1.) Letter from Secretary General

Dear Delegates,

It is my utmost pleasure that I welcome you to the 9th Annual Session of ATALMUN. As the Secretary General, I am proud to see this conference grow and thrive, bringing together bright young minds to engage in meaningful dialogue and diplomacy.

The "Commitment to Perfection" now became a reminder of our dedication to excellence in every aspect of this conference. We encourage each of you to strive for your personal best, to think critically, and to contribute constructively to the debates and discussions.

I would like to extend my gratitude to rest of the executive and the organization team whose hard work has made this event possible. I look forward to a memorable and impactful session, where we push the boundaries of diplomacy and leadership.

Best of luck to all delegates!

Sincerely,

Turgut Emir Önder
Secretary General of ATALMUN'25.

2.) Letter from Under-Secretary-General

Most Distinguised Delegates,

First of all, I would like to thank you for your choice of committee and express my pleasure that we will spend this wonderful conference together. Welcome !

I am sure that one of the most striking observations of our committee is that you yourself experienced one of these events a few years ago. My motivation is that this committee needs to exist because we have all been there and one of the best things we do is to name and recognise the situations we are in afterwards. Reflecting on our experiences is what we do best. For Ece, who survived COVID-19, this committee is a turning point, just like living through this pandemic. I am very excited that we will now discuss this pandemic process, which has been very difficult for me, more comprehensively together.

Going through difficult processes such as becoming aware and talking about them makes everyone more conscious. I know that your interests will spread to many topics in our committee, you will achieve good results and you will leave here with a good experience. I have no doubt about this.

Please, I kindly ask you to prepare for the committee and actively participate in the flow of the committee by fully reviewing this guide, which has been carefully prepared for you. Please remember that you can always reach me in any case, under any circumstances. I wish you success.

IAAP is waiting for you !

Kindest Regards
Ece Yiğit
Co-Under-Secretary- General of IAAP
Ece
eceyigit0207@gmail.com

2.) Letter from Under Secretary General

Most Distinguised Delegates,

First and foremost I would like you to welcome to the IAAP! It is my utmost honor to be serving you as the Co-Under Secretary General along side with my precious Co-Under Secretary General Ece of the committee IAAP.

As the academic team of IAAP our primary goals for this conference are to make sure that the committee works smoothly and, more importantly, to encourage you all to speak out more, express your opinions, and feel at ease in IAAP.
My utmost thanks go to my Co-Under Secretary General Ece. She took a major part in the process writing of this guide. This won't be possible without her support and help. Next up I would like to thank the Executive team for giving me the opportunity to be a part of this prestigious conference.
There is no doubt in my mind that this committee will flow smoothly, and to help along with your research processes and help you understand the topic, we have prepared a study guide for this particular agenda. This guide aimed to be both helpful and instructive.
I will be more than glad to help you if you have any inquiries about the agenda, the committee procedure, or anything related to the conference. Please do not hesitate to contact me. I am looking forward to seeing you at the conference!

Kindest Regards,
Timur Saim Tem
Co-Under-Secretary-General of IAAP
benttdegilim@gmail.com

3.) Introduction to The Committee

The International Association of Applied Psychology (IAAP) is a non-governmental organisation (NGO), accredited to the United Nations Economic and Social Council (ECOSOC) and affiliated to the Department of Global Communications (DGC), composed of psychologists from around the world. According to the mission statement of IAAP United Nations representatives: To share and communicate discussions, research, projects and information relevant to the science and practice of applied psychology and the UN NGO IAAP team with the UN and its affiliated organisations, as well as a wide range of stakeholders and actors, thereby helping to effectively address global challenges and generating ideas on where IAAP member expertise can best be used and applied. To participate in, initiate and partner with projects that are relevant to the goals of the United Nations, its organisations and a wide range of stakeholders and actors, that intersect with the field of applied psychology, that overlap with the projects and goals of the sections, and that enhance the well-being of societies.To communicate and share messages about the UN and its agencies, the UN NGO community and multiple stakeholders and actors, the role of applied psychology and the role and projects of the UN IAAP team to other psychologists and professionals in related fields, the wider general public, the private sector and other stakeholders at local, national and international levels. IAAP United Nations NGO Representatives are based in New York, Geneva and Vienna.

4.) Introduction to The Agenda Item

IAAP Agenda Item: Addressing the Negative Effects of Quarantines on People's Spiritual Wellbeing.
The International Association of Applied Psychology (IAAP) focuses on the global challenges of mental health and well-being. The agenda item "Negative Impacts of Quarantines on Society" explores the psychological and societal impacts of quarantine measures taken in health emergencies such as pandemics. It will discuss how isolation, disruption of routines and fear of illness can increase stress, anxiety and depression, especially in vulnerable groups such as children, the elderly and those with pre-existing conditions. It will also discuss how quarantine periods have historically brought economic and social hardship to humanity. Strategies to reduce ill effects, emphasise psychological support, increase community resilience and integrate mental health into public health interventions will be examined. The aim is to develop practical, research-supported recommendations for balancing public safety with individual and community well-being in future crises.

5.) *Key Terms*:

- **Pandemic: a *widespread occurrence of an infectious disease over a whole country or the world at a particular time*.**

- **Isolation: the state of one who is alone. solitude may imply a condition of being apart from all human beings or of being cut off by wish or circumstances.**

- **Quarantine: a state, period, or place of isolation in which people or animals that may have been exposed to infectious disease are placed.**

- **Chronic Illness: Chronic diseases are defined broadly as conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both.**

- **Epidemic:Epidemic refers to an increase, often sudden, in the number of cases of a disease above what is normally expected in that population in that area.**

- **Depression: Depression is a mood disorder that causes a persistent feeling of sadness and loss of interest. Also called major depressive disorder or clinical depression, it affects how you feel, think and behave and can lead to a variety of emotional and physical problems.**

- **Anxiety: Anxiety is a feeling of fear, dread, and uneasiness. It might cause you to sweat, feel restless and tense, and have a rapid heartbeat.**

