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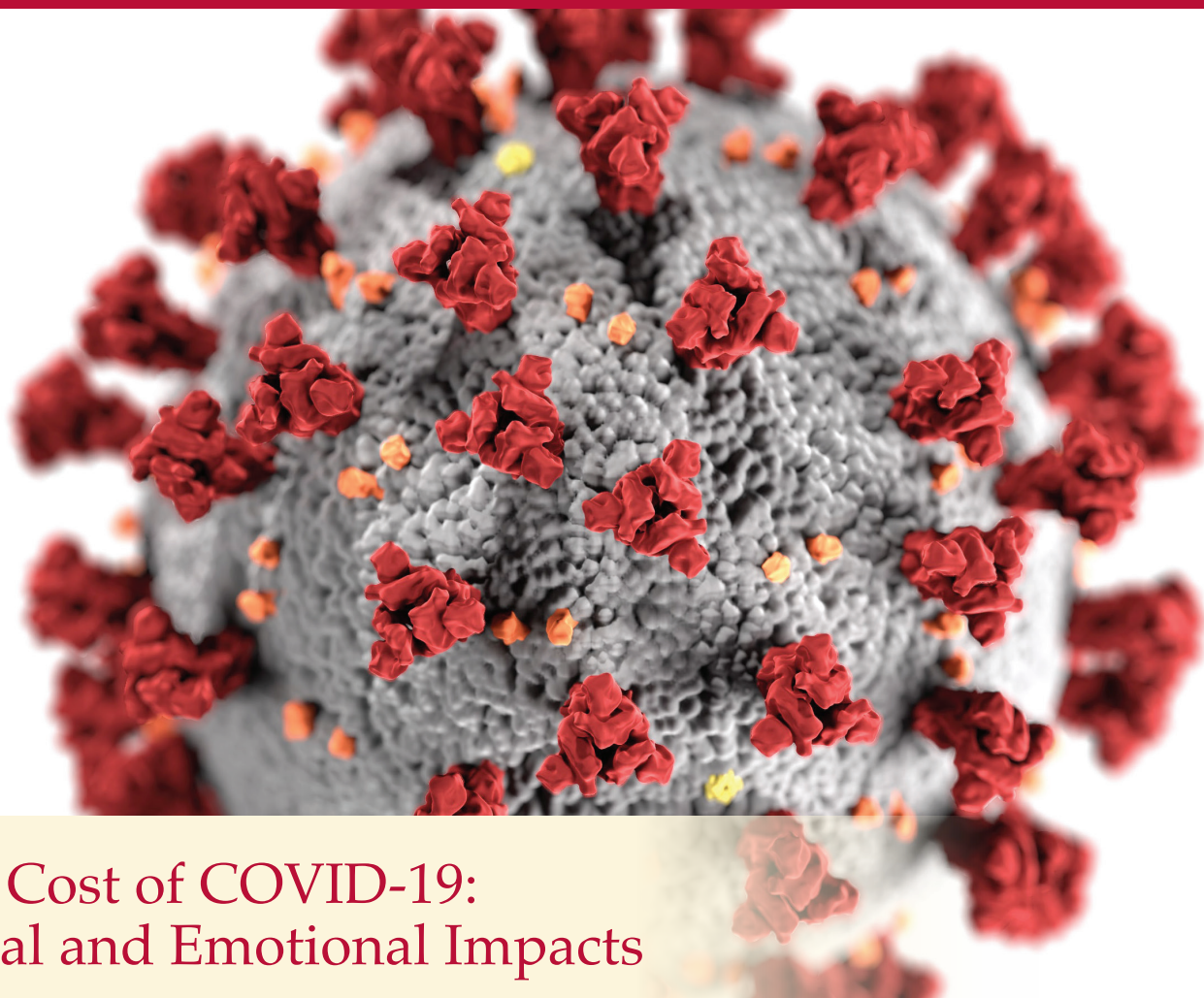
THIS ISSUE: **COVID-19**

The Cost of COVID-19: Social and Emotional Impacts

By Dr. Imaan Bayoumi

In March 2020, the World Health Organization declared the COVID-19 pandemic. As of Aug 22, 2020, there have been more than 23 million cases and 800,000 deaths internationally, and more than 126,000 cases and 9,101 deaths in Canada.

The pandemic has transformed all of our lives. Urgent public health countermeasures, including closures of schools, non-essential business and public services, and mandated physical distancing have effectively slowed the pandemic in Canada. However, these measures have also been associated with job losses, financial pressures, increased government financial assistance, dramatic changes to family life, and increased social isolation.

It is important to understand that the impact of these enormous societal changes has not been equal. The disease and public health measures are likely to disproportionately affect Canadians facing systemic barriers to good health, including Indigenous and racialized people, children, those with substance-use issues, and those living with low income or chronic disease.

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Furthermore, early indications suggest the countermeasures themselves may be associated with significant negative social, emotional, and mental health outcomes, including increased risk of intimate-partner violence, child maltreatment, and poor child and adult mental health.

The coronavirus pandemic presents significant challenges for children, who appear largely to be less severely affected by COVID-19 infection, but are living with the combined effects of the public health crisis, social isolation, school disruption, and the current and likely future impacts of economic downturns.

The "global scale and speed of the current educational disruption is unparalleled," notes Audrey Azoulay, director-general of UNESCO, with more than 1.5 billion children and youth globally now out of school. The combined impacts of such changes are expected to be associated with worsening mental health for children and youth, and concurrent mental health and social service disruptions.

Children living in families struggling with greater economic strain are expected to be particularly vulnerable. Early data suggest that fewer reports of child maltreatment have been made, leaving service providers and experts to worry that protective adults are less able to identify and act to mitigate child maltreatment and adverse childhood experiences including child maltreatment, exposure to intimate-partner violence, and exposure to mental health conditions in a parent — all of which have lifelong impacts, including increased rates of substance use, mental health conditions and suicide, and many chronic illnesses. The combined effects on children of increased stress and exposure to maltreatment, and reduced access to protective mechanisms through school and after-school programs, and health and social services could be substantial and persist long into the future.

The public health countermeasures have also been shown to be associated with greater risks for people living with intimate-partner violence. In Canada, at least nine women and girls have already been murdered during the pandemic, and phone calls to domestic and sexual violence services have increased up to 300 per cent since the pandemic began. While some women's shelters have experienced lower occupancy rates than before the pandemic, reportedly due to women's concerns about COVID-19 infection in the context of communal living situations, in many cases the violence the women presenting to shelters experienced appears to be more severe, implying that women may be tolerating increased levels of abuse before presenting to care.

Indigenous people in Canada faced health inequities pre-pandemic due to existing structural barriers such as high rates of poverty and the impact of colonial policies, which are associated with high rates of discrimination in health care, chronic disease (including mental health conditions) and lower life expectancy. More than 60 per cent of Indigenous people in Canada live in urban settings, however the government response to date has allocated very limited resources to those living off-reserve. Very little is known about the impact of the pandemic on the mental and physical wellbeing of urban Indigenous people. However, there is substantial evidence of the impact of colonialism, discrimination, and explicit and implicit bias directed against Indigenous people in Canada in health care settings.
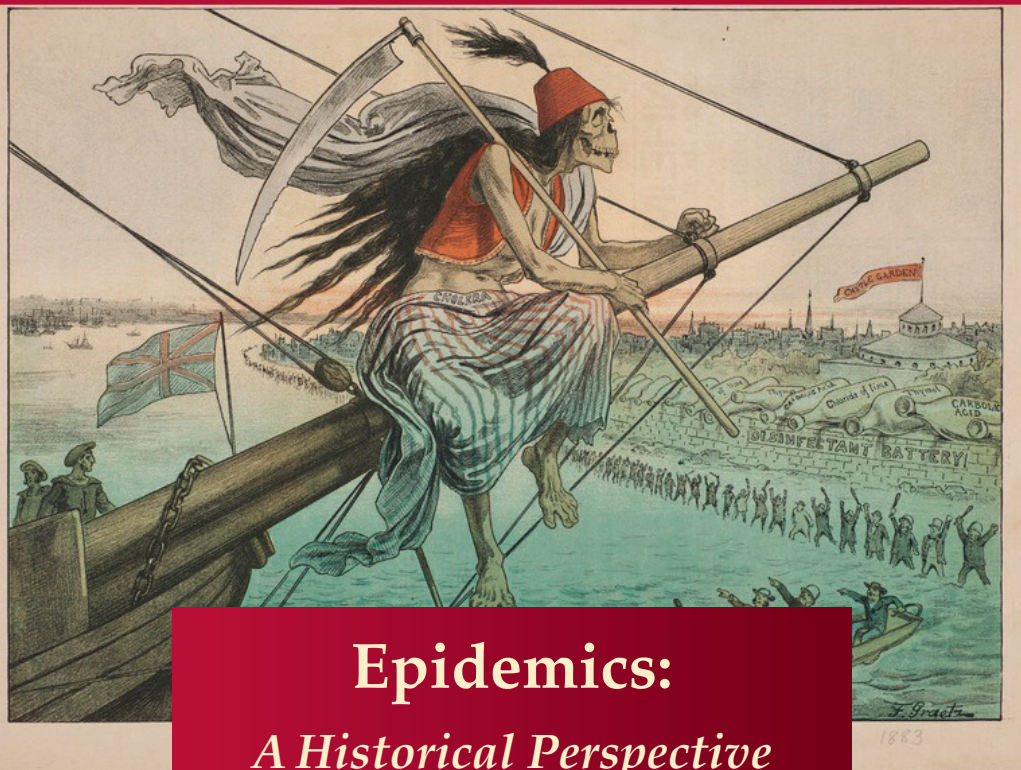
Health care delivery has also changed dramatically, and is increasingly being provided by telephone and telemedicine. In many cases, these changes present an opportunity to provide health care in a different, more patient-centred manner, but they present important limitations for groups already facing barriers to care. Limited access to a telephone, computer, internet, and computer literacy will disproportionately affect low-income Canadians. Newcomers with poor English language skills may struggle even more with virtual care. Non-verbal cues can be important in delivery of mental health care. Privacy constraints may limit the capacity for people experiencing intimate-partner violence to speak freely. Indigenous people who disproportionately experience low income, access barriers, chronic disease with higher morbidity, and cultural barriers are more likely to be affected by these constraints.

