Best Brains Exchange Proceedings Report

Strengthening the Structural Determinants of Health Post-COVID-19

Supplementary report for the Chief Public Health Officer of Canada's Report on the State of Public Health in Canada 2020

From Risk to Resilience: An Equity Approach to COVID-19

Canada

Table of Contents

Background

The COVID-19 pandemic is having unprecedented health, social and economic impacts for Canadians. The direct and indirect consequences of COVID-19 and related public health measures have exacerbated existing health inequities. These consequences are driven and shaped by structural and intermediary determinants of health.

The Canadian Institutes of Health Research's (CIHR) Best Brains Exchanges are one-day, invitation-only meetings bringing senior policy makers together with researchers and implementation experts to discuss high priority, health-related topics of shared interest.

Purpose and Objectives

A virtual Best Brains Exchange (BBE) was held July 29, 2020 as a partnership between CIHR and the Office of the Chief Public Health Officer of Canada (OCPHO) at the Public Health Agency of Canada (PHAC). Please see Appendix 1 for the agenda. The purpose of this BBE was to bring together Federal, Provincial, and Territorial policy and decision makers, researchers and implementation experts, non-governmental organizations, and other key stakeholders to inform the Chief Public Health Officer of Canada (CPHO) 2020 Annual Report on COVID-19. The BBE aimed to better understand the intersectional COVID-19 impacts on the health and well-being of priority groups in Canada to inform the design of protective strategies moving forward.

The BBE focused on the following action-oriented objectives:

- Provide input into the CPHO's equity-based framework, articulating the direct and indirect consequences of COVID-19 as part of the 2020 Annual Report;
- Share evidence-informed advice and lessons-learned on how to take an intersectional and intersectoral approach to creating structural change that leads to health improvements; and,
- Offer recommendations to identify priorities for future near- and medium-term COVID-19 actions addressed in this BBE.

This report summarizes the proceedings of the BBE. This report outlines the presentations and input from attendees at the BBE, and the contents of this report do not necessarily reflect the opinion of the CPHO. Please see Appendix 2 for a list of participants and Appendix 3 for the biographies of presenters. This report will be used as one input into the CPHO report that will be released in the fall of 2020.

Proceedings

Introductions

The BBE opened with opening remarks from Dr. Sarah Viehbeck, Associate Vice President of Research Programs Strategy at CIHR. Dr. Viehbeck started with the land acknowledgement. She noted that this is the first BBE to take place virtually, given that in-person meetings are not possible during the COVID-19 pandemic. She expressed her gratitude to the speakers and participants for joining this deliberative dialogue on the structural determinants of health and COVID-19. This dialogue will be used to help to shape Dr. Tam's 2020 CPHO Annual Report. Participants have been invited given their diverse perspectives and backgrounds that would be helpful to shape the dialogue.

Dr. Viehbeck identified some housekeeping issues, including that the session is taking place in-camera to encourage honest and free exchange in a safe space, and that Dr. Elizabeth Dyke is taking notes and developing a proceedings report from this session to capture advice and recommendations from the participants, including from the chat function used in the virtual meeting software. This information will be summarized and no comments (verbal comments or comments in the chat function) will be attributed to any one participant. Participants were then encouraged to introduce themselves via the chat function in the virtual meeting software.

Bonnie Hostrawser, Director of the OCPHO at PHAC, then welcomed everyone and thanked participants for their time. She mentioned that her office and PHAC are pleased to be partnering with CIHR. Ms. Hostrawser outlined that the objective of the meeting is an opportunity to provide key input into the CPHO's Annual Report on the state of public health in Canada for release in fall 2020. This year, the CPHO's report will focus on the broader impacts of COVID-19. This BBE will be one input into the report. Ms. Hostrawser noted that participants had been provided background information for the session. Dr. Tam's presentation includes an evidence-based framework describing the broader impacts of COVID-19 on various populations. The pandemic has clearly exposed the weaknesses in our health, social, and economic systems and structures. This analysis will describe evidence-based opportunities to move forward to support everyone as we live with this pandemic and reduce inequities. The input from this BBE will be used and referred to in the process of developing the CPHO report, and to consider actions for highlighting in the report. Ms. Hostrawser then introduced the two facilitators for the BBE: Anna Romano, Vice President of the Health Promotion and Chronic Disease Prevention Branch at PHAC, and Dr. Steven Hoffman, Scientific Director of the Institute of Population and Public Health at CIHR.

Scene Setting: Framing the 2020 CPHO Annual Report

Dr. Theresa Tam, CPHO at PHAC, kicked off the presentations by setting the scene. She noted that she would not be able to join the entire meeting given her other commitments, but she thanked the organizers of the BBE including CIHR and the participants. She was very impressed by the expertise of the presenters and participants, and looked forward to learning more from the findings of the day.

Dr. Tam presented her slides for the session, starting with the CPHO's mandate to provide the Minister of Health an independent report on the health of Canadians annually. She described how this reporting function fits within her strategic goal of her five year mandate as Canada's Chief Public Health Officer.

Dr. Tam's goal is to contribute to the reduction of health inequities in Canada. This is consistent with Dr. Tam's previous CPHO reports—a comprehensive approach to public health challenges to describe and address their social and cultural determinants and resulting inequities.

Dr. Tam stated that she did not need to re-emphasize the unprecedented event that is COVID-19, which has resulted in a great deal of uncertainty. COVID-19 provides an unprecedented illustration of the determinants of health and their importance. The pandemic has exposed the best and worst of system structures. The response in Canada has resulted in significant impacts on certain populations in particular, exposing vulnerabilities in these systems. Everyone needs to be protected. The collaboration across sectors to respond to the crisis has been impressive. Extending this collaboration to make sustainable structural changes, Dr. Tam stated that we can come out of this pandemic stronger with foundational protections for populations at higher risk of infectious diseases.

Dr. Tam outlined objectives for the annual report: to describe what we know about the magnitude of direct and indirect impacts of COVID-19, particularly the differential impacts on groups that are at higher risk, the strengths of our current pandemic response and how we can further strengthen these. The target audiences for the report include primarily public health professionals, researchers, practitioners and parliamentarians. Leaders and practitioners in social and economic sectors as well as the public will also be interested in this report.

She then explained the organization of the report in terms of 1) describing the pandemic, 2) outlining what we know on the impacts, and then 3) recommending how to move forward. In terms of the description, people are aware of the statistics including the significant impact on older adults in long-term care facilities as well as healthcare workers, particularly those who are in lower paying positions such as personal support workers and people who clean the facilities. Other congregate settings in accommodations for temporary foreign workers, in workplaces, correctional services, and group homes have also had outbreaks. Analysis by sex has shown that males tend to be more impacted by hospitalizations. The CPHO report will include a brief description of the determinants of health and indirect consequences. Following the data reporting and analysis, the final section will include how to move forward, learning from what has worked. This is an opportunity to address health inequities and strengthen our structures and systems.

The challenge is that this is vast terrain, and the CPHO report is not going to be able to cover all issues. Hence, a broad framework will be used to guide the report, and then we will focus on concrete areas to stimulate discussion and collaborative actions in some high impact areas.

Dr. Tam reiterated that today's BBE is a chance to hear from participants to provide input into the report. Addressing health inequities will be an enduring theme throughout the pandemic. Dr. Tam remarked that Dr. Margo Greenwood's presentation will also be key to provide a perspective and evidence on COVID-19 and Indigenous Peoples. It is important to have Dr. Greenwood's presentation at this opening session of the meeting to recognize and listen to the context of Indigenous health in Canada, acknowledging the unique structural determinants of health for First Nations, Inuit, and Métis people in Canada.

Indigenous Health and COVID-19

Hence, given the importance of a nation-to-nation perspective on issues impacting moving forward stronger from the COVID-19 pandemic, the opening presentations also included a presentation from Dr. Margo Greenwood. Dr. Greenwood, Academic Leader of the National Collaborating Centre (NCC) for Indigenous Health, started her presentation with a land acknowledgement. She thanked the CIHR and PHAC organizers. Dr. Greenwood noted that she would be sharing her thoughts on what she has seen with respect to COVID-19 and First Nations, Inuit, and Métis people, noting that she does not speak for all peoples but she is a First Nations person speaking from her own experience and involvement in addressing structural change.

Dr. Greenwood noted that First Nations, Inuit, and Métis (FNIM) people are amongst the most vulnerable for COVID-19. COVID-19 shines a light on these

existing inequities, making these inequities clearer; COVID-19 is "the great revealer". COVID-19 also offers an opportunity to create change. She outlined the two examples she will focus on for the presentation—one on a stigma rapid review and one on operational planning for COVID-19.

Dr. Greenwood remarked that participants would be aware of the key structural determinants of health, but that these are key to understanding the context and background of COVID-19's impacts. Colonialism is a significant structural determinant of health, and the impacts of colonialism on Indigenous Peoples continue to play out today. We see the impacts of people being displaced from their lands and placed on reserves, decisions made on who is "Indian" and who is not, and the impacts of residential schools. These have resulted in a loss of culture and language, and families being ripped apart. These impacts have manifested in a higher burden of ill health amongst FNIM people today compared to Canada overall, including infectious diseases, sexually transmitted and blood-borne infections, chronic diseases, and diabetes. There are issues of overcrowded housing, food insecurity, children still being removed from their homes, higher rates of incarceration, and high rates of mental illness. Racism is a major issue in Canada, and many FNIM people have internalized this oppression. COVID-19 shines a light on these issues and raises questions such as: "How can you self-isolate in a house that is already overcrowded or does not have potable water? What if you have nowhere else to go (which is especially a concern in northern regions)?" COVID-19 highlights these issues of poverty, lack of adequate housing, and lack of nutrition and unemployment. Past traumas impact people today. There is mistrust that is passed on from generations that can be triggered by the COVID-19 pandemic, including distrust in accessing health services, such as getting tested or seeking care. When, as a result of COVID-19, public health recommends putting a hold on traditional pipe ceremonies and sweat lodges, given the increased potential of transmission of COVID-19, this is a stark reminder of previous colonial policies that banned cultural events, bringing up fears, mistrust, and past traumas of eradication and assimilation of Indigenous cultures.

Dr. Greenwood explained that stigma remains a large issue—and any transformation and change in health at the structural level requires stigma to be addressed.

Dr. Greenwood described a recent project conducting a rapid review of stigma completed by two medical students. This review used traditional academic approaches for a rapid review, but also incorporated real-time stories. This review will be published by the NCC. The review looked at historical trauma and COVID-19, and lessons-learned from previous pandemics. Stigma is complex, and nuanced, and there is no single definition of stigma. Recommendations for stigma mitigation include context and community specific strategies, as no one size fits all. A strengths-based approach should be taken, recognizing the nation-to-nation relationships and how to include FNIM peoples in meaningful and real ways to engage in the work together. Multiple strategies across multiple systems are needed concurrently, and strategies have to evolve over time as new information becomes available. Humility should guide decision makers and other stakeholders in their work. A partnered approach should be taken, applying methodological rigour while using stories and media to provide a full picture.

