COVID-19 Lockdown and its Impact on Social–Ethics and Psycho-Social Support for Disability Care

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Abstract: This paper aims to explore the social-ethics dimension and the psychosocial support for persons with disabilities, as well as health and social care practitioners during the COVID-19 pandemic and beyond regarding quarantine conditions currently ravaging the world. The COVID-19 outbreak has motivated the enactment of public health control procedures, particularly quarantines. The impacts of quarantines during this COVID-19 outbreak period and the interventions to relieve the strain are discussed through a descriptive analysis pattern and linked with social ethic and psychosocial support for behavioural health and social work practices. The role of the social-ethic perspective is that it is geared towards reducing the psychosocial impacts of the COVID-19 quarantine for persons with disabilities and for disability care. This paper outlines psychosocial uneasiness, including distress and stressors, as a result of the hazards and anxiety sensitivities, as well as the immense concern for persons with disabilities and their care practitioners during quarantine and beyond. This paper offers new insights on the COVID-19 virus and the quarantine measures that were missed, which could have averted its spread globally; quarantine or lockdown has a secondary effect in lessening the capacity of the virus's transmission and decreases the likelihood of people contracting, and thus infecting others. This paper suggests recommendations for persons with disabilities in quarantine and their families and the management of perceptions of public health risks, threats, and issues about health and social care workers becoming "covitors" (meaning COVID-19 survivors) now and post-COVID-19.

Keywords: COVID-19, Quarantine, Psycho-social, Social-ethics, Persons with a disability, Disability care, 'Covitors'.

1. INTRODUCTION

It is increasingly becoming imperative to explore the social-ethics dimension of care and the psychosocial support for persons with disabilities during the COVID-19 pandemic that ravages the world in the most part of 2020. The impacts of quarantine during this COVID-19 period and the interventions to relieve the strain are discussed and linked with social ethics for the behavioural health and social work practices post-COVID-19. The role of the social-ethic perspectives aims to improve the psychosocial impacts of the COVID-19 quarantines for persons with disabilities. The year 2020 is becoming recognised as a colossally universal health menace and life-threatening socio-economic and psychosocial scenario. The recent quarantine measures put in place by the United Kingdom's government, from 25 July 2020, for its citizens coming back from a holiday in Spain, to quarantine or self-isolate for 2 weeks upon arrival in the UK, indicates that quarantine is here to stay if the COVID-19 infection rate is to be controlled. However, the Spanish government is struggling to save its tourism industry, which welcomed over 18 million UK citizens, who made up about a quarter of all the tourists' arrivals in Spain, in 2019 [1], expanding on how deep COVID-19 has affected social interactions. The novel coronavirus SARS-CoV-2 spreads from person-to-person through close contact, and it is the causative mode of COVID-19 that was exposed in 2019; it is a variation of the Middle East Respiratory Syndrome (MERS-CoV) and Severe Acute Respiratory Syndrome (SARS-CoV) [1, 2].

A British scientific study exposed that COVID-19 damages not only the heart, kidneys, and lungs but also the brain, making patients undergo or experience neurological disorders comprising hallucinations and paranoia [3, 4]. The report added that patients suffer from a "persecution complex", which is influenced by an obsession with constantly putting on and removing their coats. This repercussion on the brain is evident for a minimal number of patients infected with the COVID-19 virus. However, the findings suggest that although the disease is, 'a respiratory disease, it attacks the neurons just like rabies making it a "neurotropic inclination," as such, results revealed that COVID-19 patients in hospital care develop severe neurological symptoms, whereas the pulmonary symptoms were comparatively weak.' Another study, by Lancet Psychiatry, disclosed that, out of 125 patients who were seriously ill with COVID-19 at a United Kingdom hospital, half of the patients had undergone a 'stroke because of blood clots, although others suffered brain inflammation, psychosis, or dementia-like symptoms' [4, 1].