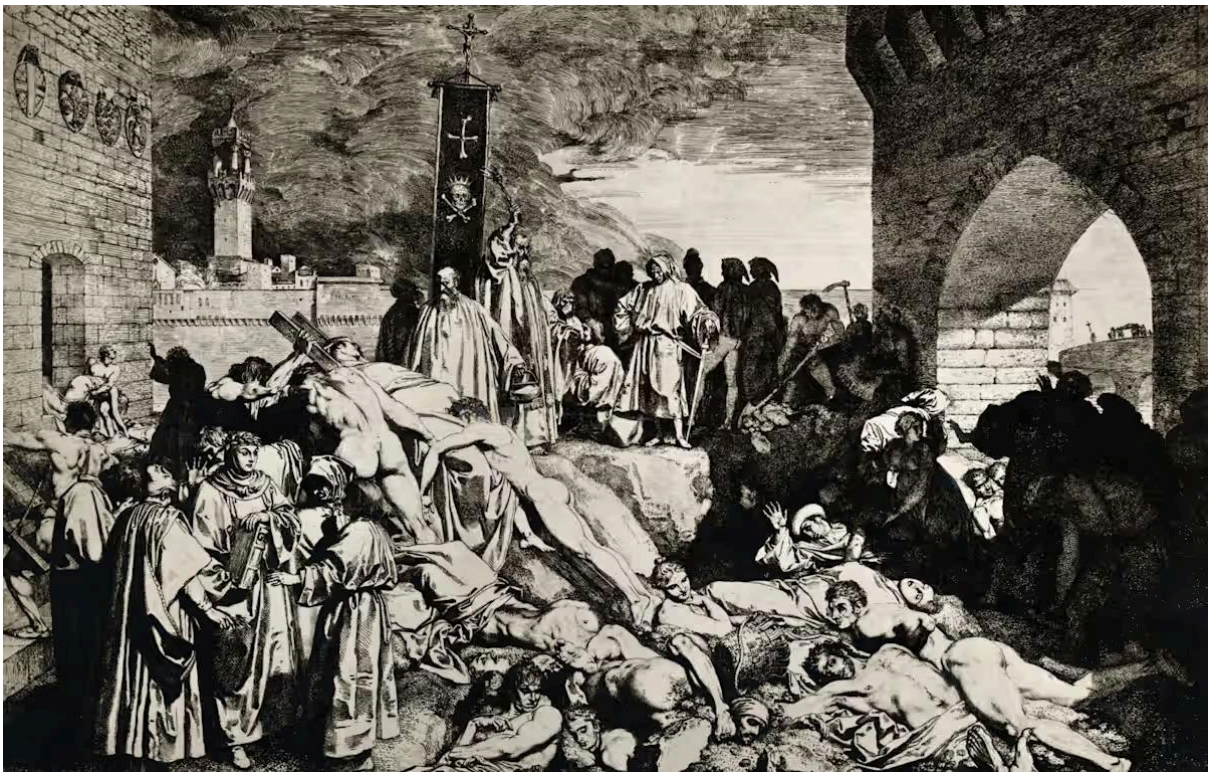
- **Plague: Plague is an infectious disease caused by the bacterium Yersinia pestis.Symptoms include fever, weakness and headache.Usually this begins one to seven days after exposure.There are three forms of plague, each affecting a different part of the body and causing associated symptoms. Pneumonic plague infects the lungs, causing shortness of breath, coughing and chest pain; bubonic plague affects the lymph nodes,**

making them swell; and septicemic plague infects the blood and can cause tissues to turn black and die.

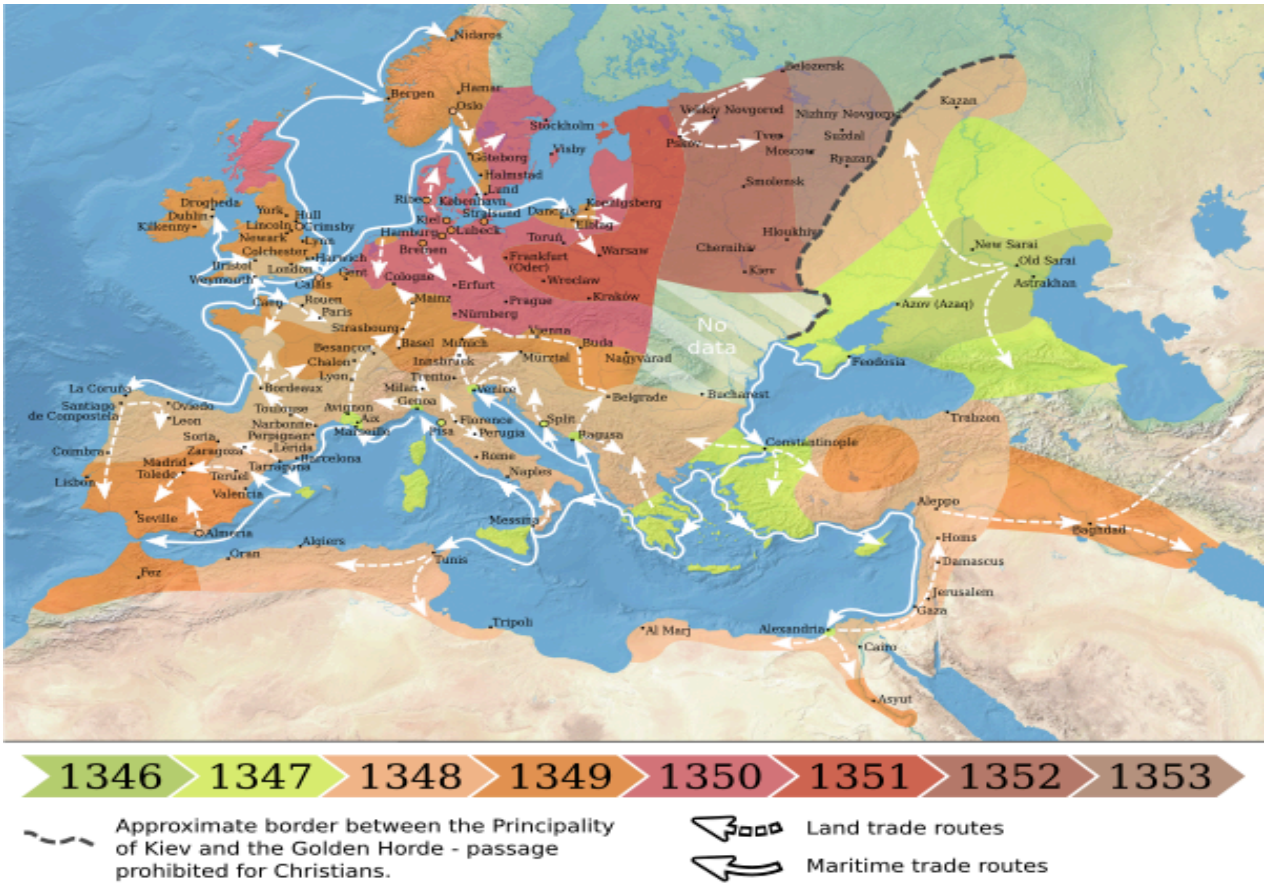
6.) ***History of the Pandemics***

Throughout the history of humanity, infectious diseases have left people and a period with many mental, physical, social and economic problems for centuries. It is also known that the diseases experienced are contagious, that efforts to prevent their spread are difficult and that they leave irreparable traumas. People who have never seen such a captivity before, who have been imprisoned in quarantine and isolation, are suddenly experiencing these due to compulsory and health problems; they feel lonely, depressed, anxious and suffer from mental illnesses that are difficult to leave behind with the repetition of all these, and these affect the whole society and future generations. The economic consequences of this tight period also trigger these difficult psychological problems of people and put them in even more distress. Although each pandemic has its own medical causes and problems, it can be said that it has been difficult and difficult to encounter throughout history.Pandemics, which are so difficult to overcome and take their place in history after the door is opened, are the subject of people's stories and subject them to compulsory awareness of different medical issues.

