



UNIVERSITY COLLEGE COVID-
PERSPECTIVES ON 19

INTRODUCTION

The declaration of COVID-19 as a pandemic on March 11, 2020, was an unprecedented event in the lifetimes of members of the University College community. However, it was not the first time we have faced adversity and responded by drawing on the strengths that define our College. While we have had to profoundly change the way we live and work to adapt to health guidelines, we have worked diligently to uphold UC's robust sense of community, tradition of service, and academic and research missions. This special publication encapsulates aspects of UC's response to the crisis thus far: from pivoting to online classes and programming for students and alumni; to asking questions informed by scholarship that help us understand how COVID-19 has changed the world; and by supporting our most vulnerable through service on the front lines, both on campus and in the community. I am grateful for how our students, alumni, faculty, and staff have come together to meet the myriad challenges the pandemic continues to thrust upon us, and look forward to our reunion at our beautiful home on campus, as soon as it is safe to congregate again.



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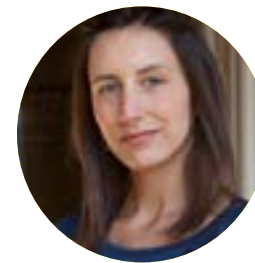
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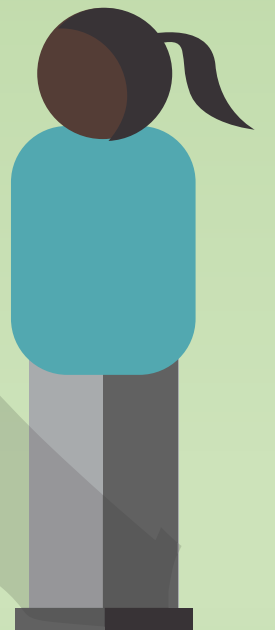
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AFTER THE VIRUS:

HOW SOCIAL SCIENCE RESEARCHERS WILL HELP WITH THE COVID-19 RECOVERY

Unprecedented and tragic. These are two of many words that have justifiably been used to describe the extraordinary situation the world finds itself in as it grapples with COVID-19. Globally, over 200,000 lives have been lost to this virus, with more than three million confirmed cases as of April 30, 2020. And for communities around the world, there is still great uncertainty around how many more will be infected, how much longer distancing measures will be in place, and when some semblance of normalcy will return.



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The immediate medical toll of COVID-19 has been felt by those who have fallen ill or lost loved ones. To help those who are ill, researchers at the University of Toronto, across Canada, and around the world have rightfully focused on quick testing, treatment protocols, and vaccine development. Thanks to their work, there is optimism that the virus will be essentially powerless in the not-so-distant future.

“ULTIMATELY, THE NEXT FEW YEARS WILL PRESENT A MOMENT WHERE THE LINKS BETWEEN PUBLIC HEALTH AND THE SOCIAL SCIENCES HAVE NEVER BEEN MORE RELEVANT. RESEARCHERS IN THIS SPACE WILL HAVE A GREAT DEAL TO CONTRIBUTE AS THE IMMEDIATE MEDICAL CRISIS SUBSIDES AND THE SOCIAL AND ECONOMIC REPERCUSSIONS OF THE PANDEMIC BECOME MORE APPARENT.”



However, for many of us, our health will not be directly harmed by the virus. This does not mean we are in the clear. COVID-19 has wreaked havoc on social and economic systems, and we are only beginning to see the repercussions of this disruption.

In order to fully appreciate the impact of the pandemic on our lives, in the coming months and years we need to proactively monitor changes to our social systems, with a particular focus on existing and emerging inequalities in health, economic, and social outcomes.

In the social sciences, researchers have long examined the links between health and social systems using their respective disciplinary methods, which are often complementary to the valuable work being done by colleagues in medicine and public health.

Many of these social science health (SSH) researchers focus on a concept known as the social determinants of health, which includes the different social, economic, and geographic factors that contribute to health outcomes and inequalities in populations. Social science health researchers will play an important role in understanding the near- and long-term impacts that COVID-19, and extended isolation measures will have on these social determinants, what the implications of these will be for our most vulnerable communities, and how we might be able to move toward a more robust and equitable society in the future.

In the near-term, SSH researchers will need to focus on the most pressing issues related to stemming the spread of COVID-19 and the impact physical distancing has had on physical and mental health, as well as financial stability. This will involve working closely with medical and public health professionals to identify whether certain populations are at increased risk of infection and what social mechanisms might be responsible for

these differences. Additionally, there is a great need to understand how physical distancing has affected social relationships. For example, there have been troubling increases in reports of domestic violence and abuse, and for some, the stress of remaining at home has negatively affected mental health. What resources and care systems can be mobilized in the current environment? Theories from psychology and sociology are well positioned to provide answers to this through identifying stressors and coping strategies, in addition to connecting people in need with mental health or domestic violence resources.

Social science health researchers must also engage in conversations about how to best address the rapid deceleration of the global economy. Many Canadians have been left without their expected wages, and subsequently, the ability to pay bills and buy groceries. Many others, who were already suffering from homelessness or food insecurity before the pandemic, are facing challenging situations at shelters and a surge in demand for food banks. How can economic assistance be quickly distributed to those with the most need, and where can additional shelters and food distribution points be set up for easy access? Here, theories from across the social sciences are able to guide government programs aimed at supporting household spending, and approaches developed in geography can help with locating shelters and mobile food banks where they are needed most.

In the longer term, after the virus has run its course, SSH researchers will be faced with more complex issues, especially if the anticipated global economic downturn materializes. Interdisciplinary teams must begin to rethink the structure of long-term care for our communities' older adults to ensure future outbreaks will not leave this population isolated and vulnerable. More generally, older adults have been hit particularly hard by COVID-19, and social scientists have the toolkit to both pinpoint which aspects of their lives were disrupted and identify social and health-care policy priorities that might shield this population from similar outcomes during future pandemics.

We have also seen the laudable efforts of essential workers at grocery stores and in delivery trucks. They perform their tasks for little pay while risking their own health and safety. What policies might improve their working conditions and ensure their health going forward, and what protections do we as a society owe to our neighbours in these roles? There are serious ethical questions we must grapple with, as so many of us rely on the essential work of those in what are commonly considered precarious jobs.

On the home front, many of us have also been made painfully aware of the limits of our own residences and the urban environments in which they are situated. Housing affordability is a major issue in Canada, and housing quality is linked to a range of health outcomes, from respiratory infections to mental health. After spending so much time indoors, will people begin to consider trading in their smaller urban homes for something more affordable and spacious in the suburbs in the name of maintaining health? And for those who live in community housing units, are public institutions investing enough in these homes to ensure that residents will not be subjected to further negative health impacts? Anthropologists, urban planners, and historians can help guide us through these questions by looking into our past, understanding our relationship to housing and shelter, and anticipating what might be needed going forward.

For those of us who have been able to leave our homes, have we been impacted by the lack of public space that would enable safe and physically distanced outdoor activities? Do we continue to build our cities in a way that emphasizes the automobile, or will this moment inspire people-oriented urban design? For many, months of being confined to relatively small geographies may have a profound impact on how we think about our physical, social, and urban environments. What are the mental health implications, and could this be an opportunity to engage in more equitable and healthier city building? Researchers in urban planning, geography, and political science should be front and

centre when discussions about urban infrastructure stimulus and future public space inevitably arise.

Finally, and perhaps most important, Social science health researchers must closely monitor the longer-term impact a post-COVID-19 financial downturn has on economic inequalities. Increases in negative health outcomes amongst those who are already in vulnerable financial situations are unacceptable. Social science health researchers across many disciplines are in an ideal position to collect data on health and economic inequalities, through techniques that range from interviews and walkalongs to GPS tracking and large-scale surveys in order to understand the struggles of our most at-risk communities and produce policy recommendations that address key economic and social drivers of these hardships.

