Journal of Conflict Transformation & Security

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Prof. Nergis Canefe – jcts.editors [@] cesran.org

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The Journal of Conflict Transformation and Security (JCTS) provides a platform to analyse conflict transformation and security as processes for managing change in non-violent ways to produce equitable outcomes for all parties that are sustainable. A wide range of human security concerns can be tackled by both hard and soft measures, therefore the Journal's scope not only covers such security sector reform issues as restructuring security apparatus, reintegration of ex-combatants, clearance of explosive remnants of war and cross-border management, but also the protection of human rights, justice, rule of law and governance. JCTS explores the view that by addressing conflict transformation and security holistically it is possible to achieve a high level of stability and human security, requiring interventions at both policy and practitioner level. These would include conflict management, negotiated peace agreements, peacekeeping, physical reconstruction, economic recovery, psycho-social support, rebuilding of primary services such as education and health, and enabling social cohesion. Other macro-level governance issues from constitution writing to state accountability and human resource management also need to be considered as part of this process of change.

Peer-reviewed | Academic journal

By CESRAN International (Centre for Strategic Research and Analysis)
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CESRAN International is a think-tank specialising on international relations in general, and global peace, conflict and development related issues and challenges.

The main business objective/function is that we provide expertise at an international level to a wide range of policy making actors such as national governments and international organisations. CESRAN with its provisions of academic and semi-academic publications, journals and a fully-functioning website has already become a focal point of expertise on strategic research and analysis with regards to global security and peace. The Centre is particularly unique in being able to bring together wide variety of expertise from different countries and academic disciplines.

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The COVID-19 pandemic has had a vast array of social, economic and legal implications, necessitating us to critically revisit the notion of human security. In addition to political and civil rights such as liberty and privacy being curtailed in relation to public health measures, social, economic and legal responses to the pandemic continue to have a far greater impact upon populations who are marginalized, who are on the move, as well as displaced communities and refugees, in radically unequal ways. The dimensions of specific populations’ subjectification to unequal measures are related to their nationality, legal status, race, gender, disability, vulnerability and social class. In particular, interventions and resort to extreme measures cause further hardship in the plight of temporary and migrant workers, asylum seekers, internally displaced peoples under COVID-19 governance regimes.

In order to deepen the public understanding of the socio-political and economic dimensions of the current crisis related to the COVID 19 Pandemic in a global context, this special issue of JCTS addresses:

- Global differences in public access to healthcare;
- The situation in conflict zones, refugee camps, border areas, marginalized communities concerning the differential effects of the Pandemic;
- Exclusion of vulnerable communities, non-status peoples, minorities and precarious labour from the networks of protection put in place in relation to the Pandemic;
- Comparative analyses of social justice issues associated with COVID 19;
- Global forms of precarity that this Pandemic makes more visible;
- Regional and national effects of health care cuts or insufficient access to publicly funded medicine;
- Long-term implications of the Pandemic on our perception of human security.

The special issue includes three full articles, a commentary, and a lengthy interview. The proliferation of narratives on COVID 19 measures makes it much harder to make sense of the prevailing cacophony and to engage in critical reflections to such an unstable landscape of policy, politics and law, as pointed out by our authors. As an alternative to this chaotic and panic-ridden environment, the authors contributing to our special issue discuss how they see COVID affecting specific communities in relation to the larger society as well as developments in their area/region of research in relation to the global context. The contributions as a whole also identify potential transformative outcomes arising from the Pandemic, and share with us the ongoing work required to build those outcomes. As such, we invite our readers to think above and beyond the politics of exigency that continues to silence critical debate on uses and abuses of power in the name of redefining human security under pandemic conditions as part of the global response to COVID 19.
Global Go to Think Tank Index Report 2020

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www.cesran.org
COVID-19 in Complacent Canada

Howard Adelman*

*Professor Emeritus, York University, Toronto, Canada

ABSTRACT

This paper argues that the management of the COVID-19 pandemic had severe repercussions for human security. Defined as an invisible enemy, different responses by select governments reveal the differential impact of the pandemic both on law and social norms. Specifically, the paper compares the management of the pandemic in Taiwan, South Korea and Vietnam as opposed to Canada.

Keywords: Management of Covid-19; Government Responses; Taiwan; South Korea; Vietnam; Rates of Testing; Vaccination; in-Hospital Deaths; Crisis Measures

Biographical Note: Howard Adelman is a Canadian philosopher and former university professor. He retired as Professor Emeritus of Philosophy at York University in 2003. He was the founder and director of York’s Centre for Refugee Studies. He was editor of Canada’s flagship journal Refuge for ten years, and since his retirement he has received several honorary university and governmental appointments in Canada and abroad. He has penned 23 books and over hundred academic articles, as well as numerous government reports and policy papers.
Introduction

What does a virus have to do with conflict and transformation? When it is connected with a pandemic, it is a human security issue. Further, the forms of governance of states impact significantly on the disruptions and deaths that result. They also divide states and societies in destructive ways. Therefore, management of a pandemic is as critical to human security as any human conflict so it is no surprise that political leaders describe themselves as at war with an invisible enemy. If an epidemic or a pandemic is a security threat, defending against that threat is a matter of human security. Threats to states not only include the armed forces of other states or terrorists. The threat may be a microscopic agent. As it turns out, COVID-19 has proven to be the most dangerous threat since the flu pandemic of 1918.

Internationally, the most glaring socio-political difference revealed by the COVID-19 pandemic is the vast range in the number of cases of infection and death rates among various governments at the national level. What do these differences have to tell us about governance at that level in dealing with human security issues? COVID-19 has perhaps had a greater effect than other phenomenon in recent years on revealing deep differences in the management of our political arenas that go well beyond discussions of whether a country is democratic or authoritarian. Further, we do well to attend to the details of the impact of COVID-19, not only for managing health care in our societies, but in the governance of society more generally.