A.Black Death:



The plague, also known as the Black Death, was a plague epidemic that ravaged Europe in 1347-1352, killing approximately 25-30 million people. The disease, carried by fleas on rodent animals, first appeared in Central Asia and spread to Crimea through Mongolian warriors and merchants. Carried by rats on Genoese merchant ships sailing out of the Black Sea, the plague entered Europe via Italy. It is thought that 30 to 50 per cent of the population in the affected areas died from the plague, with two thirds of the patients dying. The death toll was so high that it had serious consequences for medieval European society. The lack of sufficient numbers of farmers led to calls for the end of serfdom, to a general questioning of authority, to riots and the complete abandonment of many towns and villages. It would take about 200 years for the population of Europe to return to what it was before the plague.There were recurrences of the plague in 1361-63, 1369-71, 1374-75, 1390 and 1400. Modern research has suggested that the plague was introduced into Europe many times during this time and came along trade routes in waves from Central Asia as a result of climate fluctuations affecting rodent populations infected with plague-carrying fleas.



The plague is a disease caused by the bacterium bacillus, which is carried and spread by parasitic fleas, especially in rodents such as the brown sewer rat. There are three types of plague, all three of which were probably seen in the plague epidemic characterised as the Black Death. In the 14th century outbreak, the most common Bubonic plague caused severe swelling of the lymph nodes in the groin and axillae and was called the Black Death because of its disgusting black colour. These black sores, which could often cover the whole body, were caused by internal haemorrhage known as bubo, from which the bubonic (bubonic) plague took its name. Severe fever and joint pains were among other symptoms. If bubonic plague was left untreated, 30 to 75 per cent of infections were fatal, usually within 72 hours. The other two forms of plague, pulmonary and septicaemic plague, are generally fatal in all cases.

The plague doctor's costume consisted of an ankle-length coat, a bird's beak-like mask filled with sweet or strong-smelling substances, gloves and boots. The mask had glass openings for the eyes. Straps held the

beak in front of the doctor's nose, which had two small nostrils and was a kind of respirator. The beak could contain dried flowers (e.g. roses or carnations), herbs (e.g. mint), spices, camphor or vinegar sponge. The purpose of the mask was to remove bad odours, which were thought to be the main cause of the disease. Doctors believed that the herbs would counteract the "bad" odours of the plague and prevent them from becoming infected. The costume included a wide-brimmed leather hat to indicate their profession. They used wooden canes to point out areas that needed attention and to examine patients without touching them.

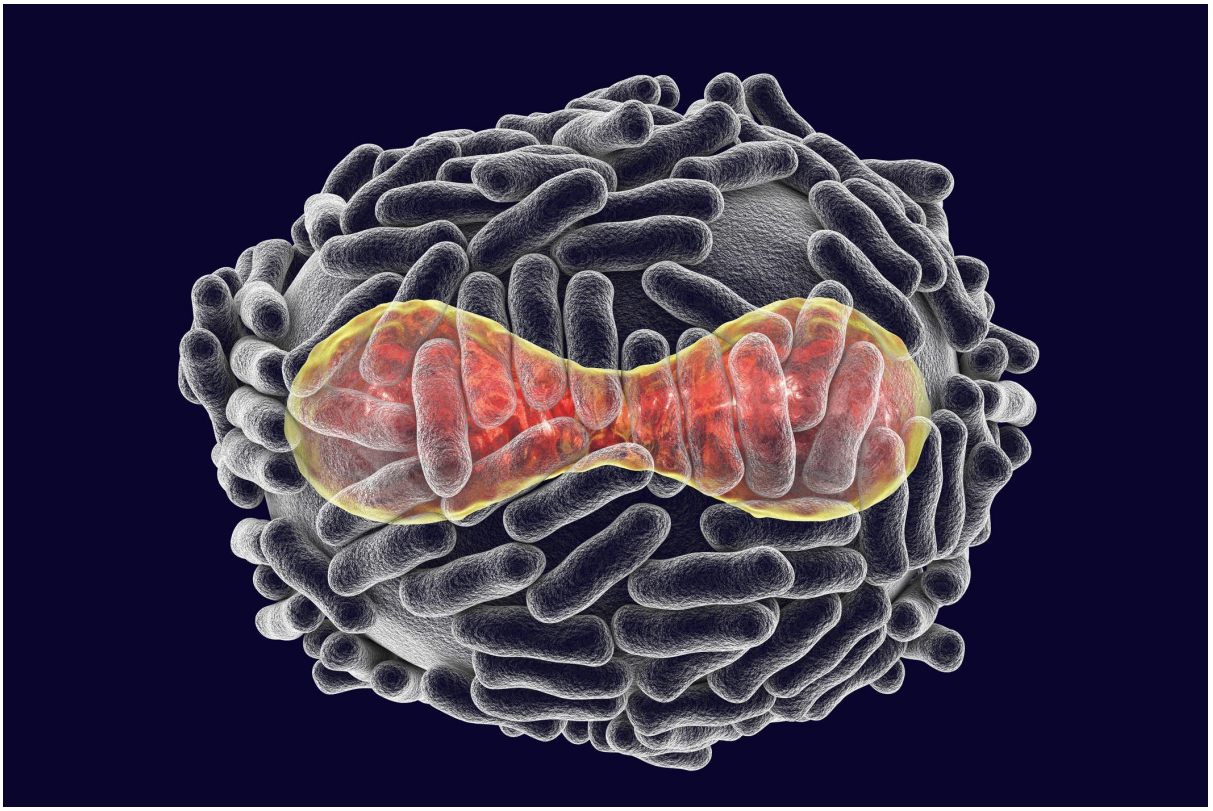
Canes were also used to keep people away and to remove the clothes of plague victims without touching them.

