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The Book DISASTER CONSTRUCTION AND RECONSTRUCTION. LESSONS FROM COVID-19 FOR ETHICS, POLITICS, AND LAW explores and presents social constructs lying under disaster preparedness, resilience, population needs, the role of crisis communication and its relation to politics and marginalization, all over embraced with ethical principles being defined or being forgotten in all disasters, specifically in COVID-19 pandemic. The concept "lessons learned" is inwrought in the text, not only as concept explained, but also as concept deconstructed at many levels and critically reviewed. The Book offers multi- and interdisciplinary insight in various perspectives on COVID-19 pandemic, arguing on pros and con of implemented actions and proposes measures for future reduction of social vulnerability in such disasters.

Prof. Iskra Alexandra Nola

The book DISASTER CONSTRUCTION AND RECONSTRUCTION. LESSONS FROM COVID-19 FOR ETHICS, POLITICS AND LAW aims to bring together various scientific perspectives toward exploring COVID-19 crises and downs, resulting in lessons that can serve relevant social actors as guides in the future answer to the pandemic. Overall, the Volume put an accent on the significance of preparedness as a precondition for minimizing potential social vulnerabilities. With such an achieved goal, this book greatly impacts all social, public health, and ethical disciplines.

Prof. Vladimir Vuletić

The volume DISASTER CONSTRUCTION AND RECONSTRUCTION. LESSONS FROM COVID-19 FOR ETHICS, POLITICS AND LAW addresses various ethical, social, legal, and political issues surrounding the COVID-19 pandemic in relation to different stakeholders' measures to react to it. This is done by way of addressing selected issues that, taken together, allow to paint a rich and exemplary picture of the wide variety of issues. Accordingly, the volume covers contributions from disciplines such as sociology, philosophy, and politics. Chapters cover a lot of topical ground, and commendably complement each other, thereby ensuring the volume's "wholeness".

Michael Kühler, PhD

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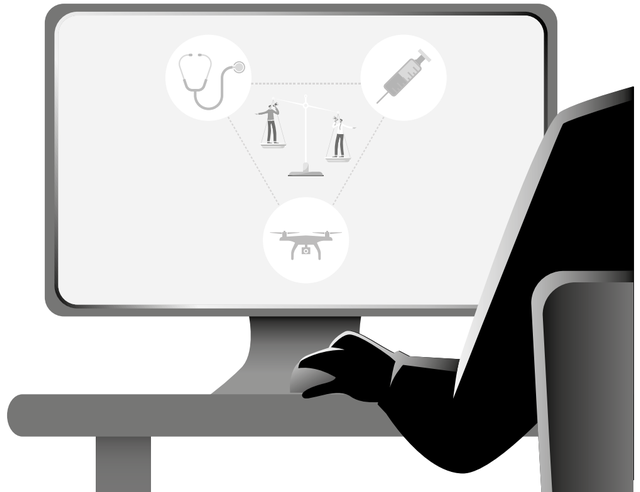
DISASTER CONSTRUCTION AND RECONSTRUCTION: LESSONS FROM COVID-19 FOR ETHICS, POLITICS AND LAW

edited volumes

DISASTER CONSTRUCTION AND RECONSTRUCTION: LESSONS FROM COVID-19 FOR ETHICS, POLITICS AND LAW

EDITORS: DÓNAL O'MATHÚNA, VESELIN MITROVIĆ



The volume DISASTER CONSTRUCTION AND RECONSTRUCTION: LESSONS FROM COVID-19 FOR ETHICS, POLITICS AND LAW has at least two general aims. One of the aims of this volume has been to reduce the disaster risks by dealing with the post-disaster recovery through chapters which examine the pandemic consequences, either through the most appropriate ethical accounts, or new recommendations. Specific protocols have even been developed for dealing with the pandemic. This knowledge should be used in future disasters. Considering resilience among the marginal, challenge trials, debates on mandatory vs. compulsory vaccination, vaccine hesitancy and rejection, human security and rights, and political and social polarisations this volume offers fresh insights into the ethical approaches which could or should be applied in a next pandemic. The second aim has been to address different crises which could be triggered by pandemics: crises in the health care, social, political, economic, and other systems. Pandemics can also lead to psychological and other, more personal, crises. The recent pandemic brought a globally accepted narrative that after this pandemic, nothing would be the same. In economic, political, and social terms, the world became different. This volume brings one perspective on these changes.

DISASTER CONSTRUCTION AND RECONSTRUCTION:
LESSONS FROM COVID-19 FOR ETHICS, POLITICS AND LAW

PUBLISHED BY

Institute of Social Sciences

Belgrade, 2024

PUBLISHER

Goran Bašić

REVIEWERS

Michael Kühler, PhD

Prof. Iskra Alexandra Nola

Prof. Vladimir Vuletić

SERIES

Edited Volumes

SERIES EDITOR

Veselin Mitrović

ISBN 978-86-7093-271-5

edited volumes

DISASTER CONSTRUCTION AND RECONSTRUCTION:

LESSONS FROM COVID-19 FOR ETHICS, POLITICS AND LAW

EDITORS
Dónal O'Mathúna
Veselin Mitrović

INSTITUTE
OF SOCIAL SCIENCES
Institute of national significance
for the Republic of Serbia

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III. DISCOURSES AND CONCEPTS OF LAW AND POLITICS IN COVID-19

Preface

This volume is the result of a longstanding cooperation between the editors and some of the contributors, which started in 2012, with their joint participation in the COST Action IS1201 Disaster Bioethics organized under the leadership of Dublin City University and Associate Professor Dónal O'Mathúna. Soon after, followed a joint workshop entitled "Disaster and Social Justice: Victims, Vulnerabilities and Resilience," at the University of Copenhagen with the COST Action IS1201 on 27-28 February 2014 in Copenhagen, Denmark. The central topic of our shared discussion since then has been the controversial relation between social and ethical issues triggered by disasters, as well as bioethics as a theoretical and applied discipline. These joint efforts resulted in an inter-universities cooperation and the volume edited by D. O'Mathúna, V. Dranseika and B. Gordijn titled *Disasters: Core Concepts and Ethical Theories*. Ten years after our firsts scientific contacts concerning disaster issues, Veselin Mitrović and Naomi Zack initiated a joint conference "Social, Economic and Political Construction of COVID-19" organized by the Institute of Social Sciences (ISS) and Lehman College, CUNY in Belgrade, Serbia and New York, USA (virtual), in May 2023.

As with all such volumes, they are the result of many people's contributions and help. First of all, we would like to express our utmost gratitude to all contributors for putting in so much hard work to provide this volume with numerous excellent and thought-provoking chapters. We are grateful to the Ministry of Science, Technological Development and Innovations of the Republic of Serbia for the financial support in realizing this book. Furthermore, we would like to say a special "thank you" to Dragica Puljarević and Goran Bašić, as well as the rest of the ISS publishing team, for their tremendous support and patience with regard to putting this volume together. We are grateful to the president of the Scientific Council of the ISS Predrag Jovanović and the entire Council membership, who supported the publishing of this book. Last, but certainly not least, we owe gratitude to our proofreaders and reviewers for their proofreading and language editing efforts. We cannot stress enough how much we appreciate the final support we received from those colleagues and honest friends who morally and collegially supported us in the final phase of this project.

Veselin Mitrović & Dónal O'Mathúna
December 2023

I
INTRODUCTION

Veselin Mitrović, Dónal O'Mathúna

Disasters Revised

1. Assessment and Utility of Ethical, Legal, Political, and Social Issues in the Recent Pandemic

Disaster is a topic that connects social sciences, medicine, ethics, geophysics, as well as other sciences and disciplines. However, besides the benefits of preventing and mitigating disaster's effects, this wide range of various sciences also contributes with their various methodologies and accounts. One of the most intriguing issues arises from the epistemological and ethical differences in defining basic concepts in disaster studies. Disasters can be natural or the result of an inadvertent or intentional human act. Such events kill or injure a significant number of people, or disrupt life in a society. Though not always unpredictable, they come with an unexpected impact and shock (Zack, 2023). However, to revise the concept or a part of it, it would be necessary to return and remind readers of the first reactions to and social concerns over the global spread of the SARS-CoV-2 virus, which caused COVID-19 and the Coronavirus Pandemic. Considering the general perspective on disaster as an event that is opposed to normal time or everyday life, opens the space for revising concepts due to the generalization of what is meant by normality. Some social group's everyday life could be comprehended as catastrophic with less chance to improve in a shorter time, e.g., those who are homeless, people with vulnerable jobs, discriminated and marginal groups, etc. Disaster also questions the legitimacy of a political system, due to poor preparation plans, or using the disaster to transform short-term paternalism into an authoritarian grip on people's everyday lives (Mitrović & Mitrović, 2023).

The epidemic began in the city of Wuhan in China in late 2019, and spread worldwide in early 2020, reaching Europe in Spring 2020. On 11 March 2020, the World Health Organization

declared COVID-19 a pandemic. During the Coronavirus pandemic, we were exposed to national and global reports covering the numbers of people tested, infected, killed, and cured. We were receiving different forecasts about the course and effects of the infection. In the very beginning, we witnessed different national scenarios and models, which all exposed different levels of national preparedness, as well as the lack of global response to such disasters.

In the first weeks and months of the pandemic (Spring 2020), two approaches dominated. The first approach amounted to the idea of letting nature take its course. Just as societies adapt to other illnesses, people would develop immunity against this disease. However, the great and rapid progression in the number of the infected and dead questioned this approach. It promised to counteract the virus very rapidly with only minor negative socio-economic side-effects. Yet, this was obviously horrendous for those most vulnerable to the virus.

The second approach opposed such a hands-off strategy. Instead, it proposed measures to restrict movement for different categories of the population, in order to minimize social contact. Unfortunately, this approach had significant negative socio-economic effects, as we indeed witnessed. Still, this was embraced as the first response by the states that maintained strong systems of primary care and institutes of public health, which included former socialist societies.

The experience showed that, before COVID-19 vaccines were introduced, both ways had their ups and downs, and involved certain misuse, due to the controlling mechanism in the case of restriction of movement, or the devastating effects that ignoring the virus had for the most vulnerable.

However, what went under the radar as a kind of latent danger causing cumulative damage, was the daily intertwining of the terms crisis and disaster in everyday, public, and scientific forms of speech.

In the scientific sense, disaster is an event (or series of events) that injures, or kills a significant number of people or, otherwise severely disrupts their daily lives in a society. Disasters can be natural, or the result of an inadvertent or intentional human act, but they are usually time framed, and with recognizable phases.

At the same time, crises may be ongoing, which leads a society to the state of collective stress, i.e., living in precarious conditions with no perspective of improving. The terms conflict and crisis are defined in opposition to disaster, yet they both imply a certain institutionalized risk of a disaster. While disasters are typically characterized by prosocial behaviors, conflicts and crises are usually framed by the various interests of opposing actors who are responsible for the conflicts and often deepen them (Barton, 2005).

More particularly, pandemic is a disaster that can cause different crises: crises in the health care, social, political, economic, and other systems. Pandemics can also lead to psychological and other, more personal, crises. Hence, although the concepts of crisis and disaster share some similarities, they are not the same, and should not be treated as such.

In addition to the deceptive intertwining of these concepts, and with its constant and circular repetition, it was globally accepted that after this pandemic, nothing would be the same. In economic, political, and social terms, the world became different. This volume brings one perspective on these changes.

These changes represent a similarity between disaster and crisis. However, this is shared by any disturbance in a relatively stable state, which needs to be removed so that the original state may be restored. Similarly, our efforts to overcome the disaster – including our technology-based efforts, such as the use of tracking technology or AI – may be explained in terms of our intention to revert our socio-economic system back to its prior "normal" state. But one question is why should we revert our system back to what used to be normal? What may be the effect of such efforts for traditional communities, or those who live in communities that are more or less closed?

Some of the chapters raise the question of whether the situation could ever be the same as before. It is questionable, for instance, whether patients, having recovered from an injury, or a serious illness, are truly the same as before, or whether they just have the impression that they have returned to their previous "ideal" state of health (Frank, 2013).

It is precisely the lack of response to these issues that leads to crises in many spheres of life, whereas the disease itself, the

current pandemic, is not a crisis in the strict sense of the term, but rather a disaster. One of the aims of this volume has been to reduce the disaster risk, by dealing with the post-disaster recovery through chapters which examine the pandemic consequences, either through the most appropriate ethical accounts, or new recommendations. Specific protocols have even been developed for dealing with the pandemic. This knowledge should be used in potential future disasters, so as to avoid facing more crises than strictly necessary. Considering the challenge trials, debates on mandatory vs. compulsory vaccination, vaccine hesitancy and rejection this volume offers fresh insights into the ethical approaches which could or should be applied in a next pandemic.

The latest pandemic officially ended in May 2023. It resulted in more than 770 million confirmed cases of COVID-19 and almost 7 million deaths. Since then, the coronavirus has not been a major health or security threat on either the local or the global level. However, it is a risk that we all have to live with, and a major threat for those being infected and especially for the vulnerable individuals and groups. Accordingly, COVID-19 as a disaster, has had its own specific characteristics which are already the subject of research, and while the distinction between the concepts of crisis and disaster may appear as only a minor aspect, it may also very well be considered a necessary step in understanding and addressing future challenges, and become beneficial in the battle with potential pandemics and crises. Some of the chapters from this volume imply that the distinction between disaster and crisis is the key to understanding (not only) the recent pandemic, and proceed further to defend this conceptual thesis and examine its practical implications from sociological, political, ethical, and medical points of view. From the various national responses presented, based on various ethical accounts and epistemological distinctions (Mitrović, 2020), more critical existential issues arise that prove to be highly important in researching susceptibility, vulnerability, and resilience of various social groups (Mitrović, 2015) and global populations.

This volume aims to contribute to elucidating some of these basic features of the groups in disasters, in different social contexts, as well as from the perspectives of different disciplines.

Such orientation opens the door to decreasing vulnerability and susceptibility, and enhancing resilience.

Susceptibility means "the state of being susceptible" or "easily affected." In the natural hazard terms, susceptibility is related to spatial aspects of the hazard. It refers to the tendency of an area to undergo the effects of a certain hazardous process (e.g., floods, earthquakes, tsunamis, subsidence, etc.), without taking into account either the moment of occurrence, or potential victims and economic losses (Domínguez-Cuesta, 2013). Susceptibility linked to slope instabilities, for instance, indicates the tendency of an area to breakdown. According to Brabb (1984), susceptibility is the probability of an event happening in a specific zone, depending on the correlation of the instability-determining factors with the distribution of past movements.

Considering that the same disaster does not have the same effect on different social groups or countries with various grade of vulnerability and susceptibility (Mitrović, 2015), we have used the COVID-19 pandemic as a case study applied in different contexts, fields, and countries. The readers will be introduced to such examples through the perspective of shifting political discourses and ambivalent, or even reversed political ideologies of various political organizations and social groups. The impact of a pandemic on various groups on the existential level is analyzed through bioethical, social, and perspective of human rights. Such an approach opens the door to redefining the concept of disaster, and applying a new and transdisciplinary approach to all aspects of disasters. For example, communication must be socially adequate and relevant to the situation. Preparedness needs to include not only self-sustainability but often exchangeability based on solidarity which includes obliteration of social apathy, as well as calls for action in acceptance of the lessons learned from the previous disaster (Mitrović & Zack, 2018). Listening to and applying the voices of the community can result in avoiding or mitigating unpopular mandatory measures that characterized the recent pandemic. Practically, this implies timely reacting to the burnout syndromes of caregivers, while permanently working on equal social distribution and promotion of the vaccines.

This edited volume brings together an international and multidisciplinary collection of essays that examine the ethical,

political, and legal issues that arose during COVID-19 and the lessons that can be learned with implications for future disasters. Presented chapters explore issues from a broad conceptual base, but also address specific problems, cases and events. The contributions in this multidisciplinary volume are based on a variety of methodologies, including philosophical and legal analyses, empirical investigations, scoping reviews and national case studies with the topic of human rights in specific contexts.

COVID-19 has raised a number of ethical issues, many of which lie at the interface between public health ethics and clinical ethics. As the impact of the SARS-CoV-2 virus and the resulting disease, COVID-19, became more widely known, governments and public health authorities made decisions with ethical, political and legal components. Various types of restrictions were introduced, raising ethical questions about the balance between public and individual welfare. The information used to make these decisions raised ethical issues for the news media and social media. The different impacts of COVID-19 on various populations raised issues of justice and equity. Research into the virus, the disease and the restrictions and interventions to prevent and treat the disease raised further ethical issues. Once vaccines were available, their limited availability raised questions of distributive justice. At each stage of the pandemic, various resources were scarce and had to be allocated according to principles of triage and fairness. The chapters explore these and other related ethical challenges which were triggered by the COVID-19 pandemic.

In addition to ethical decisions, political decisions affect the daily lives of the population and, in critical times, may even be of existential importance for some individuals and groups. In parallel with the spread of the SARS-CoV-2 virus, which caused the outbreak, and shortly thereafter the pandemic of the COVID-19 infection, different political versions of COVID-19 began to spread, mainly represented by intertwining terms such as disaster and crisis. Pandemics are usually defined as disasters, but in most political expressions, COVID-19 was described as a crisis, which is ongoing by definition, so the term has perhaps been misused in this case to justify the pre-pandemic discrimination in the unequal distribution of existential practices such as medical triage, equal access to

medical equipment, or hesitancy in some medical recommendations. There were clear cases of age being used as a proxy to decide on life-saving procedures, as well as of tired health workers, using some everyday stereotypes in their professional work.

There have also been issues with quarantine, the legitimacy of the state of emergency in some pandemic phases, mandatory vaccination and hesitancy, and the public response to all of these. All of the policy issues during a pandemic raise general societal concerns about the legitimacy of the system in critical situations such as disasters, as well as post-crisis. An objective approach to the elements of disaster and crisis in COVID-19 should serve as a bellwether for future political action in similar situations.

The Universal Declaration on Bioethics and Human Rights (UNESCO, 2005) and national constitutions should be guarantors of the service of public health and well-being (including autonomy) during a pandemic. However, some governments, or even state presidents have been overtaking judiciary roles and became the arbiters of public measures to contain the pandemic. Their attitudes have ranged from negating the pandemic to using lockdowns, AI, and surveillance, in order to restrict personal freedoms under the laws applied in public health emergencies.

2. Contributions

Chapters of this volume are interdisciplinary contributions that address multiple areas, such as the relationship between ethics and politics, or questions of legal ethics. Chapters address the dilemmas of how emergencies were handled in different countries (e.g., Serbia, Israel, Brazil, USA, EU); how vulnerable groups (disabled, African-Americans, Roma, and other people of color, homeless, prisoners, and older people) were treated in various national frameworks; what kind of discrimination they faced, and what kind of racism was dominant during the pandemic; which measures should have been taken to eliminate such discrimination, and how we could achieve the global aim of best preparation for saving as many lives as possible; what ethical accounts should be used in future vaccine trials and mandatory vaccination; and how political polarization has influenced the population's resilience and relevant

crises. In other words, what kind of lessons have been learned from the COVID-19 pandemic to improve ethical decision-making in disasters and manage and alleviate the potential crises caused by a catastrophic event?

2.1. *From Social and Ethical Perspective in COVID-19 to Disaster Studies*

In their co-authored contribution "A Scoping Review of Ethical Arguments About COVID-19 Vaccine Mandates", Zia Haider, Annie Silleck, and Dónal O'Mathúna start from the well-known fact that vaccination is among the most successful public health interventions ever introduced, and it has led to the reduction and elimination of some diseases. However the authors argue that, despite that, for some people its effectiveness and safety remains controversial, and especially in the case of COVID-19 vaccines. Such controversy intensifies when public health authorities, employers or governments make, or consider making, vaccines mandatory. Opinions were divided over whether any COVID-19 vaccination mandate would be ethical. The authors undertook a scoping review of the ethical arguments for and against mandatory vaccination policies, in order to identify the primary ethical arguments raised on both sides of this ethical debate. The authors concluded that the ethical arguments on both sides of the issue should be openly and transparently discussed by all stakeholders. If mandates are deemed necessary, they should be supported by the ethical concerns and limitations about informed consent, right to refuse, freedom of belief and religion, liberty and freedom, as well as vaccine safety. They emphasize that, before imposing mandates, authorities have obligations to provide accurate information about the risks and benefits of a disease and its vaccines, to encourage as many people as possible to get vaccinated, and ensure that the vaccines are easily obtained and distributed in an equitable manner.

In his contribution "Ethical Challenges and Hesitancy Associated with (Mandatory) Vaccination against COVID-19," Miroslav Radenković starts with the WHO's classification of COVID-19 as a pandemic and strongly advises that the global populace be shielded from the further spread of SARS-CoV-2 through fundamental

preventive measures, as well as through widespread vaccination, even if it may be mandatory for some populations. His chapter implies that mandatory vaccination increases compliance with vaccination agendas. At the global level, in the case of COVID-19, such a measure has been deemed ethically justified if the threat to public health was assessed to be serious, the population's confidence in its efficacy and safety was high, and the anticipated utility was superior to alternatives, but also if the penalties for noncompliance were balanced. Unfortunately, it has been discovered that in certain cases, unsubstantiated data and medically misconstrued information on vaccine efficacy, duration of protection, and probable adverse effects were the most important reasons for the COVID-19 vaccination hesitancy.

Considering relevant experiences with COVID-19, further analysis of (mandatory) vaccination hesitancy is still more than required, with the careful consideration of basic ethical principles that might give us some rational future directions concerning this highly sensitive issue.

In their contribution "Research Ethics Issues in Basic and Clinical Studies during the COVID-19 Pandemics" Zoran Todorović and Dragan Hrnčić analyze many issues concerning research ethics that the COVID-19 pandemic has opened. Initially, the focus of the investigation is directed at the origin of the virus, opening the question of moral and other responsibility for the emergence of the pandemic. The safety of medicines and vaccines has become a question for experts and the general public, and ongoing clinical trials have not removed distrust. The standards for conducting clinical trials for drugs in development were relaxed, even according to the recommendations of the World Health Organization and the European Medicines Agency, which created doubts about the balance between their reliability and the speed of their implementation. Redefining bioethical principles in public health research proved necessary, and easing measures against COVID-19 only softened the public debate. However, some research ethics issues still need to be resolved. Conducting both basic and clinical studies unrelated to the COVID-19 pandemic was also affected during this period, facing a lack of funding, changes in infrastructure and resources, and a sudden need to refocus the research. Discussions

on ethical issues related to allocating available resources and the urgent need to terminate some ongoing research studies should be addressed in contemporary scientific literature. On the other hand, the demand for rapid knowledge production in order to secure prompt reactions from various health system stakeholders resulted in questions about the peer-review process. That opened some ethical issues related to responsible publication practice, emphasizing the role of research ethics at every single step of the COVID-19 and non-COVID-19 biomedical, basic, and clinical studies.

In the contribution titled "Detecting Resilience Issues among Marginal Groups as a Bioethical Goal", Veselin Mitrović assumes that bioethical judgments impact actual medical and political practice, which, in turn, impacts the living conditions of marginalized groups. In this chapter, the author analyzes the resilience of marginalized social groups in two ways: 1) through a normative aspect of bioethics concerning moral judgments and their justification, and 2) through an empirical aspect, concerning the actual living conditions and changes of marginalized groups.

The author hypothesized that resilience during the COVID-19 pandemic is not closely related to the pre-existing medical issues of a group. Alternatively, structurally deep-rooted racial, social, and economic conditions significantly reduce a group's resilience. The main concern is converting the miserable survival of the most endangered, marginalized, and discriminated groups into an acceptable one. However, the recent pandemic of COVID-19 has put even more pressure on vulnerable groups, thus weakening their resilience even more.

The chapter deals with the nature of being marginal before the pandemic and the ways in which racism and discrimination lower the resilience of marginal groups, i.e., making them even more vulnerable in the case of a disaster and endangering their survival in the mid- and long-terms. Consequently, the author assumes that the general request for the normalization of the everyday lives of the majority makes COVID-19 an ongoing disaster, i.e., a longstanding crisis for the discriminated and marginal groups. The author concludes that avoiding such an outcome is in the holistic picture of the pandemic an important issue that many bioethicists and clinicians must accept.

In her contribution "Rethinking Human Security in the Post-COVID-19 World – Lessons Learned from the Human-centric Approach to Health Security," Slađana Ćurčić uses the case of the recent COVID-19 pandemic as an example of a health-security nexus. She posits that the pandemic is a health threat, but leaves space for various approaches to health security we may choose. The main aim of her contribution is to analyze COVID-19 as a health threat through the human-centric approach to health security, and to consider the relevance of this approach in the post-COVID-19 context. The research question is: what is the special value of this approach in conceptualizing COVID-19, as well as future health security threats, both in terms of theoretical contributions and practical strategies and policy solutions? The methodology used here was an academic literature review and secondary data analysis relevant to assessing the state of human security, like the Human Development Index. The theoretical and practical implications of the human security analysis of COVID-19 are discussed as a relevant factor of the health security field. In addition to the lessons that we have learned from COVID-19 that human security should be prioritized at the policy level, simultaneously with state security, the author concludes that rethinking the human security concept in the post-COVID-19 context could contribute both to clarifying the human-centered approach to health security and redefining the concept of health security itself.

2.2. *Discourses and Concepts of Law and Politics in COVID-19*

In his contribution "Constructivism in Times of Political Crisis," Michael Buckley, analyzes the impacts of human-induced risks such as those in the COVID-19 pandemic. Reimagining the liberal tradition to account for these risks will require a concept of social resilience to fortify existing conceptions of social stability. His chapter argues that a leading account of stability – an overlapping consensus – is not resilient under stress. It explains how human-induced hazards contribute to a process of pernicious polarization, and how pernicious polarization illuminates a process by which consensus breaks down and begins to reverse itself. He concludes that

a complete account of what must transpire for a society to absorb, withstand, anticipate, or recover from this destabilizing process outstrips the conceptual resources contained with an overlapping consensus, rendering it vulnerable to the human-induced threats we can expect to encounter for years to come.

In their cross-national, co-authored contribution "Human Rights and Ethics in the Management of the Covid-19 Pandemic: the Experience of Brazil and Israel," Karen da Costa and Shlomit Zuckerman, have analyzed the effects and intertwining of the local legal measures with the universal human rights within the case studies of Brazil and Israel. The two countries were characterized by different approaches, and specific subcases. The similarity was that the pandemic uncovered deeply rooted structural issues and questioned the legitimacy of the system, which led to political changes in Brazil, and citizens' protests in Israel. The paper underscores the global impact of COVID-19, emphasizing the interconnectedness of humanity. While countries experienced the disease differently, the collective response necessitates global cooperation for effective pandemic management. The authors conclude that, despite diverse local and individual experiences, global collaboration is vital in addressing future pandemics, offering valuable insights into the intricate relationship between pandemic management, human rights, and ethical considerations.

In their contribution "Between Securitization and Desecuritization: The Shifting Discourse on the COVID-19 Pandemic in Serbia," Pavle Nedić and Marko Mandić, use the theory of securitization and desecuritization, in examining the political decisions reflected in the anti-pandemic measures during the crises triggered by the COVID-19 pandemic. Securitization implies that an issue is constituted as a security threat through the use of a specific speech act performed by the securitizing actors in order to gain support by the audience for the emergency measures. As in the previous cases of Brazil and Israel, the authors argue that the constant change of the security discourse on the issue caused a loss of the authority possessed by the securitizers, induced a state of confusion among the citizens (audience), and resulted in some political shifts during 2020.

In her contribution, "Towards Global Health Governance or Towards Global Control of States and People?" Mirjana Dokmanović

presents the key challenges in the ongoing reform of the global health regime based on the initiative to adopt a binding Pandemic Treaty and a reviewed International Health Regulation. The author claims that the proposed regulation gives the World Health Organization (WHO) the ultimate authority to decide on all issues related to public health, as well as the monopoly on informing about measures to prevent and combat pandemics and other public health emergencies. The author warns that the proposed centralized global health governance opens the door to corruption, and she proposes some anti-corruption measures to be implemented in the new regulation to avoid the concentration of the decision-making power concerning all health-related issues in the hands of a few.

In his contribution "The Attitude of Far-right Organizations Towards Measures Against the Covid-19 Pandemic in Serbia 2020–2022," Jovo Bakić acquaints the readers with the relation between an authoritarian attitude of the political regime, and reactions of a wide spectrum of far rights organization in Serbia during COVID-19. The author hypothesizes that the harsher the measures against COVID-19, the harsher far-right criticism should have been. However the author draws the conclusion that the right-wingers' response to the measures of the Serbian political regime have not been consistent in all cases, thereby trying to show which of these organizations have been under the control or influence of the regime.

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II
FROM SOCIAL AND ETHICAL PERSPECTIVE IN COVID-19 TO DISASTER STUDIES

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A Scoping Review of Ethical Arguments about COVID-19 Vaccine Mandates

Abstract

Vaccines are important public health interventions to prevent diseases and counteract pandemics. The development of COVID-19 vaccines during the most intense and devastating period of the COVID-19 pandemic was a remarkable scientific achievement. Yet the availability of the COVID-19 vaccines raised challenging public health and ethical questions about how these would be made available. The morbidity and mortality when the vaccines first became available suggested that COVID-19 vaccine mandates should be introduced to achieve maximal vaccination rates. Ethical arguments were raised in support of such mandates, and other ethical arguments were presented to oppose such mandates. We undertook a scoping review to identify and summarize the main ethical arguments used for and against mandating COVID-19 vaccines. Eligible articles were published in English between January 2020 and 25 September 2021. We extracted the ethical issues and analyzed them to develop themes and subthemes. The main ethical arguments for and against COVID-19 vaccines are summarized here.

Keywords: COVID-19 vaccines, vaccine mandates, ethics, herd immunity, public good

1. Introduction

Vaccination is one of the most successful public health interventions ever introduced and has led to the reduction and elimination of some diseases, and reductions in morbidity and mortality for others (Gravagna et al., 2020). Yet its effectiveness and safety remains controversial for some people. Such debate intensifies when public health authorities, employers or governments make, or consider making, certain vaccines mandatory. During COVID-19, the identification of a vaccine against the SARS-CoV-2 virus held out hope for many people. As many people suffered and died from

COVID-19, and the virus spread globally, questions were asked about whether a COVID-19 vaccine should be made mandatory either for all people or for certain segments of the population, such as healthcare workers or those most at risk from the disease. Opinions were divided over whether any COVID-19 vaccination mandate would be ethical. We undertook a scoping review of the ethical arguments for and against mandatory vaccination policies to identify the primary ethical arguments raised on both sides of this ethical debate.

2. Historical Background

Long before COVID-19, mandatory vaccination policies were introduced by various governments and jurisdictions in various ways. Different segments of the population were required to be vaccinated, and different penalties were enforced against noncompliance. Mandatory vaccination policies were introduced before the vaccination process was fully understood. Such policies began using a variolation process during the American Revolution when a smallpox epidemic broke out in 1777. General George Washington ordered all his troops to be inoculated by variolation, with almost 40,000 soldiers undergoing the procedure (Lawler, 2020). Massachusetts was the first state in the United States (US) to pass a compulsory vaccination law in 1809 (Jackson, 1969). In 1827, Boston became the first city to require school children to receive smallpox vaccination before entering public school (Cole & Swendiman, 2014). In Europe, mandatory smallpox vaccination resulted in significantly fewer deaths due to smallpox compared to regions with voluntary vaccination. Smallpox vaccination became mandatory in England in 1853. Before the compulsory policy, there were ten times more deaths per person in England than in Italy and Sweden where vaccination was compulsory (Batniji, 2021). In 1901, the US city of Cambridge, Massachusetts enforced smallpox vaccinations for anyone over the age of 21, with financial penalties for refusal (Green, 2021). In Jacobson v Massachusetts (1905), the US Supreme Court ruled that vaccine mandates were an appropriate measure to protect public health and safety, and the common good (Gostin, 2005).

Vaccine mandates continue to be used in various ways around the world. As of 2021, 40% of European countries had mandatory vaccination policies (Odone et al., 2021). For instance, polio vaccination has been mandatory in Belgium since 1967. In Hungary, ten vaccinations have been mandatory since 1998. Several countries have recently passed laws requiring compulsory vaccination, including Italy in 2017, France in 2018 and Germany in 2019. The majority of European Union (EU) countries, 83% of them, enforce vaccination laws. Some vaccinations are mandatory in different countries; for example, in Slovenia, health workers are required to be vaccinated against measles before starting work. Children in many countries are also required to get vaccinated. Parents of unvaccinated children are subject to financial penalties in Italy, Bulgaria, Croatia, Germany, Hungary, Czech Republic, Poland, and Slovakia (Odone et al., 2021).

In Canada, most provinces (Alberta, Saskatchewan, Manitoba, Quebec, Nova Scotia, Prince Edward Island, Newfoundland) have voluntary childhood vaccination programs (Canadian Legal Information Institute, 2021). Only New Brunswick, Ontario, and British Columbia mandate proof of vaccination before entering school (Brennan et al., 2020). Several laws and regulations govern childhood vaccination in Canada and they have remained unchanged despite repeated measles outbreaks in Canada (Canadian Legal Information Institute, 2021). In Australia, mandatory vaccination policies were introduced in 2016, generally known as 'No Jab, No Pay' and 'No Jab, No Play' (Armiento et al., 2020). Family and childcare payments can be withheld from individuals who are "conscientious objectors" to vaccinations. However, the number of children catching up with their first dose of the measles, mumps and rubella (MMR) vaccines has dropped since the "No Jab, No Pay" policy was introduced, suggesting that such mandatory policies have little impact on people with anti-vaccination sentiments (Davey, 2020).

Vaccine mandates raise questions about people's rights. Human rights have become increasingly important since the Universal Declaration of Human Rights (UDHR) came into force in 1948 (United Nations, 1948). The Oviedo Convention was proclaimed in April 1997 to protect the rights and dignity of humans with regard to the application of biology and medicine. According to the convention,

health interventions should only be carried out after the person concerned has provided free and informed consent (Council of Europe, 1997). This applies even in emergency situations with unproven medical interventions where World Health Organization (WHO) guidance states, "The ultimate choice of whether to receive the unproven intervention must rest with the patient, if the patient is in a condition to make the choice" (van Aardt, 2021: 3).

However, such rights can be restricted in specific circumstances. The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights by the United Nation (UN) Commission on Human Rights on 28th September 1984 permitted invoking public health needs as grounds for limiting certain rights in order to allow a state to take measures dealing with a serious threat to the health of the population or individuals in the population (UN Commission on Human Rights, 1985). The measures should be specifically designed to prevent disease or injury or to provide care to the injured and sick. Whenever a public emergency threatens the life of the nation as it affects the whole population by either part of the state or the state's entire territory, and it threatens physical integrity of the population, it can lead to the declaration of a state of emergency (UN Commission on Human Rights, 1985).

Mandatory vaccination and compulsory vaccination are example of coercive policies. Although the terms are often confused, Mark Navin and Mark Largent distinguish between "mandatory" and "compulsory" vaccinations. Families who choose not to vaccinate their children for reasons other than medical ones are denied valuable social goods or services as a result of mandatory vaccination. For instance, in the United States, vaccination is required for admission to public schools or in Australia, some financial benefits are withheld from families that do not vaccinate their children. Compulsory vaccination according to Mark Navin and Mark Largent leads to criminalization of vaccine refusal (Giubilini, 2020). Mandates are designed to target populations that are vaccine hesitant rather than those who are staunchly opposed to vaccines (Pierik, 2018).

3. COVID-19

Discussions and ethical debates about COVID-19 vaccines began almost as soon as the pandemic started. The epidemic began in the city of Wuhan in China in late 2019, with a rapid increase in cases around the world. On 11 March 2020, WHO declared COVID-19 a pandemic, with it officially ending in May 2023 (World Health Organization, 2023a). As of the end of 2023, more than 770 million cases of COVID-19 were confirmed and almost 7 million people have died (World Health Organization, 2023b). The COVID-19 pandemic has posed a significant risk to public health systems around the world, as well as having major economic consequences. The pandemic has also affected vaccine acceptance and availability. These are complex processes and context dependent. Vaccine acceptance varies depending on time, place, and person, as well as perceived behavior and community beliefs (Al-Mohaithef & Padhi, 2020).

WHO recognized that the COVID-19 pandemic, and the potential for its resurgence, have affected public health systems in a number of unforeseen ways. For a public health response to COVID-19 to be effective and efficient, both during the pandemic and afterwards for sustained prevention, public health authorities generally recognize that a key strategy is extensive vaccination (World Health Organization, 2021). The WHO Director-General Dr. Tedros Adhanom Ghebreyesus said, "COVID-19 has robbed us of people we loved. It's robbed us of lives and livelihoods; it's shaken the foundation of our world; it threatens to tear at the fabric of international cooperation. But it's also reminded us that for all of our differences, we are one human race, and we are stronger together" (World Health Organization, 2020).

The global solidarity expressed by the Director-General has led to questions about the ethical obligations individuals have to protect and promote the health of others in their communities and around the world. To combat the pandemic, many countries undertook different preventive, protective, and curative measures (Cirrincione et al., 2020). Many specific actions were undertaken, recommended or mandated, including different levels of social restrictions, wearing masks, avoiding handshakes, and closing schools

and workplaces around the world. One of the measures was to vaccinate the population when COVID-19 vaccines became available (Loomba et al., 2021). Vaccine effectiveness is influenced by what is called 'herd immunity' (Giubilini, 2021). This term describes the reality that for a vaccine to be as effective as possible, a certain percent of the population must be immunized against the disease. While vaccination raises several ethical dilemmas, one controversial question is whether a specific vaccine should be mandatory for the population to receive in order to achieve herd immunity. Even when a population-wide mandate does not exist, debates arise about whether selected subgroups (e.g., healthcare workers or those at high risk of serious harm from the disease) should be mandated to receive the vaccine.