The impact has been on both law and social norms, social structures and modes of communication. How can governance be both accountable and effective, prudent and far seeing in a context of general ignorance about the dangers faced? Have lessons been learned and will they have a lasting impact on the way our societies manage themselves?

These are large questions. This paper is just a probe, a way of opening up the discussion. An effort to compare modes of governance to results in the COVID-19 crisis that would be comprehensive is well beyond the scope of this paper. Instead, the focus will be on Canada considered generally to be a well-governed modern state – a peaceable kingdom. How did Canadian governing institutions respond to the crisis? Three countries in the Far East are used as foils – Taiwan, South Korea and Vietnam.

Undertaking comparisons of this scope and nature is questionable. Countries vary so greatly in population size and density and in their stages of economic development. Further, calculating the rates of infection and mortality per one million inhabitants is questionable on other grounds. Actual figures can vary from official figures because counts are based on testing and rates of testing vary considerably. The number of actual cases in a country is going to be higher than official figures show, with testing rates also varying dramatically. Many countries count in-hospital deaths and largely neglect home deaths. Variables include the number of physicians and hospital beds per 1,000 members of the population, vaccination rates for those over 65, the age distribution, the population density, smoking rate, and the poverty gap. Thus, even in one country, according to epidemiologists, in mid-May the Statistics Canada report on the impact of the disease in Canada was too limited and lacking in data to be useful.

But this is not primarily a study of comparative rates of success and failure except in gross terms. Rather, it is a study of the governance of one generally highly respected country related to its governance in dealing with a human security threat when that governance structure was faced with an extreme challenge such as the COVID-19 pandemic.

On the Public Health Agency of Canada website, it reads that, "On March 11, 2020, the World Health Organization (WHO) assessed COVID-19 as a pandemic." The site also noted that, "Canada has a strong history of pandemic planning and is an international leader on this front." However, leadership in planning is not leadership in taking action. Further, waiting weeks, even months, to follow WHO in declaring the pandemic may be both a

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demonstration of the lack of action leadership and one of the reasons for that inaction.

The site continues. “Along with public health authorities at all levels of government across the country), (we) have been working together to ensure that our preparedness and response measures are appropriate and adaptable, based on the latest science and the evolving situation.” Within this perfect example of bureaucratersese can be located another explanation for Canada’s tardy and inadequate response to the COVID-19 crisis. Preparedness and response measures and references to “appropriateness” (to what?) and “adaptability” (to what?) provide other clues. Why not, “actions and initiatives necessary to minimize the negative impact of the pandemic”?

The advice in mid-March was simply, “avoid non-essential travel outside Canada until further notice.” I want to demonstrate that Canada’s response to the crisis was seriously inadequate by using three Far Eastern countries as foils and then documenting the character of the Canadian response. I will then try to explore the possible links between Canadian governance norms and standards of governance, and the failures to ensure the safety of all Canadians as a top priority.

South Korea, Taiwan and Vietnam

These countries all acted quickly, did not wait for WHO signals, and generally launched broad and innovative testing methods (drive-through testing sites in South Korea). The speed of initiative and thoroughness of action of the South Koreans was noteworthy. By the end of January, South Korea had developed successful tests for the coronavirus.

South Korea quarantined infected patients. They used GPS data on cell phones and credit card information to undertake tracing of contacts and to alert those contacts; citizens of any known COVID-19 case within 100 meters were notified. Identified infected individuals were required to go into isolation in government shelters and could be fined if they did not comply. This prevented widespread community transmission. On the other hand, and most notably, these countries did not employ dramatic shut-down measures. Though South Korea practiced, it did not enforce physical distancing. Schools reopened on 13 May.

South Korea’s Ministry of Health kept the citizenry fully informed every step of the way, both the steps being taken and the reasons for them. Further, the government trusted the public to comply. And the people did. Citizens stayed home because it was the responsible thing to do. They washed hands. They wore masks. They kept their distance. Finally, South Korea has a powerful civic ethos and memory. The people remembered MERS. They remembered SARS. They knew that everyone in society was in the same fight. They collectively vaccinate to follow the government’s lead and fully cooperated in the effort to fight the pandemic, though religious sects repeatedly undermined government efforts, not only in collecting together, but in adopting harmful methods of treatment, such as spraying salt water into the mouths of parishioners.4

According to Johns Hopkins University, by 10 May, South Korea had only 256 deaths out of over 10,000 cases.5 South Korea reported many days with zero cases. With contact tracing, 34 newly discovered cases were all tied to three nightclubs and bars in the Itaewon district of Seoul and confirmed by the Korea Centers for Disease Control and Prevention (KCDC). Seoul immediately ordered the closure of all bars and nightclubs in the area.6 South Korea with a

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4 In late February, there was a sudden jump in cases. “Patient 31” had participated in a Shincheonji Church of Jesus the Temple of the Tabernacle of the Testimony Church in Daegu which taught that illness was a result of sin. Stupid politicians are not the only source of ignorance. Of 4,400 followers of the church, 544 contracted the disease by mid-February and by the third week, 1,261 of 9,336 parishioners were tested positive. There were 245,000 members of the church and all were forcibly tested.


6 A 29-year old male who had visited five nightclubs in the area on 1 May tested positive. It is estimated that he had contact with 1,500 others. Contact tracing became intense and eventually 54 cases, 43 nightclub patrons and 11 acquaintances of the owners. were traced to the event. However, there are bound to be others if only because the Itaewon bar establishments cater to the lesbian, gay,
population of 51,269,185 had 10,822 cases and only 256 deaths, or an infection rate of 0.2%.

Taiwan, a country of 23.6 million, is closer to China than South Korea, only 81 miles from the mainland. It receives 2.7 million visitors a year from China and 1.25 million of its citizens work or reside in China. Taiwan is relatively densely populated, 651 inhabitants per square kilometer. One might have expected the country to have a very high rate of infection. In fact, it probably has one of the best records on earth. As of 5 May 2020, it has had only five deaths. Taiwan has had less than 500 cases, the majority imported.