The psychological effects of the Black Plague were reflected in a preoccupation with death and the afterlife that appeared in poetry,

sculpture and painting north of the Alps (not in Italy); the Roman Catholic Church lost part of its monopoly on the salvation of souls as people turned to mysticism and sometimes to extremes. Anti-Semitism intensified greatly in Europe, as Jews were responsible for the spread of the Black Plague. A wave of violent pogroms broke out and entire Jewish communities were murdered by malabas or burned at the stake en masse.
The Black Death was a personified name to describe what was happening to people. It was usually depicted as a skeleton body on a horse, an angel of death killing people in the prime of life with a scythe. Many people were stunned by the disease. Some thought it was a supernatural event, hypothesised to be linked to the comet of 1345. Others blamed sinners. The Flagellants of Rhineland were the first to whip themselves in the streets and tell sinners to repent so that God would remove this terrible punishment. Many thought that this was an inexplicable act of the devil, while others, with centuries of prejudice, blamed their sworn enemies. This led to attacks and even massacres of certain groups, so much so that thousands of Jews fled to Poland.
Even when the crisis was over, there were other problems to face. Wages and prices had risen rapidly because of the small number of labourers who could not keep up with demand. The need for agriculture to feed people was going to be a serious challenge because the demand for manufactured goods had fallen drastically as fewer people were buying them. Especially in agriculture, those who could work were in a position to demand wages, and the institution of serfdom, in which the labourer paid rent to the landowner and did not leave the land, came to an end. A more flexible, more mobile and more independent labour force was born. In the wake of social upheavals, rebellions often broke out immediately when the aristocracy tried to resist these new demands. Notable revolts took place in Paris in 1358, Florence in 1378 and London in 1381. The peasants did not get everything they wanted, their demands for lower taxes failed, but the old feudal system was destroyed.

B.Smallpox Epidemic:


見苗所發出候圖



One of the deadliest diseases known to humans, smallpox remains the only human disease to have been eradicated. Many believe this achievement to be the most significant milestone in global public health.Key components of the worldwide smallpox eradication effort included universal childhood immunization programmes in some countries, mass vaccination in others, and targeted surveillance-containment strategies during the end-game.Over thousands of years, smallpox killed hundreds of millions of people. The rich, the poor, the young, the old. It was a disease that didn't discriminate, killing at least 1 in 3 people infected, often more in the most severe forms of disease.The symptoms of smallpox were gruesome: high fever, vomiting and mouth sores, followed by fluid-filled lesions on the whole body. Death would come suddenly, often within 2 weeks, and survivors could be left with permanent harms such as blindness and infertility. in the most severe forms of disease.

Smallpox was a terrible disease. On average, 3 out of every 10 people who got it died. People who survived usually had scars, which were sometimes severe.

One of the first methods for controlling smallpox was variolation, a process named after the virus that causes smallpox (variola virus). During variolation, people who had never had smallpox were exposed to material from smallpox sores (pustules) by scratching the material into their arm or inhaling it through the nose. After variolation, people usually developed the symptoms associated with smallpox, such as fever and a rash. However, fewer people died from variolation than if they had acquired smallpox naturally.
The global smallpox eradication program started with CDC's venture in West and Central Africa in 1966. Funded by the U.S. Agency for International Development, CDC worked with governments and health workers in 20 countries to eradicate this ancient disease. CDC recruited a group of young physicians and public health advisors,

who for the most part were unskilled in international work. Not only did they help the countries achieve disease eradication for the first time, but they also developed the technique of containment that would be used to eradicate smallpox in the rest of the world. The eradication campaign required massive mobilization of resources and coordination with local communities. Each campaign was always seen as the country's program, with CDC staff giving technical advice and providing vaccines, transport, and encouragement.

Based on success in West Africa, CDC provided technical expertise and personnel to the World. Health Organization (WHO) as the campaign to eradicate smallpox proceeded. In 1967, smallpox was endemic in Brazil, West and Central Africa, eastern and southern Africa, a block of countries across southern Asia, and Indonesia.

The two countries that posed the greatest obstacle to smallpox eradication were India and Bangladesh. CDC assigned full-time staff to both countries and hundreds of CDC staff members served short-term assignments. The eradication strategy evolved from mass vaccinations to improved surveillance and containment, vaccinating villages and communities on a case-by- case basis. Both countries were declared smallpox-free in 1975. The last naturally occurring smallpox case in the world was observed in Ali Maow Maalin, a 23-year-old Somali hospital cook. He became sick on October 26, 1977 after transporting several children with smallpox to an isolation center. He survived and later became an important member of the polio eradication team in Somalia. WHO declared global eradication of smallpox in May 1980.

During the first year of the West African campaign, 1966-67, an astounding 25 million people were vaccinated against smallpox. The smallpox vaccine is made of live vaccinia virus, a weaker form of poxvirus. Because vaccinia is similar to smallpox, its presence causes an immune system response that also provides smallpox immunity. One challenging aspect of smallpox vaccination is that it must be administered just under the outer skin layer, not with a traditional needle. As such, the U.S. Army developed a tool called the

Ped-O-Jet for CDC field use. It was a foot-driven injector that used intense pressure instead of needles to deliver the vaccine to the correct skin layers. The operator used a foot pump to apply pressure, and the vaccine would shoot out into the patient's skin in only a fraction of a second. It was quick and effective, but it was also large and bulky.As the eradication strategy changed, mass vaccinations were phased out in favor of house-to-house procedures. Bifurcated needles were developed for the smallpox vaccine as a more portable vaccine delivery tool. The single needle split into two sharp points. These double-pronged needles were dipped in vaccine vials. The vaccine stuck to the space in between the two prongs and was administered to the skin through a series of shallow pokes to the surface of the skin.Cultural and Religious Considerations in Public Health Approaching global public health issues requires an understanding of local cultural and religious practices that may impact the way in which measures are received. Strong partnership with locals make for more effective interventions. In the case of smallpox, religion played a role in eradication.

In Nigeria, Shapona is the god of smallpox, worshipped among the Yoruba people. Shapona was given control of the earth by his father. He nourished humans by giving them all the grains of the earth, but when he punished, he caused those grains people had eaten to come out on their skins. Thus, smallpox was an indication of divine displeasure. The statue of Shapona is traditionally decorated with a monkey skull, cowrie shells, and the tail of a bush porcupine. The figure pictured was commissioned in 1969 to commemorate the efforts of public health officials and to remind us of the challenges CDC faces in adapting to and respecting local beliefs as it fulfills its global mission.In Hinduism, Shitala Mata is the dreaded goddess of smallpox. She holds a pitcher of water in one hand and a broom in the other. It is believed that whenever Shitala Mata shakes her head, she spills grain and each grain turns into a smallpox pustule, leading to an outbreak of the disease. Affected people survived if she used the water from her pitcher to clean the spilt grain; they did not survive if she used her dry broom. Representations of Shitala Mata could be found in shrines dedicated to her around the countryside in northern India.

Figure 3. A child receiving a smallpox vaccination in Mali, West Africa (CDC, 1967), and posters created to support the intensified eradication campaign (CDC, Stafford Smith, 1968).