4. Review Methodology

Our main objective was to identify the main ethical reasons and arguments for and against mandatory or compulsory COVID-19 vaccination. Our study rationale was that while COVID-19 vaccination is highly effective, making it mandatory or compulsory is ethically controversial and with significant implications for healthcare and society. To identify the ethical arguments, we undertook a scoping review to provide an overview of the available published evidence during the time that COVID-19 vaccines were being developed and first deployed. The purpose of this chapter is to provide a list of the ethical arguments identified and an overview of our perspective on the issue.

We performed a scoping review following the list of Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) extension for Scoping Reviews, or PRISMA-ScR (PRISMA, 2021). The steps were guided by the Arksey and O'Malley's five-stage framework for scoping reviews (Arksey & O'Malley, 2007). These steps are: (1) identification of the research question; (2) identification of relevant studies; (3) selection of the eligible studies; (4) charting the data; and (5) collating and summarizing and reporting the results. The scoping review protocol was developed and peer-reviewed by experts at Centre for Research and Training in Disaster Medicine, Humanitarian Aid, and Global

Health at University Del Piemonte Orientale Novara Italy and Vriji University Brussels Belgium and registered in figshare (Haider & O'Mathúna, 2021).

4.1. *Identification of Research Question*

Our research question was "What are the main ethical arguments in published literature for and against mandatory vaccination against COVID-19?" We used a modified version of the PICO(T) format to structure our question into key terms that would be used in our search of electronic databases. PICO(T) stands for population, intervention, comparison, outcome and type of studies (PRISMA, 2021; George Mason University, 2022). PICO(T) was designed for systematic reviews of intervention studies, but provided a useful framework for our purposes. For Outcomes, we were focused on studies that focused on the ethical reasons and arguments presented on mandatory COVID-19 vaccination. Comparison in PICO(T) usually refers to the interventions compared within experimental studies, but for our purposes we used it to refer to comparisons between ethical arguments. The key terms are listed in Table 1.

Table 1. PICO(T) Question

PICO(T) term	Application within our scoping review
Population	General population
Intervention	COVID-19 vaccination
Comparison	Mandatory versus non-mandatory, or compulsory versus non-compulsory
Outcomes	Ethical reasons or arguments related to mandatory COVID-19 vaccination practices
Type of studies	Any type of study

4.2. *Identification of relevant studies*

The PICO(T) terms (Table 1) were used to develop a search strategy using the key terms mandatory, vaccination, COVID-19, policies, and ethics, as well as suitable synonyms. The initial search strategy was reviewed by a professional librarian and the revised

search strategy piloted with PubMed in May 2021. Minor modifications were made to produce the final search strategy (available from the authors upon request). This search strategy was used to search two electronic databases, PubMed and Google Scholar, for eligible articles published between January 2020 and 25 September 2021. The same terms were used to search for grey literature in the websites of the WHO, United Nations Children's Fund (UNICEF) and The Vaccine Alliance (Gavi). Only English articles were included, but no restrictions were placed on study type, publication type or setting.

4.3. *Selection of the eligible studies*

Publications were first screened based on their title and abstract by two reviewers working independently to remove abstracts which did not fit the inclusion criteria. Any disagreements between the two reviewers were resolved by a third reviewer. The selected articles were obtained in full and read for inclusion or exclusion by two reviewers working independently. Final decisions on inclusion of all articles were determined through discussions between the three reviewers. All disagreements were resolved fully.

4.4. *Data extraction and analysis*

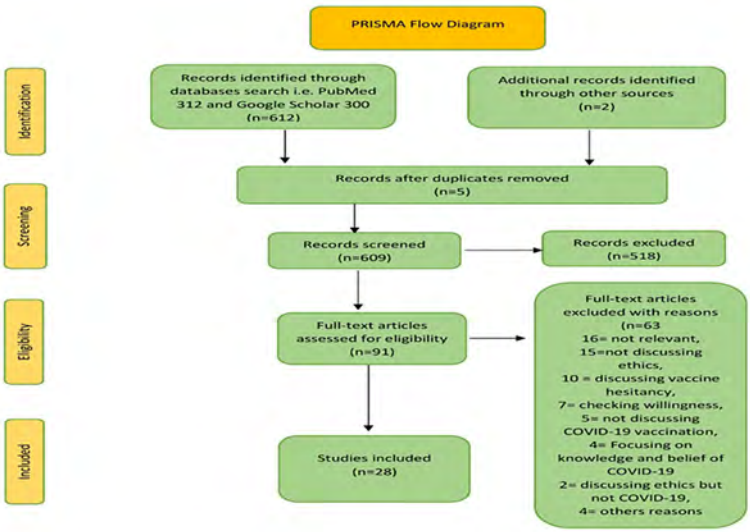
We designed a data extraction form specifically for this review and finalized it through discussions between the three reviewers. Data extraction was performed by one reviewer and verified by a second. We extracted information from each article on ethics or ethical reasoning or ethical arguments for or against mandatory COVID-19 vaccination. Background information on the history, policies, laws and outcomes related to mandatory vaccination more generally was also captured and is summarized in the section, Historical Background. The extracted data was analyzed using Braun and Clarke's approach to reflexive thematic analysis (Byrne, 2022).

5. Review Results

5.1. *Collating and summarizing data and reporting the results*

The searches identified 614 publications for screening (PubMed = 312, Google Scholar = 300, and additional records identified through other sources = 02). Five duplicate articles were identified, leaving 609 unique publications. The screening of titles and abstracts led to the exclusion of 518 publications with 91 remaining for full text review. This led to the exclusion of 63 publications for the reasons listed in Figure 1. A total of 28 publications were included for final analysis (Figure 1). The list of all included articles is available from the authors.

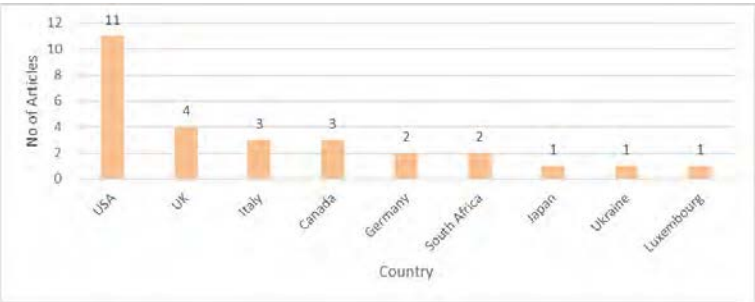
Figure 1. PRISMA Flow Diagram



5.2. *Characteristics of the included articles*

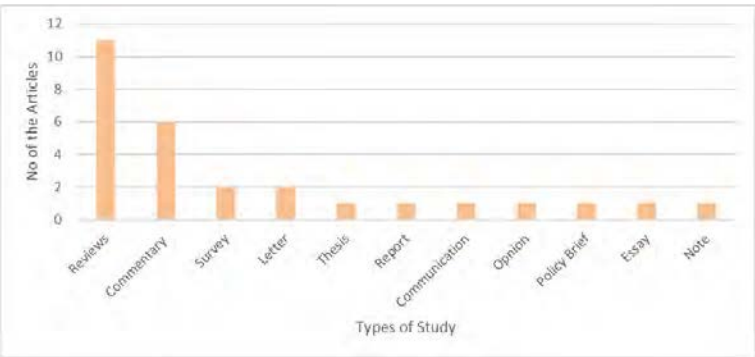
The bibliometric characteristics of the 28 publications included in the scoping review are provided in Figures 2 and 3. Approximately 40% from the US, 14% from the United Kingdom and 10% each from Italy and Canada.

Figure 2. Inclusion of Studies from Different Countries in the Scoping Review



Different types of publications were included in the scoping review, including reviews, commentaries, surveys and letters, with each type accounted for 39%, 21%, 7% and 7%, respectively (Figure 3).

Figure 3. Types of Studies included in the Scoping Review



The included studies were read a number of times to extract the ethics concepts, principles and arguments used by the authors either for or against mandatory COVID-19 vaccines. The extracted data were analyzed using Braun and Clarke's approach to reflexive thematic analysis (Byrne, 2022). In this approach, an initial list of codes was generated which consisted of 43 ethical principles, rights, duties and other reasons used to support the ethical arguments. The coded data were reexamined repeatedly to identify ways that individual codes could be combined into broader, distinct themes.

For themes that included a number of codes, these became subthemes. This led to a total of eight themes as showed in Table 2.

Table 2. Themes and subthemes from the thematic analysis of included publications

Number	Themes	Subthemes
1	Freedoms	Freedom of conscience Freedom of religion Freedom of belief Freedom of thought Liberty Negative liberty Autonomy
2	Rights	Right to life Right to freedom Right to health Right to make decision Right to treatment Right to free movement Right to information Parents rights Right to education Right to information on adverse events Right to refuse
3	Duties	Duty towards society Duty towards care of the patient Duty towards family Duty towards children Duty towards elderly
4	Other Ethics Concepts	Solidarity Dignity Utilitarianism Beneficence Non-maleficence Justice Fairness Informed Consent
5	Public Health Protection	

Number	Themes	Subthemes
6	Vaccine Science	Herd Immunity Vaccine safety Vaccine effectiveness Preventive measure Burden of the disease Vaccine licensing
7	Vaccine hesitancy	
8	Policy and pragmatic issues	Vaccine availability Using least restrictive alternatives Free-riders (the unvaccinated benefiting from those vaccinated) Incentives and penalties Exemptions (religious and/or medical)

6. Main Ethical Arguments for Mandating COVID-19 Vaccines

Further analysis of the themes and subthemes identified in our scoping review is ongoing. Here we present the primary ethical arguments identified in the included literature. First, the main ethical arguments in favor of mandatory COVID-19 vaccination are presented.

6.1. *Harm prevention*

COVID-19 vaccination mandates are most commonly justified as a way to prevent harm to individuals, communities and especially persons at high risk from COVID-19. John Stuart Mill argued that, "The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others" (van Aardt, 2021: 2). Healthcare practitioners and staff involved in the treatment and management of COVID-19 patients are particularly at risk themselves of being infected and of transmitting the infection to other patients. Healthcare practitioners have an ethical duty to do no harm to their patients and ensure their patients remain in safe environments (Gur-Arie et al., 2021).

Since healthcare practitioners can spread COVID-19 and other infections, mandating their vaccination against such agents satisfies the ethical principle of nonmaleficence in terms of harm prevention. Preventing such superspreading events is particularly important given the higher risk of getting very ill from COVID-19 among the patients and clients cared for by healthcare practitioners (Gur-Arie et al., 2021).

Proponents of vaccine mandates acknowledge that vaccines do carry some risk of harm, but state that evidence shows these risks are minimal compared to harm from the disease. Proponents agree that COVID-19 vaccines were developed and approved faster than normal, but point out that extensive safety monitoring systems are in place both before and after vaccines become available. Such systems identified rare adverse effects with an approved rotavirus vaccine in the 1990s and with a flu vaccine in 2009 within a very short time so that harm was minimized (Reiss & Caplan, 2020). Given that the COVID-19 vaccines and boosters have been given to huge numbers of people worldwide, if such serious adverse effects existed, they would be identified rapidly.

An additional system to address situations where vaccines cause serious adverse events has been the development of vaccine injury compensation programs (VICPs). While these schemes do not prevent initial harm, they aim to prevent or minimize subsequent harms that could arise, especially for those who may not have the resources to seek compensation for the initial harm. These no-fault schemes have been established in at least 24 countries, mostly in Europe, to compensate people for serious vaccine-related harms (D'Errico et al., 2021). Many VICPs include COVID-19 vaccines, although the US established a separate program which is less generous and more cumbersome than for other vaccines. The ethical reasoning behind such programs is that those who do experience harm from accepting the risks associated with vaccines (either voluntarily or by mandate) should be compensated for contributing to the public good. VICPs thus aim to promote equity and dignity among those injured. Those who favor vaccine mandates point out that in those rare situations where vaccines lead to serious injuries, compensation will be available to assist the injured and protect them from further negative consequences (D'Errico et al., 2021).

This addresses ethical concerns that when a community mandates that its members receive vaccines, knowing that some individual could be harmed, the community must share in the burden of the costs of those injuries (D'Errico et al., 2021).

6.2. *Public health protection*

Another frequent ethical argument for mandatory vaccination is the large benefit vaccines contribute to public health protection. For example, WHO data indicates that the measles vaccine saved 17.1 million lives between 2000 and 2015 (Giubilini, 2021). Globally, vaccination against diphtheria, tetanus, whooping cough and measles annually prevents approximately 2-3 million deaths among children under five years of age (Gravagna et al., 2020). In Italy alone, more than 4 million cases of vaccine preventable diseases have been prevented by vaccination programs implemented between 1900 and 2015 (Gravagna et al., 2020). Approximately 1.5 million children die each year from vaccine preventable diseases, with many millions of children and adults suffering significantly from the effects of these diseases that could be prevented (Gravagna et al., 2020). Decreases in vaccination rates can quickly undermine public health protection. For example, recent drops in measles vaccination rates in Europe led to a tripling in measles cases in Europe in 2018-2019 (Giubilini, 2021). "Vaccines are the most important public health intervention to prevent the spread of infectious diseases" (D'Errico et al., 2021: 8).

Given this large public health benefit with high vaccination rates, mandatory vaccination policies have been instituted in some circumstances. The European Court of Human Rights recognized that mandatory vaccination policies may be introduced in a democratic society when it is a necessary measure to protect public health (Frati et al., 2021). Protecting other people's health, rights and freedom is one of a number of reasons why interference with people's private decisions can be justified. Such mandates are justified when there is a serious risk to health and especially "to protect the weakest" (Frati et al., 2021: 3). With COVID-19, some people will be in particularly vulnerable states because of other health conditions or they may not be able to receive the vaccine. For example, medical reasons

(such as being immunosuppressed) may exclude some people from receiving vaccines or age restrictions may apply, as occurred early on with COVID-19 vaccines (Giubilini, 2021). Therefore it is ethically appropriate for others to take steps to protect their health by achieving adequate vaccination levels, particularly when the known risks from vaccination are minimal. Vaccination could be mandatory if it is proportionate to the achievement of an important public health goal, including protecting the capacity of the acute health care system by reducing hospitalization rates (World Health Organization, 2021). At the same time, evidence to support such determinations must be available, and less coercive or intrusive interventions must be considered. Mandatory policies should also be reviewed regularly in light of accumulating evidence regarding their need and effectiveness. The cumulative benefits in recent decades in the development and deployment of vaccines are enormous, leading to extended life expectancy, freedom from fears of crippling childhood diseases, decreased disease outbreaks and economic benefits from averting disease and disability (Schuchat, 2011). Achieving high vaccination coverage for many diseases remains one of the highest public health priorities and can, at times, ethically justify mandating specific vaccines, including the COVID-19 vaccine.

6.3. *Herd immunity*

In order to achieve optimal public health protection from a specific infectious disease, a certain proportion of the people in a community need to be immune to the disease. This situation is called achieving 'herd immunity,' also referred to as 'herd protection' or 'community protection' (Giubilini, 2021). When herd immunity is achieved, those who are not immune or vaccinated will be indirectly protected from the disease because the transmission of the infectious agent will be stopped or greatly reduced by those who are immune. The point at which herd immunity is achieved varies for each infection, and is dependent on the infectiousness of the infectious agent and the effectiveness of the vaccine.

Vaccination thus confers two types of benefits: protection of the individual receiving the vaccine and a contribution towards the protection of others in one's community. Thus herd immunity

is a public good, meaning that individuals benefit regardless of whether or not they contribute to the public good (Giubilini, 2021). This adds another ethical issue to vaccines beyond the individual's good or harm. If everyone in a community benefits from a public good, this places an ethical responsibility on all beneficiaries to contribute to the public good. Similarly, clean air is a public good and all people in a community should contribute towards it, such as through payment of taxes that support public services. Herd immunity as a public good means that those who benefit and do not contribute are being unfair to their community, and particularly towards those who accept the burdens, inconveniences and risks of being vaccinated (Graeber et al., 2021).

This argument moves beyond the balancing of benefits and burdens and gets to what it means to be a contributing member of society. Refusing to accept such social responsibilities has been termed 'free riding,' normally taken to be unethical because of its unfairness (Giubilini, 2021). The negative connotation associated with such a phrase is intended to motivate people to accept that responsibility voluntarily, much as athletes are encouraged to play fair in sports. If voluntary motivations are not sufficient to achieve herd immunity, mandatory vaccination can be justified as a way to level the playing field and ensure that people contribute to the goods they receive. This argument is said to be further strengthened by adding that free riders accept the benefits of herd immunity while simultaneously requiring those with greater vulnerabilities to the disease to take on higher risks through either failure to or delays in achieving herd immunity within their community. Free riding thus places the weak at greater risk of harm in direct opposition to the widely held ethical value of protecting the weak.

6.4. *Autonomy*

Autonomy is an important ethical principle and leads to the right in modern healthcare of individuals to make their own decisions regarding their health and bodies. Ethical questions about vaccine mandates often begin with concerns about the violation of individual autonomy. However, individual autonomy is not absolute. People's autonomy may be restricted if their choice poses a risk of

harm or injury to others (Reiss & Caplan, 2020). The decision over whether to vaccinate or not differs from most healthcare decisions because an individual's choice has direct implications for the health of others. When people are immunized against an infectious disease they help to reduce the spread of the infection among others in their community (Giubilini, 2021). In contrast to decisions about whether to take other medications or undergo surgery, for example, refusing such medical interventions will not have direct medical consequences for those around the person (though it may have other implications for their relationships or the need for care).

In situations where individual freedom of choice can endanger the health of the public, other ethical principles such as beneficence and non-maleficence must be balanced against autonomy, and may take precedence. This argument is strengthened when the health of vulnerable populations is considered (Reiss & Caplan, 2020). COVID-19 is both more contagious and particularly dangerous for certain populations, including the elderly and those with co-morbidities and compromised immune systems. While younger populations may be at lower risk of harm from the virus, when infected they can transmit the virus to these at-risk populations. The benefits to such populations of a vaccine mandate can thus be ethically justified.

6.5. *Freedom of belief and religion*

Opponents of vaccine mandates have argued that at the very least, exemptions to mandates should be allowed for those with religious, philosophical or personal beliefs that are opposed to vaccination (Brennan et al., 2021). However, such exemptions have increasingly been criticized and even withdrawn in some jurisdictions. One of the ethical arguments is utilitarian in that evidence has shown that the most effective way to increase immunization rates among children is by removing religious and philosophical exemptions (Brennan et al., 2021).

The right to freedom of thought, conscience and religion is discussed in Article 18 of the International Covenant on Civil and Political Rights (ICCPR) (United Nations, 1966). However, most of the Covenant's rights are not absolute. Article 4 of the ICCPR states that in times of public emergency, States may take measures to

suspend or restrict the exercise of these rights. Such derogations can be permitted only to the extent required to address emergencies that have been officially proclaimed and that threaten the life of the nation. Article 4 adds that derogations are not permitted for some articles, including Article 18. However, courts in the US and elsewhere have argued that vaccine mandates do not necessarily interfere with the right to freedom of religion (Calamaro, 2021). So long as a vaccine mandate does not single out religious behavior for punishment, and is not motivated by the desire to interfere with religion, it can be acceptable even without an exemption for religious or personal beliefs.

The ethical argument is that so long as a vaccine mandate does not directly target religious belief, the incidental burdening of some religious practitioners does not outweigh the benefits of vaccination. It then falls to the available evidence to show that vaccination is preferred over non-vaccination to provide protection in the event of a national crisis, such as a pandemic. A mandatory COVID-19 vaccination policy without a religious exemption could be justified if the disease was shown to spread easily, the burdens of the disease to be high, and the vaccine to be effective and safe (Brennan et al., 2020). Legally, the policy would need to show that the infringement on rights would be no more than is absolutely necessary, which is a more subjective balance to demonstrate. However, such arguments have been made to justify mandatory COVID-19 vaccination policies even without religious exemptions.

7. Main Ethical Arguments against Mandating COVID-19 Vaccines

7.1. *Liberty and freedom*

The most common argument against vaccine mandates is that they violate the principles of liberty and freedom. These two concepts are distinct but related, and often overlap in the ways they are used in discussions about vaccine mandates. Liberty refers to the rights of people to be without restrictions or interferences from authorities that limit one's way of life and behaviors. Freedom is a more general concept that refers to people's right to make their

own choices about what they think or do. Freedom is linked closely to notions of self-determination and autonomy. Vaccine mandates can be viewed as violating liberty because they impose restrictions on people requiring them to accept a vaccine and remove the freedom for people to decide for themselves how they will care for their health (Calamaro, 2021). Governments should protect such liberties and freedoms, not remove them from citizens.

Within healthcare, autonomy is viewed as an important ethical principle that should be respected. US Supreme Court Justice Cardozo in 1914 wrote in a court decision that "Every human of adult years and sound mind has a right to determine what shall be done with his own body" (Relias Media, 2019). According to bioethicists Beauchamp and Childress, "At a minimum, personal autonomy encompasses self-rule that is free from both controlling interference by others and limitations that prevent meaningful choice, such as adequate understanding" (2019: 101). Autonomy supports people's freedom of self-determination in healthcare so that individuals, not others, should make decisions about what interventions are used on their bodies and how they address their own health (Varkey, 2021). Vaccine mandates oppose this ethical principle by requiring people to use vaccines whether they want to or not.

Concerns have also been expressed that removing people's freedom to refuse COVID-19 vaccines may trigger "control aversion" which could reduce people's willingness to voluntarily receive the vaccines for internally motivated reasons (Schmeltz, 2021). This could hinder further efforts to protect communities from COVID-19 through undermining people's personal autonomy and leading people to accept restrictions only if externally motivated through compulsion or mandates.

7.2. *Informed consent*

Another implication of the ethical principle of autonomy is that people should not only be free to make their own decisions, but they should be provided the necessary information to make an informed decision. This provides the ethical foundation for the value placed on informed consent, particularly in healthcare contexts. Patients should be informed about any medical interventions they

are being offered, and should have the opportunity to ask questions about them so that they can make well-informed decisions about their health (American Medical Association, 2022). In those who are legally capable of making their own decisions, medical interventions should not be provided until the patient has given informed consent (Stirrat & Gill, 2005). In order for consent to be valid, it must be voluntary and informed, and mandatory vaccination policies take away both elements. Those opposed to mandates claim that the information available on the efficacy and safety of COVID-19 vaccines, especially shortly after their availability, was insufficient to meet the requirements for true informed consent. If people who voluntarily took COVID-19 vaccines were not truly informed, this would make mandating the vaccines even more unethical.

Instead of introducing mandatory vaccination policies, proponents argue that vaccination rates can be improved by enhancing the informed consent process. Some evidence points to the beneficial effects of targeted COVID-19 campaigns that facilitate informed, efficient and voluntary consent processes (MacDonald et al., 2021). Such processes should be sensitive to the needs of vaccine recipients, aware of contextual factors and avoid any coercion such as will be perceived through mandatory processes. When the emphasis is placed on promoting informed consent rather than pushing compliance, vaccination rates can become high (MacDonald et al., 2021).

7.3. *Vaccine safety*

Concerns about the safety of COVID-19 vaccines was another common reason provided to oppose mandating these vaccines, especially when they first became available. For example, in a rapid systematic review of vaccine hesitancy among healthcare workers, the most common concern about COVID-19 vaccines was vaccine safety, particularly potential long-term safety concerns (Frati et al. 2021). Even before COVID-19, fear of adverse events and lack of information on immunization were the main reasons given for vaccine hesitancy (D'Errico et al., 2021). Personal healthcare decisions involve weighing the potential benefits and risks. People should be provided with all of the necessary information as part of making

ethically autonomous decisions that meet the requirements of informed consent.

Opponents of vaccine mandates note that because COVID-19 vaccines were developed faster than normal, they could not be monitored for long-term adverse effects before being widely used. Since information about the safety of and risks with the vaccines was unavailable, some argue it is unethical to mandate that they be used. When COVID-19 vaccines first became available, the United States Food and Drug Administration (FDA) licensed them under an Emergency Use Authorization (EUA). An EUA does not require the same level of safety and efficacy of vaccines as full FDA approval would. Therefore, mandating vaccines with an EUA was not viewed as ethically or legally appropriate. In the end, this ethical argument is strongly influenced by the evidence regarding vaccine safety which should improve as time goes on.

7.4. *Right to refuse*

Linked to autonomy and informed consent in healthcare is the right to refuse. Patients have the right to refuse any medical intervention, even when such refusal can lead to their death. This issue arose in the included articles in this scoping review specifically in the context of parental decisions for minor children. Parents normally have the right to refuse medical interventions for themselves and their children, while vaccine mandates take on a distinct ethical challenge by disempowering parents of important freedoms around how they raise their children (Hadjipanayis et al., 2021). While interfering with parental decision-making is a serious issue, parents are also required to act in the best interests of their children. However, opponents of vaccine mandates argue that not only is such interference unethical, but it is also unlikely to improve vaccination rates. Some hold that COVID-19 vaccines are unnecessary for children because of the lower incidence of serious disease among children and therefore the minimal benefit to them from vaccines (Gur-Arie et al., 2021). Some hold that such mandates would further alienate parents who are hesitant about COVID-19 vaccines and have the potential to cause backlash (Smith et al., 2021). Mandates could possibly lead to further harms if parents became hesitant to engage with

medical care more broadly for fear of being pressured into having their children vaccinated (Hadjipanayis et al., 2021).

8. Discussion

The main ethical arguments about COVID-19 vaccine mandates identified in the literature included in this scoping review have been presented here. The arguments for and against mandates take on two generally different approaches. Those in favor of mandates focus on the harms that mandates can prevent through increased vaccination rates that lead to reduced incidence and severity of disease. Arguments against mandates focus on the restrictions in liberty, freedoms and autonomy that mandates bring. The two approaches represent two very different outlooks on ethical values and priorities. Vaccine mandates are promoted as a necessary tool to promote an important public good, even while acknowledging the restrictions placed on autonomy and freedoms. Such restrictions are viewed as necessary in some situations for some people. On the other hand, vaccine mandates are opposed on the basis of defending individual rights and autonomy, while noting potential harms from vaccines and questioning their necessity.

Arguments in support of COVID-19 vaccine mandates add that such mandates should have limits. Mandates restrict rights and freedoms and thus fall under the Siracusa Principles (van Aardt, 2021). These principles apply when civil and political rights are limited in order to promote a public good. They hold that such restrictions must respond to a pressing public need, pursue a legitimate aim, and be both proportionate and the least restrictive feasible. The mortality and morbidity of the pandemic, at least during its first 12 to 18 months was a pressing need and reducing individual and public harm was a legitimate aim. Questions continue over the remaining two principles. As the scale of the harmful effects from COVID-19 decreased, vaccine mandates would become less proportionate a response. Debate also continues about whether mandates are the least restrictive option. Some hold that addressing the concerns of those hesitant about COVID-19 vaccines, coupled with accurate and appropriate education, could also achieve higher vaccination rates without restrictive policies (World Health

Organization, 2021). Such contextualization of vaccine mandates can lead to adaptation where mandates are not applied to all groups of people, but only selected groups. Thus, mandates might only apply to healthcare workers or others working in environments where transmission is particularly high, or working with people who are at high risk for serious illness. In this way, the ethical debate about COVID-19 vaccine mandates is more complex than simply determining whether mandates are ethical or not.

9. Conclusion

This scoping review has some limitations. A limited number of electronic databases and sources of grey literature were searched. Only English language articles were included in the review. This may have limited our findings and meant that we did not identify important other ethical issues arising in other jurisdictions and cultures. This concern is supported by how all the included articles came from higher income countries (Figure 2).

Vaccination remains one of the most cost-effective ways to prevent disease (World Health Organisation, 2019a). Vaccines protect children and adults from many serious and potentially deadly diseases, and through herd immunity can help prevent the spread of diseases to people who cannot receive vaccines. Four to five million deaths worldwide are prevented by vaccines every year, and another 1.5 million deaths could be prevented if global vaccination coverage improved (World Health Organisation, 2019b). Mild side effects are sometime associated with vaccines, but they rarely last long. According to WHO, one of the greatest threats to global health is vaccine hesitancy (World Health Organization, 2019a).

Around the world, public health systems were key to combating the COVID-19 pandemic. Public health now has an important role to play during the recovery phase. In the case of mandating COVID-19 vaccination in the pandemic, the ethical dilemma arises from the conflict between the rights of individuals and public health ethics. COVID-19 vaccines have been administered to millions of people around the world and are being monitored for safety. Reports of serious side effects are rare. COVID-19 vaccines cause mild side effects which are usually short-lasting. COVID-19

vaccines have proven highly effective in reducing transmission of the disease (Cigna, 2021). Vaccines help to reduce the incidence of serious illness, hospitalization and death when vaccinated people become infected with COVID-19 (Gavi, 2021). On the other hand, the COVID-19 disease affects people in a variety of ways. Symptoms range from mild to fatal. The disease is more likely to affect elderly people with chronic diseases, but it can also affect healthy young people.

Herd immunity is important in helping communities reduce the spread of COVID-19. It is intended that populations develop a high level of immunity that will prevent spread of COVID-19 infections (Giubilini, 2021). When the virus is highly infectious, like with COVID-19, higher proportions of the population will need to be immunized either by vaccination or by acquiring the illness. Infection rates can also be affected by virus evolution and how people interact in their communities. Even achieving immunity in communities below the threshold for herd immunity has positive effects in reducing the total number of infections (D'Souza & Dowdy, 2021).

Although debate continues over the ethics and rationality of mandates for COVID-19 vaccines, mandatory vaccination is one of the most effective tools for achieving high vaccination coverage levels, which would reduce infection rates, morbidity and mortality, and protect populations from re-emergence of the infection or new strains of the SARS-CoV-2 virus (European Centre for Disease Prevention and Control, 2021). In order to control and end pandemics, high vaccination coverage is pivotal in stopping the transmission of the infecting agent. Persuasion strategies alone may not achieve adequate COVID-19 vaccination rates, so vaccine mandates may need to be considered at various points (Batniji, 2021). The ethical arguments on both sides of the issue should be openly and transparently discussed by all stakeholders. If mandates are deemed necessary, they should be supported by the ethical concerns and limitations discussed here. In addition, appropriate authorities have obligations before imposing mandates to provide accurate information about the risks and benefits of the disease and its vaccines, to encourage as many people as possible to get vaccinated, and to ensure vaccines are easily obtained and distributed in an equitable manner (Russell, 2021).

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Ethical Challenges and Hesitancy Associated with (Mandatory) Vaccination against COVID-19

Abstract

The World Health Organization (WHO) highlighted vaccination hesitancy as one of the top 10 hazards to world health in 2019, despite the fact that it has been widely known that the vaccine is an essential preventative measure to shield the vaccinated person from serious illness and death. Soon after, in March 2020, the WHO classified COVID-19 as a pandemic and strongly advised that the global populace be shielded from the further spread of SARS-CoV-2 through fundamental preventive measures as well as through widespread vaccination, even if it were mandatory for some populations.
Mandatory vaccination could be viewed as a method of increasing compliance to vaccination agendas, and in the case of COVID-19, it was deemed ethically justified if the threat to public health was serious, population confidence in its efficacy and safety was high, the anticipated utility was superior to alternatives, but also if the penalties for noncompliance were balanced. Unfortunately, it was discovered that in certain cases, unsubstantiated data and medically misconstrued information on vaccine efficacy, duration of protection, and probable adverse effects, were the most important reasons for the COVID-19 vaccination hesitancy.
Taking into consideration previous experiences with COVID-19, further analysis of (mandatory) vaccination hesitancy is still more than required, with the comprehensive consideration of basic ethical principles that might give us some rational future directions in this highly sensitive issue.
Keywords: COVID-19; ethical challenges; mandatory vaccination; vaccination hesitancy

1. Introduction

The World Health Organization declared COVID-19 a pandemic on March 11, 2020 (Wong & Lee, 2021). That declaration marked a turning point in the global response to the COVID-19 outbreak, given that the WHO's decision was based on the rapid spread

of the virus around the world and the severity of the disease. The use of protective masks, contact avoidance, and other hygiene precautions, as well as immunization, were advised as ways to protect the public against the spread of SARS-CoV-2 on a wider scale (Fisher et al., 2020; Frielitz et al., 2021). However, we know that vaccines remain one of the most important primary prevention methods.

Vaccines have been shown to be remarkably effective at reducing the incidence of disease, which has a huge impact on both public health and individual health. As a result, it was anticipated that the vaccination would guard against serious illness in those who contracted the particular infection it had been designed to combat (Nainu et al., 2020). Moreover, high vaccination rates were expected to bring significant benefits, including reductions in disease-related hospitalizations, maintaining hospital capacities, and less death outcomes.

The COVID-19 pandemic has generated distinctive and unexpected challenges to each and every healthcare system in the world. SARS-CoV-2 infection substantially raises the risk of death for immunocompromised patients, as well as other vulnerable individuals, such as the elderly population and patients with concomitant pathological conditions. As a result, we now understand that SARS-CoV-2 has significant impacts on almost every major organ system, including the immune system, lungs, blood vessels, kidneys, cardiac muscle, central nervous system, liver, and gastrointestinal system (Lee, 2020). In addition to the physical impairment, many patients have also seen a decline in their mental health, present on all social strata (Wong & Lee, 2021). Namely, the mental health impacts of COVID-19 have been severe and long-lasting, and we're still acquiring knowledge about their full extent. Many people have experienced anxiety, depression, and other mental health conditions as a result of the pandemic.

The WHO, however, listed vaccination hesitancy as one of the top 10 dangers to health worldwide in 2019, and this was something that has been a growing concern for many years now (WHO, 2019). Vaccination hesitancy is a complex issue, with many different factors contributing to it. It can be caused by a lack of trust in the healthcare system, concerns about vaccine safety or side effects, misinformation or disinformation about vaccines, and more. While

the recognition of immunization is pivotal to its success, we are very well aware of the rise of the anti-vaxxer movement, with their conspiracy speculations and misinformation distributed mainly over the Internet. Therefore, to increase public knowledge and awareness is needed without any delay.

2. The Information and the COVID-19

There has been a public agreement that most common sources of COVID-19 information for the vaccine-accepting, or resistant groups, are television and social media, respectively (Murphy et al., 2021). If we just focus on social media, it is evident that there has been a strong correlation between disbelief in vaccines' safety and use of social media, especially in the groups accessing social media often, and expectedly even more so, in the groups using social media regularly (Wilson & Wiysonge, 2020).

As for the general population, it seems that the trust in the COVID-19 information sources for the vaccine-accepting people has strongly correlated with information obtained from personal/family doctor, than healthcare professional, and finally government agencies (Reiter et al., 2020; Murphy et al., 2021). On the other hand, the mistrust has been mainly generated by social media. To some point, this has led to quite fast spreading of incorrect or misleading information about the safety and efficacy of the vaccines, which has contributed to vaccine hesitancy.

Unfortunately, the actions thus far, or worldwide education have not altered the anti-vaxxer attitudes. Moreover, they usually direct further discussion to dissident ground, where social networking applications can be extensively used to spread misinformation, further enabling people to quickly produce and distribute material globally without any oversight (Boodoosingh et al., 2020; Puri et al., 2020). While comparatively not big, the anti-vaxxer interest group aggressively uses social media to magnify sent messages, thus primarily targeting people who are unconfident about vaccines. Unfortunately, facts with low quality evidence have been spread more frequently than those with high quality content on COVID-19 (Singh et al., 2020). We can indisputably claim that misinformation has plagued the scientific community (Patten et al., 2021). Thus, it is

important to seek out information from reliable, evidence-based sources and be skeptical of any sources that are not credible.

Typical anti-vaxxer types of narratives include for example, vaccine injury (!), corrupt elites (!), freedom under siege (!), sinister origins (!), and so forth, while pompous rhetorical strategies include as follows: think of the children (!), perform your own research (!), speaking truth to power (!), and many more (Hughes et al., 2021).

Just to fulfill the previous picture, it is now more than evident that for example, ideology or level of education are also tightly connected with the knowledge regarding COVID-19, where for example, liberal orientation vs. conservative orientation, or high level vs. low level of education show positive correlations (Salmon et al., 2021; Sylvester, 2021). There are indeed studies that have shown a correlation between political ideology and knowledge about COVID-19, as well as between educational level and knowledge about COVID-19. It seems that those who have more liberal political beliefs or higher levels of education are more likely to have accurate knowledge about COVID-19, but it's important to note that correlation does not necessarily imply causation. It could be that those who have higher levels of education are simply more likely to have access to accurate information about COVID-19, for example.

3. Vaccine Hesitancy

The vaccine-related attributes positively contributing willingness to vaccinate, as expected include: high efficacy, minor side effects, only full approval by the representative drug agency, the origin, and of course, the cost, sometimes with expectations for some incentives (Kreps et al., 2021). There are other vaccine-related attributes that have been found to positively contribute to someone's willingness to vaccinate, but these are some of the key ones that have been identified.