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The COVID-19 neurological status comes in during the aftermath of the virus's attack; as such, survivors become “covitors", as a friend of mine who survived the COVID-19 virus calls it, due to what survivors have gone through, including horrible respiratory, heart, kidney, and brain damage. My friend's "covitor” explained the neuro-psychosomatic or “persecution complex” [4] experience of "feeling like everything coming to your hand would infect the next person, despite the sanitised hands, as you feel infected after sanitising everything every day… that you see everyone around you were out to infect you with their mask, and weak sanitiser…you become too emotional looking at the journey you travelled, especially nightmares." (Culled from a covitor in Pretoria, South Africa, 24 July 2020). Researchers from Kings College London, using the COVID Symptom Study App, discovered distinct types of COVID-19, each with a separate cluster of symptoms that should assist the clinical supervision and management of the disease and aid in the prediction of persons that are most at risk and could require hospital care in the course of the second wave of COVID-19 infections Sudre *et al*. [5] and maybe post-COVID-19.

The six distant types of COVID-19 and their clusters of symptoms include the following, with the most prominent symptoms written in italics: (a) “Flu-like with no fever (headache, loss of smell, muscle pains, cough, sore throat, chest pain, no fever); (b) Flu-like with fever (headache, loss of smell, cough, sore throat, hoarseness, *fever, loss of appetite*); (c) Gastrointestinal (headache, loss of smell, loss of appetite, diarrhoea, sore throats, chest pain, no cough); (d) Severe level 1, Fatigue (headache, loss of smell, cough, fever, hoarseness, chest pain, *fatigue*); (e) Severe level 2, Confusion (headache, loss of smell, loss of appetite, cough, fever, hoarseness, sore throat, chest pain, confusion, muscle pain; (f) Severe level 3, abdominal and respiratory (headache, loss of smell, loss of appetite, cough, fever, hoarseness, sore throat, chest pain, fatigue, confusion, muscle pain, *shortness of breath, diarrhoea, abdominal pain*”[5, 6]. The COVID-19 outbreak has motivated the enactment of public health control procedures, particularly quarantine. This paper outlines the considerations of social ethics as a precursor in understanding psychosocial concerns, including distress as a result of hazards and risks, and anxiety sensitivities that should influence quarantine control and how it affects persons with disabilities and disability care practitioners, who are frontline workers.

The lessons learned from quarantine regiments were enforced in Canada and China in 2003 due to the epidemic of the severe acute respiratory syndrome (SARS), which revealed the imposition of citywide quarantines and the issues of self-isolation at home and in state-owned amenities. The Ebola quarantine required the closure of entire villages in West Africa [5, 6]. The major impact, according to the [7], is that the COVID-19 quarantine has mainly affected low-income economies and households, with youths and women, self-employed, low-skilled workers, and most especially persons with disabilities being the most adversely affected. The question that arises is how do we support these vulnerable people, especially persons with disabilities and their primary caregivers/workers, during the COVID-19 pandemic with its quarantine regiments and beyond?

There has been no significant progress in the overall COVID-19 outbreak response because of the quarantine impacts on psychosocial support for persons with disabilities or the strategic COVID-19 response pillars. In tackling the COVID-19 pandemic, the OECD [7] asked a question on the impacts and consequences of the pandemic, regarding how the global effort in contributing to some solutions can assist in discovering methods of enhancing worldwide healthcare systems, protecting businesses, sustaining jobs and education, and alleviating the financial markets and economies. This paper aims to offer solutions that can boost the health, mental, and social care systems for disability care, as many governments have resorted to quarantines or lockdown measures to curb the spread of COVID-19.

2. COVID-19 QUARANTINED IMPACTS: MATTERS REGARDING PERSONS WITH DISABILITIES

Quarantine is an operational method to protect the public from spreading contagious diseases and assisting groups or people from unintentionally infecting others [8]. The public is given information about the COVID-19 pandemic and is told not to come in close contact, about 6 feet, of other people throughout a lengthy period of time, and wear a mask always. Other measures include banning the sales of alcohol and cigarettes, maintaining social isolation, and the closure of certain businesses that could trigger the spread of COVID-19. Isolation is for persons who already have the disease; it prevents them from infecting and spreading COVID-19 to healthy people. The Centre for Disease Control (CDC) gives directives on how best to behave and what happens during COVID-19 quarantine. According to Med-Associates [8:1-2], the directives are as follows:

- "**Make it a staycation:** Avoid leaving the house unless absolutely necessary. That means no work, school, or church and saying no to your cousin's baby shower.

