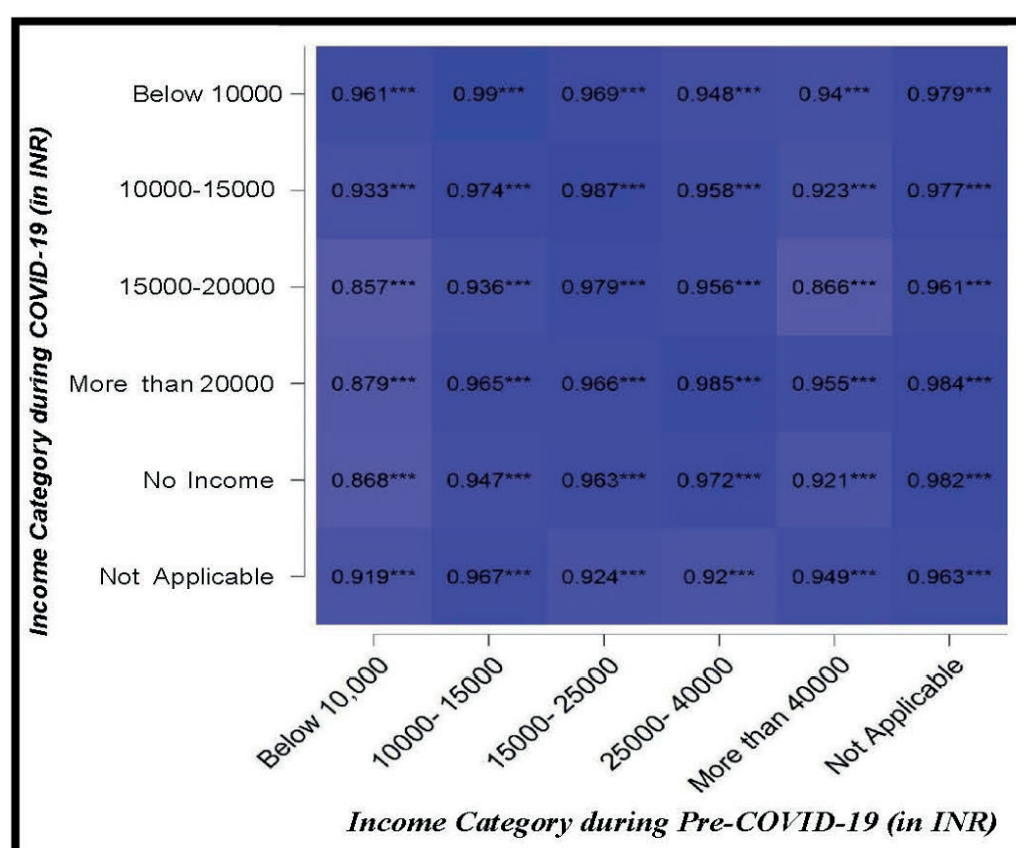
Figure 5. Percentage distribution of questions related to employment schemes, financial crisis and the future plans of reverse migrants

Source : Dinesh Prasad Saklani and Narendra Kumar, Hitesh Kumar Mandal, Ekta Singh, Rajesh Naithani, Akshita Bahuguna.

Figure 6. Types of work undertaken by reverse migrants during the COVID-19 crisis

Source : Dinesh Prasad Saklani and Narendra Kumar, Hitesh Kumar Mandal, Ekta Singh, Rajesh Naithani, Akshita Bahuguna.

Figure 7. Heatmap of correlation between income classes of reverse migrants prior to and during the first wave of COVID-19 in Pauri District, Uttarakhand



Source : Dinesh Prasad Saklani and Narendra Kumar, Hitesh Kumar Mandal, Ekta Singh, Rajesh Naithani, Akshita Bahuguna.