Regarding immunization hesitancy, the majority of studies' findings identified vaccine safety, efficacy, duration of protection, probable side effects, lack of background information, or a lack of trust in the authorities as the main causes (Janssen et al., 2021). Apart from the worries about the vaccination itself, other reasons for vaccine reluctance included a general desire for more

knowledge, anti-vaccine beliefs or attitudes, and an absence of trust (Di Gennaro et al., 2021). Moreover, as a rule, individuals who were highly opposed to vaccination were less likely to see the overall benefit of immunization. (Freeman et al., 2021). In other words, those who are hesitant about vaccination often see it as a personal decision that only affects them, rather than understanding that it has implications on public health as a whole. On the other hand, most important factors for positive response to COVID-19 vaccination in healthcare workers have been: fear of contracting COVID-19, already provided evidence-based information, easy access to vaccines, as well as self-collected information (Takamatsu et al., 2022).

Unfortunately, we cannot disregard that the required health measures have become matter of politics and have been integrated into the picture of political uniqueness that everybody aspire to protect, thereby permitting robust ideological motivations to change information comprehension and accurate understanding, where persons with strong ideological preferences will process information that matters the most to them (COCONEL Group, 2020; Sylvester, 2021). And although we know that awareness of joint responsibility can motivate immunization, we also recognize that politicization can destabilize the collective tendency to fight pandemic jointly (Paul et al., 2021). In fact, the politicization of the COVID-19 pandemic and the resulting vaccination campaigns has been one of the major barriers to achieving widespread vaccination and mitigating the effects of the pandemic. It has created a lot of mistrust and division, and made it harder for people to focus on the common goal of protecting public health.

So, the evidence-based approach for clinical establishments in addressing COVID-19 vaccine hesitancy should cover organization-level interventions, followed by interpersonal-level interventions and finally individual-level interventions (Finney Rutten et al., 2021). The evidence-based approach to addressing vaccine hesitancy needs to be holistic and multi-faceted. It is not enough to just address the individual level – we need to also consider the organizational and interpersonal levels, and how they all interact with each other. For example, clinical establishments can take a top-down approach to addressing vaccine hesitancy by providing clear and consistent messages, as well as fostering a climate in which people feel

free to make inquiries and voice their concerns. They can also train their staff to have effective conversations with patients about the benefits of vaccination. Thus, to continue, there are many specialized COVID-19 vaccination training and learning resources for clinicians, including Centers for Disease Control and Prevention, Immunization Action Coalition, Vaccinate Your Family web site, or Mayo Clinic web presentation (Finney Rutten et al., 2021). We might conclude by emphasizing the necessity for clinicians and public health experts to foresee, validate, and are ready to respond to people's queries and worries (Laine et al., 2021).

4. Mandatory Vaccination

One strategy to improve vaccination agenda compliance would be to make vaccination mandatory (Haverkate et al., 2012). However, there are a lot of ethical and legal considerations entailed in making vaccination mandatory. On the one hand, it could be argued that mandatory vaccination is the most effective way to achieve herd immunity and protect public health. So, vaccine mandates could be imposed in various sectors, but each with their particular ethical and legal considerations (Wise, 2021). The local context and customs should be however considered when developing any vaccine policy proposal, where a stepwise and adaptable approach has to be the first step, with coercive measures considered as an only remaining and transitory measure (Largent et al., 2020).

Although immunization directives for adults may be legal (Frielitz et al., 2021), rather than widely enforced, they have been generally recommended and/or applied restrictively to specific populations, such as: healthcare workers, in businesses requiring personal appearance, segments relating to education, long-distance travel companies, or entertainment sector (Largent et al., 2020: Wise, 2021). However, employment policies on immunization also need to be made in line with public health sustainable plans (Rothstein et al., 2021). There needs to be alignment between the goals of public health and the policies that are implemented by employers. For example, if an employer requires their employees to be vaccinated, they should also provide employees paid time off to get immunized and recover from any side effects. For instance, it was

suggested that pregnant employees at risk of SARS-CoV-2 proximity should be allocated to low-risk jobs because we know that providing paid time off for employees to be vaccinated and recover from SARS-CoV-2 infection, even though there are still insufficient safety and efficacy data in this specific population (Kevat et al., 2021).

Mandatory vaccination, even for COVID-19, could be justified ethically if we have a serious threat to public health, if trust in efficacy and safety is at the high level, if the projected usefulness of mandatory immunization is significantly better than the alternatives, and finally, if the charges or penalties for the lack of compliance are in balance (Savulescu, 2021).

The extension of coercive measures related to mandatory vaccination could include holding back of certain benefits, obligation of specific payments, provision of public service, or shortfall of selected freedoms (Savulescu, 2021). Unfortunately, no penalties have altered anti-vaxxer sentiment, moreover they usually direct further discussion to the dissident ground, where social networking applications can be extensively used to spread misinformation, further enabling anyone to quickly produce and release content into the world without any kind of oversight (Boodoosingh et al., 2020). While comparatively small, the anti-vaxxer movement aggressively manipulates social media to magnify sent messages, thus primarily targeting people who did not make decisions about vaccines (Megget, 2020). This is indeed a concerning trend. Anti-vaxxer groups often use fear-mongering and emotional appeals to try to convince people that vaccines are dangerous, despite substantial scientific evidence of the opposite.

However, under the belief that vaccination is not merely a personal preference, since it protects people who cannot receive vaccinations, everything is still not so hopeless, since several algorithms were actually proposed for mandatory vaccination, thus commonly resolving the confidence in vaccine-related issues first, followed by introducing measures to increase voluntary vaccination, and finally analyzing parameters related to eventual mandatory vaccination (Savulescu, 2021). The algorithms would allow for a gradual and systematic increase in vaccination rates, while still respecting individual autonomy and choice. It is important to consider all of the different factors that influence vaccination rates, and not

just mandate vaccination without first addressing the underlying issues that contribute to vaccine hesitancy.

Another sensitive matter is mandatory pediatric immunization, where joint and urgent efforts from the complete system are expected to first ensure sustainably and adequate coverage of voluntary childhood vaccination. Indeed, mandatory pediatric immunization is a very sensitive and complex issue, because it involves balancing the right of parents to make health-care decisions for their children with the need to protect the health of a broader population. There is also the added complexity of ethical and legal considerations around protecting the rights of children, who may not be able to make informed decisions about their own health. It is definitely a challenging issue, and one that demands extensive collaboration and communication among various stakeholders, including parents, healthcare providers, and public health officials. Those in favor of mandatory pediatric SARS-Cov-2 immunization argue that: children do become infected and excrete virus; childhood infection is often asymptomatic; vaccination of children will be required to achieve herd immunity; pediatric vaccination programs have a highly successful global history; pediatric vaccination will accelerate the opening of schools and the launch of regular children's activities; mandatory vaccination of children ensures high coverage, as opposed to voluntary vaccination, etc. (Plotkin & Levy, 2021) Yet, at this moment there are still many conflicting opinions and ethical concerns for potential mandatory vaccination against SARS-CoV-2 in children.

5. Ethical Aspects

We can start with the often-repeated idea that civil liberties are essential to a strong public health system, and that compelled immunization is both unnecessary and excessive (Hayes & Pollock, 2021). So, it is expected that public health interventions need to balance the goal of protecting the population with the rights of individuals.

If we take into account the ethical ramifications of mandating SARS-CoV-2 vaccine, Beauchamp and Childress's ethical theory (Ebbesen, 2013) divides ethical judgments into four principles that can be utilized as a springboard for analyzing ethical dilemmas.

These are beneficence, non-maleficence, autonomy, and justice. Although clearly stated, these principles may overlap or even clash when considering a specific problem of interest, where for example the principle of beneficence may conflict with the principle of autonomy.

Beneficence can be defined as a duty to support the well-being of patients. Since COVID-19 is linked to significant monetary repercussions like missed workdays, significant societal disturbance, and high healthcare expenditures, vaccination might actually help stop the disease from spreading. This emphasizes the seriousness of an avoidable illness and can support the notion that immunizations should be made compulsory as a gesture of beneficence (Bowen, 2020).

Healthcare personnel might indeed benefit from a SARS-CoV-2 vaccination program that is required (Kevat et al., 2021). Furthermore, by shielding them against COVID-19, medical staff who gets the vaccination uphold their duty of care to patients (Gur-Arie et al., 2021). In another words, the only way to protect the vulnerable patients is to make certain that those caring for them are completely vaccinated against SARS-CoV-2 (Glasper, 2021).

Non-maleficence can be defined as an obligation to do no harm to others. The responsibility of the healthcare professional is to confirm that prior to the immunization, each recipient has given their informed consent (Radenković, 2021). However, when a vaccination program is made necessary, the individual's right to agree is violated, which is harmful at the end. Still, the requirement of getting informed consent can be seen as the result of the principle of (respect for) autonomy, as well. Hence the whole situation is typical in which two mentioned ethical principles come into conflict. Accordingly, vaccination mandates may evoke sentiments of helplessness, which may be aggravated by false information about the vaccines themselves (Kreps et al., 2021). Indeed, the spread of misinformation and disinformation around COVID-19 has made it even more difficult to have an open and honest conversation about vaccination. So, those who oppose vaccination mandates argue that they are being forced to take a vaccine that they believe is unsafe, and this can lead to the feelings of distrust and helplessness.

A mandated immunization program runs counter to the individual's choice to decline treatment, which must be valued.

A mandatory program might encourage vaccine skepticism in some social groups, which could have psychological and cultural repercussions.

Autonomy is defined as having the power to make decisions and act within one's scope of practice. Agendas for vaccination are seen by the anti-vaccination movement as intrusions on people's privacy and autonomy. However, it is important to recognize that people who oppose vaccination mandates are not necessarily "anti-vaccination" in general, rather showing specific concerns about the COVID-19 vaccine that are not necessarily based on false information, such as concerns about the long-term safety of the vaccine or the lack of long-term data.

Healthcare workers have the option to make evidence-based choices within their knowledge base, including for a SARS-CoV-2 vaccine (Bowen, 2020). Mandatory vaccinations could have a detrimental impact on staff morale by making them feel furious, powerless, and lacking in autonomy. So, appropriate, accurate, evidence-based information should be offered for reaching autonomous informed decisions, whether they reach positive or negative decision.

When considering the autonomy, the concept of immunity passports continuously brings lots of conflicting arguments. However, it may be at least proposed that immunity passports may be considered as a potentially valuable and ethical tool to facilitate movement when it is safe to do so (Brown et al., 2021). However, this idea raises some challenging ethical questions. On the one hand, immunity passports could be seen as a way to protect people's health and allow them to return to normal life. On the other, they could also be seen as a way to discriminate against people who are unable, or unwilling to get vaccinated.

Justice can be defined as ensuring fairness, and as an equal distribution of benefits and burdens. This highlights the difficulty of balancing the possible risks to individuals and their inherent rights with the advantages to society as a whole.

Healthcare workers may agree to mandatory immunization to sustain their professional values and commitments (Biswas et al., 2021). The principle of justice supports the mandatory vaccination of healthcare workers to benefit the least advantaged in society,

since some vulnerable employees who are unable to take the vaccine may need to be moved to jobs where there is less of a chance of coming into contact with COVID-19 patients. Accordingly, from the perspective of justice, one could argue that healthcare workers have a duty to protect the health of their patients, and this includes getting vaccinated against infectious diseases. Yet, others may object to this argument on the grounds that it infringes on their bodily autonomy, but from a justice perspective, the needs of the most vulnerable must be considered.

Vaccines can be seen as a scarce resource, since after all they are not equally distributed worldwide. Therefore, if vaccination becomes mandatory for everyone, it will hinder the vaccine's availability worldwide, especially in developing countries with high disease burdens, as it is obvious that there is no practical method to produce enough doses to vaccinate everyone (Iyengar et al., 2021). Moreover, we know that many countries in the developing world lack the infrastructure and resources to distribute vaccines and it may be a long time before they have enough supply to cover their entire populations.

As for the non-COVID-19 patients, hospital capacities have become a scarce resource, which makes the principle of justice even more complicated to apply, not to mention additional obstacles, for example that living organ donation declined substantially during the COVID-19 pandemic due to concerns regarding both donors' and transplant candidates' safety (Harhay et al., 2021).

6. Future Steps

Although comparatively small, the anti-vaccination movement aggressively abuses social media to amplify and increase its coverage and is directed at people who are uncertain about vaccines, especially parent population. Continuous efforts from public health authorities to maintain trust and reduce COVID-19 vaccine hesitancy are to be expected given the need to keep the global population over the herd immunity threshold. Indeed, this is a problem that must be addressed at a societal level, with improved communication and education about the safety and benefits of vaccines.

So, joint and urgent efforts from all authorities are required to guarantee sustainably and adequate coverage of voluntary immunization. It remains to be seen whether general authorities will declare mandatory vaccinations permissible in the future, assuming that vaccinations not only protect the individual against the disease, but also prevent the disease from spreading to the population. However, even if a mandate would be implemented, it will be difficult to enforce it without the collaboration of a diverse group of parties, including governments, healthcare providers, and the general public.

Reducing vaccination hesitancy is definitely one of the most important factors in achieving high vaccination rates. There are a number of strategies that have been shown to be effective in this regard, including education campaigns, engagement with trusted community leaders, and increasing access to reliable information about vaccines.

Finally, it has to be underlined that we need to consider each and every ethical concern, to engage, listen with respect, correspond efficiently, and offer evidence-based, as well as practical assistance to those who have yet to decide about the vaccine.

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Research Ethics Issues in Basic and Clinical Studies during the COVID-19 Pandemics

Abstract

The COVID-19 pandemic has opened many issues concerning research ethics. Initially, the focus of the investigation was directed at the origin of the virus, opening the question of moral and other responsibility for the emergence of the pandemic. The safety of medicines and vaccines has become a question for experts and the general public, and ongoing clinical trials have not removed distrust. The standards for conducting clinical trials of drugs in development were relaxed, even according to the recommendations of the World Health Organization and the European Medicines Agency, which created doubts about the balance between their reliability and speed of their implementation. Redefining bioethical principles in public health research proved necessary, and easing measures against COVID-19 only softened the public debate, but still needs to resolve some research ethics issues. Conducting both basic and clinical studies unrelated to the COVID-19 pandemic was also affected during this period, facing a lack of funding, changes in infrastructure and resources, and a sudden need to refocus the research. Discussions on ethical issues related to allocating available resources and the urgent need to terminate some ongoing research studies should be addressed in contemporary literature. On the other hand, the demand for rapid knowledge production to secure prompt reactions from various health system stakeholders resulted in the flexibility of the peer-review process. That opened some ethical issues related to responsible publication practice, emphasizing the role of research ethics at every single step of the COVID-19 and non-COVID-19 biomedical, basic, and clinical studies.
Key words: COVID-19, research ethics, moral responsibility, experimental drug use, public health

1. Introduction

Not so long ago, on 5 May 2023, the WHO declared the end of the global threat of COVID-19 (United Nations, 2023). At that moment, there were 765,222,932 cases and almost seven million

COVID-19 deaths globally. Fortunately, vaccines became available (on 30 April 2023, there were more than 13 million vaccinated in the world), as well as medicines necessary for approximately 5% of those hospitalized in the most severe stages of the disease. It is not without significance to state that anti-COVID-19 drugs were not previously tested on experimental animals because, initially, there was no time for this (parallel with anti-HIV agents), while experimental application of drugs has also been widespread. We would especially emphasize the controversies surrounding the wearing of protective masks and the lockout in the first year of the pandemic, decreased focus on those suffering from other diseases (say, cancer), the risk to pregnant women, and, finally, the post-COVID-19 syndrome. In the following text, we will discuss the most crucial research dilemmas in biomedicine, which were deeply imbued with ethical controversies. The keywords in what the scientific public had encountered were – fear of the unknown, lack of trust, and lack of time. Humanity has indeed faced such cataclysmic public health events before. However, for the first time, people have become aware of how vulnerable they still are in the era of highly sophisticated antimicrobial therapy and precision medicine. We hope that some lessons will be learned from all this, to inform reactions to similar events in the future.

2. The Origin of the SARS-CoV-2 Virus as a Bioethical Problem

Wiebers and Feigin (2020) wrote an inspired article about the messages left by the COVID-19 pandemic, and they were not the only ones. Among other things, they claimed that it seems challenging to shift the responsibility for the emergence of the crisis (and, in some cases, the disaster) to bats and pangolins, but that the real culprit was man, i.e. our irresponsible behavior. The decisive role was played by our arrogance concerning nature, the idea of the omnipotence of the human race over the remaining living creatures and nature itself. Today, when settling the accounts of the three-year pandemic, the issue of moral responsibility for the first outbreak in Wuhan, which the West insisted on in previous years, has been forgotten.

According to the US Centers for Disease Control and Prevention (CDC), three-quarters of newly emerging infectious diseases in humans originate from animals (therefore, they represent zoonoses) (CDC, 2023a). This fact, on the wave of growing antimicrobial resistance, but also in the light of the COVID-19 pandemic itself, gave momentum to the idea of "One Health" promoted by the World Health Organization (WHO) (CDC, 2023b).

Moral responsibility, unlike causal responsibility, implies having the power and capacity to do something (Matthew, 2023). However, the critical point is that most philosophers do not consider ignorance as a mitigating circumstance for someone who can be considered morally responsible. Namely, if ignorance is *unavoidable*, that is a sufficient reason not to blame someone. However, moral responsibility exists if it is a case of *avoidable* ignorance, i.e., because of being negligent.

Let us now return to the specific question of moral responsibility for the appearance of the first cases of COVID-19 infection in Wuhan, which consequently caused the pandemic. There are two theories about it. According to the first, the origin of the SARS-CoV-2 virus was in a laboratory in Wuhan, China, from where it somehow got into the external environment (intentionally or not); so, researchers either collected the virus from an animal, or created it by engineering coronavirus genomes. According to the other theory, it is a zoonosis with the transfer of the virus from bats to humans via one or more vectors (e.g., pangolins) due to the consumption of game food (Wuhan market) (Maxmen & Mallapaty, 2021). The latter theory seems more likely, but in both cases, the question of the moral responsibility of specific people, or humanity can be raised. The increased consumption of wild game at the end of 2019 seems likely considering the African swine fever outbreaks in China between August 2018 and July 2019, which decimated the livestock in China just before the outbreak of the COVID-19 pandemic (You et al., 2021). In any case, man's relationship with nature raises the question of humankind's moral responsibility for the damage caused to living species and the unpredictable consequences that arise. Wiebers and Feigin wrote: "The time has come for us to rethink our relationship with all life on this planet – other humans, nonhumans, and the earth, a life form in itself. What is good for

nonhumans and the earth is virtually always in the best interests of humans, given the profound interconnectedness of all life." (Wiebers & Feigin, 2020). We return to the original words of the founders of bioethics, Fritz Jahr and Albert Schweitzer, on how the same criteria that we apply to each other should be applied to all of nature (Kant's moral imperative and the Golden Rule – do not do to others what you do not want done to you) (Jahr, 1927; Schweitzer, 1987). The possibility of leaking a virus from the lab opens the general question of moral responsibility in modern science (the moral neutrality of science) (Audi, 1982).

3. The Ethics of Clinical Trials during the COVID-19 Pandemics

3.1. *Introduction*

Just a brief background: At the beginning of the pandemic, a global crisis arose that seriously threatened the so-called Liberal International Order (LIO). It is a global process based on the rule of law that marked the period after the Second World War. International relations at the end of the 1940s became based on political liberalism, economic liberalism, and liberal institutionalism ("...open and rule-based international order that is enshrined in institutions such as the United Nations and norms such as multilateralism...") (Kundnani, 2017). For further discussion, it is essential that the LIO brought us valid bioethical norms embodied in documents such as the Nuremberg Code, the Declaration of Helsinki, and the Belmont Report. At the beginning of the pandemic, COVID-19 was not the only threat to the LIO, but it had a dominant impact. In a situation where the crisis threatened to turn into a worldwide catastrophe, and there were no medicines or vaccines, nor were any effective epidemiological measures known (the example of the "Swedish model" as opposed to the more restrictive approach in other countries, especially in China), the question arose of whether we should continue to respect and apply the same ethical norms in clinical studies as before the pandemic. The principles of Good Clinical Practice were also at issue, especially how to fully respect the subjects' autonomy or, for example, the principle of beneficence.

On the global scene, we had the "bioethics hegemony" of the United States of America (USA) on one side, and the "bioethics nationalism" of Russia and China on the other. Namely, the USA and Western countries spread their ethical standards to other countries as the only correct ones through multicenter clinical studies, based on the achievements of liberal capitalism and embodied in the Beauchamp & Childress principles of the Georgetown School of Bioethics (autonomy, beneficence/non-maleficence and justice). Consequently, for example, vaccines and medicines for COVID-19 produced in the USA and the UK had primacy in the public scene, at least in the countries dominated by the Western sphere of influence (Europe, USA, Australia, Canada, etc.). Vaccine and drug testing in Russia and China was considered (not without reason) non-transparent, which was a particular problem for national drug agencies. On the other hand, Russia and China, even Cuba promoted their own medicines and vaccines against the SARS-CoV-2 virus through a campaign that acquired a political connotation, especially considering that vaccines and medicines from Western countries were often insufficiently available in Asian countries, for example (Aripov et al., 2022). The WHO COVAX program for emergency use could cover only 20% of vaccine needs, so many countries were forced to start their own research and production of such vaccines. Of note, the principle of justice was violated in distributing vaccines and medicines, at least during the first years of the pandemic. On the other hand, producing vaccines that did not meet the highest standards in particular developing countries could violate the principle of beneficence/non-maleficence for the exposed population.

3.2. *Ethics of trial drug use*

If there are no drugs, and the infection poses a threat to public health and society as a whole, there are four options for trial drug use during epidemic/pandemic:

- Not to use any experimental drugs (EDs) until trials are completed;
- To use EDs anyway since it is an emergency and there is no alternative treatment;

- To initiate and speed up the trial phases;
- To start using EDs and start clinical trials (simultaneously or subsequently).

The first two options could not be accepted. Namely, the first option is unacceptable because it violates the principles of beneficence and justice, and the second violates all ethical principles. Accordingly, experimental drug use is inevitable, and, in parallel, as soon as possible, we need these drugs to be adequately and reliably tested so that their effectiveness is unquestionable and their safety acceptable. For a drug to be approved by the national drug agency, it is necessary to conduct a process that goes through two main phases: preclinical and clinical development. Both phases are usually divided into sub-phases. In total, they last for more than ten years and cost from hundreds of millions up to more than a billion dollars.

In the case of the vaccines and medicines against SARS-CoV-2, it was necessary to modify the entire process qualitatively and quantitatively without jeopardizing the reliability of clinical trials. In other words, speeding up the clinical development of the drug (at least the first three phases that precede registration) on one side and the credibility of the studies on the other were on a see-saw. Of note: the preclinical phases of testing drugs and vaccines were omitted in the majority of cases, at least for two reasons: either there was no time for it, or old drugs, already used for other indications, were tested for use in COVID-19 (repurposing); in any case, skipping the preclinical development of drugs was a particular ethical problem because of the possible long-term consequences for the health of the population. Thus, there is a danger that the immediate protection of the well-being of current patients was achieved at the expense of the future safety of the whole population by obtaining unreliable results of accelerated clinical trials and omitting the preclinical phase of drug and vaccine development.

In addition to the mentioned global ethical imbalance, we can also talk about individual ethical issues regarding the experimental use of drugs. Namely, the experience with the Ebola outbreak in Africa showed that the experimental application of drugs opens up many unresolved questions, for example (WHO, 2014):

- Applicability of common standards in conducting clinical trials (e.g., GCP) in epidemic/pandemic conditions that were not taken into account at all when designing those standards;
- How to implement the principle of justice in pandemic conditions when it comes to the distribution of experimental drugs;
- Whether pharmaceutical companies are obliged to produce medicines that would be used in pandemic conditions, even if it is not profitable for them to do so;
- Who is responsible for the manifestation of serious adverse reactions for experimentally applied (and insufficiently tested) drugs.

Finally, at the beginning of the pandemic, the deontological approach that some therapy needed to be given was applied more ('it is our duty to treat the sick people'), and time will show whether this was justified (the WHO concept of the emergency use of unproven drugs, see below). Later, as the evidence from clinical trials was collected, only the drugs for which a favorable benefit/risk ratio was confirmed (utilitarian approach) were included in the guidelines.

Is it morally acceptable to use experimental drugs that have not been appropriately tested for efficacy and safety in patients during pandemics? There are pros and cons to that. The former certainly include the position of WHO: "It is ethical to make investigational therapeutics available outside of clinical trials for 'emergency use' provided clinical data from their use is systematically collected and shared." Even the "monitored emergency use of unregistered and investigational intervention" was introduced (MEURI) (WHO, 2014, 2022). Also, without such experimental agents, the whole society would be more vulnerable (public health, economy, etc.). Among the cons is the fact that during a pandemic, we need to act urgently, so that can bring unreliable results (see above). However, the moral concern includes the potential of slippery-sloping the clinical trial system to an arbitrary level. Also, the data collected from such use may not be reliable for evidence-based medicine.

Hydroxychloroquine is an example of the WHO concept of 'the emergency use of unproven clinical interventions outside clinical trials' (WHO, 2022; Ebunoluwa & Kareem, 2016). This drug ultimately proved to be ineffective, although it was massively applied around the world at the beginning of the pandemic. Eventually, it was proven through meta-analysis that the drug is ineffective for the prevention and treatment of COVID-19, as well as potentially harmful, and it was accordingly omitted from further protocols (Singh et al., 2021).

3.3. *Paternalism in Clinical Trials and Public Health during Epidemics*

According to Hanna (2018), paternalism is an action performed with the intent of promoting another's good but occurring against the other's willed, or without the other's consent. We can discuss the so-called "hard" and "soft" paternalism. The former includes interventions that violate the paternalized person's autonomy, while the latter involves interventions based on non-voluntary or ill-informed choices and does not violate autonomy (Sartorius, 1983; Drolet & White, 2012; Jansen & Wall, 2018). Childress et al. (2002) wrote about paternalism in the domain of public health. During the COVID-19 pandemic, numerous studies were devoted to whether wearing face masks or vaccination should be voluntary or mandatory. The implementation of mandatory measures in the domain of public health is an ethical issue of primary importance. Childress et al. defined basic ethical principles that concern the population as a whole and differ in part from the standard ethical principles of the Georgetown School of Bioethics. Namely, the key difference is reflected in the fact that in the domain of public health (paternalistic), imposition of specific measures on the entire population, even on a particular group (say, healthcare workers), carries with it the controversy of violation of autonomy, which, on the other hand, can also be discussed if an individual, by wishing to protect his own autonomy (for example, refuses vaccination), indeed threatens the autonomy of others (Gur-Arie, 2021). Usually, in such cases, careful and detailed information about the advantages and risks of applying

a particular public health measure is recommended instead of coercion, thus strengthening trust and adherence. The analysis devoted to the wearing of face masks during the early phase of the COVID-19 pandemic in 20 European and 2 Asian countries included several aspects (Martinelli, 2021): individual perceptions of infection risk, personal interpretations of responsibility and solidarity, cultural traditions and religious imprinting, and the need of expressing self-identity, and showed the importance of a deeper understanding of the cultural and socio-political milieu that conditions the acceptance of this public health measure. Social standards and measures imposed by the state were confronted with personal attitudes and interpretations, and this indicated a way out of the controversy that arises in the domain of public health in case of the need to implement certain measures that protect society as a whole, but encroach on the autonomy of the individual. In particular, wearing protective masks indicates the level of care and protection of others (our environment) from ourselves to the same extent as our own protection.

Research into the development of vaccines against COVID-19 has opened up many bioethical questions, to mention only the most important:

- Justification of human challenge trials – targeted exposure of volunteers to the virus in order to test the effectiveness of new vaccines on them;
- Comparing the effectiveness of one vaccine with a placebo, but not with an active control in phase 3 of clinical trials (the phase that precedes and provides the most important data for any vaccine's approval and is carried out on a large number of subjects, usually in several centers), which may result in an unrealistic picture of the effectiveness of the vaccination;
- The application of a new design in the approval of vaccines, which achieves accelerated registration, but the accurate picture of the effectiveness and safety of vaccines is obtained only when all the data are accumulated (rolling submission);
- Justification of mandatory vaccination.

Of course, anti-vaxxer campaigns and the spread of misinformation about the harmfulness of vaccines also deserve to be mentioned.

Childress et al. (2002) state that in assessing the justification for imposing specific measures in the domain of public health at the expense of individual freedoms and justice, the following elements must be taken into account:

- Effectiveness – Could we protect public health by infringing one or more general moral considerations?
- Proportionality – Could public health benefits outweigh the infringed general moral considerations?
- Necessity – It is essential in realizing the goal of public health.
- Least infringement – Public health agents should seek to minimize the infringement of general moral considerations.
- Public justification – Public health agents should offer public justification for policies in terms that fit the overall social contract in a liberal, pluralistic democracy.

Highly effective vaccines that reliably protect the majority of the population from COVID-19 have been approved, and they have been applied to millions of people. However, one cannot avoid another question that belongs to the domain of ethics in the pharmaceutical industry – whether there was exaggeration in promoting particular vaccines to gain more profit (Todorovic et al., 2012).

3.4. *Clinical Trial Design*

The European Medical Agency has published special guidelines for conducting clinical trials during the COVID-19 pandemic (European Medical Agency, 2022). The standards for conducting clinical trials were significantly changed and adapted to the conditions of the impending pandemic. For example, the possibility of obtaining oral informed consent and data collection via video call or by telephone was left open: "If written informed consent is not possible (e.g., due to physical isolation of participants), consent could be given orally by trial participants in the presence of

an impartial witness." Also, the concept of telemedicine was promoted, all to protect health workers and subjects from the further spread of the infection. Other possible changes to ongoing trials (should be agreed with investigators) are the following: a temporary halt of the trial at some or all trial sites, an extension of the duration of the trial, interruption or slowing down of recruitment of new trial participants, transfer of trial participants to investigational sites away from risk zones, or closer to their home, and use local certified laboratories for diagnostic tests instead the central one. As regards safety reporting, collecting data through alternative means, e.g. by phone calls or telemedicine visits is recommended. Also, a priority of participant safety over data validity is emphasized. Finally, remote source data verification is available during the public health crisis for trials involving COVID-19 treatment or prevention or in the final data cleaning steps before database lock in pivotal trials investigating serious or life-threatening conditions with no satisfactory treatment option.

The further course of the pandemic has significantly altered the conditions for conducting such tests until today.

4. Ethical Issues Related to Allocation of Available Resources: Implications for Preclinical Studies

Conducting both basic and clinical studies not related to the COVID-19 pandemic was also affected during this period, facing lack of funding, changes in infrastructure and resources and sudden need to refocus.

Discussions on ethical issues related to the allocation of available resources and urgent need to terminate some ongoing research studies seem neglected in contemporary scientific literature.

4.1. *Ethics of Relocation of Resources within Basic Studies*

Distributive justice in allocating scarce medical resources during COVID-19 could be replicated from distributive justice in allocating financial resources related to preclinical studies. Society, as a whole, and thereafter funding agencies, relocated a significant

amount of financial resources to all kinds of research related to COVID-19. It implies that some other fields were faced with reduced resources. Not only financial resources were relocated. Actually, the whole preclinical scientific teams rescheduled their efforts toward these funds. Such united efforts gave us quick responses to the pandemic, but the trend to stay in the field of COVID-19 has prolonged. Were these just toward important topics that were left neglected? Outbreak of COVID-19 was intense, and benefits of relief thereof outweighed the costs, yet the risks were not assessed. There was the ongoing need for neuroscience, cardiovascular and cancer research during the pandemic, as well as prior to it. But, will it be possible to compensate the deficit made in these fields by COVID-19 in the post-pandemic times? Indeed, a number of reports indicated that pandemic outbreak significantly affected ongoing clinical and basic studies not related to COVID-19 (Weiner et al., 2020). It has been proposed that special ethical committees should be engaged in reallocation of research resources making some level of triage among ongoing trials (Wieten et al., 2020). Finally, the pace also slowed in benefits for brain, heart, and cancer patients in terms of slowing down development of novel therapeutic modalities and understanding these diseases. In the health economics vocabulary, opportunity costs should be also evaluated. Ethical issues related to allocation of resources are of great importance in the post-pandemic times too. Undoubtedly, proper economic evaluations of these issues are more than welcome. Only these quantitative outcomes could give answers to our dilemmas. Thus, future ethical and scientific considerations should be directed toward the understanding of:

- Just reallocation of financial resources in basic studies
- Just reallocation of human resources in basic studies
- Opportunity costs during the pandemic and post-pandemic periods
- Economical evaluation to support ethical reasoning.

4.2. *Abruptly Terminated Preclinical Studies*

We did not have clearly articulated strategies for termination of ongoing research at the moment of the pandemic outbreak and the lockdown measures to stop the spread of the virus. It was particularly important issue for in vivo studies and all others with chronic treatments requiring constant human presence. Financial resources, human efforts and time were invested in such studies that needed to be abruptly terminated. Such termination resulted in wasting all these resources together with animals. No benefits of such studies were possible to harvest. We still don't have quantitative data and analyses to show either direct or indirect, as well as opportunistic costs related to the preclinical studies abruptly terminated due to COVID-19. Certainly, we have to formulate ethical and methodological guidelines for such situations in the future and have plans for communication with state decision-makers. Protection of animal welfare and continual work of institutional committees on protection of animal welfare have been *causa sine qua non* in basic preclinical studies despite the pandemic environment, but it was obvious that we were not prepared for such scenarios and that researchers and committees acted without strategic plans and differently in each country. Also, this has not been investigated properly in the contemporary literature.

Therefore, we could identify several major issues requiring further consideration:

- Responsibility for termination of ongoing basic research
- Strategies to safely terminate basic research
- Reporting on basic research during pandemic
- Methods and channels for involving decision-makers and advocacy
- Protection of animal welfare in pandemic or similar situations.

5. Responsible Publication Practice in the Under-pressure Environment during the COVID-19 Pandemic

The demand for rapid knowledge production to secure prompt reaction of various health system stakeholders, resulted in some degree of flexibility in the peer-review process and opened ethical issues related to responsible publication practice emphasizing the role of research ethics at every single step of biomedical research.

It is interesting to articulate that the papers which had COVID-19 as a topic and key word were accepted 11.5 times faster compared to the papers on influenza in 2020 (Schonhaut, 2022). Median peer-review time was 6 days (Kun, 2020). This was a significantly lower than the usual publication practice. It could be a consequence of joint efforts of publishers to provide preprints as soon as possible. Anyhow, it was a consequence of high pressure and demands for the COVID-19-related knowledge. However, it also opened questions on quality control and publishing ethics in the pandemic environment, as arose in some publications (Kun, 2020). Moreover, it has been supported by a high number of retractions of COVID-19-related papers which were in a significant proportion related to various ethical issues (Hahn, 2023; Koçak, 2020).

On the other hand, it has been also articulated that "the early bird effect produced an ephemeral perception of a global rush in scientific publishing during the early days of the coronavirus pandemic" (Sevryugina & Dicks, 2022). These authors emphasized the need to consider the so-called early bird effect in interpreting this issue.

Obviously, these ethical issues related to responsible publication practice during COVID-19 should be investigated in more detail in further scientometric studies, with particular attention to:

- Data integrity
- Prevention of scientific misconduct
- Fair and rigorous peer review process
- Models of fast publication including preprints
- Retraction ratio and reasons for it.

In any case, preservation of trust in biomedical research in general, as well in good publication practice, should be an imperative of the whole biomedical scientific community.

6. Conclusion

During the COVID-19 pandemic, new ethical challenges appeared, such as those concerning the use of investigational drugs, abbreviation of drug development phases, and medical paternalism. Some research ethics issues were resolved gradually, especially concerning public health: mandatory vaccination, vaccine efficacy and safety, the obligation to wear protective masks, and others. However, participant/patient safety was always a priority. The main ethical principles of clinical trials were adjusted to the crisis environment to prevent catastrophe. The COVID-19 pandemic raised a number of ethical issues related to basic preclinical studies. Just reallocation of financial and human resources within these studies is of particular importance, as well as ethical considerations for sudden unexpected termination of the ongoing in vivo studies. Finally, good publication practice in pandemic times requires constant supervision. Preservation of trust in biomedical research in general, as well in good publication practice, should always be an imperative of the whole biomedical scientific community regardless of whether a pandemic is occurring.

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Detecting Resilience Issues among Marginal Groups as a Bioethical Goal*

Abstract

Bioethical judgments specifically impact actual medical and political practice, which, in turn, impacts the living conditions of marginalized groups.

In this article, we analyze the Resilience of marginalized social groups in two ways: 1) through a normative aspect of Bioethics concerning moral judgments and their justification and 2) through an empirical aspect concerning the actual living conditions and changes of marginalized groups.

We hypothesize that Resilience during the COVID-19 pandemic is not closely related to pre-existing medical issues of a group. Alternatively, structurally deep-rooted racial, social, and economic conditions significantly reduce a group's resilience.

The main concern is converting the miserable survival of the most endangered, marginalized, and discriminated groups into an acceptable one. However, the recent pandemic of COVID-19 put even more pressure on vulnerable groups, thus weakening their Resilience even more.

In five sections, we will first show what it means to be marginal before the pandemic. Secondly, how racism and discrimination lower the resilience of marginal groups, i.e., making them even more vulnerable in case of a disaster and endangering their survival in the mid and long terms. Consequently, we assume that the general request for the normalization of the everyday lives of the majority makes COVID-19 an ongoing disaster, i.e., a longstanding crisis for discriminated and marginal groups. Avoiding such an outcome is in the holistic picture that many bioethicists and clinicians must accept.