Our research team seeks to understand the social and emotional impacts of the pandemic among various groups, including children, families, and Indigenous people, and the health system barriers to access to high-quality appropriate care.

The Cost of **COVID**
A study to understand the Social and Emotional Impacts of the Pandemic

Cost of Covid Survey
https://bit.ly/3hUkAOz

Storytelling Survey
https://bit.ly/37nz8T4

Dr. Eva Purkey and Dr. Imaan Bayoumi, assistant professors at the Queen's Department of Family Medicine, are working with Dr. Colleen Davison, associate professor, Queen's Public Health Sciences; Mary Martin and Eszter Papp, research associates at Queen's Department of Family Medicine's Centre for Studies in Primary Care; Autumn Watson, Indigenous research associate seconded from the Indigenous Diabetes Health Circle; Dr. Kathy Pouteau, assistant professor, Queen's Family Medicine; Minnie Fu, medical student; and many community partners including KFL&A Public Health; the Indigenous Health Council; the Indigenous Diabetes Health Circle; Family and Children's Services of Frontenac, Lennox and Addington; the Ontario Association of Interval and Transition Houses; local school boards; and the Maltby Centre. We are grateful to Queen's University and the PSI Foundation for supporting this work.

Our research has two parts. Participants age 16 years and older are invited to complete an anonymous online Cost of COVID-19 Survey. In addition, they are invited to record a story on a smart phone, tablet, or computer about an experience during the pandemic and then to answer a few questions about their story (Cost of COVID-19: Storytelling). To date, more than 2,000 people have responded to the survey and 85 people have recorded stories, and our team is beginning to analyze the data. Our aim is to have a strong knowledge-to-action link between the research team and community partners, who are well-positioned to respond to needs identified in the research with program-delivery changes.

Initial results suggest a high burden of mental health symptoms among those completing the survey. Twenty-nine per cent of respondents report symptoms of depression, with greater likelihood seen in women and people with lower income or lower education. Anxiety symptoms are also very common, and were reported by 33 per cent of respondents. Anxiety symptoms are especially common among people with chronic health conditions. Loneliness has increased as well. Whereas 12 per cent reported feeling lonely on most days in the past, during the pandemic this figure has risen to 39 per cent. Younger people, transgender and gender-diverse people, those with chronic conditions, and those whose living situation does not include a yard were more likely to report loneliness during the pandemic.

These results point to the significant mental health strain Ontarians have experienced during the pandemic and the need to plan for increased mental health supports as we move into the next phases of reopening.

Dr. Imaan Bayoumi is a family physician and clinician researcher in the Queen's Department of Family Medicine. Her research focuses on the social determinants of health, particularly on children's health.

Epidemics:
A Historical Perspective

By Dr. Jenna Healey

When I locked up my office back on March 13 of this year, I could never have anticipated what the following weeks and months would hold. In theory, I should have been more prepared than most. Every January, I give a lecture to the Queen's medical students about the top 10 lessons we can learn from the history of epidemics. The final lesson is a simple one: There will be new epidemics.

At the close of this year's lecture, I casually mentioned the coronavirus that had recently emerged in China. Would this virus be the cause of the next great pandemic? At the time, it didn't feel significant. After all, in past years, I had asked the same question about Ebola and Zika. While I was certainly alarmed by the reports coming out of Wuhan, I imagined a situation similar to SARS or MERS, a serious but ultimately containable threat.

That humanity has conquered the threat of infectious disease is one of the most pernicious myths of modern medicine. After the Second World War, the introduction of antibiotics and the development of vaccines for childhood illnesses like polio and measles created widespread optimism among physicians and patients alike. It seemed the death and disruption caused by epidemic disease would finally be relegated to the annals of history.

But this narrative was always naïve. For one thing, this so-called triumph over infectious disease never reflected the experience of under-resourced communities with limited access to the medical technology. But even in highly resourced communities, new infectious agents continued to emerge, such as Legionnaire's disease in 1976 and HIV / AIDS in 1981. In both cases, physicians expressed their helplessness when faced with deadly threats that failed to respond to the weapons in their technological arsenal.

In the early weeks of the pandemic, I had many discussions with my students about what historical parallels might help us understand the moment we were living in. On one hand, each historical epidemic is unique because it is rooted in a specific political, cultural, and scientific moment. Indeed, historian Charles Rosenberg once described epidemics as natural sampling devices, capable of revealing the fault lines of any given society, an observation that I would argue has certainly held true for COVID-19. But on the other hand, there are some obvious historical examples that could be read as foreshadowing of our current moment.

One nearly universal feature of historical epidemics is scapegoating, the singling out of specific populations as the source of the epidemic threat. Almost always, the blame is placed on those who are already marginalized or "othered" in some way. During the Black Death, the epidemic of the bubonic plague that devastated Europe in 1348, Jews were accused of spreading the disease as part of an intentional conspiracy to poison Christians. Many Jews, already shunned in Christian society, were tortured and killed. During the 19th century, as waves of pandemic cholera circulated along global trade routes, the disease became closely associated with foreigners. In one cartoon from 1883, pictured above, cholera is stylized as a skeleton wearing a Persian fez and labelled as "the kind of 'assisted emigrant' we can not afford to admit."

On the west coast of North America, Chinese immigrants were singled out as "carriers" of plague and leprosy, and were frequently targeted for quarantine and other punitive measures. Anti-Asian racism remains ubiquitous in modern epidemics, both during the SARS outbreak in 2003 (which saw many restaurants in Toronto's Chinatown close due to lack of revenue), as well as in our present moment when US President Donald Trump deploys racist epithets like the "Wuhan Virus" or "Chinese Virus" to describe COVID-19.

Curiously, the only historical epidemic where scapegoating did not occur was the 1918 influenza pandemic. Despite being wrongly labelled as the "Spanish" flu — Spain, a neutral power during the war, was one of the few countries that didn't censor reports of the virus — no population was singled out as the cause of the disease. This is mostly likely because, in the fall of 1918, it was returning soldiers who were most likely to be infected and to spread the disease to their communities. Here, the cultural tendency towards scapegoating was trumped by the untouchable social standing of the returning war hero.

A study of historical epidemics also reveals surprising continuity in the methods we have used to control epidemic threats. One of the oldest methods of controlling contagious disease, of course, is quarantine. The term originated during the Black Death and is derived from the Italian quarantena, referring to the 40-day period ships would isolate in Venetian ports before passengers and crew could disembark. The concept of isolating carriers of disease is even older, appearing in the Old Testament as well as the writings of the Prophet Muhammed.

While the term has primarily referred to the isolation of marine vessels, accounts of plague outbreaks in London during the 17th century describe the marking and guarding of individual households known to be infected. Those same accounts also describe the lengths taken by many households to conceal the disease, both out of fear of stigma and to avoid restrictions that might be placed on their movement. Indeed, wherever public health measures clash with individual liberties — whether it be quarantine in 1665, vaccination for smallpox in 1885, or the enforcement of mask orders in 2020 — we should expect to find significant resistance.

In the 19th century, a series of International Medical Congresses were held to debate the science and economics of quarantine. Many experts insisted that isolating people and goods was an ineffective measure for controlling the spread of cholera. For imperial powers increasingly reliant on global trade, the isolation of ships and goods had dire economic consequences. In these debates, we can see echoes of our modern discourse about the necessity of "reopening" economies as soon as possible. Many historians consider the International Medical Congresses to be the earliest precursor of the World Health Organization, as it was the first time physicians and diplomats from many countries came together to draft international health policy.

In our current moment, public health officials have called upon citizens to "flatten the curve" through voluntary isolation and "social-distancing" measures. Interestingly, the expression "flatten the curve" is a relatively recent invention, coined by a historian of medicine as a way to describe the effectiveness of non-pharmaceutical interventions during the 1918 flu pandemic.

Howard Markel, a physician and historian at the University of Michigan, was commissioned by the US government in 2004 to conduct a study of the outbreak and to determine what measures were most effective in controlling its spread. Markel found that American cities that quickly implemented social-distancing measures had a low incidence of disease spread out over time, while cities that did not shut down (such as Philadelphia, which famously held a Victory parade for retuning soldiers in September 1918) had a large number of cases all at once, creating that now infamous bell-shaped epidemiological curve. The importance of flattening the curve is perhaps the most concrete lesson history can offer when faced with a highly contagious viral threat.

Historians are reluctant to predict the future, though they are often asked to do so. There is so much in this historical moment that is unique — the scale and speed of global travel, the immediate availability of information (and disinformation) on the internet, and widening economic inequality — that to predict what will happen next seems like the ultimate folly. But there is some hope among historians that this crisis can be a catalyst for change. Epidemics leave clear legacies, some of them predictable — such as the establishment of Canada's federal Department of Health in 1919 — and some less so — such as the US invasion of Cuba in 1898, which was justified by the need to control yellow fever.

What happens next is anyone's guess.

Dr. Jenna Healey is an assistant professor in the Queen's Department of History whose research focuses on the intersection of 20th-century medicine, gender, technology, and health policy. As the Jason A. Hannah Chair in the History of Medicine at Queen's, she is responsible for integrating history into the undergraduate medical curriculum.