The income of the reverse migrants surveyed fell drastically due to loss of jobs and other reasons, which ultimately lead to a financial crisis. In the Correlation Heatmap shown in Figure 7, two variables are considered: first, the income of reverse migrants prior to the COVID-19 pandemic; and, second, the income of reverse migrants during the pandemic. With the help of Pearson's r value and p -value, the assumption 'the income of migrant workers during pre-COVID-19 under a particular income group (as shown on the vertical axis) has shifted to another income group (shown on the horizontal axis) during the COVID period' was tested. Analysis of the data found that the income of reverse migrants in the income categories INR 10,000–15,000, INR 15,000–25,000, INR 25,000–40,000 and more than INR 40,000 in pre-COVID-19 times fell to below INR 10,000 during

the COVID-19 period indicating a very high positive correlation with Pearson's r -values 0.99, 0.969, 0.948 and 0.94, respectively. Reverse migrants in the income categories INR 15 000–25 000, INR 25 000–40 000 and above INR 40,000 in COVID-19 times also experienced a shift to the income group INR 10 000–15 000, showing a very high positive correlation with Pearson's r -values 0.987, 0.958 and 0.923, respectively. There was even a drastic fall in the income of reverse migrants from the income category INR 25,000–40,000 during the pre-COVID-19 era to the INR 15,000–20,000 income category during the COVID-19 pandemic indicating a very high positive correlation with Pearson's r -value of 0.956. Overall, a significant fall in the income categories of reverse migrants was observed during COVID-19 when compared with the pre-COVID-19 period.

The government has also launched numerous employment schemes to provide job opportunities to reverse migrants in their villages of origin. According to primary data, 46.39 per cent of people were aware of Migration-Specific Employment Schemes, while 19.44 per cent were not. Of those who were, 35.38 per cent participated in a work-based Government Scheme, and 25.56 per cent did not. Some 22.5 per cent of reverse migrants applied for Migration-Specific Employment Schemes, while 28.06 per cent did not submit an application for reasons including lack of proper documentation (8.06 per cent) and fear of debt (13.61 per cent). Only 6.11 per cent of reverse migrants received a benefit from Migration Specific Employment Schemes to which they applied, and 23.61 per cent did not receive any benefit (Figure 5).

Figure 8. Percentage distribution of expected income to stay back in native villages

Source : Dinesh Prasad Saklani and Narendra Kumar, Hitesh Kumar Mandal, Ekta Singh, Rajesh Naithani, Akshita Bahuguna.

Despite the government's attempt to provide jobs to reverse migrants in their home villages as a means to boost the regional economy, migration continues with an intensity similar to the pre-COVID-19 period. According to the primary data, 87.22 per cent want to migrate again and return to the cities where they were working prior to lockdown, while 12.78 per cent do not plan to migrate again. This affirms the argument that the neoliberal state-market nexus continues to function and generate cheap labour, a mechanism designed to keep migrant workers in a situation where they have no access to social or economic security in life for a prolonged period. Furthermore, the perpetuation of this scenario means that reverse migrants may again be left in a position of vulnerability during any crisis with potential for a financial collapse, as happened during the COVID-19 lockdowns.

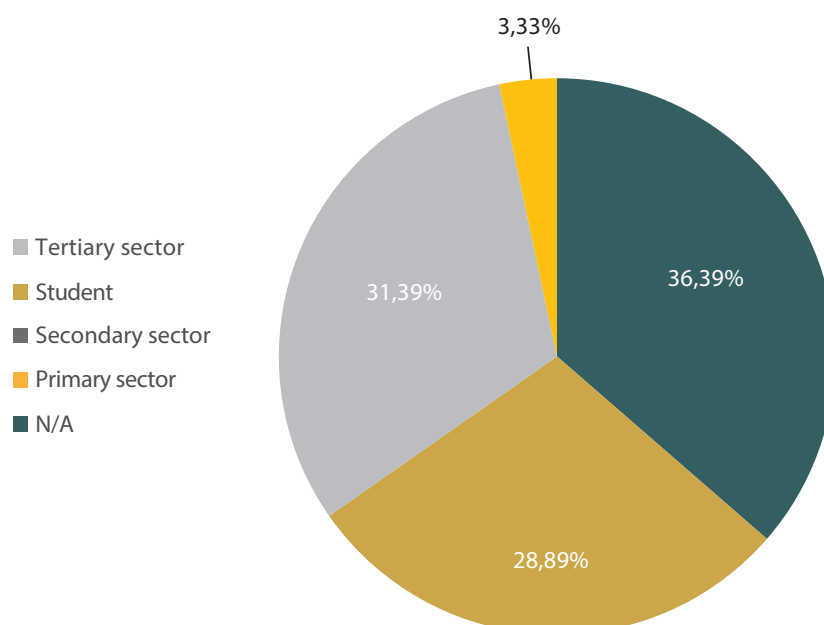
Conclusion

In the 1990s, India embraced a more globalized neoliberal economic structure with the ambition of generating greater employment opportunities and living standards. The recent emergence of a migration