Ultimately, the next few years will present a moment where the links between public health and the social sciences have never been more relevant. Researchers in this space will have a great deal to contribute as the immediate medical crisis subsides and the social and economic repercussions of the pandemic become more apparent. Beyond this, these researchers will be key in educating the next generation of social scientists, who will require broad training in many disciplines to tackle both the expected and unanticipated challenges that come after the pandemic. Units like University College's **Health Studies** program are ideally situated to provide this important training.

With a toolkit that engages directly with communities and policy makers, social science researchers have the theories and methods to ensure that the pandemic recovery happens quickly and equitably. And, perhaps, this moment will provide a once-in-a-generation opportunity for social scientists to work with community members, healthcare professionals, and politicians to reconsider how many components of our social systems work—making them fairer and more robust in the event of any future health and economic shocks.

EATING

IN THE AGE OF COVID-19: FOOD SECURITY IN CANADA DURING AND AFTER THE PANDEMIC



Food is on our minds and in the news these days. From grocery store shortages to meat plant shutdowns to YouTubers baking their own bread, COVID-19 is shifting our understanding of food access and food security in Canada.

As Canadian author Tara Henley suggests, “the coronavirus is putting into sharp focus the vulnerabilities in the way that modern society is organized.” Our food system—including the growing, harvesting, packing, processing, transforming, marketing, and consuming of food—is no exception. This novel coronavirus, SARS-CoV-2, is showing us the weaknesses in the interconnected web of activities that keep us fed, and the implications of those weaknesses on food security at both the household and community level.



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The 1996 World Food Summit defined food security as, “when all people, at all times, have physical and economic access to sufficient, safe, and nutritious food to meet their dietary needs and food preferences for an active and healthy life.” The elements of this definition are important because food security cannot exist if only one or two of the conditions are met. For example, if food is available, but those who need it cannot afford it, or if the food they can buy is unsafe, then food security is not achieved.

By now, many of us have been impacted, at least temporarily, by shortages of food. Our food security—in terms of being able to access our preferred foods when we want them—has been impacted. People are so unfamiliar with seeing empty grocery store shelves that this creates anxiety and leads to hoarding, exacerbating existing supply chain problems. People concerned about shopping in person are frustrated by the challenges of underdeveloped and overstretched shopping and delivery services, and reduce the availability of those services to the people with the most need for them, e.g., seniors and those in quarantine.

Supply chain experts suggest that there is plenty of food, and that shortages reflect distribution delays caused by having unanticipated demand. Very little food is stored in retail outlets, and deliveries are scheduled around historical demand. When demand changes abruptly, it takes time to respond, and suppliers are leery about ramping up production when the short-term surge in demand is likely temporary.

For most people, shortages have been temporary and related to specific products, e.g., “Why is there no tofu? And what happened to all the flour?” However, challenges have been significant for households that were already experiencing food insecurity and using food banks to try and fill gaps.

Food banks emerged in the 1980s in order to provide temporary, short-term relief to unemployed workers

during a recession. Forty years later, they have become important vehicles for distributing food to those without sufficient income to buy it, including those making minimum wage or on government assistance. For many of the individuals and families using food banks, these are not short-term, temporary solutions, but rather the only way to fill shortfall between income and expenses.

Food banks have been critiqued by many academics (including sociologist Janet Poppendieck, author of *Sweet Charity? Emergency Food and the End of Entitlement*) for offering relief to only a small portion of those who need it, using inefficient and highly labour-intensive “parallel” distribution networks, and stigmatizing users. Instead, they suggest that an adequate income to buy food (and other things) is the most effective and efficient way to ensure food security.

During the COVID-19 crisis, the demand for food banks has increased significantly, while their ability to meet demand has plummeted due to difficulties in sourcing and distributing food. The high levels of face-to-face volunteer labour required to pack food baskets and screen clients are untenable during social distancing. The federal government has promised \$100 million to support food banks during the pandemic, leading nutritionist and food insecurity researcher Valerie Tarasuk to remark, “Adding cash to a fragmented ... volunteer-run charity system that depends on face-to-face interactions and was only ever serving a small fraction of the people in need is completely misplaced. It isn’t about how much money the feds give to food banks. The problem is that they are trying to address serious problems of material deprivation through ad hoc community charities.”

While shortages on store shelves have thus far been temporary, there are increasing concerns about supply shortages this year and next year because of COVID-19. Many of the workers in agriculture in Canada are actually temporary foreign workers from other countries. The arrival of these workers has been delayed, and they

must go through a 14-day quarantine once they arrive. Many fruits and vegetables, however, have short windows for planting (and in the case of early spring vegetables like asparagus, harvesting), and, so, many producers are expecting their harvests to go down.

Other producers, especially in meat and dairy, are struggling to deal with fluctuating demand and processing bottlenecks that limit distribution. Demand for meat and dairy soared early in the pandemic as consumers stocked up, but now demand for their products has fallen because restaurants—important purchasers of meat, butter, cheese, and potatoes in particular—remain closed. In addition, processors, particularly meat processors, have found it challenging to prevent the spread of coronavirus in their enormous, crowded, and fast-paced “disassembly” lines. These giant facilities control huge proportions of the market: the two facilities in Alberta that experienced COVID-19 outbreaks process a whopping 70% of Canada’s beef.

While observers might see connecting farmers with food banks as a solution, this is not as simple as it seems. Emergency food providers have no capacity to treat raw milk or pack meat, and most are not capable of handling such perishable goods safely. Fruits and vegetables need to be harvested, cleaned, and prepared for distribution, and there is labour associated with those activities that make redistribution through the emergency food sector challenging.

Of course, these factors are not just challenges in Canada; countries around the world are facing similar challenges. It remains to be seen whether this will significantly affect



“WHILE WE ARE HOPEFULLY FLATTENING THE CORONAVIRUS CURVE, WE NEED TO BE BETTER PREPARED FOR FUTURE CHALLENGES, INCLUDING OUTBREAKS. OUR FOOD SYSTEM NEEDS TO BE RESILIENT—TO BE ABLE TO WITHSTAND OR RECOVER QUICKLY FROM DIFFICULT CONDITIONS—IN ORDER TO PROVIDE FOOD SECURITY NOW AND IN THE FUTURE.”

food supply globally, and if so, whether this will impact global trade, e.g., whether some jurisdictions will enact export taxes or bans to try and keep food available locally. Indeed, some countries in Africa and Asia are buying grain in bulk to hold in reserve, while Russia and Vietnam—major producers of wheat and rice, respectively—have imposed new restrictions on international sale. This is all contrary to dominant economic logic, which suggests that allowing the market to determine allocations is the most cost-effective solution.

It should be noted that none of these challenges is particularly new. Access to food in low-income households is an ongoing challenge in Canada, as the presence of food banks attests. Matching production with supply is a challenge that has dogged producers and governments for centuries; when supply is too little, prices rise for consumers, but a glut on the market can bankrupt a farm, leading to fewer producers in the future. Tactics such as supply management and farm income support are often effective but controversial.

Many observers have drawn attention to labour conditions in both farms and processing plants, noting that this physically challenging and sometimes dangerous work is done by structurally vulnerable workers, e.g., temporary workers who have limited rights in Canada and who often live communally in housing that can be crowded. Workers on farms and in slaughterhouses have few other employment options, are often from countries with different labour rules and may not communicate well in English. These factors increase their susceptibility to exploitation, because it is harder for them to object to unsafe working conditions. Relatedly, very large farms and processors are known to have ongoing challenges with outbreak control e.g., recent *E. coli* outbreaks that have been traced back to bagged spinach or prepared meat from a single processor.

The food system is routinely devastated by disease. However, this has mostly been diseases of animals and plants rather than humans. The global movement of humans and goods creates an environment ripe for the spread of pests and pathogens, a situation that is

exacerbated by climate change; this has had an enormous but underappreciated impact on food security. From early examples such as *Phytophthora infestans*, the oomycete that caused the great potato famine, and *Cryphonectria parasitica*, the blight responsible for the destruction of American chestnuts (formerly a key staple food of North America), food pathogens continue to be introduced from one area to another at an alarming rate.