In India, where smallpox was considered endemic, an initial program target of 80% vaccination coverage across the population was recommended in order to interrupt smallpox transmission. But in 1964 this target was revised upward to 100% by the World Health Assembly's expert committee on smallpox, based on observations of continuing transmission in regions of India that had purportedly achieved the target goal of 80%. Whether the failure to halt transmission in seemingly highly vaccinated populations was truly a function of insufficient coverage, or whether there might be a more proximal explanation (for example, having to do with varying degrees of efficiency of locally implemented vaccination programs), was the subject of active debate. Indeed, close analysis of vaccination records in India revealed a collection of failed vaccinations, multiple vaccinations administered to individual persons, and some apparent misrepresentations, indicating that 80% coverage had not, in fact, been achieved in many regions. This observation underscored what many believed to be the almost insurmountable difficulties faced by health authorities seeking to accomplish comprehensive vaccination programswithout adequate supervision and resources. It also supported doubts held by many decision makers that mass vaccination alone was going to be a feasible strategy to effect

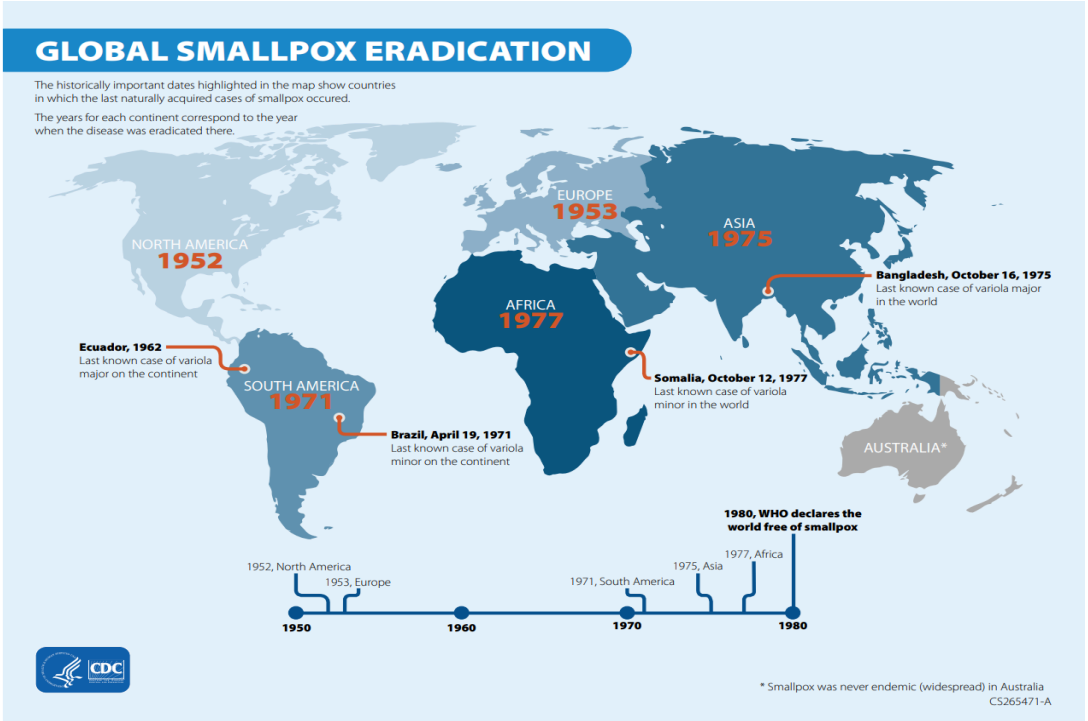
smallpox eradication – thus opening the door to consideration of alternative strategies.

One such strategy, often dubbed ‘containment and control,’ became a critical component of eradication success. As part of the Intensified Program (begun in 1967), the Director General of the World Health Assembly advocated systematic enhancements to surveillance, case investigations, and active disease containment approaches (principally vaccination), as a means to curtail ongoing foci of transmission. This approach was originally spearheaded by Alexander Langmuir of the United States Centers for Disease Control, along with colleagues, and had been successfully employed to combat other infectious disease threats in the United States, and in North Africa. In many respects this concept was historically grounded in nineteenth-century smallpox control efforts in Leicester, England, where mass vaccination programs for smallpox had met with stiff resistance from community leaders. Against such a backdrop, active case identification and quarantine of persons exposed to smallpox became the mainstays of disease control.

Ultimately In 1959, the World Health Organization (WHO) started a plan to rid the world of smallpox. Unfortunately, this global eradication campaign suffered from a lack of funds, personnel, and commitment from countries, and a shortage of vaccine donations. Despite their best efforts, smallpox was still widespread in 1966, causing regular outbreaks across South America, Africa, and Asia.

The Intensified Eradication Program began in 1967 with a promise of renewed efforts. Laboratories in many countries where smallpox occurred regularly were able to produce more, higher-quality freeze-dried vaccine. Other factors that played an important role in the success of the intensified efforts included the development of the bifurcated needle, the establishment of a case surveillance system, and mass vaccination campaigns.

By the time the Intensified Eradication Program began in 1967, smallpox was already eliminated in North America (1952) and Europe (1953). Cases were still occurring in South America, Asia, and Africa (smallpox was never widespread in Australia). The Program made steady progress toward ridding the world of this disease, and by 1971 smallpox was eradicated from South America, followed by Asia (1975), and finally Africa (1977).



C. Spanish Flu:

The pandemic occurred in three waves. The first apparently originated in early March 1918, during World War I. Although it remains uncertain where the virus first emerged, it quickly spread through western Europe, and by July it had spread to Poland. The first wave of influenza was comparatively mild. However, during the summer a more lethal type of disease was recognized, and this form fully emerged in August 1918. Pneumonia often developed quickly, with death usually coming two days after the first indications of the flu. For example, at Camp Devens, Massachusetts, U.S., six days after the first case of influenza was reported, there were 6,674 cases. The third wave of the pandemic occurred in the following winter, and by the spring the virus had run its course. In the two later waves about half the deaths were among 20- to 40-year-olds, an unusual mortality age pattern for influenza.
Outbreaks of the flu occurred in nearly every inhabited part of the world, first in ports, then spreading from city to city along the main transportation routes. India is believed to have suffered at least 12.5 million deaths during the pandemic, and the disease reached distant islands in the South Pacific, including New Zealand and Samoa. In the United States about 550,000 people died. Most deaths worldwide occurred during the brutal second and third waves. Other outbreaks of Spanish influenza occurred in the 1920s but with declining virulence.