crisis caused by the COVID-19 pandemic has shed light on the problematic nature of this *prima facie* belief. In reality, the hope of substantial employment opportunities and better living standards for rural people manifests more as exploitative working conditions in metropolitan cities in a context of urban poverty. In the case of Uttarakhand, the most common cause for migration is to seek work in the private sector, mainly in the hospitality industry (Hoffmann *et al.*, 2019). Having left their villages in Uttarakhand, many migrants worked in low-wage jobs for limited wages. Many were the sole breadwinners in their families, making them even more vulnerable to exploitation under the neoliberal economy. During the COVID-19 period, the major cause of reverse migration was loss of jobs/work and a fear of hunger, followed by fear of contracting the virus.

Although the government introduced many welfare schemes for reverse migrants, undoing the devastation created by the negligence of the neoliberal economy is proving a difficult task. Furthermore, the government is an inextricable part

of a state-market nexus driven by a market-based ideology rooted in the generation of cheap labour, and as such is accountable for the migration crisis caused by the nationwide lockdown. While the crisis created by the lockdown was an unforeseen calamity, it must not be repeated. However, this objective requires that the government first develop the rural economy and make it self-sufficient. As suggested by Sengupta, it is better to decongest cities and let migrant labour remain in the villages than move people to the cities (Sengupta, 2020). According to the primary data, 93.61 per cent of reverse migrants want to live in their native villages permanently, and 89.44 per cent want to remain in the villages with access to fewer income jobs (Figure 5). In addition, 33.89 per cent of reverse migrant workers expect a monthly income of between INR 10,000 and INR 15,000; 30.56 per cent anticipate an income of between INR 15,000 and INR 20,000, and 24.72 per cent expect more than INR 20,000. However, 10.83 per cent of reverse migrants also stated that they would remain in their native village with an expected income of below INR 10,000 (Figure 8)

Figure 9. Percentage distribution of motivational drivers to stay permanently in the village

Source : Dinesh Prasad Saklani and Narendra Kumar, Hitesh Kumar Mandal, Ekta Singh, Rajesh Naithani, Akshita Bahuguna.

The primary data also indicate that 36.39 per cent of reverse migrants in the Pauri district identified employment as the most significant motivational factor for remaining in their native village, while 28.89 per cent cited the importance of their local environment (Figure 9).

The arrival and settling of a large number of migrants in cities brings a number of challenges. City authorities have difficulties ensuring infrastructure and services to fulfill the requirements of the migrant community. Affordable housing, high-quality education and health services, easy access to essential utilities such as electricity and water, well-maintained roads and transportation, other necessary infrastructure and, lastly, integration and communal cohesion are all essential to ensure a dignified and prosperous life for migrant workers (Piccoli, Dzankic and Ruedin, 2021). However, there are signs that the poverty gap between residents of mountainous areas such as Uttarakhand and those living in other locations is widening. Mountain habitats and inhabitants are also endangered by ongoing environmental issues, migration

patterns, economic globalization and the commercialization of mountain resources (Sellmyer, 2017). Distressed out-migration can be reduced by improving careers and by promoting sustainable livelihoods, particularly micro-enterprises, wherein the region has a productive advantage.

Acknowledgments

The authors would like to thank the Indian Council of Social Science Research (ICSSR) for funding this research. They would also like to thank the Department of History and Archaeology, H.N.B. Garhwal (A Central University), Srinagar, Uttarakhand, and wish to extend their gratitude to all the migrants from Pauri district who cooperated throughout the interviews. Lastly, they would like to thank the office staff and director of Chauras Campus, HNBSGU, for their assistance.