Through an Equity Lens:
The KFL&A Public Health Experience

*By Dr. Hugh Guan and Queen's medical students
Anthony Li, Stephanie Parent, and Arsalan Rizwan*

The COVID-19 pandemic has brought issues of equity to the forefront. The virus did not affect all populations equitably. While the COVID-19 status of well-known, high-income public figures has been heavily reported in the media (think Tom Hanks, Sophie Grégoire, or Boris Johnson)[1–3], equity-seeking populations continue to carry the greatest burden of this pandemic.[4]

During the pandemic, "essential workers" included individuals working in grocery stores, cleaners and janitors, and people working in the transportation industry.[5] These are not the type of occupations one can do "from home." In addition, individuals in these occupations are overwhelmingly from lower socio-economic status. It may be harder for a lower-income worker living paycheque to paycheque to assert their right not to go to work, as opposed to a higher-income worker who could more easily choose to work from home.

As such, there is an unequal risk distribution, putting individuals working in these industries at higher risk. This points to a type of inequity brought on by COVID-19: the ability to physical distance is a privilege. This inequity is also reflected in housing: many people,

due to cultural or socio-economic factors, live in denser environments such as small apartments with many others, either roommates or family members. Physical distancing is even harder for people who do not have stable housing.

Consequently, already equity-seeking populations have faced a higher risk of exposure to COVID-19, and the disease exacerbated already existing societal inequities. For example, in the US, Indigenous and Black Americans were five times more affected than white Americans, and were also more likely to be hospitalized and to die of COVID-19.[6] Closer to home in Ontario, neighbourhoods with higher ethnic diversity were similarly disproportionately affected by COVID-19.[7]

In public health, we work from a determinant of health and upstream perspective. It is our role to examine and understand the factors that contribute to the disproportionate impact on people from different populations.

Kingston, Frontenac, Lennox, and Addington (KFL&A) Public Health took a pre-emptive approach to the pandemic, particularly as it relates to our seniors. Before any cases were diagnosed in the region, we created strategies on how to best protect our elderly population living in retirement and long-term care

homes. We learned from the lessons based off outbreaks that started in Europe and Asia. KFL&A Public Health focused on retirement and long-term care homes, ensuring they respected best infection prevention and control (IPAC) practices through regular visits by a team of inspectors and public health nurses and constant two-way communication. Collaboration with these homes began even prior to the COVID-19 pandemic, with influenza preparedness updates and visits to homes for many years. We continue to partner throughout the pandemic, and we believe that our close mutually beneficial relationship with our retirement and long-term care homes is a key factor in our success in preventing the large outbreaks of COVID-19 in these facilities.

Beyond our seniors population, KFL&A Public Health collaborates and remains in regular communication with many organizations working with equity-seeking populations to offer support and guidance, including correctional institutions and agencies that support those who are homeless and/or underhoused. In conjunction with Frontenac Paramedics, an outreach COVID-19 swabbing program is available for those with severe mobility issues or inability to access COVID-19 testing. We also provide IPAC support to our area's shelters and group homes. As a result of decreased shelter capacity, many people with no regular housing moved to an encampment located in Belle Park. KFL&A Public Health partnered with Frontenac Paramedics, Kingston Community Health Centres, Home Base Housing, Addiction and Mental Health Services (AMHS) KFLA, and City of Kingston staff to offer a variety of health services to Belle Park residents, including a mobile COVID-19 testing clinic and dental system navigation. We continue to advocate for the basic needs of homeless and underhoused individuals to be met.

Finally, when KFL&A Public Health issued an order to mandate wearing face coverings in indoor commercial establishments to decrease transmission risk, we realized that certain groups may not be able to access masks. In response, we partnered with United Way to provide and deliver masks to populations who would not otherwise be able to access them through the "United Together" initiative. The initiative sells reusable face masks to workplaces, families, and other groups, with the proceeds going towards the purchase of disposable face masks for vulnerable members in KFL&A.[8]

COVID-19 required major changes to social institutions and to how we, as a society, relate to each other. It is crucial to recognize that the public health measures put in place may disproportionately affect the already at-risk populations, putting them at a further disadvantage. Thus, it is the duty of public health to continue to collaborate and co-operate with equity-seeking populations, to ensure their health is protected, not ignored, during these unprecedented times.

For further reading and resources on COVID-19, see the following links:

Public Health Ontario

Centers for Disease Control and Prevention

Canadian Medical Association (Questions and Answers on COVID-19)

KFL&A Public Health (COVID-19: Frequently Asked Questions)

United Way KFL&A (Local Community Support Services)

United Way KFL&A (United Together Campaign)

Dr. Hugh Guan is the director of the Division of Infectious Disease Prevention and Environmental Health at KFL&A Public Health and a graduate of the Queen's Department of Family Medicine's Public Health and Preventive Medicine program.

> *KFL&A Public Health collaborates and remains in regular communication with many organizations working with equity-seeking populations to offer support and guidance.*

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Ethics, Equity, and Ageism:
COVID-19 and Generational Justice
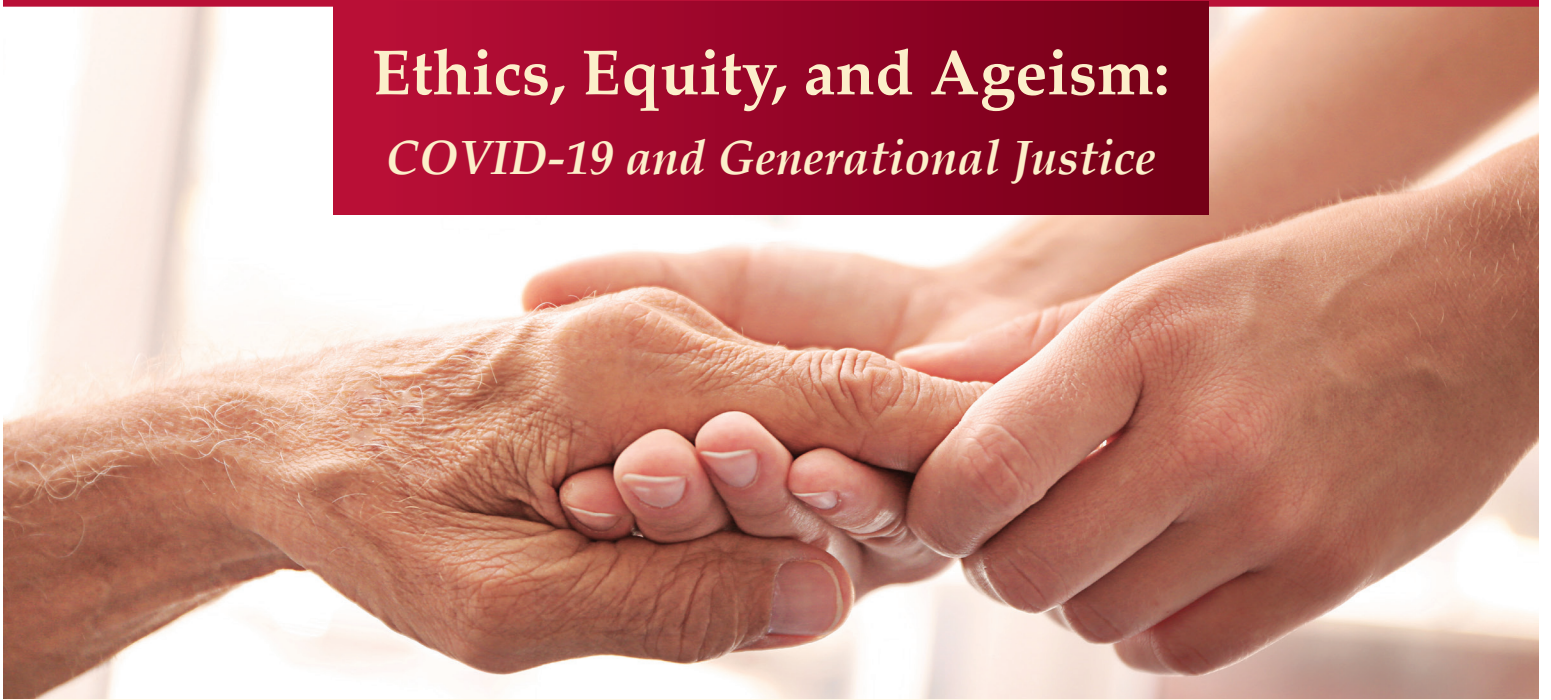
By David Campbell, PhD

It would be no exaggeration to claim that responding to the COVID-19 pandemic has been the greatest challenge our health care system has faced in recent memory. The pandemic has exposed and amplified existing inequities within our society. Individuals who are already marginalized due to their socio-economic status and biases against mental health illnesses, substance use disorders, and homelessness face even greater challenges due to COVID-19.[1] Racism, sexism, and ableism have also contributed to greater burdens and worse outcomes from COVID-19 for certain communities than others.[2]

I will focus on a less obvious but more universal form of inequity this pandemic has exposed and amplified: ageism.

Ageism is a particularly ethically challenging form of discrimination because it is very subtle and it is still socially acceptable. It is harder to identify than other forms of discrimination, and is often justified as a form of well-meaning paternalism.

Within health care, ageism is exhibited in how the elderly are infantilized, ignored, or devalued.[3] An all-too-common example of ageism is how health care providers automatically defer to the adult children of elderly patients and defer to them in decision-making.

Seniors who choose to live at risk are often considered to lack insight and therefore be incapable of making their own decisions, while younger adults who make the same risky decisions are considered autonomous adults free to live their lives as they see fit.