Taiwan has had an excellent centralized system of disease control since the SARS outbreak in 2004. Data is collected and integrated using not only national health care statistics, but migration and customs figures. Further, a command centre determines policy – the national Health Command Center (NHCC) of the Taiwan Center for Disease Control (TCDC), the agency of the Ministry of Health and Welfare of the Republic of China (Taiwan). It is charged with combatting the threat of communicable diseases and had an excellent practice run with the 2009 swine flu pandemic. Further, it is not just an information collection and analysis agency nor one that simply proposes alternative policies; it has the authority to coordinate country-wide efforts to combat threats of communicable diseases and can enlist personnel and whole departments in its efforts. From the very beginning, TCDC was off and running to collect information and determine the health challenge Taiwan was facing.

Taiwanese authorities also took steps to ensure the country had the required PPE equipment (personnel protective equipment), including respiratory protective devices in stock in sufficient quantities. PPE equipment included facemasks, gloves, isolation gowns, eye protection, N95 masks, powered air purifying and elastomeric respirators and ventilators. By the end of March, mask production had reached 13 million.

Taiwan closed off travel, but, like South Korea, there was no wide scale lockdown. Schools delayed opening and businesses kept open during the pandemic. Taiwan did not order its population to shelter in place. Instead, its inspection and surveillance strategies were specific and targeted. Isolation and quarantine were strictly enforced. Masks became de rigueur. Most of all, Taiwan was totally open and transparent with its citizens, keeping them fully informed of each step and the rationale.

Vietnam bordered on China yet it also had an exceptional record in fighting the virus. But it is neither a democracy nor a prosperous country like South Korea or Taiwan. It is both an authoritarian and a developing state. With 96 million people, it had almost twice the population of South Korea and four times that of Taiwan. Its medical and hospital system was not well-developed. In 2018, there were only 8.6 doctors per ten thousand inhabitants in Vietnam compared to 25.4 in Canada and 23.3 in South Korea.\(^7\)

However, Vietnam had had no deaths and less than 300 cases. In its first case of a Chinese man, Vietnamese physicians immediately described the coagulopathic and antiphospholipid antibodies developed in the 69-year-old, his son and a third identified case; this was the first report of human-to-human transmission outside China. The Vietnam Ministry of Health immediately established 40 mobile emergency response teams on stand-by to help detect, quarantine and trace contacts of suspected cases. Vietnamese leaders even quarantined the whole village of 10,000 of Son Loi, dividing the village into groups of 50 or so households for close monitoring. Vietnam adopted a guerilla warfare approach to dealing with hot spots.

“"The Covid-19 outbreak is a stark reminder of the ongoing challenge of emerging and re-emerging infectious pathogens and the need for constant surveillance, prompt diagnosis, and robust research to understand the basic biology of new organisms and our

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\(^7\) Countries ranked by Physicians (per 1,000 people) www.indexmundi.com/facts/indicators/SH.MED.PHYS.ZS/rankings
susceptibilities to them, as well as to develop effective countermeasures.\footnote{8}

Centralizing information, policy and decision-making was the first key peg in the tale of success. This capacity was accompanied by swift action. On 31 December 2019, TCDC initiated inspection of inbound flights from Wuhan, China. April was the turnaround month with nationwide isolation ordered from the beginning to mid-month, but by the 23 April, the social isolation rule was lifted and restaurants and schools began to be re-opened. At the same time, arrivals from abroad continued to be quarantined for 14 days. The strategy was not secret. Fast action. Effective action. Social distancing, limited testing and extensive tracing. Swift, strict and focused responses. The political leadership was effective in implementation, communication and gaining the people’s trust.

Canada

Canada attracts little attention in assessing the quality of its response because it is located next to the United States with a record of cases and deaths about twice that of Canada’s. Just past mid-May, Canada had 77,000 cases of COVID-19 with 5,782 deaths. America had 1,520,000 cases and 89,932 deaths.\footnote{9} By the end of the month, the case load was over 1.7 million and there were more than 100,000 deaths. The U.S. has a population of 328.2 million people while Canada’s has only 37.6 million. That means that, comparatively on a per person basis, Canada has suffered about half as much from the pandemic as the U.S.

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<th>Mid-May</th>
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<th>Canada</th>
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<td>Population</td>
<td>328,200,000</td>
<td>37,600,000</td>
</tr>
<tr>
<td>COVID-19 cases</td>
<td>1,520,000</td>
<td>77,000</td>
</tr>
<tr>
<td>Cases per 1,000</td>
<td>46</td>
<td>20</td>
</tr>
<tr>
<td>COVID-19 deaths</td>
<td>89,932</td>
<td>5,782</td>
</tr>
<tr>
<td>Deaths per 100,000</td>
<td>27</td>
<td>15</td>
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Further, the records of many European countries are far worse as well with a 12% mortality rate in Italy and 9-10% in Britain, France and Spain, although countries like Germany and Greece have a much better record. In comparison, what we generally know of Canada is the following:

- Canadian capacity for testing remained low
- Canada had a relatively high level of health care to deal with the disease
- Yet, Canadian testing was initiated late, was narrow in focus and could not be considered aggressive.

Although the total number of tests administered, infections, hospitalizations, intensive care patients, and deaths are all key indicators of the impact of the disease, the best indicator is the rate of change in these numbers, especially mortality and hospitalization rates; they provide more context, nuance and balance.

On the other hand, in my accounts on Taiwan (more than half of Canada’s population), South Korea (1.5 times Canada’s population), and Vietnam (2.5 times Canada’s population), the number of cases over almost the same period, was 302 and 288 from Taiwan and Vietnam respectively and 10,000 in South Korea (versus 77,000 in Canada), while the number of deaths respectively were 5 and 0 with 288 in South Korea (versus 5,782 in Canada). There is no comparison between Taiwan and Vietnam compared to Canada. Even South Korea has been far more successful in handling the pandemic. It is only when Canada is compared to the United States that the Canadian record looks reasonably good.