- **Call ahead:** While your local or state health department will most likely keep tabs on your health, you may need to see your doctor, too. Please call ahead BEFORE you visit any of our clinics so that we can take steps to prevent others from getting infected.

- **Are you worried about Fido?** At this time, the CDC says there's no evidence that companion animals, including pets, can spread COVID-19. But it may still be good to use caution still. If you've been exposed to COVID-19, one should avoid petting, snuggling, being kissed or licked, and sharing food with your pet during a coronavirus quarantine.

- **Have your own stuff:** Don't swap unwashed dishes, eating utensils, towels, or bedding with other people or pets in your home.

- **Wash, rinse, repeat:** Hygiene is an integral part of this, even at home. Hand washing should be your first line of defence when under quarantine. And don't forget to cough or sneeze into your elbows or a tissue that you then immediately throw away" [8, 7].

Furthermore, the United Nations [9:1-2] declared some key actions that states and other stakeholders are obligated to act on or perform. These obligations include the followings:

- "Prohibit the denial of treatment on the basis of disability and repeal provisions that prevent access to treatment based on disability, level of support needs, quality of life assessments or any other form of medical bias against persons with disabilities, including within guidelines for allocation of scarce resources (such as ventilators or access to intensive care).

- Ensure priority testing of persons with disabilities presenting symptoms.

- Promote research on the impact of COVID-19 on the health of persons with disabilities

- Identify and remove barriers to treatment, including ensuring accessible environments (hospitals, testing, and quarantine facilities), as well as the availability and dissemination of health information and communications in the accessible modes, means, and formats.

- Ensure the continued supply and access to medicines for persons with disabilities during the pandemic.

- Conduct training and awareness-raising of health workers to prevent discrimination based on prejudice and bias against persons with disabilities.

Closely consult with and actively involve persons with disabilities and their representative organisations in framing a rights-based response to the pandemic that is inclusive of, and responsive to, persons with disabilities in all their diversity."

Nevertheless, the quarantine measures have been a subject of political point-scoring in many countries. For example, the declaration of a state of emergency in eighty-four countries in reaction to the COVID-19 pandemic has led to suspicions regarding power abuse [10]. Further instances of COVID-19 quarantine have influenced the proscription of mass protests, elections being suspending at times when elections are being held, oppositions are disfranchised from conducting effective campaigns, discriminatorily imposing lockdown guidelines on political opponents, dispensing out relief payments to political supporters, and the exposure of extensive surveillance programs for contact tracing that increases suspicions of the state violating the privacy of minorities [10, 11]. Diplomatic rifts within countries erupted on topics such as quarantine gadgets, like masks, in the United States and Canada as President Trump, on 2 April, invoked the Defense Production Act of 1950 to stop exports of over three million masks designated to Canada and Latin America; while the Canadian leader, Trudeau, lamented such an act at this critical period, of restricting the trade of vital medical deliveries and professionals, as disappointing [11].

In view of states and stakeholders' obligations in ensuring the continued supply and access to medicines for persons with disabilities during the pandemic, the above accounts in some countries indicate the superficial approach to disability care. Nwachukwu and Segalo's [12] study revealed the cosmetic or superficial approach to the application of ethical values in the avoidance and the repetition of the misfortunate

outcomes of the mental health fiasco known as the Life Esidimeni in South Africa. They advocated for the inclusion of ethical justice in tackling mental and social care, urging practices to harbour effective services for vulnerable groups.

Another outcome of COVID-19 is that the South Africa High Court found the regulations issued in terms of section 27 of the Disaster Management Act, 2002 (Act No. 57 of 2002) (the “Act”) under Government Gazette No. 43258, unconstitutional and illegal [13]. The Court established that the regulations, in several considerable instances, are not rationally associated with the objectives of reducing the rate of spreading COVID-19 [14]. A letter was in circulation accusing the official opposition leader of the Democratic Alliance (DA) in South Africa of "playing politics" with people's lives by suggesting that the economy should reopen instead of engaging with the government [15]. However, the DA reacted by placing blame and accusing the government of senseless regulations by limiting e-commerce operations, which compelled the government to reassess said regulations [15]. These above outcomes could impact persons with disabilities due to the non-availability of adequate quarantine devices and vital medical deliveries, as well as the limited accessibility to professionals in disability care.