The Canadian Food Inspection Agency is currently on the watch for about a dozen pathogens that can affect tomatoes, potatoes, soybeans, grapes, and stone fruit, among others, and fighting previously introduced pathogens has become part of the routine for many farmers. Animal diseases such as bovine spongiform encephalopathy (BSE) can also have devastating impacts, as Canadian ranchers know. This problem is, of course, not unique to Canada; many North American pests and diseases have wreaked havoc in Europe and Asia.

While we are hopefully flattening the coronavirus curve, we need to be better prepared for future challenges, including outbreaks. Our food system needs to be resilient—to be able to withstand or recover quickly from difficult conditions—in order to provide food security now and in the future.

We need to invest in local capacity to meet food needs. In the face of shortages and export restrictions, governments are currently scrambling to develop domestic producers of personal protective equipment to ensure these essential supplies are available when necessary. Food is even more essential to human life, and we are similarly seeing that the free market may not be able to consistently deliver food across international borders in a crisis. In this context, local farmers and processors should be given support, through both farm income support and supply management, to ensure staple foods

are there when we need them. Reducing the global trade in food and plant material would also reduce the transmission of plant and animal disease.

Attention also needs to be paid to the scale of operations. A larger number of smaller farms and processors creates resilience by reducing the bottlenecks that can come when, for example, a single large processor needs to be closed. Resources for the development of online infrastructure for food sales and delivery would help smaller producers to connect with consumers in a safer way.

Canada's reliance on temporary foreign workers also needs to be reduced. Ideally, skilled agricultural workers should be given a pathway to citizenship so they can remain in Canada. Pay for food work needs to be increased and labour conditions improved so that more domestic workers can be recruited. Similarly, the essential nature of food retail work needs to be recognized through better wages and more stable work.

It is important to note that increasing wages and keeping smaller food businesses afloat in tough times will not be free. Having smaller food processing facilities will reduce economies of scale. A resilient food system will require increased government investment on the one hand, and could result in increased food costs for consumers on the other.

Access to food for low-income households through an adequate and reliable financial mechanism is needed to reduce gaps and inefficiencies in the distribution of food to those who need it most. A guaranteed income would not only reduce inefficiencies, redundancies, and lags in government support, it would also provide adequate income to all Canadians to purchase food. Experts—including leading food bank operators—agree that this is a much more efficient, comprehensive, and resilient approach than trying to prop up the emergency food sector.

THE TRUE COST OF EFFICIENCY IN THE LONG-TERM CARE SYSTEM



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As of May 11, 2020, there have been more than 68,000 confirmed cases of the SARS-CoV-2 (COVID-19) virus, resulting in more than 4,900 deaths within Canada. Tragically, 82% of all the recorded deaths in Canada due to COVID-19 have occurred in long-term care facilities (LTCFs). Evidently, this pandemic has disproportionately affected LTCFs, where the virus encountered fertile conditions for propagation, leading to an unrelenting increase in mortality. Proximal risks include close living conditions of the residents in LTCFs, many of whom have co-morbidities and compromised immune function. It is clear, however, that the structural aspects of LTCFs themselves, including conditions of employment and the lack of resiliency within institutional operating models, combined with the failure to anticipate such a pandemic, have given rise to these grim outcomes. Herein, we discuss limitations of LTC (long-term care) residences for the elderly within the current Canadian health-care system that have been revealed and exacerbated by the deadly progress of this pandemic.

Long-term care facilities are residential institutions wherein individuals who have lost some capacity for self-care receive ongoing assistance with a range of physical and/or cognitive impairments. Terminology surrounding LTCFs is ambiguous and varies by country, province, and level of assistance. In existing literature, LTCFs may be referred to as nursing homes, homes for the aged, or residential care, among others. Furthermore, while the universal health care model in Canada would presume that LTC is included within government-funded care to meet elderly individuals' physical, psychological, and social needs, this is not the case. Long-term care and LTCFs are considered extended health services under the Canada Health Act. Thus, it is at the discretion of the provinces and territories to determine whether individuals in need of care receive some level of publicly funded support.

FROM THE POORHOUSE TO LONG-TERM CARE FACILITIES

The origin of LTCFs and their evolution from poorhouses highlight the marginalization of the elderly within Canada, which arguably persists to date. In the mid-19th century, widespread structural poverty that accompanied the emergence of capitalist social reforms led to the creation of poorhouses. Poorhouses lodged the elderly, disabled, and sick, and worked to segregate the poor from the rest of society. Many elderly individuals who were too frail, sick, or senile to work for wages or unable take

care of themselves were left with little choice but to enter poorhouses due to the paucity of public support.

The expansion of medical knowledge in the late 19th century gave rise to the transfer of frail and sick elderly individuals from poorhouses to hospitals. However, as hospitals accumulated patients needing continuous care who had little hope of leaving in the short term, hospitals became overburdened. This, combined with indifference to the medical and social needs of geriatric populations and an emphasis on the treatment of acute conditions, led many provinces to create separate custodial units for patients who needed extended recovery periods (e.g., British Columbia's Hospital Clearance Program). Following World War II, improvements in public health led to a higher proportion of the population living to old age, and, subsequently, a considerable expansion of these custodial units ensued. These institutions are what we understand to be the modern-day LTCF.

The development of LTCFs illustrates how these institutions were not principally developed to promote better lives for the elderly, but rather to remove the chronically ill from hospital settings. Indeed, Katz notes that LTCFs "paid the price for their origin as poorhouses," as they never lost the stigma attached to welfare. The evolution of LTCFs further illustrates how a specific population, in this case the elderly, emerged as passive receivers of care, as opposed to policy being created at the

direction of this population. Thus, LTCFs originated in a system of marginalization. Despite significant progress in many LTCFs, systemic deficiencies still exist in some LTCFs, which continue to marginalize and medicalize the elderly population.

CURRENT LIMITATIONS IN LONG-TERM CARE

A 2019 report by the Ontario Health Coalition identified key systemic issues within LTCFs, including concerns with safety, funding, and access to care. Overall, access to care has decreased across Canada. Ontario in particular ranks second-last in the number of LTC beds per capita. This deficiency has led to extensive waitlists, ranging from 18,000 to 33,000 since the 1990s. For individuals in racialized and marginalized groups that seek ethno-culturally specific care, the waitlist is six months longer than the average wait time, due to barriers in accessing culturally appropriate, safe, and responsive services.

Rather than meeting the increasing needs of the Canadian elderly population through public LTCFs, rationed care levels and limited access have given rise to the proliferation of privatized, for-profit LTCFs. This arrangement leaves seniors to finance their care in for-profit facilities that aim to maximize the return on investment for their funders. For the elderly, who typically have fixed incomes, the drive for increased profits can mean increased and unaffordable prices for accommodations. Further barriers to access exist through means-testing, wherein individuals may receive government subsidies only if deemed eligible through LTC home rate-reduction programs.

Moreover, health-care staffing within LTCFs has decreased. Current levels of regulated staffing have dropped from a recommended four hours per day per resident, according to the 2008 Sharkey Report, to a mere 2.71 hours. The 2015 Report of the Ontario Auditor General noted that inadequate staffing was the primary reason that LTCF administrators

reported inability to achieve compliance with government requirements in inspections.

HEALTH OUTCOMES IN FOR-PROFIT LONG-TERM CARE FACILITIES

These foregoing issues are further exacerbated by the increase in for-profit corporations among the institutions that provide LTC. While small, locally-owned LTC homes have always existed within Canada, large, franchised corporations now dominate ownership of LTC markets. Private, for-profit LTCFs employ market-oriented approaches to maximize profit margins while trying to deliver some level of care and security for the elderly and entrench these practices in the system of LTC delivery. In recent years, the proportion of LTCFs owned by for-profit institutions has grown. Prior to premier Mike Harris' Progressive Conservative Ontario government in the late 1990s, there were relatively few for-profit LTCFs. By 2019, for-profit corporations owned the majority of LTCFs in Ontario. More than 59% of Ontario's LTC homes are currently owned and operated by the private sector; the largest five LTCF companies control 23.8% of beds within the province.