Why the difference between Canada and the USA? Some of the reasons are obvious. Canada was led by a reasonably articulate leader who paid attention to scientists. America was and is led by a bully and a buffoon. By and large, on this issue, in Canada, the ruling party and the opposition generally saw eye-to-eye. Conservative premiers were as rational as the federal prime minister. In addition, the United States has a raucous large minority opposed to government. The Canadian public generally trusts government. Most importantly, Canada


\footnote{9} Provisional Death Counts for Coronavirus Disease (COVID-19) \hfill \texttt{www.cdc.gov/nchs/nvss/vsrr/covid19/index.htm}
has a universal health system revered by Canadians; America does not.

But the differences go much deeper. The American political right has a distrust of not only government, but of what it refers to as the deep state. As a result, there has been a much deeper hollowing out of government in America. The resulting chronic structural weaknesses and underinvestment in governance, compounded by Republican Party hostility to a federal bureaucracy, has meant that the capacity of the government to respond adequately to a health crisis has been severely compromised.

Further, the American media has also made a difference. Daily, the media are caught up in Donald Trump’s antics and media distractions, treating his performances as news. Instead of covering the president as a performer, he is covered as a politician when he is simply a corrupt narcissist who is often downright stupid. Except, the American press remains generally obsequious to the office even when the occupant of that office is a fool, all in the name of “objectivity”; the media avoids pressing a case of manslaughter as a result of negligence.

But none of this tells us why Canada, relative to the Asian country performances already described, has performed so badly. Was Canada fast off the mark and, if not, why not? Did Canada develop a national strategy and a centralized authoritative agency to deal with the crisis? How did Canada handle the issue of providing adequate protective gear for its health professionals? What did Canada do about testing and about tracing in all its dimensions? Why did Canada opt for an almost total emphasis on a lockdown and a stress on distancing and isolation? What has Canada done to advance treatment and a protective vaccine?

Some Historical Background

At the end of December, the Wuhan Municipal Health Commission in China reported a cluster of cases of pneumonia and soon identified a unique virus. The World Health Organization (WHO) went on an emergency footing. At the beginning of January as the news of the pandemic was creeping out of China, and the day after the U.S. Centers for Disease Control and Prevention (CDC) had already created an “incident management system” and issued a travel notice for travelers from Wuhan, Hubei province, the Canadian media was understandably focused on the 63 Canadians among the 176 people killed when Ukrainian International Airlines flight UIA 752 was shot out of the sky by the Iranian military after the plane took off from Tehran Airport on 8 January 2020.

However, the existence of a possible very virulent virus was already extant. On 4 January, the head of the University of Hong Kong’s Centre for Infection, Ho Pak-eung, insisted that the city implement the strictest possible monitoring system for a mainland mystery new viral pneumonia expecting a surge in cases during the upcoming Chinese New Year. The Singapore Ministry of Health on 4 January reported the first suspected case of the "mystery Wuhan virus" in Singapore, involving a three-year-old girl from China who had traveled to Wuhan. On 7 January, the U.S. Centers for Disease Control and Prevention (CDC) had already created an “incident management system” and issued a travel notice for travelers to Wuhan, Hubei province.

Quite aside from the disease threat, given Canada’s major concern with human rights, media interest in Canada could have been expected since there were reports that China was silencing its scientists. Chinese authorities censored the hashtag #WuhanSARS. They began investigating anyone who was allegedly spreading misleading information about the outbreak on social media. On 10 January 2020, Li Wenliang, a Chinese ophthalmologist and coronavirus whistleblower, started having symptoms of a dry cough. He was summoned to the Wuhan Public Security Bureau and forced to sign an official confession promising to cease spreading false “rumors” regarding the coronavirus.11 On 12 January 2020, he started having a fever and was admitted to the hospital.

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10 Yes, Trump’s Twitter threats against Democrats are a "distraction... www.salon.com/2020/05/28/yes-trumps-twitter-threats...

11 "We solemnly warn you: If you keep being stubborn, with such impertinence, and continue this illegal activity, you will be brought to justice—is that understood?” Li signed. "Yes, I understand." The Chinese doctor who tried to warn others about coronavirus - www.bbc.com/news/world-asia-china-51364382
on 14 January 2020. He died on 7 February. Only then did the Canadian press take notice.

Why in mid-January was the Canadian media preoccupied with whether the Queen in Britain would allow Prince Harry and Meghan Markel to live part time in Canada while reporting nothing about the virus? On 5 January, WHO had already published its first Disease Outbreak News for the world community on the new virus named novel coronavirus-infected pneumonia (NCIP), although, as yet, there was no risk assessment. By 10 January, WHO had issued a technical package of guidelines to countries on how to detect, test and manage potential cases. Based on experience with SARS and MERS and known modes of transmission of respiratory viruses, the guidelines covered infection and prevention controls to protect health workers, recommending droplet and contact precautions when caring for patients, and airborne precautions for aerosol generating procedures. Two days later, China published and shared the genetic sequence of COVID-19.

On 14 January, based on the experience with SARS and MERS, WHO's technical team suggested that among the 41 confirmed cases, some limited human-to-human transmission of the coronavirus, mainly through family members, could be expected. WHO warned that there was a risk of a possible wider outbreak. In Canada, a small specialized military intelligence unit (MEDINT) began producing warnings and analyses.12 There was no indication that the intelligence reports were widely distributed within government at the time. I could find no evidence that these reports were distributed to the media.