The obligations for states and stakeholders can rekindle the following processes, which includes the, “increase temporarily the resources of institutions including human resources and financial resources to implement preventive measures, and during the emergency period, ensure continued respect of the rights of persons living in institutions including freedom from exploitation, violence and abuse, non-discrimination, the right to free and informed consent, and access to justice” [16:1; 17]. Psychosocially disabled people reported on the enlarged risk of emerging severe symptoms and death due to their, “weakened immune systems due to poor nutrition, neglect, institutionalisation, and homelessness, including in children and older persons with psychosocial disabilities;” and the, “long-term consequences of physical, psychological and sexual violence and abuse, particularly against women with psychosocial disabilities” DK-Media [15:2].

Human Rights Watch [17] advised the Nigerian government, both at state and federal levels, to ensure the rights to food, shelter, and other basic provisions for those who have suffered a loss of income and employment during the COVID-19 pandemic under lockdown regulations. The report further stated that the Nigerian government was required to join public health measures, such as quarantine, with efforts to prevent the COVID-19 pandemic impacts on the lowest income earners and vulnerable persons, as "millions of Nigerians observing the COVID-19 lockdown lack the food and income that their families need to survive" [17:3]. Conversely, the quarantine measures hit the informal sector hard, which harbors more than 80 per cent of Nigerians. Moreover, the report alleged that the Ministry of Humanitarian Affairs commenced disbursing 20,000 Naira (US$52) to families registered in the National Social Register of Poor and Vulnerable Households, consisting of over 11 million people, which was far below the over 90 million people targeted who live in extreme poverty in the country.

The lack of transparency in government to disclose important details of the cash transfer program generated uncertainty on how many people really benefited from the program; also, the economic responses of COVID-19 by the Nigerian government might not sufficiently protect the rights of the people due to inadequate food, shelter, and other necessities [17]. The plight of persons with disabilities in these above scenarios where they are affected by the COVID-19 quarantine indicates inadequate health and medical supplies, a lack of food, and an insufficient cash transfer program that might not have registered persons with disabilities, as the secrecy and non-transparency of government in disclosing the number of registered people might not have demarcated persons with disabilities under vulnerable groupings in this regard. Thus, discrimination on the basis of disability constitutes an unacceptable violation of human rights [18]. These outcomes reveal the failing on some key actionable obligations for states and stakeholders as enshrined in the United Nations’ [9:7] in “ensuring that reporting mechanism, hotlines, emergency shelters, and other forms of assistance are accessible for and include persons with disability and the monitoring of the situation of persons with disabilities, particularly those living in isolation, by engaging in proactive outreach including through community and voluntary networks.”

3. COVID-19 QUARANTINE IMPACTS: PSYCHOSOCIAL EFFECTS ON DISABILITY CARE

The psychological impacts of quarantine revealed negative psychological impacts that rekindled stressors. Observations were made that there were inadequate deliveries of items such as masks and

thermometers, or a lack of them from public health establishments, or they were merely sporadically dispersed during the quarantine period Pellecchia *et al*. [18]; Caleo *et al*. [19]. Studies by Taylor *et al*. [20], Sprang and Silman [21] and Lui *et al*. [22] on factors influencing psychological distress show that after exposure to stressful events such as lockdown measures specified that people are prone to severe acute respiratory syndrome epidemic and it becomes more critical during the Severe Acute Respiratory Syndrome (SARS) disease prevalence, with its resultant disorder among parents and youths involved in quarantine regimes. All researchers acknowledged the connection between acute stress disorders and quarantine measures.

A study found out that the quarantine experience is a predictor of post-traumatic stress symptoms and depression that can linger up to 3 years after quarantine. The researchers observed that after quarantine, 60 per cent of the sampled health workers reported high depressive symptoms, Cava *et al.* [23]. These studies indicate the various psychosocial impacts that COVID-19 quarantines have inflicted on persons with disabilities. The next subheading will be discussing the psychosocial impacts of quarantine on health and social care practitioners. Johal [24] argued that there are three areas of consideration in the course of planning care for those in quarantine, namely, the psychosocial impacts the quarantine experience could have on clients and their families, workplaces, and communities. Hence, persons with disabilities may experience quarantine anxiety, in particular how it will impact their employment (if they are laid off or are experiencing difficulties in performing their duties, as well as pressures within their families if they are breadwinners and in need of care, and their roles in their communities will be affected as well.