The Spanish influenza pandemic of 1918-19 killed between 20 and 40 million people worldwide, making it one of the largest and most destructive outbreaks of infectious

disease in recorded history. It first appeared in Newfoundland and Labrador in September 1918 and killed more than 600 people in less than five months. The effects were most devastating in Labrador, where the disease killed close to one third of the Inuit population and forced some communities out of existence. Death rates were particularly high in the Inuit villages of Okak and Hebron. Despite its name, the Spanish influenza appeared in the United States, China, and France before moving on to Spain and the rest of the world in the spring of 1918. However, the disease received more press coverage in Spain than elsewhere and it is partly for this reason that it became known as the Spanish influenza. The highly contagious nature of the virus allowed it to spread rapidly from one continent to another as hundreds of thousands of troops traveled around the world during the final months of World War One. The Spanish influenza was even more destructive in Labrador, which experienced a disproportionately high mortality rate; the same virus that killed less than one per cent of Newfoundland's population killed 10 per cent of Labrador's. Several factors contributed to this – Labrador did not possess adequate medical resources and personnel to prevent the disease from spreading, frequent storms prevented doctors and nurses from travelling to Labrador's remote communities, and inefficient modes of communication with the outside world made it difficult to request help from Newfoundland.

The virus first appeared at Cartwright after the mail boat SS Sagona docked there on October 20 with four infected crewmembers. Two days later, most of the community's residents were sick and the disease was spreading throughout Sandwich Bay. By early 1919, the influenza had killed 69 of the area's 300 residents.

The same day that the Sagona arrived at Cartwright, the supply ship SS Harmony departed St. John's harbour for the northern Labrador community of Hebron. Although the influenza had by then reached epidemic proportions in St. John's, the government placed few restrictions on shipping arriving at or departing from the city's harbour. When the Harmony arrived at Hebron on October 27, at least one infected crewmember was on board. The virus quickly spread throughout the village, killing entire families and leaving dozens of children orphaned. By November 19, 86 of Hebron's 100 residents were dead. A further 74 people died in surrounding communities, cutting the area's population to 70 from 220.

Unaware of the situation at Hebron, the Harmony's captain continued south to Okak, where he arrived on November 4. Within hours of the ship's departure on November 8, many people in the village began showing signs of illness. Two weeks later, 70 Okak residents were dead and the disease had spread to nearby hunting camps. At Sillutalik (Cutthroat), the flu killed 40 of 45 residents, while 13 of 18 people died at Orlik. Seven-year-old Martha Joshua survived alone for five weeks in Uivaq before a search party from Okak found her in early January. After the influenza killed her entire

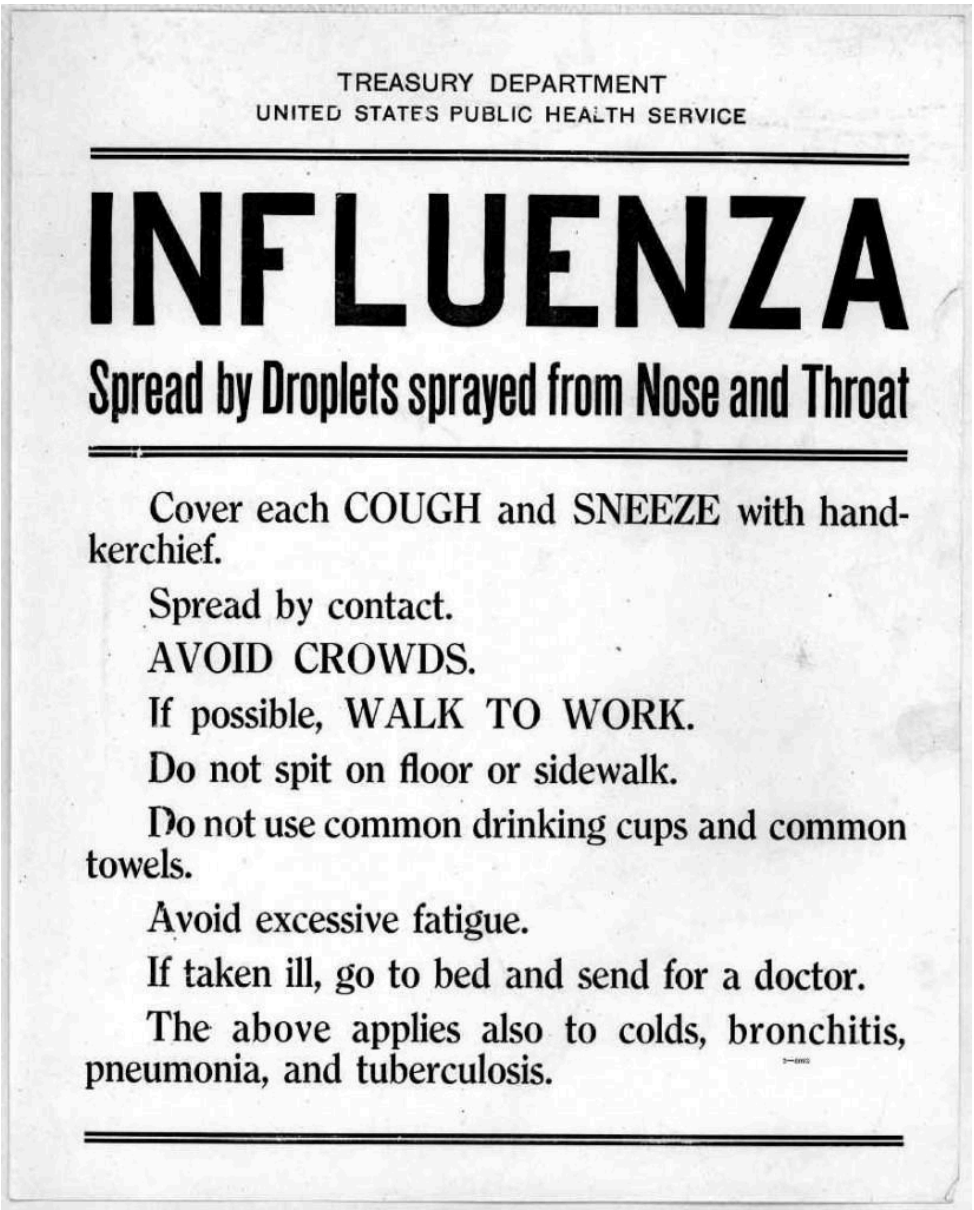
family, Joshua survived alone by eating hard bread and melting snow for drinking water.

By the end of December, the virus had decimated Okak, killing 204 of its 263 residents. It was a nightmarish situation. The frozen ground made it impossible to bury the dead in a timely fashion and residents piled corpses in a few vacant houses. Soon, the dead outnumbered the living and it was the few remaining survivors who shared a handful of houses. Making matters worse, dozens of sled dogs grew wild with hunger and began eating the corpses or attacking sick humans. Survivors had to shoot them on sight

As the virus disappeared from Labrador in late December and early January, survivors began to bury their dead. Residents at Hebron cut holes in the ice, weighted the bodies with rocks, and placed the dead in the water. At Okak, residents poured petroleum into the ground and made a large fire to thaw the soil. By January 7, all of the dead had been lowered into a mass grave measuring 32 feet long and 8 feet deep. Survivors then dismantled the community entirely, burning all houses and furniture before moving to Nain, Hopedale, or Hebron. Before the pandemic, Okak was the largest Inuit settlement on Labrador's coast and one of its most prosperous. By January, the influenza had killed every Inuit adult male at Okak and forced the community out of existence.