Organizational structure has implications for how resources are distributed in LTCFs. That is, while both for-profit and not-for-profit LTCFs are required to deliver the same minimum level of LTC, for-profit organizations must provide these services while also simultaneously generating some level of profit for their owners or investors. Apart from the funds that they receive, these profits can be increased by introducing "efficiencies" that generally reduce operating costs. In the case of LTCFs, the largest expense is the labour cost for nurses, personal support workers, cooks, caretakers, administrators, and other workers. Consistent with the current economic fashion, the costs of labour can be reduced by hiring more part-time and casual staff

and by utilizing volunteers. These downward pressures have the effect of reducing salaries and contributions to employee benefits, including health insurance, pension contributions, holidays, and sick leave.

Two important consequences of the implementation of these "efficiencies" are: i) many workers are forced to take employment at multiple LTCFs in order to meet their financial needs; and ii) LTCF residents receive inadequate attention as a result of staff turnover and inconsistency in care. It is well documented that with inconsistent care, residents receive less direct care and fewer social interactions. Inadequate care is further exacerbated by incomplete reports on the ongoing health and wellbeing of residents, which is often a result of the relatively short shifts for which healthcare workers are employed.

Health-care staffing is a proxy for the quality of care in LTCFs. Staffing has a profound role in protecting residents from infections, including the seasonal flu and, particularly relevant this year, the COVID-19 pandemic. A 2015 study found that three months after admission, residents in for-profit LTCFs had a 20% higher risk of mortality and 36% higher risk of hospitalization than those in not-for-profit facilities. After a one-year follow up post-admission, the mortality and hospitalization rates were 10% and 25%, respectively. For-profit facilities also receive a higher number of resident complaints. These data illustrate the profound limitations of the for-profit model for LTC.



“RATHER THAN MEETING THE INCREASING NEEDS OF THE CANADIAN ELDERLY POPULATION THROUGH PUBLIC LTCFS, RATIONED CARE LEVELS AND LIMITED ACCESS HAVE GIVEN RISE TO THE PROLIFERATION OF PRIVATIZED, FOR-PROFIT LTCFS.”

LONG-TERM CARE CONDITIONS ARE EXACERBATED BY COVID-19

COVID-19 highlights the deleterious impacts of the current system. In Ontario, more than one-third of the province's LTCFs are dealing with outbreaks. In Pickering, the 233-bed Orchard Villa, a privately run, for-profit institution, has one of the highest rates of infection in Ontario. At time of writing, 190 residents have been infected and 66 residents have died due to COVID-19. On April 28, 2020, *the Globe and Mail* reported that LTCFs have been connected to 79% of the COVID-19 deaths in Canada, according to statistics released by Canada's Chief Public Health Officer, Dr. Theresa Tam. *The Toronto Star* reported further that, as of May 7, 2020, 82% of all COVID-19 deaths in Canada had occurred in LTCFs.

Recently, the Ontario Health Coalition reported that for-profit LTCFs exhibit higher rates of death than not-for-profits and municipal homes (9% vs. 5.25% vs. 3.62%, respectively). *The Toronto Star* reported that while all LTCFs are experiencing similar levels of outbreaks, for-profit homes have four times as many COVID-19 deaths as municipal homes and twice that of not-for-profit LTCFs. Moreover, the death rate in for-profit facilities continues to increase at a faster rate than in non-profit and municipal homes.

DEADLY "EFFICIENCY" IN LONG-TERM CARE

Efficiency refers to a spectrum of market-based processes used to organize institutions to maximize profits. These processes may include reducing waste and increasing labour productivity, among other measures. For LTCFs, efficiency has been achieved through minimizing labour costs, excess inventory, and empty beds. As previously discussed, efficiency often results in part-time labour to reduce salaries and employee benefit payouts. Efficiency in LTCFs also recognizes that minimizing unused space in facilities maximizes profits. For this reason, many LTCFs have residents living in close quarters.

A less obvious efficiency employed by LTCFs comes from the idea of avoiding waste or excess. Long-term care facilities achieve minimal waste through an economic model termed the "Just-in-Time" (JIT) system. The JIT system is a means of producing and supplying inventory as it is needed. It seeks to increase efficiency by allowing for more precise determination of the needed supplies, minimizing excess costs and inventory, and not spending capital until absolutely needed. The JIT system is used by large retail corporations such as Amazon and Wal-Mart. Now applied to LTCFs, the JIT system has significant consequences for inventory, including essential goods such as personal protective equipment, food, and diapers. This approach means that many LTCFs keep little inventory beyond what is needed for a short period.

While this model may be successful in maximizing profits, employing an efficiency ideal in healthcare institutions leaves them vulnerable to challenges. This model of efficiency is not conducive to contingency planning, as it does not consider possible future challenges of the sort we are now experiencing. Indeed, amidst a global pandemic, the deadly limitations of efficiency have been revealed, and the safety and quality of care of the elderly population within LTCFs have been severely jeopardized.

The ongoing marginalization and subsequent medicalization of care for the elderly is contrary to the notion that LTC and home care need to be expanded, given that a quarter of Canadians will be age 65 or older by 2035. In 2002, the Romanow report on [the future of health care in Canada](#) stated, "... there is growing evidence that investing in LTC can save money while improving care and the quality of life for people who would otherwise be hospitalized or institutionalized in long-term care facilities." Due to pro-privatization and market forces, however, LTCFs have been pushed out of consideration for inclusion as essential health-care services. This currently held ideological position that greater efficiencies can accrue through private, for-profit institutions is revealed to run counter to the needs of society and marginalized elderly people, specifically amidst the current pandemic.



RACISM:

THE OTHER PANDEMIC

I feel bruised. My body, my brain,
my heart. All of me is bruised.



Carrienne Leung
Barker Fairley Distinguished Visitor in Canadian Culture 2020-21

“I STARTED TO SEE THE SIGNS, ‘WE’RE IN IT TOGETHER,’ AND THEY MADE ME WANT TO SCREAM. IT FELT LIKE ONE BIG GASLIGHT, AS THE INEQUITIES BECAME CLEAR. WE ARE NOT IN IT TOGETHER. WE ARE NOT ALL EXPERIENCING THE SAME THINGS. NOT EVEN CLOSE.”

In January, I felt it beginning. COVID-19 was at its peak in Wuhan, and the fears that the virus would jump across borders and bodies of water to become a global pandemic was just on the horizon. I started bracing for it then. In 2004, I was the lead researcher on **a community project about the social impacts of the SARS outbreak on Chinese, East Asian, and Southeast Asian communities in Toronto**. I posted the report across my social media accounts as warning and preparation for what was to come. It was immediately shared thousands of times on Twitter.

The backlash came swiftly, too. A picture of an East or Southeast Asian woman eating “bat soup” went viral. There was no context given for the photo and soon, it was revealed that the photo wasn’t even taken in China. It didn’t matter, and I won’t get into the issue of xenophobia and food here. The image had already done its work and carried with it a trail of scapegoating the Chinese as responsible for the infection. Others telling me to “go back to where you come from.” Like I said, I was braced for it because I’ve lived long enough to remember what this kind of racism feels like viscerally. As the weeks went on, and the virus spread to Europe and the Americas, anti-Asian incidents started to enter my feeds. On the TTC, I found myself seated alone in the crowded streetcar. Once, going to the grocery store, I encountered two people who literally stopped when they saw me approaching on the sidewalk and turned their backs to me. On Dufferin Street, while walking with my child, we saw a car pass by a masked East Asian man, and the passenger screamed, “Corona Chink,” out the window at him.

Even though I was braced, even though I have studied and researched exactly how this happens, fear still entered me. When I was doing a PhD at the Ontario

Institute for Studies in Education, U of T, my research was focused on race and nation. Somehow, I thought that if I could intellectually understand, I would be immune to the pain. Not true. I am not immune.