Observations indicated that persons with disabilities living in institutions such as social care centres, rehabilitation centres, old age homes, psychiatric homes, and prisons could experience abandonment from their caregivers and workers. There is a serious rate of high infections and deaths due to underlying health circumstances due to the struggle in imposing social distancing during the COVID-19 quarantine periods. A study by Comas-Herrera and Zalakin [25] revealed that 42 - 57 per cent of all COVID-19 deaths are situated in care homes. The social care favourable practices in COVID-19 indicate that Priority Testing Guidelines are allotted with explicit procedures for institutionalised settings. Where possible, persons with disabilities living in institutions are allowed to move in with their families.

4. COVID-19 QUARANTINE IMPACTS: CONCERNS FOR HEALTH AND SOCIAL CARE WORKERS

Brooks *et al*. [26] were of the view that there is mixed evidence about health workers that were quarantined having a higher risk of distress than non-health workers who were quarantined. Also, the study specified a high occurrence of psychological distress for those in quarantine. A research study comparing the effects of quarantine on children and parents and those that did not undergo quarantine revealed that those quarantined had post-traumatic stress symptoms, Sprang, and Silman [21]. The study discovered that the mean post-traumatic stress scores were four times greater in children who had undergone quarantine than in those who did not undergo quarantine. The study further indicated that 28 per cent (27 of 98) of parents who were quarantined recounted abundant symptoms which would permit a diagnosis of trauma-related mental health disorders, compared with 6 per cent (17 of 299) of parents who were not quarantined.

During the SARS outbreak, a study from Canada reported that patients with SARS testified that the effects of quarantine and infection instigated fear, anger, loneliness, and boredom, Maunder *et al*. [27]. Studies have recommended that managers' support and their ability to be cognizant of the impending risks for quarantined personnel is crucial in enabling employees to return to work and formulating plans for prompt interventions [6, 27]. It was established that reviews of the implementation science recognise that practitioner training is an essential element to applying practice efficacy, Fixsen *et al*. [28]. Furthermore, investigations have been too inadequate to augment practice mechanisms, and trainers in behavioural health are constantly unsuccessful in promoting the usage of current strategies that have been acknowledged through empirical support Stuart *et al*. [29]. There is a disengagement between scientific literature and the behaviour of community professionals, having a negative effect, not only on mental health but also on health and social care practices. Several disciplines, including medicine and education, struggle with the training patterns and understand the most efficient ways to train their personnel to implement practices acknowledged and reinforced by empirical evidence Grimshaw *et al.* [30,

31]. Stuart *et al.* [29] and [32] have all distinguished between two workforce development activities, initial education and training, retraining, or re-skilling, which connect and share a diversity of methods.

Stuart *et al*. [29] specify that the inter-change of interdisciplinary knowledge is a very good prospect which could radically advance training efforts and the application of a model of evidence-based teaching practices that are connected with the training recommended by behavioural health professionals. However, studies specify that health and social care workers should be prioritised and given special attention in this COVID-19 pandemic and throughout quarantine measures, as they are most negatively affected by the stigmatisation attitudes of people, and some that have undergone quarantine may be worried about their absence at work, causing an increased workload for their colleagues [27, 29]. The emergent of stressors in the management of quarantine measures has indicated the re-skilling or retraining of health and social care practitioners to be ready to tackle impending infection now and beyond COVID-19 is essential.

Nevertheless, a study of social justice application by Nwachukwu and Asuelime [33] indicated that positive stressors could assist health and social care workers if they include social justice approaches in implementing in their practices, the current pandemic quarantine measure included. They assert that eustress is beneficial, as practitioners look forward to assisting clients and patients reach their goals even with the presence of stressful circumstances. The health and social care practice should equally engage the recognition of the dignity and worth of a person as expressed in the NASW [34]; expanded by Nwachukwu and Segalo [12], in safeguarding patient's self-determination, autonomy and competence in understanding the quarantine measures and the ability to take into consideration individual differences in worldview, even with persons with disabilities, is imperative.