Dr. Greenwood then described the Northern BC Rural and Remote and First Nations Communities COVID-19 Response Framework. This was done in partnership with the First Nations Health Authority. Dr. Greenwood explained how they co-created a framework in partnership to address COVID-19 in 55 nations (22 rural and remote communities covering 17 language groups). This 12 page framework has four sets of tools. This includes:

1. A "Rural and Remote First Nations Communities" tool, examining assets in the community, health care information such as distance to secondary and tertiary hospitals, and the services needed to support people in making choices
2. A planning tool to understand transport and other logistical information
3. A clinical pathways tool with algorithms for any scenario that could be anticipated
4. A cohorting tool on supporting informed individual and community choice, as well as a plan for transportation

Guiding principles were developed and were applied in the work, including collaboration (all levels of government and partnering in real ways with First Nations), evidence-based decision making, informed choice (anchored in recognition of sovereign rights of First Nations), flexibility (in terms of timing and relevance

to the community), geography (considerations for transportation for example), local context (including relevance and effectiveness of public health measures), community networks, and First Nations rights and entitlements.

Dr. Greenwood then closed her session with a slide on lessons-learned. She noted there was no one solution—that to understand the complex reality, it is critical to know where we came from, including historical injustices. The work is hard but not impossible, but it takes time and commitment. There will need to be hard conversations. Partnerships are key, and things will change over time, as this is how structural change will be realized.

Discussion

Disabilities were identified as a major area needing more recognition and support, as 22% of people live with disabilities in Canada and this is higher in Indigenous Peoples. The challenge is that services are being decreased or closing down, and there are challenges for people living with disabilities to access services, and their conditions could possibly be worsening. A participant asked how the planning has incorporated a disability lens. Dr. Greenwood responded that the term disability was not used in their work, but they did have conversations on what additional supports people needed including for transportation. Two participants offered to discuss disability issues offline with Dr. Greenwood.

A few resources on the economic impact on Indigenous Peoples and mental health were posted in the chat.[1,2]

Another participant noted the importance of culturally supportive services, to address issues in a way that is culturally safe and appropriate. Other supports should include knowledge translation, identifying what physical distancing looks like for each community, and addressing overcrowded housing. Incorporating traditional and western medicine in a way that works for the community is important. In addition, substance use may be higher in communities post-phase one pandemic and this will need to be addressed.

One presenter, Dr. Ricciardelli, noted that approximately 30% of people who are incarcerated are Indigenous Peoples, and decarceration has structural determinant challenges associated with it that will need to be addressed. A couple of participants agreed.

Economic Factors and Employment Opportunities to Protect Health

Dr. Steven Hoffman introduced the next section which will include two provocateurs (with eight minutes each) to provide provocations and evidence-based information to spur out-of-the-box thinking.

The three discussion questions that will be a focus for the day were:

- What is the nature and how have structural and intermediary determinant(s) of health been exacerbated by the pandemic?
- What actions must be prioritized to address health inequities in the near-term (<12 months)?
- How can we enable longer-term (>12 months) intersectoral and intersectional structural changes that will lead to health improvements for all Canadians?

Care Work

Dr. Naomi Lightman, Assistant Professor in the Department of Sociology at the University of Calgary, presented first on “Caring work during the COVID-19 crisis”.

Dr. Lightman introduced the topic by setting the context that care work is poorly paid, dirty, difficult and dangerous particularly during a pandemic. Immigrant and racialized women (Black and Filipina women) are overrepresented amongst care workers in Canada.

These staff have increased vulnerability due to the nature of their work, gender, citizenship status, race, and/or class. Dr. Lightman made the provocation that current policies and practices systematically devalue the contribution of care workers who are deemed as "low skill".

In terms of taking action, Dr. Lightman identified that in the short-term, we need to invest in human infrastructure of care. This means protecting and improving the work environment for care workers. As long as this group is personally at risk, they will not be able to provide care services for clients. What is needed is employment protections (paid sick leave, appropriate staffing levels), higher pay (including overtime), personal protective equipment (PPE), safe transportation to and from the facilities, emergency housing for self-isolation, and access to childcare. The crisis of COVID-19 in long-term care has provided a "lightening rod" for revaluating care work during and post-pandemic.

Looking to the future, Dr. Lightman outlined that fundamental re-examination of care institutions needs to take place. She noted that we need universal and public provision of long-term care and childcare, unionized workers, and greater accountability mechanisms with full transparency for working conditions in care (including community-based care and across the continuum), client outcomes, and all fiscal transfers by the state. There is a need to look at new ways of funding care, and transitions between care. There is also a lack of clear data on the demographic profile and health and employment outcomes of care workers over the life course, to understand who is providing care. Looking to Europe and the Asia Pacific for best practices in pandemic planning and social program delivery will be important.

In closing, Dr. Lightman reiterated that the most vulnerable workers provide the most essential services to the most vulnerable clients under the worst working conditions, and she said this is unacceptable both morally and operationally. Care is essential, and we socially and economically devalue it (whether paid or unpaid forms of care). The funding needs to be tied to outcomes. Hence, giving more funding to for-profit long-term care operators in the hopes that outcomes for workers and residents will improve is the worst thing to do. She observed that the best thing to do is to invest in public and universal child and elder care, and to prioritize employment conditions and compensation of marginalized care workers.

Long-run Health Consequences of COVID-19 and the Shutdown

The next provocation was given by Dr. Audrey Laporte, Professor of Health Economics and Director, Institute of Health Policy Management and Evaluation at the University of Toronto, and Director of the Canadian Centre for Health Economics. The focus of this presentation was "Long-run health consequences of COVID and the shutdown".

Dr. Laporte began by summarizing that between February and April 2020, 3 million people were suddenly out of work. In May, the unemployment rate was 13.7%, up from 5.6% in February. Plus, 1.4 million people gave up looking for work altogether, bringing the adjusted unemployment rate to around 20%. Half of the job losses were in the bottom earning quartile. A long-term reduction in income has its own health consequences, which will be spread over future years, while COVID-19 deaths are happening now. Socio-economic inequities are tied to health inequities, and evidence shows that these recessions exacerbate these inequities. Recent evidence from the United Kingdom from the 2008 financial crisis suggests that for every 1% increase in unemployment, there was a 2% increase in chronic disease prevalence, and mental health conditions increased even more. The long-term effects on health continue well after the recession itself has ended, with empirical evidence showing that it can take up to ten years for an individual's income to return to where it would have been. This has an impact particularly on young people, women, non-union workers, service workers, and lower income earners.

In terms of taking action in the short-term, Dr. Laporte suggested that there will be a quick, immediate recovery followed by slow, long-term recovery. The economic recovery will likely be prolonged, unlike other recessions. It will take around two years to return to the

previous level of economic activity in the absence of a second wave. From a demand side, retail may recover immediately, but may stall, and many businesses might not re-open at all. People are reluctant to return to restaurants and other people-facing sites. From a supply side, workplaces will need to be safe—and this will delay recovery. Delays of reopening of schools and childcare will keep women out of the workforce and exacerbate inequities. She noted that there is a need for supporting policies that protect employment, or inequities will increase, with marginalized groups facing unemployment, increased chronic illness, and premature mortality.

For the future, inequities will increase between those with the luxury and privilege of working from home versus lower income people who have to go to work. Investing money now into ensuring workplaces and childcare are safe is needed, including for future pandemics. Tax breaks could be given for employer costs of increasing pandemic safety, and free PPE could be distributed to vulnerable populations, as other countries have done. Interventions could include income support programs for people who are unemployed (through the recovery phase), negative income tax to preserve employment, supporting basic level of incomes, or continuing wage subsidies. Also, consideration could be given to reducing the retail sales tax to help boost this sector.

Dr. Laporte closed by noting that it matters what kind of recession you are in. Looking only from the demand side will not be sufficient—the demand side supports were important to mitigate immediate damage and reduce the magnitude of the slump, including the Bank of Canada purchase of bonds, Business Development Bank having no-interest loans, and other government actions. But full recovery requires those most affected to get back into the workforce, including entry level job opportunities. Public policy support to ensure workplaces are safe will counter the tendency to replace labour with capital.

Discussion

The session then opened up to participants for questions and comments.

People Living with Disabilities

One participant commented that a disability lens was important for economic recovery, as they face additional barriers for returning to work. It is important to include people living with disabilities in the conversations. Another participant noted that people living with disabilities risk falling even further behind during the pandemic. It is a human right to work, and it is critical to ensure that people living with disabilities are able to continue engaging in the labour market. Another participant added that people living with disabilities already face barriers to employment, and suggested that basic income is an important intervention to implement. People living with disabilities still receive much lower monthly amounts than the CERB. One participant noted that we need a standard human rights-based definition of disability for these programs to work, as many people do not qualify for the Disability Tax Credit due to the current definition of disability under that program.

Another participant added that it was also important to include people who work as care workers in these conversations as well.

Sex- and Gender-based Analysis Plus and Intersectionality

A participant identified that the Sex- and Gender-based Analysis Plus (SGBA+) tool used by the federal government to conduct feminist and intersectional analysis would be a helpful tool to identify actions that could be prioritized (e.g., basic minimum wage, childcare) and ensure that no one is left behind. The participant encouraged the need to prioritize intersectional and feminist analysis in all work done.

Another participant identified that achieving an intersectional understanding of issues is an ongoing challenge.

People without Permanent Resident Status

Another participant noted that there are a million people in Canada without permanent resident status. This includes temporary foreign farm workers. These are often racialized, low-income people, with no healthcare or emergency support. Concerns were raised, including women having to move in with their abusers, and stigma against migrants as "carriers" of COVID-19. Another fundamental concern raised by this participant is that of non-citizens; over half a million undocumented residents, as well many other migrants (on work and study permits) and refugees were not able to access any of the income support programs.

The participant further stated that a shift in discussion on immigrant status needs to take place to address these issues. A link to a news story about lack of access to basic health care in Ontario (a province touted as having the best healthcare access for uninsured clients) was provided.[3] A link was also provided for a proposal on immigration reform given the role of migrant and undocumented workers as being essential to sustaining our communities.[4] The National Migrants Rights Network is a membership based organization of all migrant, refugee, and undocumented workers, including migrant care workers that is present in nine provinces. Members of this group have identified permanent resident status for migrant care workers as the "primary" demand.[5] More information on COVID-19 and migrants was also provided.[6] Other participants agreed, and noted that care workers face significant emotional, economic, and physical tolls and that substantive solutions are needed.

Employment, Housing, Other Vulnerable Populations

Employment and housing were observed as major concerns by another participant, especially when evictions are allowed. Other precarious workers (e.g., sex and massage parlour workers) were identified as facing exacerbated risk, and increased policing.

Market Inequality

Following on Dr. Laporte's presentation, one participant noted the impact of the last two big recessions on the job market. Early indications of COVID-19 show that the market inequality may increase as a result of the recession. The impacts of COVID-19 have been larger for lower income wage earners and vulnerable workers. This market inequality underscores the role of the government in mitigating inequality at the population level. The Canadian Emergency Response Benefit (CERB) has played a short-term key role in offsetting the impact on people's income. A study by CIBC suggests that at least in the short-term, average earning losses were fully offset. But people need jobs to go back to, as this impact will not last forever.