America was much further ahead. On 3 January, Dr. George Gao from China was on vacation in the U.S. with his family and briefed US CDC Director Dr. Robert Redfield, on the severity of the virus. Redfield was rattled. By contrast, in Canada, other "more serious" items appeared in the press which in retrospect are the height of irony. Boeing very reluctantly stopped its production of the 737 Max jet testing – and probably saved billions. Trump appeared before the World Economic Forum in Davos calling climate change advocates “prophets of doom” while he celebrated American oil and gas production that would soon enough result in over-production and a drastic drop in prices. Meanwhile, the Canadian government had won its case before the Supreme Court against B.C.’s rejection of pipeline expansion.

By the time President Trump's impeachment trial had opened in Congress on 22 January, two days earlier the U.S. had confirmed its first cases of COVID-19, then called the Wuhan coronavirus. While Canada was preventing Meng Wanzheu of Huawei's return to China and holding her for possible extradition to the U.S., the U.S. Centers for Disease Control and Prevention had an emergency response system and activated it. America authorities were advised to step up airport health screenings and Trump stopped flights from China.

On 22 January, the World Health Organization (WHO) convened an Emergency Committee to assess whether the outbreak constituted a public health emergency of international concern. By 30 January 2020, after a meeting in China to better understand the context and international implications as well as exchange information, upon their return, the Executive Committee of WHO reconvened and advised the Director-General that the coronavirus outbreak constituted a Public Health Emergency of International Concern with 7,818 confirmed cases, dubbing the risk assessment very high for China and high for the rest of the world. By then at very least, Canada should have stood up and taken notice. American administrative initiatives, meanwhile, were being undermined by the political administration.

By the time of Trump's impeachment, and after 300 confirmed diagnoses and 6 deaths had been reported in China, the Chinese cover-up of the spread of a new coronavirus ended. On 21 January, the Communist Party's Central Political and Legal Commission called for the public to be kept informed and warned that deception could "turn a controllable natural disaster into a man-made disaster."13 In the U.S., on the day the impeachment trial began, Dr. Anthony Fauci, America's foremost

12 Canadian military intelligence unit issued warning about Wuhan... www.cbc.ca/news/politics/coronavirus-pandemic-covid...

13 New China virus: Warning against cover-up as number of cases ...... www.bbc.com/news/world-asia-china-51185836
infectious disease expert, gave a video news report on Voice of America.

Data was quickly accumulating on the rapid spread of the disease, human-to-human transmission and a rapidly increasing rate of transmission. China shut down Wuhan with a total quarantine on 23 January and suspended its public transportation. But while the American experts were issuing alerts, at the Davos Forum, Trump assured everyone that America had the problem under control and that “it’s going to be just fine.”

The sense of the enhanced riskiness of this disease was growing by leaps and bounds. On 24 January, in *Lancet*, Chinese scientists established that people could be symptom free for a few days after being infected, thereby greatly increasing the rate of infection. Personal Protective Equipment (PPE) was strongly recommended for front line health workers. The disease had spread to Thailand, Australia, Malaysia, Sri Lanka, Japan and Singapore when Canada reported its first case in Toronto on 25 January.

Governments should have been in panic mode. Gabriel Leung, Dean of the University of Hong Kong medical school, a world expert on SARS and viruses, offered nowcasts and forecasts of the coronavirus projecting that the true number of coronavirus infections was likely 10 time more than the official reported numbers and that draconian measures were needed to slow the progress. He predicted that the number of infections would exponentially peak in late April or May when there could be up to 100,000 new infections per day. The disease had spread to Austria, Romania, Ecuador, Fiji, Samoa, Poland, Mongolia, Switzerland, Germany, France, United Kingdom, Russia, Tibet, UAE, Brazil and who knew where else.

Professional officials in the U.S. were on top of the crisis with dire warnings from its intelligence agencies. Even Trump’s acting chief of staff, Mick Mulvaney, initiated regular meetings and briefings on the virus. But Trump himself was dismissive. A senior medical adviser at the Department of Veterans Affairs, Dr. Carter Mecher, emailed public health experts in government and universities that, “The projected size of the outbreak already seems hard to believe.” There was no equivalent level of action in Canada.

On 30 January, finally there was some substantive initiatives. Air Canada halted direct flights to China following the federal government’s advisory to avoid non-essential travel to the mainland. In contrast, Peter Navarro, even as Trump downplayed the crisis, warned that the virus could evolve “into a full-blown pandemic, imperiling the lives of millions of Americans.” Azar, Redfield and Fauci supported the travel ban because it could buy some time to put into place prevention and testing measures. Little did they know or recognize that the time bought in February would almost entirely be wasted.

Meanwhile, in Canada, an op-ed appeared fearing the transportation cut-off to China would disrupt our agricultural trade with China. And the Canadian Health Minister, Patty Hajdu, not Donald Trump, was reassuring Canadians at the end of January that the risk to Canadians remained low.

David McKeown, former medical officer of health for Toronto, advised Torontonians not to “let the coronavirus mutate into an epidemic of fear and panic.” Only on 29 January, did the House Committee on Health begin to discuss the threat.

**Explaining Canada’s Alacrity**

James Somers ended his excellent article on how American engineers responded to the COVID-19 crisis, more particularly, the shortage of ventilators, with a quote from Michael Ryan, the executive director of health emergencies at WHO. Ryan stressed the

14 Donald Trump just gave the most incredible speech at Davos
www.telegraph.co.uk/politics/2020/01/21/donald-trump-just

15 How experts were sounding alarm about coronavirus since January...
www.soundhealthandlastingwealth.com/health-news/how2020-04-12


17 Risk of Chinese coronavirus to Canadians low, health minister... toto.citynews.ca/2020/01/23/coronavirus-low-risk-canada 2020-01-23

importance of speed. "If you need to be right before you move, you will never win."19

Commentators noted with favour the speed at which Vietnam, Taiwan and even South Korea responded to the COVID-19 crisis as a critical explanation of why their infection and death rates were so low in this pandemic. Canada, in contrast, acted with alacrity. One reason given for the speed of the response of the Asian countries is their experience with SARS (Severe Acute Respiratory Syndrome) in 2003. As a result of lessons learned from that new coronavirus epidemic that emerged out of Foshan, Guangdong, China, preparations were put in place for the future.20

As Christopher Kirchhoff wrote in a recent issue of Foreign Affairs, "Ebola Should Have Immunized the United States to the Coronavirus."21 And even more acutely SARS in Canada, for Canada had its own SARS crisis. A Chinese woman returning from Hong Kong on 23 February 2003 died on 5 March. Eventually, 257 individuals in the Province of Ontario were infected.