Seah *et al.* [35] recommended the critical advancement for the disinfection and Personal Protective Equipment (PPE) procedures for ophthalmic practices and clinics, as tears are shown to be one of the principal means of COVID-19 infections. This call is supported by the research by Loon *et al*. [36], which reveals that the tears of an infected person exposed to the viral infection RNA of SARS-CoV can be noticed through a reverse-transcription polymerase chain reaction (RT-PCR). Furthermore, Seah *et al*. [35], Johal [24], and Chan *et al*. [37] suggested that revisiting the strategies that curtailed the transmission of SARS in 2003 can be beneficial for the present COVID-19 pandemic. The researchers were of the view that reconsidering the case classification protocol of 2003, which triaged patients into general, suspect, and probable categories, conferring to the formed surveillance case definition of the World Health Organization [38], would be beneficial. Their recommendation further agreed that persons under the suspect and probable categories should be deferred, except in emergency cases, and a strict emphasis should be placed on full PPE, masks, and gloves, irrespective of SARS status. The emphasis should be on improving decontamination and sterilisation procedures of clinical and workplaces and apparatus to stop the coronavirus spread as it has the ability to survive in an environment for a period of time.

Studies have indicated that health care practitioners are prone to feeling conflicted while working during a public health emergency, such as the COVID-19 outbreak, as they were of the perception that they may infect their family members. Thus, the feelings of professional responsibility and anxiety, and guilt about potentially exposing their family members to the disease may arise [28, 24]. Another study on healthcare practitioners and patients disclosed that workers experience isolation and stigmas due to their SARS exposure, and being in quarantine, with its measures of constrained physical interaction, staying at home, mask-wearing, and loss of intimacy resulting in physical and psychological isolation, could be devastating for the health and social care workers, as they feel angry and hurt, Robertson *et al.* [39].

A study that investigated the case series from Wuhan, China, the epicentre of the COVID-19 outbreak, revealed that 29 per cent of patients with the disease were health care workers who must have contracted it from the hospitals where they were exposed to the infection, Xiang *et al*. [40]. However, another study explained that the risk profile for COVID-19 infections and exposure among healthcare workers declined with the intensification of understanding surrounding the disease, the rate of healthcare workers contracting COVID-19 in hospitals has reduced, but rigorous measures and intense watchfulness are compulsory in fighting the disease, Schwartz *et al.* [41] and Verbeek *et al.* [42]. A Study has recommended vibrant strategies to support and applicably cope with

exposed and ill healthcare workers are critical to guaranteeing effective workforce supervision and management strategies, which must concentrate on risk curtailing, proper clinical monitoring, access to diagnostics, and resolutions on exclusion from and reappearance to work in order to stimulate confidence in the workplace Bielicki *et al*. [43].

5. COVID-19 QUARANTINE IMPACTS: SOCIAL-ETHIC DIMENSION

Quarantine may have psychosocial problems that ought to support persons with disabilities and health and social care workers in alleviating difficulties, enhancing problem-solving solutions, and connecting with healthcare resources. This study assesses the scope of the social-ethic framework approach for psychosocial support for persons with disabilities and health and social care practitioners during this COVID-19 pandemic. The quarantine measures that may stir aspects of social ethics to reflect inspiration and self-reliance through what Haraway [44] describes as the 'capacity to pro-act with others knowledgeably.' The fusion of eco-justice and ethically practical beneficiations in handling life-threatening situations is the scope of social-ethic which involves "to care-take toward more viable and just future life with others: a 'care of the possible' [45:12], that ignites courage and agency to 'stay with the trouble" [44].

The exploration of 'crisis-linked problems that matter' [45, 46, 48] are emergent, as well as the knowledge valuable in addressing them, including 'funds of knowledge' [46-48] that occur among varied groups who live with the relevant problems. As such, the psychosocial problems for persons with disabilities and the health and social care workers become a mosaic of problems which engage an "educational praxis of dialogic democracy that involves all participants are 'apprenticing' to the problem by shaping citizen-capacities to work with each other and make knowledge of emergently richer use-value" [46:76–77]. Nwachukwu's [49:128] study that social morality, when engaged towards solving psychosocial problems, includes social and cultural norms that should emphasise the consequential good for all citizens. Virtues centre on the character of the person (virtuous quality) who assumes the action taken would encourage amiability, which supplements deontological and teleological ethical mechanisms.