Provocateur Responses

The provocateurs were each given time to respond to the comments.

Dr. Lightman responded by stating that there are a lot of important points identified in the discussion. COVID-19 has highlighted that lack of childcare, aging populations, remote working conditions, and unpaid care responsibilities resulting in women taking on a disproportionate amount of work, with a very real impact on the workforce, reinforcing already existing inequities in the labour market. In addition, the essential labour being done by people without permanent resident status highlights the intersection of precarious work and precarious citizenship status, and resulting inequities. She noted that addressing these issues has to be on the top of the agenda for recovery plans.

Dr. Laporte remarked on the many phenomenal comments, and agreed that SGBA+ was an excellent template for use to extend to other groups including racialized groups and Indigenous Peoples. She also noted that we are missing data and this challenges our ability to quantify the degree of bias and disadvantage built
into our structures. Without these data, she said we are "running blind". Dr. Laporte also observed that we spend too much time worrying about small amounts of money for people at the bottom of the income distribution (e.g., an additional $50 for people who receive social assistance) rather than looking at the top end of the income distribution and removing structural advantages for future generations. The European Union has value-added taxes when

purchasing items, which means a progressive taxation where wealthier people are taxed more. With income taxes, the more income you have, the more you can shield and hide income, which is not levelling the playing field. Inheritance and wealth taxes can level this playing field.

Living Conditions that Increase Risks and Opportunities to Protect Health

Communities

Dr. Kate Mulligan, Assistant Professor, Dalla Lana School of Public Health at the University of Toronto, and Director of Policy and Communications at the Alliance for Healthier Communities, spoke on "Rx: Communities".

She showed a map of Toronto of cumulative COVID-19 cases in mid-July 2020 and how similar this map is to maps illustrating racial segregation, working poverty, income inequality, walkability, transportation, and diabetes. This is a result of years of intersecting discrimination. Those at higher risk are people living in crowded settings, who use public transport, with unequal access to health care, and with limited natural and public spaces (which is important during lock-down). Governance structures are not inclusive, and vulnerable populations are not at the decision-making tables. There is also large untapped capacities and assets in communities, including Community Health Centres (CHCs).

Dr. Mulligan identified actions to take in the short-term to leverage capacity of the communities at highest risk, including expertise, and heeding early warnings from those working on the front-line in community, social, and health service sectors. This includes people living with disabilities and migrant workers. One example was ensuring trusted testing is in place for marginalized communities (e.g., Black Creek Community Centre), but timelines for implementation of these services need to be shortened. Another action is social prescribing—using COVID-19 testing or other visits to screen for other social needs and make referrals for health and social services, including food insecurity, social isolation, and housing. In addition, the messaging on reopening is focused on economics, but community and social supports should be prioritized as essential in recovery and reopening frameworks. Preparing for the second wave should focus on preparing primary care to leverage trusted relationships between providers and marginalized communities. Finally, accountability and performance measures on community health equity data and governance are needed to ensure data are available and the voices of the community are heard to help move policy to action.

In terms of looking to the future, Dr. Mulligan outlined that communities (including Black communities, people living with disabilities, Indigenous Peoples) need to be included in governance structures from the start (e.g., bioethics tables). Care needs to be integrated and fragmentation reduced. Data needs to flow across systems, between healthcare providers and across Ministries and services. Primary care models that are community-governed and comprehensive need to be scaled up, ensuring culturally safe, equitable services. In addition, we need to ensure equity-focused and well-being-focused systems and measures are in place for data, decisions, performance, and accountability.

To close, Dr. Mulligan summarized that, to the extent COVID-19 is a trial run for future emergencies including climate change, we need to tap the power we do have. For many historical and geographic reasons, there has been an exclusion and loss of meaningful community expertise. We need to communicate with communities and leverage the capacity they have. The messaging needs to be cognizant of their realities. One example in terms of messaging is the work Community Health Centre in Toronto (TAIBU) is undertaking with Black communities. Social determinants of health need to be addressed, health equity needs to be built in, and the work needs to be transparent. Dr. Mulligan also shared a number of links from her slides.[7–16]

Working and Living in Canadian Prisons

Dr. Rosemary Ricciardelli, Professor at Memorial University of Newfoundland, presented her provocation on "Working and living in Canadian prisons: Current challenges and recommendations" on behalf of her-self and Dr. Sandra Bucerius, Associate Professor, University of Alberta.

Dr. Ricciardelli began by noting that the information in the slides were prepared in conjunction with a diverse group of stakeholders. Dr. Ricciardelli described the current landscape in Federal, Provincial and Territorial correctional services, including that prisons are enclosed spaces, infectious diseases such as Hepatitis C and HIV are always an issue, and incarcerated individuals tend to have poorer baseline health due to health inequities. Nutrition can be subpar, exercise is limited, physical isolation is a challenge, and incarcerated individuals are often double bunked (although more often in the provincial/territorial systems, but also in the federal). Too many incarcerated individuals have experienced substance use disorder and trauma, which negatively impacts their health. COVID-19 does not discriminate between staff and incarcerated individuals; in the federal prison system there had been 146 confirmed cases among staff and 360 among incarcerated individuals, with two incarcerated individuals' deaths, as of July 17, 2020. Upon release, housing can be precarious; incarcerated individuals tend to have lower education and mental health issues, a history of substance use disorder, and Black and Indigenous incarcerated individuals face the legacy of racism and colonialism.

In terms of taking action, Dr. Ricciardelli recommended decarceration, defined as an alternative to incarceration, for those near release and based on behaviours, their record, seriousness of the offense, and security issues. Decarceration benefits incarcerated individuals, staff, and loved ones. Staff will have more time to invest in persons who remain in the prisons, and there will be more access to resources and programming for incarcerated individuals. For decarceration to be successful, support systems need to be in place for reintegration that respond to the needs and circumstances of each incarcerated individuals. Supports can involve community volunteers, and ex-incarcerated individuals as mentors if feasible. People need a safe place to go (housing), and access to healthcare services post-release. While this at first will increase the load of parole offices, investment is required at the level of community corrections for reintegration.

In looking to the future, Dr. Ricciardelli identified several key recommendations. On admission, incarcerated individuals and staff should be tested for COVID-19. Lockdowns should be minimized so that incarcerated individuals can exercise and communicate with others, which will decrease altercations. Visits and programming should continue to be reinstated (with physical distancing measures in place). Free telephone and video calls should be the norm in order to help foster relationships between incarcerated individuals and their support systems, which are critical for reintegration. Moreover, since victimization is very high among incarcerated individuals, who largely do not report their experiences, trauma-informed counselling is needed to help incarcerated individuals cope. Indeed, the severe victim/offender overlap has a significant effect on incarcerated individuals' mental health. Counselling would likely also have an influence on reducing substance use in prison. Incarcerated individuals require adequate mental health support.

Rules need to be followed by staff, contractors, and management to protect against the spread of COVID-19. Staff have not stopped working during COVID-19, and they care about those under them. There is a high level of mental illness amongst staff and this will increase with the pandemic, especially given the sickness and deaths from COVID-19. Mental health supports for staff are necessary.

In closing, Dr. Ricciardelli outlined that systems of justice need overhauling. Decarceration will, and is, helping manage COVID-19 and improve the well-being of incarcerated individuals, staff, and those being released. Continuity of care is needed from prison to community. Housing is critical for released incarcerated individuals. A major challenge is that in some provinces (such as NL, PEI and BC), released incarcerated individuals are without a health card until they are physically in the province and can apply, making a continuation in care near impossible. Dr. Ricciardelli recommends that incarcerated individuals be able to apply at least six months prior to release so Correctional Service of Canada (CSC) can do effective discharge planning (i.e., specialist appointments) for when they are in the community. Individuals housed in community correctional centres must be allowed health cards—they are not incarcerated individuals and thus not excluded from the Canada Health Act. (Also, CSC incarcerated individuals ID needs to be accepted as a valid form of ID for which to get a health card, yet provinces that will not accept CSC ID include AB, NS and QC). There are pockets of great practices across the country to facilitate patient-centred and timely discharge planning, but there are also pockets where there are policy barriers which

make this administratively difficult. This is a major policy barrier. Similar type of barriers apply to incarcerated individuals who apply for disability support plans on release. As such, disability supports are needed, as are access to trauma and substance use disorder services.

There should be a 911 equivalent for mental health and substance use disorder emergencies to be able to mobilize a response to mental health crises to address health inequities. Such practices will help alleviate prisons as a stop for people with mental illnesses.

Aging at Home and Long-term Care

Dr. Paul Williams, Professor Emeritus, Institute of Health Policy, Management and Evaluation at the Dalla Lana School of Public Health at the University of Toronto, spoke on "COVID and crisis in long-term care: Whatever happened to aging at home?".

Dr. Williams opened by discussing the crisis in long-term care (LTC) beds in Canada, with more than 5,300 older Canadians having died in LTC from COVID-19. As the military report stated, this was often in isolation and with substandard care or abusive care. 81% of all COVID-19 deaths in Canada have been in LTC, twice the OECD average of 42%. The fix has been to add more money, more staff, and more oversight to LTC, as well as more beds. But this raises the question: "Whatever happened to aging at home"? Most older Canadians (93%) want to live in the community as long as possible, and as independently as possible. In other countries, like Japan, they are dealing with this differently than Canada. LTC is a process in other countries, and people are supported to continue living in their own communities to avoid or delay institutional care. But in Canada, we think of LTC as a destination, as people decline in health in older age. Hence, Dr. Williams' provocation is "Why don't we plan to keep people out of LTC?" People in LTC are always more susceptible to the flu and other pandemics.

Dr. Williams explained that where Canada should be focusing is on healthy aging, where well-being and functional capacity are maximized even with chronic illness and disabilities. Health care is NOT a key determinant of healthy aging. Instead, the focus should be on accessible and affordable housing, assistive technologies (connecting people-to-people, information and services), transport (to get groceries and see a doctor), and social facilities (to combat loneliness and isolation). Dr. Williams argued that what should be done is to raise the bar—to ensure proactive, coordinated supports for daily living for older persons, caregivers and communities, especially for those facing marginalization and systemic barriers. This will help prevent disability and ensure people can maintain independence as they age.

Dr. Williams then outlined his recommendations of what to do in the long-term—to create integrated systems of community-based systems of long-term care, similar to what Japan has created. Japan has a coherent vision—by 2025, every municipality in Japan will have an integrated system of care over the long-term. This starts in the home by supporting older persons and the caregivers and their families. Then this moves to the community, a crucial element, with senior clubs and volunteer groups. There are multi-disciplinary teams in every community including nurse practitioners and other staff. Then, if needed, there are hospitals and nursing home care too, but people are kept in the community as much as possible.