PANDEMIC ETHICS, TRIAGE, AND THE ELDERLY

During the early stages of the pandemic, the immediate ethical dilemma was how to prepare for the feared surge of COVID-19 patients who were expected to overwhelm the health care system. A dire lack of ICU resources and personal protective equipment meant that critical-care physicians would be placed in the terrible dilemma of deciding who would live or die as our hospitals would not have the resources to save everyone.

To ensure hospitals were prepared for the worst-case scenario, ethics services were asked to help provide ethics frameworks that would help ensure that resource allocation decisions were made in a principled, ethically justifiable manner. Ethicists across North America were consistent in supporting a triage approach that focused on saving as many lives as possible and advocating strict clinical criteria that would determine who should receive scarce ICU resources. By focusing on clinical factors and explicitly rejecting social factors that could prejudice decision-making, such as socio-economic status, these triage protocols would help guide clinicians in making difficult decisions about who should receive scarce life-saving medical resources in as equitable a manner as possible.[4]

While many ethicists did not support using age as a factor that should be taken into consideration when deciding who should or should not receive live-saving treatments during triage as this would be discriminatory,[5] other ethicists argued that the concept of expected life years was an ethically justifiable factor when making these triage decisions.[6] They claimed that including expected life years in resource allocation decisions is based on commonly accepted societal norms that are accepted by not only the young but also the elderly. They also argue that by not including expected life years in triage resource allocation decisions, we would in fact be discriminating against the young, as they would be robbed of years of life that the elderly have already enjoyed.[7]

This debate identifies a fundamental ethical dilemma within identifying and addressing inequities, as addressing certain inequities can cause other inequities, depending on one's definition of an inequity. Luckily, these ethically controversial triage protocols did not have to be implemented in Canada, as our hospitals were not overrun by the expected surge of critically ill COVID-19 patients. However, this debate might have to be re-addressed if second-wave cases of the pandemic start to overwhelm our hospital capacity.

COVID-19 AND LONG-TERM CARE

While it would be ageist to set a specific age cutoff for life-saving ICU resources — a healthy 85-year-old could have a greater chance of surviving COVID-19 than a very unhealthy 35-year-old — the reality is that frail elderly patients with multiple co-morbidities are much more likely to die from COVID-19.[8] Therefore, we have an ethical duty to protect the vulnerable elderly as they are in greater danger of catching and dying from the pandemic. Yet our collective response to date in protecting our most vulnerable has been sorely lacking.

The vast majority of deaths from the pandemic in Canada have been at long-term care facilities. A report from the National Institute on Ageing states that up to 82 per cent of COVID-19 fatalities in Canada have been long-term care residents.[9] The spread of the pandemic at long-term care facilities has been exacerbated by decades of neglect and underfunding. Long-term care facilities are often understaffed and undersupplied.

The sad state of long-term care facilities and the blatant neglect of the elderly have been highlighted by the Canadian Armed Forces report that identified everything from lack of cleaning supplies to poorly trained and burned-out staff providing demeaning sub-optimal care and, in some cases, allowing patients to go hungry and unbathed.[10] The fact that the military had to be called in to rescue long-term care residents is evidence of our collective failure to protect our most vulnerable population.

The elderly have also suffered from the strict visitor restrictions long-term care facilities were forced to implement. While hospitals are able to provide the resources for patients to participate in virtual visits with their loved ones, long-term care facilities often do not have the staffing to enable virtual visits. In addition, as the majority of long-term care residents have cognitive deficits related to dementia, they might be unable to utilize tablets by themselves or, in some cases, might be unsettled by virtual visits.

While strict visitor restrictions in long-term care homes can be justified on safety grounds and the duty to avoid or minimize harm, this must be balanced with the harm to the mental and emotional health of seniors who often already feel lonely or forgotten by society.

CONCLUSION: PANDEMICS AND GENERATIONAL JUSTICE

It is important to remember that ageism is not just discrimination against the elderly. It can also include discrimination against the young. The concept of generational justice will become more urgent in the future as health care costs continue to escalate while the long-term economic burdens of closing the economy and the social and psychological burdens of social and physical distancing are largely being borne by the young.

We simply do not know when or if the economy will recover or how we will pay for the massive public debt that is accumulating due to this pandemic. We can only speculate on how closing schools, daycares, and playgrounds will affect our children's well-being.

The COVID-19 pandemic has not only exposed ageism against the elderly; the ramifications of our response to this pandemic will produce ongoing ethical challenges for our young, who will pay for our mistakes and miscalculations for many years to come.

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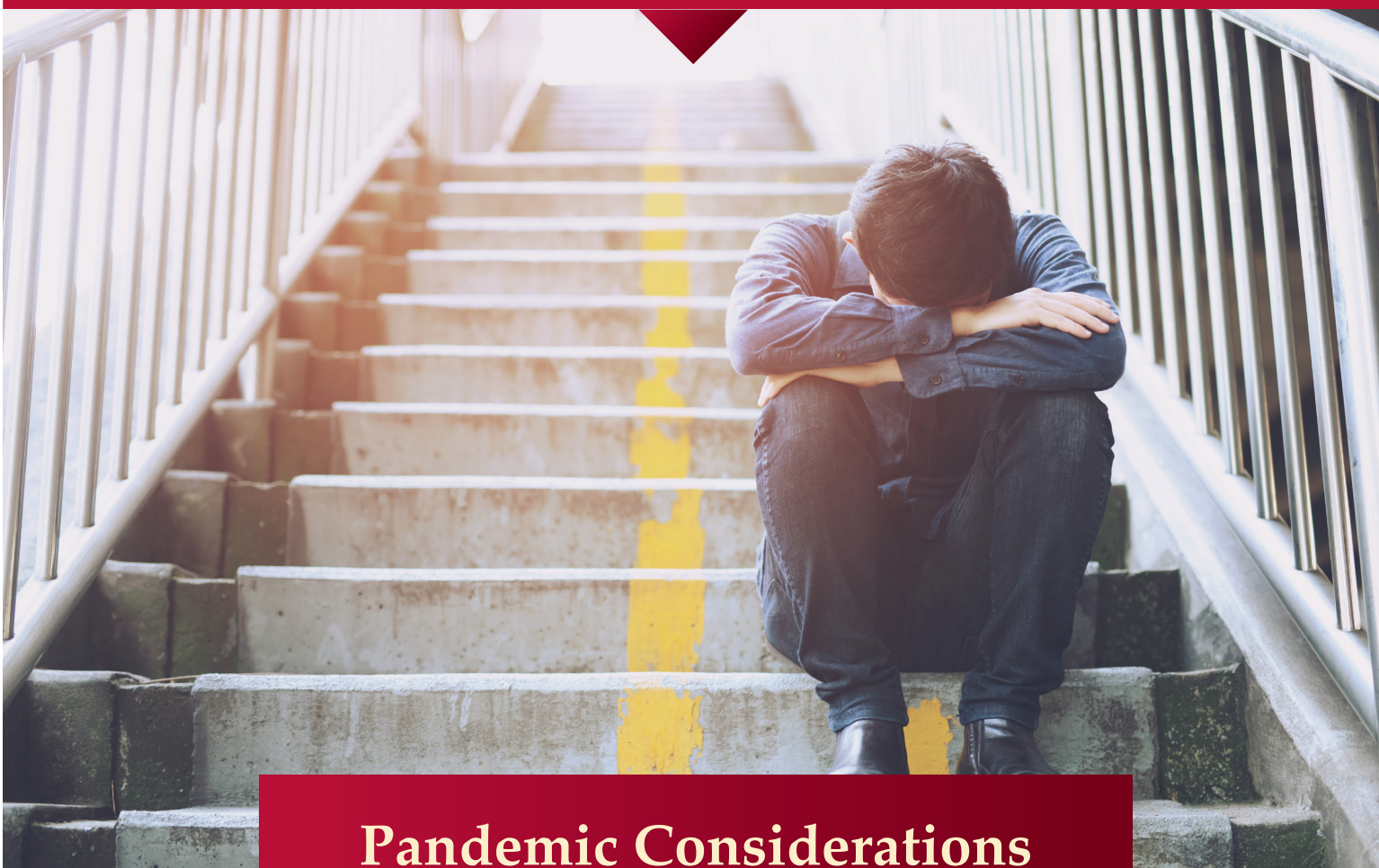
Pandemic Considerations for Child Welfare

By Lousanne Rodé and Michelle Campigotto

On March 11, 2020, Dr. Tedros Adhanom Ghebreyesus, director-general of the World Health Organization (WHO), declared the situation created by COVID-19 as a pandemic (2020). Since that historic date, health care providers, politicians, community service providers, families, and individuals have been contending with the implications of the pandemic, for most people an area of circumstances well outside any previous experience.

As we move through this pandemic, it has become abundantly clear that all areas of human functioning must be examined with a view to understanding health and safety concerns. The relationship between COVID-19 and the social determinants of health need assessment in order for community service providers to offer the wide range of responses required for the population's well-being.

In Canada, the social determinants of health include Aboriginal status, disability, early childhood development, education, employment and working conditions, food insecurity, gender and gender identity, health services, housing, income and income distribution, race, sexual orientation, social exclusion and social safety net, and unemployment and job security. (2020)

During the weeks following the pandemic's declaration, Family and Children's Services of Frontenac, Lennox and Addington began to see the immediate influence of COVID-19 response planning on the population's physical health, the economy, and community-service provision. Life's tasks would become more onerous for those reliant on community social services to help meet their psycho-social needs. Concern about mental health stability in the context of social isolation, financial stress, and the difficulties with conducting the most routine activities of daily living soon became apparent.