The Asian states were determined never again to be caught unprepared. The COVID-19 crisis proved that they were not. Why was Canada seemingly caught unawares when it had its own terrible experience with SARS? Canada, too, had responded to the 2003 crisis with a provincial thorough investigation and a detailed report by Justice Archie Campbell; the federal government issued the Naylor Report.22

The final report of the Ontario independent commission was completed in 2006 and the Minister of Health and Long-Term Care made it

20 The crisis in the ill-prepared Hoping Hospital in Taiwan where the hospital was sealed off with 1,000 patients inside in response to the SARS scare in April 2003 was an example of a panic reaction when there was an absence of preparation. Vietnam had a similar fright. A Chinese-American, Johnny Chen, carried the SARS virus to Hanoi where, when in the French Hospital, he infected 38 members of the staff. He died on 13 March.

public on 9 January 2007. The report documented how the SARS virus came into the Province of Ontario, spread and the inadequate response of the health authorities and recommended the need to isolate and quarantine, to test and track contacts, how to work on treatments and vaccines, but the greatest stress and emphasis of the report was on the measures needed to protect public and health workers. Quality tested masks, gowns and other protective equipment had to be purchased and stockpiled.

At the same time, a few racist Canadians attacked Canadians of Chinese ancestry. There were fears of domestic tensions with racist overtones. Attention was also given to the airlift to extract Canadians from Wuhan. At the same time, public health research was referred to as supporting the Government refusal to ban travel. The federal government has decided to follow the WHO’s advice against travel bans. According to Health Minister Patty Hajdu on 17 February, "There isn’t evidence’ that they effectively contain viral outbreaks."23 There were many distractions.

Imposing a total travel ban on China was viewed as contrary to both Canadian foreign policy and a source of stimulating anti-China sentiment. China, in turn, referred to Canada as a bulwark of calm in response to the crisis. Andre Picard in The Globe and Mail on 4 February24 even questioned whether Canadians returning from Wuhan who were quarantined for 14 days at Canadian Forces Base Trenton needed to be. He had clearly not read the Campbell Report and, it turned out, few had. Picard advised, “Canada hasn’t acted promptly, so at least it can do so smartly.” He argued that medically, quarantine was unnecessary but politically essential. "Politicians and public health officials have to be seen acting, even if their actions are not especially useful.”

However, the problem was not pretence, but that officials were not acting sufficiently quickly and implementing what had been learned from prior experience. As Dr. David Butler-Jones, Canada’s first chief public health

24 Andre Picard, “Ontario’s Health System is in Trouble.”
officer and Deputy Minister of the Public Health Agency of Canada, wrote, in opposition to Picard, there was a dire need for public health specialists and expertise. “There are few things that focus the mind quite like the fear of contagion. With the emergence of a new coronavirus, the world is once again reminded of the outbreak of SARS in 2003.”25

However, Butler-Jones insisted that, “Public health officials and governments across the country are responding quickly and diligently to the current outbreak, applying lessons from SARS.” If this were true, why the failure to introduce a travel ban? Why was there no systematic effort to document the poor state of our protective equipment and, more importantly, take action to redress the problem? Butler-Jones, while mentioning the Campbell Report, focussed on the federal Naylor Report response to the 2003 crisis which stressed communication, coordination and cooperation across jurisdictions. Was the bureaucracy more concerned with coordination and communication than taking action? Was it a matter of cultural values? While China, Taiwan and Vietnam were promoting dedication and sacrifice, Canadian officials were reassuring its citizens that there was little to worry about.

The Public Health Agency of Canada (PHAC) and Public Health Ontario were created in response to SARS in 2003 and that proved crucial in stopping the H1N1 pandemic in 2009. Since then, however, “many governments seem to have forgotten those lessons as changes since 2014 have diminished the capacity of public health to prepare for and respond to new and inevitable threats, as well as to carry out their mandate to protect and promote health and prevent illness and injury.”26 Government offices have been fragmented and depleted. Generic public servants have replaced specialists. Economic management rather than resource expertise has been at the forefront.

However, changes in the make-up and organization of the Canadian civil service were not the only problems. For why were the experts complacent even in light of past evidence and reports? The University of Toronto by the end of the first week in February had established a steering committee of senior administrators and infectious disease experts who announced that, “the risk in Canada is low.” A more serious concern was stigmatization and discrimination.

There was another problem. Most observers attended to the economic crisis that followed the COVID-19 crisis. However, even before the crisis in early December, Statistics Canada revealed the loss of a staggering 71,200 jobs, the worst month since the Great Depression.27 The monthly consumer confidence index slumped to its lowest reading in three years. The fear of a made-in-Canada recession became extant.