Keywords: Bioethics, Resilience, Vulnerability, COVID-19, Racism, Discrimination

* The paper presents findings of a study developed as a part of the 2023 Research Program of the Institute of Social Sciences with the support of the Ministry of Science, Technological Development and Innovation of the Republic of Serbia.

1. Introduction

Bioethical judgments specifically impact actual medical and political practices which, in turn, impact the living conditions of marginalized groups. In this article, we analyse the resilience of marginalized social groups in two ways: 1) through the normative aspect of bioethics concerning moral judgments and their justification, and 2) through the empirical aspect concerning the actual living conditions of and changes in marginalized groups.

We hypothesize that resilience during the COVID-19 pandemic has not been closely related to the pre-existing medical issues of a group. Alternatively, structurally deep-rooted racial, social, and economic conditions significantly reduce the group's resilience.

Considering these hypotheses, the main concern is to convert the miserable survival of the most endangered, marginalized, and discriminated groups into an acceptable one (Potter, V. R., 1971; 1988; Potter, V. R. & Potter, L., 1995). However, the recent COVID-19 pandemic has put even more pressure on vulnerable groups, thus weakening their Resilience even more (Samour, 2020; Zack, 2015).

Resilience to an unwanted situation, e.g., a disaster, is one of the essential survival capacities interconnected with the vulnerability of a group (Mitrović, 2015). One of the essential inner features of such capacity is the group's anticipation potential, in planning improvements to their lives and avoiding potential threats. The same potential is vital for the group's survival in the bioethics framework, which ranges from miserable to ideal, including the acceptable survival as the minimum aim worth striving for.

Considering that racism undermine resilience of the discriminated groups, we are going here to define it from the liberal angle: "Liberalism generally defines racism as the result of an illegitimate racial consciousness or racial awareness, in which the race of an individual is noted and taken to be significant, setting aside the question of who is noting who or how the significance is understood" (Alcoff, 2021). However, this concept is criticized from the point of decontextualisation of racism. Defining racism from a more contextual and empirical angle various scholars perceive racism as a form of exploitation, deprivation, racial profiling, and homicide contributing to the premature mortality of Black lives (Zack, 2015).

Considering the concept of racism, the endangered population's vulnerabilities are primarily the result of racism and other forms of discrimination. Discrimination and injustice occur in our interpersonal relations and institutions and influence people's access to fair health outcomes.

In the following sections, we will first show what it meant to be marginal before the pandemic. Secondly, here will be presented the ways in which racism and discrimination lower the resilience of marginal groups, i.e., making them even more vulnerable in case of a disaster and endangering their mid- and long-term survival. Consequently, we assume that the general request for the normalization of everyday life for the majority, has made COVID-19 an ongoing disaster, i.e., a longstanding crisis for discriminated and marginal groups.

The last section is devoted to the relationship between racial profiling and health issues, a health barrier for the discriminated population.

2. Being Marginal before the Pandemic

Marginal and discriminated groups live in a state of collective stress. Enduring miserable lives and various existential risks, Black, Indigenous, People of Colour (BIPOC) and Gypsies, Roma, and Travellers (GRT) are victims of a slow disaster, not unlike a sudden one, such as war or natural disaster. It determines the catastrophic everyday lives and survival routines of the vulnerable and marginalized population, whose capacity for planning and response is low, i.e., anticipation is decreased due to uncertainties which are the results of the lack of basic living requirements, e.g., fresh water, medicines, shelters, or living space, as well as of the general social and economic autonomy, necessary for the well-being and survival in the long run. Slow disasters, or crypto-catastrophic living conditions, directly increase apathy and decrease anticipation and, consequently, the resilience of vulnerable and marginal groups, endangering survival in the long run for discriminated populations.

From the time perspective, all marginals live for very long time in a state of collective stress, generally marked with enormous social and economic discrimination.

Among the various definitions of discrimination, considering their many critics, here is one which may cover a range of the issues in this article. Namely, according to Eidelson's account "acts of discrimination are intrinsically wrong when and because they manifest a failure to show the discriminates the respect that is due them as persons." (Eidelson, 2015: 7).[1] Transgenerational discrimination of one population makes them highly susceptible and vulnerable to different sudden disasters, ranging from floods such as those in New Orleans (Zack, 2012) to the pandemics such as the recent caused by COVID-19.

The most visible pre-pandemic institutional forms of racism were identifiable in the systems of justice and Police. One of the many relevant indicators is "sentence statistics, racial Police profiling, and detained-by stop and frisk-practice of the Police," which indicate structurally rooted racism (Zack, 2015: 28; 46–48).

Such discrimination was the product of homogenization of one group at the expense of another which became an enemy and was held responsible for larger social ills – a legitimate and punishable prey. Such a pattern is a kind of "hunting schema" (Zack, 2015: 79–85).

Considering this, it is not surprising that attention of many bioethicists, as well as that of general public, is caught by the discriminatory and institutional forms of racism and by the racial ideas closest to the hearts and minds of racists (Russell, 2021; Ganguli-Mitra et al., 2022).

3. How Marginalization and Discrimination Lower Resilience

In this section, it is analyzed the ways in which racism, marginalization, and discrimination influence the resilience of marginalised groups.

Such empirical relation could help in making bioethical judgments, which in turn may help in preventing the causes for the

[1] See more in the online edition of the Stanford Encyclopedia of Philosophy (2020). "Discrimination." Cit. from Altman, Andrew, "Discrimination", *The Stanford Encyclopedia of Philosophy* (Winter 2020 Edition), Edward N. Zalta (ed.), URL = https://plato.stanford.edu/archives/win2020/entries/discrimination/

decrease in resilience during and after disasters, i.e., preserving the most vulnerable lives.

A part of examining the marginal's resilience involves detecting their susceptibility. From the bioethical perspective (UNESCO, 2005), racial profiling is one of the causes of susceptibility for individuals and groups.

Besides vulnerable jobs (World Bank),[2] ghettoization leads to social apathy among and towards those groups. Longstanding apathy could decrease action potential, i.e., loss of life plans, aspirations, and perspectives. It can also be associated with carelessness towards weaker group members, i.e., erode caring potential. Contrary, the caring and action potential of the groups are recognized as an indicator of the resilience of a community (Mitrović, 2015).

Along with the previously described racial profiling, abstaining from moral action against discrimination and racism leads to the loss of duty to act toward subject well being in the broader society. The defined context in critical situations such as pandemics and other sudden disasters, opens the door for decisions based on age, ethnicity, and race (Mitrović, 2015: 197). The following section will classify and analyse those indicators in various social and ethnic groups.

However, the actual racial issues do not open only the question of the role of society at the historical crossroad of racial injustice in the US (Russell, 2021: 9–11) but rather that of the role of the health care system, professionals, as well as of the ethics of surviving in the long run for discriminated groups, which is also one of the bioethical issues. At the first sight, the justified social request for post-pandemic life normalization has produced fertile soil for the ignorance of the entire range of both old and new forms of racism and discrimination. The COVID-19 has revealed adverse health effects and deaths for BIPOC and GRT populations. Analysing the relationship between such health results and racism is of fundamental importance during disasters (such as the COVID-19 pandemic), and of vital interest for the survival of vulnerable populations and marginal groups in the long run (Mitrović, 2015).

[2] Definition of such jobs are given in the Meta glossary of the World Bank, Vulnerable employment is contributing family workers and own-account workers as a percentage of total employment. World Bank, https://databank.worldbank.org/metadataglossary/world-development-indicators/series/SL.EMP.VULN.ZS

In the following section, we will use the data from relevant literature (Ganguli-Mitra et al., 2022) to analyse the ways in which racism influences vulnerabilities and resilience indicators, such as vulnerable jobs, action, and caring potential, in BIPOC populations during disasters.

4. Decreased Resilience during the COVID-19

This section analyses how racism and discrimination lead to a non-resilient state of an individual or a relevant community during the pandemic. Moreover, with the requests for normalization of everyday lives for individuals and groups and restoration of pre-disaster patterns, resulted in continuation of spreading racism, ageism, and other forms of discrimination in the aftermath of the disaster.

Nevertheless, before we start with analysing this claim, let us see how race is comprehended today:

"Everything about race, including perceived physical differences and distinctions, is today recognized as a social construction of race, and the idea of biological race is abandoned among scientists. Many in medicine and ordinary life continued associating social races with some illnesses and diseases biologically because some diseases occurred more frequently in some races. In all cases, no racial identity itself, but social factors and inequalities, such as poverty, bad nutrition, access to health care, etc., are responsible for disproportionate racial frequencies of illnesses" (Zack, 2021).

Considering that race itself is unrelated to infection risk, the COVID-19 pandemic has revealed three kinds of racism: heart and mind racism, discrimination, and institutional racism (Ganguli-Mitra et al., 2022; MacDuffie, 2022; Zack, 2021). "Hearts and minds racism is explicit, conscious, and deliberate contempt or hatred of people because of their race" (Zack, 2021). However, in this type of racism, prejudice based on race could exist on the borderline between conscious and unconscious. Even though, there have been several vulnerable and marginal groups, especially prone to infection and high probability of death in this pandemic due to pre-existing social inequalities. Endangered groups' vulnerabilities do not originate from their race, or social construct, but rather from the social and

economic status, gender, and age, both in the USA and in general (Zack, 2021).

The resilience of one marginal group could be detected through indicators of the group's vulnerabilities (Mitrović, 2015). Here the groups' pre-existing risks and vulnerabilities based on race, ethnicity, gender, and age in the USA and Europe are summarized. Similarly, we distinguish the marginalization of certain groups based on age, health/disabilities, and residence/exile (Tables 1 and 2). Such characteristics are crucial to a group's resilience and survival during COVID-19.

For African Americans, the population which comprises 13 percent of the US population, the death ratio during COVID-19 was 24 percent, due to structural reasons, such as public and social care politics, and as a direct result of the voting will (Abbasi, 2020).

Besides these issues, health risks resulting from racism and vulnerable employment during the pandemic have influenced a prolonged tension and stress imposed on family and children (Zack, 2021), affecting personal health conditions (Joanee, 2023). The following section will analyse these issues from the bioethical and healthcare perspectives.

Exposed to structural poverty, frontline-extensive work, and multigenerational living with vulnerable elders, the population of Latinx Americans is susceptible to the high risk, affecting all, and especially vulnerable members of the family and the group in general. Asian Americans face physical and verbal assaults and discrimination due to the virus's origin. Discrimination of this group leads to existential and health risks for individuals and their families, e.g., losing their jobs and health risks of infection due to assaults (Zack, 2021).

Majorities of the Native Americans are more or less residential isolated and socially marginalized in a broader way. Their social and economic vulnerability is ubiquitous in the COVID-19 pandemic. On the one hand, most of the high income comes from the Casinos on their territories, which were closed due to the pandemics, and the group became exposed to the existential risks of losing their jobs and vital income. On the other hand, the poverty rate in this community is some 25 percent, and on some reservations, this rate is even higher and amounts to about 40 percent. Over one-third

of the Navajo population has no running water, and the number of households entirely lacking plumbing is even higher (Schultz, 2020).

This group suffered from pre-existing unfavourable health conditions, like cardiac disease and high blood pressure, which made them susceptible to the complicated forms of the infection of COVID-19, and the death rate was twice as higher as in the white population (Schultz, 2020).

The pre-existing residential marginalization was enhanced by the preventive self-isolation in reservations, to minimize the infections inside the group. However, this isolation may have been one of the factors to increase mental health issues. During COVID-19, the community faced the highest rate of mental health challenges. Almost 75 percent of the Native-American households reported at least one member of their family experiencing various mental-health problems, while the rate was 52 percent in white population (Chatterjee, 2021).

A significant indicator of preserved resilience is respecting and "caring for the weaker and older family member and groups" (Mitrović, 2015: 192–193). This cultural factor influences the relatively high rates of vaccination among Native Americans. Half of this population is fully vaccinated, and about 60% have received at least one dose, compared to only 42% and 47% of all whites (Chatterjee, 2021).

The most detectable, yet not publicly visible, inequalities in Europe are those related to Roma, Gipsies, and Travellers (GRT) population. These populations face hindered or no access to fresh water and sanitary means, which are crucial in the times of a pandemic. One of the health-related characteristics of this community is premature death due to miserable health conditions, poor residential conditions, and multigenerational living. Defaults like "online school lectures were not accessible to children of the Roma population in their non-sanitary residential locations due to no access to computers, internet, or electricity" (Reljić & Simeunović, 2021). This group has less or no health and social insurance and is more prone to infection than the white population.

Considering residential isolation like living in ghettos or slums, they were additionally isolated and guarded by the Police, soldiers, and drones, as all exits from these slums were controlled

during the pandemic. Moreover, surveillance was more present than medical doctors, nurses, and medical supplies in those communities. Aside from similar mistreatment in Italy, Spain, Hungary, and Romania, GRT people were also presented as a source of infection on some social media in Bulgaria and Slovakia (Korunovska & Jovanović, 2020).

However, such outside isolation of the GRT population differs from the self-isolation by Native Americans. Yet, it yields almost the same results regarding the infection rates, as well as poor institutional care for those populations in their respective societies. Moreover, "the call for vaccination in the GRT population was constantly low for different sorts of vaccines, not just against COVID-19 infection" (Korunovska & Jovanović, 2020: 8).

Women's and children's inequalities and vulnerabilities reflect in the risk of restoring job, or income rates after returning to work. The usual housework and childcare are supplemented by extra domestic work, such as supporting school activities after online courses. Besides the pandemic casualties, this group has shown a 20% rise in domestic violence in the US and Europe (The Economist, 2020).

Table 1. COVID-19 and Inequalities

Inequalities	**Racial/Ethnic**					**Sex and Age**
Pre-existing risks and potentials	**USA**				**Europe**	
	African Americans	Latin Americans	Asian Americans	Native Americans	Gypsies, Roma, and Travellers (GRT)	**Women and Children**
Vulnerable jobs	+	+	+	+	+	+
Action potential	–	–	–	–	–	–
Caring potential	–	–	–	+	+	+
COVID-19 casualties	↗	↗	↗	↗	↗	↗

+/– Presence/Absence

↗ Increasing trends regarding mortality in the relevant population

Table 2. COVID-19 and marginalization

Marginalization	Age	"Exiled"		Health condition
Pre-existing risks and capacities	Elderly	Prisoners	Homeless	Disabled
Action potential	–	–	–	–
Living in a cramped/ crowded space	+	+	+	+
Social isolation	+	+	+	+
Mortality effects of the pandemic	↗	↗	↗	↗

+ Presence of pre-existing risks

↗ Increasing trends regarding mortality in the relevant population

Aside from inequalities, marginalization is a part of the vulnerability puzzle. During COVID-19, some of the most susceptible groups were extra marginalized, this having catastrophic effects.

Pre-existing health issues related to the late stage of life, living in elderly centres, and loneliness are the most relevant yet publicly invisible risks of extra marginalization of the elderly. During the pandemic, such circumstances have led to higher death rates and dying alone, in addition to the concerns related to the destiny of the descendants in the pandemic. Moreover, there have been cases during the pandemic where the patients' age figured in the decisions concerning life-saving procedures, thus deepening the ageism already existing in everyday life (Jecker, 2022).

Practically, prisoners are an isolated and exiled community within the same country. Considering their living in cramped and closed spaces, the health issues related to COVID-19 for this group include high blood pressure, cardiac diseases, isolation, and risk of infection transfer during transfers of prisoners. These issues are one of the disaster's major causes of the death ratio among prisoners that is multiple times higher than in the free population. Accepting previous ethical approaches may lead to prolonged discrimination, favouring one life, instead of another.

Usually, disaster is comprehended as an extraordinary event. Ordinary or regular everyday routines are altered to a critical or catastrophic point. However, the everyday life of some social groups, such as the homeless, can already be described as a catastrophe. Homeless people live in the condition of a slow disaster (Mitrović & Zack, 2018). In general, such living conditions are described as miserable survival. Besides such conditions, they are susceptible to transmitting or getting viruses due to sleeping in overcrowded shelters during the winter. This community's death ratio has been constantly increasing, especially during the pandemic, and it is multiple times higher than in the common population.

The main concerns related to persons with disabilities during the COVID-19 pandemic involved health issues and losing tutors, or personal caregivers due to the pandemic, which resulted in multiple times higher death ratios. Considering the cases of the pandemic triage in elderly population, where the age has been a factor in deciding about the life-saving procedure, disabilities may become a latent proxy in making such decisions during a disaster triage which is different from the "standard triage" (Jecker, 2022: 2–3). Potential decisions in disasters that use disability as a proxy, represent a latent and dangerous threat to this population, and a clear case of a eugenic choice.

5. Post-pandemic Normalization as an Ongoing Disaster in Healthcare

The pandemic caused by the SARS-CoV 2 virus infection is a disaster that raises or amplifies pre-existing crises in various social systems and affects the lives of individuals or groups. That crisis led to various breaking points and contributed to the premature death of individuals belonging to non-resilient groups.

One of the worldwide proclaimed aims during the pandemic was to return to everyday routines, i.e., the pre-pandemic state in different countries. In a broader sense, the bioethical momentum was a situation in which the conditions and issues of the discriminated collided with the social request of the so-called normalization and restoration of the pre-pandemic life. The request of the privileged to return to normal life for the discriminated and vulnerable

groups implied returning to daily racism. Such general demands of normalizations are not an issue of the marginal. From the marginal's perspective, it means to accept the premature death of members of the marginal groups.

However, the general desire developed during the pandemic to return to normal could imply a slow disaster in the aftermath of the pandemic, i.e., returning to the normal racism and marginalization. The general sentiment has, thus, been expressed by the privileged groups, rather than by the marginalized and vulnerable groups.

Unlike sudden disasters, discrimination in health and care is a type of a "slow disaster", not very much different in its effects (Mitrović & Zack, 2018). However, slow disasters threaten to become crises that, unlike sudden disasters, may be ongoing (Mitrović, 2020; 2021).[3]

The combination of the slow disaster and the pandemic (sudden disaster) is crucial in comprehending the way in which racism works against the resilience and as a barrier to the health care of the BIPOC and GRT population. The general will and efforts to return to the normality of everyday routines following the pandemic, means the return to daily racism for discriminated populations.

There are indicators pointing that exhausted caregivers often use stereotypes in social and professional spaces, similar to racial profiling, which appears in other social systems (Jecker, 2022).

Moreover, Blacks and vulnerable groups in the US are often less insured than the whites, and consequently, they lack health care, or necessary medical supplies. The situation with the Roma population in the EU is similar, "where in some member states, only 50 percent of the GRT population have health insurance" (Korunovska & Jovanović, 2020). During COVID-19, "some non-EU European countries lacked medical treatment for the uninsured, although national law allows medical treatment for the uninsured in some instances, among which are infectious diseases."

[3] For a deeper insight into the epistemological crisis which is a part of the COVID-19 pandemic see the differentiation between the concepts of disaster and crisis in Mitrović, V. (2020) Double Effect of the Pandemic (Corona). *Sociological Review.* LIV(3): 609–626. Mitrović, V. (2021), and Crisis in the Time of Disaster (Coronavirus). *The European Sociologist*. 46(2).

Last but certainly not the least, racism is a barrier to better health care policies. One of the handful values of the series of examined papers[4] is the latent and complex bioethical risk rooted in racism and the race ideas presented through illustrative examples of the ways in which racism in health care policies endangered the health and the well-being of both the discriminated and the discriminators (and the health care system in general).[5] However, many such studies fail in developing these bioethical issues on the ethical and existential levels of the groups and not only of specific individuals. In the discriminated population of BIPOC responders, the absence of health care and insurance has not been the result of an autonomous and free choice, while in the population of the discriminators it is indeed a product of the free latent social, economic, and political choices, manifested through the health-care system, as free willed abstaining from participation in health insurance which would benefit both BIPOC and the Whites. Those groups who, due to racism, do not participate in the common health insurance system, are guided with a kind of heart and mind racism, i.e., racial ideas. However, relevant papers explain race as a bioethical issue, assuming that race is a biological and social category.

Observing race in a bioethical context, specific authors used a well-tailored sociological tool to emphasize practitioners' social roles and duties in medicine and science. All those professionals are

[4] See more in a series of papers which appeared seemingly and independently in different journals and editions. Ganguli-Mitra, A., Qureshi, K., Curry, G. D. & Meer, N. (2022). Justice and the racial dimensions of health inequalities: A view from COVID-19. *Bioethics,* 36(3): 252–259. https://doi.org/10.1111/bioe.13010; Russell C. Meeting the Moment: Bioethics in the Time of Black Lives Matter. *Am J Bioeth.* 2022, Mar; 22(3): 9–21. doi: 10.1080/15265161.2021.2001093. Epub 2021, Dec 2. PMID: 34854793; Zack, N. Op. cit. note 6.

[5] Russell followed Meltz's research with a focus group, analysing the acceptance of the supported health care system among Afro-American, as well as among the Whites. The results show that the majority of the white men show clear willingness to literally die, rather than to embrace legal measures that would give more access to health care to vulnerable persons, even if it helped them as well. See more on this research in Metzl, J. M. 2019. *Dying of Whiteness: How the politics of racial resentment is killing America's heartland.* New York: Basic Books. Cit. from Russell C. Meeting the Moment: Bioethics in the Time of Black Lives Matter. *Am J Bioeth.* 2022 Mar; 22(3): 9–21. doi: 10.1080/15265161.2021.2001093. Epub 2021, Dec 2. PMID: 34854793. P.14.

embodied in society, and only a holistic social picture may explain the way that racist ideas (as a virus) can circulate and be replicated again and again in both spaces: wider society and science. Although the latest studies use cultural patterns and theories to explain this racial circulation and perpetuation, the authors miss adding deep and structurally rooted social and economic divisions of one highly developed and rich society, such as the US, finally reflected in health care and survival of individual groups. This bioethical distinction (surviving privilege) results from the high standards and lifestyles, impacting the population's health.

Researching the social and economic indicators of the marginal's resilience opened the question of the existential risks for the marginal and vulnerable groups when an apathetic society meets an unwanted situation (Mitrović, 2015). An apathetic society is mainly represented through the reduction of anticipation and action potential in marginal groups due to miserable living conditions, and the higher social strata that refrain from acting in cases where they are obliged to act.

Different authors[6] proposed a similar momentum that professionals and bioethicists must recognize in the BLM protests. The open question is, is there enough power to face and process all the needed health care and other social reforms, to enhance the health and well-being of the BIPOC and GRT populations?

6. Conclusion

Considering the pre-existing risks such as isolation or marginalization of one community, shows that the consequences of COVID-19 are detrimental. Even though the isolation of one group may act as a protective measure, discrimination in the distribution of medical and social care, as well as of the scarce resources needed in containing the pandemic (from sanitary to medical supplies), and living in confined spaces, play a crucial role in the increased mortality of discriminated populations. Nevertheless, traditionally discriminated communities, such as indigenous peoples in the United States, responded en masse to vaccination when provided.

[6] For comparative examples, please see Russell, (2021); Zack (2015; 2021).

What would happen if racism did not figure in the American health-care system? In other words, what would happen to the mortality rate of the BIPOC population?

Would such a response reduce the mortality of the black population if discrimination, or racism and the inherent risks were absent from the health care system?

However, the question arises as to whether something like this could have happened, bearing in mind that catastrophes (pandemics) are transient, while crises can be long-term, tending to become permanent and ubiquitous. Such is the case with racism, a constant crisis that, in the face of a catastrophe, weakens the resilience of the population and their response to the catastrophe, precisely because of their long-term coping with stress. In addition, such normalization of the crisis ends in apathy and loss of deontology of the wider community, or the society and its systems, primary health care which also fails to adequately respond to an undesirable situation such as the COVID-19 pandemic.

According to the Universal Declaration of Human Rights, in some communities, collective consent could be sought from the community leader (UNESCO, 2005, Article 6, point 3, p. 23). Such a situation can be treated as a kind of paternalism. A pandemic also reveals another kind of paternalism in a case of discriminated and marginal populations. Disasters can be used for putting those populations under non-autonomous control, i.e., a catastrophe can be the reason for introducing new surveillance technologies (Hendl & Roxanne, 2022) and AI paternalism (Kühler, 2022).

It is necessary to set practical steps for clinicians and bioethicists considering the bioethical issues analysed in this paper. Hopefully, such actions will become a part of everyday life and work in the US (as well as in other societies). Hope lies in the holistic approach that many bioethicists and clinicians need to accept. However, tending to prevent the loss of duty to act toward subject well being should not push bioethics into the trap of becoming an omniscient and contingent discipline, striving to become a worldview. The primary goal of bioethics, i.e., the long-term survival with preserving social, bio, and cultural diversity, is real and possible only through the interaction between responsible professionals and broader society.

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Rethinking Human Security in the Post-COVID-19 World – Lessons Learned from the Human-centric Approach to Health Security

Abstract

The COVID-19 pandemic is an example of the health-security nexus, as a topic of increasing importance in security studies. Speaking broadly, this perspective is close to the political construction of the health threats, but depends on the approach to health security we take. Specifically, the aim of this paper is to analyze COVID-19 as a health threat through the human-centric approach to health security and to consider the relevance of this approach in the "post-COVID-19 context". The research question is: what is the special value of this approach in the conceptualization of COVID-19 and future health security threats, both in terms of theoretical contribution and strategic and policy solutions? The paper is based on an academic literature review, and secondary data analysis relevant to the assessment of the state of human security, like the Human Development Index. The paper is structured as follows: in the introductory part, academic perspectives on health security are presented. Then, through the seven dimensions of the human security concept, it is analyzed how COVID-19 threatened human security. The next part considers the characteristics of a human-centric approach to health security in the COVID-19 context. Finally, the theoretical and practical implications of the human security analysis of COVID-19 and its importance for the health security field, are discussed. It is concluded that rethinking the human security concept in the post-COVID-19 context could contribute both to clarifying the human-centered approach to health security and redefining the concept of health security itself.
Keywords: COVID-19, human security, health security, "post-COVID-19 world"

1. Introduction – Academic Perspectives on Health Security

In the post-Cold War period, security studies, as a sub-discipline of international relations, were marked by the well-known "broadening" and "deepening" of the research field. This refers to the security sectors (military, political, economic, social, and environmental security) (Buzan, 1983), as well as levels of analysis (human, national, regional, and global security) (Waltz, 1959; Singer, 1961). This academic shift induced more interest in the so-called non-traditional (non-military) security issues. One of them is health security. When it comes to the term itself, there is not much consensus about it. This is primarily due to the interdisciplinary disposition of the term – since health and security correspond to different disciplines – and to its usage in a variety of contexts (individual, national, and global) for a variety of purposes (Malik, Barlow & Johnson, 2021). Thus, as it is still not a coherent field, three broader perspectives on health security can be distinguished. The dominant one and the so-called "traditional" is the state-centric approach to health security, which emphasizes the state as a referent object, or state as an endangered entity. This approach relies on the securitization process or social construction of the threat (Buzan, Wæver, & De Wilde, 1998). Remembering COVID-19, it was reflected in the war rhetoric used by political actors ("We are at war with an invisible enemy", and similar phrases), which presented speech act, used to securitize the virus, to frame it as a threat and thus mobilize the audience (people) and legitimize special measures aimed at responding to the pandemic. So, in this perspective, health issues are considered through the national security agenda (McInnes, 2015), and accordingly, responses are based on individual states' policies, usually the application of the so-called hard-security measures – military, police, and territorial control.

Although widespread, this approach has also received serious criticism – some critics say that it represents a narrow view of health security, which ignores wider consequences of health threats and cannot address complexities of the health security issues or the cross-linkages between poverty, health, and development, while state-centric measures for containing the virus, often carry

a risk of violating human rights and freedom (Elbe, 2006; McInnes, 2015; Stoeva, 2020). Opposed to the state-centric approach, a human-centric paradigm of health security is focused on individuals and communities as referent objects. Thus, the concept of human security is seen as a way of "reconciling" health security and human rights. The key proponent of this approach is the United Nations Development Program (UNDP) which introduced the human security concept as consisting of several dimensions – economic security, food, health, environmental, personal, community, and political security (UNDP, 1994). Specifically, health security as a dimension of human security refers to threats to human life and health caused by infectious and parasitic diseases, diseases caused by polluted air or water, as well as inadequate access to health services (UNDP, 1994). Human security, therefore, repositions security as an everyday struggle enacted through different aspects of life, ranging from the political to the biological (Daoudi, 2020). The human-centric approach to health security gained additional attention during the COVID-19 pandemic, which really showed how all these dimensions – from health to economy – are intertwined and interdependent.

Very similar to the human-centric approach to health security is the global (public) health security, mostly advocated by the World Health Organization (WHO). According to the WHO (2007), "global public health security implies the necessary proactive and reactive activities, to reduce vulnerability to acute public health problems, which threaten the collective health of the population worldwide" (p. 9). It embraces a wide range of complex issues, from the health consequences of poverty, wars and conflicts, and climate change to natural catastrophes and man-made disasters. So, pandemics are just one of the threats to health security. Others include foodborne diseases, toxic chemical accidents, radio nuclear accidents, environmental disasters, etc. (WHO, 2007). In general, global (public) health security is motivated by the belief that risks to public health have been globalized, requiring a response beyond that which individual states are capable of (McInnes, 2015). This is why some authors even speak about "statist" and "globalist" perspectives of health security (Davies, 2010).

This complex and nuanced connection between security and health is what is called a "health-security nexus" in academic

literature. In other words, "there are multiple grammars of security in the global health security narrative" (Wenham, 2019: 1096). This paper deals with the human-centric approach to health security: first, because COVID-19 has encouraged more thinking about human security in health crises, as opposed to the hitherto dominant, state-centric approach; second, because the human-centric approach to health security, although similar to global health security, is more academically developed and more thematized in the literature, and therefore provides more tools for analysis.

2. COVID-19 as a Threat to Human Security

This part aims to analyze how human security is threatened by COVID-19, through the seven dimensions of human security.

Health security – the health of people around the world is threatened in many ways during the COVID-19 pandemic – at this moment there have been more than 770 million confirmed cases and almost 7 million deaths caused by COVID-19 (WHO, 2023). At the same time, there have been many indirect deaths resulting from delays in seeking healthcare for other diseases, from overwhelmed health systems or the diversion of resources to deal with the coronavirus (Di Liddo, 2021). Moreover, discrimination and unfair treatment are also evidenced in some cases, because some people had limited access to healthcare systems on the basis of resources, employment and/or immigration status (Estrada-Tanck, 2020). The pandemic also increased mental health problems (Fiorillo & Gorwood, 2020), which may be even more evident now, after a certain time. Periods of isolation, accumulated stress, anxiety and feeling of uncertainty, are prolonged health consequences of the pandemic. So, indirect health effects of the COVID-19 showed that the health security of people who were not infected is also endangered, because of inadequate or completely disabled access to health services and healthcare. An additional indicator of health security during the pandemic is the Global Health Security Index (GHSI).[1]

[1] The GHS Index assesses countries' health security and capabilities across six categories (prevent, detect, respond, health, norms, risk), 37 indicators and 171 questions using publicly available information. More about GHS Index could be find at: https://www.ghsindex.org/

It is focused on a state level, but it could be very useful in understanding many of the health insecurities people faced during the pandemic. Key findings from the GHSI report for 2021, show that the average country score in 2021 was 38.9 out of 100, which is essentially unchanged from 2019. It signals that significant gaps exist for all countries and across all GHSI categories and reinforces that preparedness remains fundamentally weak at all country income levels. Although evidence shows that countries built new capacities during the COVID-19 pandemic, many of them are temporary, short-term COVID-19-specific measures and were therefore not given full credit by the GHSI (Bell & Nuzzo, 2021).

Economic security – containment measures during the pandemic consequently led to economic decline worldwide. In 2020, the first full year of the COVID-19 pandemic, the global economy shrank by approximately 3%, while global poverty increased (World Bank, 2022). As well as at the global economic scene (reflected in the disruption of the global market, global supply chains, inequalities between states, etc.), an economic crisis hit almost every household due to increased job losses, shortages of food, price increases, and worsened living conditions. According to the World Bank (2022), in 2020, more than 50% of households globally were not able to sustain basic consumption for more than three months in the event of income losses, whereby disadvantaged groups have been disproportionately affected.

Food security – increased food prices, disrupted food supply chains and general socio-economic conditions, resulted in food insecurity as well, primarily reflected in problems of food availability, as well as its amount and quality (Abdullahi et al., 2023). In just two years, the number of people facing, or at risk of acute food insecurity increased from 135 million in 53 countries pre-pandemic, to 345 million in 79 countries in 2023 (World Food Programme, 2023). As well as in other security dimensions, food insecurity particularly threatened poor and most vulnerable groups, like lower-income workers and workers in informal sectors, who have less protection than formal sectors (Nurhidayah & Djalante, 2022).

Environmental security – although there have been some short-term positive changes when it comes to air quality, water pollution, etc., environmental security has worsened as international

climate change resolutions have been pushed back (Sagris, 2020). At the same time, the negative environmental effects of the pandemic are reflected in the increase of medical and municipal waste, inadequate disposal of used safety equipment (face masks, gloves), and reduced recycling (Rume & Islam, 2020). Additionally, the pandemic also caused regional and local changes in water use and thus exacerbated the already existing critical issues related to sustainable future water use (Bhowmik & Roy, 2022). For example, many communities across ECOWAS countries experience water shortages both in urban and rural communities across the region, due to COVID-19 (Chukwufumnaya & Oghuvbu, 2020).

Community security – the lack of community security is reflected in disruptions of social life, social connections, and community development. At the same time community members' trust in each other has declined, especially when it comes to solidarity, the certainty that everyone will behave responsibly for the purpose of collective protection. This is also one form of disrupted social cohesion, the consequences of which are still visible and present. Moreover, the virus disproportionately affected certain communities, highlighting underlying structural inequalities and discriminatory practices that need to be addressed in the response to and aftermath of this crisis (UN, 2020a).

Personal security – personal security is endangered by increased discrimination, xenophobia, racism, and attacks against migrants and refugees, often blamed as the main carriers of the disease. Other vulnerable and additionally marginalized groups include older persons, racial, ethnic, and religious minorities, persons with disabilities, etc., each of whom carried the specific burden of the pandemic (UN, 2020a). Additional threats to personal security are urban violence (Haer & Demarest, 2020), and increased domestic and gender-based violence, of which economically insecure and dependent women, women without adequate social support, etc., are especially at risk (Mittal & Singh, 2020). In general, personal security is mostly affected by different forms of human rights violations, due to emergency measures imposed by COVID-19.

Political security – last, but not least, the COVID-19 pandemic has also emerged as a political crisis with increased authoritarianism, manipulation of democratic and electoral processes, and

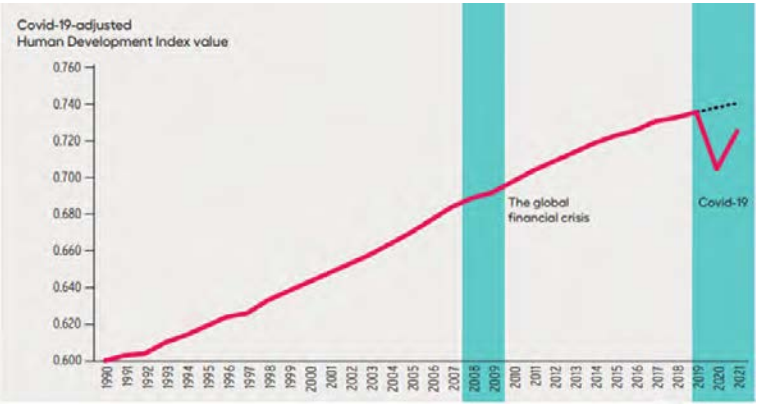
violations of human rights (Haer & Demarest, 2020). So, we can see that human rights are the issue of personal security, as well as of community and political security. The evident interdependence of human rights and human security made this issue even more sensitive in the crisis situation imposed by COVID-19 and susceptible to different types of violations and jeopardizing. Moreover, some research showed the intensification of conflicts during COVID-19 (e.g., in Libya, Nigeria, Afghanistan), both in the sense of the pandemic as a situation that worsened the already existing causes of conflicts, as well as the situation that was politically and military exploited by states or non-state actors (Polo, 2020).

This analysis shows how all human security dimensions are intertwined and interconnected and how threats to one dimension spill over to another. A domino effect is noticeable: the health crisis caused the reduction of economic activities, leading to an increase in unemployment and poverty, which consequently caused food insecurity. Further, the long-term measures of isolation and quarantine and the general state of emergency triggered different forms of discrimination, violence, and political instability, but also increased psychological problems among people, as an additional health issue. In some way, this illustrates a kind of "closing of the circle" or returning to the health of people, as a primary need that still suffers. It could be considered not only through the psychological consequences, but also through the so-called "prolonged COVID-19" or "post-COVID-19 syndrome", with damage to physical health as well. Thus, in its scope and consequences, COVID-19 has been a real existential threat that threatens human's "freedom from fear" and "freedom from want" (Alamsyah, Alfian & Darussalam, 2021). As a part of a broader picture and additional indicator of the state of human security during the COVID-19 pandemic, the Human Development Index (HDI)[2] is presented. Figure 1 shows that the global HDI value has been in decline two years in a row, specifically the first two years of the pandemic, and erased the gains of the preceding five years (UNDP, 2022a). Moreover, UNDP (2022b) emphasizes that for the first

[2] More about HDI could be find at: https://hdr.undp.org/data-center/human-development-index#/indicies/HDI

time, HDI values have declined drastically, unlike anything experienced in other recent global crises, and resulted in a clear setback to human security. At the same time, perceived human insecurity has increased in most countries, even in some countries with very high HDI, which is why UNDP claims that the pandemic has gone from a health crisis to a full-fledged human development crisis (2022b).