However, the pandemic's effect on the health and well-being of children, especially those who live in marginalized circumstances, has not been as readily transparent. As Dr. Ronald Cohn, president and CEO of SickKids, said, "It is difficult to capture this in numbers and data but … we are significantly underestimating the impact this has on children of all socio-economic classes, particularly ones who are coming from vulnerable life and family conditions." (2020)

For approximately the last three decades, children's aid societies have utilized a social-ecological model

composed of four levels — the individual, their relationships, their communities, and the wider society — to inform their strategies in the prevention of maltreatment and neglect. This model is based on the belief that these levels are interwoven to provide risk and protective factors (2019, 1993). The practice principles currently used in service delivery at many children's aid societies nationally, called the Signs of Safety (SOS), replicate the social-ecological model in considering child safety within the context of their relationships and community. The social determinants of health are also encompassed in the four levels of the social-ecological model. Therefore, it is vital to children's safety that families can access community resources for their health and well-being supports.

The pandemic impacted the functioning of many societal institutions that intersect with both the social determinants of health and the safety net for children. Perhaps none of these were as concerning as the closure of schools. Schools are critical to children's well-being. Not only do they aid in numerous areas of growth in childhood development and reduce social isolation, they also provide parents the time for employment outside of the home, which, in turn, includes social determinants of positive health.

> *It is difficult to capture this in numbers and data but … we are significantly underestimating the impact this has on children of all socio-economic classes, particularly ones who are coming from vulnerable life and family conditions.*

"The impact on the mental, behavioural, and developmental health of children not going to school, not being exposed to in-person teaching and not being with their friends and peers is something that myself and many of my colleagues in pediatrics are literally losing sleep over," noted Dr. Cohen (2020). Absent the safety net schools afford, how do we create opportunities for all children to reach out for help?

Family and Children's Services of Frontenac, Lennox and Addington, as the local child protection agency, receives referrals for services from a wide range of sources. Given the amount of time children spend in schools and the close relationships they form with education personnel, it is not surprising that children disclose their worries or fears, or that educators observe signs of possible maltreatment or neglect.

When comparing the number of referrals the agency received from education sources from March to May over the past three years for child-protection concerns related to children's exposure to adult conflict and / or to partner (parental) violence, conflict between caregivers / parents and their child, or parents with problems (substance abuse) that may impede parenting or the caregivers' / parents' response to emotional harm, it is most concerning that we saw a 76-per-cent decrease in referrals.

Referrals from police services remain the highest source of agency referrals over this period, with a perceived increase in the severity of incidents being reported.

Other areas of reported concern in which the data reflects a significant reduction in reported calls across all referral sources are concerns about physical or sexual harm to children.

Do these numbers suggest the pandemic and ensuing isolation have left some children more at risk of maltreatment? Has this left children exposed to a more frequent and more serious risk of harm prior to the society being notified?

There is limited information that some children are not feeling safe. According to Kids Help Phone president and CEO Katherine Hay, the calls from youth with concerns about the pandemic had risen 350 per cent over two weeks.

"Kids are not immune to depression or anxiety over social isolation and money concerns," said Hay. "We are worried about increased suicide ideation with young people. We are also worried with increased isolation with domestic violence and abuse." (March, 2020)

While it is positive that youth are calling the help line, this is not a resource available to younger children; the benefit of this resource is influenced by the child's age and their ability to privately access technology to reach out for assistance. Reliance on, and assumption of access to, technology to engage virtually may leave out those most marginalized in our population.

The pandemic raises a multitude of questions about how we provide for the safety and well-being of children, which is embedded in our community responsibilities.

> *When comparing the number of referrals the agency received from education sources from March to May over the past three years for child-protection concerns … it is most concerning that we saw a 76-per-cent decrease in referrals.*

We know from news reports and data that caregivers are struggling with social isolation, financial uncertainty, reduced or removed service supports, emotional and mental health, and addictions. Families are struggling with physical isolation from family, friends, and other informal supports such as neighbours.

School closures and online learning has led to the absence of important relationships between children and school personnel, relationships that created a social safety network prior to COVID-19.

Without community service supports, how are we to expect there would not be an increase in risks to children?

As our community moves through this pandemic, together we must work to reduce social isolation and increase the positive impact to the social determinants of health.

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The Ethical Challenges of the SARS-CoV-2 Pandemic in the Global South and the Global North — Same and Different

This editorial was first published in Developing World Bioethics in April 2020. It is reprinted here with permission from Dr. Udo Schuklenk, joint editor-in-chief of the journals Bioethics & Developing World Bioethics.

By Dr. Udo Schuklenk

The global COVID-19 death toll[1] stands at the time of writing at 163,500. By the time you read this, that number will have increased significantly, and it is likely that we won't have seen the end of it by that time. Policy makers in both the global north as well as the global south rose to the challenge, with decidedly mixed responses as well as decidedly mixed results, as comparisons between reported case loads of, say the UK and Germany or between Brazil and the PR of China, show. Discipline specific responses translated into many global collaborative efforts aimed at developing treatments, modelling of the impact of varying policy options on the continuing pandemic, preventive vaccine trials, and so on and so forth.

Unsurprisingly, as bioethicists we contributed in our own discipline-specific ways. Firstly, we took aim at determining what we considered relevant ethical issues. We focused initially on producing frameworks or guidance documents in various areas, one of the most prominent of which was fairness in triage decision-making.

TRIAGE AND INEQUALITY

Why did triage come up in the first place? Mostly because we had seen in the PR of China, Italy, Spain, and in New York City that there likely would be a significant shortage of ventilators and ICU beds. Invariably these shortages would occur both in the global north (see Italy, the USA and UK), as well as in the global south (see PR of China). The difference here was one of several magnitudes of higher need. India, for instance, has 2.3 intensive care unit (ICU) beds available per 100,000 people, while Germany has 29.2.[2] In Germany access to ICU beds is provided not on an ability-to-pay basis, but based on clinical need. Brazil has ostensibly 10 ICU beds per 100,000 people. Why 'ostensibly', you ask? Because half of these ICU beds in Brazil exist in private sector

hospitals, and they serve a mere 25 per cent of the country's population.[3] Uganda has reportedly only 55 ICU beds for its 43 million citizens.[4] So, while the ethical question remains the same, and the ethical frameworks available to drive that decision-making remain the same, what complicates matters in a health care system like Brazil's is that patients competing there for the same resource, say, a scarce ventilator, are not in the same boat, as it were, unlike in Germany. In Germany a homeless person admitted to hospital on the same day as a captain of industry would find themselves subjected to the same triage algorithm as the wealthy patient. Their wealth would not feature as a relevant consideration. What this example suggests is that in Brazil at least the impact of the pandemic will disproportionately hit the country's poorest, both because of their living conditions, but also because of how access to scarce ICU beds is limited by having access to private health care facilities with their own supply of ICU beds.

DUTY TO TREAT?

A similar picture emerges vis à vis a different question: Do health care professionals have a professional obligation to provide care to COVID-19 patients? This question arose largely because in the two countries with the highest patient case loads at the time, the PR of China and Italy (since then well overtaken by the USA), health care professionals often provided care while having no or sub-optimal personal protective equipment (PPE). As a result of their inability to practice universal precautions, many of these professionals acquired a SARS-CoV-2 infection, and indeed, many of them died of COVID-19. I have argued elsewhere that health care professionals who refused in various countries of the global north to take such risks were not ethically blameworthy.[5] After all, we were warned that this kind of pandemic would occur during our lifetime, and the lack of respirators, gloves and all, was a direct consequence of our refusal to pay taxes sufficiently high to enable our health care systems to protect our health care workers adequately. By electing and re-electing low-tax politicians we accepted that our health care system would not be able to protect its staff in an outbreak like SARS-CoV-2. Arguably then those professionals serving in the global north's health care systems do not owe us care, given society's neglect of their needs in terms of protective equipment. A province in Canada, for instance, proposed in all seriousness that health care professionals could only refuse to provide care if there was certainty that serious harm would be incurred by them otherwise.[6] Of course, there is pretty much no certainty ever in medicine, so this standard was probably quite deliberately designed to maximise the number of health care professionals

available even if they were lacking PPE. Given that the purchase of sufficient respirators, gloves, face shields and gowns would not have brought the economies of countries like Italy, Canada or the USA to their knees, such demands on health care professionals are unjustifiable. The British Medical Association, as one of many such doctors' groups, was right to promise to defend any of its members who might get censured, if they refuse to provide care to COVID-19 patients when PPE is inadequate.

While the same question arises in the global south, the ethical analysis is not as easy, unfortunately. In Zimbabwe, for instance, reportedly a hospital shut down because its staff refused to work without protective equipment.[7] The reality is that, globally, many health care workers lost their lives after acquiring SARS-CoV-2 from their patients, so the anxiety expressed by the striking health care workers in Zimbabwe is understandable. However, Zimbabwe is also a country whose economy is broke and has been broken for many years. The purchase of large quantities of PPE may have genuinely been beyond its reach. Now even non-COVID-19 patients may die due to health care workers refusing to provide the professional health care services they promised during their graduation ceremonies to provide. I am less certain about the obligations of health care professionals operating under such conditions. Would what occurred in Zimbabwe be a case of indefensible patient abandonment, especially if the professionals in question did not suffer from health conditions that put them at high risk for death in case of an acquired SARS-CoV-2 infection?

FLATTEN THE CURVE VS ECONOMIC SURVIVAL?