Canada faced a real firestorm – fear of an even greater impact on an already endangered economy, especially in the oil and gas sectors and in the tourist sector as the lucrative Chinese tourist industry (750,000 the previous year) died overnight. The fear was economic, not health. This was true internationally as well as locally.28 “As the coronavirus's effects on the economy continue to mount, political leaders and central bankers are starting to take action. This morning the finance ministers of the G7 countries issued a joint statement saying, ‘they would ‘use all appropriate policy tools’ to try to contain the virus and its effect on the economy. (The virus has jittered markets, slowed manufacturing in China and put a dent in international travel.)”29

27 “Economy lost 71,200 jobs in November, unemployment rate climbs to 5.9 per cent,” The Canadian Press, 6 December 2019.
28 By 4 March, the U.S. Federal Reserve cut its interest rate by 50 basis points. The Bank of Canada quickly followed the American lead. Dozens of Canadian businesses included new disclosures in their financial reports that outlined the impact coronavirus could have on their operations and the growing risks that could affect profits. Media reports carried warnings of a coming coronavirus recession. Health reports from around the world enhanced the growing panic.
Isaac Bogoch, an infectious-disease specialist and physician with the University of Toronto, advised that. “Travellers need to be aware of where they are going, how they are getting there and know the latest [travel] restrictions, but they don’t need to cancel trips or stop thinking about future ones. Canadian tourists consoled themselves: the decreased volume of tourists was a godsend as we encountered smaller lineups, less traffic and easier access to everything.”

Where was the real crisis in Canada located? – the Wet’suwet’en blockades that had brought the rail transportation system to an effective halt. Bruce Aylward, a renowned Canadian epidemiologist who led a team of experts to China to study the novel coronavirus on behalf of the World Health Organization, was still living in an echo chamber in which Canadians did not or would not listen to his insistence that an aggressive approach to managing and treating the disease was needed. By the end of February, Canadians began to fear that the new virus was about to assault Canada, there were still relatively few cases. However, epidemiologists saw what was coming. Instead of reassuring Canadians about the low risk, they now urged immediate action, including:

- Directives for walk-in clinics, policies on patient transfers and guidelines on the appropriate use of isolation rooms and masks.
- Large-scale tests of people who visited clinics and hospitals to determine if and when the virus starts spreading in Canada.
- Ensuring there are enough ventilators, an especially important treatment tool for people over the age of 65, who appear to experience the worst effects.

Federal Health Minister Patty Hajdu changed her tune from reassurance to urging Canadians to prepare by ensuring they have an adequate supply of food and any prescription medications, and be vigilant about hand washing and staying at home when sick.

Why was Canada so complacent and passive as the COVID-19 crisis grew in January and came to world attention? Why did this complacency continue almost through all of February? We noted that the intelligence about contagious diseases had been tucked away in a small unit if the Defence Department. But defence itself as a whole had been grossly neglected. According to scholarly research, Canada was not only complacent about its security interests related to contagious diseases, but about all security matters, particularly those that arose in the Far East.

The scholars concluded not simply that Canada was asleep at the switch, but that Canada was just not there. Canada was absent without leave. In other words, complacency in Canada was a trademark rather than an aberration.

Many factors combined to reinforce Canadian inertia. The lessons from SARS in 2002 had not been institutionalized. The Canadian administration had been hollowed out of expertise; administrators with a primary preoccupation with budgets replaced the experts. Stress was placed on cooperation and coordination rather than action and initiative. Canadian leaders feared Chinese and anti-China prejudice more than COVID-19. They were even more fearful of the already looming

30 Can you contract COVID-19 passing others on the sidewalk? Answers...
www.ctvnews.ca/health/coronavirus/can-you-contract-covid-19

31 In a commissioned research paper by the Canadian Department of Defence, “A mapping exercise of DND and CF activities related to Asia Pacific and Indo Pacific security, 1990-2015,” in a time when security concerns, diplomacy, and governance, non-state and state institution building, security concerns and dialogue, were all bywords, in a time when China was being acknowledged as a major player in the region, and when Canadian soft as well as hard policy was pivoting to Asia, “there has been a noticeable decline (my italics) in the Canadian presence, never mind leadership.” By neglecting our interests and opportunities, we undermined Canada’s security interests now most apparent in the health field. Canada just does not, and did not, sustain or maintain its commitments even in areas central to our security concerns. The authors (David Dewitt, Mary Young, Alex Brouse and Jinelle Piereder) of the report in the article they published in International Journal in 2018 (Vol. 73:1, 5–32) entitled their piece, “AWOL: Canada’s defence policy and presence in the Asia Pacific.”
economic downturn and did not want to face the economic disaster that would result from the COVID-19 crisis. Diplomatic priorities with China in foreign policy also took priority. Initiative, entrepreneurship and action were effectively undercut until the crisis loomed like a huge monster before Canadian leaders.

Canadian health professionals had started issuing warnings. “Person-to-person spread of the coronavirus within Canada unrelated to travel to an outbreak region is inevitable,” experts said as they called for more aggressive testing. “You can slow it down, but you can’t stop it,” said Gardam, chief of staff at Toronto’s Humber River Hospital. “Local transmission is coming.”

In Washington state, six died. Reports suggested the virus has been circulating for at least six weeks. There were fears that the virus would spread to British Columbia. Ontario initiated “pilot” sites testing patients with flu-like symptoms for COVID-19. By early March, there were 27 confirmed Canadian cases – 18 in Ontario, 8 in B.C. and 1 in Quebec. Canadians abroad, specifically ones on the cruise ship Diamond Princess, tested positive for the virus. Hope had been abandoned that health authorities could contain the epidemic. Isolation and separation, testing, and tracing, new treatments and a new vaccine would help mitigate, slow and eventually stop the disease. But the possible devastation was incredible. Harvard University epidemiologist, Marc Lipsitch, forecast that without adequate interventions, an infection rate of 20-60% might result. At a mortality rate of 1%, that would mean 30 million deaths.