In terms of actions needed now, Dr. Williams noted that it is difficult to make changes in the Canadian system. Although he argues that we have great hospital and doctor care now in Canada, other changes, including pharmacare, have been challenging to implement. In many countries (Japan, Germany, Sweden, and others), funding for older persons and caregivers is allocated based on assessed needs, not where care is located. Users, not just providers, can make choices on programs and services. Instead of being only allowed "traditional" community care (e.g., food care, homemaking, transportation, meals on wheels, caregiver respite and counselling), other countries like Denmark allow supports form non-traditional providers including neighbours, friends, community groups, local business, faith organizations, and cities for services such as mobility, home maintenance, snow shovelling, grocery shopping, banking, and social activities.

In closing, Dr. Williams summarized that COVID-19 did not cause the root problems in LTC, but it revealed the consequences of the pathway that led to institutionalization by default, particularly for underserved individuals and communities. Dr. Williams' question is "If we, as a society, are willing to spend billions to put even more older Canadians into LTC beds, why not spend the same amount to keep them out?" He argues that we

need a vision, with long-range planning for integrated systems of community-based LTC, and action now to ramp-up self-directed funding for older persons, caregivers and communities to disrupt the institutional gridlock and spur innovation for aging at home.

Discussion

Healthy Aging

One participant noted that health care can be a key to healthy aging insofar as it can connect people to address their social needs and social determinants of health (i.e., social prescribing, access to community health centres). Another participant noted that creating more nursing home beds is the exact opposite of the correct direction and Dr. Williams has provided the evidence for this using COVID-19 mortality rates. A participant highlighted that aging in place also has to consider people living with disabilities, including younger people who are in LTC homes. Data on deaths in long-term care facilities should be disaggregated by age as well. Alternative care options for people living with disabilities also need to be found.

Homelessness

A participant stated the importance of shining a light on homelessness, given the higher mortality rate of people experiencing homelessness. People experiencing homelessness, by virtue of not having a home, live in shelters or on the street. A rights-based approach is needed, and housing is critical to keep people safe and address inequities. There needs to be a moratorium on evictions during the pandemic to help to address economic insecurities. Home safety and security needs to be prioritized. Others agreed that homelessness is a large challenge, as is the intersection with other vulnerabilities including disability. One participant noted that housing that is accessible for people living with disabilities is limited. Accessible housing has to be prioritized if we want people to remain in the community.

Housing and Migrant Farm Workers/Undocumented

Housing was also identified as a concern by a participant given outbreaks with migrant farm workers as well as in food processing in Alberta. Temporary farm workers living in employer-provided or employer-controlled housing are vulnerable. There is no national housing standard, and no monitoring or enforcement. When a worker is sick, they continue to work. This is the same issue for people who are undocumented—they have no access to CERB and can face eviction. These are structural inequities that require immigration reform (so everyone has the same rights) and national housing standards for employer-controlled housing.

LGBTQ2+

One participant, building on the homelessness discussion, identified an important population not addressed in the discussion to date—LGBTQ2+ populations. There is an overrepresentation of LGBTQ2+ youth who are homeless, as they have been rejected from families or suffered abuse or child maltreatment. With COVID-19, they may be forced to isolate with family members who are not supportive, or in environments that are dangerous. LGBTQ2+ populations also face additional barriers in LTC facilities. A number of people thanked the participant for drawing attention to this population.

People Living with Disabilities

A participant commented that learning from other programs that are working will help in moving forward, including having discussions on self-directed care for people living with disabilities. Parents of children with disabilities live in fear of oversurveillance of their parenting, and therefore can fear reaching out or fear being tested for COVID-19. Social prescribing is important for people living with disabilities. Very vulnerable groups are missing out on social visits and community connections.

Prisons

A participant noted that Indigenous Peoples are overrepresented in both the Provincial and Federal system. Having access to cultural supports from elders and the community while in prison is key. In addition, accommodations for people living with disabilities in prisons is critical (e.g., having accommodations for people who are deaf). The participant noted there is technology to address these issues, so during a pandemic or other times, these should not be denied.

Another participant agreed with Dr. Ricciardelli that supports are needed in terms of health and social care for people being released from correctional facilities, and that these are often not in place.

Dr. Ricciardelli also noted that prisons also serve as long-term care facilities for people living with disabilities, seniors, and other vulnerable populations.

Overall Determinants of Health

One participant remarked that recovery for all fundamentally requires an accessible home for all, with tailored social and healthcare supports with financial security. They argued that this is not an impossible "wicked problem" policy space. No matter who you are, where you live or how old you are, basic income, childcare, pharmacare and affordable housing for all with targeted health and social care is needed across the continuum for basic safety and security needed to weather COVID-19 and beyond for a resilient society.

Policy Windows

One provincial government participant noted that policy windows are opened up now, and they encouraged people to send their solutions to those people in decision-making positions, given this unique point in time. This was reiterated by a federal government participant.

Provocateur Responses

Dr. Kate Mulligan responded to the comments by agreeing with the importance of safe living conditions. It is also important to continue to have a conversation on the role of health care in intersectoral and intersectional structural change—what is the role of the healthcare system? There is potential to leverage where there are trusted relationships, as this can be a significant barrier. Some community providers have the mandate and expertise in building trusted relationships with vulnerable populations using a person-centred approach. More work needs to be done on addressing inequities, living conditions, and inherited colonial structures. These conversations are critical.

Dr. Paul Williams reiterated that we have to rethink how care is provided, For example when people with physical disabilities also have dementia which may undercut the model of self-directed care. Having clients themselves involved in decision-making at the corporate governance level is another area being pushed, to provide different perspectives and help to build more trusting relationships. He mentioned that the number of young people in LTC facilities is shocking, and we do not have accessible housing for younger men who have acquired brain or spinal cord injuries. This is morally difficult and costly over the long-term. The pandemic is an opportunity to ensure people's wishes and needs are fulfilled, and changes made to ensure self-directed care with multi-disciplinary teams.

Dr. Ricciardelli observed that more resources are needed in the community for decarceration, and reiterated the need to be able to get a healthcare card before leaving the correctional facility. She remarked that this is an easy policy fix.

Access to Health and Social Supports During the Pandemic and Key Considerations for Essential and Equitable Access

Intersectional Approach

Dr. Olena Hankivsky, Director, Centre for Health Equity, Melbourne School of Population and Global Health at the University of Melbourne, and on leave as Professor and Director of the Institute for Intersectionality Research and Policy at the School of Public Health at Simon Fraser University, presented on "A call for an intersectionality perspective for addressing COVID-19".

She began by outlining that COVID-19 is a stark reminder of social inequities and their deep entrenchment. The heterogeneity of COVID-19 risks and consequences must be captured to fully understand the scope of impacts and inform actions. Despite common practices in research and policy, people do not neatly fit into categorical boxes (e.g., sex, gender, sexual orientation, age, ethnicity/Indigeneity, socio-economic status [SES], geographic location). Intersectionality encourages understanding of how multiple factors interact, how they are shaped by interconnected structural inequities,

and why analysis of power must be front and centre in COVID-19 responses, as well as future pandemics and disasters. Intersectionality does not make a hierarchy of which factors are more important—but what are the synergies of different factors and processes together?

It is also important to acknowledge the historic roots of intersectionality—the term was coined by Kimberlé Crenshaw to explain overlapping forms of discrimination faced by Black women. But the term goes back to the 19th century in Black feminist activism. The value-add of this approach is the policy analysis framework on intersectionality, from the Canadian context.

In the taking action slide, Dr. Hankivsky argued that a response to "build back better" includes establishing a COVID-19 Intersectionality Task Force that would complement and coordinate with other national medical research strategy initiatives to combat COVID-19. Disaggregated data needs to be available by sex/gender, age, disability, ethnicity, and SES. Multi-level, intersectoral data linkages are needed, as well as a push for sub-group assessment within clinical trials of therapeutics and vaccines, and ensuring equitable access to vaccines when they are available. A strategy needs to be developed that supports mixed-method, qualitative research, and policy analysis (with targeted funding from CIHR and Social Sciences and Humanities Research Council [SSHRC]) based on more than single demographic/social group categories. These studies could focus on the COVID-19 experience (e.g., Indigenous women 50–60 years of age, and non-Indigenous men with disabilities 70–80 years of age). These could be case studies and participatory pilot work on intersecting drivers of health and well-being, testing of preventive and intervention policies, and evaluation of reactive policies that can often sustain and widen inequities.

Dr. Hankivsky identified that this is a watershed moment and an opportunity for Canadian leadership. COVID-19 is more than just a health crisis—a paradigm shift is required for the whole-of-society, government, and global responses. Business as usual is not an option. Canada could lead an orchestrated UN response that champions intersectional thinking, demonstrates its links with increasing equity work, using COVID-19 as a test case, and situate such efforts within the 2030 Development Agenda. By viewing health and development through an intersectionality lens, this can: strengthen the empiricism of lived experiences; improve healthcare systems; generate effective and asset-based approaches in policy, programming, and public health messaging; and capitalize on existing community strengths and resources. Canada has long been regarded as a leader in addressing the social determinants of health, and can be a leader in linking systems.

In closing, Dr. Hankivsky noted the role of power—that COVID-19 does not discriminate, but that structures, policies, and people do. Questions that are worth raising are: Who determines what is essential and important? Whose lives are expendable (e.g., who works, who thrives, and who dies in the COVID-19 era)? What political will, resources and change in values would it take for a paradigm shift to actually occur? COVID-19 is not a one-off pandemic—our very human existence is at stake, and there will be more waves and more pandemics. We need to navigate this new reality. Vaccines are important but we need to continue with other public health measures. Intersectionality can provide a unifying framework in terms of how to analyse and address inequities in health.

Disability Justice

Dr. Pamela Block, Professor, Department of Anthropology at the University of Western Ontario, provided a provocation on "Disability justice".

She opened by outlining the activist approach, which focuses both on holding systems accountable and on mutual support and interdependence. The Disability Justice approach fills the gaps left by human rights and diversity-based approaches. Another key theme is the dangers of congregate settings. She recommends thinking historically about how polio affected and transformed experiences and opportunities for people living with disabilities. There was a crisis, then a vaccine, but then there was a transformation in the United States in terms of community-based services, changes in policies, and cultural changes in the community that resulted in focused community-based supports for people living with disabilities. With COVID-19, there will need to be policy work done on the long-term disability consequences for people with COVID-19. Another

area of concern for people living with a disability are shortages, barriers, and dangers to accessing services, supports, medicines, supplies, and technologies as a result of the disruption from COVID-19. There are ethical concerns in the current system; people without disabilities decide what constitutes good quality of life, and they tend to radically underestimate this in people living with disabilities, imagining that living with disabilities is not worth living. COVID-19 brings with it the impact of isolation, trauma of loss, and new disability from COVID-19 survivors. However, there is also increased access is some areas, including employment and education. This virtual BBE is one such example. She asked "What does 'back to normal' mean?" Hopefully this does not mean going back to being less accessible.