Let me give you a third example where the ethical challenges faced in the global north and the global south are the same, yet different answers may be justifiable due to different economic circumstances. At issue is the question of how a country should respond to the challenge of flattening the epidemic curve, as it were, in order to ensure that the health care delivery system is not overwhelmed by patients needing care suddenly, and in very large numbers. While there has been some debate about this in the global north, eventually most countries shut down most non-essential business activity, and asked citizens to stay home. The predictable harmful consequences of this public health response: a dramatic rise in unemployment, rises in domestic violence cases and deaths resulting from that, increases in depression and anxiety and so on and so forth. The choice here was essentially to balance those harms against the harms incurred in terms of COVID-19 deaths if there had been business as usual. Significantly, by using as the unit of comparison lives preserved and not quality adjusted

life years preserved, the justification of the economic shutdown appeared uncontroversial. By virtue of being comparably well-resourced each of those countries spent very significant amounts of money to tie people over, and support businesses as good as they were able to, to ensure there would be businesses to return to after the forced shutdown would come to an end. So, despite significant hardship most people in those countries had a roof over their heads, and food on their table.

Things could have not been more different when countries in the global south copied their own policy response from those playbooks. When India's Prime Minister Narenda Modi and South Africa's President Cyril Ramaphosa introduced similarly draconian shutdown measures the consequences of their policies were much more costly. The stakes are high. The lack of strong health care infrastructure meant that it was important to flatten the epidemic curve quickly and efficiently. However, unlike in the global north, hundreds of millions of people in countries of the global south are day laborers, they work in the informal sectors of the economy, in order to avoid starvation they must work. I recommend to your attention a video produced by Picturing Health, people there explain vividly why their real-life choice consists between starving to death during the lockdown, or taking their chances with acquiring SARS-CoV-2.[8] To them it's not even a choice, a coronavirus infection is preferable to starvation. Academics like Johannesburg-based philosopher Alex Broadbent have picked up on this and ask the question whether Western public health responses are appropriate for 'Africa', taking into account these predictable costs.[9] He drew a sharp response from another South African philosopher, Lucy Allais, and her co-author, HIV specialist Francois Venter. They defend the current South African lockdown, while acknowledging that it cannot go on for much longer, precisely due to the cost that Broadbent is noting in his piece.[10] They question whether Broadbent has sufficient evidence to support the empirical assumptions motivating his normative analysis. As I write this the United Nations warns that the world's poor face a devastating-in-scale famine, due to the global economic collapse, where a quarter of a billion people face starvation. The world body's World Food Programme in its report warns that the coronavirus pandemic has doubled the number of people facing acute food insecurity and starvation from 130 million to 265 million.[11] Public health experts will rightly reply that because their policies were so successful, we only see a relatively small number of COVID-19 deaths globally, and yes, they may well be dwarfed by the number of deaths caused by the economic meltdown their policies triggered. However, we also could not know what the death count would have looked like had we not intervened. Quite likely we will never know. Perhaps a team of South African academics has found the holy grail with their proposal on how to end the economically catastrophic lockdown in the country.[12]

Ethics certainly provides us with the tools to think about such difficult policy choices.

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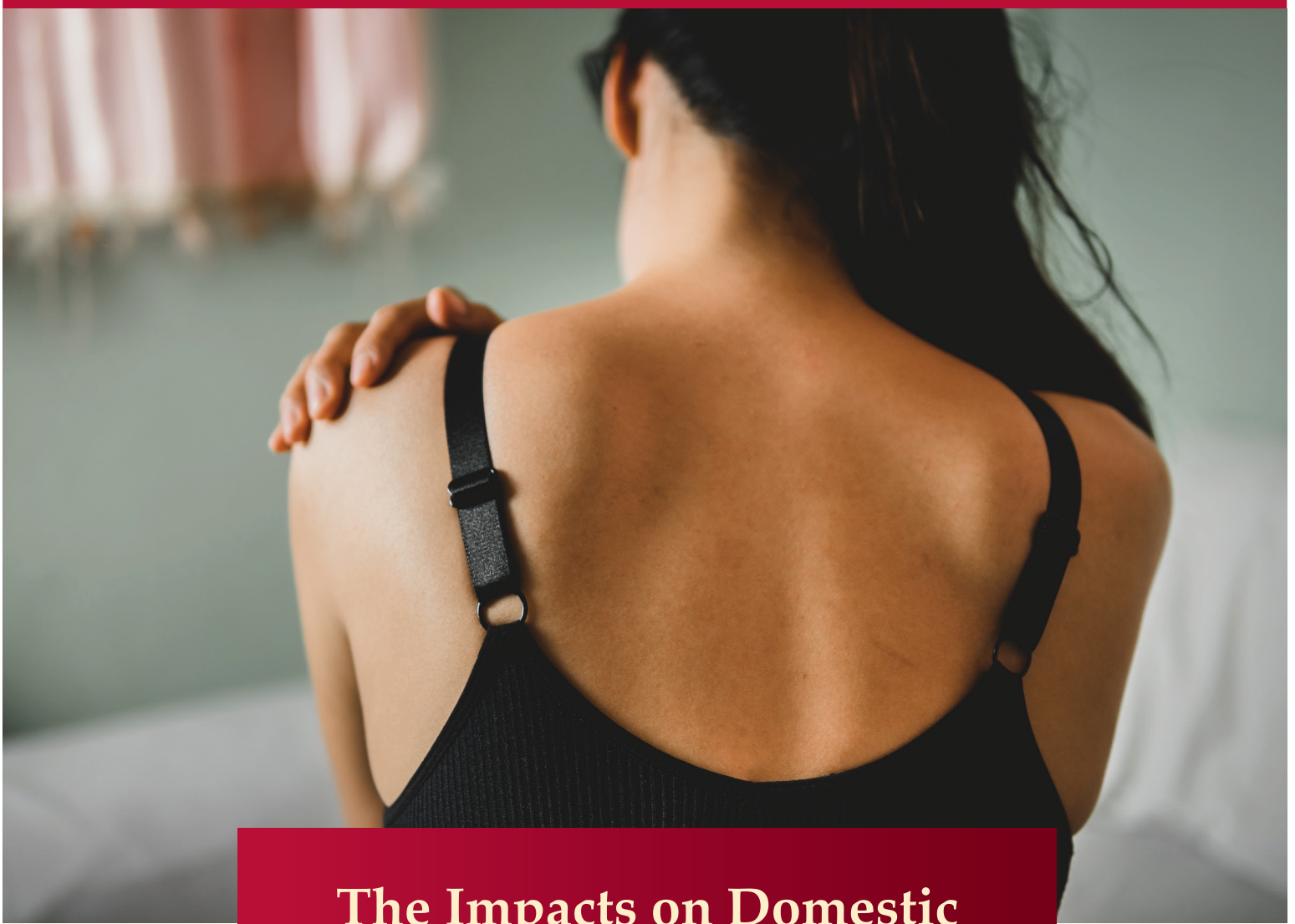
The Impacts on Domestic and Sexual Violence

By Kim Graham

Self-isolation makes for the perfect storm for domestic and family violence. Compounding stresses over job changes, working from home, financial insecurity, lack of childcare, and school uncertainties can all contribute to violence in the home.

For abusers, power and control are part of the harmful relationship with their victim. COVID-19 is out of their control, which inevitably presents more anger, stress, and violence in the home, evolving out of the need to garner some sense of control during an unknown time. Eighty-four per cent of domestic violence occurs in a private dwelling (Canada, 2018) and Kingston has the highest rate of police-reported sexual violence crimes in Ontario, and the second-highest rate in the country for child sexual offences (Canada, 2018).

Economic stress has been proven repeatedly (Economic Stress and Domestic Violence, 2009) to be a factor in homes in which domestic and family violence is present. With COVID-19, there has been an increase in anxiety around job security. This increase in economic stress can also lead to an increase in substance abuse, most often alcohol. In fact, the LCBO has reported an increase in alcohol sales, which the World Health Organization has recognized with great concern. Abusers' stress and alcohol intake is a catalyst for domestic violence.

During the pandemic, victims of abuse have been unable to attain the little bit of respite from domestic violence they previously had when they left the house. Self-isolation has also limited a victim's ability to access help through counselling, a hospital, or a shelter.

For victims who are self-isolating at home with their abusers, to access virtual support and have privacy is an almost futile endeavour. Overwhelmingly, victims are women, who are now at home, many with children, who also cannot access safe spaces such as their school or childcare centres. Trying to have a private conversation with a support person, even if their abuser is out of the house, is near impossible while managing working from home, childcare, homeschooling, and the added pressure of keeping the family safe when at any moment the abuser could explode.

Vulnerable victims and survivors have developed a way to manage during the pandemic. We have heard of women and children who are sleeping most of the day to avoid their abusers, or appeasing abusers by giving in to demands they otherwise might not, if they were able to leave the home.

The risk of contracting COVID-19, for many, is greater than the abuse they are suffering. They are choosing to stay with their abusers because perhaps they don't want to risk being at a shelter or potentially infecting a loved one, or they can't travel to a safe space because of travel bans or reduced services. Safety plans that were once created are obsolete during a pandemic as communities shut down. However, we know that survivors and victims are resilient. They have managed before and they will do it again.

Court systems are releasing abusers back into the community because court processes are being delayed and correction centres are not taking additional offenders due to COVID-19 safety measures. This presents an increased safety risk for the victim and family members, and poses a threat to the community.

A clear example of how deadly domestic violence can turn is the recent killing spree in Nova Scotia. Twenty-two people were murdered after the assailant kidnapped and assaulted his girlfriend in a violent tragedy that escalated. In April, the first month of the pandemic, we saw nine murders of women and children across Canada. A nurse in Brockville, 85 km east of Kingston, was one of the murdered.

We already know that 70 per cent of family violence (Canada, 2017) is not even reported to the police, leaving the majority of victims to suffer in silence and the majority of abusers to have no police-reported history of domestic violence. Instead, victims of domestic and intimate-partner violence reach out to access supports or continue to live within the constant threat of death.

Canada's minister for women and gender equality, Maryam Monsef, has said there has been a surge in calls to shelters and demands on the gender-based violence sector since the start of the pandemic. Sexual Assault Centre Kingston has seen a near doubling of calls to our 24/7 crisis and support line compared to the same period from 2019.