The story had switched from complacency to near panic. On 7 March, B.C., Provincial Health Officer Dr. Bonnie Henry announced a COVID-19 outbreak at a long-term care home in North Vancouver after two residents were diagnosed with the virus. What a difference a week makes. As Thomas Homer-Dixon in a Globe and Mail op-ed observed, “What a difference seven days make. Shopping for groceries at a big box store near Victoria during the last week of February, I found nothing amiss. Shelves were well-stocked, people’s carts contained the regular assortment of necessities and goodies, and everyone seemed to be happily going about their daily lives. A week later, I stood in front of the same shelves, expecting to find them filled with the usual staples – flour, pulses, sugar and the like. But they’d been stripped bare. Now, shopping carts were groaning under giant bags of potatoes, stacks of packages of frozen chicken and large jugs of water. People kept their distance from each other in the aisles. No one was smiling.”

Governance and COVID-19

Clearly, the way the states and sub-state units were managed to respond to the virus made a difference. Rules and norms structured, sustained and regulated the way the state and businesses delivered goods and services in the face of the threat. Further, as I have emphasized, the gap between accountability and performance was glaring in Canada. Different systems of governance had different priorities and different modes of action. Most glaring in Canada, was the discrepancy between the government’s performance and how it was held responsible and accountable. Canadians generally took pride in the way their government performed but I have suggested that this was largely a by-product of America serving as the main measure of comparison.

Governance is about action. Canada was very slow to take initiatives – except perhaps in the area of creating welfare cushions for its citizens. Canada offered small businesses a wage subsidy of up to 75% to retain employees. The general priority was economics over collective health, not in terms of ensuring businesses could operate, but in terms of tackling economic insecurities. Manufacturing had been hit, the international travel market was devastated and small businesses were closed everywhere.

How would the virus be contained with the minimal effect on the economy? Given the very late start, hope had been abandoned that health authorities could contain the epidemic. Isolation and distancing or separation, testing and tracing, new treatments and a new vaccine would

34 “Coronavirus will change the world. It might also lead to a better future,” The Globe and Mail, 11 March 2020.
mitigate the pandemic. But testing was initiated very late and very sparingly. There was effectively no tracing. Finally, on 23 March the federal government announced a lockdown. On 25 March, the Province of Ontario announced its emergency plan.

However, Ontario’s Bill 188, the Economic and Fiscal Outlook Act, primarily offered amendments to the Personal Health Information Protection law which focused on personal privacy when information was being collected. The largest provincial government allowed organizations to collect personal data only with permission and in a system to prevent unauthorized snooping. There would be no use of emails to determine everyone’s location. And to issue warnings.

Governance determines value priorities. Canadian initiatives focused on the rights and welfare of individuals and not on the well-being of the community as a whole. There was no obligation to wear masks. A significant minority of Canadians believe that the requirement to wear a mask is an imposition on their individual freedom just as they once insisted that wearing a motorcycle helmet was as well. But wearing a mask is sensible and protects others. That is not difficult to grasp. Why should wearing a mask be a matter of individual volition? Because it offends our sense of independence and even masculinity? Because we do not want to be identified with “political correctness”? But the vast majority of Canadians and even Americans concur that wearing a face mask is a matter of public health rather than a matter of personal choice.

There were no fines for disobeying norms for gathering. There was no enforced quarantine. The possible devastation was incredible. Harvard University epidemiologist, Michael Lipsitch forecast that, without adequate interventions, an infection rate of 20-60% might result. 35 With a mortality rate of 1%, that would mean millions of deaths in the United States and Canada. Canadian interventions may have been inadequate and very late, but they played a significant role in mitigating the pandemic.

Privacy protection is fine. Negative freedom and protections against external controls are important. But what about positive freedom? What about ensuring collective safety and security? Was negative freedom a priority as a pandemic was about to take off and when “we were not doing well in all the efforts to mitigate the disease itself,” when “testing was rare,” when “there was no tracing of those who came in contact with a person diagnosed with thee disease”? Most embarrassing of all was “the severe shortage of Personal Protective Equipment (PPE) for frontline health workers. For this was a matter of both personal and collective freedom.” It is really a Wild West when it comes to buying medical supplies right now,” Deputy Prime Minister Chrystia Freeland said. By the first of May, reports documented that Canada’s emergency stockpile of personal protective gear was ill-prepared for the pandemic and constituted a fraction of what had been and what was still needed. 36

The death toll was often very concentrated. A large number of deaths were taking place in long term care facilities. “Nursing homes account for 81 percent of the country’s COVID-19 deaths,” according to Theresa Tam, Canada’s chief public health officer. Other centres were meat packing plants. After Cargill closed the doors of one of its plants for two weeks because of a high rate of infections among its workers, when the plant was re-opened, less than half the workers were wearing masks. A week later, Cargill suspended operations at Chambly, Quebec when 10% of the workers there tested positive.

The problem is that Canada over April and May remained relatively complacent. David Fisman, a professor of epidemiology at the University of Toronto’s Dalla Lana School of Public Health emphasized the necessity of testing aggressively as a key to a healthy province that could also enjoy a reasonably rapid economic recovery. When asked why the same discussion recurs over and over again, he responded, “I am completely baffled. I’ve expressed some frustration over the past couple of days with some of the contacts I do have with the province, saying I’m not playing this game


36 “The federal agency did not have a target for the levels of personal protective gear it should maintain in the stockpile, did not know what level of stockpiles the provinces and territories had and did not advise lower-level governments about how much should be stockpiled.” (Globe and Mail)
anymore. Various people reach out and ask for your opinion or ask for your work, and it disappears down a black hole. That pithily sums up what has happened from March through April and May.

The problem was clearly multifaceted. Canada acted too slowly. It had failed to institutionalize lessons learned from the SARS epidemic. The country stressed coordination and cooperation over initiative and action. Though not nearly as much as the U.S., the country had a culture which stressed negative freedoms over positive freedoms. But quite aside from its culture, Canada failed to inventory its PEP. Was that a result of the Canadian version of hollowing out the civil service under Prime Minister Harper? And why did the fear of racism loom so large when that was a minor sideshow? It seems clear that the culture of polite and moderate Canadians has its own problems when facing a crisis. Will Canada learn from COVID-19?

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