When restrictions were put in place with school, work, and retail closures, I was grateful to be locked at home. While others became scared about getting infected, I felt the added layer of fear about getting assaulted or harassed or shunned. I had grown too anxious to be in public spaces, including my own neighbourhood. The fear felt so familiar, reminding me of being a child immigrant in the 70s and 80s when this was common: When overt acts of racism were common, and I had to witness the countless times when people were openly disparaging of me and my family, and I would start to feel my body shut down, lose sensation, feel cold and be on the constant verge of vomiting. That’s what racial fear feels like for me, and my body always remembers it.

I started to see the signs, “We’re in it together,” and they made me want to scream. It felt like one big gaslight, as the inequities became clear. We are not in it together. We are not all experiencing the same things. Not even close. As I see people share images of the feral life reclaiming spaces all over the world, I think of the humans whose spaces are shrinking.

My post about what we learned from SARS continued to gain traction, and the backlash continued to come. Some were very plain in wanting me to just die. White friends privately messaged me that they were “shocked,” and this only added to the pain. Why shocked? That they were surprised only emphasized the structural difference between their embodied reality and mine. Friends who like many of my funny posts are silent on the ones when I am showing my wounds publicly. The silence feels like conspiracy, feels like the growing terror in my body.

The silence is cutting. It has mostly been other racialized friends who have reached out to me, and those messages have given me relief that others are seeing this terror.

Someone asked me if I was more afraid of becoming infected with COVID-19 or being targeted for racist backlash when I have to go for groceries. I have no idea. I can’t tell. It is a giant lump that resides in my body, and I feel vulnerable in every way. My child, who is mixed race, volunteered to go shopping for us because he said maybe he could “pass.” I cried in front of him, and he was concerned he was adding to my pain. Out of everything in these last few weeks, this moment devastated me the most.

This loss of mobility and space angers and saddens me. As someone who is very self-sufficient, it is excruciating for me to rely on others. A neighbour was kind enough to think of me and ask if she could pick up anything for me on her grocery run, and I was so moved that she was thoughtful enough of these contexts to think of me. Otherwise, I have not been able to ask for help. Even though I know there are friends who care about me, it feels like added humiliation and loss of autonomy.

I think of the everyday lives of Black, Brown, and Indigenous folks, trans folks, queer folks. I think of how our bodies cycle through these moments of crisis as the enemy. I think Donald Trump called COVID-19 the “invisible enemy,” but its subtext is clear. There are many of us with the tag “invisible enemy” on our backs, and we are in plain view.

Derek Sloan, federal conservative leadership candidate, questions if Dr. Teresa Tam is working for China or Canada. Ezra Levant circulates a petition to fire her. Two nurses, assumed to be Chinese by the perpetrators, are harassed in Toronto while trying to go to work. In Vancouver, a 92-year-old Chinese man with dementia is called a racist slur, pushed out of a store and onto the ground. Bryan Adams tweets spectacularly about having to cancel concert dates and activates the bat trope, laying blame on wet markets. Still, the overwhelming conversation I see on social media is a debate whether or not it was racist. I can go on,

but I am tired of trying to make a point by throwing exhibits A, B, C, etc., onto the table. This is the problem and frustration that racialized people have—we have the findings, the reports, the analyses, the rigour of excellent scholarship—but what changes? What changes when the public discourse is still about whether something is or is not harm and the people who are/were harmed and put at risk fade into the background?

Other things are going on. There are reports of anti-Black racism in Southern China. Black people are facing harassment, evictions, barred from restaurants and public spaces. I despair at this show of hate. I search for solidarity, alliance, coalition. I rail against the anti-Blackness and state-sanctioned racism in China that has also put Muslim Uighurs in internment, that still occupies Tibet. And yet, the conflation of the Chinese state with Chinese bodies in the diaspora only adds fuel to the backlash. We are not only read as people who would “eat anything” and cause viruses but, also, we practice anti-Blackness. Let me be clear. None of the harm and injustice is okay.

Racism is a form of terrorism. This kind of stress on our minds, bodies, and spirits can't be diminished. Racist speech and acts are meant to send the message that you do not belong, that you don't have the right to space. Once enacted, it fills the air and all the spaces unless there is a swift intervention on an individual scale and an analysis that identifies and speaks back on a global scale. Otherwise, the toll is extraordinary, so I am very concerned about the mental health of racialized people.

A former student asked me in an interview if I had anything that I would like to say to racialized people who are scared, angry, targeted, and harmed by what is happening at the moment. I had to reflect on that.

The trauma that is inflicted at this time does not begin or end with being the recipient of hate. And also, where can we trace its beginning and end when historically, structurally, anti-Asian racism has always been there?

Perhaps it has been below the surface at different moments, but it has always been there, ready to take a step back into the light with a boldness and vigour that does harm. If you are feeling vulnerable, reach out. Connect with other racialized people who understand. The **Chinese Canadian National Council** has a place for you to document anything you have experienced or witnessed.

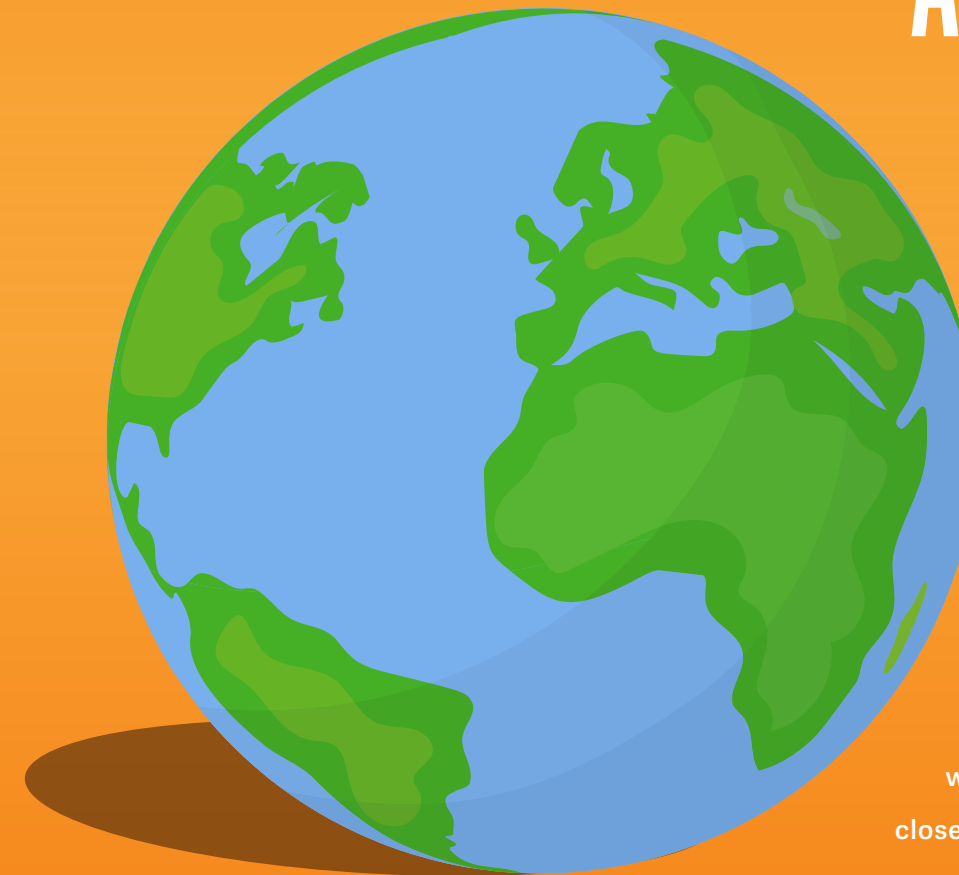
If you need to talk to someone, **a collaborative project between organizations and health professionals has developed a new resource to support you.**

There have been articles and blogs being passed around about what to do in case you are a witness to racial incidents but not what to do if you are the one who is the target. I am not satisfied with this. I understand the politics of not putting the onus on the victim to do anything at all because, of course, they are the one receiving harm. But I also need to reach for agency here. Those folks who have been targeted don't appear to be strong enough to defend themselves. They are often alone, are elderly, are women. There has also been evidence from some of the attacks of added vulnerabilities—international students, the homeless, the poor, the disabled. If you feel able, defend yourself. Use your voice and scream, holler. Make a scene. If you are being physically assaulted, and you feel you can, punch, kick, bite, spit. I am not saying you should. You don't have to do anything and especially something that would put you in more danger. But I also want you to know that you are allowed to make yourself as large as you can. You deserve the space too.