Once social isolation ends and school and childcare resumes, our government, social service agencies, medical professionals, and counsellors should be prepared for an influx of victims seeking support. The long-term impact of COVID-19 will be insurmountable, especially on women and children who have been and will continue to be disproportionately affected by the pandemic.

Kim Graham is community education coordinator at Sexual Assault Centre Kingston, a member of the Ontario Coalition of Rape Crisis Centres. The centre provides crisis and support services, counselling, and psychotherapy to survivors of sexualized violence, recent or historic, 12 years of age and older, regardless of gender or identity.

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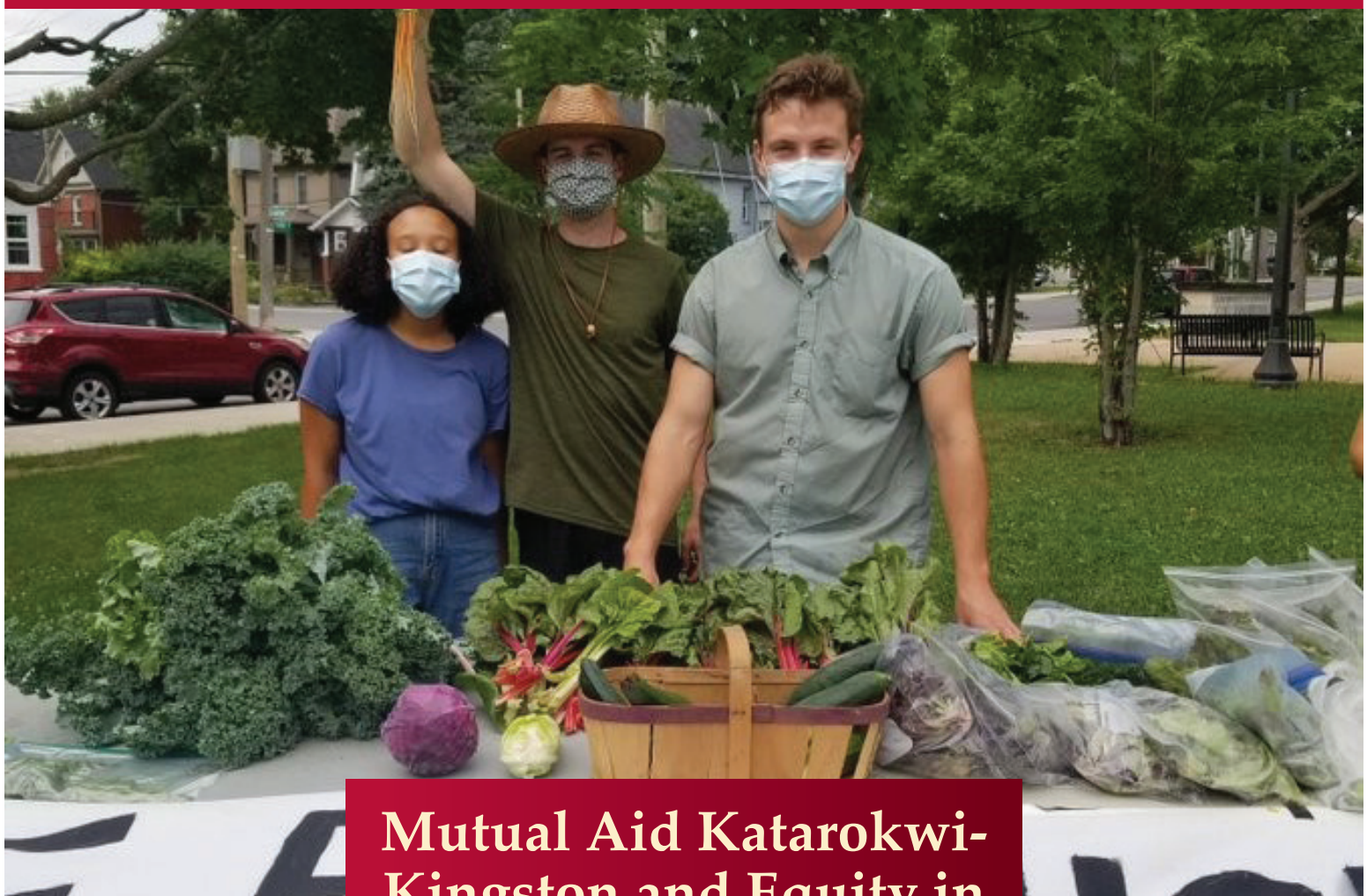
Mutual Aid Katarokwi-Kingston and Equity in COVID-19

MAKK's "really, really free veggie market"

By Tatiana Yunadi

Public Health Ontario's COVID-19 report[1] has highlighted inequities in access to health care and social supports. While Canada maintains some stability through public health care, the reality of Ontario's situation has shown that its most ethno-culturally diverse neighbourhoods are disproportionately impacted by the pandemic. Additionally, the report reveals these demographics are significantly more likely to experience more severe outcomes in terms of hospitalization, ICU, and even death rates.

This brings to attention what other public infrastructures are lacking in COVID-19 supports for the population at large. Marginalized populations, often intersecting in terms of socio-economic status as well as ethno-cultural backgrounds, are facing increased stressors made more palpable through the pandemic. The Canadian Human Rights Commission identifies economic strain, housing, and food insecurity as main factors contributing to disproportionate vulnerability.[2]

While government programs such as Canada Emergency Response Benefit (CERB) and Canada Emergency Student Benefit (CESB) have been strategized to address these issues, in many cases they have shown to be insufficient in reducing disparities. Their pace of implementation has been inadequate to the momentum of COVID-19's spread, and consequent rise of needs.

In working with the Canadian Centre for Policy Alternatives, economist David Macdonald criticizes CERB's failure to protect workers who refuse to return to inadequately prepared workplaces. Millions of people are at high risk of coming into contact with COVID-19 due to the nature of their work, and will be ineligible for financial support if they choose to leave.[3] Kingston presents a notable case, as it is home to a breadth of socio-economic disparity and a longstanding housing crisis.

Mutual Aid Katarokwi-Kingston (MAKK) is a grassroots activist network that began at the start of the pandemic's takeoff, in March. With ideas of community care entrenched in its organization, it is built on the belief that co-operation among people, rather than the competitive nature engendered by our market economy, will help communities thrive. Accordingly, it is entirely run on a volunteer and donation basis.

The model of mutual aid is not exclusive to Kingston — its history traces back across cultures worldwide, especially during times of economic or social hardship. Notably, events such as natural disasters and disease can be a catalyst in the spread of mutual aid models, as materialized in different organizational forms. Its popularity arose during the era of industrialization in the 18th and 19th centuries, especially in societies facing mass urbanization that lacked social supports, such as Europe and North America. Mutual aid's conceptualization built upon shared aims to shift the modern focus on individuality to the ideas of community care, and through this, expands one's own relation to their social environment as well as nature itself. In response to the pandemic, hundreds of networks are operating from Mexico, Thailand, the US, Italy, and more.[4]

The pandemic's most adverse effects can be attributed to the modern culture of industrialization and competing over self-determined needs, resulting in mass climate change, which has greatly contributed to the disease's transference to humans as well as its quick spread among dense population centres.

Mutual aid is grounded in the belief that the earth's resources are sufficient for sustaining its current populations around the world, but the problem of wealth disparities results in the unequal extraction and distribution of such resources, which benefits only a certain percentage. Emphasis is placed on striving to disrupt the social actions perpetuating current structural inequalities. Efforts are therefore aimed to address the needs of marginalized and vulnerable persons through collective community action, especially when government-implemented structures have shown to be insufficient in mitigating them throughout the population at large. Social solidarity builds community strength in areas of the state's blind spots, and challenge the status quo of idealized models for support.

In keeping with its belief in community care during this pandemic, MAKK also promotes and facilitates networks of neighbours assisting in contactless delivery of groceries, pharmacy items, and foodbank boxes to surrounding households who are at high risk or quarantining. Typically, those who request a delivery will reimburse the deliverer through the network. In the event recipients are unable to pay the full expenses, MAKK assists in covering some or all of the costs. Repeat matchups between recipients and deliverers are encouraged to further this idea of developing relationships within neighbourhoods.

MAKK's recent initiative for community gardening also addresses the same issues of food security. Groups of people are matched and regularly meet to take care of plants at the city's community gardening spaces and backyards shared among community members. Their harvest is shared among the groups, and optionally distributed to the general public in the form of "really, really free veggie markets." Such a skill-sharing and resource-honing initiative enables the potential for locally sourced and sustainably grown options, under the discourse of mutually sharing and giving back to the community.

Recognizing housing security is an important determinant of health, in particular during a worldwide pandemic — an issue especially pertinent in a city touted to have the lowest vacancy rate in the entire province, as well as continually rising rent prices — MAKK also organizes communications with the local government and physically distanced gatherings in support of housing-security efforts, and aims to reduce the prevalence of evictions.

Phone lines connecting tenants with free legal aid have been set up, as many landlords continue to send eviction notices even as Ontario has temporarily suspended evictions. The issue of homelessness continues as the number of beds in all of Kingston's shelters are scarce in contrast to its displaced populations. Open letters and calls to the municipal government are organized to demand the City's commitment to protecting these individuals.

In a time of a pandemic when people are encouraged to "socially" distance, where the rhetoric is focused on social limitation rather than physical safety, many individuals feel isolated and sheltered in their own home spaces. Persons who are at high risk for developing severe outcomes are particularly vulnerable to the effects of the pandemic-imposed loneliness, or even confinement to abusive households. Access to mental health care and help hotlines are increasingly in demand, and made less available to those with growing economic strain.