Former Okak resident Kitora Boas, who was 20 years old in 1918, described a lingering depression that followed the pandemic: “For a long time after there was this sense of decline as far as yearly activities were concerned among the Inuit and in all northern Labrador communities. A sense of let down was in the air for a long time.”

Although its effects were both devastating and far-reaching, the influenza spread through Labrador in a matter of weeks, killing more than 30 per cent of the Inuit population and infecting many others. Those who did not die from the disease often experienced heart and respiratory troubles for the rest of their lives.



TREASURY DEPARTMENT
UNITED STATES PUBLIC HEALTH SERVICE

INFLUENZA

Spread by Droplets sprayed from Nose and Throat

Cover each COUGH and SNEEZE with handkerchief.

Spread by contact.

AVOID CROWDS.

If possible, WALK TO WORK.

Do not spit on floor or sidewalk.

Do not use common drinking cups and common towels.

Avoid excessive fatigue.

If taken ill, go to bed and send for a doctor.

The above applies also to colds, bronchitis, pneumonia, and tuberculosis.

d.HIV/AIDS:

Doctors are not exactly sure when HIV originated, but they believe it developed from a type of chimpanzee virus in West Africa called the simian immunodeficiency virus.

People who hunted chimpanzees for meat came in contact with the blood containing the virus and contracted HIV. Researchers believe the virus mutated at some point into the human form of HIV.Researchers collected the earliest detected HIV in 1959 from a man in the Democratic Republic of the Congo. Later, genetic analysis determined the virus might have developed between 1910–1930.

Misunderstandings about the virus and its transmission plagued the early years of HIV in the United States.In 1981, doctors and researchers began to notice a set of symptoms in previously healthy young males who had sex with other males. At first, healthcare providers called the disease gay-related immune deficiency.However, doctors also began to observe that intravenous drug users also experienced the same symptoms.In 1982, health experts realized that the symptoms and related conditions were due to a compromised immune system.They began to call it AIDS. Scientists thought those living with conditions, such as Kaposi sarcoma — a rare cancer, or a form of pneumonia called *Pneumocystis jirovecii,* had acquired them through AIDS.In 1983, the scientific community identified the virus responsible for AIDS. They first named the virus human T-cell lymphotropic virus type lll, or lymphadenopathy-associated virus.Later, researchers changed the name to HIV. They also identified the leading methods of HIV transmission and learned that a person could not contract HIV from casual contact, food, water, or air.In 1985, the first International Conference on AIDS took place in the U.S. During the same year, the Food and Drug Administration (FDA) licensed the first commercial blood test to test for viral antibodies. This test was a simple way of diagnosing the condition. Blood banks also began screening their blood supplies for the virus to prevent transmission through blood transfusions.

In March 1987, the FDA approved zidovudine, the first antiretroviral medication that could treat HIV.In 1988, the first World AIDS Day took place on December 1. By 1989, an estimated 100.000 people in the U.S. were reportedly living with AIDS, which develops from untreated HIV.

According to the United Nations' 2004 report, 38 million people in the world were living with HIV, 5 million people were infected with the virus every year and 3 million people were dying from AIDS.Between 1981 and 2008, 20 million people died from AIDS.Statistical studies conducted in early 2005 showed that there were over 40 million HIV+ patients; statistics in 2010 showed that the number of deaths from AIDS exceeded 1.5 million.HIV, which was previously thought to be transmitted only sexually, has been found to be transmitted by other routes such as oropharyngeal and gastrointestinal mucosa, blood, placenta and breastfeeding. HIV is transmitted from person to person through blood and blood products, ejaculate or other sexual fluids. It can also be

transmitted from mother to her baby through the placenta or milk. Therefore, direct contact with bodily fluids is necessary for transmission. Sexual diseases such as syphilis, genital herpes (herpes, gonorrhoea) and chlamydia cause wounds and tissue deterioration in the sexual areas, increasing the risk of HIV infection.

AIDS, which occurs as a result of untreated HIV (human immunodeficiency virus) infection and its progression, is a serious health problem. This disease can negatively affect both the physical and mental health and psychosocial status of individuals and reduce their quality of life. Since AIDS is a health problem that is not sufficiently understood due to social stigma and HIV/AIDS myths, it also makes it difficult for people to access accurate information about the disease. However, it is possible to break prejudices and raise public awareness through awareness activities and accurate information.Social stigma can be defined as a negative attitude or behaviour resulting from the social disapproval of a person or group because of a physical, mental or social characteristic. An example of such attitudes and behaviours is seen in stigma towards individuals living with AIDS. HIV stigma, which is known as negative attitudes and beliefs towards people with HIV, can cause discrimination and negatively affect both the health and well-being of people with HIV. In addition, HIV stigma can also be an obstacle for people to get tested, to share this situation and to access HIV services.

Social stigmatisation may cause individuals with HIV to feel some negative emotions such as fear, abandonment, guilt, worthlessness, and to experience emotional and psychological problems such as harassment. It may also cause individuals to be discriminated against in matters such as employment and education. As a result, some individuals may also avoid getting tested for HIV and receiving

treatment. This disease, which negatively affects the quality of life, may cause fear of stigmatisation and prevent individuals from seeking treatment or cause them to neglect treatment. In addition, individuals who may experience discrimination in accessing health services may have difficulty in receiving the care and support they need.An AIDS epidemic may also have negative consequences for the health sector. It leads to an increased demand for medical care and a reduced supply of affordable and quality care. HIV/AIDS treatment may become more difficult and expensive for everyone to access. It also leads to increased health expenditures.