In terms of what actions must be prioritized to address health inequities in the short-term, Dr. Block identified the restructuring and reimagining of congregate settings to increase safety (such as the Greenhouse Project)[17] as one priority. Another is to include people living with disabilities and organizational representatives in all levels of planning and implementation, such as that modelled by the Federal Emergency Management Agency (FEMA) Core Advisory Group in the United States.[18] After superstorm Sandy, FEMA facilitated connections between leaders with disabilities and emergency responders on local and regional levels, resulting in communication strategies and relationships between these entities. This made a crucial difference when COVID-19 hit. Dr. Block also noted it is important to educate and provide immediate policy protections against prejudicial treatment (e.g., triage protocols). There is an opportunity to expand conception of COVID-19 survival needs to include long-term post-COVID-19 supports, and to continue to expand new access options as part of this transformation.

Looking to longer-term change, Dr. Block suggested dismantling large congregate settings and offering community-based alternatives such as the Greenhouse model. She also recommended encouraging proactive planning on individual and systemic levels, led by leaders with disabilities (such as the Take Charge not Chances, FEMA model identified above, Be prepared videos, and Sins Invalid).[19–29] She noted we should not be rewarding industries who are enacting poor practices—instead there should be policy protections and penalties to combat structural inequities. Service and support systems should be strengthened for survivors (including peer support). She identified the importance of disability justice models of care and collective access.

In terms of where resources should be invested, Dr. Block said that people at the intersections are at the highest risk but also have the most expertise in survival strategies. People with complex medical conditions are reliant on technology and human supports. People have complex co-existing diagnoses (such as psychiatric and intellectual disabilities), plus intersections with ethnicity, race, and sexual minority status. We need to listen to older adults and young people, and emerging scholars in this area who have career trajectories that have been disrupted in major ways.

Translating Intersectionality into Practice

Dr. Akwatu Khenti, Assistant Professor, Dalla Lana School of Public Health at the University of Toronto, spoke on translating intersectionality into practice.

He started by acknowledging that intersectionality is challenging to accomplish. Racism is a social determinant of health, and the structural impacts are pervasive, with social inequities compounded via education, housing, employment, and the criminal justice system. COVID-19 has magnified these health inequities, and this needs to be addressed. There is an emerging pattern of over-representation of racialized people with COVID-19. Early sociodemographic data in Ottawa and Toronto illustrated an increased exposure and risk for lower-income earners and people employed on the front-line. Racialized groups also have a higher risk of developing chronic diseases, which makes COVID-19 even more dangerous. However, the challenge is that with limited real-time, equity-informed data on intersecting factors creating disparities for COVID-19 outcomes, it is difficult to understand the critical nature of the problem to inform action. Black and racialized communities across North America and the world bear a greater burden of COVID-19 mortality because of challenges such as limited social capital and

micro-aggressions. He noted that in Ottawa, the areas with the highest proportion of recent migrants have higher rates of COVID-19 than areas with fewer racialized minorities. Hence, the positive immigrant effect is diminishing in the case of COVID-19.

In terms of taking action in the short-term, Dr. Khenti explained that prospective and retrospective collection of race-based data is needed, and is critical to create and develop policies and interventions. These data need to be collected, analysed and reported publicly, and complemented by key social indicators of disparity. These data should be collected in timely collaboration with communities, as their involvement is key. Testing, contact tracing, and care needs to be accessible and available for members of vulnerable and racialized communities. This includes the expansion of testing sites beyond hospital locations, to include community institutions in areas where there is greater prevalence of infection. Trusted community members should be engaged to facilitate contact tracing, which will also provide employment opportunities and help to address the social determinants of health. This can include training community health workers who provide services including COVID-19 coaching to strengthen protective factors with vulnerable communities.

Looking to the future, Dr. Khenti noted that there needs to be government commitment to health equity, and relevant public health bodies need to have a mandate to collect race-based data. There should be an obligation to use these data for equity purposes. Intersectoral action is needed to reduce anti-Black racism, including initiatives to counter the impact of racism on systems that inform planning, policy, and service delivery. Primary health care also has to have strengthened capacity to address mental health and substance use disorder needs of racialized populations. Successful interventions in mental health need to be scaled up, including funding tailored mental health services to meet the needs of Black communities during the COVID-19 pandemic and beyond.

In closing, Dr. Khenti identified that an equitable emergency response is needed to address additional risks for racialized Canadians, distribute vaccines based on equity-informed data, and engage the community in vaccination planning. To disrupt racialized trajectories, we have to understand how and where decisions and practices create and sustain racism. He stated that if you cannot grasp the racialized experience in the emergency room, how will we recognize this in testing, vaccine planning and distribution, even in uptake? African Americans in the United States are significantly less likely to be immunized for the flu, hence they have higher rates of morbidity and mortality. We need to ask: "What do we need to do for messaging to ensure people are vaccinated for COVID-19?" Policy is the vaccine for chronic disease, and race-based data is the most effective early intervention for systemic racism in health care right now.

Discussion

Intersectionality

A participant noted that all provocations illustrated the importance of an intersectional approach. Another participant noted that intersectionality cannot be overstated (e.g., racialized persons with disabilities). SGBA+ was again mentioned as one way to systematically implement this. One participant observed that it is critical that there is clarity and consistency on how intersectionality is conceptualized and operationalized. A few participants concurred. A participant identified a paper on the strengths of different kinds of qualitative and quantitative intersectional research.[30] The tensions around the concept of intersectionality were also noted, including using the term with caution. Furthermore, it was mentioned that intersectorality also needs to be addressed—how do we bring sectors together around policies?

People Living with Disabilities

A participant commented that in times of crisis, the reins on non-insured health benefits need to be loosened so that people living with disabilities are given the resources they need. Another participant noted that in congregate living or support spaces, it is non-COVID-19 physical health, mental health, and social needs that get completely disrupted and fragmented rather than COVID-19 being the "problem" per se.

Another participant recognized that the Greenhouse Project is a great example of what could be done (e.g., residents with private rooms and bathrooms supported by mentors and interdisciplinary teams). They also noted that, unfortunately, in Ontario they

are now building more conventional beds, with two people to a room, shared bathrooms, and with little privacy, increasing vulnerability to COVID-19 and annual flu epidemics. This also diverts resources away from community-based alternatives.

One participant agreed that working from home has increased accessibility for some people living with disabilities. They mentioned that they hope this is not lost post-COVID-19, and that it opens up conversations with potential employers about accessibility and accommodations. The inclusion of disability groups in the triage protocols was also identified as critical. It was noted that the Ontario triage protocols are quite concerning for the disability community and that people living with disabilities are thus afraid to reach out for health or assessment of symptoms. The concerns that people without disabilities think disabled lives are less valuable was identified as a concern. Public messaging may help to shift ableist ideas of disabled lives.

Other Vulnerable Populations

Another vulnerable population mentioned by a participant is that of Hutterite communities. There are currently outbreaks within several of these communities, and these communities should be considered within the context of the discussion.

Opioid Crisis

The dual crises of COVID-19 and the poisoned drug supply/opioids was identified by a number of participants. The challenge is that the infectious approach (e.g., messages to “isolate”) does not align with public health advice on the chronic disease prevention side (e.g., messages to reduce substance use harm such “never use alone”). There is an open policy window now to address this, including a national approach to safe drug supplies and decriminalization. Work also needs to be done on providing PPE for harm reduction and involving people with lived experience in co-designing solutions (including peer support, peer workers). It was also noted that the opioid crisis extends into prisons.

Support for Mental Health During COVID-19

Mental health was identified as a major concern. People who are suicidal are being turned away at emergency rooms, or are not going to the hospital for fear of COVID-19 exposure. People with mental illness are having more difficulties during COVID-19, and there is a surge of mental health difficulties for those who were in remission or who previously had their mental illnesses under control. A participant also noted the importance of looking at mental health implications from COVID-19 for front-line works and vulnerable groups. Public health can play an important advocacy role in mental health.

Impact on Other Conditions (e.g., Chronic Disease, Surgery)

The impact of COVID-19 on other chronic disease prevention and management (with many deaths as a result of delayed care), as well as the impact on waitlists for surgery, were identified as critical issues.

Integration of Health and Social Care Including in Long-term Care

The need for integration of health and social care (as is the case in a number of European Ministries who have a single Ministry covering these areas) was identified by a number of participants. Health Canada used to be Health and Welfare Canada. The idea of seeing a physician who is linked to a network of resources, so they can also help with housing needs, meals and wheels, and social supports, is viewed as critical. CHCs in Ontario offer a potential model to bridge these sectors. Moving Canada’s system from being mostly focusing on health care, to scaling and spreading important innovations that also consider social areas, was noted as important to ensure a person-first perspective approach. A true primary health care approach is needed (as outlined in Alma Ata and the 2018 Declaration of Astana).

This integration is also critical for long-term care in Canada. The PACE model was mentioned as an important model. One participant noted that from a client perspective, the model provides seamless interdisciplinary health and social care. Operationally, however, it faces major challenges since each service and

program has different criteria, funding arrangements, accountability requirements, and service limits. They argued there is a real need to attach funds to people, not service or location of care as the PACE model in the US does. This would enable real PACE replications that engage a wide range of community partners and spur innovation.

Another participant noted that the determinants of health are all within the federal government's jurisdiction. The federal government could have a steering role to incentivize innovation and bring social care and health together (e.g., national housing strategy).

Data Needed

The critical need for demographic data was identified, including on health outcomes of those who are disproportionately affected (Indigenous Peoples, racialized people, immigrant, LGBTQ2+, people living with disabilities) by COVID-19, and also on individuals providing front-line care. It was noted that there are clear intersectional implications.

Representation

A number of participants observed that we need accountability from our institutions, ensuring that they are reflective of the population of Canada. Measuring the extent to which members from racialized, disability, immigrant, and LGBTQ2+ communities are represented in the halls of policymaking and in government roles that involve designing health and social policy would help to reassure that these perspectives are represented and have the force of authority to make the changes that are required.

One participant noted that their organization has identified a number of key themes for bringing an equity and social determinants of health perspective to COVID-19 including the importance of a whole-of-community approach. Individuals and organizations need to be involved in emergency planning, response, and recovery. There has to be intentional and legitimate collaboration and partnership between the health and non-health sector. Messages need to be framed in the media to address the importance of a just and sustainable system, and keeping solutions doable in the public consciousness. Finally, it is important to see how the formal system can harness or tap into the current social movements.

Governance Approaches

One participant identified that one strategy for institutionalizing intersectoral/intersectional structural change, Health in All Policies (HiAP), is not only a policy principle but an actionable yet flexible set of governance and accountability structures, mechanisms, and processes that has been implemented in jurisdictions around the world. Two references were also provided.[31, 32] Another participant noted that two governance approaches that would be interesting to explore in the context of recovery to address structural determinants of health are HiAP and Wellbeing Budgets. A number of other participants agreed, and one participant commented that the HiAP should be equity-focused.

Provocateur Responses

Dr. Khenti noted that the data you gather is what you prioritize. Having data that can address intersectionality is key to addressing inequities. Mental health work needs to be scaled up especially for racialized groups. Addressing decriminalization of all substance use is important, as is implementing basic income, as the evidence is there to support that this works. We also need a whole-of-community approach to address stigma.