In line with mutual aid organizations' belief in establishing and growing ties within the community, check-ins are available person to person. MAKK pairs individuals based on their interests and preferences for identity sensitivity, such as LGBTQ+ and ethno-cultural affiliations. Contact information is exchanged between pairs and they are encouraged to reach out to each other as a resource for their social

Number of workers who will have to choose between income and health, by wage decile
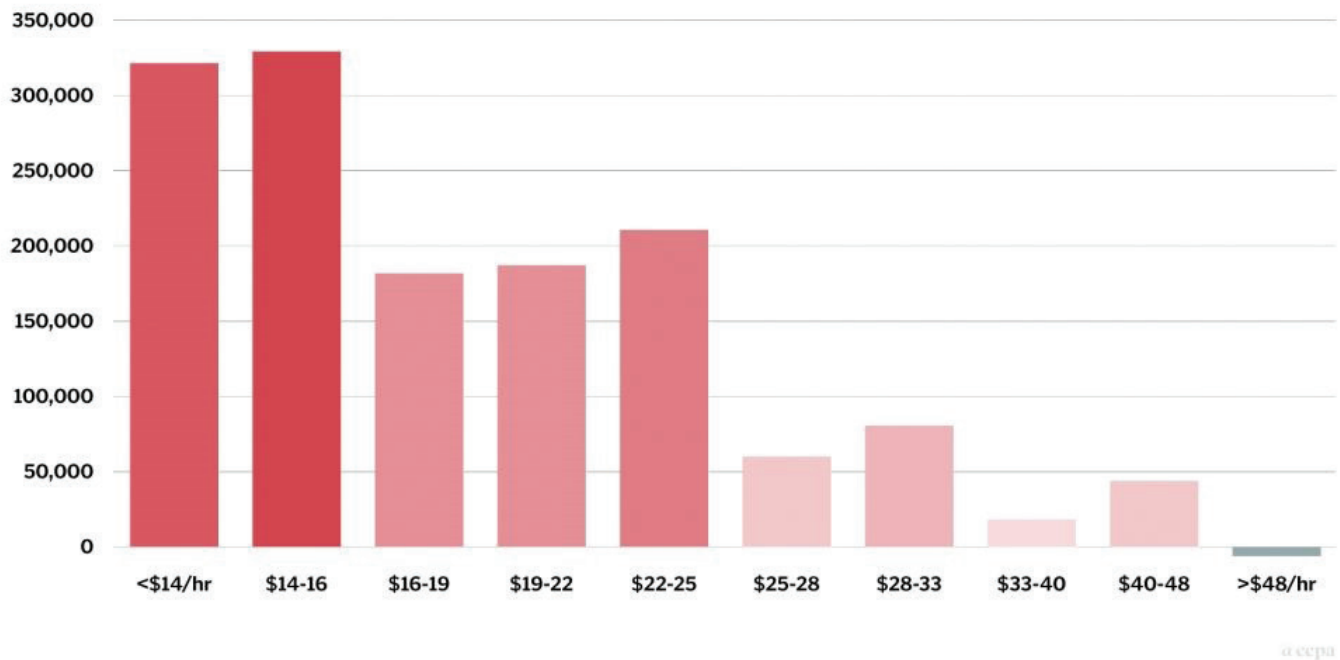
Source: Between a rock and a hard place: Which workers are most vulnerable when their workplaces re-open amid COVID-19? (Canadian Centre for Policy Alternatives)

and emotional support needs. This work strives to demonstrate the continued existence of community care and solidarity.

MAKK engages interconnected networks of people within the community to participate in co-operative efforts, in hopes of mitigating structural concerns. While these issues have long pre-existed the pandemic, they have been made more tangible through the intersects. Now, more than ever, the matter of health can be seen on a macro-level — so long as the most vulnerable are at stake, so too is the rest of the population.

Fostering solidarity during this uncertain time through everyday action alongside neighbours can re-orient us to move forwards from the "old normal" of skewed advantage towards a more mutual assurance of meeting needs.

For more information about MAKK, visit its website.

Tatiana Yunadi is a third-year sociology student at Queen's University, focusing on deviance and social determinants of health, and is a MAKK volunteer.

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Health Disparities Revealed, More Than Ever:
Locally, Nationally, and Internationally

By Dr. Nazik Hammad

In the last 12 months, the world has witnessed, in action, the unfolding of two global health threats: worsening climate change effects and the COVID-19 (SARS-CoV-2) pandemic. This pandemic is now considered a "syndemic" because other health threats, such as non-communicable disease and structural inequalities, have resulted in worse outcomes among vulnerable populations.[1-2]

According to UN Secretary General Antonio Guterres, the COVID-19 pandemic has played an important role in highlighting growing inequalities and exposing the myth that everyone is in the same boat, because "while we are all floating on the same sea, it's clear that some are in superyachts, while others are clinging to the drifting debris."[3]

Response to the pandemic and its health and societal outcomes reveals the importance of intersectionality when considering social determinants of health and pandemic outcomes at the level of the individual and at the population level. Risk factors for worse outcomes include age, geography, disability, race/ethnicity and Indigeneity, migration/refugee status, poverty, incarceration, and mental health or substance use concerns. Other structural conditions include precarious housing, which includes homelessness, unstable housing or substandard housing; living in long-term care homes; unemployment; and political and environmental stressors.[4]

The pandemic has revealed disparities related to access to technology, connectivity and transportation, geographic distance to health centres, and basic shelter. Disparities in access to information is highlighted by the fact that many people do not have access to the internet, up to 20 per cent of people in Canada are functionally illiterate, and up to 20 per cent of Ontarians do not have English or French as their mother tongue and many do not read their mother tongue.[5]

Women, especially those who are burdened with other intersectional factors such as poverty, are bearing a huge brunt of the pandemic, often

manifested as loss of employment, an increase in care duties, and exposure to domestic violence.

A stark example of how the pandemic has brought inequalities to the forefront is how Black Lives Matter (BLM) transformed from a US domestic movement of limited reach prior to the pandemic into a global social movement during the pandemic. BLM started on July 13, 2013. Most people around the world knew nothing or little about the movement. However, the glaring disparities in COVID outcomes among racialized people and the mounting economic insecurity brought the endemic police brutality against Black people and all manifestations of anti-Black racism to the forefront of social and political agenda, thus creating a global movement.

George Floyd was a Black man who died May 25 in Minneapolis, Minnesota, after being arrested by police outside a shop. A white officer has been charged with murder in his death. The fact that Floyd was COVID-infected and had lost his job during the pandemic is a further illustration of the compounding effects of structural inequalities.

In response to a call from Ontario health leaders, the Toronto Board of Health voted unanimously in June 2020 to declare anti-Black racism a public health crisis.[6] The move calls for a "reprioritizing" of city resources to address anti-Black racism during COVID-19 recovery planning and in the city's next annual budget. Similarly, in June 2020, the Ottawa Board of Health also voted unanimously to recognize racism as a public health issue.[7]

Long-term commitments to these declarations will hopefully be seen across all institutions in Ontario. There is now a call for academic health centres across North America to address anti-Black racism in all teaching and learning activities. Among the recommendations are a call to make the "mastering of the health effects of structural racism" a professional medical competency and a call for health care systems to mandate and measure equitable outcomes (i.e. performance measures addressing structural racism).[8] Policy makers, governments, and health care systems are now being asked to go beyond the "tell" that Black Lives Matter and to "show" that they indeed do matter.[8]

We also learned from the pandemic the value of humility in global health. Countries that had the strongest voices and touted the highest expertise in global health, such as the US and the UK, have experienced some of the worst outcomes of the pandemic. At the heart of this is the fact that health equity was not considered in pandemic-response preparedness. At the beginning of the pandemic in late 2019, the US and the UK ranked at the top among 195 countries in global health security (GHS) index, which included pandemic preparedness.[9] Germany ranked at 14. The actual performance of the US and the UK, lagging far behind Germany and South Korea, revealed fragile and

> *In response to a call from Ontario health leaders, the Toronto Board of Health voted unanimously in June 2020 to declare anti-Black racism a public health crisis.*

non-resilient health systems riddled with inequalities, wastage, and poor political leadership.

The pandemic also revealed that technical advances in medicine must be accompanied by equitable access to these technical advances and by building egalitarian just societies.[10] The failure of GHS to predict pandemic preparedness at country levels calls for a new reality and model of shared global learning[11] and solidarity (i.e. "more democratic, more multipolar, more networked, and more distributed understanding and operation of global health").[12]

At Queen's University, the COVID-19 Pandemic Working Group of Global Health at the Office of Professional Development & Educational Scholarship (OPDES) issued a position statement on May 12, 2020.[13] This group of faculty and staff members within the Faculty of Health Sciences (FHS) endeavours to:

- *advocate for health equity to be considered in all aspects of the Faculty of Health Sciences and Queen's University's response to the pandemic;*

- *raise the health concerns of and challenges faced by marginalized patients and populations in our community;*

- *support global health and equity-focused practitioners, researchers, and learners in local and international communities;*

- *support community partners who are already engaged in equity-focused work and;*

- *support and advance the work of the director of global health at OPDES.*

The group aims to encourage dialogue, bring resources, facilitate partnerships, and highlight advocacy, education, and research in health equity at the FHS.[14-15] Anyone interested in learning more or becoming involved is invited to contact its members at Global.Health@queensu.ca.

The pandemic is still unfolding. Despite the gloomy picture caused by health inequities and disparities, we are also witnessing new emphasis on resilience and activism. There is room and opportunity for action. In order to enhance our response to this pandemic and to enhance our preparedness for the next pandemic and other global health threats, we must come together and work towards equitable health care systems and just societies.

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