E.COVID-19:

The first official cases of COVID-19 were recorded on the 31st of December, 2019, when the World Health Organization (WHO) was informed of cases of pneumonia in Wuhan, China, with no known cause. On the 7th of January, the Chinese authorities identified a novel coronavirus, temporally named 2019-nCoV, as the cause of these cases.Weeks later, the WHO declared the rapidly spreading COVID-19 outbreak as a Public Health Emergency of International Concern on the 30th of January 2020. It wasn't until the following month, however, on the 11th of February that the novel coronavirus got its official name - COVID-19. Nine days later, the US Centers for Disease Control and Prevention (CDC) confirmed the first person to die of COVID-19 in the country. The individual was a man in his fifties who lived in Washington state.In the first months of COVID-19, global health authorities, government agencies, and the public were unsure of how the disease would spread and how it would impact everyday life. On the 1st of March, 2020, the United Nations released $15 million in funds to support the global COVID-19 response. A week later, on the 7th of March, cases of COVID-19 reached 100,000. Several days after that, on the 11th of March, COVID-19 was declared a pandemic by the WHO. COVID-19 rapidly transformed from being a severe problem seemingly confined to China, to a global health emergency almost overnight.By this time, the situation in Wuhan had been diffused following the introduction of unprecedented measures to contain the virus. At the beginning of the outbreak, China was reporting thousands of new cases per day, which had reduced to dozens by March. In Europe, on the other hand, cases were rising rapidly day by day, with Italy recording what was an

unprecedented 250 deaths in the 24 hour period between March 12th and March 13th. As a result, on March 13th the WHO declared that Europe had become the epicenter of the pandemic. On the same day, the US declared a state of emergency.To tackle the pandemic, strict measures were put in place around the world. Social distancing and travel restrictions began to come into force in March, along with advice on proper handwashing techniques. However, these measures were predicted to only slow the spread of the virus, scientists understood that to overcome the pandemic, a vaccine needed to be developed/ On the 17th of March, 2020, the first COVID-19 human vaccine trials begin with the Moderna mRNA vaccine.It was clear that initial restrictions were not enough to stop the spread of COVID-19. Quickly, restrictions in most regions became harsher, with the UK enforcing a stay-at-home rule on the 26th of March. Many European countries implemented their own national lockdown around this time. By the 2nd of April, total global COVID-19 cases had shot up to 1 million.

Symptoms of coronavirus infection include fever, cough, shortness of breath and breathing difficulties. In more severe cases, the infection can lead to pneumonia, acute respiratory failure, kidney failure and even death. Coronaviruses are zoonotic viruses that carry the risk of transmission between animals and humans. In the past, Middle East Respiratory Syndrome, known as MERS, is thought to have developed and Severe Acute Respiratory Syndrome, known as SARS, is thought to have been transmitted from civets to humans.Standard recommendations to prevent the spread of coronavirus infections include regular hand washing and cleaning with alcoholic hand sanitisers or soap and water, covering the mouth and nose with a handkerchief or the inside of the elbow when coughing and sneezing, and avoiding intimacy with people with these symptoms. The used

handkerchief should be thrown away immediately.It is recommended to stay away from live animal markets where coronavirus cases are seen.The most common symptoms of coronavirus are high fever, headache and dry cough that persist for several days.COVID-19 threatens everyone, regardless of class. However, the virus did not affect all social groups economically in the same way. In particular, the poor, young people, students, women, and those whose jobs are not suitable for digital labour have been affected much more negatively by the pandemic. As a matter of fact, 40% of respondents to a comprehensive survey conducted in April 2020 stated that they were worried about not being able to meet their basic needs.In addition to economic concerns, it has been observed that depression and stress increase during pandemic periods. People's existential anxieties about getting infected, losing loved ones and death have also increased. As the duration of the epidemic prolonged, fatigue, boredom and increasing symptoms of depression became the most important problems, so much so that fear and anxiety increased far beyond what was expected. The results of the researches also revealed that anxiety and depression symptoms increased. As a matter of fact, in one study, 65 per cent of the participants stated that their restlessness increased, 53 per cent stated that their sleep quality deteriorated, 31 per cent stated that they lost control over their lives and 41 per cent stated that they were in constant fear of being infected. Initially, Istanbul, as a global city, felt the effects of the pandemic more deeply.On the other hand, increasing anxiety and the need to reduce uncertainty have made people believe in conspiracy theories more easily. Conspiracy theories have generally attracted a lot of attention both in countries such as the USA and in Turkey. Interest in conspiracy theories continued to increase during the pandemic. Indeed, in a survey of Arab countries, 46 per cent of respondents said that they

saw COVID-19 as a conspiracy of great powers.In surveys conducted in Turkey, the proportion of those who see COVID-19 as a conspiracy of great powers has steadily increased. Research emphasises the serious social impact of conspiracy theories in the context of COVID-19. As the belief in conspiracy theories increases, trust in experts and authorities decreases, and the tendency to comply with pandemic measures, especially vaccination, decreases.During the pandemic period, people have gone beyond the norms they are used to. As mentioned above, they have become living with the fear of contracting the virus, death and losing their loved ones. Their areas of movement and income opportunities have narrowed and they have become afraid of hugging their loved ones. Therefore, it is observed that life satisfaction decreased during the pandemic period. In a global survey conducted in 26 countries after COVID-19, the countries with the highest mortality rates were also the countries with the highest decline in life satisfaction.

QTBA:

1) ***How can we best understand and communicate the impact of pandemics and epidemics on human health and psychology? How can public awareness be raised to understand human psychology?***
2) ***What are the decisions that can be taken to manage pandemic processes more positively and what needs to be done to improve economic, social and cultural impacts?***
3) ***What are crisis managements to optimise and control quarantine and isolation periods in terms of human psychology and trauma management?***

4) ***How is it possible to minimise pandemic isolation and disease effects to control children's future success and psychological orientation? How can children be protected from this period for the future?***
5) ***Which studies can be continued in this field in order to care about the psychological effects of pandemic and epidemic periods?***
6) ***How to minimise interference with other factors in order to prevent intellectual, psychological and induced effects and traumas from being influenced and exacerbated by other factors ?***
7) ***How to prevent the continuation of the state of fear and anxiety experienced during and after epidemics in society?***
8) ***How can the reflections of the effects that have become taboo and social pressure in society on human psychology be minimised completely? How can life be made easier for the patient and the people affected by it?***
9) ***How does the end of the pandemic period advance anxieties about the future? How can people's fears, worries and anxieties about the possibility that the pandemic may continue in the future or that its effects may not end completely be managed?***

8.Bibliography:

https://social.desa.un.org/everyone-included-social-impact-of-covid-19

https://www.kff.org/mental-health/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

https://youtu.be/J9H_g4li0Pc?si=ZDjeilYsz-EEV60-

https://dergipark.org.tr/tr/download/article-file/3425275

https://youtu.be/A5xDksTPJNI?si=0Ehi13Bi3IN3eTIW

https://youtu.be/GM_WZITwwnE?si=kw5dQn3Mcnsmc5nx

https://youtu.be/Rn306wjvl3g?si=5Jc3ZkPewfJcyTqQ

https://youtu.be/GQF_0xscWcQ?si=NK4-XCBRJkg0VtXD

https://youtu.be/3x1aLAw_xkY?si=3WEysFlkN25cTBLN

https://youtu.be/Di3T2-liFTs?si=o2D8RIPAO5PqCbK2