Dr. Hankivsky observed that the SGBA+ framework is an important advancement and puts Canada on the international map as a promising practice. However, it gives primary importance to sex and gender. We need more training and skill development to understand intersectionality and how to hold attention on various factors and work across sectors to ensure understanding. Dr. Hankivsky agreed that you can only count what is counted. Data need to be more inclusive and fine grained to do analysis that intersectionality requires. This includes quantitative, qualitative, and mixed methods. Forging collaboration and partnerships between health and non-health sector is key. The framing of the 2030 agenda is an ideal opportunity to think of COVID-19 responses.

Dr. Block observed that pouring more resources into an already broken system in congregate settings, without major restructuring, was not acceptable.

Building a Stronger Future: Reflections on Key Actions for Moving Forward Together

Bonnie Hostrawser thanked the presenters, CIHR and the participants. She provided a few remarks on behalf of the OCPHO. She noted a few key themes from the session:

1. Stigma is fundamentally woven into everything discussed today. We need to address ageism, ableism, and racism, among other socially constructed stigmas. COVID-19 has further exposed the systematic devaluation of a number of groups and there is an opportunity for a paradigm shift.
2. Data and frameworks are needed to understand inequities in an intersectional manner. A framework of SGBA+ can be useful for this work, as well as equity-based data. This was also identified in the 2019 CPHO Annual Report focused on stigma.
3. Governance is critical, and needs to include community members and diverse leadership. We need to ensure people are not left out.
4. We need to rethink and reform our current structures. Fundamental reforms of many systems are needed, including immigration, caring for seniors, primary care, employment, and correctional facilities.
5. We need to ensure integration across these systems, including addressing other issues or crises as they arise.

Ms. Hostrawser outlined the next steps from the BBE. She thanked presenters for sending the key references they had identified. The OCPHO team will continue to write the CPHO report for the fall. The input and discussion from today will be used to guide this report.

Dr. Viehbeck closed the session by reiterating what Dr. Hankivsky said in her provocation—that COVID-19 does not discriminate, but that structures, policies and people do. We need to address how to accelerate change, allocate resources, and put in place mechanisms for engagement that can help with designing, implementing, and evaluating actions. She stated that evidence plays a critical role to inform what actions to take and also to evaluate and study interventions made in systems to see what works. Collateral challenges also need to be addressed including the opioid crisis, chronic diseases, and the impact of deferred healthcare procedures. Dr. Viehbeck thanked all the presenters and participants for taking part, and asked people to complete the evaluation.

Via the chat function, a number of participants thanked the organizers for a stimulating conversation.

APPENDIX 1
Agenda

CIHR IRSC Canadian Institutes of Health Research / Instituts de recherche en santé du Canada

Public Health Agency of Canada / Agence de la santé publique du Canada

Virtual Best Brains Exchange – Agenda

Strengthening the Structural Determinants of Health Post-COVID-19

Meeting Purpose & Objectives

The COVID-19 pandemic is having unprecedented health, social and economic impacts for Canadians. The direct and indirect consequences of COVID-19 and related public health measures have exacerbated existing health inequalities. These consequences are driven and shaped by structural and intermediary determinants of health.

The purpose of this Best Brains Exchange (BBE) is to bring together Federal, Provincial and Territorial policy and decision makers, researchers and implementation experts, non-governmental organizations and other key stakeholders to inform the Chief Public Health Officer of Canada's (CPHO) 2020 Annual Report on COVID-19. The BBE will aim to better understand the intersectional COVID-19 impacts on the health and well-being of priority groups in Canada to inform the design of protective strategies moving forward.

The BBE will focus on the following action-oriented objectives:

1. Provide input into the CPHO's equity-based framework, articulating the direct and indirect consequences of COVID-19 as part of the 2020 Annual Report;
2. Share evidence-informed advice and lessons-learned on how to take an intersectional and intersectoral approach to creating structural change that leads to health improvements; and
3. Offer recommendations to identify priorities for future near and medium-term COVID-19 actions addressed in this BBE.

Time	Item	Speaker
9:45 – 10:00 am	**Registration & Networking**	
10:00 – 10:15 am	**Welcome** • Opening Remarks • Acknowledgement of the Territory • Overview of BBE Objectives	**Dr. Sarah Viehbeck**, Associate Vice President, Research Programs Strategy, Canadian Institutes of Health Research and **Bonnie Hostrawser**, Director, Office of the Chief Public Health Officer, Public Health Agency of Canada
10:15 – 11:15 am	**Scene Setting:** **Framing the 2020 CPHO Report** **Indigenous Health and COVID-19** *20 minute presentations, followed by facilitated discussion*	**Dr. Theresa Tam**, Chief Public Health Officer of Canada and **Dr. Margo Greenwood**, Academic Leader, National Collaborating Centre for Indigenous Health

Discussion Guide

The following questions will be used to guide presentations and discussions within each theme:

1. What is the nature and how have structural and intermediary determinant(s) of health been exacerbated by the pandemic?
2. What actions must be prioritized to address health inequities in the near-term (<12 months)?
3. How can we enable longer-term (>12 months) intersectoral and intersectional structural changes that will lead to health improvements for all Canadians?

Facilitators

Thematic presentations and discussions will be facilitated by:

- **Dr. Steven Hoffman**, Scientific Director, Institute of Population and Public Health, Canadian Institutes of Health Research
- **Anna Romano**, Vice President, Health Promotion & Chronic Disease Prevention Branch, Public Health Agency of Canada

Time	Item	Speaker
11:15 am – 12:00 pm	**Economic Factors and Employment Opportunities to Protect Health** *Rapid-fire presentations (8 minutes each), followed by facilitated action-oriented discussion*	**Dr. Naomi Lightman**, Assistant Professor, Department of Sociology, University of Calgary **Dr. Audrey Laporte**, Director and Professor, Institute of Health Policy, Management and Evaluation, University of Toronto
12:00 – 12:30 pm	**Lunch Break & Networking**	

Time	Item	Speaker
12:30 – 1:30 pm	**Living Conditions that Increase Risk and Opportunities to Protect Health** *Rapid-fire presentations (8 minutes each), followed by facilitated action-oriented discussion*	**Dr. Kate Mulligan**, Assistant Professor, Dalla Lana School of Public Health, University of Toronto & Director, Policy & Communications, Alliance for Healthier Communities **Dr. Rosemary Ricciardelli**, Professor, Department of Sociology, Memorial University of Newfoundland (in collaboration with **Dr. Sandra M. Bucerius**, Director, Centre for Criminology Research, University of Alberta) **Dr. Paul Williams**, Professor, Institute of Health Policy, Management and Evaluation, University of Toronto
1:30 – 2:30 pm	**Access to Health and Social Supports During the Pandemic and Key Considerations for Essential and Equitable Access** *Rapid-fire presentations (8 minutes each), followed by facilitated action-oriented discussion*	**Dr. Olena Hankivsky**, Professor, School of Public Health, Simon Fraser University **Dr. Pamela Block**, Professor, Department of Anthropology, University of Western Ontario **Dr. Akwatu Khenti**, Assistant Professor, Dalla Lana School of Public Health, University of Toronto
2:30 – 3:00 pm	**Building a Stronger Future—Reflections on Key Actions for Moving Forward Together** *Opportunities identified in previous sessions with final overall discussion, followed by closing summary and remarks*	**Bonnie Hostrawser** and **Dr. Sarah Viehbeck**

APPENDIX 2

List of Participants

Keynote Speaker		
Theresa Tam	Chief Public Health Officer of Canada	Public Health Agency of Canada
Presenters		
Pamela Block	Professor, Department of Anthropology	University of Western Ontario
Margo Greenwood	Academic Leader	National Collaborating Centre for Indigenous Health
Olena Hankivsky	Professor, School of Public Health	Simon Fraser University
Akwatu Khenti	Assistant Professor, Dalla Lana School of Public Health	University of Toronto
Audrey Laporte	Director and Professor, Institute of Health Policy, Management and Evaluation	University of Toronto
Naomi Lightman	Assistant Professor of Sociology	University of Calgary
Kate Mulligan	Assistant Professor, Dalla Lana School of Public Health & Director, Policy & Communications	University of Toronto Alliance for Healthier Communities
Rosemary Ricciardelli	Professor of Sociology	Memorial University of Newfoundland
Paul Williams	Full Professor Emeritus, Health Policy	Institute of Health Policy, Management and Evaluation, University of Toronto
Facilitators		
Bonnie Hostrawser	Director, Office of the Chief Public Health Officer	Public Health Agency of Canada
Steven Hoffman	Scientific Director, Institute of Population and Public Health	Canadian Institutes of Health Research
Anna Romano	Vice President, Health Promotion & Chronic Disease Prevention Branch	Public Health Agency of Canada
Sarah Viehbeck	Associate Vice President, Research Programs Strategy	Canadian Institutes of Health Research
Participants		
Evan Adams	Deputy Chief Medical Officer of Public Health	Indigenous Services Canada
Kim Barker	Medical Officer of Health—South Region	Government of New Brunswick

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Neil Belanger	Executive Director	British Columbia Aboriginal Network on Disability Society (BCANDS)
Olivier Bellefleur	Scientific Lead	National Collaborating Centre for Healthy Public Policy
Claire Betker	Scientific Director	National Collaborating Centre for Social Determinants of Health
Andrew Bond	Medical Director and Co-Chair	Inner City Health Associates Canadian Network for Health and Housing of People Experiencing Homelessness
Ian Culbert	CPHO Health Professional Forum Co-Chair	Canadian Public Health Association
Franca Gatto	Director, Health Promotion & Chronic Disease Prevention Branch	Public Health Agency of Canada
Rick Glazier	Scientific Director, Institute of Health Services and Policy Research	Canadian Institutes of Health Research
Andrew Heisz	Director, Centre for Income and Socioeconomic Well-being Statistics	Statistics Canada
Deena Hinshaw	Chief Medical Officer of Health	Government of Alberta
Edward Hon-Sing Wong	Co-Chair	Chinese Canadian National Council
Syed Hussan	Executive Director	Migrant Workers Alliance for Change
Beth Jackson	Senior Science Advisor, Health Promotion & Chronic Disease Prevention Branch	Public Health Agency of Canada
Fiona Kouyoumdjian	Associate Chief Medical Officer of Health	Government of Ontario
Rhonda Kropp	Associate Vice-President, Infectious Diseases and Prevention Control Branch	Public Health Agency of Canada
Susan MacPhee	Director, Social Programs Division	Employment and Social Development Canada
Elizabeth Mooring	Health Services Director	AiMHi
Will Prosper	Co-founder	Hoodstock Social Forum
Brian Rowe	Scientific Director, Institute of Circulatory and Respiratory Health	Canadian Institutes of Health Research
Jennifer Russell	Chief Medical Officer of Health	Government of New Brunswick
Jane Rylett	Scientific Director, Institute of Aging	Canadian Institutes of Health Research
David Sabapathy	Deputy Public Health Officer	Government of Prince Edward Island
Jewelles Smith	Past Chairperson	Council of Canadians with Disabilities
Lisa Smylie	Director General, Communications and Public Affairs and Research, Results and Delivery Branch	Women and Gender Equality Canada
Robert Strang	Chief Medical Officer of Health	Government of Nova Scotia