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Conclusions and recommendations of the coordinators

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This colloquium provided illuminating insights into the multidimensional impacts of the COVID-19 pandemic through contributions from the social sciences. Over the course of the two-day program of presentations and discussions, several key lessons emerged for better understanding this unprecedented crisis and considering recommendations for readiness and better management of future pandemics.

Firstly, the communications demonstrated how human behavior lies at the heart of both the spread and response to the epidemic. The pandemic revealed pre-existing vulnerabilities related to social and economic inequalities, between and within nations-states. A key lesson is that human behavior is central to both virus transmission and societal responses; the pandemic is not a purely biological phenomenon. It exacerbated pre-existing vulnerabilities, particularly among economically marginalized groups. It also highlighted the adaptive capacities of individuals and communities in the face of adversity. Medical, educational and religious institutions mobilized to meet populations' essential needs, sometimes innovatively.

However, the crisis also caused harmful effects on mental health and individual well-being, particularly for vulnerable groups such as the elderly. Lockdowns and isolation generated long-term stress, anxiety and sleep disorders. By isolating individuals from their social networks, it generated a silent crisis of mental health. Elderly and vulnerable people were particularly affected by loneliness and lack of human contact. Thus, for instance even the use of the term "social distancing" instead of another term that would emphasise the physical distancing, became questionable. We must draw lessons from this experience by developing sustainable plans for psychological support in future crises.

Public policies also proved critical to addressing the epidemic. Health measures such as travel restrictions and border closures helped curb virus transmission. Nevertheless, these measures also disrupted social interactions and generated negative socio-economic impacts, especially for the most precarious.

The communications underlined the importance of effective coordination between central and local authorities to account for territorial specificities

in crisis response. Epidemiological statistics also guided policy action and enabled access to international aid, which proved valuable for many countries.

Finally, the pandemic had major impacts on migration and border communities and even internal movements inside countries and communities. It abruptly halted human mobility and stigmatized certain groups. Migrant workers, across borders and inside countries, found themselves particularly vulnerable to illness and economic insecurity.

In light of these lessons, six main **recommendations** emerge for better anticipating potential future pandemics:

1. Strengthen the resilience of institutions and vulnerable populations through long-term structural policies.
2. Develop multi-sectoral action plans closely involving health, social, educational authorities and local communities.
3. Establish stronger international coordination to facilitate universal access to care, vaccines and epidemiological information.
4. Anticipate sustainable psychological support systems to limit impacts on individual and collective mental health.
5. Better address the precarious situation of migrant workers and promote their inclusion in health responses.
6. Continue multidisciplinary research efforts to analyze crisis effects in real-time and guide policy-making.

This colloquium clearly demonstrated the utility of social sciences for informing public decision-making in the face of pandemics. A global and solidarity-based approach is needed to rise to this type of global health challenge, with a focus on the reduction of economic, educational, cultural and medical inequalities.

Preparing for the next pandemic: Leveraging social and human sciences for crisis response

Lessons from COVID-19

Understanding the social impact of the COVID-19 pandemic is crucial for shaping preventive policies for future crises. Prior to the pandemic, growing disparities in well-being were already undermining environmental sustainability, social cohesion, and global progress. Fragile and unequal systems were pre-existing factors that exacerbated the pandemic on a global scale.

COVID-19 widened the gap between developed countries, which had the financial means to respond to the crisis and easy access to vaccines, and the rest of humanity, resulting in devastating effects in the Global South, with over 130 million people pushed below the poverty line.

This publication, intended for policymakers and scholars, offers a comprehensive overview of the social science perspectives on the COVID-19 pandemic. It covers a wide range of topics, including its impact on mental health, education, climate change, the economy, governance, migration, demography, digitalization, and more. The authors analyze the challenges society faced during the pandemic and propose actionable recommendations for policymakers and practitioners when designing responses to future global crises.

This publication serves as a reminder of the vital role of Social Sciences and the Humanities in addressing global challenges. It provides a roadmap for future research and policy action to build more resilient societies.