Finally, the whole time I was writing this, I worried you would read this as a passive spectator to my pain. I'll be very honest with what I want from your reading: I want you bruised, too. I don't want empty comfort. I don't want shock emojis. I can't bear silence. I want to know that you are bruised because you are human, too. That you recognize that we share this space, and some of us are in pain.

What are we going to do? What attention will you pay?

CANADA'S BORDERS AND COVID-19



On March 16, 2020, Canada announced that it was closing its borders to all foreigners, except Americans. On March 21, 2020, however, Canada and the United States made the unprecedented announcement that their shared border would be closed, except to essential travel. An Angus Reid poll has suggested that many Canadians would like to see the border remain closed into the fall and even into 2021.

 **Emily Gilbert**
Professor, Department of Geography & Planning
Vice-Principal, University College

The unprecedented closing of Canada's borders—to the US and to much of the world—might seem to be a no-brainer. Yet in my writing and teaching on borders, I always push for critically examining the ways that borders are mobilized, particularly given that they are used to monitor, police, and exclude.

National borders and immigration policies have always been wielded to manage health and disease. Canada's first Immigration Act of 1869 was mostly about ensuring the health of passengers, rather than explicitly restricting mobility. Quarantine officers were directed to board any arriving ship to determine if there were any passengers who were "Lunatic, Idiotic, Deaf and Dumb, Blind or Infirm," and, if so, to ensure that they had financial means for their own support. Into the early 20th century, new immigration acts were more restrictive and disease was one category of inadmissibility.

With the first Immigration Act, the federal government also assumed responsibility for two existing quarantine stations. The first of these was on Melville Island, really a peninsula in the Halifax municipality. The island had been used to detain American prisoners of war in the War of 1812. After the war, former Black slaves from the US—the so-called Chesapeake Blacks—were quarantined at the prison hospital for smallpox and typhus as they arrived in Canada. The site was then regularly used for quarantine. When more than 1,200 Irish immigrants arrived in Halifax in 1847, fleeing the potato famine, they were isolated on Melville Island en masse.

Grosse Île, in the St Lawrence estuary, began as a quarantine station in 1832, when fears of cholera were rife. The island is located about 50 kilometres downstream of Quebec City, which was then the main port of entry to Canada. At mid-century, Irish immigrants also passed through: in one year (1847) more than 90,000 Irish arrived there at the height of

a typhus epidemic. Nearly 5,500 people were buried on the island that year. Quarantine facilities were significantly expanded in the 1880s, applying new medical knowledge about the spread of disease, and better separating the sick from the healthy. Boats, people, and their belongings were all disinfected. One building was installed with 44 shower units that sprayed hot water and mercury bichloride (now known to be very toxic to humans). Hotels followed in the early 20th century, with separate facilities for first-, second- and third-class passengers, as wealth was determined to be an indicator of risk. By the time the quarantine facilities closed in 1937, over four million immigrants had passed through Grosse Île. An Irish Memorial was erected in 1997, which bears the names of over 8,000 people of various nationalities who were buried on the island between 1832 and 1937.

Just after British Columbia joined Confederation, William Head Quarantine Station was opened on Vancouver Island. Migration was increasing to the region, prompted by the gold rush, but also due to Chinese labourers brought in to build the railroad. During World War I, over 80,000 labourers from China who were recruited to do the war's grunt work were held in quarantine for 14 days at William Head, before embarking by train across Canada on their way to Europe. A "Coolie Camp" was erected, guarded by the garrison artillery. After the war, on their way back to China, they again passed through William Head, which was now heavily fortified with barbed wire and armed guards and a marine gunship patrol, all in an attempt to dissuade any Chinese from settling in Canada. In 1958, the quarantine facilities were closed, and the 42 buildings were turned into a minimum security federal penitentiary.

This history shows how foreign bodies, invariably racialized, have been characterized as diseased, which is then used to rationalize their exclusion. The quarantine sites described above used to be

common around the world, but are no longer. Today, in response to COVID-19, the global response has been to shut down borders altogether. Currently, about 90% of the world's population lives in countries where there is full or partial border closure to non-citizens and non-residents, and sometimes to them, too.

Closing Canada's border to the US has been rationalized in terms of the much larger number of COVID-19 cases and deaths there. As I write, the US has the largest number of confirmed cases of COVID-19 in the world, and the largest number of confirmed deaths, just over 100,000. In Canada, by contrast, the number of confirmed deaths has just passed 6,500.

This is not to suggest that Canada should be either self-congratulatory or complacent, especially as new cases are on the rise in both Quebec and Ontario, and both provinces have fallen short in their testing programs. Yet, the numbers also speak to how jurisdiction can and does make a difference with respect to government policies and leadership, how governments work together (or not) across multiple scales of jurisdiction, the coordination and collaboration with public health officials, and public behaviour.

Indeed, these kinds of differences exist not only at the national scale, but have also prompted internal borders to be erected within Canada by some provinces and territories. Newfoundland has even passed legislation (Bill 38) that gives its police the power to detain and remove those in contravention of its public safety measures. Some Indigenous communities—already beset by under-resourced health care, lack of access to clean drinking water, and sub-standard housing—have also restricted access to their territories because they are at greater risk, while having fewer protections.

Given that jurisdictional differences clearly matter, why not close Canada's national borders

as tightly as possible as long as the pandemic still rages? What is the problem? I want to suggest three issues that warrant our close attention.

First, border closings are generally not considered to be effective ways to prevent the spread of viruses. In principle, the World Health Organization (WHO) does not advocate border closure as a health strategy. Their International Health Regulations, to which 196 countries are signatory, prohibit restrictions on trade or travel, unless based on scientific principles, risk to human health, or a WHO directive. Border closings can be dangerous as people will try and circumvent the rules regardless, and clandestine crossings make tracking the virus—which is one of the most effective forms of management—much more difficult, especially if access to health care is impeded. The WHO also cautions that border closures might direct resources away from other, more effective measures. All of these fears were realized around the Ebola outbreak in Western Africa.

Moreover, border closings can be driven by politics and not health priorities. Canada and the US both imposed restrictions on China fairly quickly, but not on other countries that are traditionally considered allies. In the US, new epidemiological testing indicates that the sweep of COVID-19 cases in the US are actually strains from Europe—travellers there went untested, even when the outbreak was already unfolding. In Canada's provinces that have been hardest hit by COVID-19, more cases can be traced to the US than to travellers from other countries. If national borders are to be used to manage the coronavirus, this should be based on health data, not on geopolitical interests.

Second, closing the border can fuel anti-immigration and xenophobia. [As University College's incoming Barker Fairley Distinguished Visitor, Carriane Leung, has detailed, anti-Asian racism is rife during the COVID-19 pandemic.](#) There is nothing new



“THE PROMISE OF IMMUNITY PASSPORTS, WHICH WOULD FACILITATE TRAVEL FOR THOSE WHO ARE VIRUS-FREE, IS ONE EXAMPLE OF HOW BORDERING PRACTICES COULD BE ROLLED OUT IN A MORE WIDESPREAD WAY, BUT COULD ALSO BE USED IN DISCRIMINATORY WAYS.

here, as the history of border quarantine outlined above shows how foreign bodies are targeted as disease carriers. At the turn of the 19th century, when anti-Asian sentiments were also heightened, fears of disease were used to argue against immigration. In 1906, for example, the Trades and Labour Congress of Victoria warned against Indian migrants, arguing they carried diseases such as bubonic plague, smallpox, cholera, and hookworm. When the *Komagatu Maru* arrived off the shores of Canada in 1914, the fear of disease was one reason used to deny landing to the South Asian passengers. Similarly, when boats of asylum seekers from Fujian province arrived off the shores of Vancouver in 1999, and then again when ships of Sri Lankan asylum seekers arrived in 2010 and 2011, disease was again invoked to try to prohibit their landing.