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Nicole Szajcz-Keller	Special Projects Coordinator, Institute of Indigenous Peoples' Health	Canadian Institutes of Health Research
Patrick Verreault	Acting Director, Food Policy Division	Agriculture and Agri-Food Canada
Tom Wong	Chief Medical Officer of Public Health	Indigenous Services Canada
BBE Planning Team		
Grace Alessi	Initiative Officer, Knowledge Translation Strategies, Science Policy Branch	Canadian Institutes of Health Research
Meghan Baker	Senior Advisor, Knowledge Translation Strategies, Science Policy Branch	Canadian Institutes of Health Research
Laura Bland-Lasso	Policy Analyst, Office of the Chief Public Health Officer	Public Health Agency of Canada
Marie Chia	Manager, Office of the Chief Public Health Officer	Public Health Agency of Canada
David Grote	Senior Research Analyst, Office of the Chief Public Health Officer	Public Health Agency of Canada
Observers		
Marisa Creatore	Assistant Director, Institute of Population and Public Health	Canadian Institutes of Health Research
Elizabeth Dyke	Independent Health and Social Development Consultant	
Albert Kwan	Senior Policy Analyst, Health Promotion & Chronic Disease Prevention Branch	Public Health Agency of Canada
Christine Maika	Acting Director, Office of the Chief Public Health Officer	Public Health Agency of Canada
Heather Orpana	Senior Research Scientist, Health Promotion & Chronic Disease Prevention Branch	Public Health Agency of Canada
Kelly Taylor	Director General, Infectious Diseases and Prevention Control Branch	Public Health Agency of Canada
Tasha Yovetich	Senior Policy Analyst, Office of the Chief Public Health Officer	Public Health Agency of Canada

APPENDIX 3

Biographies of Presenters

Scene Setting: Framing the 2020 CPHO Annual Report/ Indigenous Health and COVID-19

DR. THERESA TAM

Chief Public Health Officer of Canada

Public Health Agency of Canada

Dr. Theresa Tam was named Canada's Chief Public Health Officer on June 26, 2017. She is a physician with expertise in immunization, infectious disease, emergency preparedness, and global health security. Dr. Tam obtained her medical degree from the University of Nottingham in the U.K. She completed her paediatric residency at the University of Alberta and her fellowship in paediatric infectious diseases at the University of British Columbia. She is a Fellow of the Royal College of Physicians and Surgeons of Canada and has over 55 peer-reviewed journal publications in public health. She is also a graduate of the Canadian Field Epidemiology Program. Dr. Tam has held several senior leadership positions at the Public Health Agency of Canada, including as the Deputy Chief Public Health Officer and the Assistant Deputy Minister for Infectious Disease Prevention and Control. During her 20 years in public health, she provided technical expertise and leadership on new initiatives to improve communicable disease surveillance, enhance immunization programs, and strengthen health emergency management, laboratory biosafety and biosecurity. She has played a leadership role in Canada's response to public health emergencies, including Severe Acute Respiratory Syndrome (SARS), pandemic influenza H1N1, and Ebola. Dr. Tam has served as an international expert on a number of World Health Organization committees and has participated in multiple international missions related to SARS, pandemic influenza and polio eradication.

DR. MARGO GREENWOOD

Academic Leader
National Collaborating Centre for Indigenous Health

Dr. Margo Greenwood, Academic Leader of the National Collaborating Centre for Indigenous Health, is an Indigenous scholar of Cree ancestry with years of experience focused on the health and well-being of Indigenous children, families, and communities. She is also Vice-President of Indigenous Health for the Northern Health Authority in British Columbia and Professor in both the First Nations Studies and Education programs at the University of Northern British Columbia. While her academic work crosses disciplines and sectors, she is particularly recognized for her work in early childhood care and education of Indigenous children and for public health. Margo has undertaken work with UNICEF, the United Nations, the Canadian Council on Social Determinants of Health, Public Health Network of Canada, and the Canadian Institute of Health Research, specifically, the Institute of Population and Public Health. Margo received the Queen's Jubilee medal in 2002 in recognition of her tireless work to promote awareness and policy action on the rights and well-being of Indigenous and non-Indigenous children, youth, and families. In 2010, she was named 'Academic of the Year' by the Confederation of University Faculty Associations of British Columbia, and in the following year, she was honoured with the National Aboriginal Achievement Award for Education.

Presenters: Economic Factors and Employment Opportunities to Protect Health

DR. NAOMI LIGHTMAN

Assistant Professor
Department of Sociology
University of Calgary

Dr. Lightman is an Assistant Professor of Sociology at the University of Calgary. Her research interests include migration, care work, the sociology of work, gender, and research methodology. As of 2018, Dr. Lightman is the principal investigator of the SSHRC Insight Development Grant "Sorting and Shaping: The Dynamics of Labour Market Exclusion for Female Migrant Care Workers in Canada, 1980–2014." For this project, Dr. Lightman is using administrative longitudinal data from Statistics Canada to explore how institutional settings and immigration paradigms lead to outcomes of labour market exclusion for female care workers coming from poor to wealthier nations. In Canada, she measures the impact of different migrant entry categories on care work wages over time and the upward and downward employment trajectories of women working in low wage occupations in health and education. In addition, Dr. Lightman has collaborated on research focused on immigration, race, and inequality with various social agencies and government bodies including Social Planning Toronto, the Wellesley Institute, the Calgary Local Immigration Partnership, and the Calgary Immigrant Women's Association.

DR. AUDREY LAPORTE

Director and Professor
Institute of Health Policy, Management and Evaluation
University of Toronto

Professor Audrey Laporte's research focusses in general on the development of micro-economic theory and the application of micro-econometric methods to address questions of policy interest to health and health care. More specifically, her work has centered on a set of themes: modelling of individual health capital accumulation and addictive behaviours; health human resource modelling (e.g., nurse, physician and personal support labour markets) and modelling the impact of policy changes on the performance of health care organizations (e.g., institutional long-term care, hospitals). Her more recent work in collaboration with her students has focused on the impact of health conditions and socio-economic circumstance in early life on later life outcomes. Professor Laporte is President-Elect of the International Health Economics Association and Director of the Canadian Centre for Health Economics. She is an incoming Associate Editor of Health Economics, International co-Editor of International Journal for Reviews in Empirical Economics, and incoming co-Editor of Healthcare Papers.

Presenters: Living Conditions that Increase Risk and Opportunities to Protect Health

DR. KATE MULLIGAN

Assistant Professor
Dalla Lana School of Public Health
University of Toronto &
***Director**, Policy & Communications*
Alliance for Healthier Communities

Dr. Kate Mulligan is a health geographer advancing health equity and healthier communities through community- and practice-informed policy. She leads Ontario's first social prescribing project, creating supported, tracked referrals between health and social systems, and is a board member at the Toronto Board of Health, the Association of Local Public Health Agencies, and 8-80 Cities. Her teaching includes public health policy, ecological public health, and political communications for Canada's first DrPH program. Her research and policy work has been supported by Toronto Public Health, the Ontario Ministry of Health and Long-Term Care, Health Canada, and the United Nations.

DR. ROSEMARY RICCIARDELLI

Professor
Department of Sociology
Memorial University of Newfoundland

Dr. Rosemary Ricciardelli is a Professor of Sociology, the Coordinator for Criminology, and Co-Coordinator for Police Studies at Memorial University of Newfoundland. Elected to the Royal Society of Canada, she is founding member of Canadian Institute for Public Safety Research and Treatment (CIPSRT) and an inaugural member of CIPSRT's Network Advisory Council. Her additional affiliations and appointments include: an Associate Scientist at Ontario Shores Centre for Mental Health and an Affiliate Scientist with Toronto Rehabilitation Institute. She has published over 115 journal articles, 35 chapters, and over 300 presentations and invited talks. She has authored 5 available books and 3 edited collections, her first entitled *Surviving Incarceration: Inside Canadian*

Prisons, explores the realities of penal living for federally incarcerated men in Canada. Other books include *Violence, Sex Offenders, and Corrections* (co-authored), one on Cyber-Risk (co-authored, 2018), and *Also Serving Time: Canada's Provincial and Territorial Correctional Officers* (2019) which focuses on the work experiences of correctional officers (2019). She has also published 3 edited collections, including *Engaging with Ethics in International Criminological Research* (co-edited) and *After Prison: Navigating Employment and Reintegratio*n (co-edited). Her research is centered on evolving understandings of gender, vulnerabilities, risk, and experiences and issues within different facets of the criminal justice system. Beyond her work on the realities of penal living and community re-entry for federally incarcerated men in Canada, her current work includes a focus on the experiences of correctional officers and staff given the potential for compromised psychological, physical, and social health inherent to the occupations. She is an advocate for non-criminalizing processes for all citizens who transgress the law and has worked on the created and implementation of restorative practices for youth. Her sources of active research funding include: Correctional Services Canada, Union of Canadian Correctional Officers (UCCO-SACC-CSN), Union of Safety and Justice Employees, the Social Sciences and Humanities Research Council of Canada, the Canadian Institute of Health Research, Memorial University's Office of the Vice President Research, and Harris Centre.

DR. SANDRA M. BUCERIUS

Director
Centre for Criminology Research
University of Alberta

Dr. Sandra M. Bucerius is the Director of the Centre for Criminological Research at the University of Alberta and an Associate Professor of Sociology and Criminology in the Department of Sociology. Dr. Bucerius deploys extensive qualitative and ethnographic research to reveal the intricacies of settings that are difficult both to access and understand: prisons, police organizations, and marginalized street and newcomer communities. She conducts rigorous research designed to understand criminal justice institutions and those who encounter them, particularly those marginalized by factors related to race, gender, social class, addictions, and other factors. She works with various stakeholder groups to confront the challenges of the criminal justice system and translate her knowledge and findings into best practises and create positive system changes. She has won multiple awards for her research and teaching, including the Martha Cook Piper Award, which recognizes 2 faculty members across the university in the early stages of their career that enjoy a reputation for original research and show outstanding promise as researchers. Together with Dr. Kevin Haggerty, Dr. Bucerius leads the *University of Alberta Prison Project* (twitter @theUAPP). She has published 3 books with Oxford University Press and is Co-editor of the Oxford University Press Handbook series in Criminology (with Dr. Michael Tonry). She also serves on the advisory board of her discipline's flaghship journal *Criminology* and is an Executive Member of the *Canadian Research Network of Terrorism, Security, and Society* (TSAS). She is also on a German advisory board for immigration related questions (Rat für Migration).