Figure 1. HDI values



Source: UNDP, 2022b.

3. Human-centric Perspective of Health Security in the Context of the COVID-19 Pandemic

Although it has been mentioned that the state-centric approach to health security dominated during COVID-19, this part of the chapter aims to present the advantages of the human-centric perspective of health security in the context of COVID-19. As time went by, it was becoming more and more evident that the national security paradigm failed in combating "the invisible enemy". Border closures, nationalistic rhetoric, power disparities, "vaccine and mask diplomacy", and a general lack of solidarity, undermined the proclaimed striving for global and human values while dealing with the global threat. This way of responding to the pandemic caused a conflict between the need to protect the health of people and their basic rights and freedoms.

From the human-centric perspective, this is wrong – health security shouldn't be achieved at the expense of human rights. Moreover, as Daoudi (2020) emphasizes, the human security approach tries to bridge the gap between security and development, health and stability, and individual and national security. This people-centric approach embraces both the dichotomies of individuality and indivisibility of personal freedom of people's collective and individual rights, but a balance must be struck between the authority of the state and the freedom of the individual (Chukwufumnaya & Oghuvbu, 2020). This is a sensitive line, which is usually crossed exactly during a serious crisis, when a state could become a threat to its own citizens. For example, very stringent emergency measures and proclaimed successful securitization of COVID-19 in Asian countries had a very negative impact the overall human security of citizens in Asia (Sornbanlang, 2022). Although securitization is useful when it comes to quick mobilization of resources, as well as raising attention and preparedness of people, critiques claim that it is a short-term strategy, aimed primarily at stopping the spread of disease, while its effectiveness in improving health systems and preventing future health crisis is questionable, especially in the long run (Malik, Barlow & Johnson, 2021). Such a narrow approach to health security in a practical sense, cannot encompass the whole complexity of the threat (i.e., COVID-19), because it overlooks the entanglement of health, human rights, development, equity, and solidarity, which are at the core of the human security concept. During the pandemic, it was shown that health security does not only mean that one is not sick, but also that he/she has access to regular health services, end enjoys absence of fear of existential threat, absence of threats to human rights and basic needs, etc. That is why a systemic approach reflected in human security is relevant.

So, instead of deploying soldiers along the borders and within countries, and declaring "war on COVID-19" as mobilizing rhetoric, a systemic, human-oriented response would include strengthening health systems, securing equal access to vaccines, masks, protective equipment, and healthcare in general. At the same time, it ensures more preparedness for the future. Speaking about the relevance of the human security paradigm in broadening the concept of health security, in the COVID-19 context, Malik, Barlow and

Johnson (2021) point out these characteristics of the human security approach: *universalism* that defies 'we' versus 'they' dichotomy by locating the problems of human insecurity in both the developing and the developed world; *interconnectedness* that emphasizes an interconnected understanding of security; *indivisibility* of threats; *the attention to prevention* rather than the cure.

To summarize, in contrast to traditional security efforts in managing the pandemic, motivated by narrow national interests, human-centered approach implies measures and policies that have broader and long-term implications for health security. In other words, the complex threat that affects all human security dimensions requires a holistic response. That requires health-security multilateralism on a global scale – cooperation between states, and between states and international organizations (WHO, UN), as well as multisectoral cooperation within states – integrating solutions from medicine, economy, politics, etc. In the end, the effectiveness of epidemiological measures and improvement of health security depend on responsibility of the state, but also the people - through the compliance behavior with those measures. This new form of social behavior actually represents a specific safety culture in relation to COVID-19 as a health security threat. It is a response to the great transformation of the previously known way of life, caused by the existential threat. It could be said that it is a long-term strategy, in accordance with a human-oriented response to COVID-19, because it encompasses not only behavioral aspects, but also emotions, knowledge, awareness, and values, which together constitute the general attitude towards the threat.

It could seem that we only learn through the reflection on past events and that the potential of a human-centric approach to health security is discussed more only after the crisis and facing the consequences, but there are examples that indicate the prevention and preparedness as important aspects of the human-centric approach to health security. Some analyses show that Canada, as one of the proponents of human security, has demonstrated a high level of preparedness before the pandemic, as well as the successful management of the crisis itself. It is reflected through multisectoral coordination before the pandemic, a well-prepared health system, adequate investment in healthcare, scientific research as well as

active engagement in health diplomacy – cooperation with individual states and international organizations (WHO) (Chattu et al., 2020). Therefore, the practical application of the human-centric approach to health security would imply achieving health security before a concrete threat occurs, i.e., by continuous systemic improvement of every dimension - economic, social, etc. Thus, in a potential future pandemic or any health crisis for that matter, a certain level of health security would have already been achieved and preconditions created for its further improvement. This should happen through the joint coordination of the state and citizens – the state, which would ensure the aforementioned systemic solutions, and the citizens which would demonstrate their awareness and responsibility, i.e., the already mentioned safety culture. Understandably, this would not mean absolute health security, because it is impossible. However, as people, i.e. the main referent objects of human security, we would be empowered by the mutual support, support of the government and relevant institutions and would have more capacity and potential to handle the crisis in the best possible way.

Although it seems that COVID-19 has further deepened the differences between state-centric and human-centric perspectives on health security, those are not mutually exclusive. Instead, state security is necessarily closely related to the security of citizens. So, an effective and accountable state should be the main provider of security for its citizens (Newman, 2021). Moreover, "when health-related risks and challenges pose an existential danger, they need to be considered as security risks, in recognition that individual and community security is as relevant a consideration to state security and vice versa" (Stoeva, 2020: 7).

4. A Way Forward for a Human-Centric Approach to Health Security in the "Post-COVID-19 World"

The experience gained during the COVID-19 pandemic opened the question about how the "revival" of human security could help frame future health insecurities, especially infectious diseases in the post-COVID-19 period. This question will be addressed through the analysis of theoretical and practical implications of human security analysis of COVID-19 in the health security field.

On the theoretical level, it is obvious that the pandemic induced renewed academic curiosity for the human security concept. Many authors recognized the limitations of the dominant realist security paradigm to effectively manage today's complex health crises and thus emphasized the value of a human security framework in addressing such crises (Milani, 2020; Malik, Barlow & Johnson, 2021; Morrissey, 2021; Kumar, 2022; Newman, 2022). For example, Newman (2022) emphasizes the normative value of human security as a framework for understanding the impact of COVID-19, which actually provided a chance for revisiting human security more broadly as a tool for understanding and contesting questions of security and insecurity in domestic and international society. An important lesson from COVID-19, according to Kumar (2022), is that the pandemic has made clear that nothing matters more to people than security in their daily lives, and thus the helplessness and lack of preparedness among individuals, families, communities, and governments during the pandemic has underscored the need to focus on human security. In general, the need for a deeper consideration of the human-centric approach to health security, authors mainly see in the breadth that this framework provides for understanding the complexity of health security threats and responding to them, which the state-centric paradigm obviously lacked during COVID-19.

As the UNDP (2022b) underscores, reaffirmation of the human security lens is especially important in the Anthropocene context, because the nature of health shocks will continue to evolve, not only in the form of future pandemics, but also the hazards associated with climate change and other processes of dangerous planetary change. Actually, three recent UNDP reports represent valuable theoretical contributions to the human security analysis of COVID-19, but also consist of many practical recommendations for enhancing health security in the future: Human Development Report 2020: *The Next Frontier – Human Development and the Anthropocene* (UNDP, 2020); Special Report *New Threats to Human Security in the Anthropocene,* (UNDP, 2022b), and the Human Development Report 2021/2022: *Uncertain Times, Unsettled Lives: Shaping Our Future in a Transforming World* (UNDP, 2022a).

At a practical level, COVID-19 also induced some kind of shift of individual states and international organizations towards more human-centered policies. For example, the United Nations Security Council (UNSC) adopted two key resolutions regarding the COVID-19 Pandemic – Resolution 2532 and Resolution 2565. Resolution 2565 addresses broader implications of COVID-19 and reflects "human security thinking", by emphasizing the need for solidarity, a coordinated, inclusive response in combating and sustainably recovering from COVID-19, as well as the importance of equitable global access to healthcare services, with special reference to the most vulnerable (frontline workers, older people, refugees, migrants, etc.) (UNSC Resolution 2565, 2021). Discussions on these Resolutions were also marked by the individual states' reorientations towards human-centered policies. For example, India called for a more human-centered approach to the pandemic and emphasized that the Council's initiatives on combating COVID-19 should transcend conflict lines and contribute to social cohesion (Ozguc & Rabbani, 2023). Japan's health policy, based on the human security paradigm, has been considered quite successful during and after COVID-19. Accordingly, Japan's call to cooperation, solidarity, and systemic approach to health security threats in the future, has actually reflected its ambition to remain the leader in health diplomacy (Takao, 2020). This is obvious also from its Global Health Strategy (2022), where Japan confirms its strong commitment to human security principles in global health, while recognizing that COVID-19 demonstrated that global health should be considered and protected from a broad perspective, which encompasses sociological, political, ecological, and other dimensions. So, those Resolutions, along with the establishment of the Independent Panel for Pandemic Preparedness and Response, and many other specific measures, represent important steps in global health security reform induced by COVID-19. As the past teaches us, crises usually represent great turning points in policy evolution and strategies for countering specific threats. The same can be expected from the lesson that COVID-19 gave us. A human security-oriented approach could be an adequate long-term response in health-security policy, which is not only a theoretical insight, but a really recognized need evident in states' official policies and strategies.

In the end, COVID-19 also induced a rethinking of the human-environment relation. The pandemic has reminded us of human dependence on nature, brought attention to new ways of thinking about human health and security, encouraged more climate awareness, new climate change policies, etc. (Tashiro & Kotsubo, 2022). COVID-19 elevated the importance of holistically conceiving human-environmental well-being and tackling the overarching insecurities of our ecologies, societies, and public health (Morrissey, 2021). Those insights are very important for ecological recovery in the post-COVID-19 period, and in the long run, improving the ecological dimension will positively affect all other dimensions of human security.

5. Concluding Remarks

Summing up the insights from this chapter, it could be said that a human security analysis of COVID-19 is useful, not only in understanding broader, multidimensional implications of this existential threat, but that the human-centric paradigm has great potential as a relevant theoretical framework for considering health security threats in general. Solidarity and cooperation at all levels (people, communities, nations), prevention through education and preparedness, interdependence of all dimensions, holistic response, respect of human rights and needs, inclusiveness, strengthening people's agency, proactivity instead of reactivity, are just some of the characteristics of the human-centric approach to health security. As COVID-19 really showed how health security varies between high political issues and people's everyday insecurities and challenges, the debate between traditional, state-centric, and human-centric perspectives on health security is inevitable. Of course, both perspectives have their advantages and shortcomings, but we have learned from COVID-19 that "human security should be prioritized at the policy level along with state security" (Majee, 2020). The pandemic induced reconsideration of both the role and responsibility of the state and individuals in such a crisis. Moreover, human security has been criticized as well, and this analysis is not to say that it is a perfect framework to capture everything. It is just a way to bring to attention perspectives that

are in accordance with the changed global security landscape, and offer some additional and different insights into new or "non-traditional threats", compared to what the narrow, traditional perspectives could. Although the human security concept is often criticized as too broad and unclear, as it encompasses almost everything as a security issue, at the same time this could be seen as its advantage, since its multidimensionality is critical in understanding and coping with complex, interconnected challenges and its spillover effects in the globalized world. Anyway, it could be expected that the previously mentioned renewed interest of researchers in human security will contribute to the clarification of the human security concept itself, and its further development. Consequently, it could be of great importance in redefining the concept of health security, which should be adequately defined to frame contemporary and future public health threats in an effective manner.

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III
DISCOURSES AND CONCEPTS OF LAW AND POLITICS IN COVID-19

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Constructivism in Times of Political Crisis

Abstract

The COVID-19 pandemic has demonstrated how deeply engrained in the functionality of societies human-induced risks have become. Political philosophers can no longer treat these hazards as improbable threats too far removed from everyday life to properly count as basic questions of justice and stability. Reimagining the liberal tradition to account for these risks will require a concept of social resilience to fortify existing conceptions of social stability. This paper argues that a leading account of stability – an overlapping consensus – is not resilient under stress. It explains how human-induced hazards contribute to a process of pernicious polarization, and how pernicious polarization illuminates a process by which consensus breaks down and begins to reverse itself. A complete account of what must transpire for a society to absorb, withstand, anticipate, or recover from this destabilizing process outstrips the conceptual resources contained with an overlapping consensus, rendering it vulnerable to the human-induced threats we can expect to encounter for years to come.

1. Introduction

The COVID-19pandemic had devastating and destabilizing impacts on families worldwide. However, it also accelerated discussions about how best build resilient institutions that can withstand future pandemics and other human-induced hazards (United Nations, 2020). Similar discussions have not penetrated the philosophical literature on social justice and political stability.[1] The pandemic might also change that. COVID-19has demonstrated how deeply ingrained in the functionality of societies these risks have become (United Nations, 2020: 6). We can no longer treat them as improbable threats too far removed from everyday life to properly count

[1] One exception is the ethics of disaster (Zack, 2010). Another is the field of transitional justice, which focuses on the moral dilemmas of political transitions to democracy (Buckley, 2013; Murphy, 2017).

as basic questions of social justice and stability. The effects of COVID-19and other human-induced hazards will reverberate long into the future. How their burdens are distributed is a question of justice, and whether political institutions can absorb, withstand, anticipate, or recover from them is a question of stability.

Contemporary liberal theorists have not fully appreciated the above considerations. This chapter explains why a leading liberal account of social stability is vulnerable to the stresses associated with human-induced hazards. The account in question shows how morally diverse citizens can endorse the same conception of justice for different moral reasons. Philosophers have discussed at length how an 'overlapping consensus' might emerge where none exists. They are only beginning to analyze the processes by which consensus breaks down and reverses itself (Badano & Nuti, 2018). This chapter argues that a complete account of what must transpire for a society to absorb, withstand, anticipate, or recover from human-induced hazards outstrips the conceptual resources contained with an overlapping consensus.

The argument consists of three parts. The next section presents a familiar interpretation of an overlapping consensus and introduces the idea of resiliency as the capacity of institutions to absorb, withstand, anticipate, or recover from human-induced hazards. Section II explains how certain human-induced hazards contribute to a process of pernicious polarization that threatens the stability of democratic societies. Section III argues that an overlapping consensus is not resilient because it is vulnerable to the stresses associated with the human-induced hazards identified in section II. And the concluding section suggests how a philosophical account of stability might benefit from a resilience lens.

The literature on an overlapping consensus and its related account of justice is vast. Consequently, I will focus on one influential model and whether its account[2] of stability can plausibly withstand, anticipate, or recover from human-induced hazards. Assuming the model is stable during calm times, it is reasonable to ask whether it is resilient under stress. An inquiry into this latter question raises other intriguing questions about the formulation

[2] Other important models include (Quong, 2010) and (Gaus, 2011).

of the problem of stability and the practical feasibility of its related conception of justice under less than favorable conditions. I have pursued these questions elsewhere but do not pursue them here (Buckley, 2022).

2. Stability versus Resilience

Political philosophers have recently framed the problem of stability as follows: How is it possible to maintain social unity on a basis of mutual respect in a diverse setting characterized by reasonable disagreement over moral and religious issues? From the perspective of a theory of liberal justice, the primary concern is that diverse and yet irreconcilable disputes over the true nature of the good life will percolate up into the political domain as irreconcilable disputes over questions of basic justice. In a diverse society, it is always possible that some group will demand that the state advance its conception of the good, no matter how controversial, and then reply to its opponents that, though they may be reasonable, they are simply wrong about what makes life worth living (Larmore, 2008: 127). Such demands are inconsistent with liberal commitments to freedom and equality. A liberal solution must explain how a group of people can "affirm a comprehensive doctrine as true or reasonable and yet hold that it would not be reasonable to use the state's power to require others' acceptance of it or compliance with the special laws it might sanction" (Rawls 2001a: 189).

An overlapping consensus is an important element of a leading response to this problem. At its simplest, an overlapping consensus means that people endorse a liberal conception of justice and abide by its laws for different reasons stemming from their personal moral conception of the good (Freeman, 2007: 366). For such a consensus to emerge in a morally diverse setting, the justification of the political conception must avoid ongoing disputes about ultimate human value when formulating its political principles and justifying their content (Nussbaum, 2011: 17). Each reasonable citizen will then be able to affirm, for different normative reasons related to their deeper moral identities, the same political conception of justice provided that the conception, itself justified on moral and political ideals, does not conflict with these moral doctrines.

John Rawls's Political Liberalism provides an influential account of an overlapping consensus. Rawls introduces the idea after having constructed a public conception of justice from shared political ideals. The construction involves deliberating about justice in an 'original position' that mitigates bias and avoids controversial metaphysical and epistemological disputes by bracketing people's non-political commitments. After constructing a conception of justice with shared political ideals, the conception is further justified by seeing whether it can serve as a 'module' that fits into citizens' broader moral doctrines (Rawls, 1993: 386). If it can, the resulting consensus is stable because it unifies two parts of a citizen's normative view (Rawls, 1993: 38). One part concerns a 'public' sense of justice characterized as a willingness to do one's share in maintaining fair terms of cooperation as defined by a political conception (Rawls, 1993: 19; 1999: 442). The other expresses a 'private' moral motivation that makes it rational for them to affirm their sense of justice from the moral point of view (Scanlon, 2003: 160).

The congruence between these two normative features is essential to both the liberal theory of justice and its subsequent account of stability. Absent the appropriate moral motivation, a sense of justice (as specified by the political conception) is neither practically sufficient to guarantee stability nor theoretically adequate to satisfy the liberal values of freedom and equality. On the practical side, laws sanctioned by the public political conception may conflict with judgments authorized by one's private conception of the moral good. At this point, the moral motivation to follow one's private moral judgment may outweigh one's sense of justice, causing a person to defect from liberal norms. Theoretically, one's lived experience is neither free nor equal if the public laws and institutions that regulate one's life are built on a political conception that one cannot willingly endorse (Nussbaum, 2011: 35). An overlapping consensus aligns citizens' moral commitments with their sense of justice. All endorse the same conception of justice despite their different moral reasons, lending the political conception moral legitimacy and practical stability.

Notice that the congruence established by an overlapping consensus resolves a paradox long associated with democratic

theory. The logic of the paradox is to assure that 'popular will' upholds certain constraints upon itself in virtue of its precommitment to certain formal and substantive interpretations of human rights and 'the rule of law' (Benhabib, 2004). An overlapping consensus illustrates how a people can freely give itself the law that constrains the free use of reason. I will return to this point in the next two sections.

The concept of resilience is related to but different from the concept of stability. Resilience refers to the way a system, community, or society can resist, absorb, adapt to, respond to, anticipate, and recover from a wide range of risks in a timely and efficient manner, including through the preservation and restoration of its essential basic structures and functions through risk management (United Nations, 2020: 31). Risk refers to how natural and human-induced hazards interact with a community's vulnerabilities or capacities to manage hazards. Vulnerabilities that influence risk levels include poverty, inequality, exposure to the effects of climate change, rapid urbanization, overexploitation of renewable resources, demographic changes, epidemics, and pandemics. "When risks accumulate and interact, they can manifest as crises and unleash cascading impacts on sectors and across systems, causing loss of life and livelihoods and dramatic socio-economic and environmental damages" (United Nations, 2020: 24).

Let us assume that a society characterized by the above account of congruence between the public conception of justice and citizens' private moral views is stable and just. How, then, might it respond to political shocks? No society, not even a just and stable one, can guarantee that the conditions favorable to its stability will endure uninterrupted over time. Sometimes societies experience political shocks that split coalitions, fragment parties, weaken public confidence, and polarize the electorate (Linz, 1978: 66). These events can unsettle the congruence established by an overlapping consensus. A person's moral identity can conflict with the shared conception of justice. A conception of stability that is resilient provides the conceptual resources for anticipating the conflict and thus contains resources for managing its effects before a crisis emerges. Failure to head off a crisis could result in a process of re-equilibrium whereby rebuilding the legitimacy and effectiveness

of democratic institutions requires non-democratic means (Linz, 1978: 87–97).

Nations and global organizations are thinking carefully about how to build resilient institutions. These discussions focus on ongoing risks associated with natural and human-induced hazards, but they occur against the backdrop of political divisions, fragmented parties, weakened public confidence, and polarized electorates. Social divisions pose an additional risk since they obstruct the collective efforts required to address pressing global challenges. A recent empirical study covering the past 120 years found no case of a liberal society recovering from pernicious levels of polarization through liberal democratic means (McCoy et al., 2022). The challenges generating today's polarization crosscut one another and cascade across global, regional, and local governance systems. For instance, the effects of climate change increase the likelihood of conflict (Koubi, 2019: 355); conflicts create transnational migration flows (McAuliffe & Ruhs, 2017: 2); negative attitudes toward out-group populations increase during conflict (Canetti-Nisim et al., 2009), shaping people's attitudes toward displaced persons. It is not surprising, then, that even though people are, on average, living longer, healthier and wealthier lives, they are also reporting increased feelings of insecurity and declining levels of trust (United Nations, 2022: iii).

The above domestic-expansive challenges place enormous pressure on people and their shared democratic institutions. Data from Freedom House shows that the COVID-19pandemic worsened conditions for democracy and exacerbated the 15-year-long democratic recession (Repucci & Slipowitz, 2020). The Economist Intelligence Unit found that just 8.4% of the world's population lived in a democracy in 2020 ("Global Democracy Has a Very Bad Year," 2021). The Variety of Democracies' Democracy Report 2021 registered another declining year for liberal democracy on top of a decade of declines (Alizada et al., 2021: 13). The rise of illiberal nationalism accompanying the fifteen-year democratic backsliding threatens the collective effort required to build resilient communities (United Nations, 2020: 24). In the next section, I explain how illiberal movements aggravate feelings of insecurity and contribute to a destabilizing process of pernicious polarization.

3. The Problem of Pernicious Polarization

In a speech delivered in 2014, Hungary's Prime Minister, Victor Orbán, described a "national approach" as an alternative to a liberal approach for organizing the central elements of the state (Pech & Scheppele, 2017: 2). Orbán's national approach guarantees elections and tolerates protests, but it is illiberal in its contempt for independent institutions and its identification of the state with Orbán's Fidesz party (Nations in Transit 2018: 2). Through a series of orchestrated steps, Fidesz now controls the media and the Electoral Commission, as well as other offices designed to place checks on executive power, such as the Prosecutor-General's Office and the Fiscal Council (Krekó & Enyedi, 2018: 42). It has accrued a long list of EU violations, including legislation stigmatizing NGOs receiving foreign money, and targeted the Central European University (Pech & Scheppele, 2017: 18). In 2019, Hungary lost its status as a free democracy and now qualifies as a transitional or hybrid regime.[3]

Hungary is not unique. Slim majorities are electing political officials who openly oppose the constitutional protections of liberal democracy. At a minimum, these protections ensure basic human rights, create open and fair elections, guarantee a political voice for minority groups, place checks on the concentration of power, and establish independent and impartial judiciaries. In countries where illiberal nationalists have firmly seized power, such as Hungary, and India, these protections are being eroded and replaced by measures hostile to the very freedoms that enabled citizens to elect their governments in the first place.

Today's backsliding cases comprise several features related to the question of resilience. One feature concerns the social challenges that reliably correlate with partisan shifts in the electorate (Jost, 2017). A second involves the politicians who leverage these shifts for political gain by mobilizing supporters around divisive platforms (McCoy et al., 2022). And a third consists of worsening perceptions of politics as an 'us-versus-them' struggle between

[3] https://freedomhouse.org/country/hungary/nations-transit/2020 (accessed June 29, 2023).

opposing binaries of right and left, globalist and national, religious and secular, urban and rural, traditional and progressive, and participatory versus representative democratic models (McCoy et al., 2018: 20).

The second and third features are associated with pernicious polarization (McCoy et al., 2022). Like affective polarization, pernicious polarization occurs when people construct new identities based on their affinity with or hostility toward a political party (Wagner, 2021). Unlike affective polarization, pernicious polarization captures the broader circumstances supporting newly formed identity-based conflicts. Together, the features approximate the paradox of democratic legitimacy noted above. One version of the paradox dates back to Carl Schmitt's assessment of parliamentary democracy nearly a century ago (Schmitt, 1988). Schmitt argued that a society's stability depends on whether its principle of legitimacy is believed to be justified. Democratic regimes operate with two principles of legitimacy: a democratic principle associated with popular will and a liberal principle associated with parliamentary procedures for establishing the rule of law. When some segment of society bases its claim to legitimacy on the rule of law and another segment bases its opposing claim to legitimacy on popular will, instability results. Absent a more fundamental principle for adjudicating the conflict, competing parties may use non-democratic means to settle the dispute.

India's ruling Bharatiya Janata Party (BJP) illustrates how a political party can use pernicious polarization to its advantage by pitting popular will against the rule of law. The BJP uses electoral majorities and referendums to consolidate power by changing foreign political donation laws, creating simultaneous elections that disadvantage regional parties, sidelining the opposition, interfering with judicial independence, and charging academics, journalists, and activists with sedition (Khaitan, 2020). The incrementalism of BJP's assault against the rule of law is characteristic of backsliding cases. No one step seriously threatens the integrity of liberal democracy, and some steps may even enjoy the legitimacy of parliamentary approval or favorable judicial review (Levitsky & Ziblatt, 2018: 77). However, their cumulative effect degrades liberal institutions.

An important feature of today's democratic breakdown is the cross-cutting normative problems that flow across borders and trigger political partisanship. Over the past century, banking, currency, and debt crises reliably correlate with a decreasing share of moderates within a country and an increasing share of left or right-wing extremes (Mian et al., 2014). Following the Great Recession, "right-wing populist parties more than doubled their vote share in many advanced economies, including France, the UK, Sweden, Finland, the Netherlands, Portugal, and Japan (Funke et al., 2016: 233). Similarly, indiscriminate acts of violence against civilian populations have tended to align public opinion with political views emphasizing cultural tradition and unequal treatment (Jost, 2017: 169, 185). Such shifts could be why negative attitudes toward out-group populations increase after acts of terror (Canetti-Nisim et al., 2009).

Illiberal movements amplify these partisan effects through emotional rhetoric and divisive platforms. Poland's Law and Justice party (PiS) had consolidated support in 2015 by stoking small-town resentment against urban centers that were said to have unfairly gained from Poland's transition to democracy (Przybylski, 2018: 56). Legal and illegal human migration was the topic most associated with Trump's 2016 presidential win (Benkler et al., 2018: 17). And Hungary's Fidesz party focused its 2018 reelection campaign on the need to stop Brussels from allowing Muslim migrants to flood Europe and threaten the identity of White, Christian Hungary (Krekó & Enyedi, 2018: 48). When successful, these techniques fashion in-group identities from narratives of injustice superimposed onto otherwise manageable challenges. The us-versus-them political environment that ensues has "pernicious consequences for democracy: parties become unwilling to compromise, voters lose confidence in public institution, and normative support for democracy may decline" (McCoy et al., 2022).

A plausible account of what must transpire for a society to resist, absorb, anticipate, or recover from pernicious polarization includes (a) resources for disrupting the process by which partisan shifts degenerate into pernicious, identity-based conflicts, (b) the capacity for diagnosing cross-cutting triggers of partisanship that flow across global, regional, subnational, and local contexts; and (c) the ability to assess a government's performance legitimacy

concerning a set of questions broader than the set generally included in domestic justice. In the next section, I argue that an overlapping consensus is vulnerable to pernicious polarization because items a-c are absent.

4. Overlapping Consensus: A Vulnerable Stability?

As noted in section I, an overlapping consensus shows why conflicts between citizens' different moral doctrines do not necessarily threaten political unity. It is one aspect of a broader theoretical attempt to reconcile citizens to the fact that moral conflicts, indelible though they may be, do not necessarily undermine the basis of consent on which a well-ordered democratic regime rests (Rawls, 1993: lx). Interestingly, Rawls is not similarly worried about identity-based conflicts deriving from race, ethnicity, and gender because, he thinks, these conflicts "can be largely removed by a reasonably just constitutional regime" (Rawls, 1993: lx). Presumably, a theory of justice characterizes the just relations between citizens. Identity-based conflicts are not an indelible feature of those relations. Instead, they violate standards of justice.

Feminist philosophers and philosophers of race have long criticized the exclusion of gender and race from the construction of an ideal theory of justice (Kittay, 1997; Mills, 2005). Far from settling conflicts deriving from these identity-based affiliations, ideal theories, like Rawlsian constructivism, risk rendering them invisible by excluding the asymmetries that oxygenate them. For example, asymmetric relations associated with caregivers and care recipients are as indelible as moral diversity (Kittay, 1997). A just society can no more eliminate them than it can erase moral differences. If one's theory excludes these asymmetries from the outset, its ensuing account of stability will lack the conceptual resources that might otherwise anticipate and disrupt the power relations that drive gender injustice.

Feminist philosophers have exposed deficiencies associated with the abstractions informing Rawlsian constructivism. A similar argument extends to pernicious polarization. Social uncertainties associated with financial crises, migration shifts, and organized violence are reliably linked to partisan shifts in the electorate.

If no well-ordered society can guarantee favorable conditions for its stability over time, then each well-ordered society must prepare for these partisan triggers. A society's resilience depends partly on assessing how well it mitigates conflicts deriving from these shifts. Excluding identity-based shifts from the construction of justice renders newly constructed binaries – religious/secular, globalist/nationalist, urban/rural – as potential conflicts to be policed rather than processes to be anticipated. This creates a problem for the subsequent account of stability. To see why, suppose the congruence between the public political conception and citizens' private moral conception is a necessary and sufficient condition of stability. In that case, the account of stability lacks the conceptual resources needed to anticipate and disrupt the identity shifts that drive pernicious polarization. Social unity would only be as stable as the political environment in which it subsists. Disruptions to the environment would threaten unity.

The theoretical response to the paradox of democratic legitimacy compounds the above deficiency. Popular will and the rule of law serve as two sources of legitimacy within a democratic society that can come into conflict. Rawls expresses it this way: "in light of what principles and ideal must we, as free and equal citizens, be able to view ourselves as exercising that [political] power if our exercise of it is to be justifiable to other citizens and to respect their being reasonable and rational?" (Rawls, 1993: 137). His answer is the liberal principle of legitimacy: "our exercise of political power is fully proper only when it is exercised in accordance with a constitution the essentials of which all citizens as free and equal may reasonably be expected to endorse in the light of principles and ideals acceptable to their common human reason" (Rawls, 1993: 137). This response creates two further vulnerabilities for an overlapping consensus. One results from narrowing the application of a conception of justice to constitutional essentials and matters of basic justice emerging with a society's domestic basic structure (Rawls, 1993: l). A second concerns the relationship between public consent and political performance.

A narrow scope should help solve the problem of legitimacy by limiting consensus to key political arrangements and avoiding non-political affiliations and values in associational, familial, and

personal domains of life. Although this strategy plausibly addresses the paradox in the domestic case, it creates a silo effect that weakens resilience in the real world. Today's destabilizing events "are occurring across global, regional, subnational and local scales, with cascading effects among interconnected social, governance, economic, ecological and physical elements" (United Nations, 2020: 12). These events create challenges that outstrip the decision-making capacities of any country's domestic institutions. A conception of justice designed for domestic institutions alone risks treating human-induced hazards as problems residing outside its scope of application by rendering them as international problems related to international justice. In fact, they cascade across different levels of governance. If a theory of justice were to misdiagnosis the causes of domestic conflict by placing those drivers outside its scope of application, then its ensuing account of stability would lack the conceptual resources required for absorbing, withstanding, anticipating, or recovering from those threats.

A related, less serious vulnerability concerns the relationship between public consent and political performance. As discussed in section II, these features are related. The inability to solve pressing social challenges undermines a government's legitimacy with the people (Linz, 1978: 66). By placing willing consent at the center of an overlapping consensus, the model of stability lacks a criterion independent of consent for assessing a regime's administration of the state's critical infrastructure. A state's critical infrastructure includes those assets, systems, and networks so vital to a country "that their incapacity or destruction would have a debilitating effect on security, national economic security, national public health and safety, or any combination thereof."[4] Effective administration of this infrastructure enhances a state's performance legitimacy. The importance of performance legitimacy can be gleaned from those who argue that citizens would not be supporting illiberal movements if Western states had done a better job of realizing liberal standards of justice. This is not implausible, but it condemns the shortcomings of actual liberal societies as it celebrates

[4] The definition comes from CISA: https://www.cisa.gov/topics/critical-infrastructure-security-and-resilience/critical-infrastructure-sectors (accessed June 30, 2023).

the accomplishments of liberal theorists (Scheffler, 2019: 10–11). One could just as well assess liberal theories against the repeated failures to realize their principles in practice. If the repeated failure is a consequence of excluding identity-based processes or misdiagnosing pressing social challenges, as argued above, then this alternative criticism rests on solid ground. Today's social challenges emerge from natural and human-induced hazards playing out across levels of governance. Addressing these challenges will require new cross-border institutions distinct from those that have traditionally served as the focus of liberal justice. The legitimacy of these new institutions will require a distinct set of principles for assessing their performance. Liberal theories associated with an overlapping consensus acknowledge the performance legitimacy of economic relations within a society's basic structure, but do not encompass a society's broader critical infrastructure. Nor do they, to my knowledge, extend beyond the basic structure to include the cross-border institutions required to address domestic-expansive risks.[5] Failure to make the extension renders the conception of stability vulnerable to emerging challenges.

5. Conclusion

Rawls reminds us that political pessimism precipitated the fall of the Weimar Republic; people "no longer believed a decent liberal parliamentary regime was possible," and Nazism followed (Rawls, 1993: lxi–lxii). Fascism has crept back into politics and now seriously threatens democratic stability. This is profoundly troublesome but also an opportunity to fortify liberal accounts of social stability with a conception of resilience by taking seriously the domestic-expansive problems that polarize societies. Although these problems are not among the ones for which liberalism was devised, liberal theorists have long used their experiences and observations to develop the tradition. J. S. Mill saw the tyrannical potential of the people, whereas previous generations of liberals saw only the tyrannical power of government (Mill, 2002). John Dewey

[5] A possible exception is James's *Fairness in Practice: A Social Contract for a Global Economy* (James, 2012).

reimagined liberalism's enduring values for an industrial age that, up until then, lacked the conceptual resources for protecting liberty from the marketplace (Dewey, 1935: 5–6). Rawls resuscitated Kant's account of liberal legitimacy to explain how citizens might come to share the same conception of justice for moral reasons despite their incommensurable yet reasonable conceptions of a good life. The COVID-19 pandemic has demonstrated how deeply engrained human-induced risks have become in the functionality of societies. Liberals must now reimagine the tradition for a set of new, cross-cutting challenges that cascade across global, regional, and local systems of governance. Developing the tradition to meet today's challenges will require discussions on a concept of resiliency, and those discussions will certainly reverberate back into the way we think about justice and stability.

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Human Rights and Ethics in the Management of the COVID-19 Pandemic: the Experiences of Brazil and Israel

Abstract

This paper examines Brazil and Israel's responses to the COVID-19 pandemic, focusing on human rights and ethical issues. Through documental analysis, utilizing primary sources such as official reports and regulations, as well as secondary sources, especially academic literature, the research explores how these nations addressed the pandemic with respect to human rights and ethical conduct.

In Brazil, a convergence of health emergencies and governance crises contributed to a heightened death toll, emphasizing the need to learn from past mistakes, enhance healthcare systems, and eliminate discriminatory policies against vulnerable groups. The shift in rhetoric under President Lula's new government since January 2023 reflects a more human rights-friendly approach, prioritizing dialogue and incorporating lessons from the pandemic.

In contrast, Israel faces a trajectory marked by a right-wing government's proposed judicial reform, challenging democratic principles and sparking a constitutional crisis. Public protests, especially from healthcare professionals, criticize the reform for potentially undermining human rights, notably the right to health, through unchecked decisions that neglect health implications, disproportionately affecting vulnerable groups.

Beyond these cases, the paper underscores the global impact of COVID-19, emphasizing the interconnectedness of humanity. While countries experienced the disease differently, the collective response necessitates global cooperation for effective pandemic management. The study concludes that despite diverse individual experiences, global collaboration is vital for addressing future pandemics, offering valuable insights into the intricate relationship between pandemic management, human rights, and ethical considerations, with implications for future public health crises.

Keywords: Human rights, Ethics, COVID-19, Brazil, Israel

1. Introduction

The COVID-19 pandemic, also known as the novel coronavirus pandemic, originated in Wuhan, China, in December 2019. Symptoms were often linked to severe acute respiratory problems, but they varied among individuals, with some patients experiencing mild or severe flu-like symptoms, headaches, chest pain, respiratory difficulties of varying degrees, and other manifestations. The death rate varied by location and time period during the pandemic, while death outcomes were more frequent in certain populations, especially those most vulnerable in a society.

The virus quickly spread, causing havoc across the world, and the World Health Organization (WHO) declared it a pandemic on March 11, 2020 (World Health Organization, 2023). According to the information reported to the WHO, the global death toll directly linked to COVID-19 as of June 2023 is estimated at around 7 million people (WHO Coronavirus (COVID-19) Dashboard, n.d.).