Moreover, in the current pandemic, Canada is abrogating its commitment to asylum seekers. In cooperation with the US, Canada has agreed to turn back all undocumented arrivals at the land border. Effectively, these asylum seekers are placed into the hands of US Immigration and Customs Enforcement, who will most likely detain and/or deport them, as the Trump administration is using the pandemic to expedite its anti-immigration policies, including building its wall with Mexico and sending more military to its borders. This not only diverts resources, but also increases human vulnerability. Since the election of President Trump, tens of thousands of asylum seekers have been crossing into Canada annually, seeking a safe haven. Now, that is no longer possible. Where have all these vulnerable people gone? And are they safe?

Third, closing national borders promotes nationalist responses to our global problem, rather than treating coronavirus as a collective problem to solve. The warmongering rhetoric of COVID-19 as an enemy to fight, or a battle to be won reinforces this. It encourages attacks on international organizations such as the WHO—for example, those made by Trump—that undermine longstanding international cooperation. Between 1851 and 1951, a series of International Sanitary Conferences were held to address infectious diseases such as cholera, plague, and yellow fever. These conferences were precursors to the WHO and international health governance. There is no need to romanticize these efforts, which were limited in scope and inclusion and prioritized trade and national interests. But they did create opportunities for sharing science and prophylactic approaches and promoted support for more robust forms of public health, all of which should receive continued support today.

Border closings may also exacerbate rising economic nationalism. While the COVID-19 crisis has exposed many of the problems of global capitalism, the solution is not necessarily to re-centre the nation, e.g., with Buy American or Buy Canadian programs. President Trump’s attempt to prevent 3M medical face masks (N95s) from being shipped to Canada is yet another example of how economic nationalism could have negative health effects. Prioritizing health and welfare, as well as workers rights and incomes, over corporate profit is our challenge, which does not require economic nationalism, but can be addressed at multiple scales: local, national, and global.

Clearly, the political and social ramifications of border closures need to be considered alongside health concerns. This is not to suggest that temporary border closures are not warranted right now, only that we shouldn’t do so uncritically. This is especially the case because the unprecedented can quickly become the

new normal. Crisis measures—like increased security and surveillance—are nearly impossible to strip back.

The promise of immunity passports, which would facilitate travel for those who are virus-free, is one example of how bordering practices could be rolled out in a more widespread way, but could also be used in discriminatory ways. Already, identity cards have been issued to seasonal migrant workers by the health unit of Haldimand and Norfolk region in Ontario. The cards confirm that their holders have completed the two-week isolation that is required of all travellers from outside the country. But why are these workers expected to carry special cards? Who would ask to see the card? For what purposes? There are concerns that the racialized bodies of these workers, who are predominantly from Mexico and the Caribbean, are being singled out, just as police carding disproportionately targets Black, Brown, and Indigenous people.

While the pandemic still rages, keeping Canada’s borders closed can be an effective tool of disease management alongside other isolation and physical distancing measures. We must be careful, however, to examine who these measures impact and how, and to be vigilant against the new forms of policing and surveillance that are being introduced.

DIARY OF A COVID CLEANER

UC ALUMNUS SHEDS LIGHT ON LIFE IN A LONG-TERM CARE HOME



Yvonne Palkowski (BA 2004 UC)
Communications Officer, University College

As a veteran IT project manager with the City of Toronto, **Stephen Lew (BSc 1992 UC)** typically works at a computer. But when the COVID-19 pandemic hit and his role was deemed non-essential, he was redeployed as a cleaner at Castleview Wychwood Towers, a City-run long-term care facility. Despite the risks, the 51-year-old Lew, who has asthma and high blood pressure, has enthusiastically embraced his new role. He documents his experiences interacting with residents and disinfecting surfaces to protect them in [Diary of a COVID Cleaner](#), a series of Facebook posts that have captured international attention for providing a humble, candid, and cautiously optimistic take on life in a long-term care home during the pandemic. We sat down with Stephen to find out more about what motivates him and what it's like on the front lines.



Photograph courtesy of Stephen Lew



Thanks for speaking with us! Can you please tell us a bit about your time as a student at University College?

I was a bachelor of science student at UC from 1987 to 1992, staying my first two years in residence at Whitney Hall. I was supposed to graduate in 1991, but I ended up starting a bachelor of social work degree at Ryerson University in my final year, so didn't finish until 1992.

My arrival at UC started off a little shaky when I was picked up from the airport at the beginning of frosh week in 1987 by an uncle I had never met.

He took me to his house, with the expectation that he was to house and feed me for the next four years, only to realize that all that was required was to drive me down to Whitney Hall for move-in day and the start of orientation.

I was assigned to what was supposed to be a double room, only to find when I opened my dormitory room that two of the three beds were taken, and that I was to live in a triple with people I had never met. We ended up becoming great friends that I still keep in touch with, and we kept our triple arrangement, even after single rooms were offered ... Until one of my roommates got a girlfriend, and then he wanted out ... fast.

Having never lived on my own before, my UC days were quite formative and taught me how to learn, how to meet people out of my comfort zone, and how to live independently of parental help (outside of the much-appreciated financial support).

These days, you're an IT project manager for the City of Toronto. What was your reaction when you learned that you were being redeployed to a long-term care home as a cleaner?

I wasn't surprised. Immediately prior to the start of COVID-19 redeployment of management staff, the City was in preparations for continuance of City services

with a possible labour disruption due to the ongoing negotiations of labour agreements between the inside and outside workers' unions. I had been redeployed three times in the past—first typing manual, paper welfare cheques for social services in the mid-1990s, once as a cleaner at the Seaton House homeless men's shelter, and once as a cleaner for the special police units, including the hold-up squad, undercover, electronic crimes, and surveillance units. As management staff, we are used to performing "other duties as required," and, in fact, this is often written into our job descriptions.

When I was told of a request for staff identified as non-essential to indicate if they would be willing to be redeployed to help support the City's pandemic response, I felt the need was there, and sent in the notification of my availability.

Both my family and I had concerns, as the highly infectious nature of COVID-19 was only just starting to be known. I have high blood pressure and asthma, both conditions that put me at a higher level of risk for complications if I happen to get infected. Some of the horror stories we are all too familiar with about COVID-19-related tragedies that have occurred in some long-term care homes (not City-run homes, mind you) had not yet surfaced.

Perhaps ignorance was bliss ... But I felt strong and capable, and figured I had the skills, oddly enough as both a cleaner from prior redeployments and as a social worker, and energy to help, and I wanted to do so.

You record your experiences in a series of public entries on your Facebook page, entitled *Diary of a COVID Cleaner*. Why did you start the diary, and what has been the response?

Although I had some script writing and theatre experience back in high school with Alberta Theatre Proj-

ects and the Loose Moose Theatre Company, I actually consider myself more of a photographer than a writer.

I have a really bad memory. Combined with being given the opportunity to have been exposed to some extraordinary experiences during past travel, sporting, and cultural adventures, as well as raising a couple of very active kids, I have always found the need to ensure I don't forget about some of the adventures I have been fortunate enough to have been be a part of.

Thankfully, a number of major adventure magazines (including most of the rock climbing and paddling magazines, as well as major corporate clients like sporting goods companies and airlines like American Airlines) have been interested in some of the photographs and travelogues I have created, so I have benefited greatly from the support and guidance of some good photo and content editors.

I have always found that taking pictures helps trigger so many memories and details from events every time I review my slides, photobooks, or images on my computer, that I am motivated to ensure I have some form of decent camera with me at almost all times so I can capture slices of the amazing moments that seem to have a tendency to happen a lot around me.