The quarantine processes have motivated the shaping of the citizenship's capacity to engage with each other in the apprenticing of psychosocial problems that could threaten social cohesion. Now is the time in which more empathy and emotional vulnerability are most needed, more emphasis on up-skilling, re-skilling, and training to adapt to and connect to the new normal way of living that COVID-19 has brought to humanity is needed. Pignarre and Stengers [48] disclose that people need projects that build a life and "sustain-abilities," particularly those pertaining to, "citizen capacities to collaborate, across diverse community groups, on 'problems that gather them together." Zipin and Brennan [50:6] assert the "counter-senses of perilously complex social futures that abide by the new emergency among diverse people living the perils and calling for capacities well beyond skills for work." Thus, the re-skilling and upskilling of health and social practices, with ethically-driven policies for the ethical practice of education, refers to the strength of the "teaching-and-research capacities of citizens" [50:7]. Service providers need to exhibit trustworthiness and honesty in order to enable them to carry out their duties and improve the social harmony of the community they serve [49:129].

The linkage between quarantine measures and social-ethics towards curbing psychosocial disorders offers problem-solving strategies that could focus on clinical attention for depression, anxiety, anger, feelings of not being wanted, stigmas, the lack of intimacy, and social isolation in this current COVID-19 lockdown period. It would offer an informational acknowledgement for the "teaching-and-research capacities of citizens; they need practising strength in both dimensions" [50:7]. Sensitivity and the application of strengths-based, culturally-sensitive interviews in conveying resources was promoted by Nwachukwu and Mazibuko's [51] and Nwachukwu' [52] studies, which disclose the strength-based and cultural-sensitive interviews could assist in decreasing prejudiced evidence and unconventional approaches in understanding obstacles, opening resources, and competencies for persons with disabilities and health and social care practitioners in lessening the weaknesses of anger, boredom, post-traumatic stressors, depression, and stigmatisation. Nwachukwu's [52:262] study asserts that social workers must promote ethical values in fighting psychosocial fears by improving virtues such as self-determination and fairness.

The social-ethics aspect of quarantine or lockdown regulations are geared to uphold human rights and the dignity of people as well as their worth and health.

While improving disability-care, social care workers should assist in the mitigation of disappointment, which has been escalated due to the quarantine measures. They can achieve this by redirecting policies, communities, and governments, and other stakeholders to their obligations, which are protected in the United Nations [9]. The lack of implementing ethical practices and professional competence could be the main issues concerning health and social care practitioners' feelings of disappointment, flaring up their stressor modes, and perceived stigmatisation.

Social ethics are integrated into the ethical practice and competencies, which should acknowledge the existence of the competence of the practitioner's encounters with citizen participation. This notion can be linked to the structural crisis of built and natural worlds, which are captured by most citizens as glitches in infrastructures; specifying that their 'lifeworld of structure', which provides food, health, and transport and, "all systems that link ongoing proximity to being in a world-sustaining relation" Berlant [53:393-409]. Calder [54:400] asserts that there is a lack of institutional merging of normative, applied, and meta-ethics in the field of social philosophy and proposes that ethics and social ontology need to be highlighted concurrently, instead of distinctively; as such, the "thoughtfulness to relationality is a vital component of any applied ethics well-intentioned in attaining to the understandings with relationality" which is vital to any suitable purpose of the stance and their specific types of challenges therein.

Calder [54:430] ontological reassurances are portrayed in his assumptions too, "qualified, ethical naturalism", where an ethicist is committed in a non-precautionary position for current normative philosophy, which has demanding challenges but is eager to achieve a greater, "ideal of ethics" for the human social world. He emphasises that, in assessing diverse dimensions of ethicists' views on applied, meta, and normative ethical reasonableness, one must reflect into distinctive areas of practical social ontology. However, he contends that "they do not reflect principally well within the context of practical reasoning is, and neither do they help us tackle the nuances of the 'values issues' we confront." [54:433]. Healthcare workers returning to work must prioritise their clinical and psychological welfare and the consequent ability to reenter the workspace.