The aim of this paper is to present the key human rights and ethical issues during the pandemic across two countries in different areas of the world, namely Brazil and Israel. Both countries were severely affected by the pandemic, but governmental responses and their impact on the population were very different, as it will be presented below. Due to reasons of space, the chapter focuses on particular groups of individuals, or rights that were affected in each country.

It is clear that we cannot provide an in-depth account of the impact of COVID-19 across the world, but we consider that by covering these two selected countries we can provide an account of the variety of impact that COVID-19 had in the world, and manners in which differently key issues were experienced by different societies.

The research question is: How has the management of the COVID-19 pandemic taken into account human rights and ethical conduct?

The methodology used in the paper consists mostly of documental analysis of the material covered. We provide a background on the management of the pandemic in each country while identifying some of the most relevant issues relating to human

rights that each country faced. In terms of the material used, we engaged with primary sources (especially official reports, laws and regulations issued by the states), and secondary sources (particularly academic literature, but also gray literature and media, whenever relevant). A limitation of the research is its depth, due to the short length of this contribution (in terms of word count) and retrospective point of view but the latter can also help us to give a better insight into events that happened too quickly to be analyzed as they were actually happening. We also reflect on our positionality (namely the two countries covered are the authors' countries of origin), which gives us an insider-outsider perspective that may benefit our research, though we are aware that this may also hinder our ability to engage with the subject in a more neutral way, a feature that we tried to pay attention to throughout the research.

In terms of the theories and concepts used in the paper, we have used a normative approach based on human rights provisions contained in international treaties that have particular relevance to each case study. We also refer to public health ethics when addressing the case studies, in an attempt to identify the most relevant values being violated in regard to affected individuals. When selecting the situations and groups depicted in the paper we strived to take into account medical and health policy issues but also socio-economic aspects affecting those in a position of vulnerability during the pandemic.

The paper is organized as follows: after this introduction, the main section provides an account of how the two countries handled the COVID-19 pandemic, mostly in regards to human rights and ethical issues. This is followed by conclusions and references.

2. Brazil's Handling of the Pandemic, Including Human Rights and Ethical Aspects

Despite Brazil having the middle income country status, it does have a public health system with universal access, meaning that everyone is covered by it. However, the level of healthcare in the public healthcare system (named 'public unified health system', in Portuguese, 'Sistema Único de Saúde – SUS') is as a general rule

rather low, and most people that can afford it, subscribe to private health insurance in order to have access to private health services. During COVID-19, the good news was that everyone in principle had access to public healthcare services, though due to the system's mostly poor state, it soon practically collapsed when confronted with the magnitude of the task of handling the pandemic, combined with the chaotic response to the pandemic orchestrated by the federal government, under the leadership of the former president Jair Bolsonaro (Di Giulio et al., 2023).

The situation in Brazil during COVID-19 has been described as 'catastrophic' (Ortega & Orsini, 2020), especially in the first months of handling the crisis. A sad example regards the city of Manaus, which experienced two peak crises connected to the COVID-19 pandemic – the first took place in early January 2021, regarding the failure of the funerary services to deal with the number of COVID-19 deaths, which led to the collective burial of many deceased in mass graves (Reeves, 2021). The second crisis took place in late January 2021, when hospitals were faced with acute shortage of oxygen supplies and many intensive care patients who were hospitalized due to COVID-19 died. At that point intensive care units in the city of Manaus were overwhelmed with COVID-19 patients and were referred to as "asphyxiation chambers" (Bergamo, Mônica, n.d.).

The severe losses the country experienced during the pandemic can be linked partially to the federal government's initial denial of the seriousness of the virus and of its effects on humans (Smith, 2020). The then president Bolsonaro openly dismissed the virus, calling it a 'little flu', and denied the severity of the disease, contributing to the spread of disinformation. The bottom line was that he argued that the economic impact of the pandemic was more dangerous than the virus itself, and he therefore vehemently opposed lockdowns and any other restrictions on economic activity (Reverdosa et al., 2021). Furthermore, the president advocated for the intake of medically unproven substances to prevent and combat the virus, namely chloroquine and hydroxychloroquine (CNN et al., 2021). He also appealed to religious beliefs, saying that he had been diagnosed with COVID; but that his body was protected by god, and that therefore he had just mild symptoms.

Furthermore, under Bolsonaro, and especially at the beginning of the pandemic, there was a series of changes in key positions in the country's Ministry of Health, which negatively affected the handling of the crisis. Although at the beginning of his term the Ministry of Health had been led by a medical doctor, after the minister dismissed the 'treatment' advocated by the president on medical grounds, Bolsonaro viewed this as defying his authority and the Minister was fired. During a short time no less than three health ministers were nominated to handle the pandemic in the country. Later on, a military person with no medical knowledge was appointed to occupy the post (Paes & Kavanami, 2020); (Di Giulio et al., 2023). Meanwhile, the number of deaths was steadily mounting.

According to the WHO, between January 2020 and March 2023, Brazil had over 35 million cases of COVID-19 reported, and about 700,000 deaths (WHO, n.d.). The worst of the pandemic in the country took place between late 2020 and early 2021.

Although Brazil has a universal healthcare system, to which in principle everyone has access, the service is quite underfunded, meaning that the facilities and quality of the public healthcare system is often low, and the people who can afford that, pay for private healthcare services in order to receive better healthcare treatment. With the COVID-19 pandemic, both public and private hospitals were soon full, and there was a lack of beds and oxygen for patients. There were also issues of the lack of protective equipment for healthcare personnel, beside excessive levels of stress and burnout among healthcare workers. As mentioned earlier, the capital of the state of Amazon, Manaus, faced an extreme situation, with lots of COVID-19-related deaths due to, among other reasons, a combination of the lack of medical oxygen reaching public hospitals, the new Delta variant, and poor isolation policies (Di Giulio et al., 2023). Pictures of hundreds of graves in Manaus (including collective graves) linked to COVID-19 deaths in the beginning of 2021 were broadcasted all over the world.

Beside the health crisis, a political crisis severely affected the country, with other actors trying to counteract the lack of effective measures by the federal government. In other municipalities, those that followed Bolsonaro's position (namely, the denial

of the virus and disregard for protective measures) had proportionally higher numbers of coronavirus cases; this has been referred to as the 'Bolsonaro effect' (Di Giulio et al., 2023). Some sub-national authorities tried to act according to medical advice and scientific expertise and thus adopted more strict measures (such as social distancing, and the wearing of face masks) and sought to purchase and set up COVID-19 vaccination initiatives, as has been the case of the government of the state of São Paulo. Although the federal government of Bolsonaro was initially strongly against such measures, it later started changing its strategy, beginning with vaccination campaigns and acting more in line with medical advice practiced in other countries (thus favoring the use of face masks, hand washing measures, etc.). But overall, the handling of COVID-19 by Brazilian authorities, especially the federal government in the early stages of the pandemic, was very problematic.

Moreover, criticism was being raised due to the fact that public policies had a particular negative impact on certain societal groups, especially poor urban communities, many of them composed of Brazilians of African descent, and indigenous peoples located in remote (often forest) areas. Critics have blamed the Bolsonaro administration and President himself for promoting genocidal policies targeting indigenous peoples, or at least facilitating the commission of crimes against humanity in relation to them, and the matter was sent to the International Criminal Court for consideration (Paes & Kavanami, 2020; Di Giulio et al., 2023). Although this chapter does not envisage going deeper into this discussion, these series of events do suggest severe disregard by the federal government for both human rights and ethical principles in its management of the pandemic. Foucault's ideas about biopower provide a theoretical way to reflect on these developments, namely where the state exercises authority over human bodies, by enacting or abstaining from adopting laws and policies (Zaidi et al., 2021). In this case, this may ultimately amount to deciding on who is to be healthy and who not, by offering (or not) health service to groups of the population. Furthermore, another theory that has been referred to in relation to the Brazilian handling of the pandemic is Mbembe's necropolitics (Mbembe, 2003). Although it originally mostly drew upon the colonial experience of African peoples,

it ultimately does refer to the power over the life and death of the colonized body and people (Bastos Lima et al., in press).

In the Brazilian case, this could similarly inform how the country dealt with particular sections of its population that suffered the most with the COVID-19 pandemic (Lopes & Bastos Lima, 2020). Beyond the urban poor, and mostly Black communities, the indigenous communities were hit particularly hard. As put by the UN Committee on the Elimination of Racial Discrimination: "Indigenous peoples in voluntary isolation or initial contact require specific measures of protection, as they are extremely vulnerable to new or external diseases" (UN Committee on the Elimination of Racial Discrimination, 2017; UN Committee on the Elimination of Racial Discrimination, 2018). In the Brazil case, care towards the indigenous population was blatantly lacking, with authorities been accused of having overtly neglected this community (Newey, 2020).

The management of the pandemic by the federal government in Brazil raises questions pertaining to international human rights legal standards, especially the two international covenants, on civil and political rights (ICCPR)(UN General Assembly, 1966a), and on economic, social and cultural rights (ICESCR)(UN General Assembly, 1966b). Brazil is a state party to the two treaties, and therefore it is internationally legally bound to act in accordance with them.

Examples of the rights affected in the country during the pandemic include the right to life (article 6 ICCPR), especially due to the failure to effectively take action to avoid deaths linked to COVID-19, including timely starting of vaccination campaigns. Also the right to health (article 12 ICESCR) was violated, for example due to misinformation and obstruction by the federal government of the efforts towards protection of this right by other actors, especially regional authorities. Similarly, the prohibition of discrimination (article 2, paragraph 1 ICCPR and article 2, paragraph 2 ICESCR) was also disregarded, especially through policies (or the lack thereof) that badly affected those who had found themselves in a position of vulnerability prior to the pandemic, due to, among other factors, long-lasting socio-economic disparities that have affected the country. Both the urban poor Black community and indigenous peoples experienced higher mortality rates than the rest of the

population. Another right that was considerably disregarded during the pandemic was the right of citizens to take part in the conduct of public affairs (article 25 ICCPR), namely through participation in deciding on the public health measures adopted during the pandemic. At least some form of popular consultation and risk assessment needed to be conducted, in particular since the proposed measures were expected to disproportionately impact parts of the population. Under Bolsonaro, several important issues were debated and decided on by a selected 'parallel cabinet' that was neither publicly elected, nor qualified in medical issues, but that nevertheless decided or had a say during the management of the pandemic (Di Giulio et al., 2023).

Regarding ethical conduct, one especially worrying issue is the misinformation and the promotion of early (alleged) treatments for COVID-19, which were largely considered ineffective by the medical and scientific community, and international organizations such as the World Health Organization. This raises questions in relation to good faith by the federal government and the violation of principles of beneficence and nonmaleficence regarding patients who received unapproved and even ineffective interventions without the approval of an official scientific review board statement on their safety and efficacy. In addition, autonomy of patients was not respected as informed consent was not obtained from them prior to provision of such care. That said, it is important to note that in Israel, as well as in other places, the same management of provision of unapproved and unregistered interventions was common in the early stages of the disease (Zuckerman et al., 2022).

Another issue that has raised concern was the lack of transparency in relation to the reporting of COVID-19 deaths by the federal government. It prioritized publishing data on recovered cases rather than reported cases and deaths in an attempt to protect the economy. This raised concerns in relation to transparency, accountability and ultimately public trust in federal authorities. Regarding this particular example, thanks to the initiative of six Brazilian communication companies, a media consortium was created to fill this important information gap and provide the latest information on the number of cases, obtained directly from states rather than through the federal government (Di Giulio et al., 2023).

3. Israel's Handling of the Pandemic, Including Human Rights and Ethical Aspects

In Israel, like in Brazil, there has been a universal health care system since its very establishment 75 years ago, based on the vision of Israel as a welfare state. Unlike Brazil, the level of care is very high, in particular since the enacting of the (National Health Insurance Law, 1994) which is based on the principles of justice, equality and mutual aid. Since then, the state has been providing a "basket" of medical services through four Health Maintenance Organisations (HMOs) for all residents (WHO MiNDbank – 1994 – ממלכתי התשנ"ד חוק ביטוח בריאות (National Health Insurance Law), n.d.). The SARS-CoV-2 outbreak occurred in Israel in mid-March 2020. Unlike Brazil, the leadership considered the possible risks of the disease seriously from the outset. Prime Minister Netanyahu announced that the government would take all possible measures to stop the spread of the virus and handle its effects. The Ministry of Health defined hospital wards in which patients were to be admitted and treated regardless of the severity of the disease. As discussed elsewhere, there were no national recommendations at the time for the standard of care in COVID-19 patients, either in mild or severe condition. Consequently, physicians treated patients individually, according to their own perception and experience, with no guidelines or protocols. This situation contributed to off-label treatment with no evidence base to support it, or follow-up on outcomes (Zuckerman et al. 2021), thus compromising the right to health and ethical principles of beneficence and nonmaleficence. In addition, several issues and societal groups were particularly affected during the early stages of the pandemic and deserve further scrutiny. However, due to the short scope of this paper the focus will be limited to two particular issues, namely the robust digital surveillance in the name of management of the pandemic, and the effects of the management of the pandemic on Jewish Orthodox communities.

3.1. *Robust Digital Surveillance during the Pandemic*

At the onset of the COVID-19 epidemic in Israel, two emergency regulations were approved by the government in March

2020 to enforce isolation of infected individuals and for tracking them. Soon afterwards, the mandate of the Israel Security Agency (ISA), which routinely identifies and prevents counter-terrorism using digital surveillance, was modified to allow tracking of people who were in contact with COVID-19 patients. The justification for applying this surveillance method by the Ministry of Health was that effectively, only 33% of confirmed cases were tracked using epidemiological investigation, while digital surveillance, as the Ministry of Health anticipated, could add 60% more isolations of infected people (Knesset Foreign Affairs and Defense Committee, 2020).

This development was highly criticized by the public and research community as Israel was, at the time, according to the Israeli Center for Democracy, the only developed country that used its secret services for health-related purposes (Altshuler & Hershkovitz, 2020). Following a petition submitted by human rights organizations, journalists and others, the High Court of Justice, after hearing the petitioners, as well as the response by the government officials, approved the extension of the digital tracking of individuals by the national security legal authority for the benefit of the Ministry of Health on the condition that a primary law (as opposed to executive order that was the legal basis for the contact tracing at the time) would be passed and enacted for a limited period of time (three weeks), which was done (The Subcommittee on Intelligence and Secret Services, 2020). Later on, following the ongoing criticism for the practice of tracking citizens using secret service robust measures, the surveillance was modified to be performed by a voluntary application of the Ministry of Health named "Magen" that people could upload to their phones, as opposed to the mandatory ISA surveillance method (Amit et al., 2020).

The justification for the digital surveillance of the ISA was and still is controversial. On the one hand, public health officials and some researchers argued that with mobile phone tracking, privacy and civil liberties were protected as long as this measure was time limited, conducted by civilian operators rather than crime-monitoring authorities such as the ISA, transparent regarding data collection and use, with limited access, requiring voluntary participation, and under the supervision of an independent committee (Amit et al., 2020). Notably, human rights organizations

in Israel (Altshuler & Hershkovitz, 2020), as well as media reports (Silverstein, Richard, 2020) have criticized the model. The digital phone tracking for contact tracing, it was argued, and even more so the digital data collection and analysis of infected people without being transparent about the scope and aim of it, constituted severe violations of the right to privacy under the Protection of Privacy Law, 5741–1981. As one human rights advocate argued at the parliamentary committee "we are patients, not criminals" (Silverstein, Richard, 2020).

In order to find the middle way between those contradicting views regarding the digital surveillance by the ISA, we point out the theoretical framework used by Sekalala et al. which applied the principles of legality, necessity, and proportionality. If those aspects are justified, it suggests that the restriction of human rights law is legitimate (Sekalala et al., 2020). Following this framework, which also reflects international standards on the topic (United Nations, 1984), we believe that the measures used by the Israeli government through Magen application were justified. They allowed voluntarily conducting of digital surveillance for the purpose of contact tracing, thus demonstrating an adequate balance between keeping public health and protecting the right to privacy of individuals. Admittedly, this balance was only achieved after criticism of the original measure by the stakeholders, followed by public discourse and legal proceedings. Hopefully a lesson for future pandemics is to design measures that do take into account from the outset the need to balance different rights that may be at stake in a situation such as pandemics.

However, as suggested by Couch et al. the response to the pandemic across the world did facilitate a shift towards more intrusive surveillance measures, and the risk of their 'normalization', which needs to be constantly criticized and assessed. In their words, in "all states of exception, a risk, or indeed a likelihood, exists that the newly established structures will persist – not the laws and regulations but the social and cultural ways of living, the behaviors, and the embedded emotional and psychic responses." (Couch et al., 2020: 5) The need for scrutiny of measures limiting rights and their potential long-lasting effects in society is equally important in the case of Israel.

3.2. *Impact on Particular Societal Groups: the Jewish Orthodox Community*

The second violation of human rights and ethical conduct in the early stages of the pandemic in Israel was the management of the disease in the ultra-orthodox (Haredi) Jewish community. This group is characterized by a lower socioeconomic status, which entails crowded living conditions in isolated cities or neighborhoods, mainly Bene Beraq in the suburbs of Tel Aviv which consists mainly of Haredi Jews, and the city of Elad which accommodates both Haredi and national religious communities. The Haredi community generally opposes many characteristics of the non-orthodox society and public life in Israel and both communities run a traditional community-based lifestyle, including group studies of the Bible (Torah), public prayers consisting of at least 10 men (Minyan) in close physical contact a few times a day, and ritual public baths. Unsurprisingly, the emergency orders regarding isolation during COVID-19 clashed with fundamental aspects of their Jewish identity and personal manifestation of religion. Additionally, it highly affected their family life, where women traditionally stay in crowded homes, having significantly more children than the OECD countries' average.

The Haredi community is also not exposed to the internet as much as the secular community, they do not own smartphones and their source of information is often their religious community leader, namely the Rabbi, and their colleagues in Bible (Torah) studying. Medical and lifestyle decision-making is highly influenced by the community Rabbi. Despite the biblical rule of "Pikuach Nefesh," meaning that for the sake of saving lives Bible studying ought to be postponed, Haredi community leaders refused to endorse the governmental instructions of closing schools and strict lockdown (up to 100 meters from home) while the COVID-19 morbidity and mortality rates peaked in the country. Consequently, their followers kept their usual routines and the numbers of positive cases and hospitalized patients and fatalities highly increased. However, it was not until the infection had massively spread in those communities and a special commissioner was appointed to handle the situation, that the opposition against social distancing turned into acceptance by the leaders and followers. At that point, a strict quarantine

was imposed on the cities of Bnei Brak and Elad and the curve of COVID-19 spread eventually flattened (Saban et al., 2022).

A previous study suggests that the high infection rate resulted from various elements, such as structural, religious and socio-ideological factors, which are all ultimately connected to religion (Zalcberg & Block, 2021). This example demonstrates how the right of religion, in this case the manifestation of the right to freedom of religion, which is a human right protected in article 18 of the International Covenant on Civil and Political Rights was limited by state authorities, despite the resentment of community leaders and the refusal of their followers to act upon the social distancing guidelines. Only after the leaders had experienced the severity of the disease in their own communities as opposed to others and a strict quarantine was widely imposed, did they consent to the limitation of their right to practice religion in community with others. Here, as opposed to the digital surveillance case, the community did not from the outset cooperate with the limitation of their right to religion, as well as of their social and cultural ways of living.

4. Conclusion

This paper dealt with how the two countries experienced the COVID-19 pandemic very differently, and how human rights and ethical issues arose in both contexts.

The case study of Brazil demonstrates how coupled crises such as health emergencies and governance issues contributed to the higher number of deaths during COVID-19. Preparedness for the next pandemic includes learning from what went wrong in the past, especially on how to avoid preventable deaths through a better healthcare system and policies that do not discriminate against the sectors already in a position of vulnerability in society. Since January 2023, Brazil has had a different federal government (under the presidency of Lula), which is very critical of how the COVID-19 pandemic was handled, and is much more friendly regarding human rights issues and vulnerable populations, promoting dialogue among societal groups. It seems the rhetoric has changed favorably and the country is trying to learn from the bitter lesson of COVID-19.

In Israel, it seems like the things are going in the opposite direction. As of January 2023, the new right wing government declared its plan for a judicial reform, aiming to change basic democratic principles that have been in place throughout the 75 years of the existence of the democratic Jewish state. As a starter to this reform, Israel's Parliament approved an amendment to the "Basic Law: The Judiciary", disallowing court scrutiny of the reasonableness of ministerial decisions. The Supreme Court discussed the legality of this amendment in September and its decision is yet to be given. Consequently, the country is now approaching a serious constitutional crisis. The crisis has raised ongoing public protests against the policy of the government. The protestors come from all sectors of the population, and notably healthcare professionals (Devi, 2023). Protestors and scholars argue that the judicial reform (or "revolution" in their view) threatens to limit a number of human rights, including the right to health. Broadly speaking, the amendment may lead to unchecked decisions without consideration of the health implications, while removing court scrutiny might cause health rights to be eclipsed by other policy considerations, particularly affecting vulnerable groups. More specifically, scholars argue that by restricting judicial oversight and public recourse against harmful healthcare decision making, a risk occurs of appointing unfit individuals to key roles during an epidemic. The amendment may also affect access to public health services for citizens, for example by restricting distribution of food vouchers to certain populations, following governmental (political) decisions while missing other food insecure populations (Kamin-Friedman et al., 2023).

Beyond the two cases, this chapter illustrates the way that COVID-19 affected countries across the world, and indicates that without a concerted effort it would be difficult to effectively deal with later pandemics. Although countries across the world had very different experiences with the disease, the virus and the disease have affected humanity as a whole. This indicates that we are in this together as humans, and have to act in a concerted fashion, despite our many differences.

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Between Securitization and Desecuritization: The Shifting Discourse on the COVID-19 Pandemic in Serbia*

Abstract

The COVID-19 pandemic has urged the political decision-makers to assess numerous factors when choosing between the options they perceive an optimal response to this global crisis. Using the theory of securitization, which claims that an issue is constituted as a security threat through the use of a specific speech act performed by the securitizing actors in order to gain support by the audience for the emergency measures, the article examines how Serbian government's decisions followed a pattern of revolving securitization and desecuritization of the COVID-19 pandemic in their response to the crisis. Serbian government's initial approach of downplaying the threat was immediately followed by the state of emergency which lasted until the June 2020 parliamentary elections' campaign. The shifts between the securitization and desecuritization processes lasted until the unsuccessful securitizing move in July demotivated the government from further attempts to securitize the issue out of fear of the audience's reaction. The authors argue that the constant change of the security discourse on the issue caused a loss of the authority possessed by the securitizers, induced a state of confusion among the citizens (audience), and was primarily shaped by the context of potential political implications it can bring, particularly in relation to the parliamentary elections of 2020.
Keywords: securitization, desecuritization, COVID-19, pandemic, Serbia

* The paper presents findings of a study developed as a part of the research project "Serbia and Challenges in International Relations in 2023", financed by the Ministry of Science, Technological Development and Innovation of the Republic of Serbia, and conducted by the Institute of International Politics and Economics, Belgrade and as a part of the 2023 Research Program of the Institute of Social Sciences, also realized with the support by the Ministry of Science, Technological Development and Innovation of the Republic of Serbia.

1. Introduction

The unprecedented upheaval that affected every aspect of life brought about by the COVID-19 pandemic required a response from states, the actors people most usually expect to manage, direct and control various issues, both predictable and unpredictable ones. As Jović points out, the COVID-19 pandemic created a sort of social laboratory, an opportunity to ascertain what the state was and how powerful or powerless it could be in facing a crisis it might have not been able to adequately respond to (Jović, 2020: 473).

Viewed from the angle of security studies, the need to introduce new emergency measures that disrupt the normal procedures, proposed by authority figures on the basis of the rise of a new existential threat, recommends securitization theory as an appropriate framework for analyzing the effects of the pandemic and different reactions it produced. Securitization theory claims that an issue is constituted as a security threat through the use of a specific speech act performed by the securitizing actors, usually elites, in order to gain support from the audience for the emergency measures. Accordingly, the COVID-19 pandemic satisfied the criteria of an existential threat through its sudden impact and the danger it presented for the survival of several referent objects deemed important by the audience. The governments determined that regular practices were not suitable enough as a response and attempted to present it as exceptional security case that required measures falling outside of the scope of standardized procedures, in this case those regarding the health risks for the population.

However, the reactions by different states varied on the basis of diverse historical, cultural, political, economic, climate and geographical factors. The role of securitization in these responses by specific states has been analyzed (Molnár, Takács, & Jakusné Harnos, 2020; Vankovska, 2020; Ramadhan, 2020). In the case of Serbia, securitization of the COVID-19 pandemic in 2020 was closely followed by the reverse process of desecuritization. This repeated several times, creating a revolving loop, which was mainly influenced by political developments in the country, the most important being the parliamentary elections held in June. Accordingly, the article focuses on the year 2020, in an attempt to trace effects and

causes of this loop of securitization and desecuritization, which was not present in the same way in the later period of the COVID-19 pandemic. The constant change of the security discourse on the issue throughout the year caused the loss of the authority possessed by the securitizers, induced a state of confusion among the citizens (audience), and was primarily shaped by the context of potential political implications it could bring, particularly in relation to the parliamentary elections of 2020. Thus, even though securitization of COVID-19 by the state was a logical reaction, one that was not exclusive to Serbia, this shifting discourse whose changes were not emanating from the evolving circumstances produced specific consequences that affected its success in the second part of the year.

The article is divided into two parts. The first part explains the central concepts of the securitization theory and its main critiques, which contributed to its further evolution or pointed out some of its major flaws. The second part deals with the securitization and desecuritization of the COVID-19 pandemic in Serbia in 2020. First the timeline of the events is offered, followed by an analysis of specific characteristics stemming from the constant switching between securitization and desecuritization attempts.

2. Securitization Theory

The securitization theory emerged as one of the defining contributions to the security studies by the Copenhagen School.[1] This group of scholars, gathered around authors such as Barry Buzan and Ole Waever, proposed and developed in their works the specific way to research how security was understood, how it could be defined and how it functioned. Besides introducing a new and influential framework for analyzing security and its many facets, it was also subjected to different types of critiques, some aiming to refine the theory and make it more applicable, and others

[1] The term Copenhagen School, as is often the case, was not a name that originated from the scholars for whom it could be said to have belonged to it. Instead, it was introduced by an author analyzing their work and attempting to point out their common ideas and approaches. In this case, the term was coined by Bill McSweeney in his book review article "Identity and Security: Buzan and the Copenhagen School" (1996).

that were more dismissive of its usefulness or, its normative foundations.

In its core form, the securitization theory is based on the speech act theory introduced by J. L. Austin (1962) and refined by John Searle (1979). It relies on the performative function of language and its ability to shape reality, create something new through its application, and not just describe the world as it is. Thus, the often-quoted description made by Waever, of security as a speech act lies at the center of the securitization theory in its original form: "security is not of interest as a sign that refers to something more real; the utterance itself is the act. By saying it, something is done (as in betting, giving a promise, naming a ship)" (Waever, 1993: 7). Accordingly, the securitization is the process by which an issue is constituted as a matter of security. More specifically, by framing some issue as a (existential) threat to a particular referent object, the securitizing actor attempts to gain support from the audience to enact special measures to address the said issue (Nedić & Mandić, 2023: 158). From this definition, several key elements of securitization can be identified: referent object, threat, securitizing actors, securitizing move, special measures, functional actors, and audience.

Referent object lies at the center of securitization; it is the entity that is worth protecting and keeping. In the traditional understanding of security, the referent object is the state and its survival against the military threats presented by other states. This fundamentally realist approach provides the foundation for the expansion of the concept of security from the military sector to other sectors, and introduces corresponding referent objects for each of them. Buzan, Waever and de Wilde identify four additional ones: the political sector, where the referent object is the constituting principle of sovereignty or ideology of the state; the economic sector, where the most common referent object is the global market itself, although the national economies or even particular specific firms could also be designated as such; the societal sector with large-scale collective identities, such as nations or religions, as its referent object; the environmental sector with its referent object ranging from individual species or types of habitat to the whole biosphere (Buzan, Waever & de Wilde, 1998: 22–23).

Whichever sector the referent object belongs to, securitization relies on the successful presentation of the existence of an existential threat endangering it. Again, stemming from the military sector, their main characteristic is swift emergence and ability to "undercut the political order within a state and thereby 'alter the premises for all other questions'" (Waever 1993: 5). Emergency measures required to curb these threats, which include "actions outside the normal bounds of political procedure", are proposed by securitizing actors. They are usually speaking from a position of formal authority that provides them with the means and opportunities to conduct the measures if they are approved by the audience. In other words: "successful securitization is not decided by the securitizer but by the audience of the security speech act" (Buzan et al., 1998: 31). Thus, the audience plays a crucial role, although it remains rather underdeveloped as a concept, an important criticism that will be further elaborated below. Another important element are functional actors, who, while not performing securitization by themselves, play an important role to enable or hinder it.

However, not every securitizing move, i.e., a speech act aimed at securitizing a certain issue, succeeds. As Waever (1993: 12) says: "the most interesting about a speech act is that it might fail". Every speech act consists of an explanation of what is necessary in order to address the threat, but also what will happen if the required measures are not taken. Its positive outcome is a possibility, not a certainty. Authors propose three facilitating conditions that affect the result of a securitizing move: adherence to the grammar of security, social capital of actors, and features of the alleged threat. Taken together, these three facilitating conditions reinforce the point that securitization is an intersubjective process that "rests neither with the objects nor with the subjects but *among* the subjects" (Buzan et al., 1998: 31). On the other hand, while the first of these conditions is internal, as it relates to the characteristics of the speech act itself, the second and the third are external, as they stem from the context in which the speech act is performed.

Rising from this brief presentation of the core concepts of the securitization theory is one final point. The securitization is a process of taking issues outside of normal field of politics,

where it is handled through the standard procedures of the political process, to the heightened sphere of security, a sphere above politics, reserved for urgent issues requiring immediate response and leaving less room for debate and differing opinions. In a sense, securitization leads to a depoliticization of an issue. Conversely, the opposite process of desecuritization is a form of politicization (Balzacq, 2019: 11). It is based on moving an issue from the high-tension field of security to the political field, where opinions, contestation, different attitudes and proposed solutions are argued and decided upon. Although members of the Copenhagen School show normative preference for desecuritization, the particularities of the process are not elaborated in detail. This is one of the aspects that was further developed in some of the more constructive critiques of the original securitization theory, as it will be shown in the next section.

2.1. *Critiques of the Securitization Theory*

Some of the most potent criticism aimed at the securitization theory addresses the concept of audience. Buzan et al. (1998: 41) define it as "those the securitizing act attempts to convince to accept exceptional procedures because of the specific security nature of some issue". However, they do not develop it much further. In an attempt to enhance the audience concept, Balzacq introduces two types of support: moral and formal. The first relates to the general, more tacit support for an action, which is necessary but usually not sufficient. The second is understood as a direct support to the act given by formal institutions, or from other positions of authority (Balzacq, 2005: 184–185). The importance of audience links to the issue of internal or external focal point of securitization or, in Balzacq's terms, the distinction between the philosophical and sociological views: "for the philosophical view, the audience is a formal-given-category, which is often poised in a receptive mode. The sociological view emphasizes, by contrast, the mutual constitution of securitizing actors and audiences" (Balzacq, 2011: 2). The philosophical view of securitization positions the speech act of securitizers as crucial and constitutive in itself, reshaping the context by its performative power, while the sociological view identifies the key

elements for the successful securitization in a wider social context and interrelations between the actor and the audience.

The second important strand of criticism stems from the normative implications of the theory as it is envisioned by the Copenhagen School. For example, McDonald points out how the securitization theory centers on the dominant actors, leaders with authority and ability to extract resources and gather general support for their proposals. He stresses that "the focus only on dominant voices and their designation of security and threat is normatively problematic, contributing to the silencing of marginal voices and ignoring the ways in which such actors have attempted precisely to contest these security constructions" (McDonald, 2008: 574). One clear example of this issue is given by Hansen, who analyzes gender aspects of securitization and identifies two problems. The first is the "security as silence" that occurs when insecurity cannot be voiced. The second, "subsuming security", arises because gendered security problems are connected with other aspects of the subject's identity, and are usually treated as individual and secondary security problems (Hansen, 2000: 287). On the other hand, Floyd attempts to determine when a securitization is justifiable. She proposes three criteria to determine the moral rightness of securitization: there must be an objective existential threat, the referent object of security must be morally legitimate, and the security response must be appropriate to the threat in question (Floyd, 2011: 428).

The issue of just securitization leads to the concept of desecuritization. Aradau argues that "being intrinsically linked with securitization as its mirror image, desecuritization suffers from the same contradictions that plague the concept of securitization" (Aradau, 2004: 389). Relying on the ideas stemming from critical security studies, she presents how desecuritization can be strengthened through connection with the idea of emancipation. Further development of the desecuritization concept is given by Hansen, who makes a distinction between four different types of desecuritization:

> "Change through stabilization is when an issue is cast in terms other than security, but where the larger conflict still looms; replacement is when an issue is removed from the securitized, while another securitization takes its place;

> rearticulation is when an issue is moved from the securitized to the politicized due to a resolution of the threats and dangers, that underpinned the original securitization; and silencing is when desecuritisation takes the form of a depoliticisation, which marginalizes potentially insecure subjects" (Hansen, 2012: 529).

Finally, Balzacq attempts to transcend the need to situate securitization and desecuritization on the axis between politics and security. He offers an alternative understanding of securitization as "politics of the extraordinary". In this reading of the concept "securitization does not give vent to exceptional procedural rules that lie beyond politics [but] intensifies the political saliency of public problems" (Balzacq, 2019: 13), thus strengthening the connections between security and politics. Conversely, desecuritization does not lead from the domain of security back to the domain of politics, since the distinction between the two is not precise and their boundaries are much less strictly defined. He envisions securitization as a specific regime of practices, whose components are connected through the concept of legitimacy. Legitimacy has three aspects: legality, justification, and consent. Legality is based on the fact that in part the legitimacy of the process relies on the legal rules and procedures. But, "the support of the public is acquired through justificatory processes and not exclusively from the legality of security practices" and thus depends on the leaders' ability to persuade the public (Balzacq, 2019: 15). Finally, consent gives the elites the right to develop new rules and obligations for the public, while for the public it means the duty to comply to the power granted to the elites. It has both a moral and a symbolic dimension:

> "On the one hand, when people conduct themselves in accordance with the regime of practices established thanks to deontic powers, they contribute to the maintenance of normative consent toward those practices. This is the moral aspect of consent. On the other hand, actions that manifest consent are carried out in public, which means that third parties, whether acting in the same way or not, can indeed testify that the actors conform to prescribed regimes of practices. This is the symbolic aspect of consent" (Balzacq, 2019: 16).

3. Securitization and Desecuritization of COVID-19 in Serbia in 2020

3.1. *Key Breaking Points And Outcomes of COVID-19 (De)Securitization in 2020*

The COVID-19 crisis in Serbia started in February 2020, much like in the rest of the world, as the disease started to spread on the European continent. First signs of precaution followed after Italy was struck by the virus in the same month. As the news of the increasing number of cases in Italy started to show up in Serbian media, it was evident that something had to be done (Srna, 2020; Radio Slobodna Evropa, 2020a). The first significant breaking point in Serbia was the joint press conference of Serbian government officials, led by the president Aleksandar Vučić and well-renowned Serbian medical doctors. The overarching atmosphere of the press conference was one of relaxing the situation. From security studies angle it can be said that the goal of the conference was to silence the looming issue in front of the wider public. Doctor Branimir Nestorović, a pediatric pulmonologist and one of the publicly most popular doctors in the country, addressed the public after a meeting with president Aleksandar Vučić about the coronavirus and stated "that there is no reason to panic, because more people are dying today from many other diseases in Serbia" (Novosti, 2020). Amongst other statements, more or less in the same manner, doctor Nestorović also said that he "can't believe that people who survived sanctions, bombing, all kinds of harassment, were afraid of the most ridiculous virus in the history of mankind" (Novosti, 2020). These were first, preventive desecuritization narratives on COVID-19. However, after this conference the situation with COVID-19 in Serbia rapidly worsened.

The beginning of March 2020 marked the start of the COVID-19 epidemic in Serbia. The first case was registered on March 6 (BBC, 2020a). Only a few days later, the government formed a Crisis HQ which consisted of state officials and experts from a wide range of important fields for combating the growing issues that surrounded the whole new reality regarding coronavirus (Vlada Republike Srbije, 2020). A state of emergency was declared and imposed on March 15. This proclamation included few

measures that the government and the Crisis HQ thought were necessary for combating the disease: the work of preschool, school and higher education institutions was suspended and online teaching was introduced; working from home was recommended; self–isolation was suggested for everyone, meaning there would be no public gatherings; people over 65 were advised not to go outside; the working hours of cafes and restaurants were shortened and the number of people who could stay in them was limited; the borders were closed; for travelers from abroad, 14–day self–isolation was introduced, or 28–day, if they came from higher risk areas; public transport in Belgrade stopped working; a curfew was introduced on March 18 (Radio Slobodna Evropa, 2020b).

The public discourse on the crisis escalated even further afterwards. One of the most significant breaking points was the SMS which was sent to citizens during the ongoing lockdown. The message contained the following: "The situation is dramatic. We are approaching the scenario from Italy and Spain. Please stay at home" (Đurović, 2020). In that period the Italy and Spain scenario meant that the health system would not able to cope with the increasing number of virus cases and, consequently, the death toll would grow. So, that message created the unpleasant association among the citizens which led to, as the media reported, a certain amount of panic which was evident on social media (Đurović, 2020). April was a hard month with a large number of virus cases, strict measures and intensive lockdowns. This was the period with the biggest effect of successful securitization speech acts.