DR. PAUL WILLIAMS

Full Professor Emeritus,
Health Policy
Institute of Health Policy, Management and Evaluation
University of Toronto

A. Paul Williams, PhD., is Full Professor Emeritus, Health Policy, Institute of Health Policy, Management and Evaluation, University of Toronto. He was founding Director of the Health Services Management Program at Ryerson University and more recently, Director of the MSc/PhD Program in Health Services Research at the University of Toronto. He is Co-Chair of the Canadian Research Network for Care in the Community based at Ryerson University. Paul's work focuses on the design, delivery and outcomes of community-based services and supports for vulnerable groups including older persons with multiple chronic health and social needs, and their unpaid careers, and marginalized communities

including persons living with dementia, families of children with complex medical needs, First Nations, and LGBTQ. Paul has extensive international experience. He has taught and conducted research in countries including the U.K., China, the Netherlands, Mexico, Hungary, Ukraine, Jordan, Israel, and the Palestinian National Authority. He is currently Visiting Professor (In Residence) of Canadian Studies at Kwansei Gakuin University in Japan where he conducts field research on integrated community-based systems of care for aging populations. Paul is strongly committed to community service. In addition to serving as a consultant and reviewer for numerous public and private sector agencies, he has served on the boards of community-based organizations such as the Ontario Community Support Association, the Anne Johnston Health Station, Bellwoods Centres for Community Living, and Carefirst Seniors.

Presenters: Access to Health and Social Supports during the Pandemic and Key Considerations for Essential and Equitable Access

DR. OLENA HANKIVSKY

Professor
School of Public Health
Simon Fraser University

Olena Hankivsky, PhD—Director, Centre for Health Equity, Gender and Equity Research Chair, School of Population and Global Health, University of Melbourne Australia. She is currently on leave as Professor, School of Public Policy and the Director of the *Institute for Intersectionality Research and Policy* at Simon Fraser University in Vancouver, Canada. Dr. Hankivsky is trained as a political scientist. She is an internationally recognized expert in gender mainstreaming, gender-based analysis, and intersectionality-based analysis. In 2009, Dr. Hankivsky was awarded a Research Chair in New Perspectives in Sex and Gender and Health by the Canadian Institutes of Health Research and a Senior Scholar Career Award in Population Health by the Michael Smith Foundation for Health Research. Dr. Hankivsky has extensive experience working across academic, government, NGO, and international organizations including the World Health Organization and the United Nations. She has been a Visiting Professor at the United Nations University, International Institute for Global Health in Kuala Lumpur (2020 to present), Graduate Institute, Geneva (2017–2019), London School of Hygiene and Tropical Medicine (2013–2015), and Columbia University (2008). Dr. Hankivsky has been an invited speaker in over 25 countries internationally. Her publications have been featured in *Lancet, BMJ*, and *Social Science and Medicine*. She has recently completed *Women's Health in Canada* (2nd volume University of Toronto Press) with Drs. Morrow and Varcoe and *The Palgrave Handbook of Intersectionality in Public Policy* with Dr. Julia Jordan Zachery. She is currently a Commissioner on the Lancet Commission on Gender and Global Health.

DR. PAMELA BLOCK

Professor
Department of Anthropology
University of Western Ontario

Dr. Block's research focuses on "disability culture" and cultural perceptions of disability in the United States, Brazil, and Canada. Dr. Block studies disability experience on individual, organizational, and community levels, focusing on socio-environmental barriers, empowerment/capacity-building, and health promotion. Her qualitative research methodologies combine historical and discourse analyses with community-based ethnographic and participatory approaches. She is particularly interested in multiple marginalization and the intersections of gender, race, poverty, and disability in movements for disability liberation (justice and

rights) and disability oppression (eugenics, sterilization, mass-incarceration and killing in Brazil, the United States, and Canada. Dr. Block engages actively in discussions of the emergence of neurodivergence and disability studies in Brazil and other Global South Countries. Current research includes "Aging Out of Children's Hospitals and Health Systems," the study of youth and adults with complex medical conditions that require technologies such as mechanical ventilation and 24-hour skilled nursing for survival.

DR. AKWATU KHENTI

Assistant Professor
Dalla Lana School of Public Health
University of Toronto

Akwatu Khenti was Ontario's first Assistant Deputy Minister, Anti-Racism Directorate and a Senior Scientist at CAMH's Institute for Mental Health Policy Research. He is an Assistant Professor with the Dalla Lana School of Public Health at the University of Toronto. He has a specialist degree in economics, a master's degree in political science from the University of Toronto, and a PhD in health policy and equity from York University. He is involved in a wide variety of international initiatives on mental illness including mental health capacity building in primary care. He previously led CAMH's development of a specialized drug treatment and prevention program for Black youth in Toronto, called the Substance Abuse Program for African and Caribbean Youth (SAPACCY). Akwatu Khenti's innovative global health research includes a Grand Challenge in Global Health project to improve mental health conditions in Gujarat, India, using human rights-based approaches, and a CIHR-funded randomized clinical trial to test an anti-stigma intervention in primary health care in Ontario. He has also co-led drug research capacity-building with the Inter-American Drug Control Commission (CICAD, OAS) involving 30 universities across Latin America and the Caribbean. He is a collaborator in a Peruvian cluster randomized clinical trial on a stigma intervention in primary care, as well as on a pilot study of a telephone application for psychosis linking traditional healers with the psychiatric system in Tanzania. He was a principal investigator for the development of easy-to-follow, culturally adapted cognitive-behavioural therapy (CBT) interventions for working with individuals of Latin American origin and individuals of African Caribbean origin (both English-speaking and French-speaking). He has recently completed a feasibility study of a CBT intervention with spiritual leaders in Haiti to see whether it can strengthen the system of informal care. He was one of Canada's first health leaders to call for Toronto's gun violence to be recognized as a public health crisis.

Facilitators

DR. STEVEN HOFFMAN

Scientific Director
Institute of Population and Public Health
Canadian Institutes of Health Research

Dr. Steven J. Hoffman is the Dahdaleh Distinguished Chair in Global Governance & Legal Epidemiology and a Professor of Global Health, Law, and Political Science at York University, the Director of the Global Strategy Lab, the Director of the WHO Collaborating Centre on Global Governance of Antimicrobial Resistance, and the Scientific Director of the CIHR Institute of Population & Public Health. He holds courtesy appointments as a Professor of Clinical Epidemiology & Biostatistics (Part-Time) at McMaster University and as an Adjunct Professor of Global Health & Population at Harvard University. He is an international lawyer licensed in both Ontario and New York who specializes in global health law, global governance, and institutional design. His research leverages various methodological approaches to craft global strategies that better address trans-national health threats and social inequalities. Past studies have focused on access to medicines, anti-microbial resistance, health misinformation, pandemics, and tobacco control. Steven previously worked as a Project Manager for the World Health Organization in Geneva, Switzerland, and as a Fellow in the Executive Office of United Nations Secretary-General Ban Ki-moon in New York City, where he offered strategic

and technical input on a range of global health issues. He also previously worked for a Toronto law firm specializing in cross-border intellectual property litigation, health product regulation, and government relations. Steven recently advised the World Health Organization on development of a global strategy for health systems research and was lead author on the background paper that provided the strategy's conceptual underpinnings. For 3 years he convened an academic advisory committee on science reporting for Canada's only national weekly current affairs magazine. He was previously an Associate Professor of Law at the University of Ottawa (2014–2017) and a Visiting Fellow at the University of Oxford (2018–2019). Steven holds a Bachelor of Health Sciences from McMaster University, an MA in Political Science and a Juris Doctor from the University of Toronto, a PhD in Health Policy from Harvard University, and a doctorate in law from Sciences Po Paris. You can follow Dr. Hoffman on Twitter at @shoffmania.

ANNA ROMANO

Vice-President
Health Promotion & Chronic Disease Prevention Branch
Public Health Agency of Canada

Anna has over 25 years of experience in providing strategic policy advice, briefings, and recommendations to decision-makers in the federal public service. She has had the opportunity to work in 10 federal organizations, including central agencies and Deputy Minister's offices. Over the last several years, Anna has led a number of crosscutting initiatives and delivered on key federal policy priorities, including the introduction of new or amended legislation. Anna enjoys motivating individuals and teams to superior levels of output and achievement. She strives to work collaboratively and develop environments of trust—within the public service, with external stakeholders, and political staff. Having worked in both economic and social policy portfolios, Anna is always up for a spirited debate on the federal role in areas of provincial jurisdiction.

DR. SARAH VIEHBECK

Associate Vice-President
Research Programs – Strategy
Canadian Institutes of Health Research

Dr. Sarah Viehbeck is the Associate Vice-President, Research Programs Strategy at CIHR. In this role, Dr. Viehbeck is responsible for all science-related strategy and policy development. She also leads the design of a comprehensive suite of programs and initiatives to support CIHR's mandate, with a priority focus on growing and maintaining a strong and sustainable Canadian health research workforce. Prior to this role, Sarah was Head of Governance Renewal at the Agency and, in this capacity, led an agency-wide change and continuous improvement agenda to clarify decision-making processes and structures, and CIHR's Head Performance Measurement where she played an instrumental leadership role in the implementation of the Government of Canada's Policy on Results. Sarah has offered leadership for strategic activities related to performance measurement and evaluation, population and public health ethics, knowledge translation, international partnerships, and Indigenous health research. Sarah is a member of the Canadian Evaluation Society and graduate of the International School on Research Impact Assessment. Through her role as an adjunct faculty member at the University of Waterloo's School of Public Health and Health Systems and the University of Ottawa's Interdisciplinary School of Health Sciences, Sarah maintains a research program and is engaged in teaching. Sarah is a proud mother and volunteers as a Board member of the National Collaborating Centre for Determinants of Health and as President of her neighbourhood's Community Association Board.

BONNIE HOSTRAWSER

***Director**, CPHO Reports*
Office of the Chief Public Health Officer
Public Health Agency of Canada

As the Director of the Reports Team in the Office of the Chief Public Health Officer of Canada (CPHO), Bonnie leads the development of evidence synthesis reports on the key priorities of the CPHO. Evidence includes peer-reviewed research and wisdom from experts with lived and living experience, organizational, and academic expertise. Bonnie has worked more than 10 years in the Public Health Agency of Canada, leading policy teams on areas like prevention of substance use harms, science to policy integration, healthy living, and chronic disease prevention. Prior to joining the federal government, Bonnie led non-governmental organizations in health and social justice sectors. She has led organizations at the national, provincial, and local levels, advancing issues on chronic disease prevention, violence against women, and homelessness. Bonnie holds a Masters in Public Health from the University of Waterloo.

Acknowledgments

Dr. Tam and the OCPHO are grateful to all of the presenters and participants for insightful discussions and valuable contributions at the Best Brains Exchange, as well as CIHR for sponsoring, hosting and co-organizing this event. Special thanks to Elizabeth Dyke for documenting the discussion.

We respectfully acknowledge that the land on which we developed this report is in traditional First Nation, Inuit, and Métis territory, and we acknowledge their diverse histories and cultures. We strive for respectful partnerships with Indigenous Peoples as we search for collective healing and true reconciliation. Specifically, this report was developed in Ottawa, on the traditional unceded territory of the Algonquin people.

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