Additionally, health and social care practitioners are dedicated to their work in caring for persons with disabilities and controlling disability care management, even in very challenging situations. The social-ethics dimension seeks to assist health and social care workers to reflect on "building life sustain-abilities" in the mode of ensuring citizen capacities to work with them" [55:112]. It also supports the accessibility of clear procedures and quarantine processes as well as medical and psychosocial support systems that can strengthen disability care holistically, and could advance outcomes for persons with disabilities and allow for health and social care workers to be self-sustaining and self-maintaining in the COVID-19 pandemic.

6. CONCLUSION

In the search for significant progress in the overall COVID-19 outbreak response and in view of the quarantine impacts on psychosocial support for persons with disabilities, the researcher has indicated that the strategic COVID-19 response pillars should be adhered to by states and other stakeholders. This paper extolled that the COVID-19, SARS-CoV2 disease variation of Middle East Respiratory Syndrome (MERS-CoV), and Severe Acute Respiratory Syndrome (SARS-CoV), with its family cluster, signalled human infections which should have been classified earlier during the outbreak at Wuhan, China in 2019. The quarantine measures were delayed and not enforced; the COVID-virus could have been averted globally. The quarantine measures used during the outbreak in 2003 in Canada and China, developed by the World Health Organization and applied by both countries for a total lockdown of cities, as well as the Ebola quarantine of villages in West Africa, could have been very valuable for the current COVID-19 pandemic from the onset of the virus's spread.

The easing of lockdown restrictions by many governments has been criticised, as the World Health Organization's Emergency Director, Mike Ryan, warns of the adverse consequences, "even if the vaccine is found, controlling the virus will take a massive effort." Although, the WHO's Director-general Tedros Ghebreyesus disputed that, "any easing of conditions of lockdown risks a second wave spike in infections later in the year, the trajectory is in our hands…we should all contribute to stopping this pandemic" [56]. This is not the time to travel because it could be a matter of life or death; thus, reinforcing quarantine measures is imperative. This is where the social-ethics approach of the quarantine comes in, as a means to reorient the ways in which we programme our actions

to consider the ethical, social interactions and attitudes required to curb the spread of COVID-19.

The current increase of the COVID-19 virus infections in Europe and America and the reckless behaviour in our communities since the easing of the lockdowns or quarantine regimes might call for new lockdown rules to curb infections in Europe now. In Africa, there is a need to curb the infections spreading because of low, inadequate health facilities, Personal protection equipment (PPE), stealing, and corruption marred by health resources to fight the COVID-19 and reckless behaviour in social distancing and hygiene attitudes not be sustained. Consequently, better capabilities to test, safeguard, treat, and cure are indispensable criteria for all countries. If the reconsideration of the case classification protocol of 2003, which triaged patients into general, suspect, and probable categories, conferring to the informed surveillance case definition, those categorised under suspect and probable are deferred only in emergency cases. If a strict emphasis was placed on PPE, masks, gloves, sanitisation, and improving the decontamination and sterilisation processes of clinical areas and workplaces [35, 36, 24], as well as medical apparatus to stop the coronavirus spread, maybe the infections globally would have been prevented. The current classification is that COVID-19 is not only a respiratory or pulmonary disease that damages the lungs, kidneys, and heart as it has developed aspects of neurological disease; it attacks and damages the brain causing hallucinations and some mental illnesses, as well causing elements of post-traumatic stress. This comes together to make COVID-19 very ascetic and needing of self-disciplined social-ethics that can assist the world's psychosocial aspects of living.

This assertion was supported by the Director-General of the World Health Organization, Tedros Ghebreyesus, who underlined the seriousness of the disease as explained: "it's very difficult to predict the eventual impact of the COVID-19 pandemic; however, it will be prudent to utilise the lessons gained from the SARS-COV and prepare for the worst" [56]. The quarantine impacts of the lessons gained in 2003 could have been useful in the present COVID-19 virus outbreak, though, only if applied strictly without political shenanigans from governments, practitioners' stigmatisation, and the feelings of anger due to social isolations from family and friends. This paper has offered new insights on the COVID-19 virus and the quarantined measures that were missed that could have averted its spread globally; the quarantine or lockdown had a secondary effect in lessening the capacity of the virus's transmission and decreasing the likelihood of people having it infecting others.

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