All of a sudden, the situation with the emergency measures changed with the beginning of May. Although the number of cases had not stopped increasing, the state of emergency and curfew ended on May 6 (N1, 2020a). The general stance of the government and the official experts was that life had to slowly start returning to normal, although adherence to measures such as wearing protective masks should remain (Stanković, 2020). This coincided with the upcoming parliamentary elections. They were initially supposed to happen on April 26 but were postponed due to the pandemic and the state of emergency. The rhetoric before and during the campaign for the parliamentary elections of 2020 represented the second desecuritization process in Serbia which resulted in a steady

removal of the COVID-19 topic from public and political discourse. The ruling party tried to shift the direction of the debate towards other topics, while the opposition organized protests throughout May that were mainly aimed at showing dissatisfaction with the rule of Aleksandar Vučić. Although the elections in question were parliamentary and the president did not run for reelection at the time, all political actors positioned themselves in relation to Vučić's politics. This was due to the power he had accumulated in the function of the president, enabled in part through the characteristics of the Serbian semi–presidential political system with a directly elected president (Mandić & Nedić, 2021). In the end, when the elections were held on June 21, leading parties of the opposition boycotted them. Vučić's Serbian Progressive Party again emerged victorious without any relevant alternatives on the ballot, winning 188 out of 250 seats in the Parliament (Miladinović, 2020).

This period was followed by the first unsuccessful securitization process which occurred in July 2020 and resulted in mass protests. The attempt to again raise alertness towards the threat of the COVID-19 pandemic and talk about a new state of emergency, caused an unexpected response by the citizens. The first cause was the proposed closure of student dormitories which incited gathering of students and an almost immediate withdrawal of this plan at the very beginning of July (Insajder, 2020). Then, on July 7, president Vučić announced that the situation in the capital was critical. As a response, public gatherings were to be banned and curfew reinstated. This caused large and violent protests on the same evening and for the next several days (Radio Slobodna Evropa, 2020c). The government abandoned these measures, and in general, for the rest of the year, no larger securitization processes were initiated by political leaders and government officials.[2] The July protests showed that, while the formal support of the institutions could somewhat easily be gathered, after the constant alternating

[2] On the other hand, political opposition and the media not supporting President Vučić and the Serbian Progressive Party constantly pointed out the growing number of infected people and the flaws in the government's relaxed approach during the autumn and winter, thus conducting a securitizing move. However, their type of authority, relationship with the audience, and the (lack of) ability to introduce emergency measures would require a separate analysis altogether.

between securitizing and desecuritizing moves, the moral support of the general audience would be harder to get.

3.2. *The Effects of the Constant Change of the Security Discourse*

This breakdown of the timeline of securitization and desecuritization attempts during the COVID-19 pandemic in Serbia during 2020 leads to several key points. First, the constant change of rhetoric by the (de)securitizing actors, which oscillated greatly and constantly shifted in its position, significantly influenced the authority of the securitizing actors. The first attempt of desecuritization before the first case of COVID-19 was registered in Serbia, quickly succeeded with a hard securitization discourse, affected the authority of the securitizers in the perception of the public. The authority inherently held by the members of the government combined with the authority of expertise that the leading health experts and doctors possessed, was in large part lost by July when the second major attempt to securitize the issue occurred. The fact that the existential threat was portrayed in a different manner in a short period of time without qualitative changes to support this shift largely contributed to this loss of authority.

Consequently, these later attempts to securitize the COVID-19 pandemic failed, since the facilitating conditions were not met in their entirety. The grammar of security was implemented in a way that stressed the gravity of the situation, direct comparison with previous months suggested an even greater level of threat, but the authority of the securitizing actors was put in question. The important point here is that this authority was lost due to previous securitizations and desecuritizations, leading to the conclusion that the securitizers' authority is not an infinite resource, but is spent more and more by every (de)securitizing speech act. Even further, the change from securitization to desecuritization and *vice versa* leads to a faster and larger expenditure of this resource, due to the perplexity it produces. Thus, even though the pandemic was still in full swing and circumstances favored securitization, securitizing actors lacked the authority to successfully achieve it, and resulting confusion further enhanced the crisis.

Second, the loop of securitization and desecuritization shaped the reaction of the audience. It created a state of confusion among the citizens and decreased the overall level of consent for the emergency measures. The authority figures failed to create a consistent approach that would promote uniform emergency measures required to deal with the existential threat and this opened the space for the audience to perceive the issue in a variety of different ways. The lack of consistency gave strength to the facilitating actors in the form of critics of the government's approach, including both the experts in the medical field arguing for more strict measures and those promoting alternative, non–scientific views of COVID-19. Furthermore, in some cases these two types of criticism were not that clearly and easily differentiated. The legitimacy of the whole process of securitization, including the question of the existence of the existential threat, the authority of the (de) securitizing actors, and the nature and form of emergency measures was questioned. Although the legality of the measures was in a sense established, the justification for them did not have sufficient support to incite an overwhelming consent of the public.

Here, an important caveat must be noted. Even though it is stated in the previous sentence that the measures were legal, this understanding was not a universal stance. There was important and strong criticism of the state of emergency on the basis that it had not been introduced in a way prescribed by the law (Beta, 2020). Authors of this article do not favor or argue for or against this opinion, but consider the introduced measures as legal in the sense that the authority figures invoked the legal framework of the state to introduce them, and the public generally accepted them as such. Furthermore, there was no successful legal attempt to challenge the legality of the measures, as the Constitutional Court dismissed the submitted initiative (N1, 2020b). Thus, from a pragmatic standpoint, and for the purpose of this article they are considered legal. Whether that was the case or not from the perspective of the law falls outside the scope of this research.[3]

[3] For an analysis of the conformity of this measures with the Constitution see, for example, Marinković, 2021.

Going back to the question of consent, the behavior in accordance with the introduced emergency measures has showed the interlinkage of both moral and symbolic aspects of consent. The moral aspect manifests through the behavior conforming to the measures, indicating one's support for the authorities, while the symbolic consists of demonstrating your support to third parties. The specific characteristic of the COVID-19 emergency procedures was that they required submission of securitizing actors as well, and their behavior reflected their own level of support for the introduced measures. The fact that some of the leading securitizers, including President Vučić, failed on numerous occasions to conform to the expected practices, such as wearing masks or avoiding public gatherings, and thus failing to show symbolic consent, decreased the overall moral consent of the general audience (BBC, 2020b; Mirković, 2020).

Third, the wider context of the (de)securitization processes was predominantly shaped by the political considerations, especially the parliamentary elections, eventually held on June 21. This issue loomed over all decisions regarding the COVID-19 pandemic and directly influenced the rationale behind various attempts to securitize or desecuritize. This was most evident in the strong efforts by the securitizing actors in the government to desecuritize the pandemic by terminating the state of emergency and attempting to steer the political field towards a return to regular procedures in order to hold elections, at the same time pushing forward the discussion on other topics in the campaign. On the other hand, attempts to securitize the issue again almost immediately after the elections were held caused a very negative reaction by the public. The failure of those speech acts comes in large part from the fact that the audience recognized the motives behind these securitizing moves and thus remained unconvinced of the justifications presented by securitizers. The loop of securitizing and desecuritizing the same issue over a short period of time exposed the logic of the pattern. This goes to show that after a successful securitization of an issue, the reverse process of desecuritization does not lead to a return to the same political field that existed before. The political field is irrevocably transformed by securitization, and is then again transformed by desecuritization, creating a new

status quo in which the reprise of the same securitizing move cannot work anymore.

Having the presented analysis in mind, it must be pointed out that, although the authors have chosen securitization theory as a theoretical framework for the COVID-19 pandemic crisis in Serbia as an adequate analytical tool, they do not disregard other sociological approaches which attempt to describe this phenomenon, which can be compatible with our reasoning and strengthen it further, or offer opposite views and arguments. Responses to pandemics and other types of social disasters present a very complex type of situations. Therefore, securitization theory has not been applied as a strong type of causal chain explanation, but rather as a broader framework of processes, where socially constructed practices form a situation in which certain narratives prevail over others. Therefore, the authors argue that the chain of events described in this article invites an analysis from the point of view of the securitization theory as we have identified and examined a certain number of securitization and desecuritization processes which are confined by postulated theoretical and analytical framework. Still, the explanation based on securitization theory does not exclude other interpretations, either compatible or conflicting with the one presented here, of the evolution of the responses to COVID-19 and the measures introduced by the government to combat it.

4. Conclusion

Analyzing the COVID-19 pandemic through the securitization theory lens, it becomes evident that, due to its nature and widespread impact, it was securitized in many countries. In Serbia, this securitization took form of a loop of securitizing and desecuritizing moves, some successful and some not. This constant shift caused several important consequences. It showed that the change from securitization to desecuritization of an issue in a relatively short period of time expends the resource of authority that the securitizing actors possess. Taken together with some specific actions they performed, such as ignoring the introduced emergency measures while preaching to the public to adhere to them strictly, caused confusion in the public and opened the space for various

facilitating actors and their views to gain in importance and impact. The consequence was a lessened support for the emergency measures. All of this was taking place in a context of the coming parliamentary elections and the specificities of the political life in Serbia, including significant polarization between the government and the opposition. These conditions shaped the way in which the securitizers decided whether and when to securitize or desecuritize the pandemic, resulting in the periodical changes in the discourse regarding the threat that COVID-19 presented. Based on this, it can be concluded that the specific context promoted constant switches between the securitization and desecuritization, which in turn affected the authority of the securitizing actors, as well as the audience's attitude.

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Towards Global Health Governance or Towards Global Control of States and People?

Abstract

This chapter presents key challenges in the ongoing reform of the global health regime based on the initiative to adopt a binding Pandemic Treaty and a reviewed International Health Regulation. The analysis of the proposed regulation from the human rights perspective leads to a conclusion that it entails a great potential to produce negative effects on both human rights and on the right of states to decide sovereignly on health-related issues. The proposed regulation gives the World Health Organization (WHO) the ultimate authority to decide on all issues related to public health, as well as the monopoly on informing about measures to prevent and combat pandemics and other public health emergencies. The influence of the corporate sector on the WHO will be strengthen and formalized by its inclusion in a new political body, the Global Health Threats Council. The author warns that the proposed centralized global health governance opens the door to many abuses and allows the concentration of the decision-making power concerning all issues related to the health of all people in the hands of a few.
Keywords: Pandemic Treaty, public-private partnership, International Health Regulation, public health, COVID-19

1. Introduction

The most far-reaching outcome of the COVID-19 pandemic is the initiative to establish a global health governance with the World Health Organisation (WHO) as the central authority in pandemic prevention, response, and recovery. The global health emergency preparedness, response, and resilience (HEPR) architecture is proposed to be grounded on three pillars: governance, system and financing (WHO, 2023). The new governance is based on grounding the WHO's leadership in the HEPR, reforming the regulation, and imposing accountability on Parties to comply with the new regulation. The reform of regulation is based on two documents: a new

binding international instrument, the so-called Pandemic Treaty, and on the amended International Health Regulations (IHR).[1] As justified by the WHO, the goal is to address the gaps that have been highlighted during the COVID-19 pandemic and to help anticipate and prevent future ones, because "it is not a question if there will be other pandemics, but when".[2] The process started in December 2021 by establishing an intergovernmental negotiating body (INB) to draft and negotiate the binding treaty,[3] and should end in May 2024 with the adoption of both the Treaty and the amended IHR at the 77th World Health Assembly. The new regulation will launch radical changes not only in national health sectors, but in many spheres of life, and all people will be affected.

This chapter presents key novelties foreseen by the proposed regulation and assesses their possible effects on state sovereignty, health policies and human rights. The aim is to highlight the main concerns that may have far-reaching consequences on countries and citizens.

2. Literature Overview

Opinions of authors on the proposed global HEPR are divided. Some authors (Phelan, 2023; Shan, 2022; Po-Han & Ming-Jui, 2022; Eccleston-Turner, 2022; Faviero et al., 2022; Hannon, 2022; Gostin, Meier & Stocking, 2021; Fukuda-Parr, Buss & Ely Yamin, 2021; Halton, 2021; Labonte et al., 2021) share the same narrative,

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[1] The International Health Regulation, based on the WHO Constitution, entered into force on 15 June 2007. World Health Organization (WHO). International Health Regulation. https://www.who.int/health-topics/international-health-regulations#tab=tab_1 (accessed 20 July 2023).

[2] World Health Organization (WHO) (2021). COVID-19 shows why united action is needed for more robust international health architecture. 30 March. https://www.who.int/news-room/commentaries/detail/op-ed---covid-19-shows-why-united-action-is-needed-for-more-robust-international-health-architecture (accessed 20 July 2023).

[3] The Zero Draft of the Pandemic Treaty (WHO CA+) is agreed on 1 February 2023, the Bureau's text of the convention on 2 June 2023, and the latest version, the Negotiating Text, was prepared on 16 October 2023. WHO. Negotiating Text of the WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response (WHO Pandemic Agreement), 16 October 2023. A/INB/7/x

stating that the Pandemic Treaty will facilitate global solidarity, health security and international accountability.[4]

Johnson Sirleaf and Clark (2023: 16) state that "WHO must be fully supported with the authority, independence, and funding required"; "every aspect of managing a pandemic threat, or a pandemic, should be placed in the right hands", namely within the authority of the WHO, that "must be fully supported to be the technical lead for the health response with full independence and integrity in their work." Besides, Hayman and Wollaston (2023) urge the WHO to incorporate an overarching One Health framework into the Treaty. According to Faviero et al. (2022: 730), the new instrument should address the scarcity of accountability mechanisms to independently assess compliance, and introduce sanctions for non-compliance. Faviero et al. (2022) recommend establishing an international oversight body, independent from the WHO, to avoid being subject to greater political influence.

Wenham, Eccleston-Turner and Voss (2022: 852) assess that the Pandemic Treaty is "rooted in globalist ideals of what the perfect pandemic governance should look like." Thus, these authors argue that a potential alternative to the Pandemic Treaty would be "to update the IHR, making them more relevant, and addressing the governance and compliance gaps, moving them beyond the current 'name and shame'" (Wenham, Eccleston-Turner & Voss, 2022: 846). Namely, it is a monumental task to harmonise different legal regimes for health emergencies that are already deeply fragmented, so the new instrument is likely to make them more fractured.

Velásquez and Syam (2021: 10) do not question the necessity of introducing a binding treaty to promote and protect health in the context of a pandemic, but question how such a treaty can address issues related to the needs of countries that have different

[4] It was found that many authors in favour to the Pandemic Treaty belong to institutions that are co-funded by the foundations that are promoters of the WHO's reform. For example, the Global Health Centre at the Graduate Institute of International and Development Studies, Geneva, has published more than 160 publications and other resources "about a more equitable and effective global system for governing potential pandemics". The research and publishing are done within the project Governing Pandemic Initiative, co-founded by the Bill & Melinda Gates Foundation. See: Global Health Centre. The Governing Pandemic Initiative. https://www.graduateinstitute.ch/GoverningPandemics (accessed 20 September 2023).

levels of development, thus "different capacities to implement the obligation it may impose." Therefore, before launching negotiations for a pandemic treaty, it should be identified what the major elements on which a possible new instrument should be focused are (Velásquez and Syam, 2021: 6).

Authors who challenge the WHO's narrative highlight omissions in this process in terms of human rights and accountability. Fidler (2021) notes that "many who favour a treaty believe it offers the best way to increase political commitment from states to reform global health governance. But COVID-19 demonstrates that this proposition has no clothes." Novičić (2022) admits that "coordinated activities at international level are sometimes needed to respond to pathogens that cause infections with very high level of mortality," but centralisation of international action, without taking into account local circumstances and preferences, with a technocratic top-bottom approach, may only overpass the state's duties to safeguard and fulfil human rights. Looking at the pandemic treaty idea "through the lens of the asphyxiation of capitalism's new unbridled pandemic tides," Dentico, van de Pas and Patnaik (2021) list numerous arguments in favour of dismantling such an idea, because "the world has not yet immunised itself from its dysfunctional power structures" and neoliberal economic ideology.

3. What will new Regulation Bring and what will it take?

3.1. *Definitions of a Pandemic and Health*

Currently, not one official document of the WHO, including the Pandemic Influenza Preparedness Framework (2011), provides a definition of a pandemic, but rather some descriptions. The Pandemic Treaty will fill the gap by defining a pandemic as:

> "the global spread of a pathogen or variant that infects human populations with limited or no immunity through sustained and high transmissibility from person to person, overwhelming health systems with severe morbidity and high mortality and causing social and economic disruptions, all of which require effective national and global collaboration and coordination for its control." (Article 1(e)).

The definition includes some vague terms that may lead to arbitrary interpretation, such as “severe morbidity”, “high mortality”, “pathogen or variant”. Further confusion is made by introducing a definition of a “pathogen with pandemic potential” that also contains vague terms such as “likely to cause significant morbidity and/or mortality in humans” (Article 1(h)).

Considering the case of the pandemic influenza A(H1N1) in 2009, Kelly (2011: 540) argued that the classical definition of an epidemic occurring worldwide (Last, 2001) was sufficient to define a pandemic. He considered that the WHO’s attempt to complicate the definition was aimed at gaining “political attention and financial support for pandemic preparedness”, and that evidence should be used “to assess severity early to anticipate risk” (Kelly, 2011: 541; Doshi, 2011: 532) also questioned labelling the H1N1 influenza outbreak a “pandemic”, as the outbreak had far less serious consequences than experts had predicted; thus, he raised concerns over “ties between WHO advisor and industry that fuelled suspicion about the independence and appropriateness of the decisions made at the national and international levels.”

The definitions of a health emergency and public health risk in the proposed amendments of the IHR are also expanded and changed. The term ‘a potential’ to impact public health is introduced instead of ‘an actual’ risk or harm (Articles 2, 12). The change of ‘public health risk’ to ‘all risks with a potential to impact public health’ may mean that almost everything may be considered a trigger to proclaim a risk to public health. A mandate to determine that the event constitutes a public health emergency of international concern will be given to the Director-General (Article 12).

The proposed amendments to the IHR introduces a definition of health products that includes ”therapeutics, vaccines, medical devices, personal protective equipment, diagnostics, assistive products, cell- and gene-based therapies, and their components, materials, or parts”. The list of health products does not include herbal remedies, health supplements, natural therapies, natural health products, etc.

3.2. *One Health Approach*

The Pandemic Treaty introduces the One Health approach defined as "an integrated, unifying approach that aims to sustainably balance and optimize the health of people, animals and ecosystems" (Articles 1(d)). It covers a very broad range of issues that may affect infectious diseases to emerge and spread, such as the use of land and water, trade in wild animals, food safety, agriculture, urbanization, water pollution, air pollution and climate change.[5] Thus, it is related to multiple sectors and disciplines to address threats to health of people and animals, environment and ecosystems, including energy, water, air, food, climate change and human habitat. The Treaty will oblige the Parties to implement the One Health approach for pandemic prevention, preparedness and response with the application of, and in accordance with, national law (Article 5.1), and collaborate in order "to identify, conduct risk assessment at the interface between human, animal and environmental ecosystems" (Article 5.2). The Parties should also develop, implement, and strengthen One Health surveillance systems to monitor implementation of the One Health approach (Article 5.7).

Inclusion of the One Health in the Draft Treaty is the result of the efforts invested since 2005 to embed this approach within existing global health institutions. Despite wide-ranging commitment to the One Health approach, and recognition of interdependence of human, animal, and environmental health, its operationalisation has been hindered by dysfunctional global health governance (Kelley & Brumme, 2012). The COVID-19 pandemic has urged strategic adoption of this initiative, along with an integrated and coordinated cooperation, surveillance and monitoring system (Bonilla-Aldana, Dhama & Rodrigez-Morales, 2020). Ruckert et al. (2021) advocate an integrated One Health approach and adoption of a set of principles for pandemic prevention and preparedness based on this concept in the Pandemic Treaty.

Undoubtfully, human, animal and environmental health and sectors are interconnected and interdependent, and wildlife,

[5] World Health Organization (WHO) (2023). One Health: Key facts. 23 October. https://www.who.int/news-room/fact-sheets/detail/one-health (accessed 25 October 2023).

animal, and environmental health affect public health. However, Woolaston and Lewis (2022: 13–15) question "whether the wildlife and environmental-related considerations are essential to deep prevention of pandemic". They also notice that the WHO has no authority and no mandate to govern wildlife or environmental health in the WHO Constitution, beyond the function of promoting environmental hygiene for the benefit of human health. Having in mind that the Pandemic Treaty will become legally binding once a State consents through signature or ratification, it is also questionable how will a State Party implement specific obligations related to address the drivers of pandemics and the emergence of disease at the human-animal-environmental interface and other commitments listed in the Article 5 of the Draft Treaty. The One Health approach as elaborated in the Treaty will also have a potential to broaden the scope of public health to food production, urbanisation, climate change and international travel, and thus, give the WHO an authority to interfere in these sectors.

3.3. *Infodemic and Infodemic Management*

Infodemic is a new term that the WHO introduced in early 2020 after the COVID-19 outbreak to address "misinformation and rumours, along with manipulation of information with doubtful intent," amplified through social networks (Pan American Health Organization and World Health Organization (2020: 2). Since then, the WHO developed a broad infodemic management system "to immunize the public against misinformation", to eliminate and prevent any information that does not come out of "trusted sources", in other words, from the WHO sources (Pan American Health Organization and World Health Organization (2020: 5). This system included, amongst others, establishing EARS, "an early AI-supported response and social listening tool to help health authorities quickly identify rising narratives and 'information voids' that interfere with people getting the information they need to make good health choices", running a weekly aggregate of publicly available social and news media, to identify online infodemic-related conversation patters, establishing a repository of active COVID-19 fact-checking groups that verify COVID-19 related claims in more than 40

languages, and an AI-based infodemic observatory.[6] The application of the EARS AI-system presents clear and direct violation of individuals' right to privacy and data protection (Dokmanović, 2022). The system "listens-in" to individual's speech and writing on social networks, blogs and news media, without his/her knowledge and informed consent. It is also unknown where the gathered information will be stored and for what purposes used.

The Draft Pandemic Treaty includes a definition of infodemic as "too much information, false or misleading information, in digital and physical environments during a disease outbreak. It causes confusion and risk-taking behaviours that can harm health. It also leads to mistrust in health authorities and undermines the public health and social measures" (Article 1(c)). The Article 9 related to research and development includes promoting infodemic management. State Parties are also expected to combat false, misleading, misinformation or disinformation on pandemics and their effects and drivers (Article 18.1). The proposed amendments to the IHR (2005) also include obligations of State Parties to counter "the dissemination of false and unreliable information about public health events, preventive and anti-epidemic measures and activities in the media, social networks and other ways of disseminating such information" (new Articles 44.1(h) and 44.2(e)).

The proposed provisions related to infodemic management open a door to an opportunity that the WHO will become the only relevant source of all information and data in the case of a pandemic. The infodemic management during the COVID-19 pandemic has already caused suppression of public expression of critical views and opinions different than the mainstream about the implemented measures (lockdowns, masks, COVID-19 passports, vaccines, etc.). The infodemic management has also led to censorship not only in mainstream media, but also on social platforms such as Facebook and YouTube. Even now, although the COVID-19 pandemic ended, YouTube "doesn't allow content that poses a serious risk of egregious harm by spreading medical misinformation that contradicts local health authorities' (LHAs) or the WHO' guidance

[6] World Health Organization (WHO). Infodemic Website. https://www.who.int/health-topics/infodemic#tab=tab_3 (accessed 29 June 2023).

about specific health conditions and substances."[7] These practices contributed to stigmatization of those who expressed critical thinking ("anti-vaxxers", "conspiracy theorists"), and violated the rights to information, free speech and expression of opinion (Dokmanović, 2022). The Malaysian Consumers' Association of Penang (2023: 2021) noted that the WHO "would have power to designate opinions or information as 'misinformation' or 'disinformation' and require governments to intervene and stop such expression and dissemination". The implementation of infodemic management in all countries in future, as it is foreseen, will directly suppress freedom of speech, expression of opinion, independent research and open dialogue, that are the grounds of a science.

Moreover, the principle of the implementation of the IHR (2005): 'full respect for the dignity, human rights and fundamental freedoms of persons' is in the amended version replaced by the principle of 'equity, inclusivity, and coherence' (Article 3.1). The Parties would implement the new regulation "in accordance with their common but differentiated responsibilities", "taking into consideration their social and economic development."

3.4. *New Mechanisms*

The proposals for strengthening global health emergency preparedness, response and resilience (HEPR) architecture includes establishing the Global Health Emergency Council. The rationale given by the WHO Director-General is that reviews of the COVID-19 response indicated "a lack of sustained political commitment to health emergency prevention and response between global health crises", as well a lack of "a formal established mechanism through which a health emergency can be escalated to the level of Heads of Government and Heads of State".[8]

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[7] YouTube. Medical misinformation policy. https://support.google.com/youtube/answer/13813322?hl=en#zippy=%2Cvaccine-misinformation (accessed 26 November 2023).

[8] WHO Executive Board. Strengthening WHO preparedness for and response to health emergencies. Strengthening the global architecture for health emergency preparedness, response and resilience Ten proposals to build a safer world together. Report by the Director-General. 5 January 2023, EB152/12, para. 16.

The future Global Council will comprise heads of states, chairs of regional political entities and other international leaders, and will be responsible to address obstacles to the equitable and effective HEPR, foster compliance with global health instruments, norms and policies, and ensure mobilization and deployment of resources for the HEPR. It will consist of 18 members (ten representatives of Member States in five regions, three private sector representatives, three civil society representatives, and two prominent global citizens or experts), and three co-chairs, two appointed by the UN General Assembly and two nominated by the G20.

The work of the Council would be linked with the work of the Standing Committee on Health Emergency Prevention, Preparedness and Response, established in May 2022 by the WHO Executive Board. There is also a proposal to establish a new open-ended committee of the Health Assembly on emergencies.

The Pandemic Treaty proposes establishing another two new mechanisms: the WHO Global Pandemic Supply Chain and Logistics Network and the WHO Pathogen Access and Benefit-Sharing System (WHO PABS System). The WHO PABS System should enhance access to the rapid sharing of pathogens and other biological materials with epidemic and pandemic potentials through "laboratories in the WHO coordinated laboratory network". The State Parties are expected to ensure that all components of this System are operational no later than 31 May 2025.

The core role of the proposed new mechanisms is to establish an authority with the ability to hold actors accountable regarding implementation of the universal health and health crisis preparedness commitments. However, there is no mechanism foreseen to challenge assessments, decisions and binding recommendations of the Council, the Director-General, and any other existing or proposed WHO bodies. There is also no mechanism foreseen for the correction of the WHO's assessments and decisions. This is particularly worrying having in mind that the State Parties will be obliged to initiate and complete all health measures, including those in temporary and standing recommendations (that will become binding), without delay.[9]

[9] Amendments to Article 42 of the IHR.

3.5. *Impact on State Sovereignty*

The legally-binding characteristic of the future Pandemic Treaty has sparked some public discussion in social media, emphasising the fear that the WHO aims to interfere in states' sovereignty, that lockdowns and mandatory vaccination can be forced upon people, that digital passports would enable the WHO to track and monitor movement of individuals, and that national armed forces would be deployed to implement the treaty under UN orders (Soliman et al., 2023: 1322). Soliman et al. (2023) claim that these assertions are misinformation and false, "leading to negative attitudes towards the pandemic accord", and that the future treaty will fully adhere to the principle of sovereignty. They argue that "WHO's powers are delineated in a legally binding international constitution that confines its authority to undertaking international health work" (Soliman et al., 2023: 1322). Tulp (2023) also writes that many experts agree that the Pandemic Treaty "will not give the WHO the authority to control national policies during pandemic". These authors indicate that the Article 3 of the Draft Treaty includes sovereignty among the general principles of its implementation. According to this principle, states will have, "in accordance with the Charter of the United Nations and the general principles of international law, the sovereign right to legislate and to implement legislation in pursuance of their health policies. In doing so, they shall uphold the purposes and objectives of the Treaty and carry out their obligations under the Treaty in a manner consistent with the principles of the sovereign equality and the territorial integrity of States and that of non-intervention in the domestic affairs of other States."

Gostin, Moon and Meier (2020) argue that populist nationalism and nationalist governments were the main obstacles to global solidarity in responding to the COVID-19 pandemic. Therefore, these authors advocate establishing the new global health architecture in which the WHO will play an essential role and lead "a universal response across all nations". The WHO should get "both the authority and the resources to mount an effective response to a global emergency that affects all countries" (Gostin, Moon & Meier, 2020: 1618). Hallas (2023: 2653–2654) notices that due to the

nature of global health, the WHO is not allowed "to enforce obligations by turning on and off other benefits like a spigot", because "such punitive withdrawal of health resources would violate the WHO's obligations to protect the health of the global citizenry." Fidler (2021) considers that "loading so much into the health 'cart' risks allowing politics more room to determine priorities at the expense of science and epidemiology" and reminds the readers that governments' responses to COVID-19 have violated or manipulated many human rights treaties.

In its explanation of the pandemic accord, the United Nations Foundations (D'Auterive, 2023) also stresses that the new instrument "would not hand over control of domestic health policies to WHO or any other international body, and that it would not affects countries' sovereignty". The WHO is not a law-enforcing organisation, and it does not have a position to enforce obligations nor the power to sanction those who do not fulfil their responsibilities toward the global community.

On the other side, the WHO's documents related to this process insist on strengthening of this agency at the centre of the global health emergency preparedness, response and resilience (HEPR) architecture. In his report on "Ten proposals to build a safer world together", the WHO Director-General insists that the world needs a strengthened WHO, with "the authority, sustainable financing and accountability to effectively fulfil its unique mandate as the directing and coordinating authority on international health work."[10]

The author of this chapter strongly disagrees with these claims that the Pandemic Treaty would not give the WHO the supreme authority to control national health policies and enforce obligations on Parties. on the contrary, the author claims that it is inevitable for two reasons: (1) due to the fact that international law obliges a treaty party to comply with duties accepted by its ratification or accession with due diligence; and (2) due to the fact that the Pandemic Treaty is foreseen to complement the IHR (that are

[10] WHO Executive Board. Strengthening WHO preparedness for and response to health emergencies. Strengthening the global architecture for health emergency preparedness, response and resilience Ten proposals to build a safer world together. Report by the Director-General. 5 January 2023, EB152/12, para. 64.

already binding) so that the assessment of the impact of these instruments on state sovereignty should be assessed jointly; a WHO Member State may decide whether to join the Treaty or not, but the amended IHR will completely diminish its right to autonomy regarding any health matter.

The amendments to the Article 42 of the IHR oblige State Parties to initiate and complete all WHO's health measures and recommendations without delay. Moreover, State Parties should also ensure that not only state actors, but also non-state ones, would comply with such measures. This is very worrying, as the currently non-binding temporary and standing recommendations by the WHO will also become binding. The proposed new annex 10 of the IHR introduces the obligation by a State Parties "to cooperate in any of the activities in which collaboration with regard to health emergency preparedness and response become necessary." However, Article 43 on additional health measures indicates that "these regulations shall not preclude State Parties from implementing health measures, in accord with their relevant national law and obligations under international law, in response to specific health risks or public health emergencies of international concern with achieve the same or greater level of health protection than WHO recommendations".

The new Article (13A) of the IHR demands States Parties "to recognize WHO as the guidance and coordinating authority of international public health response during public health Emergency of International Concern and undertake to follow WHO's recommendations in their international public health response." The given amendments describe in detail obligations and duties of State Parties with respect to this, including introducing vaccination certificates, in both digital and paper forms.

If a state decides to join the Treaty, the process of incorporation of its norms depends on the constitutional order of the state. If it accepts the primacy of international law (monistic system), as soon as the state ratifies or accede to this Treaty, its provisions can be applied directly in the national legal system and implemented by the state's institutions and bodies. If a state applies a dualistic system in which the national legislation has a primacy over international law, the Treaty may not be implemented directly prior its

transposition to the national legislation in a manner prescribed by a constitution (e.g. by adopting new legislation or amending the existing one).

The Treaty and the amended IHR do not foresee sanctions for a Party thereto that does not comply with its obligations, but a new mechanism is foreseen to be established, the Compliance Committee, that will regularly assess and report on the Parties' compliance with the obligations under the revised IHR (New Chapter IV of the IHR).

Therefore, Soliman et al. (2023: 1322) are right when claiming that "the WHO does not hold jurisdiction over national health work," and that "the WHO Director-General and staff cannot enforce decisions, such as imposing a lockdown, mandating vaccination, or dictating the opening or closing of borders", but they are not right when state that "such decisions remain within the sovereign domain of each country." This will change, because the proposed amendments to the Article 12 of the IHR intend to strengthen the authority of the WHO Director-General regarding determination of a public health emergency of international and regional concern, as well as intermediate health alert, without previous consultation with the State Party in whose territory the event arises.[11] It is also proposed to give the Director-General the authority to issue at any time an intermediate public health alert, even where the event has not been determined to meet the criteria of a public health emergency of international concern, yet the Director-General believes that "it requires heightened international awareness and preparedness activity".

As elaborated in this section, the future Treaty and the new health regulation will inevitably decrease, or even diminish sovereignty and autonomy of States in any health-related matter (meaning in all matter), including to question the WHO's instructions or to seek correction, due to the obligation to complete them immediately, without any delay.

[11] World Health Organization (WHO). Article-by-Article Compilation of Proposed Amendments to the International Health Regulations (2005) submitted in accordance with decision WHA75(9) (2022). Document A/WGIHR/1/5.

3.6. *Towards Privatization of the WHO?*

The assessment of the impact of the future Pandemic Treaty and the amended IHR on states' sovereignty, over their national health systems would not be comprehensive if we do not consider the current and future position of the private sector in the WHO. Ever since its establishment as a specialised agency of the UN in 1948, revenues that come from the public sector and voluntary contributions of the Member States have prevailed. The share of the Members-due contributions to the total revenue has steadily decreased (21% in 2011, 22.95% in 2012, 17% in 2018, 14% in 2021 and 11% in 2022) (Table 1). On the other hand, revenues from voluntary contributions increased by 154% between 2011 (USD 1,424 million) (WHO, 2013: 4) and 2022 (USD 3.619 million).

Table 1. Financial overview of the WHO, years 2018–2022, all funds (in USD millions)

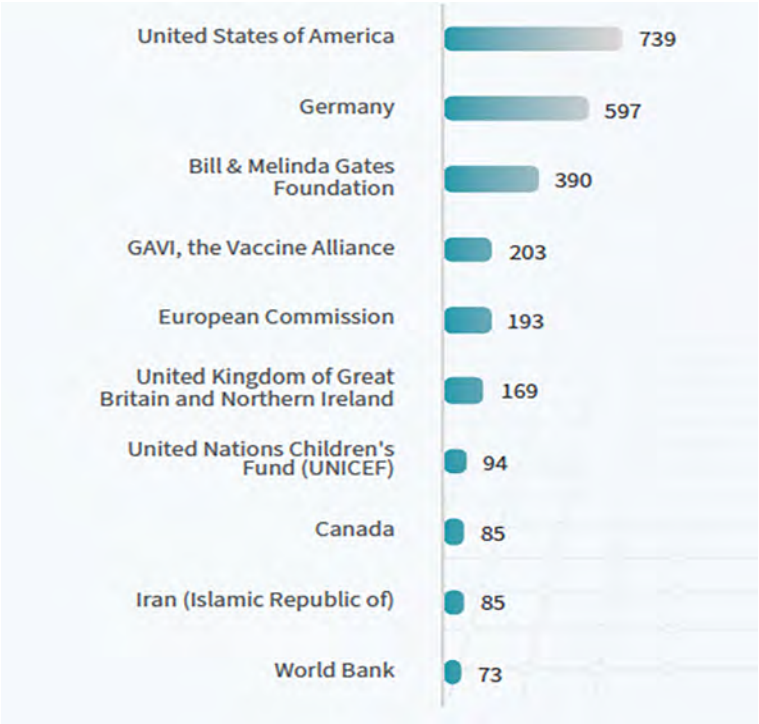
	2018	2019	2020	2021	2022
Assessed contribution	501	490	465	549	496
Voluntary contributions	2,243	2,447	3,704	3,365	3,619
Non-Programme budget	157	179	130	152	239
Total	**2,901**	**3,116**	**4,299**	**4,066**	**4,354**

Sources: World Health Organization (2023). *Audited Financial Statements for the year ended 31 December 2022*. Geneva: World Health Organization, p. 103; World Health Organization (2022). *Audited Financial Statements for the year ended 31 December 2021*. Geneva: World Health Organization, p. 29; World Health Organization (2020). *Audited Financial Statements for the year ended 31 December 2019*. Geneva: World Health Organization, p. 5.

In 2012, the contributions of foundations comprised 20% of the total voluntary contributions, and private sector donations accounted for 1%. While in 2012, there was no private foundation among the top ten voluntary contributors to the WHO, the situation changed over time. In 2020–2021, top private contributors to the WHO include Bill & Melinda Foundation (USD 751 million), the GAVI Alliance (USD 432 million), and Rotary International (USD

174 million).[12] In 2022, among the top ten voluntary contributors are the Bill & Melinda Gates Foundation, with 14.84% of the total sum of voluntary contributions to the Programme Budget, and GAVI, the Vaccine Alliance (co-founded also by Bill & Melinda Gates Foundation), with the share of 7.72% (Figure 1) (WHO, 2023a: 11). The contributions of these two private stakeholders, the major global promoters of vaccines (USD 593 million in total), were 19.56% higher than the total amount of the contributions by all 194 Member States.