With my time in redeployment at the Castlview Wychwood Towers Long-Term Care Facility, I found that although I have been able to capture some phenomenal photographic images and moments from everyday life in the midst of a viral pandemic lockdown, there were so many stories behind the images that I felt I needed to remember, that writing the details down was the only way to ensure some of these memories would not get lost.

Traditionally, my Facebook feed has been predominantly a format for me to post sarcastic comments, cheesy memes, or photos from my various outings

"IT EVENTUALLY BECAME SOMEWHAT OF A PERSONAL MISSION TO ENSURE THAT I TOOK THIS OPPORTUNITY TO PRESENT A DIFFERENT SIDE OF THE COVID-19 EXPERIENCE THAN THE ONE I WAS BEING BOMBARDED WITH IN THE NEWS."

with a focus and intended audience of a only few family members and a handful of close friends.

As a reflection of this narrow focus, the first entry of my *Diary of a COVID Cleaner* was, in fact, merely a photo of the disinfecting chemical dispensing unit, with the simple statement that some of the slots in the machine dispensed beer and whiskey.

A few days after this first post, I came to the realization that every day was offering a glimpse into a whole world that was both foreign, fascinating, and frightening at the same time, and I needed to start writing some of my experiences down before I forgot about them. I quickly found that my posts were being shared and re-posted, and I was starting to get feedback from distant friends, and eventually from some families of the residents that I am in contact with, about how much they appreciated hearing the stories I was sharing from the inside. It eventually became somewhat of a personal mission to ensure that I took this opportunity to present a different side of the COVID-19 experience than the one I was being bombarded with in the news.

I was surprised at how positive an experience my redeployment was, even though the risk of viral exposure was there. Every day, there were nuggets of life that were so different from what I would normally experience that it became a real joy to start looking for these shareable snippets and to match them to some of the images I have been capturing. When my

kids started rushing down to greet me at the end of my day to hear the stories I had to share with them, I knew I was experiencing something really special.

When the *Toronto Star* found my posts after a retired colleague had forwarded them to Jack Lakey as part of his regular Fixer column, my posts gained a little more traction. Following the publication of Jack's [interview](#), Andy Slavitt (ex-head acting manager of the US Centers for Medicare and Medicaid Services) re-tweeted the article about me, and I started receiving interest in my experiences more internationally.

By the way, Andy said I was a credit to my mother. Who can argue with one of the former heads of Obamacare?

Unfortunately, due to privacy concerns and photo release requirements we are working through, some of the stunning images I have taken can't be shared ... yet. But we are exploring some options through the executive team at the home and through some other partner divisions to put something together, so stay tuned.

What do you like best about your new role, and what will you miss about it when you return to IT?

I am really inspired by the team I am working with—my co-redeployees, Jane French from Toronto Museums, Laurie Belzak from Economic Development, and Amy Condon from Courts Services have been super, and bring such an interesting and diverse set of experiences to this pandemic response, making the days fly by quickly. We have all maintained a resident-centric approach to our redeployed experience, in spite of the work and environment being well out of our comfort zone of usual professional experience.

The management team, starting with Bahar Karimi, the Facility Administrator, has been amazing ... resident-focused, inspirational to staff, and

firecrackers for enforcement of professional nursing practices and infection prevention and control.

What I am really enjoying now is the opportunity to experience a privileged view on life and one that may very well be mine in a few years. I am seeing inside a world that, due to infection control procedures, not even family can witness first-hand.

Knowing that I can see these things and capture them in a variety of mediums, like images combined with narrative that can be shared with others, is a real privilege and something so deeply personal that it will be near impossible to recreate the same emotional intensity in my regular day job as a technology-based project manager.

As a front-line worker, what advice can you provide to others about dealing with the virus, both physically and emotionally?

Take care of yourself. Wash your hands. Do what you can to protect others.

You don't have to be symptomatic to be a carrier, and a little bit of discipline can help protect a fragile, vulnerable population.

Build a community of support around you where you can. This can start with simply saying "hi" to people, and not being a jerk in a long lineup at the grocery store.

If three months of restricted movement and self-imposed quarantine have shown anything, it is the importance of maintaining positive connections with the people around you, whenever and however you can.

Anything else you would like to share?

Cough and sneeze in your sleeves. Pay it forward and look out for the people around you. Did I say wash your hands already?

UC STAYING SOCIAL WITH ENGAGING ONLINE CONTENT



Kirk Sibbald
Freelance Writer



When they're not being chased by evil squirrels or having segments usurped by doppelganger imposters, Adrian Leckie and Kimiya Karbasy are working hard to keep University College connected.

In the months since campus was closed due to the COVID-19 pandemic, the Student Life employees have launched several [videos that are published weekly](#) on social media. Polished, informative, and engaging, the videos have gotten rave reviews and are helping UC maintain its close-knit community while remaining physically distant.

"The main motivation for these segments is that we really want to remind students that we're still here," explained Karbasy, UC's Residence Life Coordinator. "We can't see each other face-to-face, but we are still available to support them."

When the U of T shut down in mid-March, Karbasy and Leckie quickly joined forces and began working on plans to keep UC students connected to campus remotely. Their efforts have been particularly important for the approximately 70 international students who remain in residence at UC, unable to go home due to travel restrictions.

The UC Daily, published on Mondays, blends comedy with college updates and interviews with others from the UC community. Episode 7, for example, started with Karbasy being chased by "Bob," a nefarious squirrel in the UC quadrangle, before moving on

to information about Hart House launching a virtual art museum. Another begins with Leckie humorously walking in on his doppelganger talking to Karbasy before providing updates on journaling workshops and the fall semester.

Wellness Wednesdays, produced by Leckie, focuses on topics such as healthy eating, exercising, and mental health. Cooking with Kimiya videos are published every Tuesday and feature Karbasy making easy and healthy meals or snacks.

UC's student council also hosts Student Central on Thursdays, and Make Fridays Matter is an online study hub, meaning UC has something for students to tune into every weekday. The videos are hosted on Instagram and Facebook, and Leckie and Karbasy have also made a foray into Tik Tok with comical videos about studying and other college-related initiatives.

"We really wanted to have a different segment every day to meet the diverse needs of students," says Leckie, UC's Student Life Coordinator. "Whether they are enrolled in classes or not right now, there are still many ways for them to stay informed, to learn about wellness, and to stay connected with others."

After a few weeks of producing the videos on their own, Leckie and Karbasy wanted to get students more directly involved. They therefore developed a contest where students could submit their own Wellness Wednesdays or Cooking with Kimiya videos to win gift cards, which several students have already done.

Though the pandemic has completely changed the daily nature of their jobs, both Leckie and Karbasy have enjoyed the opportunity to try new things and dive more deeply into certain tasks that they did not have as much time for previously.

"When this pandemic happened, it kind of gave us this opportunity to put time into exploring what we can really do through social media," says Karbasy. "We've also gotten really great feedback from students, and administration and staff as well, and that's been really motivating for us."



With remote learning likely to continue for many in the fall semester, Leckie said he is looking forward to fine tuning and potentially expanding UC's virtual student programs. And despite the many challenges brought about by the pandemic, he is also appreciative of the many learning opportunities it has presented.

"Come fall, things like orientation are going to be great learning experiences for lots of professionals," he says. "And I think being able to continue finding those opportunities to keep students feeling connected is going to be really interesting and important."

[quarantine]



K Zimmer (BA 2020 UC)
Winner, Norma Epstein Award in Poetry 2020

[gloves]

Disposable latex gloves collect in corners
where sidewalk meets road—
five-pronged shocks of industrial blue
against concrete, colour half-buried
under desiccated leaves fragmenting
like papyrus from a forgotten time.

I count four gloves along Pendrith Lane,
fingers splayed like mangled feathers
of a dead bird whose unprotected flight
met with windshield, a transparent lie
promising flyable air.

These palm-sized blues punctuate
the sentences of streets,
turquoise commas
suspending the full stop
until the full story
unfolds.

Litter never looked more noble,
holding discarded memories of hands
held through untouchable times.