Figure 1. Top 10 voluntary contributors to the WHO Programme budget in 2022 (in USD millions)



Source: World Health Organization (2023). *Audited Financial Statements for the year ended 31 December 2022*. Geneva: World Health Organization, p. 11.

[12] World Health Organization (WHO). Our contributors – Partnering for a healthier world. https://www.who.int/about/funding/contributors (accessed 20 September 2023).

It should also be taken into consideration that influenza vaccine diagnostic and pharmaceutical manufacturers regularly contribute to the Pandemic Influenza Preparedness Framework Benefit Sharing System with annual cash contributions of USD 28 million (that is the amount of assessed contributions higher than that made by the majority of the Member States).[13]

These numbers indicate the evident presence of the private sector in this UN agency. The new global health architecture will additionally strengthen its influence by formalizing its presence in the new body. Namely, out of 18 seats in the future Global Health Threats Council, three will be reserved for representatives of the private sector (at the head of organisation level with a high public profile and a track record of working on relevant issues).[14] According to the Independent Panel for Pandemic Preparedness and Response, this Council will ensure sustainable high level political leadership to pandemic prevention, and will be "an inclusive and legitimate voice of authority with the ability to utilise both accountability mechanisms and provide access to financing".[15]

It may be expected that the proposed reform of the WHO will enable corporate actors to have a strong impact on decision-making and policy-shaping. There is no mechanism proposed to prevent and eliminate conflict of interests of private corporations as a profit-driven companies and as contributors to the budget of the WHO. The public-private partnership in all other areas, not only in the health sector, is susceptible to corrupt activities, particularly in highly profitable sectors such as pharmaceuticals. As a rule, the private sector is mainly focused on maximisation of profit, and that is often incompatible with the public interest and safeguard of human rights. Corrupt practices may also occur in projects supported by donor agencies and foundations, particularly

[13] World Health Organization (WHO). PIP Framework Partnership Contribution. https://www.who.int/initiatives/pandemic-influenza-preparedness-framework/partnership-contribution (accessed 20 August 2023).

[14] The Independent Panel for Pandemic Preparedness and Response. Terms of reference for the Global Health Threats Council. https://recommendations.theindependentpanel.org/main-report/07-terms-of-reference/ (accessed 2 October 2023).

[15] Ibid.

if anti-corruption policy is not integrated in all levels of the design, implementation, monitoring and evaluation of their programmes and projects. These negative practices and conflict of interests of various actors may be prevented by implementation of the WHO's accountability, procurement and audit rules and procedures. However, the author of this article agrees with the remark of Dentico, van de Pas and Patnaik (2021: 21) that the world is on a way towards the privatization of global health rights: "the emergence of private actors, and their incorporation into what used to be a publicly dominated health governance system, are manifestations of a phenomenon that has revolutionized the health architecture into a hustling unordered arena of wealthy influential entities claiming their role in global health."

4. Conclusion

In the last two years, the WHO worked on drafting a new regulation that should be the legal foundation for the new global health emergency preparedness, response, and resilience (HEPR) architecture "with the principles of equity, inclusivity and coherence at its centre." The rational is to "strengthen the way the world prepares for, prevents, detects and responds to health emergencies, and to ensure that the collective efforts of Member States, the WHO Secretariat and partners are coordinated and coherent."[16] The proposed Pandemic Treaty and amendments to the IHR span a broad spectrum of issues of legal, political, multisectoral and institutional nature and will require State Parties to fully comply.

The analysis of the proposed regulation from the human rights perspective indicates its large potential to radically reshape the global health law, but not for the benefit of states and people. There is no indication found that the new international regulation will facilitate global solidarity, health security and international accountability, as some authors claim. In contrast, there are indications that the regulation will radically decrease, or even diminish

[16] WHO Executive Board. Strengthening WHO preparedness for and response to health emergencies. Strengthening the global architecture for health emergency preparedness, response and resilience Ten proposals to build a safer world together. Report by the Director-General. 5 January 2023, EB152/12, para. 64.

state autonomy in any health-related matter. The WHO will take exclusive authority and expertise to assess any issue that may be considered a threat or likely to cause a threat to public health, social and economic stability, and deliver binding instructions to Member States which have to complete them without any delay. There is no mechanism proposed to question or correct WHO's decisions, or to hold its bodies accountable. The WHO Director-General will have stronger authority to determine public health emergency of international and regional concern even without previous consultation with the state in whose territory the event arises. Moreover, the mandate of the Director-General will include issuing an intermediate public health alert even where an event has not been determined to meet the criteria of a public health emergency of international concern, based only on an opinion that "it requires heightened international awareness and preparedness activity".

The proposed regulation foresees the monopoly of the WHO on information about public health events, preventive, and anti-epidemic measures. The Member States will be obliged to "manage infodemic" and to counter any information that do not come from the WHO sources, that being a direct violation of the rights to information, free speech, and expression of opinion. Infodemic management, as it is prescribed by the WHO, has a potential to suppress expression of opinion, independent research, and open dialogue that are foundations of science.

The presence and influence of the corporate sector in the WHO will be strengthened and formalized via a new political body, the Global Health Threats Council. On the other hand, there is no mechanism foreseen to counter possible conflicts of interests of private corporations and foundations as members of the WHO Council. This omission opens the door to privatization of the WHO.

To sum up, the proposed global health governance architecture has a greater potential to control states and people, than to effectively respond to global health emergencies.

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The Attitude of Far-Right Organisations towards Measures against the COVID-19 Pandemic in Serbia 2020–2022

Abstract

The research subject is the attitude of far-right organizations towards the measures of the Aleksandar Vučić regime against the COVID-19 pandemic. It is based on the findings of previous research that right-wingers in general, extreme ones in particular, are less concerned about the coronavirus, often expressing doubts about its very existence, or considering it artificially produced and deliberately released due to a conspiracy of the elites against the people. Their attitude towards the measures taken by the Aleksandar Vučić regime against the spread of the pandemic should be in line with that. The harsher the measures against COVID-19 were, the harsher their criticism should have been. However, since some studies have shown that there have been some far-right organizations serving the authoritarian regime, it is expected that they would support all the regime's measures all the time. Indeed, it turned out that "Srpska desnica", "Levijatan", "Srpska radikalna stranka", "Srpska stranka Zavetnici" and the far-right football-fan tribes welcomed the measures, or kept silent about them ("Svetosavski savez Obraz", which voiced its criticism only at the time of Easter, 19th April, "Srbska čast" and "Nacionalni srpski front"). However, there have also been extreme right-wing organizations that harshly criticized the measures during the state of emergency ("Srbska akcija", "Narodne patrole", "Zentropa"), and even radical right organizations that have been constantly doing this: "Srpski pokret Dveri", "DjB-Suverenisti", "Živim za Srbiju".
Key words: far-right, authoritarian regime, COVID-19 measures

1. Introduction

The COVID-19 pandemic was going on for three years in the period 2019–2022. It had originated in late 2019 in China, and arrived in Serbia in March 2020, and from that point, then was sweeping the population in waves of variable strength, leaving temporary

and sometimes permanent psycho-somatic consequences in a considerable number of people, while a smaller part remained unaffected. As time passed, the attitude of the most powerful stakeholders changed towards the coronavirus and its numerous mutations. In just the first three months, the regime oscillated between initially downplaying the epidemic, and turning a blind eye on the danger, under the pretext of not spreading panic, through unprecedented intimidation and spreading panic, to politically motivated triumphalism, with corresponding measures ranging from no measures at all, to a state of emergency, to almost totally abolishing the measures once again. After the elections of June 2020, there had been attempts to return to a stricter regime of measures, if not that to the very state of emergency, but the strong opposition of a significant part of society thwarted this (Bakić, 2021; Petrović Trifunović, 2021; Pešić, 2021; Poleti Ćosić, 2021; Popadić, 2021; Spasić, 2021). Since then, there has been a gradual reorientation of society to a neoliberal mode of managing the pandemic crisis, following the example of Sweden, but without public recognition of that fact (Pešić, 2021; Popadić, 2021).

The research subject is the attitude of far-right organizations towards the measures of the Aleksandar Vučić regime against the COVID-19 pandemic. The Vučić regime, established after the 2012 elections, is an example of competitive authoritarianism (Bieber, 2018). According to Freedom House, Serbia is only partly free, and "Vučić's move to the presidency (he was prime minister in two terms 2014–16, and 2016–17, J. B.) in 2017 raised new concerns about the personalization of governance and politicization of state institutions. Vučić has remained the dominant figure in government despite the presidency's limited executive powers under the constitution, creating a de facto presidential system. For instance, Prime Minister Ana Brnabić used to address President Vučić as her "boss" (šef) in public, although she should be much more powerful than him by the Constitution. By the same token, in August 2022, before a new government took office, Vučić announced that the prime minister's new mandate would extend only until 2023, rather than a full four-year term, due to unspecified 'changes to the government'." (Freedom House, 2023). Indeed, he has kept his promise since President of Serbian National Assembly set the election date

for 17th December 2023, despite of the absolute majority supporting the government in the National Assembly.

There are indicators that such an authoritarian regime has controlled intertwined parts of organized crime groups and far-right organizations since 2015 (Bakić, 2022; 2023). Bearing in mind that the ruling Serbian Progressive Party has its roots in the far-right Serbian Radical Party (Bakić, 2009), there is always a possibility that the leading figures of the regime could revert to a variant of far-right ideology. It would be dangerous for Serbian society for sure. However, it might also be dangerous as a model of behavior for other societies ruled by similar regimes in the Western Balkans (Bieber, 2018), or even some member-states of the EU, e.g. the Orban regime in Hungary. By the same token, one can recall the Trump administration 2017–2021, and its relations with both far-right and plutocrats (Hacker, Pierson 2020).[1] Such authoritarian leaders could use both controlled media and far-right organizations intertwined with organized crime, to intimidate intellectuals, political opponents, as well as to discipline broader public.

The far right has authoritarian nativism, i. e. xenophobic nationalism, at its ideological core (Mudde, 2007). There are two kinds of far right: 1) the extreme right, which openly reject the idea of democracy and use physical violence against their enemies, and 2) the radical right, which do not use physical violence against their enemies, but are obsessed with xenophobic nationalism and law and order, while presenting themselves as champions of democracy (Bakić, 2023: 9).

Serbian Extreme Right Organizations:

Serbian Radical Party was being the most influential amongst the many far-right organizations, not only in the 1990s, but all the way to 2008 and the party's split. It has been led by former communist dissident, university lecturer, and convicted war criminal Vojislav Šešelj since its foundation in 1991. Former President of the Republic of Serbia, Tomislav Nikolić (2012–2017) was the party's second-in-command, while today's President of the Republic of

[1] One can argue that independent judiciary and non-controlled media prevented prevailing of authoritarian tendencies in the US political system from prevailing.

Serbia Aleksandar Vučić (first mandate 2017–22; second mandate 2022–27) was third-in-command in the party. In 2008, Nikolić and Vučić formed Serbian Progressive Party, which abandoned Serbian xenophobic and expansive nationalism and became the ruling party in 2012. However, Vučić has nurtured his old connections and created new ones with various far-right organizations, football fan tribes, and criminal gangs (Bakić, 2009; 2022; 2023).

Konzervativni pokret Naši (Conservative Movement Ours) is a local extreme-right organization from the small town of Aranđelovac. The organization is led by a catechist Ivan Ivanović. CM Naši was named after the homonymous Russian organization, and it is infamous for its incidents at liberal public events (Vreme, 2010).

Levijatan is a movement led by Pavle Bihali, ostensibly interested in animal protection, while disseminating violent Antigypsyism and the Islamophobia based anti-immigration attitude (Istinomer, 2020; Bakić, 2023: 18).

Nacionalni srpski front previously *Nacionalni stroj* (National Serbian Front/National Formation) is a Neo-Nazi organization led by Goran Davidović aka. Führer. The organization was forbidden by the Constitutional Court on account of national and religious intolerance and hatred provocation in 2011. Davidović ran away to Italy in order to escape the one year imprisonment received for attacking antifascists in 2007. Finally, he came back to Serbia, after the Court of Appeal abolished the sentence. Moreover, he has had appearances at a nationally broadcasted TV-station (Radio Free Europe, 2011; 2020; Bakić, 2023: 16).

Narodne patrole (National Patrols), led by Damjan Knežević, is an extreme-right movement especially engaged in anti-immigration violence (N1, 2021; Bakić, 2023: 18).

Srbska akcija (Serbian Action) appeared only after the two organizations (Obraz and National Formation) had been forbidden by the Constitutional Court. The organization combines the Obraz's clero-fascist[2] and the National Formation's national socialist features (Bakić, 2023: 17).

[2] The Obraz movement is the successor of the Serbian fascist movement of Zbor (1935–45), which was influenced by Orthodox Christian mysticism and several clerics of the Serbian Orthodox Church.

Srpska desnica (Serbian Right), led by Miša Vacić, consists of nationalists, organized criminals, and football hooligans, and has been used in attacking the regime opponents. Miša Vacić is President Vučić's close collaborator (Vreme, 2010; Bakić, 2023: 18).

Srbska čast (Serbian Honor) is an extreme-right organization led by Bojan Stojković. They are especially infamous for their Anti-gypsyism, in addition to their other xenophobic, nationalistic and authoritarian features.

Svetosavski savez Obraz previously *Otačastveni pokret Obraz* (Saint Savan Covenent of Honor/Fatherland's Movement of Honor) is a clero-fascist organization led by Mladen Obradović. The organization was forbidden by the Constitutional Court in 2012 on account of national and religious intolerance, hatred incitement, and brutal violence against police on the occasion of the 2010 Pride Parade. Mladen Obradović was sentenced to two years of imprisonment (Radio Free Europe, 2012; Bakić, 2023: 16–17).

Zentropa is the Serbian branch of the international Neo-Nazi movement Zentropa Srbija (2021).

Football Fan Tribes:[3]

United Force is the most extreme among the fan tribes in Serbia. It is a typical Neo-Nazi paramilitary organization (Bakić, 2023: 17).

Delije is a football fan tribe which supports the most popular football club in Serbia – Red Star, Belgrade. There are six sub-tribes, and most of them are nativist and led by criminals close to the Aleksandar Vučić regime, and especially to President's son Danilo Vučić (Bakić, 2023: 14, 18).

Grobari (Grave Diggers) are supporters of the FC Partisan. There are several nativist sub-tribes, and some of them were created by the Aleksandar Vučić regime (Bakić, 2023: 15).

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[3] Croatian sociologist Srđan Vrcan introduced the term "football fan tribe"in order to stress the significance of the sense of honor among the warlike football fan groups (Vrcan, 2002).

Serbian Radical Right Organizations:

DjB Suverenisti (DjB Sovereignists) appeared as a neoliberal party, but they transformed into a radical-right nativist party. Saša Radulović has been the party's leader since its foundation.

Srpski pokret Dveri (Serbian Movement Dveri) is a radical right party led by a Member of Parliament (MP) and former secondary school literature teacher Boško Obradović. It is committed to Orthodox Christianity and religiously based moral, defense of the patriarchal family, and the consequential moral condemnation of homosexuality. "Dveri" have promoted an anti-immigrant attitude based on Islamophobia since 2015, and explicitly state that Le Pen's Rassemblement National has been a model for the organization (Bakić, 2023: 17).

Srpska stranka Zavetnici (Serbian Party Covenant Loyalists), led by MP Milica Đurđević Stamenkovski, is a nationalist and strongly anti-Western party.

Živim za Srbiju (I live for Serbia) is a small nativist and anti-elitist movement led by an MED and anti-vaxxer Jovana Stojković.

The paper has been based on previous research results, showing that right-wingers in general, especially the extreme ones, have been less concerned about the coronavirus, and that they often expressed doubt in its very existence, or considered it artificially produced and deliberately released due to a conspiracy of elites against the people. While this has not been necessarily true for the far-right parties in power, this has indeed been the case when it comes to the far-right parties in the opposition (Mudde, Wondreys, 2022: 97). Therefore, their attitude towards the measures taken by the Aleksandar Vučić regime against the spread of the pandemic was supposed to be in line with that. The tougher the measures against COVID-19, the tougher their opposition should have been. However, as the measures against the spread of the pandemic became milder and especially as their application was increasingly lacking over time (Pešić, 2021; Popadić, 2021), the attention of the far-right would have supposedly shifted to other topics. Indeed, one study confirmed this using the example of "Srbska akcija" (Kostić, 2021), from which it may be concluded that the latter has probably not been under the control of the Vučić regime.

The main hypothesis, derived from the previous research (Bakić, 2022), is that at least a part of the far-right organizations has been under the control of the regime, reflected in their support, or at least their lack of criticism for the measures. Additionally, it is assumed that the far-right organizations not under the control of the regime, were supposed to criticize the regime during the state of emergency, as well as when the regime tried to tighten the measures after their relaxation, but completely give up on that topic when the already relaxed measures were no longer applied, which mostly coincides with the second half of 2021 and 2022 (Popadić, 2021; Pešić, 2021; Poleti Ćosić, 2021).

We sourced information from whatever could be found on the Internet when the names of these organizations and their leaders were entered into the search engine in combination with the words "pandemic", "corona", "COVID-19": from the official pages of the organizations and the social networks where they have been active, right down to the means of mass communication they employ to convey their views.

2. The Pandemic and the Extreme Right under the Control of the Regime

There are some extreme right-wing movements in Serbia that are under the control of the regime (Bakić, 2022), but also those for which this may not be ascertained. For example, if anyone ever doubted it, the COVID-19 pandemic completely exposed the pro-regime activities of "Srpska desnica" and "Levijatan". The day after the declaration of the state of emergency, "Levijatan" put themselves at the regime's disposal, allegedly following an invitation of the Ministry of the Interior, since it maintained a "hot line" with it, which the Ministry of the Interior admittedly denied: "The Levijatan movement in Serbia, regardless of political differences and the unrewarding position of such smaller opposition factions, at the invitation of the state from this moment on makes itself available in its full capacity to the Ministry of Interior, the Ministry of Defense and other relevant public authorities in the fight against the 'COVID-19' pandemic (...) Levijatan, with all affiliated patriotic organizations, will undertake activities to equip the old, infirm and frightened with

the necessary supplies according to the plan (...)" (Raskrikavanje, 2020). Helping the elderly and the infirm as a political tactic was successfully used by the neo-Nazi "Golden Dawn" in winning over voters in Greece (Bakić, 2019: 535), and Levijatan previously, under the smokescreen of caring for animals, actually spread poisonous antigypsyism and then clearly manifested an Islamophobic anti-immigrant orientation.

Similarly, the leader of "Srpska desnica", Miša Vacić, said: "Srpska desnica supports and helps the difficult fight of our health system against the coronavirus pandemic" (Vacić, 2020), while he also claimed that the volunteers of "our political organizations participate in bringing aid to people over 65 years old". As a return favor, the regime, without a public call, which is not illegal in a state of emergency, recruited "Poslovi grada", a company founded in December 2017 for the construction of residential buildings and owned by Vacić's decade-long "comrade", at that time twenty-nine-year-old Stefan Janković, for the very lucrative job of disinfecting buildings on the territory of several Belgrade municipalities, even though they had no experience in that line of business and despite the fact that other companies offered lower prices (BIRN, 2020).

The leader of "Srpska radikalna stranka" (SRS), Vojislav Šešelj, on the other hand, promoted vaccination on TV Pink, especially since he himself was "in the risk group" and had been vaccinated, though with the Russian and Chinese vaccines ("there are no consequences from the Chinese and Russian ones"), while he spoke disparagingly about vaccines produced in the West (for Astra Zeneca, he said that "there are not enough chimpanzees"; "you will experience negative consequences from Pfizer" and "it has not been tested"; Moderna was "similar to Russian technology, but it is inferior in terms of quality"). In addition, he criticized the West for inhumanity, while praising the "friendly relations" with Russia and China that "we must preserve" (Novosti, 2021). Nevertheless, SRS also criticized the government, since "domestic businessmen are failing because of COVID", and "the state gives millions to foreigners" (SRS, 2021).

The "Svetosavski savez Obraz" was not particularly involved in the fight against the measure, but its leader still stood up in the "protection of the Liturgy and Communion", when the celebration of Easter in 2020 was designated a potential focus of the spread

of the infection, because "these days we are fighting not only against coronavirus, but also against the evil virus of impiety and Serb hatred". Like "Srbska akcija" (Kostić, 2021), which after all was created by the merger of dissidents from "Obraz" and "Nacionalni stroj", when these organizations were banned (Bakić, 2013), the leader of "Obraz" emphasized: "The Holy Communion is a panacea and therefore let's approach it with faith, hope and love" (M. Obradović, 2020).[4]

In a manner similar to Šešelj, Milica Đurđević Stamenkovski, the face of the "Srpska stranka Zavetnici", stated, also on TV Pink, that the pandemic would lead to a "reset on the geopolitical map of the world", adding that "we saw that the EU did not have and it still has no capacity to resist the epidemic", while "one small Serbia, due to its sovereignty and the ability to lead its own foreign policy and decide on the procurement of vaccines, provided a far more effective response to the epidemic" (pink.rs, 2020).

When it comes to football fan groups, being the strongest extreme-right groups under the control of the regime at the moment (Bakić, 2022), they were invisible during the state of emergency, although there were no matches for two and a half months, and after the abolition of the state of emergency they were allowed to violate the already overly relaxed measures. Indeed, the means of mass communication in Europe largely expressed surprise at the holding of the Partizan-Zvezda derby in front of twenty-five thousand spectators at the Partizan football stadium during the period when the championship was not even resumed in Italy, Spain and England, while matches were played without spectators in Germany (BIZLife, 2020). Apparently, there was a perfect understanding between the football fan tribes and the regime until 4 February 2021, when Belivuk's group was arrested, and subsequently, a part of the "Grobari" fans (FC Partizan) got out of control again (Bakić, 2022).

Finally, it should be said that for the two organizations "Srbska čast" (Serbian Honour) and "Nacionalni srpski front" (National Serbian Front formerly "Nacionalni stroj" – National Formation), for which there are other indicators that they have been under the

[4] This tweet, however, had only two shares and 12 likes, which testifies to the weak influence of the leader of "Obraz" in the public.

control of the regime (Bakić, 2023), no traces were found on the Internet about their stance towards the COVID-19 pandemic and anti-COVID19 measures.

3. The Pandemic and the Non-regime Far Right

Previous research has clearly identified the far-right as opponents of the strict measures to protect public health, who considered the virus itself to be an example of a conspiracy by globalist elites. For example, the extreme right-wing "Srbska akcija", practicing authoritarian ethno-confessional[5] and xenophobic nationalism, was unequivocally against any health policy measures three days before the state of emergency was declared, supporting the position of the Serbian Orthodox Church that everyone needed to continue receiving the communion from the same spoon, because Orthodoxy is "the only adequate medicine against every disease, and thus also against this virus, which was very likely artificially created with the aim of easier implementation of the globalist and capitalist plans" (Srbska akcija, 2020; Kostić, 2021: 107). Soon, both "Atlantists-Zionists"[6] and the Communist Party of China were blamed for producing the virus, which gave rise to anti-Semitism, anti-Americanism and anti-communism, but also to Sinophobia, since some aspects of Chinese culture were considered "unnatural and disgusting", and the whole "conspiracy" was in an Islamophobic manner associated with the belief that the virus had been invented only to divert attention from the intention of the "Islamist decapitators" to settle in Europe, while Aleksandar Vučić was considered a "globalist servant" and an "anti-Serbian freak" who carried out "the orders of his foreign masters" in cooperation with "a heathen and impostor Predrag Kon" (Srbska akcija, 2020; 26 March 2020; 15 April 2020; Kostić, 2021: 108–109). Kon was also depicted in an anti-Semitic manner with a caricature "in one of Srbska akcija's last announcements regarding COVID-19" of 19 March 2021 (Srbska akcija, 2021; Kostić, 2021: 109). However, after March

[5] Serbian nationalism is historically closely connected with Orthodox Christianity. Srbska akcija impregnates xenophobic nationalism with Orthodox Christian religiosity.

[6] Phrase relates with Srbska akcija enemies NATO and Jews.

2021, "Srbska akcija" lost interest in the "corona circus" (Srbska akcija, 2020; Kostić, 2021: 109), since the measures were significantly relaxed (Popadić, 2021: 86).[7]

The Serbian branch of "Zentropa", an international organization of national revolutionaries, which has existed, according to their own testimonies, since 2016, is recognized for its racist and xenophobic nationalism, undisguised sympathies for classical and modern fascism, the propagation of the cult of heroes and death, and unlike some other far-right organizations is not under the control of the regime.[8] It is safe to say that there is no significant foreign or domestic fascist who has not been quoted on the Facebook page of the domestic "Zentropa". The place of honor is certainly held by Dragoš Kalajić, whose paintings and thoughts are transmitted, and the French "new rightists". They had only two posts about the pandemic: the first one a shared article by Dugin, previously taken from geopolitica.ru, from "Zentropa's" blog "Kulturni klub Plamen" (24 March 2020), and the second one an anti-Semitic post about Predrag Kon.

We should also mention the enthusiasm for the July 2020 protests, in which they claim to have actively participated, but the pandemic has not been mentioned at all, despite the reason given by the Serbian Progressive Party (SNS) president's announcement that he would reintroduce a curfew. It is teherfore evident that their attitude towards the pandemic and the regime's measures was extremely instrumental. Like Dugin, they hoped that the pandemic would stop globalization and lead to the closure of civilizational-national borders. When it comes to Kon, they highlighted his photo with a quote from Carl Schmitt: "If a nation accepts that a foreigner dictates the choice of its enemy and tells who it can or cannot fight against, it ceases to be composed of politically free

[7] "In the first two months since the declaration of the pandemic (11 March–11 May), Serbia was fifth out of 186 countries in terms of the strictness of the measures. In the last two months (1 April 2021–31 May 2021), it occupies the middle, 98th place" (Popadić, 2021: 79).

[8] As its first edition in 2020, "Zentropa" published the "Manifesto of Revolutionary Nationalism", in the unexplained traffic accident of the early martyred national revolutionary and anti-Semite François Dupret, one of Jean-Marie Le Pen's closest collaborators from the 1970s (Bakić, 2019: 125–126, 128–129, 251, 253).

people and it incorporates itself or subordinates to another political system" (Zentropa Srbija, 2021).

Although out of all doctrinal far-right organizations, the "Srbska akcija" (Serbian Action) paid the most attention to the pandemic, including it in the wider far-right propaganda, some other, not so doctrinaire organizations were more successful, at least when it comes to followers on social networks and activities in the streets, in attracting the sympathies of the citizens, so they also attracted members of the "Srbska akcija" to joint actions in the streets. We are talking about the "Narodne patrole" (People's Patrols), which were actually created in order to fight against immigration four years after the beginning of mass immigration to Europe, i.e. immediately before the start of the pandemic in February 2020, by the organization "Nema predaje Kosova i Metohije" (No Surrender of Kosovo and Metohija), and they have been led by the former founder and vice-president of the "Srpski sabor Zavetnici" Damnjan Knežević, who left "Zavetnici" in late 2014, after being dismissed from the position of vice-president (BBC News, 9 March 2020). This extremely aggressive anti-immigrant far-right group was connected to the fastest growing and largest Facebook group in Serbia, "STOP naseljavanju migranata" (STOP immigrants' settlement), which grew the following of over 330,000 members in but a couple of months. It spread fake news in order to incite moral panic that the regime was trying to smuggle "migrants" and settle them in Serbia, while the local population was imprisoned (BBC News, 2020). In other words, the "Narodne patrole" used the pandemic and the state of emergency to spread xenophobic nationalism.[9]

However, the radical-right movement "DjB-Suverenisti" (formerly "Dosta je bilo" – Enough is enough) has continued to criticize the approach to the pandemic until the moment of writing this text (September 2022), so on several occasions, through neoliberal arguments, it opposed "closure measures" (DjB-Suverenisti, 2021;

[9] "Konzervativni pokret Naši" is another extreme right-wing group with a clear anti-regime orientation, but on the Internet one can only find the title "The Corona Pomp is a Prelude to the Formation of a World Government", as well as the half-title "Sorosh Governs Serbia", of an interview of its leader Ivan Ivanović on his Twitter account, while the recording of the interview has apparently been deleted (Ivanović, 31 March 2020).

Pešić, 2021: 116)[10] and advocated for the "abolition of the Covid Ausweise" (DjB-Suverenisti, 27 September 2021;[11] 20 October 2021;[12] 10 March 2022), and conveyed the terrifying opinions of doctors who opposed the vaccination against COVID-19 (DjB-Suverenisti, 10 August 2022; 30 August 2022), thus making it clear that they were symbolically equating the vaccination advocates with Nazis: "This is another example of the enormous damage to the citizens when the government accepts to give up part of its sovereignty, this time in healthcare, and accepts that supranational structures, in this case the WHO, impose policies on it" (DjB-Suverenisti, 10 March 2022). It is obvious that vaccination is framed in a nationalist framework, because the WHO is understood as a "supranational structure" that "imposes politics" on those who agree to give up sovereignty "this time in health care", which indicates the dissatisfaction of this movement due to the ceding of national sovereignty to such structures in other areas of social life as well.

When it comes to the "Srpski pokret Dveri" (Serbian Movement Dveri),[13] a radical right party, the situation is a bit more complicated, on the ground that one can find very well-argued criticisms of the government's measures on their official website; for example, in the article by anesthesiologist Dragan Branković, member of the Main Board and president of the Municipal Board of this party in Aleksinac (Branković, 2020). However, this article is contradicted by the fact that two years later, Branimir Nestorović, a former member of the COVID-19 crisis response team, who was decorated by the regime just like Predrag Kon, became a member

[10] DjB was originally a neoliberal movement, but in the past few years it has clearly turned towards the radical right, retaining its neoliberal orientation.

[11] They filed a criminal complaint against the dean and secretary of the Faculty of Medicine because of the COVID-19 passes.

[12] "DJB is the only relevant political option in Serbia that stood up against unreasonable and unscientific measures and the media hysteria related to the coronavirus, from the unconstitutionally imposed state of emergency until today. DJB are Sovereignists. Freedom or nothing. DJB warns the government not to play with the freedom of the Serbian people. The ausweis was imposed on us by various occupiers. On whose part this government wants to introduce Covid ausweis to its own people, we will not ask. Serbia, of course, will not allow the Covid ausweis" (Suverenisti, 20 October 2021). Therefore, a liberating discourse was used, with a call for science and reason, while the government was indirectly accused of treason.

[13] "Dveri" is a term that signify doors at the Orthodox churches.

of the coalition around "Dveri", despite the fact that the two had completely opposite views on COVID-19, vaccines and methods of treatment.

Nestorović, otherwise a well-respected pediatrician and allergist, is known for recommending on 26 February 2020, that women should travel to Italy, already heavily involved in and affected by the pandemic, "for shopping", and said: "I can't believe that the people who survived sanctions, bombing, all kinds of bullying, get scared by the funniest virus in the history of mankind which exists on Facebook" (BBC News, 3 July 2020). In addition, he stated on TV Happy that "we don't know if the vaccine maybe more dangerous than the virus" (RSE, 2021).[14] In addition to Nestorović, Žika Gojković, another regular guest on television programs controlled by the regime and leader of the Movement for the Restoration of the Monarchy known for its close political and business ties to the regime, joined the coalition with "Dveri" (Danas, 2022). The above facts may be in favor of the fact that "Dveri" left the position of a consistent opposition to the authoritarian regime.

Finally, we should mention psychiatrist Jovana Stojković, the leader of the "Živim za Srbiju" (I live for Serbia) movement, as well as clinical psychologist Mila Alečković. Both are clearly on the far-right pole of Serbia's ideological-political spectrum, and both are known for their opposition to both vaccines and the authoritarian regime.[15] The former was against the MMR vaccine even be-

[14] Nestorović is also known for his other bizarre views, including that blue-eyed people are a product of the ancient cross-breeding between blue-eyed aliens and women from the *homo sapiens species* (Blic, 2 May 2020).

[15] In her announcement, Jovana Stojković tells her supporters, whom she addresses as "brothers and sisters", that she will fight for "optional vaccination", "preservation of parental rights and the traditional family", "against the introduction of homosexual ideology in schools", "against social engineering by (non)governmental organizations, commissioners for equality and other senseless and harmful apparatuses that are paid for with our money", as well as "other Western 'values' that are forcibly imposed on our majority Orthodox and traditionally oriented people, and are aimed at destroying the family as the core cell of every, including our Serbian society". In addition to the above, she adds that: "The current situation surrounding the migrant crisis is becoming more and more alarming, and the behavior of the actors of this sponsored invasion is becoming more arrogant and reckless every day towards the local population, both in Europe and in Serbia" (Živim za Srbiju, 27 October 2018).

fore the pandemic, which is why she ended up before the Court of Honor of the Medical Chamber of Serbia. After the invention of the COVID-19 vaccine, she claimed "that a large number of our people get sick and end up on ventilators after vaccination", and then added that measures against COVID-19 in Serbia are "illogical, inconsistent, scientifically unfounded, whereas vaccination, according to the admission of some opposition leaders, is part of the third phase of clinical trials, while it is presented to the people as the respectable diplomatic skills of the president of the state" (RSE, 2021). The latter, on the other hand, said that the pandemic was a "global experiment for population control", and that "the Serbian government introduced additional measures that did not exist anywhere in the world and the purpose of which was to intimidate citizens, resulting in a psychological weakening of the immunity" (Istinomer, 2021).[16]

4. Conclusion

Based on the previously known theoretical knowledge and empirical research, conservatives and extreme right-wingers do not want the state to interfere in private lives in general, and not even when it comes to the regulation of public health. Hence, one could have expected the hostility of the domestic far right towards the measures against the pandemic in Serbia, and especially against the state of emergency. However, since there are studies (Bakić, 2022; 2023) that show that the Vučić regime controls most of the far right, the opposite hypothesis was created, that the far-right parties would mostly support the measures taken by the regime against the pandemic, which would actually confirm the regime's control over them.

The hypothesis that a significant part of the far right would support the regime's anti-pandemic measures, whatever they may be, has been confirmed by the unequivocal support by a part of the supporters' groups, "Srpska desnica", "Levijatan", "Srpska stranka Zavetnici" and "Srpska radikalna stranka", or by keeping silent in

[16] Mila Alečković was close to "Dveri" until 2014, and then she got closer to the phantom movement "Otadžbina" (Istinomer, 2021).

the case of "Srbska čast", "Nacionalni srpski front" and "Svetosavski savez Obraz" (which criticized the measures only during Easter on 19th April 2020).

Nevertheless, there have been far-right groups that sharply criticized the measures against the pandemic, fitting them into a wider far-right narrative that referred to Islamophobic, sometimes openly racist anti-immigrant propaganda, as well as the fight against the conspiracy of the global elites and the domestic regime. Such organizations include: "Srbska akcija", "Narodne patrole", "Zentropa", "Konzervativni pokret Naši", "DjB-Suverenisti", "Srpski pokret Dveri", "Živim za Srbiju" and "Otadžbina". But even in this second group there have been movements inclined to cooperate with the regime, such as "Dveri", as evidenced by the fact that they formed coalitions with those who were very close to it (Branislav Nestorović at the 2022 elections, and Zavetnici at the 2023 election). By the same token, there are indicators that extreme-right organization "Narodne patrole" has been organized by the regime (Bakić, 2023: 18–19). That is why one cannot fully estimate the regime's influence on Serbian far-right only by one indicator, e.g. in relation to the anti-COVID-19 measures, but has to take into account other indicators as well.

Finally, the authoritarian regime's control of far-right organizations raises issues of ideological mimicry and would-be intimidations of political opponents. The regime leaders have been able to use far-right organizations more or less secretly in order to escape politically correct accusations that they were far-rightists themselves. Moreover, they like to demagogically present themselves as champions of democracy. In other words, since competitive authoritarian regimes operate in formally multi-party systems, in order to present themselves democratic, they can secretly control and manipulate far-right organizations thus saving face in front of international and domestic public, while simultaneously using these organizations to intimidate their critics and rivals.

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CIP – Каталогизација у публикацији
Народна библиотека Србије, Београд

316.2:[616.98:578.834(082)
316.62:172(082)

DISASTER construction and reconstruction : lessons from covid-19 for ethics, politics and law / editors Dónal O'Mathúna ,Veselin Mitrović. – Belgrade : Institute of Social Sciences, 2024 (Beograd : RIC Grafičkog inženjerstva Tehnološko-metalurškog fakulteta). – 244 str. : tabele, graf. prikazi ; 22 cm

Tiraž 150. – Str. 7–8: Preface / Veselin Mitrović & Dónal O'Mathúna. – About the authors: str. 237–243. – Napomene i bibliografske reference uz tekst. – Bibliografija uz svaki rad.

ISBN 978-86-7093-271-5

а) Ковид 19 – Пандемија – Друштвени аспект – Зборници
б) Друштвено понашање – Етички аспект – Зборници

COBISS.SR-ID 133895177

Language proofreading: M. Prevodi | **Graphic design and layout:** MITRACK | **Print:** 150 copies | **Printed by:** Faculty of Technology and Metallurgy, Research and Development Centre of Printing Technology